COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF SOCIAL SERVICES

2022 HUD CONTINUUM OF CARE PROGRAM SPECIAL UNSHELTERED HOMELESSNESS SET ASIDE COMPETITION – SUPPLEMENTAL APPLICATION

On June 22, 2022, the U.S. Department of Housing and Urban Development (HUD) released the 2022 Continuum of Care (CoC) Supplemental Notice of Funding Opportunity (NOFO) to Address Unsheltered and Rural Homelessness (FR-6500-N-25S).

The County of San Luis Obispo is requesting proposals for the 2022 Continuum of Care Program Special Unsheltered Homelessness Set Aside competition administered by HUD and will be accepting applications for new funding projects.

All 2022 Continuum of Care Program Special Unsheltered Homelessness Set Aside applicants will need to submit a supplemental application in addition to the HUD application submitted in e-snaps.

Please submit Supplemental Applications by email to ss_homelessgrants@co.slo.ca.us or deliver to George Solis at the County Department of Social Services, 3433 S. Higuera, San Luis Obispo, CA. Both the esnaps and Supplemental Application must be received no later than **Thursday, September 8, 2022, at 5pm**

Additionally, additional documents described on page 14 of this RFP must be submitted by email or in person no later than September 8, 2022.

I. PRIMARY APPLICANT INFORMATION

Organization Name	Community Action Partnership of San Luis Obispo Co., Inc.
UEI Number	GBL8FWWVCLC5
Contact Person/Title	Elizabeth "Biz" Steinberg/CEO
Phone Number	805-544-4355
Email	esteinberg@capslo.org
Address	1030 Southwood Dr.
City, State, Zip	San Luis Obispo, CA 93401

II. PROJECT

Project Name	
Application Type	☐ Permanent Supportive Housing ☐ Rapid Rehousing ☐ Joint Transitional Housing/ Rapid Rehousing ☐ Coordinated Entry ☑ Supportive Services Only

III. EXPERIENCE

1. Describe the experience of the applicant and sub-recipients (if any) in working with the proposed population and in providing housing similar to that proposed in the application.
See attachment E.
2. Describe experience in effectively utilizing federal funds including HUD grants and other public funding, including satisfactory drawdowns and performance for existing grants as evidenced by timely reimbursement of subrecipients (if applicable), regular drawdowns, timely resolution of monitoring findings, and timely submission of required reporting on existing grants.
See attachment E.
3. What is the date of the organization's most recent audit? *(Attachment requirement)* *Please submit a copy of the organization's most recent audit by email (ss_homelessgrants@co.slo.ca.us) or in person to George Solis at DSS no later than September 8, 2022.*
See attachment A.
4. Housing First and/or Lower Barrier Implementation *(Attachment requirement)* **Describe experience with utilizing a Housing First approach. Include:** **1) eligibility criteria;** **2) process for accepting new clients;** **3) process and criteria for exiting clients.** **Must demonstrate there are no preconditions to entry, allowing entry regardless of current or past substance abuse, income, criminal records (with exceptions of restrictions imposed by federal, state, or local law or ordinance), marital status, familial status, self-disclosed or perceived sexual orientation, gender identity or gender expression.**

Must demonstrate the project has a process to address situations that may jeopardize housing or project assistance to ensure that project participation is terminated in only the most severe cases.

Existing projects should submit a copy of the project's relevant policies and procedures by email (ss_homelessgrants@co.slo.ca.us) or in person to George Solis at DSS no later than September 8, 2022.

See attachment E.

5. **Describe how Housing First protocols will be incorporated into the proposed project and what will you do to ensure that people can succeed in programs that cannot have service participation requirements or prerequisites.** *Housing First is a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as sobriety or a minimum income threshold). Transitional housing and supportive service only projects are considered using a Housing First model for the purposes of this application if they operate with low barriers, work to quickly move people into permanent housing, do not require participation in supportive services, and, for transitional housing projects, do not require preconditions for moving into the transitional housing (e.g., sobriety or minimum income threshold) but do provide or assist with access to such supportive services if needed and requested by program participants.*

See attachment E.

IV. Design of Housing & Supportive Services

6. Describe the needs of the clients to be served.
See attachment E.
7. (PSH, RRH & Joint TH-RRH Projects) Describe the type and scale of all the supportive services that will be offered to program participants to ensure successful retention in or help to obtain permanent housing, regardless of funding source, meets the needs of clients to be served.
N/A
8. (Supportive Services Only Projects) Describe the proposed project's strategy for providing supportive services to those with the highest service needs, including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services.
See attachment E.

9. (Supportive Services Only Projects) Describe the proposed project's strategy for providing supportive services to participants placed into housing after 6 months of eligible supportive services assistance has ended (if needed).
See attachment E.

