HomeBase Submission

Responding to RFQ to Assist Homeless Response System Improvements

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If you have questions about this submission, please contact:
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1. Background and Capacity

HomeBase/The Center for Common Concerns is a nationally recognized expert on homelessness and a skilled technical assistance (TA) provider, known for our ability to successfully build community capacity to address homelessness. Over the past 30 years, HomeBase has consistently provided highly effective assistance that fosters sustained system and program performance in responding to homelessness over the long term. Our TA ranges from targeted guidance in complying with federal Continuum of Care (CoC) requirements and implementing best practices to broader change management, such as facilitation of system redesign efforts aimed at improving performance and ensuring best use of resources. We regularly support communities in improving their system-level operations, including facilitation of community-wide strategic planning; system integration and redesign efforts; improvement of HMIS; design and implementation of coordinated entry systems and other best practices; and data-based evaluation and performance measurement.

HomeBase's Established Track Record of Success Building Collaboration Towards Goals

HomeBase works with dozens of diverse communities in California and across the country to analyze and design their homeless systems of care. In the past six months, for example, HomeBase has facilitated nine strategic planning processes to support communities in achieving their goals in coordinating and implementing a robust response to homelessness. These processes are grounded in analysis and mixed-methods assessment of local needs to design an effective system of care, and involve active engagement and facilitation of key community stakeholders and committee processes to foster collaborative decision-making processes that ensure buy-in and effective processes and post-process implementation.

Hallmarks of HomeBase's work include real and respectful engagement of diverse stakeholders through meeting facilitation and other strategies, guiding communities through challenging decision-making processes while meeting deadlines and maintaining focus on the overall goals, and responding to community priorities and client needs while maintaining impartiality. For these reasons, we have been working with numerous communities, including several California counties, continuously for many years.

HomeBase's Experience Implementing and Evaluating Changes in Communities and Agencies

HomeBase has supported many, many communities and agencies to implement changes in their systems that result in better responses to homelessness. We have facilitated many change processes with committees of community partners; we have evaluated progress along the way and in formal reports. We have specific expertise in coordinated entry evaluation, but we have created evaluations of system improvements, facility asset use, prevention and diversion programs, implementation of best practices, and other means to analyze the impact of system changes. We support implementation

processes at the agency and system level, providing expertise and using change management practices to, for example, more fully and effectively implement housing first practices or change how the full homeless system of care is accessed.

- Santa Clara County (ongoing): HomeBase has supported Santa Clara County in the four years since it completed its five-year strategic plan, both to implement key elements of the plan and to evaluate its progress. Our annual training series paired with agency monitoring has supported the plan goals of building agency capacity. We undertake data analysis and the drafting of their annual State of Homelessness report (the 2017 version is attached to this submission, 2018 version is forthcoming), which provides graphic and narrative description and evaluation of progress made. We present it in multiple forums (e.g. Board of Supervisors, CoC) each year.

HomeBase's Experience with the Consultant Services Requested

a. System Maps and Gaps Analysis: HomeBase has extensive experience developing systems maps and carrying out gaps analyses, both to support strategic planning and to inform system evaluation and improvement. Our system-mapping involves thorough research, based on input from consumers, stakeholders and providers, and analysis of key documents and data, into all parts of a community's homeless response system documenting inflows and outflows, what housing and services exist, and related systems of care that are serving the target population. The end product is a conceptual map that shows how consumers flow into, across, and out of the system, as well as referral patterns. For example, we have prepared systems maps in multiple communities as part of their youth homelessness planning processes, each of which has involved multiple rounds in input from diverse stakeholders and has resulted in a visual understanding of the community's resources and challenges.

Our gaps analyses often build on a system-mapping exercise but then focus on the identification of key gaps in the homeless housing and service system, using combination of quantitative and qualitative data, along with recommendations for filling them. The following are examples of previous work HomeBase has done in this field:

- Missouri Balance of State (2018): HomeBase conducted a gaps analysis of the Missouri Balance of State CoC that involved evaluation of: 1) Housing Inventory Count and Point-In-Time (PIT) counts to determine size and type of need and comparison with existing inventory; 2) HMIS Consumer Records, focusing on consumer demographics, housing placements and length of time in programs; 3) Consumer Focus Groups; 4) Key Stakeholder Interviews; 5) CoC Board and Provider Surveys; and 6) Review of applicable federal requirements/guidance and examples from other communities. The final report identified key unmet needs in the housing and services system, focusing on overall needs as well as specific sub-population and geographic needs. It included system- and program-level gaps categorized by system component, each accompanied by recommendations for improvements based on national best practices, adjusted for local implementation.

- <u>Destination: Home Technology Assessment (2018-19):</u> HomeBase (with partner Viztric) conducted a technology needs assessment of Santa Clara County's Supportive Housing System to identify opportunities to leverage technology, strengthen the system of care to end homelessness and make the system more sustainable, reliable, and effective. The assessment included conducting consumer and provider focus groups to identify existing system gaps and ways to leverage technology and data sharing to strengthen system flow and improve outcomes in ending homelessness. The final report detailed priorities for addressing identified challenges and listed pilot, middle, and higher cost solutions as well as next steps and potentially success measures.

b. CES and Other System Assessment and Redesign: HomeBase has extensive experience working with communities to design, launch and evaluate Coordinated Entry Systems, and we are a lead participant in the national policy arena on this issue. We are experienced in designing and implementing family and single adult Coordinated Entry Systems that facilitate placement in shelter, rapid rehousing, and permanent supportive housing. We have assisted in selecting and evaluating screening tools and helped develop customized tools; developed referral management systems, including integrated community housing queues for all subpopulations, and facilitated used of HMIS and mainstream data to inform prioritization and referral. We provide HUD-funded TA coordinated entry implementation to CoCs across the country. Our local team has conducted evaluations of CES processes and/or supported system improvements in diverse Continuums of Care, including Contra Costa County, Southern Nevada, San Francisco, and Santa Clara County. We have created operational documents to improve assessment and referral processes, significantly revised policies and procedures to improve coordinated entry processes in partnership with CoC committees, and facilitated inclusion of additional programs with diverse funding into coordinated entry systems. Examples of this work include:

- <u>Contra Costa County (2013- present)</u>: As part of an overall CoC redesign effort, HomeBase assisted the County in developing a consensus-based coordinated entry (CE) system for single adults and families though a four-phased process: planning, pilot, implementation, and ongoing evaluation. TA has included facilitation of a meeting process that mapped the system access points and client flow, considered structure and process issues, and developed consensus on key decision points, including assessment tool selection, staffing and budgetary requirements. We also conducted evaluations of three pilot efforts, and helped with subsequent revisions to the system design. We also developed policies and procedures to support the full implementation that took place in early 2017.

- <u>Maricopa County, AZ (2018):</u> We evaluated the Maricopa Regional CoC coordinated entry system, which consists of two distinct systems for single adults and for families with children. Key community stakeholders and HomeBase developed a primary set of questions to guide the focus of the evaluation and report covering three areas: 1) Ensuring Access, 2) Assessment and Prioritization, and 3) Referrals and Placements. Our methodology included HMIS data analysis,

an online stakeholder survey, four consumer groups, key-informant interviews at system entry points, and review of key documents. The final report identified key areas for improvement and addressed the need for open communication between the two coordinated entry systems and to prioritize development of strategies to more fully support youth within the bifurcated system. We have completed similar evaluations in Southern Nevada and Santa Clara County in the past two years.

c. Evaluation Processes: HomeBase works with communities to collect and analyze qualitative and quantitative data, and to use data insights to evaluate system- and program-level outcomes and thus guide planning, policy and resource allocation. As one example:

- San Francisco County, CA (2018): HomeBase conducted a mixed method evaluation to measure volume and outcomes of evictions, identify trends, and provide an analysis to support early identification of at-risk households and better targeting of services. The methodology included comprehensive multi-sourced quantitative data analysis of eviction and eviction-defense-related data sets to identify risk factors for eviction, causes of eviction and causes of outcomes and in-depth qualitative analysis (interviews and focus groups with landlords, attorneys and tenants) to map and the current system, provide details about why evictions occur; identify potential improvements, and contextualize the quantitative findings. HomeBase developed a report with recommendations on how to reduce tenant evictions and improve provision of eviction defense services.

d. Program Standards, Policies and Procedures, Operations Manuals, and Training Curriculum: HomeBase provides a wide variety of customized technical assistance on best practices and to support agency operations, delivered through a range of modalities, including one-on-one on-site guidance; availability to answer questions or give strategic advice by phone or email; onsite group trainings; remote webinars; development of customized written guidance, templates and tools; and referrals to existing guidance and tools from HUD and other sources. We have helped develop program standards and operations manuals for emergency shelters, transitional housing, and rapid re-housing programs. We have also drafted policies and procedures for the CoC Board and committees and for coordinated entry systems. For example, we drafted and regularly update the Santa Clara County policies and procedures related to quality assurance that institutionalize best practices as well as their rapid rehousing and prevention operations manuals. We provide hands-on TA to agencies in San Mateo, Santa Clara, Napa, Marin, Fresno and Madera Counties to update their policies and procedures to align with funding and local standards. HomeBase has revised CES policies and procedures in multiple counties.

We have designed and carried out a wide range of trainings, each complemented with user-friendly materials designed to function as ongoing reference tools on wide variety of topics. In the past year, our trainings topics have included, among many others: Housing Quality and Meeting Federal Standards, Financial Management, Privacy Laws and HMIS Client Consent, Rapid Rehousing, and Equal Access and Fair Housing.

e. Technical Assistance on Grants Compliance: HomeBase has been a HUD TA provider for more than 18 years and we have significant experience providing TA and training to support compliance with HUD regulations and priorities. We have designed curricula and conducted national- and local-level trainings to facilitate CoC and agency compliance with HUD guidance and requirements, addressing topics such as homeless eligibility documentation and understanding and complying with the Violence Against Women Act (VAWA). We have deep expertise on the ESG program, having been a co-manager of HUD's national ESG Ask-A-Question (AAQ) Pool, a participant in HUD's ESG Workgroup, and a TA provider to many communities. We are also fully versed with key staff funding streams including HEAP, CESH and NPLH. The following are two examples of our work providing technical assistance to support grant compliance:

- Santa Clara County, CA (2014-2019): HomeBase provided technical assistance to help the Office of Supportive Housing (OSH), the direct recipient for HUD Continuum of Care (CoC) grants, to monitor its subrecipients for grant compliance and to build its internal capacity to carry out its monitoring responsibilities. We annually visited the offices of all 17 subrecipients for four years and conducted a thorough review of their policies and procedures, client eligibility documentation, and financial records. HomeBase used these reviews to draft formal compliance reports; facilitate conversations between OSH and its subrecipients regarding the root causes of compliance problems; and inform provision of training on areas of difficulty. Finally, HomeBase prepared checklists (for the monitoring visits) and templates (for the monitoring reports), and trained a Santa Clara County staff person to conduct the monitoring visits and fill out the reports without further direct assistance from HomeBase.

- San Mateo County, CA (2016-current): HomeBase provides annual capacity building support to CoC agencies. Each year, based on interviews and data gathering with the CoC and providers, key areas of need are identified as the focus for monitoring, TA, and training. These areas have included: CoC Compliance Review, Data and Systems Performance, Coordinated Entry System, Equal Access Rule, Lowering Barriers for Special Populations, Trauma-Informed Agencies, Housing-Focused Case Management, Housing First Implementation, Connecting Clients to Benefits, Eligibility Documentation, and Fair Housing. We arrange one-on-one agency assessment visits, focusing on that year's topics, and provide each agency with a summary of the findings and an individualized TA Plan. The TA Plans have included support for development of policies and procedures and ground-level support for improving agency operations. Follow-up and support are provided through telephone and email contact and linkage with peers. In addition, each year, monthly trainings are carried out addressing key topics and customized TA materials and tools are provided at each event.

2. Proposed Approach

Management of Proposed Work. HomeBase organizes its work using a team structure in order to leverage a diverse mix of skills, expertise, and experience to best meet client needs. We propose that the same team that is guiding the Sacramento CoC's Performance Review Committee (PRC) undertake this scope of work. **Bridget Kurtt DeJong**, our proposed Project Team Lead, will direct the project and provide overall oversight, subject matter expertise, and quality control. Bridget will attend as many meetings as possible via Zoom videoconference (provided by Homebase) or via audioconference, if videoconference technology is not possible, and will attend key Advisory Board meetings and other necessary meetings in person. In addition, **Meadow Robinson** will act at Team Coordinator. She will be responsible for day-to-day project management and team member coordination, will serve as point of contact for SSF and stakeholders, and will facilitate and present at meetings. Meadow and/or other members of the team **will attend all meetings in person**. Bridget and Meadow are supported by HomeBase's Executive Director, Nikka Rapkin, who provides support and expertise.

Working with SSF and Partners to Build Scope of Work. HomeBase understands that the proposed scope of work is key to the overall success of ending homelessness in the Sacramento region, and that SSF and community stakeholders have extensive expertise and local experience addressing these issues. As such, HomeBase will honor the experience of the people on the ground in building the scope of work and will supplement their work with our expertise from our work with other communities and projects with the goal of meeting community goals effectively and efficiently.

HomeBase has worked with SSF and the Sacramento CoC for many years. In our current work with PRC we have tried to be diligent about ensuring that we understand stakeholder goals, meet expectations, leverage SSF staff and community stakeholder expertise, and make best use of community resources. Similarly, for this scope, HomeBase will provide iterative drafts of products to all relevant existing groups to leverage their expertise and respond to their needs; set regular check-in meetings with the SSF staff project manager or other community leaders; use surveys and focus groups to gather input; and use goal-oriented facilitation that is targeted towards engagement of all relevant stakeholders. We pay special attention and consideration when working directly with persons with lived experience of homelessness and we make every effort to ensure their voices are included.

For purposes of Phase One, we expect to first speak with SSF staff about upcoming deadlines or concerns that would impact this scope of work. We will then, building from the version included in the RFQ, draft and provide a detailed workplan to a group of key stakeholders (e.g., key SSF staff, CoC Advisory Board chairs, representatives of key funders, specific CE line staff) via email and then meet with them to revise the plan together, responding to feedback and concerns. After revisions, we would circulate the workplan to the CoC Advisory Board, the CES Evaluation Committee, Funders Collaborative, and other relevant bodies to gather their feedback, then we will revise the scope of work again.

Timeline

	Activities and Deliverables
May 2019	**Contracting** **Refining Scope of Work** (described above) **Gather Information for Systems Map.** HomeBase will gather written information, including data, from SSF to prepare the first draft system map.
June 2019	**Finalize Scope of Work**[1] with stakeholder input (described above). **Develop Systems Map.** Using the initial draft as a starting point, HomeBase will work with SSF staff to conduct a focus group with consumers[2] to gather feedback and either host or attend an existing(s) meeting with providers/stakeholders (especially from systems of care that contribute to homelessness or provide mainstream services to homeless people) to get additional input. HomeBase, with SSF staff, will prepare iterative drafts before presenting a version to the CoC and Funders Collaborative for final input. **Begin Education Regarding Gaps Analysis**. At systems map meetings, HomeBase will begin discussing the gaps analysis and how it could proceed, to create shared expectations about the uses of the gaps analysis.
July-Aug 2019	**Finalize System Map** with extensive stakeholder input. **Build Model for Gaps Analysis.** Leveraging the expertise of the SSF data team and building stakeholder input (including recent Advisory Board meeting), HomeBase will work with SSF staff to create a proposed process for identifying key unmet needs in the community. HomeBase will then present the model, with SSF, at multiple stakeholder meetings in a user-friendly way that clearly informs stakeholders about the utility of the model, and then revise the proposal to address new concerns raised by meeting participants.
Sept 2019	**Finalize Gaps Analysis**. After the model is approved by key parties, HomeBase will support SSF in creating a procedure for updating the analysis. **CE Assessment.** HomeBase will begin CE assessment by requesting data, forms, procedures and documentation from SSF staff. HomeBase will release online surveys to stakeholders who engage with CE, including providers (line staff and executive staff), SSF staff, and other partners.

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[1] Note: In this proposed timeline, in most cases, we have proposed providing each deliverable one month after we complete our substantial draft, because we want to ensure there is time for the various stakeholders to meet and review the deliverables before they are complete.

[2] Note: HomeBase will rely heavily on the SSF Program Manager to arrange meetings and logistics (including identifying and inviting participants, finding rooms, arranging Zoom conferences, etc.) for the various meetings and focus groups proposed in this scope of work.

	Activities and Deliverables
Oct 2019	**CE Assessment**. HomeBase will continue the CE assessment by facilitating or supporting SSF staff in facilitating 2-3 consumer focus groups with a diversity of involvement with CE. HomeBase will begin to analyze available data, and draft report. If desired, HomeBase can work with LeSar Development Consultants to assess this CoC's readiness for real-time CES data integration, including by interlinking real-time data from health systems (Medicaid) with HMIS data to identify the frequent utilizers of each system and ensure resources are targeted to the highest need population. This could include peer-to-peer discussions and resource sharing with other CoCs.
Nov-Dec 2019	**Finalize CE Assessment** and begin **Redesign**. HomeBase will share draft report with SSF staff and other key stakeholders to get initial feedback and then prepare final assessment. Then, HomeBase will immediately begin preparing recommendations for strategies to improve gaps identified. HomeBase will work with CES Committee to create strategies and action steps to meet the redesign priorities.
Jan-Feb 2020	**Finalize CE Redesign Plan** with stakeholder input and begin **Implementation**. **Draft written standards** using the information gathered through CE assessment and redesign and other Sacramento standards. Vet **written standards** with stakeholders**.**
Mar-April 2020	Continue to support **CE Implementation, governance, and evaluation** activities through change management and subject matter expertise support. Develop and give **training for written standards** and evaluation of alignment and **certification** process.

Planned Staff and Subcontractors. HomeBase employs a highly capable and specially-trained staff of public policy lawyers and project research and management professionals that offer experience in all aspects of homelessness policy, systems and programs, as well as experience with effective technical assistance and capacity building techniques, including facilitation, consensus development, strategic planning, assessment, training, and other methods. In addition to the management staff proposed (Bridget Kurtt DeJong, Meadow Robinson, and Nikka Rapkin) staff members proposed to complete the scope of work include Colin Sorensen and Tara Ozes. In addition, HomeBase's full roster of talented staff will be available to provide subject matter expertise and support to the Project Team as needed. For example, Piper Ehlen (Managing Director- Federal Programs) has led multiple CE evaluations in diverse cities and may provide support to the CE Assessment and Redesign stage. In addition, LeSar Development Consultants may assist with CE assessment and redesign related to data sharing. LeSar has deployed practical solutions to increase affordable housing and end homelessness for 20 years. LeSar staff Jamie Taylor and Kris Kuntz are currently supporting cross-sector data integration projects across the U.S.

3. Proposed Method of Compensation

This budget reflects our estimated costs to do the work described in this proposal, as presented. We are happy to adjust as necessary to meet your needs. We could either invoice based on deliverables or hourly, as desired.

HomeBase

Task Phase I-Scope	Estimated Hours/Expenses	Estimated Cost
Meet with Sacramento Steps Forward		
Create Scope of Work		
Stakeholder Meetings		
Multiple Revisions		
TOTAL	**44** Staff Hours	**$5,493**
Task **System Map**		
Gather Data and Information		
Draft System Map		
Focus Group		
Stakeholder Meetings		
Multiple Revisions		
TOTAL	**173** Staff Hours	**$17,342**
Task **Gaps Analysis**		
Stakeholder and SSF Meetings		
Draft gaps analysis process		
Multiple revisions		
TOTAL	**190** Staff Hours	**$21,530**
Task **Coordinated Entry Assessment, Redesign, Implementation, and Ongoing Governance & Evaluation**		
Gather Data and Information		
Design and Conduct Surveys and 2-3 Focus Groups		
Analyze Data		
Draft and Revise Assessment Report		
Creation of Redesign Strategy		
Support for Implementation of Strategies (e.g., support for written policies, procedures, change management, communications, staffing)	**524** Staff Hours	**$57,888**

Create evaluation protocol, including benchmarks and metrics		
Multiple stakeholder meetings		
TOTAL		
Task **Written Standards**		
Draft and Revise Written Standards		
Stakeholder Meetings		
Prepare and Give Training on Written Standards		
TOTAL	**139** Staff Hours	**$12,497**
HOMEBASE GRAND TOTAL	**1,070** Staff Hours	**$114,751**

Optional Addition: LeSar Development Associates

Task **Support for CE Assessment and Redesign**	**Estimated Hours/Expenses**	**Estimated Cost**
Assess Sacramento readiness for real-time, cross-sector coordinated entry system data integration, with health systems.		
Support for cross-sector data-sharing coordination.		
TOTAL	**90** hours	**$18,100**

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Proposed Project Team to Assist with
Homeless Response System Improvement

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1. ***Lead Responsible for the Project****:* Bridget Kurtt DeJong, Managing Director, State and Local Programs

   Project Responsibilities: Responsible for overall project oversight and quality control. Provides work plan support, training and TA. Subject Matter Expert (SME) on system mapping, needs assessment and gaps analyses, Coordinated Entry System design and implementation; performance measurement; and system redesign. Relevant Qualifications/Expertise: 12 years of experience in project management and providing TA to CoCs, led Sacramento's Homebase LOT TA team from 2007-2013, and current team lead; Expert facilitator. Experience with program evaluation; program design and implementation; performance outcome measurement systems; and using data to inform policy decisions.

2. ***Project Oversight and Subject Matter Expert****:* Nikka Rapkin, Executive Director

   Project Responsibilities: Provides contract oversight, work plan support, and quality control of work product. SME on HUD policy, gaps analyses, operational policies, and evaluation processes. Relevant Qualifications/Expertise: Over 10 years of experience developing agency capacity, with experience facilitating community planning processes and assisting with multi-sectoral collaboration; strategic reallocation of resources, including TH redesign; CoC governance structure; and conducting trainings and developing toolkits. Experience with CE development and system evaluations.

3. ***On-site Staff Team Lead****:* Meadow Robinson, Team Coordinator

   Project Responsibilities: Responsible for day-to-day project management and team member coordination; point of contact; meeting facilitation and presentations; training and TA provision. Relevant Qualifications/Expertise: Coordinates TA and training for CoC bodies and providers in Marin County; experience in Stanislaus and Contra Costa Counties; strong facilitator with experience with multiple review and rank processes; Coordinated Entry planning and implementation; youth system mapping; supports community planning efforts; expertise in health care services; experience with evaluation of systems and projects.

4-5. ***Team Members Performing Day-to-Day Work****:*
   - Tara Ozes, Project Assistant
   - Colin Sorensen, Project Assistant

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Project Responsibilities: Research; data analysis; draft guidance, meeting materials and reports; meeting logistics; facilitation, presentations, training and TA provision.

Relevant Qualifications/Expertise:

- ✓ *T. Ozes:* Worked on Coordinated Entry planning and implementation, program- and system-level performance evaluation, strategic planning, and governance in multiple California communities including Marin and Humboldt Counties; provides TA to providers related to funding requirements; trainer on best practice and compliance topics; provides user support and data analysis.
- ✓ *C. Sorensen:* Provides support for strategic planning, needs assessment and gaps analyses, and CoC governance in Contra Costa County, Stanislaus County, Tulsa, OK; strong experience with data analysis and visualization; provides support for evaluation for multiple communities.

OPTIONAL SUBCONTRACTOR

6-7. *Staff from LaSar Development Consultants*
- • Jaime Taylor, PhD
- • Kris Kuntz

Project Responsibilities: Research, data analysis, and TA provision related to cross-sector data integration to support coordinated entry system functioning. Jamie Taylor and Kris Kuntz are currently supporting cross-sector data integration projects in Indiana, Utah, and Virginia, and CoC expansion work in sites across the west coast.

Relevant Qualifications/Expertise:

- ✓ *J. Taylor*: Has program evaluations and providing technical assistance on evaluation design and data utilization to improve policy and program planning for over 25 years. Provides subject matter expertise on the structural determinants of homelessness, and its intersection with health and criminal justice systems. Currently leading a multi-site data integration project, combining data analytics, rapid-cycle evaluation, and a sustainable integrated data infrastructure to connect health, and housing data, supporting cross-sector goals for health and housing stability.
- ✓ *K. Kuntz:* Specializes in developing creative approaches to addressing homelessness and housing issues. Recent work includes providing HUD technical assistance on Coordinated Entry to the Nashville CoC, and advising a large national health plan on homelessness and housing strategies. Collected data and performed analysis on San Diego's chronically homeless frequent user effort, Project 25, and worked with several Medicaid Managed Care Organizations to expand the program.

Organization Chart

HomeBase Organizational Chart
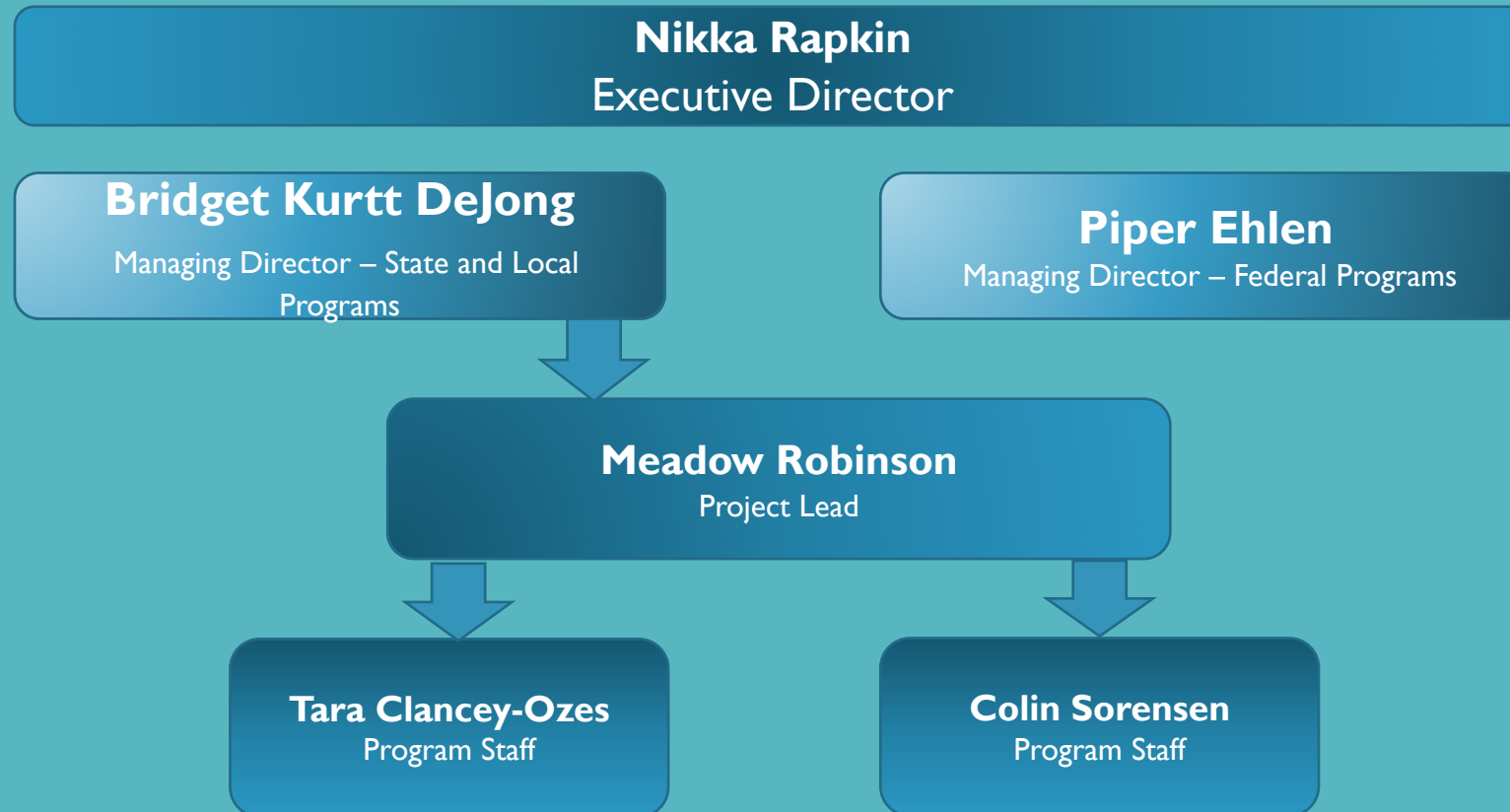
Nikka Rapkin
Executive Director

Bridget Kurtt DeJong
Managing Director – State and Local Programs

Piper Ehlen
Managing Director – Federal Programs

Meadow Robinson
Project Lead

Tara Clancey-Ozes
Program Staff

Colin Sorensen
Program Staff

Resumes

HomeBase
- Nikka Rapkin
- Bridget Kurtt DeJong
- Meadow Robinson
- Tara Ozes
- Colin Sorensen

LaSar Development Associates
- Jaime Taylor
- Kris Kuntz

Job Description

Ms. Rapkin has over a decade of experience in public health, non-profit management and system and program design to respond to global social challenges. She works with federal, state and local partners to develop and implement policies that enhance equitability of access to housing, health and well-being for persons experiencing and at-risk of homelessness. Her work engages mainstream and public institutions in developing integrated solutions to end homelessness and supports communities of all sizes in building robust systems of care. She is a skilled trainer and has worked globally to design and disseminate best practices, partnering with local leadership, cross-system stakeholders, service providers and program participants to translate policy to practical reality. In her role as Executive Director starting in 2019, Ms. Rapkin will oversee all aspects of HomeBase operations and financial administration, staff management and development, implementation of HomeBase's vision, and quality assurance of HomeBase work product.

Professional Experience

HomeBase, Deputy Executive Director

Expertise and Recent Projects

- *Strategic Planning and Cross-Sector Problem Solving*: Convenes and facilitates strategic planning and implementation processes, working with local, regional and state stakeholders to build consensus, momentum, and leadership. Fosters buy-in by elected officials, executive administrators of government agencies and non-profits, providers, and community members to commit to practical and innovative strategies. Facilitated development and adoption of strategic plans in several California counties to implement solutions around resource allocation and cross system partnerships, including a corrections system discharge/re-entry summit in Washington State, regional housing and healthcare integration planning in Central California, and strategic planning and implementation in Shasta, Mariposa, and Santa Clara Counties.

- *System Design and Evaluation*: Facilitates stakeholders to design, assess and improve homeless systems of care, including system mapping to integrate multiple sectors into the homeless response, design and evaluation of coordinated entry systems, Homeless Management Information System (HMIS) gaps analyses, and development of agency and community-level policies. Led a variety of qualitative and quantitative needs assessment processes, synthesizing data to identify opportunities for aligning resources and collective impact, and facilitated stakeholder processes to analyze and take action to address gaps. Recent examples include an evaluation of the Santa Clara County Coordinated Assessment System, a gaps

analysis of the Redding/Shasta County homeless services system, an analysis of gaps in discharge processes from state systems (prison, mental health hospitals, and in-patient drug and alcohol treatment) in Washington State, and system mapping and facilitation to support a rural community integrate its Health and Human Services and non-profit programs into a comprehensive system of care.

- *Non-Profit and Provider Capacity Building*: Works with public and non-profit service providers to implement robust programs to prevent and end homelessness, including prevention, diversion, crisis shelter, rapid rehousing and permanent supportive housing. Designed portfolio of capacity-building trainings and toolkits and facilitates one-on-one meetings with agency staff to evaluate opportunities to streamline agency systems, strengthen service outcomes and deepen application of best practices through agency-wide change management. Supports establishment of service provider networks and platforms for peer learning, and facilitates regional peer communities, including the Bay Area Regional Steering Committee on Homelessness and Housing (RSC), the longest standing homelessness learning community in the country, and the Northern California and Central California Roundtables.

- *Regional Homelessness Policy and Data Integration*: Facilitates urban and rural regions across the country to identify core challenges and foster collaboration between diverse stakeholders to leverage resources, engage in creative problem solving, and develop and implement actionable plans for transformative impact, and coordinates regional leadership to provide state and federal advocacy on related policy issues. Most recently, facilitated ongoing efforts to integrate data in the San Francisco Bay Area, participates in HomeBase regional convenings of system leadership from Bay Area counties and Big 11 cities, and facilitated regional action planning in Central California to develop community strategies to enhance health care and housing intersystem coordination to better serve people experiencing or at-risk of chronic homelessness.

- *Access Equity and Inclusion*: Coordinates workshops, develops tools and curriculum, and facilitates community working groups to identify gaps and strengthen outcomes for underserved populations, including persons identifying as LGBTQ+, youth, people of color, survivors of domestic violence, and individuals with severe mental illness. Works directly with agencies to strengthen competencies in serving diverse clientele, and led, facilitated and coordinated advisory boards, advocacy and feedback processes by diverse persons with lived experience of homelessness. Most recently, led HomeBase teams in conducting data analysis in several California communities to identify racial disparities in system access, facilitated a process to revise coordinated entry and continuum of care policies and procedures to ensure safe access for households fleeing domestic violence in Santa Clara County, organized LGBTQ+ cultural humility workshops in three CoCs, and was a lead presenter and expert panelist for 2018 California Association of Counties workshop on youth homelessness.

- *Public Education and Engagement*: Educates community stakeholders about the root causes of homelessness and effective interventions through presentations,

issue summits, and publications. Works with local agencies and officials to develop talking points to communicate effectively with the public and galvanize buy-in and support for the community's response to homelessness. Most recently, led development of Santa Clara County 2018 annual report on the state of the supportive housing system, facilitated community meetings in Redding and Mariposa, CA, and developed messaging to support provider agencies in discussing the adoption of coordinated entry processes and low-barrier housing first approaches to funders and board of directors.

- *Federal Homelessness and Housing Policy*: Provides technical assistance (TA) for HUD programs (CoC, ESG, HMIS, CDBG and HOME), including direct TA and group trainings, and leads development of training materials to support grantee compliance and effective program operation, including design of a comprehensive toolkit and robust training programs for new and experienced federally-funded programs. Conducts regulatory analysis and interpretation of federal and state policy around homelessness and health and human services, and supports local and regional advocacy to develop issue briefs and promote policy change. Surveys regional housing and service providers on proposed federal and state legislation, budgets, and specific government agency initiatives and grant processes to support advocacy efforts.

- *Performance Measurement, Analysis and Data Management*: Works with numerous communities and agencies to identify performance metrics and leverage data to understand system flow and opportunities for strengthening outcomes in addressing homelessness. Led teams to facilitate gaps analyses of data and technology systems, HMIS vendor transitions, and local processes to expand functionalities of HMIS software to strengthen the usability of HMIS data to respond to homelessness. Provides guidance on collecting, interpreting, presenting and applying data to support monitoring of strategic plan implementation and project and system performance, most recently in Santa Clara and San Mateo Counties.

Prior Experience

Bay Area Community Resources
Program Director, March 2013 – November 2014

International Cardiovascular Health Alliance
Executive Director, January 2008 – May 2013

Orrick, Herrington, and Sutcliffe LLP
Attorney, October 2006 – March 2013

Honorable Robert B. Kugler
Judicial Law Clerk, August 2005 – August 2006

Education

2005   JD, University of California, Berkeley, School of Law

2001   BA, University of California, Davis

Job Description

In her 12 years at HomeBase, Ms. Kurtt DeJong has provided a wide variety of technical assistance and training to communities and states. She assists with program design and implementation; provides training on a variety of program and policy issues; conducts needs assessments; facilitates strategic planning processes; and helps communities carry out system- and program-level evaluations. She also provides direct agency capacity-building support to enhance program and system capacity and quality of care. As Managing Director for State and Local Programs, she also oversees all of HomeBase's contracts with State and Local Communities, providing quality control and content support.

Professional Experience

Homebase, Managing Director-State and Local Programs, 2014-present
  Senior Staff Attorney, 2008-2014
  Staff Attorney, 2006-2008

Expertise and Projects

- *Homelessness and Housing Policy:* Manages and provides technical assistance to assist communities in complying with federal program requirements and policy priorities (CoC, ESG, HMIS, HUD-VASH, Homeless Preferences in Project-Based Section 8, Housing Choice Vouchers) and state program requirements (California's CESH, HEAP and NPLH programs). Includes direct technical assistance, group trainings, site visits, and development of training materials on such topics as equal access, serving vulnerable populations, and grants management.

- *Continuum of Care (CoC) Planning, Structure and Operations:* Provides trainings and has developed tools and materials, including a CoC policies toolkit. Assists numerous CoCs with planning, data analysis, monitoring/evaluation and grant administration. Helps establish HUD-compliant CoC structures (Board and committees) and policies, including facilitated HEARTH-oriented systems transformations in Santa Clara and San Francisco Counties (CA). Developed Hand-in-Hand Program to support staff of rural, small or new CoCs in learning the CoC Program, leading their CoC, and responding to the CoC NOFA – support provided through a series of video trainings, peer calls, written materials and one on one TA.

- *Performance Measurement and Evaluation:* Assists numerous communities in performance measurement system design and implementation, including organization of staff trainings and guidance on using data to guide policy and decision-making. Annually leads CoC housing and services project-level evaluation in multiple communities. Developed customized project level performance measures

for CoC programs in San Francisco and Santa Clara Counties (CA). Oversaw performance evaluation in Fresno/Madera CoC (CA).

- *Coordinated Entry Systems:* Assists with design, implementation, and evaluation of coordinated entry systems, including overall system redesigns. Supports CoCs in creating and implementing coordinated entry policies and procedures. Provides training for coordinated entry stakeholders, including videoconference series for Nevada Balance of State CoC.

- *Resource Allocation*: Supports multiple communities in California, Missouri and Georgia, through direct TA, on call TA, or peer-based TA, in identifying priorities, designing resource allocation systems, and evaluating funding use.

- *Data, Reporting, Analysis and Management:* Assists CoCs to collect, manage and utilize data to guide homelessness planning and program development and operation, including for system resource allocation purposes. Has expertise with Homeless Management Information Systems (HMIS) transitions, including providing support to numerous CoCs, including San Francisco and Santa Clara County (CA), in the operation and improvement of their systems.

- *Needs Assessments and Gaps Analyses:* Has conducted a wide range of needs assessments and gaps analyses to help communities evaluate and understand their needs, including conducting stakeholder and consumer focus groups and surveys. Facilitated a continuum-wide analysis of gaps in the crisis housing and services delivery system in Santa Clara County (CA). Completed a system-level gaps analysis related to availability, accessibility and coordination for Missouri Balance of State CoC.

- *Rural Homelessness:* Supports rural community efforts to build capacity and design effective systems and projects. Led the Northern California and Central California Roundtables, two regional peer networks supporting action on homelessness in rural communities. Provides capacity-building, peer-based assistance with HUD CoC NOFA applications. Supports planning and program design efforts.

- *Organizational Development and Capacity Building:* Provides a wide-variety of organizational capacity building and other support to community-based agencies, including board development, agency transition, change management, and grants management systems. Provides targeted assistance to under-performing CoCs and agencies.

- *Strategic Planning and Implementation:* Led strategic planning processes to identify community priorities, analyze system gaps and needs, obtain stakeholder commitments, and isolate key metrics of success, including ten-year plans to end homelessness in Yolo, San Francisco, and Santa Clara Counties (CA) and is currently leading a planning process in Tulsa, Oklahoma and overseeing a process in Yuba and Sutter Counties (CA). Facilitated Plan implementation including processes in Santa Clara and San Francisco Counties (CA).

- *Special Needs Sub-Populations:* Assisted San Francisco County (CA) in designing, securing funding and implementing youth programs.

Orrick, Herrington & Sutcliffe LLP
Global Finance Associate, October 2003-April 2006

Legal Aid Society
Orrick, Herrington & Sutcliffe LLP Extern to the Civil Division of the Legal Aid Society,
May 2005-August 2005

Brennan Center Public Policy Clinic at the Center for Constitutional Rights
Student Advocate, Policy Strategy, August 2002-May 2003

Women's Institute for Leadership Development (WILD) for Human Rights
Legal Intern May 2001-August 2001

Education

2003   JD, New York University School of Law
2000   BA, University of Iowa

Job Description

Ms. Robinson provides technical assistance and training to aid states and communities in their work to end homelessness. She assists with systems mapping, redesign and implementation; HUD compliance efforts; and system- and program-level evaluations. She conducts facilitation and research support; provides direct agency technical assistance; conducts trainings and focus groups tailored to meet the specific goals of clients; and develops a wide variety of tools and materials.

Professional Experience

HomeBase, Staff Attorney, 2016-present

Expertise and Projects

- *Federal and State Homelessness and Housing Policy:* Supports technical assistance to aid states and communities in complying with federal and state program requirements and policy priorities (CoC, ESG, CABHI, CESH, HEAP), including direct TA, group trainings, and development of training materials. Re-designed application and review/rank process for successful funding of projects under the ESG program in Marin County.

- *Continuum of Care (CoC) Planning, Structure and Operations:* Provides technical assistance and training on CoC operations in Marin, Stanislaus, Contra Costa, Mariposa and Sonoma Counties, CA on HEARTH compliance, CoC governance and performance measurement. Assists with the development of annual HUD Homeless Assistance application and acts as neutral third party facilitator. Provided analysis and supported development of CoC Written Standards of Service and Governance Charter and Bylaws, ensuring full compliance with new regulations and HUD notices.

- *Coordinated Entry Systems:* Facilitates development and implementation of coordinated entry systems in Contra Costa and Marin Counties, CA, including program eligibility streamlining in HMIS, implementation of prioritization policies, development of coordinated entry evaluation metrics, and implementation of best practices for Domestic Violence survivors.

- *Strategic Planning and Implementation:* Supports community policy and planning efforts by conducting intensive outreach and feedback sessions from diverse groups of stakeholders including community members, local officials, and homeless service and housing providers. Facilitated and drafted strategic plans for Tuolumne, Mariposa and Marin County with a specific focus on systems mapping and identifying unmet needs in housing and services. Facilitated youth systems mapping meetings in Marin County with multiple youth stakeholders laying the groundwork for a coordinated youth system of care.

- *Rural Homelessness:* Provides technical assistance to rural CoCs across Northern California, including Mariposa and Tuolumne Counties, related to state grant program compliance, CoC governance, and system level evaluation.

- *Behavioral Health:* Provided research, data collection, and technical assistance strategy development for the Cooperative Agreements to Benefit Homeless Individuals (CABHI) Program, which serves people with behavioral health issues that are experiencing homelessness. Facilitates the design of team meetings and promotion of evidence-based practices, and developed a communities of practice proposal and communication framework for CABHI grantees.

- *Health Care and Housing Intersection:* Lead organizer for AmeriHealth Caritas Leadership Summit: *Health Is More Than Health Care: Maximizing the Value of America's Investment in Medicaid,* in which eighty stakeholders collaborated at a one-day convening to develop workable solutions to address the most challenging social determinants of health, including lack of housing, HIV diagnosis and community violence. Crafted event proposal, provided planning and coordination, and developed supporting materials and final strategy report.

Prior Experience

City of Calgary Law Department
Articling Student, June 2014-June 2015

Safebrain Systems, Inc.
Brand Ambassador, January 2012-September 2013

Roadlawyers
Research Assistant, Summer 2012

Education

2014   JD, Thompson Rivers University, Faculty of Law
2010   BA, Athabasca University

Job Description

Ms. Ozes works directly with communities and agencies, providing technical assistance to aid their work to end homelessness. She guides both leadership and community stakeholders through decision-making processes concerning strategic planning, system- and program-level design and evaluation, Homeless Management Information System (HMIS) implementation, Continuum of Care (CoC) grant management and compliance, and design and implementation of Coordinated Entry systems. She has significant expertise providing technical assistance directly to agencies, conducting research and developing a wide variety of materials and tools to support their ongoing efforts. Ms. Ozes also has experience regularly facilitating presentations and discussions between community members, both in the communities she serves as well as in peer-community, cross-team collaborations.

Professional Experience

HomeBase, Staff Attorney, 2016-present

Expertise and Projects

- *State and Federal Grant Tracking, Interpretation, and Implementation*: Staying up-to-date on new state and federal funding opportunities, clarifying grant program guidelines for county/development sponsor applicants and community stakeholders, and providing targeted assistance (e.g., supporting community processes to develop county homelessness plans, drafting strategic plan updates in preparation of submitting development proposals, etc.)

- *Federal Homelessness and Housing Policy:* Supports technical assistance to aid agencies and communities in complying with federal program requirements and policy priorities (CoC, ESG, RHSP), including development of TA and training materials.

- *Continuum of Care (CoC) Planning, Structure and Operations:* Provides technical assistance and training in Marin, Yolo, Humboldt, Contra Costa, and other California Counties on HEARTH compliance, governance models and CoC operations. Has experience drafting the annual HUD Continuum of Care Competition Application, having drafted the Humboldt CoC Application three years in a row, and experience designing and facilitating the CoC Program Review and Rank process for Marin two years in a row, and Humboldt three years in a row.

- *Coordinated Entry Systems:* Facilitates development and implementation of coordinated entry systems in the Marin, Yolo, and Contra Costa Continuums of Care, including analysis of entry points, development of HMIS-based referral processes and client matching processes, and ongoing evaluation.

- *Best Practices Program Design and Implementation:* Provides technical assistance and training on how to implement Housing First, landlord engagement, prioritizing Chronic Homelessness, Equal Access Rule requirements, cultural competence criteria for serving Youth and LGBTQ, and other best practices.

- *Performance Measurement and Evaluation:* Conducts trainings and webinars on project performance review and facilitates decision-making processes to support data-driven systems change. Programs the annual CoC Competition for Marin, Contra Costa, and Humboldt, and provides user support and data analysis for HomeBase's Program Evaluation and Scoring Tool (PRESTO), a web-based platform for analyzing the performance of homeless housing and service projects and systems of care.

- *Data Gathering, Reporting, Analysis and Management:* Conducted the 2017 Sheltered Point-In-Time Count for the Marin CoC through outreach to homeless housing and service providers and gathered data according to HUD criteria for submission on the Homeless Data Exchange (HDX). Collects and analyzes APR data from CoC-funded homeless housing providers as part of the annual CoC Competition.

- *Peer Networks/Learning Communities:* Organizes and facilitates regional convenings of homeless policymakers, service providers, and thought leaders at the Bay Area Regional Steering Committee on Housing and Homelessness and the Northern and Central Valley Homeless Roundtables.

- *System Redesign and Integration:* Supported efforts to integrate the Contra Costa County's Mental Health, Alcohol and Other Drugs and Homeless Programs into one Behavioral Health Division, including facilitating the design of team meetings and promotion of evidence-based practices.

- *Rural Homelessness:* Provided technical assistance to rural CoCs across Northern California, including Humboldt, related to HEARTH Implementation, CoC governance, and program evaluation.

- *Disaster Relief, Recovery and Preparedness Planning:* Facilitates the HomeBase Disaster Relief and Preparedness Committee, which gathers information on needed resources and funding opportunities for communities affected by the 2017 Northern California and Southern California wildfires. Prepared and submitted a workshop proposal titled "Disaster Readiness: Prepare, Respond, Recover" for the 2018 Housing California Annual Conference.

Prior Experience

Northwest California School of Law
Adjunct Faculty, 2016-Present

Immigrants & Language Rights Center, Indiana Legal Services, Inc.
Post-Grad Fellow, 2015-2016

Migrant Farmworker Law Center, Indiana Legal Services, Inc.
Post-Grad Fellow, 2015-2016

Indiana Department of Child Services
Intern, 2014-2015

2015   JD, Indiana University School of Law, Bloomington
2011   BA, University of California, Davis

Job Description

Mr. Sorensen has worked with both urban and rural communities across California, Oklahoma, and Missouri. His experience includes providing technical assistance around governance structures, coordinated entry solutions, state and federal grants, research and analyses, and strategic planning. In addition, he has engaged in significant work with a county behavioral health department, where he has developed knowledge on substance use disorder treatment and other services for individuals experiencing homelessness.

Professional Experience

HomeBase, Policy Analyst, 2018-present

Expertise and Projects

- *Strategic Planning and Implementation:* Assisted in facilitating long-term strategic planning process for Tulsa County (OK) and Tuolumne County.

- *Qualitative Data Gathering, Management:* Created and administered community and provider-specific surveys in Tuolumne County (CA) and Tulsa County (OK). Conducted focus groups with various stakeholders in Tuolumne County and focus groups with homeless consumers in Tulsa County. Conducted phone interviews with high-level stakeholders in Tulsa County, including the deputy mayor.

- *Data Analysis, Reporting, and Visualization*: Compiled and analyzed information to identify available resources/systems in each respective county, with a specific focus on mapping resources/systems that are not currently a part of the homeless response system.

- *Needs Assessments/Gaps Analyses:* Evaluated the data collection practices and gaps of various homeless providers in the Missouri Balance of State CoC and recommended strategies to improve systems. Drafted a gaps analysis/needs assessment of Tulsa's homeless system of care based on focus groups, interviews, and analyses of various quantitative data (e.g. PIT Count, HIC, SPMs, APR)

- *Facilitation, Trainings and Presentations:* Co-facilitated Stanislaus County's 2018 CoC Competition, which included creation of scoring materials and overseeing the Review and Rank process. Facilitated a feedback session with providers focused on organizational improvement within Contra Costa*'s* Behavioral Health Department. Presented at Homebase's March 2019 Northern California Roundtable.

- *Continuum of Care (CoC) Planning, Structure and Operations:* Facilitated CoC operations in Contra Costa County, including HEARTH compliance, grant application and administration, trainings, and agency-level technical assistance.

- *Coordinated Entry (CES) Assessment Redesign, and Development:* Supported Contra Costa CoC's Coordinated Entry Oversight Committee. Facilitated conversations around system performance improvement and integrating affordable housing units into Contra Costa's coordinated entry system.

- *Expanding Affordable Housing Opportunities*: Conducted research on innovative housing models and urban planning practices to aid in the development of affordable housing. Participated in state-level meetings and monitoring of state affordable housing policy priorities and legislative developments.

- *Monitoring and Evaluation*: Designed program evaluation framework, including various performance and outcome metrics, for a Proposition 47 grant.

Prior Experience

University of Pennsylvania Fels Institute of Government
Graduate Public Speaking Teaching Assistant, 2018

Camden City School District
Special Projects Manager, 2017-2018

School District of Philadelphia
Graduate Research Assistant, 2017-2018

Oregon Department of Education
Graduate Policy Fellow, 2017

Firstline Schools
5th/7th Science Teacher, 2015-2016

KIPP: New Orleans Schools (via Teach for America)
5th Science/Social Studies Teacher, 2013-2015

Education

2018   MPA, University of Pennsylvania Fels Institute of Government
2018   MSEd, University of Pennsylvania Graduate School of Education
2013   BA, University of Colorado-Boulder

EDUCATION

Ph.D. Public Policy, The New School for Management and Urban Policy, 2013.
MHS, Master of Health Science in Maternal and Child Health, Johns Hopkins University, School of Public Health and Hygiene, 1985.
B.S. Human Development and Family Relations, University of Connecticut, Storrs, 1979.

EMPLOYMENT HISTORY

3/19 – Present: Senior Principal, LeSar Development Consultants
Dr. Taylor, a Senior Principal at LeSar Development Corporation, has been conducting program evaluations and providing technical assistance on evaluation design and data utilization to improve policy and program planning for over 25 years. Working for federal, state and local agencies, Dr. Taylor provides subject matter expertise on the structural determinants of homelessness, and its intersection with health and criminal justice systems. Dr. Taylor is currently leading a multi-site data integration project, combining data analytics, rapid-cycle evaluation, and a sustainable integrated data infrastructure to connect health, and housing data, supporting cross-sector goals for health and housing stability. Dr. Taylor is also currently leading a Shared Housing initiative being implemented in three sites, developing a Shared Housing Toolkit and Training Curriculum to advance capacities to implement this housing approach for all populations experiencing homelessness.

3/09 – 3/19: SME Director, Cloudburst Consulting Group, Inc., Landover, MD.
Dr. Taylor lead a HUD-funded, six-site data analytics project, combining research analytics with HMIS data to assess local effects of the homeless service systems, developing data maturity across each system and deploying advanced statistical analysis to assess the effects of RRH and other housing programs on decreasing risk of homelessness. For the Office of Women's Health, Dr. Taylor lead the development of the HIV Prevention Gender Toolkit, Facilitator manual, and Participant manual that are being published April 2016 across multiple HIV prevention sectors. Working with Alaska's state health department, Dr. Taylor established data reporting frameworks for the evaluation of their Garrett Lee Smith suicide prevention training project, to promote expanded understanding and funding for suicide prevention training programs across Alaska. With SAMHSA's Now is the Time - NITT Project AWARE, Dr. Taylor is leading Project Evaluation TA and Training for twenty Project AWARE sites with webinars, virtual TA, site visits and partner TA planning calls with SAMHSA and RTI.   Presenting at SAMHSA Implementation Academies on Veteran Suicide Prevention in Veterans, and Substance Abuse Prevention, Dr. Taylor is an SME data expert providing TA for the Service Member Veterans and their Families TA Center, currently developing a Veterans Briefing Book for the state of Ohio. Dr. Taylor is also leading multiple learning communities with states involved with SAMHSA's SOAR Center, guiding their use of state-level SOAR data reports and SOAR priorities for the ending of homelessness for disabled populations. Dr. Taylor is also developing a Public Health Approach to Disaster Resilience for states and counties, focused on disaster resilience at the neighborhood level in vulnerable communities. Past projects include the completion of a Behavior Health Quality Measurement project with training for

behavioral health service coordination efforts focused on the integration of military and civilian systems of care.

2002 – 2013: Facilitator, National Policy Academies. Ms. Taylor provided expert facilitation services for national Policy Academies, including SAMHSA's Bringing Recovery Supports to Scale, Returning Warriors, Co-occurring Disorders; Sustainability Plan for Chronic Homelessness Initiative; HUD and DHHS Policy Academies on Improving Access to Mainstream Services for People Experiencing Homelessness, Child and Family Homelessness; and the SAMHSA, DOD, VA National Behavioral Health Workforce Development Conference.

9/09 - 2011: Adjunct Professor Central Connecticut State University.
Ms. Taylor taught Homelessness - Housing Policy courses in the Sociology Department
Co-PI – Development of Comparative Case Study Evaluation of Ten Year Plans to End Homelessness and their Impact on ending homelessness; establishing theoretical framework to measure innovation dissemination and local translation mechanisms, creating analysis framework for determining the structural determinants of homelessness.

10/07 – 3/09: Consultant, Ms. Taylor was responsible for strategic planning, committee partnership, development, design and implementation of City of New Britain's Work Plan to End Homelessness, targeting the development of multiple supportive housing projects.

2002 – 2009: Consultant, Connecticut Communities. Ms. Taylor led the planning and development of the Continuum of Care (CoC) HUD Exhibit One applications with six Connecticut communities; Strategic Planning with Connecticut Planning and Evaluation Council; provided training and facilitation to CoC committees around HMIS, Goal Setting, Workforce Development, and Housing First topics.

2007 – 2008: Development Consultant, Pathways to Housing, New York, NY. Ms. Taylor provided development and planning support for the national supportive housing program helping to implement activities to bring to scale housing first replication efforts.

2001 – 2008: Consultant, Clemow Consulting Group. Ms. Taylor provided strategic planning facilitation and development trainings for communities and organizations.

3/00 – 10/01: Planner: Chrysalis Center, Inc., Hartford, CT.   Ms. Taylor was responsible for planning and development of funding sources for comprehensive, community-based mental health service agency. She developed federal and foundation strategies for agency-wide services, focus on permanent supportive housing/employment programs. Over $2 million funding secured.

3/99 – 3/00: Planning Analyst, Community Renewal Team, Inc. (CRT), Hartford, CT. Ms. Taylor was responsible for program planning and grants for multiservice anti-poverty agency. She developed successful grants for CRT's Head Start program, Literacy Projects, Youth substance abuse prevention project, and employment training programs.

1996 – 1997: Research Analyst, for Medicaid managed care and community wellness, health education models for California-based consulting group.

10/88 – 7/95: Program Founder and Director, Seacoast HealthNet, Exeter, NH. Ms. Taylor directed the planning, implementation and funding of innovative community health care program, networking 200

physicians to provide free health care homes to medically indigent populations, and leveraged community-based family support services and dental care to coordinate with medical services under Seacoast HealthNet, serving over 1000 clients/year.

PUBLICATIONS

Taylor, J., Steed, R., (June 2018) Shared Housing / Alternative Housing: Projects and Promising Practices, white paper submission to Substance Abuse and Mental Health Services Administration.

Brennan, M., Cunningham, M., Gastner, J., & Taylor, J. (2017). Ending Family Homelessness: An Opportunity for Pay-for-Success. Urban Institute.

Kieffer, C., Stillman, L., Taylor, J., Gibson, B., Hurd, K. (2016). A Qualitative Assessment of Parental Preschool Choices and Challenges Among Families Experiencing Homelessness: Policy and Practice Implications. HUD Office of Policy Development and Research.

Taylor, J. (2016). Data Essentials. A self-paced, interactive online curriculum of eight modules to understand the development of a culture of evidence, and applied data collection, data utilization and data visualization strategies. SAMHSA's Grantees Data Technical Assistance Center (GDTA)*. Website only accessible to grantee*

Taylor, J., Gibson, B., & Hurd, K. (2015). Parental preschool choices and challenges when young children and their families experience homelessness. Children &Youth Services Review, 56, 68-75.

Taylor, J. (2014). "Housing Assistance for Households Experiencing Homelessness." Doctoral dissertation, The New School, New York.

PRESENTATIONS

October 2018. "Cross Sector Data Integration – Lessons Learned". *National Human Services Data Consortium,* Portland, OR.

October 2018. "Data to Action Data Maturity Training." *National Human Services Data Consortium,* Portland, OR.

July 2018. "Shared Housing Options for People Experiencing Homelessness". National Alliance to End Homelessness National Conference, Washington DC.

November 2017. "Data Integration for Improved Health and Housing System: System Mapping and Theory of Change", Indianapolis, IN.

July 2016. "Rapid Re-Housing Outcomes Review". National Alliance to End Homelessness National Conference, Washington DC.

May 2016. "Reckoning with Homelessness: Rapid Rehousing". Reckoning with Homelessness in New York City Conference, New York City.

October 2016. Using Data and Research Findings to Influence Decisions", National Human Service Data Consortium, Pittsburgh, PA

January 2016. "Social Returns on Investment in Housing Assistance", Utah Social Innovation Summit, Salt Lake City, UT.

Professional Experience

PRINCIPAL
LeSar Development Consultants | 2015 – Present
Responsible for the development and implementation of housing and homelessness policy, planning, and program initiatives. Recent work includes serving as the policy advisor for the City of San Diego's Select Committee on Homelessness, providing HUD technical assistance on Coordinated Entry to the Nashville CoC, and advising a large national health plan on homelessness and housing strategies.

ADJUNCT FACULTY
San Diego Community College District, San Diego City College, Sociology Department | 2013 – 2017
Taught two sociology courses titled, "Principles of Sociology," and "Contemporary Social Problems."

PROGRAM AND RESEARCH ANALYST
Father Joe's Villages, San Diego, CA | 2007 – 2015
Responsible for supporting evaluation activities on the various housing and services programs at Father Joe's Villages. Participated in several local committees on various topics related to homelessness including the Continuum of Care (CoC) Data Advisory Committee, CoC Systems Modeling Committee, and the Community Information Exchange Advisory Committee. In partnership with CSH, developed, coordinated, and provided trainings for San Diego's SOAR initiative. Created a partnership with the graduate program in sociology at Cal State San Marcos to provide a research and evaluation internship paired with a graduate course on poverty and homelessness.

> **Project 25 Program Analyst 2011-2013**
> Responsible for research design, data collection, reporting, and analysis of Project 25, a United Way funded high utilizer program that provided Permanent Supportive Housing to 36 of San Diego's most expensive chronically homeless individuals.
>
> **Social Services/Clinical Teams Manager 2008-2011**
> Responsible for administrative management of the social service and clinical programs at Father Joe's Villages. Programs included case management, mental health and substance use disorder treatment, intake/assessment, as well as a SAMHSA funded Assertive Community Treatment (ACT) model. Services were targeted to individuals and families in transitional and permanent supportive housing.
>
> **Assessment Specialist/Supervisor 2007-2008**

Supervised and performed biopsychosocial assessments on individuals and families entering shelter.

