HOMEFORALL

THE MARIN COUNTY CONTINUUM OF CARE

10 YEAR PLAN

TO PREVENT & END HOMELESSNESS (2013 – 2023)

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ACKNOWLEDGEMENTS

The Marin County Continuum of Care (CoC) wishes to acknowledge the hundreds of people who participated in the charrette planning process to update our community strategic plan to prevent and end homelessness. Most especially, we thank Lisa Sepahi for her tireless efforts to organize the various charrette meetings and her exhaustive outreach to include as many stakeholders as possible at each step along the way. We also thank the Corporation for Supportive Housing for identifying experts and facilitating the charrette week meetings.

Thanks to the time and energy that so many people and agencies have committed to this process, a new spirit of collaboration and a renewed sense of purpose have emerged. We hope that the increased level of excitement about improving our community's response to homelessness continues throughout the first year of plan implementation and lasts for as long as there are homeless people in need of our community's support.

EXECUTIVE SUMMARY

Home For All is focused on three key outcomes, which, if achieved, will lead to significant reductions in homelessness in our community. They are: (1) drastically reducing chronic homelessness in 5 years; (2) reducing the total number of homeless individuals and families over 10 years; and (3) reducing the amount of time individuals and families spend in programs before becoming self-sufficient.

In order to achieve these goals, three Outcome Action Plans have been developed to outline key action steps and performance targets over the next year. They are attached in Appendix A and are the central feature of the plan. Progress towards achieving *Home For All* outcomes will be measured quarterly by the Marin County Health and Human Services Homelessness Analyst. As needed, action steps and benchmarks may be adjusted over time to keep the CoC on track to meet our ultimate goal of preventing and ending homelessness in Marin.

OVERVIEW OF HOMELESSNESS

Marin follows HUD-approved methodology for counting sheltered and unsheltered homeless populations. Our most recent count was conducted on January 24, 2013. We used multiple data collection methods including: conducting a brief housing survey, utilizing data from the Homeless Management Information System (HMIS), using information collected by special outreach teams who worked to identify persons living in encampments, and incorporating data from teams that work among the day laborer population.

The Count is intended to provide a **one-day snapshot** of homeless families and individuals in Marin County. It is not a comprehensive or complete measure given that one-day counts often underestimate the number of people experiencing homelessness throughout the course of a year. In addition, Marin is an especially challenging place to count the homeless population due to its geography, which includes various places not easily accessible to count volunteers (forests, open space, etc.). Due to safety concerns related to entering these areas at times when people are likely to be present (early in the morning or late in the evening when it is still dark), the large geographic distances between sites, and the limited number of volunteer outreach teams, our ability to count persons in these isolated and encampment areas has always been particularly challenging.

2013 ONE DAY POINT-IN-TIME HOMELESS COUNT

Count Year	2009	2011	2013
Unsheltered and other homeless populations	1,044	687	414
Sheltered	726	533	519
Total	**1,770**	**1,220**	**933**
Chronically Homeless	141	226	89
Households with Children	222	155	93
Persons Experiencing Domestic Violence	194	138	156
Veterans	67	78	66
At Risk of Homelessness	3,095	4,179	4,388

AVAILABLE SHELTER AND SUPPORTED HOUSING OPTIONS

Each year, in conjunction with our count of homeless persons, the CoC surveys providers to determine the number and type of housing and services available to individuals and families experiencing homelessness. Below is a summary of Marin's housing inventory for 2013.

Constantly evaluating resource investment decisions to ensure that Marin can maintain and expand the shelter, supported housing options, and services that are currently available to persons experiencing or at risk of homelessness will be key to *Home For All's* success.

2013 HOMELESS HOUSING INVENTORY

	Emergency Shelter	Transitional Housing	Permanent Supportive Housing	Total # of beds
Family Beds	49	252	185	486
Individual Beds	216	90	316	622
Totals:	**265**	**342**	**501**	**1,108**
Chronic Homeless Beds	Varies	Varies	209	209
Veteran Beds	1	16	35	52
Seasonal Beds	66	—	—	66
Domestic Violence Beds	20	84	—	104

OVERVIEW OF CHARRETTE PROCESS

A charrette is an intensive planning process that jumpstarts and streamlines how a community develops or updates its plan to end homelessness. It provides an opportunity for collaboration among diverse stakeholders to solve community problems related to homelessness within a very short period of time. The Marin County CoC worked with the Corporation for Supportive Housing (CSH) to facilitate an update of our 10 Year Plan using the CSH charrette process.

CHARRETTE WEEK

A series of six solution-focused planning meetings were held during the week of June 25, 2012. The topic areas were selected based on community feedback and input from the Homeless Policy Planning Committee. They were: Harm Reduction/Crisis Intervention, Chronic Homeless, Developing Housing Options, Prevention, Improving Access to Services, and Criminalization of Homelessness.

