Mission*: *Build partnerships and promote strong collaborative action to ensure all residents within the County have stable, safe, and healthy places to live.

Santa Cruz County
Housing for Health Partnership (H4HP) Policy Board
Regular Meeting Agenda
April 19, 2023; 3 pm
420 Capitola Avenue, Capitola, CA 90501 - Capitola City Hall - Community Room

Call-in # for Public Participation: (831) 454-2222 and Meeting ID: 697 057 250#

Call to Order/Welcome

1. Welcome New Members: Justin Cummings, District 3, County Board Member; Kate Nester, Program Development Manager, Central California Alliance for Health

Non-Agenda Public Comment

Action Items (vote required)

2. Approval of Minutes: February 15, 2023, Regular Meeting
3. Provide Guidance on Coordinated Entry Policy Updates, Approval of Housing for Health Partnership Connector MOU, and Approval of Steps to Steps to Set Housing Queue Threshold Scores (Coordinated Entry Policy Actions)

Information Items (no vote required):

4. Behavioral Health Bridge Housing Funding – Application Due April 28, 2023 - $10,171,130 available
5. FY 2022 HUD CoC Award Announcement for Santa Cruz County - $5.57M (≈7% increase)

Report/Discussion Items (no vote required):

6. Performance Metrics for Temporary Housing, Safe Sleeping, and Safe Parking Programs Last 12 Months
7. Public Dashboards – Brainstorm Desired Information

Board Member Announcements

Adjournment

Next Meeting: Wednesday, June 21, 2023, 3 pm

The County of Santa Cruz does not discriminate based on disability, and no person shall, by reason of a disability, be denied the benefit of the services, programs, or activities. This meeting is in an accessible facility. If you are a person with a disability and require special assistance to participate in the meeting, please call (831) 763-8900 (TDD/TTY- 711) at least 72 hours in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format. As a courtesy to those affected, please attend the meeting smoke and scent free.

Action Item 2: Approval of Meeting Minutes

(Action required) – Robert Ratner

Recommendation

Approve the February 15, 2023, Housing for Health Partnership Policy Board Regular Meeting minutes.

Suggested Motion

I move to approve the February 15, 2023, Housing for Health Partnership Policy Board Regular Meeting minutes.

Mission*: *Build partnerships and promote strong collaborative action to ensure all residents within the County have stable, safe, and healthy places to live.

Housing for Health Partnership (H4HP) Policy Board
Regular Meeting Minutes
February 15, 2023

Call to Order/Welcome
Present: Heather Rogers, Jamie Goldstein, JP Butler, Judy Hutchison, Manu Koenig, Mariah Lyons, Martine Watkins, Susan True, Suzi Merriam, Tamara Vides

Absent: *Larry Imwalle, Ryan Coonerty, Stephanie Sonnenshine, Tiffany Cantrell-Warren*

Additions and Deletions to the Agenda: None

Non-Agenda Public Comment
No public comment received.

Action Items (vote required)

1. Approval of Minutes: December 14, 2022, Regular Meeting

Discussion:	*None.*
Public Comment:	*None.*
Motion to Approve:	*Suzi Merriam*
Motion Seconded:	*Susan True*
Abstentions:	*Heather Rogers, Jamie Goldstein, Martine Watkins, Tamara Vides*
Board Action:	*Motion passed with all members except those that abstained.*

2. Approval of 2023 New Board Nominee from Central California Alliance for Health

Discussion:	*None.*
Public Comment:	*None.*
Motion:	*Approve Kate Nester as a replacement for Stephanie Sonnenshine as the Health representative on the Housing for Health Partnership Policy Board.*
Motion to Approve:	*Heather Rogers*
Motion Seconded:	*Suzi Merriam*
Abstentions:	*None.*
Board Action:	*Motion passed with all members.*

Mission*: *Build partnerships and promote strong collaborative action to ensure all residents within the County have stable, safe, and healthy places to live.

3. HUD Continuum of Care (CoC) 2023 NOFO Review Committee Nominees

Discussion:	*Potential nominees discussed. Some proposed nominees ruled out because of potential conflict of interest due to history of their entity receiving CoC grant funds or the entities plan to apply for grant funds in the next round.*
Public Comment:	*None.*
Motion:	*Approve the following individuals to participate in HUD CoC Funding Review Committee for 2023 - Larry Imwalle, Heather Rogers, Carlos Landaverry, and Karen Kern.*
Motion to Approve:	*JP Butler*
Motion Seconded:	*Martine Watkins*
Abstentions:	*None.*
Board Action:	*Motion passed with all members.*

4. Approval of Housing for Health Partnership (H4HP) Operations Committee Coordinated Entry System (CES) Policies and Procedures

Discussion: *Housing for Health Division staff shared a powerpoint presentation with updates on the proposed CES redesign. Discussed need for staff to review final policies and procedures with Tony Gardner to ensure compliance with HUD regulations and make updates to sections as outlined in the shared DRAFT materials. Questions were raised about the implications of providing points for having been arrested in the past year. Discussed how the additional eligibility questions will not be scored but used to help match individuals to programs based on eligibility. Clarified that "challenge" items will only receive a maximum of five points in the scoring. Discussed how the threshold score for getting added to the housing queue will get determined and how staff will address issues that arise if a program does not have enough potential referrals from the queue. Discussed what happens to someone once they are on the queue and clarified that once on the queue scoring will not impact their status and position on the queue is not based on total score. Matching will occur with the following sequence – (1) Meets eligibility; (2) Meets project preferences, e.g., geographic; (3) Household has the core documents required for enrollment, e.g., homelessness verifications, photo ID; (4) Date of Housing Needs Assessment; (5) Housing Needs Assessment score (used as a tiebreaker, if needed). New approach prevents newly assessed individuals from jumping the queue among those waiting on the queue for long periods of time. Intention of queue to ensure a referral is highly likely for the households within a six-month period. Discussed the critical importance on ensure there are enough well-trained Housing for Health Connectors. Discussed value of training peer specialists and community health workers and the Connector learning community. Mentioned that UC Santa Barbara may have students/program using HMIS as a potential example of ways to expand Connector role. Discussed when someone is closed/exited from the queue and*

	from the Coordinated Entry project in HMIS. Discussed the expectation of Connector follow-up every 90 days.
Public Comment:	*None.*
Motion:	*Approve the DRAFT CE policies and procedures with expectation that staff will update to ensure complies with HUD CoC standards and staff will return with information about Connector responsibilities, threshold score methodology, and regular reports on implementation starting with October 2023 meeting.*
Motion to Approve:	*Manu Koenig*
Motion Seconded:	*JP Butler*
Abstentions:	*None.*
Board Action:	*Motion passed with all members.*

Information Items (no vote required):

5. 2023 Point in Time (PIT) Count Community Planning and Volunteer Recruitment

Discussion:	*Reviewed plans for the 2023 PIT Count to be held on February 23, 2023, and that volunteer recruitment had gone well. Initial data to be submitted to HUD by the end of April 2023, and final report to likely be available in September 2023.*

Report/Discussion Items (no vote required):

6. Temporary Housing Capacity and Financing Update

Discussion:	*Reviewed documents on the status of the CoC in meeting Housing for a Healthy Santa Cruz temporary housing capacity goals and current shortage. Highlighted impact of unstable state funding and the impacts on programs, staff, and participants. Discussed whether HOME-ARP funding could be helpful for paying for shelter and current state DRAFT program regulations indicate funds will not be available for shelter.*

Board Member Announcements

No additional announcements.

Adjournment

Next Meeting: Wednesday, April 19, 2023, 3 pm

The County of Santa Cruz does not discriminate based on disability, and no person shall, by reason of a disability, be denied the benefit of the services, programs, or activities. This meeting is in an accessible facility. If you are a person with a disability and require special assistance to participate in the meeting, please call (831) 763-8900 (TDD/TTY- 711) at least 72 hours in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format. As a courtesy to those affected, please attend the meeting smoke and scent free.

Action Item 3: Provide Guidance on Coordinated Entry Policy Updates, Approval of Housing for Health Partnership Connector MOU, and Approval of Steps to Set Housing Queue Threshold Scores (Coordinated Entry Policy Actions)

(Action required) – Monica Lippi/CoC Operations Committee

Recommendation

(1) Provide specific guidelines for Housing for Health staff on Coordinated Entry policy changes that should be brought to the Policy Board for consideration before adoption.
(2) Approve the Connector Services MOU Between Covered Homeless Organization and Housing for Health Partnership; and
(3) Approve Next Steps for Setting Threshold Scores to Move Participants to the Housing Queue.

Background

The U.S. Department of Housing and Urban Development (HUD) requires Continuums of Care (CoCs) to establish and operate a "centralized or coordinated assessment system" (referred to as "coordinated entry" or "coordinated entry process") with the goal of increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources, including mainstream resources. Both the CoC and ESG Program interim rules require use of the CoC's coordinated entry process if it meets HUD requirements. Coordinated entry processes are intended to help communities prioritize people who are most in need of assistance. They also provide information to CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.

Housing for Health Division staff, working with Bitfocus and Focus Strategies, has developed a redesign of the coordinated entry process for the CoC approved by the CoC Policy Board at its February 15, 2023, meeting. H4H staff involved community members and people with lived experience of homelessness in the development of the redesign. The proposed redesign uses a problem-solving approach to work with people experiencing homelessness in moving towards stable housing; staff providing this service are referred to as Connectors. The approach is intended to facilitate frequent and useful engagement with people experiencing homelessness, as well as more transparency for participants and service providers about who will be referred to housing programs and realistic timeframes for referrals. These are particularly critical changes because the CoC does not have sufficient CoC-linked permanent housing resources to refer all people experiencing homelessness to dedicated housing resources within the system.

The Policy Board approved several action steps related to updating the CoC coordinated entry policy at its December 2022 and February 2023 meetings. The redesigned Coordinated Entry System (CES) began implementation on April 1, 2023. Three issues are presented for your consideration.

Coordinated Entry System Policies

In January 2023, the H4HP Operations Committee approved the Draft CE Policies document. The Draft CE Policies were also shared with the Continuum of Care's HUD expert consultant to ensure compliance with HUD regulations and expectations. After approval from the Operations Committee, the CoC HUD expert provided comments and suggestions for the H4HP to consider for integration into the approved draft document. In February, the Policy Board provided preliminary approval for the Draft CE Policies pending edits based on the HUD expert's input.

H4H Division staff thoroughly reviewed and responded to all input provided by the HUD consultant. The HUD consultant reviewed and agreed with the changes, and the Draft CE Policies were subsequently approved by the Operations Committee in March 2023. The Policies now reflect current policy of the CoC.

We are also requesting that the Policy Board consider the extent to which the Operations Committee and H4H Division staff can modify and/or refine the CE Policy document over time without Policy Board approval. We anticipate that the CE Policies will evolve with changes to the H4HP priorities, local context, and other factors. We are asking the Policy Board to propose specific guidelines for staff on policy changes that should be brought to the Policy Board for consideration before adoption.