EDUCATION

California State University, San Marcos
Master of Arts, Sociological Practice, 2006
Conducted Master's level thesis at Monarch School, a school for children and adolescents experiencing homelessness

California State University Chico
Bachelor of Arts, Sociology 2003

Sample of System Map Prepared by HomeBase

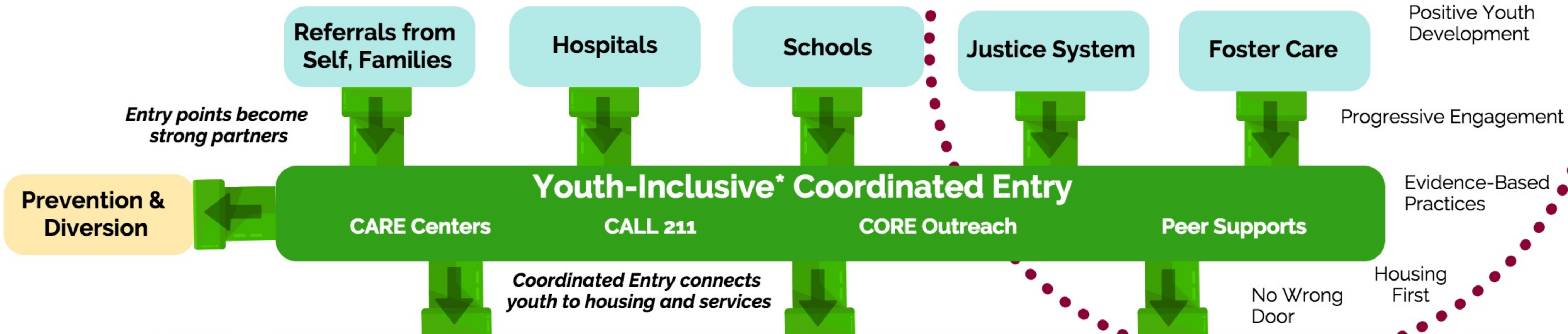Contra Costa County Map of Homeless Youth System of Care (2018)

CONTRA COSTA YOUTH SYSTEM MAP

Prevent and end youth homelessness in Contra Costa County using a nimble, data-driven, trauma-informed approach that includes youth voice, supports new partnerships, and infuses equity and positive youth development throughout all services.
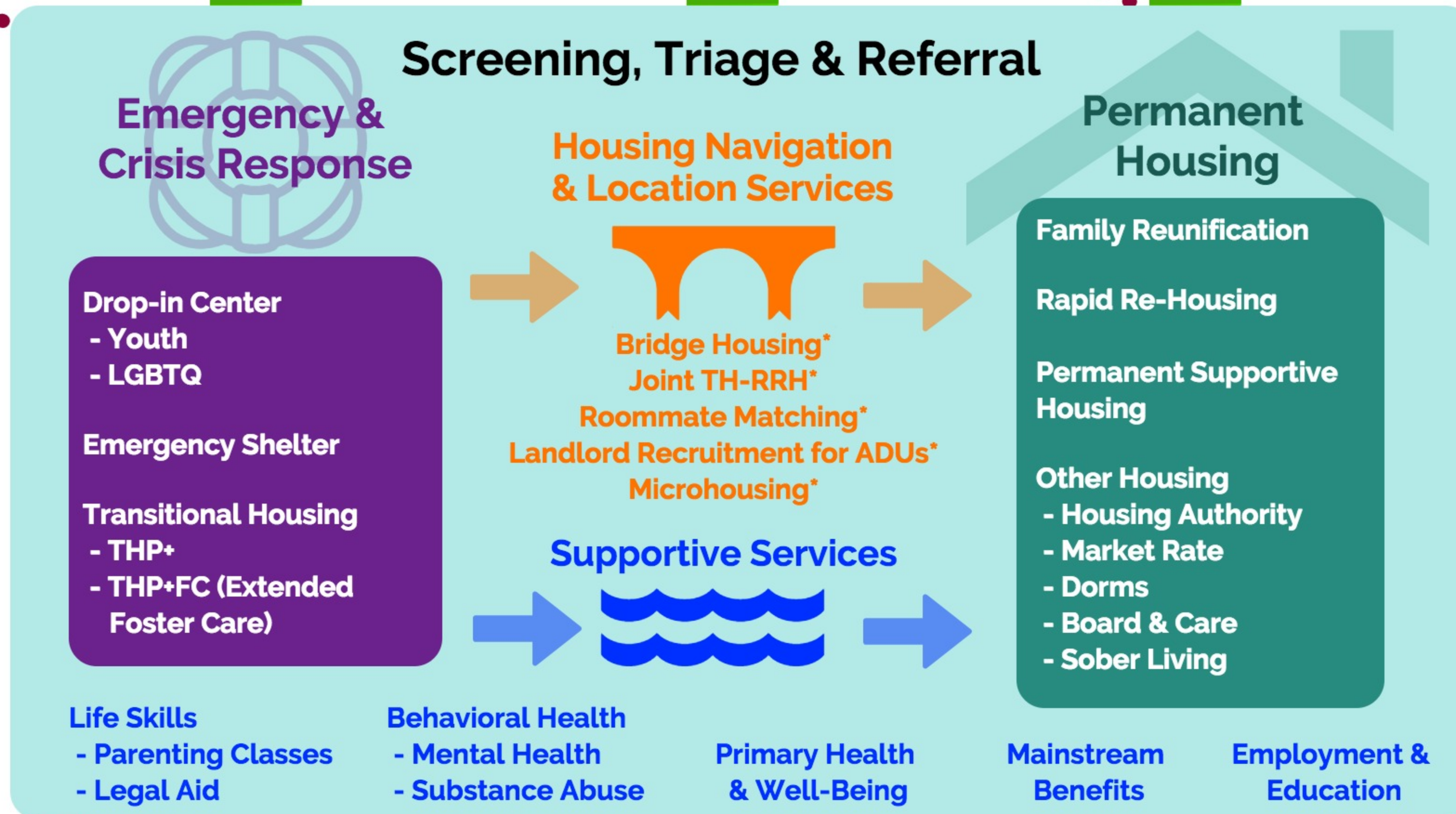
Philosophy and Values

Youth Driven

Data Driven

Continuous Quality Improvement

Youth Choice

Trauma-Informed Care

Equity

Positive Youth Development

Progressive Engagement

Evidence-Based Practices

Housing First

No Wrong Door

Referrals from Self, Families

Hospitals

Schools

Justice System

Foster Care

Entry points become strong partners

Prevention & Diversion

Youth-Inclusive* Coordinated Entry

CARE Centers   CALL 211   CORE Outreach   Peer Supports

Coordinated Entry connects youth to housing and services

Screening, Triage & Referral

Foundational Supports

YHDP Team

Youth Action Council

Coordinated Entry Committees

Funding

County and City Jurisdictions

Contra Costa Council on Homelessness

CONTRA COSTA HEALTH SERVICES

Emergency & Crisis Response

Drop-in Center
- Youth
- LGBTQ

Emergency Shelter

Transitional Housing
- THP+
- THP+FC (Extended Foster Care)

Housing Navigation & Location Services

Bridge Housing*
Joint TH-RRH*
Roommate Matching*
Landlord Recruitment for ADUs*
Microhousing*

Supportive Services

Permanent Housing

Family Reunification

Rapid Re-Housing

Permanent Supportive Housing

Other Housing
- Housing Authority
- Market Rate
- Dorms
- Board & Care
- Sober Living

Outcomes

Stable Housing

Feel Safe

Academic Connections

Health Needs Met

Employed at a Living Wage

Positively Connected to Adult in Community

Life Skills
- Parenting Classes
- Legal Aid

Behavioral Health
- Mental Health
- Substance Abuse

Primary Health & Well-Being

Mainstream Benefits

Employment & Education

*Future Interventions

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Sample of Gaps Analysis Prepared by HomeBase

Missouri Balance of State Gaps Analysis Report (March 2018) and Expansion
Appendices (July 2018)
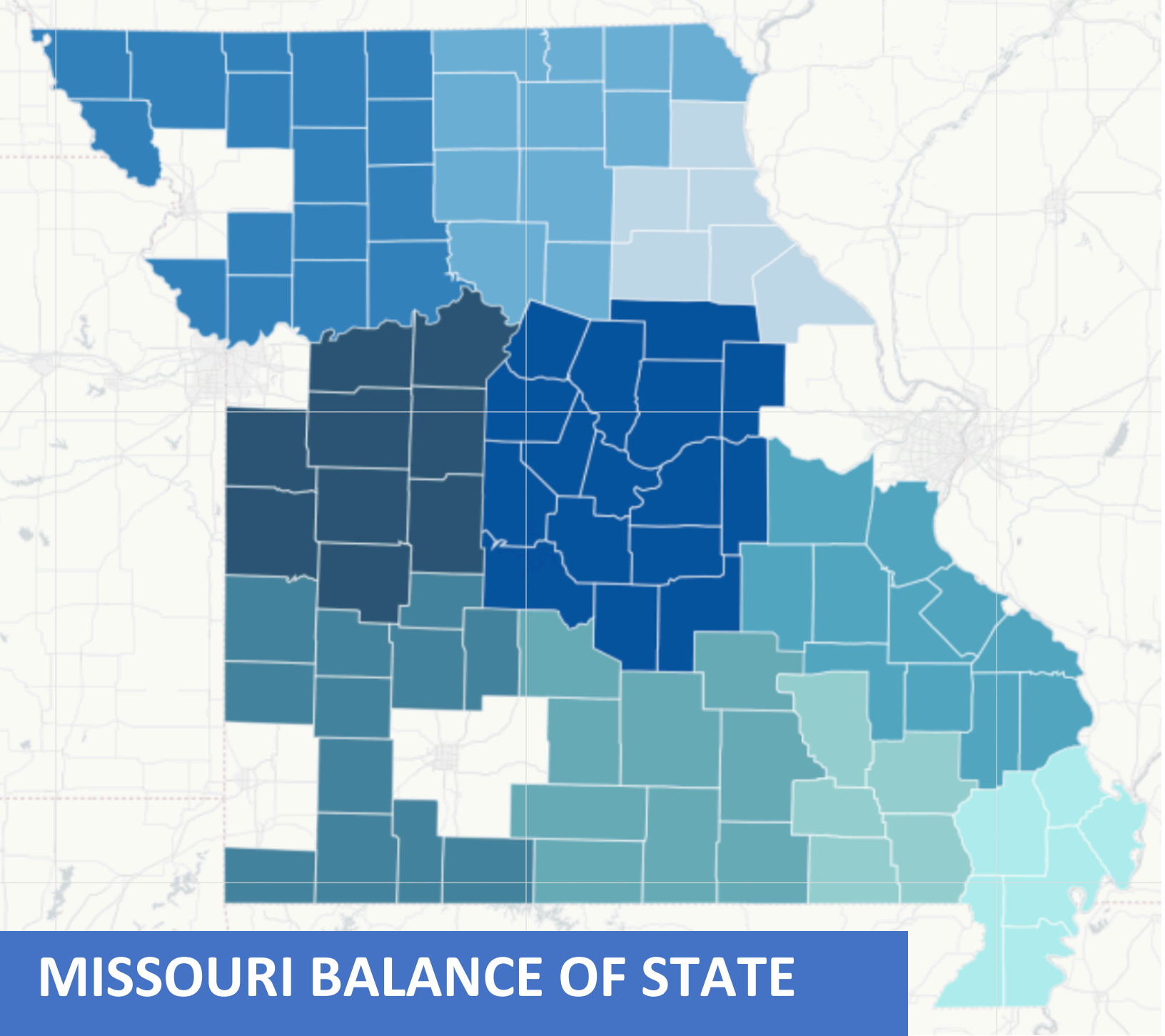
MISSOURI BALANCE OF STATE

Gaps Analysis Report

March 2018

HomeBase
Advancing Solutions to Homelessness

870 Market Street, Suite 1228
San Francisco, CA 94102
homebaseccc.org
(415) 788-7961

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INTRODUCTION

Pursuant to 24 CFR 578.7(c)(3), one of the primary duties of a Continuums of Care is to conduct an annual gaps analysis of the needs and services available within its geographic area related to homelessness. HomeBase, a national technical assistance provider on homelessness, prepared this Assessment of the Missouri Balance of State Continuum of Care (CoC) under contract with Missouri Housing Development Commission, the Collaborative Applicant of the Missouri Balance of State CoC.

This analysis strives to evaluate the current system, identify existing gaps, and make recommendations designed to improve the overall system of care to better address the needs of the homeless population in the Missouri Balance of State CoC region. This report is structured into three key areas:

Availability: The first chapter of this report identifies gaps and makes recommendations to improve the availability of homeless-dedicated housing stock and best meet the needs of people experiencing homelessness within the CoC. The chapter focuses on: (1) housing need and the availability of the housing stock geographically; (2) housing availability for special subpopulations; and (3) service availability throughout the CoC.

Accessibility: The second chapter of this report identifies gaps and makes recommendations to improve the system components and systemic qualities that tend to encourage or inhibit the ability of homeless persons to access housing or services appropriate to their needs. This chapter reviews: (1) the performance of the Coordinated Entry system; (2) the programmatic entry barriers and program rules within the system of care; and (3) system performance that reflects access, or lack thereof, to quality programming.

Coordination: The third and final chapter of this report identifies gaps and makes recommendations to improve the overall function and guidance of the system. This includes analysis about: (1) the functioning of the CoC structure and governance, and participation by key stakeholders; (2) funding attainment and maximization; and (3) data reliability and utilization to support the CoC in measuring performance and supporting continuous improvement.

This Assessment is structured into chapters and sections. Each section is structured as a "mini-report," providing analysis and recommendations regarding its subject matter to facilitate the development of community action plans around the issues raised by HomeBase's analysis.

Methodology

This report summarizes the results of an extensive evaluation process that included analysis of relevant data, solicitation of community and stakeholder feedback, and research into applicable requirements and best practices.[1] The evaluation utilized information from the following sources:

HOUSING INVENTORY COUNT (HIC), POINT-IN-TIME (PIT) COUNT, AND HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS) DATA

HomeBase analyzed the most recently available community-wide data from the annual housing inventory count and point-in-time counts (2017) as well as historic housing inventory count and point-in-time data to help establish the size of the population of people experiencing homeless and available housing resources within the CoC both currently and over time. The demographic information within this data also helped establish a better understanding of need and services for special populations, such as families, youth, people experiencing chronic homelessness, veterans, and domestic violence survivors. In addition, HomeBase worked with Institute for Community Alliances (ICA) to analyze HMIS data on clients served at the county level and preliminary coordinated entry data collected during the time period from January 1, 2017 – December 31, 2017.

Survey and Interview Respondents by Region	
Region	**Number of Respondents**
1	5
2	3
3	4
4	6
5	6
6	2
7	2
8	3
9	6
10	4
State-wide	6

KEY STAKEHOLDER INTERVIEWS, MEETINGS & SURVEYS

HomeBase conducted phone interviews with nine key stakeholders in the Missouri Balance of State CoC, including CoC board members, and attended a CoC meeting to solicit general feedback. These interviews provided information on the strengths and challenges within the Balance of State CoC, what additional services are needed, where need is the greatest, and what populations require additional focus.

Survey and Interview Respondents by Service Area	
Rural	21
Urban	6
Suburban	7

HomeBase distributed an electronic survey to CoC providers and partners, including CoC board members who were unable to participate in phone interviews. Thirty-two CoC members/partners participated in the survey, providing feedback on the strengths and challenges within the CoC, what they would like to improve upon, and where to focus additional services. Multiple stakeholders noted that, due to the timing of this outreach overlapping with the final preparations and completion of the

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[1] HomeBase had planned to include interviews with consumers who utilized services within the Missouri Balance of State CoC but was unable to successfully connect with any consumers during the time period allotted to complete the report.

point-in-time count, they could not participate to the degree they would have at other times in the year. See Appendix B for a compilation of survey and interview responses from stakeholders and Appendix D for a copy of the survey questions used.

RELEVANT FEDERAL REQUIREMENTS AND COMMUNITY EXAMPLES/BEST PRACTICES

In addition to conducting a quantitative and qualitative data analysis, HomeBase researched and incorporated relevant federal requirements and guidance into this report. The report also includes community examples and best practices to provide the CoC with additional resources to help address gaps in its homeless system.

AVAILABILITY 44

The first chapter of this Assessment focuses on the availability of homeless-dedicated housing within the CoC and whether that housing stock adequately and appropriately meets the needs of those experiencing homelessness in the Missouri Balance of State CoC. The following three subject topics are addressed in this chapter:

- *Housing Stock Availability* analyzes trends in the need for housing in conjunction with the availability of homeless-dedicated housing, including where housing exists geographically, how and how well current needs are being met, and potential gaps.

- *Special Populations* looks at the demographic data on need amongst particular vulnerable populations, focusing in on family homelessness, unaccompanied youth, domestic violence survivors, veterans, and chronic homelessness. This analysis looks at what homeless-dedicated housing is currently available to meet these populations' needs and geographical distribution.

- *Comprehensive Services* discusses the importance of making comprehensive services available to clients to address their needs across urban, suburban, and rural areas of the CoC. This analysis reviews the gaps in services, particularly transportation, and how coordinated entry can help improve communication and knowledge around service availability.

Housing Stock Availability

In order to effectively address homelessness in a CoC, it is critical to understand existing housing stock and maintain an appropriate balance of housing of different component types in response to CoC need. Communities around the country struggle to provide an adequate quantity and diversity of housing options for those experiencing homelessness. This is even more challenging in Balance of State CoCs, due to their greater geographic diversity and larger size.

Homeless-dedicated housing interventions are organized into four main component types:

- *Emergency Shelter:* Emergency shelters play an important role in offering a safe and secure place for people to access the emergency services and temporary shelter needed to help stabilize individuals and families while they seek permanent housing.[2] Shelters should be low-barrier, operating with few to no eligibility requirements apart from homelessness.
- *Transitional Housing:* Transitional housing is a time-limited housing intervention that offers intensive support services, often in a facility-based environment. Over time, HUD has encouraged communities to evaluate and reassess the effectiveness of transitional housing programs, but has also recognized that transitional housing may prove effective for certain subpopulations or circumstances.[3] In the 2017 CoC funding competition, HUD introduced a new joint transitional housing-rapid rehousing project type designed to provide greater flexibility to communities with either high unsheltered populations or few safe crisis housing options for youth or persons fleeing domestic violence. The joint project is meant to provide rapid connections to temporary housing with the support needed to quickly transition to permanent housing.[4]
- *Rapid Rehousing:* Rapid rehousing quickly connects individuals and families to permanent housing through a combination of short-term rental or housing-focused financial assistance and supportive services. The rapid rehousing model is informed by a Housing First approach, emphasizing rapid connections to stable housing, followed by the supportive services needed to maintain housing and offer greater economic opportunity.[5]
- *Permanent Supportive Housing:* Permanent supportive housing provides a permanent connection to housing, targeting persons with the most intensive-service needs, including

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[2] National Alliance to End Homelessness (NAEH). Webinar. The Emergency Shelter Learning Series: The Critical Role of Emergency Shelter in a Crisis Response System (April 2017), slides 25-27.

[3] U.S. Department of Housing and Urban Development (HUD), Recovery Housing Policy Brief (December 2015), https://www.hudexchange.info/resource/4852/reovery-housing-policy-brief/.

[4] HUD "SNAPS In Focus: The New Joint Transitional Housing and Rapid Rehousing Component" (July 13,2017), https://www.hudexchange.info/news/snaps-in-focus-the-new-joint-transitional-housing-and-rapid-rehousing-component/.

[5] HUD, "Rapid Rehousing Brief," https://www.hudexchange.info/resources/documents/Rapid-Rehousing-Brief.pdf.

those experiencing chronic homelessness and persons with disabilities. As with rapid rehousing, permanent supportive housing best practices incorporate a Housing First approach, emphasizing few-to-no barriers for entry.

Homeless Population and Bed Availability Across the Missouri Balance of State CoC

A CoC's ability to effectively meet the housing need of people experiencing homelessness depends on a number of factors related to housing availability: (1) number of housing beds and units in the CoC, (2) distribution of housing beds and units by component type, (3) geographic accessibility and coverage of housing resources, and (4) availability of housing for special populations of people experiencing homelessness.

Data analysis and feedback from stakeholder interviews and surveys indicate that the following gaps in housing and service availability exist within the Missouri Balance of State CoC:
1. There is a need for an increase in rapid re-housing and affordable housing to meet the long-term housing needs of people in the CoC experiencing homelessness;
2. There is an imbalance in the allocation of housing units by component type and the geographic distribution of housing that limit housing availability;
3. Housing need and housing supply are not aligned for subpopulations of people experiencing homelessness, such as youth and survivors of domestic violence; and,
4. The CoC should maximize utilization of its current housing stock, which may potentially include diverting some emergency shelter beds dedicated to domestic violence survivors to serve other homeless subpopulations.

An analysis of how the population experiencing homelessness and homeless-dedicated housing stock within the CoC have changed over time highlights both the strengths and gaps in the Missouri Balance of State CoC's current housing supply.

TRENDS IN THE POPULATION EXPERIENCING HOMELESSNESS

As of the January 2017 Point-In-Time (PIT) Count, 1,243 individuals experience homelessness on a given night in the Missouri Balance of State CoC. Approximately 77 percent of these individuals were sheltered (living in emergency shelters or transitional housing) and 23 percent of these individuals were unsheltered (living on the street or another place not meant for human habitation). This is the lowest point-in-time count recorded between 2013 and 2017 and represents a 36 percent decrease in the overall population of people experiencing homelessness since 2013.

Between 2013 and 2017, the number of unsheltered persons experiencing homelessness fluctuated between approximately 20 and 28 percent of the overall homeless population, peaking in 2013 (28

percent) before hitting a five-year low in 2014 (20 percent). As of 2017, unsheltered persons made up approximately 23 percent of the homeless population.

2013- 2017 Sheltered and Unsheltered Homeless PIT Count
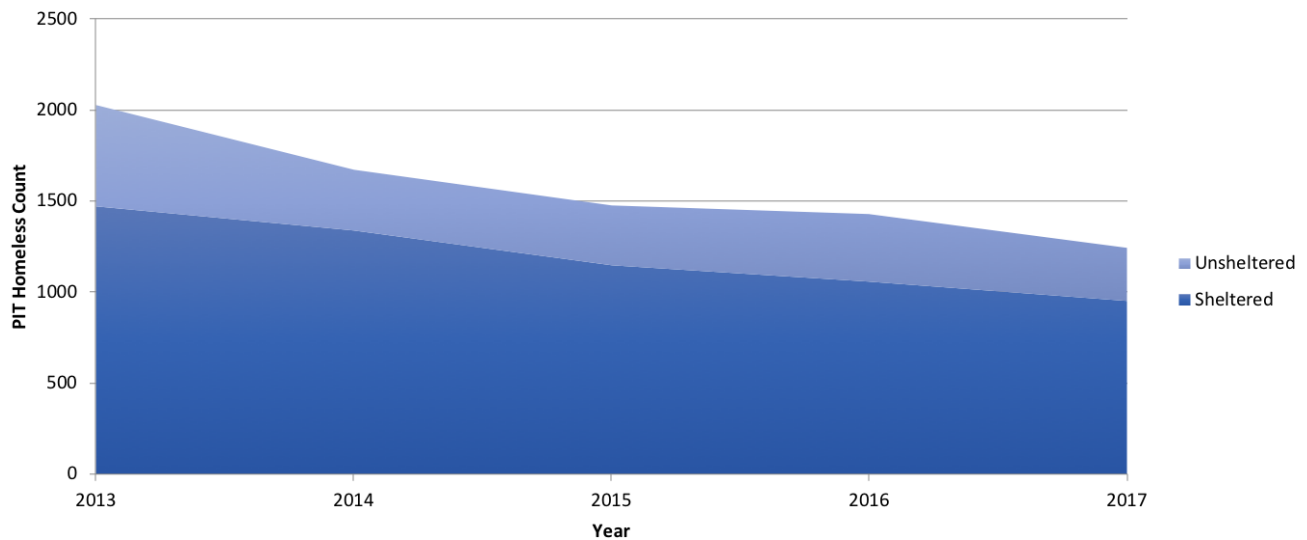
CHANGES IN HOUSING STOCK OVER TIME

While the number of people experiencing homelessness in the Missouri Balance of State CoC declined from 2013 to 2017, the total number of year-round homeless-dedicated beds declined as well. Between 2013 and 2017, the overall number of year-round beds within the CoC decreased by 9.6 percent. The total number of homeless-dedicated beds peaked in 2014 at 3,976 beds and ebbed to its lowest point in January 2017 at 3,275 beds.

Permanent supportive housing and rapid rehousing component types have seen the largest total increases over this period of time. Permanent supportive housing stock increased from 1,317 to 1,508 beds between 2013 and 2017, an increase of nearly 15 percent. The number of rapid rehousing beds within the CoC also significantly increased during this time from 2 to 230 beds. However, the CoC did experience a decrease in rapid re-housing beds of 32 percent from 2016 to 2017, experiencing a drop from 337 to 230 available rapid-rehousing beds.[6]

Meanwhile, emergency shelter beds decreased by 22 percent from 1,561 beds in 2013 to 1,206 beds in 2017, the largest decrease of any component type as measured by overall number of beds lost. Additionally, 55 percent of transitional housing beds were lost during this period. These trends in

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[6] The reduction in rapid rehousing beds was due to reductions in several programs: Supportive Services for Veteran Families, MHDC MHTF Rental Assistance, and MHDC Housing First. A slight increase in ESG-funded rapid rehousing occurred in the same timeframe.

permanent supportive housing, rapid rehousing, and transitional housing mirror national trends that have been driven by federal policy and research regarding best practices over the past five years.

Missouri Balance of State Total Year-Round Homeless Beds
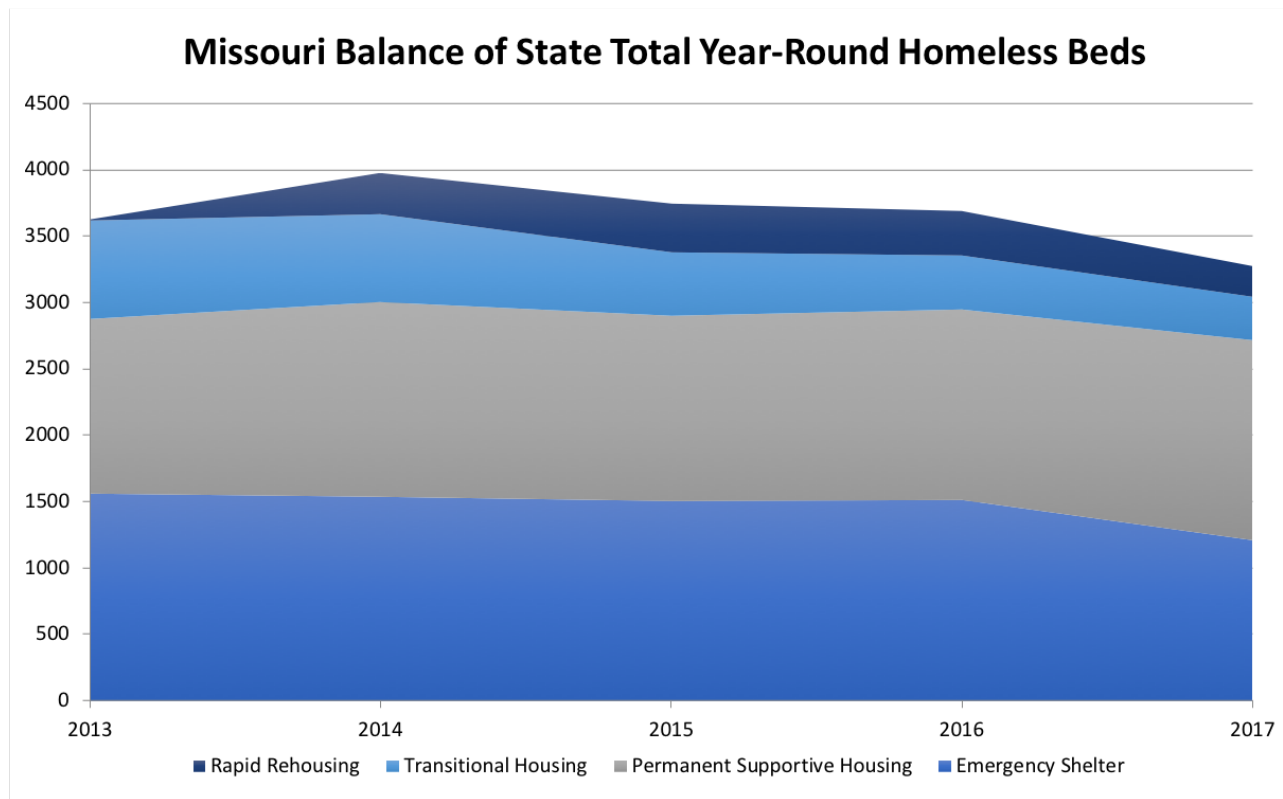
While the point-in-time count and year-round total homeless-dedicated bed counts declined, feedback from stakeholder interviews and a survey of CoC members and partners reflect continued need for increased housing stock and a diversity of housing type options. When asked to identify the CoC's biggest current need, survey respondents and stakeholder interviews most commonly remarked on the need for increases in:

- Rapid rehousing and other long-term vouchers (27 percent);
- Affordable housing (20 percent); and,
- Emergency shelter beds (17 percent).

Multiple stakeholders identified rapid re-housing as an important need within the CoC due to its flexibility. Regarding affordable housing, one respondent expressed a desire to get more stakeholders involved in the Missouri Balance of State CoC homeless response system to increase affordable housing availability. In reference to emergency shelter, one stakeholder commented that more emergency shelter beds – in particular, those targeted to single adults and families with children – represents one of the biggest needs in their region. The stakeholder noted that additional emergency shelter beds would allow them to serve households for a sufficient time period to access housing, whereas now they can only provide hotel/motel vouchers for a night or two due to cost. Stakeholder

responses demonstrate the continued need for additional housing stock within the CoC, but also highlight that different housing component types and interventions may be needed across the CoC depending on current distribution and geographic allocation of housing types.
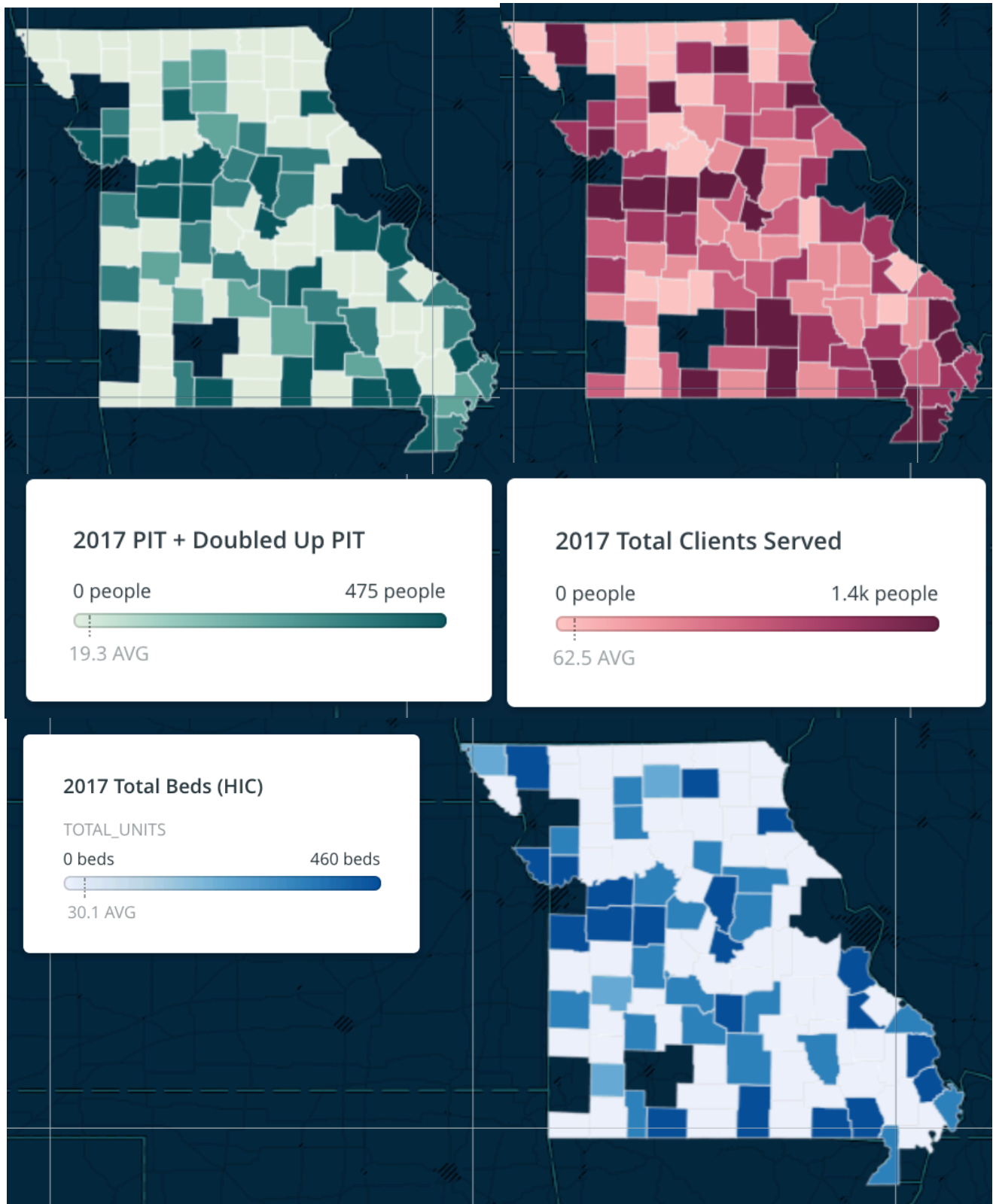
The Missouri Balance of State CoC achieved a decrease in its overall homeless population between 2013 and 2017. While the decrease in overall homeless population is promising, this information does not provide a complete picture of need within the community. Geographic disparities in housing availability exist within the CoC, as do housing availability gaps for some subpopulations of people experiencing homelessness.

Geographic Accessibility in the Missouri Balance of State

The Missouri Balance of State CoC covers 101 predominantly-rural counties spanning the entire state of Missouri. The large and geographically-diverse areas covered by rural Balance of State CoCs can make it challenging to identify people experiencing homelessness and connect them to the housing and services they need. Some of the prevalent challenges to providing homeless services and housing in rural areas identified by the U.S. Department of Housing and Urban Development (HUD) include:

- **Transportation:** Large distances must be traversed to reach services and there are usually limited or no public transportation options available.
- **Isolation:** Rural areas can be isolating due to their expansiveness and/or sparse populations. People who are homeless often feel cut off, geographically and, for recently arrived immigrant populations, linguistically and culturally, from the services that are available in the area.
- **Shortage of Services:** Few homeless-specific providers operate in most rural areas and mainstream services can be difficult to access, spread thin over large areas, and are not often structured to accommodate the homeless population.[7]

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[7] U.S. Department of Housing and Urban Development (HUD) Office of Community Planning and Development, "Rural Continuums of Care," June 2009, https://www.hudexchange.info/resources/documents/RuralCoCGuidebook.pdf

2017 PIT + Doubled Up PIT

0 people	475 people

19.3 AVG

2017 Total Clients Served

0 people	1.4k people

62.5 AVG

2017 Total Beds (HIC)

TOTAL_UNITS

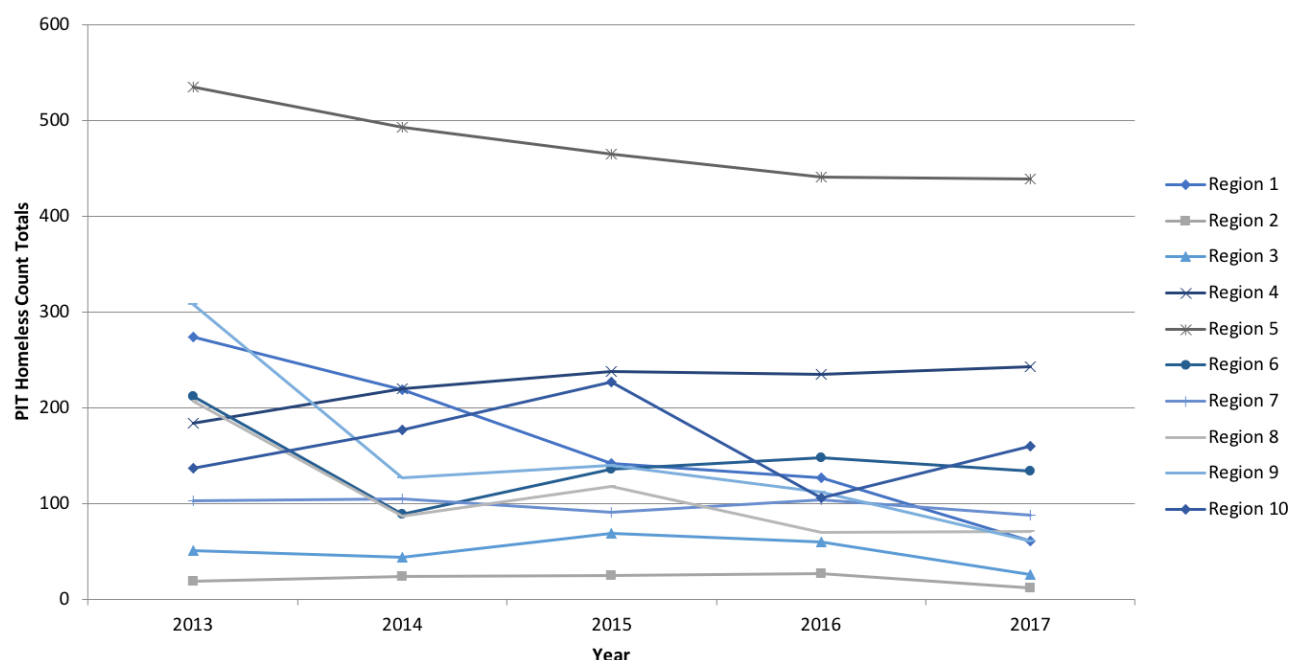|	
0 beds	460 beds

30.1 AVG

The Balance of State CoC is divided into 10 regions, which is intended to help the CoC address the challenges of working across a large geographic area and allow for better coordination within the homeless service delivery system.[8] Across the ten regions of the Balance of State CoC, all but two regions (Region 4 and Region 10) experienced a decline in overall homelessness from 2013 and 2017 of between 18 and 80 percent. Region 4 experienced an overall increase of 32 percent during this period, while Region 10 experienced a smaller increase of 17 percent.

Change in PIT Homeless Count Totals by Region (2013-2017)			
Region	2013 PIT Count	2017 PIT Count	Percent Change
Region 1	274	61	-78%
Region 2	19	12	-37%
Region 3	51	26	-49%
Region 4	184	243	32%
Region 5	535	439	-18%
Region 6	212	134	-37%
Region 7	103	88	-15%
Region 8	207	71	-66%
Region 9	308	61	-80%
Region 10	137	160	17%
Total	**2030**	**1295**	**-36%**

Although almost all Regions experienced an overall decrease in homelessness between 2013 and 2017, a majority of the ten Regions in the CoC experienced fluctuation in their point-in-time counts over this period of time. Regions 1 and 5 were the only Regions to experience a consistent decline in population over this five-year span.

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[8] Liz Gebhart and Lindsay Wallace, "Missouri Balance of State Thoroughness of Reach," February 2014, https://static1.squarespace.com/static/54ca7491e4b000c4d5583d9c/t/55a92ccde4b02b78a7032113/1437150413080/MO+BoSThoroughnessofReach.pdf

2013-2017 Balance of State PIT Homeless Count Totals by Region

The ten Regions within the CoC attempt to work across boundaries and with each other to ensure that this regional structure does not present a barrier to housing availability. In an interview, one stakeholder expressed that "For being such a big area, we do a really good job of staying in communication and trying to know what the other areas are doing."

	PIT	Doubled Up PIT	PIT + Doubled Up PIT Total	Total Clients Served in 2017	ES Beds	TH Beds	RRH Beds	PSH Beds	Total Beds
2017 Comparison by Region: PIT Count, Clients Served, and Number of Beds									
Region 1	61	83	144	624	133	0	12	193	338
Region 2	12	29	41	293	28	0	2	98	128
Region 3	26	8	34	184	17	0	0	76	93
Region 4	243	38	281	658	113	173	8	69	363
Region 5	439	221	660	1938	407	69	37	369	882
Region 6	82	16	98	845	71	31	16	72	190
Region 7	88	10	98	429	105	24	127	377	633
Region 8	71	53	124	782	110	0	0	63	173
Region 9	61	23	84	159	81	8	23	81	193
Region 10	160	172	332	396	141	26	5	110	282
Total	1243	653	**1896**	**6308**	1206	331	230	1508	**3275**

The number of people identified as experiencing homelessness varied greatly among Regions, ranging from 12 people in Region 2 to 439 people in Region 10.

2017 PIT Count by Region: Sheltered and Unsheltered Populations					
	% Sheltered	% Unsheltered		% Sheltered	% Unsheltered
Region 1	75%	25%	Region 6	70%	30%
Region 2	83%	17%	Region 7	75%	25%
Region 3	62%	38%	Region 8	60%	40%
Region 4	78%	22%	Region 9	72%	28%
Region 5	86%	14%	Region 10	65%	35%

The ten Regions in the Missouri Balance of State CoC demonstrated varying rates of sheltered and unsheltered homelessness as assessed during the 2017 point-in-time count. Additionally, 2017 point-in-time count estimates revealed that at the county level:

- 26 counties reported having both sheltered and unsheltered homeless households;
- 45 counties reported having either sheltered or unsheltered homeless households; and
- 56 reported that they identified zero individuals or households experiencing homelessness.[9]

Although rates of unsheltered homelessness are overall low across CoC counties and Regions, understanding rates of sheltered versus unsheltered homelessness within a geographic area can help Regions identify which housing component types they can utilize to best address local need.

For example, 86 percent of people identified as experiencing homelessness in Region 5 were **sheltered** during the 2017 point-in-time count. The high rate of sheltered homelessness is aligned with the Region 5's strong portfolio of emergency shelter (407) and transitional housing (69). Region 5 may consider expanding access to rapid re-housing and permanent supportive housing options to help move people experiencing sheltered homelessness out of shelters, transitional housing, and safe haven programs and into longer-term housing options.

In contrast, 40 percent of people identified as experiencing homelessness in Region 8 were unsheltered during the 2017 point-in-time count. Regions and counties with higher rates of **unsheltered** homelessness may want to increase local availability of crisis housing options to help quickly move people off the streets and into a more stable environment while permanent housing options are identified. Although Region 8 has 110 emergency shelter beds according to housing inventory count data, 71 beds (64 percent) are dedicated for domestic violence survivors. The Region also currently has zero transitional housing beds. Region 8 thus might consider working with

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[9] Missouri Housing Development Corporation (MHDC) and Institute for Community Alliances (ICA), "2017 Missouri Balance of State Report of Sheltered & Unsheltered Point-in-Time Count of Homelessness,'
https://docs.wixstatic.com/ugd/8ff70b_db6430f723354088abe90f99f84a2c77.pdf

providers to explore the possibility of redirecting some of their domestic violence-dedicated emergency shelter beds to increase emergency shelter availability for non-specific populations.

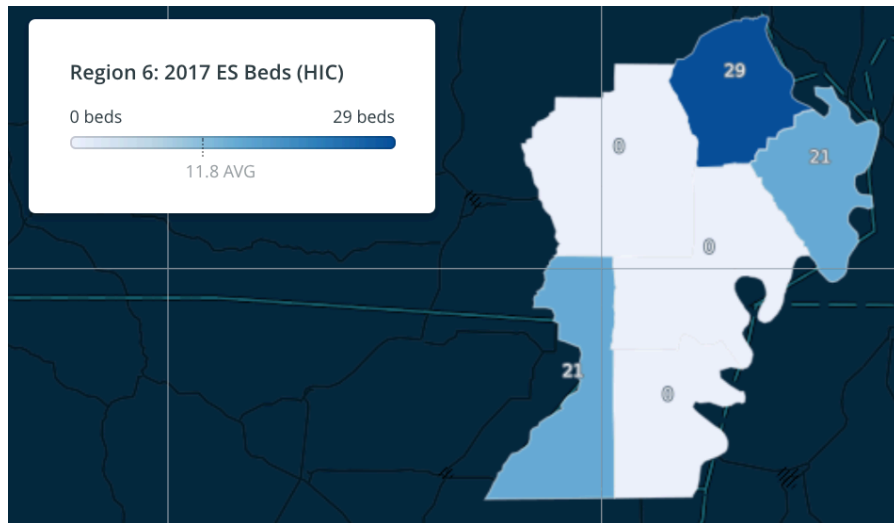## GEOGRAPHIC DISPARITIES IN HOUSING AVAILABILITY

With 3,275 housing units reported in the CoC's Housing Inventory Count – including 1206 emergency shelter beds, 331 transitional housing beds, 230 rapid rehousing beds, and 1508 permanent supportive housing beds – Missouri Balance of State CoC has a diverse portfolio of housing options and a strong beds-to-population ratio. However, imbalances in the geographic distribution of housing beds exist within and among the Balance of State's CoC Regions, including disparities in access to different housing component types. Such disparities can create housing availability gaps that are particularly difficult for consumers in rural areas to overcome.

Additionally, there is a significant number of homeless service providers operating within the CoC who do not receive HUD-funding and/or do not participate in HMIS, including faith-based organizations and domestic violence providers. While these providers likely play a vital role in responding to local needs and increasing housing and service availability in their service areas, we do not have data on housing provided and clients served by these providers.

Through a series of provider focus groups in February 2014, researchers for the Homeless Missourians Information System (HMIS) Project identified significant geographic challenges and disparities around housing access and availability with the Regions of the Balance of State CoC:

- Providers from Region 1 described a geographic divide between services in the Farmington area near St. Francois County and the Cape Girardeau area.[10] A map of total housing beds reported in the 2017 Housing Inventory Count for Region 1 supports that a geographic divide remains within the area. There is a significant lack of housing availability in St. Francois County and its surrounding areas compared to the Cape Girardeau area.

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[10] Liz Gebhart & Lindsay Wallace, Homeless Missourians Information System (HMIS) Project, "Missouri Balance of State Thoroughness of Reach," February 2014, https://static1.squarespace.com/static/54ca7491e4b000c4d5583d9c/t/55a92ccde4b02b78a7032113/1437150413080/MO+BoSThoroughnessofReach.pdf

- Region 2 providers explained that grant and service limitations make it difficult to provide services to households that live outside Marion County, requiring households to either relocate to Marion County or travel out-of-Region to access services.[11] The map below demonstrates the extensive concentration of Region 2's housing resources in Marion County that still exists and the lack of available resources in other counties, creating significant limitations on housing availability for consumers residing outside of Marion County.

- In Region 6, housing and services providers expressed a need for emergency shelter beds to service the area south of New Madrid.[12] A map of emergency shelter beds reported in Region 6's Housing Inventory Count shows that the majority of the Region's emergency shelter beds – and all of the Region's non-population specific emergency shelter beds – are clustered in the northern part of the Region in Scott and Mississippi counties.

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[11] Ibid.
[12] Ibid.

Other Regions in the Missouri Balance of State face similar challenges in the uneven geographic distribution of housing, resulting in housing availability gaps. Some of the challenges faced by CoC Regions around geographic disparities in housing access and availability will be eased through the increased regional coordination and more standardized referral processes being established through coordinated entry implementation. HMIS data from 2017 showed that rapid rehousing programs were much more likely than other housing types to serve persons from multiple counties. Increasing local utilization of more geographically flexible housing resources such as housing vouchers can also help increase the reach of the Region's housing supply to areas that currently lack substantial site-based housing options.

For additional analysis of regional distribution of housing resources and persons experiencing homelessness, please see Appendix C.

RURAL, URBAN AND SUBURBAN HOUSING AVAILABILITY AND NEEDS

The Missouri Balance of State CoC is a predominantly rural CoC, and therefore many of the considerations regarding housing availability are focused on the needs of rural communities. However, there are a number of urban and suburban areas in the Missouri Balance of State CoC that face their own housing availability challenges and require consideration as well. Some stakeholders that responded to surveys or participated in interviews described tension around the balance of housing and services that exists between urban, suburban, and rural areas, as well concerns regarding how to best assist clients within these different types of regions to access housing and services.

Stakeholder feedback identified that rural housing providers lack sufficient access to resources and as such have limited capacity to serve clients that present with a housing need. Stakeholders reported

that insufficient transportation options and mainstream services in rural areas exacerbate the already limited capacity of rural housing providers. Stakeholders also reported that, at times, there is a lack of coordination and collaboration within rural areas related to which providers have available services, inhibiting effective referrals among rural providers.

While urban and suburban areas have access to a greater number of housing resources, they also have high housing demand. For example, while Boone County in Region 5 has 497 total homeless-dedicated beds, including a diverse portfolio of 146 emergency shelter beds, 53 transitional housing beds, 37 rapid-rehousing beds, and 261 permanent supportive housing beds, they also experience a high demand for services. According to HMIS data collected over the course of 2017, Boone County served a total of 1,382 people experiencing homelessness, 835 of whom were served by housing providers and 547 of whom were served by non-housing providers. Urban and suburban counties thus face the same challenge as rural areas in trying to align housing supply with housing demand.

Additionally, several counties in Missouri serve multiple CoCs, particularly counties that share a border with one of Missouri's urban Continuums of Care. One stakeholder noted that such "border" counties often struggle with data quality, coordinated entry, and referral issues as a result of their involvement in two separate CoCs.

EMERGENCY SHELTER ACCESS AND AVAILABILITY

The need to increase the availability of emergency shelter, particularly for single adults and families, was a commonly discussed theme during interviews and in survey responses with stakeholders for this gaps analysis. The reasons for insufficient emergency shelter availability in the Missouri Balance of State CoC are multi-faceted and include:

- ***Too many emergency shelter beds have eligibility restrictions and are inaccessible for general use.*** Regions experiencing this challenge could investigate options for redirecting population-dedicated beds, such as emergency shelter beds dedicated for domestic violence survivors, for general population use. Regions with a large number of population-specific dedicated emergency shelter might work with providers to examine funding requirements and bed utilization rates for these projects and identify projects that have some funding flexibility and are being underutilized by the intended population for restructure.
- ***Emergency shelter services are concentrated or clustered too far away, oftentimes in areas that are difficult for clients to access from rural geographies***. A lack of emergency shelter access in rural areas is a difficult challenge for many communities within the Missouri Balance of State CoC. Some strategies for communities to consider are (1) working with new partners, including faith-based organizations, to create locally accessible crisis housing options, (2) using coordinated entry, including across Regions and CoC boundaries, to connect people with

shelter where it is most accessible for them, and (3) investigate new transportation services and models for bridging the geographic divide between where services are and where people are who need them.

- *Emergency shelter beds lack the geographic flexibility of other housing resources, such as rapid re-housing vouchers and permanent supportive housing vouchers, to be targeted to areas with the greatest need*. Although emergency shelter beds are often facility-based, some U.S. communities are exploring alternative emergency shelter program designs that allow for greater geographic flexibility, beyond hotel/motel vouchers. The San Francisco Navigation Center model establishes temporary emergency shelter facilities on underutilized properties, such as vacant lots sites slotted for future development or warehouses, allowing for flexibility in where they can be located and the ability to relocate facilities based on where local need is identified. Many communities are also exploring the use of host homes as an alternative to emergency shelter for youth experiencing homelessness, particularly in rural areas.

Recommendations

HomeBase recommends that the Missouri Balance of State CoC take the following steps to increase the availability of homeless-dedicated housing:

Work to increase housing availability and maximize utilization of existing housing stock in rural, urban, and suburban areas of the Missouri Balance of State CoC. Data analysis and stakeholder feedback from interviews and surveys indicate that housing availability is not just a rural issue – urban and suburban areas also face challenges in connecting clients to appropriate housing options and maximizing utilization of their housing resources in response to client need. The Balance of State CoC should assist rural, urban, and suburban designated counties in calculating their unmet need for homeless individuals and families; analyzing coordinated entry data and real-time utilization rates of different projects and housing components to isolate housing need; and targeting increases and changes in housing stock to those interventions which will most directly respond to current housing gaps and unmet need.

Increase availability of rapid re-housing vouchers. Voucher programs were able to serve a wide swath of counties across the CoC and across CoC regions in 2017, including predominantly rural areas with very few site-based housing options. The portability of vouchers enables providers to serve larger geographic areas, which is important given the Balance of State CoC's wide and diverse geography as detailed above. Rapid re-housing vouchers allow Regions great flexibility in targeting housing assistance to where it needed the most and can be effectively utilized in rural, urban, or suburban areas.

Increase bed availability and program turnover by supporting clients in moving through the homeless system of care into stable, permanent housing options. The Missouri Balance of State CoC has a strong ratio of beds-to-population and a diverse portfolio of housing opportunities by component type. However, the CoC needs to ensure that it is maximizing utilization of these resources by supporting the flow of clients from homeless situations into stable, non-homeless-dedicated permanent housing, thus creating program turnover and space in the system to serve more people experiencing homelessness. Programs should ensure that clients have access to comprehensive wraparound services that can help increase self-sufficiency, including case management, employment and income supports, and health services. The Missouri Balance of State CoC should also consider the use of "moving on" subsidies, which are portable subsidies to help formerly homeless individuals and households in permanent supportive housing move into affordable housing opportunities. Many stakeholders noted that current levels of affordable housing stock are insufficient to meet current housing need. To help address this need, the Missouri Balance of State CoC should work to leverage additional local, state, and funding resources for affordable housing development (See Funding Attainment and Maximization section of this report).

Monitor 2018 point-in-time count, housing inventory count, and HMIS data to confirm Assessment findings and track relevant data to support decision-making. The Missouri Balance of State should utilize 2018 data to confirm findings regarding gaps in housing availability and to track relevant data on how, where, and for whom the CoC's housing supply is being utilized. This data can help the CoC make important decisions regarding housing availability, including where to target housing increase and reallocations.

AVAILABILITY

Special Populations

Homeless subpopulations such as people experiencing chronic homelessness, transitional-aged youth, veterans, and survivors of domestic violence may benefit from dedicated housing options that respond to their circumstances and need. Oftentimes these subpopulations are also the most vulnerable within the homeless system of care and are more successful when matched with certain housing and service models. Federal efforts to prioritize the most vulnerable populations and integrate a Housing First philosophy into local homeless systems are embodied in coordinated entry.[13] It is important to note that although dedicated housing can increase accessibility and availability for people within these subpopulations, too much specialization can result in beds being under-utilized. Individuals can and should have the choice to be served in all housing options which are safe and appropriate to their needs and for which they are eligible.

Special Populations in the Missouri Balance of State CoC

The rollout of coordinated entry within the Missouri Balance of State CoC, and the process of developing a prioritization scheme to connect the most vulnerable populations to services, brings to light the importance of understanding the size and demographics of vulnerable subpopulations and what housing services are currently available to meet their needs. Missouri's Balance of State CoC Coordinated Entry System prioritizes access to services using the following criteria:

- Length of Time Homeless
- Level of vulnerability as indicated by a consumer's score on the VI-SPDAT 2.0
- Veterans who are not eligible for other veteran specific services
- Families with children or youth only households

The CoC's policy also encourages local agencies to consider additional factors when prioritizing services. This may include:

- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs
- The extent to which people (especially youth and children) are unsheltered
- Vulnerability to illness or death

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[13] HUD, Coordinated Entry Policy Brief (February, 2015), https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/.

- Risk of continued homelessness
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

The 2017 Balance of State CoC application also reflects these priorities. The Missouri Balance of State CoC prioritized funding for permanent supportive housing projects that demonstrated preference for households with children who also exhibited: a history of vulnerability of victimization, the number of previous homeless episodes, unsheltered homelessness, and/or a head of household with a mental/physical disability. In addition, the CoC application outlines the Balance of State CoC's prioritization of unaccompanied youth based on a history of vulnerability of victimization, the number of previous homeless episodes, and/or unsheltered homelessness.

Given the populations emphasized in the CoC's coordinated entry policies and procedures and 2017 CoC application, this report looks specifically at the following subpopulations:
- Families experiencing homelessness;
- Unaccompanied youth;
- Domestic violence survivors (and like populations); and,
- Persons who are chronically homeless, including individuals with serious mental illness or substance use disorders.

These groups reflect the priorities of the CoC in its policies and are also the groups most frequently cited by CoC stakeholders as in need of increased attention and resources.
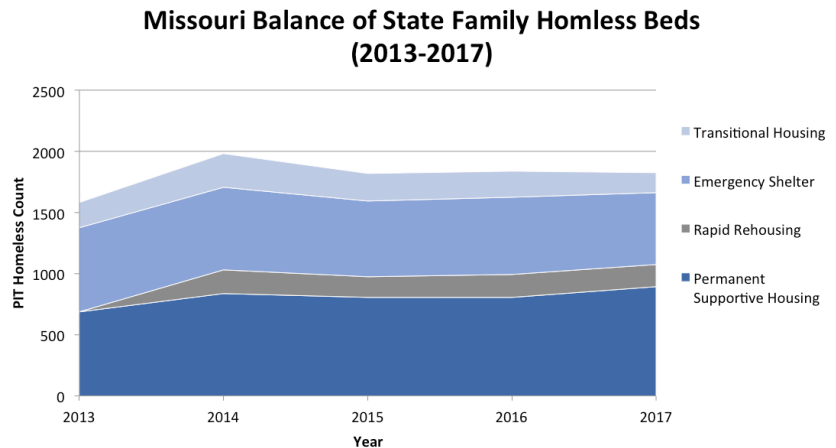
FAMILY HOMELESSNESS

Family homelessness was a common concern among stakeholders. Through interviews and surveys, there was especially the concern that families were not getting enough attention within the Balance of State CoC's homeless services. One stakeholder said, "Sometimes I feel like in my area we talk a lot about chronic homeless and vets. Families, I sometimes worry, don't get enough [attention]." Over half (55 percent) of survey respondents commented that families are one of the subpopulations that need more attention. This was tied for the highest number of responses with the subpopulation of those "precariously housed." Addressing family homelessness is a priority for some CoC members and partners.

According to the 2017 point-in-time count, Missouri's Balance of State had 170 families (households with at least one child) experiencing homelessness. Of these households, 145 were sheltered in emergency shelter or transitional housing and 25 were unsheltered. This is the lowest number of families experiencing homelessness between 2013 and 2017; down 36 percent from a high of 265 households in 2013. The number of unsheltered households (25) is down from 34 in 2016, but not quite as low as it was in 2015 (22 households).

The number of available family homeless beds peaked in 2014 at 1,979. As of January 2017, there were 1,824 family dedicated homeless beds in the Missouri Balance of State CoC. This number is down slightly from 1,836 in 2016. Between 2016 and 2017, the CoC lost 45 emergency shelter family beds and 50 transitional housing beds. During this same period, the CoC increased the number of family permanent supportive housing beds by 85. While providing permanent supportive housing resources for families is important, the Missouri Balance of State had only 24 households with children experiencing chronic homelessness in the 2017 point-in-time count. The 2016 point-in-time count identified 19 chronically homeless families in the CoC (48 people total). Investing in housing options (like rapid rehousing vouchers) for families with fewer intensive needs could help families make faster connections to permanent housing across the CoC.

Missouri Balance of State Family Homeless Beds (2013-2017)

YOUTH HOMELESSNESS

Analysis of interview and systems data indicates that housing options for transitional-aged youth (ages 18-24) is an area of need and currently a gap in the Missouri Balance of State CoC. The 2017 point-in-time count identified 58 transitional-aged youth experiencing homelessness; 608 transitional-aged youth clients were served across the CoC in 2017. However, there is a total of only 60 units dedicated to youth within the CoC. In addition, several stakeholders we interviewed think that many homeless transitional-aged youth are invisible to the homeless system of care.

Statewide K-12 education data on students experiencing homelessness reflects an increase in number of youth experiencing homelessness. During the 2016-2017 school year, 33,757 homeless students were enrolled in schools across the state and 2,959 of these students were in shelters, over 28,000 were doubled up, 559 were unsheltered, and over 2,100 were living in hotels or motels.[14] This is up from the 2015-2016 and 2014-2015 school years, which reported homeless student populations of 32,354 and 30,656, respectively.[15]

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[14] Missouri Department of Elementary and Secondary Education, Statewide Homeless Data Results (2017), https://dese.mo.gov/sites/default/files/qs-fc-hmls-Statewide-Homeless-Data-Results-2017.pdf.
[15] Ibid.

Missouri Department of Education: Statewide Homeless Data Results 2013-2017					
School Year	Total Homeless Students Enrolled	Shelters	Doubled Up	Unsheltered	Hotels/Motels
2016-2017	33,757	2,959	28,063	559	2,176
2015-2016	32,354	2,858	26,856	579	2,061
2014-2015	30,656	2,392	25,675	773	1,816
2013-2014	29,525	2,634	24,606	566	1,874

Furthermore, although every Region within the CoC served transitional-aged youth experiencing homelessness in 2017, there are three Regions that have dedicated housing units available for youth – Regions 4, 5, and 6. However, there currently remains a gap in the availability of youth housing units to meet the potential need.

2017 PIT Count for Transitional-Aged Youth: 58					
	Total TAY Clients Served	Youth ES Beds	Youth TH Beds	Youth PSH Beds	Total Youth Beds
Region 1	42	0	0	0	0
Region 2	18	0	0	0	0
Region 3	10	0	0	0	0
Region 4	215	30	10	0	40
Region 5	132	14	4	0	18
Region 6	58	0	0	2	2
Region 7	22	0	0	0	0
Region 8	69	0	0	0	0
Region 9	6	0	0	0	0
Region 10	36	0	0	0	0
Total	608	44	14	2	60

Stakeholders within the CoC recognize the need for focusing more resources on youth. Fifty percent of survey respondents indicated that youth were one of the subpopulations in need of greater resources. Responding to this increased need will be an important feature of the CoC's efforts to increase housing availability.

SURVIVORS OF DOMESTIC VIOLENCE

In 2017, the point-in-time count identified 294 survivors of domestic violence, 22 of whom were unsheltered. The Missouri Balance of State CoC served 154 survivors of domestic violence in 2017 as recorded in HMIS. It is important to note that due to safety and privacy concerns and due to Federal requirements, information on victims of domestic violence served is often not captured in HMIS, and thus the number of survivors experiencing homelessness served within the CoC is likely much higher than this data indicates.

Homeless beds dedicated to domestic violence survivors are most prevalent in emergency shelters. In 2017, there were 775 emergency shelter beds for domestic violence survivors (64 percent of overall emergency shelter beds). There were also 38 transitional housing beds dedicated to domestic violence survivors in 2017. While there are significant emergency shelter resources dedicated to domestic violence survivors, 30 percent of survey respondents indicated that more resources should be directed to address this particular subpopulation. One stakeholder commented in an interview, "I know housing for our DV clients has been a struggle for many, many years. I just know there's not enough." Domestic violence is often underreported, which may explain the lower totals in point-in-time and service data. However, the number of shelter beds for domestic violence survivors is significant.

| 2017 Point-in-time count for Survivors of Domestic Violence: 294					
	Total DV Clients Served as reported in HMIS[16]	DV ES Beds	DV TH Beds	DV PSH Beds	Total DV Beds
Region 1	22	75	0	0	75
Region 2	7	14	0	0	14
Region 3	3	17	0	0	17
Region 4	37	83	0	0	83
Region 5	45	201	22	0	223
Region 6	14	56	8	0	64
Region 7	4	64	0	0	64
Region 8	1	71	0	0	71
Region 9	12	81	8	0	89
Region 10	9	113	0	0	113
Total	154	775	38	0	813

[16] Due to safety and privacy concerns and due to Federal requiremetns, information on victims of domestic violence served is often not captured in HMIS, and thus the number of survivors experiencing homelessness served within the CoC is likely much higher than this data indicates.

Although emergency shelter is a significant need for survivors of domestic violence, it is also intended to provide temporary assistance while households are assisted in finding permanent, stable housing solutions; as such, one emergency shelter unit can serve multiple clients within the span of a year. With only 295 survivors of domestic violence identified in the point-in-time count and 154 survivors reported being served in HMIS, the current number of domestic violence emergency shelter beds (775) suggests that there may be an oversaturation of emergency shelter units for this population within the CoC.