Local and national experts were organized into "fishbowls" during each meeting. The charrette fishbowls were highly structured, focusing first on listening to key experts and then an opportunity for the audience to reflect on what was heard.

PRIORITY RECOMMENDATIONS FOR YEAR 1

At the conclusion of the charrette week, CSH prepared a *Framework to Inform the Marin Community Plan to Prevent and End Homelessness*, a copy of which is attached as Appendix B. After a community process, the following recommendations were prioritized for implementation in 2013 based on: (1) the feasibility of implementation over the course of one year; (2) an assessment of their impact on homelessness in Marin; and (3) the availability of funding/resources to follow through on potential action steps associated with each recommendation.

After the recommendations were prioritized, responsible agencies were identified to implement them as noted in Appendix A: Outcome Action Plans.

OUTCOME ACTION PLANNING GROUPS

Between October 2012 and February 2013 action planning groups convened to develop a series of action steps that would comprise a one-year action plan to implement the charrette recommendations. The groups targeted key stakeholders to be involved in this critical phase of planning. Each group will continue to meet regularly as *Home For All* is implemented to coordinate efforts and identify resources needed to meet performance benchmarks.

FOCUS ON SUBPOPULATIONS & CULTURAL COMPETENCY

Homelessness is a complex problem with many different causes and contributing factors. In order to effectively address the issue, communities must adapt solutions to meet the varying needs of all homeless individuals and families as they change over time. In particular, ongoing planning and evaluation efforts should account for the unique needs of specific subpopulations including:

- Chronically homeless persons
- Severely mentally ill persons
- Chronic substance abusers
- Veterans
- Persons with HIV/AIDS
- Persons with chronic illness, including Hepatitis C
- Survivors of Domestic Violence
- Unaccompanied Youth (18-24)

Because the causes of homelessness and the specialized interventions needed by each of these subpopulations requires special attention, the CoC will form a standing committee dedicated to monitoring ongoing plan implementation efforts and providing recommendations about resources allocation and strategies best suited to meet the needs of homeless subpopulations.

The Marin Health & Human Services Homelessness Analyst will convene the Subpopulations Committee at least quarterly beginning in the Summer of 2013 to evaluate data (described in more detail below). The Committee will also attend the meetings of the Outcome Action Planning Groups to provide information about best practices and otherwise serve as a resource for identifying strategies to successfully meet the needs of homeless subpopulations.

OUTCOME ACTION PLANS

Home For All is focused on achieving three outcomes: (1) reducing chronic homelessness; (2) reducing the total number of homeless individuals and families; and (3) reducing the length of time people spend in programs before achieving self-sufficiency.

In order to meet these outcomes, the Outcome Action Planning Groups (described above) identified a series of strategies and action steps, and a person or agency to be responsible for implementing them. The groups also developed performance targets and benchmarks that can help the CoC evaluate our progress towards achieving each outcome.

The Outcome Action Plans are attached as Appendix A. They will be updated at least annually.

MEASURING SUCCESS

Regular performance measurement and reporting on plan progress will keep the CoC focused on plan implementation. It will also allow us make decisions and adjustments designed to improve our results.

DATA COLLECTION AND EVALUATION

The Homeless Management Information System (HMIS) will be the primary source of data to measure plan progress. Participating agencies are already collecting many of the data elements needed for this purpose. Where necessary, we will add additional data fields and encourage additional agencies to participate in the HMIS. We will also use other sources of data, as appropriate, including: non-HMIS data systems used by provider agencies and records from other public agencies (such as law enforcement).

The Health & Human Services Homelessness Analyst will determine relevant baselines for each measure using data from 2012 (or other timeframes as needed to create the most relevant baseline figures). The baselines will be the initial data points that will serve as a basis for comparison with subsequently acquired data. The Homelessness Analyst will gather and evaluate data on plan progress and prepare a quarterly dashboard report for review by the Homeless Policy Steering Committee, the subpopulations committee, and other interested stakeholder groups (such as local cities and business leaders).

IMPORTANCE OF DATA SHARING

Data not captured in HMIS will need to be regularly gathered from relevant agencies. The Homelessness Analyst will coordinate with these agencies to minimize the administrative burden and resources involved with sharing data, and will be available as needed to assist them to address data quality concerns.

IMPLEMENTATION TIMELINE

The Homelessness Analyst will also maintain a current timeline of plan implementation activities, which will be regularly reviewed by the Homeless Policy Steering Committee, the subpopulations committee, and other interested stakeholder groups (such as local cities and business leaders).

ACHIEVING RESULTS

In order for *Home For All* to be successful, the CoC will need support from a broad base of community partners, local business, elected officials, and city and county agencies.