Connector Services MOU Between Covered Homeless Organization and Housing for Health Partnership

The H4H Division, with input from the H4HP Operations Committee, has developed a Memorandum of Understanding (MOU) to define roles and responsibilities of the H4H Division, Provider Organizations (CHOs), and staff serving as H4HP Connectors. The MOU is entered into between the CHO and the Santa Cruz County Housing for Health Partnership (H4HP) and covers responsibilities of the H4H Division, responsibilities of the CHO, and responsibilities of the Connectors. An addendum to the MOU also requests information about each person identified to be a connector from the CHO (name, title, contact information, supervisor, expected number of hours per week, population to be engaged with).

In March 2023, the H4HP Operations Committee reviewed the draft Connector Services MOU, provided feedback, and approved the document pending incorporation of the feedback. H4H Division staff has also shared the MOU with current Connectors and has received no additional suggestions for revision. We are asking the Policy Board for approval of the MOU.

Setting Threshold Scores to Place Households on the Housing Queue

One of the primary goals of the Coordinated Entry redesign is to put households on the Housing Queue who have a high probability of being matched and referred to a CoC housing program within the next six months. To determine the number of households on the Housing Queue that will achieve that desired result, information about the number of households completing the HNA, their scores on the HNA, and the number of H4HP housing resources becoming available for each household type is

required. Data shared with the H4HP Operations Committee in March 2023, indicated that housing opportunities over a six-month time frame included availability for 10 seniors and adults with disabilities, 22 transition aged youth, and 56 families. Additional permanent housing inventory (22 units) for adults with disabilities is expected to come online in 2023, increasing the number of people that may be matched to a housing opportunity.

Housing Needs Assessment (HNA) thresholds represent the minimum score that households, based on their household type, must have to be placed onto the Housing Queue and are based on the anticipated inventory for each population (household type). In February 2023, the Policy Board approved the recommendation that no more than the top 10% of the scoring range (the total possible points for Adults and TAY are 23 and 25 points for Families with Children) would be referred to the Housing Queue upon implementation in April 2023, meaning the intended starting threshold based on the possible points would be 20 for Adults and TAY and 23 for Families.

Preliminary HNA scores, however, indicate that households are scoring considerably lower than these thresholds. Moreover, the number of households with complete HNAs is very low; only 17 households had completed an HNA as of March 31, 2023. Their scores according to household type are reflected in the table below.

Population	Possible Range	Approved Threshold February 2023	# of HNAs	Actual Range	Average Score
Families with Children	0-25	23	6	5-16	8.8
Transition Age Youth	0-23	20	2	14-15	14.5
Adults	0-23	20	9	3-13	9.1

In addition to the scores being relatively low, current data indicate that among Adult households with completing HNAs none meet the HUD criteria for chronic homelessness. Chronic homelessness is an eligibility criterion for almost all of the CoC-linked permanent housing resources available to Adult households in the community. At this time, no Adult households with complete HNAs are eligible for referral to CoC-linked permanent housing with chronic homelessness eligibility criterion.

<u>Immediate Next Steps Proposed</u>

To avoid full implementation of a CE process prior to having sufficient information for setting appropriate thresholds, the H4H Division proposes the following approach for moving households to the Housing Queue and referring them to housing opportunities:

1) Continue the current HNA process as new participants are encountered, adding, as appropriate, families with children, TAY, and adults experiencing chronic homelessness to the Housing Queue regardless of their threshold scores.

2) In those cases when no eligible households are available to refer from the Housing Queue, identify households from the "retired" SmartPath Housing Queue that have a completed VI-SPDAT within the last 12 months and meet eligibility criteria for the housing opportunity.

In addition, the H4H Division will:

3) Develop and implement an interim web-based method for stakeholders and people experiencing homelessness to express interest in linking with a Connector. The proposed process will collect basic eligibility information to support linking households with a Connector.

4) Engage in targeted recruitment of additional Connectors from specific agencies most likely to be engaged with people in Santa Cruz experiencing longer-term homelessness. The goal is to increase the availability of connection opportunities for adults experiencing chronic homelessness to complete HNAs and thus be available to be moved to the Housing Queue.

Staff will return to the Policy Board at the June meeting with updates on progress.

Suggested Motion

I move to approve:

(1) The <following> specific guidelines for Housing for Health staff on Coordinated Entry policy changes that should be brought to the Policy Board for consideration before adoption.
(2) The Connector Services MOU Between Covered Homeless Organization and Housing for Health Partnership supported by the Operations Committee with changes incorporated.
(3) Next Steps for Setting Threshold Scores to Move Participants to the Housing Queue approved by the Operations Committee and as outlined in this Board action memo.

DRAFT – HOUSING FOR HEALTH PARTNERSHIP
SANTA CRUZ COUNTY COORDINATED ENTRY POLICIES - DRAFT
April 2023

1. INTRODUCTION AND OVERVIEW

1.1 Why Coordinated Entry?

Coordinated Entry is a community's systemic approach to connecting people experiencing homelessness with available assistance in the community. The Santa Cruz County Coordinated Entry System is designed to integrate and utilize Housing for Health Partnership Connectors and Housing Problem Solving as the core approach to providing support and assistance to all persons experiencing homelessness. This approach recognizes that there isn't an immediate housing resource available for each person but understands that most persons can benefit from support, services, and partnership in problem solving to resolve homelessness.

The Santa Cruz County Coordinated Entry System is guided by the belief that homelessness is preventable and solvable. Santa Cruz County's response to homelessness is grounded in guiding principles to ensure equitable access that is culturally responsive, compassionate, and trauma informed. Linkages to permanent housing through coordinated entry will utilize a Housing First[1] approach.

The goals of Santa Cruz County's Coordinated Entry System include: (1) Facilitating connections to mainstream and community services for as many persons experiencing homelessness as local resources allow; (2) Streamlining the process for matching to limited housing resources within the Housing for Health Partnership network (CoC); and (3) Prioritizing resources to households with the most significant barriers to getting and keeping housing without support and to those with the greatest personal health and safety risks.

1.2 Coordinated Entry Process Overview

Santa Cruz County's Housing for Health Partnership defines Coordinated Entry as the approach to coordinate and manage the system's housing, participating shelter and supportive services resources[2] to enable providers to make equitable decisions to best connect people experiencing homelessness to interventions to end their homelessness based on available information and resources.

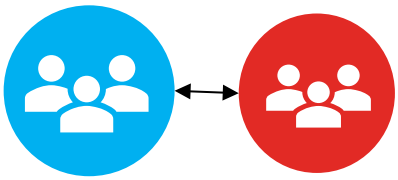
The Coordinated Entry *process* seeks to ensure that people experiencing homelessness have fair and equitable access to the set of resources and services for which they are eligible, regardless of where they present for assistance, and that resources designed for households

[1] Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. See U.S. Department of Housing and Urban Development's (HUD) Housing First Policy Brief for additional information: https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/

[2] Housing and service resources formally linked to Santa Cruz County's Continuum of Care (Housing for Health Partnership) through funding expectations or written partnership agreements.

Coordinated Entry Process Overview

Steps to Housing with Connectors and Participants



Engagement

Connectors engage with people experiencing homelessness to build relationships and support immediate needs.

Housing Needs Assessment (HNA)

Connector and participant have conversations and may complete a Housing Needs Assessment. The HNA provides information on the participant's circumstances, needs, desires and strengths.

Housing Action Plan (HAP)

Connector and participant may use the Needs Assessment to identify areas to work on together and create a Housing Action Plan. Steps in the Plan connect participants to help they may need to secure housing, income, and other services.

Housing Secured

Participants continue to get support to identify a solution and regain housing in the community. Those with a program referral are supported to get into the housing program they are referred to.

Shelter/Temporary Housing

Designated Connectors may refer eligible participants directly to shelter if beds are available. *Due to supply limitations most participants will not get immediate shelter.*

Steps at the County Housing for Health Office

Scoring

When completed, the HNA is automatically sent to the County Housing for Health office and a score is calculated.

Participant may be added to housing queue

Some participants who are eligible and score highly are added to a queue for limited permanent housing resources. H4HP will notify the Connector if this happens. *Only a small percentage of participants are added to this queue.*

Referral

H4HP refers households from the housing queue based on availability and eligibility. Connectors are notified when this happens.

with highest service and housing needs are targeted to those who need them most. The process recognizes that housing resources and services are limited. Housing for Health Partnership (H4HP) Connectors, designated people specifically trained in this process, work to provide as many people as possible experiencing homelessness with support, connection to services, problem solving partnership with the goal of resolving homelessness.

The Coordinated Entry *system* refers to the whole of the public, private, and non-profit agencies and programs that participate in Coordinated Entry in any of the ways defined in and governed by these policies.

1.3 Coordinated Entry Policy Requirements

The U.S. Department of Housing and Urban Development (HUD) requires Continuums of Care (CoCs) to develop and maintain policies and procedures covering a wide variety of Coordinated Entry (CE) practices including, but not limited to, geographic coverage and access including for specific populations; the assessment, prioritization and referral process and criteria/factors used to prioritize; privacy protections, appeals, marketing, outreach, prevention, and evaluation. This Coordinated Entry Policy document, along with procedures established for specific areas of Coordinated Entry and memorialized in other policy documents referenced herein (such as the Homeless Management Information System (HMIS) Privacy and Security Policies,) constitute the required Policies and Procedures for Coordinated Entry.

1.4 Scope of Coordinated Entry

Coordinated Entry is a required process for all communities that receive funding from the U.S. Department of Housing and Urban Development.

1.4.1 Programs Required to Participate

Housing and services programs and projects that receive certain types of federal, state, or local funding, including HUD Continuum of Care (CoC) funds and Emergency Solutions Grant (ESG) funds, are required to use the HMIS system and participate in Coordinated Entry.

Programs funded by other sources *may* be required to participate as part of an agreed funding structure, such as having received additional points or priority in a competitive bidding process such as a Request for Proposals (RFP) based on a commitment to participate in CE.

Required participation may vary depending on the design of the program and whether access to it depends on prior enrollment in another CE program.

1.4.2 Programs Encouraged to Participate

In order to make available the widest possible array of resources to people experiencing homelessness, other programs such as shelters and housing that do not receive any of the above funding are strongly encouraged to participate. Efforts to engage such programs will

be made regularly, and non-participating programs are invited to share their rationale or concerns for not participating to allow them to be addressed, if possible.

1.4.3 Participation by Domestic Violence programs

The Federal government prohibits programs that specifically serve survivors of domestic and/or gender-based violence from entering client data into HMIS. DV providers utilize a HMIS comparable database that is separate from the Housing for Health Partnership response system to protect the confidentiality and safety of survivors. Persons identified as seeking DV services for immediate safety needs will be referred directly to the DV system. Once their immediate safety needs have been addressed, they may participate in Coordinated Entry through the existing network of Connectors, including H4HP Coordinated Entry provisioned DV providers.

2. GOVERNANCE

2.1 Required Roles

The Coordinated Entry system and process require ongoing day-to-day management as well as community participation in design, implementation, evaluation, and improvement of the process. HUD requires that the entity charged with management of day-to-day operations and the entity charged with oversight be distinct and that both be designated by the HUD recognized Continuum of Care (CoC).