10. (Coordinated Entry Projects) Describe how the proposed project will align with the County's existing Coordinated Entry System.
N/A

11. For the proposed project, please estimate the expected % of households that will experience an increase in earned income from program start to program exit:	5 %
12. For the proposed project, please estimate the expected % of households that will experience an increase in non-employment income from program start to program exit:	50 %
13. For the proposed project, please estimate the expected % of households that will experience an increase in total income from program start to program exit:	55 %

IV. Leveraging Housing Resources

14. For permanent housing applications (PSH) (RRH) (TH-RRH), describe how the project will utilize housing subsidies or subsidized housing units not funded through the CoC or ESG programs. (Housing subsidies or subsidized housing units may be funded through any of the following sources: Private organizations; State or local government, including through the use of HOME funding provided through the American Rescue Plan; Public Housing Agencies, including through the use of a set aside or limited preference; Faith-based organizations; or Federal programs other than the CoC or ESG programs.)

Applicants must attach letters of commitment, contracts, or other formal written documents that demonstrate the number of subsidies or units being provided to support the project. For a new permanent supportive housing project, provide at least 50 percent of the units included in the project; or for a new rapid re-housing project, serve at least 50 percent of the program participants anticipated to be served by the project.
N/A
15. For permanent housing applications (PSH) (RRH) (TH-RRH), describe the current strategy used to recruit landlords and show how well it works at identifying units across the entire CoC area, including areas where the CoC has historically not been able to finds units.
N/A

16. For permanent housing applications (PSH) (RRH) (TH-RRH), identify any new practices that have been implemented to recruit landlords in the past 3 years and the lessons learned from implementing those practices.
N/A
17. For permanent housing applications (PSH) (RRH) (TH-RRH), describe how you will use data to update your landlord recruitment strategy.
N/A

IV. Leveraging Healthcare Resources

18. For permanent housing applications (PSH, (RRH) (TH-RRH), describe how the project will utilize healthcare resources to help individuals and families experiencing homelessness. (Sources of health care resources include: Direct contributions from a public or private health insurance provider to the project (e.g., Medicaid), and Provision of health care services, including mental health services, by a private or public organization (including

FQHCs and state or local health departments) tailored to the program participants of the project, direct partnerships with organizations that provide healthcare services, including mental health services to individuals and families (including FQHCs and state and local public health departments) experiencing homelessness who have HIV/AIDS). Eligibility for the project must comply with HUD program and fair housing requirements. Eligibility criteria cannot be restricted by the eligibility requirements of the health care service provider). *Applicants must attach formal written agreements and must include: value of the commitment, and dates the healthcare resources will be provided. In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who quality and choose those services; or the value of assistance being provided is at least an amount that is equivalent to 50 percent of the funding being requested for the project, which will be covered by the healthcare organization. In-kind resources must be valued at the local rates consistent with the amount paid for services not supported by grant funds.*
N/A

V. Addressing Severity of Needs

19. Estimated percentage of participants to be served that are chronically homeless:	80	%
20. Estimated percentage of participants to be served that have low or no income:	100	%
21. Estimated percentage of participants to be served that have history of victimization/abuse, domestic violence, sexual assault, childhood abuse:	10	%

VI. Timeliness

22. Describe plan for rapid implementation of the program, documenting how the project will be ready to begin housing the first program participant. Provide a detailed schedule of proposed activities for 60 days, 120 days, and 180 days after grant award. Please also estimate the average time from a client's program entry to housing placement.
See attachment E.

VII. Project Effectiveness

23. Coordinated Entry Participation- Minimum percent of entries projected to come from CE referrals	300
24. Projected number of households to exit to permanent housing	150

VIII. Equity Factors

25. Project has under-represented individuals (BIPOC, LGBTQ+, etc) in managerial and leadership positions	(●) YES ( ) NO

26. Project's organizational board of directors includes representation from more than one person with lived experience (per 24 CFR 578.75(g) Participation of Homeless Individuals)	(●) YES ( ) NO

27. Describe how your organization has identified any barriers to participation (e.g., lack of outreach) faced by persons of different races and ethnicities, particularly those over-represented in the local homelessness population.

Those with severe and persistent mental illness and substance abuse disorders are quite often over-reprsesented in the population of those experiencing homelessness. The feedback we have received over the years is that the program requirements of CAPLSO were at odds with the needs and abilities of those populations. Over time this resulted in high barriers to services. Many participants were suspended due to behaviors stemming from those barriers, and negative perceptions in the homeless services community were established. Specifically, policies that mandated chores, sobriety or treatment for the use of services, suspensions without the ability to resume services, and unclear rules regarding resuming services were identified. These were realized as barriers through staff meetings, client focus groups, and strategic discussions regarding best service delivery practices.

This process has evolved into a continual improvement process that staff implements with participants to review all policies and processes, complimented by a planned process to use all data gathered by programs to analyze how outcomes might vary by special populations who are experiencing homelessness (those who are chronically homeless, those with disabilities (mental health, substance abuse, developmental), LGBTAQ+, BIPOC, older adults, etc..)

