

Sonoma County Continuum of Care
10-Year Homeless Action Plan
2014 Plan Update





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1 Executive Summary

The Sonoma County Continuum of Care (CoC) provides a “collective impact” infrastructure for planning and action towards ending homelessness in Sonoma County. Three U.S. Department of Housing and Urban Development (HUD) entitlement jurisdictions—the City of Santa Rosa, the City of Petaluma, and the “Urban County” (comprised of the unincorporated County and seven smaller cities)—jointly convened the CoC in 1997. The CoC functions as a “joint powers” collaborative, with the Sonoma County Community Development Commission (SCCDC) as lead agency.

Since the Sonoma County CoC adopted its 10-Year Homeless Action Plan in 2007, there have been enormous changes that led to this Plan Update: 1) the Great Recession reversed much of the progress made in the Plan’s first few years; 2) the depressed housing industry and loss of affordable housing funding sources rendered some of the Plan’s strategies obsolete; 3) the Homeless Emergency And Rapid Transition to Housing (HEARTH) Act of 2009 gave rise to the first Federal Strategic Plan to Prevent and End Homelessness; and 4) aligning the 10-Year Plan with the Upstream and Health Action “collective impact” efforts had become a high priority.

HOMELESSNESS IN SONOMA COUNTY

Homelessness is a dire and growing problem in Sonoma County: 4,280 homeless people were counted on a single night in January 2013, and about 9,749 residents experience homelessness every year—2% of Sonoma County’s overall population. This yields a regional homelessness rate that is almost four times the national rate. The vast majority of local homeless persons are single adults, but there are beds for fewer than 1 in 4.

Currently, Sonoma County’s homeless population has been homeless longer and is more medically compromised than in the past. One-third of the homeless population is under the age of 25, and despite significant investments in the past 7 years, the number of homeless veterans remains high.

Sonoma County’s high rate of homelessness has emerged against the background of a severe shortage of affordable housing. By every measure, Sonoma County is one of the nation’s least affordable housing markets. Recent trends have created new obstacles to homeless persons who seek to re-enter housing.

HOUSING + HEALTH + INCOME: KEY GOALS

This Plan Update challenges our community to ensure that all Sonoma County residents have an opportunity to access the building blocks that make up the Plan’s key goals: Housing + Health + Income.

1. HOUSING: Increase permanent affordable housing to meet the need—4,128 units

Ending homelessness in Sonoma County requires 1,015 affordable housing units for extremely low income households; Rapid Re-Housing assistance for 959 households; and 2,154 units of Permanent Supportive Housing. Aligning with national research and practice, the CoC prefers a “Housing First” approach that eliminates barriers or conditions to housing, while providing services to stabilize homeless people.

2. HEALTH: Ensure access to integrated health care

Ending homelessness requires enrolling the vast majority of homeless persons in health coverage and establishing healthcare homes. Partnerships with clinics and County Departments of Health Services and Human Services are essential to ensure that homeless persons may access primary and behavioral health care.

3. INCOME: Increase incomes

Ending homelessness will require a two-pronged income initiative to address the vast majority of homeless adults who have no income. The **Work Readiness Initiative** will develop pathways to earned income for approximately half of homeless adults who can work. This collaborative Initiative will expand pre-employment soft-skills preparation and training in homeless services settings, with the goal of connecting participants to existing County services and employment. Half of all homeless adults are disabled: a **Disability Income Initiative** will convene the many partners providing benefits advocacy, to create the necessary capacity to garner them benefits. This Initiative will use national best practices to prepare the strongest possible initial applications, increasing successful first-time claims from 15% to well over half of applications.

CREATING THE CONDITIONS TO END HOMELESSNESS

This Plan Update notes policy changes that could more quickly expand affordable housing, such as preferences or quotas in Housing Authority policies; public financing strategies; and converting existing large facilities to housing. It also summarizes activities needed to build nonprofit agency capacity to manage a much larger housing inventory. It focuses on evidence-informed, cost-effective interventions; putting housing best practices onto the Upstream Portfolio; and utilizing new opportunities presented by the Affordable Care Act.

Sonoma County's Coordinated Intake Project will soon launch a "no-wrong-door," single point of entry that will serve the most vulnerable people first. Services will be targeted more accurately to hasten the resolution of housing crises. State of the art system entry will require expansion of street outreach and homeless prevention services—and engaging institutional partners to divert people from homelessness on exit.

This Plan Update focuses on what is needed to *end* homelessness, not manage it. It proposes a \$557.4 million investment in housing construction (including less costly conversions of existing large facilities), requiring a local construction investment of \$167.2 million. Housing operations, rental subsidies and the income initiatives will require another \$23 million annually. Appendices include detailed descriptions of how housing needs were estimated, housing cost estimates with resource development options, and a listing of proposed action steps.

Importantly, despite the great need, this Plan Update makes no projection of need for short-term emergency housing, winter shelter or other emergency efforts. Rather, it proposes evaluation of the many creative and promising emergency health strategies and homelessness prevention models, to identify the most cost-effective set of short-term interventions, in the context of the need for permanent affordable housing.

If a full commitment can be made to creating the necessary housing and services to end homelessness, community leaders will have the satisfaction of moving beyond expensive emergency measures. They will have the pleasure of knowing they made a real impact on an urgent issue that challenges the dignity of us all.



2 Introduction

THE SONOMA COUNTY CONTINUUM OF CARE

The Sonoma County Continuum of Care (CoC) is a public/private partnership that brings together local government, service providers, and community activists to develop collaborative strategies for reducing homelessness. The CoC provides a “collective impact” infrastructure for collaborative planning and action to end homelessness.

The term "Continuum of Care" also refers to a funding stream from the federal Department of Housing and Urban Development (HUD), dedicated to services and housing to end homelessness. The local CoC planning process is required in order to access those funds. While small in terms of what is required to end homelessness in Sonoma County, the Continuum of Care funding stream reliably brings about \$2.6 million annually to the county to address homelessness. Local Continua of Care are designated by federal and state funders as **the central planning body for ending homelessness**.

The three HUD entitlement jurisdictions in Sonoma County (the “Urban County,” the City of Santa Rosa, and the City of Petaluma) joined together informally in 1997 to create the Sonoma County Continuum of Care, with the Sonoma County Community Development Commission (SCCDC) lending staff for administrative support. In 2003, these partners began jointly funding a contractor to coordinate the growing CoC planning process and produce the required collaborative funding application. The Continuum of Care now engages more than 160 people from over 50 organizations in collaborative planning and project development, hosted by the SCCDC. Increasing local and federal reliance on the CoC to lead policy development around homelessness (not to mention the need to retain competitiveness for funding) have required increased staffing; therefore, the Coordinator function was recently combined with other funds to create a regular position housed within SCCDC, dedicated largely to the Continuum of Care.

SCCDC is named as the CoC’s lead agency for purposes of a collaborative application, but the CoC functions as a “joint powers collaborative” with funding from all three jurisdictions, and SCCDC contributing staffing, data management, and other services. SCCDC also receives direct HUD funding for several CoC Rental Assistance projects operated by the Sonoma County Housing Authority, a small grant to support CoC Coordination, and pass-through funding for a Coordinated Intake system for homeless services, to be launched October 2014.

Recent changes to the CoC funding stream have required this collaborative to become more formalized, for example to adopt a written charter. Under this charter, the CoC is governed by a 15-member Continuum of Care

Board with representatives from the three HUD entitlement jurisdictions, private funders of homeless services, advocates for homeless people, consumers of homeless services, County agencies serving the homeless population, non-profit service agencies serving the homeless population, and other interested parties.

THE 10-YEAR HOMELESS ACTION PLAN

Spurred by national planning models and the drive to remain competitive for CoC funds, the Sonoma County CoC adopted its first 10-Year Homeless Action Plan in early 2007. The Plan was subsequently endorsed by the Sonoma County Board of Supervisors. Over the ensuing 5 years, the CoC developed much improved data on the extent and variety of local homelessness. Some of the Plan's efforts were enormously successful, such as the vigorous effort to document and end veteran homelessness that led to the launch of Sonoma County Vet Connect (2008), hundreds of new housing units dedicated to homeless veterans, and the Sonoma County Housing Veterans Campaign launched in 2013.ⁱ Sonoma County's accomplishments in documenting homeless youth now serve as a national model. Each year the CoC Coordinator catalogued and reported on progress towards 10-Year Plan goals.ⁱⁱ

Numerous factors led to a decision to review and update the 10-Year Plan in FY 2013-14:

- The extended economic impacts of the deepest economic downturn since the Great Depression reversed much of the progress that had been made since 2007. By 2011, Sonoma County's state-of-the-art Homeless Count confirmed that homelessness had grown by more than 25%: more than 4,500 people were homeless in Sonoma County on any given night.
- The extended slump in the housing industry and the loss of a key affordable housing funding source through the dismantling of Redevelopment agencies, together rendered obsolete some of the initial 10-Year Plan's key strategies, and created new challenges to addressing increased homelessness.
- Passage of the Homeless Emergency And Rapid Transition to Housing (HEARTH) Act of 2009 gave rise to the first Federal Strategic Plan to Prevent and End Homelessness, titled *Opening Doors*, in 2010. This plan promulgated national best practices such as the Housing First and Rapid Re-Housing models, as well as the benefits of a Coordinated Intake system. The HEARTH Act made new funding available for local communities to build Rapid Re-Housing programs and a vast amount of capacity building, policy and program development materials became available from national agencies. To prepare CoCs for the new requirements of HEARTH, HUD encouraged local communities to revise their 10-Year Plans to align with *Opening Doors*.
- The idea of "collective impact" came to Sonoma County through Health Action, a framework which establishes the vision and plans to be the healthiest county in the state, focusing on fundamental drivers of health, including economic security and educational attainment. The County's new Upstream Investments Initiative aimed at supporting evidence-informed and prevention-focused interventions to meet the County's strategic goals. These efforts led the CoC's leadership to acknowledge that homeless services had operated in a silo too long. The evidence-based collective impact approach could benefit homeless services, and aligning with Upstream and Health Action emerged as a high priority for the CoC.

DEVELOPMENT OF THIS 10-YEAR PLAN UPDATE

The 2007 Homeless Action Plan was driven by the expertise of providers—with all the strengths and weaknesses of that approach. At that time the CoC did not yet have reliable data to drive the Plan; indeed, development of state-of-the-art Homeless Counts and a Homeless Management Information System (HMIS) were key Plan goals and one of the areas in which the CoC performed most successfully against its goals. The 2014 Plan Update builds on this success.

In May 2013, the CoC convened a group of respected leaders to review the 2013 Homeless Count data and structure the Plan Update. These included:

- Community Foundation Sonoma County: Robert Judd (Vice President for Programs, now retired)
- Sonoma County Community Development Commission: Mark Krug (Community Development Manager)
- Sonoma County Department of Health Services: Peter Rumble (then Division Director for Health Policy, Planning and Evaluation) and Jen Lewis (Health Action Program Manager)
- Sonoma County Human Services Department: Karen Fies (Assistant Director)

The 10-Year Plan Update was staffed by CoC Coordinator, Jenny Abramson and HMIS Coordinator, Teddie Pierce.

This multi-agency planning group met approximately monthly between May and December 2013 to evaluate the needs of the homeless population per the 2013 Homeless Count, and to shape the structure, messages, and key goals and strategies of the Plan. Once this leadership group established the structure and key goals, public input was solicited over a 10-week period from October 1 through December 10, 2013. Input was gathered from approximately 70 individuals in meetings, interviews, and via on-line surveys. The 10-Year Plan leadership reconvened in December to structure the enormous amount of material received into a streamlined and prioritized report.

Work on the 10-Year Plan Update was interrupted by winter emergency activities and the implementation of the 100,000 Homes Campaign's Vulnerability Registry in April 2014. These activities, and the needs identified by advocates and elected officials, also informed the final drafting of the 10-Year Plan Update.

Communities across the country have made enormous inroads towards actually *ending* homelessness, and the Sonoma County CoC posits that it must be possible to reverse the trend, even in one of the nation's most expensive housing markets. This Plan challenges our community to ensure Sonoma County's least fortunate have an opportunity to access the key building blocks that make up this Plan's goals: **Housing + Health + Income**. If a full commitment can be made to creating the necessary housing and services to end homelessness, community leaders will have the satisfaction of moving beyond expensive emergency measures. They will have the pleasure of knowing they have made a real difference on an urgent local issue that challenges the dignity of us all.



3 Homelessness in Sonoma County

4,280 homeless people were counted on a single night in January 2013, all of them meeting the narrowest federal definition of homelessness — sleeping in a place not meant for human habitation, or in emergency or transitional housing for homeless people. Based on the length of time and number of times that randomly selected respondents had been homeless, it is estimated that 9,749 residents experience homelessness over the course of a year—2% of Sonoma County’s overall population of 484,102 people.ⁱⁱⁱ This yields a regional rate of homelessness per 1,000 residents (7.7) that is almost four times the national rate.

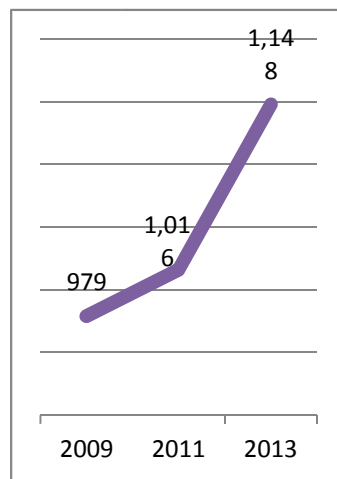
- ✦ **The great majority (83%) of Sonoma County’s homeless population is comprised of single adults.** On any given night, family households represent 11% of the homeless population, and unaccompanied minors account for 6%.
- ✦ **77% of the homeless population is unsheltered.** Almost all homeless families were sheltered on the night of the last point-in-time Count, but 84% of homeless single adults, and 98% of homeless teenagers under the age of 18, had nowhere to stay.
- ✦ In 2013, more than half of homeless survey respondents had been **homeless for more than a year**. In 2014, surveys conducted among *unsheltered* homeless persons revealed that two-thirds had been homeless for more than 2 years; nearly 1 in 4 had been homeless for more than a year. Almost half of these were unknown to the local homeless system of care.
- ✦ About **2/3 of survey respondents reported major health conditions**.