COMMUNITY AWARENESS

To build and maintain support for the plan, the Homelessness Analyst will oversee a variety of community awareness strategies in coordination with the Outcome Action Planning Groups. The full list is contained in the CSH Charrette Recommendations document attached as Appendix C. Key strategies include:

- Support the development of a consensus based advocacy agenda that brings together homeless, behavioral health and housing agencies on a collaborative agenda to take to key constituencies and elected officials.
- Post information about meetings and updates on homeless services on bulletin boards at libraries as a way to reach the homeless and housed communities.
- Research and distribute information about how much it costs to not end and prevent homelessness (via inappropriate use of jails, hospitals, and other expensive institutions).
- Provide regular updates on progress on the Plan. Consider doing this through the Marin Independent Journal via a regular op-ed piece.

ANNUAL EVALUATION & ADJUSTMENT

The Plan will be a living document, which can be updated as often as needed by the Homeless Policy Steering Committee and the Outcome Action Planning Groups. In addition, the CoC will evaluate progress towards meeting *Home For All* objectives each year and will develop new outcome action plans each January.

FOR MORE INFORMATION

Please contact Jason Satterfield, Marin County Department of Health & Human Services, Homelessness Analyst. JSatterfield@marincounty.org or 415-473-3501.

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A1
Strategy	As a community, we will need to partner with developers to create more permanent supportive housing (PSH) that meets the needs of chronically homeless persons, including implementation of housing first and harm reduction models.
Estimated Cost(s)	$15,000-$25,000 per year per bed. Potential funders: Marin Community Foundation, County of Marin, State and Federal grants.
Lead Contact(s)	• HHS Homelessness Policy Analyst [Jason Satterfield] • Marin Partnership to End Homelessness [Joe Hegedus]
Action Steps	Meet with elected officials in each city and town to discuss this strategy and promote geographic diversity of housing options.
Timeframe	**Early 2013:** Marin Community Foundation (MCF) and the County sponsored an affordable housing funders forum to discuss strategies to support development of new units. (Action Step Completed) **Spring /Summer 2013:** County and MCF staff will jointly convene homeless providers and affordable housing funders/ developers to develop coordinated priorities for future funding. **Ongoing/Fall 2013:** Pursue funding opportunities, including HUD resources, to support development of new units.
Benchmarks for Success	New PSH beds for chronically homeless persons will be created: **Year 2:** 20 new beds will come online compared to baseline* **Year 3-4:** 75 new beds will come online compared to baseline* **Year 5:** 200 new beds will come online compared to baseline* *The number of beds needed to meet this benchmark is based upon the number of chronically homeless persons in our community. It is subject to change as estimates of the number of chronically homeless persons in Marin is updated.
Data Sources	Annual Housing Inventory Count

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A2	
Strategy	Create Street Outreach and Crisis Response Teams made designed to meet the unique needs of chronically homeless persons in downtown San Rafael and throughout Marin County. Teams should be a multi-disciplinary and focus on linking highly vulnerable people with housing and supportive services (including clinical, employment, social, and community supports).	
Estimated Cost(s)	• Estimated Costs and potential funder (CARE Team): To be determined by Community Action Marin. • Estimated costs and potential funder (SRPD Mental health position): To be determined by SRPD	• Estimated Costs and potential funders (Downtown Streets Team): $272,000 for the first year
Lead Contact(s)	• Community Action Marin (CAM) [Gail Theller] • San Rafael Police Dept. (SRPD) [Ralph Pata]	• Ritter Center [Diane Linn] • Andrew Hening [Downtown Streets Team]
Action Steps	• CAM will form CARE Team 2.0 and provide funding for at least 1 year. The team will focus on assisting persons in San Rafael with severe alcohol abuse and related issues. The Team will assist persons to access permanent supportive housing, in partnership with other agencies including Ritter Center. • San Rafael and HHS will pool resources to support the creation of a Downtown Streets Team Volunteer and Work Training program.	• SRPD will hire a mental health outreach provider for San Rafael who will become a valuable part of the first responder group by effectively communicating with clinicians and mental health providers in a clinic or
Timeframe	**January 2013:** CAM launched CARE Team 2.0 (Action Step Completed) **March 2013:** SRPD posted the mental health outreach position. (Action Step Completed) **July 2013:** Downtown Streets Team launched in San Rafael.	**Summer/Fall 2013:** Evaluate CARE Team 2.0 and SRPD successes and identify strategies to sustain effective outreach activities beyond year 1. **Winter 2013/Spring 2014:** Replicate effective outreach activities in other areas of the County outside of San Rafael.
Benchmarks for Success	Chronically homeless persons engaged by CARE Team 2.0 and the SRPD will be linked to permanent supportive housing through collaboration with community partners, including Ritter Center*: **Year 1:** 5% of contacts **Year 3:** 30% of contacts **Year 5:** 75% of contacts *Achieving these benchmarks will require specialized offers of assistance and education for chronically homeless persons who may be reluctant to accept services/housing.	Reduce the number of incidents and arrests between chronically homeless persons in downtown San Rafael and the SRPD: **Year 1:** 40% compared to baseline **Year 2:** 80% compared to baseline **Years 3-10:** Maintain at 80% or less compared to baseline
Data Sources	HMIS	SRPD Data Sources

