HOMELESS SERVICES & HOUSING RESOURCES
RFP # 14026-2025

AGENCY APPLICATION

Instructions:

Each applicant agency (or group of collaborative partners) must submit one completed Agency Application. Program-specific information must be submitted separately in the appropriate Program Application(s).

Please limit the total length of your completed Agency Application – including the questions, tables and narrative responses – to no more than **7 pages**. Applications that exceed this limit may not be fully reviewed. This page limit does not include requirement attachments (e.g., financial audits or financial statements).

AGENCY INFORMATION

Applicant Organization:	Madison Area Care for the Homeless (MACH) OneHealth dba **Madison Street Medicine**
Contact Person Name and Title:	**Brenda K. Konkel, Executive Director**
Address:	**1202 Williamson St. #101 Madison, WI 53703**
E-Mail:	**brenda@madisonstreetmedicine.org**
Phone:	**608-676-7826**
Website:	**www.madisonstreetmedicine.org**
Federal Tax ID or EIN:	**81-2102647**
Unique Entity ID (UEI) Number:	**UBTGTY45V521**
Legal Status**:**	**XX** Corporation
Tax Exempt Status:	**XX** Non-profit: 501 (c)(3) since **2017**

AGENCY REQUEST SUMMARY

Program Type	**Request Amount**
Homeless Services	
A. Homelessness Prevention	$
B. Diversion	$
C. Emergency Shelter	$
D. Street Outreach	$ 350,00 $ 179,500
E. Extreme Weather Hotel for the Unsheltered	$
F. Rapid Rehousing (RRH)	$ 230,000
G. Permanent Supportive Housing (PSH)	$
H. Other Permanent Housing (OPH)	$
I. Other Programs that Promote Pathways to Stable Housing	$
Housing Resources	
J. Tenant Support	$

TOTAL REQUEST	$ 759,500

AUTHORIZATION TO SUBMIT PROPOSAL

This application is submitted with the knowledge and approval of the organization's governing body. To the best of the undersigned's knowledge, the information provided is accurate and complete. The undersigned also certifies that they have reviewed and accept the terms and conditions outlined in the Request for Proposals (RFP).

Brenda K Konkel — 6/26/25

Signature **Date**

AGENCY QUALIFICATION

1. AGENCY MISSION AND RELEVANT EXPERIENCE (10 POINTS)

1) **Mission Statement:** Provide your agency's mission statement.

Vision: We envision a community where individuals experiencing housing insecurity have housing and healthcare.
Mission: We are on a mission to develop programming and services to fill gaps in access to healthcare and housing in the Madison area.

2) **Relevant Experience:** Describe your agency's experience delivering the types of services proposed in this application.

Brenda Konkel, our Executive Director has over 30 years of experience in nonprofits, has served on over 20 non-profits Boards and has supervised a staff of up to 17 people and run or supervised three different extensive volunteer programs (Madison Street Medicine, Tenant Resource Center and Occupy Madison). She has extensive experience in housing and homelessness programs and supervising staff running those programs. She has administered federal (CoC, EHH/ESG, HUD & ARPA), State (DHS, DECHR) as well as City and County funds for the city-sanctioned campground, outreach programs as well as rapid rehousing & prevention (funds and services) programs. She has almost 15 years of experience in leadership at Occupy Madison tiny house villages. She keeps up to date on system changes through active participation in the Homeless Services Consortium and serves on multiple committees. She currently serves as the Vice Chair of the Homeless Services Consortium Membership. Our Executive Director is also very active in the community, has extensive knowledge of city and county government and has been a Madison resident for over 30 years.

She leads a team that comes from a wide range of backgrounds which is best equipped to help the diverse clients that we provide services to. This starts with having members of staff with lived experience of homelessness. Having staff with that lived experience is an important part of our ability to provide quality and responsive care. They help as mediators between our volunteers who provide medical assistance and other staff and our clients who may not have established trust with those physicians or case managers because of lack of trust in the medical and other systems. They also provide a wide body of expertise on areas around Madison where individuals living outside may choose to temporarily stay which allows our outreach team to better serve the population compared to if they did not have that knowledge. They serve as advocates for our clients in agency and community meetings and in discussions with city officials to make sure the voice of the

homeless population in Madison does not go unheard. Finally, they understand the realities of being homeless and know best how to meet the needs of our clients where they are.

We also pride ourselves on having staff on our team with experience of navigating substance use and mental health services so they have understanding for what our clients deal with. With this experience, they know how to best support our clients in navigating those same services to receive support. This is especially impactful in our harm reduction efforts to distribute safer use kits, testing kits, and treatments to reverse an opiate overdose.

Our agency been running the following programs with the following start dates:

- Footcare clinic (2016)
- Community Health Needs Assessment (2017)
- Medical street rounds (2017)
- Encampment Outreach (2020)
- Housing Focused Outreach (2020)
- Housing Focused Case Management (2020)
- Beacon Medical Clinic (2020)
- Nurse Care Coordination (2021)
- Men's Shelter Medical Clinic (2021)
- Dairy Drive Campground (2021)
- SOS Outreach Coordination (2023)
- Public Health Vending Machine (2024)

See below for organizational partners, case conferencing and HSC involvement.

2. ORGANIZATIONAL AND FISCAL MANAGEMENT (10 POINTS)

1) **Quality Improvement:** Describe your agency's internal quality improvement processes, including how you review program outcomes and incorporate feedback from program participants.

Quality Improvement: Continuous Quality Improvement and PDSA (Plan, Do, Study, Act) are principles we build our processes around. We may not technically perform PDSA analysis but we utilize the principles. This is baked into our organization through practicing Sociocracy as our governance model. As a group reviews proposals and develops policies and procedures, we assign a review date to make sure what we thought was "good enough for now and safe enough to try" is still working and to review and make improvements. Any group member can also call for an earlier review or make an alternative proposal.