Homeless services providers must address many challenging special needs, including multiple disabilities, multiple generations of homelessness, homeless seniors, runaway youth, and returning veterans.

CHRONICALLY HOMELESS PERSONS

Chronically homeless people are severely underserved in Sonoma County.

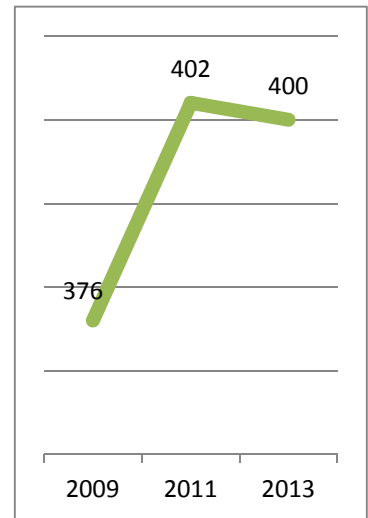
- ✦ 1,148 chronically homeless persons were found: adults who have disabilities and have been homeless for more than a year, or have experienced at least four episodes of homelessness in the past three years. **This number has risen with each homeless census since 2009.**
- ✦ **Chronically homeless people make up nearly one-third of the unsheltered population.** Only 1 out of every 6 reports staying in emergency shelters.



HOMELESS VETERANS

400 veterans were found during the 2013 Count. This number has remained high despite well over 200 Veteran-dedicated beds added to our system since 2007. Veterans are overwhelmingly unsheltered: 4 out of every 5 homeless veterans are living outside.

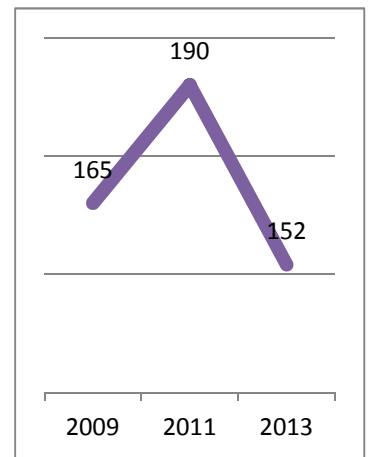
- ✦ In 2013, there was a significant increase in the number of young, recently returned veterans.
- ✦ More than half of homeless veterans were chronically homeless (210 persons).



FAMILIES WITH CHILDREN

The number of homeless families with children dropped 20% from 2011 and below the number found in 2009, due to diversion of families from shelter waitlists, and new Rapid Re-Housing resources.

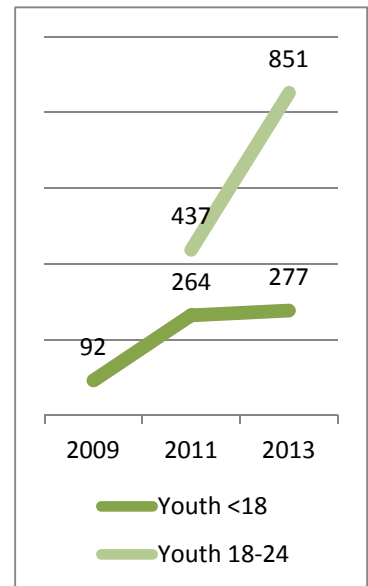
The 152 families found in 2013 had 451 family members, and were 89% sheltered. Overall, Hispanics are under-represented in Sonoma County’s homeless population, but 40% of the homeless families served at the county’s main family shelter are Hispanic.

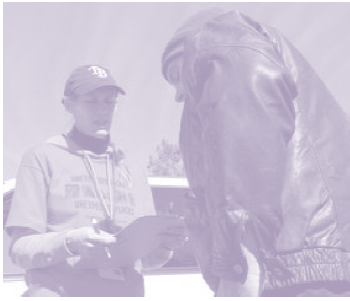


YOUTH

One-third of those counted were **under the age of 25**.

- ✦ Partners in the Youth Count have improved their methodology and expanded the territory covered each year since 2009. The increases shown here are due to a change in federal methodology for counting homeless youth, rather than more numerous homeless youth. (Had all the current methods used to count youth ages 18-24 been used in 2011, the number would have been significantly higher in 2011 than in 2013.)

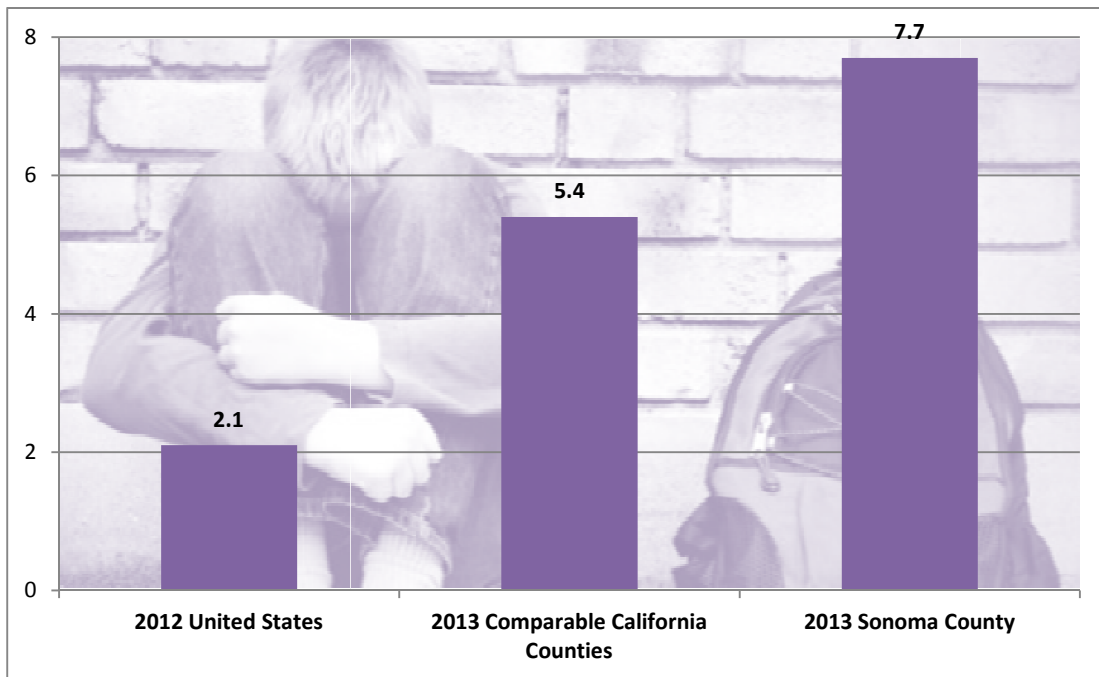




4 Maps and Data From the 2013 Sonoma County Homeless Count

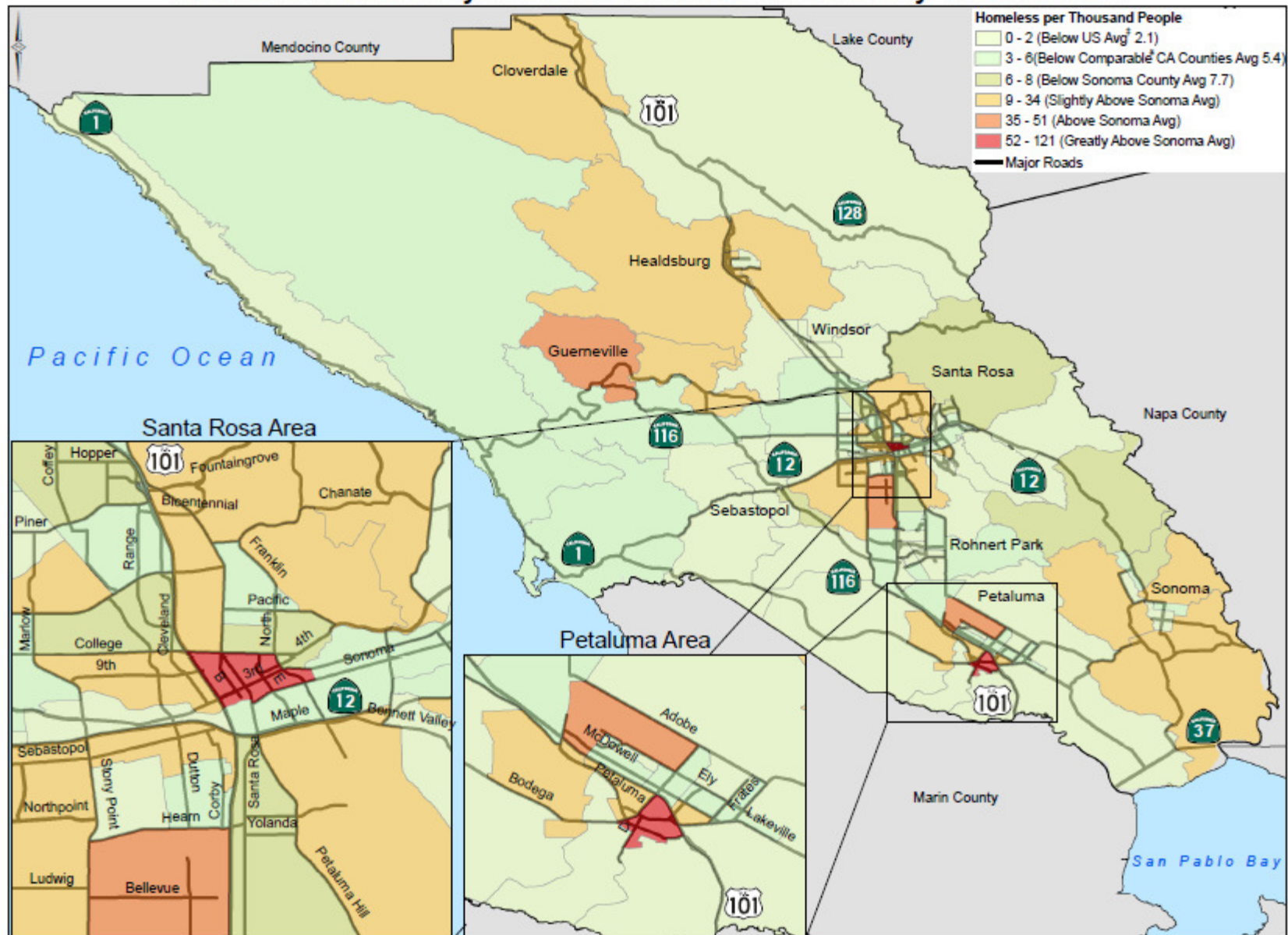
The maps on the following pages show where homeless people were living during the 2013 Count. The Sonoma County rate of homelessness (7.7 per 1,000 residents) is both well above the US average and **above the average for California counties using the same count methodology** (5.4 per 1,000). The map on page 10 shows all homeless persons (both sheltered and unsheltered), therefore the “hot spots” often indicate shelter locations. The map on page 11 shows the distribution of the *unsheltered* population. The data illustrated in these maps is consistent with the *Portrait of Sonoma County* needs assessment, released in May 2014, which includes in-depth analyses of disparities in health, education and income across neighborhoods and along the lines of race, ethnicity, and gender in Sonoma County.^{iv}

As the map of the total homeless population (both sheltered and unsheltered) shows, there is a concentration of homeless persons in communities with shelters. The map of unsheltered persons indicates higher concentrations of unsheltered persons not just in communities with services, but also in unincorporated areas on the *outskirts* of Healdsburg, Petaluma, and Santa Rosa—and in the lower Russian River area. These outlying areas may be preferred for people living outside due to privacy concerns or less law enforcement.



Data Sources: 2013 Sonoma County Homeless Point-In-Time Census & Survey, National Alliance to End Homelessness “The State of Homelessness in America 2012,” Community Development Commission Ad Hoc Report “Comparative CA PIT Counts 2012,” 2007-2012 Census ACS 5-year estimates.

