

Oakland, Berkeley/Alameda County CoC (CA-502)
Plan for Serving Individuals and Families
Experiencing Homelessness with Severe Service Needs

Introduction

Rising housing costs, a lack of affordable housing, the COVID-19 pandemic, and poverty linked to structural racism have all contributed to a humanitarian crisis in our community, which has left thousands of community members without stable housing. Between 2017 and 2022, the Point-In-Time count of people experiencing homelessness in Alameda County, California grew 73% (from 5,629 to 9,746) and the number of people experiencing unsheltered homelessness climbed 85% (from 3,863 to 7,135). In the same time period, the percent of people who are unsheltered versus sheltered within the population experiencing homelessness increased from 69% to 73%. We recognize that even the Point-in-Time count does not capture the full scope of the crisis, and some populations are especially likely to be undercounted. We do know that the County is in the midst of a crisis of unsheltered homelessness, with many unhoused people living in their vehicles and in large encampments along city streets, highway exits, and other public spaces. We know also that Black, Indigenous, and People of Color communities are disproportionately impacted because of historical and ongoing systemic racism. While Black or African American people comprise 10% of the population of Alameda County, they are 43% of those experiencing homelessness in the County (2022 PIT Count).

The nature and proportions of this crisis demand that we integrate new strategies to reduce unsheltered homelessness. We envision a future in which housing is a human right. Working toward this future requires high level policy changes, increased collaboration and accountability, significant investment of resources, and concentrated effort to increase affordable housing options. At the same time, people who are living outside and in their vehicles also need immediate, easy-to-access, trauma-informed services to meet their health and housing needs. People need more intensive, supported, and well-coordinated transitions to services-enriched, low-threshold crisis housing and permanent housing. A work group of people with lived expertise of homelessness, including people with experiences of unsheltered homelessness, contributed to developing this Plan. Work group members emphasized that people who are unhoused experience trauma, violence, and chronic stress while living outside. In the midst of ongoing trauma, some people who are experiencing unsheltered homelessness need additional support to make appointments and navigate services systems. People experiencing homelessness must be treated with dignity and respect, and afforded access to basic necessities. Members underscored that maintaining employment and securing housing are impossible without ready, daily access to bathrooms, showers, laundry facilities, and telephones; clear, transparent real-time information about resources; flexible rules and policies that respect the unique situation of each person; and streamlined access to trauma-informed mental health and substance use services. It is also critical to shift more decision-making authority about program design and implementation to people who have lived expertise, and to ensure accountability and transparency about the funding and operation of housing, shelter and support services programs.

In addition, our efforts to address racial disparities in who is experiencing homelessness in our communities must be deliberate and actionable. Recommendations from the CoC's 2021 *Centering Race Equity in Homeless System Design* report included creating dedicated affordable housing and shallow subsidies for people with very low incomes, as well as reducing programmatic barriers to crisis services and increasing autonomy. Accordingly, the Continuum of Care is introducing new homelessness response system interventions to respond to the needs of underserved communities and reduce the racially disparate experience of homelessness in Alameda County. Our CoC's new Racial Equity Workgroup is recommending training and process changes to ensure that our CoC consistently applies a racial equity framework to ensure fairness and justice in all we do.

As part of its pandemic response, the County leased more than 1,400 non-congregate sheltering opportunities in hotels and housed over 5,000 people experiencing unsheltered homelessness. An incredible 70% of those served have been able to exit to permanent housing with appropriate levels of financial and non-financial support that make it sustainable for them. This showed how crisis housing must screen in and welcome people with severe service needs, support them while they transition, provide flexibility, safety, and privacy, and smooth the way to permanent housing. These are the systemic changes that make it easier for people to come inside and stay inside and will be programmed into future interventions as we scale this approach.

The County's need for new resources to address our crisis is vast. Not all of the activities we know are necessary are eligible for funding through the current Supplemental CoC NOFO. Most notably, there is a significant need to provide practical support to people living outdoors (e.g., daily access to showers, laundry, clothing, etc.) that are not eligible uses of CoC funds. The County and CoC intend to apply to the State of California for these needs through its Encampment Resolution Funding program and other funding opportunities as they become available.

The projects submitted for consideration through the Supplemental CoC NOFO represent a new level of support for transitions out of unsheltered homelessness in Alameda County. They include:

- 100 new permanent housing units for individuals with severe service needs, providing enhanced care to address chronic illnesses, serious mental illness and substance use disorders
- A new rapid rehousing project providing rental assistance, housing search, case management and after care services targeted to people living in encampments in the City of Oakland, including many who are accessing the Community Cabins emergency shelter program;
- Expanded street outreach and housing navigation via mobile access points focused on serving individuals living in encampments and vehicles in five designated geographic zones;
- Specialized peer Outreach Ambassadors who will outreach to seniors living in encampments, particularly in West Oakland;
- Trauma-informed advocacy and legal services for unsheltered seniors to increase income and remove barriers to housing, and;
- A new Street Health Rapid Response Team to link unsheltered persons in crisis to medical and mental health supports.

Two of the projects submitted focus specifically on serving older adults experiencing homelessness. Additionally, the permanent supportive housing project included for consideration focuses on individuals with severe service needs due to chronic illness. Locally, a recent UCSF study on mortality among unhoused seniors found that their study participants were 3.5 times more likely to die during the study period than adults in the same age group in Oakland, and seniors who remained unhoused were at greater risk (Brown et al., 2022).¹ It is critical to address the urgent, and often life-threatening, needs of a growing population of older adults experiencing unsheltered homelessness. The organizations who have proposed legal advocacy and outreach ambassador projects for older adults bring considerable experience working with this unique population.