28. Describe the actions the organization has taken or will take to eliminate the identified barriers.

CAPSLO s Homeless Services Department, based on this feedback and analysis, removed or modified these barriers to be more aligned with the philosophies of Harm Reduction and Housing First. For example, CAPSLO eliminated the requirements for all participants to breathalyze and drug test upon entry to the night program roughly three years ago because it resulted in many individuals being barred from services or increased their time experiencing homelessness further and only targeted individuals who had known addiction issues. One year ago, these barriers were reduced further to those with behavioral issues on site and were then placed on contracts for drug testing and breathalyzing. After further feedback, these program requirements were completely eliminated. CAPSLO continues to offer drug tests and breathalyzing as a service to participants if they so elect for their own recovery. They are no longer used to determine someone s ability to access services.

29. Describe the actions the organization will take to serve subpopulations that the CoC has identified as being underserved.
See attachment E.

IX. Involving Individuals with Lived Experience of Homelessness in Service Delivery and Decision Making and Providing Professional Development and Employment Opportunities.

30. Describe and provide examples of Professional Development (e.g. internships, continuing education, skill-based training) and employment opportunities provided to individuals with lived experience of homelessness by your organization.
CAPSLO has a long track record of professional development of former participants; many staff persons employed by CAPLSO are former participants. The core mission of CAPLSO is to address the underlying issues of poverty in SLO county. One of the most effective ways to do that is through employment and opportunities for training and advancement. Specifically, in homeless services, some roles are designed to elevate those with lived experience, such as the role of peer advocate. This role has been a hallmark of CAPLSO homeless services for several years and is an effective pathway for those with lived experience to start a career in homeless services. In addition to the direct employment of those with lived experience, CAPSLO partners with myriad local education and workforce development programs to link participants with these opportunities. 32% of all referrals in CES were from employment-related programs, including programs designed for career advancement.

31. Do you have a mechanism for obtaining feedback from program participants? Please describe (e.g. annual focus groups, consumer advisory panels, etc.).
CAPSLO has a long track record of professional development of former participants; many staff persons employed by CAPLSO are former participants. The core mission of CAPLSO is to address the underlying issues of poverty in SLO county. One of the most effective ways to do that is through employment and opportunities for training and advancement. Specifically, in homeless services, some roles are designed to elevate those with lived experience, such as the role of peer advocate. This role has been a hallmark of CAPLSO homeless services for several years and is an effective pathway for those with lived experience to start a career in homeless services. In addition to the direct employment of those with lived experience, CAPSLO partners with myriad local education and workforce development programs to link participants with these opportunities. 32% of all referrals in CES were from employment-related programs, including programs designed for career advancement.

32. Do you agree to work with the CoC's Working Group for the Unsheltered Homelessness Set Aside	(●) YES ( ) NO

X. Addressing the Needs of LGBTQ+ Individuals

33. Does your agency have anti-discrimination policies in place.? *(if so please provide copy as an attachment)*
CAPSLO does have this in place. Specifically, see sections in the attachment F: 10.6 CAPSLO s Position & 10.7 Abusive Conduct.

34. Describe what actions your organization will you take to ensure that LGBTQ+ individuals and families receive supportive services, shelter, and housing free from discrimination?
We provide training for all staff and ensure that all subcontracted agencies have anti-discrimations training. In addition, we work to ensure that all participants can voice concerns when potential harassment or discrimination occurs. There are frequent reviews of staff interactions and actions to ensure that discrimination is not occurring. Specifically, within CAPSLO s Homeless Services Department, all participants can fill out (verbally or physically and with options for anonymous submission) a conflict resolution form. This form is transcribed into our database (coded to a generic profile if anonymous) and is reviewed by the appropriate management team. The resolution is recorded in our database. If an issue arises more than once or is profoundly severe, it is escalated to the appropriate management role within CAPSLO. Provision, denial, and exit from services are reviewed monthly. Special attention is given to those who are in underserved or protected classes. In cases where it is at the very least unclear if there was any discrimination based on these or any other protected factors, an investigation is undertaken by CAPSLO management in documented communication with the CAPLSO Human Resources team.

XI. Alignment with the San Luis Obispo Countywide Plan to address homelessness

35. Describe how the project will align with a Line of Effort to support the San Luis Obispo Countywide Plan to address homelessness (2022- 2027).
See attachment E.

X. Attachments

Attachment A – Organizations most recent audit (Required)

Attach a copy of the organizations most recent audit no later than September 8, 2022

Attachment B – Project's Policies and Procedures (Required)

Attach a copy of the project's Housing First Policies and Procedures no later than September 8, 2022

Attachment C – Leveraging Housing Resources Commitment

PSH, RRH, Joint TH-RRH Applicants must attach letters of commitment, contracts, or other formal written documents that demonstrate the number of subsidies or units being provided to support the project. For a new permanent supportive housing project, provide at least 50 percent of the units included in the project; or for a new rapid re-housing project, serve at least 50 percent of the program participants anticipated to be served by the project.