2013 Sonoma County Homeless Count: Homeless by Census Tract

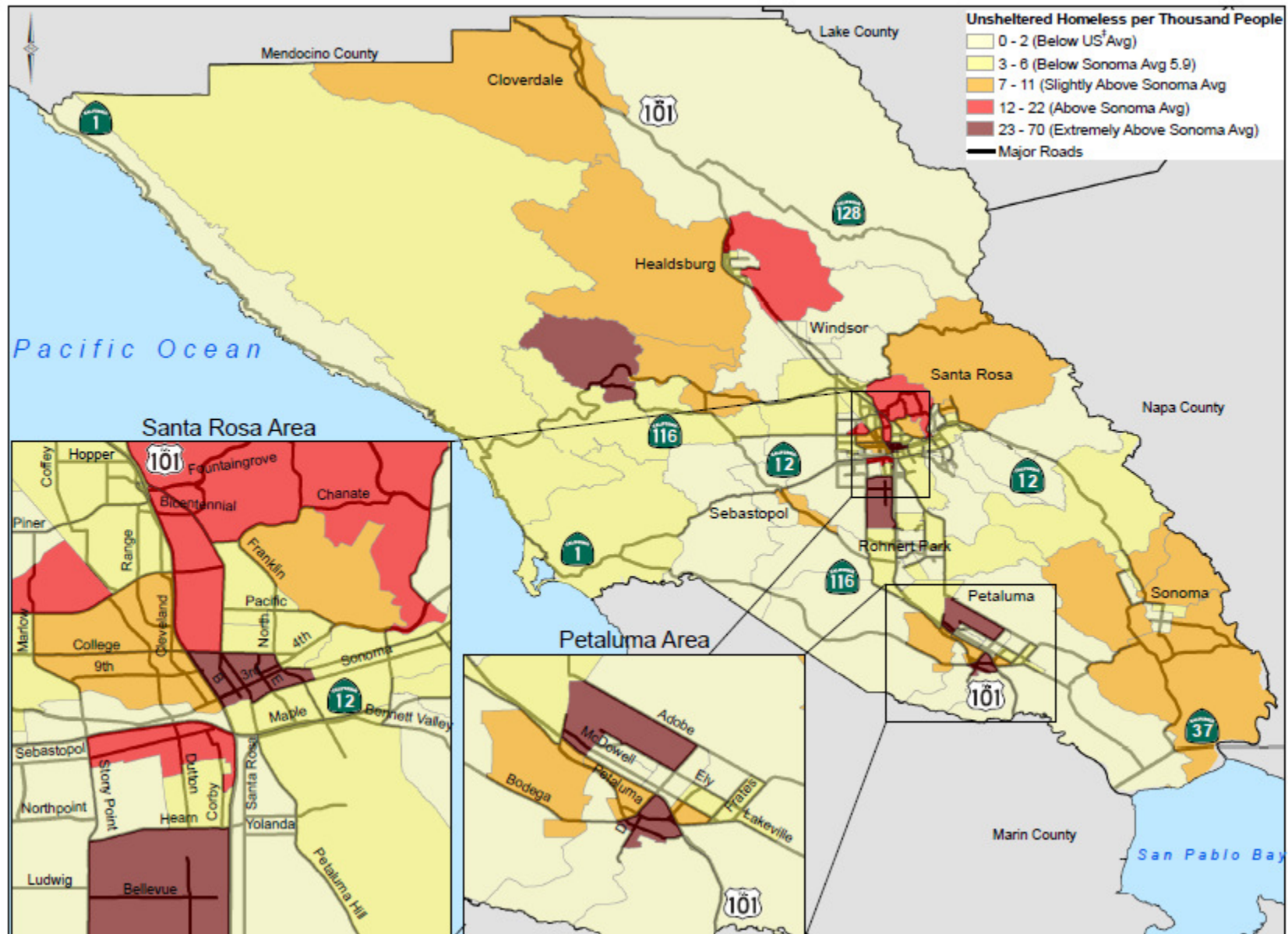


Created by George Malachowski, HSD, 707.565.5815, 3/4/13. Homeless Data from 2013 Sonoma County Homeless Count. Population data from 2007-12 ACS 5-year estimates.

‡ US average from the National Alliance to End Homelessness, "The State of Homelessness in America 2012," www.endhomelessness.org.

*Comparable counties used similar count methodologies and include: Santa Clara, San Francisco, Monterey, San Benito, Santa Cruz, Anaheim, Orange, and Riverside counties.

2013 Sonoma County Homeless Count: Unsheltered Homeless by Census Tract



Created by George Malachowski, HSD, 707.565.5815, 3/4/14. Homeless Data from 2013 Sonoma County Homeless Count. Population data from 2007-12 ACS 5-year estimates, available at www.census.gov. † US average from the National Alliance to End Homelessness, "The State of Homelessness in America 2012," www.endhomelessness.org.



5 Continuing Challenges & Encouraging Trends

Over 35 years, the nonprofit housing and service agencies, the County departments and agencies delivering health care, social services and housing, the cities of Santa Rosa and Petaluma, and increasingly other cities, have built a homeless assistance network comprised of over 50 housing and service programs. In 2013, Sonoma County providers helped 751 people to exit homelessness to permanent housing, and the point-in-time number of homeless families with children dropped by 20% to 152 families (from 190 in 2011). According to the 2014 Homeless Housing Inventory (submitted annually to HUD), Sonoma County homeless service providers currently offer:

	Single Adults	Families	Unaccompanied Minors
Emergency Shelter	355 beds	43 units	6 beds
Transitional Housing	189 beds	61 units	
Permanent Housing:	542 units	177 units	
Rapid Re-Housing (time-limited supports)	30 units	67 units	
Permanent Supportive Housing (services for as long as needed)	512 units	110 units	

Those homeless persons who are able to access homeless housing receive effective services such as case management; health, mental health and substance abuse treatment; life skills training; transportation; child care; employment services; and many other resources including placement in permanent housing.

But the situation is dire: The system-wide coordination that might prevent more than 300 people from becoming homeless every month does not yet exist. Those on shelter waitlists must wait at least 6 weeks to get in. They must call daily to retain their place on the waiting list, leaving many homeless persons with disabilities living outside the longest.*

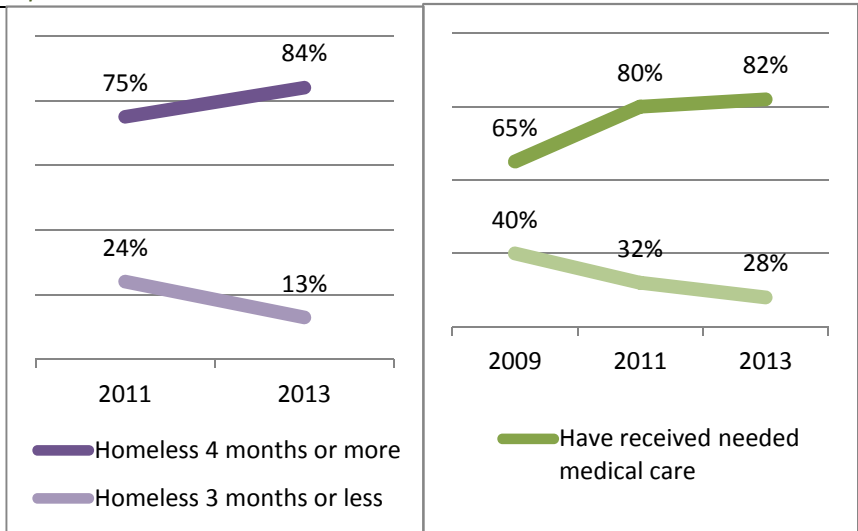
A large population of disabled single adults is living outside; five times the size of the sheltered population. The vast majority of homeless teens are living outside as well, since beds for unaccompanied minors are only adequate for about 2% of the homeless teen population. Once housed through the existing system of care, more than 20% of single adults and 6% of families with children, return to homelessness within a year.

The homeless population found in 2013 has been homeless longer and is more medically compromised than in past studies. The number of people who are newly homeless (up to 90 days) has dropped, but the number of people who have been homeless 4 months or more has increased.

* Rates of new homelessness come from the 2013 homeless survey; these are corroborated by the number of new records of clients seeking services, in the local Homeless Management Information System. The length of shelter waiting lists is in part due to regulations requiring shelters to admit people on a “first-come, first served” basis. The appearance of fairness is deceptive, as requirements to retain one’s place on a waiting list require a high level of functionality, and therefore the shelter population is skewed to the persons who need shelters the least.

10-Year Homeless Action Plan—2014 Plan Update

The percentage of homeless persons who use hospital Emergency Rooms as a usual source of care has dropped steadily since 2009. The percentage who have been able to receive needed medical care has increased: 51% now report receiving health care at community clinics. But 28% still use the Emergency Room for usual care, and 35% have been to an Emergency Room in the past 3 months.

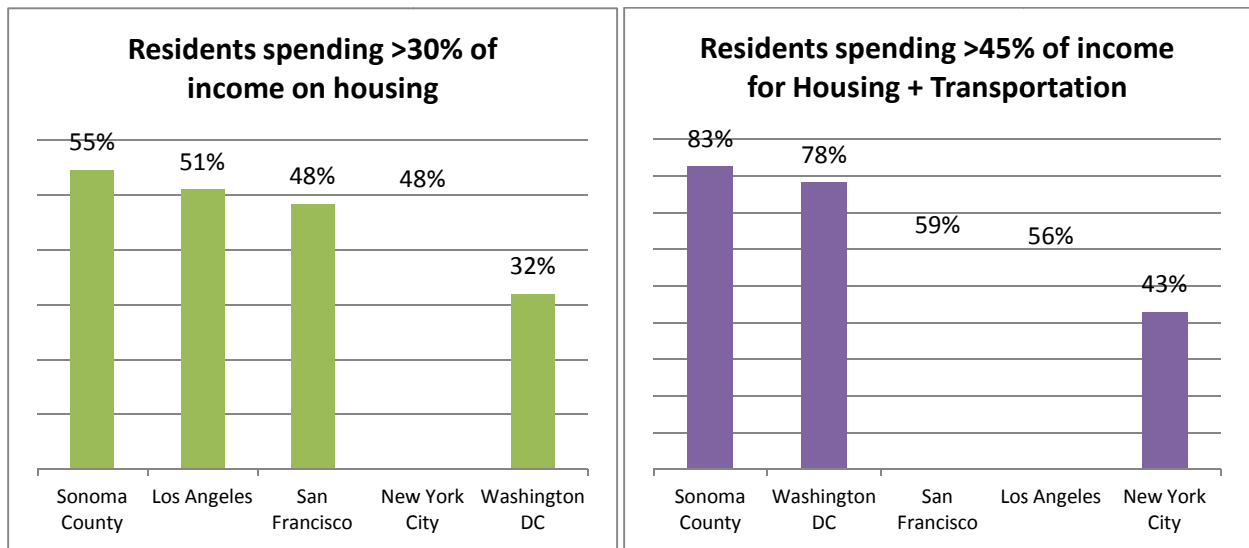




6 Major Concerns That Inform the 10-Year Plan

☀ Sonoma County has a severe shortage of affordable housing.

More than half of Sonoma County households spend more than 30% of their income on housing—the national benchmark of housing affordability. Nearly 83% spend more than 45% of their income on housing and transportation combined, a new affordability measure promulgated by the Center for Neighborhood Technology.^v These figures confirm that Sonoma County is one of the nation’s least affordable housing markets:



Spending on Housing and Transportation in High-Cost Markets, 2011 (<http://htaindex.cnt.org>).

A lack of high-density housing, limited public transportation, flood zones, steep slopes, environmental protection, neighborhood concerns, cost, and the decimation of funding sources for affordable housing such as the dismantling of Redevelopment, all present barriers to developing new affordable housing. In this environment of scarce resources and low vacancy, the challenges of expanding permanent housing options for homeless people, necessitate **evidence-informed strategies** that deliver the needed outcomes for the least cost.

The shortage of affordable housing creates a bottleneck: homeless persons living in shelters who are ready to move into their own housing are forced to stay in the shelter because they cannot find vacant housing they can afford. As long as they remain in a shelter they no longer require, they use space and services that others desperately need, but cannot access. This creates a deceptive appearance that more shelter beds are needed, when in fact **the need is for affordable housing**.

☀ Sonoma County’s current homeless population has been homeless longer, and is more medically compromised, than in the past.

Two-thirds of the homeless population experienced one or more serious medical conditions, and/or conditions that are considered disabling by federal agencies. Many report the “vulnerability” risk factors that most commonly lead to death on the street (homeless for more than 6 months and experiencing a range of serious medical conditions—or simply being over the age of 60). This medically compromised population accounts for untold expense in the County Jail (at \$340 per booking) and hospital emergency rooms (at about \$4,500 per visit), compared to the cost of permanent housing (\$31 per night).^{vi} There is a great unmet need for integrated health care, including substance abuse and mental health treatment, plus ongoing services in permanent supportive housing.

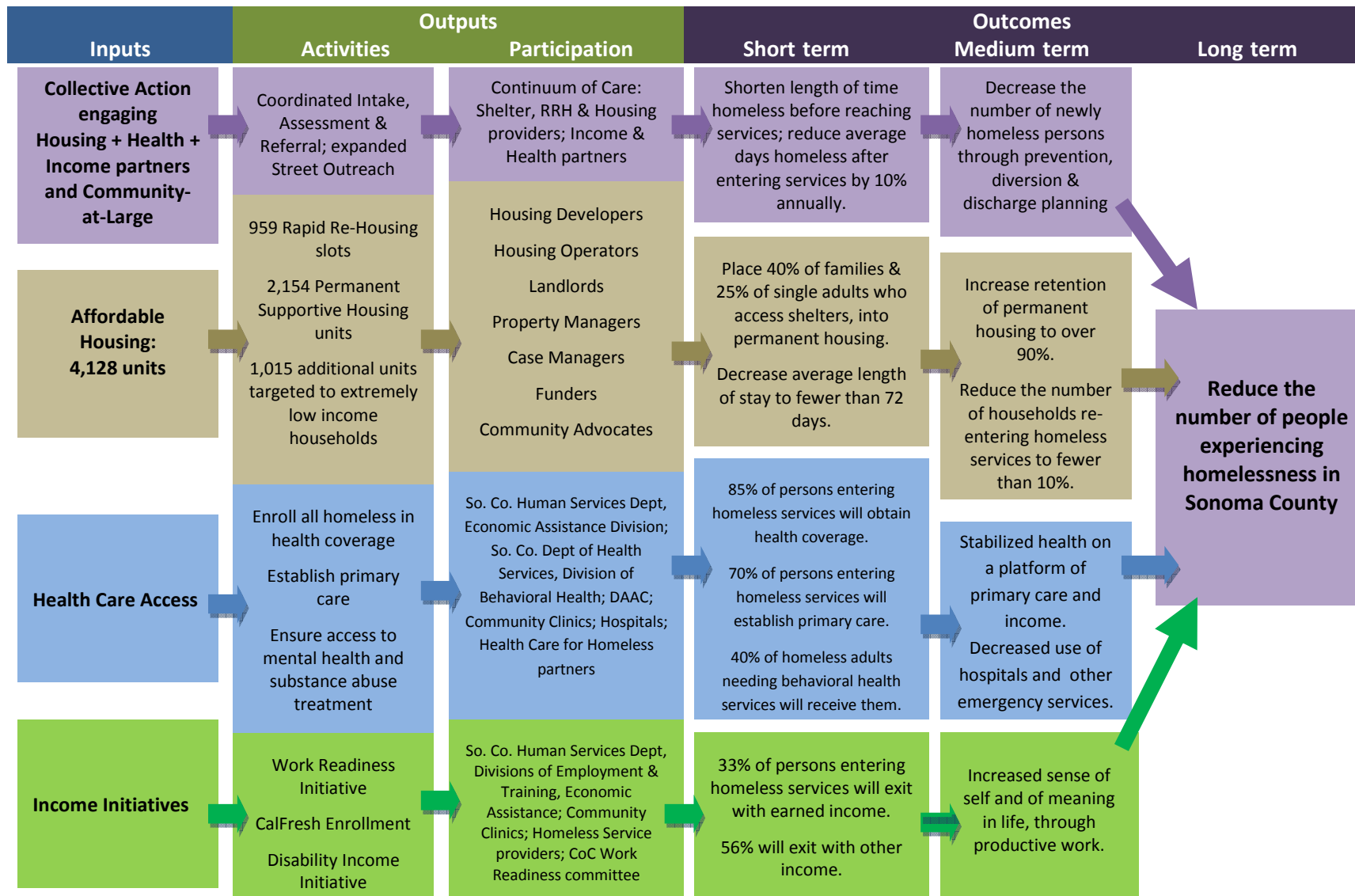
☀ One-third of the homeless population is under the age of 25.