Importantly, all of the proposed outreach programs will include staff who have experienced unsheltered homelessness. This aligns with the recommendations of our work group, who emphasized that peer ambassadors can build more trust when entering encampments, as people who are known to communities and have “been there.” It is essential for people with lived expertise to have opportunities for leadership roles, and to be well-compensated for their time. Among the organizations with proposed projects, Homeless Action Center has a goal for at least 30% of staff to have lived expertise of homelessness, and St. Mary's Center has proposed

¹ Brown, R.T., Evans, J.L., Valle, K., Guzman, D., Chen Y., & Kushel, M.B. (2022). Factors associated with mortality among homeless older adults in California: The HOPE HOME study. *JAMA Intern Med*, 182(10), 1052–1060. doi:10.1001/jamainternmed.2022.3697

a project to provide leadership training and ongoing support to Outreach Ambassadors employed to outreach to seniors.

The Continuum of Care acknowledges and thanks HUD for this unique and timely opportunity to help more people move from homelessness to safe, healthy, connected lives in Alameda County communities. The CoC, our service provider partners, and numerous community stakeholders stand ready with innovation, compassion, and commitment.

P-1. Leveraging Housing Resources

P-1a. Development of New Units and Creation of Housing Opportunities – Leveraging Housing

*See **Leveraging Housing Commitment** attachment to the 4A. Attachment Screen.*

P-1b. Development of New Units and Creation of Housing Opportunities – PHA Commitment

*See **PHA Commitment** attachment to the 4A. Attachment Screen.*

P-1c. Landlord Recruitment

1. Current strategy to recruit landlords, and their units, in which to use tenant based rental assistance:

Through the Landlord Liaison and Housing Subsidy Management Services program, Alameda County contracts with three non-profit housing and services agencies, Abode Services, Bay Area Community Services, and East Bay Innovations. These providers reach out to property owners and housing providers and provide financial assistance as well as supportive services in exchange for their agreement to work with individuals referred by the County who are experiencing homelessness. Outreach materials discuss the benefits of this approach for the property owner, including guaranteed on-time monthly rent payments, a single point of contact to help with any tenant issues, a case manager to support the long-term success of the tenant, low turnover, a 24-hour emergency phone number for after-hours support, post move-in assistance for clients, and a fund for landlord incentives and to pay for extraordinary expenses. Outreach to landlords includes one-on-one engagement, attending property owner association meetings, and holding special recruitment events. Providers are expected to maintain landlord participation through regular contact, incentives, and appreciation events. They are also expected to develop positive working relationships with landlords so as to prevent eviction and loss of units from the programs when tenants are facing potential loss of their unit. Alameda County has also begun coordinating collaborative efforts to promote landlord incentive programs throughout the county by establishing and running a hotline for landlords to call to learn more about these programs, producing promotional materials to engage more landlords, and joining with service provider organization staff to present to membership organizations where landlords can be informed about opportunities to make their housing units available to people in need of housing.

a. How well this strategy works in identifying units across the CoC's entire geographic area: The Landlord Liaison program has worked with more than 1,000 landlords and has secured units in all areas of the County, including Berkeley, Oakland, Mid County, South County and East County. One provider alone, Abode Services, has secured more than 3,000 units since its program began in 2013. The hotline for landlords and related collaborative activities coordinated by the County have resulted in engaging more than 120 new landlords and housing dozens of clients in different regions throughout the county. County and provider staff gave presentations in each region of the county and have worked closely with all five housing authorities in the region to promote connections.

b. How well this strategy works in identifying units in areas where the CoC has historically not been able to identify units:

These strategies have strengthened relationships and communication among agencies with landlord engagement programs, allowing targeted focus of efforts in areas of the county where it has historically been challenging to

identify units. The increased collaboration, and specifically, landlord referral sharing among agencies (e.g., when an agency cannot use a referral, they can pass it along to other agencies in the network), has supported timely client placements and strengthened relationships with landlords. As a result, a large percentage of new units were identified in Southern Alameda County, where homelessness has increased but where housing has not been accessible to county programs.

2. New practices the CoC has implemented to recruit landlords in the past 3 years and lessons learned: The existing infrastructure of the County’s Landlord Liaison program has allowed the County to quickly expand the model to transition people leaving COVID-19 non-congregate shelters to permanent housing, thereby avoiding a return to unsheltered homelessness. Providers were able to activate ESG-CV funds and later convert them to EHV vouchers. Abode Services assembled a real estate team focused entirely on building an inventory of units and designed a placement workflow that allowed groups of participants to be matched to apartments within one day at onsite housing fairs using virtual property tours. Abode Services has created a state-of-the-art landlord/unit database and financial system to track program outcomes, manage landlord relationships, and ensure accurate and timely rent payments.

As successful as this work has been, we know that many landlords are still unwilling to rent to people experiencing homelessness, especially people who have experienced a previous eviction, and that additional recruitment strategies and incentives are needed to increase the number of participating landlords. Work group members noted the need for more incentives, and to address discriminatory practices by some landlords.

3. How the CoC will use data (including specific data points) to update its landlord recruitment strategy: Alameda County currently coordinates with local service providers to help promote landlord engagement throughout the county. Through this collaboration, a shared database of landlord contacts with information about the properties they have available is managed and used as a tool to identify units to match with clients. With centralized, system-level tracking tools in place, our providers are better able to analyze program performance and refine recruitment strategies. This includes data points such as the relationship between rents/incentives paid, program retention, and landlords’ stated reasons for leaving the program. Such data allows us to periodically revisit program policies, integrate new practices to enhance the attractiveness of the program to landlords, and create new strategies for landlord recruitment.

P-2.Leveraging Healthcare Resources

See Healthcare Leveraging Commitment attachment to the 4A. Attachment Screen.

P-3. CoC’s Current Strategy to Identify, Shelter and House Individuals and Families Experiencing Unsheltered Homelessness

P-3a. Current Street Outreach Strategy

1. Current strategies to ensure outreach teams are coordinated: Street Outreach services in Alameda County are coordinated by countywide Health Care for the Homeless Street Health teams and supplemented by Coordinated Entry access points (Housing Resource Centers) located throughout the County and by city-contracted outreach teams operating in Oakland, Berkeley and other jurisdictions. There are 14 Street Health teams, each assigned a geographic zone within the County where at least 500 unsheltered individuals are living. These teams include social workers, navigators, and nurses to ensure they can connect people to appropriate services. They distribute resources and provide basic medical care at the sites where unsheltered people are living. Many street outreach teams serve as access points for Coordinated Entry, with some able to do the full assessment and some coordinating with Housing Resource Centers for Coordinated Entry services.