Program Outcomes: With help from the Board of Directors, we are developing 3-5 "metrics" for each of our programs. The metrics will be both leading metrics and process measures. The program circle is to review them monthly and the board will review them quarterly. This will serve as a dashboard for our organization to measure our effectiveness and progress. The Outreach Circle, which has the most clients and moving pieces, also reviews data and information in its weekly meetings for various data quality aspects as well as housing outcomes for our clients.

Feedback from Program Participants: When Madison Street Medicine was first founded in 2016 we developed a Community Health Needs Assessment that would serve over the years to guide our programming to fill gaps. Survey developers, administrators, and respondents worked with people with lived experience of houselessness to develop the survey. Our first survey in 2016 led to the inception of our Foot Care Clinics and our medical street outreach. Those programs were developed in response to the greatest barriers to healthcare being identified as cost, transportation, and not knowing where to go. Our CHNA has continued to serve as a valued resource as it gives us insight into issues facing the houseless community. Having a robust CHNA with as many respondents as possible is also crucial for gathering representative data that we can use in our advocacy efforts. It gives us the ability to compare the assessments we do every three years and allows

us to bring research-backed claims to the local healthcare systems in Madison (UW Health, Meriter, SSM) and to our systems work in the Homeless Services Consortium in developing solutions and system change. Finally, it also allows our organization to evaluate the effectiveness of our programming and identify where gaps in services present themselves so that we can shift our priorities if the community needs calls for change.

2) **Financial Management:** Describe how agency ensures sound financial accountability and sustainability.

Financial Accountability: We have developed Finance Policies at the Board and Resource Development and Finance Circle levels that the Executive Director used to guide day to day activities. We review these policies every two years and make changes if there are any recommendations during our annual audit. We also work with Common Good Bookkeeping who provides meticulous bookkeeping services and we work with two CPAs for grants tracking and reporting purposes. Our Executive Director has over 30 years of nonprofit finance experience in multiple organizations. Our primary CPA worked with Wegner CPAs for a few years doing audits and is extremely knowledgeable about compliance issues. They provide detailed monthly financial reports and checklists for checks and balances to the Treasurer of the Board and the Executive Director. The monthly reports to the Treasurer include reports to be passed on to the Board of Directors for review. Every spring our organization works with Wegner CPAs to complete a financial audit and 990s. We work to be transparent with the community by posting our financial reports on our website as well as digestible financial information such as our budget in our annual report.

Sustainability: We initially had a 5 year grant that covered the vast majority of our Executive Director's pay. That grant has ended and we are working to distribute her time to grant projects as well as seeking general operating support from various foundations. We have been fortunate to have had unrestricted funding from Roots and Wings over the past few years that helps us fill gaps between grants. We have started billing 1915i and are hopeful that the program will continue, but do have some concerns that our clients may qualify at decreasing rates with increased work requirements and reviews that are difficult for people without homes to navigate. If 1915i continues to go well, we are planning to also explore CCS funding but we have a few hurdles to qualify to do that work.

The other part of sustainability we are working on is as our organization matures and our Executive Director nears retirement age, we are focusing our efforts on building experience of our team and middle management to ensure long term sustainability and knowledge transfer. We also have developed a series of wikis and guides that provide policy, procedure and technical guidance for our programs and staff to preserve institutional knowledge.

3) **Financial Audit:**

Does your agency complete annual certified financial audits? **XX** Yes ☐ No

If yes, were there any significant deficiencies or material weaknesses identified in the most recent audit?

☐ Yes **XX** No

If **yes**, summarize the findings and describe how they are being addressed.

4) **2025 Agency Operating Budget**

AGENCY REVENUE

Source	2025 Budget

AGENCY EXPENSES

Category	2025 Projected Expenditure

City of Madison	652,400
Dane County	none direct
State of Wisconsin	81,361
HUD	281,280
Other Government	
United Way of Dane County	
Other Foundations	130,000
Fundraising	83,000
User Fee	
Other (Specify: carry over savings*)	269,000*
TOTAL REVENUE	1,497,041

Personnel	$1,242,368
Operating	183,875
Space	48,194
Special Cost	19,500
TOTAL EXPENDITURE	$1,493,937

	2025 Projected
Surplus or (Deficit)	$3,104

*We have already decreased this amount to be carried over to subsequent years through multiple small grants for operating costs at about $50,000 and expect this number to continue to decrease throughout the year.

3. SYSTEM COORDINATION (10 POINTS)

1) **Collaboration with Other Providers:** Describe how your agency collaborates with other providers in the homeless services and housing systems. Include examples such as referrals, case conferencing, shared service planning and delivery.

Referrals: Our agency runs the referral process for people experiencing unsheltered homelessness to get connected to a housing case manager. We call it the SOS line and people can contact us through walk-ins, phone, email, website form or we may contact people in the field. Our coordinator evaluates the caller's needs and pairs them with the outreach organization that may meet their specific needs (Youth - Briarpatch, Vets - VA, severe and persistent mental illness - Tellurian, etc.) or refers them to Urban Triage, Catalyst for Change or Madison Street Medicine. He also makes referrals to other community agencies as needed.

Case Conferencing: Our SOS coordinator also runs the case conferencing meetings of the outreach organizations where we talk about any clients we have concerns about, review 10-15 of the people who have been on the list the longest, review people who are new as well as people who are on Tier 2 but don't have their paperwork completed. We also developed a system where agencies will be entering case notes for the group and then designating a time to next review the client as a group. This is still work in progress but beginning to work better. In addition to internal case conferencing, we also do case conferencing with Kabba for our clients at Dairy Drive and some case conferencing with the Dane County Behavioral Health Group.