These include unaccompanied teens, youth ages 18-24, young parents (18-24), and children who are homeless with their parents—more than 1,400 persons under the age of 25. Homeless youth are more multi-ethnic than the overall homeless population and more often identify as gay, lesbian or bisexual. 20% have been in foster care; 13% had homeless parents. Nearly 40% have not finished high school.

☀ The number of homeless veterans remains high.

400 homeless veterans were found in 2013, nearly the same number as in 2011—likely due to an increased number of newly returned veterans, and a need for more extensive outreach to the veterans who have lived outside the longest. Over half of the homeless veterans had the combination of disabilities and lengthy periods of homelessness that define chronic homelessness; the vast majority is unsheltered.

7 Logic Model



Until needed housing exists, prioritize those with most vulnerable health for shelter/permanent housing with a Housing First approach. **External Factors** include success of capacity expansion, and funding availability: \$167.2 million local investment needed to leverage balance of construction funding; \$23 million annually needed for housing operations, rental assistance, work readiness & benefits advocacy initiatives. Consider policies to facilitate housing creation during the lag to site/develop/build housing.



8 Three Key Strategies: Housing + Health + Income

Consistent with Sonoma County’s commitment to upstream interventions, all county health and social service programs should be engaged in a **common preventive framework**. Upstream principles apply at every point in the spectrum from housing crisis to housing stability:

- ✦ Diverting those at imminent risk of homelessness from entering shelters—including data-informed targeting and bundling of services to stop the flow of new people into homelessness;
- ✦ Intervening to resolve homeless episodes before people become acculturated to living without a roof; and
- ✦ Avoiding high criminal justice and hospital costs, and preventable homeless deaths, with appropriate housing and services.

Homelessness is a complex issue involving loss of income, loss of housing, and loss of health. Ending homelessness is equally complex, requiring three key and interconnected strategies:

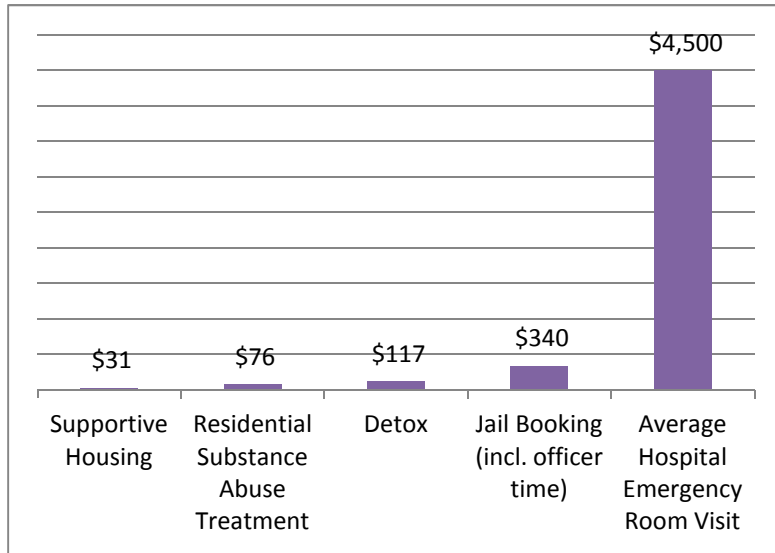
1. INCREASE PERMANENT AFFORDABLE HOUSING TO MEET THE NEED

Housing is an upstream investment that is crucial to health, healing and stabilization, endorsed by the County of Sonoma through the Health Action goal of “designing & promoting affordable, accessible, safe and healthy housing.” In alignment with national research and practice, the preferred strategy is a “Housing First” approach that quickens the pace of placement and eliminates any barriers or conditions to housing while providing the critical services needed to stabilize homeless people in housing.^{vii}

Ending homelessness in Sonoma County will require 4,128 permanent housing units.*

- ✦ **1,015 affordable housing units targeted to people with extremely low incomes** (below 30% of the Area Median Income). These will serve the highest-functioning population of homeless persons who require little support to obtain or retain housing.
- ✦ **Rapid Re-Housing (RRH) assistance for 959 households:** RRH provides flexible, time-limited rental assistance and case management in existing rental housing, cost-effectively serving persons with few-to-moderate barriers to housing. RRH ends homelessness more quickly, with more long-term stability, and at a lower cost than the familiar shelter-and-transitional-housing route. At the federal level, it is the preferred strategy to end family homelessness, and is being used nationwide as the preferred first intervention.

* A detailed explanation of housing need calculations appears in Appendix A.



Cost Per Person Per Day, Sonoma County 2014.

☀ **2,154 units of Permanent Supportive Housing (PSH):** Provided either in existing rental housing or in dedicated facilities, permanent supportive housing is an evidence-based practice that is crucial to ending chronic homelessness and per day, costs half the per day costs of residential substance abuse treatment, less than 1/10th the per day cost of jail booking, and well under 1/100th the per day cost of an emergency room visit (see chart at left).

While Rapid Re-Housing depends on existing rental housing, affordable housing units and permanent supportive housing can be delivered in a range of ways: rental assistance, master-leasing of existing housing, new housing construction, or conversion of existing facilities such as hospitals, motels or nursing homes.

Approximately 270 units should be targeted to youth under age 25. These units must offer age-appropriate services addressing the developmental needs of both unaccompanied minors (ages 12-17) and transition-aged youth (18-24). The 68 beds planned at SAY’s Dream Center will make a big contribution to addressing this need, but will address only one-quarter of the youth-specific need.

Expanding homeless-dedicated housing will require ongoing public education. Community members need to learn that strategies exist to successfully reduce homelessness. This will increase acceptance and support for these strategies. Public and private funders must be convinced to tackle the necessary capacity building. The community at large, landlords, and property managers must be engaged in a broad effort to build a healthy community in which residents have adequate housing and the resources to make ends meet.

2. ENSURE ACCESS TO INTEGRATED HEALTH CARE

A medical home and integrated health care is essential to stabilizing in housing, as housing is essential to health. The advent of the Affordable Care Act, Medi-Cal expansion, and “Parity” (the inclusion as essential covered benefits) of mental health and substance abuse treatment offer a fundamental opportunity to address health needs that constitute one of the primary causes of homelessness and an enormous challenge to the public health. Access to health care is a critical component to increasing income and achieving stable housing.

Twenty-four percent (24%) of respondents to the Vulnerability Surveys conducted in April 2014, indicated they had no health care coverage. Many of those who had been transitioned to Medi-Cal from the County Medical Services Program were unaware that this change had occurred. The Continuum of Care and its homeless service agencies must partner ever more closely with Federally Qualified Health Clinics and the County Departments of Health Services and Human Services to **enroll 100% of homeless persons in health coverage, establish primary**

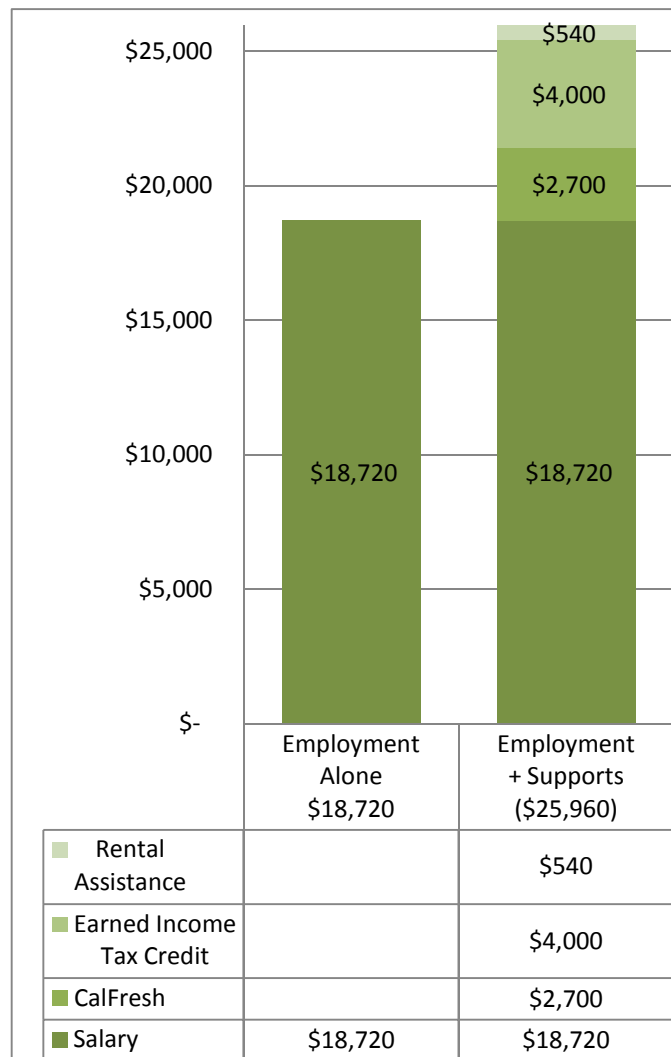
care, and ensure access to mental health and substance abuse treatment. This will also address Health Action goals of coordinating patient care across the continuum of health care and community-based services, and ensuring that each person and family is engaged as partners in their care. Partnership with local healthcare providers is essential to ensure that homeless persons have access to a multitude of health services, including ongoing primary care and complex behavioral health treatment.

In addition, it is critical to build agency capacity to obtain Medi-Cal reimbursement for case management and other services needed to house vulnerable people in the community, through Home and Community Based Services (HCBS) waivers and State Plan Amendments such as the Community First Choice and the Medicaid Rehabilitation Options. Expansion of provider capacity to utilize these funding options is a critical first step.

3. INCREASE INCOMES

Whether from benefits or employment, increasing income is a crucial component to housing stability. More than 80% of homeless adults report they are not working; “not enough income” is cited by over 60% of homeless adults as their primary barrier to getting permanent housing. While more than half of homeless adults report eligible disabilities, fewer than 15% receive disability income. The following strategies address Health Action, Economic Wellness and Cradle to Career goals of promoting financial stability and independence, and supporting education, employment & employment training for special needs populations (including disabled, foster youth, probation, and other disadvantaged persons):

Currently, a Sonoma County resident earning minimum wage would have to work 79 hours a week to afford a studio apartment.^{viii} The planned increases to California’s minimum wage are encouraging: within a few years single adults working full time at minimum wage might be able to support themselves in rental housing. Homeless services providers have demonstrated that **bundling a range of benefits, financial education and asset building** can make the difference between unsustainable poverty at minimum wage, and economic self-sufficiency.



Minimum Wage + Bundled Supports = Self-Sufficiency

- ✿ A system-wide **Work Readiness Initiative** is needed to develop pathways to earned income for approximately half of homeless adults who can work. Building on the above understanding of bundled benefits and services, homeless services providers have developed an equation to help work-ready single adults to exit homelessness:

Full-time work at 2014 minimum wage (\$18,720) + CalFresh =
independent living in *shared* rental housing.

Once a single adult is working full-time and receiving key benefits such as CalFresh, he can exit homelessness to shared rental housing. At the \$9/hour minimum wage, an adult working full-time would be able to afford approximately \$5,616 in rent annually (30% of income), lowering the overall investment needed to end homelessness. The National Alliance to End Homelessness has published promising strategies for focusing the entire Continuum of Care, and individual program services and program staff, on prioritizing employment and reinforcing a culture of work.^{ix}

To implement this strategy, the Continuum of Care will partner with the Sonoma County Human Services Department's JobLink and other existing employment development efforts. However, many long-term homeless persons have inconsistent work histories, if they indeed ever had employable skills—and indeed, if they ever learned how to present themselves in a job interview. Thus the Work Readiness Initiative will require a collaborative effort that *expands pre-employment training and placements in homeless services settings* and which connects participants with JobLink's myriad offerings.

This income strategy will additionally build on Sonoma County Human Services Department's CalFresh Outreach efforts of the last several years. As a result of those efforts, 75% of those receiving government assistance now receive Cal Fresh, and 78% of homeless people surveyed now report getting enough to eat (compared to 51% in 2009).^x Continuing CalFresh Outreach to homeless persons will not only be crucial to their health, but will also enable homeless persons to *establish the income needed to exit homelessness*.