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A3	
Strategy	Ensure that the County's systems integration work for mental health, alcohol and other drugs, and primary care considers and prioritizes services for chronically homeless persons, focused on housing stability. It should also be paired with supported housing options to the maximum extent possible.	
Estimated Cost(s)	This strategy relies on existing programs. No additional cost is anticipated.	
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]	
Action Steps	Designate a liaison who can participate in County systems integration work, advocate for the needs of chronically homeless persons, and coordinate efforts among relevant providers to keep them in housing (including housing providers and case manager forums).	
Timeframe	**Spring 2013:** Identify liaison. Throughout systems integration effort: Liaison will advocate and update, seeking to ensure that a procedure is developed before the completion of systems integration effort to link all chronically homeless persons with integrated services teams (ISTs).	
Benchmarks for Success	Increase the number of all unsheltered chronically homeless (CH) persons in Marin connected to ISTs: **Year 1*:** 15% of total CH pop. **Year 2*:** 40% of total CH pop. **Year 3*:** 75% of total CH pop.Cpopulation **Years 5+*:** 100% of total CH pop.	Increase the number of all housed, formerly chronically homeless (CH) persons connected to ISTs: **Year 1*:** 40% of formerly CH pop. **Year 2*:** 100% of formerly CH pop. *will be measured from the date County ISTs are available.
Data Sources	HMIS	HMIS

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A4	
Strategy	Facilitate the creation of an alternative place where people can go 24/7. The program should be highly supported and low-barrier. Connect this place with the crisis intervention team as well as a multi-disciplinary team working with chronically homeless individuals. Ensure there is a safe place for women to stay at this site, or consider a second site for women only.	
Estimated Cost(s)	Estimated cost and potential funders: to be developed by the Task Force	
Lead Contact(s)	Marin Interfaith Council Interfaith Street Chaplaincy [Bob Hirni]	
Action Steps	Form a task force to identify priority features, research potential models, and develop strategies to build community support.	
Timeframe	**January 2013:** The task force was formed. (Action Step Completed) **Spring 2013:** Coordinate with the Marin Organizing Committee and develop a community engagement plan. Seek additional partners. **Spring/Summer 2013:** Research models/best practices. Identify priority features, services, and attributes the Center should contain. Seek additional partners. **Summer/Fall 2013:** Engage community stakeholders; refine Center design in response to feedback. Seek resources and additional partners. **Fall/Winter 2013-14:** Finalize Center concept, including potential partners and funding sources. Prepare funding proposals	
Benchmarks for Success	**Planning Phase Targets:** • Create a comprehensive community engagement plan. • Develop a written strategy for coordination/ collaboration among partners • Identify numerous potential resources and funding streams that could support the Center. • After community engagement, prepare a concept paper for the Center, and eventually a proposal to funders.	**Ultimate performance target:** The Center will be created. Also, depending on the Center's final concept, though likely to include reducing the number of unsheltered chronically homeless persons, reducing recidivism among chronically homeless persons, and/or other targets
Data Sources	Task Force Updates	HMIS

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A5
Strategy	Design a course for law enforcement and fire department personnel focusing on how to respectfully engage homeless individuals, and educating them about the current options for housing or services. The course should include training on how to effectively employ harm reduction techniques (such as motivational interviewing) at homelessness encampments to engage homeless people in reducing the impact of encampments and ensuring the health and safety of homeless individuals and neighboring communities. It should also provide engagement/educational opportunities for persons who are "literally homeless" to help support the community to develop ways to reduce conflicts with police or local business owners.
Estimated Cost(s)	Negligible.
Lead Contact(s)	St. Vincent de Paul Society [Suzanne Walker]
Action Steps	Develop curriculum in consultation with homeless persons, providers, and law enforcement representatives. Offer courses on a regular basis, open to all law enforcement and fire department personnel across the County.
Timeframe	**January-March 2013:** St. Vincent de Paul facilitated several meetings between homeless persons, police officers, elected officials, and local business owners to help meeting attendees better understand each other's perspectives. (Action Step Completed) **Spring/Summer 2013:** Plan curriculum and develop course materials. Identify a group of trainers, including homeless persons. **Summer/Fall 2013:** Pilot 1-2 training sessions. **Fall 2013 and beyond:** Refine curriculum based on feedback from pilot and set a regular course schedule (such as once every 6 or 12 months) beginning in Fall/Winter 2013.
Benchmarks for Success	Provide training to all relevant personnel at Sherriff's, Police, and Fire Departments within 3 years: **Year 1:** 33% of all relevant staff trained **Year 2:** 67% of all relevant staff trained **Year 3+:** 100% of all relevant staff trained
Data Sources	Training Sign-in Sheets