Attachment D – Leveraging Health Care Resources Commitment

PSH, RRH, Joint TH-RRH Applicants must attach formal written agreements and must include: value of the commitment, and dates the healthcare resources will be provided. In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who quality and choose those services; or the value of assistance being provided is at least an amount that is equivalent to 50 percent of the funding being requested for the project, which will be covered by the healthcare organization. In-kind resources must be valued at the local rates consistent with the amount paid for services not supported by grant funds.

Attachment E – Supplemental Answers to Questions (Optional)

If you need more room to answer any of the application questions, please attach the additional information here. Include the question number for each question being answered.

For other additional or optional attachments, please label them clearly (e.g. Attachment E – "Title").

XI. APPLICATION SUBMISSION:

Supplemental Applications will be due to Homeless Services Unit, County of San Luis Obispo Department of Social Services, September 8, 2022, 5PM.

Applicants may submit digital or hard copy applications to the locations below:

1. Soft Copy – email to SS_HomelessGrants@co.slo.ca.us
   Subject line: FY 2022 HUD CoC Unsheltered Set Homelessness Aside Supplemental Application – (Applicant Name)
2. Hard Copies – Mail or Drop-off
   Attn: Homeless Services Unit
   County of San Luis Obispo Department of Social Services
   3433 South Higuera Street
   San Luis Obispo, CA 93403

Exhibit E – CoC FY23, Unsheltered NOFO

Street Outreach Coordination

1. **Describe the experience of the applicant and sub-recipients (if any) in working with the proposed population and in providing housing similar to that proposed in the application.**

San Luis Obispo County (SLO) Continuum of Care (CoC) has the third largest percentage of unsheltered homeless in the nation. The COC also ranks as the second least affordable small metro area in the country, with the cost of housing more than 50% higher than the national average. Limited housing resources and under-resourced services across the supportive services spectrum have made this reality even more challenging resulting in inconsistent service access and coordination. This grant proposes to strengthen the Coordinated Entry System (CES) by strategically unifying and expanding already established housing-focused case management and outreach services with the major service providers in the COC: Community Action Partnership of San Luis Obispo County (CAPSLO), 5Cities Homeless Coalition (5CHC), El Camino Homeless Organization (ECHO), Transition Mental Health Association (TMHA), and Salvation Army (SA). These organizations each have extensive track records in outreach to the unsheltered population of SLO and work collaboratively to provide non-duplicative supportive services throughout the county. Of note, In keeping with the COC's newly adopted strategic plan, efforts are underway to integrate SA and TMHA into the CES system to better improve the administrative functioning of the CES in SLO CoC and strengthen the service referral process. The funding of this grant will allow ensure that all services are coordinated between the partners, and they act with a unified focus to deliver consistent and coordinated outreach services throughout all geographic areas of the county (north, central, south, and coastal areas) and to allow for cross-agency integration. Of particular importance, the grant provides enhanced staffing to improve progressive engagement efforts with service-resistant individuals who are experiencing prolonged instances of unsheltered homelessness.
Street Outreach Coordination Project has two main components.

The first structured component, coordination, is to coordinate all outreach efforts in the CoC to ensure that there is no duplication of services and the best possible match based on participant needs and location with existing outreach teams. The intent of coordination is to align all outreach activities in a regionally needs-based approach with pathways and policies & procedures that are CoC-wide, allowing for flexibility when needed. This coordination especially involves the tracking of all outreach activities via HMIS and multiple case-conferencing meetings to ensure that participants are being met "where they are at." This coordination will allow for decreased engagement time and decreased time overall for all individuals experiencing unsheltered homelessness as a major component of outreach activities, which are currently spent determining referral pathways and communicating with multiple providers to ensure non-duplication of services provided.

The second structured component is the addition of an intensive multi-agency outreach team that is focused on households that have experienced long-term unsheltered homelessness and those households that are service disengaged. Currently, in SLO CoC there is only one Assertive Community Treatment (ACT, aka Full-Service Partnership (FSP)) team targeting those who are

long-term chronically homeless and service disengaged, with a total capacity of roughly 30 households. There are no other teams that are targeting this population and there is a major demand as the FSP team here has to prioritize an already highly prioritized population. This outreach team will consist of senior outreach case managers from all partner agencies and will utilize an integrated innovations team approach, having both physical health and mental health providers interlayered for support to each individual and to allow for multiple points of service delivery and engagement. CAPLSO will integrate "The Clinic" - an FQHC that is part of CAPSLO to provide needed reproductive healthcare and women's healthcare as an integrated partnership. The Clinic is already integrated into a 5CHC interim housing project, Cabins for Change, and will build upon this partnership to integrate into this new outreach team. In addition to this integration of healthcare, THMA is an already established provider of Mental Health care and will continue to provide this service in this team-based approach. This street outreach team will meet monthly and will focus on specific individuals that are identified throughout SLO CoC as being in higher need, or more service resistant to typical outreach activities, and are not already engaged with FSP outreach. In this way, this team will fill a current outreach services gap for those who are waiting for FSP services or are not deemed high acuity enough for FSP and are not a good match for typical outreach services already provided in the county.