2.1.1 Policy Oversight Entity

The Policy Board of the Housing for Health Partnership (H4HP) serves as the Policy Oversight Entity and Continuum of Care board which reviews policy and establishes participation expectations, performance standards, and data collection, quality and sharing protocols. The Policy Board has designated primary responsibility for this function to the System Operations, Data and Evaluation Committee (Operations Committee).

2.1.2 Management Entity

The Housing for Health division (H4H) of the County of Santa Cruz Human Services Department has been designated by the H4HP Policy Board to serve as the Coordinated Entry Management Entity to implement day-to-day workflow of the Coordinated Entry process. Management Entity responsibilities include establishing management structures, ensuring access, promoting standardized screening and assessment processes, developing, and delivering training, and conducting monitoring. H4H also serves as the Collaborative Applicant for Continuum of Care grants,

Further information about the Governance and roles and responsibilities of the Policy Oversight and Management Entity can be found in HUD's Coordinated Entry Management and Data Guide and in the Santa Cruz County Housing for Health Partnership Governance Charter.

2.1.3 HMIS Lead Agency

The lead entity for the CoC implementation of Homeless Management Information System (HMIS) is the County of Santa Cruz Human Services Department Housing for Health Division (H4H) and the system is administered by Bitfocus. Bitfocus has been designated by the H4H Policy Board to operate HMIS, ensuring that the Coordinated Entry System has access to HMIS software and functionality for the collection, management, and analysis of data on persons served by coordinated entry.

2.1.4 Covered Homeless Organization (CHO)

A Covered Homeless Organization (CHO) is an organization participating in HMIS that has agreed to provide services and supports to people experiencing homelessness on behalf of the CoC. CHOs execute an Organization Partnership and Data Sharing Agreement with the CoC, may act as Referral Partners and agree to receive direct referrals from the CoC. CHOs receiving CoC or ESG funding must participate in Coordinated Entry.

2.1.5 Mainstream System Provider

A Mainstream System Provider is any agency, other than a CHO or program that specifically serves survivors of domestic and/or gender-based violence that provides services or assistance to those served by coordinated entry.

2.2 Use of the Homeless Management Information System (HMIS)

The Homeless Management Information System (HMIS) is the data system that is used for all Coordinated Entry activities including, enrollment, Housing Needs Assessments and housing action planning, prioritization, queue management, and matching.

2.2.1 HMIS Training and licensing

All Connectors and program staff supporting CE activities must be trained and licensed to use the HMIS system and follow all requirements in the HMIS policies.

2.2.2 Privacy and Security

All staff supporting CE activities will follow HMIS protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the Coordinated Entry process and providing Connection and Problem-Solving services including the development of Housing Action Plans. This includes a requirement to follow all rules regarding the capture, transmission, and storage of Personally Identifying Information (See HMIS Privacy and Security Standards).

2.2.3 Use of a Comparable Database

Victim Service Providers are prohibited from entering data into HMIS and may be required to use a comparable database to participate in CE. A comparable database is a relational

database that meets all HMIS Data Standards and does so in a method that protects the safety and privacy of survivors.

2.2.4 Right to Abstain from Disclosing or Sharing Information

Coordinated Entry participants may freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal. However, participants may be unable to qualify for consideration for specific programs or services that require disclosure of specific information for purposes of establishing or documenting program eligibility.

2.3 Non-discrimination and Affirmative Marketing

2.3.1 Applicable Civil Rights and Fair Housing Law

All programs that receive referrals from CE are permitted and expected to comply with all applicable State and Federal civil rights and fair housing laws and requirements, including, but not limited to:

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and
- Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.
- Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.
- HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

2.3.2 Affirmative Marketing

Housing providers participating in CE must affirmatively market their housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and to maintain records of those marketing activities. Housing assisted with CoC funds must also be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2).

Use of the Santa Cruz Coordinated Entry system may be considered consistent with affirmative marketing as the CE system affirmatively markets to all eligible persons as specified above. Housing providers may advertise that they participate in CE and should at a minimum ensure that this information is made available to any potentially eligible person who contacts them directly or who seeks information in publicly available ways such as a housing provider's website.

3. ACCESS

3.1 Full Coverage

Housing for Health Partnership's Coordinated Entry approach covers the entire geography of Santa Cruz County, which is the same as the Continuum of Care boundaries, through a variety of methods which include Connection Points with designated H4HP Connectors, as well as street outreach which covers all regions of the County, and phone line access.

3.2 Connection Points

Connection Points (formerly referred to as Access Points) are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness seeks and receives assistance to connect to resources and services that are available through Coordinated Entry. A full list of Connection Points is available either by calling the 2-1-1 line or by accessing the H4HP Website.

3.2.1 H4HP Connectors

The people who work at Connection Points and carry out the participant-directed key activities of Coordinated Entry are called Connectors. H4HP Connectors serve the system by meeting persons experiencing homelessness where they are and initiating strengths-based problem-solving conversations and conducting housing needs assessments. H4HP Connectors may work as part of an outreach team, drop-in center, multi-service center, or other program serving people experiencing or at-risk of homelessness. They work to identify persons experiencing homelessness to build rapport; conduct initial triage and safety screenings; enroll participants in HMIS programs and collect participant data; engage participants in the Housing Needs Assessment and problem-solving; support individuals and families to identify housing outside of the Housing for Health Partnership response system;

create a Housing Action Plan; and make referrals that support participant goals identified in the Housing Action Plan.

3.3 Connection Points for Designated Subpopulations

To ensure that access is both convenient, comfortable, and appropriate to the range of potential persons and households needing assistance in Santa Cruz County, certain subpopulations of people experiencing homelessness may access the Coordinated Entry system through designated Connection Point providers or Connectors with specialty services designed for this population. One or more designated Connection Points may be established for:

- Families experiencing homelessness
- Transition Age Youth
- People fleeing domestic or gender-based violence

Members of subpopulations are not required to use a designated Connection Point and may seek and receive services at any Connection Point.

3.3.1 Connection for Veterans

Veterans experiencing homelessness may connect to services through coordinated entry Connection Points or through direct connection to programs administered by the VA and their community partners. Veterans who are identified through the Coordinated Entry system will be given a brief assessment to determine if they are eligible to receive services through the Veterans Administration (VA). Veterans seeking such housing and services will be referred to local Supportive Services for Veteran Families (SSVF) contractors and the Santa Cruz County Human Services Department's Veterans Services Office. SSVF will refer participants to HUD VASH services when applicable.

Veterans who do not qualify for VA services may be served through the Coordinated Entry process and may be served at any Connection Point based on their other population characteristics (adult, family or TAY).

3.4 Weekend and Evening Access

To ensure that persons experiencing homelessness or a housing crisis that could lead to literal homelessness can get information about how to access the system during times that Connection Points are not open and/or street outreach teams are not operating, H4H has designated the 2-1-1 line to serve as 24/7 Call Center. Crisis resources are limited. The call center will have information about resources such as any shelter beds that may be open and accepting referrals over a weekend or in the evenings and will inform callers about how to access Connection Points as soon as possible to complete the Housing Needs Assessment and Connection supports, including locations, target populations (if any) and hours.

3.5 Non-discrimination and accessibility

3.5.1 Non-discrimination

The Coordinated Entry system including all Connection Points and other participating programs may not discriminate against any populations or subpopulations in Santa Cruz County in the Coordinated Entry process. This includes people experiencing chronic homelessness, veterans, adults with children, transitional aged youth, and survivors of domestic violence, regardless of the location or method by which they access the H4HP response system.

3.5.2 Language Access

The Management Entity and Connection Points must take steps to ensure equal access for speakers of other languages. At a minimum this means that telephone interpretation in the County's threshold languages will be available via a County-sponsored language line. The Management Entity will also arrange for translation of public facing documents that are key to the CE process into Spanish. Connection Points are encouraged to hire staff who speak languages other than English, and which are widely spoken within the population and/or geography of the Connection Point.

3.5.3 Physical Accessibility

When selecting agencies to serve as physical Connection Points, the County will contract with agencies proposing locations that are physically accessible or are able to make modifications such as adding ramps or elevators for persons who require them. Visual and auditory accessibility accommodations are also available upon request. The County will also consider the availability of public transportation and the proximity of Connection Points to other frequently used resources such as emergency shelters, drop-in centers, free food resources, and other crisis response service locations.

4. ASSESSMENT AND PRIORITIZATION

4.1 Overview of Assessment and Prioritization

The Coordinated Entry process uses a strengths-based approach to provide support to individuals and families experiencing homelessness to leverage connections to mainstream and community resources while also utilizing a housing problem solving approach. The goal is for all persons experiencing homelessness to be connected to services available such as healthcare, employment, benefits, and other resources that help meet their basic needs.

Through this approach, Connectors will conduct the Housing Needs Assessment (HNA). The HNA serves to provide Connectors and participants with the information needed to create and act together on an individualized Housing Action Plan, and to provide information to

H4H to determine which participants are eligible and prioritized for H4H supported housing and services. Most of the HNA questions are self-reported by a participant. The questions are intended to be asked in a conversational way and Connectors are trained to use the HNA to help meet immediate needs as well as identify longer-term strategies to assist participants. A question is included in the HNA that records the Connector's observations based on their interactions with the participant.

4.2 Overview of Assessment and Prioritization Workflow

The workflow for the phased assessment approach is intended to only collect the information that is needed at each step and to avoid misleading expectations of certain types of assistance.

4.2.1 Steps in Workflow

The Assessment and Prioritization workflow has core steps with Housing Problem Solving occurring throughout the entire process. These steps include:

1. Triage, Assessment, and Addressing Immediate Health and Safety Issues
2. Coordinated Entry Project Enrollment
3. Housing Needs Assessment and Housing Problem Solving
4. Housing Action Plan

4.2.2 Timeframes

The steps of the Assessment and Prioritization process are independent and may occur together or sequentially and in a single interaction or over multiple interactions. Triage should always occur first and Housing Problem Solving should be offered as soon as appropriate. The Housing Needs Assessment may be started right away along with Problem Solving or may begin after an initial Problem Solving exploration. There is no specific time frame for completion of the Housing Needs Assessment. However, Connectors are expected to be in touch with participants at least once a week while they are active in Coordinated Entry and should seek to keep the conversations timely and the information gathered relevant. The timeframes should be client driven, keeping in mind the participant's needs and preferences. Completed Housing Needs Assessments should be updated at least every 90 days while the participant remains active.

After the Housing Needs Assessment and Housing Action Plan process is implemented, the Management Entity will closely monitor the length of time Connectors take to complete the Assessment and Prioritization process. The monitoring process will include review of HMIS data and feedback provided by Connectors during the regularly scheduled Learning Collaborative. By the end of the first quarter (June 2023), the Management Entity will establish an average expected time for Connectors to complete the Assessment and Prioritization process.

4.3 Triage

Triage is the first step in the Coordinated Entry process. This step consists of a set of initial questions and steps to determine that the person presenting qualifies for and needs the services of Coordinated Entry. This step also screens for any health and safety needs. It includes three topics areas: urgent needs, safety planning, and eligibility.