YEAR 1— OUTCOME MEASURE A

REDUCE THE NUMBER OF CHRONICALLY HOMELESS PERSONS BY AT LEAST 75% IN 5 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	A6				
Strategy	Facilitate coordination between Public Defenders, Legal Aid, and the District Attorney's office regarding sentencing and diversion efforts.				
Estimated Cost (s)	As much as $250,000-$300,000, depending on program design. Potential funding sources: Marin County Department of Health & Human Services				
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]				
Action Steps	Develop alternative sentencing strategies for chronic alcohol users with justice involvement. Identify local best practices from that program that can be adapted for sentencing of other chronically homeless persons with justice involvement. Ensure that the effort is coordinated with the item #5 (curriculum for law enforcement and fire department personnel) and St. Vincent's community court program.				
Timeframe	**Spring/Summer 2013:** An existing advisory group will develop alternative sentencing / diversion strategies for chronic alcohol users with justice involvement as part of a serial inebriate program (SIP). **Summer/Fall 2013:** As alternative sentencing / diversion strategies are implemented, the HHS homelessness policy analyst will consult with the advisory group regarding the need for similar strategies aimed at other populations. **Winter 2013:** If warranted, the HHS homelessness policy analyst will facilitate a process to adapt local best practices for sentencing of other chronically homeless persons with justice involvement.				
Benchmarks for Success	Reduce the number of contacts between SIP participants and SRPD*: **Year 1:** 75% compared to baseline (reduce from 337/yr to 253/yr) **Year 2:** 50% compared to baseline (reduce from 337/yr to 169/yr) **Year 3+:** Maintain at least 50% reduction compared to baseline (≤ 169/yr) *This measure is focused on a subset of all chronically homeless persons, for which similar benchmarks are set above in item #2.	Reduce the number of SIP participants arrested for 647(f) violations [drunk in public] by Sherriff's Office: **Year 1:** 75% compared to baseline (reduce from 314/yr to 236/yr) **Year 2:** 50% compared to baseline (reduce from 314/yr to 157/yr) **Year 3+:** Maintain at least 50% compared to baseline (≤157/yr)	Reduce the cumulative number days that SIP participants spend in jail on an annual basis: **Year 1:** 75% compared to baseline(reduce from 3,256/yr to 2,442/yr) **Year 2:** 50% compared to baseline(reduce from 3,256/yr to 1,628/yr) **Year 3+:** Maintain at least 50% compared to baseline (≤1,628/yr)	Reduce the number of court appearances by SIP participants: **Year 1:** 75% compared to baseline(reduce from 1,587/yr to 1,190/yr) **Year 2:** 50% compared to baseline(reduce from 1,587/yr to 794/yr) **Year 3+:** Maintain at least 50% compared to baseline (≤794/yr)	Reduce costs to MGH's EDs associated with treating the SIP population: **Year 1:** 75% compared to baseline (reduce from $977,000/yr to $732,750/yr) **Year 2:** 50% compared to baseline (reduce from $977,000/yr to $488,500/yr) **Year 3+:** Maintain at least 50% reduction compared to baseline (≤ $488,500)
Data Sources	Law Enforcement Data Sources				

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B1
Strategy	As a community, support the creation of affordable and permanent supportive housing that provides access to a wider range of people experiencing homelessness, especially households with high barriers to accessing housing and services through the strategies listed above. To accomplish this, enhance collaborative partnerships between affordable housing and fair housing coalitions and the homeless provider community.
Estimated Cost(s)	$15,000-$25,000 per year per bed. Potential funders: Marin Community Foundation, County of Marin, State and Federal grants.
Lead Contact(s)	• HHS Homelessness Policy Analyst [Jason Satterfield] • Marin Partnership to End Homelessness [Joe Hegedus]
Action Steps	• Meet with elected officials in each city and town to discuss this strategy and promote geographic diversity of housing options. • Coordinate with affordable housing funders and developers to include housing for homeless individuals and families in mainstream projects. • Support efforts to maintain and expand Marin's Rapid Rehousing program. • Identify new resources, including federal grants, to support development of new beds. • Support efforts of transitional housing programs to convert to permanent housing.
Timeframe	**Early 2013:** Marin Community Foundation (MCF) and the County sponsored an affordable housing funders forum to discuss strategies to support development of new units. (Action Step Completed) **Spring /Summer 2013:** County and MCF staff will jointly convene homeless providers and affordable housing funders/ developers to develop coordinated priorities for future funding. **Ongoing/Fall 2013:** Pursue funding opportunities, including HUD resources, to support development of new units.
Benchmarks for Success	New beds for homeless individuals and families will be created: **Year 1:** 10 bed will come online compared to baseline* **Year 5:** 300 beds will come online compared to baseline* **Year 10:** 900 beds will come online compared to baseline* *The number of beds needed to meet this benchmark is based upon the number of homeless individuals and families in our community. It is subject to change as estimates of the number of homeless households in Marin is updated.
Data Sources	Annual Housing Inventory Count