- ✿ The **SSI/SSDI Outreach, Access & Recovery (SOAR)** process for disability qualification and enrollment is a successful SAMHSA-supported evidence based approach to establishing income for homeless persons with disabilities.^{xi} When claimants file on their own, and scarce resources are invested primarily in appeals, only 10%-15% of SSI applications are successful the first time.

The SOAR method focuses on preparing the strongest possible case in the *initial* application, with the case manager acting as the client's Authorized Representative. Nationally with the SOAR method, **65% of applications have been successful on initial application**. The time from initial application has been reduced from 9-12 months, to 60-90 days.

Currently such methods are used successfully, but only by a small minority of benefits advocates in Sonoma County. Three local staff were trained as SOAR Trainers in 2009 and introduced this method to at least 25 case workers throughout the county. Refresher courses have been given, and the SOAR Technical Assistance project now makes on-line training available to the field, at no charge. Nationally, the Social Security Administration has been supportive of SOAR implementation, and a state-wide SOAR effort now seeks to support local implementation under the leadership of the California Institute for Behavioral Health Services. A system-wide **Disability Income Initiative** would involve convening public and private healthcare, eligibility,

and benefits advocacy partners; developing a training and resource development plan to address the need, and **creating sufficient benefits advocacy positions** to garner appropriate benefits for approximately half of homeless adults who cannot work. At current SSI disability rates, each person qualifying for SSI would be able to contribute \$3,096 (30% of income) annually to the annual cost of their housing—thus reducing the overall cost of ending homelessness.



9 Create the Conditions to End Homelessness

1. POLICY CHANGES TO MORE QUICKLY EXPAND AFFORDABLE HOUSING

This Plan estimates that ending homelessness in Sonoma County requires 4,128 housing units: 2,394 in existing housing and 1,734 units that need to be built or converted from existing facilities. Public policy changes can set the stage for achieving this Plan’s housing goals more quickly. Policies that would support the creation of needed housing might include:

- ✦ **Change Housing Authority policies** to create preferences for homeless persons if they do not yet exist, to set a specific quota of rental assistance for homeless or chronically homeless persons, or to **set a quota for persons identified as highly vulnerable to dying outside** (through the Vulnerability Index screening tool). Although homeless dedicated units would be produced only through turnover of tenant-based rental assistance, this would be a relatively quick and simple way to create dedicated capacity in existing rental housing.
- ✦ Local government could **buy down already-restricted rents to accommodate targeting to a lower income level** (e.g., below 30% of Area Median Income). It would be worthwhile to calculate the per-unit cost to fund subsidy increases for the purpose of making existing affordable housing accessible to extremely low-income homeless persons.
- ✦ Local government could float a **Bond Issue** to purchase existing rental properties and to develop new affordable housing, including units set-aside for homeless persons. Such a strategy would require additional sources in the future, to service bond repayment.
- ✦ Local governments could identify **existing large facilities that they own, which could be converted into housing**, as SAY is planning for the former Warrack Hospital. Large properties with facilities that are no longer used could be considered for conversion to housing at a much lower cost than building new.
- ✦ In general, reducing barriers that slow the development of *any* rental housing would contribute to loosening up a housing market with a chronically low vacancy rate, and would make it easier to use rental assistance programs to house homeless persons.

2. BUILD THE CAPACITY TO SCALE UP

The housing needed to end homelessness in Sonoma County requires *triple* the current number of beds dedicated to homeless people. Homeless service providers cannot expand to the needed level of housing operations without sufficient infrastructure and training. Existing homeless service agencies must be sustained and strengthened so they may launch needed programs and measure their success.

- ✦ The Continuum of Care will engage its partners in Upstream Investments and Health Action to promulgate evidence-informed model programs and cost-effective interventions. Examples of evidence-informed practices include Motivational Interviewing, Seeking Safety, Permanent Supportive Housing and Rapid Re-Housing. Upstream Investments staff will be engaged to train homeless service agencies on using evaluation to inform and strengthen interventions in alignment with the Upstream Investments Initiative, and submitting evidence-based and innovative program designs to the Upstream Investments portfolio.
- ✦ Utilize opportunities presented by the Affordable Care Act to provide the supportive services that chronically homeless people need, including comprehensive behavioral health support and access to prevention-oriented health services. One such vehicle is the North Bay Learning Community hosted by the National Center for Excellence in Homeless Services.^{xii}
- ✦ The Continuum of Care will partner with Upstream Investments to develop the curriculum required to scale up, including training on shared outcomes measurement and engaging all homeless service providers in common performance measures.
- ✦ As the collective impact backbone for homeless services, the Continuum of Care must take the initiative to build agencies' capacity for collaborative action, expand resource development efforts to garner large scale grants, and build organizational competence in managing public dollars (including appropriate fund accounting for federal grants). The Continuum of Care needs to partner with local public and private funders to stabilize non-profit agencies serving the homeless, support succession planning and the retention of leadership, and help leaders of homeless services to use their own data to identify the most effective and cost-effective strategies.

3. SYSTEM-WIDE COORDINATED INTAKE

Communities across the nation that have a single point of access to services have been the most effective in providing comprehensive but standardized assessment, quickly linking people with appropriate services, and shortening the length of time people experience homelessness. As a result, new federal regulations to obtain Continuum of Care targeted homeless assistance require the Continuum of Care to establish a Coordinated Intake system. After two years of planning, Sonoma County's Coordinated Intake Project will launch late in 2014, and will provide a "no-wrong-door,"^{xiii} single phone call or walk-in entry system that prioritizes the use of limited resources to serve the people with the most vulnerable health and the lengthiest homeless histories. Coordinated Intake will triage client needs so as to achieve the quickest possible entry into appropriate services, and the quickest possible resolution of housing crisis.

Coordinated Intake will utilize research-based screening and assessment tools that identify the vulnerability factors that are most likely to lead to death outside as well as capacity to live independently, to identify who most needs the assistance of this system of care, which currently lacks adequate housing resources. The project will provide crisis case management and waitlist management, with the goal of diverting as many people as possible from literal homelessness. Coordinated Intake will provide real-time referral into housing, health care, and other systems.

To the greatest extent possible, the **Coordinated Intake system should be expanded with street outreach** to engage unsheltered persons in services, **homeless prevention and diversion services**, and **Rapid Re-Housing assistance**. In addition, the advent of Coordinated Intake is a prime opportunity to engage hospitals and criminal justice partners in designing **discharge strategies to avoid new homelessness**. The success of the Coordinated Intake system will be judged by reductions in the average number of days between entry into services and resolution of homelessness, as well as by the satisfaction expressed by consumers of homeless services.


4. SHORT-TERM STRATEGIES, HOMELESSNESS PREVENTION & DIVERSION

This Plan focuses on what is needed to *end* homelessness, not manage it. Consequently it focuses on what is needed to permanently house Sonoma County's homeless population, and Appendix A, *Estimating Needed Housing*, posits that if the needed permanent housing were made available, at some point in the future Sonoma County agencies could actually look at converting some emergency shelter and transitional housing facilities into permanent supportive housing. Thus, **this Plan makes no projection of need for short-term emergency measures** such as winter shelter expansions, winter warming and summer cooling programs, safe parking programs, public sanitation facilities, legalized camping, and so on. The design of such emergency programs should align with this overall Plan to end homelessness, and **connect unsheltered people to case management and housing as much as possible**.

The mission of the CoC is resolving homelessness; it follows that the Plan is housing-centric. Inclement weather does not create homelessness, but rather, creates a very real endangerment to those already unsheltered. Addressing these life-threatening situations is a crucial public health responsibility, but separate from what is required to end homelessness (the focus of this Plan). A separate "Winter Weather Response Plan" will analyze the public health impacts of cold and wet winter weather on unsheltered persons, and articulate mitigation plans.

🌟 **Research Cost-Effective Short-Term Strategies:** Given that existing homeless dedicated housing can serve just 1 out of every 4 homeless persons, an evaluation is needed of the wide range of possible short-term emergency measures such as those listed above, and the myriad creative ideas to safeguard the health of people who are living outside. Mounting a new shelter is an expensive enterprise, and ongoing operating funds for such facilities are ever scarcer. Therefore despite the great need, launching new permanent year-round emergency shelter facilities is not a high priority strategy for the use of public dollars. The Continuum of Care and its partners should examine all possible options for advancing the health and safety of unsheltered persons, with the goal of identifying a short list of cost-effective

outreach strategies that can be implemented as a way of engaging homeless persons in services and housing.

 **Homelessness Prevention:** For this Housing + Health + Income strategy to actually *reduce* homelessness, we must look seriously at **preventing new homeless episodes**. Expanded investments will be needed for services that divert and stabilize people who are on the verge of literal homelessness.

To best utilize limited resources, the Continuum of Care and its partners should undertake a survey of existing research, to evaluate cost-effective and promising strategies to prevent homelessness and divert those seeking to enter shelter from the homeless services system into permanent housing. Documenting effectiveness with homeless prevention programs is particularly challenging because it involves measuring negative impacts that have *not* happened; however a number of communities have demonstrated promising results. A comprehensive prevention strategy needs to inform development of a Sonoma County program that can lessen the inflow of new people into homelessness.



10 What Will It Cost to Create the Needed Housing?

FUNDING THE PERMANENT HOUSING WE NEED

This Plan describes a need for 4,128 permanent housing units – 1,734 units requiring construction and 2,394 units created in existing rental housing. Below, one-time construction cost is estimated at \$350,000 per new unit and rehabilitation cost is estimated at \$200,000 per unit, to come up with an estimate of \$557.4 million in construction costs.

Permanent Affordable Housing NEW CONSTRUCTION	Dedicated Services	Units	Construction Cost/Unit	Total Construction Cost
Affordable to 30% AMI	none	1,015	\$ 350,000	\$ 55,250,000
Permanent <i>Supportive</i> Housing				
New construction set-asides	long-term	389	\$ 350,000	\$ 136,150,000
Acquisition/conversion	long-term	330	\$ 200,000	\$ 66,000,000
Total units needing construction	42%	1,734		\$ 557,400,000

Affordable rental housing development for low income households is typically funded from many sources, mostly public funding. Targeting units for the “extremely-low income” category is what is required to serve homeless and formerly homeless households. The corresponding extremely low rents essentially preclude any commercial mortgage debt. Thus, rental housing development for homeless persons is nearly 100% public funding and it is estimated from local experience that at least 30% of the development cost would be financed from local government sources. **Thus the local investment needed is \$167.2 million.**

Other sources include tax credits, private mortgages, and public financing such as the Affordable Housing Program or California’s Multi-Family Housing Program.

SOURCES OF CONSTRUCTION FUNDS	
Housing investments (e.g. tax credits, bond/private mortgage, Affordable Housing Program, State Multi-Family Housing Program, etc)	\$ 390,180,000
Local/private investment needed (approx. 30% of construction cost)	\$ 167,220,000
Total Construction Sources	\$ 557,400,000

ANNUAL OPERATING EXPENSE

Projects created in existing rental housing require rental assistance, operating subsidies, and a minimum of attached case management services. Acquisition/conversion projects often need annual operating funds as well as the construction funding noted on the previous page. Cost per unit varies based on the housing type and client needs; potential sources of annual operating dollars and rental subsidies are shown on the following chart.

Permanent Affordable Housing ANNUAL OPERATING EXPENSE	Dedicated Services	Units	Operating/ rental subsidies
Permanent Supportive Housing			
Acquisition/conversion	long-term	330	\$ 3,132,360
Master-leasing projects	long-term	330	\$ 4,950,660
Rental Assistance projects	long-term	1,105	\$ 10,301,235
Rapid Re-Housing rental assistance (short-term with case management)	short/ medium term	959	\$ 3,892,581
Total Annual Operating/Rental Subsidies			\$ 22,276,836

POTENTIAL SOURCES OF ANNUAL OPERATING & RENTAL SUBSIDIES	
Resident rents at 30% of income	\$ 11,693,034
Federal & State grants	\$ 6,868,000
Local/private investment needed	\$ 3,715,802
Total Sources	\$ 22,276,836

Acquisition-conversion projects are shown both on construction and annual operating charts because they often need both kinds of funding. A detailed explanation of cost assumptions and potential funding sources appears in Appendix B.

HOUSING SUCCESS DEPENDS ON INCREASING INCOME

The Income Initiatives described in Section 6 above are designed to establish participant incomes, but not solely to create a platform for health and a meaningful life. Participant income is critical to developing a housing system that can sustain itself. If formerly-homeless individuals can contribute to their rent at the rate of 30% of their income, this represents **more than half the annual cost of operating the needed housing.**

In the case of the **Work Readiness** strategy, assuming the current minimum wage of \$9/hour, each fully-employed adult would earn an annual income of \$18,720 and generate a minimum annual contribution toward housing operations of \$5,616. If half of homeless adults were able to find full-time minimum wage work, the

expansion of pre-employment work readiness efforts described in Section 6 could generate as much as \$29 million in income and \$ 8.7 million in rents. Assuming the work-readiness expansion cost \$350,000 per year over 5 years (a total of \$1,750,000), it would return more than \$16 in participant income for every dollar invested ($\$29,137,680 \div \$1,750,000 = \$16.65$). For each dollar invested in the work-readiness initiative, \$5 (30% of \$16.65) would be generated toward the cost of housing as rent. When the California minimum wage increases to \$11/hour in 2015, the return on investment will be considerably higher.

Similarly, a **Disability Income Initiative** using national best practices^{xiv} would reliably and quickly establish income for disabled homeless adults. In addition to the health benefits to disabled individuals who have no financial resources, an SSI income of \$861/month would enable formerly-homeless individuals to pay rent at the current rate of 30% of their income (\$258.30). This would generate an annual contribution toward housing operations of \$3,096 per adult, saving on the local investment required to create that housing. Expanded benefits advocacy is estimated to cost approximately \$325,000 annually; over the course of 5 years, the cost would be \$ 1,625,000. If half of homeless adults were able to obtain SSI or comparable disability benefits over 5 years, they would secure almost \$1.4 million in annual income—a return of \$10 per dollar invested. For every dollar invested in this effort, the client would be able to contribute \$3 back to the cost of housing, as rent.