4.3.1 Urgent needs

Prior to any other services, a Connection Point will assess whether the participant is expressing or displaying any urgent needs such as a health or behavioral health emergency. In such situations Connection Point staff will call crisis services or 911.

4.3.2 Safety Needs and Safety Planning

A safety risk assessment is conducted to determine if someone may be fleeing or attempting to flee domestic violence or human trafficking or is a survivor of the same. Anyone who at this point is identified as fleeing or potentially fleeing, or is a survivor who desires DV services, should be offered connection to DV resources for immediate safety needs and ongoing supports. If the person who is a survivor declines these resources and continues to the next step in the workflow, safety considerations and safety planning should be addressed in the Housing Action Plan.

4.3.3 Housing Status Determination

Resources available through the Coordinated Entry process and through referrals to external partners are different and prioritized depending on the housing status of the participant household, with priority for housing resources given to those who are "literally homeless". After initial triage for safety, Connectors will ask questions to determine a participant's current housing status. Literal homelessness includes individuals or families living in places not meant for human habitation including on the streets, in tents, make-shift shelters, or in a vehicle. Individuals and families staying in emergency shelters, transitional housing or placed in temporary accommodations paid for by a third-party also meet the definition of literal homelessness.

If the participant meets the definition of "literal homelessness" they are eligible for the problem solving/housing needs assessment workflow. The H4HP Connector will start with explaining the coordinated entry/connection process, review the HMIS Consumer Information Sharing Authorization with the participant, and will proceed to create or update a Client Profile in HMIS.

If the household is at-risk of homelessness but not eligible for the housing and shelter resources of Coordinated Entry and could benefit from homelessness prevention, the H4HP Connector will provide prevention services if they have them available within their agency. If they do not have such resources they will refer at-risk participants to the 2-1-1 line or other

prevention services providing agencies to determine where prevention resources are currently available.

4.4 HMIS Coordinated Entry Enrollment

All Coordinated Entry participants that proceed from triage to a Housing Needs Assessment and Problem-Solving conversation must first be enrolled in in the Coordinated Entry Program by following the appropriate HMIS Policies and Procedures. An up-to-date enrollment allows the CoC to report as required on the operations and outcomes of Coordinated Entry. The enrollment process includes adding/updating the Client Profile, HMIS Consumer Information Sharing Authorization, Client Enrollment in Coordinated Entry, and the Current Living Situation Assessment.

4.5 Housing Needs Assessment

4.5.1 Purpose of Housing Needs Assessment

The Housing Needs Assessment (HNA) is the conversational tool used by Santa Cruz County Housing for Health (H4H) Partnership to understand participant needs, resources, and goals and to support participants with accessing housing and other resources. Information collected during this assessment helps identify potential problem-solving resolutions and helps develop a Housing Action Plan (HAP) with action steps for participants and Housing Connectors. The HNA includes standardized questions that help establish priority and matching information for limited housing resources available through the H4HP System. Information collected helps determine the likelihood of a participant getting matched to a specific H4HP resource.

4.5.2 Scope of Housing Needs Assessment

The Housing Needs Assessment covers six domains of participant household experience and needs: Household Composition; Housing History; Income and Benefits; Social Supports; Legal and Documentation Issues; and Health. Each section includes prompts for a Connector and participant to have a wide-ranging conversation on the topic area and some specific questions that are used for either scoring and/or matching information for housing programs. The Housing Needs Assessment is designed to be used in one or multiple meetings and to feed into the Housing Action Plan.

4.5.3 Housing Needs Assessment Prioritization Factors

The Housing Needs Assessment incorporates factors from the participant profile and program enrollment as well as new questions in each of the topic domains. Certain questions are used to establish a score which indicates relative need or vulnerability in each domain. Factors used in scoring include:

- Household size and ages of household members
- Housing history, length of time homeless and housing barriers

- Income, benefits, and financial "well-being"
- Social supports
- Legal issues (e.g., criminal involvement and documentation)
- Disabilities and health related questions

In addition, the HNA collects information about housing preferences and provides an opportunity for the Connector to make note of specific observations that may point to additional participant needs.

4.5.4 Conducting the Housing Needs Assessment

H4HP Connectors will ensure that the time and privacy needed to conduct a Housing Needs Assessment are available and that the participant is comfortable proceeding before beginning a Housing Needs Assessment. When starting the HNA, H4HP Connectors should explain the process, the purpose, and the potential outcomes, including that available housing resources are extremely limited. The HNA is designed with prompts to encourage the coverage of certain topics, but each conversation may be different and Connectors are encouraged to use the prompts as suggestions rather than required questions. The HNA may be completed in one or several settings and in any order that is comfortable for the participant and Connector. Participants are not required to answer any or all of the questions on the HNA including but not limited to disability information.

At the bottom of each section are specific response choices that are related to scoring or matching. These need to be completed before the HNA can be considered complete and the Assessment score generated.

Questions in the HNA related to income level, health, social history and other factors are designed to identify those with high service needs and to connect individuals with appropriate housing and services to meet their needs. Questions in the HNA are never used to screen people out of consideration for services or housing due to any perceived barriers such as a lack of income, past or current substance use or criminal justice history, DV history, past experiences in services or housing, or type of disability.

4.6 Generating the Housing Action Plan

Information in the Housing Needs Assessment can be used to generate a Housing Action Plan. At the end of each domain is a question about whether anything among the topics just discussed are a priority for the Connector and participant to work on. Checking that box opens a row in the Housing Action Plan and carries over the notes from that section. The Housing Action Plan includes space to identify specific goals, the strengths brought by the participant to achieve the goal, resources needed to achieve the goal, the steps that each of the Connector and participant agreed to take to address the identified need, the time frame for completion, and the status of the goal.

Excerpt from an Example Housing Action Plan

Section 1: Household Goals						
Goal(s)	**Participant Strengths**	**Resources Needed to Achieve Goal**	**Participant Will**	**Connector Will**	**By When**	**Goal Status**
Establish childcare for child (age 3)	*Understands childcare system, has had other children in daycare*	*Financial support*	*Contact childcare referral network (include contact information)*	*Provide information and support making contact. Follow up with participant by (include date)*	*Date* _____	*In progress*

Housing Action Plans should focus on steps that support the participant on a path toward housing. They must be client directed and should be limited in scope to between two and five things that can be worked on at time.

4.6.1 Housing Problem Solving

A primary purpose of the HNA/HAP process and the role of Connectors is to determine with a participant what steps can be taken to resolve their homelessness or help them establish a path to housing, in most cases without a dedicated H4HP housing resource.

Housing Problem Solving is an approach that utilizes strengths-based engagement to identify and explore options for safe housing solutions outside the Housing for Health Partnership response system. The HNA is used to help facilitate a Housing Problem Solving conversation and explore opportunities to help participants become rehoused outside the system while also identifying service needs of the participant.

If an immediate resolution is identified, such as moving in with family or friends, or quickly securing a new place to live, the Connector and participant should focus on immediate steps needed to secure this resolution. Some limited financial assistance may be available to support resolutions of this type. The Housing Problem Solving strategies and steps are reflected in the HAP.

4.6.2 Messaging after Housing Need Assessment

Although Connectors are able to see the score resulting from the completed HNA, they do not add participants to queues. After completing an HNA and associated Housing Action Plan, a Connector should reiterate to the participant that housing resources are very limited, and the participant will be notified by the Connector or someone else with whom they are working if they are added to the queue. Connectors should ensure that they have recorded in HMIS multiple ways to contact participants (phone, mail, email, alternative contacts and should set up a scheduled time to meet with the participant to engage on next steps with the Housing Action Plan. Working together on the Housing Action Plan should allow time for a determination to be made if the participant will be added to the queue. Connectors will work with participants for up to 90 days following completion of a HNA with opportunities for extensions if the participant remains homeless and in need of support.

Connectors should emphasize that they will continue to work with the participant on the Housing Action Plan and Housing Problem Solving to seek a resolution. They should also share information about other resources that may be available to them, such as getting on affordable housing waitlists, funds for move in costs, and potential flexible funding.

4.6.3 Active Time Frame of Housing Needs Assessment

A Housing Needs Assessment is considered valid and active for 90 days as long as nothing has changed. After such time, or if the participant has had a change in circumstances or housing status, the Housing Needs Assessment should be updated. The HNA expires if no updates are made after 90 days, and the participant will not be considered for referral.

4.6.4 Updating the Housing Action Plan

The Housing Action Plan is intended to be a living tool for the participant and Connector. The Housing Action Plan should be updated frequently during the time the Connector and Participant are working together to reflect current status of participant needs and the progress made on specified activities.

4.6.5 Handoff of the Housing Action Plan

While the Housing Action Plan may be generated and begun with a Connector, a participant may have the opportunity to work with another service support staff to carry out the steps. For example, a household that goes into shelter where there is case management available can and should be encouraged to work with the new case management or service support staff on the Housing Action Plan, including new or remaining steps.

5. QUEUES AND QUEUE MANAGEMENT

5.1 Overview of the Housing Queue

The Housing Queue is a list of eligible and prioritized households used to match and refer to a specific set of corresponding resources available through the Coordinated Entry process. The Queue is established and maintained in the HMIS system. A queue will not be established for access to family or adult shelter; Coordinated Entry will designate certain Outreach teams to make direct referrals to emergency shelter programs. Shelter referrals will not use the Housing Needs Assessment score for prioritization but will take into account participant willingness to consider shelter as well as other participant characteristics.

5.2 Housing Queue

Households that complete the entire HNA and score at or above a corresponding threshold will be added to the Housing Queue, which is a list of prioritized households maintained in the HMIS system. The Housing Queue pulls information from the HNA and the head of household's profile and enrollment to be used for matching and referral (see below.)

5.3 Threshold Score

A Threshold Score refers to the score on the Housing Needs Assessment that qualifies a participant household to be added to the housing queue and to be considered *prioritized* for one or more of the resources available to persons on that queue.

5.3.1 Establishing threshold score

A threshold score is established by the Management Entity by reviewing the current and anticipated inventory over a period of 90-180 days and estimates of how many referrals may be necessary to fill openings in a timely fashion while not adding participants to queues who are extremely unlikely to receive a referral.

The specific factors for the ratio of anticipated referrals to openings and the length of time for the openings to occur is adopted and posted as a separate policy to allow for regular updating.

5.3.2 Threshold variation by subpopulation

Because resources for certain subpopulations are more plentiful relative to the population group, such as Veterans, Transition Age Youth (TAY) and families with children, threshold scores may be different or there may be no threshold score required for certain household types.

5.3.3 Adjusting threshold scores

Because thresholds scores are established based on available and anticipated inventory and on the number of referrals that are typically needed to fill an opening, H4H can and should adjust thresholds when:

1. A significant increase in inventory occurs or is anticipated that could result in resources being unused or underused if more households are not prioritized for those resources, for example, the anticipated opening or one or more new projects or programs.
2. A significant decrease in inventory occurs that could result in many more households being prioritized than can be anticipated to be served.
3. The ratio at which referrals result in enrollments changes such that more or fewer households should be prioritized in order to fill openings in a timely fashion.

Anyone determined to be eligible and prioritized who is added to a queue will retain their status on the queue even if a threshold is adjusted to be higher than the score they originally received.