2. Current strategies to ensure outreach is frequent: Outreach operates daily on varying schedules, including mornings, weekends and evenings. Outreach schedules are set to ensure more frequent visits at sites with larger populations and where more vulnerable people are staying. For example, a site with multiple seniors

with health conditions will receive visits twice a week on the same days every week so that residents know when to expect their service provider to arrive. These services are coordinated with visits from primary care clinic vans, so medical and social service providers can coordinate in real time.

3. Current strategies to help people exit homelessness and unsheltered homelessness: Outreach teams serve as access points for the County's Coordinated Entry System and can link unsheltered persons to all the housing and services managed through Coordinated Entry. Based on their crisis assessment and housing assessment, people living in unsheltered situations are often prioritized for shelter and housing based on health conditions and length of time homeless. One of our proposed projects to be funded through this NOFO will provide additional mobile access points in five designated geographic zones to further engage people who are unsheltered in the County's array of housing programs and supports.

4. Current strategies to ensure specific engagement strategy will engage individuals and families experiencing homelessness with the highest vulnerabilities and will use culturally appropriate strategies: Outreach teams are trained to engage with individuals and families experiencing the highest vulnerabilities and obstacles to housing using a harm reduction and housing first approach. Many people in unsheltered situations such as homeless encampments are reluctant to accept shelter because they have had bad experiences in shelters and/or because shelters have rules that they cannot consent to (e.g., not being able to bring a partner or pet, curfews that conflict with a job). It often takes a period of building trust before the person is willing to be linked to shelter or services. Outreach teams can link vulnerable individuals to low-barrier shelter opportunities such as Navigation Centers, Safe Parking or Community Cabins (see description below, Section P-3b) that may be more appealing because of their flexible policies. Such programs operate under the premise that getting off the streets should be as easy and unrestrictive as possible. Three of our proposed projects are outreach projects that target individuals experiencing unsheltered homelessness with the highest vulnerabilities: rapid crisis response for people with urgent physical and mental health needs, peer outreach for seniors living in encampments, and income and legal advocacy for seniors living in encampments and other unsheltered situations. The local application for this funding opportunity evaluated applicants on steps they are taking to ensure racial equity. As one example, Homeless Action Center's team receives ongoing training in trauma-informed, anti-racist advocacy, which equips them to offer culturally appropriate services that center race equity.

In terms of needed enhancements to the CoC's current strategy, we know from our workgroup members that it is pivotal to have people with lived experience as part of outreach teams, particularly teams that will be working in encampments. The success of outreach efforts depends upon building trust between outreach workers and the people with whom they are engaging, and this is much more successful when the worker is a peer. Expanding outreach hours, especially in the evening hours when people are more likely to be awake and open to engaging, is another key needed enhancement to our current outreach strategy recommended by our workgroup. Work group members also highlighted the need for outreach workers to be able to access HMIS in real-time and offer immediate resources: the proposed mobile access points would allow for these types of real-time connections. Work group members also emphasized that the 211 system needs to maintain up-to-date and accurate information to allow for immediate connection to resources.

5. Current strategies to use the outreach teams to connect individuals and families experiencing unsheltered homelessness to permanent housing: As stated above, outreach teams serve as access points for the County's Coordinated Entry System and are able to link unsheltered persons to all the housing and services managed through Coordinated Entry. Based on their crisis assessment and housing assessment threshold scores, people living in unsheltered situations are often prioritized for shelter and housing based on health conditions and length of time homeless. Frequently, people who are highly prioritized for permanent housing are placed in interim housing immediately so service providers can work closely with them to ensure all needed documents are available and appointments can be kept for housing opportunities. Providers also utilize a community health record that shares data across systems to provide alerts to housing, shelter, and health care providers when people are prioritized or when they enter shelter or hospital settings.

6. Current strategies to hire people with lived experience of unsheltered homelessness to conduct street outreach: County outreach teams already employ people with lived experience, using Health Care Trainee and Community Health Worker training and employment classifications. However, given how important this is for engagement, we know that we must make this a more prominent part of our street outreach strategy. For some people, earned income can be a barrier to retaining disability or housing benefits, so we must assist peer workers in being able to earn income for part-time work without affecting their benefits, and advocate for policy change where needed. Additionally, County and provider agencies are working to design employee support programs for people who are working and formerly homeless to provide additional resources and confidential support services to aid with that transition. All of the outreach programs included in this application will include staff with lived experience of unsheltered homelessness. One project includes leadership training and ongoing support for part-time Outreach Ambassadors.

P-3.b. Current Strategy to Provide Immediate Access to Low-Barrier Shelter and Temporary Housing for Individuals and Families Experiencing Unsheltered Homelessness

1. Current strategy: The CoC has developed a robust system of access points, street outreach, and low-barrier shelter and temporary housing options. The CoC continues to expand neighborhood-based access points to the system's housing and shelter resources where people are most often experiencing homelessness. The number of access points has more than doubled in the last two years and continues to expand. Added access point outreach staff (part of Street Outreach) will connect people experiencing unsheltered homelessness in the field.

The CoC is working to significantly increase the availability of shelter, especially low-barrier non-congregate models, to reduce unsheltered homelessness. The CoC will add 1,625 temporary shelter beds to serve vulnerable adults and families with children. New shelters will be primarily non-congregate and include access to support services. As new housing comes online, these temporary non-congregate shelter resources will be converted into permanent housing or taken off-line if no longer needed.

Low-barrier shelter and temporary housing options reduce obstacles to entry by staying open 24/7, eliminating requirements for sobriety or for income and other policies that make it difficult for people to enter or stay in shelter. Instead, low-barrier shelters establish clear and simple expectations to ensure a safe environment for all. Staff members are trained in trauma-informed care and de-escalation techniques in order to help residents understand and conform to these expectations. Low barrier shelters frequently allow people to stay with their partners and/or pets, and provide opportunities for people to store their possessions, do laundry, access showers, and receive health and safety resources to meet their needs. Our workgroup members identified a need for continued efforts to ensure all shelters are aligned to Housing First principles, specifically that rules should not be inflexible and punitive. They noted that people who have not experienced homelessness sometimes create and enforce rules that are inflexible and fail to take into account the stress and trauma of being unhoused. This once again highlights the importance of people with lived expertise informing decisions about rules and program structures.