VETERANS

Veteran homelessness has been a focus population for ending homelessness nationally since the adoption of *Opening Doors* in 2010.[17] Communities around the country have made significant progress toward this goal, with a number of them effectively ending veteran homelessness. While the

Missouri Balance of State Veterans Experiencing Homelessness (2013-2017)
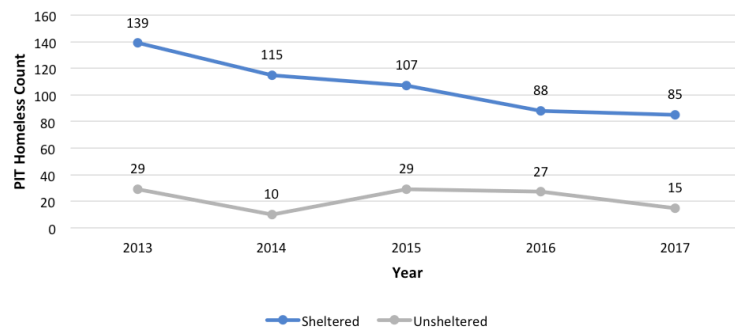
Balance of State CoC has not ended veteran homelessness, it has steadily declined since 2013. During the 2013-2017 period, the number of unsheltered veterans decreased by 48 percent and the percentage of sheltered veterans decreased 39 percent.

In 2017, 98 veterans experienced homelessness (as identified during the point-in-time count) and 531 homeless veterans were served in the Missouri Balance of State CoC. Throughout the CoC, there are 465 total housing units dedicated to veterans experiencing homelessness, 74 percent of which were permanent supportive housing. Overall, there is a potential housing gap of 66 units based on total veteran units and total veteran clients served in 2017 within the CoC. However, it is important to note that many veterans may be served through non-veteran targeted or dedicated housing options, therefore this potential housing gap should not be a significant of a concern for the CoC.

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[17] Opening Doors Federal Strategic Plan to Prevent and End Homelessness, adopted June 22, 2010 (since amended), available at: https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf

2017 PIT Count for Veterans: 98						
	Total Veteran Clients Served	Veteran ES Beds	Veteran TH Beds	Veteran RRH Beds	Veteran PSH Beds	Total Veteran Beds
Region 1	53	0	0	0	0	0
Region 2	4	0	0	0	0	0
Region 3	13	0	0	0	0	0
Region 4	9	0	0	7	0	7
Region 5	263	27	17	8	151	203
Region 6	21	0	0	0	0	0
Region 7	70	14	0	46	192	252
Region 8	34	0	0	0	0	0
Region 9	23	0	0	0	1	1
Region 10	41	0	0	2	0	2
Total	531	41	17	63	344	465

Additionally, it important to note that although veteran housing units appear to be clustered in only five of the CoC's ten Regions, many of the veteran housing units are provided through the Department of Veteran Affair's SSVF and VASH programs that are able to serve multiple counties:

- SSVF projects are operated by private nonprofit organizations and consumer cooperatives – Catholic Charities of Southern Missouri, Catholic Charities of St. Joseph/Kansas City, Salvation Army – KC, and Welcome Home in the Missouri Balance of State CoC – and may serve a large number of counties with their resources.
- The VASH program is operated through local VA facilities – the Department of Veterans Affairs – Columbia, John J. Pershing Veterans Administration, and Veteran's Healthcare System of the Ozarks (VHSO) Mount Vernon CBOC in the Missouri Balance of State CoC – and may serve a number of counties through the distribution of permanent supportive housing vouchers.

It is important for the CoC to maximize utilization of these flexible resources for veterans as they can be targeted to areas with the greatest number of veterans in need.

CHRONIC HOMELESSNESS

Individuals experiencing chronic homelessness have experienced homelessness for at least a year (or four periods over three years adding up to a year) while also struggling with a disabling condition, such as a serious mental illness, substance use disorder, or physical disability. For more than a decade, federal policy efforts have focused on ending chronic homelessness.

2017 PIT Count for People Experiencing Chronic Homelessness: 245			
	Total CH Clients Served in 2017	CH PSH Beds	Total CH Bed
Region 1	28	44	44
Region 2	7	0	0
Region 3	8	10	10
Region 4	33	69	69
Region 5	196	109	109
Region 6	36	20	20
Region 7	40	205	205
Region 8	27	0	0
Region 9	18	2	2
Region 10	41	33	33
Total	434	492	492

In 2017, 245 chronically homeless persons were identified during the point-in-time count.[18] Twenty percent of these individuals were unsheltered. During 2017, the Missouri Balance of State CoC served 434 chronically homeless persons. Throughout the CoC, there are 492 total housing beds dedicated to persons experiencing chronic homelessness, all of which are permanent supportive housing beds, in alignment with best practices. The number of beds within the CoC meets the potential need for housing among people experiencing chronic homelessness, and the focus on permanent supportive housing is aligned with best practices for housing this population.

The coordinated entry system, in alignment with HUD policy as stated in Notice 16-11,[19] prioritizes persons who are chronically homeless first. However, stakeholders interviewed for this report suggested that the chronically homeless may not require additional resources. One CoC member called the emphasis on chronic homelessness in the Balance of State CoC as "overhyped." Another interviewee suggested that chronicity was not the best population to prioritize in the CoC. (However, note that persons who are chronically homeless appear to be disproportionately unsheltered. See the "Housing First and Lowering Barriers to Housing" section below.)

While increased availability of housing for chronically homeless individuals may not be an immediate need for the CoC, 50 percent of survey respondents indicated that more attention should be focused on individuals with serious mental illnesses. In the 2017 point-in-time count, 200 homeless individuals

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[18] Please note that the point-in-time count identifies persons experiencing chronic homelessness that are not currently housed, they are either living in a place not meant for human habitation, in an emergency shelter, in a safe haven, or in transitional housing. Therefore, the population counted does not include current residents of permanent supportive housing units.

[19] Office of Community Planning and Development, U.S. Department of Housing and Urban Development, Notice CPD-16-11, Notice Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, issued December 4, 2015.

identified as having a serious mental illness. Connections to appropriate health and behavioral health services appears to be a need within the CoC.

Recommendations

In order to improve the availability of housing and services for subpopulations in the Missouri Balance of State CoC, HomeBase recommends:

Improve the availability of housing for specific subpopulations so that housing stock better aligns with demonstrated needs across the CoC and within each region. While transitional-aged youth lack homeless-dedicated housing options, there an is overconcentration of emergency housing units available for survivors of domestic violence. The CoC should consider working with domestic violence emergency shelter providers to explore whether some of these units could be made available to the general population of people experiencing homelessness or to a different population of focus within the community, such as transition-age youth (either on a case-by-case or on an ongoing basis). The CoC may also want to consider diversifying the portfolio of housing options for survivors of domestic violence to include other housing options (e.g., rapid rehousing). (See also the recommendations in the Housing First and Lowering Barriers to Housing section.)

In addition, there are potential limitations in housing availability for people experiencing chronic homelessness and veterans based on the geographic distribution of housing units within the CoC. While some of these concerns can be addressed through the flexible use of existing resources and utilizing non-population-dedicated housing options to meet housing need as well, the CoC would benefit from increasing housing for specific subpopulations, especially youth. Youth-specific projects provide greater choice for those who may be hesitant to enter the adult homeless response system and can provide more appropriate and targeted supportive services responsive to transitional-aged youth needs. Federal efforts to address youth homelessness through the Youth Homelessness Demonstration Program can also help provide a framework for increasing homeless-dedicated youth housing and coordinating partners to address youth homelessness across the Balance of State CoC.

Continue to leverage opportunities to better understand needs, utilizing data from coordinated entry, point-in-time count, HMIS, and other sources. In order to understand if the availability of housing matches the need among the population, the data must provide an accurate and consistent description of the population. When looking at these special subpopulations within the CoC, analyzing multiple data sources will offer a fuller picture of what housing should be made available to meet the needs of these subpopulations. Reviewing the data both for similar and varying patterns will help shed light on who is and who might not be captured. In addition, utilizing a variety of data sources will also allow the CoC to learn more about needs among other vulnerable populations not explicitly addressed in the analysis above. For example, 55 percent of those surveyed said that

individuals and families who are precariously housed need additional attention, and 25 percent indicated that more attention should be spent on other populations, including ex-offenders, couch surfers, and those with substance use disorders. Using multiple data sources to track the size of these populations, and whether housing is available to meet their needs, will help improve the overall CoC.

AVAILABILITY

Comprehensive Service Availability

Making connections to mainstream services is critical to supporting individuals and families who are currently or formerly homeless. The Housing First philosophy incorporates the delivery of permanent housing-focused services at each connection point, taking the time to connect clients to services even with the most basic outreach. Comprehensive service availability requires that CoCs develop and utilize partnerships across their communities to ensure that there are services to meet consumers' full range of needs and that they have access to these services.

The Missouri Balance of State CoC covers a vast geography that includes rural, suburban, and urban areas. The service need and availability vary significantly across the CoC with rural areas often finding themselves underserved and facing a unique set of challenges in accessing these services. Coordinated entry is a process for making services more widely known and available throughout each CoC's regions as well as across the entire CoC. Utilizing coordinated entry to both take stock of current services and service gaps will help the CoC in sharing resources and determining what services to invest in and where.

Service Availability in the Missouri Balance of State CoC and Analysis

Stakeholder interviews and survey responses from across the Missouri Balance of State described a system with pockets of resources, primarily clustered in urban areas. Rural areas are left with fewer resources and are challenged to figure out how to access what might be available in more urban areas. Over a quarter of survey respondents called out the lack of resources in rural areas. One respondent said that there needed to be a larger service presence in the rural areas and more effective communication. Another survey respondent felt that suburban areas get lost.

Areas closer to an urban core, and other CoCs, recognize the advantage they have in being able to access both the services in their CoC as well as the services available in surrounding areas. One program lead located close to an urban area commented: "Being where we are, I think that we have more services available to us and to our clients."

CoC stakeholders expressed a need for a variety of additional services. Transportation was one of the mostly commonly discussed challenges. Thirty percent of survey respondents indicated that transportation was one of the most needed services in the CoC. One s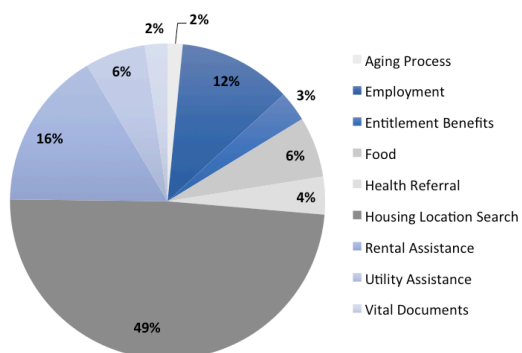takeholder commented: "Transportation is a huge gap. We have huge gaps in public transportation and gaps in the ability to maintain private transportation." In addition to needing transportation services, 20 percent of those surveyed indicated a need for more health, including behavioral services, employment and education services (20 percent), and case management. The smallest percentage (10 percent) of respondents thought additional income support/benefits advocacy was needed.

Missouri Balance of State CoC Gaps Analaysis Survey: Homeless Services Most Needed

Service Type	Percentage
Health (Including Behavioral Health)	20%
Income Support/ Benefits Advocacy	10%
Employment and Education	20%
Transportation	30%
Case Management	20%
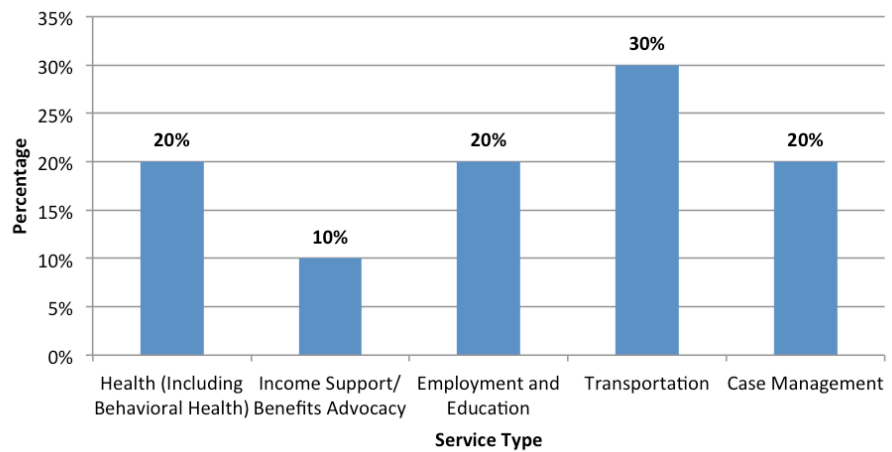
There was also a common theme of not knowing what services and resources were available outside of one's immediate agency. When asked what one stakeholder would most like to have more information about she said, the "...availability of resources as well as knowing who has what. I couldn't tell you who in my region right now has PSH." Another stakeholder commented that we "still don't know everyone who is trying to tackle this issue," and that a big piece of the work was meeting partners and trying to tap into new resources in their region.

2017 Coordinated Entry: Critical Need Data

Category	Percentage
Aging Process	2%
Employment	12%
Entitlement Benefits	3%
Food	6%
Health Referral	4%
Housing Location Search	49%
Rental Assistance	16%
Utility Assistance	6%
Vital Documents	2%

Coordinated entry has proved one means of improving regional understanding of available services. The asset mapping process helped one region "see what they do have and what they have missing," allowing "agencies to come together and figure out what everyone's strengths are." In addition, preliminary coordinated entry data has begun to inform the services consumers need. Coordinated entry pilot data in Regions 8 and 10 provided some early insights into what some of the most commonly needed services might be. Early data on the critical needs of those coming through coordinated entry indicated that just under half are in

critical need for housing location services (49 percent), 16 percent need rental assistance, and 12 percent need employment. Consistently and accurately tracking this data to help determine how service need changes and if service availability matches this need will help the CoC further understand gaps in service availability.

Recommendations

In order to address gaps in data and availability of services across the Missouri Balance of State CoC, HomeBase recommends:

Investigate new and expanded transportation options for people experiencing homelessness, particularly in rural areas. Transportation can be a significant barrier to accessing housing, particularly in rural areas where overall housing stock or availability to specific housing types, such as permanent supportive housing, may be limited. The CoC should consider what transportation options are currently available within each Region and what new and alternative transportation options could be pursued to increase accessibility to available housing and services. Below are some strategies identified by HUD that have been used by rural CoCs to increase access to transportation:

- **Van or bus service:** Some CoCs have started their own transportation programs using a car or bus to connect homeless individuals to services. CoCs can partner with local nonprofits or other mainstream agencies to obtain access to a vehicle if they do not have the resources to purchase a dedicated vehicle. Many CoCs have begun to utilize mobile outreach teams/vans to meet people experiencing homelessness where they are at and connect them to coordinated entry access points or emergency shelter in order to be assessed and connected to housing and services. The Veterans Administration's (VA) model is one that CoCs can also consider replicating. The VA has volunteer van programs, often staffed by retired veterans, to bring patients to medical appointments. The van usually picks up multiple patients at one time. Patients have to wait until all appointments are complete before they are driven home, but the VA often works with the facilities to bundle appointments.
- **Used car program:** CoCs can work with partner agencies or businesses within their community to provide donated used cars to people experiencing homelessness. With vehicles of their own, homeless individuals can drive themselves to homeless services. Owning a car removes a significant barrier to obtaining and maintaining employment and expands the geographic range of where the individual can seek affordable housing. However, this program can raise liability issues that must be overcome.
- **Legal services:** Individuals experiencing homelessness sometimes need help resolving legal issues in order to have their driving license privileges restored. CoCs can work with nonprofit partners and legal service agencies to offer these legal services on a pro-bono basis. In areas

with law schools nearby, CoCs may be able to arrange for a pro bono legal services program staffed by student volunteers.

- **Bus referrals:** In rural communities that lack needed services but have bus service, continuums can provide a bus ticket to transport individuals experiencing homelessness to the nearest town or city providing the needed services. Social service agencies throughout Nevada, for example, have a set-aside to cover transportation costs to get persons experiencing homelessness to service providers in Reno and Las Vegas. Some transit authorities may even be willing to donate bus passes or vouchers.[20]

Utilize coordinated entry to improve information sharing about regional services available, paying particular attention to rural areas. Understanding who has what resources and services is important to helping consumers access the services they need. Coordinated entry has helped lay the groundwork for regions to better understand the resources available to them, but this information is still difficult to obtain and not located in a centralized place. The Balance of State CoC can help facilitate regions sharing this information both internally and externally so that partners are aware of what services are available and where. In addition, coordinated entry data should be regularly reviewed to help assess what services are most needed and how that need matches the availability as currently understood. Rural areas in particular struggle to know about resources and what services are available. Knowing this, attention should be paid to using coordinated entry to better understand what is available for rural areas.

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[20] U.S. Department of Housing and Urban Development (HUD) Office of Community Planning and Development, "Rural Continuums of Care," June 2009, https://www.hudexchange.info/resources/documents/RuralCoCGuidebook.pdf

ACCESSIBILITY 74

The second chapter of this Assessment focuses on the accessibility of housing and services that meet the needs of persons experiencing homelessness in the Balance of State CoC. Three subjects are addressed below:

- *Coordinated Entry* focuses on the accessibility of the coordinated entry system and how it supports increased accessibility of resources, including outreach and marketing, referral process, and equal access.

- *Program Barriers* analyzes barriers to housing and services, including entry requirements and program rules that reduce the ability of persons with certain backgrounds, experiences, or characteristics to access resources they need.

- *System Performance* discusses how the system of care is performing and thereby how accessible effective resources are to the population of people experiencing homelessness in the CoC.

ACCESSIBILITY 75

Coordinated Entry

HUD requires each CoC to establish and operate a coordinated entry process with the goal of increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources, including mainstream resources. Coordinated entry processes coordinate client intake, assessment and referral. Coordinated entry systems should prioritize and serve the people who are most in need of assistance. Coordinated entry systems are required to cover the full geographic area of the CoC, be easily accessible by individuals and families seeking housing or services, be well advertised, and include a comprehensive and standardized assessment tool. The data collected by coordinated entry systems informs CoCs and their stakeholders of service needs and gaps and can help guide resource allocation. Coordinated entry requirements are set forth in CoC Program interim rule and the Notice CPD-17-01.[21]

Coordinated Entry in the Missouri Balance of State CoC

The Missouri Balance of State CoC piloted coordinated entry systems in Regions 8 and 10 in late 2016 and coordinated entry is now underway CoC-wide. Each Region of the CoC operates a separate coordinated entry system in alignment with Balance of State CoC structure and priorities.

Each regional coordinated entry committee must implement its own coordinated entry system. The regional committees are responsible for: maintaining a housing resource list, conducting outreach and marketing, determining access points, developing and providing training, maintaining a prioritized list of consumers, organizing case conferencing, and conducting landlord engagement. The CoC's Coordinated Entry Committee has met diligently to create a toolkit to support regional implementation, including: policies and procedures, tools and procedures for each phase of coordinated entry, intake procedures, written standards, training resources, and marketing materials.

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[21] Office of Community Planning and Development, U.S. Department of Housing and Urban Development, Notice CPD-17-01, Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System, issued January 23, 2017.

The CoC's coordinated entry policies and written standards describe the processes and standards for the CoC's entire coordinated entry system. The assessment model includes a pre-screening, prevention and diversion assessment, collection of data on an intake tool, and an assessment using the VI-SDPAT (Vulnerability Index - Service Prioritization Decision Assistance Tool). Households are added to the Prioritization List in order of vulnerability, with the most vulnerable at the top of the list for prioritized access to housing and services. The CoC's order of priority is: 1) Chronically Homeless, 2) Severity of Needs, 3) Length of Time Homeless, 4) Disability, 5) Currently unsheltered, 6) Currently fleeing domestic violence or like situation, 7) Currently living in safe haven or emergency shelter, 8) Currently living in transitional housing, 9) veteran status, and 10) Family size.

In accordance with HUD requirements, the CoC's coordinated entry policies state that all access points will "ensure fair and equal access to CES programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, veteran status, sexual orientation, or domestic violence status. To ensure fair access by individuals with disabilities, physical and communication accessibility barriers must be addressed by appropriate accommodation within each regional CES."

The CoC's policies include a detailed plan for evaluating the system's impact at least annually, including data points that each regional system will report and a process to collect stakeholder feedback. Regional committees are encouraged to evaluate their systems more frequently using the same tools.

Analysis

Many stakeholders surveyed or interviewed indicated that coordinated entry is a very exciting development for the CoC. Survey and interview respondents indicated that the system has surfaced previously unknown resources, engaged new partners, and unified the system of care. While barriers to service (see "Program Barriers" section below) continue in multiple regions, coordinated entry is also giving regional planners a means to understand and respond to program- and system-level impediments to service, in some cases spurring action and adjustment resulting in improved access.

Data about coordinated entry is limited. Caution should be used when drawing any conclusions about performance from this data because implementation and HMIS participation is limited to a few regions of the CoC. With that caveat, the data reflects some success.

- 13 percent of households (52 of 404) were successfully diverted.
- The average length of time between assessment and referral was just under 13 days, with only six clients having a wait longer than 30 days.

- The average length of time between being placed on the Prioritization List and entering permanent housing was approximately 42 days, with 48 of 286 clients (17 percent) waiting more than 30 days for housing.
- The average VI-SPDAT score for families was highest at 9.2, individual households had an average score of 7.8 and youth had an average score of 5.4.
- Sixty-five percent (65 percent) of clients were households without children, 33 percent were households with children, and 2 percent of clients were youth.
- Only 16 clients did not get referred, with the majority not being referred because the client self-resolved the housing issue (81 percent).
- Clients who did not enter housing primarily did not because they self-resolved/successfully diverted (59 percent) or disappeared/did not arrive (32 percent), only a few were ineligible (4 percent) or refused services (2 percent).
- A total of 38 referrals were made to permanent supportive housing, with 9 enrollments recorded. A total of 81 referrals to rapid rehousing were made with a total of 18 enrollments recorded.

The coordinate entry pilot Regions conducted outreach and marketing through direct outreach to homeless housing and service agencies, schools, law enforcement, and other partners and through the public distribution of

	Coordinated Entry	2017 Housing Programs Using HMIS	2017 Point in Time Count
Adults without children	66%	75%	60%
Adults with children	33%	17%	40%
Only children	2%	7%	6%
Disabled	56%	30%	NA
Veterans	4%	15%	4%

posters, brochures and business cards in English and Spanish. Regional coordinated entry coordinators feel these outreach strategies are effective in both rural and more urban areas within their Regions. Data is not available at this time to determine the effectiveness of coordinated entry outreach and marketing efforts.

With regard to fair and equal access, a comparison of data about who coordinated entry has served thus far with 2017 HMIS housing data and point-in-time count shows varying levels of service access based on race. However, at this stage in coordinated entry development, with limited regional-level participation in HMIS, a conclusion cannot be drawn from this data, although this information should be reviewed further, including in the first annual coordinated entry evaluation.

Comparison of Data Regarding Race and Persons Served in 2017				
	Coordinated Entry, 2017	2017 Housing Programs Using HMIS	2017 Point in Time Count	Missouri General Population
White	89%	71%	72%	83%
African American	7%	24%	22%	12%
Asian	1%	0%	1%	2%
American Indian/Alaska Native	1%	1%	1%	1%
Native Hawaiian/ Pacific Islander	0%	0%	0%	0%
Multiple Races	0%	4%	3%	3%

Recommendations

Because coordinated entry implementation is fairly recent, HomeBase could not yet identify gaps in system implementation. HomeBase does make the following suggestions that align with recommendations in this Assessment:

Continue sharing outcomes and strategies across Regions through the CoC's Coordinated Entry Committee to leverage impact. As with other CoC activities, coordinated entry implementation is rolling out differently in different regions. As the Regions employ different strategies to conduct outreach, provide training, or engage landlords, coordinated entry leads should be diligent about identifying early lessons, engaging in peer sharing, and applying strategies from other regions. For example, a Region that struggles with law enforcement engagement could partner their county sheriff representative with her counterpart in a Region where law enforcement is highly supportive of coordinated entry and arrange for information sharing among law enforcement agencies.

Continue to evaluate duplication of effort or different structures that may better meet community needs. Because regions cover a variety of communities and border on other regions and CoCs, the regional model of coordinated entry may prove inefficient or impractical for some areas. In such circumstances, continuing to identify other approaches to coordination could result in strategic gains (e.g. creating coordinated entry regions that do not align with CoC planning regions or establishing a 24-hour, CoC-wide call-in and referral hotline with full time staffing).

Continue to partner with mainstream agencies and local businesses to implement coordinated entry. Interview respondents noted that coordinated entry opened up a window to increased partnership with state agencies (e.g., the Department of Mental Health and Department of

Corrections), schools, and other partners. As coordinated entry implementation gets underway, regional coordinated entry committees should be entrepreneurial about engaging partners in their response to homelessness. This might look like engaging a night manager at a 24-hour gas station or the local campground manager in referring persons experiencing homelessness to the coordinated entry hotline, or it might look like data sharing with schools to facilitate the provision of needed services and the identification of populations that require increased outreach. This implementation period provides significant potential for engaging new partners and establishing new strategies.

Housing First and Lowering Barriers to Housing

Housing First is an evidence-based practice for all elements of a homeless system of care that prioritizes assisting persons experiencing homelessness to access permanent housing quickly with few to no treatment preconditions, behavioral contingencies, or other barriers to service. Many studies have demonstrated that Housing First improves individual, project, and system outcomes and, for chronically homeless people, reduces system costs because persons placed in permanent supportive housing often reduce usage of more expensive interventions, like those provided by the health or corrections systems of care.

In a Housing First CoC, programs should minimize documentation requirements and unnecessary program rules to ensure that low-barrier housing and services are made available to individuals and families expediently.

Housing First Practices in the Missouri Balance of State CoC

The Missouri Balance of State CoC is implementing Housing First policy in several ways. First, one of the guiding principles of the Balance of State CoC's coordinated entry system is that the coordinated entry system shall not screen out any participant from receiving assistance due to a perceived lack of housing readiness, including but not limited to real or perceived mental and/or physical disability, lack of employment or income, substance use disorder, criminal history, or domestic violence, sexual assault, human trafficking, dating violence, or stalking.[22]

All regional coordinated entry committees have at least started creating asset maps, which includes identifying enter requirements for each program. One person interviewed for this Assessment noted that just knowing the entry barriers at other projects has been an effective first step for the coordinated entry system to break down program barriers in the Region.[23]

The CoC also has adopted a Housing First policy to ensure that actual or perceived barriers are not contributing factors for households remaining in homelessness longer than necessary. The policy states that, beginning with the FY2016 CoC Program Competition, any projects included in the application for CoC funding must follow a Housing First approach. This means the projects must allow entry into CoC programs for participants regardless of their income, current or past substance use,

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[22] Missouri Balance of State Continuum of Care Coordinated Entry Written Standards, approved by the MO BoS CoC Board December 21, 2017, p.8.
[23] Asset maps were unavailable for review and analysis for this Assessment.

criminal records – with the exceptions of restrictions imposed by federal, state or local law or ordinance (e.g., restrictions on serving people who are listed on sex offender registries) – and history of domestic violence. As a result, 100 percent of programs submitted for funding in the FY2017 CoC funding competition have adopted a Housing First approach.

Entry Barrier to Emergency Shelter. While the entry requirements and program rules for all shelters in the Balance of State CoC's geography were not reviewed for this Assessment, one potential barrier to service is the disproportionate number of emergency shelter beds dedicated for domestic violence survivors. In the Balance of State CoC region, the housing inventory

Comparison of 2017 Housing Inventory Count and Point-in-Time Count related to Domestic Violence

count for 2017 found 1,206 emergency shelter beds, 775 of which were dedicated for domestic violence survivors. As a result, only 36 percent of emergency shelter beds are available to people who are not experiencing domestic violence, yet the 2017 point-in-time count found that 76 percent of the homeless population were not experiencing domestic violence.[24] Furthermore, only 18 percent of emergency shelter beds area available for families with children who are not experiencing domestic violence. While data about the number of people experiencing homelessness as a result of domestic violence is not easily accessed due to Federal requirements requiring domestic violence providers to not participate in HMIS (see Availability section above for more information), that data that is available does not support this level of set-aside for this one population.
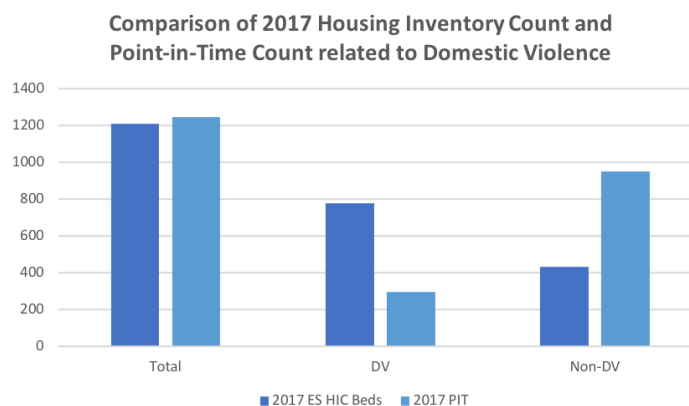
Respondents to surveys and interviews often noted the need for more emergency shelter and some also noted this discrepancy, that there were more women's domestic violence shelters than other resources. One interview respondent explained that although some faith-based organizations support hotel/motel stays when there are not shelters available, the stays are typically just one or two nights, too short to support a household in locating and accessing permanent housing. Taken together, this data reflects a barrier to services for homeless persons who are not fleeing domestic violence.

Subpopulations Served. Data analysis can identify homeless population sub-sets that may be experiencing barriers to housing access. For example, comparing the characteristics of those unsheltered in point-in-time data to those housed in project data can assist in determining whether

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[24] HMIS data also reflects a smaller population with domestic violence experience with 11 percent of those served by housing programs in the past 5 years reporting they had a history with domestic violence, and only 17 percent of those reporting that they are currently fleeing domestic violence. However, pursuant to Federal law, victim service providers (e.g., domestic violence shelters) cannot input data in HMIS, so this data likely reflects an undercount.

there are homeless subpopulations having systemic difficulties accessing the CoC's housing resources, thus remaining unsheltered without targeted systemic changes being made. The 2017 point-in-time count identified 48 unsheltered chronically homeless persons, representing 16 percent of the unsheltered population, and 77 persons with alcohol and other drug disorders, representing 33 percent of the adult unsheltered population. By contrast, HMIS data from Balance of State CoC's housing projects (including emergency shelter, transitional housing, rapid rehousing, and permanent supportive housing) from 2013 to 2017 reflected that only 18 percent of adults served had an alcohol or other drug disorder and only four percent of people served were chronically homeless. The significantly lower percentage of persons in these sub-sets housed in the CoC's housing projects compared to their prevalence in the unsheltered population provides support for a closer look into systemic housing barriers for persons with alcohol and drug conditions and persons who are chronically homeless, particularly those with chronic substance abuse issues (e.g., sobriety requirements). Further investigation is needed to determine the causes of this disparity, but if these potential findings hold true, the CoC may wish to create additional interventions to change program rules and practices in order to successfully reduce unsheltered homelessness in the CoC.

As noted in the Special Populations section above, most of the people who responded to the survey or interviews did not believe the CoC needed to increase its focus on the chronically homeless population, however, these potential findings lend support to the current prioritization by the coordinated entry system of people experiencing chronic homelessness.

Comparison of 2017 PIT Count Data to 2013-2017 HMIS Data from Housing Projects
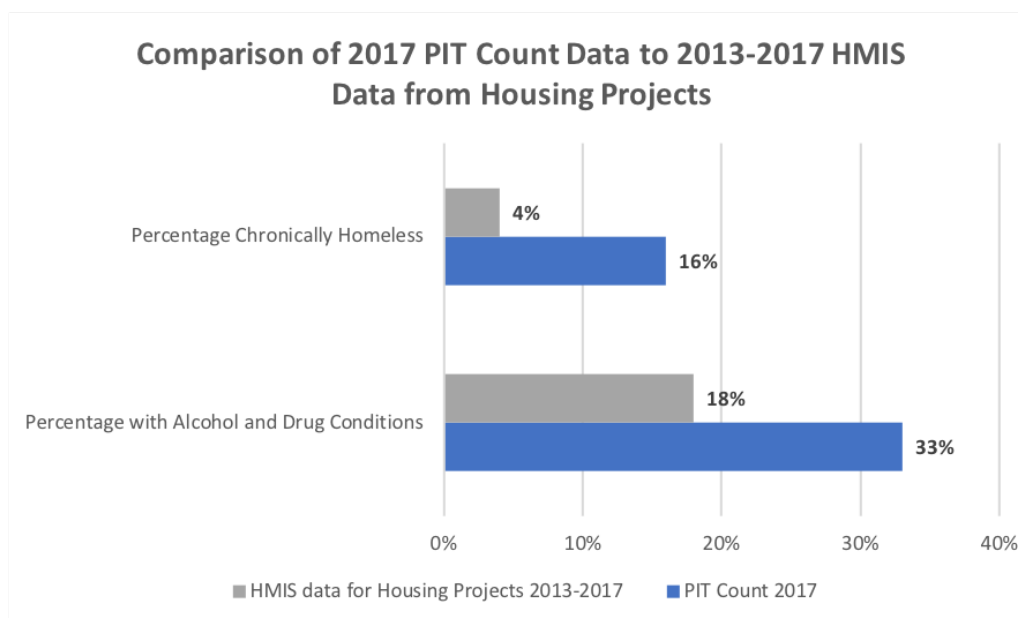
Recommendations

Approach domestic violence shelter providers to discuss the possibility of changing some program entry requirements. Regional coordinated entry committees may wish to begin conversations with domestic shelter providers about the unmet needs in the community and incorporating Housing First principles to expand shelter services to other subpopulations not experiencing domestic violence in order to support a right-sized system of care. Many domestic violence shelters receive funding that limits who they can serve to solely survivors of domestic violence, however, other domestic violence shelters will have at least some general-purpose funding that might allow them some flexibility to serve other homeless persons. Some shelters may be willing to consider a full population shift, but others may be willing to serve families or youth if they have space on a given night or they may be willing to shelter people in cold weather. The conversation will be situation-dependent and the outcome will differ from one provider to another. (See also the recommendations in the Special Subpopulation section.)

Consider offering targeted technical assistance to providers regarding the implementation of Housing First principles. Building from the information gathered during coordinated entry implementation, regional coordinated entry committees could begin to identify technical assistance needs by conducting a Housing First program assessment to determine which program entry requirements and program rules are funding requirements and which are self-imposed. The Continuum may then wish to provide targeted technical assistance regarding Housing First, how it relates to program entry requirements, and support for the transition to Housing First. This may include community trainings about topics such as motivational interviewing or housing-focused case management practices, with individualized follow-up with providers. Follow up meetings with provider leaders or line staff could provide resources and support to counteract any reluctance to implement practices aligned with Housing First and address specific concerns preventing the reduction of barriers to entry (e.g., how client to staff ratios may need to be adjusted, changes in job descriptions).

The CoC could also consider giving additional weight to implementation of Housing First practices during local funding competitions. Further, as a next step in the development of the CoC's Housing First policy, the CoC could use monitoring tools like the Housing First Assessment Tool (https://www.hudexchange.info/resource/5294/housing-first-assessment-tool/) to ensure that providers funded through the CoC Program are operating in alignment with their CoC Application responses regarding Housing First, as those responses become part of their grant agreement with HUD after the project is successful in the competition.

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System Performance

While coordinated entry helps individual households access the system, analysis of system performance allows CoCs to determine whether the system is effective and whether the homeless population is accessing the type and amount of assistance that is needed to reduce and end homelessness.

Measuring improvement in system performance can involve looking at a number of factors and metrics. This Assessment will rely mostly on the framework created by HUD's System Performance Measures. Congress established certain performance measures in the HEARTH Amendment to the McKinney Vento Act to support CoCs in analyzing performance and progress towards their goal of ending and preventing homelessness.[25] HUD then expanded upon these measures, defining the metrics and calculation processes. The seven measures are:
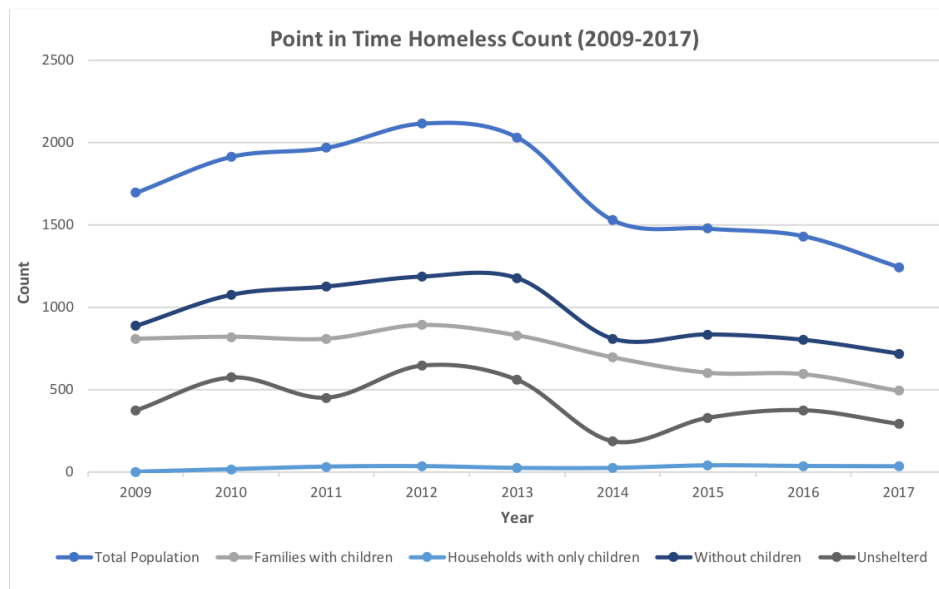
1. The length of time a person remains homeless.
2. The extent to which persons who exit homelessness to permanent housing destinations return to homelessness.
3. Number of homeless persons.
4. Jobs and income growth for homeless persons in CoC Program-funded projects.
5. Number of persons who become homeless for the first time.
6. Homelessness prevention and housing placement of persons defined by Category 3 of HUD's homeless definition in CoC Program-funded projects.
7. Successful housing placement.

Performance of Missouri Balance of State CoC and Analysis

Change in Annual Counts.[26] Related to System Performance Measure 3, the Missouri Balance of State CoC's annual point-in-time count of homeless persons shows a downward trend from 2009 to 2017 overall from 1,694 in 2009 to 1,243 in 2017. The point-in-time count also shows a downward trend for all household types, such as families with children (808 in 2009 to 493 in 2017), households with only children (40 in 2015 to 34 in 2017), and households without children (886 in 2009 to 717 in 2017). Finally, the unsheltered population has a downward trend from 374 in 2009 to 292 in 2016. These trends indicate that the overall strategy to reduce homelessness in this Balance of State CoC's geography is successful.

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[25] The McKinney-Vento Homeless Assistance Act As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 42 USC 11386, Section 427 (b).

[26] This change in annual point-in-time count is also address in "Housing Stock" section of this Assessment above.

Point in Time Homeless Count (2009-2017)

Legend: Total Population — Families with children — Households with only children — Without children — Unshelterd
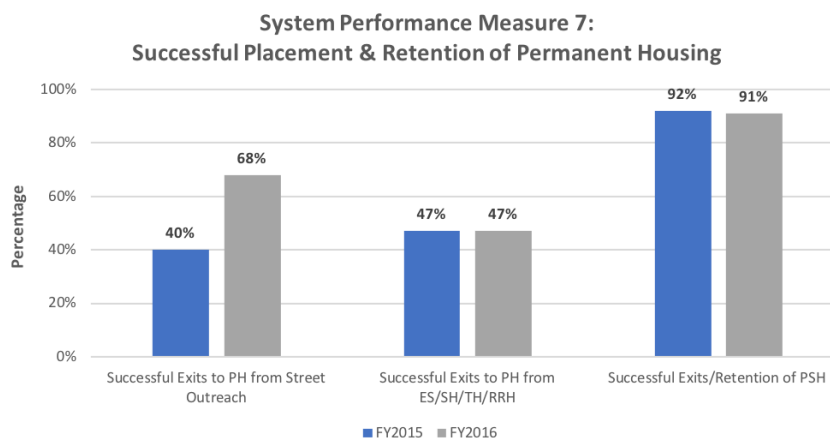
Access to Permanent Housing.

HUD's benchmarks for the full points in the FY2017 CoC funding competition related to successful permanent housing placement or retention was 80 percent for transitional housing, rapid rehousing, and permanent supportive housing project types. The CoC's benchmark for housing placement in the same project types is 90 percent for full points in the CoC competition, and 80 percent for partial points. The CoC's benchmark for housing retention in permanent housing in the local competition is 95 percent for full points.

When looking at exits from all emergency shelters, transitional housing, rapid rehousing, and permanent supportive housing recorded in HMIS over the five-year period from 2013 to 2017, the percentage of persons who exited to positive destinations (e.g. permanent housing, with exit to death and some institutions excluded from the calculation) trends upward from 34 percent in 2013 to 54 percent in 2017. Overall, housing programs participating in HMIS are consistently doing better at exiting people to permanent housing. This trend can also be seen in the youth subpopulation, with an increase from 33 percent in 2013 to 48 percent in 2017 of youth exiting to permanent housing. Programs serving veterans have also maintained similar performance since 2014, with all years exiting between 56 and 62 percent of veterans to permanent housing.

Percentage of Exits to Positive Destinations from Missouri Balance of State CoC Housing Programs (2013-2017)
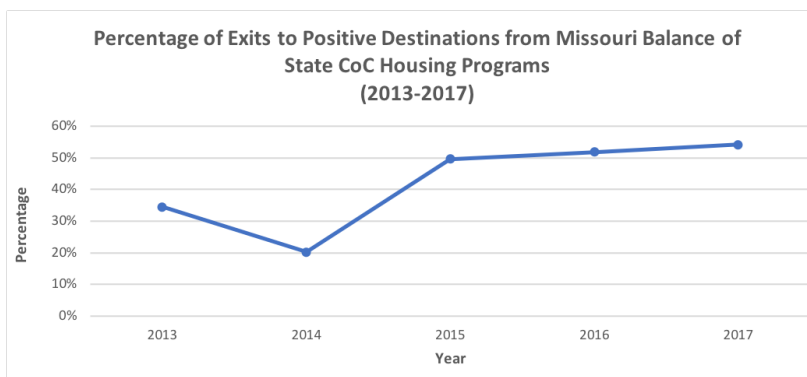
Measure 7 of HUD's System Performance Measures supports analysis of placement and retention of permanent housing by program type. Permanent supportive housing in the Balance of State CoC sustained a similar rate of maintaining permanent housing for tenants (92% in

System Performance Measure 7:
Successful Placement & Retention of Permanent Housing

FY2015 and 91% in FY2016) either by keeping them in the program or exiting them to other permanent housing. As a whole, emergency shelter, safe haven, transitional housing and rapid rehousing project types maintained a 47 percent rate of successful exits to permanent housing. Street outreach had an increase in successful exits to permanent housing, from 40 percent to 68 percent. However, in the same period the number of people served by street outreach decreased markedly. In FY2015 138 persons exited street outreach to permanent housing, only 54 did the same in FY2016.

While the permanent supportive housing project type exceeded HUD's goal, the project type as a whole did not exceed the local goals. Other project types, together, reached 47 percent. This number includes exits from emergency shelter and safe havens, which tend to have lower permanent housing placement outcomes, but this may be an area to encourage improvements in performance.

First Time Homelessness. HUD's fifth system performance measure reflects the percentage of the homeless population that are homeless for the first time (measured by the persons served during the year who did not have entries in emergency shelter, safe haven, transitional housing, or permanent supportive housing in the prior year). The Missouri Balance of State's data reflects that 86-88 percent of the persons served in shelter or housing are homeless for the first time.

Length of Homelessness. HUD's first system performance measure focuses on length of time persons remain homeless, with a goal of reducing time spent homeless, and is measured in bed nights spent in interim housing (i.e., emergency shelter, safe havens, or transitional housing). The benchmark for a HUD high performing community with regard to length of homelessness is to have an average length of homelessness episode of less than 20 days or a reduction of more than 10 percent in length of time homeless year over year. This goal is intended to challenge CoCs.

In the Balance of State CoC, the average length of time persons remain homeless in emergency shelter, safe havens, and transitional housing was reduced between FY2015 to FY2016, from 107 bed

nights to 97 bed nights, a reduction of 9.3 percent (close to HUD's high-performance benchmark of 10 percent). However, looking at the same measure for only emergency shelter and safe haven programs, the length of time homeless increased from 64 to 69 bed nights. Causation cannot be known, but these two data points

System Performance Measure 1: Length of Time Persons Remain Homeless
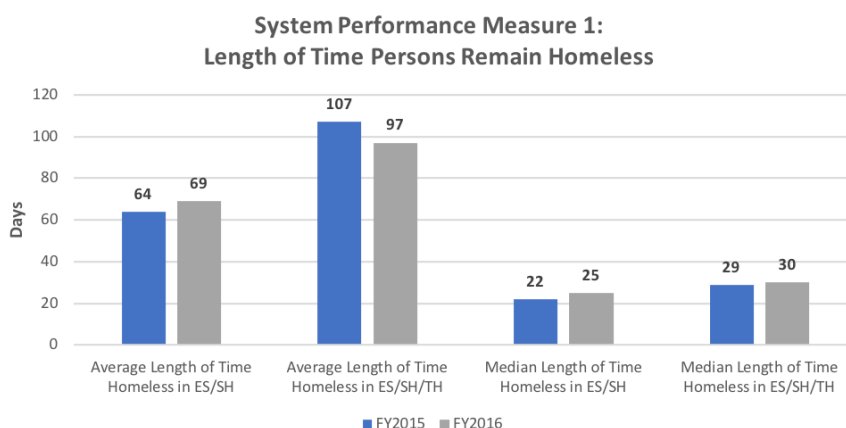
might indicate a reduction in transitional housing length of stay between the two years, since adding the transitional housing data resulted in such a steep decrease. Median length of time homeless for both measures is in the 22-30 bed night range over the two fiscal years measured, while average length of time homeless ranged from 64-100. This indicates that more people experience shorter periods of homelessness, which might be either because households locate housing and move on from the programs quickly, or because the shelter, safe havens, or transitional housing programs have program rules that require brief lengths of stay.

Income. HUD's System Performance Measure 4 provides some information about changes in income for clients participating in CoC-funded projects. HUD has not published a benchmark for this measure. However, in prior NOFAs, HUD's benchmark for employment at exit in CoC-funded projects was 20 percent. The CoC's benchmarks used in the CoC competition are (i) 10 percent of adults must increase earned income for full points (8 percent for partial points) and (ii) 20 percent of adults must increase non-employment income for full points (15 percent for partial points). Neither leavers nor

stayers exceeded the HUD or CoC benchmarks in FY2016. In FY2016 in the Balance of State CoC, a larger percentage of adults leaving the system had increases in both earned and non-employment income, than those who stayed in the system. The total increase for system leavers was 25 percent and the total increase for system stayers was 10 percent.

System Performance Measure 4: Employment and Income Growth for Homeless Persons in CoC-Funded Projects
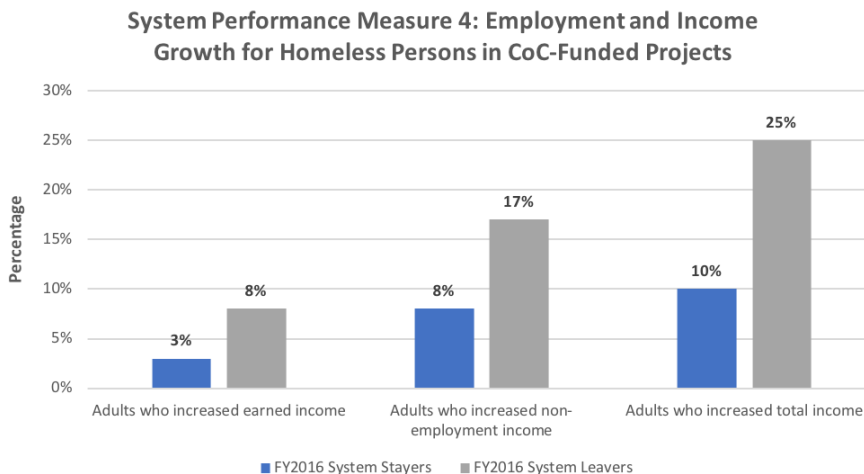
Recommendations

Overall, the system of care's outcomes appear to be improving on some measures. HomeBase makes the following recommendations for the CoC's consideration:

Focus efforts on prevention and diversion resources and assessing accurately who needs this assistance. Because a large percentage of those served are homeless for the first time (86-88 percent) , prevention and diversion resources may be a cost-efficient and effective response to the housing crisis experienced by people who touch the Missouri Balance of State CoC's system of care. Some of the stakeholders interviewed also stated a preference for more prevention and diversion resources, and 55 percent of those surveyed said precariously housed persons need more CoC attention. However, because a number of people accessing coordinated entry are self-resolving their homelessness (e.g., 59 percent of clients that did not enter housing after entering the coordinated entry system self-resolved or were successfully diverted), the CoC should make efforts to assess and prioritize prevention and diversion resources to those persons least likely to resolve their own homelessness. Currently the CoC's Coordinated Entry policies and procedures task prioritization of prevention efforts to the regional coordinated entry committees, although the Balance of State Coordinated Entry Committee did create a standardized prevention and diversion tool. At some point, the CoC's Coordinated Entry Committee may want to reconsider delegating the decision about how to prioritize prevention efforts or the Committee may want to undertake additional analysis and/or provide supplementary tools and resources to regional committees to support successful prioritization and allocation of such resources. Like voucher programs, sharing prevention or diversion resources across regions maybe the most effective allocation of resources.

Set benchmarks for performance by each program type for each relevant performance measure and review quarterly. The CoC has enough historic data and reliable enough data (see "Data Reliability and Utilization" section below) to set benchmarks for performance for each program type for each relevant measure. However, such benchmarks should be reviewed and may change in future years as more data is available. Having benchmarks can support periodic analysis of system- and project-level performance and can alert the CoC to projects that need technical assistance or homeless subpopulations that need additional resources.

In partnership with providers, analyze the barriers to improving performance and address them individually. For each system performance measure, there are a number of factors that go into the final numbers and performance reported. For some of these factors, a small workgroup reviewing the data for a single performance measure in a detailed way would be able to ascertain what part of the system is most impacting performance (e.g. a certain region, a certain housing type). In partnership with providers, the CoC may be able to identify some resources that could improve current practices,

starting with low-hanging fruit. For example, to increase the percentage of persons accessing non-employment income, there may be a data entry issue that could be addressed with additional HMIS training; or, it may be possible that improved training and a change in job description for case managers to focus their time and attention towards attaining permanent housing could help increase access to permanent housing out of emergency shelters.

COORDINATION

The third and final chapter of this Assessment focuses on system-level coordination within the Missouri Balance of State CoC. Three subjects are addressed:

- **CoC Structure, Governance and Participation** reviews the CoC's regional structure, community engagement, the CoC's activities, and staffing.

- **Funding Attainment and Maximization** considers ways in which the CoC can leverage additional local, state, and federal funding resources to maximize utilization of existing funding and increase the CoCs' capacity to serve people experiencing homelessness.

- **Data Reliability and Utilization** addresses the reliability and utility of the CoC's data to measure performance and support continuous improvement.

CoC Structure, Governance & Participation

A Continuum of Care is the community planning body that addresses the needs of individuals and families who are homeless or experiencing a housing crisis for a certain geographic area.

A CoC should:

- Promote a community-wide commitment to the goal of ending homelessness;
- Provide funding for efforts for rapidly re-housing homeless individuals and families;
- Promote access to and effective use of mainstream programs; and,
- Optimize self-sufficiency among individuals and families experiencing homelessness.[27]

A CoC also undertakes certain responsibilities, including:

- Operating the Continuum of Care (e.g., meetings, written policies, evaluation of performance);
- Designating and operating an HMIS;
- Planning for Continuum of Care activities responding to homelessness (e.g. system coordination, Point-In-Time count); and,
- Preparing an application for funding.

Each CoC is composed of representatives of community stakeholders, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve veterans, and individuals and families who are homeless or who have experienced homelessness. Each CoC tailors its structure to its unique community. Additionally, each CoC must also have a Board that is compliant with HUD requirements and that will lead the community to prevent and end homelessness.

Pursuant to the CoC Interim Rule, each CoC must designate a Collaborative Applicant and an HMIS Lead. The Collaborative Applicant is an entity, eligible to apply for HUD CoC funding, that applies for CoC planning funds on behalf of the Continuum. Most Collaborative Applicants also undertake additional duties for the CoC. The HMIS Lead operates the Continuum's HMIS on its behalf. Having a Collaborative Applicant and an HMIS Lead that are capable, compliant, and savvy is key to many CoCs' success.

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[27] HUD, Establishing and Operating a CoC, 2012, available at:
https://www.hudexchange.info/resources/documents/EstablishingandOperatingaCoC_CoCProgram.pdf

Structure, Governance, and Participation in the Missouri Balance of State CoC

The Missouri Balance of State CoC covers 101 counties in the state of Missouri, including rural, suburban, and urban areas with a density range of approximately 8 persons per square mile to 559 people per square mile. The CoC has a width of 240 miles wide and a length of 300 miles.

	Total Population (2010 Census)	Total PIT (2017)	Percentage of Total Population Homeless
Region 1	583,484	61	0.01%
Region 2	82,888	12	0.01%
Region 3	119,416	26	0.02%
Region 4	463,724	243	0.05%
Region 5	589,102	439	0.07%
Region 6	152,722	134	0.09%
Region 7	83,376	88	0.11%
Region 8	179,180	71	0.04%
Region 9	294,158	61	0.02%
Region 10	319,207	160	0.05%
Total	2,867,257	1,295	0.05%

To address this wide geography and range of needs, CoC leadership divided the CoC into ten Regions, organized geographically for more localized planning and coordination. Each Region is made up of between 6 and 16 counties, with a homeless point-in-time population ranging between 12 and 439 people, and a percentage of homelessness ranging between .01 to .11 percent (or stated differently, 1 in 10,000 people to 11 in 10,000 people). While still below the national homelessness average of .17 percent in 2017, this range of homelessness frequency, in combination with the diversity within the CoC's geography makes this CoC's responsibilities more complicated than some other CoCs expereince. By design, each Region includes rural areas and then a larger urban area that acts as an anchor for the Region. The regional structure is used for coordination activities (i.e., regional meetings), service coordination (including coordinated entry), and data analysis.

The Balance of State CoC recently completed a redesign of its governance structure, severing CoC leadership from the Governor's Committee to End Homelessness and creating an independent CoC Board. The Board is made up of representatives from all Regions within the Balance of State CoC, as well as at-large representatives. Representatives of all sectors are encouraged to participate, including representatives of victim services providers, human trafficking providers, sexual assault providers, the education sector, the healthcare sector, law enforcement, local, state and federal government, emergency assistance providers, addiction and recovery providers, formerly homeless persons, veterans, and all other types of homeless service providers. Staff from the Collaborative Applicant and HMIS Lead Agency serve on the CoC Board as ex-officio, non-voting Members.

The current CoC Board includes members from all regions and a variety of jurisdictions and agencies providing housing and services, including employment, counseling, health services, and

transportation. Members represent subpopulations including youth, families, domestic violence survivors, veterans, and persons with behavioral health disorders.

The Balance of State CoC is supported by two full-time staff members at the Missouri Housing Development Commission, which acts as the CoC's Collaborative Applicant, and in addition to applying for CoC Planning Funds, this staff also undertake coordination, staffing, and analysis duties. Institute for Community Alliances (ICA), a non-profit entity, is the HMIS Lead. In that role, ICA oversees the HMIS, provides training and resources to housing and service providers, and undertakes data analysis for the CoC.

Analysis

Stakeholders who responded to interviews and surveys commented on the CoC's structure, governance, activities, and staffing.

REGIONAL STRUCTURE

Most stakeholders found the regional structure adequate for meeting CoC needs. Sixty percent of survey respondents were neutral in their assessment of the regional structure's effectiveness at responding to homelessness. HomeBase found in the interviews and surveys that Regions varied widely in structure, culture, leadership, membership, type of community served, and resources available. A few stakeholders indicated an interest in further formalizing the regional structure by requiring parallel structures by each region. While many respondents wanted rural concerns to be prioritized, some shared that rural areas have spoken in favor of the regional structure because of the balance of providers and skill sets that results.
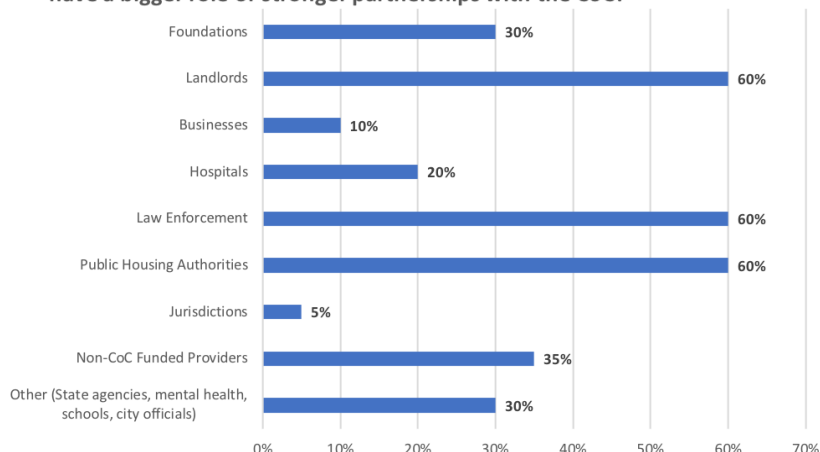
REPRESENTATION IN THE COC

Many stakeholders are excited about the new CoC governance structure and are supportive of the CoC Board's next steps. The Board is representative of the CoC's geography and subpopulations. Survey and interview participants indicated that, while additional partnership could be beneficial from a number of sectors (including State departments, schools, and non-CoC-funded providers), the most commonly desired entities to augment the CoC's efforts to prevent and end homelessness are additional Public Housing Agencies, law enforcement, and landlords.

Affordable housing was the most common type of housing resource that respondents cited as being needed in the Balance of State region and integrating Public Housing Agencies and landlords into the Balance of State CoC could support the

Missouri Balance of State CoC Survey Results: Which stakeholders need to have a bigger role or stronger partnerships with the CoC?

Stakeholder	Percent
Foundations	30%
Landlords	60%
Businesses	10%
Hospitals	20%
Law Enforcement	60%
Public Housing Authorities	60%
Jurisdictions	5%
Non-CoC Funded Providers	35%
Other (State agencies, mental health, schools, city officials)	30%

goal of increasing that resource. Public Housing Agencies could create or increase set asides of housing vouchers or increase homeless preferences. Landlords could make units available to house homeless persons with a voucher. In addition, law enforcement was cited as a great resource and asset in some regions of the CoC, and other regions hope to better partner with law enforcement. Specifically, as coordinated entry gets underway, law enforcement has been a strong asset in outreach related to the coordinated entry system in certain areas.

COC ACTIVITIES

Stakeholders who responded to interviews and surveys often cited communication and coordination as some of the key strengths of the Balance of State CoC. Stakeholders found the administrative structure, including trainings and communications available, to be beneficial. At the same time, many stakeholders could not answer questions about challenges or activities of the CoC as a whole, as they only knew about their specific geography, or the subpopulation they serve. Many stakeholders also lauded the Balance of State CoC for its success at meeting HUD requirements, particularly regarding the annual point-in-time homeless census and the review and rank process that prioritizes housing resources for funding in the annual HUD CoC funding completion. Of those surveyed, 60 percent thought the CoC was on the road to ending homelessness.

STAFFING

Most stakeholders feel that CoC and HMIS staff were helpful in the completion of CoC activities and requirements and appreciate the efforts of MHDC and ICA. A few stakeholders would like the CoC to consider creating a 501(c)(3) and establishing staff independent of state government, to open up funding and other opportunities for the CoC. In the meantime, stakeholders stated that they would like to see clearer expectations regarding roles and responsibilities of the various actors within the CoC, including the CoC Board, the Regions, the HMIS Lead, and the Collaborative Applicant.

Recommendations

HomeBase makes the following recommendations for the CoC's consideration:

Remember the limitations of the regional structure when making decisions. While the regional structure has been useful for administering the Balance of State CoC, and stakeholders who participated in this study do not have a stated interest in considering other divisions, the current structure has limitations. The division of the counties was top-down, not necessarily taking into account on-the-ground concerns. Counties at the edges of a region may have service or other ties to neighboring regions or other CoCs, so regional CoC participation may not be representative. When using the structure for data analysis, rural needs and resources can be masked by the resources or needs in more urban areas of the CoC. The CoC Board and many stakeholders voiced a concern about if the CoC was adequately serving rural, suburban and urban areas of the CoC's geography; analyzing data with those divisions in mind may produce more actionable information.

Transition the CoC Board's focus to strategic responses to homelessness. A transition to a different CoC governance structure, especially while creating a coordinated entry system at the same time, is complicated and time-consuming. As a Balance of State CoC, the Missouri Balance of State CoC also has additional administrative hurdles that CoCs with smaller geographies do not have to overcome. However, because the CoC appears to operate primarily as an administrative structure and not as a strategic coalition pushing forward ideas and actions to end homelessness, as this governance transition completes, HomeBase encourages the CoC Board to attempt to streamline, minimize, or delegate administrative or regulatory tasks and to focus energy and resources, including committee time and resources, on identifying and implementing more focused, data-driven strategies to end homelessness (e.g., developing strategic plan, setting performance-driven action plans). This adjustment in approach would also unify and inform CoC members about the CoC's goals and activities*.*

Create multi-directional communication opportunities. Following from the recommendation immediately above, if the CoC created more opportunities for information sharing and communication from a variety of stakeholders the CoC as a whole may better understand the reality of homelessness in this region, including needs and gaps and successful programming. This could be achieved through increased opportunities for peer sharing, including training by provider agencies or other stakeholders, or establishing peer groupings across regions (e.g. law enforcement) to support capacity building and shared problem solving.

Prioritize Public Housing Agency and landlord engagement. The hardest to house populations, such as persons with criminal records, multiple evictions, behavioral health challenges, and long-term or chronic homelessness, have historically faced difficulties affording market rate rental units and

meeting the screening criteria set by property owners, managers, landlords, and Public Housing Agencies. Given the need to increase access to affordable housing to impact homelessness, the CoC should consider prioritizing efforts to engage Public Housing Agencies and landlords in the coming year. Engaging these entities need not include CoC Board meeting participation to be successful, the CoC could develop service partnerships or create a specialized committee related to their interests.