5.3.4 Frequency of adjusting threshold scores

The Management Entity will review all threshold scores for confirmation or adjustment not less than annually, and more frequently if warranted by one or more of the three conditions described above. However, very frequent changes in thresholds are not desirable as this may cause confusion and could result in persons with similar needs getting unequal access to resources.

Information regarding the establishment and adjustment of threshold scores, including the factors used to set them and their operative time frames will be retained by the Management Entity to ensure that changes over time can be tracked and measurement and research on impacts of changes is possible.

5.3.5 Responsibility for Queue Management

H4H manages the Housing Queue and is the only entity that can add participants to it. H4H will add households to the queue who have expressed interest in the resources associated with the queue, completed any corresponding assessment fully and, if applicable, have received a score which meets or exceeds the threshold required to be placed on the queue.

H4H will notify Connection Point staff or other staff attached to a participant when the participant is added to the Housing Queue. Connectors will have read-only access to viewing the Housing Queue to determine if participants have been added.

5.4 Removal from the Housing Queue

5.4.1 Removal from the Housing Queue

A participant will be removed from the Housing Queue if 6 months have elapsed with no contact, or when they have been referred to a permanent housing resource within the Housing for Health Partnership CES system, or if they are connected to and enrolled in a

mainstream housing resource such as a Housing Choice Voucher, even if they are still engaged in housing search.

Once on the housing queue, a participant household remains on the queue until they are removed from the queue for one of the reasons mentioned above***. A household already on the queue does not lose their place on the queue if the threshold score is changed,*** however the HNA still needs to be updated every 90 days regardless of queue placement**.** Changes in threshold score apply only to new or updated HNA's.

A participant will be exited from the Coordinated Entry program in HMIS (if enrolled) and removed from the housing queue, if not already done, when they move into any type of permanent housing including on their own without assistance, if they leave the county without the intention to return within 90 days, are in institutional care for longer than 90 days, if they are deceased, or are no longer interested in being considered for any resource within Coordinated Entry.

5.4.2 Re-referral to a Queue

If a participant is automatically or manually removed from the queue they may be reinstated through an updating of the assessment if they meet the current threshold score when reassessed. The queue entry, however, will be updated with any new information or any change in score, and will include the date of the re-referral to the queue.

6. MATCHING

6.1 Overview of Matching

Matching and Referral are the steps used by Coordinated Entry to identify open and available resources for participant households on the Housing Queue that fit their eligibility and expressed preferences. Prior to a formal referral being made for any housing resource, one or more matches to an available opening must be identified. A match is based on the information in HMIS.

6.2 Matching for Permanent Housing Resources

Households on the Housing queue are matched to openings based on the following factors, in this order:

1. Household meets eligibility criteria for the program or opening
2. Household meets project preferences, such as geographic targeting, as stated in MOUs and/or contracts with programs
3. Household has all of the documents that are required for enrollment in the housing program (document readiness status)
4. Date of Housing Needs Assessment (oldest first)
5. Housing Needs Assessment score (used as tiebreaker if needed)

If a participant is otherwise eligible but not document ready, H4H will contact their Connector or other identified party to make clear that a referral cannot be made until all documentation is complete. Connectors should upload all documents to HMIS and may inform H4H once this is done.

Households with medical necessity for an ADA unit will be prioritized for these units when available. Matching will follow the above prioritization criteria with this filter added.

If there is no participant on the queue that can be connected to the opportunity after all eligible participants have been matched, then households below the threshold score will get screened for matching in order of their score.

6.3 Document Readiness

In order to receive a referral to a housing resource, participants must be "document ready" This means that they have documentation needed to prove their identity, and their eligibility for the unit or resources available. Typically, this includes photo identification, verification of homeless status, proof of disability (if an eligibility requirement) and verification of Social Security number (if an eligibility requirement).[3]

6.3.1 Assistance with Document Readiness

Because document readiness is a factor in the order in which participants are offered access to housing resources, as well as accessing other public and private resources, assistance with getting and storing necessary documents is a critical aspect of Coordinated Entry services. H4HP Connectors should determine whether a participant desires and needs such assistance, and whether they have an existing service relationship (for example with a shelter or case manager) that can assist with this task. High priority participants without such assistance will be prioritized for Navigation services. However, if a participant is not assigned to a Navigator and does not have another source of this assistance the H4HP Connector should provide the service.

7. REFERRAL

7.1 Referral

A referral is the formal connection by Coordinated Entry of a participant who has been matched to a resource such as a shelter or housing program. CoC and ESG funded projects must only accept referrals made through the Coordinated Entry System.

Prior to referral, H4H will ensure that participants have the needed documentation including homeless verification and disability verification where needed. Eligibility criteria will be used

[3] H4HP Connector Document Readiness Checklist will be included in appendix when finalized.

to pre-screen participants on the Housing Queue for potential project eligibility. H4H will use the HMIS matching feature whenever possible.

Based on the results of the housing match, H4H will make the referral in HMIS to the designated housing project staff.

7.2 Direct Referral to Shelter

Coordinated Entry will designate certain Outreach teams or specific entities to make direct referrals to family and adult emergency shelter programs within the Housing for Health Partnership. Shelter referrals will be made after taking into account a participant's desire to consider shelter as well as other participant characteristics.

7.2.1 Direct Referral to Family Shelter

The Coordinated Entry process refers families for placement in family shelter. Families with children who are unsheltered and who are interested in shelter may be directly referred. Prioritization of family shelter referrals is not dependent on the HNA score. Family characteristics are used to prioritize if there is more than one eligible and interested family for a given vacancy. These characteristics include:

- families with a family member who is pregnant,
- families with children under the age of 5, and
- large families (five or more members)

7.2.2 Direct Referral to Adult Shelter

Most adult shelter is accessed outside of the Coordinated Entry process. For shelters or beds that the County is able to fill, Coordinated Enty will designate certain Outreach teams or other entities to make direct referrals to emergency shelter programs. Shelter referrals are not dependent on the HNA score but use participant characteristics.

7.2.3 Number and Timing of Eligible Referrals

Shelter resources are referred to one at a time, with one eligible participant referred to each opening.

7.2.4 Confirmation of a Referral

Because it is imperative to fill shelter beds quickly and not leave available beds open, a participant or their representative must respond to the offer of a referral as quickly as possible and within 1 business day.

7.2.5 Denial of Shelter Admission

Any household referred to emergency shelter may only be denied admission for reasons including:

- The program does not have a current or upcoming vacancy.

- The participants present with more or fewer people than the shelter opening is designed for.
- The participants are not eligible under funding source or the project's written eligibility requirements for the project.
- The individual or household requires care and supervision to manage their activities of daily living and the agency lacks the resources needed to effectively or safely serve and support the referred party.
- The agency has a restraining order that prohibits admission to the facility.
- The participant presents violent or threatening behavior during an intake interview.
- The participant has a criminal record involving sex offenses, arson or violent crime that poses a current risk to the health and safety of staff and/or other participants. When considering a participant's criminal record, shelters must include an assessment of the length of time since the crime occurred and efforts made towards rehabilitation in the evaluation of eligibility for entrance.
- The agency provides documentation that the participant has been banned due to conduct from a prior stay that puts the health and safety of staff or guests at risk per written agency policies. H4H will discuss reason for ban with agency before the referral may be declined.
- Significant safety concerns, (i.e. domestic violence history with existing participant in program).
- The referred party has an infectious disease that significantly increases the risk of harm to other participants. The County Health Services Agency should be consulted about a given health condition prior to rejecting a referral.

In addition, if shelter is denied, the shelter operator must inform the referring entity immediately so that the household may remain eligible to be referred to another available resource.

7.3 Referral to Permanent Housing Resources

When a participant is matched to a potential housing resource, H4H notifies the provider associated with their Coordinated Entry Enrollment, and/or any other service provider contact such as a Navigator, identified case manager, or someone else designated by the participant. The service provider has five (5) business days to respond.

7.3.1 Number of eligible referrals

Depending on the program type and the number of openings, H4H may provide more than one eligible referral for any given opening.

When there is a single opening within an operating site, Coordinated Entry will make one to three referrals. For a scattered site program in which the applicant will receive a voucher or rental subsidy, Coordinated Entry will typically send only one referral at a time.

Housing operators are expected to process referrals in the order referred by Coordinated Entry.

7.3.2 Confirmation of a Housing Referral

The housing operator must confirm receipt of a referral to Coordinated Entry. The agency must make an initial attempt to contact the participant(s) within three business days and a total of 3-5 separate attempts within five business days to find the participant(s) using all of the contact information provided in HMIS, contacting other service agencies that the participant(s) work with, and visiting locations that the participant(s) are known to frequent. All attempts to find the participant(s) must be documented in HMIS. Contact attempts will typically occur in coordination with the Connector.

7.3.3 Verify Eligibility

In order to confirm project eligibility, agencies will complete the project's regular eligibility and intake process. For HMIS participating agencies, the agency will enter the standard HMIS project entry information into HMIS.

7.3.4 Acceptance of the Referral and Arrangements for Move-In

If it has been determined that the referred participant(s) are eligible to participate in the project, the agency will accept the referral in HMIS. For HMIS participating agencies, the agency will enter the participant into the project in HMIS.

7.3.5 Denial of Referral

If it has been determined that the referred participant(s) are not eligible to participate in the project, the agency will decline the referral in HMIS following the guidelines below. If the agency met with the participant(s) to determine eligibility, they must be notified of a decision.

Additional reasons an agency may decline a referral:

Participating projects are expected to accept all referrals received from H4H, unless any of the following exceptions are demonstrated:

- There is no vacancy available.
- The participants present with more or fewer people than the unit or project is designed for.
- The participants are not eligible under funding source or the project's written eligibility requirements.
- Participants miss two or more mutually agreed upon intake appointments after the housing agency has provided all reasonable supports, such as transportation, reminders, and flexible scheduling to overcome barriers to attending the intake

appointment. H4H Case Conferencing should occur before the housing provider may decline the referral.

Agencies may not decline referrals for reasons not included here without consulting with H4H. In particular, agencies may not decline referrals for the following reasons:

- Participants with psychiatric disabilities who refuse to participate in mental health services.
- Participants with substance use disorders who refuse to participate in treatment services.

Additional reasons a referred participant may not be placed into the project:

- Participants cannot be located: If the participant(s) ultimately cannot be located after the agency's 3-5 separate attempts within five business days, their information will be added back to the Housing Queue and a new match will be initiated for the housing agency.
- Participants are deemed ineligible for project assistance: If the participant(s) are ineligible for the project, the agency will decline the referral in HMIS and the participant(s) information will be added back to the Housing Queue according to their HNA Score. The agency must indicate the reason the referred participant(s) were not eligible for assistance. Depending on the reason for ineligibility, an appeal may be requested by the participant(s).

7.3.6 Refusal by Participant

Participants may decline a referral for any reason, including because of project requirements that are inconsistent with their needs or preferences. If the participant(s) are determined eligible but decline assistance, their information will be added back to the Housing Queue. A new referral will be initiated to the housing agency.