11 Performance Measurement

HEARTH PERFORMANCE MEASURES

The strategies proposed by this Plan are **informed by local data, research, cost-benefit analysis and evaluation.** In the big picture, success in the above efforts will be demonstrated through new units opened, additional rental assistance becoming available, and ultimately a reduction in the total number of homeless persons found during the HUD-mandated point-in-time homeless counts. The US Department of Housing and Urban Development and the US Interagency Council on Homelessness have created a series of interim performance measurements, below, which will allow the Continuum of Care to gauge progress in the short run, as well.

The Continuum of Care Board will assess progress on the Plan twice a year, using these objective measurements related to the goal of permanently housing Sonoma County’s homeless persons. These will include the number of housing units available; the length of time people are homeless before they enter permanent housing; how stable they are in permanent housing; successes in establishing an income source; and access to needed healthcare and other services to avoid new homeless episodes. These measures have been established through federal legislation, relieving planners from the need to design indicators locally.

The chart below summarizes measures in national use, local baseline data for Sonoma County’s homeless population, and local goals where they have been set by the Continuum of Care. The success of this Plan will be measured against these metrics.

HEARTH Act Performance Measure	National Benchmark	Local Baselines (2013)	Local Goal for 2014
Shorten the average length of stay in emergency shelters and transitional housing, for households exiting to permanent housing.	< 20 days OR > 10% less than prior year for persons in similar circumstances	Shelter-Individuals: 80 days Shelter-Families: 169 days	Decrease average length of stay 10% from 2013: Shelter-Individuals: 72 days Shelter-Families: 152 days Transitional-Individuals: 200 days Transitional-Families: 317 days
		Transitional-Individuals: 222 days (7.4 mos.) Transitional-Families: 352 days (11.7 months)	
Reduce the number of households re-entering the homeless system after exiting to permanent housing.	< 5% within the next 2 years OR Decrease of > 20% over prior year for persons in similar circumstances within next 2 years	Shelter-Individuals: 18% Shelter-Families: 8%	Reduce the number of households re-entering homeless services to 10%.
		Transitional-Individuals: 30% Transitional-Families: 2% Overall: 14%	

ADDITIONAL NATIONAL PERFORMANCE MEASURES FOR HOUSING & INCOME

The US Department of Housing & Urban Development (HUD) has set additional performance measures for Continuum of Care, and requires annual reporting and goal-setting to access approximately \$2.6 million that comes into Sonoma County annually from the CoC funding stream. Following HUD’s practice, the Sonoma County CoC has set goals of a 1% annual increase on each measure. Some measures include larger goals related to HUD’s federal initiatives or local initiatives contained in this Plan.

HUD Continuum of Care Performance Measures	HUD Benchmark	Local Baseline (2013)	Local Goal: 2014	Local Goal: 2015
Housing Stability Measures				
Increase % of households exiting emergency shelters and transitional housing to permanent housing.	<i>No national benchmark has been set for emergency shelters.</i> Transitional Housing benchmark: 65%	Shelter-Individuals: 23% Shelter-Families: 35% Transitional-Individuals: 52% Transitional-Families: 69%	Shelter-Families: increase to 40% by 2015 using Rapid Re-Housing Others: 1% increase/year over 2013:	
			Shelter-Individuals: 24% Transitional-Individuals: 53% Transitional-Families: 70%	Shelter-Individuals: 25% Transitional-Individuals: 54% Transitional-Families: 71%
Increase % of Permanent Supportive Housing participants retaining permanent housing	80%	89%	89%	91%
Increased Income Measures				
Increase the % of participants exiting with employment income	20%	31%	31%	33%
Increase the % of participants that exit with income from sources other than employment.	54%	54%	55%	56%
Increase the % of participants exiting with non-cash mainstream benefits	56%	73%	80%	83%

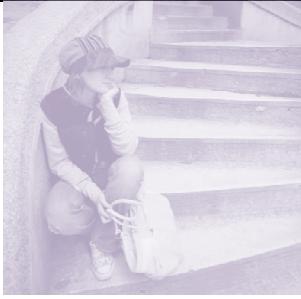
HEALTH PERFORMANCE MEASURES

In aligning this Plan with Health Action and other local Collective Impact efforts initiatives, the Sonoma County Continuum of Care has established baseline data for the Health Action indicators that are most relevant for the homeless population.

Health Action 2020 Goal	County comparison (2009 unless otherwise noted)	Sonoma County homeless baseline (2013)	CoC Goal: 2014	CoC Goal: 2015
100% of adults will have health insurance	81.2%	23.4% enrolled in Medi-Cal; 0% of persons >65 reported enrollment in Medicare.	80% Medi-Cal enrollment; 2% of persons >65 enrolled in Medicare	83% Medi-Cal enrollment; 4% of persons >65 enrolled in Medicare
96% of people will have a usual source of health care	85.6%	59% report using clinics, private doctors, VA	**	**
75% of adults needing Behavioral Health Care Services will receive them	57.5% (2011-12)	30.5% of those reporting Mental Health problems receive services. 32.6% of those reporting AOD problems receive AOD counseling.	**	**

Data Sources: HMIS data and Biennial Point-in-Time Count & Survey.

*Goals marked ** will be set by the Continuum of Care Board in consultation with healthcare partners, later in 2014.*



12 Plan Monitoring, Data Collection & Analysis

The Sonoma County Continuum of Care is committed to ongoing measurement of progress on the Plan as described above; the Continuum of Care Board will review and adjust plan goals and objectives every three years. System-wide working groups will be established in the coming 12 months, to develop and refine collaborative efforts to impact each of the key strategies and their performance measures.

The Sonoma County Continuum of Care participates in a mandated federal Homeless Management Information System (HMIS) initiative. In 2012 a system conversion was undertaken to move to Social Solutions, Efforts to Outcomes HMIS. The conversion not only provided local homeless services providers with an easier system to comply with data collection requirements, but expands data collection from statistical reporting to the evaluation of performance management. HMIS staff will design tracking systems in the HMIS for the measurable outcomes described above, and data collection efforts will be systematically analyzed to monitor progress against Plan goals.

To do this, the Continuum of Care’s HMIS data management team will:

- ✦ Enhance longitudinal reporting systems that measure progress against all stages of the logic model on page 16;
- ✦ Assist homeless services leaders to design, develop and utilize agency level performance reporting systems;
- ✦ Strengthen current HMIS User training to offer local testing and certification upon course completion;
- ✦ Through additional training, increase data analysis proficiency among homeless service organizations at all staff levels;
- ✦ Implement quarterly tracking of the housing stock dedicated to the homeless; and
- ✦ Design reporting dashboards targeted to all stakeholders who are collaborating to end homelessness.

The Point-in-Time Homeless Count has been conducted biennially, but will become an annual event beginning in 2015. This will at last allow annual collection of information on health data points such as the percentage with a usual source of health care and the percentage of those needing mental health or chemical dependency treatment who receive such care.

These efforts will support twice-annual updates to the CoC Board on progress against the Plan goals. CoC staff will prepare an Annual Report to be shared with the CoC Board and to other bodies, documenting progress on Plan goals and reporting on emerging strategies.



13 Glossary

Affordable Care Act—The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obama-care," is a United States federal statute signed into law by President Barack Obama on March 23, 2010.

Affordable housing—Housing units for which rent plus tenant-paid utilities do not exceed 30% of the tenant household's gross monthly income.

CalFresh—The name for California's Food Stamp Program. CalFresh is a Supplemental Nutrition Assistance Program (SNAP) that provides assistance for households to purchase nutritious food.

Chronically homeless—Per federal definition, a homeless adult with a disabling condition who has been continuously homeless for a year or more, or who has had at least 4 episodes of homelessness in the past 3 years. Originally including only unaccompanied adults, the definition has been expanded to include the entire household presenting for services with the disabled adult.

Continuum of Care—A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional and permanent housing, along with prevention and other services to address the various needs of homeless persons. The US Department of Housing & Urban Development (HUD) also refers to the group of community stakeholders involved in the decision making process as the "Continuum of Care."

Coordinated Intake—A centralized process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system must cover the geographic area; be easily accessible to individuals and families seeking housing or services; be well-advertised; and include comprehensive and standardized assessment tools.

Diversion—A strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program wait lists. Diversion programs can also help communities achieve better outcomes and be more competitive when applying for federal funding.

Emergency Shelter—Any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of the homeless. "Temporary" has been defined as anywhere from 1 day to 180 days.

Homeless Family—In local usage, a household consisting of at least one adult over the age of 18, and at least one child under the age of 18 (what HUD defines as a "household with children"). HUD has discontinued use of

the word “family” in favor of the less value-laden word, “household”; and uses three categories of household: a household with children, a household without children (adults only), and a household of children only (unaccompanied minors).

Medi-Cal Expansion—A feature of the Affordable Care Act, the expansion of Medicaid eligibility to people with annual incomes up to 138% of the federal poverty level, or \$26,347 for a family of three and \$15,417 for an individual. Based on Point-In-Time survey responses, it is anticipated that 95% of Sonoma County’s homeless persons are eligible for Medi-Cal under the Affordable Care Act Medicaid expansion.

Motivational Interviewing (MI)—A method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Parity, aka the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)—A federal law that prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated it is only through the Affordable Care Act of 2010 that coverage of mental health and substance use disorder services is now required as one of 10 Essential Health Benefit categories.

Permanent Supportive Housing—A cost-effective combination of housing and services intended to help people with complex challenges to live more stable, productive lives. As a key means to address homelessness, supportive housing seeks to address two key problems: without housing, there is at best a highly problematic basis from which to mitigate the factors which lead to homelessness and expensive problems which burden social service systems; but without supportive services, the tenant is likely to regress for the reasons that are presumed to lead to their loss of housing in the first place.

Point-In-Time Count—A one-day count of all homeless persons in a defined area. HUD requires local Continuum of Care to conduct a biennial point-in-time count during the last 10 days of January in odd-numbered years.

Prevention—Activities or programs designed to prevent the incidence of homelessness, including short-term subsidies to defray rent and utility arrears for households that have received eviction or utility termination notices; security deposits or first month’s rent to permit an evicted household to move into a new apartment; short- or medium-term rental assistance to enable an at-risk household to retain its housing; and legal services programs for the representation of indigent tenants in eviction proceedings.

Rapid Re-Housing—A relatively recent social policy innovation that provides time-limited flexible funds to secure permanent housing, partnered with in-home housing support. Rapid Re-Housing is designed to help homeless people transition more rapidly out of the shelter system or to avoid a shelter stay altogether.

Seeking Safety—A present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on helping clients attain safety in their relationships, thinking, behavior, and emotions; working on both posttraumatic stress disorder (PTSD) and

substance abuse at the same time; a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; cognitive, behavioral, interpersonal, and case management content areas; and helping clinicians work on counter-transference, self-care, and other issues.

SOAR—SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national project funded by the Substance Abuse and Mental Health Services Administration, that is designed to increase access to SSI/SSDI for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder.

Transitional Housing—A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living within 24 months.

Upstream Investments—A policy, sponsored by the Sonoma County Board of Supervisors and widely supported throughout the community, seeks to eliminate poverty in Sonoma County and ensure equal opportunity for quality education and good health in nurturing home and community environments. The three primary strategies are: Invest Early (whenever possible, dedicate funding and other resources to prevention-focused policies and interventions); Invest Wisely (ensure that upstream policies and interventions have the highest possible likelihood of success by selecting those that are backed by sound evidence); and Invest Together (focus community-wide upstream policies and interventions on preventing six targeted factors and improving 22 indicators of success to achieve the Upstream vision, mission, goals, and measurable impacts).

Vulnerability—According to the survey and analysis methodology developed by Dr. Jim O'Connell of Boston's Healthcare for the Homeless organization, the health problems that led to homeless persons being "most at risk for dying on the street." If identified in unsheltered persons, 4 major health conditions (Kidney disease, Liver disease, cold or wet weather injuries, and HIV) are the most predictive of dying outside. In addition, tri-morbidity between alcohol or other drug abuse, mental illness, and any of the above health conditions or a range of other serious health conditions is highly predictive of dying outside.