- According to a HUD study completed in 2014, Public Housing Agencies that reported participating in the local CoC or other community efforts to respond to homelessness are more likely to make efforts to serve homeless households. Additionally, when Public Housing Agencies do not participate with their local CoC, it was most often due to lack of knowledge or funding, or historical lack of participation.[28] While stakeholders indicated that Public Housing Agencies in the Balance of State CoC region were not willing to participate in the CoC or serve people experiencing homelessness, a coordinated effort and educational effort about HUD guidance[29] and Federal policy[30] may shift the role and interest of at least some Public Housing Agencies.

- Landlord engagement has been an increasingly higher need within CoCs in recent years, especially as the rapid rehousing model becomes more common. Programs to engage and support landlords can be financial in nature, for example: providing pre-leasing incentives, risk mitigation pools, increased security deposits, protective payee programs, or focusing on costs saved in tenant vetting and referrals when the landlord partners with a CoC agency. Non-financial incentives may include: tenant certification and recommendation programs, case management and support services provided during a transitional housing period, landlord access to support hotlines, property maintenance for client-occupied units provided by rental assistance program or associated agencies, character letters from case managers and/or respected third parties (e.g. religious leader, employer) or recognition (e.g. appreciation events).

As one possibility, a CoC Committee could create materials that could be adapted for use with Public Housing Agencies and landlords at the local level, as it does for the point-in-time count and coordinated entry, including a social media guide, media releases, and other templates. Alternatively, a CoC Committee could create a website like Washtenaw County, Michigan did to provide resources and information to landlords at http://www.housingaccess.net/landlords.html.

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[28] Office of Policy Development and Research, U.S. Department of Housing and Urban Development, *Study of PHAs' Efforts to Serve People Experiencing Homelessness*, February 2014, pages 34, 36.

[29] Office of Public and Indian Housing, U.S. Department of Housing and Urban Development, Notice PIH 2013-15 (HA) Guidance on housing individuals and families experiencing homelessness through the Public Housing and Housing Choice Voucher programs, issued June 10, 2013.

[30] United States Interagency Council on Homelessness, PHA Guidebook to Ending Homelessness, November 2013, available at: https://www.usich.gov/resources/uploads/asset_library/PHA_Guidebook_Final.pdf.

Building Effective Landlord Partnerships

Solving homelessness in a competitive housing market requires a strong commitment to landlord engagement. A three-prong approach to **Access**, **Engage & Sustain**, and **Mitigate Risk** has proven successful in recruiting and retaining landlords as critical partners in our work to end homelessness.

1 ACCESS

Outreach to potential landlords is coordinated, targeted, & sustained, with effective systems for direct solicitation, tailored outreach materials, & strategies for leveraging entry points and building relationships.

Steps You Can Take:

1. DIRECT SOLICITATION
- Establish an agency-wide outreach system, identifying & prioritizing prospective landlords.
- Train staff to reach out, ensuring they are familiar with your program and talking points.
- Integrate "sales" techniques.

2. DEVELOP OUTREACH MATERIALS
- Develop physical & web-based materials that are educational, engaging, and succinct, encouraging landlords to contact your program.

3. LEVERAGE & ENTRY POINTS
- Mobilize community stakeholders to help you with your efforts.
- Provide consistent marketing through newsletters and events for messaging in the community.

2 ENGAGE & SUSTAIN

Relationships must be cultivated by minimizing the burden on landlords through administrative flexibility, identifying ways the program can benefit landlords, and focusing resources on being a good partner.

Steps You Can Take:

1. SUSTAIN CORE MESSAGING
- Follow through with using your materials & prepare a coordinated marketing campaign that is flexible & targeted, honest about program realities, and fosters and deepens landlord relationships.

2. REASSURE & MOTIVATE LANDLORDS
- Reassure landlords that it is safe & easy to rent to your clients, emphasizing timely rent, administrative ease, & wraparound support services. Give references of other landlords in the community.

3. DEEPEN RELATIONSHIPS
- Provide landlord recognition opportunities & pursue ways to expand commitment.
- Consider coordinating a landlord advisory committee.

3 MITIGATE RISK

Long-term support & quick responses to crises reduce adverse business impact, assuage landlord fears, and engender relationships of trust. This helps keep landlords working with your clients over the long term.

Steps You Can Take:

1. FINANCIAL MITIGATION
- Commit to reducing landlord exposure to financial liability through a risk mitigation fund, higher security deposits, or gratitude bonuses.

2. PROVIDE LANDLORD SUPPORT
- Make frequent direct contact with landlords and ensure staff is available to swiftly respond to crisis and address concerns.
- Consider recruiting a housing specialist.

3. INCREASE TENANT VIABILITY
- Work with clients to obtain recommendation letters & credit history, and provide opportunities for landlords to meet with clients in person and ask questions.
- Offer regular case management and other program supports.

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Target invitations to participate in the CoC to the audience. To the extent that Public Housing Agencies, landlords, law enforcement, state departments, representatives of certain counties, or other entities are invited to participate in the CoC, CoC members should target the specific requests to the audience. Such agencies will only continue to participate in the CoC if they find benefit in participating. For example, in one Balance of State region, law enforcement and Department of Mental Health have been highly engaged in coordinated entry implementation because the system supports their success. Implementing coordinated entry continues to surface additional partners and resources that were not previously engaged in CoC planning. Other CoCs have also found success in: collaborating on grant applications, participating in the other system's planning efforts, or, after involving one representative in CoC activities, sending them to engage their sister agency. In the case of meetings attended by new partners, meeting agendas should be engaging and relevant for the attendees. Because of the size of the regions of the Balance of State CoC, meeting planners may want to find reliable ways to host meetings where individuals can participate remotely, and also productively.

Create clear expectations of roles and responsibilities among CoC-related entities. As a next step in the redesign of the CoC governing structure, establish clear, written expectations of roles and responsibilities for all of the actors related to the Balance of State CoC. Following HUD's approach in the Interim Rule, the Balance of State CoC does not have to be prescriptive to the regions about *how* they structure their meetings or workgroups but should be clear about *what* each Region must do. Understanding the expectations of the CoC as a whole better allows each Region to participate. Similarly, the Collaborative Applicant and HMIS staff would benefit from having clear expectations about their roles and responsibilities within the CoC. While the CoC may want to consider creating an independent structure at some point, the cost and complexity to do so would be substantial. HomeBase did not find evidence of sufficient concern or resources to support a shift in the near future.

COORDINATION

Funding Attainment and Maximization

The Continuum of Care Program is a vital source of funding for housing and services to help prevent and end homelessness in communities. However, a wide range of local, state, and federal funding sources accessible to communities that can complement CoC funding and increase local capacity to meet the needs of people experiencing homelessness. In addition to other homeless targeted funding sources, mainstream programs such as TANF and Medicaid can provide funding for housing and services that benefit people experiencing homelessness but are not dedicated to serving this population alone.

Furthermore, HUD encourages CoCs to maximize the use of mainstream and other community-based resources when serving persons experiencing homelessness as part of their efforts to strategically allocate and utilize resources.[31]

The CoC's data reflects a clear need for more housing and homeless-targeted resources. By advocating for, attaining, and leveraging additional sources of funding, CoCs can address gaps in housing and services within the local homeless response system, increase funding support for interventions that work, and more comprehensively and effectively meet the needs of people experiencing homelessness.

Analysis of Attainment and Maximization of Local and State Funding Sources

MISSOURI HOUSING TRUST FUND[32]

The Missouri Housing Trust Fund (MHTF) was created by the state Legislature in 1994 to help meet the housing needs of very low-income families and individuals. The Missouri Housing Development Commission (MHDC) administers the MHTF, which provides funding for a variety of housing needs, such as homeless prevention; rehab or new construction of rental housing, rental assistance; and home repair.

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[31] U.S. Department of Housing and Urban Development (HUD) Community Planning and Development, Notice of Funding Availability (NOFA) for the Fiscal Year (FY) 2017 Continuum of Care Program Competition," FR-6100-N-25, https://www.hudexchange.info/resources/documents/FY-2017-CoC-Program-Competition-NOFA.pdf

[32] Missouri Housing Development Commission (MHDC), "Missouri Housing Trust Fund: Program Description," http://www.mhdc.com/housing_trust_fund/MHTF-info.htm and "Missouri Housing Trust Fund FY 2018 Allocation Plan," http://www.mhdc.com/housing_trust_fund/documents/FY2018/2018_MHTF_AllocationPlan.pdf

The Trust Fund is supported by a $3 recording fee on all real estate documents filed in the state of Missouri. As such, the annual funding level depends upon the level of real estate activity. The estimated amount of funding available in FY2018 through the MHTF is **$4 million.**

Missouri Housing Trust Fund FY2018 Geographical Allocation Plan	
Allocation Area	**Allocation**
St. Louis Metropolitan Area: Franklin, Jefferson, Lincoln, St. Charles, St. Louis City, St. Louis and Warren Counties	22%
Kansas City Metropolitan Area: Caldwell, Cass, Clay, Clinton, Jackson, Lafayette, Platte and Ray Counties	15%
North Region: Adair, Andrew, Atchison, Buchanan, Carroll, Chariton, Clark, Daviess, DeKalb, Gentry, Grundy, Harrison, Holt, Knox, Lewis, Linn, Livingston, Macon, Marion, Mercer, Monroe, Nodaway, Pike, Putnam, Ralls, Randolph, Schuyler, Scotland, Shelby, Sullivan and Worth Counties	16%
Central Region: Audrain, Bates, Benton, Bollinger, Boone, Callaway, Camden, Cape Girardeau, Cole, Cooper, Crawford, Gasconade, Henry, Howard, Iron, Johnson, Madison, Maries, Miller, Moniteau, Montgomery, Morgan, Osage, Perry, Pettis, Phelps, Pulaski, Saline, St. Clair, St. Francois, Ste. Genevieve and Washington Counties	20%
South Region: Barry, Barton, Butler, Carter, Cedar, Christian, Dade, Dallas, Dent, Douglas, Dunklin, Greene, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Mississippi, New Madrid, Newton, Oregon, Ozark, Pemiscot, Polk, Reynolds, Ripley, Scott, Shannon, Stoddard, Stone, Taney, Texas, Vernon, Wayne, Webster and Wright Counties	27%

The Missouri Balance of State CoC can work to ensure that counties where there is a gap between housing need and available housing for people experiencing homelessness are applying for funding from the Missouri Housing Trust Fund every year and are maximizing utilization of these funds by targeting them to areas, project components, and populations with the highest need.

AFFORDABLE HOUSING ASSISTANCE PROGRAM (AHAP)[33]

The Affordable Housing Assistance Program (AHAP) housing production tax credit is used as an incentive for Missouri businesses and/or individuals to participate in affordable housing production. This state tax credit is earned by an eligible donor for the donation of cash, equity, services, or real or personal property to a non-profit community-based organization for the purpose

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[33] MHDC, "Affordable Housing Assistance Program (AHAP)," http://www.mhdc.com/rental_production/ahap/

of providing affordable housing assistance activities or market rate housing in distressed communities.

There are two types of AHAP tax credits: production credits for donations related to construction, rehabilitation, and rental assistance activities and operating assistance credits for donations that help fund the operating costs of the non-profit organization. The program offers $10 million in production credits and $1 million in operating assistance credits annually.

The Missouri Balance of State CoC can leverage the AHAP tax credits to encourage the investment of private equity in the development of affordable rental housing for low-income households, particularly for rural areas within the CoC that lack sufficient affordable housing resources.

HOUSING FIRST PROGRAM (HFP)[34]

The Housing First Program (HFP) was established in 2012 to provide funding to support upcoming, new, or existing Housing First programs in order to address the housing and housing service needs of people experiencing homelessness and chronic homelessness. Projects targeting veterans experiencing homelessness, individuals experiencing chronic homelessness, or both were prioritized for funding in FY2017. Recipients of HFP funding must follow a Housing First approach, including the following components:

- Crisis intervention and voluntary case management
- Recipient-directed assistance in accessing housing as well as agency and community resources and services
- Voluntary participation of recipients in programs and services
- Recipient participation in the decision-making process
- Recipients, landlords, and service providers work together as a team
- Ongoing support and monitoring available for recipients as requested

In FY2017, 2 of 14 HFP grants awarded were to agencies in the Missouri Balance of State CoC:

- Delta Area Economic Opportunity Corporation - $22,500
- Catholic Charities of Southern Missouri, Inc. - $20,000

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[34] MHDC, "Housing First Program (HFP) FY 2017 Notice of Funding Availability (NOFA)," http://www.mhdc.com/nofa/FY2017_NOFAs/2017_HFP_NOFA.pdf and "FY 2017 Housing First Program Funding Approvals," http://www.mhdc.com/ci/hfp/2017/HFP_2017_Approvals%20-%20UPDATE.pdf

The Missouri Balance of State CoC can encourage additional agencies and community organizations to apply for funding in future HFP funding rounds and can support agencies in adopting Housing First approaches in upcoming, new, and existing programs that would be eligible for HFP funding.

MISSOURI HOUSING INNOVATION PROGRAM[35]

The Missouri Housing Innovation Program aims to provide flexibility to CoCs to address their evolving needs, diminish the burden of coordination of care across large geographic areas, and offer an opportunity to implement or sustain coordinated entry to meet HUD deadlines. There are many components to coordinating care in an effective way which includes access, direct client assistance for prevention/diversion, housing assessment, housing referrals, housing placements, housing location and on-going case management determined by client-driven choice. Grants types supported by the Missouri Housing Innovation Program include Coordinated Entry System, Street Outreach, Housing Assistance/Services, and HMIS.

For FY 2018, the Balance of State Regions requested the following funding amounts from the Missouri Housing Innovation Program:

- Region 1 - $197,365
- Region 2 - $98,877
- Region 3 - $227,150
- Region 4 - $42,875
- Region 5 - $364,500
- Region 6 - $162,539
- Region 7 - $28,250
- Region 8 - $153,375
- Region 9 - $202,125
- Region 10 - $200,250

This program can provide vital funding support to help the Missouri Balance of State CoC Regions build out their Coordinated Entry and HMIS capacities, increase street outreach efforts, and increase housing assistance and services.

Analysis of Attainment and Maximization of Federal Funding Sources

EMERGENCY SOLUTIONS GRANT (ESG)

The Emergency Solutions Grants (ESG) program is a formula-funded program that provides funding to eligible recipients, including states, territories, and qualified metropolitan cities and urban counties to:

1. Engage individuals and families experiencing homelessness living on the street;

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[35] MHDC, "Missouri Housing Innovation Program FY 2018 Notice of Funding Availability (NOFA)," http://www.mhdc.com/ci/mohip/2018/2018_MoHIP_NoFA_Posting.pdf and "FY2018 Missouri Housing Innovation Program Applications Received," http://www.mhdc.com/nofa/FY2018_Applications/MoHIP_2018_Applications_Received.pdf

2. Improve the number and quality of emergency shelters for individuals and families experiencing homelessness;
3. Help operate those shelters;
4. Provide essential services to shelter residents;
5. Rapidly re-house individuals and families experiencing homelessness; and,
6. Prevent individuals and families from becoming homeless.[36]

In FY2017, the State of Missouri received a total ESG allocation of **$2,930,526.** The Missouri Housing Development Commission (MHDC) is responsible for administering the Missouri State Allocation of the ESG Program funds granted to MHDC by the Missouri Department of Social Services (DSS). For program year 2018, MHDC made up to $3,307,300. ESG funds (including some funds from previous funding year) available to Missouri applicants, with a goal of providing 47 percent of available funds to the Missouri Balance of State CoC.[37]

Regions within the Missouri Balance of State CoC can ensure that they are applying for ESG funds to help support and increase street outreach activities, homeless prevention efforts, emergency shelter services, and the provision of short-term or medium-term rental assistance. Additionally, under the ESG program, transportation is an allowable expense and could be used as a resource.

COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG)

The Community Development Block Grant (CDBG) program is a flexible program that provides communities with resources to address a wide range of unique community development needs. CDBG funds 28 eligible activities, including infrastructure, economic development projects, installation of public facilities, community centers, housing rehabilitation, public services, clearance/acquisition, microenterprise assistance, code enforcement, and homeowner assistance.[38]

In 2017, the State of Missouri received a CDBG allocation of **$20,328,096**. Missouri's FY2018 Annual Action Plan includes a goal to increase the number of people provided with new or improved availability/accessibility of economic opportunity through job creation, retention and business infrastructure assistance to for-profit companies.[39]

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[36] HUD, "ESG Requirements," https://www.hudexchange.info/programs/esg/esg-requirements/
[37] MHDC, "Emergency Solutions Grant Allocation Plan," September 7, 2017, http://www.mhdc.com/ci/esg/documents/2018/2018_ESG_AllocationPlan_Posting.pdf
[38] HUD, "The Community Development Block Grant (CDBG) Program – Frequently Asked Questions," https://www.hudexchange.info/onecpd/assets/File/The-Community-Development-Block-Grant-FAQ.pdf
[39] Missouri Department of Economic Development et al, "The State of Missouri 2018-2022 Consolidated Plan and 2018 Annual Action Plan," December 2017, https://ded.mo.gov/sites/default/files/2018-2023_ConsolidatedPlan_Draft.pdf

Additionally, the following local jurisdictions within the Missouri Balance of State CoC received CDBG awards:

Columbia, MO - $837,401

Recent CDBG funding project/goal highlights:[40]

- Provide vocational training to 70 participants, particularly low-income youth.
- Acquire, renovate, or expand five community facilities providing services to youth, homelessness, ex-offenders, and mental health.

Jefferson City, MO - $244,499

Recent CDBG funding project/goal highlights:[41]

- Provide funding up to 15 percent of annual CDBG allocation to local non-profit organizations for supportive services. Services are either new or a substantial increase over previous year and may include employment services (e.g. job training), crime prevention and public safety, child care, health services, substance abuse services (e.g., counseling and treatment), fair housing counseling, education programs, services for senior citizens and services for homeless persons.

Jefferson County, MO - $1,064,354

Recent CDBG funding project/goal highlights:[42]

- Developed a Transportation Assistance Program to provide public transportation (bus) passes to low-to-moderate-income residents of Jefferson County for transportation to jobs, medical services & essential needs

Lee's Summit, MO - $354,769[43]

Recent CDBG funding project/goal highlights:[44]

- Support Lee's Summit Social Services in providing emergency assistance to persons and families who need food, clothing, utility assistance, medical assistance, school supplies, etc.
- Assist individuals and families by helping them find employment, keep jobs and become economically stable.

As demonstrated above, CDBG funds are a flexible resource that may be used to assist a wide range of activities that may help address the needs of people experiencing homelessness, including job

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[40] City of Columbia 2016 Annual Action Plan, available at: https://www.hudexchange.info/programs/consolidated-plan/con-plans-aaps-capers/

[41] Jefferson City 2016 Annual Action Plan, available at: https://www.hudexchange.info/programs/consolidated-plan/con-plans-aaps-capers/

[42] Jefferson County 2016 Annual Action Plan, available at: https://www.hudexchange.info/programs/consolidated-plan/con-plans-aaps-capers/

[43] Lee's Summit, MO crosses the boundary between the Kansas City CoC and the Balance of State CoC.

[44] Lee's Summit Annual Action Plan, available at: https://www.hudexchange.info/programs/consolidated-plan/con-plans-aaps-capers/

training/employment services and emergency assistance. CDBG funds may also be used for developing or supporting the development of permanent housing, as well as emergency shelter and transitional housing. The Missouri Balance of State can consider working with CDBG funding recipients, including the State of Missouri, to increase the amount of funding that is targeted to housing and services for people experiencing homelessness.

HOME INVESTMENT PARTNERSHIPS (HOME) PROGRAM

The HOME Investment Partnerships Program (HOME) provides formula grants to states and localities to fund a wide range of activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership and providing direct rental assistance to low-income persons. HOME is the largest federal block grant to state and local governments designed exclusively to create affordable housing for low-income households.[45]

In 2017, the State of Missouri received a HOME allocation of **$8,580,593**, which will support the following projects in FY 2018:

- Missouri plans to utilize HOME funds in conjunction with National Housing Trust Fund (HTF) dollars to preserve and provide affordable housing for low-income households and seniors through homeless prevention, tenant-based rental assistance/rapid re-housing, and unit construction and rehabilitation.
- Additionally, HOME funds and HTF dollars will be used to provide more accessible and affordable housing for MHDC's set-aside populations. The set-aside preferences consist of two separate and distinct priorities: Special Needs and Vulnerable Persons.
  - A person with special needs is a person who is: (a) physically, emotionally or mentally impaired or is diagnosed with mental illness; or (b) developmentally disabled.
  - A vulnerable person is a person who is: (a) homeless, including survivors of domestic violence and human or sex trafficking; or (b) a youth transitioning from foster care.[46]

Additionally, the city of Columbia, MO received a FY2017 HOME allocation of $435,421. In the city's most recent Annual Action Plan (2016), it set a goal to utilize HOME funds to provide development financing for two affordable housing developments funded through the Missouri Housing Development Commission.[47]

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[45] HUD, "Home Investment Partnerships Program,"
https://www.hud.gov/program_offices/comm_planning/affordablehousing/programs/home
[46] DED et al, "The State of Missouri 2018-2022 Consolidated Plan and 2018 Annual Action Plan,"
https://ded.mo.gov/sites/default/files/2018-2023_ConsolidatedPlan_Draft.pdf
[47] City of Columbia 2016 Annual Action Plan, available at: https://www.hudexchange.info/programs/consolidated-plan/con-plans-aaps-capers/

HOME funds cannot be used to provide supportive services or to fund shelters, but the HOME program can be an invaluable resource for acquiring and/or developing transitional or permanent rental housing and provide tenant-based rental assistance for individuals experiencing homelessness. Additionally, the flexibility of the HOME program enables HOME to work well with other Federal homeless housing programs. The Missouri Balance of State can consider working with HOME recipients, including the State of Missouri, to advocate that funds be used to establish affordable housing and provide tenant-based rental assistance in areas that lack sufficient housing stock and that such resources be targeted for individuals experiencing homelessness.

NATIONAL HOUSING TRUST FUND (HTF)

The National Housing Trust Fund (HTF) is an affordable housing production program that complements existing federal, state, and local efforts to increase and preserve the supply of decent, safe, and sanitary affordable housing for extremely low- and very low-income households, including homeless families. HTF funds are made to states and state-designated entities and may be used for the production or preservation of affordable housing through the acquisition, new construction, reconstruction, and/or rehabilitation of non-luxury housing with suitable amenities.[48]

In 2017, Missouri received an HTF allocation of **$3,357,775.** The State of Missouri's HTF allocation is administered by MHDC, ensuring that HTF dollars are coordinated and leveraged with other affordable housing resources including ESG and HOME.[49] Planned HTF-supported activities for FY2018 are to be carried out in coordination with HOME funding and are detailed above.

While HTF dollars are already targeted to extremely low-income renter households, the current Housing Trust Fund Interim Rule allows states to choose to target those funds to specific subpopulations, such as people experiencing homelessness.[50] The Missouri Balance of State CoC can advocate for HTF to be targeted to serve people experiencing homelessness and for an increase in the amount of HTF dollars that are directed toward affordable housing development within the Balance of State CoC.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

The Housing Opportunities for Persons with AIDS (HOPWA) program provides states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of low-income persons living with HIV/AIDS and their families. HOPWA is the only

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[48] HUDExchange, "Housing Trust Fund," https://www.hudexchange.info/programs/htf/
[49] DED et al, "The State of Missouri 2018-2022 Consolidated Plan and 2018 Annual Action Plan," https://ded.mo.gov/sites/default/files/2018-2023_ConsolidatedPlan_Draft.pdf
[50] U.S. Interagency Council on Homelessness (USICH), "Housing to End Homelessness: How the National Housing Trust Fund Will Help, June 2015, https://www.usich.gov/resources/uploads/asset_library/Fact_sheet_HTF.pdf

Federal program solely dedicated to providing rental housing and other types of housing assistance and supportive services to this special needs population.[51]

In 2017, the State of Missouri received a HOPWA allocation of **$619,625.** The State of Missouri plans to utilize these funds in FY2018 to provide tenant-based rental assistance/rapid re-housing to 175 households and to provide other housing and supportive service assistance to 150 households.[52]

The Missouri Balance of State CoC served four people experiencing homelessness with HIV/AIDS in 2017, all of whom were unsheltered. The CoC can work with the State of Missouri to ensure that HOPWA-funded tenant-based rental assistance and rapid re-housing can be made available and utilized for unsheltered clients within the CoC living with HIV/AIDS.

FEDERAL LOW-INCOME HOUSING TAX CREDIT (LIHTC) PROGRAM

The Federal Low-Income Housing Tax Credit (LIHTC) provides a federal tax credit to investors in affordable housing. The program provides competitive awards of federal tax credits to developers to assist in the creation of affordable rental housing including supportive housing. It requires that 20 percent of LIHTC units be made available for households at or below 50 percent of area median income (AMI) or that 40 percent of LIHTC units be made available for households at or below 60 percent of AMI. The LIHTC can be used each year for 10 years and is allocated to the owner of an affordable housing development.[53]

Missouri's Federal LIHTC program is administered by MHDC and will allocate an estimated **$14,600,000** tax credits in 2018. As with the state AHAP program, the Missouri Balance of State CoC uses the LIHTC program to encourage the investment of private equity in the development of affordable rental housing for low-income households.

Missouri also has a state LIHTC and may allocate an amount annual equal to 100 percent of the Federal LIHTC. The Missouri Housing Development Commission, which includes Governor Greitens, withheld the state LIHTC for 2018, without significant review of the impact on homelessness and the development of homeless housing. The CoC will want to monitor the impact of this decision over the next year.

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[51] HUD, "Housing Opportunities for Persons with AIDS (HOPWA)," https://www.hud.gov/hudprograms/hopwa
[52] DED et al, "The State of Missouri 2018-2022 Consolidated Plan and 2018 Annual Action Plan," https://ded.mo.gov/sites/default/files/2018-2023_ConsolidatedPlan_Draft.pdf
[53] MHDC, "Low Income Housing Tax Credit (LIHTC) program," http://www.mhdc.com/rental_production/low_inc_tax_pgrm.htm

COMMUNITY SERVICES BLOCK GRANT (CSBG)

The Community Services Block Grant (CSBG) is a federal anti-poverty block grant that funds the operations of state-administered networks of local agencies called Community Action Agencies. CSBG funding supports projects that lessen poverty in communities; addresses the needs of low-income individuals, including homeless people, migrants, and elderly people; and provides services and activities addressing employment, education, better use of available income, housing, nutrition, emergency services, and/or health.

Community Action Agencies (CAAs) within the Missouri Balance of State CoC	
Community Action Agency	**Geographic Area Served (by County)**
Central Missouri Community Action (CMCA)	Audrain, Boone, Callaway, Cole, Cooper, Howard, Moniteau, Osage
Community Action Partnership of St. Joseph (CAPSTJOE)	Clinton (Andrew, Buchanan, and DeKalb)
Community Services, Inc. of Northwest Missouri (CSI)	Atchison, Gentry, Holt, Nodaway, Worth
Delta Area Economic Opportunity Corporation (DAEOC)	Dunklin, Mississippi, New Madrid, Pemiscot, Scott, Stoddard
East Missouri Action Agency (EMAA)	Bollinger, Cape Girardeau, Iron, Madison, Perry, St. Francois, Ste. Genevieve, Washington
Economic Security Corporation (ESC)	Barton, McDonald (Jasper, Newton)
Green Hills Community Action Agency (GHCAA)	Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, Sullivan, Carroll, Ray
Jefferson-Franklin Community Action Corporation (JFCAC)	Franklin, Jefferson
Missouri Ozarks Community Action, Inc. (MOCA)	Camden, Crawford, Gasconade, Laclede, Maries, Miller, Phelps, Pulaski
Missouri Valley Community Action Agency (MVCAA)	Carroll, Chariton, Johnson, Lafayette, Pettis, Ray, Saline
North East Community Action Corporation (NECAC)	Lewis, Macon, Marion, Monroe, Montgomery, Pike, Ralls, Randolph, Shelby, (Lincoln, St. Charles, Warren)
Northeast Missouri Community Action Agency (NMCAA)	Adair, Clark, Know, Scotland, Schuyler
Ozark Action, Inc. (OAI)	Douglas, Howell, Oregon, Ozark, Texas, Wright
Ozarks Area Community Action Corp. (OACAC)	Barry, Dade, Dallas, Lawrence, Polk, Stone, Taney (Christian, Greene, Webster)

Community Action Agencies (CAAs) within the Missouri Balance of State CoC	
Community Action Agency	Geographic Area Served (by County)
South Central Missouri Community Action Agency (SCMCAA)	Butler, Carter, Dent, Reynolds, Ripley, Shannon, Wayne
United Services Community Action Agency (USCAA)	Clay, Platte (Jackson)
West Central Missouri Community Action Agency	Bates, Benton, Cass, Cedar, Henry, Hickory, Morgan, St. Clair, Vernon

Many of the above CAAs are already actively involved in housing and homeless assistance efforts within the CoC and their Region(s). The Missouri Balance of State CoC can work to encourage and/or maintain the active participation of CAAs in the local homeless response system and also ensure that CSBG funds are being leveraged to the greatest extent possible to address the needs of people experiencing homelessness.

Recommendations

To maximize attainment and utilization of additional funding for housing and supportive services, HomeBase recommends the Missouri Balance of State CoC consider the following action steps:

Continue to ensure that homeless services providers, counties, and Regions are aware of local, state, and federal funding resources that can support their work and how they can apply for or access these resources. Homeless service providers may not be aware of the release of a Notice of Funding Availability for a funding opportunity related to their work, or they may not be aware that a given funding source can be used to provide housing, homeless prevention, and/or supportive services. The Missouri Balance of State CoC can share knowledge with localities and their providers on what local, state, and federal funding resources exist that touch the homeless response system and how these resources can be used to complement existing funding sources. Additionally, the Missouri Balance of State CoC can advocate for additional funding, including non-homeless-targeted funding sources, such as the CDBG and HOME programs, to establish individuals experiencing homelessness as a priority population for funding and assistance.

Consider alternative sources of funding for supportive services. The more that the CoC is able to maximize utilization of alternative funding sources to provide supportive services, the greater the ability of the CoC to align other funding to meet identified housing needs. Examples of alternative funding sources for supportive housing include:

- **Medicaid** can provide stable source of financing for case management, life skills, health and behavioral health services in permanent supportive housing, and the formation of health care and social services partnerships.
- **Temporary Assistance for Needy Families (TANF)** funds can provide a range of benefits and services for needy families, including families at-risk of and experiencing homelessness, for both assistance (payments to cover basic needs such as food, clothing, and shelter) and "non-assistance" (e.g., supportive services, work subsidies).
    - o Jurisdiction can use federal TANF funds to provide short-term rental or mortgage assistance, security and utility payments, moving assistance, motel and hotel vouchers, case management services, financial and credit counseling, legal services, housing search and placement services, supportive services in housing, and administrative costs associated with any of these activities.
    - o TANF funds can be used in coordination with HUD's targeted homeless assistance grants programs such as the CoC and ESG program to maximize the impact of both resources. For example, TANF could be used to pay for rental assistance while ESG is used to pay for supportive services to help a family remain housed.[54]
- **The U.S. Health and Human Service (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) grant program** funding can be used to provide access to mental health, behavioral health, and substance use services and treatment for low-income individuals.
    - o Mental Health Block Grant (MHBG) funds can be used to fund comprehensive community mental health services for low-income individuals with serious mental illness.
    - o Substance Abuse Prevention and Treatment Block Grant (SABG) funds can support specialty substance abuse treatment for uninsured, low-income individuals.
    - o The Access to Recovery (ATR) program expands access for low-income individuals to a comprehensive array of clinical treatment and recovery support options
- **Supplemental Security Income (SSI)** and **Social Security Disability Insurance (SSDI)** provide benefits for many individuals with disabilities experiencing homelessness, including income, access to health care coverage through Medicaid and Medicare, and help with workforce reconnection through work incentives and services.

Engage local businesses, foundations, and other potential stakeholders who may be willing to invest – literally and figuratively – in the goal of preventing and ending homelessness. Members of the private sector, including local businesses, faith-based organizations, hospital/health systems, and

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[54] U.S. Department of Health & Human Services, Administration for Children & Families, Office of Family Assistance, "Use of TANF Funds to Serve Homeless Families and Families at Risk of Experiencing Homelessness," February 20, 2013, https://www.acf.hhs.gov/ofa/resource/tanf-acf-im-2013-01

foundations, can be vital partners in developing a coordinated community response to prevent and end homelessness, both by investing resources and funding and by investing time and energy. As members of the community, private sector stakeholders should be involved in community planning efforts to address homelessness and invited to participate in public-private partnerships to forge solutions for ending homelessness. Examples of successful public-private partnerships include:

- **Maricopa County, AZ:** Valley of the Sun United Way has been deeply involved in the Maricopa County CoC, paving the way for the development of critical partnerships with the Arizona Department of Housing, Maricopa County Human Services and the Arizona Department of Veterans' Services. Through these partnerships, a pilot program started in Tempe, AZ with a goal of 1,000 units of permanent supportive housing for the chronically homeless. Out of those 1,000 units, 790 units are either online or in development with 25 percent of those units dedicated to veterans.[55]

- **Minnesota:** The Heading Home Minnesota Funders Collaborative is comprised of 12 philanthropic organizations that work with Minnesota Interagency Council on Homelessness and other state and community partners to: (1) invest in public-private strategies to prevent and end homelessness, (2) build public will for investing in effective housing solutions, (3) test, evaluate, and advance promising practices system changes, (4) raise awareness and promote policy changes, and (4) support new partnerships, including an initiative involving schools, local governments, and community partners to address student homelessness.[56]

- **Orlando, FL:** In November 2014, Florida Hospital announced a $6 million pledge to address homelessness in Central Florida, with the goal of housing 300 of Orlando's chronically homeless individuals in three years. $4 million was earmarked to support PSH units using a Housing First model. Florida Hospital's contribution served as the kick-off investment in the Central Florida Foundation's "Impact Homeless Fund," a collaborative, public and private investment-solutions vehicle to help those facing homelessness in Orange, Osceola, and Seminole Counties.[57]

Additionally, private funding often provides greater flexibility than government funding resources. As such, private funding can serve an important role within a CoC to by providing a source of flexible funding to address barriers to housing that are often ineligible under HUD-funded programs, such as transportation costs, utility costs, and moving expenses.

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[55] Funders Together to End Homelessness, "Public-Private Collaborations to Prevent and End Homelessness," http://www.funderstogether.org/public_private_partnerships
[56] Heading Home Minnesota Funders Collaborative, http://headinghomemnfunders.org/about/what-we-do/
[57] Corporation for Supportive Housing, "Florida Hospital Pledges Millions to End Homelessness," November 12, 2014, http://www.csh.org/2014/11/florida-hospital-pledges-millions-to-end-homelessness/

COORDINATION

Data Reliability and Utilization

Having complete, reliable data allows CoCs to measure performance and support continuous improvement. Collecting quality data and reviewing it regularly is key for coordinating housing and service delivery, for informing CoC decisions about resource allocation and community needs, and for supporting applications for funding and resources.

CoCs collect data and information to support understanding throughout the year in a number of different ways. Data collecting occurs through the following efforts:

- Continuously, as close to real-time as possible, participating housing and service projects[58] input data into the CoC's Homeless Management Information System (HMIS) about characteristics of people they serve and project performance. HMIS data is used as the basis for system-wide performance reporting (e.g., most of the System Performance Measures submitted annually to HUD), as well as for projects (e.g., Annual Performance Reports to HUD, others about project performance). CoCs can use HMIS for conducting annual homeless population and system inventory counts as noted below.
- Annually, CoCs conduct a homeless point-in-time count and a housing inventory count that give a snapshot of the homeless population and housing and shelter available in the CoC's geography. CoCs are strongly encouraged to use HMIS to generate point-in-time data with projects with 100 percent of their beds participating in HMIS. A number of communities use HMIS to generate their housing inventory counts, although HUD does not require this.
- Each year, HUD submits the Annual Homeless Assessment Report (AHAR) to the U.S. Congress, which describes the extent and nature of homelessness in the United States. CoCs can contribute local data, including from point-in-time counts, housing inventory counts, and HMIS. The AHAR uses HMIS data for reporting categories broken out by population (all populations, veterans), household type (families, individuals) and project type (emergency shelter, transitional housing, and permanent supportive housing).[59] Each reporting category must meet three data quality thresholds to be included in the AHAR: (1) at least 50 percent of beds community-wide represented in their HMIS, excluding domestic violence provider beds;

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[58] Victim services providers, as the Violence Against Women Act defines, are not permitted to enter client-level data into HMIS. Victim service providers are required to use comparable databases. For more information, see Sec. 407 of the McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009; and the 2017 HMIS Data Dictionary Version 1.2, p. 2, footnote 1. Legal services providers may enter data into a comparable database instead of HMIS if they can document that entering client-level data into HMIS may violate attorney-client privilege. *See e.g.*, https://www.hudexchange.info/programs/hmis/hmis-requirements/. Comparable databases still must meet the 2017 HMIS Data Standards per the 2017 HMIS Data Dictionary Version 1.2 (page 2).

[59] The AHAR design will be changing, but this report includes AHAR data prior to the 2018 AHAR change.

(2) reasonable bed utilization rates, usually between 65 to 105 percent; and (3) reasonable missing data rates (e.g., 5 percent or below). HUD considers AHAR participation to be a benchmark for a high-quality HMIS implementation,[60] so incentivizes AHAR participation in the annual CoC Program funding competition.

CoCs need to review and use the data often, engaging in a continuous data quality improvement and data analysis to understand the system of care. Data tells a story about how the overall system is functioning, who receives resources or struggles to access resources, what resources are available or are missing, and what could be better.
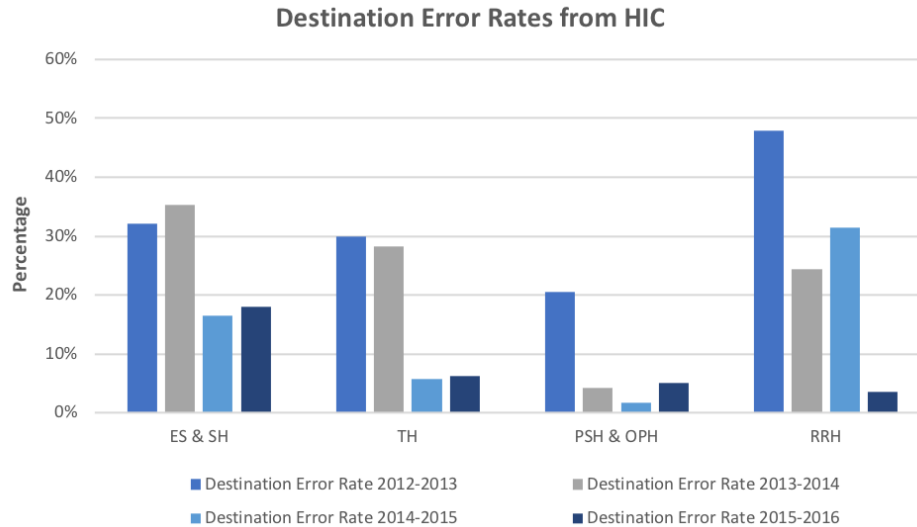
Data in the Missouri Balance of State CoC

In the Balance of State CoC, the Data Committee provides guidance to the CoC on HMIS participation rates, data quality and security, and other HMIS policies to the CoC and CoC Board. The Committee also oversees other data collection and submission, including the point-in-time count and AHAR.

The Missouri Balance of State CoC's HMIS has undergone two data migrations in the past several years due to changes at the HMIS provider. Data migrations often impact the ability of the CoC to maintain quality, reliable data. In the case of the Balance of State CoC, survey and interview respondents noted that the newest HMIS is better situated for identifying and correcting data errors and seems more reliable and easy to use.

The data reported to HUD also reflects improved data quality in recent years. This can be seen in the FY2016 System Performance Reports, which reflect much improved destination error rates in the past two years, with specifically rapid rehousing dropping to 3.6 percent from 31 percent in the prior year. Emergency shelter/safe haven, transitional housing, and permanent supportive housing/other permanent housing also show significant reductions in error rates in the last two years. Destination collection is particularly important since it impacts the CoC's ability to assess returns to homelessness (HUD System Performance Measure 2) and the successful ends to homelessness (i.e., successful placements, which is HUD System Performance Measure 7). Destination is a Universal Data Element that all projects participating in HMIS collect, regardless of funding source.

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[60] See 2017 AHAR Webinar Part 1, available at https://www.hudexchange.info/course-content/webinar-1-an-introduction-to-the-2017-ahar-data-collection-process/webinar-1-an-introduction-to-the-2017-ahar-data-collection-process-slides.pdf

Destination Error Rates from HIC

CoCs should establish an expectation that 100 percent of data elements are complete, as defined by program type, with minimal levels (e.g., the AHAR target generally is 5 percent or below) of null or missing data, as indicated by the error rates. Annual performance reports for the full CoC from 2013 to 2017 also show fairly stable and good data quality, with most error rates less than 5 percent, for the personally identifying information input into HMIS.

	2013 Housing	2013 Services	2014 Housing	2014 Services	2015 Housing	2015 Services	2016 Housing	2016 Services	2017 Housing	2017 Services
Community Wide APRs for Housing and Services 2013- 2017 **Data Quality: Error Rates of Personally Identifying Information**										
Name error rate	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%
Social Security Number error rate	**6%**	3%	**7%**	3%	5%	**8%**	3%	**13%**	5%	**8%**
Date of birth error rate	0%	1%	0%	1%	1%	3%	1%	2%	0%	0%
Race error rate	3%	4%	2%	4%	1%	2%	0%	1%	0%	1%
Ethnicity error rate	5%	2%	2%	3%	1%	2%	2%	1%	3%	1%
Gender error rate	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Error rates on universal data elements impact the CoC's HUD System Performance Measures since each System Performance Measure is made up of only a small number of universal data alements.

The chart below indicates the universal data elements and the System Performance Measures they impact:[61]

	Universal Data Element?	Affects HUD System Performance Measure(s)?
Date of Birth	YES (#3.3)	YES: Income Growth (#4)
Project Start Date	YES (#3.10)	YES: All
Project Exit Date	YES (#3.11)	YES: All
Destination	YES (#3.12	YES: Returns to Homelessness (#2), Successful Placements (#7)
Housing Move-In Date (all PH)	YES (#3.20)	YES: Length of Time Homeless (#1)
Income & Sources	NO (#4.2)	YES: Income Growth (#4)

In addition to data quality, HMIS participation rates also impact the ability of CoCs to understand their system of care, as greater participation results in more complete information. HUD gives full points in the CoC funding competition for this factor to CoCs with 85 percent participation rates in all housing types (leaving beds funded by victim service providers out of the calculation). HMIS participation rates in the Balance of State CoC were fairly stable between 2012 and 2016, except for a steady decrease in permanent supportive housing participation rates. The only PSH beds not in HMIS are HUD-VASH (HUD-Veterans Affairs Supportive Housing) which have been steadily increasing in recent years, thereby decreasing the HMIS participation rates of PSH. The CoC noted in its
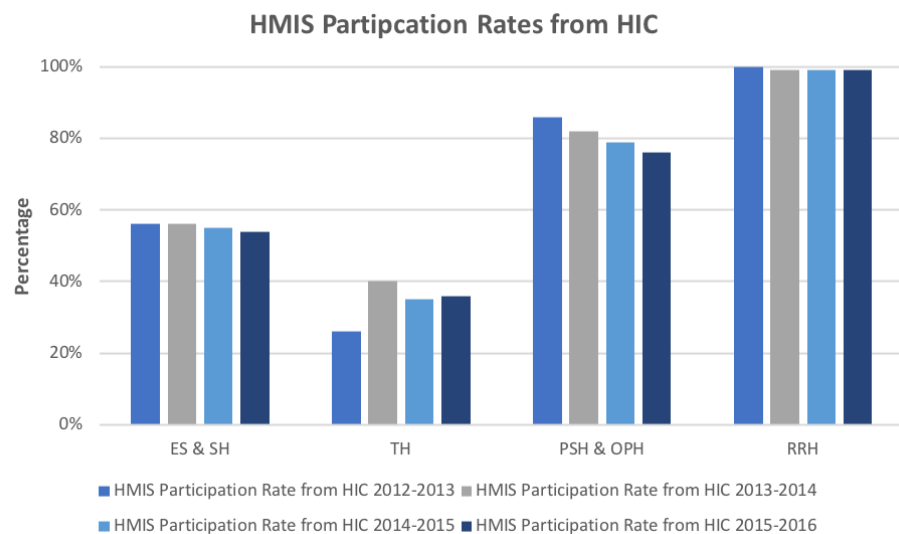
HMIS Partipcation Rates from HIC

FY2017 CoC application that it will work with the VA to try to identify a way to input VASH data into HMIS.[62]

HMIS participation rates did change in 2017, but still only safe haven and rapid rehousing program types exceeded the 85 percent benchmark. In 2017, the Emergency Shelter HMIS participation rate increased markedly to 81 percent from 53 percent, likely related to a 21 percent decrease in Emergency Shelter beds reported on the housing inventory count. Transitional Housing also reported a 17 percent reduction in beds from 2016, however the effect on the HMIS participation rate was the opposite, likely due to HMIS participation of the beds removed from the housing inventory count, reducing the HMIS participation rate to 20 percent.

HMIS participation impacts the CoC's system performance, as reported to HUD annually via the System Performance Measures. The following chart, from HUD's System Performance Improvement Brief, shows which project types contribute to HUD's System Performance Measures. [63]

Project Type	Total Beds in 2017 HIC	Total Beds in HIC dedicated for DV	Total Beds in HMIS	HMIS Participation Rate
Emergency Shelter Beds	1,206	775	351	81%
Safe Haven Beds	8	0	8	100%
Transitional Housing Beds	331	38	59	20%
RRH Beds	230	23	200	97%
PSH Beds	1,508	0	1,158	77%

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[62] For general information about the VA's HMIS guidance and related plan to fully participate in HMIS, see this VA issued memo: VA HMIS Participation Memo (December 2010), available at https://www.hudexchange.info/resource/1251/va-hmis-participation-memo/.
[63] System Performance Improvement Briefs, available at: https://www.hudexchange.info/resource/5291/system-performance-improvement-briefs/.

		SYSTEM PERFORMANCE MEASURE QUESTIONS	1	2	3	4	5	6	7
	1	Emergency Shelter	x	x	x		x		x
	2	Transitional Housing	x	x	x	x	x		x
	3	PH - Permanent Supportive Housing (disability required for entry)	x	x		x	x		x
	4	Street Outreach		x					x
	5	RETIRED							
	6	Services Only							
	7	Other							
	8	Safe Haven	x	x	x	x	x		x
	9	PH – Housing Only	x	x		x	x		x
	10	PH – Housing with Services (no disability required for entry)	x	x		x	x		x
	11	Day Shelter							
	12	Homelessness Prevention							
	13	PH - Rapid Re-Housing	x	x		x	x		x
	14	Coordinated Assessment							

(left vertical label: HMIS PROJECT TYPES)

AHAR participation reflects reliability of CoC data, and the Missouri Balance of State CoC has increased and maintained AHAR participation over past years. However, the quality of the CoC's AHAR submission is near the bottom compared to many Balance of State CoCs, as indicated by the 6 usable table shells (out of 12) shown in the 2016 AHAR Submission Report used for the 2017 CoC

AHAR Participation by Missouri Balance of State CoC 2008-2017						
Year	Emergency Shelter for Individuals	Emergency Shelter for Families	Transitional Housing for Families	Transitional Housing for Individuals	PSH for Individuals	PSH for Families
2008	Not Useable	Not Useable	Useable	Useable	*	*
2009	Not Useable	Not Useable	Not Useable	Useable	*	*
2010	Not Useable	Not Useable	Not Useable	Not Useable	Useable	Useable
2011	Useable	Useable	Not Useable	Not Useable	Useable	Useable
2012	Useable	Not Useable	Useable	Not Useable	Useable	Useable
2013	Useable	Not Useable	Not Useable	Not Useable	Useable	Useable
2014	Not Useable	Not Useable	Not Useable	Not Useable	Useable	Useable
2015	Useable	Useable	Not Useable	Not Useable	Useable	Useable
2016	Not Useable	Useable	Not Useable	Not Useable	Useable	Useable
2017	Useable	Useable	Not Useable	Not Useable	Useable	Useable

Program funding competition. Many Balance of State CoCs submitted 12 usable table shells,[64] so received all the available CoC Program funding competition points.

In 2017, both transitional housing report sections were not useable, likely due primarily to lack of HMIS participation with some data quality concerns (see chart below); CoCs must have at least 50 percent of beds community-wide participating in their HMIS (excluding domestic violence provider beds).

Missing Data Rates from FY2017 AHAR Submission						
	Emergency Shelter	Emergency Shelter for Individuals	Transitional Housing for Families**	Transitional Housing for Individuals**	PSH for Families	PSH for Individuals
Gender	0%	0%	0%	0%	0%	0%
Age	0%	0%	0%	0%	0%	0%
Ethnicity	0%	1%	0%	0%	0%	0%
Race	0%	0%	0%	0%	0%	0%
Living Arrangement the Night Before Program Entry	2%	9%	0%	5%	0%	0%
Disability Status	2%	6%	0%	2%	0%	0%
Veteran Status	0%	0%	0%	0%	0%	1%
Household Size	0%	0%	0%	0%	0%	0%
Household Type	0%	0%	0%	1%	0%	0%
Length of Stay	4%	11%	0%	10%	0%	0%
Number of nights - Adults	0%	0%	0%	0%	0%	0%
Number of nights - Children	0%	0%	0%	0%	0%	N/A
Destination at Exit					3%	1%
**Data in this category did not meet minimum participation criteria for participation in HUD's Annual Homeless Assessment Report.						

Recommendations

HomeBase makes the following recommendation for the CoC's consideration:

Increase HMIS participation. HMIS participation from emergency shelter, transitional housing, and permanent supportive housing program types should be higher in order to better understand the system of care. The CoC should continue to work with non-participating providers to encourage participation. The period while coordinated entry is gaining momentum in all regions could be an

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[64] AK, AZ, CO, CT, GA, HI, ID, ME, MS, NH, NV, OH, OK, Puerto Rico, TX, UT, WV, Virgin Islands, VT. 6 submitted 10 usable table shells (AR, IN, KY, MI, NC, NE), and 4 submitted 8 usable shells (KS, MA, NM, VA). 2 Balance of State CoCs (AL, LA) submitted only 2 table shells.

opportunity to reopen conversations with certain providers who have declined to participate in the past.

Expand efforts to analyze and rely on HMIS data for decision-making. The HMIS has completed two major transitions in a short time, which have resulted in a stable HMIS with good quality data. Using HMIS data to further inform CoC decisions about topics like resource allocation, strategic responses to homelessness, and project and system evaluation will support CoC functioning, both at the CoC and regional levels. Making the data more relevant at the system and project level will also encourage increased HMIS data quality, both from participation from currently non-participating agencies and from increased vigilance with regard to data quality by agencies that do currently participate.

Work to get aggregate data from non-HMIS-participating agencies. Because of the relatively low HMIS participation rates, the CoC may want to attempt to collect aggregate data from domestic violence providers, data about VA resources, or data from other non-HMIS-participating agencies to inform decisions about resources. This Assessment has relied on assumptions because of a lack of information about survivors of domestic violence and distribution of VA resources. Additional data about these two areas would result in more complete data to support decision-making.

Conclusion

The Missouri Balance of State CoC has dedicated partners, a robust array of housing, and a coordinated entry system with a lot of potential. This Assessment has focused on gaps in the current system of care and the CoC and is not intended to highlight the full array of the strengths of this CoC's housing, services, and coordination. This Assessment has reviewed gaps related to availability, accessibility and coordination and has made the following recommendations of activities the CoC should undertake:

AVAILABILITY
Housing Stock Availability
- Work to increase housing availability and maximize utilization of existing housing stock in rural, urban, and suburban areas of the Missouri Balance of State CoC.
- Increase availability of rapid re-housing vouchers.
- Increase bed availability and program turnover by supporting clients in moving through the homeless system of care into stable, permanent housing options.
- Monitor 2018 point-in-time count, housing inventory count, and HMIS data to confirm Assessment findings and track relevant data to support decision-making

Special Subpopulations
- Improve the availability of housing for specific subpopulations so that housing stock better aligns with demonstrated needs across the CoC and within each region.
- Continue to leverage opportunities to better understand needs, utilizing data from coordinated entry, point-in-time count, HMIS, and other sources.

Comprehensive Service Availability
- Investigate new and expanded transportation options for people experiencing homelessness, particularly in rural areas.
- Utilize coordinated entry to improve information sharing about regional services available, paying particular attention to rural areas.

ACCESSIBILITY
Coordinated Entry
- Continue sharing outcomes and strategies across Regions through the CoC's Coordinated Entry Committee to leverage impact.

- Continue to evaluate duplication of effort or different structures that may better meet community needs.
- Continue to partner with mainstream agencies and local businesses to implement coordinated entry.

Housing First and Lowering Barriers to Housing

- Approach domestic violence shelter providers to discuss the possibility of changing some program entry requirements.
- Consider offering targeted technical assistance to providers regarding the implementation of Housing First principles.

System performance

- Focus efforts on prevention and diversion resources and assessing accurately who needs this assistance.
- Set benchmarks for performance by each program type for each relevant performance measure and review quarterly.
- In partnership with providers, analyze the barriers to improving performance and address them individually.

COORDINATION

CoC Structure, Governance & Participation

- Remember the limitations of the regional structure when making decisions.
- Transition the CoC Board's focus to strategic responses to homelessness.
- Create multi-directional communication opportunities.
- Prioritize Public Housing Agency and landlord engagement.
- Target invitations to participate in the CoC to the audience.
- Create clear expectations of roles and responsibilities among CoC-related entities.

Funding Attainment and Maximization

- Continue to ensure that homeless services providers, counties, and Regions are aware of local, state, and federal funding resources that can support their work and how they can apply for or access these resources.
- Consider alternative sources of funding for supportive services.
- Engage local businesses, foundations, and other potential stakeholders who may be willing to invest – literally and figuratively – in the goal of preventing and ending homelessness.

Data Reliability and Utilization

- Increase HMIS participation.
- Expand efforts to analyze and rely on HMIS data for decision-making.
- Work to get aggregate data from non-HMIS-participating agencies.

Appendices

Appendix A: Recommendations for Annually Updating the Gaps Analysis

In order to build on HomeBase's gaps analysis structure, the Missouri Balance of State CoC can develop a process for annually updating this Assessment. HomeBase recommends that the CoC take the following steps to reference and update this report:

Step One: Assemble available information about the past year's activities and outcomes.
- **Debrief** the past year's activities and performance with the CoC Board and CoC staff to identify areas of focus and concerns for the annual gaps analysis.
- Circulate an annual **electronic and/or paper survey** to CoC members, providers, stakeholders and consumers (see Appendix D for potential survey model). Analyze the results for themes, surprises, and concerns. This information will help to assess how needs are changing and if progress is being made in addressing the concerns of CoC members.
    - o Consider doing the survey at a time other than January when many CoC stakeholders are preparing for the point-in-time count at the end of the month.
- **Collect available data** about prior year, including from point-in-time count, housing inventory count, HMIS, and coordinated entry. Assessing this data both Regionally and CoC-wide will help the CoC see trends over time, across the CoC, and regionally related to where the need is and what housing resources are meeting this need. Potential data to include may be:
    - o Point-in-time count report
    - o HUD HDX Full CoC Profile Report
    - o System Performance Reports
    - o System-wide APRs for prior calendar or fiscal year
    - o Coordinated entry referral guidance and tools used at local level
    - o Coordinated entry data reports

Step Two: Analyze information about topics of key interest to the CoC.
- **To identify gaps in the coordinated entry system**: Please refer to the coordinated entry policies for a detailed plan for evaluation of the system's functioning.
- **To identify gaps related Housing First and barriers to programming**: Data from the coordinated entry systems will be key to analyzing gaps related to housing and service barriers. The analysis could compare the characteristics of those who got housing quickly with those who contacted the system who did not get housing. The reviewer could also look at the resource lists of all coordinated entry systems and analyze the projects' eligibility requirements to determine if there may be unnecessary barriers to housing.
- **To identify gaps related to system performance**: The system performance measure reports to HUD combined with Annual Performance Reports can provide a complete summary of system performance. Reviewers should ask questions not only about changes in the data year over year, but the drivers that create certain outcomes. In addition, if the CoC develops a strategic plan or like document, that document should include measures to review to understand system outcomes.

- **To identify gaps related to availability**: Data from the annual point-in-time count regarding total population and subpopulations experiencing homelessness, as well as rates of sheltered versus unsheltered homelessness, can help define current housing need. Housing inventory count data can be used to determine the number of beds available, their component type, and their distribution within a defined geography, whether that be a county, Region, or across the CoC. Data reported into HMIS regarding clients served, bed utilization rates, and housing status at exit provides insight into how well the homeless response system is operating to get people connected to get people housed and support them in making successful exits from homelessness. This data can be evaluated at the county, Region, and CoC levels to determine housing availability at different systems levels. Additionally, consumer and provider feedback can help identify gaps in housing availability that may not be apparent through the data.
- **To identify gaps related to CoC structure, governance and participation**: The surveys of CoC stakeholders may be a good source of information about these gaps.
- **To identify gaps related to funding attainment and maximization:** The CoC can review recent fiscal year awards made for local, state and federal programs that provide relevant housing or supportive services, including but not limited to the funding sources highlighted in this report. The CoC should also review any relevant allocation plans or funding priorities that might have changed for the fiscal year.
- **To identify gaps related to data reliability and utilization:** HUD collects information about data quality in the system performance measure reports, AHAR reports, annual performance reports, and CoC application. Reviewers could review all of this information together to identify gaps in data reliability. Reviewers could also do a thorough review of all data collected to identify which data is being collected but not analyzed and used to support system adjustments, either leading to reductions in data collection or expanded data analysis.

Appendix B: Compilation of Survey and Interview Responses from Stakeholders

Q: What are the Missouri BoS CoC and its stakeholders doing really well?

- Coordinating services as a large BoS area
- Conducting point in time counts to identify homeless
- Sharing info with and between regions
- Having working committees/groups to establish and maintain the things that need to be in place
- Establishing formal governance structure
- Identifying individuals needing assistance
- Completing process of separating from the statewide homeless coalition
- Ensuring programs are informed
- Creating policy and procedures
- Implementing coordinated entry
- Providing educational/training materials
- Meeting on a regular basis
- Attempting to coordinate better quality of life for families
- Communicating across regions
- Expanding and becoming active in rural areas
- Sharing updates and links on NOFA, new initiatives, etc.
- Recognizing the need for additional youth resources
- Avoiding duplication of services
- Involving programs in processes
- Responding to questions
- Promoting cooperation between agencies/regions
- Recruiting of non-HUD funded agencies to participate in the CoC and CE
- Tracking of individuals and hopefully their success
- Trying to be more transparent

Q: What are the biggest needs the CoC should address?

Housing/Shelter

- Access to affordable housing
- Need more affordable housing statewide
- Lack of transitional housing
- Rapid rehousing is needed to move people out of homelessness quicker
- Need more rapid rehousing vouchers
- Lack of homeless shelters
- Access to emergency shelters
- Housing programs for unserved areas
- Need more long-term subsidies for those not well served through RRH
- Temporary housing/hotel vouchers while being evaluated for CE, with no homeless shelter, person has no place to stay while being evaluated for CE
- Need to advocate for LIHTC reinstatement or replacement

Rural

- Need more employment resources in rural areas
- Acknowledgement that rural areas have specific needs along with larger urban areas
- Needs overall program options for rural areas
- Need more access points in rural areas
- Need more affordable housing options in rural areas
- Need transportation options for rural areas
- Need more low-income housing for rural areas

Youth

- Youth housing
- Youth need more program options in rural areas

Seniors, Veterans, and Persons with disabilities

- More services for veterans, elderly and persons with disabilities

Domestic Violence

- Treat DV programs the same as housing programs...more inclusion on the operating systems HMIS vs non-HMIS users
- Fair rank and review system for DV programs vs housing programs

Support

- Funds are needed for additional staff to sufficiently serve the homeless population in our region
- CoC wide CE call in and referral hotline (24 hours with full time staffing)
- Consider applying to be a 501(c)(3) so we can get planning dollars, which might allow us more staff to help coordinate these efforts. This is a huge rural CoC!
- Operations Support
- More HMIS training
- Address smaller agencies without the staff or expertise to respond to NOFA and make applications for funding
- Establishment of secure email server to share BNL outside of HMIS

Logistics/Data collection

- Establishment of formal structure for the regions
- Streamlining CE...all regions are at different spots in the process and functioning differently.
- Besides just counting homeless we need to count unmet needs
- Continue fine tuning Coordinated Entry - still much to figure out and learn about how to serve people who aren't literally homeless (doubled up, couch surfing, unstably housed, in motels, etc.)
- Schools participation in sharing information
- Need to finish developing coordinated entry process

Funding

- Make sure existing projects are funded before handing funding off to a new program.
- More project homeless connect
- Must find funding for BoS CoC administrative infrastructure
- Need home rehab funds
- Mortgage assistance
- Additional funds are needed to assist with emergency housing situations

Scoring

- Work on scoring criteria for grants. If a client increases income, benefits will decrease. This goes hand in hand. It should not cause a loss in points.
- Fair rank and review system for DV programs vs housing programs
- The CoC should have its own process for appeals in grants before it appeals through HUD

Q: Which homeless subpopulations need more attention from the CoC? (Listed in order of greatest to fewest mentions by those surveyed – see Q9 graph below)

- Precariously Housed
- Families
- Seriously Mentally Ill
- Youth
- Chronically Homeless
- Domestic Violence
- Veterans
- Other

Q9 Which homeless subpopulations need more attention from the CoC? Please check all that apply.