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B2	
Strategy	Create funding opportunities through public and private resources to expand successful homeless prevention (combined with rapid re-housing) activities, especially among individuals and families with high barriers for accessing housing and services. As part of this strategy, create a "risk mitigation pool" to attach to clients/potential tenants who pose risks to landlords. In addition, establish distinct role for Housing Locator Service to identify available housing opportunities for homeless and precariously housed households, supplementing case management activities provided to these households.	
Estimated Cost(s)	$300,000/year Potential Funding Sources: Marin County HHS	
Lead Contact(s)	• HHS Homelessness Policy Analyst [Jason Satterfield] • Marin Partnership to End Homelessness [Joe Hegedus]	
Action Steps	• Develop a prevention/rapid rehousing program modeled after HPRP. • Develop a universal assessment tool to be used at shelters and other service locations to screen and refer households to the rapid rehousing program. Eventually the tool will be incorporated into Marin's coordinated assessment system.	• Identify funding sources to support the risk mitigation pool, which will be used to guarantee landlords will be fully reimbursed for damages or other costs incurred as a result of renting to tenants who pose risks to landlords. • Develop a scope of work for the housing locator service, which includes protocols for referrals and a prominent role in the coordinated assessment system.
Timeframe	Early 2013: HHS launched a County-funded Rapid Rehousing rental assistance program. (Action Step Completed) **Summer 2013:** Develop universal assessment tool and scope of work for housing locator service.	**Summer/Fall 2013:** Evaluate Rapid Rehousing program successes and identify strategies to sustain effective activities beyond year 1. **Fall/Winter 2013:** Seek resources to support the risk mitigation pool. Determine whether rapid rehousing funds should be used, based the program evaluation.
Benchmarks for Success	The Rapid Rehousing program will support households to obtain or maintain permanent housing and avoid shelter stays or episodes of literal homelessness: **Year 1:** 75 total households **Year 3:** 200 total households **Year 5:** 500 total households	
Data Sources	HMIS and Agency Databases	

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B3
Strategy	Update information and resources regarding homelessness prevention on 211 information hotline/website, and promote the information hotline/website as a relevant communitywide resource – especially as providers commit themselves to routine update of information and resources. Update existing 2012 Marin Community Resource Guide, and provide more detailed information about housing and services available in the community. Include distribution to the larger community.
Estimated Cost(s)	Negligible
Lead Contact(s)	Marin Partnership to End Homelessness [Joe Hegedus]
Action Steps	• Engage the United Way, which administers 211, and provide regular updates about available resources. Explore the possibility of creating a Marin-specific portal page that will prominently feature prevention resources. • Regularly update the existing Marin Community Resource Guide to provide current information about available housing and services. Include a flowchart that helps users understand the services system and index them by subpopulations.
Timeframe	**Early 2013:** Identify a point of contact at the United Way and begin discussing the possibility of the Marin-specific portal. Develop an update schedule, such as every 6 months, to ensure that the information is always current. **Spring/Summer 2013:** Update the Marin Community Resource Guide. Develop an update schedule, such as every 6 months, to ensure that the information is always current. .
Benchmarks for Success	Information available at 211 and the Resource Guide will remain current. Progress can be measured by tracking the frequency of updates.
Data Sources	211 Website and Resource Lists and Community Resource Guide