Shared service planning and delivery: We collaborate with many organizations for multiple reasons, here are some of the primary ones related to these grants.

- **Housing Coordination** - At Dairy Drive we currently are working closely with Urban Triage, CDA, and the HSC Coordinator with 10 Section 8 vouchers and 5 Rapid Rehousing slots. We also work with all the HSC nonprofit housing providers and Rapid Rehousing Programs. We take referrals from Coordinated Entry as people move into Tier 2 and coordinate with outreach groups and shelters to make sure the VISPDAT and paperwork are completed. We also work with private landlords and other affordable housing providers like Enso, Stonehouse, Gorman & Company and other WHEDA tax credit programs.

- **Basic Needs Coordination -** We work with several groups to ensure basic needs of our clients are met. We are located in the Social Justice Center which provides computers, phones, personal essentials, food, phone charging and other services which lightens the load of what we need to provide. We regularly visit and work with First United Methodist Church (community breakfast), Bethel Church, Off the Square Club and the Beacon to locate our clients and connect them to services. We coordinate food through Second Harvest Food Bank for both outreach and Dairy Drive. We take Dairy Drive campers to multiple food pantries and community meal sites. We regularly work with Friends of the State Street Family to coordinate needs. We also have a staff member that is great and we have coordinate donations through shoe drives at the three Willy St. Coop locations, food drives at various stores, donations from individuals, churches and community groups. Many UW student groups also do donation drives for things we need. UW Athletics donates shoes, Bombas donates socks, a local pharmacy donates meds for our approved medications lists and this list continues to grow.
- **Behavioral Health Coordination** - We work with many CCS providers, particularly for our folks at Dairy Drive. We also work with the Dane County group that brings together Outreach Providers and Behavioral Health programs funded by the county. We have brought multiple clients with a signed ROI to that group for care coordination. Our nurse on staff also helps to coordinate behavioral health services and medications for our clients. At Dairy Drive we work with Kabba Inc. for substance use services for our campers.
- **Health Care Coordination & Harm Reduction** - We have strong working relationships and collaborate on multiple levels with UW Health, Meriter, Access Community Health, Vivent Health, and Public Health Madison & Dane County. Read-only access to the Epic EHR systems at UW Health and Meriter has significantly improved our ability to coordinate care across providers. We also participate in the Public Health Vending Machine Roundtable and meet quarterly with the Narcan Direct program to align efforts around overdose prevention.Our team maintains ongoing partnerships with Porchlight through the Men's Shelter Clinic every Monday, and with The Beacon, where we provide a weekly Tuesday morning clinic and monthly foot care clinics.
- **Systems Change Work** - For systems change work our staff are founding members of the Affordable Housing Action Alliance and HSC Education and Advocacy Committee. We have also started working with ABC for Health around healthcare needs of our clients.
- **Organizational Capacity** - We are members of the Wisconsin and National Free and Charitable Clinics organizations as well as the International Madison Street Medicine Institute. We also work with several UW departments (School of Nursing, Emergency Medicine, Family Medicine and Public Health) as well as the MEDiC students. Our Americorp volunteers have also been restored.

2) **Integration into the System of Care:** Describe strategies your agency uses to ensure alignment with the broader local system of care such as Homeless Services Consortium (HSC). Include strategies such as supporting staff or participants in system-level planning, participating in HSC committees or workgroups, providing staff training aligned with system priorities or best practices.

Strategies to Ensure alignment with broader systems of care - See Case Conferencing section above. We also were active in the Community Plan to Prevent and End Homelessness Dane Forward process. For the unsheltered SNOFO we helped develop the 15 page plan to address unsheltered homelessness and continue to work on various aspects of that work. See also HSC involvement above.

HSC Committee participation: Our Executive Director is the Vice Chair of the Homeless Services Consortium Membership. She has served on the Board of Directors, was President of the Board and has served on the following committees: Community Plan Committee, Core Committee, Reimagine Coordinated Entry Workgroup, Data Committee, Education and Advocacy Committee, Funders Committee, Nominating and Governance Committee, Outreach Committee, Point in Time Committee and attended the Shelter Services Committee along with many other ad hoc committees or committees that no longer exist. Our outreach staff actively participate in multiple committees including Outreach Committee, Education and Advocacy,

Point-in-Time and Reimagine Coordinated Entry Committee. Team members are encouraged to engage in any HSC committee that aligns with their interests and areas of passion.

Staff training aligned with system priorities or best practices: New staff go through a two week training period that includes not only standard agency onboarding, but training for Clarity, HIPAA compliance, Housing First, an overview of the Homeless Services Consortium, Written Standards, Coordinated Entry and case file requirements. While we talk about the importance of data, we have found focusing on why the data matters is more motivating for our staff. Our training focuses on elements of best practices including Housing First, Trauma Informed Care, Harm Reduction, Motivational Interviewing, Peer Support/Lived Experience, Cultural Competency, the importance of Interdisciplinary Teams, Continuous Quality Improvement, Collaboration and Self-Care.

We also have built in training opportunities throughout the year. We have full staff meetings every two weeks that have a training element to them. Our outreach and Dairy Drive teams meet weekly to address issues and learn from each other. Dairy Drive also has a meeting with Kabba every two weeks where additional training is provided. We also have one Clarity and one Housing meeting each month to answer questions and provide additional training as needed. Both the Dairy Drive and Outreach teams have case conferencing meetings that focus on skill building for staff as well as our clients. Each staff member meets with our Executive Director for a half hour every two weeks to have individual questions answered. We are currently doing training on the 1915i program. We also continue to work with Abha Thakkar from Mosaic who consults on various issues as needed.

