Housing First for High Service Utilizers

Summary

"Housing First for High Service Utilizers" will utilize $2,000,000 from the County of Marin and local cities and towns, primarily from American Rescue Plan (ARP) funds, to create 68 new units of housing-focused case management. Based on ARP spending requirements, the proposed funding will cover four years of operations. This memo will describe the funding, services provided, operationalization, and administration.

The purpose of this program is to leverage available emergency funding that was allocated to the jurisdictions to help address the increased burden caused by the pandemic while remaining faithful to the evidence-based practices of the Housing First philosophy embraced in Marin County. The program's intent is to allow those using the greatest quantity of municipal services to have access to federal housing vouchers by providing them the case management required to attain stable housing and to qualify for housing voucher referrals. Homelessness is a county-wide issue; though homelessness is more visible in some jurisdictions than others, high housing costs across Marin are a primary driver of homelessness. Marin County programs regularly serve people experiencing homelessness who grew up and became homeless in Marin cities in which no people are experiencing unsheltered homelessness.

Marin's Coordinated Entry system assigns homeless housing resources (including vouchers) based on vulnerability. Most tenant-based vouchers are assigned to the next eligible individual or family that has case management. By providing case management, this program will effectively prioritize high service utilizers for housing resources.

As not all resources (both case management and housing) are available immediately at program launch, this program will be phased in over 6-12 months.

1. Funding

Housing First for High Service Utilizers will begin as a $2 million program. This funding will come from the County of Marin, as well as local cities and towns, per the following commitment levels, if all jurisdictions agree to participate[1]:

Total Program	$	2,000,000
County contribution	$	1,165,408
City/town contribution	$	834,592

Jurisdiction	Population	Proposed Contribution[2]
Corte Madera	9,459	$41,497.50

[1] As of July 20, 2021, San Rafael, Novato, Sausalito, Mill Valley and Fairfax are participating jurisdictions.

[2] Proposed contributions were based on city/town general population

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Fairfax	7,607	$33,372.60
Larkspur	12,204	$53,540.06
Mill Valley	14,311	$62,783.67
Novato	54,194	$237,754.03
Ross	2,464	$10,809.79
San Anselmo	12,605	$55,299.29
Belvedere	2,122	$9,309.41
San Rafael	58,994	$258,812.07
Sausalito	7,099	$31,143.96
Tiburon	9,179	$40,269.11
Subtotal (cities and towns)	**190,238**	**$834,591.51**

The program described in this memo outlines what is possible from a one-time funding commitment by the cities, towns, and County. Future funding could be added to increase the number of case management slots and/or extend the number of years covered by the program.

2. **Allocation of Case Management Resources:**

The County allocation will provide a 100% match of the city contributions in each region; the unmatched County dollars will serve individuals County-wide. To distribute services equitably across the County, taking into consideration need in the various regions, the relative funding commitments from different partners, and logistical concerns in operating a case management program, this program will divide the County into four service areas covering the incorporated cities in Marin: Central Marin, Novato, Southern Marin, San Rafael. In addition, the Coordinated Entry program will act as a fifth service area and serve highly vulnerable clients countywide.

Service Area	Number of Case Management Units
San Rafael	17
Novato	17
Southern Marin	13
Central Marin	9
Coordinated Entry	12

Each case manager will carry a case load of 17 individuals. The cost of Housing First case management is $595 per person per month or $121,380 per case manager per year (includes salary, benefits, and management overhead). When fully committed, this program will fund four new Housing First case managers for four years, thus providing 68 new case management units. When the available case management units are divided across the five regions, the number of case managers per regions is:

- 1 dedicated case manager for San Rafael
- 1 dedicated case manager for Novato
- 2 dedicated case managers for the combined Central, Southern, and Coordinated Entry service areas

Each service area will identify a lead agency (e.g. a nonprofit or government agency) to maintain a by-name-list (BNL) of people known to be or suspected of experiencing chronic homelessness within the service area.

Individuals on the list will then be screened for "service utilization" (e.g. police, EMS, fire, and public works contacts). It is not necessary that every service area prioritize in the same way, but the criteria must be applied consistently and developed in partnership with the County. The chronically homeless individuals with the highest service utilization in a given service area will be prioritized for any available case management slots allocated to that region. When service impacts are identical, the Coordinated Entry assessment (VI-SPDAT) score and client age will be used as tie-breakers.