YEAR 1— OUTCOME MEASURE B	
REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS **MEASURED BY ANNUAL PIT COUNTS*	
	B4
Strategy	Explore diversion strategies for those who are at imminent risk of homelessness to move rapidly into housing (or are supported in their current housing if feasible) to avoid shelter stays. Educate and build awareness of prevention resources and eligibility requirements to private landlords and property managers to prevent evictions and homelessness.
Estimated Cost(s)	As much as $25,000-$30,000/year for operation of coordinated assessment system. Potential Funding Sources: HUD CoC grants, other State and Federal grants
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]
Action Steps	• Incorporate diversion strategies into the new coordinated assessment system that will be developed for all Continuum of Care and Emergency Solutions grant programs. • Use County Rapid Rehousing funds to divert those who are imminently at risk of becoming homeless by screening individuals and families attempting to access shelter and other targeted services.
Timeframe	**Spring/Summer 2013:** Develop diversion protocols. As needed develop memorandums of understanding to facilitate implementation of protocols. **Fall/Winter 2013:** Evaluate diversion protocols and identify strategies to sustain effective activities beyond year 1. **Summer/Fall 2013:** Evaluate Rapid Rehousing program successes and identify strategies to sustain effective activities beyond year 1.
Benchmarks for Success	Individuals and families who attempt to access shelter and other targeted services will be diverted to the Rapid Rehousing program and other appropriate services to support housing stability: **Year 1:** 15% **Year 2:** 25% **Year 3+:** 40%
Data Sources	HMIS

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B5
Strategy	Consider a faith-based mentoring model that matches congregations to recently housed families or individuals to promote housing stabilization.
Estimated Cost(s)	Will depend on volunteers; negligible cost
Lead Contact(s)	• Marin Interfaith Council • Marin Organizing Committee
Action Steps	Develop a program model based on Open Table Ministry, which builds upon the foundations of the REST program.
Timeframe	**Spring/Summer 2013:** As REST comes to an end, convene congregations and other relevant stakeholders to explore options to develop and launch the mentoring program.
Benchmarks for Success	• An increasing number of congregations will be engaged and paired with formerly homeless households each year for 3 years. • The number of congregations will be maintained at Year 3 levels.
Data Sources	Mentoring Program Logs

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B6
Strategy	Promote C4yourself as an effective online tool for individuals and families to apply for a variety of benefits and assistance. Promote programs such as the Supplemental Nutrition Assistance Program (SNAP) throughout the community and not limited to service locations.
Estimated Cost(s)	This strategy will rely on existing resources and programs. No additional cost is anticpated.
Lead Contact(s)	• HHS Homelessness Policy Analyst [Jason Satterfield] • Ritter Center [Diane Lin]
Action Steps	• In conjunction with Social Security advocacy services at Ritter Center (the RISE program) and representative payee services, encourage consumers to use C4yourself to apply for other benefits. • Once it is up and running, promote C4yourself to all users of the coordinated assessment system. • Prominently promote C4yourself through 211 and the Marin Community Resource Guide.
Timeframe	**Spring/Summer 2013:** Develop diversion protocols. As needed develop memorandums of understanding to facilitate implementation of protocols. **Fall/Winter 2013:** Evaluate diversion protocols and identify strategies to sustain effective activities beyond year 1. Summer/Fall 2013: Evaluate Rapid Rehousing program successes and identify strategies to sustain effective activities beyond year 1.
Benchmarks for Success	• A network of public work stations will be developed, maintained, and promoted to users of the coordinated assessment system: **Year 1:** 10 stations will be maintained **Year 2:** 20 stations will be maintained **Year 3+:** 30 stations will be maintained • All users of RISE and representative payee services will be supported to use C4yourself. • Resource Guides and 211 information sources will promote C4yourself
Data Sources	HMIS and Workstation Maps

YEAR 1— OUTCOME MEASURE B

REDUCE THE TOTAL NUMBER OF HOMELESS INDIVIDUALS AND FAMILIES BY 75% IN 10 YEARS

**MEASURED BY ANNUAL PIT COUNTS*

	B7
Strategy	Work closely with criminal justice system and area hospitals to expand existing discharge planning protocols and resources for individuals discharged from hospitals, jails, and prison who are homeless or at high risk of homelessness to receive appropriate access to care and treatment to prevent recidivism.
Estimated Cost(s)	Negligible.
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]
Action Steps	Building upon the Chronic Alcohol Users with Justice Involvement Project, work with relevant systems of care to expand discharge planning protocols and resources.
Timeframe	**Fall/Winter 2013:** Convene meetings with relevant systems of care to discuss status of current discharge planning protocols, implementation challenges, and areas for improvement.
Benchmarks for Success	Following development of improvement discharge planning protocols, the number of persons discharged from public systems of care into homelessness will be reduced. Targets will be developed to accompany the discharge planning protocols.
Data Sources	Data Sources TBD

YEAR 1— OUTCOME MEASURE C

REDUCE THE LENGTH OF TIME PEOPLE SPEND IN PROGRAMS BEFORE ACHIEVING SELF-SUFFICIENCY & STABLE HOUSING **MEASURED BY LENGTH OF STAY IN PROGRAMS*