The following guidelines apply for participant(s) who decline offers of project assistance:

- If the participant(s) have expressed a preference not to receive services through a particular agency or project, the H4HP Connector or service provider will double check with participant(s) before referring to those projects.
- There is no limit to the number of resources participants can refuse. Participants may continue to be contacted when a resource they are likely eligible for is available; if they refuse the resource, the H4HP Connector or case manager will seek to understand why they are refusing the resource and ensure participant(s) are eligible for other resources they may be more interested in. If participants are not interested in resources available through H4H they may ask to be exited from the housing queue and CES project and will be marked as inactive.

8.TRAINING AND LEARNING COLLABORATIVE[4]

8.1 Connector Trainings

All Connectors that conduct Housing Needs Assessments, carry out Housing Problem Solving and develop and work on Housing Action Plans must be trained in the Coordinated Entry Workflow and the use of HMIS. This includes having Privacy and Security training, a valid license for use of HMIS, and participating in all introductory level trainings before performing Coordinated Entry work. As feasible, H4H will make all required training available through recordings and self-guided modules so as not to delay the start of work for new hires.

8.2 Annual Trainings and Refreshers

All Connectors are expected to participate in at least one training annually which will be made available by the Management Entity. Connection Point staff and supervisors are also expected to use the recorded trainings and accompanying materials to refresh their knowledge as needed and may be directed by H4H to review an existing training prior to proceeding with work.

8.3 Learning Collaborative

H4H will convene one or more a Learning Collaborative of Connectors and other providers engaged with Coordinated Entry. The Learning Collaborative will include:

- Training and reinforcement of training
- Resource presentations and sharing
- Housing problem solving consultations
- Networking opportunities

Connection Points must participate in the Learning Collaborative, and representatives should communicate to their staff information that is provided in the Collaborative meetings related to the appropriate delivery and recording of Coordinated Entry services.

[4] H4HP Connector expectations and agency connector participation agreements will be added to this document's appendix when finalized.

9. DATA AND EVALUATION

9.1 Data Collection and Management Reports

The Management Entity uses information collected in the HMIS system to prepare periodic and regular CE Management reports that reflect the operations and outcomes of the CE system and its components. Reports also provide information about the process and results for participants based on race and ethnicity in order to investigate racial and ethnic disparities and therefore promote racial equity.

9.2 Evaluation

9.2.1 Annual Evaluation

HUD requires that CoCs solicit feedback at least annually from participating projects and from households that participated in Coordinated Entry during that time period. Solicitations must address the quality and effectiveness of the entire Coordinated Entry experience for both participating projects and households. This activity may be undertaken by the CoC Board, the Policy Oversight Entity or another entity designated by the CoC Board but may not be undertaken by the designated Management Entity.

The Management Entity will participate in the annual evaluation by providing information to the CoC, which may include data such as in the reports mentioned above, a self-evaluation using a tool such as the HUD Self-Evaluation format or such form as the CoC may prescribe, and other information as requested and feasible depending on time.

9.2.2 Third Party Evaluator

The CoC does not have to but may choose to engage a third-party evaluator. If such a determination is made, the CoC and the Management Entity will work together to develop a scope for outside evaluation work. The Management Entity will not have a vote in the selection process for an Evaluation Entity if one is to be selected through a competitive process but is able to participate in review and discussion. The Management Entity must provide access to a selected Third-Party Evaluation Entity as needed to conduct its work, including to Management Entity staff and materials.

10. GRIEVANCES AND COMPLAINT TRACKING[5]

10.1 Right to File a Grievance

Participants and potential participants in Coordinated Entry have the right to file a grievance, receive a response and, if they desire, appeal the determination regarding any aspect of their

[5] Additional detail will be included when the H4HP Grievance Policy is finalized

experience or treatment including discrimination complaints, regardless of where or from what Connection Point they receive services.

The Coordinated Entry Grievance Policy includes a requirement that all Connection Points have a program or agency Grievance Policy that meets the requirements of the Policy and that they make a copy of the grievance policy and their procedure available to all participants.

10.2 Tracking and Reporting

The Management Entity requires all Connection Points track and log complaints and grievances and share the log no less than annually with the Management Entity. The Management Entity shall review the logs and the dispositions of all grievances and present a summary of the findings to the CoC as part of any annual evaluation process.

APPENDIX A: GLOSSARY

Access: The method by which people experiencing a housing crisis learn that Coordinated Entry exists, access crisis response services, and are connected to the process to determine through *assessment* which intervention might be most appropriate to rapidly connect those people to housing.

Assessment: The use of one or more standardized assessment tool(s) to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes.

Access Point: See Connection Point

Connection Point: Connection Points are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness accesses the H4HP response system and may receive assistance to connect to resources that are available through Coordinated Entry.

Client: Client is a term used within the HMIS system for a participant or potential participant in Coordinated Entry that has a record in HMIS. This term may be used when specifically referring to HMIS but for Coordinated Entry the terms potential participant, participant and participant household are preferred.

Comparable Database: A comparable database is a relational database that meets all HMIS Data Standards and does so in a method that protects the safety and privacy of a survivor.

Connector: Individuals trained to conduct a Housing Needs Assessment and that assist participants in accessing resources and achieving self-identified goals that will support them in accessing housing. Connectors may work as part of an outreach team, drop-in center, or multi-service program. Connectors must participate in regular connector meetings and meet expectations of Connectors as established in the Connector Role description document.

Continuum of Care (CoC): A geographically based group of representatives that carries out the planning responsibilities of the Continuum of Care program pursuant to HUD regulations. These representatives come from organizations that provide services to the homeless or represent the interests of the homeless or formerly homeless.

Family: a family household is a household with at least one adult and one minor child.

Homeless Management Information System (HMIS): A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care (CoC) is responsible

for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Housing Action Plan (HAP): The Housing Action Plan (HAP) is a living document that includes space to identify specific goals, the strengths brought by the participant to achieve the goal, resources needed to achieve the goal, the steps that each of the Connector and participant agreed to take to address the identified need, the time frame for completion, and the status of the goal. The HAP focuses on steps that support the participant on a path toward housing. Goals must be client directed and should be limited in scope to between two and five things that can be worked on at time

Housing Needs Assessment (HNA): The Housing Needs Assessment (HNA) is the conversational tool used by Santa Cruz County Housing for Health (H4H) Partnership to understand participant needs, resources, and goals and to support participants with accessing housing and other resources. Information collected during this assessment helps identify problem solving resolutions and/or develop a Housing Action Plan (HAP) with action steps for participants and Housing Connectors. Some questions on the HNA also help establish priority and matching information for limited housing resources available through the H4H System. The HNA is recorded in the HMIS System.

Housing for Health Partnership Response System: The set of programs, funding, activities, and coordination that is specifically intended to address the needs of people experiencing homelessness.

Housing Problem Solving: Housing Problem Solving is an engagement approach that is versatile and utilizes empowering engagement to identify and explore options through creative, strengths and resources-focused interaction. The goal is to determine options and participant action toward safe housing solutions outside of the formal H4HP response system as soon as possible and without need for ongoing support.

Housing Queue: The Housing Queue is a list of households maintained in the HMIS system that have indicated an interest in one or more types of housing resources and been assessed and prioritized for such resources. The Housing Queue contains key information about the household that is used to match clients to available and anticipated housing resources.

Housing Resources: Housing resources that clients are matched to though Coordinated Entry including Permanent Supportive Housing, Dedicated Affordable Housing, and Rapid Re-Housing (RRH) resources.

Match: Matching is the process of identifying one or more participants who are eligible for an available or anticipated resource and making a connection between them which begins the process which may lead to a referral.

Participant: A person who for themselves, or on behalf of a household experiencing homelessness, receives services from the Coordinated Entry system.

Potential Participant: A person who for themselves, or on behalf of a household experiencing homelessness, seeks services from the Coordinated Entry system.

Prioritization: The Coordinated Entry-specific process by which all persons in need of assistance who use Coordinated Entry are assessed using standard and consistent information and given a priority rank, score or status relative to other eligible persons.

Queue: A list of clients maintained in the HMIS system that have been assessed and prioritized for a resource.

Referral: The process by which persons who are prioritized for available resources within the Coordinated Entry process are connected to the resource(s) for which they are prioritized and eligible. Referral process includes eligibility screening, monitoring project availability, enrollment coordination, managing referral rejections, and tracking the status of the referral throughout the referral process.

Resource: Refers to any program opening that is filled used the Coordinated Entry process. A Housing resource is an opening in a housing-related program. A shelter resource is an opening in emergency shelter.

Subpopulation: A subset of people experiencing homelessness or at risk of homelessness who share certain characteristics of household type, age or status and may be served based on their membership in the subpopulation. Subpopulation categories in Coordinated Entry include Adult Only households, Family Households with Minor Children, Transition Age Youth (TAY) ages 18-24, Veterans of the U.S. Military, and Survivors of Domestic Violence.

Threshold Score: The score on an assessment needed to qualify the participant to be placed on the corresponding queue.

Victim Service Provider (VSP): A Victim Service Provider is a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. Providers include rape crisis centers, domestic violence shelter and transitional housing programs, and other programs.

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

Connector Services MOU Between Covered Homeless Organization and Housing for Health Partnership

The Policy Board of the Housing for Health Partnership (H4HP) has tasked the County of Santa Cruz Human Services Department Housing for Health Division (H4H) to implement a redesigned Coordinated Entry System (CES) for the Watsonville/Santa Cruz City & County Continuum of Care (CoC). As part of this redesigned CES, specific Covered Homeless Organizations (CHOs) will designate staff as "H4HP Connectors". H4HP Connectors will play a primary role in the new CES by assisting people experiencing homelessness to identify opportunities that will help them in their search for stable and affordable housing. H4HP Connectors will work with participants to complete a Housing Needs Assessment (HNA) and develop a Housing Action Plan (HAP) to identify specific steps towards securing housing and meeting other identified needs. The HNA is also used to determine eligibility for the limited permanent housing resources within the H4HP Response System. H4HP Connectors may work as part of an outreach team, drop-in center, or multi-service program, so long as they are able to meet with participants to help them connect to resources to meet their needs and support them in securing permanent housing.

The signature of the Executive Director of the CHO indicates agreement with the terms set forth below. Executive Director approval is required before the CHO and its staff members engage in Connector services associated with the Watsonville/Santa Cruz CoC CES.

I. Purpose

This Memorandum of Understanding (MOU) is entered into between [*CHO*] and the Santa Cruz County Housing for Health Partnership (H4HP). The H4H Division, with input from the H4HP Operations Committee and Policy Board, have developed this MOU to define roles and responsibilities of the H4H Division, CHO, and staff serving as H4HP Connectors for the CES.

II. Responsibilities of the H4H Division

a. Develop and implement CES policies and procedures that address the process and approach for H4HP Connectors to interact and work with participants experiencing homelessness.

b. Provide ongoing training and learning opportunities to support H4HP Connectors' successful implementation of the CES policies and procedures through hosting a regularly scheduled Connector's Learning Collaborative.

c. Notify H4HP Connectors within one business day when a participant has been placed on the Housing Queue or receives a Housing referral.

d. Follow the CES policies and procedures for referring participants to housing programs, making every effort to maintain a threshold that allows at least one referral within six months of queue placement.

e. Maintain the prioritization list for CoC housing resources.

f. Monitor provider and participant experience for continuous improvement.