Additional funding provided will allow for a more focused approach to those who are experiencing prolonged unsheltered homelessness. Through the formation of an inter-agency team, each partner will commit up to 1.5 outreach workers to this effort. This unique team, a first in SLO CoC, will coordinate efforts targeting the unsheltered population countywide with a specific focus on linkage to both interim and permanent housing solutions. This team will take an integrated innovations team approach, having both physical health and mental health providers interlayered for support to each individual and to allow for multiple points of service delivery and engagement. This expansion is needed to reduce the time of individuals experiencing unsheltered homelessness and improve the integration of outreach into CES in SLO CoC. As an example, currently outreach groups are attending three different monthly meetings that are independently run and focused on various populations, without coordination between the groups. This new project would be focused on the coordination of all efforts, streamlining meetings, improving consistency in outreach efforts, data collection and CES referrals while also ensuring deduplication of services and improved engagement. A major component of an effective Housing First system is coordinated engagement and outreach efforts. The COC's CES system has strong partners, many of these agencies have long track records of effective outreach, for example, ECHO, 5CHC, and CAPLSO have worked together in multiple outreach projects, with over 3000 individuals engaged with and connected to housing resources since 2020. This grant will allow the next step of integration needed to help those who are experiencing prolonged instances of unsheltered homelessness find stable housing in this extremely challenging housing market.

In addition to this ECHO, 5CHC, and CAPSLO have established a robust partnership with San Luis Obispo Legal Aid Foundation (SLOLAF) to provide legal assistance to individuals who are seeking housing assistance, for both those who are currently experiencing homelessness and those at risk of experiencing homelessness. Over 50 individual households have been helped in this way since the partnership was established in 2021.

2. **Describe experience in effectively utilizing federal funds including HUD grants and other public funding, including satisfactory drawdowns and performance for existing grants as evidenced by timely reimbursement of subrecipients (if applicable), regular drawdowns,**

timely resolution of monitoring findings, and timely submission of required reporting on existing grants.

Since its designation as the county's federal Community Action Agency in 1965, CAPSLO has been awarded countless government grants. For over 17 years, CAPSLO has consistently received US Department of Housing and Urban Development (HUD) funding, successfully providing services to San Luis Obispo County's homeless population. CAPSLO also receives funding through the US Departments of Health and Human Services (HHS), Energy, Agriculture, and Veterans Affairs (VA). State grants include Community Services Block Grants (CSBG), and those through the Departments of Housing Community Development, HHS, and Social Services (DSS). Numerous County of SLO grants is received annually. With over 225 grants awarded each year, CAPSLO is meticulous in completing the required program activities and outcomes as requested by the funder and has a long record of passing all audits/reviews with no findings.

With the necessary infrastructure to successfully implement and monitor complex grants and contracts, CAPSLO undergoes an agency-wide, rigorous audit process annually, including inquiry and observation to understand and evaluate CAPSLO'sinternal controls, confirmations, interim testing, and compliance audits, and substantive, procedural analysis. Critical audit areas include compliance with federal and state awards, program and support services expenses, accounts payable and accrued liabilities, program revenue and unearned deferred revenue, cash, property, equipment, and long-term debt.

CAPSLO's Finance Department will be responsible for processing payment requests. They have a long history of working with the County of San Luis Obispo in submitting payment requests for many grants from various County departments.

4. **Housing First and/or Lower Barrier Implementation (Attachment requirement) Describe experience with utilizing a Housing First approach. Include: 1) eligibility criteria; 2) process for accepting new clients; 3) process and criteria for exiting clients. Must demonstrate there are no preconditions to entry, allowing entry regardless of current or past substance abuse, income, criminal records (with exceptions of restrictions imposed by federal, state, or local law or ordinance), marital status, familial status, self-disclosed or perceived sexual orientation, gender identity or gender expression. Must demonstrate the project has a process to address situations that may jeopardize housing or project assistance to ensure that project participation is terminated in only the most severe cases.**
    1. All agencies CAPSLO, ECHO, THMA, SA, and 5CHC work in partnership to follow a Housing First, low barrier approach to working with individuals experiencing homelessness. There are no preconditions to entry, allowing entry regardless of current or past substance abuse, income, criminal records (with exceptions of restrictions imposed by federal, state, or local law or ordinance), marital status, familial status, self-disclosed or perceived sexual orientation, gender identity or gender expression. Salvation Army has a robust history of implementing effective street-to-home engagement at multiple locations throughout the county. TMHA has extensive experience in implementing Housing First practices through its Full-Service Partnership (FSP) for the most vulnerable in SLO County into Permanent Supportive Housing (PSH) in a Housing First framework. FCN and FRC use a client-centered approach with their families, placing families back into permanent housing with supportive services. FCN is

the only administrator of the Brining Families Home & Housing Focus Program Programs in SLO county, which both operate on a Housing First approach.