APPENDIX A

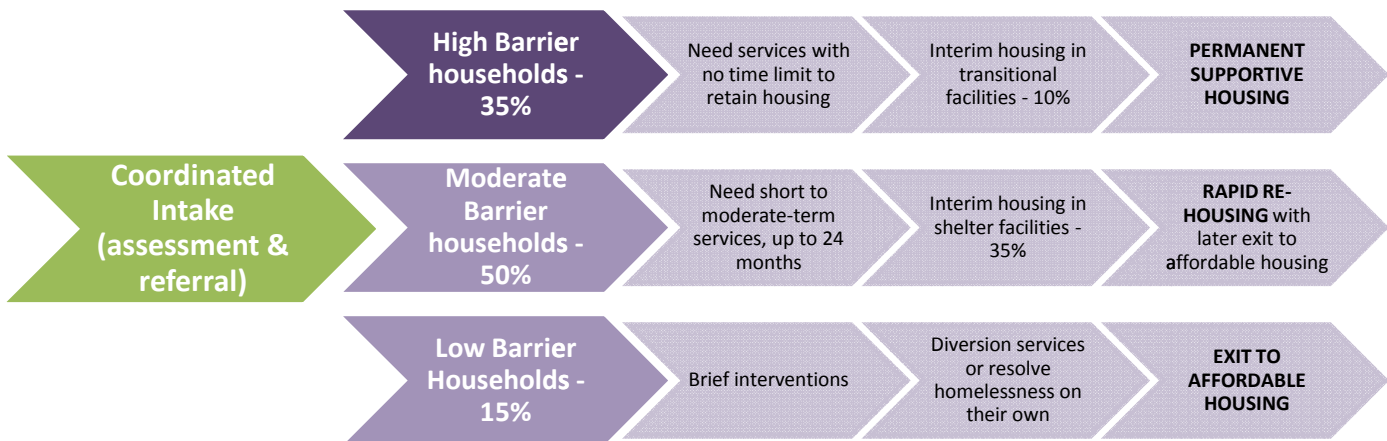
Estimating Needed Housing

This analysis is based on designing an idealized “Right-Sized System” that would be adequate to end homelessness in Sonoma County. Following methodology developed by Matt White of Abt Associates (a HUD technical assistance provider), the analysis below interprets Sonoma County data from its Homeless Management Information System (HMIS), Homeless Count, and recent Vulnerability Surveys among unsheltered homeless persons, to design that ideal system. Specifically we have used the following sources of information:

- ✦ Count data: total number of sheltered and unsheltered families and single adults; annual and monthly inflow into homelessness;
- ✦ HMIS data: Average lengths of stay and turnover in shelters, transitional housing, rapid re-housing units, and permanent supportive housing for families vs. single adults; average size of family households (to convert from persons in homeless families into number of families); annual inventories of existing homeless-dedicated housing;
- ✦ Count, HMIS, and the Vulnerability Surveys (VI-SPDAT screening tool): Qualitative data on the service needs of homeless families and single adults, as they relate to housing needs; and
- ✦ Provider input: Known permanent housing solutions for single adults (e.g., shared housing).

OVERVIEW: THE RIGHT SIZED SYSTEM

The hypothetical Right-Sized System asserts that, with the Coordinated Intake system planned for launch fall 2014, Sonoma County’s homeless service system will begin to assess needs and refer people into housing appropriate to their needs (see diagram below). This system will also prioritize for housing those homeless persons most likely to die outside over those most capable of caring for themselves. Lastly, this analysis asserts that if adequate permanent housing existed to address the need, we could reduce reliance on emergency shelters and transitional housing as *de facto* affordable housing, and even re-purpose them as other needed housing.



- High barrier households:** Based on the recent Vulnerability Assessments and previous in-depth analysis of the Count data, we estimate 35% of homeless households have disabilities or other high barriers to obtaining housing, and need **Permanent Supportive Housing** supportive services without set time limits, to become and remain housed. These units may be facility-based or provided on the open market through rental assistance.

 - Facility-based transitional housing can be used for people awaiting a permanent supportive housing placement or who require time-limited service-enriched housing for re-entry clients, people recovering from substance abuse, and others. The CoC projects that 10% of homeless persons will need this kind of housing on an interim basis.
- Moderate barrier households:** Based on the recent Vulnerability Assessments and previous in-depth analysis of the Count data, the CoC estimates that 50% of the homeless population needs case management and other services, but could exit homelessness with medium-term **Rapid Re-Housing** rental and other financial assistance, in rental housing.

 - Short-term facility-based emergency shelter stays will be needed by about 35% of the homeless population, while they are seeking an apartment with rapid re-housing assistance.
- Low barrier households:** Based on the recent Vulnerability Assessments, the CoC estimates that 15% of homeless households could resolve their homelessness with short-term prevention/diversion efforts for people who are imminently at risk of literal homelessness. If prevention services can reduce the demand for shelter needs by 15%, this is a cost-effective approach as it is estimated that the cost-per-household diverted is approximately \$4,000. These households will need affordable housing units, best targeted to extremely low-income (<30% AMI) households.

ADJUSTING FOR TURNOVER

Most housing stays are for less than a year. Therefore the CoC has calculated average lengths of stay for each type of housing, to see how many people each bed can serve in a year.

TURNOVER CALCULATIONS	Shelter		Transitional		Rapid Re Housing		Permanent Supportive Housing	
	Avg Length of Stay	Annual persons/bed	Avg Length of Stay	Annual persons/bed	Avg Length of Stay	Annual persons/bed	Avg Length of Stay	Annual persons/bed
Families	169	2.16	352	1.04	301	1.21	1,008	0.36
Single Adults	80	4.56	390	0.94	297	1.23	787	0.46

EQUATION FOR A HYPOTHETICAL RIGHT SIZED SYSTEM

$$\text{Right-Sized System} = \frac{[(\text{Current monthly demand}) + (\text{annualized unsheltered population}) - (\text{Diverted Population})] * \text{Service Needs}}{\text{Turnover}}$$

Example: The need for Emergency Shelter works out as follows:

$$\text{Families: } \frac{[(\text{Current monthly demand (40)} + \text{annualized unsheltered population (103)}) - (\text{Diverted population (117)})] * 35\%}{2.16 \text{ persons per bed per year}} = \mathbf{59 \text{ beds.}}$$

Single Adults: $\{[(\text{Current monthly demand (139)} + \text{annualized unsheltered population (1,481)}) - (\text{Diverted population (328)})] * 35\% \div 4.56 \text{ persons per bed per year} = \mathbf{217 \text{ beds.}}$

Other homeless housing types have been calculated similarly to yield the following capacities for a “Right Sized System”:

Emergency Shelter	Transitional Housing	PERMANENT HOUSING		
		Rapid Re Housing (rental assistance slots)	Permanent Supportive Housing (mix of facilities & rental assistance)	Affordable Housing targeted to <30% AMI
320 beds	786 beds	1,522 beds	4,035 beds	1,381 beds

EXISTING HOUSING CAPACITY

The county’s Current Homeless Housing Inventory was then subtracted to find the Remaining Homeless Housing Need, then convert beds to units as needed:

	Emergency Shelter	Transitional Housing	PERMANENT HOUSING		
			Rapid Re Housing (rental assistance slots)	Permanent Supportive Housing (mix of facilities & rental assistance)	Affordable Housing targeted to <30% AMI
Current Capacity (beds as of 4/30/2014)	718	418	178	1,029	--
Remaining Capacity needed (beds)	(398)	(368)	1,344	3,006	1,381
Remaining Capacity needed (units) ²	(293)	(451)	959	2,169	1,015

POTENTIAL FOR EVENTUAL CONVERSION

In the idealized Right Sized System, with adequate permanent housing, the CoC would be able to reduce emergency shelter and transitional housing bed capacity. Sonoma County data has demonstrated this potential since 2007. The CoC has interpreted this as a reflection of the lack of permanent affordable housing options for homeless persons—homeless families in particular. The lack of permanent housing options creates a bottleneck

² The conversion to units assumes family households average 3 persons and that half of permanent units for single adults will be provided as shared housing. Thus needed units are proportionately lower than needed beds.

in shelters and transitional housing, and creates the appearance of a need for more of these types of housing. Currently there is a need for all shelter and transitional beds, but if the needed permanent housing were available, there would not be a need for quite so many shelter beds.

Therefore for planning purposes, there should be an anticipation of one day **converting** “excess” shelter and transitional housing facilities from families to single adults (the vast majority of the homeless population) to address the remaining transitional housing need, then some of the permanent housing need:

	Emergency Shelter	Transitional Housing	PERMANENT HOUSING		
			Rapid Re Housing (rental assistance slots)	Permanent Supportive Housing (mix of facilities & rental assistance)	Affordable Housing targeted to <30% AMI
Remaining Capacity needed (units – from previous table)	(293)	(451)	959	2,169	1,015
Needed capacity with Conversions	0	0	959	2,154	1,015

TOTAL UNMET HOUSING NEED: 4,128 UNITS

- ✱ Rapid Re-Housing (RRH): **959 units**
- ✱ Permanent Supportive Housing (PSH): **2,154 units**
- ✱ Affordable Housing targeted to <30% AMI: **1,015 units**

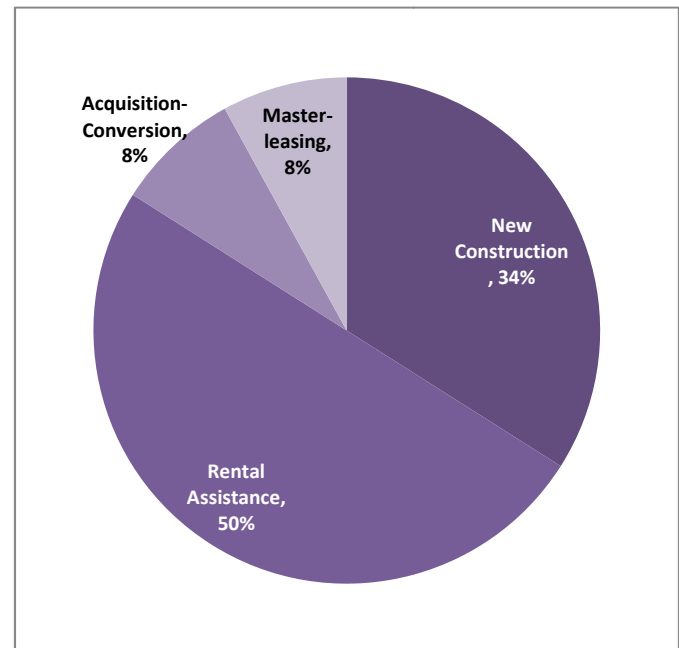


APPENDIX B Housing Cost Estimates

DEVELOPING PERMANENT HOUSING FOR HOMELESS PERSONS—THE PAST AS GUIDE

Past experience provides a guide to the different methods of developing homeless-dedicated housing, and to the annual costs of sustaining that housing.

Of Sonoma County’s current inventory of homeless-dedicated permanent housing, roughly half has been created through **rental assistance in existing rental housing**. These include VA Supportive Housing and “Shelter Plus Care” units in a model that matches rental assistance managed by one of the county’s two Housing Authorities, with case management provided by agencies such as the Veterans Administration, Sonoma County Behavioral Health, Face to Face, or Social Advocates for Youth. Rental assistance allowances are set annually by the US Department of Housing & Urban Development (HUD) through its Fair Market Rent (FMR) standards. Funding is equivalent to the full FMR; as tenant incomes rise, funds can be used to expand the number of households served.



Existing Permanent Housing for Homeless Persons, by Type of Housing

The 2014 rate of rental vacancy is extremely low, presenting serious challenges to agencies working to place homeless persons in rental housing—even with intensive services attached. Therefore, until the housing market loosens up significantly, it would be wise to limit the use of existing rental housing to no more than half of the planned units.

Just over one-third of existing permanent housing units for the homeless were created as set-asides through **new affordable housing construction**: the housing developer committed a certain number of units to be targeted to extremely low-income (<30% AMI) households through the project’s construction financing. Such financing typically includes competitively awarded tax credit investing; one of the key elements to compete for such funding is local investment. This process creates affordability restrictions that remain with the units for decades. Housing management companies then partner with service providers to identify appropriate tenants to fulfill the commitment.

The balance of existing permanent housing for homeless households is about evenly split between **master leasing**, and **acquisition and conversion** of existing properties. Master-leasing involves housing rented by a service provider, who then provides both property management and case management services to residents.

OPTIONS FOR FUNDING THE HOUSING WE NEED

Because housing development is so challenging, opportunities must be seized as they come up. Therefore the historical distribution of permanent housing for homeless persons is perhaps the best guide to what is possible in the future. We anticipate an approximate distribution of the needed units as shown in the chart to the right:

	%	# units
Rental Assistance	50%	2,064
Affordable Housing Construction	34%	1,404
Master-Leasing	8%	330
Acquisition-Conversion	8%	330
Total	100%	4,128

For the purpose of cost estimates, these units either involve construction or will be created in existing rental housing:

Construction	Number of Units	Existing Rental Housing	Number of Units
Affordable housing: subsidies enable units to be restricted to the extremely low-income population (below 30% of Area Median Income).	1,015	959 units of Rapid Re-Housing rental assistance with short-to-medium term case management.	959
Permanent Supportive Housing – set-aside units in new affordable housing developments	389	Permanent Supportive Housing – Master-leasing projects – examples include a variety of Continuum of Care projects operated by Buckelew Programs, COTS, & Catholic Charities.	330
Permanent Supportive Housing – facility-based acquisition/rehab projects – SRO and shared housing projects	330	Rental Assistance – examples include VA Supportive Housing, Continuum of Care rental assistance	1,105
Total Units to be Constructed	1,734	Total units in Existing Rental Housing	2,394

One-time construction cost is estimated at \$350,000 per new unit and rehabilitation cost is estimated at \$200,000 per unit, to come up with an estimate of \$557.4 million in construction costs:

Permanent Affordable Housing NEW CONSTRUCTION	Dedicated Services	Units	Construction Cost/Unit	Total Construction Cost
Affordable to 30% AMI	none	1,015	\$ 350,000	\$ 355,250,000
Permanent <i>Supportive</i> Housing				
New construction set-asides	long-term	389	\$ 350,000	\$ 136,150,000
Acquisition/conversion	long-term	330	\$ 200,000	\$ 66,000,000
Total units needing construction	42%	1,734		\$ 557,400,000

Affordable rental housing development for low income households is typically funded from many sources, mostly public funding. Targeting units for the “extremely-low income” category is what is required to serve homeless and formerly homeless households. The corresponding extremely low rents essentially preclude any commercial mortgage debt. Thus, rental housing development for homeless persons is nearly 100% public funding and it is estimated from local experience that at least 30% of the development cost would be financed from local government sources. **Thus the local investment needed is \$167.2 million.**

Other sources include tax credits, private mortgages, and public financing such as the Affordable Housing Program or California’s Multi-Family Housing Program.