Service Area	Lead BNL Agency	Criteria
Central Marin	Central Marin Police Authority	TBD
Novato	City of Novato	PD contacts, EMS contacts, DPW over the preceding 12 months
Southern Marin	TBD	TBD
San Rafael	City of San Rafael	PD contacts, EMS contacts, DPW over the preceding 12 months
Coordinated Entry	Coordinated Entry	General Coordinated Entry prioritization protocols

When considering the service impact of people residing in encampments, if the encampment receives general calls for service rather than for a specific individual (e.g. DPW trash pickup, PD calls for noise), those general calls may be allocated equally across all the individuals residing within that encampment. In cases where, a call to an encampment is clearly tied to an individual (e.g. a medical call), then the service contact only counts towards the individual.

3. Services Provided

The target population for this program is people experiencing chronic homelessness[3] who are high utilizers of public services, including Emergency Medical Services transports, police interactions, and jail stays. (See Distribution of Case Management Resources on Page 3.)

[3] Housing funded through County general funds or the Housing Choice Voucher Chronic Homeless set-aside shall be limited to individuals with disabilities and families in which one adult or child has a disability, including unaccompanied homeless youth, that at intake are:

(1) experiencing chronic homelessness as defined in 24 CFR 578.3;

(2) residing in a place not meant for human habitation, emergency shelter, or safe haven; but the individuals or families experiencing chronic homelessness as defined at 24 CFR 578.3 had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement;

(3) residing in an institutional setting for more than 90 days or residing in transitional housing and who were experiencing chronic homelessness as defined at 24 CFR 578.3 prior to entering the project;

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Housing First for High Service Utilizers will provide Housing First case management; each case manager will carry a maximum case load of 17 clients at any given time.

The program will provide case management in accordance with Housing First principles and HHS's Housing-Based Case Management protocol (see attachments). Case managers will engage with identified clients while they are unsheltered, assist with the transition to housing, and provide clients with the support they require to stabilize in housing.

Access to Housing
Many of Marin County's permanent supportive housing placements are independent, tenant-based vouchers combined with housing-based case management from a variety of programs. When vouchers are available through Coordinated Entry (CE), the CE program reviews the list of eligible households, sorted by vulnerability, and assigns a voucher to the next eligible household with case management. Currently, there are more housing vouchers available than case management units; therefore, participants in the High Utilizer Case Management Program will be among the next clients allocated a housing voucher.

4. Program Administration
The funding will be pooled and administered by the County of Marin's Health and Human Services Department (HHS). HHS will be expanding staff and technical assistance capacity in this domain and has already established guiding principles and contractual language for Housing First programs. HHS will expand and extend existing case management contracts to accelerate program launch. HHS has already begun the contracting process.

During the first two years of operation, HHS will provide quarterly updates about the program, with semi-annual reports thereafter. Those reports will include:

- Case management utilization
- Housing placement status (e.g. enrolling, searching, housed, fallout)
- Aggregate data on where housing placements are occurring

5. Projected Timeline

Timeline subject to changed based on ability to hire case managers quickly.

Date	Activity
June 2021	• Identified nonprofits begin recruitment • HHS begins contract modifications

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(4) residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or

(5) receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.

	• Cities and County begin approving program funding
July 2021	• Case manager recruitment continues • Program details developed and approved
August 2021	• First case managers hired • Case manager onboarding/training • Program participants identified
September 2021	• Participants enrolled in case management; engagement begins
October 2021 – April 2022	• Program participants enter permanent housing
May 2022-June 2025	• Program participants stabilize in housing • HHS develops plan for ongoing program funding

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Attachment A
PRINCIPLES OF HOUSING FIRST

1. Clients are moved into permanent housing as quickly as possible, with no service or program readiness requirements.
2. The project's rules are limited to client safety, and do not try to change or control clients or their behaviors.
3. The project uses a trauma-informed approach.
4. The project does not require detox treatment and/or days of sobriety to enter.
5. The project does not conduct drug testing.
6. The project does not prohibit program entry on the basis of mental illness diagnosis and does not have a policy requiring medication and/or treatment compliance to enter.
7. The project does not bar clients based on past (non-violent) rule infractions.
8. The project accepts all clients regardless of sexual orientation or gender identification and follows all fair housing laws.
9. The project does not exclude persons with zero income and/ or limited to no work history.
10. If the project is short-term or time-limited, the services provided to enrolled clients should be focused primarily upon securing permanent housing and enhancing housing stability upon exit, as opposed to building "housing readiness," attaining sobriety, or adherence to treatment.

11. The project does not terminate program participants for any of the above listed issues. The project also does not terminate participants for:
    a. low or no income,
    b. current or past substance use,
    c. history of domestic violence,
    d. failure to participate in supportive services,
    e. failure to make progress on a service plan, and criminal records – with the exceptions of restrictions imposed by federal, state or local law or ordinance.
12. If the project entails housing placement and/or housing stability services, program staff treat eviction and/or termination of housing as a last resort. Before termination/eviction, staff should engage as many other alternative strategies as are applicable and reasonable, including – but not limited to – conflict resolution, landlord mediation, support with rental/utility arrears, tenancy skills building, and relocation.