Additional training support includes the Ryan Dowd Homeless Training series that we use as needed. It includes over 50 videos that include practical tips for working with homeless individuals as well as the science behind how people act and react to things. There are also educational elements on a variety of issues including mental illness, substance use, addressing behavioral issues, backing up coworkers, de-escalation, safely breaking up fights, addressing prejudicial comments, traumatic brain injuries and more.

HOMELESS SERVICES & HOUSING RESOURCES
RFP #14026-2025

PROGRAM APPLICATION

D. STREET OUTREACH

Instructions:

This Program Application form must be completed for each proposed **street outreach** program. Applicants may submit multiple program applications if applying for more than one program area under the RFP.

Please limit the total length of your completed Program Application – including the questions, tables and narrative responses, to no more than **12 pages**. Applications that exceed this limit may not be fully reviewed. This page limit does not include requirement attachments (e.g., HMIS reports, agency outcome reports).

Agency Name:	Madison Street Medicine
Program Name:	DD 2.0
CDD Funding Request:	$179,500

1. PROGRAM DESCRIPTION (30 POINTS)

1) Target population

Describe the population you expect to serve, including:

- **Projected annual number of unduplicated participants with outreach contacts (enrollment)**

We intend to serve unsheltered singles (or couples) who have reached Tier 2 in Coordinated Entry.

- **Projected annual number of unduplicated participants with agreed-upon service plans (HMIS date of engagement)**

We understand there about 30 names pulled per month, but this is a new program since February and that may change over time. In May 2025 we had 1035 singles in street outreach or shelter, and only about 7% get into housing through Coordinated Entry so that would be about 72 people a year. Not everyone who reaches tier 2 will be part of the 72 that get into housing and not everyone who reaches Tier 2 will want to go to Dairy Drive. Plus Dairy Drive is partially funded through the HUD Unsheltered NOFO so we need to serve people not staying in shelter. We are predicting that once people reach the top of the list it can take 2-4 months to get into housing. So considering all those factors, our best guess is that we would serve about 50-60 people per year, but we would have the capacity to serve more if people can move through the system more quickly.

- **Key characteristics of the target population (e.g., age, household type, length of homelessness, special needs, shelter use)**

To date the folks we have served at Dairy Drive are as follows:

- 97 unique individuals
- 66 chronically homeless individuals
- 64 men
- 29 women
- 4 non-binary persons
- 2 youth (18-24)
- 14 age 25-34
- 34 age 35-44
- 26 age 45-54
- 18 age 55-64
- 3 age 65+
- 59 white individuals
- 24 black individuals
- 10 mixed race
- 4 latina/e/o

Our clients report the following

- 80 mental health challenges
- 14 alcohol use
- 30 drug use
- 28 both alcohol and drug use
- 44 chronic health conditions
- 2 HIV/AIDS
- 17 Developmental Disability
- 28 Physical Disability
- 33 Victims of Domestic Violence
- 66 no income
- 9 earned income
- 13 SSI
- 10 SSDI
- 78 receive FoodShare/SNAP
- 64 on MEDICAID
- 12 on MEDICARE

We expect the population to be similar, but with the Reimagined CE process only in its 4th month, it is difficult to know if we should expect anything different.

2) Outreach Geography

Describe the geographical areas where outreach will occur, including high-priority locations. Discuss your rationale for choosing, or modifying, these areas.

This is classified as an outreach program, but we don't do traditional outreach except when we are first locating the person and helping them to move to Dairy Drive. We will serve and do outreach to anyone within the Dane County Continuum of Care that is in Tier 2 and not sleeping in the shelter.

3) Intake Process

From the perspective of a participant, describe the intake process that will be used. What is the number of new intakes you expect on a weekly basis?

Engagement Activities - We will work with the outreach providers who attend the case conferencing to find people who we have learned are in Tier 2. If they already have an outreach provider, we will work with that provider. From the clients perspective they would be contacted by an outreach worker, hopefully someone who is already familiar to them and be told that they have reached Tier 2. We would explain to them what the means and that we have to do paperwork. We would also explain that to make things easier for them and us, there is an opportunity to live at the Dairy Drive Campground until they get into housing, hopefully in less than 4 months, but it could be longer. They would hear about Dairy Drive and what it has to offer and be asked if they would like to tour the campground. If they turn it down, they would continue to do the Tier 2 paperwork if willing. We would also continue to offer that they can come and check out Dairy Drive at any time and they are still welcome as long as there is still a cabin

available. If they say yes, we would arrange a tour of Dairy Drive facilities and they could see inside a cabin and be shown various amenities they could use. We would also explain basic community rules to them. They would then go away and think about if this is a good fit for them. In some circumstances, especially extreme weather, it may be less than 24 hours, but we prefer people would think about it for 24-48 hours to make sure they commit to being there, so we don't save a cabin for someone who doesn't use it. If they are still interested a day or two later, they would be told they can move in and ask them when they can move in and if they need help doing so.

Date of Engagement - At move-in the client would be given a welcome packet (written information so they don't have to remember everything, as it can be overwhelming) and an orientation with a lot of information. They get a tour by the facilities manager explaining mechanics of various things and how various features in the cabin work. They would also get a tour from the case manager letting them know about the donations we have available, the food pantry and other services we provide. We try to explain they don't need to remember it all and that we will be there to answer questions. They would then return to the office and sign lots of intake paperwork and be given copies. We would also talk to them about the harm reduction supplies we have available on camp. During the tour and the intake, they will meet a lot of people, staff and campers, some will be strangers and others will be familiar to them - which can be both positive or negative. We try to minimize the amount of personal questions we ask them at the first meeting, but we do need to complete much of the paperwork on their first day. We would try to get them any hygiene or other supplies they may need from our donations - towels, curtains, sheets, pillows, blankets, one setting of dishes and more will be included if available. This is an overwhelming experience. Typically we see campers sleep for much of the first week when they move in. After a week or two, we re-review much of the information they were given as we know it is a lot. We also have lots of signs and reminders about things around camp.