III. Responsibilities of CHO

a. Designate specific staff to serve as H4HP Connectors and agree that each provides at least the minimum number of hours identified in the addendum to this MOU in the Connector role.

b. Adhere to all policies and procedures outlined in the CES Policy and Procedure Manual.

c. Provide support and supervision to H4HP Connectors within the Organization.

d. Ensure CHO is maintaining expected staff/participant ratios which may vary depending on the hours per week that Connectors are available per the addendum to this MOU.

e. Ensure Connectors adhere to the expectations regarding HMIS data collection for privacy, security, timeliness, accuracy, completeness, and quality.

f. Ensure Connectors regularly attend the monthly Connector's Learning Collaborative.

g. Provide ongoing feedback to H4H to support provider and participant experience continuous improvement.

h. Immediately notify the H4H Division of any staffing changes to the H4HP Connectors including any decrease or increase in availability.

IV. Responsibilities of H4HP Connectors

a. Adhere to all policies and procedures outlined in the CES Policy and Procedure Manual and in any relevant guidance provided by H4H.

b. Identify individuals experiencing homelessness and build rapport.

c. Conduct initial triage and safety screenings and direct participants to crisis assistance if needed.

d. Engage participants in ongoing meetings to complete the Housing Needs Assessment and problem-solving process.

e. Support participants to identify housing outside of the H4HP Response System.

f. Create a Housing Action Plan (HAP) with participants who choose to do so; identify priorities to work on that move participants toward housing.

g. Support the participant in making connections that assist participant achievement of HAP priorities.

h. Connect with participants an average of one time per week while they remain active (estimated to be over about 90 days) regarding their HAP and revise as needed.

i. Support participants prioritized for a referral to a housing program. For participants who receive referrals to housing programs that do not provide case management support, Connectors will help with the housing search and move-in process, including securing required documents completing applications, and securing housing. For housing programs that offer case management support to help participants enter the program, Connectors will help only with securing required documents.

j. Maintain expected staff: participant ratios which may vary depending on the hours per week a Connector is expected to engage in this role, but no more than 15-20 participants at a time for a full-time Connector.

k. Participate in ongoing training, professional development, and the monthly scheduled Connector Learning Collaborative.

l. Provide ongoing feedback to the H4H Division to support continuous improvement of the Connector Role and CES process.

m. Collect data in HMIS according to established privacy and security standards that is timely, accurate, complete, and high quality. Data collection expectations include:

    i. Enroll participants in the CE HMIS program and collect all participant data (including a profile if one does not exist, , HMIS Consumer Information Sharing Authorization, Program Enrollment, Contact/location information, and Current Living Situation Assessment)

    ii. Complete the Housing Needs Assessment (HNA).

iii. Complete a Housing Action Plan (HAP) with participants that want to prepare one. For Connectors primarily working in other systems of care such as Health or Behavioral Health other goal-setting tools may be used in lieu of the HAP, provided they cover the same or similar domains including housing, income and health, include Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) goals and have clear expectations for who is responsible for completing tasks, These plans should be uploaded into HMIS and updated regularly.

iv. Record referrals and services, including flexible funding assistance.

v. Update required assessments every 90 days (Current Living Situation. Status Updates, Contact/location information HNA, HAP)

vi. Record participant exit information when a participant is no longer active in services or has been enrolled to another program.

V. Terms and Conditions

a. This MOU shall be in-force until revoked in writing by either party.

b. This MOU may be terminated with 30 days written notice.

Number of H4HP Connectors Assigned by CHO _____

Number of hours/week dedicated to Connector Services _____

The signature below constitutes acceptance of the CHO and H4HP Connector Services MOU:

_____ _____

Executive Director Signature Date

_____ _____

Executive Director Printed Name CHO Name

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Connector Services MOU Between Covered Homeless Organization and Housing for Health Partnership
Addendum

Active H4HP Connectors: The following individuals are identified as active H4HP Connectors performing duties on behalf of [*CHO*].

Connector Name & Title	Connector Email	Connector Phone	Supervisor Name & Phone	Expected Hours / Week	HMIS Status[1]	Only People From Own Org	Population Served

[1] Indicate whether the Connector is a (1) Current User of HMIS or (2) New User that needs New User training and an HMIS license.

Housing for Health Partnership Coordinated Entry

Housing Queue Threshold Setting

April 19, 2023

The adopted Coordinated Entry policies (CES) for the Watsonville/Santa Cruz City & County Continuum of Care (CoC) establishes "thresholds" to determine the minimum score that households, based on their household type, must receive on their completed Housing Needs Assessment to be placed onto the Housing Queue. This document details the approach to threshold setting to be considered by the Policy Board.

Monthly Estimate for Number of Households to Refer from the Housing Queue

Data provided below represents the number of permanent housing (PH) openings expected to be available for referral from the Housing Queue over a 180-day period. The data in the table below is based on the average number of PH program enrollments in Calendar Year 2022.[1] The final column indicates the total number of households of each population type required to be referred each month to fill the anticipated PH openings.

Population[2]	Actual PH Openings over 180 days	Estimated Number of Households to Refer per Opening	Estimated Number of Households to Refer Each 180 days	Estimated Number of Households to Refer Each Month
Families with Children	56	1.5	84	14
Transition Age Youth	22	1	22	3 - 4
Adults	10	2.5	25	4 – 5

Additional PH inventory is expected to come on-line during 2023. Specifically, there will be 28 new PH units for Adults (22 in late spring, 6 in late fall) and 14 more units for Transition Age Youth (TAY - late fall). **The additional 22 Adult PH units this spring indicates there may need to be as many as a total of 65 Adult households available for referral from the Housing Queue by mid-June 2023.[3]**

[1] The data reflects the average of total enrollments for two 6-month timeframes; January-June 2022 and July-December 2022.

[2] Veterans are not reflected in this table as most veterans identified through the CES will complete a brief assessment to determine their eligibility to receive services through the Veterans Administration (VA); if determined eligible, the CES will refer them to local Supportive Services for Veteran Families (SSVF) contractors and the Santa Cruz County Human Services Department's Veterans Services Office. The SSVF contractors will refer participants to HUD VASH services when applicable. Veterans who do not qualify for VA services will continue to work with a CES Connector as described in the CES P&P.

[3] Between April and Mid-June 2023 approximately 3-4 openings are expected to occur for Adults. The 22 new units will provide up to 26 PH openings. If all 26 units are available for referral, the number of Adults needed on the Housing Queue falls between 26 (assume 1:1 ratio for referral : opening) and 65 (assume 2.5:1 ratio for referral : opening).

Preliminary Data to Recommend the Threshold Score

The table below includes the number of households counted in the 2022 Point in Time Count (PIT), the number of households that have historically enrolled in Coordinated Entry over a 6-month timeframe,[4] and the number of households estimated to be referred to permanent housing (data from above) every 180 days. The 2022 PIT data and number of enrollments in CE are both indicators of the number of households that need housing services and supports.

For Adults, both indicators illustrate that the number of referrals estimated over a six-month timeframe is extremely low (about 1% of PIT and 9% of CE enrollments). The reverse is true for Families with Children, where the estimated number of referrals is essentially equal to (CE enrollments) or larger than (PIT) the data indicate. The number of TAY households compared to the PIT and CE enrollments suggests that more information is necessary to understand these ratios fully.

Population	2022 PIT Number of Homeless Households	Enrollments in CE every 180 days	# Estimated for Queue Every 180 Days
Families with Children	50	90	84
Transition Age Youth	222	27	22
Adults	1,919	271	25

Housing Needs Assessment (HNA) thresholds represent the minimum score that households, based on their household type, must have to be placed onto the Housing Queue and are based on the anticipated inventory for each population (household type). In February 2023, the Policy Board approved the recommendation that no more than the top 10% of the scoring range (the total possible points for Adults and TAY is 23 and 25 points for Families with Children) would be referred to the Housing Queue upon implementation in April 2023, meaning the intended starting threshold based on the possible points would be 20 for Adults and TAY and 23 for Families.

Preliminary HNA scores, however, indicate that households are scoring considerably lower than these thresholds. Moreover, the number of households with complete HNAs is very low; only 17 households had completed an HNA as of March 31, 2023. Their scores according to household type are reflected in the next table.

Population	Possible Range	Approved Threshold February 2023	# of HNAs	Actual Range	Average Score
Families with Children	0-25	23	6	5-16	8.8
Transition Age Youth	0-23	20	2	14-15	14.5
Adults	0-23	20	9	3-13	9.1

[4] Enrollments in CE every 180 days is based on the average number of CE program enrollments in Calendar Year 2022, which reflects the average of total enrollments for two 6-month timeframes; January-June 2022 and July-December 2022.

In addition to the scores being relatively low, current data indicate that no Adult households are experiencing chronic homelessness. Because chronicity is an eligibility criteria for almost all of the permanent housing available to Adult households in the community, no Adult households with complete HNAs are eligible for referral to housing.

Immediate Next Steps Proposed

To avoid full implementation of a CE process prior to having sufficient information for setting appropriate thresholds, the H4H Division is proposing the following approach for moving households to the Housing Queue and referring them to housing opportunities:

1) Continue the current HNA process as new participants are encountered, referring, as appropriate, families with children and TAY and adults experiencing chronic homelessness to the Housing Queue.

2) In those cases when no eligible households are available to refer from the Housing Queue, identify households from the "retired" SmartPath Housing Queue that have a completed VI-SPDAT within the last 12 months and meet eligibility criteria for the housing opportunity.

In addition, the H4H Division will:

3) Develop and implement an interim web-based method for stakeholders and people experiencing homelessness to express interest in linking with a Connector. The proposed process will collect basic eligibility information to support linking households with a Connector.

4) Engage in targeted recruitment of additional Connectors from specific agencies most likely to be engaged with people in Santa Cruz who are experiencing longer-term homelessness. The goal is to increase the availability of connection opportunities for adults experiencing chronic homelessness to complete HNAs and thus be available to be moved to the Housing Queue.

Return to the Policy Board June meeting with updates on our progress.

Information Item 4: Behavioral Health Bridge Housing Funding

Complete information about the Behavioral Health Bridge Housing Funding Request for Applications can be found at: [County Behavioral Health Agencies - BHBH (buildingcalhhs.com)]

The information below contains a summary of this funding opportunity.

Summary of First Round Funding: $907,936,000 available statewide to counties for planning & implementation of bridge housing services for Californians experiencing homelessness with serious behavioral health conditions (Serious Mental Illness or Substance Use Disorders). Noncompetitive funding. *Santa Cruz County maximum funding available = $10,171,130.*

Subsequent Competitive Rounds: Summer 2023 and FY 24-25 for BHAs and tribal entities, $250M available for each round.