Answered: 20   Skipped: 12
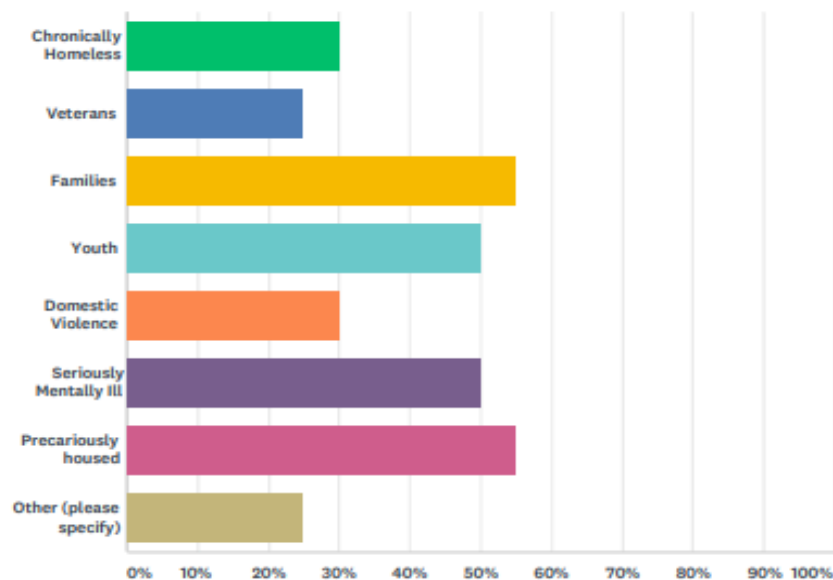
ANSWER CHOICES	RESPONSES	
Chronically Homeless	30.00%	6
Veterans	25.00%	5
Families	55.00%	11
Youth	50.00%	10
Domestic Violence	30.00%	6
Seriously Mentally Ill	50.00%	10
Precariously housed	55.00%	11
Other (please specify)	25.00%	5
Total Respondents: 20		

Q: Of the subpopulations above, which needs the most attention? Why? What needs to change?

Precariously Housed

- Our biggest population of homeless is the Precariously Housed. This is not only unsafe in many situations it also endangers the housing of the person they are couching surfing with. Many lose their housing because they are trying to help others.
- Precariously Housed - they are usually couch surfers who do not fit into certain definitions that are needed in order to receive permanent housing.
- Those precariously housed have few options for assistance, primarily due to federal regulations and restrictions, not the inability to provide services.
- There are few funds for the precariously housed. (prevention funds)

Seriously Mentally Ill

- Mentally Ill are in need of great amount of service and resources. Mental Health is often the root cause of chronic homelessness due to lack of resources in the rural areas and self-medicating practices.
- Seriously mentally ill due to the effects preventing employment and often their ability to maintain stability once housed. The Disability Income process is very long and makes it difficult for clients to become stable.
- Seriously mental ill - I'm not sure what needs to change.

Youth

- Youth tend to not fit well into boxes from funding streams and are more likely to fall through the cracks. Need more ongoing long term supports for those not well served through mainstream resources.
- Youth because their homelessness is primarily a result of issues which can be addressed (e.g. foster care).
- Beds for youth are lacking.
- I don't think youth are getting enough attention. There are a lot of challenges. Under 18, you can't sign a lease. There aren't enough supportive services, transitional housing/services. This isn't unique to BoS but is an issue everywhere.

Families

- Families. Additional stress because may have to break up families to get shelter, lack of storage of what they may have managed to keep, need for child friendly environment.
- Families- particularly with children. Increased funding.

- Beds for families are lacking.

Domestic Violence

- A lot of victims have negative rental history, evictions, damage to property, etc. Finding landlords that will accept them as tenants is difficult.
- Beds for those fleeing DV are lacking.
- I know housing for our DV clients has been a struggle for many, many years. I don't know if that's TH, RRH. I just know there's not enough. Talking with other DV providers I hear that's a common trend.

Chronically Homeless

- Chronically homeless because they are typically the most vulnerable, tend to utilize services that create the most economic or financial burden on communities (using ER, ambulance/EMT, hospital, etc.).
- Chronically Homeless-need more permanent housing vouchers for them.
- CH is getting a lot of attention because of the federal emphasis on it. In the region I'm in, we had one of the higher increases in youth homelessness (that meet the HUD definition of homeless). We're more suburban. You have a lot of youth sleeping in cars; not enough shelter for them.

Q: What type of homeless services are most needed in the Missouri BoS Region? (Listed in order of greatest to fewest mentions by those surveyed – see Q14 graph on next page)

- Transportation
- Health (including Behavioral Health
- Employment and Education
- Case Management
- Income support/ benefits advocacy

Q14 What type of homeless services are most needed in the Missouri BoS Region?

Answered: 20   Skipped: 12
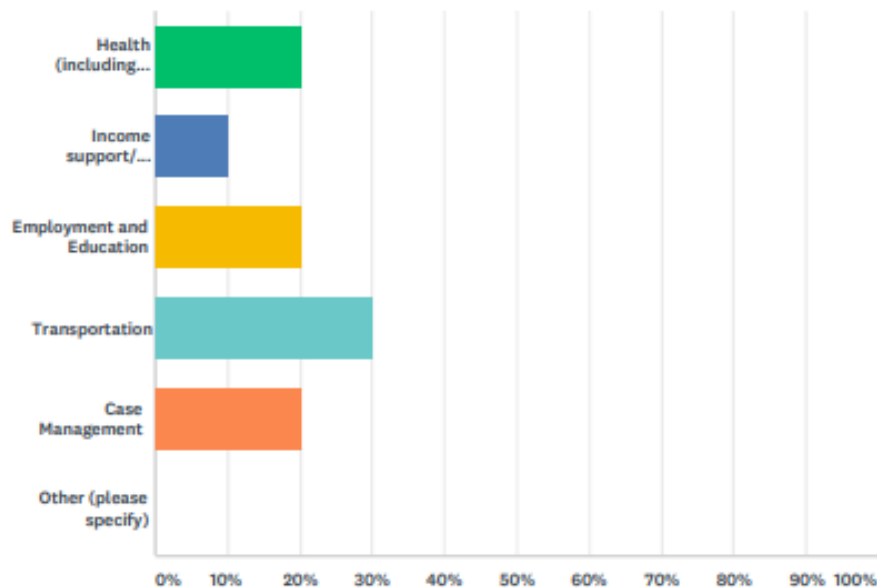
ANSWER CHOICES	RESPONSES	
Health (including Behavioral Health)	20.00%	4
Income support/ benefits advocacy	10.00%	2
Employment and Education	20.00%	4
Transportation	30.00%	6
Case Management	20.00%	4
Other (please specify)	0.00%	0
TOTAL		20

Q: Are there other areas or types of housing that are being impacted by a lack of resources?

- Single mothers who are working cannot make ends meet and it's really hard to afford housing.
- The other gap is the income gap. The minimum wage needs raised.
- We are lacking in ES. We have huge pockets that don't have services. Also have organizations serving the homeless that are not part of the CoC, and it's hard to bring them in and have them participate in CE. I understand why, but it's also frustrating that we can't get these other housing resources to the table to have conversations about how we could be better about doing referrals.
- I would like to find a way for more PSH or RRH to be offered for youth. Having more options, whether it's landlords or others who are offering to work with younger people. Building landlord relationships so that if they get an application from a 19- or 20-year-old without a rental history, they are more open to letting them rent. Working on the permanent housing options so we're not just discharging them back to an unstable situation.
- We can definitely use more prevention dollars but I think it's a matter of knowing how best to utilize those resources. Most agencies have operated on, I have X amount of money and when it's gone it's gone instead of looking at how money can be spent best per client.
- Affordable housing is a big challenge. RRH obviously helps. The clients we would put in RRH need supportive services, so we need to figure out how we can provide those supportive services. We provide them even when they enter RRH. So, we've stretched ourselves thin.
- Limited access to ES; biggest challenge. Enlist help of ministerial alliances to do hotel/motel vouchers. ES would be a step up because clients would be able to stay there for a week or two (hotel/motel are expensive).

Q: What type of homeless housing resource is most needed in the Missouri BoS Region? (Listed in order of greatest to fewest responses by survey respondents – see Q13 graph on next page)

- Affordable housing/ permanent vouchers without services
- Prevention
- Emergency Housing
- Rapid Rehousing
- Transitional Housing
- Permanent Supportive Housing
- Other: 3-way tie between 1) Affordable housing 2) PSH and 3) Prevention

Q13 What type of homeless housing resource is most needed in the Missouri BoS Region?

Answered: 20   Skipped: 12
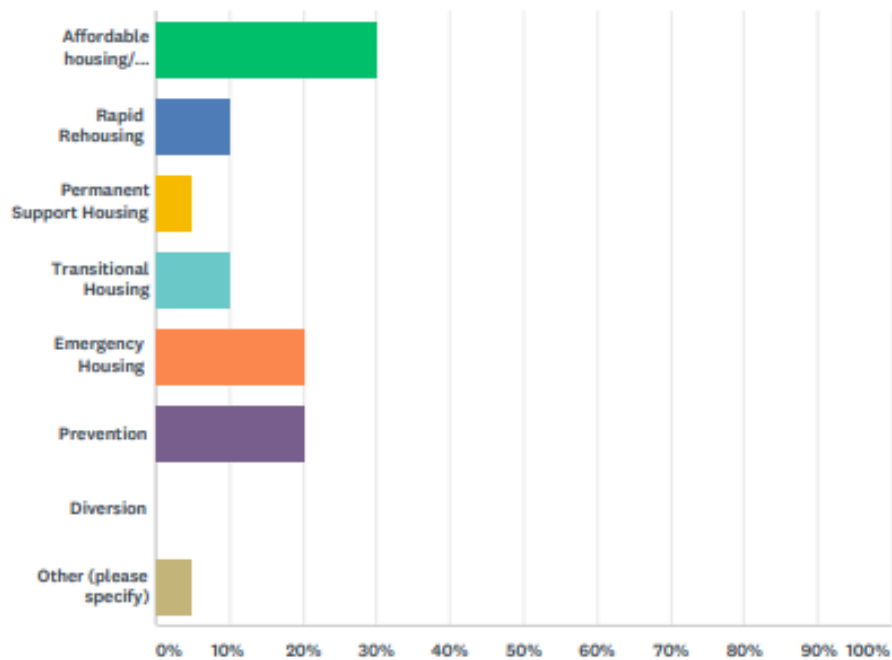
ANSWER CHOICES	RESPONSES	
Affordable housing/ permanent vouchers without services	30.00%	6
Rapid Rehousing	10.00%	2
Permanent Support Housing	5.00%	1
Transitional Housing	10.00%	2
Emergency Housing	20.00%	4
Prevention	20.00%	4
Diversion	0.00%	0
Other (please specify)	5.00%	1
TOTAL		20

Q: How well is the CoC doing in addressing rural/suburban/urban areas/needs?

- I'm not sure what the CoC could do better or more of. I think we're trying to address all the issues as best we can.
- I don't know about all the services in the rural areas.
- I don't think we've dealt with it very well. The programs that are CoC and ESG funded are the most active and resources/training have been thrown their way. These also tend to be more urban/suburban. The rural programs are lacking resources. They are operating teeny tiny programs. The Continuum model is good but when you have counties serving multiple CoCs you have data issues, referral issues, CE issues. No one sees those artificial lines.
- It's a challenge. Other CoC doesn't want us to sit at the table because we don't fall in the boundaries. We also get some people in the BoS who don't understand why we're there because we aren't rural. We're becoming more urban than suburban.
- There have been times in the past where we've struggled with the rural vs urban. Balances are always going to struggle with how to make things fair. Need to make sure we're not swinging the pendulum one way or the other. There were some interesting discussions the last time about the idea of gerrymandering regions to call out unheard voices was brought up. But for everyone who thought there was a good idea you had someone who didn't think it was a good idea from the rural areas.
- The data that is used to identify need in more rural parts of CoC is lacking. You try to do PIT and there will be counties that report 0 for unsheltered and I'm going to tell you that that is not accurate. We all know it's hard.
- Suburban areas often get lost in between the two ends of the continuum with rural and urban services. There are often higher costs and stereotypes about middle class that can impact access to services. Sometimes just takes stepping back and recognizing assumptions to help serve this population better.
- In my opinion there needs to be more of a presence in rural counties. Improvement needs to be made to simplify the BoS CoC membership and participation. More effective communication using technology and less red tape.
- I have seen the CoC providing opportunities to sub populations that formally would not be served, bringing in housing first standards was critical in this. As felons, they usually didn't have an opportunity to successfully enter into a public housing program.
- I think they are responding well but each area has different types of needs. Not every area will have the same resources available, i.e., homeless shelters.
- It appears that there is always one "focus" or practice being worked on at one time. Currently it is Housing First. We really need to be more focused on the causes of homelessness and address those issues to reduce the risk of homelessness in the first place.
- This is hard work without additional funds for staff, support, coordination, etc. We are hopeful the MOHIP funds are a game changer in adding resources. I think rural is so hard because of

the vast geographic area to cover - getting staff there is hard, esp. places where there are little or no resources. The urban areas may have better coordination of services right now, but there still isn't enough housing for the # of people experiencing homelessness.

- I feel the CoC is on-board for increasing housing funds in the rural areas.
- We just need more options for the rural area.
- I believe it is hard for the CoC to address the needs in the rural area because a lot of needed services do not exist in the rural areas to help address the needs of individuals.
- Suburban and urban areas have many more resources. It is the rural area that lacks the needed resources. CoC funding does not provide enough funds to assist with the vast array of needs. Transportation is a major need for the rural areas. Often jobs and all other resources are a distance from the home. Providing additional funds for the travel expenses of education and new employment would help to end the ongoing need of many clients.
- Lots of issues to address. Can't do it all alone.
- It's difficult due to the lack of services in rural areas.
- Fairly well actually because responses are pretty localized.
- There is obviously a difference in capacity levels in some areas than others. What doesn't help this are the increasing number of regulations and documentation that needs to be done.

  o I think why we see less funding in more rural areas is that you don't see people applying because they don't think they the fiscal capacity for federal grant or for state grants don't want to go through admin/documentation to administer this grant.
  o See funders who say they will fund that agency because they provide services in 12 counties, but then there is nothing in the funding that says they need to serve people in all 12 counties, so the funds go toward like, 3 counties.

Q: Which stakeholders need to have a bigger role or stronger partnership with the CoC to prevent and end homelessness in the Missouri BoS region? (Listed in order of greatest to fewest mentions by those surveyed – see Q11 graph on next page)

- Public Housing Authorities
- Landlords
- Law Enforcement
- Non-CoC-funded providers
- Foundations
- Advocates
- Hospitals
- Businesses
- Jurisdictions
- Other: Legislators or their area representative; City officials; Mental Health and Treatment Centers; Schools; State and quasi-state agencies

Q11 Which stakeholders need to have a bigger role or stronger partnership with the CoC to prevent and end homelessness in the Missouri BoS region?

Answered: 20   Skipped: 12
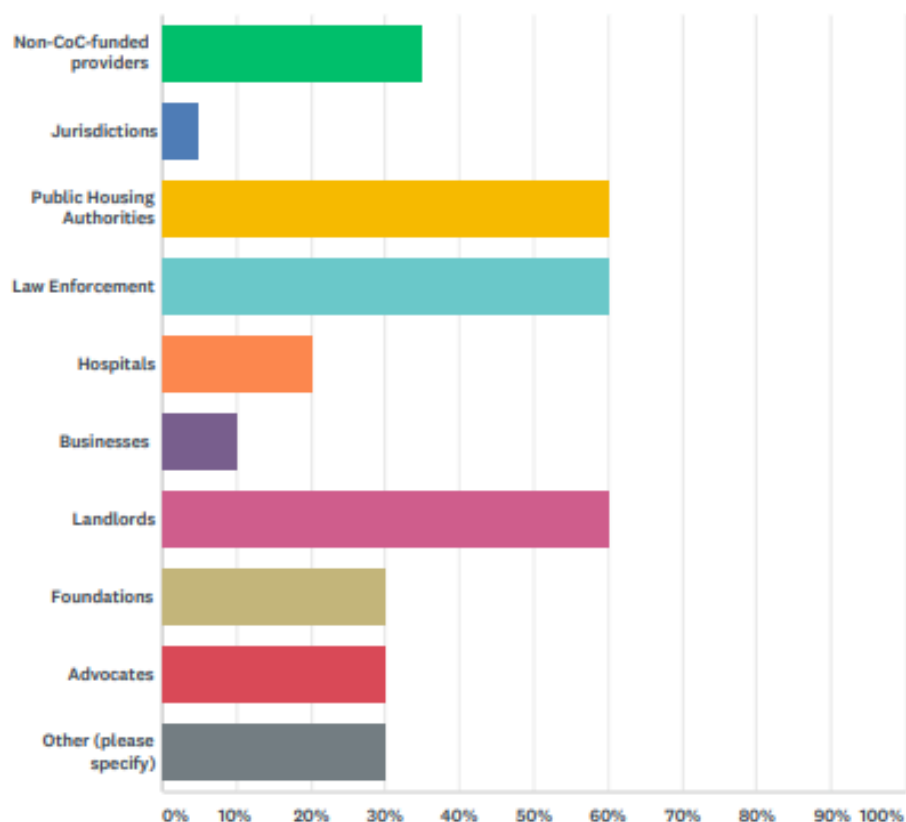
ANSWER CHOICES	RESPONSES	
Non-CoC-funded providers	35.00%	7
Jurisdictions	5.00%	1
Public Housing Authorities	60.00%	12
Law Enforcement	60.00%	12
Hospitals	20.00%	4
Businesses	10.00%	2
Landlords	60.00%	12
Foundations	30.00%	6
Advocates	30.00%	6
Other (please specify)	30.00%	6

Total Respondents: 20

Q: Of the stakeholders above, which is the most important? Why? What do you hope stronger partnership would accomplish?

- **Businesses** are often untapped resources not only for flexible funding but volunteers. They also tend to think/function in ways outside of social service paradigms which can lead to creative innovations and solutions.
- Stronger partnerships with **Mental Health Providers and Health care collaboratives** to serve the underserved.
- **Non-funded providers** need to be educated and brought together that may offer additional viewpoints and resources.
- **Public housing authorities** should be at the table anytime we're trying to house any of the sub populations because they could serve eligible consumers. And, consumers turned away should be referred to CE assess points
- I cannot choose. We have so little interaction with our public housing authorities and reaching out has not helped the matter. Law Enforcement turns a blind eye many times and does not assist the homeless. I see many of them that have the stigma against the homeless instead of seeing them as a person and giving them resources. Housing authority makes it hard for a person to get housed.
- **Landlords**, to educate them on why they should take a chance on nontraditional renters.
- **Foundations/private funders**, to help provide more unrestricted dollars to increase affordable housing stock as well as services.
- I believe that **law enforcement** is the most important as they see the invisible homeless and many times do not know who to refer them to
- **City Officials** have the most power locally and are able to advocate above their positions as well
- I've read a lot about other communities that have had **housing projects funded by hospitals** because they realized that the cost of housing clients was cheaper than the way the client was utilizing the local health care system.
- **DV programs** have a long-standing obstacle when it comes to transitioning out of shelter into affordable, adequate housing. Advocates bring a wealth of knowledge to the table.
- **Schools**-they are reluctant to share information regarding their homeless students/families.
- The **state systems**, or lack thereof, are a primary driver of homelessness in our state.

Q: How are the various CoC stakeholders doing in supporting the effort to prevent and end homelessness? Who has been a good partner and who has been a barrier?

- The VA has been a great partner across all continuum. Their notice about mandatory participation in CE is great. The push for VASH vouchers with RRH is huge. The VA is a huge partner and continues to be.
- Law enforcement is a great partner in select pockets of the CoC. We definitely need better partnerships with law enforcement in our rural communities. Best relationships have been suburban. It speaks to lack of resources to make connections.
- Relationships with child welfare could be improved. Relationships with public housing authorities are improving but don't have preference in all PHAs.
- We have heard some law enforcement admit to seeing a homeless person in their county, picking them up in their car and driving them across the border of the county and letting them out there.
- Could always have more involvement from our private foundations, local cities, from Chambers of Commerce. It's a matter of establishing an effective message and why it's important for them to be involved. For a lot of CoCs we are able to message that effectively but once they're active and attending meetings they don't understand why they need to be there. The CoC is not good about communicating why the CoC needs them involved and what they can do.
- Our collaborative applicant is doing what they've always done and speaks to what the board needs to determine about what else we want them to do.
- Have fire department and sheriffs on board.

Q: Are there certain stakeholders that need to better partner with the CoC?

- Schools, children's physician, there are a lot of service providers who should be at the table. (Also agrees that PHAs and law enforcement needs to be at the table.) There is also the opportunity to have larger presence from the faith-based community.
- Partnership with PHAs and getting them CoC funds would be good.
- Partnership with landlords would be helpful.
- Better connections to ERs and Hospitals.
- I see my role as making sure the youth voice is heard.
- I hope we can figure out how to get some more stakeholders involved to get more affordable housing.

*Q: From your perspective how is the BoS doing in responding in homelessness?*

- With CE, we're doing a lot better at being organized.
- In the rest of the BoS there aren't many options for under 18. And then over 18 you get programs geared toward adults.
- We've got some great agencies that are doing good programs. We're still so far and spread apart that establishing best practices is hard. The programs are pretty disparate and we're each doing our own thing. Everything we've done so far is great and we can only improve from here.
- For being such a big area, we do a really good job of staying in communication and trying to know what the other areas are doing. When I first started it was just [meetings for one region] but over time they've had more CoC meetings, and now have the Board. So, we're getting better at communication.
- Nothing works really well right now. We just established an actual functioning Board with a charter. We have lots of kinks we still need to work out since we just got a full board. Overall, the governance is effective. The relationship between the Board, HMIS lead, and the collaborative applicant is not great right now.
- The HMIS lead staff have a tendency to take things over and assume responsibility for things that they shouldn't or assume that they need to have their fingers in every piece of the pie. No one wants to see them go away but we need to be better about establishing roles and responsibilities. This has been difficult for our collaborative applicant staff and also for our HMIS lead.
- We're at a really good beginning place on trying to come up with a coordinated entry plan. We also do pretty well with homeless young people. I say that because there are not many youth providers across the state, BoS or other parts of the state, we communicate really well when we have openings and work really well together.
- Dealing with the area that we have, it's hard to get everyone there. Having the state there helps with getting people to the table.
- We have a little bit of a struggle in making sure comprehensive voices are coming in across the different geography. For the longest time, people out in the rural areas have been comfortable saying "y'all know how this should be run, we'll just listen to you." Want to make sure this isn't happening and that we're getting participation. We're headed in the right direction
- All CoCs eventually embraced [cleaning data] and have worked really hard on their data quality. Now we have some really good tools to ensure data quality and do some data quality checks.
- In BoS we're about a year behind the ball implementing CE. The CoC did not do enough earlier. We hit the deadline -- and we now have everything in place. We have an active CE and some areas are more active than others.

Q: Is the Missouri BoS CoC on the road to ending homelessness? (Listed in order of greatest to fewest mentions by those surveyed – see Q18 graph below)

- Yes
- No
- Other: I'm not convinced anyone can end homelessness
- Other: Maybe, some day
- Other: So hard to say because the CoC structure is brand new, but it seems like we are starting to form a plan that will lead us there!
- Other: There are so many sub-populations dealing with homelessness, it's unreasonable to believe the BOS COC can do it alone.... mental health providers, chemical dependency programs, etc. are going to need to jump on board to provide their expertise to ensure, once housed, the tenant, will be successful with ongoing services.

Q18 Is the Missouri BoS CoC on the road to ending homelessness?

Answered: 20   Skipped: 12
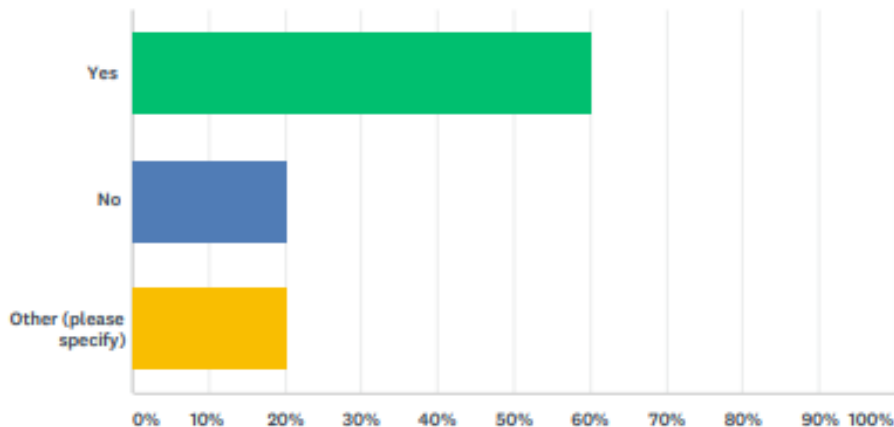
ANSWER CHOICES	RESPONSES	
Yes	60.00%	12
No	20.00%	4
Other (please specify)	20.00%	4
TOTAL		20

Q: What could your region be doing better in implementing policies, practices, funding?

- I don't know of any. We haven't done much analysis.
- As we put policies in place for CE we need to make sure we're considering how this might look different for youth. How do you fill in some of the gaps (like needing to have signed releases for those under 18) while also keeping a similar approach [as used for everyone else]?
- There just isn't enough affordable housing. Most of the homeless people here are doubled up. The waitlists for section 8 are incredibly long.
- Help agencies identify how a project is having an effect on SPMs. Look to see where there are issues where they might provide TA to address. Or, if through evaluating the project is not meeting the needs of the community. Or, is there a capacity issue.
- A lot of the population I serve are disabled. Finding someone housing who's on disability and getting $700/month is impossible. We need more rental assistance and housing.
- I do like involving law enforcement in street outreach. Involving the court system as a whole would be a game changer. Getting hospitals involved from an outreach and fiscal perspective. We could get better numbers. Involving those big entities would definitely be helpful.
- [Primary housing challenges are] availability of resources, as well as knowing who has what. Like, I couldn't tell you who in my region right now has PSH. There are a couple of us in our position that are close to an urban area so refer there rather than a rural CoC.
- Still don't know everyone who is trying to tackle [the coordinated entry] issue. Dealing with 9 counties – 2 of which we've never worked with before.
- In the past year, we became much more involved in looking at HMIS data when making decisions about funding and policy. Staying on this trajectory is going to be important.
- The leadership in the BoS is invested and have the capacity to do what needs to be done. The struggle is to get the investment and "own-ness" from everyone within the CoC and not just from the upper crust or those on the Board or getting funding from the state. This is a disconnect that you struggle with.
- We have come a long way in increasing confidence of data quality used. There is a lot of confidence and capacity to do some data analysis and data visualization. Hope to see some of these conversations in the data committee in the CoC and see what we see in our system of care.
- Don't have VASH vouchers in HMIS which has huge effect on coverage. Hope with CE might get to a point where they want to enter this but right now not a conversation.
- Some Agencies prefer to enter data into other CoC because they consider themselves a part of that community. Because they feel that their clients are coming and going into that other CoC and want to see this. (Even though they are part of BoS.) We talked about trying to bridge data somehow but still have issues with up-to-date data (bridging is not instantaneous).

Q: What do you hope the CoC is going to become and do that is going to change things?

- I hope we can get the CE running smoothly. We have a lot of work to do.
- Making sure the CE will work how it's supposed to work around the BoS will be the most important thing.
- Ultimately, I would like us to have the capacity to establish our own 501c3 for the BoS and become our own collaborative applicant but right now there isn't the capacity. This is a long – term goal.
- I would like to see [the BoS] make decisions independently of the Governor's committee. I understand the purpose behind the Governor's Committee to End Homelessness, but because the BoS operated under them for so long, some people put more on their requests than appropriate. The priority should be coming from the CoC and flowing to the Governor's committee not the other way around.
- I see a need to have a good way to have feedback from all members of the Balance. Need a better feedback loop so not just a few members are making decisions for all the parts.
- I hope to see a coordinated effort across all service providers. I hope we are able to break down the service barriers and territorial issues and figure out a way to prioritize people to get the most people housed.

Q: Is there anything else that you want to make sure we're thinking about or data to look at?
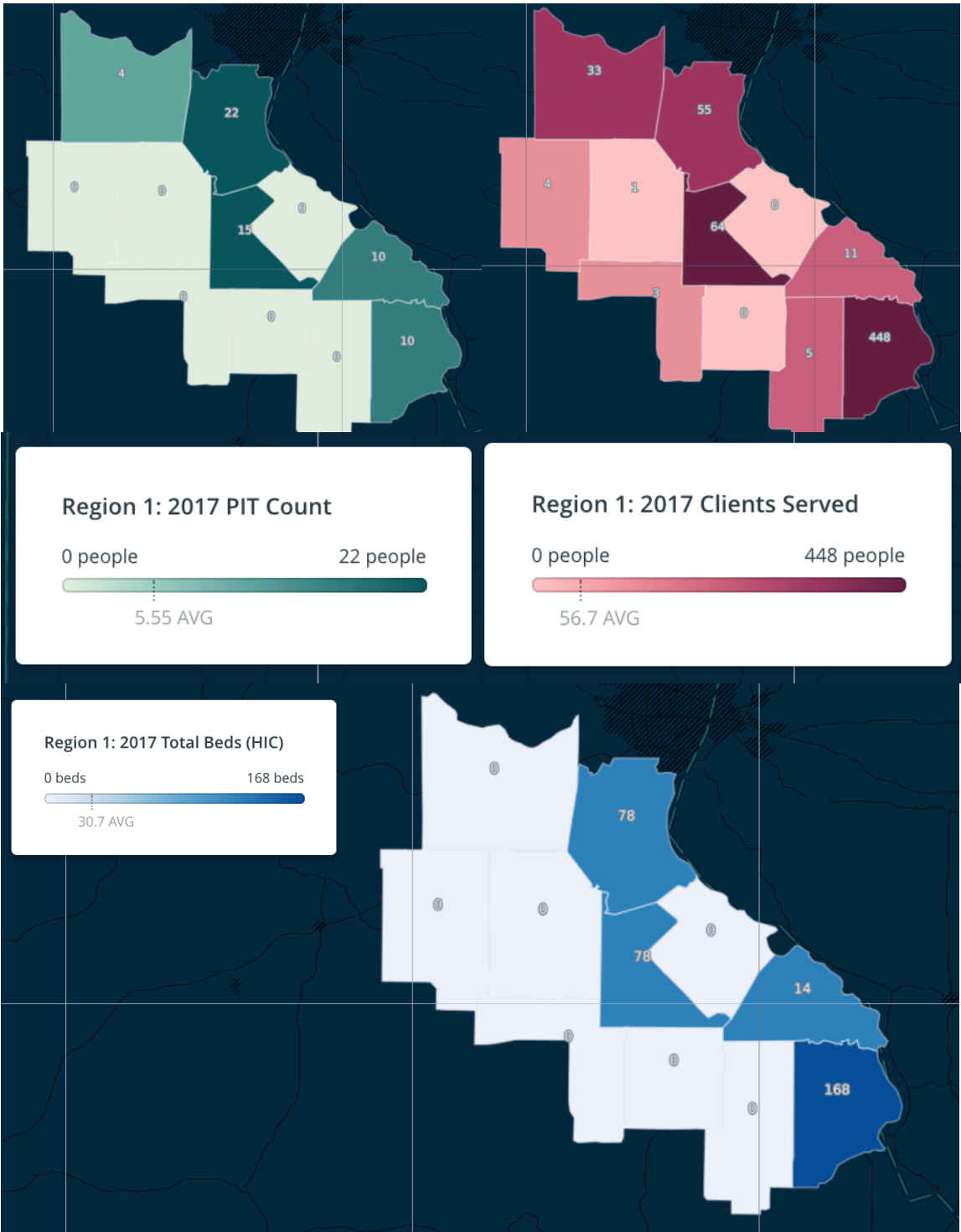
- Sometimes, I feel like in my area we talk a lot about CH and Vets. Families I sometimes worry don't get enough. On the Board, we've done a good job of making sure every population is represented. DV providers are good about speaking up and advocating. I don't know about the CoC as a whole.
- The emphasis on chronic in BoS is overhyped. We've put our bonus emphasis on youth and families over the past 2 years because that is our priority.
- I hope that we can better a picture of what we're looking at outside of the PIT count.
- From a numbers perspective, we get a lot of information from the PIT count, which doesn't necessarily help for the age group that I'm serving. Better outreach outside the PIT count would help with better numbers. Having the raw data could be helpful when trying to communicate the scope of the issue.
- Finding a way to get regional leads and feedback from all the people that they are represented.
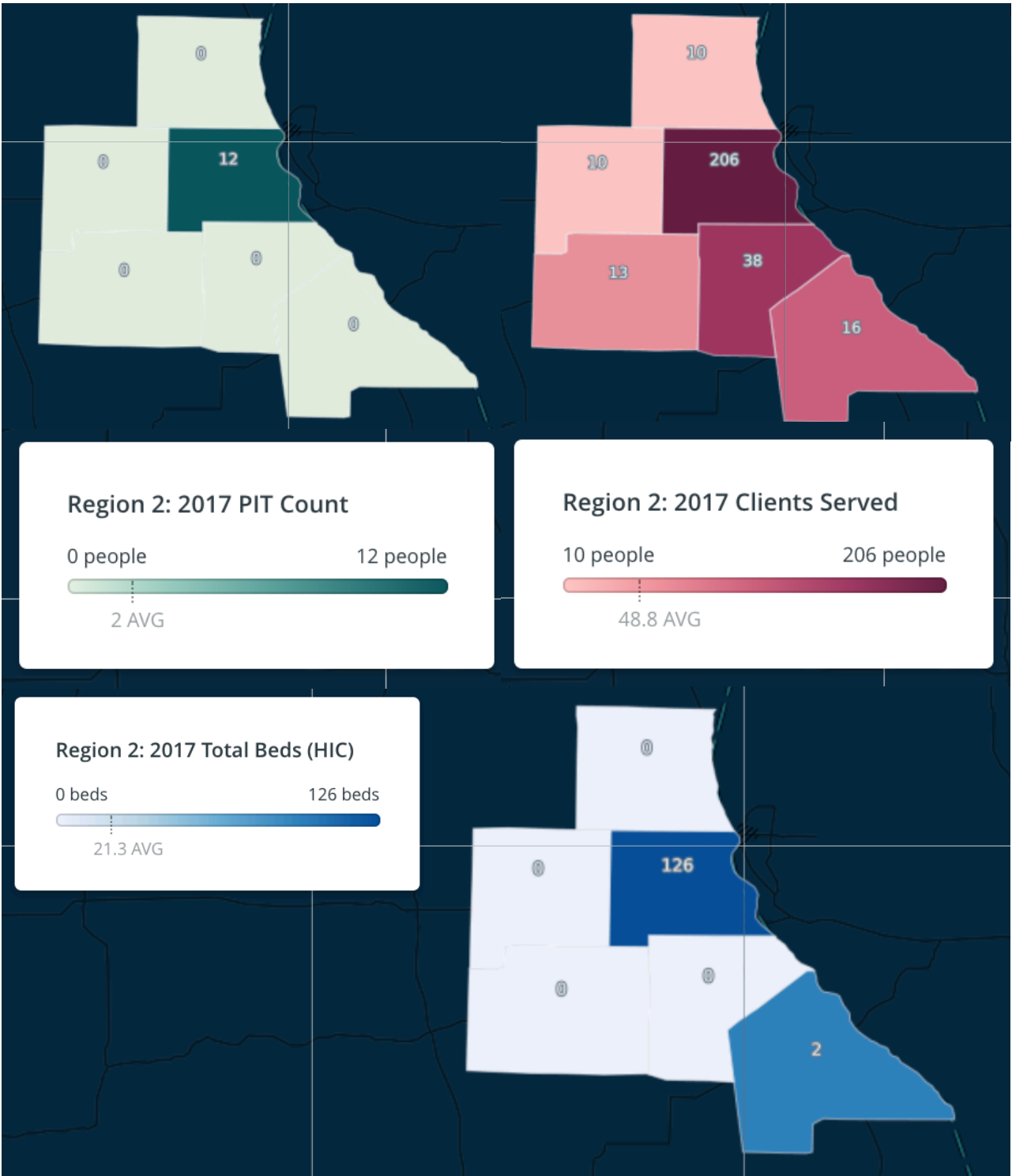
Appendix C: Regional Analysis

2017 Point-In-Time Count, Clients Served, and Number of Beds by Region

This analysis provides a visualization by Region of county-level 2017 data, including: point-in-time count totals, number served and recorded in HMIS, and number of beds based on the housing inventory count. While none of these factors is an exact measure of need or resources, instances where these numbers differ significantly may indicate an unmet need or redundant resources.
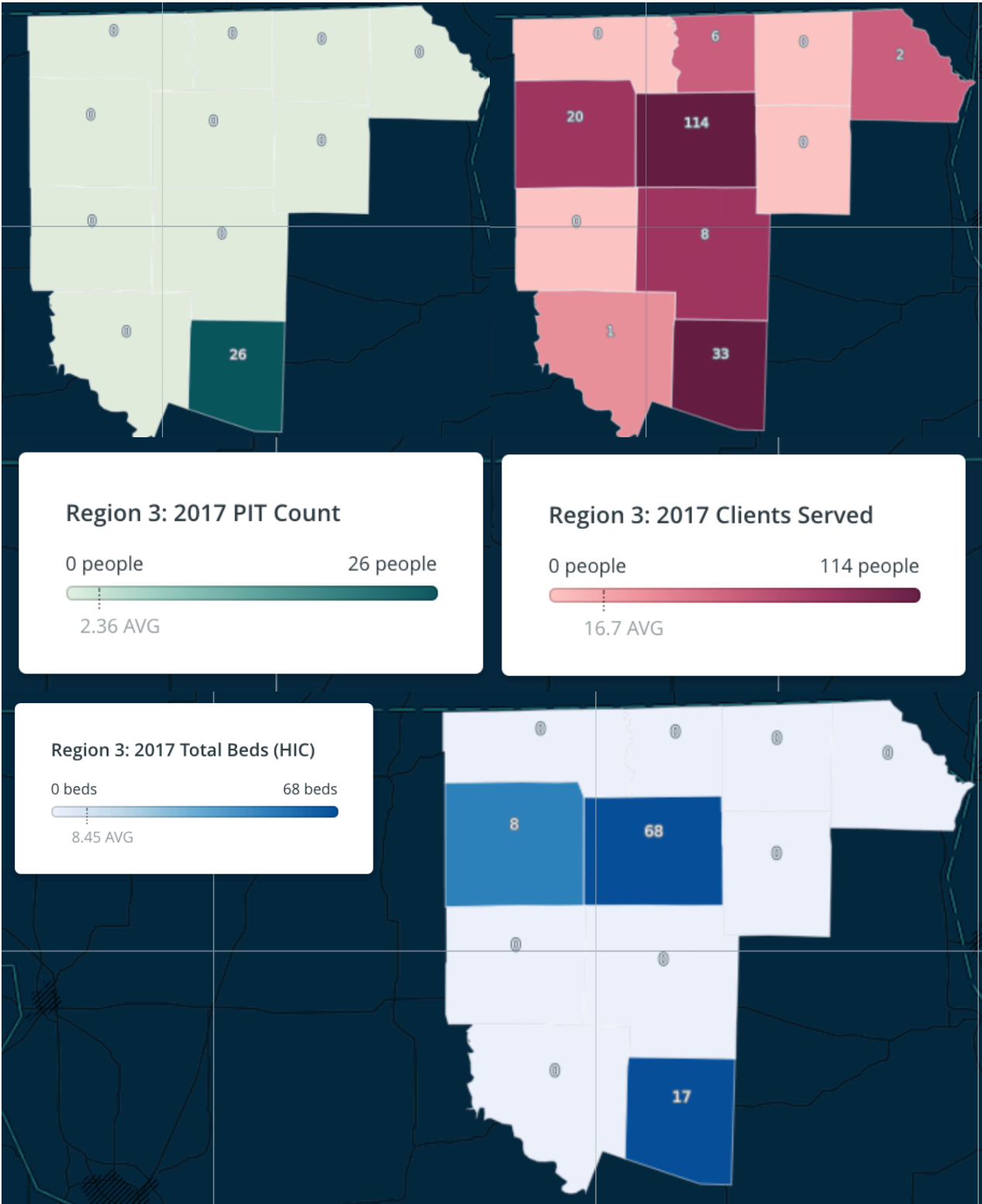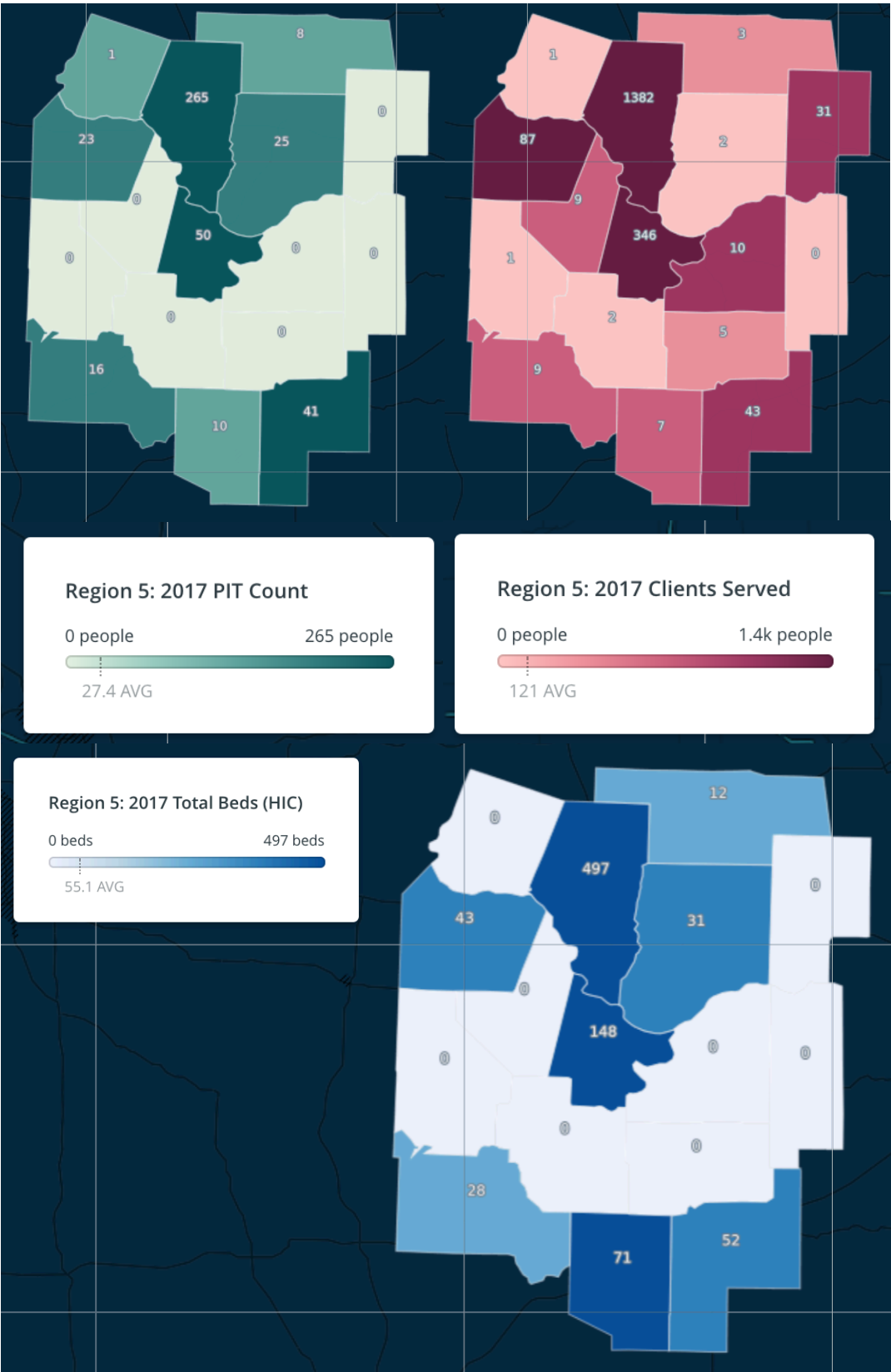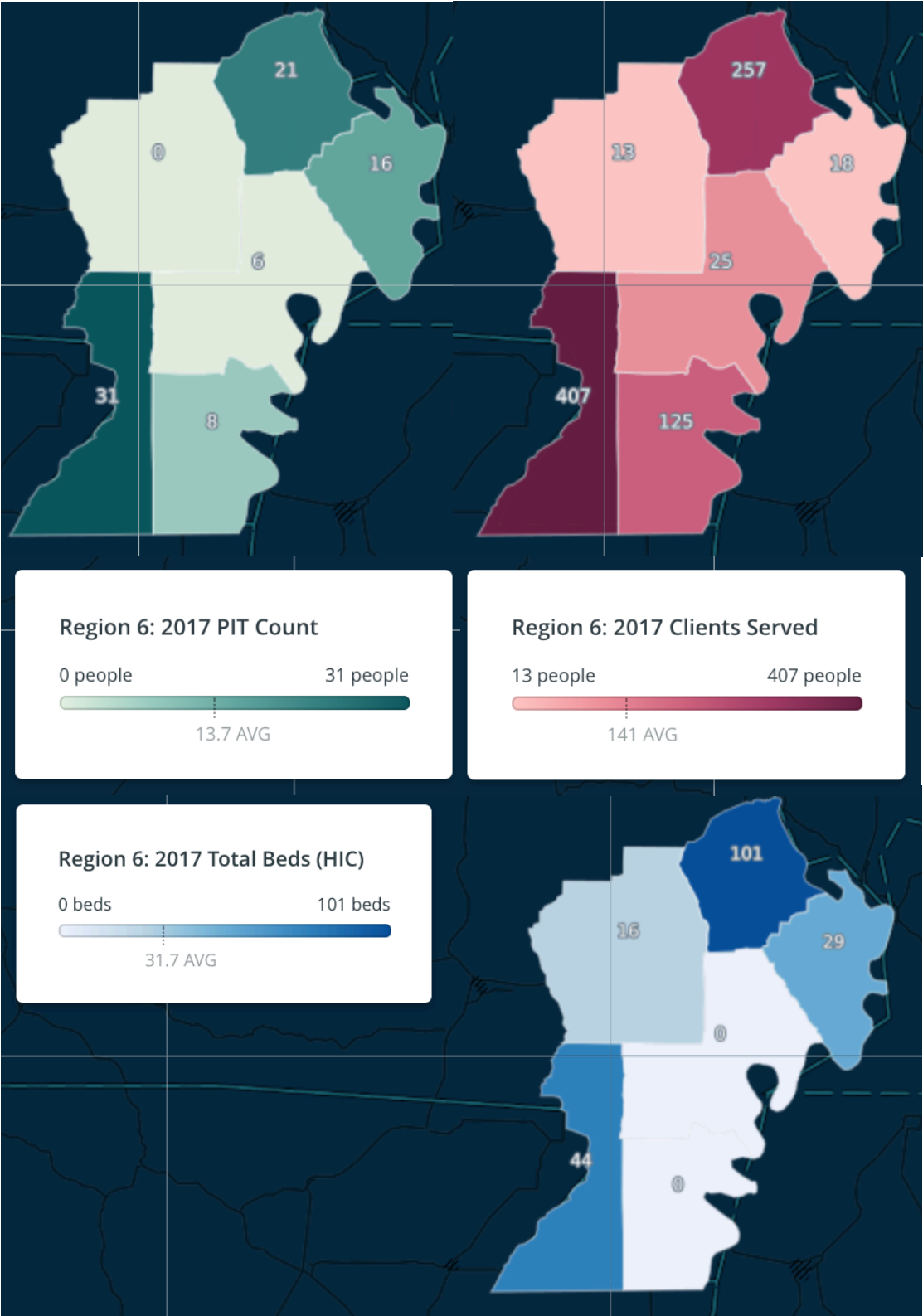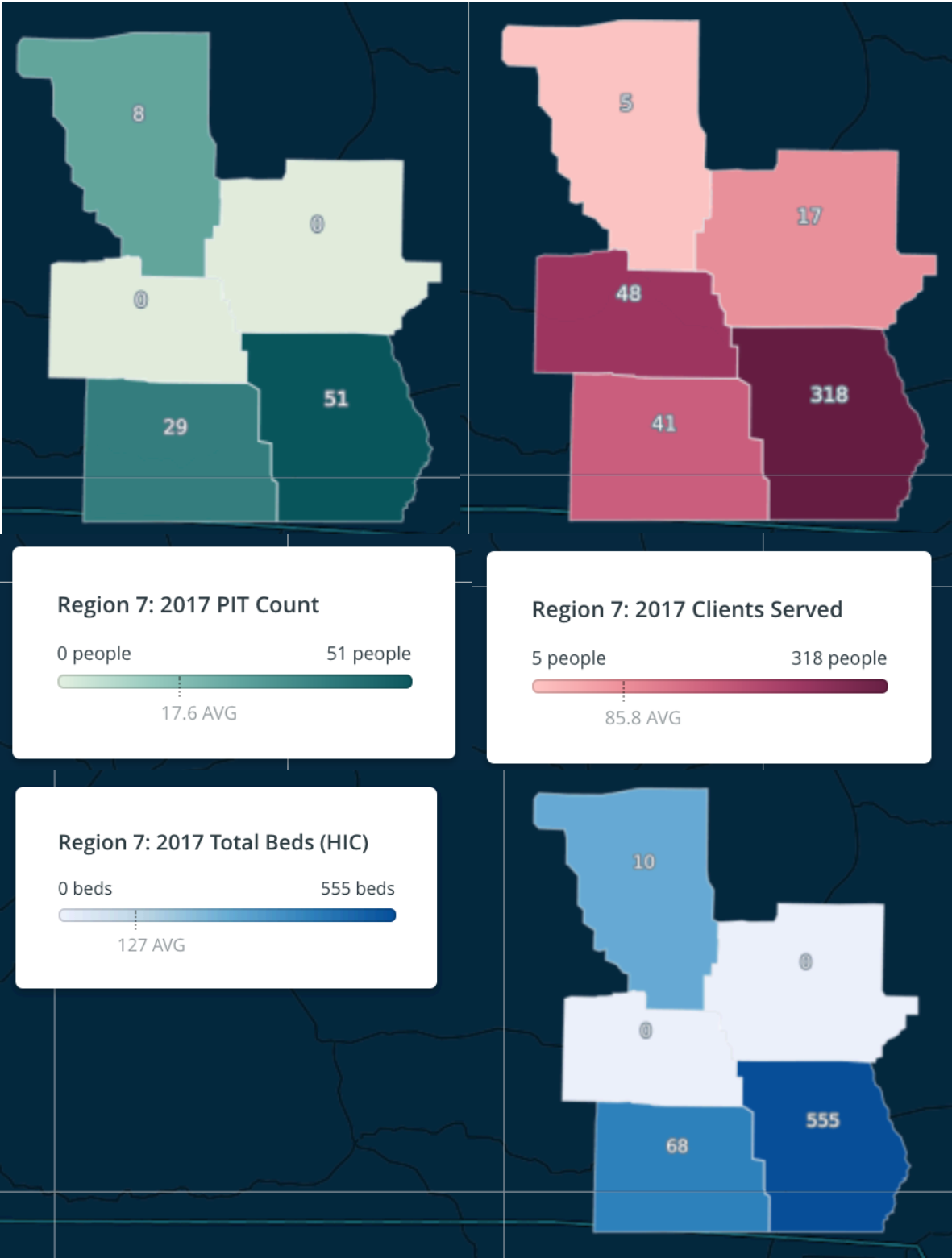
REGION 1

Region 1: 2017 PIT Count

0 people — 22 people

5.55 AVG

Region 1: 2017 Clients Served

0 people — 448 people

56.7 AVG

Region 1: 2017 Total Beds (HIC)

0 beds — 168 beds

30.7 AVG

REGION 2

Region 2: 2017 PIT Count

0 people → 12 people

2 AVG

Region 2: 2017 Clients Served

10 people → 206 people

48.8 AVG

Region 2: 2017 Total Beds (HIC)

0 beds → 126 beds

21.3 AVG

REGION 3

Region 3: 2017 PIT Count

0 people   26 people

2.36 AVG

Region 3: 2017 Clients Served

0 people   114 people

16.7 AVG

Region 3: 2017 Total Beds (HIC)

0 beds   68 beds

8.45 AVG

REGION 4

Region 4: 2017 PIT Count

0 people	143 people

15.2 AVG

Region 4: 2017 Clients Served

0 people	369 people

41.1 AVG

Region 4: 2017 Total Beds (HIC)

0 beds	139 beds

22.7 AVG

REGION 5

Region 5: 2017 PIT Count

0 people   265 people

27.4 AVG

Region 5: 2017 Clients Served

0 people   1.4k people

121 AVG

Region 5: 2017 Total Beds (HIC)

0 beds   497 beds

55.1 AVG

REGION 6

Region 6: 2017 PIT Count

0 people — 31 people
13.7 AVG

Region 6: 2017 Clients Served

13 people — 407 people
141 AVG

Region 6: 2017 Total Beds (HIC)

0 beds — 101 beds
31.7 AVG

REGION 7

Region 7: 2017 PIT Count

0 people — 51 people

17.6 AVG

Region 7: 2017 Clients Served

5 people — 318 people

85.8 AVG

Region 7: 2017 Total Beds (HIC)

0 beds — 555 beds

127 AVG

REGION 8

Region 8: 2017 PIT Count

0 people — 44 people

7.89 AVG

Region 8: 2017 Clients Served

4 people — 366 people

86.9 AVG

Region 8: 2017 Total Beds (HIC)

0 beds — 111 beds

19.2 AVG

REGION 9

Region 9: 2017 PIT Count

0 people   28 people

5.08 AVG

Region 9: 2017 Clients Served

0 people   108 people

13.3 AVG

Region 9: 2017 Total Beds (HIC)

0 beds   87 beds

16.1 AVG

REGION 10

Region 10: 2017 PIT Count

0 people — 48 people

17.8 AVG

Region 10: 2017 Clients Served

0 people — 156 people

44 AVG

Region 10: 2017 Total Beds (HIC)

0 beds — 74 beds

31.3 AVG

Appendix D: Model Survey

A Little About You

1. Your Name:

2. Your Role Within the Continuum of
Care:

3. Your Organization/Agency/Affliation:

4. Your Email Address (optional):

0 of 20 answered

156

5. Your Phone Number (optional):

6. Your County or Region: (Please put "none" if you work statewide.)

NEXT

0 of 20 answered

Identifying Gaps

7. From your perspective, what are three things the Missouri BoS CoC and its stakeholders are doing really well?

1.

2.

3.

8. From your perspective, what are the three biggest needs the CoC should address? Please try to be specific (e.g., instead of "housing" say "need more rapid rehousing vouchers", or instead of "better serve subpopulations" say "youth need more program options in rural areas").

1.

0 of 20 answered

2.

3.

9. Which homeless subpopulations need more attention from the CoC? Please check all that apply.

- [ ] Chronically Homeless
- [ ] Veterans
- [ ] Families
- [ ] Youth
- [ ] Domestic Violence
- [ ] Seriously Mentally Ill
- [ ] Precariously housed
- [ ] Other (please specify)

10. Of the subpopulations you checked, which needs the most attention? Why? What needs to change?

0 of 20 answered

11. Which stakeholders need to have a bigger role or stronger partnership with the CoC to prevent and end homelessness in the Missouri BoS region?

- ☐ Non-CoC-funded providers
- ☐ Jurisdictions
- ☐ Public Housing Authorities
- ☐ Law Enforcement
- ☐ Hospitals
- ☐ Businesses
- ☐ Landlords
- ☐ Foundations
- ☐ Advocates
- ☐ Other (please specify)

12. Of the stakeholders you selected, which is the most important? Why? What do you hope stronger partnership would accomplish?

0 of 20 answered

13. What type of homeless housing resource is most needed in the Missouri BoS Region?

○ Affordable housing/ permanent vouchers without services

○ Rapid Rehousing

○ Permanent Support Housing

○ Transitional Housing

○ Other (please specify)

○ Emergency Housing

○ Prevention

○ Diversion

[   ]

14. What type of homeless services are most needed in the Missouri BoS Region?

○ Health (including Behavioral Health)

○ Income support/ benefits advocacy

○ Employment and Education

○ Other (please specify)

○ Transportation

○ Case Management

[   ]

15. In your opinion, how well is the CoC

suburban and urban areas? How could the CoC improve this response?

[text box]

16. Is the current regional structure within the CoC effective for responding to homelessness?

5 Very Effective	4	3 Neutral	2	1 Not Effective
○	○	○	○	○

17. As a CoC member or partner, what are three ways the CoC/CoC Board/CoC staff/HMIS staff better support you? Please be specific.

1.

[text box]

2.

[text box]

3.

[text box]

18. Is the Missouri BoS CoC on the road to ending homelessness?

◯ Yes

◯ No

◯ Other (please specify)

[   ]

19. If you answered No or Other, what is the most important thing that needs to happen for the CoC to be able to end homelessness in this region?

[   ]

20. If you would like to explain any of your answers above, or provide additional information about gaps in the Missouri BoS CoC, please include that here.

[   ]

PREV   DONE

0 of 20 answered

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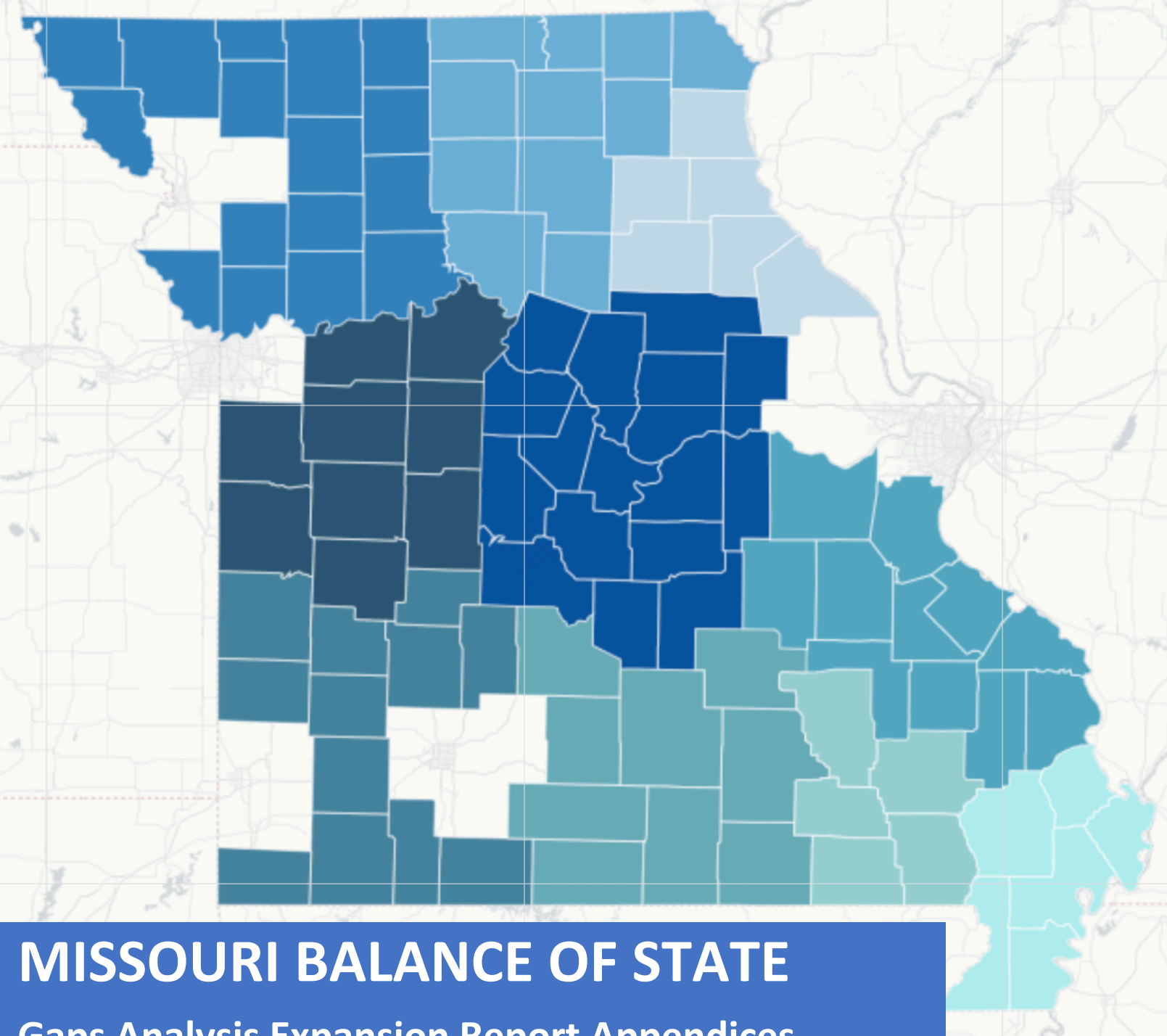
MISSOURI BALANCE OF STATE

Gaps Analysis Expansion Report Appendices
July 2018

HomeBase
Advancing Solutions to Homelessness

870 Market Street, Suite 1228
San Francisco, CA 94102
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APPENDIX E: Funding Attainment and Maximization

Federal, State, and Local Homeless Funding Attainment and Need

Federal and state funding for homeless services makes up millions of dollars in support for the Balance of State CoC. Trends in funding amounts across and within Regions of the Balance of State CoC offer insight into the stability and geographic distribution of funding. This analysis is intended to enable the CoC to identify opportunities to further maximize its funding and more strategically allocate funds toward areas of greatest need.

Understanding the funding sources available, and how to maximize each of them, is vital to the work of homeless service providers. The initial Missouri Balance of State CoC Gaps Analysis Report offers an overview of the state and federal funding streams available to support affordable housing and homeless services, along with recommendations for maximizing these funding streams. This Appendix provides a more detailed analysis of the federal and state funding by region within the Balance of State CoC compared with Homeless Management Information System (HMIS) service and point-in-time count data. It incorporates provider-level survey results detailing which funding streams are commonly utilized while also identifying gaps in need.

In order to expand upon the initial funding coordination and maximization analysis and better identify potential gaps, this Appendix will analyze:

- *Federal and State Funding Trends*: assessing allocations of the largest blocks of state and federal homeless assistance funding, looking across regions in the Balance of State CoC from 2015-2017.

- *Funding Compared with Need*: assessing the geographic allocations of funds and how they compare with geographic need as indicated through Balance of State CoC service and point-in-time count data.

- *Funding at the Provider Level*: looking at provider survey feedback to assess how programs are utilizing federal, state, and local funding sources along with their knowledge of funding sources and areas of additional need.