Examples of the low-barrier models available in the CoC include:

- *Navigation Centers* are Housing First, low-barrier, service enriched shelters focused on moving people into permanent housing that provide temporary living facilities while case managers connect individuals experiencing homelessness to income, public benefits, health services, shelter, and housing.
- *Community Cabins* are a geographically based intervention designed to reduce the impact of a large encampments on both unsheltered and housed residents. Sites are selected based on proximity to large street encampments. Each site typically has 20 two-person cabins, with a goal of serving 80 residents a year (40 for 6 months each). Cabins are fully insulated with double-paned windows and locking doors. They have interior and exterior lights and offer enough electricity to charge mobile phones. Participants may bring their pets, possessions, and partners. The program is extremely low barrier and 100% voluntary. All sites are managed by service providers who are on the premises 24-7. Housing navigators help residents work toward

self-sufficiency and housing exits, utilizing a budget of flexible rapid rehousing funds. Sites have controlled entry, porta-potties, overnight security guards, two hot meals a day, a common area with TV, coffee and microwaves, dog runs, pet food, and weekly shower truck visits. There continues to be great need to expand these services. As one example, work group members noted that weekly access to showers is insufficient, and that people need consistent access to daily showers and other hygiene services to support their dignity and success. The City of Oakland is applying to expand the availability of rental assistance, case management and housing location services to unsheltered people who are staying in encampments and/or in the Community Cabins through an application for rapid rehousing under this NOFO.

- *Overnight Safe Parking* is a program model that is designed to provide safe and legal locations for people to stay overnight when they are living in cars. Local programs vary, but they usually provide access to a bathroom or portable toilet, overnight staffing for safety, and sometimes case management services to help people find housing. Some safe parking programs serve families with children, while others are limited to adults without children. Most safe parking programs require that participants complete an application and intake process in advance, leave during the day, and agree to program rules that are intended to balance the needs of participants and neighbors. Some Safe Parking programs set limits (e.g., 30 to 90 days) on how long people can stay. Some programs operate 24/7 in order to allow people and their vehicles to stay during the day and come and go at any time.
- *Safe RV Parking* sites are outdoor parking lots which accommodate anywhere from 17-60 RVs depending on the lot size. The safe RV Parking model is focused on increasing people's health, stability, dignity, and safety. The intervention addresses the significant safety and sanitation impacts to both RV dwellers and their sheltered neighbors. The program is 100% voluntary, and people can come and go 24/7. The sites are designed to be extremely low barrier, with minimal rules designed to maintain a healthy and safe community. The sites include: porta-potties, handwashing stations, garbage service, on-site shower service weekly, 24/7 site security, low voltage electricity to each RV, and drinking water. Once again, workgroup members emphasized that access to daily shower services is needed.

Behavioral health services are a critical component of service delivery in all areas of the homelessness response system, including Street Outreach and crisis housing. A supervising psychiatrist works directly with Street Health, along with on the ground partnership with Alameda County Behavioral Health staff. Efforts are being made to increase clinical support, including immediate access to substance use treatment available through Street Health, Shelter Health, and other teams as part of the Health Care for the Homeless programs. Work group members called attention to the need for more trauma-informed mental health care, including mobile mental health options. One of the projects included in this application would provide a Street Health Rapid Response Team for unsheltered persons with urgent mental health needs who are not connected to care with the goal of avoiding psychiatric hospitalizations. The other outreach projects also include linking people with needed mental health care.

2. How well current strategy performs at providing access to low-barrier and culturally appropriate temporary accommodations to all individuals and families experiencing unsheltered homelessness:

According to the CoC's HUD System Performance Measures report for FY 2021, of the 706 persons who exited Street Outreach, 133 (19%) exited to temporary housing and specific types of institutional destinations and 202 (29%) exited to permanent housing destinations, for a total of 47% successful exits from Street Outreach. This rate of successful exit is the same as the successful exit rate for people living in emergency shelter, safe houses, transitional housing, Rapid Rehousing and other permanent housing situations (also 47%). We continue to improve training and practices for entering data on people experiencing unsheltered homelessness into HMIS so we have a clear and accurate assessment of the County's success in providing access to low-barrier and culturally appropriate temporary accommodations.

3. New practices implemented over the past three years and the lessons learned from implementing those practices:

During the COVID-19 pandemic, Alameda County participated in the State of California's

Project Roomkey program to utilize hotels and motels as temporary emergency non-congregate shelter options with health care and other services and housing navigation for people experiencing homelessness. At the height of the pandemic, the County operated 10 hotel sites consisting of more than 1,400 rooms. Since March of 2020, Alameda County has served over 5,000 people in its Project Roomkey sites. As of June 2022, two of the hotel sites (total of 240 guest rooms) remain in operation as temporary non-congregate shelter sites. After three years, they will convert to permanent housing under the State’s Project Homekey. Another two non-congregate sites (total of 140 guest units, many double occupancy) will continue to operate as shelters. Among the people who took part in the “shelter in place” model in Alameda County in 2020-2022, more than 70% of exits were to housing, often with linked subsidies. From the Project Roomkey experience, the County learned several lessons: 1) The low-barrier, non-congregate shelter model was universally preferred by service providers and made shelter more appealing to many people living outside; 2) The health care services and amenities provided at Project Roomkey sites helped participants stabilize and address long-standing medical issues; 3) The focus on housing navigation and the creation of new housing subsidies for people at Project Roomkey sites led to a high percentage of exits to housing, nearly double that of traditional congregate shelters; and 4) The speed at which the program was implemented required government and nonprofits to collaborate in new, beneficial ways that will outlive the program.