2. In the previous grant year, CAPSLO, ECHO, and 5CHC worked to modify all intakes to a universal intake, combining and simplifying all agencies' intakes and Coordinated Entry Assessment - this process will be integrated into all agencies for this project and will allow for a no wrong door approach for outreach services. In outreach and engagement work it is often difficult to get all the required CES and HMIS data elements for a new intake to fully accept someone into services (enrollment). The process of this is something all agencies have over 10 years of experience in here in SLO County, progressive engagement - to work with all individuals who are citing or appear to have the need for outreach services and having targeted client-centered engagements with them. This will be more formalized in this project year through the improvement of the CES universal intake.

3. All participants are provided the tools to problem-solve their housing situation, even when engaged during street outreach. Since there are limited case managers in SLO County, only those who are VISPDAT scoring a 3 and above will be assigned to a housing-focused case manager. Clients may be referred to Adult Protective Services (APS), THMA FSP, County Behavioral Health, or any other appropriate referral based on their needs. Households are exited from services when they have continually refused services, have been successfully referred to other housing project types, or cannot be located. Individuals are not exited from services in CES due to mental health, substance abuse, mental disability, or other disabling conditions.

5. Describe how Housing First protocols will be incorporated into the proposed project and what will you do to ensure that people can succeed in programs that cannot have service participation requirements or prerequisites.

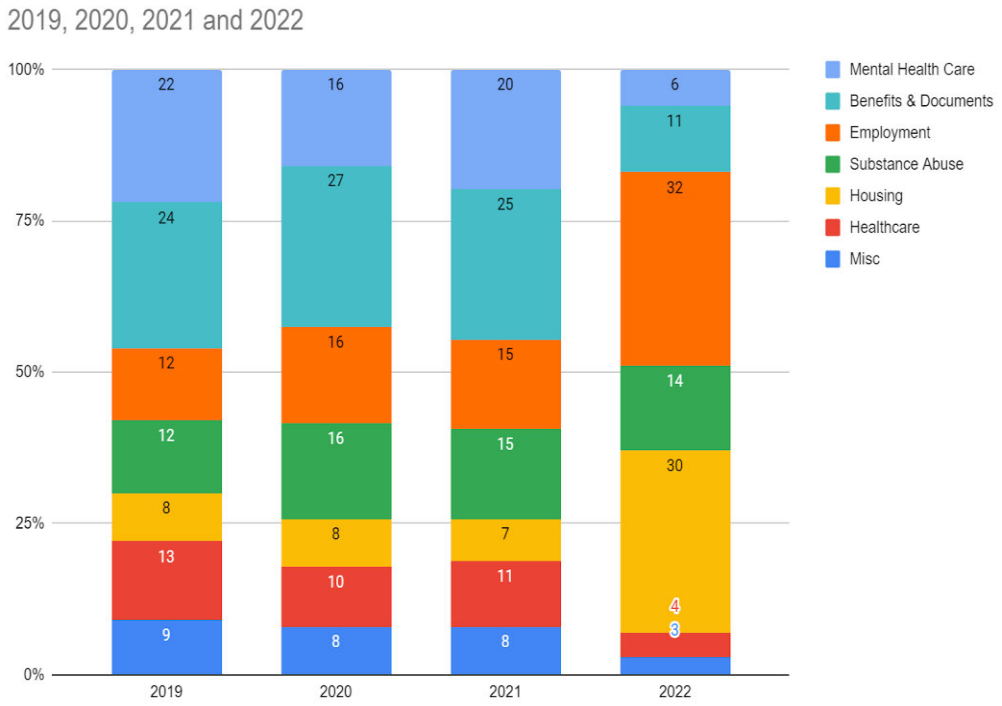
This project will bolster, coordinate, and support all existing outreach efforts in SLO CoC. All outreach here is primarily focused on placement into housing programs, where individuals are quickly housed without preconditions or service participation requirements. There are no exits or any pre-screening of assistance due to perceived barriers to housing or services, including, but not limited to: too little or no income, active or a 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. All participating agencies are adherent to this approach. A core component of a functional Housing First system is leveraging and enhancing current community-based partnerships and programs. All agencies in this application have a long history of linking households successfully with housing resources such as RRH and PSH, they are also linked with wraparound services throughout the housing and stabilization process. There are times in which outreach teams and efforts can often get hampered by trying to treat mental health or substance abuse prior to the establishment of a housing-focused care plan and connections o housing resources. This project will commit itself and all outreach projects in SLO CoC to have all providers establish a housing forced care plan as a primary area of activity. This is already in place at all current agencies and it will be the goal of this project to ensure that there is continued uniformity to this.