Federal and State Homelessness Funding Trends

FEDERAL HOMELESSNESS FUNDING

Federal Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funding make up two of the largest overall sources of funding for homeless assistance programs in the Balance of State CoC. Analyzing how this funding is distributed across the Balance of State CoC provides an opportunity to assess geographical differences and changes in allocations. In order to determine the distribution of funding, the Region of the funded location is used as a proxy for the geographic allocation. This is an approximate representation of where CoC and ESG funds are being utilized. A funded agency likely serves individuals from other Regions who present for services. In addition, a funded agency may have locations that serve multiple regions or operate across regions. Despite these concerns, this analysis provides a proxy for understanding geographic distribution of CoC and ESG dollars.

Balance of State CoC awards have overall seen an increase of 21.6 percent from 2015 – 2017. This is an increase of $911,435. The Balance of State CoC Planning Grant received the largest percent increase of 85.4 percent. While the Balance of State CoC has seen an overall increase in funding, this increase has been concentrated in certain regions. Of all the Regions, Region 8 saw the largest percent increase in CoC funding from 2015-2017 (72.1 percent). Regions 4, 7, and 10 experienced percent increases in CoC funding of 32.9 percent, 28.2 percent, and 37.8 percent, respectively. No region experienced a dramatic decrease in CoC funding, but Regions 2, 5, and 6 experienced decreases of 2.6 percent, 1.1 percent, and 4.6 percent, respectively.

Change in Balance of State CoC Award Funding by Region (2015-2017)				
Region	FY2015 CoC Awards	FY2016 CoC Awards	FY2017 CoC Awards	Percent Change 2015-2017
Region 1	$817,970	$817,970	$840,742	2.8%
Region 2	$308,005	$290,996	$300,063	-2.6%
Region 3	$234,398	$234,398	$262,915	12.2%
Region 4	$670,151	$724,974	$890,807	32.9%
Region 5	$897,651	$961,655	$888,047	-1.1%
Region 6	$398,690	$374,527	$380,487	-4.6%
Region 7	$367,555	$456,555	$471,156	28.2%
Region 8	$126,852	$215,852	$218,372	72.1%
Region 9	$209,591	$209,591	$215,891	3.0%
Region 10	$196,411	$263,012	$270,571	37.8%
HMIS	$239,947	$239,947	$239,947	0.0%
Planning	$86,134	$152,726	$159,712	85.4%
Total	**$4,227,273**	**$4,942,202**	**$5,138,708**	**21.6%**

Note: For CoC awards explicitly listed as being shared across regions award amounts were evenly divided by the number of Regions sharing the funding.

Similarly, ESG funds received across the Balance of State CoC experienced an overall increase of 19.0 percent but did not result in universal increases for each Region's awarded ESG funds. The majority of regions experienced an increase in ESG funding from 2015-2017, with Regions 3 and 4 seeing the largest percent increases of 79.1 percent and 172.9 percent, respectively. Region 6 went from not receiving any ESG funds in FY2015 to receiving $36,502 in FY2016 to $62,160 in FY2017. The two Regions experiencing the largest decreases between 2015 and 2017 are Regions 5 and 7, which saw percent decreases in funding of 4.1 percent and 12.4 percent, respectively.

Change in Balance of State ESG Award Funding by Region (2015-2017)				
Region	FY2015 ESG Awards	FY2016 ESG Awards	FY2017 ESG Awards	Percent Change 2015-2017
Region 1	$139,781	$139,670	$139,122	-0.5%
Region 2	$100,000	$100,000	$100,000	0.0%
Region 3	$12,378	$13,772	$22,174	79.1%
Region 4	$86,479	$186,368	$236,000	172.9%
Region 5	$398,904	$399,504	$382,375	-4.1%
Region 6	$0	$36,502	$62,160	70.3%*
Region 7	$113,874	$100,000	$99,750	-12.4%
Region 8	$35,688	$35,577	$43,780	22.7%
Region 9	$244,122	$260,547	$248,036	1.6%
Region 10	$207,332	$237,192	$260,138	25.5%
Total	$1,338,558	$1,509,132	$1,593,535	19.0%

*Region 6 percent change is calculated between FY2016 and FY2017 awards.

Veterans homelessness funding is also a significant source of homeless assistance funding for many CoCs. The Balance of State CoC receives funding from both the U.S. Department of Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) voucher program along with U.S. Department of Veterans Affairs Supportive Services for Veteran Families (SSVF) program. However, these funds are not universally distributed to each region and make up a much smaller portion of homeless assistance funds.

Cumulatively, from FY2015 to FY2017 the number of HUD-VASH vouchers in the Balance of State CoC increased. However, the total increase varies from year to year. In FY2017, HUD-VASH funding increased by $15,070 whereas in FY2015 the increase was $73,436. Additionally, funding for HUD-VASH vouchers is primarily concentrated in Regions 5 and 7.

SSVF funds increased between FY2015 and FY2017 from $390,790 to $405,795, but the FY2017 funding was down slightly from FY2016 ($417,264). However, SSVF funds are used to support

veterans' services in counties in select regions. In FY2017 Regions 2, 3, 5, and 10 received services through SSVF funding.

STATE HOMELESSNESS ASSISTANCE FUNDING

State funding for homeless assistance is a critical source of support for homeless housing and support programs across the state. The Balance of State CoC receives funding from a variety state programs that target resources toward homeless housing and services. State funding for homeless services has overall increased despite funding for the Missouri Housing Trust Fund (MHTF) decreasing and fluctuations in Housing First Program (HFP) funding. This analysis looks specifically at state programs offering rental and housing assistance as well as support services for those experiencing or at-risk of experiencing homelessness and does not consider funding that goes specifically toward low-income and affordable housing development.

The Missouri Housing Trust Fund (MHTF) provides funding for a variety of housing needs, such as homeless prevention, rehab or new construction of rental housing, rental assistance, and home repair. Matching the agencies receiving MHTF funding with the Regions they are located in, indicates that from 2015 to 2017 MHTF funding decreased by 14.7 percent across the Balance of State CoC. However, a few regions saw increases in funding. Most notably, Regions 2, 3, 6, and 10 saw increases in MHTF awards whereas Regions 1, 7, 8, and 9 experienced larger percent decreases in MHTF amounts awarded. Region 4 is the only Region where an agency within its geographical area was not awarded MHTF funds.

Change in Balance of State MHTF Award Funding by Region (2015-2017)				
Region	FY2015 MHTF	FY2016 MHTF	FY2017 MHTF	Percent Change 2015-2017
Region 1	$293,600	$158,750	$75,000	-74.5%
Region 2	$138,779	$88,215	$185,740	33.8%
Region 3	$24,000	$12,731	$30,636	27.7%
Region 4	$0	$0	$0	--
Region 5	$285,576	$267,000	$290,000	1.5%
Region 6	$120,000	$0	$158,000	31.7%
Region 7	$40,000	$0	$10,000	-75.0%
Region 8	$392,000	$271,708	$225,700	-42.4%
Region 9	$32,000	$0	$16,000	-50.0%
Region 10	$11,830	$222,455	$150,216	1169.8%
Total	**$1,337,785**	**$1,020,859**	**$1,141,291**	**-14.7%**

The Housing First Program (HFP), established in 2012, offers funding to support upcoming, new, or existing Housing First programs in order to address the housing and housing service needs of people

experiencing homelessness and chronic homelessness. The funds that agencies within the Balance of State CoC receive through HFP are relatively small compared to CoC or ESG funds. Award amounts fluctuated between 2015 and 2017 from a total $41,400 in 2015 (allocated to Regions 1 and 2) to $52,500 in 2016 (allocated to regions 2, 7, and 8), and $42,500 in 2017 (allocated to Regions 6, 7, and 8).

In 2018, Balance of State CoC Regions benefited from the Missouri Housing Innovation Program (MoHIP), which aims to provide flexibility to CoCs in addressing their evolving needs, diminishing the burden of coordination of care across large geographic areas, and offering an opportunity to implement or sustain coordinated entry to meet HUD deadlines. MoHIP funding can support Coordinated Entry System, Street Outreach, Housing Assistance/Services, and HMIS. The Balance of State CoC received a total of $824,814 in MoHIP funding with each Region receiving some allocation. Below are the allocations for FY2018 by Region.

- Region 1 - $81,000
- Region 2 - $53,514
- Region 3 - $64,800
- Region 4 - $42,300
- Region 5 - $121,400
- Region 6 - $113,400
- Region 7 - $27,600
- Region 8 - $112,700
- Region 9 - $104,200
- Region 10 - $103,900

While state funding for homeless services through MHTF and HFP fluctuated from 2015 to 2017, funding through the MoHIP program in 2018 reflects a focused investment in helping CoCs in Missouri access more flexible funds to address their needs.

Funding Compared with Need

Analyzing homelessness funding at a regional level within the Balance of State CoC presents the opportunity to also analyze this funding in comparison to overall need in a Region. As stated earlier, the funding breakdown by region is a rough comparison and cannot account for agencies that have locations in other Regions or serve individuals and families who are receiving services in multiple Regions. Despite this caveat, comparing funding by region with need offers an approximation of the extent to which funding is reaching areas and individuals with the greatest need.

COC AND ESG FUNDING COMPARED WITH HOMELESS SERVICE NEED

Given that the CoC and ESG funds comprise a large component of homelessness funding received by the Balance of State CoC Regions, these two funding sources are the focus of comparing funding allocation with need. Comparing funding allocated to Regions within the Balance of State CoC with both point-in-time count and service data provides two approximate measures of whether funds are

matched to areas with the greatest need as measured by the number of individuals experiencing homelessness.

As a point of reference: a 2010 HUD report, "Costs Associated With First-Time Homelessness for Families and Individuals," looks at the average cost of different homeless programs per individuals per month. While the study looks at only specific sites, Des Moines, IA, which was included in the study, can be used as a rough proxy for the Missouri Balance of State CoC area. The study found that emergency shelter costs, on average, $541 per individual per month, and permanent supportive housing costs $537.[1] For a more recent and local measure, the FY2018 Fair Market Rents (FMRs) for a one-bedroom apartment in the Balance of State CoC regions ranges from $713 in Platte County (Region 4) to $437 in Shelby County (Region 2).[2]

The Balance of State CoC service data for 2017 includes those who received both housing as well as supportive services from agencies participating in the Balance of State CoC HMIS. Point-in-time count data, while much smaller, offers another approximation of homelessness within the Balance of State CoC and is often used by HUD and others to help identify the level of need for homelessness services and funding.

Comparing 2017 service data with CoC and ESG funding allocations across Regions in the Balance of State CoC, reveals Regional variations in funding allocations per person served. The CoC overall received $1,068 per individual served in 2017. The region with the lowest CoC and ESG Funding per individual served was Region 8 at $340, followed by Region 6 at $528. The Regions receiving the highest amount of CoC and ESG funding per individual served were Region 9 at $2,949, and Region 4 at $1,720. The average CoC and ESG funding allocated per individual served was $1,329, and the median was $1,356.

CoC and ESG Funding Per Individual Served in 2017 by Region (Using HMIS Balance of State CoC service data)			
Region	2017 Individuals Served	CoC and ESG Funding	CoC and ESG Funding Per Individual Served
Region 1	624	$994,994	$1,595
Region 2	293	$426,092	$1,454
Region 3	184	$296,630	$1,612
Region 4	658	$1,131,826	$1,720
Region 5	1938	$1,272,903	$657
Region 6	845	$445,936	$528

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[1] U.S. Department of Housing and Urban Development, "Costs Associated With First-Time Homelessness for Families and Individuals," 2010. https://www.huduser.gov/publications/pdf/costs_homeless.pdf.
[2] U.S. Department of Housing and Urban Development, FY2018 Fair Market Rents. https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2018_code/select_Geography.odn.

Region 7	429	$577,358	$1,346
Region 8	782	$265,506	$340
Region 9	159	$468,824	$2,949
Region 10	396	$533,083	$1,346
Total	**6308**	**$6,737,025***	**$1,068**

*This total includes CoC funds received for HMIS and Planning grants even though they are not attributed to any Region in particular. These are viewed as shared costs across the Regions and included in the total.

Comparing CoC and ESG funding received per individual identified in the 2017 point-in-time count reveals a similar pattern, with certain Regions receiving more funding than others per individual. Overall, the Balance of State CoC received $5,202 in CoC and ESG funding per individual counted. The Region with the lowest CoC and ESG funding per individual counted was Region 5 at $2,900. Regions with the next lowest CoC and ESG funding per individual include: Region 6 ($3,328), Region 10 ($3,332), and Region 8 ($3,740). The Region with the highest CoC and ESG funding per individual counted in the point-in-time count was Region 2 at $35,508. The Regions with the next highest funding allocation per individual counted include: Region 1 ($16,311) and Region 3 ($11,409). Across all Balance of State CoC Regions, the average allocation of CoC and ESG funding per individual in the 2017 point-in-time count was $9,148, and the median was $5,202.

CoC and ESG Funding Per Individual Identified in the 2017 Point-In-Time Count by Region			
Region	**2017 Point-In-Time Count**	**CoC and ESG Funding**	**CoC and ESG Funding Per Person Counted in the Point-In-Time Count**
Region 1	61	$994,994	$16,311
Region 2	12	$426,092	$35,508
Region 3	26	$296,630	$11,409
Region 4	243	$1,131,826	$4,658
Region 5	439	$1,272,903	$2,900
Region 6	134	$445,936	$3,328
Region 7	88	$577,358	$6,561
Region 8	71	$265,506	$3,740
Region 9	61	$468,824	$7,686
Region 10	160	$533,083	$3,332
Total	**1295**	**$6,737,025***	**$5,202**

*This total includes CoC funds received for HMIS and Planning grants even though they are not attributed to any Region in particular. These are viewed as shared costs across the Regions and included in the total.

The Regions serving the greatest number of individuals, and with the highest point-in-time count numbers, also tend to have the lowest allocations of CoC and ESG funds per person. However, these funding allocations vary quite significantly by Region and whether service data or point-in-time count

data is used to make the comparison. For example, Region 2 has a very high allocation when looking at the point-in-time count data, but when looking at service data, the allocation is just slightly higher than the average allocation ($1,454 vs. $1,329). Region 1 and Region 3 reflect a similar pattern. Region 9 has one of the highest allocations when looking at both point-in-time and service data, $7,686 and $2,949 respectively. Regions 5, 6, and 8 have the lowest allocations for both point-in-time count and service data.

CoC and ESG Funding Received Per Service and PIT Count Data by Region (2017)
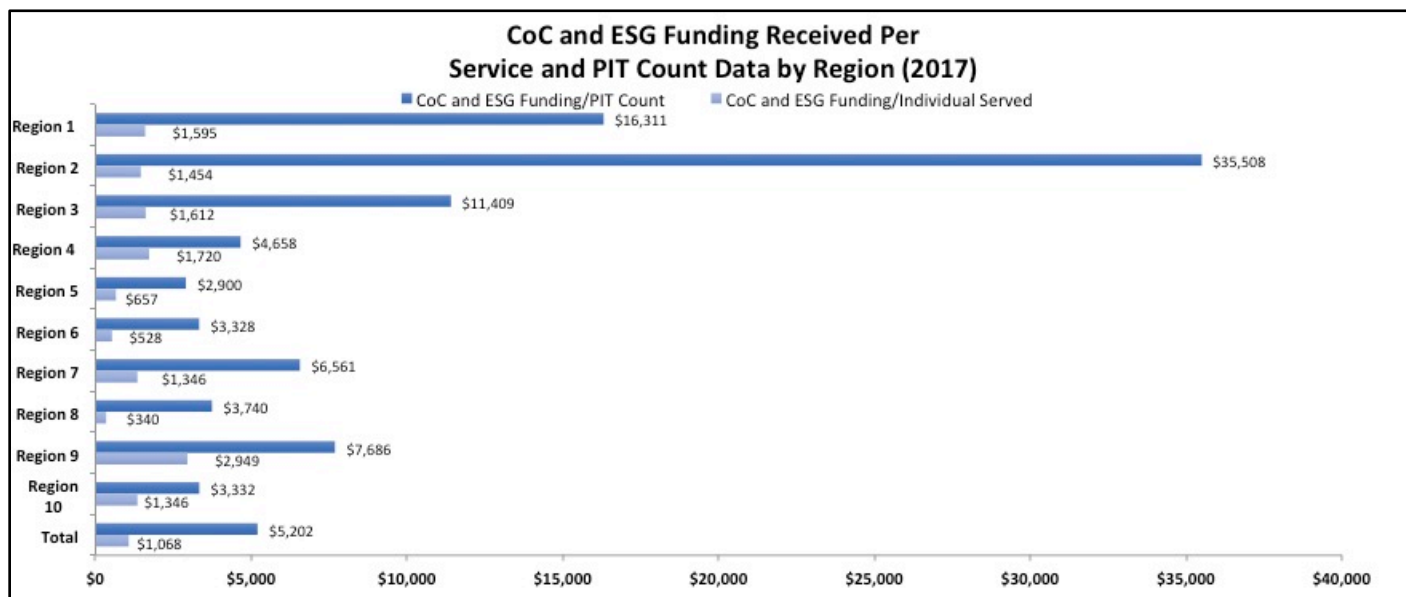
While this analysis offers a lens to better understand how CoC and ESG funding allocations compare to measures of need and services provided per Region, they do not provide a complete picture of whether funding is aligning appropriately with need or not. For some Regions, such as Regions 1 and 2, which border the larger urban and suburban areas of St. Louis, their location may contribute to lower point-in-time count numbers.

In addition to understanding the geographic allocations of CoC and ESG funding, analyzing the type of need within region will also affect what might be an appropriate funding allocation. Funding allocation per person or per need (as indicated by point-in-time count numbers) does not provide any information on effectiveness. Utilizing funding information to understand the types of outcomes achieved across regions with that type of funding is an important measure of how well funding is meeting and responding to need.

Funding Utilization at the Provider Level

PROGRAMMATIC FUNDING SOURCES

In order to gain an understanding of how on-the-ground funding operated, HomeBase sent a survey to 71 providers across the Balance of State CoC regions, including those who are not receiving CoC funding. The survey results offer insight into what federal, state, and local funding sources programs are utilizing to serve those experiencing homelessness. Thirty organizations answered a series of questions in the survey about funding attained. Answers from these organizations represent all ten Regions in the Balance of State CoC with the largest number of responses coming from Regions 4 and 5.

Private donations were the most commonly mentioned source of funding from programs, with 16 programs responding as receiving private donations in their funding. Foundation grants were the second most common source of funding among respondents with nine programs utilizing foundation grants. Eight programs responded as utilizing Continuum of Care funding, Missouri Housing Trust Fund dollars, and local city-level funding. Seven programs reported using Emergency Solutions Grants and local county-level funding to help support their homelessness programs. In addition to these sources, programs also cited utilizing VA funding, FEMA Emergency Food and Shelter Program funding, and Runaway and Homeless Youth funding. While these survey results do not reflect a comprehensive picture of all the providers or funding sources utilized, it demonstrates the diversity of funding sources programs utilize and the important role that local funding and private donations play in supporting the work of homeless service providers. Future analysis on what types of city and county funding exists to support the work of these programs could help shed additional light on funding attainment.

Programmatic Funding Sources Utilized Across Balance of State CoC Regions

| Funding Source	Number of Survey Responses
Federal - Continuum of Care Program	8
Federal – Emergency Solutions Grant	7
Federal – Community Development Block Grant	1
Federal – Home Investment Partnerships Program	0
Federal – National Housing Trust Fund	1
Federal – Housing Opportunities for Persons with AIDS	0
Federal – Low-Income Housing Tax Credit	2
Federal – Community Services Block Grant	2
State – Missouri Housing Trust Fund	8
State – Housing First Program	3
State – Missouri Housing Innovation Program	4
State – Affordable Housing Assistance Program	2
Local – County-level Funding	7
Local – City-level Funding	8
Foundation Grants	9
Private Donations	16

The majority of organizations reported that their programmatic funding goes primarily toward rental assistance and housing support. Emergency shelter and support services were also common answers for how the majority of funds are expended.

While programs use a variety of funding types to provide services and housing, there does not appear to be consistency in how these different funding sources comprise budgets. Approximately 27 percent of program respondents noted that federal or state grants make up between 50 to 80 percent of their overall budget, whereas 20 percent of programs responded that they relied on private donations and/or foundation grants for 40 to 100 percent of their overall funding. Of the programs that responded as having fifty percent or more of their budget comprised of federal or state grants, four of these programs received CoC program funding. For programs that rely on city and county funding, they commonly responded that these sources of funding totaled 15 to 20 percent or more of their overall funding for homelessness services and housing.

GAPS IN KNOWLEDGE, CAPACITY, AND NEED

Homeless programs are making use of a variety of funding sources in order to support their programs and services. The use of diverse funding sources suggests that programs have an understanding of the different funding streams available and how to maximize these funds. Survey responses also suggest this is true.

How would you rate your knowledge of local, state, and federal funding sources for homelessness programs?
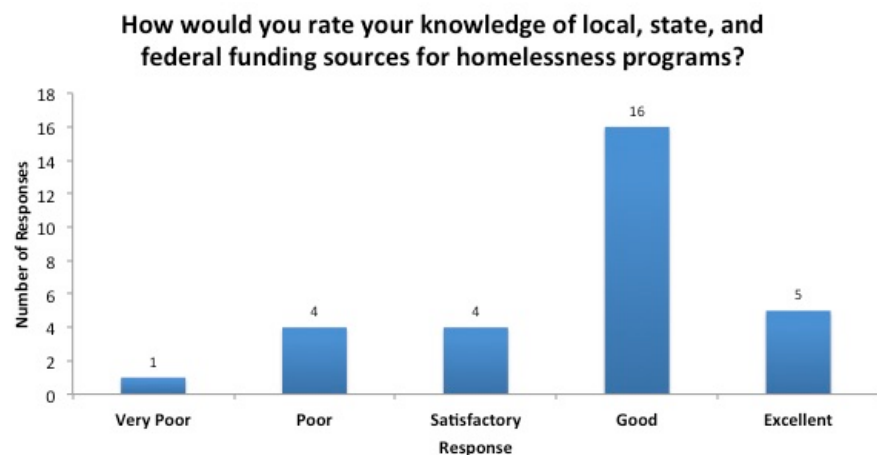
Of the 30 organizations that responded to the survey, 70 percent of respondents rated their knowledge of available local, state, and federal homelessness funding as "Good" or "Excellent." Of the remaining 30 percent, 16.7 percent rated their knowledge as "Poor" or "Very Poor," and 13.3 percent rated their knowledge as "Satisfactory." While a limited sample, these results suggest that there is room to improve everyone's knowledge of available funding and how to utilize and maximize funding resources, even though a majority of organizations would rate their knowledge of these funding streams highly.

While a majority of organizations rate their knowledge of the funding available as good or excellent, one-third of these same organizations still identified limited understanding by their staff, limited time

to research new grants, or the need for additional capacity as limiting their ability to actually apply for funding and manage grants. Eight of the organizations (26.7 percent) responded as needing additional capacity or having limited capacity to manage funds.

One respondent commented that, "We don't have the staff to research all the funding that is available to us…[but] we have hired an Operations and Development Director to expand our funding." Another respondent commented: "We have only one paid staff who runs our programs, so funding applications are completed by one volunteer. We really need help with grant applications." This reflects a need among organizations for additional support and guidance when it comes to having an understanding of the breadth of grants available, having the capacity to apply for relevant opportunities, and managing funds and coordinating funding streams once they are received.

Ten percent of respondents (3 out of 30) explicitly commented that they were concerned about funding requirements and keeping track of these different requirements. One respondent wrote "Funding requirements are difficult, especially the different documentation requirements," while another respondent commented on the limited capacity of staff at their domestic violence-focused program to focus specifically on homelessness-related funding requirements. However, ten percent of respondents also commented that they did not feel that grant requirements were a challenge for their organization or homelessness program. This indicates that there is wide range of experience and capacity at organizations providing homelessness services across the Balance of State CoC.

The survey also asked providers to respond to whatever gaps in need there are within the current funding they utilize to meet client needs. Answers were varied, with little consensus regarding which areas of operations and services need additional funding. Funding for emergency housing or shelters received the highest number of responses (5) and affordable housing received the next highest number of responses (4). Overall there were 13 responses that mentioned the need for additional rental assistance, emergency shelters, transitional housing, or affordable housing, driving home the need for greater investment in support for housing. Non-housing gaps identified included the need for prevention funding (3 responses). Two responses were given for each the following needs: capacity building, transportation, veterans funding, health services, and employment services.

Are there gaps in current funding opportunities that you would like to see addressed?

Category	Number of Responses
Prevention	3
Veterans Funding	2
Capacity	2
Rental Assistance	2
Affordable Housing	4
Health Services (Including Mental Health)	2
Empolyment Services	2
Transitional Housing	2
Emergency Housing	5
Food Assistance	1
Clothing	1
Furniture	1
Transportation	2
Coordinated Entry	1

Overall, providers indicated a wide variety of needs that additional funding would likely support. Given the geographical diversity of the Balance of State CoC and varying issues that each Region finds most pressing, this variation is unsurprising. The variety of funding needed by organizations suggests the importance of investments in flexible funding streams. With flexibility, programs can utilize funding in accordance with where their greatest gaps are.

Recommendations

Continue advocating for flexible, consistent funding streams. The overall funding levels for the Missouri Balance of State CoC have increased over the past few years, helping support the CoC to continue working toward ending homelessness. However, provider survey feedback indicates the need for flexible and more consistent funding streams. Provider survey results suggest that there is not one overwhelming gap in funding. While additional funding for rental assistance, affordable housing and emergency/transition housing was widely cited as a gap, providers also indicated the need for funding that helped them build internal capacity, could support prevention services, employment services, or veterans. Another provider would like to allocate additional funds for Coordinated Entry work. The diversity of needs suggests the usefulness of more flexible funding for programs.

The Missouri Housing Innovation Program (MoHIP), which awarded funding in 2018, offers an example of how flexibility in funding can work for the Balance of State Regions. MoHIP funding can go toward supporting Coordinated Entry System, Street Outreach, Housing Assistance/Services, and HMIS. Continuing to invest in MoHIP funds while also offering providers access to other flexible funds

that can support their own capacity building will help address the needs as indicated by providers and give them latitude to allocate funds toward where their gaps are.

Analyze funding distribution geographically while also considering depth of needs and program effectiveness. The geographic distribution of funds is important to understanding where homelessness dollars are going within the Balance of State CoC and whether they are aligning with where the greatest needs are. Comparing 2017 CoC and ESG funding allocation with 2017 service and the point-in-time count data provides an initial proxy for determining where this funding is being distributed and how much is being spent per person served and per person counted. This analysis reveals the varying amount of funding distributed across regions and can suggest where additional funds may want to be allocated. However, it is not a perfect measure of whether funding is appropriately aligned with need.

In order to fully explore whether funding aligns with need, the Balance of State CoC should continue analyzing the Regional distribution of funding while also taking into consideration the type of services the funding is going toward, how the funding is meeting the understood need in the community, and what types of outcomes are being achieved with the funding, as well as applicant capacity. Combining these measures will provide for a more holistic view of how well funding is being allocated to meet the different needs of each region and whether regions are achieving desired outcomes with their funding allocations.

Support capacity building throughout the Balance of State CoC, potentially by writing a funding 101 guide, hosting grant-writing workshops, and leveraging connections through coordinated entry. A majority of providers in the Balance of State CoC indicated that they have a good or excellent knowledge of the funding available; however, there were still many providers who offered written feedback stating they did not have the capacity to fully investigate all the funding streams available, let alone attempt to apply and try to comply with them.

In order to support providers across the Regions, the CoC as a whole could consider developing a basic "Funding 101 Guide" that can help providers both access descriptions of the funding streams available for homelessness housing and support services while also providing general eligibility, application, and management requirements. The materials in the "Funding Attainment and Maximization" section of the March 2018 Missouri Balance of State Gaps Analysis offer a template for what funding streams could be included along with descriptions of what each funding opportunity offers. Building off of this information to include additional overviews on eligibility, application, and management requirements could help organizations and new staff to understand what is available and the time commitment needed to apply for and manage those funds.

Additionally, the CoC could host grant-writing workshops to provide staff training, building agency capacity to investigate and successfully apply for funding available to them. The workshops could include tips and tricks, a panel of funders explaining what they look for, and include writing practice. For geographic areas of the CoC that appear to be under-resourced, building agency capacity to apply and manage funding may fill a key gap in the system of care.

In addition, the Balance of State CoC should work to leverage Coordinated Entry to better connect homeless providers with other providers using additional funding streams. This will allow providers within regions to better leverage the resources that other organizations are bringing to address homelessness and poverty and maximize their own new and existing funding to target resources and services of the greatest need for their clients. This process will also help make organizations aware of what funding/services are available in their region with which they can connect. Ideally, the Funding 101 Guide, along with leveraging Coordinated Entry networks, will help make providers aware of the funding and services accessible to them and their clients. This will also support maximization of funding resources at the programmatic and Regional levels.

APPENDIX F: Non-HMIS-Participating Provider Services, Data, and Gaps

In the Missouri Balance of State Gaps Analysis Report, HomeBase noted that due to lack of participation in HMIS, some recommendations and conclusions could be more informative to CoC decision-makers if data was collected from additional providers. Therefore, to better understand resource availability and accessibility, and to support relevant decision-making, HomeBase contacted non-HMIS participating agencies to request available data, including Veterans Affairs, the Missouri Coalition for Domestic Violence (MCDV), and additional providers within the Missouri Balance of State.

Using data collected from non-HMIS participating providers, this Appendix analyzes how well data not relied on in the initial Gaps Analysis Report aligns with the Report's findings and identifies additional potential gaps in services offered and data collected. This analysis includes looking at new data from providers serving:

- Homeless veterans
- Survivors of domestic violence
- Homeless individuals and families throughout the Balance of State CoC served by agencies not participating in HMIS.

Since most of the data collected was statewide data, not restricted to this CoC's geography, HomeBase was limited in its ability to produce precise numbers around homeless subpopulations and services for veterans and survivors of domestic violence. While the estimates provided by the derived multipliers (described in more detail below) are within a certain margin of error, more accurate conclusions could be drawn from CoC-level or county-level data.

Services for Homeless Veterans

HomeBase determined that Department of Veterans Affairs (VA) programs were within the scope of this appendix because several of their programs do not participate in HMIS according to the 2017 Housing Inventory Count. VA programs, especially HUD-VASH do not participate in HMIS in many CoCs, and the lack of information about veterans and those units can hobble CoC strategic efforts. While the Gaps Analysis report did discuss the number of beds available to homeless veterans and changes in point-in-time counts for veterans, the report did not analyze specific data regarding wraparound services available to veterans. This section analyzes various data trends, including:

1. Number of veterans served
2. Homeless history at time of assessment
3. Chronic homelessness
4. Placement in permanent housing
5. Outreach
6. Services accessed, including usage rates

METHODOLOGY

Pursuant to a HomeBase request for available data, the Department of Veterans Affairs provided data around homeless veterans and veterans services. As anticipated, data collected and provided does align with the CoC's geography, HUD or CoC definitions of data standards, or CoC priorities. The VA's data priorities and data collection practices differ from the CoCs, so the information available is limited.

Since much of the data provided was state-wide, HomeBase used a multiplier derived from 2017 point-in-time count data on veterans to estimate proportionate numbers for the Balance of State CoC. The 2017 point-in-time count showed that there were 98 homeless veterans in the Missouri Balance of State and 562 for Missouri in total. This calculation produced a multiplier of .174, which HomeBase then used to adjust the data from Veteran's Affairs.

$$\frac{Veteran\ PIT\ Count\ (Missouri\ Balance\ of\ State)}{Veteran\ PIT\ Count\ (Missouri)} = \frac{98}{562} = .174$$

Because the numbers used in this section were derived proportionally from the state's numbers as a whole, they are only estimates.

NUMBER OF VETERANS

In 2017, 98 veterans experienced homelessness (as identified during the point-in-time count) and 531 homeless veterans were served in the Missouri Balance of State CoC according to HMIS. The point-in-time counts over the past five years indicate a downwards trend in homelessness.
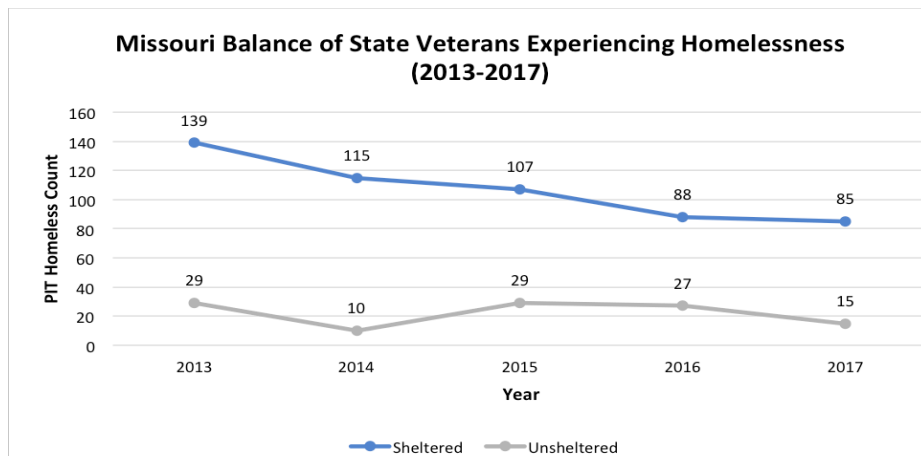
The VA provided data for a larger and different group of veterans, including veterans in Missouri who are homeless, at risk of homelessness, or have a homeless benefit who were served at a VA facility. This data is not intended to reflect the number of homeless veterans, but it does show a similar trend with reductions in the number of veterans with these qualities being identified year to year, except for an increase between FY2016 and FY2017.

Number of Veterans in Missouri Who Are Homeless, At Risk, or Have a Homeless Benefit Who Were Served at a VA Facility (FY2013-FY2017)
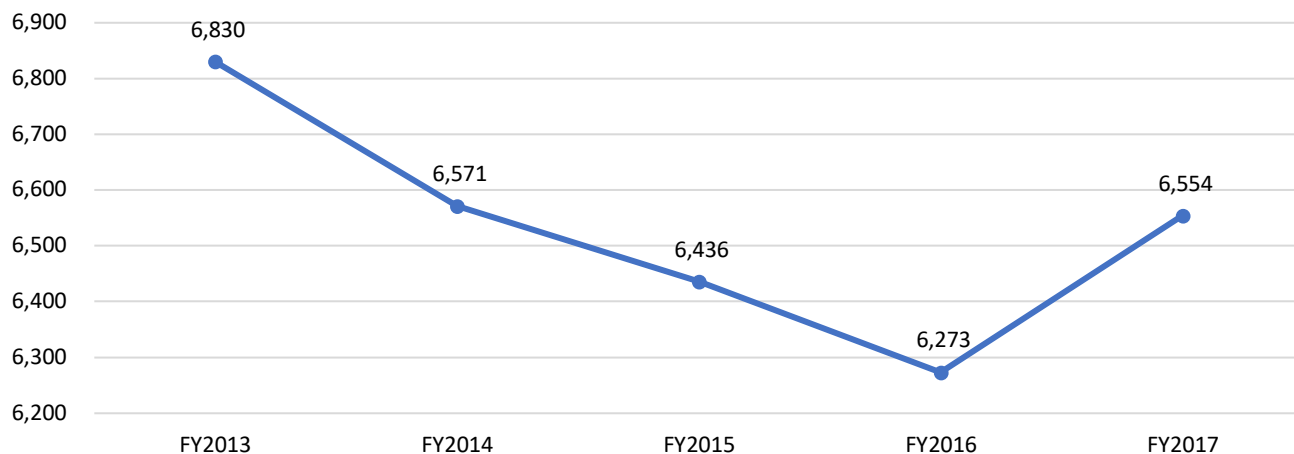
VETERAN HOMELESS HISTORY

While the VA does not collect data on the length of time a veteran experiences homelessness, it does collect a veteran's homeless history at the time of intake and assessment.

In FY2013, approximately 140 veterans in the Balance of State CoC region reported their homeless history at the time of the assessment; by FY2017, this number had dropped to 133 (a decrease of 5%). State-wide, 801 veterans reported their homeless history in FY2013, and this decreased to 764 by FY2017.

Length of Time Veterans Spend Homeless in Missouri BoS
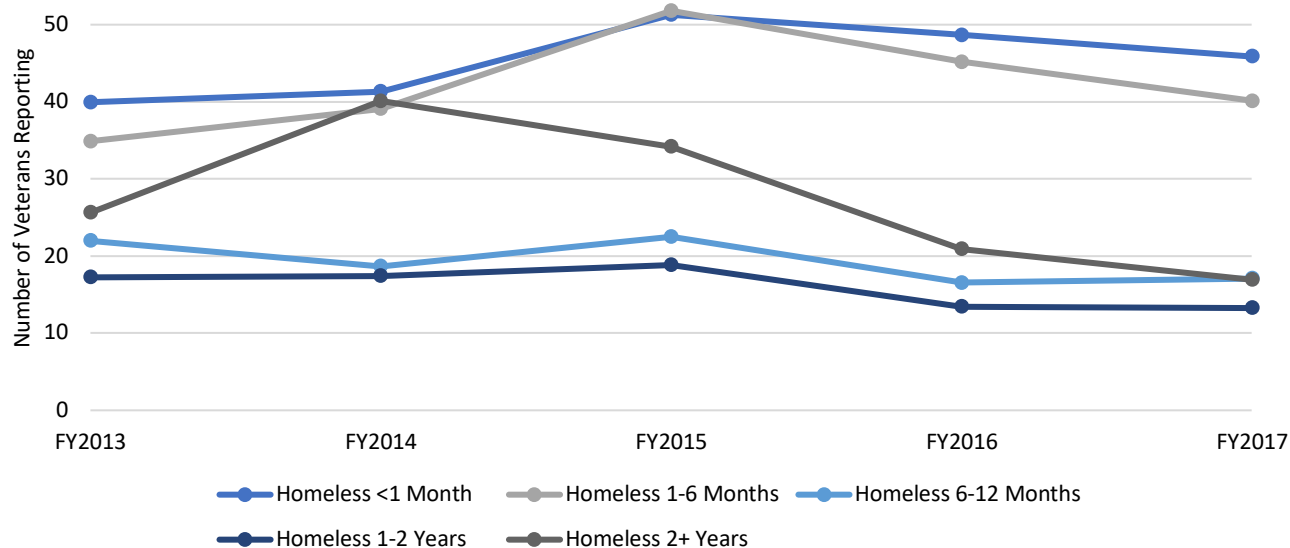
From FY2013 through FY2017, the number of veterans that reported they had been homeless for one or more years dropped by 30 percent (from 43 to 30 veterans). The number of veterans experiencing homelessness for six to twelve months similarly decreased by 22 percent (from 22 to 17 veterans).

Meanwhile, the number of veterans reporting homelessness for between one and six months increased from 35 veterans in FY2013 to 40 veterans in FY2017 (an increase of 15 percent). The number of veterans reporting homelessness for less than one month also increased by 15 percent, (from 40 to 46 veterans). This suggests that veterans may be experiencing homelessness for shorter lengths of time than they had previously, or that they may be seeking assistance sooner.

This data has limitations. Because the data given is not broken down by individual veteran, it is difficult to discern how many existing veterans moved between categories from FY2013-FY2017 (for example, a veteran that reported experiencing homelessness for less than one month in FY2013 and later reported between one and two years in FY2014). Additionally, it is impossible to determine how many new veterans appeared in the dataset in a given year. Furthermore, in cases where a veteran was assessed more than once in a year, they may appear in the data multiple times (for example, two or more times in one or more categories). Additionally, this data is largely self-reported and is not documented, which limits data reliability in and of itself.

Despite these limitations, (1) the decrease in total responses combined with (2) the large decrease in the number of veterans reporting homelessness for one year or more, corroborate the finding that the Balance of State is improving its ability to respond to veteran homelessness and reduce the amount of time veterans spend homeless.

CHRONIC HOMELESSNESS

Chronic homeless status is also collected at intake and assessment, and the chronic homelessness data reflect the same trends noted above. Chronic homelessness has been decreasing year over year. Using the Balance of State multiplier, in FY2017, data reflects the VA assessed approximately 23 chronically homeless veterans in the Balance of State CoC area, down from a high of 76 in FY2014. Relatedly, the data reflects slight increases in the number people who are not chronically homeless, with 134 homeless veterans not chronically homeless at assessment in FY2017, an increase of 30 from 104 in FY2016 but only an increase of one from FY2015 where there were 133 non-chronically homeless veterans.

The same limitations apply relating to this data as apply to the data related to history of homelessness, including that the information is not deduplicated and the information is self-reported and not verified. However, even with these limitations, this data supports the conclusion that veterans may be experiencing homelessness for shorter lengths of time than they had previously, or that they may be seeking assistance sooner.

Number of Chronically Homeless and Not Currently Homeless Veterans at Time of Assessment (FY2013-FY2017)
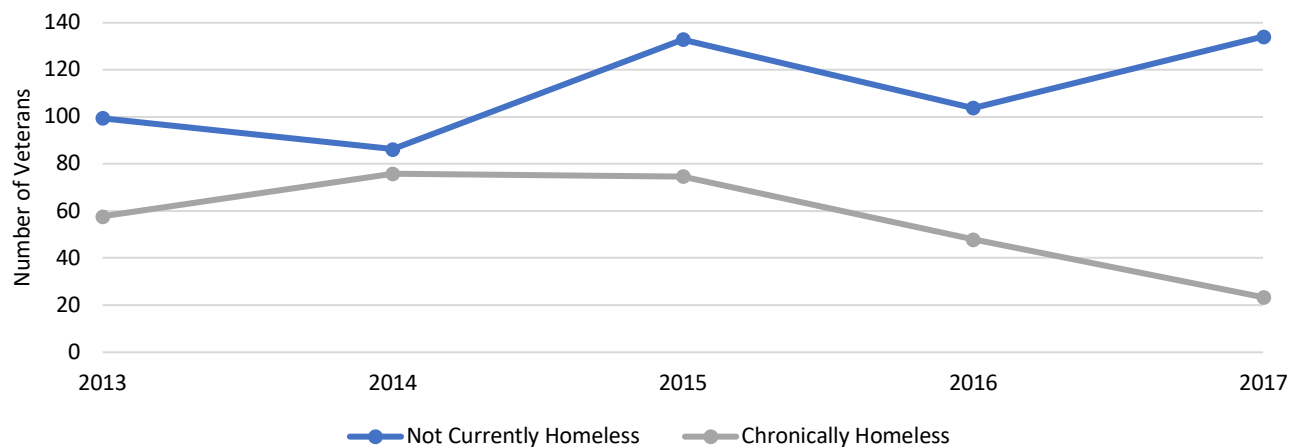

PLACEMENT IN PERMANENT HOUSING

One of the key metrics of success in ending homelessness is the number and percentage of placements in permanent housing. Since 2015, the VA has tracked the number of people placed in permanent housing by CoC, so data in this section correctly reflects monthly placements of veterans through VA services into permanent housing.

Over this period of time, an average of 26 veterans each month are placed in permanent housing, with a range between 12 and 49. Over time, the placement rate is trending down, and the average placement in the first five months of 2018 is 19.6.

Total Number of Veterans Placed in Permanent Housing For Missouri Balance of State CoC (2015-2018)
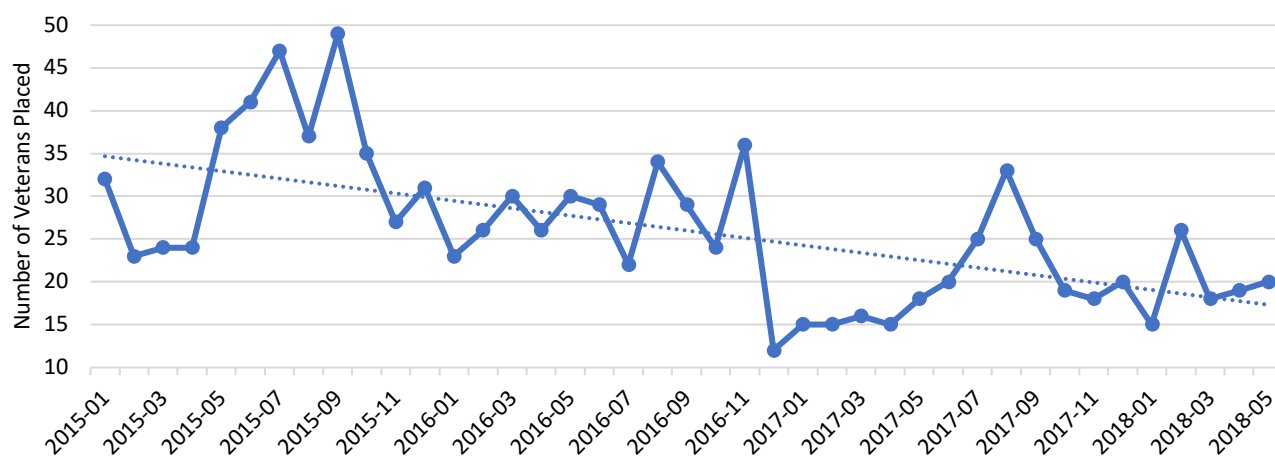
OUTREACH

During FY2016, the VA conducted substantial outreach efforts through the Health Care for Homeless Veterans (HCHV) program with veterans across the state. Using the multiplier, there were 132 successful outreach attempts in FY2006, the first year of data available to HomeBase. Outreach efforts grew from FY2006 through the program's peak in FY2014, when HCHV engaged in outreach 536 times.

Outreach by Health Care for Homeless Veterans (FY2013-FY2017)
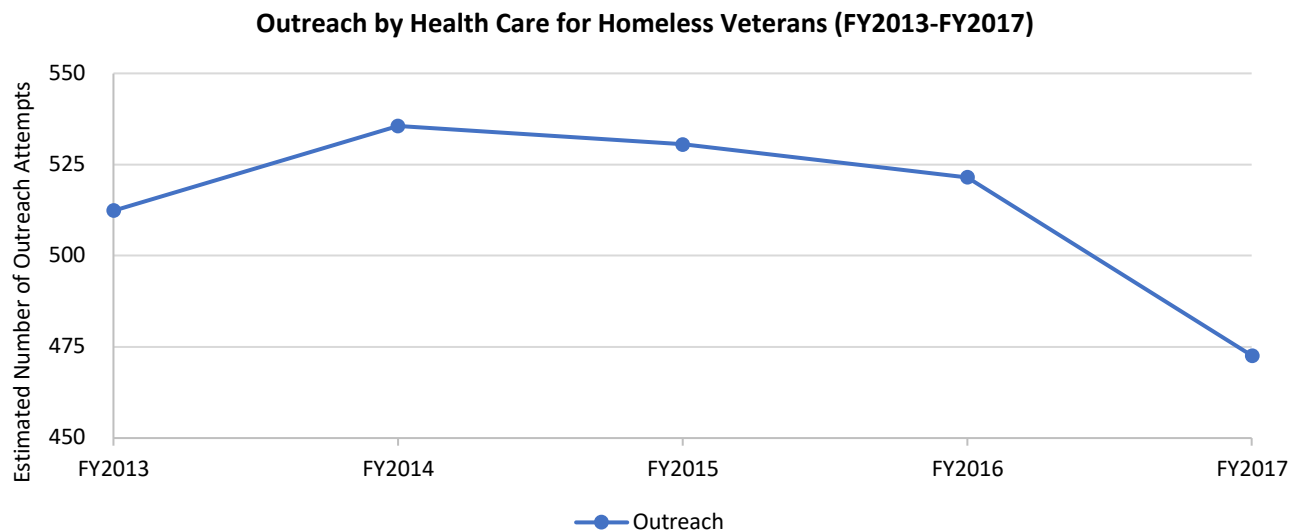
However, since FY2014, outreach has dropped significantly. Using the multiplier described above, HomeBase estimates that during FY2017, the VA engaged in 473 successful outreach attempts within the Balance of State region, a decrease of 12 percent since FY2014. This may be directly related to a decrease in demand, since the overall number of veterans experiencing homelessness decreased from 168 to 98[3] between 2013 and 2017 (a decrease of 41 percent). In other words, it appears more veterans are being housed, which both reduces the need for outreach, as well as indicates that the VA and CoC programs are working.

OTHER HEALTHCARE FOR HOMELESS VETERANS (HCHV) PROGRAMS

Like the previous sections, HomeBase derived the data below by again multiplying statewide data by a .174 multiplier to estimate proportionate numbers for the Balance of State.

From FY2013-FY2017, Veteran's Affairs provided the following services to the Missouri Balance of State through the VA's Healthcare for Homeless Veterans (HCHV) Program: (1) Case Management, (2) Emergency Housing, (3) Contract Residential, and (4) Safe Havens. The HCHV "serves as the hub for a

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[3] This number includes both sheltered and unsheltered veterans.

myriad of housing and other services that provide VA with a way to reach and assist homeless Veterans by offering them entry to VA care."[4] Please note that some HCHV emergency housing is included in HMIS, although not all. The information below is based solely on data provided by the VA.

Estimated Number of Veterans that Accessed HCHV Programs in the Missouri Balance of State Region (FY2013-FY2017)
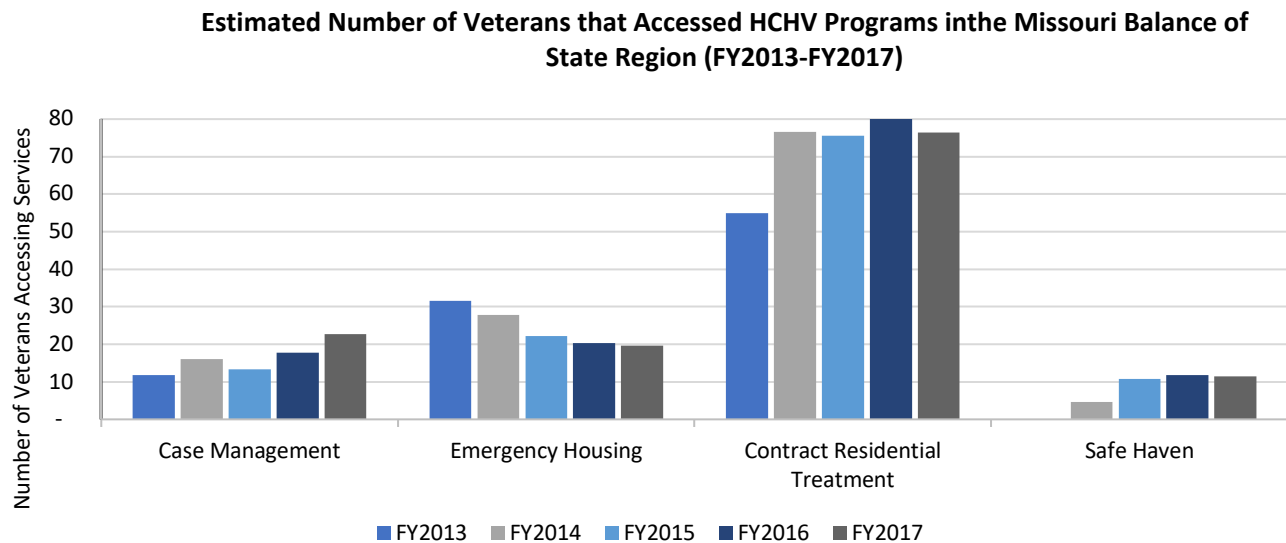
Similar to a decrease in outreach between FY2013 and FY2017, other programs provided by HCHV as estimated for the Balance of State region also saw decreases in veterans served. For example, the number of homeless veterans using Emergency Housing services dropped by 38 percent (from 32 to 21 veterans). That said, this may also be related to a decrease in demand due to a decrease in the number of homeless veterans, as opposed to a reduction in supply.

On balance, some HCHV services saw an increase in the number of veterans served, despite a drop in the overall population of veterans. For example, the number of homeless veterans accessing Case Management services doubled between FY2013 and FY2017, with the total number of homeless veterans served increasing from 12 to 24. Safe Haven usage rose similarly in that same time period, increasing from 5 clients to 10. It is unclear whether this increase was because of an increase in supply to meet an already existing demand for services, or an increase in usage of an already existing supply.

Additionally, while the number of veterans using Contract Residential Treatment has fluctuated between FY2013 and FY2017, HomeBase estimates its usage has increased by at least 39 percent (from 55 to 76). This is despite seeing fewer veterans than its peak of 84 in 2016.

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[4] U.S Department of Veterans Affairs, "Health Care for Homeless Veterans," https://www.va.gov/homeless/hchv.asp

OTHER VA PROGRAMS

HomeBase also received data from other VA programs, including: (1) Grant and Per Diem, a program to "fund community agencies providing services to homeless veterans"[5], (2) HUD-VASH, which combines HUD housing vouchers with VA supportive services to support veterans in remaining permanently housed, (3) Veterans Justice Outreach Program, which provides "direct outreach, assessment and case management for justice-involved Veterans in local courts and jails and liaison with local justice system partners", and (4) Health Care for Re-Entry Veterans which "promote[s] success and prevents homelessness among Veterans returning home after incarceration."[6]. Like HCHV programs, these programs are within the Department of Veterans Affairs, though administered outside of HCHV.

Estimated Number of Veterans That Accessed Certain VA Services in Missouri Balance of State Region (FY2013-FY2017)
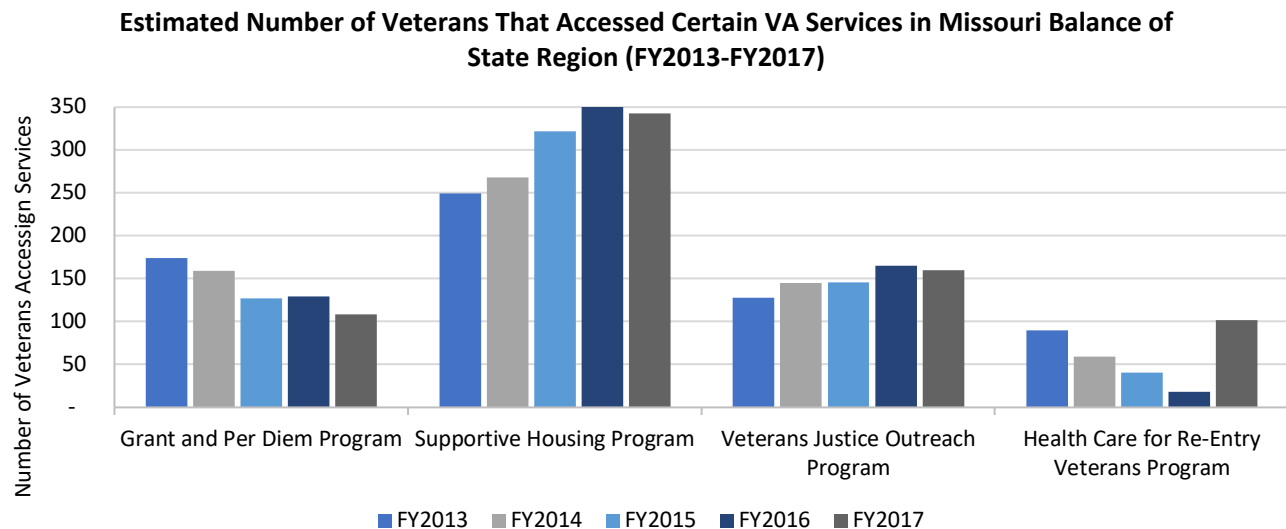
Like HCHV-provided services, these programs saw similar fluctuations in the number of veterans served, though they most appear to correspond to the drop in the number of homeless veterans. This includes the Grant and Per Diem Program, which experienced a 38 percent drop in usage between FY2013 and FY2017 (from 174 users to 108 users). Supportive Housing and Veterans Justice Outreach have seen similar reductions in usage overall (despite a spike in their respective numbers in FY2015).

The Health Care for Re-Entry Veterans Program (HCRV) is the only service where the number of veterans served appears unrelated to total veteran numbers. While Supportive Housing and Veterans Justice Outreach saw a peak in numbers in FY2015, Health Care for Re-Entry Veterans actually served

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[5] U.S Department of Veterans Affairs, "Grant and Per Diem Program," https://www.va.gov/homeless/gpd.asp
[6] U.S Department of Veterans Affairs, "Health Care for Re-Entry Veterans Services and Resources," https://www.va.gov/homeless/reentry.asp

the fewest number of veterans that same year. It served 18 veterans in FY2015, which was a 56 percent decrease from the previous year (serving 41 in FY2014). That said, because this program serves previously incarcerated veterans that have re-entered society, its numbers fluctuate yearly based on the number of re-entry veterans. Because this number changes annually, the number of veterans needing this service may also fluctuate.

Overall, there appears to be some correlation between the services offered and outcomes. For example, case management usage has increased since FY2013—and this may be a cause for the decrease in the usage for other services, such as emergency shelters or the Grant and Per Diem program. It may also correlate to the reduction in homeless veterans overall. That said, because usage among other services varied during this same time period, and especially with imperfect data (see below), it is challenging to draw true conclusions about cause and effect.

Furthermore, data for both HCHV and non-HCHV is limited because it is not unduplicated by program. Therefore, a veteran can be in multiple programs (for example, both Supportive Housing and Grants and Per Diem), which does affect the accuracy of the data.

SUMMARY

In conclusion, while numbers varied between data collected from HMIS and from the VA, overall, homelessness among veterans does appear to be decreasing with less veterans accessing crisis services and more veterans accessing permanent housing.

Services for Domestic Violence Survivors

Due to safety and privacy concerns and Federal requirements, information on domestic violence survivors is often not captured in HMIS. In fact, victim services providers are prohibited from participating in HMIS. Because of this, information about this homeless subpopulation and services provided to it is less known, and data about domestic violence services provides a similarly valuable opportunity to learn about homelessness in the Balance of State CoC. This section analyzes various data related to domestic violence service providers, including:

1. Number of domestic violence survivors accessing shelter services
2. Number of cumulative bed nights for domestic violence survivors for both transitional housing and emergency shelters
3. Where domestic violence emergency shelters are located across the Balance of State geography.

This section corroborates many of the findings in the original report; for example, the majority of homeless beds for domestic violence survivors are emergency shelter beds.

METHODOLOGY

Pursuant to HomeBase's request, the Missouri Coalition for Domestic Violence (MCDV) provided data around domestic violence survivors and domestic violence services in Missouri. Similar to the data from the VA, MCDV's data was also state-wide, not broken out by County or CoC. Therefore, HomeBase again used a multiplier based on 2017 point-in-time data to estimate proportionate numbers for the Balance of State. The 2017 point-in-time count showed that there were 294 survivors of domestic violence in the Missouri Balance of State and 1,421 for Missouri in total. This calculation produced a multiplier of .206, which HomeBase then used to adjust its data from MCDV to reflect persons and services available in the Balance of State CoC geographic area.

$$\frac{Victims\ of\ Domestic\ Violence\ (Missouri\ Balance\ of\ State)}{Victims\ of\ Domestic\ Violence\ (Missouri)} = \frac{294}{1,421} = .206$$

Because the numbers used in this section were derived proportionally from the state's total numbers, they are only estimates.

Additionally, HomeBase emailed a surveymonkey.com survey to homeless housing and services providers in the Balance of State region (described in more detail below), including victim services providers, but the survey results did not provide extensive information. Finally, HomeBase mapped out the domestic service providers found across the Balance of State and compared these to county populations to determine where gaps exist.

DOMESTIC VIOLENCE SURVIVORS ACCESSING SHELTER SERVICES

The Missouri Coalition on Domestic Violence provided data about domestic violence services from calendar year 2016 and 2017. This included information about the number of domestic violence survivors accessing services in 2016 and 2017.

In 2016, within the Balance of State CoC, approximately 1,225 women and 1,009 children were served over the calendar year (with a total (including men and unspecified) of approximately 2,252 served), and in 2017, approximately 1,304 women and 1,044 children were served in shelter (with a total number of approximately 2,370 served). Comparatively, over the 2017 calendar year, HMIS record 154 victims of domestic violence, which confirms that the HMIS count is an extreme undercount.

The point-in-time count in 2017 for sheltered survivors of domestic violence was 272, so the MCDV annual count is approximately 8.7 times larger than the point-in-time number. In contrast, the total clients served in 2017 as recorded in HMIS was 6308, approximately five times larger than the total point-in-time count.

Number of Domestic Violence Survivors Receiving Shelter Services (2016-2017)
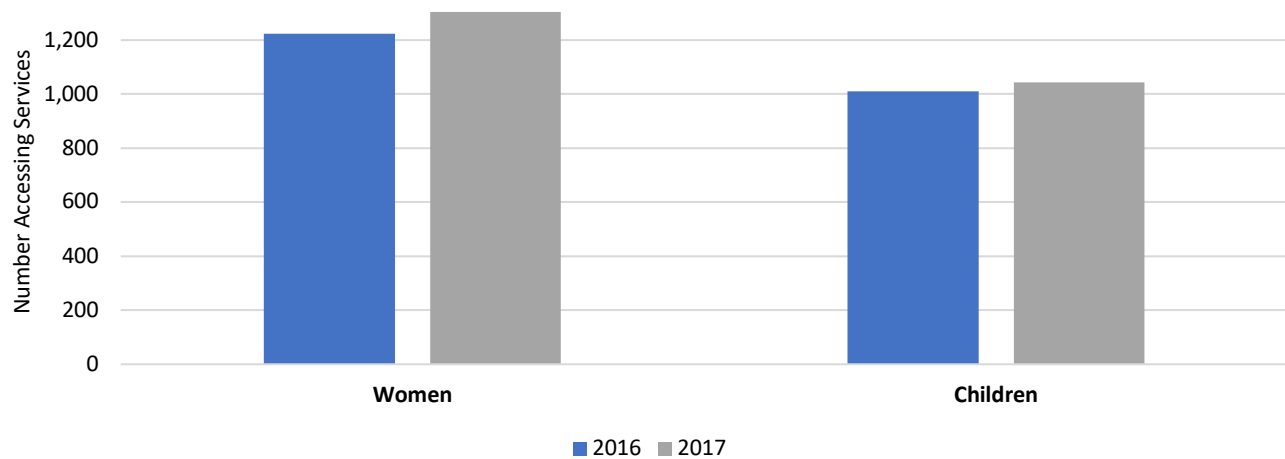
The most notable finding from the data received is the increase in the number of women and children using shelter services between 2016 and 2017. This is different than the full CoC's trend, where the total point-in-time count went down from 1,430 to 1,243 from 2016 to 2017. This is also surprising given the original report's findings that the amount of homeless beds across the Balance of State decreased during this same time (see Page 10 of original report), including for domestic violence emergency shelters—from 960 beds to 775 beds. Transitional housing for domestic violence survivors also reduced from 55 beds to 38 beds. Assuming the estimated number of women and children shown above is within the margin of error, this suggests that this population accessed a greater percentage of the housing stock in 2017 than 2016, despite there being less total stock.