4) Services Provided

Describe how you will incorporate best or evidence-based practices in delivering the following services:

Generally speaking, the work we do incorporates the following core principles, many of which have common elements to them:

- **Housing First** - our program will be housing focused, with housing being the primary goal. We center client choice, make sure our services are low barrier and client centered. We will aggressively work to get VISPDATs and paperwork completed to get a referral.
- **Social Determinants of Health/Housing is Healthcare** - the whole premise of our organization is to holistically, through interdisciplinary teams, address all factors that impact health. 70-80% of health outcomes are driven by social determinants of health. Housing is one of the key determinants and therefore we strongly believe Housing is Healthcare and approach housing through that lens. People experiencing homelessness die 20-30 years earlier than the average American due to a combination of poverty, exposure, untreated health conditions, violence and lack of healthcare access. We are seeking to end that.
- **Trauma informed** - during our interactions we understand that people may respond based on past trauma, and that houselessness itself creates more trauma. We focus on safety for the clients by respecting their spaces and being predictable. We work on building trust, following through on promises and giving clients choices, always respecting if they say they do not want

services, but continuing to offer. We work with people where they are at from a strengths based perspective. We work hard to avoid retraumatization and making people re-tell their stories. However, if they are sharing with us, we listen with patience and free of judgement. We seek to understand when people have trauma responses to this work.

- **Harm Reduction** - which we provide in many forms - water, narcan, sun screen, cold weather gear (hats, gloves etc), hygiene items, healthcare items (condoms, electrolytes, snacks, etc), etc. is a big element of our outreach. We focus on reducing harm, not changing people's behaviors while providing education as appropriate and offering services to change behaviors. We also have a strong substance use harm reduction approach distributing narcan, testing strips and safe use kits in on site thanks to our partnerships with Narcan Direct, Vivent Health & PHMDC.
- **Street Medicine principles** - Street Medicine is a healthcare delivery model that brings medical care directly to people experiencing unsheltered homelessness, where they are. It focuses on meeting people where they are, both physically and emotionally, often building trust over time with individuals who are disconnected from traditional healthcare systems. It is relationship based care.
- **Motivational interviewing principles** - We work compassionately and in partnership with our clients drawing out their own motivations, strengths and reasons for change, accepting them as they are and exploring choices and honoring them. We work to ask open ended questions, recognize strengths and efforts, mirroring back what people say to show understanding and summarize key points. All of this is to help the person see they are capable of change.
- **Peer Support/Led by people who have experienced houselessness** - At the moment, our 3 case managers and 3 part-time outreach workers have lived experience of houselessness as well as staff members with lived experience of substance use and mental health challenges. 2 of our outreach workers are Peer Support Specialists and a 3rd is signing up for the training. Being a Peer Specialist and having lived experience in the field is very beneficial as it helps build trust and rapport with the client because staff has "been there". They are able to reduce barriers by supporting the client navigating complex systems and translate jargon.
- **Cultural Competence & Equity** - We have staff who speak Spanish as well as Urdu and Hindi, or we use the language line, we identify and talk openly about systemic barriers and inequities. We also have non-binary staff and respect people's pronouns and identities. We advocate for change in systemic barriers and we try to always remain humble, stay curious and open to learning. Adapting as we learn and to understand various cultures.
- **Interdisciplinary Teams** - Our housing and healthcare work means we have a staff nurse as well as access to volunteers from the medical, mental health & limited behavioral health professions.
- **Continuous Improvement through data** - Plan, Do, Study, Act (PDSA) principles from the healthcare field were taught to our HSC community through Built for Zero and Continuous Quality Improvement through data analysis is a principle our board is helping us to work on as we develop metrics for each of our programs. The concept of quality improvement and using the PDSA cycle are concepts that are baked into our organization through our governance model of Sociocracy and constant work in progress in our organization.
- **Collaboration -** Our organization sees a great value in collaboration with our community. Specific to outreach we wrote a grant to HUD to hire a community outreach programs coordinator to help unsheltered people get connected to case managers. We are strong partners in the Homeless Services Consortium (Our Executive Director is the Vice Chair of Homeless Services Consortium Membership and has been an active member of the Core Committee and several

subcommittees, Community Plan Committee, Reimagine CE Workgroup, Education & Advocacy Committee and Outreach Committee) and coordinate with many homeless services organizations including we hold weekly medical clinics at the Beacon and Porchlight Men's Shelter. Beyond that we work in collaboration with healthcare partners (Access, UW Hospitals, Meriter, UW School of Medicine and Public Health, MEDiC UW healthcare students, UW School of Nursing, Public Health, Vivent Health, Wisconsin Association of Free and Charitable Clinics, Hoey Pharmacy), obtain food for clients from Second Harvest Food Bank, River Food Pantry and numerous other community meal sites and pantries as well as receive donations from many organizations.

- **Self-care and staff development** - In the past year we have spent much time on staff development and balancing self-care with the difficult work we do. We have opportunities to debrief difficult situations and work on improving staff wellness.

a. Meeting basic health and safety needs of individual participants, especially during periods when individuals experiencing unsheltered homelessness are particularly vulnerable (e.g., extreme weather, public health emergencies)

The cabins have electricity, heat and air conditioning. We also now have back up generators if needed. We have arrangements with the local church to use their building as a tornado shelter if needed. During extreme hot weather and throughout the year, we really push water and electrolytes. We try to educate and encourage people about very basic healthy living practices. We offer masks during periods of poor air quality. Much of the other things we do during street outreach are not necessary for people living in these cabins. These practices incorporate basic social determinants of health as we know people who experience houselessness die 20-30 years earlier than the average American. We do have staff who have lived experience of homelessness who work nights and weekends. We deliver all these services with harm reduction in mind and through a trauma informed lens and using the best practices listed above such at motivational interviewing, collaboration, cultural competency and more.