P-3.c. Current Strategy to Provide Immediate Access to Low Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

1. Current strategy: The CoC is working to add units and subsidies for supportive housing, including new models for medically frail/older adults. Activities include expanding the supply of supportive housing subsidies and units through Coordinated Entry prioritization and matching strategies and new development funding; creating a new model of supportive housing for older/medically frail adults with more intensive health service needs; and providing services for funding for supportive housing through expansions of Medi-Cal enrollment and the CalAIM program. The CoC will also create a time-unlimited dedicated affordable housing subsidy program and a shallow subsidy program for people who do not need intensive services. Creating shallow subsidy options was a key strategy identified in the CoC’s *Centering Racial Equity in Homeless System Design* report to better address the needs of families experiencing poverty due to structural racism.

a. CoC’s Housing First approach: All CoC programs, including permanent housing, follow a Housing First approach and must operate with as few barriers to entry as possible. No one may be screened out of housing programs due to perceived barriers related to housing or services, including too little or no income, active or history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record. The Housing First approach includes access to tenancy sustaining services that help ensure that, once housed, individuals are assisted in maintaining their housing regardless of obstacles. Based on our experience with Project Roomkey and other types of non-congregate interim housing, going forward the CoC will prioritize creating additional low-threshold, trauma-informed Housing First permanent housing for individuals and families experiencing unsheltered homelessness that make it as easy as possible to come inside.

b. How strategy is connected to the permanent housing resources identified in the Leveraging Housing Resources portion of the CoC Plan: One of the projects in this application will create 100 new units of low-barrier permanent supportive housing with enhanced care that will leverage housing resources the State of California’s Project Homekey. Alameda County has secured State funding to acquire and rehabilitate several hotels that are currently operating as temporary housing and will be converted to permanent housing in 2023 and 2024. A minimum of 60 out of the 100 new units to be created in the Enhanced Care Vouchers project will leverage these State housing resources.

2. How the CoC’s current strategy performs at providing low-barrier and culturally appropriate access to permanent housing to individuals and families who have histories of unsheltered homelessness:

According to the CoC’s HUD System Performance Measures report for FY 2021, of the 706 persons who exited Street Outreach, 133 (19%) exited to temporary and specific types of institutional destinations and 202 (29%) exited to permanent housing destinations, for a total of 47% successful exits from Street Outreach. This rate of successful exit is the same as the successful exit rate for people living in emergency shelter, safe houses, transitional housing, Rapid Rehousing and other permanent housing situations (also 47%). Those who entered permanent housing from Street Outreach also tended to have rates of returns to homelessness that were the same or better than those who exited from shelter, safe houses, and transitional housing.

3. Evidence that supports the use of the CoC’s current strategy: As stated above, 29% of Street Outreach exits were to permanent housing destinations, and 70% of those who took part in “shelter in place” non-congregate interim housing programs during the pandemic exited successfully to permanent housing, a much higher rate than those in traditional (congregate) sheltered and unsheltered settings. This confirms the importance of comprehensive street outreach strategies to engage those experiencing unsheltered homelessness, low-threshold housing opportunities that make it as easy as possible to come inside, and access to permanent supportive housing exits and/or subsidies for permanent housing.

4. New practices CoC has implemented across its geographic area in the past three years and lessons learned: The State of California implemented Project Roomkey to utilize hotels and motels as temporary emergency non-congregate shelter options with health care and other services and housing navigation for people experiencing homelessness. This showed how, with sufficient resources, new housing stock can be acquired quickly and efficiently to house large numbers of people experiencing unsheltered homelessness. The availability of flexible housing subsidies facilitates exits from interim housing to permanent housing.

P-4. Updating the CoC’s Strategy to Identify, Shelter and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

The CoC’s Home Together 2026 Plan created a series of goals to strengthen system coordination, communication and capacity. This includes a community-wide commitment to use and improve the community’s HMIS data for tracking and accountability. The CoC will improve HMIS coverage so that HMIS may be used as the primary method of tracking performance across the homelessness response system. All access point staff and all receiving entities for referrals are trained and licensed to use the HMIS system and follow all requirements in the HMIS policies. The CoC’s HMIS Oversight Committee developed a data quality plan, which was approved in June 2022 and sets data quality standards related to timeliness, completeness, accuracy, consistency and coverage. Improving data quality system-wide supports our CoC’s ability to use data to inform decisions about interventions and strategies. Our CoC has also submitted a new Project Application for HMIS Expansion in the annual FY 2022 CoC Competition. If this grant is awarded, it will support services for end users to improve data quality, as well as increased data analysis capacity to inform system level decision making.

HMIS also supports the operation of the CoC’s housing and service system, including Coordinated Entry. HMIS is used for all Coordinated Entry activities, including Housing Problem Solving, enrollment, prioritization, queue management, posting openings in shelter programs, and matching. A separate database is used for tracking and matching to permanent housing openings. Currently, our CoC is in the process of a Coordinated Entry evaluation, which involves collecting qualitative data about experiences with Coordinated Entry from staff and from youth and adults with lived experience of homelessness. In addition, analysis of coordinated entry HMIS data will be used to supplement the findings of the qualitative evaluation. Data from this evaluation will be used to inform ongoing improvements to Coordinated Entry.

The CoC has established a System Impact Committee to measure how the homeless response system is helping people exit homelessness and become rehoused quickly. The committee's work is to implement system-level effectiveness activities, identify system needs and gaps, promote efficient flow to housing, and conduct system modeling. Members of the work group of people with lived expertise who contributed to this plan called for increased tracking and transparent communication about housing (i.e., how many units are available, how quickly they are filled) and about how funding is distributed. These recommendations can be incorporated into the work of the System Impact Committee. Overall, the work group emphasized the need for increased accountability and transparency in all areas, and especially in how funding is distributed.

Alameda County has also recently expanded the Social Health Information Exchange (SHIE) and community health record, a data platform designed to enable cross-sector collaboration and care coordination for people with the most severe service needs who are connected with multiple systems of care. The SHIE brings together data from multiple systems (including health, behavioral health, housing, crisis response, and the jail and legal system) into a community health record that providers can use to coordinate care and bring a more whole-person approach for each client. There are more than 30 participating organizations, 100 programs, and 1,000 users that are using the community health record.