Regardless of an increase in usage by women and children, the MCDV reports that there were still 4,712[7] unmet requests for shelter by domestic violence survivors in 2017, which was a decrease of 256 from 2016 (when unmet requests totaled 4,968). This reduction in unmet requests may be related to the increased number of survivors accessing shelters.

NUMBER OF BED NIGHTS

MCDV tracked the number of emergency shelter and transitional housing bed nights (that is, the number of nights a survivor of domestic violence spent in emergency shelter or transitional housing) from 2014-2017.

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[7] Using .206 multiplier found in "Methodology"

While the number of bed nights in emergency shelters dropped slightly (by 6.1 percent), it stayed relatively constant during this time.[8]

Bed Nights of Emergency Shelter and Transitional Housing For DV (2014-2018)

■ 2014 ■ 2015 ■ 2016 ■ 2017
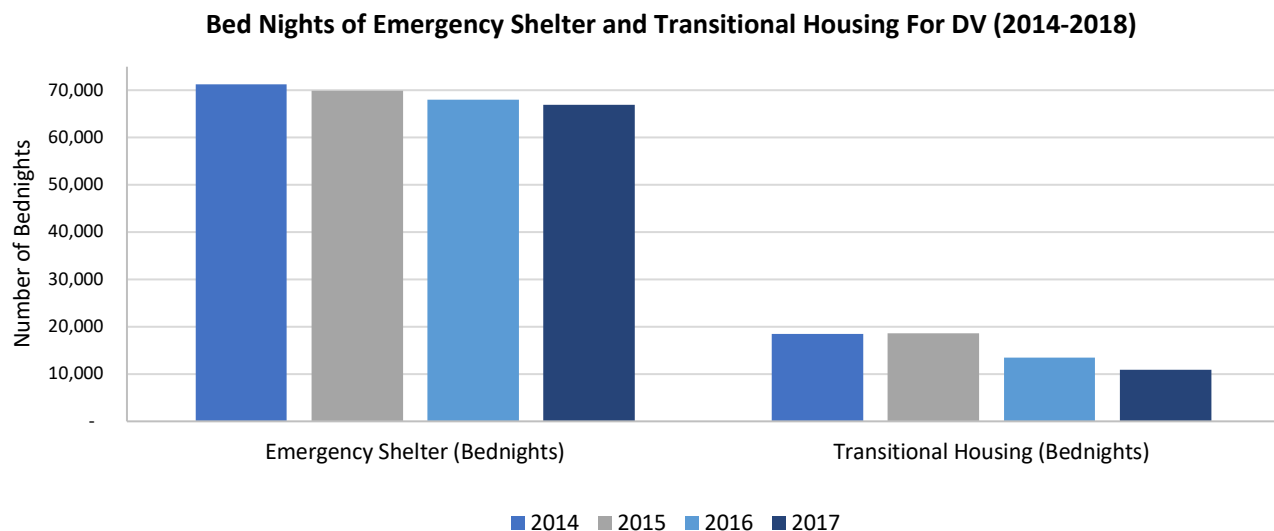
By contrast, the number of bed nights in transitional housing dropped by 42 percent (from 18,524 bed nights to 10,912 bed nights). This reflects the findings of the March 2018 Gaps Analysis Report, which found a 17 percent reduction in transitional housing beds between 2016 and 2017.

WHERE DOMESTIC VIOLENCE SHELTERS ARE LOCATED

To better understand where these shelter services exist compared to population, HomeBase mapped the municipalities that have domestic violence shelters, as listed in the Balance of State housing inventory count.

On a regional level, Regions 5, 4, and 10 have the largest populations of domestic violence survivors according to 2017 point-in-time count data (approximately 66, 56, and 46 survivors, respectively). As evident from the map and the original report, providers are more present in those areas. This is expected because 93 percent of domestic violence survivors were counted in sheltered locations during the point-in-time count.

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[8] In 2017, there were 66,650 shelter bed nights recorded in the MCDV data, which equates to 183 full shelter beds every night of the year. Because the Balance of State has 775 shelter beds, this indicates that the data trends are a more useful focus, rather than trying to align the two separate data sets, even though the point-in-time count found that 49% of domestic violence shelter beds were empty the night of the count (which may be impacted by variances in family size and a number of other factors).

Geographic Locations of Shelters DV Within the Missouri Balance of State[9]

Legend:
- DV Shelter
- <10,000 people
- 10,001-20,000 people
- 20,001 to 50,000 people
- >50,001 people
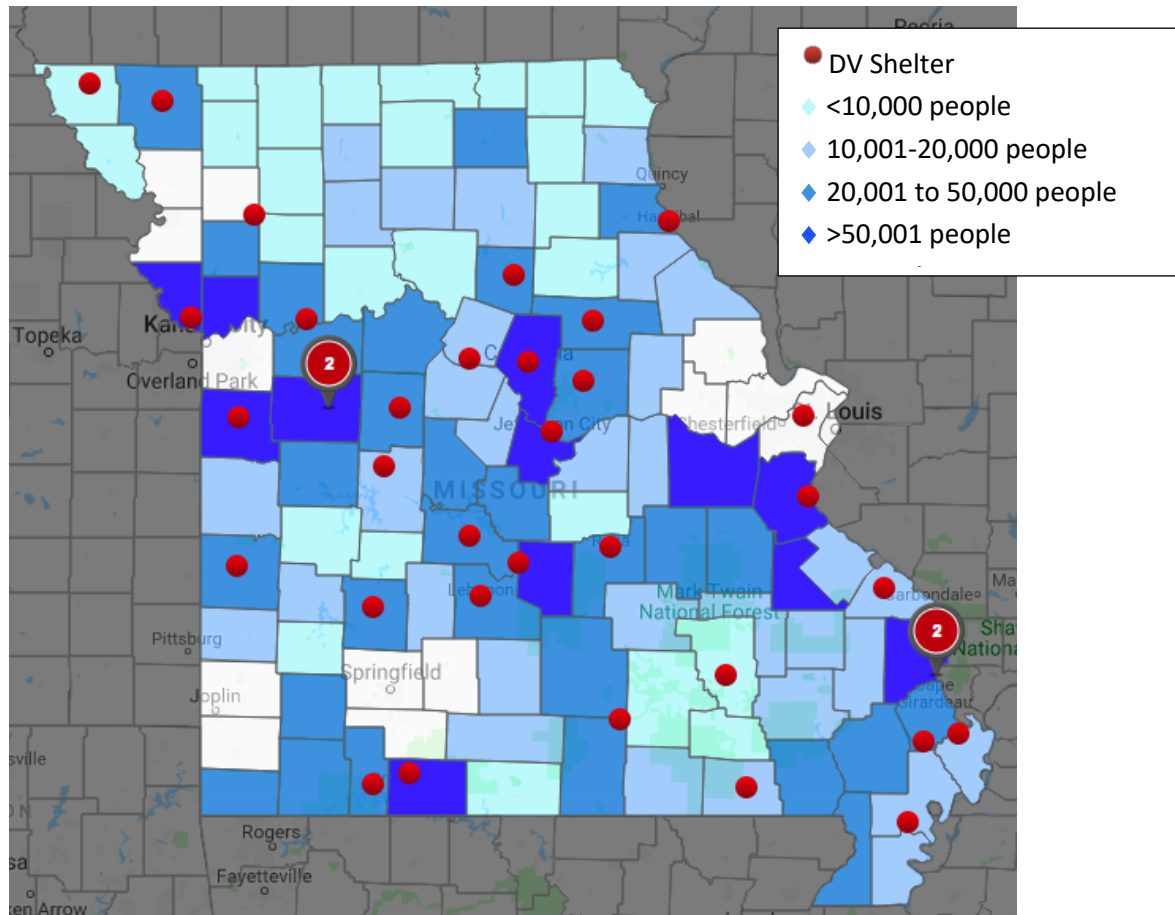
Regions 2 and 3 have the fewest available services for survivors of domestic violence (only one municipality with domestic violence services in each of these regions). That said, this is proportionately related to the number of domestic violence victims counted in the 2017 point-in-time count data (5 and 10 survivors, respectively).

Other Homeless Housing and Services Providers Not Participating in HMIS

METHODOLOGY

HomeBase identified 71 providers within the Balance of State and sent out a survey consisting of 15 questions. It sought a group of providers representative of geographic location, programs, and target subpopulations. Forty-two providers responded to the survey—a response rate of 59 percent.

The respondent group seems to be representative of the Balance of State CoC geography. In total, the 42 responding providers represent at least 94 counties within the Balance of State CoC, with many providing services to multiple counties. Notably, some counties have significantly more provider

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[9] From the Missouri Balance of State Inventory Count.

respondents than others. For example, twelve providers reported that they serve Boone County, seven serve Clay County, and five serve Ray County. However, 75 counties only had one provider respondent.

Missouri Balance of State CoC Counties With the Greatest Number of Provider Respondents
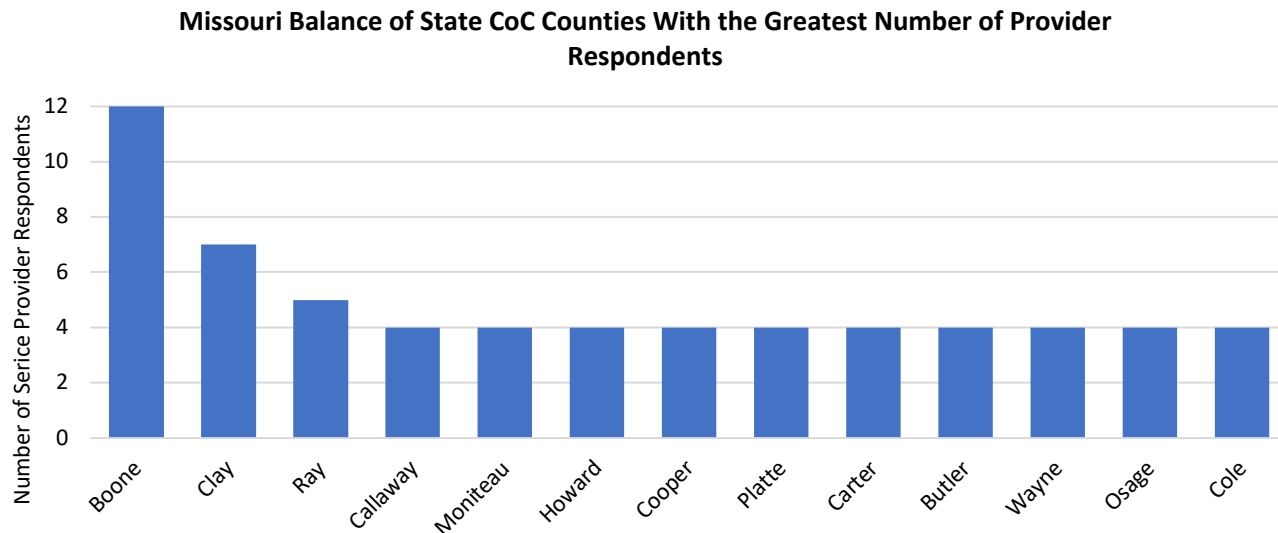

Respondents also seem to be representative of all service types and subpopulations. Respondents reported their primary services and their target populations served. Respondents could list multiple services and subpopulations. The services least offered by respondents were transitional housing, Permanent Supportive Housing, and Health Related Services. The subpopulations least targeted by respondents were Families, the Severely Mentally Ill, and Youth.

Services	% of Responses
Outreach	51.35%
Connection to Benefits	51.35%
Emergency shelter	43.24%
Rapid Rehousing	43.24%
Other (please specify)	40.54%
Employment services	35.14%
Transitional housing	27.03%
Permanent Supportive Housing	27.03%
Health-related services	21.62%

Subpopulation	% of Responses
Chronically Homeless	45.95%
All	43.24%
Veterans	40.54%
Domestic Violence Survivors	35.14%
Families	29.73%
Severely Mentally Ill	27.03%
Youth	10.81%

DATA COLLECTED

Respondents answered whether they use HMIS to collect data. Of the 39 responses to this question, 23 providers (58.9 percent) use HMIS systems and 16 (41 percent) do not.

Percent of Respondents Using HMIS vs. Alternative Data System
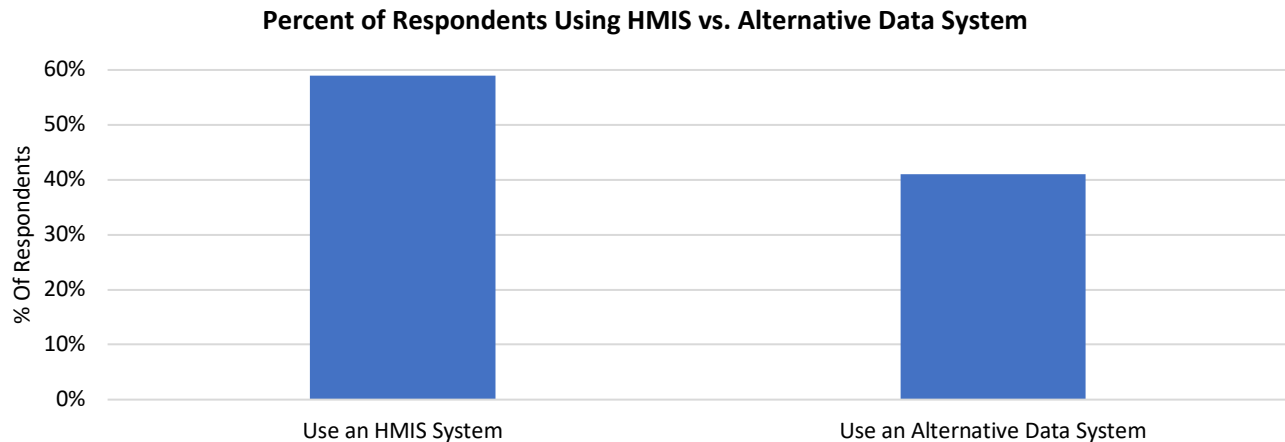
Of the providers that do not use HMIS, 21 percent (3 respondents) do not collect any data on their programs and more than 85 percent collect age, gender, race/ethnicity, veteran status, and connections to benefits (see table below).[10] Fewer non-HMIS-participating providers collect data about presence of physical disabilities, mental health illnesses, or location prior to experiencing homelessness. Fifty percent or fewer collect data about Exits to Stable Housing, Length of Time Homeless, or Experience of Domestic Violence. A standard HMIS requires these data-points.

Percent of Non-HMIS-Participating Respondents Collecting Data Type for Their Program	
Answer Choices	Response Percent
Age	100.0%
Gender	100.0%
Race/Ethnicity	92.9%
Veterans Status	85.7%
Connections to Benefits	85.7%
Presence of a Physical Disability	78.6%
Presence of a Mental Health Illness	64.3%
Location Prior to Experiencing Homelessness	57.1%
Exits to Stable Housing	50.0%
Length of Time Homeless	42.8%
Experience of Domestic Violence	35.7%
Other (includes SSVF, barriers, etc.)	21.4%

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[10] Two providers HMIS chose not to answer these questions (of 14 providers that do not use HMIS).

Of the sixteen non-HMIS-participating respondents, eleven stated they would share data with HomeBase and four agencies ultimately did. When assessing individual data supplied to HomeBase, it became clear that many individual non-HMIS providers have chosen to collect their own unique data points using their own unique methods. As a result, it was not possible to aggregate and make any conclusions from the data provided. In many cases, this choice may be an active effort to collect data relevant to the services provided (for example, some providers collected information such as family size, which would be relevant in determining the number of beds required). Yet, in many other cases, this limited data collection might be due to (1) lack of a standardized data system, (2) lack of capacity to collect data, (3) lack of foresight about information necessary to understand program outcomes, (4) lack of awareness regarding the need for data, or even (5) the choice to forego data collection.

While many of these non-HMIS-participating agencies do collect a basic amount of information, it lacks the necessary breadth to draw significant conclusions about program effectiveness.

Recommendations

HomeBase makes the following recommendations for the CoC's consideration:

Continue to encourage HMIS usage and/or create a set of standard data points for all providers to collect, ideally modeled after HMIS data points. HomeBase made multiple data requests to various providers, typically seeking data parallel to what standard HMIS systems currently collect. During this data collection process, it became clear that much of the data requested is not currently recorded. While HomeBase did receive and analyze some data from various sources, much of the analysis in this appendix was based on estimates and assumptions that could be made more accurate with more intentional data collection. For example, while the Department of Veterans Affairs collects a significant amount of data and aggregates it at the state-level, a county-by-county or CoC-by-CoC breakdown could lead to greater context to improve strategic planning. Similarly, while various providers may collect demographic or program-specific data, these providers—and the Balance of State as a whole—could make more deliberate decisions if it collected more standardized data similar to HMIS. In cases where HMIS is truly not possible or desirable (for example, domestic violence providers who do not receive funds that require them to have a comparable database to HMIS), HomeBase recommends that the Balance of State consider working with providers to collect a standard set of data points—beyond simple demographic information—and ask them to submit project-level data quarterly to help inform decision-making.

Continue using HMIS to inform CoC decision-making. While there continues to be gaps in the HMIS data available due to non-participation, this analysis found that additional data sets either supported the same conclusions as HMIS data or had slight differentiations. In an ideal world, the CoC would have a full data set before making decisions and recommendations, but this exercise demonstrates that making decisions based on available HMIS data will often result in similar outcomes.

APPENDIX G: Consumer Feedback

One of the goals of the Missouri Balance of State Gaps Analysis Report was to identify existing system and service gaps related to homelessness services accessibility, availability, and coordination. To fill out the understanding of system gaps described in the Gaps Analysis report, MHDC requested that HomeBase undertake additional efforts to gather feedback from people currently or recently experiencing homelessness to further inform the understanding of system and services gaps and needs. Over June and July 2018, HomeBase scheduled focus groups and distributed surveys to people who are currently or recently homeless. This Appendix describes HomeBase's process, summarizes themes from feedback received, provides the demographics of people who participated in providing feedback, and reports out all of the information participants shared with HomeBase.

Methodology

Working with providers in three regions (Regions 4, 5, and 8) in the northern, central and southern areas of Missouri, HomeBase scheduled three focus groups to meet with consumers to gather feedback about the homeless system's gaps and needs. Flyers were prepared and shared with multiple providers in each of the three regions. The first focus group was scheduled in Chillicothe, Missouri, on June 28, 2018. One person experiencing homelessness submitted written comments, but no one attended the focus group. The second focus group was scheduled in West Plains, Missouri, on July 9, 2018 at Samaritan Outreach Center. At this site, HomeBase staff conducted eight interviews in place of a focus group. The third focus group was scheduled in Columbia, Missouri, on July 9, 2018 at Salvation Army Harbor House and was attended by 20 people. HomeBase staff asked a series of questions designed to elicit responses about systems gaps related to accessibility and availability of resources. The interviews and focus group were conducted in English; no one requested interpretation services. Participants' responses were recorded. HomeBase took notes and electronically recorded all participant interviews and focus groups. All participant responses (lightly edited for clarity and arranged thematically) are included at the end of this Appendix. In addition, participants filled out a short form that gathered demographic information about them and their families. Interviewees and focus group participants were given a $10 gift card to Wal-Mart in gratitude for their time.

HomeBase also created an online survey via surveymonkey.com and distributed it with MHDC to providers throughout the Balance of State CoC region, asking them to share the link with people experiencing homelessness. No responses were submitted.

Demographic Information from Participants

Of the 29 homeless and formerly homeless individuals who participated in the focus groups, 21 filled out demographic information forms. The demographic information indicates that the representation of the feedback participants was skewed toward people staying in a shelter, but otherwise was somewhat representative of the homeless population in the Balance of State CoC region.

- Participant ages ranged from 21 years old to 62 years old.
- 57% of participants were male; 43% were female.
- 62% were white, 19% were black or African-American, 14% were of mixed racial heritage, and 5% were Native American.
- Most were staying at a shelter, but four participants had stayed with a friend the previous night.
- The average length of stay in the current place of residence for all participants was 37 days.

Summary of Themes

Each of the currently or recently homeless individuals who responded with feedback about the homeless system of care identified several gaps in the system of care that resulted in them experiencing homelessness. With a few exceptions, the feedback from currently or recently homeless individuals aligned with the Gaps Analysis findings, and participant responses added additional depth to the picture created by HMIS and point-in-time count data.

AVAILABILITY:

- Several people reported not being able to access shelter or necessary resources in the community they were living in when they first experienced homelessness. Multiple people reported traveling between one and three hours to access services.
- Three people noted that youth (people under 24) had a lack of available resources (including at least one person who was not in that age group); two people noted a lack of shelters that serve men.
- Participants identified health care (especially dental care) and transportation as the services most needed.

ACCESSIBILITY:

- The most common ways participants learned about resources were word of mouth, flyers, and through case managers. Many participants felt that they had to work very hard to learn about and access resources. No one mentioned coordinated entry systems as a resource.
- Program rules, either for accessing certain programs or for staying in certain programs, were a barrier to ending homelessness for most participants.
  - Examples of program rule requirements that resulted in participants losing housing included: missing curfew due to work, forgetting to sign in and out when he/she left the site, or getting in a confrontation with another program participant.
  - Multiple people also noted that allowable lengths of stay were too short to find and access permanent housing.

- On the other hand, three people wanted more rules to distinguish people deserving of help from people abusing the system.
- Participants also noted that mainstream program barriers to access were impeding their ability to end their homelessness.
  - People with any criminal history, in particular, have very few resources available to them.
  - In addition, the Food Stamp Program was mentioned several times as serving a limited population (although one person thought it should be more exclusionary).

Findings and Recommendations

The feedback received from currently and recently homeless people reinforced many of the recommendations from the Gaps Analysis report, especially the following six points:

- **Work to increase housing availability and maximize utilization of existing housing stock in rural, urban, and suburban areas of the Missouri Balance of State CoC.** The consumer feedback identified a lack of housing resources, especially in certain areas of the state.
- **Improve the availability of housing for specific subpopulations so that housing stock better aligns with demonstrated needs across the CoC and within each region, including specifically increasing homeless-dedicated housing options for transitional-aged youth.** Several participants outside of the Columbia area noted the need for increased resources for youth, which was supported by the data analysis completed as part of the Gaps Analysis report. The CoC may want to consider prioritizing funding for youth programs and/or building agency capacity in serving this subpopulation.
- **Investigate new and expanded transportation options for people experiencing homelessness, particularly in rural areas.** Consumers at every focus group location mentioned the need for increased transportation resources. Transportation is needed to get jobs, to access medical care, and to access housing.
- **Utilize coordinated entry to improve information sharing about regional services available, paying particular attention to rural areas.** Participants generally did not feel informed about the housing and services available to them. Continuing to market and share information about coordinated entry will support homeless people in understanding the system they are using.
- **Consider offering targeted technical assistance to providers regarding the implementation of Housing First principles.** Perhaps the strongest theme in the focus group and interviews, participants reported not being able to access or maintain shelter or housing due to program rules. The CoC should work with providers, offer training and technical assistance, and otherwise support agencies in minimizing program rules.

Feedback from consumers also highlighted two points that were not emphasized in the Gaps Analysis report, which were:

- A need for access to health care, especially dental care, resources.

- A need for support in accessing mainstream programs that create barriers to access, including the Food Stamps Program, which was raised as a particular barrier to stability in three interviews and was discussed extensively in the focus group.

Participant Feedback

Included below are all participant interviews and focus group feedback. It is lightly edited for additional clarity and arranged by theme.

SYSTEM STRENGTHS:

- This shelter [Harbor House in Columbia]
- Medicare works. I've been homeless for a while and I didn't know that I had a mental disability. When I got on my medicine I got better. It helped me.
- [This agency] has been very blessed with food.
- Bedding, eating, clothes.
- My case worker points me in the right direction, who to talk to, without going through 90 different channels.
- Samaritan Outreach Center, Food Bank at church, Ozark Action.
- My behavioral health therapist and case worker.
- Turning Point is a really good place.
- Voluntary Action Center has good resources.
- The Health Department is good.
- Ozark Action is a really good community program. It will help anyone.
- I have been getting [vocational] rehab. They have helped me with [getting a device for my disability]. I'm trying to get on Medicaid.
- Ozark Action. If they can't help right then, they can point you to who to talk to.

ACCESS TO RESOURCES:

- [I learn about resources by] word of mouth (3 responses)
- [I learn about resources] from a friend.
- [I learn about resources] by papers given to you.
- [I learn about resources] by postings, flyers.
- [I learn about resources through] Flyers.
- [I learn about resources through] Literature, flyers – they give it to you or you ask for it.
- [I have needed something and didn't know where to go] (2 responses)
- [Do you know how to access the resources you need?] No. (Some agreement)
- [Do you know how to access the resources you need?] Um, yes.
- [Do you know how to access the resources you need?] Mystery.
- Columbia as a whole is a friendly homeless community compared to other communities I've been to.
- You can have all the resources but it's up to us to use those programs available to us.
- Let me put it this way, no one has ever come up to me to tell me about a resource.
- I'm always learning about things.

- My care coordinator found [me shelter] and helped me get meds for free.
- My mom's very helpful when it comes to stuff like that. Very helpful.
- I just know about 'em.
- [Do you have trouble learning about resources you need?] A lot of people will tell you yes, but to me, just pull out the phone book and start looking.
- Actually, there [are] none around here in this community.
- Because you've got all these people that are just using it for whatever and for the longest time. You've got these people that just didn't want to work, you know, just taking up space here. And/or they just using the government, for, you know what I mean. And people like me out here trying to get help, can't get no help, I can't get no assistance. I don't know, especially information wise, where to get information to even help me, to start. I don't even know where to start.
- [I learn about resources] because my friend lived next door and advised me. I had to get rid of my dogs though.

RESOURCES THE SYSTEM NEEDS MORE OF:
Housing Resources
- [Longer time to find housing] Only have 30 or 90 days in shelter.
- More recovery houses, especially for women. When they [are available], there's a waiting list.
- Help with paying rent.
- Homeless shelter for men, there's not another shelter for men.
    o There's not [enough] resources for men or women. More and more people are being homeless, even kids are out there. When your time is up, you are just like…
    o It's like a big circle.
    o You get back in line.
- Better Section 8. Give people housing! Stop the red tape! People are homeless they can't keep up with what they need.
- People with children, they should put them in housing immediately, because people break the rules and it may be unsafe for some people. (2 responses)
    o I don't want kids to be here.
- Housing, that's it.
- They should cut the nonviolent offenders in prison loose and use that money to serve dual diagnosis.
- Some of us aren't able to find housing in 3 months or what have you. There should be some type of transitional place we can go until we're able to find a permanent place. I know there could be some place out there that could be found.
- I would like everybody to have a home, I really would. I would just make sure everybody had a home.
- Homeless shelters for men. I mean if you're a single man. If you're a woman, especially if you have kids, [you can find shelter]. But...single men, that's nothing. And I'm trying to get my disability back but finding somewhere stable place to lay my head-- it's impossible to stay alive and live somewhere. That's my biggest frustration.

- I'm from [town two hours away] and there's nothing there! You can throw that in there. I had to come 2 hours away, just for a homeless shelter. [It has made it harder to get stabilized again.]
- Just having a safe, stable environment that's clean.
- Bigger shelter.
- I would say like more safe houses for people that want to get away from the drugs and you know, most of them are so turned out now, you see these kids and some of these people running around, they're so turned out by this dope now. It don't even make no sense. They're getting worse and worse and worse.
- I guess if there was a way to where people could actually show they were…say I come in and I have my rent, but I didn't have my deposit or something like that. You know just programs that will give you a little boost where you need it. Even if you need to pay that money back you know. Just ways to prove that this person has talked to this person…just little programs.
- We need more housing assistance for young single men.
- Shelter needs assistance with utilities.
- More homeless shelters, there is only the one [for over 100 miles]. People are outside. There is no assistance in the County I'm from, no nothing. There is nothing in neighboring counties.
- I came maybe an hour...an hour and fifteen minutes. And I've never really been around this town.
- I came to this area [several] years ago. I was losing my home and it was the only shelter within 200 miles.

Supportive Services
- Hire people with hearts, who care about other people. More people that care about other people.
- More caseworkers.
- They should make sure they got responsible people; there needs to just be more responsible people.
- A lot of resources that they have aren't very helpful. People don't care.
- They ran out of money & can't do anything. Don't care about no one but themselves.
- Programs they have where you work with a case manager to help with managing money. I think that's helpful.
- Resource information.
- This is the first time [I've ever been homeless]. Most thing I'd say is the lack of staff. I mean I'm not trying to talk bad about anyone but there's a lack of staff.
- Consistency and follow up.
- I had two good case managers at rehab. I was placed by drug court [to a place over an hour away] and they helped me with services and food. They haven't helped me with housing and jobs.
- Need bigger outreach center.

Health- Related Supportive Services
- Health care, especially dental care (2 responses)

- Health care.
- Access to better healthcare and dental care. I've lost out on jobs because my teeth are bad because I work in customer service industry. They won't come out and say that.
- You know, try to get back on Medicaid.
- The director [of an agency I go to] was extremely helpful and connected me with behavioral health care and a family doctor and a [specialty doctor], but I had Blue Cross then. Now I don't.
- We need family resource, more behavioral health and medical help.
- I'm telling you, drugs [are] probably the biggest problem in this damn community. Everyone's being strung out on that meth…I'm sure that's everywhere now but in this community everyone and their mother is high.

Food-Related Supportive Services

- [We don't always have the food we need to make meals.] (e.g. meat, milk, butter) (2 responses)
- Food stamps. I own a house and property, but the house is unlivable right now. But I can't get food stamps because I own them. It's stupid, you know.
- When I went up to the food stamp office to get food stamps, and I work but you know, I'm only getting 20 hours a week right now, and because I didn't have a steady address, I told them I was homeless. They didn't have a thing to send me my paperwork to do what I need to do to update my stuff and now I ain't got food stamps because they said they mailed me my stuff and that it's just too bad. But because I didn't do what they said to do, and I've bounced back and forth, I couldn't get my mail. That it's just too bad. So, I can't get no help there now. Because you need to work so many hours and I've got my hours, but I need to work to actually qualify for it, you know. In my mind, it's just all these people just using this stuff and the people that actually need it can't get no help.
- They used to put out snacks. All this shit is donated for the community. It's bullshit.
- We need more food assistance.
- We need bigger food pantry, with toiletries.
- I think we could stand a better nutritional program because it's lacking sorely. One of the sad things is that we're getting all this beautiful produce and they throw them away because they don't know how to use it.
  - o Anytime you pull a fruit or vegetable off the stem it dies and then you put it into a can and it dies more.
  - o It's up to the cook whether we get access. We get locked out and can't come in here and get ice. Door is locked.
  - o Kids need snacks. Kids love snacks. Snacks should be available.

Employment-Related Supportive Services

- Since I've become mentally unstable in the past year, I haven't been able to get a job. So that was my biggest thing, is getting a job. It means that I can't work. I'm really nervous right now talking [to you].

- Because [this community] is so small, [one] of our biggest problems I see is daycare. I have found a lot of our mothers that come in have no one here to watch their kids. If they do find work, they have to find someone at the shelter to watch the child or children. That's not only scary for the children and the mother, but it also holds the sitter up from finding a job, and then there is also the fact that people complain about not getting paid.
- It used to be that you could [use computers at local site] and job search but staff got upset because you had some dumbass come in here and watch pornography well you know, that's not everybody else's fault. There's people that come in here and want to look for a job, you know to do those types of things and we can't now because some dumbass decided to look at pornography. In my eyes, they should just kick that dude out or put a lock on that site or whatever it is they need to do, instead of just getting upset and pulling out the whole internet because now I can't get no help, no nothing. What am I supposed to do? I mean, I could go out there, to that job place. But I mean I don't have a vehicle. So, it don't really do me no good.
- I just filed for SSI. [Around here] to get a job, its either somebody's uncle or brother, or through an agency and its factory work. And I can't do that. So, it's hard to keep and find a job.
- [We need more] Work, employment opportunities.
- I have been associated with [a homeless services agency] for 3.5 years because my NA sponsor suggested it. I think 70% of people here are here because of job loss and the other 30% are waiting for housing resources. We need work opportunities. Even work for a day! [A local agency] used to have a large board and use to suggest opportunities like being a golf caddy at events. Or being able to put a free ad in the newspaper about our services. There are talented people [who are homeless], a plumber or an electrician, who can't get work.
- I don't like that people don't like to hire [homeless] people. I don't have an address, a local work history. It's hard to find employment.
- I need to get a good paying job.
- Homeless are lost here, it would be of wonderful help to have OATS tickets on hand more often so they can look for work, get back and forth until they have their first check. Also, for going to any one of our temp jobs. Or jobs center.

Transportation

- I think it would be better if we had some type of something to help us get around during the day like if someone had to go to Wal-Mart. Wal-Mart is so far away. I have to get a prescription filled. I've been through the ER twice. One of them is because I have a big old sore on my foot and I need the antibiotic that was prescribed to me and I have no way to get there because of my foot [so I can't walk]. So, I can't get the prescription filled. I had to have somebody walk to the Family Dollar, which isn't too far, to get me some bandages and Neosporin.
- They give you two half fares barely. The two half-fare bus fares I get, I use them in one bus ride. If someone didn't give me the other $1.50, I'd be walking.
- Maybe a little map that we can print off to show [homeless people] where things are while they try to make their way.

Other

- Free waterpark passes.
  - Response from co-participant: You can get those.
- I don't know.
- Better police station. They're not all trustworthy.
- Clothing. For men. And for diapers. I was trying to get diapers for my kid, and I had to wait three weeks for an appointment, but my kid needed diapers then. So, I went to jail, because I went to Wal-Mart and stole a handful of diapers from a box.
- Maybe cell phone assistance to keep in contact with parole officer and case managers.

SUBPOPULATIONS LACKING RESOURCES:

- I have a college degree and [military experience and related disability] but the VA here can't help me.
- I don't know if you've ever actually- but the generation- like these 19, 20 year olds that are growing up right now. They just, they don't know. There's no programs that are teaching them how to take care of themselves and like. Mental health shit to make them have some self-worth. Just kind of mental health. A lot of them don't even understand because they're not being taught. And how to take advantage of the programs that we do have. They're not taught how to take care of themselves. There's so many kids I've met that can't do their own damn laundry. There should be more programs that teach them simple, basic life skills. Hell, half of them don't even do what we learned in kindergarten. . . .Even like a safe house would be so much better around here where these kids that are out here. Just like, I was talking to that kid. He didn't have nowhere to go, he's 19, he ended up with this weirdo drunk. And that drunk tried to sell him off or trade him off for dope. And that kid was telling me. You got all these fuckin weirdos and all these strung out people and that kid ain't got nowhere else to go and he ain't even smart enough to do anything because nobody taught him better. That's the type of resources we need is to teach these kids how to be responsible for themselves. Half of these people they don't even have any self-worth, they don't even know what their own worth is…so how are they supposed to go off and do anything and feel good about themselves. They're not taught to feel good about themselves. And these people have no knowledge of that. And they don't see that, so they can't grasp. All they see is what we look at and they can't grasp anything more than that. Do you get what I'm saying?
- I'm 22 years old and there are no resources for me. I have a long track record. I was married at 18 and held a full time job for three years, age shouldn't be an ultimate denier.
- Mentally ill. There was a lady [around here]. There are lots of people running around, she was in the public view, but no one helped her. They wind up falling through the cracks.

PROGRAM RULES/ACCESS:

- More or less you get one shot at a lot of things [referring to resources], sometimes it's not enough.
- I like their shelter. Their rules are really strict. This can be good but sometimes if we break them its bad. It's hard because I have a medical issue. I think if you break a rule you shouldn't be threatened. Especially with mental illness you forget. Signing a paper when you leave and come back isn't normal and it's easy to forget. I have a lot of bad memory issues. If I forget I

don't want to be threatened all the time. Maybe like warnings – you have two reminder warmings and then you get written up. There are a lot of rules and then you've got a lot going on with your mental illness. We have a lot going on, stress from experiencing homelessness; we don't need threats. They sometimes make up rules that aren't even in the rule book.

- I couldn't myself [access housing] because I have a second-degree assault, which makes it very hard for me to find a place at all anyway. If I was to get help from somebody, they'd turn me down. But they do have better assistance. I mean they…uh. There's a lot of places to rent there. I mean, the same three people own all the places to rent there so it's not hard to find as long as somebody has the funds to do it. But, there's a lot of drug heads in that city.
- So many restrictions to get in! Restrictions may be background, certain peoples background, past due bills, you need to pay all those bills up before you can qualify for housing. We're already broke.
  - There's no starting with a clean slate. No hit restart button.
- If you have any kind of drug case or come out of prison no matter what you did, all treated the same.
- If you haven't found a place in 90 days, you get kicked out.
- With food stamps, any drug charge you have, you are ineligible. But people with violent crimes, rapists, they are eligible.
  - And you have to work 80 hours a week to be eligible.
  - You have to job search 80 hours to be eligible.
  - So, you have to work 80 hours. I can't remember if it was a week or month.
- I missed my ride, I couldn't stay [in a shelter] for up to 6 months, because I missed my ride, when I was working on this farm. But my ride didn't pick me up on time, so I called trying to get from [a place 45 minutes away] to here. I called, and they told me that's not their fault and it was my problem, that I shouldn't have gone out there and I should've just stayed here but that's $160 when I had nothing! And now I gotta couch surf because I couldn't get a ride? And I called and tried to…and you know…where's the…? So, I can't get help because I was trying to help myself. I don't get enough money you know. The person that took me didn't know I was staying here and they thought that I was cool there but I wasn't cool there. So, I got caught in the crossfire on that, and now I'm out 6 months and I gotta go out and couch surf, I can't have a steady place to lay my head? I have nowhere to go, the only people I know are drug heads. I've been clean for about 7-8 months now. I was on the needle a bit. I seen it, I see these people all the time. But I have to fall back and be around all these people because I don't have a safe spot to lay my head. Or I don't have…there needs to be a place when people when they actually want a safe spot, and they're actually doing what they need to do, can have that, you know? And there's nothing like that here.
- Behavioral Health caseworkers were very good, but their SOPs have changed and they aren't as helpful anymore. They therapists and psychologists take good care.
- I am here because I have a felony record. I've been clean since February, I go to NA, I've raised a family, and I can't get assistance because of my past when in active addiction.
- Food pantry [helped me], everyone else denied me [due to criminal record].
- I only had a couple of weeks to move, and [my family could not help]. There need to be more programs for people with records. I plead guilty to something I shouldn't have, and now can't get housing.

- [Shelters] are supposed to give people a chance, but as soon as you do one thing wrong. Get in a confrontation, they kick you out. We need a chance! The minor things don't make sense to me.
- There a lot of people abusing, using the system that the ones who need it and can use the help to get straight don't get it.
- I do go, you know. To programs that would help me like, just a little ways, you know. And the government...like they talk about drug testing people for their food stamps, they don't give them none of that shit, it's the same shit. These people running around you know, selling...doing whatever. They get hundreds of dollars you know, just because they have kids. And that's bullshit! I mean, that's what my taxpayer dollars go for? For people to sit around and have babies and like...collect off the government and not try to do anything because they don't have to? Because the government just takes care of them, because they don't pull their end? And with these programs, there should be stipulations and the stipulations should actually be followed; so there's a backbone and structure, you know? There's no structure...in my mind. From what I've seen on a daily basis. And it makes me sick.
- Some of these people are actually trying. Some of them are actually. You know. I do think that some of these people should better trained on how to scope these people out. To know bullshit when you hear bullshit. Not to just hear some sob story and.... I think there should be more providing proof about what you're talking about if you want actual resources that are going to help you. I think they should be more strict on the drug thing. Because these kids are on these drugs, they ain't taught shit, they ain't....and so they're here and they get turned out on these drugs and shit. And then you got people like me...like why get mad instead of creating a structure in here? So, what if you have basic comforts in here? They're going to take all that because of other people's bad doings? But that's not everybody.
- You know the government now is giving out all these damn hundreds and thousands of dollars to whoever. I know a person right now that has a bunch of fucking kids that gets almost $1,000 in food stamps and uses them to buy drugs or sell them. Or do whatever the hell he wants to do with them. And I can't even go out, I gotta come here and eat here because I can't get food stamps because I didn't have a mailing address to do what they needed to do. So I'm just shit out of luck. And yet they give this person...And I see it every day. All because they don't make sure. Are they drug testing these people like they say they're supposed to? Hell no they don't. They say they do. But I've never seen it, have you? Make these people that actually sit around and do...you know. Let them go out and have to do it. Then see what happens. Then the people who are actually doing what they need to do, can get some of the resources out there and want to better themselves.
- There are people who abuse the system of course, to take away from the undeserving.
- Find a better way. Cut out who's using the system and find out who wants to leave the system [to use resources better]. Find out how to separate them.

OTHER COMMENTS:

- We have many people who come in, get all their paperwork done, and feel so ashamed that before the night is over, they leave. Many times, they don't say anything.
- I been basically couch surfing around just trying to...you know. I'm just stuck in this hole here.
- There are a lot more opportunities on the West Coast.

- The bathrooms have mold.
- A lot of people don't like the shelter being here. [I would like to change] people's perspective on homeless people. We aren't stupid or dirty, the path we chose didn't work out. I almost ended up in a psych ward because they thought I didn't have family and [I was very physically sick]. I don't do drugs, I haven't had a drink in [more than 2 decades].
- I think this place needs remodeling.
- Stress kills people.
- It's good to have men and women separated in different programs. It's socially easier. To get selves right without being hassled.
- Other than that, we take care of everything. Like I lost a phone yesterday and somebody found it and they waited to see whose it was and gave it back to them. Nobody's trying to steal from each other, we all know what it's like. So, other than that, we do have some outsiders that wander in and try to take stuff that's not supposed to be taken. Then the chore list. I mean there's chores that we all have to do. and staff takes care of that which I think is a great idea to make sure everyone is up doing what they should do.

Sample of Coordinated Entry Assessment Prepared by HomeBase

Southern Nevada Continuum of Care Annual Coordinated Entry System Evaluation Report
(2019)

COORDINATED ENTRY

SOUTHERN NEVADA CONTINUUM OF CARE ANNUAL COORDINATED ENTRY SYSTEM EVALUATION REPORT

February 2019

ANNUAL COORDINATED ENTRY SYSTEM EVALUATION

2018

SOUTHERN NEVADA HOMELESSNESS CONTINUUM OF CARE'S COMMITMENT TO EVALUATING THE COORDINATED ENTRY SYSTEM

Each Continuum of Care (CoC) that receives CoC and/or ESG Program funding from the US Department of Housing and Urban Development (HUD) is required to develop and implement a centralized or coordinated assessment system, commonly known as "coordinated entry". Coordinated entry is a process for assessing the vulnerability of all people experiencing homelessness within the CoC to prioritize those most in need of assistance for available housing and services. The goals of coordinated entry are: (1) to increase the efficiency of the local crisis response system, (2) improve fairness in how housing and services are allocated, and (3) facilitate rapid access to services, including housing and mainstream benefits.

Southern Nevada is committed to these core principles as a key method for ensuring that the most vulnerable persons can access the resources that they need to end their homelessness.

ANNUAL EVALUATION OF COORDINATED ENTRY

HUD requires each CoC to conduct an annual evaluation of its coordinated entry system, focusing on the quality and effectiveness of the entire coordinated entry experience—including intake, assessment, prioritization, and referral processes—for both programs and participants. While HUD does not specify the scope or methods of the annual coordinated entry evaluation, HUD recommends that the annual assessment include, at a minimum, review of the effectiveness and efficiency of the overall process, feedback regarding the ease of use from those who experienced a housing crisis, and an analysis of referral outcomes.

Consistent with HUD requirements, Southern Nevada has committed to conducting an annual evaluation of its coordinated entry system to determine whether it is meeting HUD's standards and the CoC's goals. To do so, it employs multiple feedback mechanisms, including individual interviews with service providers and other stakeholders, surveys designed to reach a representative sample of participating providers, and focus groups that approximate the diversity of the households participating in the system during the year.

In 2018, the CoC commissioned HomeBase to conduct and prepare the annual evaluation of its coordinated entry system. This evaluation is designed to focus on the system and its functioning, as well as the extent to which it has streamlined access, assessment, and referral processes for housing and other services. To determine whether the coordinated entry model is functioning as it was designed, and how responsive the system is to client and provider needs, the evaluation considered a range of issues including:

Evaluation of Access, Assessment, and Prioritization

- Do the system entry points adequately cover the full geographic area of the CoC? Are people able to access the coordinated entry system?
- Are coordinated entry staff able to effectively determine client needs during assessment?
- What is the distribution of client assessment scores for each of the assessment types (single adults, families, youth/TAY, and survivors of domestic violence)?
- What type of information is missing from the assessment and/or the centralized waiting list that would help better inform matchers of client needs?
- Are the tools and protocols developed to support assessment and prioritization serving their intended purpose, or could they be improved?
- To what extent is the prioritization process effectively ensuring that clients are able to access all resources for which they are eligible, regardless of the type of assessment received (e.g., are clients receiving the TAY VI-SPDAT accurately prioritized for housing programs intended for single adults, if appropriate)?
- What is the time from assessment to referral?

Evaluation of Referrals, Placements, and Outcomes

- Are provider agencies able to serve clients who are referred to them?
- What is the time from referral to placement? Is the community able to efficiently locate clients in the event that a housing placement becomes available? What can be changed so that this wait time is reduced?
- What is the rate of denial and the reasons for denial? Are there any common patterns among agencies or client subpopulations?

- How is the centralized wait list functioning?
- Are certain client subpopulations more successful in their placements than other subpopulations?
- Is the average length of stay in homelessness decreasing?
- Have rates of exit into permanent housing for every intervention increased?
- Have rates of returns to homelessness decreased?
- Does the community have appropriate metrics in place to evaluate the performance of the coordinated entry system on an ongoing basis?

This evaluation report seeks to answer the above questions and provide recommendations for how the Southern Nevada CoC can improve the efficiency and effectiveness of its coordinated entry system.

EVALUATION METHODOLOGY

HomeBase collected and analyzed data from the following sources for this evaluation report:
- *HMIS data* in aggregate tables corresponding to evaluation questions.
    - Information was provided by the CoC's HMIS Lead.
    - The client pool for HMIS data is clients with HMIS system interaction between October 1, 2017 and September 30, 2018.
- An *online survey* targeted to all stakeholder organizations involved in the Southern Nevada Homelessness CoC coordinated entry system.
    - The survey was distributed by the CoC Lead to a comprehensive list of stakeholders.
    - It contained questions regarding overall perceptions of coordinated entry, as well as questions targeted only to those involved in distinct phases of the system: assessment, prioritization, matching/case conferencing, and referrals/placements.
    - The survey opened on January 18, 2019, and closed on January 30, 2019.
    - There were 30 total survey responses from representatives of a range of organizations. The types of stakeholders included providers of emergency shelter, transitional housing (TH), permanent supportive housing (PSH), rapid rehousing (RRH), street outreach, and other services. A slight majority of respondents (16) came from organizations that act as assessment sites for coordinated entry. Two-thirds of respondents (20) serve in management or as executive director of an organization, with only one-third (10) serving in front-line positions.
    - Respondents were not required to answer every survey item, and as described above, only answered questions about different phases of the system if they indicated participation in that phase. Thus, the survey responses presented here are only from those respondents who chose to answer a given question.
- Eight *consumer focus groups* facilitated on-site by HomeBase staff[1]:
    - Consumers housed through coordinated:
        - Youth & TAY – 1/15/19
        - Domestic violence – 1/16/19
        - Single Adults – 1/17/19
        - Families – 1/17/19
    - Unhoused consumers:
        - Youth & TAY – 1/18/19
        - Domestic violence – 1/16/19
        - Single adults – 1/16/19
        - Families – 1/16/19
    - Due to timing constraints, attendance at the focus groups was not ideal. In planning focus groups for future evaluations, attention should be paid to client work/school schedules, and resources for and time to organize transportation for clients.
- Four system-level on-site focus groups for *providers* facilitated by HomeBase staff (invites sent to all providers in these groups):
    - Matchers focus group – 1/8/19[2]

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[1] Focus groups were used to gather feedback and inform this report, but were not conducted in a scientific manner.
[2] This focus group included matchers who recently stopped performing this role due to a reorganization of matching duties in the CoC.

- o Coordinated Entry Task Force focus group – 1/8/19
  - o Coordinated Entry Working Group focus group – 1/15/19
  - o Domestic Violence provider focus group – 1/17/19
- One interview with Head Matcher conducted remotely by HomeBase – 1/24/19
- Review of key documents related to the coordinated entry system as provided by the CoC Lead, including coordinated entry policies and procedures.

COORDINATED ENTRY SYSTEM FRAMEWORK

Coordinated entry in Southern Nevada is governed by the Coordinated Entry System Policies and Procedures, effective January 2, 2018. The system is overseen by the Coordinated Entry Working Group, which is responsible for providing input and making recommendations to the CoC Board on principles and guidelines for the coordinated entry system. The Southern Nevada Coordinated Entry system was designed according certain guiding principles, which include: easily accessible for clients; ease of use for agencies; housing focused; prioritize based on need; Housing First; sustainable; client centered; coordinated services; use of real-time data; accountable; leverage existing partnerships and resources; quality assurance; access; interdependency; and streamlined process.

The Southern Nevada Coordinated Entry system assesses severity and type of need by first using the Short Assessment Triage Tool (SATT) for all clients, which identifies the best sub-population assessment tool to use. Tools specific to sub-populations are: Community Housing Assessment Took (CHAT) for single adults; Family Community Housing Assessment Tool (FCHAT) for families; TAY VI-SPDAT for youth; and the DV Assessment for individuals or families who were initially assessed through a DV crisis assessment and are now residing in a DV shelter.

Once assessed, all clients are prioritized within a single Community Queue based on their individualized vulnerability. A client's placement on the Queue is made by comparing the raw assessment score to the scores of other clients that have received the same assessment type. Clients are then prioritized based on this comparative assessment (i.e., clients at the top of the Queue are those that have been deemed most vulnerable compared to the full range of clients receiving the same assessment). In this manner, clients can be prioritized for and placed into any program type for which they are eligible, without regard to the type of assessment received. Providers inform the matching team of programmatic vacancies and matchers make referrals from the top of the Queue, considering differing program eligibility requirements wherever possible. It is then incumbent on the provider to physically locate the client, confirm eligibility, and either enroll the individual or family into the program or reject the referral, in which case the client is returned to the Queue for additional referrals.

ANALYSIS AND RECOMMENDATIONS

This report analyzes the strengths and challenges of the Southern Nevada's Coordinated Entry system, and makes recommendations in four key areas: Access; Assessment and Prioritization; Referral and Placement; and Outcomes. Note that comprehensive recommendations from all sections are available in Appendix A.

Access focuses on the system's accessibility for people experiencing homelessness. Specifically, this section explores how households throughout the geographic area enter the system, how coordinated entry initially responds to the varied needs of those households, and how the system keeps people engaged. Specific areas reviewed were: full geographic coverage; fair and equal access; and effective engagement.

Assessment and Prioritization evaluates the effectiveness of the assessment in determining client need and explores opportunities to improve the assessment process, including messaging to clients and system expansion. Specific areas reviewed were: accurate determination of client needs; consistent messaging; and prioritization.

Referral and Placement focuses on ensuring an expeditious and effective referral and placement process, including discussions related to equitability of referrals, referral denials, and progressive engagement. Specific areas reviewed were: efficient timeline; effective referral scheme; and appropriate referral.

Outcomes focuses on the available indicators that might show whether coordinated entry is achieving its goals. This section has just one subsection reviewing these outcome metrics.

ACCESS

A coordinated entry system can only be successful if those people experiencing housing crises or homelessness know about the system and have a way to gain access to it. As such, HUD requires that coordinated entry cover the entire geographic area of a CoC with access points that are accessible and well-advertised to the people living there. CoCs must be mindful of local need, geography, capacity, and available services when designing a coordinated entry system that facilitates fair and equal access to all. HUD also required CoCs to engage with affected populations to make them aware of coordinated entry.

HUD requires CoCs to use standardized access points in a coordinated entry system; however, it does allow for separate access points to the extent necessary to meet the needs of certain populations, including individuals, families, youth, survivors of domestic violence, and persons at risk of homelessness.

As noted by HUD, the purpose of designating access points is to ensure that all people in a community have equal access to all crisis response system resources in the CoC. Equal access is an important part of the overall strategy of coordinated entry, which shifts the system from a project-centric focus to a person-centric focus.

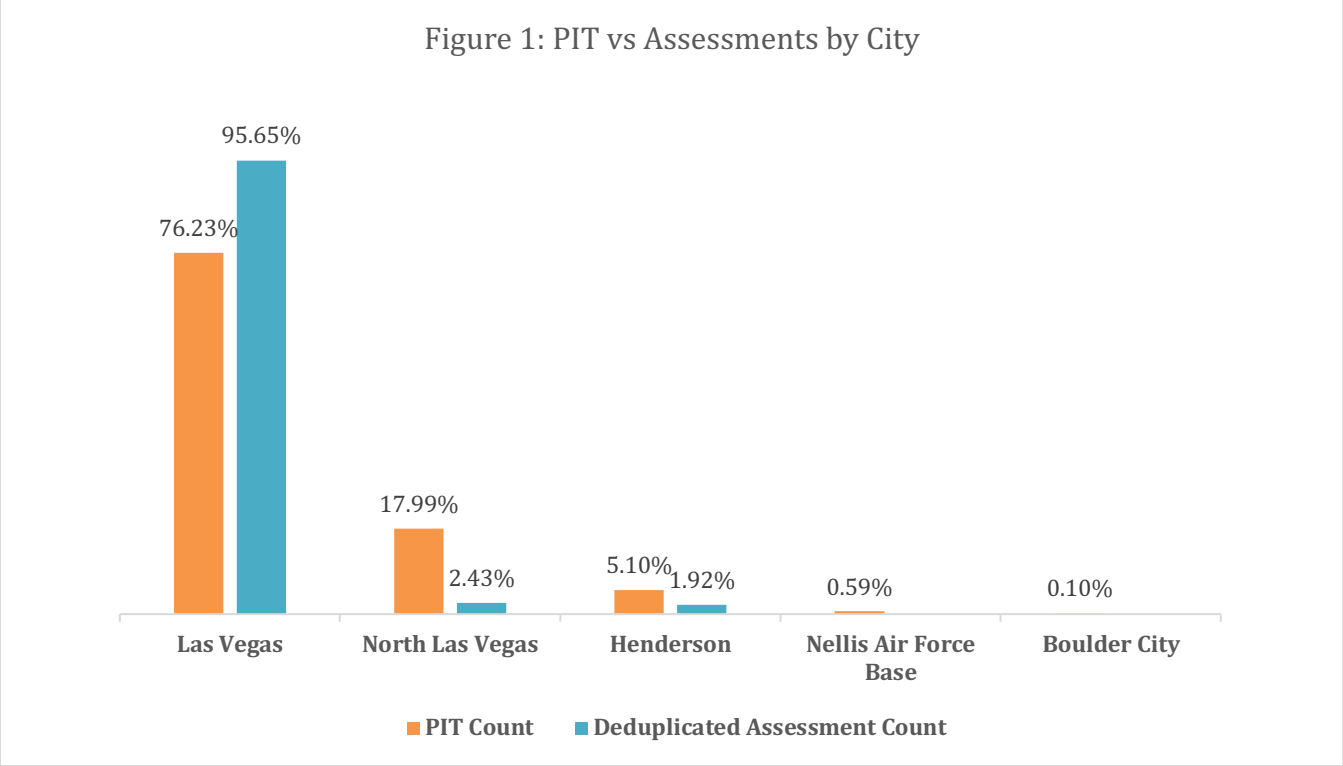### FULL GEOGRAPHIC COVERAGE

Successes

Stakeholders and consumers reported overall general satisfaction with the geographic coverage of Southern Nevada's Coordinated Entry system. Of the 30 responses to the stakeholder survey, 19 consumers (63.33 percent) indicated that the Coordinated Entry system adequately covered all geographic areas of the CoC. In addition, nearly every consumer focus group participant indicated that while they were experiencing homelessness, they were aware of shelters, outreach teams, or other service providers that are (or could be) access points to coordinated entry.

Challenges

Despite the general satisfaction with geographic coverage, data collected for this report shows that there are possible improvements. For example, based on a review of HMIS data, it appears that North Las Vegas and Henderson are underrepresented in coordinated entry assessments as compared to the percentage of the

sheltered and unsheltered homeless population counted in these cities during the PIT count. *See Figure 1 below.* This suggests a gap in adequate coverage for these areas, possibly preventing some clients from accessing coordinated entry or forcing them to travel into Las Vegas to do so.

Figure 1: PIT vs Assessments by City

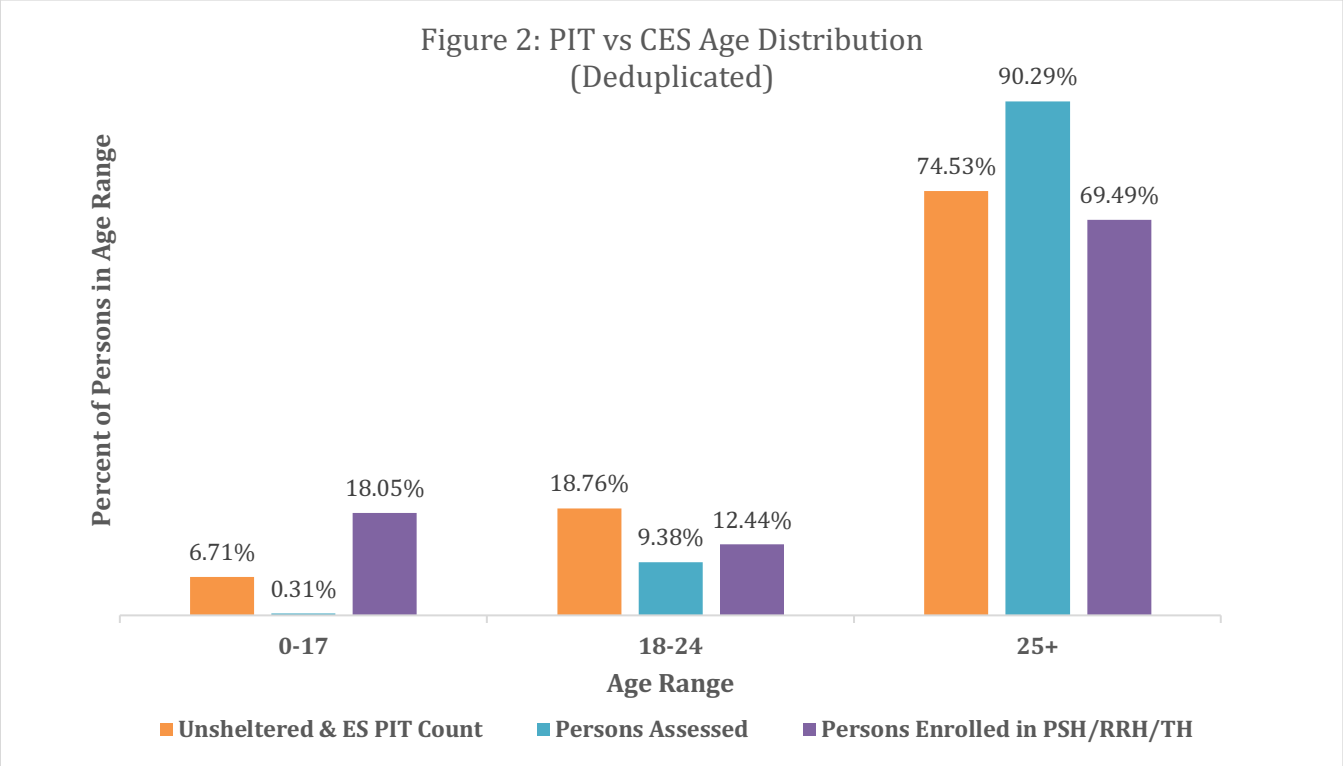|	PIT Count	Deduplicated Assessment Count
Las Vegas	76.23%	95.65%
North Las Vegas	17.99%	2.43%
Henderson	5.10%	1.92%
Nellis Air Force Base	0.59%	
Boulder City	0.10%	

In addition, while only 2 survey respondents (7 percent) indicated they do not think coordinated entry adequately covers all geographic areas of the Southern Nevada Homelessness CoC, another 9 survey respondents (30 percent) responded that they did not know whether there was adequate geographic coverage. This could indicate a greater need for explanation and marketing of the coordinated entry's purpose and requirements.

FAIR AND EQUAL ACCESS

Successes

Figure 2 below compares the age distribution of persons counted during the 2018 Point-in-Time (PIT) count with the age distribution of persons assessed during the reporting period and the age distribution of persons enrolled in PSH, RRH, or TH during the reporting period.

Figure 2: PIT vs CES Age Distribution (Deduplicated)

Age Range	Unsheltered & ES PIT Count	Persons Assessed	Persons Enrolled in PSH/RRH/TH
0-17	6.71%	0.31%	18.05%
18-24	18.76%	9.38%	12.44%
25+	74.53%	90.29%	69.49%

HMIS data analysis shows that most vulnerable and protected classes are equitably served by coordinated entry. Minors (children under 18) were overrepresented in the population of persons enrolled into PSH, RRH, or TH during the reporting period as compared to the PIT count. *See Figure 2 above.* In addition, there is equity in access to coordinated entry among genders and among HUD's prescribed race and ethnicity categories. *See Appendix B.*

Furthermore, most stakeholder survey respondents whose agencies performed coordinated entry assessments indicated that their organizations are equipped to provide assessments accommodating the diverse needs of Southern Nevada residents. Among survey respondents, 85 percent reported being equipped to provide the assessment to persons who do not speak English and 60 percent reported being equipped to work with persons who are visually impaired or blind.

Challenges

While minors were overrepresented in the population of persons enrolled into PSH, RRH, or TH, they were severely underrepresented among persons assessed during the reporting period. *See Figure 2 above.* This trend is surprising because over half (55.10 percent) of minors counted in the PIT count were unaccompanied by adults. In addition, youth 18- to 24-years-old were underrepresented in the population of persons assessed and in the population of persons enrolled in PSH, RRH, and TH as compared to the PIT count. *See Figure 2 above.* This data suggests that youth might be inconsistently referred to and aware of the coordinated entry process.