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Attachment B
ROLES AND RESPONSIBILITIES OF
HOUSING-FOCUSED CASE MANAGERS

Any team serving individuals receiving housing vouchers shall:

- Provide housing location services tailored to the needs and preferences of the client.
    - Housing location services include, but are not limited to, determining the characteristics of a unit appropriate for a client (including geographic location, community ties, safety, unit accessibility, etc.; locating potential units near public transportation and other amenities; networking with landlords, renter's associations, property management businesses to stay abreast of available units; selling the program to potential landlords and property managers, and developing and maintaining relationships with landlords renting to clients. Develop and maintain relationships with property owners/managers by contacting them for your client and saying hello when you are on their site. Accompany client to open houses, apartment viewings and housing application appointments to assist with locating and securing housing, often during regular working hours.
- Screen available units to determine the potential for a unit to pass Housing Quality Inspections (HQS) performed by the Marin Housing Authority prior to move-in or approval of a rental subsidy agreement.
- Assist client in securing necessary personal documentation and completing required paperwork, including "reasonable accommodation" if appropriate, to qualify for a Marin Housing Authority, or other, rental subsidy. Provide direct support and assistance and work in partnership with clients to help them move into housing.
    - May include arranging for or directly helping the client move their items to the unit because they do not have any other way to transport their items. This also means ensuring the client is set up with basic items, such as linens, pots/pans, towels, etc. Homeward Bound works with our volunteer coordinator to gather a basket of basic items to assist a client start off with basic items.
- Provide housing stabilization services. Services should flex in intensity to match the client's need. For example, services are generally intensive when clients are first placed in housing and may taper as the client gains stability.
    - Housing stabilization services include, but are not limited to, ensuring the client is able to maintain a space clean enough to pass inspection; is able to manage their finances or is connected to a representative payee, is able to navigate transportation if necessary to reach appointments related to health, benefits, etc.; intervening with landlords in the event that behavioral or neighborhood issues arise.
- Work collaboratively with client to mitigate tenancy issues early with the goal of helping formally homeless clients retain their housing.
    - Can occur in regularly scheduled client meetings. Can involve helping solve roommate disputes, community disputes (comes up often when living in a community where neighbors tend to report concerns), help the resident set boundaries around guests and their behaviors within the unit and around the complex, timely rental payments, maintaining cleanliness in and around the unit, proactively avoiding lease violations, etc.

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- At move-in, make attempts to meet with client weekly, 60-90 days after move-in to housing to discuss client successes and any challenges in housing, and, if necessary, to develop strategies to address housing challenges to ensure client retains housing. At least one of these meetings per month will be a home visit in the client's home, if client permits.
    - The purpose of home visits is to partner with client to identify needs for support and assistance to maintain their new home and remain a tenant in good standing with their property manager.
- After housing stabilization (likely after 60-90 days of tenancy), the case manager will continue to meet with the client frequently as determined by their needs for clinical and housing support. There will continue to be home visits at least one time per month.
- Annual assessment of the client including the following domains: client strengths and resources, Cultural Identity, Behavioral Health, Medical, Social, Family Support, Education and Employment History.
- Work in partnership with the client to create a treatment plan that articulates the client's goals for treatment and details the specific interventions planned to assist the client to achieve these goals.
- Develop and provide (or connect to) high quality interventions and services in support of wellness and recovery. Services include strength-based case management, skills development, medication support, therapy, crisis intervention, and peer and family support.
- Does "whatever it takes" to provide the type and intensity of service that the client needs to have the best opportunity for success in housing.
    - This can mean checking on the client that you know is particularly vulnerable more frequently, being willing to transport them to other services when needed, proactively working with them to address issues that arise from their mental illness and/or substance use and how it may be impacting their living situation, enlisting service providers that may be need to stabilization and/or crisis services.
- Maintain contact at least once per month or more often if needed with the client's housing property manager to provide a regular opportunity to be informed of any housing challenges for the client. Sometimes this takes the form of dropping by to say hello each time you are at the site for any client. Getting the appropriate release of information from the client to talk to the property manager allows sharing information both directions, without it you can still get information from the property manager.
- Provide client with skills training to understand their tenancy rights and fulfill their tenancy responsibilities as articulated in their landlord/tenant lease.
- Attend a WIZARD training and use the system for coordination with other providers involved in the client's care.
- Document all housing and clinical services in the client file within 72 hours.

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