On one occasion we had open cabins during severe weather and we had people stay at Dairy Drive. We would be open to doing that again, especially since there should be more turnover with the changes we are proposing and it will be more likely we would have empty cabins.

b. Connecting participants to shelter or other immediate housing options

The main goal while at Dairy Drive will be Housing First. With Kabba, Inc. as our former partner, much of case management time was not spent on housing, but on reaching therapeutic goals to make people successful in housing. We would like to return to a Housing First approach that prioritizes getting people into housing quickly, with less focus on recovery. As we have re-learned the hard way recently, this will start with ensuring people have their ID, SS Card and Birth Certificate and we will offer to hold on to them for the client so they are not lost. We have found that some landlords will only accept originals, not our copies. We will also work on getting pay stubs, current bank statements and SSA award letters. Collecting all this paperwork can take weeks or more and slow down the application process. This process will be a collaboration with the housing provider and other service providers the client has. We will also get them connected to CCS or if they are interested and not already enrolled, enroll them in our 1915i program. We will do all of this work incorporating the principles listed above.

c. Supporting participants in identifying and addressing specific barriers to housing, including housing navigation, connections to healthcare, behavioral health services, long-term case management, and other benefits

At intake clients are asked to list their housing and other goals. The 1915i intake process also asks them about their strengths and goals. We will review these goals throughout with them. We can connect them to our staff nurse who will help them address any healthcare concerns. We will connect people to CCS and other behavioral health services. Our intake process also includes evaluating mainstream resources to see what they might be available for. All of this work is again done incorporating all the principles listed above.

5) Encampment Response

City-supported street outreach teams will be expected to collaborate with various City agencies, including Community Development, Public Health, Engineering, Parks, Streets and Police, in addressing issues related to encampments. This includes:

- **Responding to referrals from City agencies for street outreach support;**
- **Engaging with individuals and providing timely information before encampment closures or cleanups;**
- **Mediating situations to reduce the need for law enforcement involvement and prevent involuntary displacement**

Describe your agency's approach to encampment response, including:

- **How your team will coordinate with the City to reduce harm, while connecting individuals to services and housing options.**
- **How your team will engage with individuals who view camping in unauthorized/prohibited areas as a medium- to long-term solution, including strategies for understanding their experiences and challenges and how you will support their transition to stable housing.**

Dairy Drive is a non-traditional outreach program and we would not be engaging in these activities. We do from time to time encounter campers who may be experiencing some of this and we refer them to the SOS program.

6) Staff Training

Describe your agency's plan for staff training. Include both new staff and ongoing training plans.

New staff go through a two week training period that includes not only standard agency onboarding, but training for Clarity, HIPAA compliance, reviewing the Guide to Dairy Drive and our wiki, Housing First, an overview of the Homeless Services Consortium, Written Standards, Coordinated Entry, funding source requirements, 1915i, finding housing, affordable housing types (PSH, RRH, Section 8, public housing, Section 42, VASH, GPD), case file requirements, why the data is important, driving our van, orientation to the Dairy Drive facilities and more. It also includes shadowing current staff and being shadowed by current staff once ready to do the work. It also includes some of the Ryan Dowd videos mentioned below.

For on-going support we have the “Guide to Working at Dairy Drive” document that includes many of our agreed-upon policies for doing this work as well as our “wiki” that has workflow steps and links to the documents needed to do the work. We are also developing a step by step guide for Clarity specific to outreach requirements. We have full staff meetings every two weeks that have a training element to them. Our Dairy Drive team meets weekly to address issues and learn from each other. We also have one Clarity and one Housing meeting each month to answer questions and provide additional training as needed. Dairy Drive does case conferencing on Tuesday mornings. In this meeting we also address any incident reports that have been filed. These conversations often lead to informal training. Each staff member meets with our Executive Director for a half hour every two weeks to have individual questions answered. Dairy Drive has started the 1915i program and we are in process of developing training for that. We also continue to work with Abha Thakkar from Mosaic who consults on various issues as needed.

Additional training support includes the Ryan Dowd Homeless Training series that we use as needed. It includes over 50 videos that include practical tips for working with homeless individuals as well as the science behind how people act and react to things. There are also educational elements on a variety of issues including mental illness, substance use, addressing behavioral issues, backing up coworkers, de-escalation, safely breaking up fights, addressing prejudicial comments, traumatic brain injuries and more.

7) Staffing Structure

Describe the proposed staffing plan. Fill out the table below.

Staff Position Title	Hiring Plan (Current/ New/ Expanded)	Total Program FTE	City-Funded FTE	Proposed Hourly Wage	Responsibilities
Facilities Manager	Current	1	.5	$31.25	Repairs, maintenance, lawncare, cabin turnovers, camper support
Nights and Weekends Staff	Current	2.5	1.25	$22-25	Assisting campers with needs, de-escalation, guest monitoring
Camper Needs Coordinator	Current	.3	.3	$22	Coordinate food pantry, transportation and donations
SOS Coordinator	Current	.25		$26.44	Connect guests to outreach programs
Office Manager	Current	.25		$26.44	Scheduling and logistics
Executive Director	Current	.15	.15	$48.07	Program Management, Supervision, Financial Management and Technical Expertise
Case Manager	Current	2		$31.25	Housing focused case management, housing search and placement

8) Outreach Schedule

Provided a detailed schedule of the proposed outreach activities, specifying the location and activities for each staff member proposed to be funded by the City grant. Include all planned activity types (e.g., 4-8pm downtown outreach, 10-2pm encampment outreach, 9am-11am in-reach at the Beacon, 2-5pm outreach follow-up work in the office, 10am-2pm admin work in the office). While it is understood that outreach schedule may change daily based on emerging needs, please provide the envisioned typical schedule for summer months.