Street Outreach: The CoC's Coordinated Entry approach provides full coverage of the entire geography of Alameda County through a variety of methods that include physical open access points known as Housing Resource Centers distributed across the county, as well as street outreach, which covers all regions of the County. The County's Street Health teams serve as an access point for Coordinated Entry targeting people living in encampments and other outdoor locations. Outreach teams enroll their clients in Coordinated Entry and HMIS to ensure that people who are unsheltered have access to the full range of housing and services, and so that the CoC can accurately assess successful exits to indoor locations (temporary accommodations and permanent housing) from street outreach activities. Accurate accounting of street outreach contacts helps the CoC to determine the need for additional outreach resources and geographic distribution of outreach resources.

Four of the projects proposed under this application will expand and enhance the current street outreach strategy in Alameda County and will gather data the CoC can use to further refine and improve outreach efforts:

- New mobile Access Points will be deployed by Alameda County Health Care Services in five geographic zones, providing the full complement of Housing Resource Center services in the field to people living in homeless encampments, vehicles, and RVs. An estimated 1,000 individuals will receive services to help them access housing.
- A new Health Care for the Homeless Street Health Rapid Response Team will serve people who are unsheltered and in need of behavioral health support or substance use treatment, with the goal of avoiding psychiatric hospitalization, preventing overdose, and connecting them to ongoing help.
- A new Neighbor to Neighbor Street Outreach team will utilize a trained cadre of Outreach Ambassadors who have experienced unsheltered homelessness to engage vulnerable seniors living in encampments and connect them with the full range of services offered by St. Mary's Center.
- The Homeless Action Center will help unsheltered seniors obtain income, housing, and health care coverage. In line with recommendations from the work group, the Homeless Action Center will help reduce barriers to accessing these critical services by assisting with transportation, receiving mail, and completing assessments.

Per the recommendations of our workgroup, all four of these projects will include staff with lived experience and will increase the capacity of the system to provide outreach in the evenings, when people are awake and more likely to engage.

Low-Barrier and Temporary Accommodations: Accurate and real-time data is essential to the CoC's ability to assess, prioritize and match unsheltered individuals and families to low-barrier and temporary accommodations. All individuals and families who participate in Coordinated Entry complete a crisis

assessment and are put in the crisis queue based for emergency shelter and transitional housing based on factors such as length of time homeless and condition, disability or health need. HMIS data is used to determine how long individuals and families have waited for placement in temporary accommodations, and success in linking those served to permanent housing. Furthermore, per the recommendations of our workgroup, we will ensure that Housing First principles are honored by all shelter programs as a condition of funding, and that programs are systematically and regularly evaluated on their observance of Housing First principles.

Permanent Housing: Coordinated Entry and HMIS are also used to assess, prioritize and match unsheltered individuals and families to permanent housing. The Coordinated Entry housing assessment incorporates questions regarding a participant’s length of time homeless, housing barriers, and health and other care needs – information that is used to prioritize and match participants in the housing queue to housing opportunities. Accurate data maintained in Coordinated Entry and HMIS helps to ensure that participants are prioritized according to the current size of the housing inventory and likely upcoming availability of housing, and that participants receive timely and accurate information regarding housing opportunities. The housing queue is vital to the CoC’s planning around the need for new housing resources. It is also essential to provide supports to individuals who are waiting to be matched to housing. A work group member shared that they missed multiple housing opportunities because they did not receive mail or messages in time. Among the proposed projects, Homeless Action Center will offer services to help prevent this type of situation by offering ongoing follow up, mail services, and advocacy.

Two of the projects proposed under this application will expand access to permanent housing according to best practices:

- Alameda County Health Care Services Agency (HCSA) will create 100 new units of permanent supportive housing with rental assistance and enhanced care specifically dedicated to individuals experiencing unsheltered homelessness. Borrowing from its experience providing on-site clinical services at a County Homekey hotel for the most vulnerable (medically frail individuals with complex chronic illnesses and individuals with serious mental illness and/or substance use disorders), the new housing will address medical and mental health care needs with on-site services.
- The City of Oakland will create new rapid rehousing capacity that will provide medium-term rent subsidies, case management, housing search and aftercare services for people living in encampments within the City, some of whom may also stay briefly in the Community Cabins emergency shelter program as they transition into housing.

P-5. Identify and Prioritize Households Experiencing or with Histories of Unsheltered Homelessness

1. Strategy for ensuring resources provided under this NOFO will reduce unsheltered homelessness: The CoC has selected projects for this Special NOFO that build on and expand the strategies already in place to reduce unsheltered homelessness, as well as the priorities identified by the work group. Part of the evaluation of local applications included assessing their responses about how the projects will reduce unsheltered homelessness in the county. Three of the six projects have a geographic focus in Oakland, where nearly half of people experiencing unsheltered homelessness in Alameda County reside (per 2022 PIT Data). These projects will enhance the CoC’s ability to provide comprehensive and effective street outreach, intensive support for transitions inside and rapid access to low-barrier interim and permanent housing and increase the number of permanent housing units available to people experiencing unsheltered homelessness. The lessons learned by providing non-congregate shelter and intensive health and housing focused services during the pandemic will be the foundation of all interventions funded through this Special NOFO. Further integration of housing navigation and mobile access points in street outreach, and the addition of more peer positions within outreach teams will ensure that people who are unsheltered can be linked to the full array of existing and new housing and services available in our Continuum of Care.