	C1
Strategy	Select agencies across the county to act as key entry points for all those experiencing homelessness Create a simplified referral system using 211 that sets up appointments and handles transportation to one of these participating outreach and placement organizations. Prioritize access of clients with high barriers in all aspects of the community's approach to ending homelessness.
Estimated Cost(s)	As much as $25,000-$30,000/year for operation of coordinated assessment system. Potential Funding Sources: HUD CoC grants, other State and Federal grants.
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]
Action Steps	• Facilitate a community process to develop and implement a coordinated assessment and intake system. Seek to include as many agencies as possible, including those that do not currently receive HUD funds or participate in HMIS. • Review assessment tools that are in place in other communities to create a triage tool that works for Marin County to identify those who are most at risk. • Develop communitywide standards of care, which will encourage and support agencies to provide "just enough" assistance to facilitate housing stability.
Timeframe	**Spring 2013:** Announce and launch coordinated assessment planning process, which will take several months to complete.
Benchmarks for Success	As part of the coordinated assessment planning process, specific targets will be developed. They will likely include goals for the number of agencies that participate in the system, targets for the number of individuals and families who access services at participating agencies using coordinated assessment, and targets to reduce the number of people who access services through means other than coordinated assessment.
Data Sources	HMIS

YEAR 1— OUTCOME MEASURE C

REDUCE THE LENGTH OF TIME PEOPLE SPEND IN PROGRAMS BEFORE ACHIEVING SELF-SUFFICIENCY & STABLE HOUSING **MEASURED BY LENGTH OF STAY IN PROGRAMS*

	C2
Strategy	Create a forum for case managers from different agencies to come together and share their experiences and provide solutions
Estimated Cost(s)	Negligible.
Lead Contact(s)	Adopt A Family [Leanne Watson & Sarah Estes-Smith]
Action Steps	• Develop a regular meeting schedule, such as once each quarter, and prepare meeting agendas and materials. • Meetings will be planned based on Bridges Out of Poverty principles and will including training to encourage use of proven practices by case managers. • Recruit case managers to attend the forums through coordination with supervisors and Executive Directors.
Timeframe	**Spring 2013:** Develop a meeting schedule, identify training topics, and create structured conversation tools to facilitate peer sharing and networking. **Summer/Fall 2013:** Launch case manager forum meetings. **Winter 2013:** After 1-2 meetings, evaluate the success of the forum and identify improvement strategies.
Benchmarks for Success	In collaboration with supervisors and Executive Directors, we will develop a list of training topics and identify households for structured case conferencing.
Data Sources	Sign-In Sheets

YEAR 1— OUTCOME MEASURE C

REDUCE THE LENGTH OF TIME PEOPLE SPEND IN PROGRAMS BEFORE ACHIEVING SELF-SUFFICIENCY & STABLE HOUSING **MEASURED BY LENGTH OF STAY IN PROGRAMS*

	C3
Strategy	Work with funders and providers to reduce the number of barriers consumers face when accessing the system. Review agency grievance procedures to ensure they are up to date, accessible, and responsive to consumers. Consider a pooled grievance process.
Estimated Cost(s)	Negligible.
Lead Contact(s)	St. Vincent de Paul [Christine Paquette]
Action Steps	Gather and analyze current intake policies and grievance procedures compared to local and national best practices.
Timeframe	**Summer/Fall 2013:** Prepare analysis and recommendations for intake policies and grievance procedures. **Winter 2013:** Facilitate meetings to support agencies to consider recommendations.
Benchmarks for Success	• All agencies serving homeless individuals and families will evaluate their intake policies and grievance procedures and determine which local and national best practices to incorporate. • Updated policies and procedures will be incorporated into standards of care (see #1 above).
Data Sources	Agency Policies and Procedures

YEAR 1— OUTCOME MEASURE C

REDUCE THE LENGTH OF TIME PEOPLE SPEND IN PROGRAMS BEFORE ACHIEVING SELF-SUFFICIENCY & STABLE HOUSING **MEASURED BY LENGTH OF STAY IN PROGRAMS*

	C4
Strategy	Regularly monitor and take action to reduce recidivism.
Estimated Cost(s)	Negligible; will rely on existing programs and services
Lead Contact(s)	HHS Homelessness Policy Analyst [Jason Satterfield]
Action Steps	Review individual instances of recidivism and determine what steps can be taken to rapidly rehouse people who return to homelessness and how to reduce recidivism overall.
Timeframe	**Spring/Summer 2013:** Develop recidivism reports using HMIS data. **Ongoing:** Regularly review recidivism reports and consult with provider agencies to reduce the number of people returning to homelessness.
Benchmarks for Success	Recidivism will be reduced: **Year 1:** 10% reduction compared to baseline **Year 3:** 30% reduction compared to baseline **Year 5:** 50% reduction compared to baseline
Data Sources	HMIS