While this question doesn't apply as we won't be doing traditional outreach, here are some of the details of our Dairy Drive 2.0 staffing.

- The facilities manager will work Monday through Friday day shift, 40 hours a week.
- The Campers Needs Facilitator will work 3 days a week - Monday, Wednesday and Friday, 24 hours a week.
- Tuesday and Thursdays the Office Manager and the SOS Coordinator will work one day a week on site for about 5 hours or as needed.
- Nights and weekends staff will work in pairs Monday - Friday 4pm - 11pm and weekends either 10am - 5pm or 4pm - 11pm. Hours will range from 14 - 28 depending on scheduling.
- If we are going through a period of time where we need on site staff after 11pm, shifts will be offered to our staff otherwise our on-call case manager will respond to any incidents during the time we are not staffed.
- Case managers will not be housed in that office, but will be based in our downtown office to have uninterrupted work time and focus on their clients housing needs. They will spend a significant amount of time at Dairy Drive to meet with campers, but will not be there to meet the daily needs of campers, monitoring guests and property management activities. They will likely spend even more time going to housing appointments, getting documentation and other activities with campers off site.

2. OUTCOME AND PERFORMANCE (20 POINTS)

Select one and complete the appropriate section below:

XX A. Existing Program with HMIS Data

A. **Existing Program with HMIS Data**

Use HMIS-reported data for past outcome fields. Refer to RFP **Appendix C** for instructions on generating the required reports. The HMIS report must be submitted with your application.

1) Data Standards

The Wisconsin HMIS data quality standards for street outreach require: 90% for data completeness and 6 calendar days for data entry for participants with date of engagement.

Please complete the following:

- 2024 data completeness score: **98.10%**
- 2024 average days to data entry for new entries: **9.4 days**
- 2024 average days to data entry for exits: **12.2 days**

Describe your agency's current practices to meet these standards and any planned improvements.

We will be eliminating paper tracking. We have found that staff record services and current living situations on paper and de-prioritize data entry. This is partially due to the chaotic nature of the small office and the large amount of non-case management activities that need to be done while on site. These are major reasons we are removing our case managers from site and giving them office time downtown to ensure that each week all data entry is completed.

On Friday afternoons the Executive Director spot checks data entries for the week and sends reminder emails to staff about the amount of data they entered for the week. We are also going to implement some of the practices the outreach team has developed such as monthly review of HMIS reports, monitoring exits and checks on our 1915i documentation.

2) **Use of Data for Performance Improvement**

Describe how your agency uses data to evaluate and improve outcomes. Include the key data points or reports that are reviewed, who reviews them, and how the data are used to inform program changes.

We will add to our case managers meeting agenda to review our CAPER, services provided, data quality, SOS referrals, CE referrals and program rosters from Clarity at our meetings. The board has requested that we develop 5 "metrics", including leading and process measures for each of our programs. We will be working on those metrics for DD 2.0 and review them monthly and the board will review them quarterly. Similar to the outreach program, we will track clients housed, client services provided and current living situations. Program changes will be proposed at our weekly circle meetings as we review the reports. Changes will be based on data and observations and tend to be primarily tweaks in process and workflow or changes to locations we do outreach.

3) **Performance Outcomes**

Performance Measure	CDD Target	2022 Outcome	2023 Outcome	2024 Outcome	Proposed Outcome
% of Leavers Exiting to Permanent Destinations	30%	48.6%	46.4%	43.8%	40%
% of Leavers Exiting to Positive Destinations (including shelter and temporary destinations)	60%	48.6%	50%	43.8%	60%

4) **Outcome Analysis**

Compare your agency's past performance to CDD targets. Discuss trends and what you think explains your successes or challenges. What changes/strategies do you think could help improve outcomes?

With this population it is difficult to meet the 60% target. Many of our clients leave to jail or other not positive destinations and they are not shelter users, which is why they are at Dairy Drive in the first place. Here is where people left to:

- 6 returned to unsheltered houselessness
- 2 left to the shelter
- 1 left to a long term hospital stay
- 8 left to jail or prison
- 1 left to a substance use treatment center
- 1 went to a halfway house
- 3 left to temporarily stay with family
- 5 left to temporarily stay with friends
- 1 left to "other"
- 3 were deceased

The CAPER says from start to date 76.12% left to positive housing destinations.

TOTAL	72
Total persons exiting to positive housing destinations	51
Total persons exiting to destinations that excluded them from the calculation	5
Percentage of persons exiting to positive housing destinations	76.12%

5) Additional Outcome Measures

List any additional outcomes your agency tracks or proposes to measure.

As mentioned above, we are working on the metrics, but we will be tracking our agreed upon metrics.

3. PROGRAM BUDGET (20 POINTS)

1) Leveraging Medicaid Resources

Describe how your agency will utilize Medicaid 1915(i) and/or Comprehensive Community Services (CCS) to support the proposed program. Include:

- **Specific services or costs for which you expect to seek Medicaid 1915(i) or CCS funding**
- **A realistic estimate of revenue you expect these sources to generate**
- **Steps, if any, your agency has already taken to access these funding sources and/or a timeline for securing necessary certifications and training**
- **Any preparation or infrastructure you think your agency will need to support billing and compliance**

Note: City-funded emergency shelters and outreach programs selected through this RFP will be required to utilize Medicaid 1915(i) to support eligible services and/or move-in cost assistance. Other program types are not required, but are strongly encouraged to incorporate Medicaid funding strategies where feasible.

Our agency doesn't have the staff qualifications to manage a CCS program, but we are exploring doing that in the next two-three years.