Eligible Entities: County Behavioral Health Agencies

Timeline: Applications available starting Feb. 24, 2023, accepted until April 28, 2023, at 4pm

Program Requirements (highlights of some key requirements):

- Must include supportive services and housing navigation to assist with transition to permanent housing for target population
- CARE program participants prioritized for BHBH resources
- Designate program lead/point of contact
- Coordinate with CoC and other services for people experiencing homelessness
- Include people with lived experience of homelessness and serious behavioral health conditions in program planning, implementation, and quality improvement
- Must have written programs policies and procedures for certain services
- Infrastructure funding requires site control; insurance; legal compliance; certifications
- 75% of funding must be used for operational costs ($7,628,348); 25% available for infrastructure ($2,542,782). Maximum of $75,000 per bed (Up to 34 beds @ 25% of total). *Can request an exception to these limits if can demonstrate lack of existing suitable facilities.*

- Infrastructure activities and beds must be available within 1 year of contract execution; counties with beds available in 90-180 days have a competitive advantage in future rounds

- Up to 10% of modified direct costs for indirect costs

Application Details:

- 27+ questions, significant details requested on plans, will require staff from Behavioral Health and Housing for Health to complete, may need support from Capital Development and Infrastructure Department

Information Item 5: FY 2022 HUD CoC Award Announcement for Santa Cruz County - $5.5M (≈7% increase)

On March 28, 2023, the federal Housing and Urban Development Department (HUD), announced the Santa Cruz County Housing for Health Partnership (CoC) was awarded $5.57 million in the FY 2022 CoC funding competition, representing the largest competitive federal Continuum of Care (CoC) allocation in County history. The table below shows HUD CoC grant awards for Santa Cruz County over time.

FY 2018	$	2,629,841
FY 2019	$	3,662,605
FY 2020	$	4,972,008
FY 2021	$	5,207,237
FY 2022	$	5,570,269

HUD funded all 20 projects that were submitted from Santa Cruz County. This includes three new projects: Housing Matters' permanent supportive housing project at 801 River Street, as well as Walnut Avenue Family & Women's Center and Monarch Services, two programs that provide refuge to domestic violence survivors.

Among the projects were seven that specifically requested Youth Homelessness Demonstration Program (YHDP) grant funding. These programs were funded with $1,285,268, dedicated to providing services to youth experiencing or at risk of homelessness. One project, Covenant House, a new service provider in Santa Cruz County, received approximately one-third of the total allocation to provide rapid rehousing services to youth.

A complete list of the funding projects and their award amounts is included as an attachment after this memo.

Santa Cruz County CoC - Final 2022 HUD CoC & YHDP Awards						
Rank	**Applicant Name**	**Project Name**	**New or Renewal**	**Grant Term**	**Project Component**	**Total HUD Budget**
	CoC Competitve					
1	Housing Matters	801 River Street	Renewal	1 Year	PSH	$159,911
2	Walnut Avenue Family & Women's Center	Walnut Avenue Housing & Employment Program	Renewal	1 Year	RRH	$266,274
3	Encompass Community Services	Freedom Cottages	Renewal	1 Year	PSH	$15,645
4	Housing Authority of the County of Santa Cruz	Shelter+Care Consolidate	Renewal	1 Year	PSH	$1,342,434
5	Encompass Community Services	Housing for Health 3	Renewal	1 Year	PSH	$90,429
6	County of Santa Cruz Health Services Agency	MATCH	Renewal	1 Year	PSH	$945,315
7	Santa Cruz County HSD	County of Santa Cruz Homeless Management Information System	Renewal	1 Year	HMIS	$91,699
8	County of Santa Cruz	Coordinated Entry Expansion	Renewal	1 Year	CES	$228,362
9	Housing Matters	801 River Street Expansion	New	1 Year	PSH	$62,964
10	Families In Transition of Santa Cruz County, Inc.	First Step-Scattered Site Housing for Families with Children	Renewal	1 Year	RRH	$560,228
11	Monarch Services	Monarch DV Bonus	New	1 Year	RRH	$105,567
12	Walnut Avenue Family & Women's Center	Walnut Avenue DV Bonus	New	1 Year	RRH	$264,098
	YHDP Non-Competitve					
N/A	Bill Wilson Center	Santa Cruz County Shared Housing	Renewal	1 Year	Shared Housing	$137,767
N/A	Community Action Board of Santa Cruz County, Inc.	YHDP - Youth Homeless Response Team (YHRT)	Renewal	1 Year	SSO	$99,175
N/A	County of Santa Cruz	Youth CES	Renewal	1 Year	CES	$60,000
N/A	Encompass Community Services	Drop-In Center	Renewal	1 Year	SSO	$296,903
N/A	Families In Transition of Santa Cruz County, Inc.	Y.A.A.S. (Young Adults Achieving Success)	Renewal	1 Year	RRH	$263,387
N/A	Covenant House	YHDP New Roots RRH	Renewal	1 Year	RRH	$197,505
N/A	Covenant House	Youth Rapid Rehousing	Renewal	1 Year	RRH	$230,531
	Planning Grant Non-Competitive					
N/A	County of Santa Cruz	CoC Planning Grant	New	1 Year	Planning	$152,075
				Total Funding Awarded		**$5,570,269**

Report/Discussion Item 6: Performance Metrics for Temporary Housing, Safe Sleeping Park Programs Last 12 Months (March 2022 to March 2023)

The following data comes from a Santa Cruz County Homeless Management Information System (HMIS) Performance Metrics dashboard report that utilizes standard performance metrics across multiple program types serving different populations. The agencies and specific program names have been removed from the initial reports below since agencies and programs have not been provided with a formal opportunity to review and correct their data. "Error Free" exits refers to the percentage of clients with complete data entered at the time of their program exit. It's an indicator of program data quality.

Code	Project Type	Households Served	Clients Served	Household Exits	Avg. Days for Those with Exits	"Error Free" Exits (%)	% of Exits to Permanent Housing
E3	Emergency Shelter	14	15	4	203	100%	100%
F3	Transitional Housing	15	68	2	350	25%	100%
B2	Safe Parking (RV)	21	22	3	185.33	67%	67%
H1	Emergency Shelter	7	14	2	356	67%	67%
E2	Emergency Shelter	42	134	14	147.79	72%	65%
C1	Safe Sleeping	22	23	5	279	40%	60%
F1	Emergency Shelter	18	42	8	109.13	24%	57%
D1	Emergency Shelter	31	31	18	48.67	100%	50%
F2	Transitional Housing	8	21	2	159	50%	50%
A2	Safe Parking	58	60	26	146.38	96%	46%
G1	Emergency Shelter	32	32	11	201.55	64%	36%
E5	Emergency Shelter	14	14	6	29.67	100%	33%
A1	Emergency Shelter	23	26	13	98.31	63%	31%
E1	Emergency Shelter	91	93	44	192.75	64%	16%
G2	Safe Sleeping	199	203	93	89.44	95%	16%
E4	Emergency Shelter	41	41	30	107.13	63%	7%
B1	Storm Shelter	233	235	48	4.38	12%	0%

The data below comes from the same performance metrics dashboard from HMIS. It shows the % of clients in a given program that have had documented services in HMIS and documentation of maintaining or increasing their income or public benefits during their enrollment in the program.

Code	Project Type	% Service Entered in HMIS	Maintained/Increased Health Insurance (%)	Maintained/Increased Income (%)	Maintained/Increased Non-Cash Benefits (%)
E3	Emergency Shelter	0%	27%	20%	0%
F3	Transitional Housing	0%	46%	33%	13%
B2	Safe Parking (RV)	0%	14%	5%	14%
H1	Emergency Shelter	57%	43%	0%	43%
E2	Emergency Shelter	10%	25%	30%	22%
C1	Safe Sleeping	0%	22%	17%	13%
F1	Emergency Shelter	0%	44%	28%	39%
D1	Emergency Shelter	0%	56%	47%	31%
F2	Transitional Housing	0%	33%	17%	8%
A2	Safe Parking	0%	39%	36%	15%
G1	Emergency Shelter	0%	21%	12%	12%
E5	Emergency Shelter	0%	43%	43%	43%
A1	Emergency Shelter	0%	54%	42%	25%
E1	Emergency Shelter	6%	55%	28%	47%
G2	Safe Sleeping	100%	39%	16%	32%
E4	Emergency Shelter	7%	74%	40%	52%
B1	Storm Shelter	63%	3%	1%	2%

The final data table below shows how well given programs help participants identify and record primary care and emergency contacts within HMIS. These metrics are used to monitor the ability of a program to help participants identify and make connections.

Code	Project Type	Primary Care Provider Contact (%)	Emergency Contact (%)
E3	Emergency Shelter	93.30%	60.00%
F3	Transitional Housing	0.00%	2.90%
B2	Safe Parking (RV)	0.00%	4.50%
H1	Emergency Shelter	0.00%	0.00%
E2	Emergency Shelter	0.00%	2.20%
C1	Safe Sleeping	4.30%	4.30%
F1	Emergency Shelter	0.00%	16.70%
D1	Emergency Shelter	0.00%	0.00%
F2	Transitional Housing	0.00%	4.80%
A2	Safe Parking	1.60%	3.30%
G1	Emergency Shelter	3.00%	6.10%
E5	Emergency Shelter	21.40%	21.40%
A1	Emergency Shelter	3.80%	0.00%
E1	Emergency Shelter	4.30%	5.40%
G2	Safe Sleeping	4.70%	4.20%
E4	Emergency Shelter	7.10%	11.90%
B1	Storm Shelter	1.70%	3.30%

Report/Discussion Item 7: Public Dashboards – Brainstorm Desired Information

The Housing for a Healthy Santa Cruz Framework vision includes six guiding principles for the community's collective efforts: (1) Actionable; (2) Person Centered; (3) Equity and Inclusion Lens; (4) System Approach; (5) Countywide Scope; and (6) Data Driven. The Housing for Health Division (H4H) has worked to improve the quality and use of data from the local Homeless Management Information System (HMIS) over the past two years. H4H staff are asking for input from Policy Board members on proposed key public metrics to update at least every quarter and post on the Housing for Health Partnership website. The proposed metrics should align with the guiding principles articulated in the Framework.

HUD maintains dashboards at a national level for all CoCs - CoC_Dash_CoC_CA-508-2021_CA_2021.pdf (hudexchange.info) - and produces other reports through multiple systems. These reports are not generally accessible to the public without specialized knowledge or authorized access.

California maintains a Homeless Data Integration System (HDIS) Homeless Data Integration System - California Interagency Council on Homelessness – with some information on CoCs around California. HDIS provides more robust reports for CoC lead staff but does not make this data available statewide.

Many CoCs publish data in various forms on websites. Some examples are given below:

Los Angeles County - Data (lahsa.org)

Monterey County - Lead Me Home Plan Dashboard - The Coalition of Homeless Service Providers (chsp.org)

Alameda County - Data | Homelessness Solutions | Alameda County (acgov.org)

San Diego County - Reports & Data - Regional Task Force on Homelessness (rtfhsd.org)

Alameda County - EveryOne Home - The 2022 Practitioner Scorecard (clearimpact.com)

King County, Washington - Data and Measurement - KCRHA

Charlotte- Mecklenbrug CoC, North Carolina - Housing Data Snapshot - Mecklenburg County - Housing & Homelessness Dashboard (mecklenburghousingdata.org)