6. Describe the needs of the clients to be served.

This project will primarily serve those who are experiencing unsheltered homelessness in San Luis County. Based on the most recent Point in Time County (PIT) 1,448 individuals were experiencing homelessness and the vast majority (80%) experiencing unsheltered homelessness. the majority of the population experiencing homelessness were male (55%), white (84%), over the age of 25 (77%), and over 40% over the age of 51, and had been in SLO County for over 10 years (52%), with a year or more spent expending homelessness (83%). Additionally, this population has profound health barriers, yet does not identify disabling conditions at the same rate (30%) as other specific health conditions PTSD (46%), psychiatric or emotional conditions (43%), alcohol and drug use (35%), and traumatic brain injury (31%). Demographically speaking, this population is getting older and continues to have increased needs for medical services, housing services, transportation services, and housing/sheltering resources. Outreach activities conducted by partner agencies have also found that many need food assistance and legal assistance in addition to the aforementioned needs

.

Through an examination of the Coordinated Entry (CE) data, there are trends that emerge from those who are currently experiencing homelessness (see chart below). Mental health benefits enrollment and documentation possession are substantive and consistent barriers for this population. In an analysis of CE data in the last three years detailed in the chart below, the largest, historically identified need (25% in 2021) is to increase/gain public benefits and/or obtain required documents to secure permanent housing or other resources. In a massive shift to the system, the referrals to housing and employment programs increased dramatically. Previously, the number of referred-to-housing remained low because of all the documentation needed to obtain housing and the lack of connection to the housing system. In the past year, the CES in SLO focused efforts to increase housing linkages and effectively utilized Emergency Housing Vouchers (EHV) provided by HUD. The EHVs required less work for staff to make referrals, thus increasing the referrals to housing resources. Additionally, staff at all CES participating agencies embraced a diversion/problem solving approach - which increased referrals and uncovered increased housing needs of households. While these are not new needs (housing) this was a shift in providing resources to match the need.



8. Describe the proposed project's strategy for providing supportive services to those with the highest service needs, including those with histories of unsheltered homelessness and those who do not traditionally engage with supportive services.

Through a progressive coordinated engagement model, this project proposes to work with individuals who have been or continue to be service disengaged by providing needed services for humanitarian needs. The progressive engagement approach is rooted in a Trauma Informed and Harm Reduction approach, that is the team will work with individuals to meet their basic humanitarian needs without the condition of service enrollment focusing all efforts on establishing trust with participants to best understand their needs and meet those needs with direct services or linked/leveraged services. For this approach to be effective across systems it needs to have a large coordination component - that is it needs to ensure that all existing outreach programs are working with their clients in a unified and focused manner. This coordination would include twice-monthly multiagency planning and case conferencing meetings to ensure that we are engaging with all folks who have the highest service needs and those who are service resistant.

This outreach team will be the coordinating body for all outreach teams in SLO and will be integrated into the Slo CES CoC expansion, which will allow for prioritization of the most in need throughout the county. Through a combination of case conferencing and universal assessments, this team will ensure that all individuals who is experiencing unsheltered homeless in SLO CoC will be able to work with the team that best suits their needs. Specifically, this team will focus on those who are in high need (as measured by case conferencing, ViSPDAT (if available), and other assessments or known histories) but do not meet the need for the already established THMA Full Service Partnership team, a Medi-Cal supported program that provides intensive community-based wrap-around services to help people in recovery live independently in a variety of community housing and rentals throughout San Luis Obispo and Atascadero. There are a total

of 33 beds of Congregate Supported Independent Living for enrollees of the FSP program. This project is typically focused on individuals who have or are currently experiencing chronic homelessness and severe and persistent mental illnesses. This integrated outreach team would focus on individuals who might need a referral to the FSP team or are deemed not high acuity enough. Currently, these are not provided with any specialized team beyond basic outreach services.

9. **Describe the proposed project's strategy for providing supportive services to participants placed into housing after 6 months of eligible supportive services assistance has ended (if needed).**

   CAPSLO, ECHO, THMA, 5CHC, and SA provide case management services to all individuals placed in supportive housing, these services are sometimes informal as there is often not enough funding for housing stabilization services. All agencies work with HASLO to provide supportive services to participants who are placed within vouchered units as well. However, some units do have services provision attached to them and others can have these services attached through community-based partners. This project will ensure that all placements into housing are linked with supportive services from one of the main homeless services providers to a community-based resource that can support these individuals to transition to a more stable housing status.

   This project will partner with the CLO CoC CES to best match individuals into the best housing resource based on their needs. Moreover, this system of matching will also include leveraging local funding programs to ensure sustainable supportive services in housing placement.