2. How CoC will adopt:

a. Program eligibility processes that reduce unsheltered homelessness: The CoC will continue to ensure that program eligibility processes reflect a low-barrier, Housing First approach that makes it as easy as possible for individuals and families experiencing unsheltered homelessness to come inside.

b. Coordinated entry processes that reduce unsheltered homelessness: The Coordinated Entry process uses specific assessments to obtain information about both the immediate and long-term needs of persons and households seeking services. Portions of these assessments are weighted and assigned points leading to a score which is used, along with eligibility information, for placing participants onto prioritized queues for referral to crisis and housing resources. The prioritization process is designed to ensure that those applicants in greatest need of crisis and housing services are linked as quickly as possible. Weight is given to health/disability and self-care needs, duration of literal or chronic homelessness, household size and ages of members, and presence of housing barriers (evictions, arrests and convictions, income issues). Any additional system resources added under this Special NOFO will be included in Coordinated Entry and HMIS, and, as such, will be subject to the same prioritization and matching process that is described above. The new mobile Coordinated Entry Access Points in five designated geographic areas included in this application will increase engagement with people who are unsheltered and connect them to housing. The Homeless Action Center's housing advocacy project will help remove barriers that may prevent seniors living in encampments from completing assessments and follow up as part of the Coordinated Entry system.

3. How CoC will use street outreach to connect those living in unsheltered situations with housing resources: Street Outreach Teams in Alameda County serve as Coordinated Entry access points and also work closely in tandem with Housing Resource Centers, which provide additional housing problem solving and housing navigation assistance, as well as referrals and linkages to other health and human services. Per the recommendations of our workgroup, we will make additional resources available to support transitions: improved access to bathrooms, showers, clothing, laundry facilities and telephones, along with better real-time information on housing availability and housing application status. All of the four outreach related projects included in this application will include an emphasis on housing navigation and connection to housing resources.

4. Additional steps CoC is taking to ensure that people who are unsheltered or have histories of unsheltered homelessness can access housing and other resources in the community, including steps to:

a. Increase access to identification: Street Outreach teams and Housing Navigators within Housing Resource Centers are trained to help clients obtain identification and all other documents needed to obtain housing (this is called "document readiness"). Assistance with getting and storing necessary documents is a critical aspect of Coordinated Entry services. Housing Resource Centers determine whether a participant desires and needs assistance gathering necessary documents, and whether they have an existing service relationship (for example with a shelter or street health case manager) that can assist with this task. High priority participants without such assistance will be prioritized for Housing Navigation services. However, if a participant is not assigned to a Navigator and does not have another source of assistance the Housing Resource Center or the access point (e.g., Outreach Team) provides this service. Four of projects included in this application feature a strong emphasis on housing linkage and housing navigation, which includes being "document ready" with identification.

b. Provide housing navigation services: Housing Navigators identify barriers to housing, help develop a progress plan to overcome those barriers, assist in completing applications, guide clients through the housing application process. Housing Navigation is a central feature of Navigation Center shelters, which are low-barrier, housing focused shelters. Housing Navigation is a key feature of four of the projects included in this application.

c. Provide access to healthcare and other supportive services: Alameda County Health Care for the Homeless (ACHCH) is the federally funded health center program that serves homeless patients exclusively and

provides comprehensive integrated services under one roof. ACHC operates the County’s Street Health outreach teams. These teams specialize in highly accessible, patient-centered care. They build relationships that lead to long-term health through connections to primary care, social services, housing, and other resources. The ACHCH/Lifelong Trust Health Center offers primary care, laboratory services, comprehensive behavioral health care, recovery focused medical care, specialty medical care, housing coordination, showers, clothing donations, computer access and groups and workshops. ACHCH offers a mobile clinic that provides urgent care, care coordination, linkage and referrals to community resources, and comprehensive primary care with integrated behavioral health services at four wellness clinics. All participants being served under this Special NOFO will have access to the full range of health and social services offered by ACHC, as well as to the housing and services available through the CoC’s Coordinated Entry System. One of the projects in this application will enhance the physical and mental health services available to unsheltered populations through a new Street Health Rapid Response Team. Another project in this application will provide access to clinical care and other supportive services in new permanent supportive housing dedicated to people who formerly experienced unsheltered homelessness. The other two projects, Neighbor to Neighbor Outreach and Housing Advocacy for Unsheltered Seniors have also leveraged healthcare resources from West Oakland Health Council and TRUST Council to provide healthcare services worth at least 25% of the HUD funds being requested.

P-6. Involving Individuals with Lived Experience of Homelessness in Decision Making – Meaningful Outreach

1. Outreach efforts to engage those with lived homelessness experience to develop a working group: The CoC convened a working group of six people with lived experience of homelessness to provide meaningful input into this Special NOFO response. EveryOne Home (the CoC backbone agency) recruited work group members via its mailing list and targeted outreach to alumni of the Emerging Leaders program, a leadership and advocacy training program offered by the CoC for people with lived expertise. Of the six workgroup members, five are Emerging Leaders alumni, two serve on the Leadership Board and one on the NOFO Committee for the CoC. As with other CoC work, work group members were compensated \$25 per hour for their contributions to the planning work. The working group met three times and produced a list of priorities that project applicants were instructed to review and incorporate as much as possible into their program designs. Representatives of the working group presented these priorities to the NOFO Committee prior to their review of local applications for this funding opportunity, and CoC staff provided an analysis of how each application aligned with work group priorities for reviewers. Key themes from the work group sessions included improved connectivity and assistance with system navigation and the transition into housing, more flexibility with program rules, greater access to basic needs assistance (daily showers, laundry, clothing, bathrooms, phones), and reducing barriers that make it difficult to make critical appointments. They also stressed the need for more mental health services to address the trauma resulting from homelessness, more integration of peer ambassadors in street outreach, providing outreach at night, equipping outreach workers with real-time, up-to-date, information on available resources, more integration of street outreach in HMIS, and creation of physical “hubs” for drop-in services and checking in on housing application status. They emphasized the need for accountability about how funding is spent and elevated the importance of service providers treating people with understanding and respect.