We are currently charging 1915i for Dairy Drive Services. We started charging in May ($1500) and have not yet billed for June. We have charged for Consultation and Transition services in May. In June will include Relocation (security deposit, basic home furnishings). In July we will begin charging 1915i for our outreach program.

We don't know what other outreach groups are planning when it comes to 1915i and if they will have enrolled people prior to arriving at Dairy Drive. And, it is the client's choice who they want to work with, so it is difficult to predict. This is our best guess at this time.

	# Clients	Charge	Total
Consultations	25	$84	$2,109
Security Deposits	25	$1,282	$32,050
Move in Costs	25	$718	$17,950
			$52,109

Relocation costs are reimbursements, so there would be no profit for the agency to re-invest. The Consultations would likely result in about $1,800 for our agency.

Calculating Transition charges is much more difficult, because we have limited experience with it. This is our best estimate, if we have 25 clients who we can work with, at this point we would predict that at least 20 would qualify for Medicaid. This will be a smaller case load and we predict we will be able to spend 4- 5 hours a week on eligible activities for the 1-4 months we will spend with people. If we are right, we may generate $89,984.

However, we are concerned. Right now, about 85% of our clients qualify for Medicaid and 1915i, but if Trump's work requirements and 6 month redeterminations pass, it could significantly reduce the number of people who qualify for Medicaid. Additionally, we were one of the first agencies to do 1915i but as more agencies start charging 1915i it is likely that we cannot enroll some of our clients because they are enrolled with other agencies. Only time will tell how much money this program can save and we can't rely on it at this time.

2) Use of Emergency Solutions Grant (ESG) Funds

Can your agency accept federal ESG funding for this program, either in full or in part? ESG-funded programs must comply with all applicable federal regulations.

XX Yes ☐ No

If yes, identify:

- Source(s) of required 100% matching funds (cash or in-kind): City and County GPR
- Maximum estimated annual match your agency can provide: $314,708

3) Program Budget Form

Complete the **Program Budget Form (Excel)** for a full program year. Only expenses listed as eligible in Appendix B of the RFP may be included in the funding request to the City of Madison.

4) Budget Narrative and Clarifications

Use this section to explain any assumptions, nuances or clarifications needed to fully understand your budget proposal as presented in the Program Budget Form (Excel).

Up until recently we were operating under the assumption that Dairy Drive would be closing. I do not know if we will be expected to pick up city costs of water, electricity, trash pick up and pest control. If we are, we will write grants or use 1915i funding for these costs, but we need to get numbers on what it costs so we can appropriately budget. Also, if the city were interested in selling us the property for $1 with the right of first refusal to purchase it back for $1, that might be something to consider so the city does not have liability for the campground. If the city does not purchase it back, we could have an agreement to share proceeds from the sale.

Agency & Program: **Madison Street Medicine - Dairy Drive 2.0**

ACCOUNT CATEGORY	City of Madison Request Amount	Non-City Sources	Total Program Budget	Budget Details (e.g., Case manager and supervisor wages; $1,000 for application fee; $3,000 for bus passes)
A. PERSONNEL				
Salary	122,828	295,328	418,156	see chart -> plus on-call pay
Taxes/Benefits	34,392	60,192	94,584	08 taxes and health, dental, vision costs
Subtotal A.	157,220	355,520	512,740	
B. OTHER OPERATING				
Insurance	1,000	1,000	2,000	General liability, vehicle
Professional Fees	3,000	3,000	6,000	Accounting services
Audit	2,500	2,500	5,000	Annual Audit
Postage/Office and Program Supplies	500	500	1,000	Office supplies, printing
Equipment/Furnishings/Depreciation			0	
Telephone	3,030	3,044	6,074	Cell phone costs
Training/Conferences	1,000	1,000	2,000	Ryan Dowd Training Fees, Misc. Conferences
Food		10,000		Meals and Second Harvest Food Bank purchases
Household Supplies			0	
Auto Allowance/Travel		10,000	10,000	Staff mileage and cabs
Vehicle Costs/Depreciation	1,500	1,500	3,000	Van costs
Other (Specify):			0	
Subtotal B.	12,530	32,544	35,074	
C. SPACE				
Office or Facility Rent	4,750	4,750	9,500	Office rent for case managers and storage
Utilities			0	
Maintenance	5,000	5,000	10,000	Supplies, repairs and materials
Mortgage Principal/Interest/Depreciation			0	
Property Taxes			0	
Subtotal C.	9,750	9,750	19,500	
D. SPECIAL COSTS				
Assistance to Individuals - Rent (monthly rent and rent arrears)			0	
Assistance to Individuals - Other Financial Assistance (security deposit, application fee, bus passes, etc.)		10,000		Bus passes, security deposits, application fees (does not include 1915i)
Program Subcontracts (Specify):			0	
Other (Specify):				
Other (Specify):			0	
Subtotal D.	0	10,000	0	
TOTAL (A.-D.)	179,500	407,814	567,314	
	31.64%			

NOTES:

STAFFING: Include ALL staff working for the program

Staff Position Title	City-Funded FTE	Total FTE, including Non City Sources	Roles and Responsibilities
Facilities Manager	0.50	1.00	Repairs, maintenance, lawncare, cabin turn overs, camper support
Nights and Weekends	1.25	2.50	Assisting campers with needs, de-escalation, guest monitoring,
Camper Needs Coordinator	0.30	0.30	Coordinate food pantry, transportation (van trips, bus passes) and donations
SOS Coordinator		0.25	Connect guests to outreach programs
Office Manager		0.25	Scheduling and logistics
Executive Director	0.15	0.15	Program Management, Supervision, Financial Managemetn, Technical Expertise
Case Manager		2.00	Housing focused case management