   Locally, CAL-AIM is being implemented to include enhanced case management and housing stabilization services. This local resource will be utilized and if there are no supportive services offered on a unit placement then providers will connect the participant for housing stabilization services supported by CAL-AIM. As a matter of process, those who are not placed in housing that has supportive services attached (THMA, 5CHC RRH, HASLO) individuals will have a facilitated referral to Cal-Aim Enhanced case management

22. **Describe plan for rapid implementation of the program, documenting how the project will be ready to begin housing the first program participant. Provide a detailed schedule of proposed activities for 60 days, 120 days, and 180 days after grant award. Please also estimate the average time from a client's program entry to housing placement.**

   60 days: CAPSLO will allocate efforts of existing staff and being hiring of additional staff for this project and work with all partner agencies to allocate or staff these positions. Within this time a clear focus on engagement would be outlined by reviewing all efforts of the existing outreach team in SLO CoC. This effort would result in a strategic engagement throughout the county in areas that are underserved by outreach, or individuals who are not service engaged. Within the first 60 days, there is a goal to be targeting up to 50 individuals in service, with 10 enrollment in a project with a full HMIS and CES intakes completed in HMIS.

   Working with the CES system to improve and if needed build all referral pathways into engagement and outreach and out (to health, housing, mental health, transportation, etc.)

120 days: Once the core CAPLSO team is established, by this point all partner agency positions would need to be staffed within 60 days ■ outreach workers, a system/outreach coordinator, a nurse/CNA, a health educator, and any other administrative supports needed). Within this timeframe, this project will have enrolled at least 50 more individuals and will have achieved housing placement for 10 individuals into interim or permanent housing solutions. Leveraged clinic staff and mental health staff have established care relationships with individuals and have at least 20% of all participants enrolled with a healthcare provider

180 days: Complete integration of the program into CoC CES with referral pathways completed. All system-wide outreach efforts would be coordinated by this group and a layered approach for countywide outreach would be implemented with connection to existing and new housing projects that each respective agency that is part of this project would be participating in. At least 30 households in this project will have achieved permanent housing.

29. Describe the actions the organization will take to serve subpopulations that the CoC has identified as being underserved.

CAPSLO is committed to continuing and expanding this work, not just in interim housing but in all programs (including CES). This commitment involves four legs, accurate and meaningful data collection, intentional training and program policies, frequent and diverse venues for current and former participant feedback, and documented quality improvement mechanisms.
Initially, there need to be clear definitions around all data collection in all programs that are clear and coherent so that each staff understands differences between services, incident reports, how to document program exits, etc.. Oftentimes, those who are underserved in a CoC are engaged by program staff who are not as adept in data collection and often do not prioritize this. This initial barrier is best addressed through clear definitions and determining the most efficient and meaningful data collection points - that is, data will only be collected to help a person obtain housing and to determine what steps are taken or not taken to help them achieve this goal.
Training is critical for correct data collection and effective policies and procedures. CAPLSO will continue implementing a training program that brings in national and regional experts for staff training and partnered agencies. This annual training program includes training on trauma-informed care, housing first, harm reduction, client-centered care, fair housing, lived experience panels, etc.

CAPSLO and its partner agencies will commit to a multivenue approach to get feedback from current and former participants with mechanisms to integrate this feedback to improve services. This leads into the last leg - a quality improvement process - in which CAPLSO will move from an informal process to a formalized process throughout all programs.

35. Describe how the project will align with a Line of Effort to support the San Luis Obispo Countywide Plan to address homelessness (2022- 2027).

While the improved CES efforts identified in this proposal touch on nearly all of the lines of efforts identified in the plan, most of the strategies in the Line of Effort 2 will be impacted by this work. This proposal intends to improve several of the key metrics that have been identified:

- System-wide, reduce the average length of time people experience homelessness by 10% each year.

- Increase the number of people being served in shelters or by outreach staff that access permanent housing by 10% each year.

As a noted objective in the plan, this proposal will expand services, training and coordination, especially within outreach, with improved skill development, and behavioral health.

The efforts will ensure that services are housing-focused and provided across the region, by increasing coordinated entry and outreach staff; utilizing best-practices (A1)and will ensure that the outreach workers are trained to recognize and provide interventions, referrals, and care for both mental health and substance use disorders. (2.F.2).

This grant will support program staff in delivering effective services by developing and implementing community standards and best practices for each service area (including outreach, case management, coordinated entry) with a universal focus on housing navigation (B1) and ensure that the coordinated entry system is used as the foundation for service assessment across the continuum (B3).

We intend to expand the referral system to maximize community resources (B4) and will improve coordinated assessment tools for use in the field (B6). lient signatures.

As the partners in this grant already bring extensive experience to this work, our coordinated efforts will also leverage the expertise and success of existing models with proven outcomes to inform new and expanding programs. (B8).

As noted in subpoint 2C, we seek to improve CES outreach services targeting high needs populations throughout the region by revamping the coordinated entry system to prioritize services based on need for higher threshold chronically homeless throughout the geographic region (C1); coordinate outreach strategies across multiple agencies to allocate and prioritize resources geographically and across populations and to improve information-sharing (C2) and target program services to address the specific needs of subpopulations (C6). health and/or substance use disorder.

Line of Effort 3: Improve and expand data management efforts through HMIS and coordinated entry system to strengthen data-driven operational guidance and strategic oversight.

The efforts of our unified approach will also have significant impacts on Line of Effort 3. by improving data collection efforts and coordinated entry referrals.