2. How individuals and families experiencing homelessness, particularly unsheltered homelessness, are meaningfully and intentionally integrated into the CoC decision making structure: The CoC recognizes that people with lived experience of homelessness have expertise and insight that must inform how we design and implement an effective homelessness response system in Alameda County. In the revision to its governance charter approved in February 2022, the CoC set a representation metric of at least 33% of committee members with lived experience on all boards, committees, and workgroups. To make this possible, the CoC committed to providing ongoing financial

compensation for participation and transportation to attend meetings; ensuring all members have access to technology and equipment necessary to attend virtual meetings; and offering training, orientation, and ongoing mentorship for committee members with lived experience. Over the past year, the CoC has held two cohorts of the Emerging Leaders program, which is a leadership development and advocacy training program that prepares participants to apply for seats on CoC committees and pursue other leadership roles. In consultation with HUD TA, the CoC is also training all board and committee members to ensure an inclusive environment at meetings and engagements, including offering training on authentic engagement of people with lived experience, trauma-informed care, and race equity. The Leadership Board agreed to hold itself and each committee/workgroup chair accountable for achieving and maintaining the 33% metric. Of the 31 seats on the Leadership Board, 8 are currently filled by people with lived expertise, and recruitment is about to begin for all other committees.

3. How the CoC encourages projects to involve individuals and families with lived experience of unsheltered homelessness in the delivery of services (e.g., by hiring people with lived experience of unsheltered homelessness): Our CoC providers have long had a practice of hiring people with lived experience to provide direct services. The CoC supports this by offering programs such as our mentoring program and our Emerging Leaders Program. These opportunities support individuals with lived experience to serve in leadership roles both in their organizations and in CoC boards, committees and workgroups. Applicants for the 2022 CoC NOFO and this Supplemental Unsheltered NOFO were evaluated on their responses on how they engage people with lived experience in decision-making.

P-6a. Involving Individuals with Lived Experience of Homelessness in Decision Making– Letter of Support from Working Group Comprised of Individuals with Lived Experience of Homelessness.
*See the **Lived Experience Support Letter** attachment to the 4A. Attachment Screen.*

P-7. Supporting Underserved Communities and Equitable Community Development

1. Current strategy to identify populations that have not been served by the homeless system at the same rate they are experiencing homelessness: In 2020, the CoC completed a racial equity and homelessness response system report, *Centering Racial Equity in Homeless System Design (CRE)*. This included a racial equity impact analysis, quantitative analysis of PIT and HMIS data; and focus groups with 53 individuals experiencing homelessness who identified as Black, Indigenous and People of Color. In 2021, EveryOne Home created a Race Equity survey for CoC applicants to assess the extent to which they are enacting specific racial equity policies and practices. Also in 2021, the CoC developed 13 new equity indicators that use HMIS data disaggregated by race and additional data sources. This data is reviewed on a quarterly basis and significant findings are lifted up to the Leadership Board for review. In Spring of 2022, consulting firm Focus Strategies conducted an independent analysis of the new Coordinated Entry scoring system to evaluate whether the results were equitable across race/ethnicity and other demographic factors. The results were presented to the CoC in June of 2022, and recommendations on how to improve the assessment tools and scoring criteria were presented. The CoC's newly formed Racial Equity Workgroup has emphasized the importance of using a racial equity framework from the start of all evaluation and data projects. One area of continued need for action is to address the high rates of returns to homelessness among Black and African American residents of Alameda County.

2. How underserved communities in the CoC interact with the homeless system, including a description of those populations: HMIS data shows racial disparities in both first-time homelessness and returns to homelessness, with African Americans and Native Americans experiencing homelessness at a rate four times higher than Alameda County's general population. Black and African American people experiencing homelessness are the largest population of people represented in our homeless system. The Black and African American population is approximately 10% of Alameda County, but 43% of those experiencing homelessness. In FY 2021, persons who were Black or African American represented 55% of homelessness system enrollments, but 57% of those who returned to homelessness after two years. The *Centering Racial Equity in*

Homeless Services Design report highlighted how historical trauma and structural racism, including redlining and discriminatory housing practices, have contributed to and uphold these disparities. As noted in that report, many more people become homeless each year than return to housing because of a lack of sufficient resources, and Black and Indigenous people are extremely overrepresented among people who become homeless. The report emphasized the need for deeply affordable housing and shallow subsidies without time limits, to better meet the needs of people experiencing poverty linked to structural racism.

3. CoC's current strategy to provide outreach, engagement, and housing interventions to serve populations experiencing homelessness that have not previously been served by the homeless system at the same rate they are experiencing homelessness: CoC strategies to improve services in underserved communities include contracting with place-based CBOs that are representative of populations experiencing homelessness, incorporating peer specialists and people with lived experience in service teams and placing additional homelessness system access points in neighborhoods with higher populations of Black and Native American residents. [The Centering Racial Equity in Homeless System Design report \(CRE\)](#) modeled what an optimal system to respond to homelessness and reduce racial disparities would look like and what gaps need to be filled. Moving forward, informed by the CRE, the County and its contracted providers will focus efforts on increasing long-term interventions like ongoing shallow subsidies that bridge the gap between earned income and the cost of housing and dedicated affordable housing for extremely low-income households with low service needs, and creating significant additional affordable housing dedicated specifically to people experiencing homelessness. Other strategies include developing supportive housing for people who need increased supports, such as older and frail adults, growing the supply of transitional housing for youth, expanding current program models such as Rapid Rehousing and supportive housing, expanding targeted behavioral health services throughout the system, and improving and expanding targeted homelessness prevention.

In February of 2022, a new CoC Governance Charter was adopted that designates that all boards and committees include 1/3 individuals with lived experience of homelessness and reflect the racial demographics of the people served by our homelessness response system. The racial diversity metric for our boards, committees, and workgroups will be set by the racial demographics reflected in our annual Point-In-Time count: for instance, per the 2022 PIT Count, 43% of people experiencing homelessness identify as Black or African American. During the recruitment process for the new Leadership Board, many BIPOC-led and BIPOC-serving organizations were outreached to directly to encourage participation in the Leadership Board.

A Racial Equity Workgroup has been created as part of this new charter to help ensure that racial equity is centered across the homelessness response system and that racially disparate outcomes around homelessness and housing are addressed and eliminated. The committee will advise and hold accountable all other boards, committees, and workgroups, including the Leadership Board on racial equity goals, metrics, and outcomes. The newly formed Racial Equity Workgroup is in the process of developing recommendations for the Leadership Board and other committees to ensure that our CoC applies a racial equity framework from the start of all initiatives and efforts to end homelessness.