SOURCES OF CONSTRUCTION FUNDS	
Housing investments (e.g. tax credits, bond/private mortgage, Affordable Housing Program, State Multi-Family Housing Program, etc)	\$ 390,180,000
Local/private investment needed (approx. 30% of construction cost)	\$ 167,220,000
Total Construction Sources	\$ 557,400,000

ANNUAL OPERATING EXPENSE

Projects created in existing rental housing require rental assistance, operating subsidies, and a minimum of attached case management services. Acquisition/conversion projects often need annual operating funds as well as the construction funding noted above. Cost per unit varies based on the housing type and client needs; potential sources of annual operating dollars and rental subsidies are shown on the following chart.

Permanent Affordable Housing EXISTING RENTAL HOUSING	Dedicated Services	Units	Annual cost per unit	Operating/ rental subsidies
Permanent Supportive Housing				
Acquisition/conversion ³	long-term	330	\$ 9,492	\$ 3,132,360
Master-leasing projects	long-term	330	\$ 15,002	\$ 4,950,660
Rental Assistance projects	long-term	1,105	\$ 9,322	\$ 10,301,235
Rapid Re-Housing rental assistance (short-term with case management)	short/ medium term	959	\$4,059	\$ 3,892,581
Total Annual Operating/Rental Subsidies				\$ 22,276,836

Annual cost per unit is calculated based on average annual operating costs reported to HUD through Annual Performance Reports submitted by Continuum of Care-funded providers. All reported awards and cash match were analyzed by housing type and, since each has a different number of units, averaged by the total number of units in each housing type, which were included in the analysis.

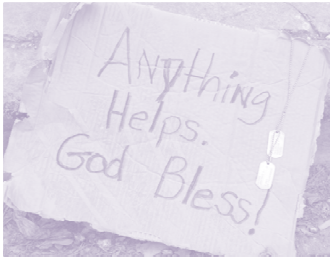
POTENTIAL SOURCES OF OPERATING & RENTAL SUBSIDIES	
Resident rents at 30% of income	\$ 11,693,034
Federal & State grants	\$ 6,868,000
Local/private investment needed	\$ 3,715,802
Total Sources	\$ 22,276,836

Notes on potential sources of operating and rental subsidies:

☛ Resident rents are based on 30% of SSI for all permanent supportive housing units, as the definition of permanent supportive housing requires a disability.) For the 1,015 new affordable units with affordability restrictions, the resident rent calculation assumes there is earned income at the top of the 30% AMI range, for example \$16,500 for 1 person. This calculation does not include a resident rent contribution for the 959 Rapid Re-Housing units: actual resident rents are not available at the time of this writing, and Rapid Re-Housing cost estimates are based on program-delivery costs only.

☛ Potential Federal and State operating sources can be brought to bear to create the needed housing. Anticipated sources include: Emergency Solutions Grants (County and State); Supportive Services for Veteran Families (for Rapid Re-Housing); and VA Supportive Housing (VASH), and CoC rental assistance (for Permanent Supportive Housing). Per the policy recommendations in Section 8 above, Housing Choice Vouchers represent another possible funding source. Federal and State grant funds are limited by funding formulas as well as competitiveness; the total listed above reflects Sonoma County’s historical experience in garnering these grants.

³ Acquisition-conversion projects are shown both on construction and annual operating charts because they often need both kinds of funding.



APPENDIX C Top 15 Action Steps

The Continuum of Care’s solicitation of community input generated a plethora of ideas. These are grouped into 15 major areas of action below.

1) **Promote Evidence Informed Practice:** **Housing** **Income** **Health**

Activities include:

- Catalog current local assets and evidence-informed practices via HEARTH-mandated program standards development process.
- Training in national best practices: highlight one Evidence-Based Practice at each CoC Quarterly Membership meeting; develop an educational certificate program for homeless services workers;
- Bring Rapid Results Institute to Sonoma County homeless services providers to fully implement a 100K Homes placement effort for chronically homeless persons.
- Continue Seeking Safety program fidelity initiative, and start similar initiative for Motivational Interviewing
- Put Permanent Supportive Housing and Rapid Re-Housing onto the Upstream Portfolio.

2) **Collaborative outcomes measurement:** **Housing** **Income** **Health**

Activities include:

- Train HMIS users to properly administer and track mid-term assessments so that changes due to new initiatives can become visible through the data.
- Develop a key performance measurements dashboard for review by CoC Board, including housing placement and income change.
- Fully implement data sharing and shared outcome measurement to understand what works best to end youth homelessness.

3) **Coordinated Intake:** **Housing** **Income** **Health**

Activities include:

- Establish one-stop access to all homeless services on the Family Justice Center or Vet Connect model.
- Train Coordinated Intake providers to assist with benefits enrollments.
- Improve provider communications about resources available (especially housing availability, access to mental health and substance abuse services)

Two-Fold Income Initiative: Housing Income Health

Engage with partners to expand county-wide activities:

- Work Readiness Initiative described on page 20.
- Disability Income Initiative described on page 20-21.

4) **Expand access to safety-net programs:** Housing Income Health

Activities include:

- Expand one-time financial assistance programs
- Build a closer partnership with the *Earn It! Keep It! Save It!* Volunteer Income Tax Assistance Program and other programs designed to build savings and other financial assets.
- Provide bundled services to increase CalFresh (Food Stamp) enrollment, maximize Earned Income Tax Credits, and coordinate other Prevention services.

5) **Community education:** Housing Income Health

Activities include:

- Create a marketing plan for the 10-Year Plan to build public understanding of solutions to homelessness, to include regular presentations at City Councils, Board of Supervisors; ongoing *Close to Home* articles in the Press Democrat and other newspapers; tours of local provider programs for targeted audiences.
- One major component is a Landlord Education & Engagement Campaign: Develop a CoC fund for rent/damage guarantees for the first 18 months of tenancy, modeled on COTS' Rent Right guarantees (COTS has never had to pay out these funds). Rent/damage guarantees would be extended to tenants who have completed tenant education programs or otherwise receive tenant support services. Engage rental housing industry representatives.
- Institute a donation program with collection cans at businesses throughout Sonoma County to use for difficult-to-fund basic needs such as transportation, identification, and so on.

6) **Expand permanent housing⁴** Housing Income Health

Activities include:

- End family homelessness through adequate Rapid Re-Housing (expand from current 41 unit capacity to 58 units); and expand Rapid Re-Housing to meet single adult housing needs (expand from current capacity of 30 adults to 847 single and shared units). Based on historical experience, all but about 140 units can be funded through Emergency Solutions Grants and Supportive Services for Veteran Families. Additional funding needs to be identified.
- Revise Housing Authority policies to establish Housing Choice Voucher quotas for medically vulnerable and chronically homeless persons, to expand rental assistance opportunities per HUD guidance. Expand VA Supportive Housing and CoC Rental Assistance projects as possible; identify new sources to create a total of 1,105 new units through rental assistance programs.

⁴ See p. 17-18 and Appendix A for a detailed description of methodology in calculating housing needs.

- Establish policies to expand affordable housing for the extremely low income (<30% AMI) population. Ensuring jurisdictions and developers are aware of this as a priority within their Regional Housing Needs Allocations (RHNA). Estimated need: 1,404 units, 389 permanent supportive housing set-aside units (with services attached), and 1,015 units with affordability restrictions only.
- Significantly expand shared master-leasing and shared single adult living models (such as Buckelew Programs’ Supportive Housing Program or COTS’ local Integrity House model) to create 330 units, approximately 55 master-leased facilities (average 6 persons per facility).
- Convert approximately 41 properties (to serve average 8 persons per property, 330 persons total) into shared or SRO housing on the model of local projects such as Stony Point Commons or Mill Street Supportive Housing.
- Explore partnerships between agencies that are acquiring properties and those implementing shared housing.

7) **Homeless Youth Task Force:** Housing Income Health

Activities include:

- 270 of the needed units should serve homeless youth, with specialized services that increase their economic security.
- Establish a homeless youth seat on the CoC governing body to ensure youth issues are heard.
- The Youth Task Force should engage Cradle to Career and Sonoma County Behavioral Health in strategizing critical barriers to youth becoming housed. Stigma presents a major barrier to getting services, but a diagnosis can be the key to housing.

8) **Collaboration with corrections** Housing Income Health

Activities include:

- Ensure transfer from corrections facilities to housing to best serve mutual clients.
- Analyze homeless arrest data for kinds of arrests and design program responses
- Advocacy on decriminalizing homeless status
- Waivers for safe parking and camping
- Engage in County Probation’s planning efforts

9) **Education Initiatives:** Housing Income Health

Activities include:

- Establish a collaborative scholarship program to assist homeless persons to access education.
- Engage college prep specialists to provide information sessions in homeless service settings, about the earning power of different educational levels and about GED opportunities.

10) **Integrated health care model** Housing Income Health

Engage with partners to expand county-wide activities:

- Build a true street outreach program to identify persons in need of health services, and connect them with housing and medical care.

- Develop integrated health care model at all homeless services sites in partnership with health center care teams. Homeless service providers should follow up on referrals and help re-engage people who have left treatment.
- Expand existing collaborations between Redwood Community Health Coalition and Sonoma County Behavioral Health to more sites serving homeless persons.

11) **Health Care providers:** Housing Income Health

Activities include:

- Expand the Care Transitions project to reach out to additional homeless “high utilizers” in emergency rooms and clinical situations.
- Expand the number of Medi-Cal Health Care providers to meet the new demand.

12) **Substance Abuse Treatment:** Housing Income Health

Activities include:

- Maximize access to Orenda Detox (including unfunded beds) and residential treatment.
- Combine housing resources such as Rapid Re-Housing with outpatient substance abuse treatment
- Address the huge need for men’s step-down sober living (transitional housing or sober shared Rapid Re-Housing units).

13) **Food Security:** Housing Income Health

Activities include:

- Implement a gleaning program at restaurants and agricultural producers to address food insecurity.
- Connect homeless service providers with Health Action Food Aggregation System and Agricultural Cooperative Agreements and/or farmers markets

14) **Alignment:** Housing Income Health

Activities include:

- Assign CoC liaisons to Upstream Investments, Health Action, and Cradle to Career collective impact efforts, and engage with the Innovation Action Council.
- Educate the CoC Membership about the *Opening Doors* Federal Strategic Plan to Prevent & End Homelessness through the Quarterly Membership meeting.



14 Contributors to this Plan Update

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(with apologies for any missed names):

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Buckelew Programs

Community Support Network

Cradle 2 Career Operational Team

Face to Face

Health Care for the Homeless Collaborative

So. Co. Department of Human Services

So. Co. Task Force for the Homeless

Community & Family Service Agency

Community Housing Sonoma County

Community Foundation Sonoma County

COTS

Interfaith Shelter Network

Petaluma People's Service Center

So. Co. Adult & Youth Development

Catholic Charities

So. Co. Community Development Commission

North County Community Services

City of Santa Rosa

North Bay Veterans Resource Center

Social Advocates for Youth

Community Action Partnership

Santa Rosa Community Health Centers

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Rob Durborough

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Marian Lindner

Heather Sweet

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Melinda Rivera

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Pamela Swan

Amber Twitchell



15 References

ⁱ <https://www.facebook.com/SCHousingVeterans>.

ⁱⁱ Reports on the initial 10-Year Homeless Action Plan are available at: <http://sonoma-county-continuum-of-care.wikispaces.com/Sonoma+County%E2%80%99s+10-Year+Homeless+Action+Plan>.

ⁱⁱⁱ 2013 Sonoma County Homeless Census & Survey, p. 7:

“As the homeless count on January 25, 2013 only provides a snapshot of homelessness at a single point-in-time, it may not adequately reflect the number of people experiencing homelessness at a different time of year, nor may it reflect the number of people who access the homeless support system over a given year. Therefore, an annual estimation formula was used to extrapolate the number of persons over a given year.”

A description of the methodology used to develop an annual estimation appears at p. 46-47.

^{iv} Burd-Sharps et al., *A Portrait of Sonoma County*, County of Sonoma Department of Health Services, 2014, <http://www.measureofamerica.org/sonoma/>.

^v See the H+T Affordability Index, <http://htaindex.cnt.org/>.

^{vi} Law enforcement and hospital cost data per Malachowski et al., *What we know about the costs of chronic intoxication in Sonoma County*, private communication, May 19, 2014, p. 3. Permanent supportive housing per Continuum of Care calculations, average annual per unit operating cost (\$11,143) based on analysis of existing Continuum of Care-funded projects; personal communication June 30, 2014.

^{vii} For a summary of the Housing First approach, see “What is Housing First?” (National Alliance to End Homelessness, 2006, http://b.3cdn.net/naeh/b974efab62feb2b36c_pzm6bn4ct.pdf) and “The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice,” (US Interagency Council on Homelessness, http://www.usich.gov/usich_resources/fact_sheets/the_housing_first_checklist_a_practical_tool_for_assessing_housing_first_in/. Accessed September 9, 2013.)

^{viii} National Low Income Housing Coalition, *Out of Reach 2014: California*. State data file, July 28, 2014: <http://nlihc.org/oor/2014/CA>.

^{ix} See for example <http://www.endhomelessness.org/library/entry/3.5-improving-economic-self-sufficiency-enhancing-employment-outcomes-and-i>.

^x 2013 Sonoma County Homeless Census & Survey, p. 28-29.

^{xi} See SSI/SSDI Outreach, Access & Recovery: <http://www.prainc.com/soar/>.

^{xii} <http://www.albany.edu/excellencehomelessservices/>

^{xiii} “No wrong door” has been described as “a philosophy of public service that strives to give consumers access to services regardless of how or where they first encounter the system.” Blakeway, C., *One-Stop and No Wrong Door Models: Integration or Coordination*, Oregon Department of Human Services, <http://www.oregon.gov/DHS/spwpd/sua/docs/one-stop.pdf>; accessed August 4, 2014.

^{xiv} *Op cit.*, SSI/SSDI Outreach, Access & Recovery.