While providers generally believed that access was fair and equal, they also offer some ideas on improving access for specific populations. Feedback from the survey and focus groups indicates a lack of capacity for assessing those who are hard of hearing or deaf, as well as those who require Tagalong translation service, which is not used on a widespread basis. In addition, agency staff serving survivors of domestic violence indicated that further CoC-wide training on identifying signs of domestic violence and other abuse could help more rapidly identify clients needing specialized services.

EFFECTIVE ENGAGEMENT

Successes

Many participants in consumer focus groups reported experiences with effective messengers of coordinated entry, with outreach teams receiving particular praise ("They were pretty informative and let you know what you were doing and why"). In the youth-specific focus groups, many participants said they had been referred to coordinated entry by a school counselor. Throughout the consumer focus groups, participants consistently mentioned a robust word-of-mouth information sharing network among their peers experiencing homelessness which referred them to access points. This suggests both that the CoC has had success in marketing coordinated entry, in general, and that this word-of-mouth network is an asset that may be leveraged in improving engagement.

Challenges

Despite the general successes outlined above, some specific populations in the focus groups shared experiences that suggest a need for improved engagement. The youth consumer focus groups reported mixed awareness of coordinated entry, with one participant stating he lived "out in the washes," where there was no discussion of coordinated entry. Some youth reported that they accessed coordinated entry through Safe Place sites, but that staff at the sites (grocery stores or gas stations) were not aware of their roles in the Safe Place program. Some youth disagreed with their peers as cited above (in "Successes") about school counselors, contending that counselors did not know how to refer them to help. Youth awareness of coordinated entry, therefore, seems mixed, and the population may be better served through more training and awareness campaigns for school counselors, Safe Place sites, and other youth-serving organizations.

The consumer focus group for unhoused single adults was conducted exclusively with clients in a shelter-based, employment-centered program. These clients were all literally homeless before entering shelter, but none were aware of coordinated entry, and only one thought that he had received an assessment. Their feedback highlights the need for all providers to be aware that everyone in need of housing should have access to

coordinated entry, regardless of whether there is a non-coordinated entry resource they can utilize in the meantime.

Other issues raised during the focus groups included: participants lacked internet access or a charged cell phone to learn about resource; information on the internet was too difficult for participants to interpret; the printed resource lists were sometimes out of date; and difficulties in transportation to coordinated entry access points and other service providers.


RECOMMENDATIONS: ACCESS

1. Develop strategies to better inform and promote access for clients in remote areas and other populations that utilize coordinated entry at lower rates, including:
   a. Conduct regular comparisons of completed assessments and homeless populations data (PIT, etc.) to determine if any populations are disproportionately disconnected from coordinated entry;
   b. Develop and distribute targeted marketing tools, such as small cards that clients can keep and share with others, to better inform clients about coordinated entry;
   c. Ensure that all coordinated entry resources are available to any large local populations of non-English speakers; and
   d. Utilize communication networks among those experiencing homelessness, including utilizing the resources outlined above.
2. Address access issues specific to coordinated entry for youth, including:
   a. Conduct deep analysis of coordinated entry accessibility for unaccompanied minors; and
   b. Ensure that Safe Place sites and school counselors receive consistent training on coordinated entry.
3. Ensure staff at all access points are regularly trained on identifying the signs of domestic violence so they can more quickly refer survivors to DV-specific providers.

ASSESSMENT AND PRIORITIZATION

HUD requires that each CoC incorporate a standardized assessment practice across its coordinated entry system. While there are a variety of methodologies for collecting information, the assessment process must document sufficient data to make consistent determinations on how to prioritize persons experiencing homelessness for housing and services. CoCs are expected to create prioritization standards based on a household's level of vulnerability and need to determine where households will be referred through coordinated entry. In addition, providers should provide clients with consistent and accurate information about the assessment and prioritization processes and outline what is expected from clients in these processes.

The clear majority of assessments administered in the Southern Nevada Homelessness CoC during the reporting period were performed by Veterans Affairs (19.01 percent), the Mobile Crisis Intervention Team (17.30 percent), and City of Las Vegas – MORE (14.80 percent). *See Figure 3 below.*

Figure 3: Total Assessments per Agency
(Duplicate)
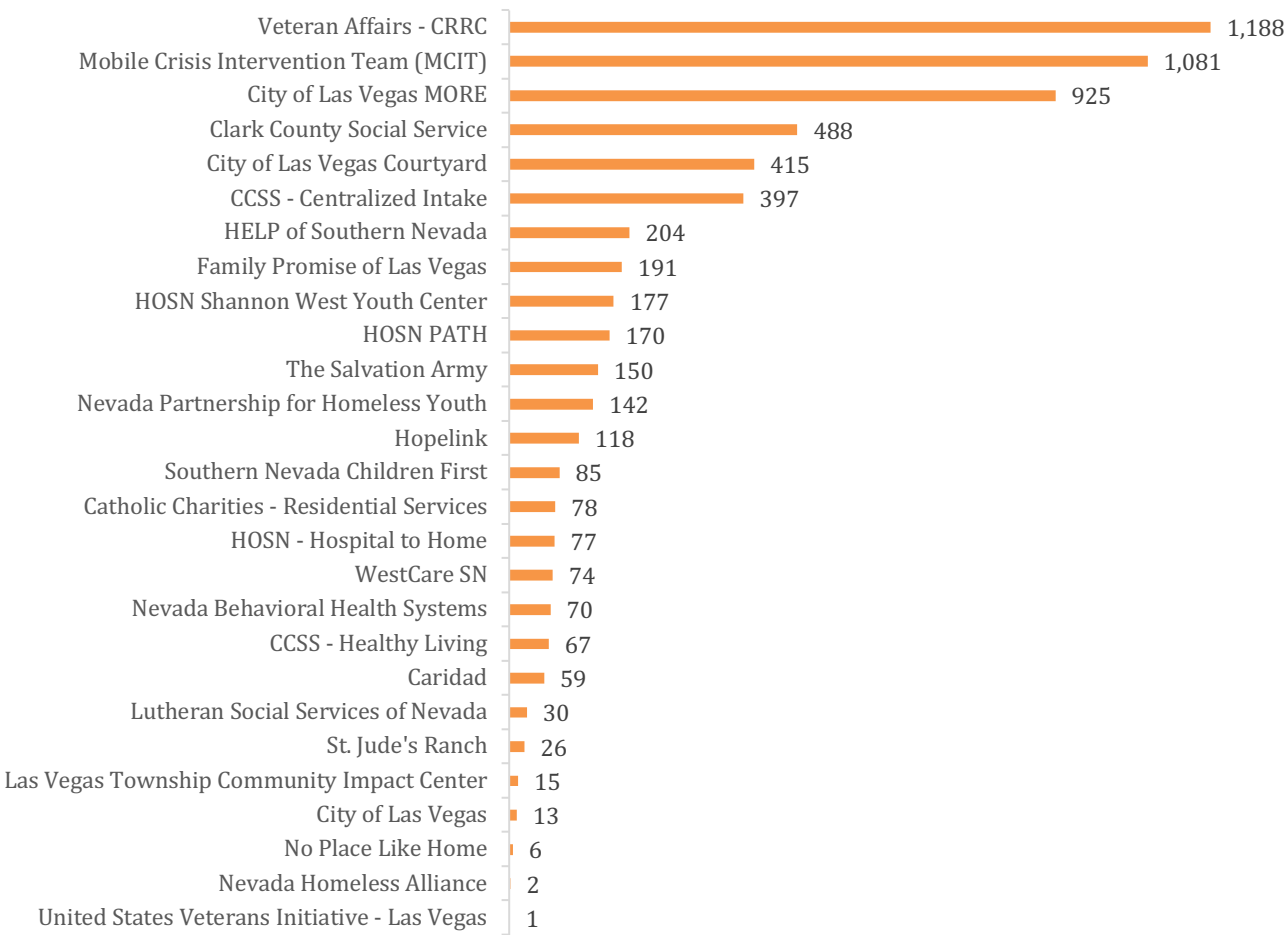
As described previously, the Southern Nevada Homelessness CoC employs distinct assessment tools for single adults, families, youth, and survivors of domestic violence. The distribution of scores is roughly bell-shaped (normal) for each population. *See Figure 4 below.*

Figure 4: Assessment Scores
(Deduplicated by Latest Assessment)
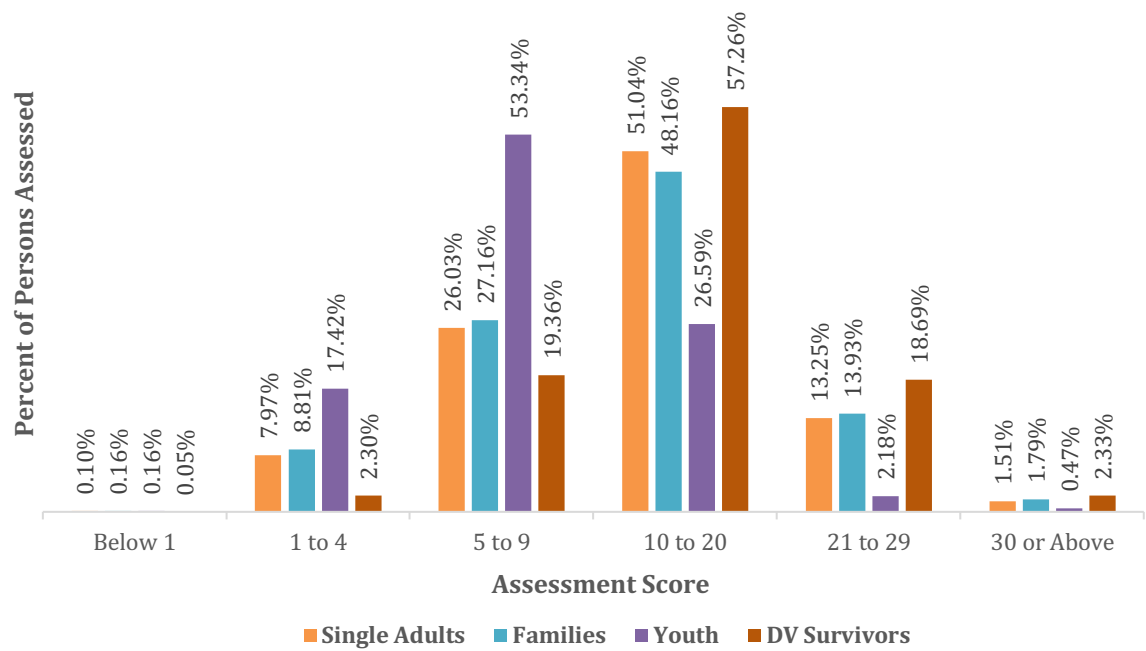
ACCURATE DETERMINATION OF CLIENT NEEDS

Successes

Overall, stakeholders reported confidence in the accuracy of the assessment tools. Of survey respondents whose agencies performed coordinated entry assessments, the majority (73 percent) agreed that, overall, the assessment tools worked well. Similarly, the majority of respondents agreed that the tools accurately (59 percent) and consistently (64 percent) assess client vulnerability. In addition, providers reported in focus groups that the CHAT provides a more accurate assessment of client vulnerability among families and single adults than the VI-SPDAT, which was used for those populations in the past. An overwhelming majority (95 percent) of survey respondents who work on assessments also felt that training, materials and guidance about assessment tools was sufficient.

Challenges

While they had overall confidence in the assessment tool, some survey respondents doubted the accuracy of assessments when a there is a delay between assessment and placement, suggesting there should be a set of short follow-up questions to identify any major changes in vulnerability. One survey respondent who disagreed that the assessment was accurate suggested: "Vulnerability should also include their current homeless situation and priority given to youth in our respective programs whose situations changed to desperate." Furthermore, some commenters suggested that a three-year data look-back period for assessments was not comprehensive enough to capture vulnerability, stating: "Someone who has been sober for three years, but a lifetime of substance abuse has left them with little to no options does not have that vulnerability captured."

More urgently, some providers who had confidence in the tools themselves expressed concern about the administration of assessments. In focus groups, providers shared anecdotal evidence of reassessments within days or weeks of the previous assessment, sometimes with drastically higher scores. Some providers shared concern about the large number of assessors, though others expressed a desire to add emergency shelter staff as assessors. When asked about how assessments are administered, most providers mentioned a need for previously-trained assessors to be regularly retrained or certified, and some suggested remedial measures for staff or organizations that consistently ignore the established policies around assessments. The level of concern in this area was high among providers, suggesting it may be a priority area for the CoC to address in the future.

CONSISTENT MESSAGING

Successes

The data collected for this evaluation suggest that clients are receiving consistent messaging about coordinated entry when undergoing assessment. Feedback from most of the consumer focus groups suggests that those who have gone through the coordinated entry process generally have an accurate understanding of the purpose of coordinated entry and its general operations. When asked about their understanding of the need for coordinated entry, clients across multiple focus groups responded: "It's what needs to happen to get housing." Consumer focus group participants also understood that the assessment, while necessary, was not a guarantee of housing, either in the short or long-term. Many, though not all, understood that they would have to check back with their case worker to know if a housing placement became available for them.

In addition, stakeholder survey results show that most respondents (75 percent) believe that clients are clearly informed of follow-up requirements related to the Community Queue post-assessment.

Challenges

While consumers understand most general concepts around coordinated entry, they generally did not understand prioritization, its purpose, and what it means for those who are not on the top of the list. Some consumers expressed a desire to receive updates on their place on the list, and suggested an in-between contact person to provide these updates. One stakeholder survey respondent suggested that assessors should give a clear explanation to participants that completing an Assessment for Services does not guarantee entry into shelter or housing, and that while waiting to see if any resources are available, participants should continue to seek employment (if not employed or able to work) and other housing options.

PRIORITIZATION

Successes

A majority (70 percent) of survey respondents involved with the prioritization process agreed that the coordinated entry process works well. Almost 59 percent agreed that the prioritization process accurately reflects client vulnerability. This sentiment was echoed in the provider focus groups, where a success consistently cited across all groups was that coordinated entry is prioritizing the most vulnerable for housing and services.

Challenges

While the general feedback from stakeholders about prioritization was positive, there are several specific areas related to prioritization where the CoC could take concrete actions to improve the performance of coordinated entry.

One possible area where the CoC can continue to improve is in its prioritization of those with disabilities. Per an analysis of HMIS data, while 43.78 percent of persons assessed during the reporting period had a disabling condition, 50.23 percent of those enrolled in PSH, RRH, and TH had one. We would expect an optimal system that prioritizes the most vulnerable persons for housing to have a greater proportion of disabled persons enrolled in PSH, RRH, and TH. (This is especially the case with HUD-funded PSH programs, where a disabling condition is an eligibility requirement.)

Another specific area of attention that was discussed during the provider focus group was the need to develop a policy on how to prioritize clients who were evaluated using the VI-SPDAT and remain on the list. Focus group participants commented that there are still clients on the list who had been evaluated using the VI-SPDAT, and that there is no set policy on how to prioritize their scores.
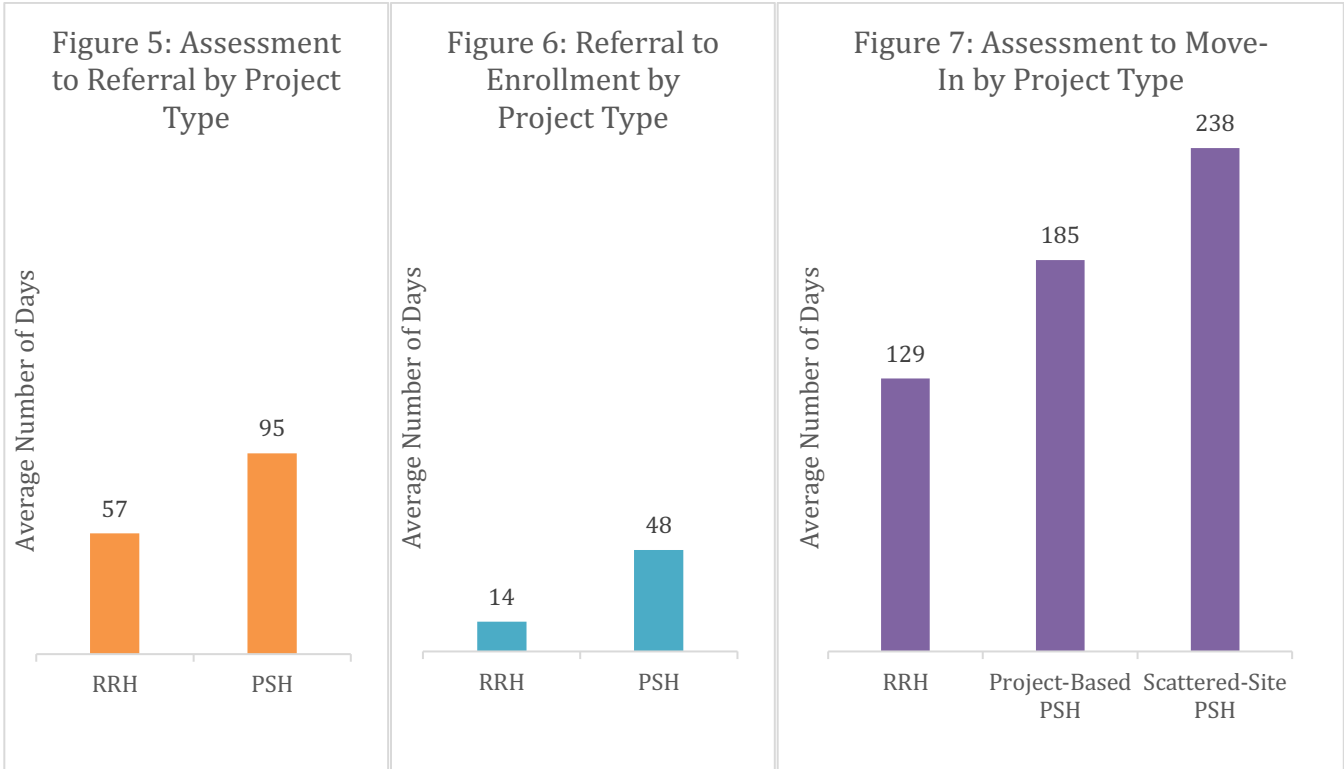

RECOMMENDATIONS: ASSESSMENT AND PRIORITIZATION

1. Implement strategies to improve the consistency and validity of assessments, including:
   a. Establish a process for the review of re-assessments that occur soon after an original assessment and/or produce an assessment score much different than the original assessment, including establishing a threshold above which a significant score change would trigger case conferencing to understand and address the situation;
   b. Require all assessors at an organization to complete an annual recertification to continue administering assessments. Recertification might include a review of the organization's previous year assessments to pinpoint any areas requiring discussion or clarity; and
   c. Consider sanctions for organizations that do not follow established policies and procedures around administering assessments, including temporary loss of assessment privileges.
2. Develop an orientation packet for clients that contains information about what to expect and what is expected after the assessment is complete.
3. Set policy on how to prioritize clients who were assessed using previous assessment tools (i.e., VI-SPDAT).
4. Consider extending the period of time that is considered by assessment tools (beyond the current three-year period).

REFERRAL AND PLACEMENT

The goal of coordinated entry is to create a system that allows for intentional referrals of people to housing and services based on their vulnerability and need. Through these systems, those people with the highest priority, as determined by the CoC's intentional protocol, are referred to the available interventions first. Whenever possible, referrals should be appropriate for the receiving agency and should house the most vulnerable clients as efficiently as possible.

EFFICIENT TIMELINE

Figures 5, 6, and 7 below demonstrate the coordinated entry system timeline by project type.

Figure 5: Assessment to Referral by Project Type

Figure 6: Referral to Enrollment by Project Type

Figure 7: Assessment to Move-In by Project Type

Figures 8, 9, and 10 below demonstrate the coordinated entry timeline by client population.

Figure 8: Assessment to Referral by Population
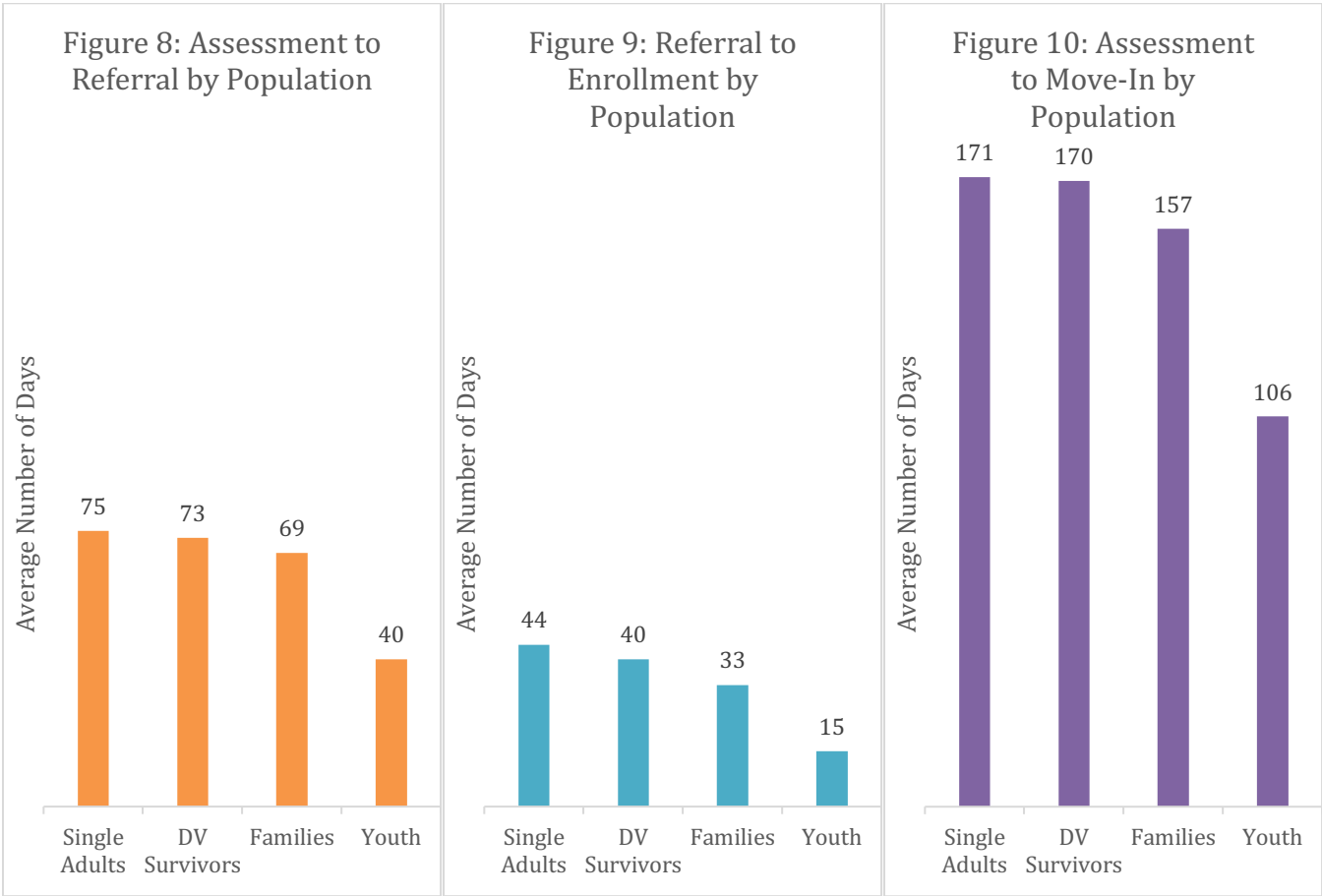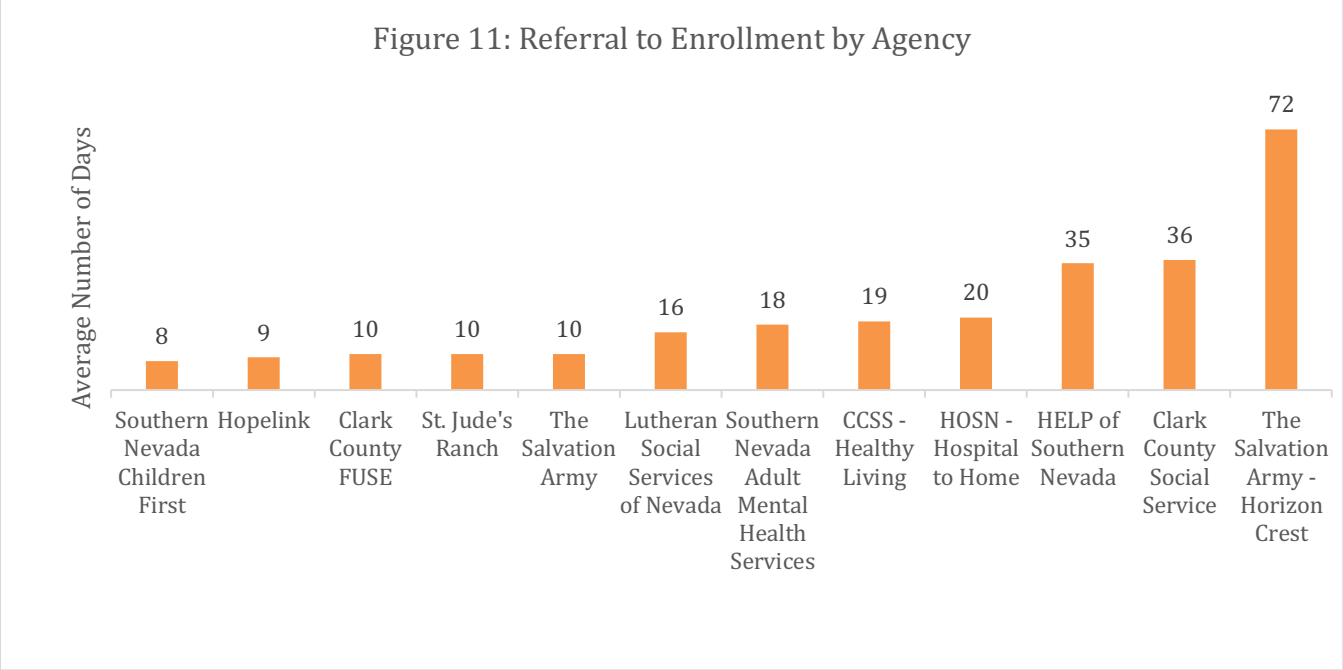
Figure 9: Referral to Enrollment by Population

Figure 10: Assessment to Move-In by Population

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Figure 11 below demonstrates the average time each agency took to enroll referred persons.

Figure 11: Referral to Enrollment by Agency

Successes

Analysis of HMIS data shows some successes related to timeliness of referral and placement. On average, less than two months elapsed between first assessment and referral to RRH for persons referred during the reporting period. *See Figure 5 above.* Just two weeks elapsed between first referral and program enrollment for those who were enrolled in RRH during the reporting period. *See Figure 6 above.* Nevada Children First, Hopelink, Clark County FUSE, St. Jude's Ranch, and the Salvation Army were particularly efficient in enrolling referred persons within ten days of referral. *See Figure 11 above.* The CES timeline was particularly efficient for youth, who were referred within 40 days of first assessment and enrolled within 15 days of referral. *See Figures 8 and 9 above.* Overall, youth were housed three and a half months from first assessment. *See Figure 10 above.*

In addition, one consumer focus group participant reported that she was housed within two weeks, which greatly exceeded her expectations. Others in focus groups indicated time from referral to housing generally ranged from one to six months.

Challenges

While we highlighted some successful program types and providers above, the HMIS data show that other programs struggled with timely referral and placement. For example, over four months elapsed between first assessment and housing move-in for persons in RRH, which is somewhat long for that program type. *See Figure 7 above.* However, timelines related to PSH were even longer than RRH. On average, persons referred to PSH during the reporting period had waited over three months after their first assessment. *See Figure 5 above.* Almost two months elapsed between first referral and program enrollment for those who were enrolled in PSH during the reporting period. *See Figure 6 above.* Overall, between first assessment and housing move-in, over six months elapsed for persons in project-based PSH and almost eight months went by for persons in scattered-site PSH. *See Figure 7 above.* PSH programs often have longer timelines because they serve higher-need (and thus sometimes harder to house) clients. However, participants in provider focus groups described one possible reason for extended timelines for PSH referrals and placements in Southern Nevada: the closing of some existing PSH projects required programs to accept those project's existing clients, elongating wait times for clients captured in the reporting period.

Among providers, HELP of Southern Nevada, Clark County Social Service, and the Salvation Army - Horizon Crest averaged particularly extended wait times between referral and enrollment. *See Figure 11 above.* This could be related to the types of programs these providers administer (i.e., programs for harder to serve clients). If not, the CoC should investigate how to address issues related to timeliness.

The waiting time was comparable and extended throughout the phases of coordinated entry among single adults, families, and survivors of domestic violence. This fact is especially concerning for the survivor population whose safety needs are particularly acute. *See Figures 8, 9, and 10 above.*

In focus groups, some providers commented on the pattern of having the same clients referred to them multiple times, but being unable to house them because after referral, they are unable to locate them. The stakeholder survey revealed an area of difficulty in the referral process was locating clients who had been referred to a program. *See Figure 12 below.*

While the issues outlined here are not unique to the Southern Nevada Homelessness Continuum of Care, they are important areas for continued analysis and problem-solving.

Figure 12: Ease of Receiving Referrals from Coordinated Entry
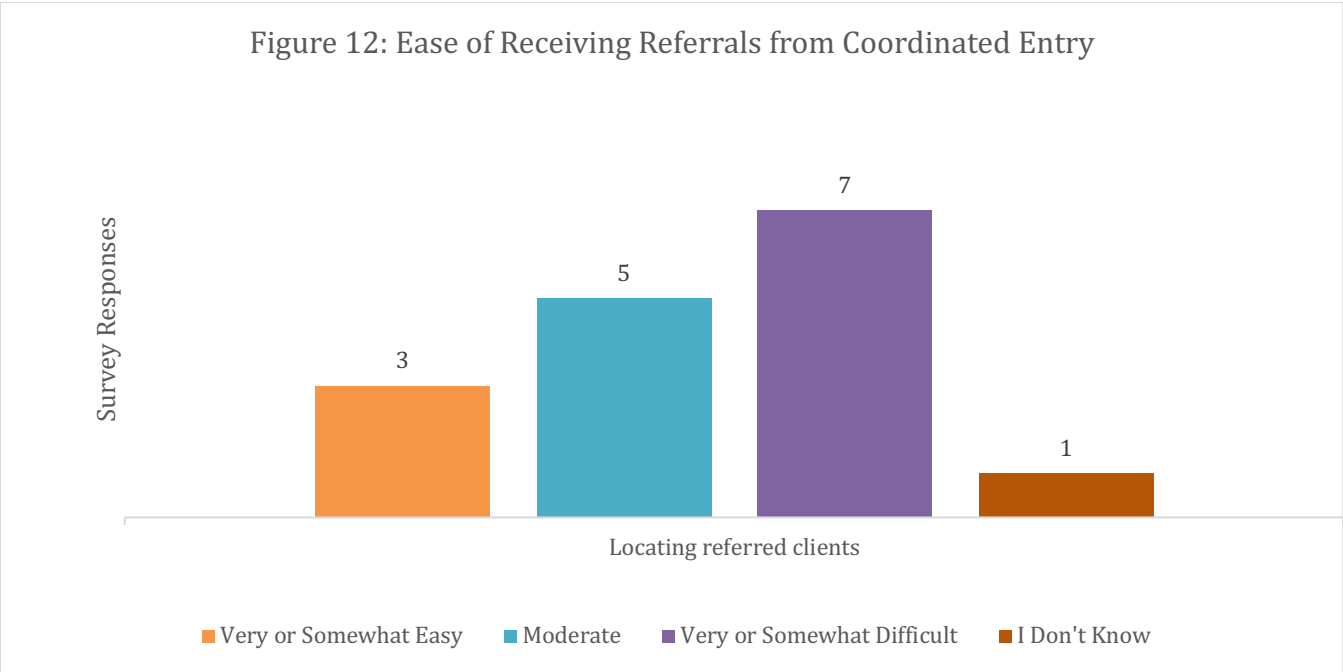
EQUITABLE REFERRAL SCHEME

Overall, 17.42 percent of households first assessed during the reporting period have received referrals to permanent housing: 22.78 percent of survivors of domestic violence, 21.07 percent of youth, 13.72 percent of single adults, and 10.83 percent of families.

Successes

Results from the stakeholder survey show that 75 percent of those responding (of just eight respondents) agreed that, overall, the Community Queue was running well. Of those same respondents, 63 percent indicated that it was not difficult for their organization to tell where a client was on the Community Queue. Some comments on the survey conveyed that the centralized wait list has improved over time. Similarly, providers in focus groups praised the recent change from a decentralized, multi-provider matching process to a centralized matching team housed within one provider.

Challenges

Some survey respondents stated that a challenge of the Queue is keeping the list up-to-date by removing people who have resolved their housing situation in another way or have not been in contact with any providers for an extended period. One focus group participant described one of the challenges of the Queue this way: "Some clients are on the queue for years. They talk to someone often enough to remain on the list, but they don't want to accept referrals that are given for whatever reason (they won't take my dog, etc.)."

APPROPRIATE REFERRALS

Successes

HMIS data shows that the family referral process seems to be functioning well, with 82 percent of families' referrals accepted during the reporting period.
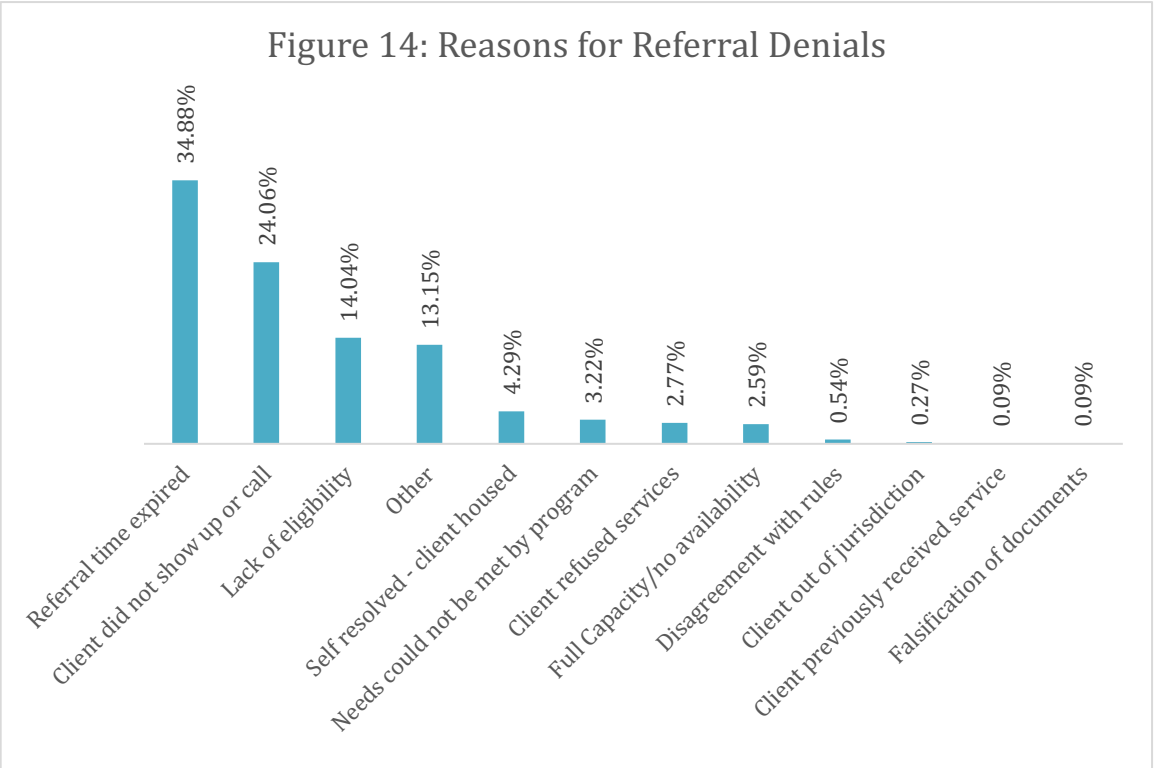
Respondents to the stakeholder survey highlighted other successes related to appropriate referrals. Most respondents who accept referrals indicated that ineligible referrals were rare (53 percent), that the referral process works well (82 percent), and that coordinated entry makes it easy to fill program vacancies (59 percent). In addition, almost all (seven of eight) respondents familiar with the matching process reported that matchers have the necessary information to match clients with the appropriate service and housing intervention. This last data point was supported by providers in focus groups who praised the new dedicated matching team, saying that it has increased consistency and allows for observation and analysis of patterns across the system.

Challenges

While providers clearly believe that referrals are generally appropriate, some HMIS data suggest the opposite. During the reporting period, only 34.36 percent of all referrals were accepted. Unlike the high acceptance rate for families shown above, the numbers were low for single adults (33.07 percent), youth (27.78 percent), and survivors of domestic violence (34.56 percent). While a few programs accepted most of their referrals, the clear majority had very high referral denial rates. *See Figure 13 below.* There was no relationship between time spent on the community queue waiting for a referral and the likelihood of referral rejection. *See Appendix B.*

Figure 13: Referral Denial Rate by Program
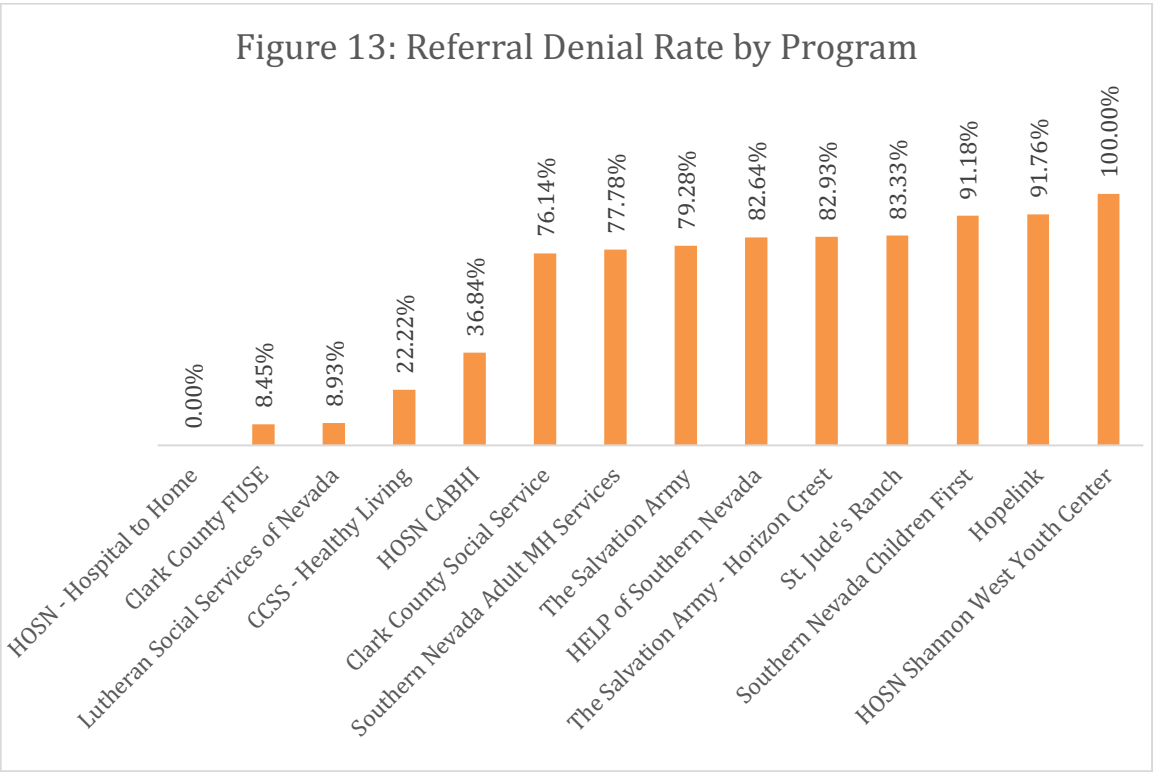
About one third of referrals expired back to the queue after pending for 30 days. The other most common reasons cited for denied referrals were client did not show up or call, lack of eligibility, and "other" reasons. *See Figure 14 below.*

Figure 14: Reasons for Referral Denials

Reason	Percentage
Referral time expired	34.88%
Client did not show up or call	24.06%
Lack of eligibility	14.04%
Other	13.15%
Self resolved - client housed	4.29%
Needs could not be met by program	3.22%
Client refused services	2.77%
Full Capacity/no availability	2.59%
Disagreement with rules	0.54%
Client out of jurisdiction	0.27%
Client previously received service	0.09%
Falsification of documents	0.09%

While 14 percent is a large proportion of denied referrals to be caused by lack of client eligibility, it is unclear whether the eligibility issues would have been detectable to matchers before the referral.

In provider focus groups, many participants did cite an inability to locate clients after referral as a major problem. However, some providers shared concerns that programs may sit on referrals until they expire, as suggested by the HMIS data. Whatever the case, there is frustration around the lack of information about reasons for expired and denied referrals. Sometimes, a lack of information leads matchers to re-refer clients to the same program. These incidents are frustrating for the housing providers and matchers, but even more so for clients who remain homeless.

Denial or expiration of referrals and an inability to locate referred clients are common issues in all coordinated entry systems, but they seem particularly acute in Southern Nevada. Our recommendations to address this issue are provided below.

RECOMMENDATIONS: REFERRAL AND PLACEMENT

1. Address the very high proportion of referrals that are denied for cause or let expire through a variety of measures, including:
    a. Consider removing referral expiration and requiring that programs check in with a matchmaker before denying referrals;
    b. Consider updating the referral denial reasons and providing guidance to agencies receiving referrals regarding when it is appropriate to select a reason. If guidance already exists, failure to comply should be addressed;
    c. Encourage providers to add notes that will help the matchmaker for future referrals (for the client or for the program); and
    d. Consider adding auto-generated HMIS notices that pop up when referrals are denied and include next steps that users should take if they are still in contact with the client, or if the client returns in the future for services (e.g., making sure contact and assessment information is up-to-date).

2. Experiment with methods to increase provider ability to locate clients after referral, including:
   a. Consider leveraging outreach teams to contact persons near the top of the community queue before enrollments are made to begin working on documenting eligibility for PSH;
   b. Ask additional questions about how to locate client and collect client contact information (i.e., email address, family member or friend who can get a message to client about housing opportunity);
   c. To decrease the time between referral and enrollment, consider developing a standard referral location checklist to support providers in finding referred persons; and,
   d. Follow written policies about removing clients form queue if they have not checked in within a certain time and update system accordingly.
3. Consider conducting a deeper analysis of the factors affecting the PSH CES timeline to answer the following questions:
   a. Is the recent closure of other PSH projects responsible for the extended timelines from assessment to housing move-in?
   b. Are referrals held up due to a lack of communication around program openings?
   c. Are PSH providers appropriately moving on participants who have stabilized to free up capacity to serve more vulnerable clients?
   d. What is causing delays between enrollment and move-in for project-based PSH participants?
4. Support RRH and PSH providers in building capacity around landlord engagement and housing-focused case management.
5. Create and implement a strategy for regular review (i.e., quarterly) of referral outcomes to respond to any system challenges and trends.
6. Ensure that policies and procedures around matching have been updated to reflect recent centralization of matching into one agency, and that all stakeholders understand the new matching process.
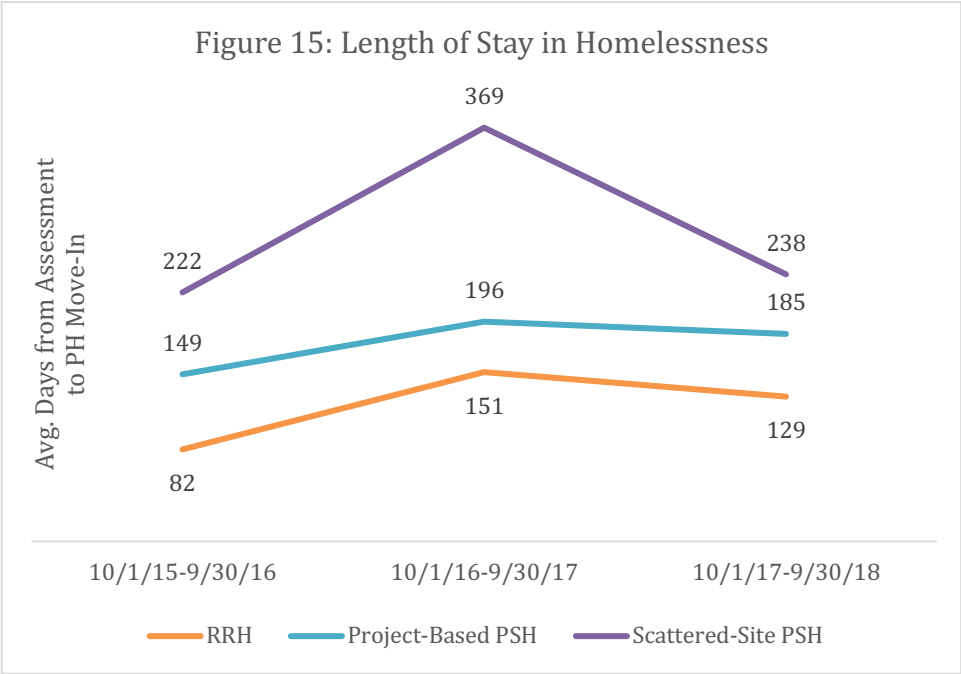
OUTCOMES

While the purpose of coordinated entry is to identify and prioritize the most vulnerable clients experiencing homelessness and place them in housing and services, it should also improve the outcomes for the clients who are served. This section explores HMIS data and some qualitative information around outcomes to offer insight into how coordinated entry might be affecting outcomes.
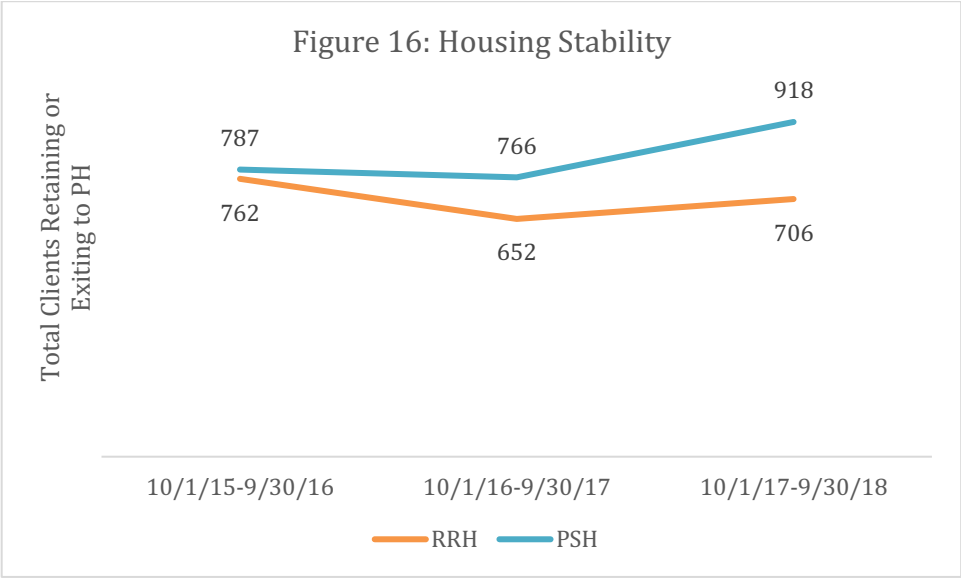
Successes

Race and disability status do not appear to affect housing placement for persons enrolled in PSH and RRH. HMIS data demonstrate a consistent race distribution among persons enrolled and persons housed. *See Appendix B.* In fact, more people among those housed (71.24 percent) than those enrolled (50.23 percent) had a disabling condition, indicating that programs are advocating effectively for the most vulnerable persons.

Coordinated entry is becoming more efficient in moving people out of homelessness. The average time from a client's first assessment to permanent housing move-in decreased for all project types during the reporting period. *See Figure 15 below.*

Figure 15: Length of Stay in Homelessness

Avg. Days from Assessment to PH Move-In

	10/1/15-9/30/16	10/1/16-9/30/17	10/1/17-9/30/18
Scattered-Site PSH	222	369	238
Project-Based PSH	149	196	185
RRH	82	151	129

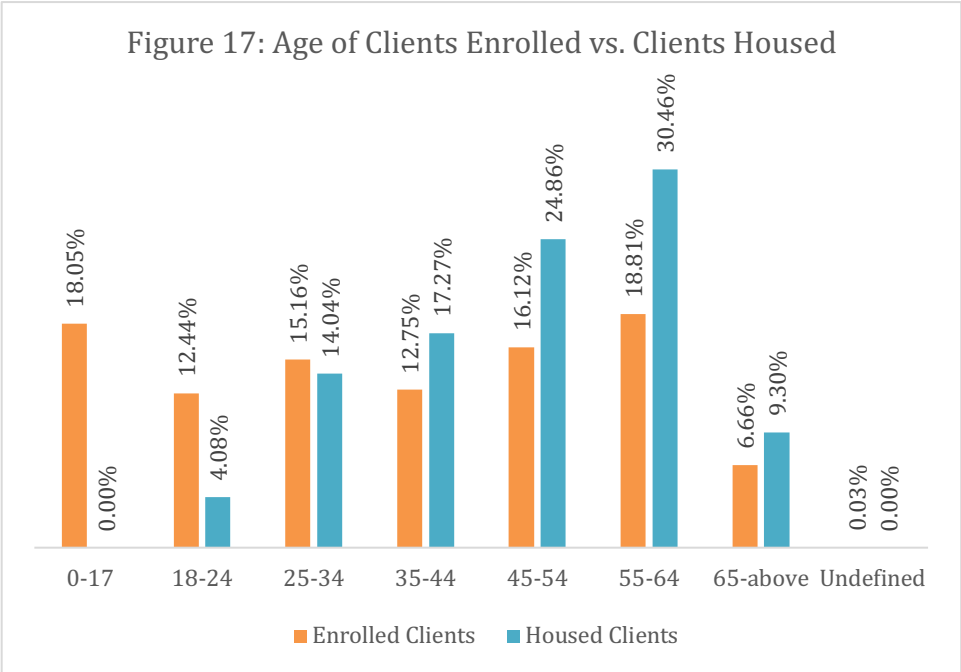— RRH — Project-Based PSH — Scattered-Site PSH

Coordinated entry is helping more households achieve housing stability. The total number of clients retaining or exiting to permanent housing increased during the reporting period and represented increased housing stability achieved in both PSH and RRH. *See Figure 16 below.*
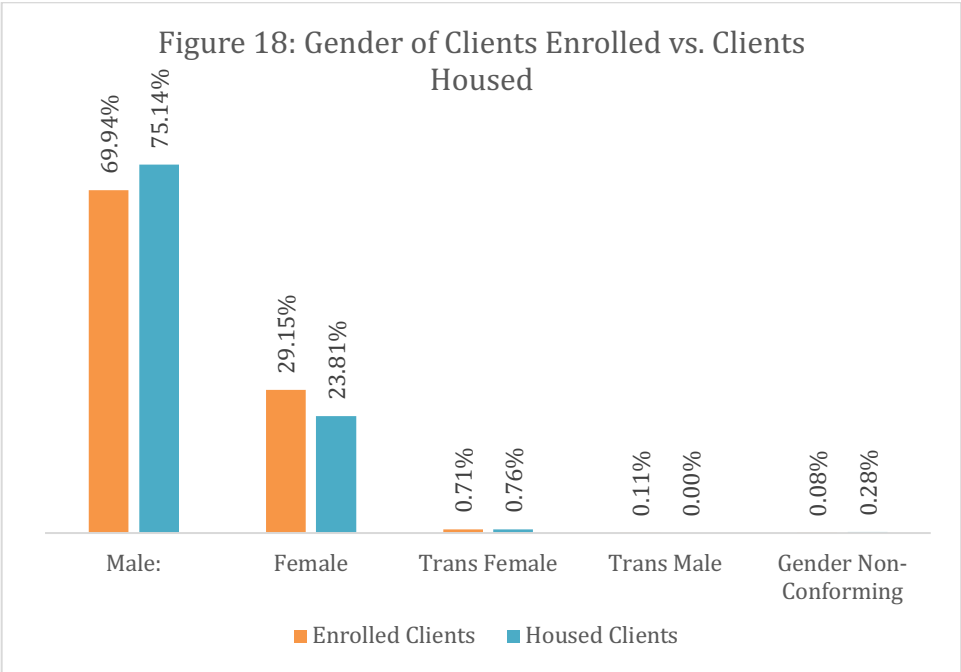
Figure 16: Housing Stability

Total Clients Retaining or Exiting to PH

	10/1/15-9/30/16	10/1/16-9/30/17	10/1/17-9/30/18
PSH	787	766	918
RRH	762	652	706

— RRH — PSH

Challenges

Hispanic/Latinx persons, youth, and females enrolled in permanent housing programs are experiencing challenges securing units. While there are 12.83 percent Hispanic/Latinx among clients enrolled in permanent housing programs in the reporting period, there were only 8.25 percent Hispanic/Latinx clients housed. *See Appendix B.* Youth enrolled in permanent housing programs are also experiencing challenges securing units. While the distribution is relatively flat among the age ranges of persons enrolled into permanent housing, youth are severely underrepresented among the housed client population, which skews towards older adults. *See Figure 17.*

Figure 17: Age of Clients Enrolled vs. Clients Housed

Age	Enrolled Clients	Housed Clients
0-17	18.05%	0.00%
18-24	12.44%	4.08%
25-34	15.16%	14.04%
35-44	12.75%	17.27%
45-54	16.12%	24.86%
55-64	18.81%	30.46%
65-above	6.66%	9.30%
Undefined	0.03%	0.00%

Females are also underrepresented among housed clients as compared to those enrolled into permanent housing. *See Figure 18.*

Figure 18: Gender of Clients Enrolled vs. Clients Housed

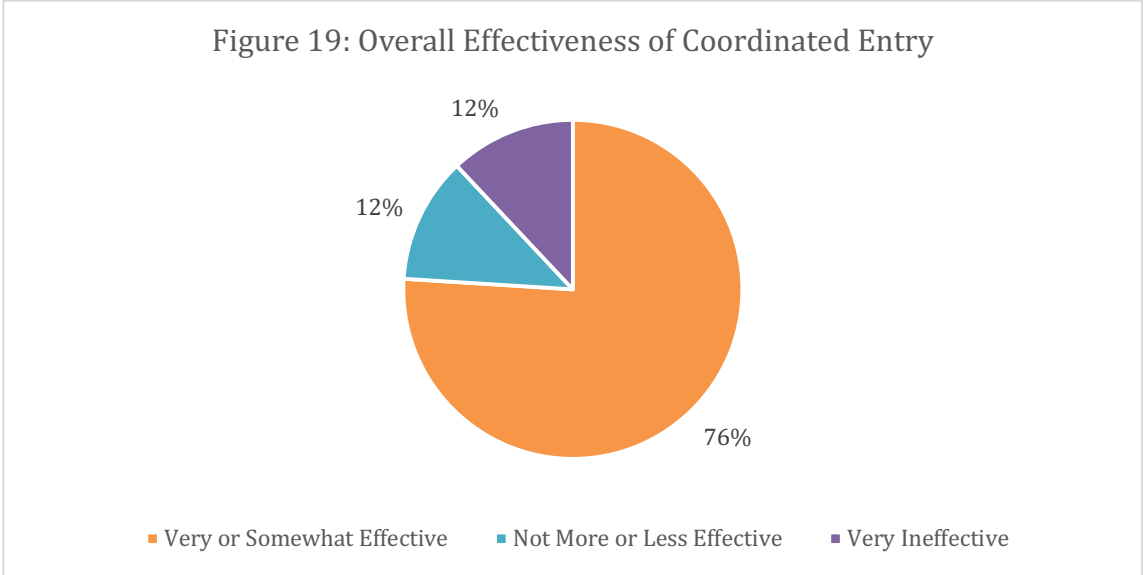| Gender	Enrolled Clients	Housed Clients
Male:	69.94%	75.14%
Female	29.15%	23.81%
Trans Female	0.71%	0.76%
Trans Male	0.11%	0.00%
Gender Non-Conforming	0.08%	0.28%

RECOMMENDATIONS: OUTCOMES

1. Consider conducting a deeper analysis of the challenges Hispanic/Latinx persons, youth, and females are experiencing in securing units once enrolled in permanent housing programs.
2. Continue tracking data around housing stability and length of stay homeless to ensure continued success in these areas.

CONCLUSION

This evaluation shows that the Southern Nevada Homelessness Continuum of Care has implemented a coordinated entry system that is successful in many core areas. The community believes this is the case as well; results from the survey show that, overall, system stakeholders feel that coordinated entry is effective: 76 percent of those responding to this question on the survey indicated that coordinated entry is either somewhat or very effective, with only 12 percent answering very ineffective (and none somewhat ineffective). *See Figure 19 below.*

Figure 19: Overall Effectiveness of Coordinated Entry

- Very or Somewhat Effective   ■ Not More or Less Effective   ■ Very Ineffective

While those achievements should be celebrated and built upon, the CoC should also work to address some key areas of concern. Perhaps most important among these areas of concern are: inconsistent administration of assessments, lack of clarity around denied and expired referrals, inability to located referred clients, and extended wait times from assessment to housing move-in. We have provided the CoC with recommendations on how to address these challenges throughout the report, which are also compiled in *Appendix A* below.

APPENDIX A

COMPREHENSIVE LIST OF RECOMMENDATIONS

ENSURING ACCESS

1. Develop strategies to better inform and promote access for clients in remote areas and other populations that utilize coordinated entry at lower rates, including:
   a. Conduct regular comparisons of completed assessments and homeless populations data (PIT, etc.) to determine if any populations are disproportionately disconnected from coordinated entry;
   b. Develop and distribute targeted marketing tools, such as small cards that clients can keep and share with others, to better inform clients about coordinated entry;
   c. Ensure that all coordinated entry resources are available to any large local populations of non-English speakers; and
   d. Utilize communication networks among those experiencing homelessness, including utilizing the resources outlined above.
2. Address access issues specific to coordinated entry for youth, including:
   a. Conduct deep analysis of coordinated entry accessibility for unaccompanied minors; and
   b. Ensure that Safe Place sites and school counselors receive consistent training on coordinated entry.
3. Ensure staff at all access points are regularly trained on identifying the signs of domestic violence so they can more quickly refer survivors to DV-specific providers.

ASSESSMENT AND PRIORITIZATION

1. Implement strategies to improve the consistency and validity of assessments, including:
   a. Establish a process for the review of re-assessments that occur soon after an original assessment and/or produce an assessment score much different than the original assessment, including establishing a threshold above which a significant score change would trigger case conferencing to understand and address the situation;
   b. Require all assessors at an organization to complete an annual recertification to continue administering assessments. Recertification might include a review of the organization's previous year assessments to pinpoint any areas requiring discussion or clarity; and
   c. Consider sanctions for organizations that do not follow established policies and procedures around administering assessments, including temporary loss of assessment privileges.
2. Develop an orientation packet for clients that contains information about what to expect and what is expected after the assessment is complete.
3. Set policy on how to prioritize clients who were assessed using previous assessment tools (i.e., VI-SPDAT).
4. Consider extending the period of time that is considered by assessment tools (beyond the current three-year period).

REFERRAL AND PLACEMENT

1. Address the very high proportion of referrals that are denied for cause or let expire through a variety of measures, including:
   a. Consider removing referral expiration and requiring that programs check in with a matchmaker before denying referrals;

b. Consider updating the referral denial reasons and providing guidance to agencies receiving referrals regarding when it is appropriate to select a reason. If guidance already exists, failure to comply should be addressed;

c. Encourage providers to add notes that will help the matchmaker for future referrals (for the client or for the program); and

d. Consider adding auto-generated HMIS notices that pop up when referrals are denied and include next steps that users should take if they are still in contact with the client, or if the client returns in the future for services (e.g., making sure contact and assessment information is up-to-date).

2. Experiment with methods to increase provider ability to locate clients after referral, including:

a. Consider leveraging outreach teams to contact persons near the top of the community queue before enrollments are made to begin working on documenting eligibility for PSH;

b. Ask additional questions about how to locate client and collect client contact information (i.e., email address, family member or friend who can get a message to client about housing opportunity);

c. To decrease the time between referral and enrollment, consider developing a standard referral location checklist to support providers in finding referred persons; and,

d. Follow written policies about removing clients form queue if they have not checked in within a certain time and update system accordingly.

3. Consider conducting a deeper analysis of the factors affecting the PSH CES timeline to answer the following questions:

a. Is the recent closure of other PSH projects responsible for the extended timelines from assessment to housing move-in?

b. Are referrals held up due to a lack of communication around program openings?

c. Are PSH providers appropriately moving on participants who have stabilized to free up capacity to serve more vulnerable clients?

d. What is causing delays between enrollment and move-in for project-based PSH participants?

4. Support RRH and PSH providers in building capacity around landlord engagement and housing-focused case management.

5. Create and implement a strategy for regular review (i.e., quarterly) of referral outcomes to respond to any system challenges and trends.

6. Ensure that policies and procedures around matching have been updated to reflect recent centralization of matching into one agency, and that all stakeholders understand the new matching process.

OUTCOMES

1. Consider conducting a deeper analysis of the challenges Hispanic/Latinx persons, youth, and females are experiencing in securing units once enrolled in permanent housing programs.

2. Continue tracking data around housing stability and length of stay homeless to ensure continued success in these areas.

APPENDIX B

DATA TABLES

ENSURING ACCESS

FAIR AND EQUAL ACCESS

Gender	Unsheltered & ES PIT Count	Persons Assessed	Persons Enrolled in PSH/RRH/TH
Male	69.02%	62.19%	69.94%
Female	30.40%	37.03%	29.15%
Trans Female or Trans Male	0.51%	0.61%	0.82%
Gender Non-Conforming (i.e., not exclusively male or female)	0.07%	0.12%	0.08%
Left Blank (null)/Data Not Collected/Client Refused/Client doesn't Know	N/A	0.05%	0.00%

Race	Unsheltered & ES PIT Count	Persons Assessed	Persons Enrolled in PSH/RRH/TH
White	54.21%	49.19%	46.69%
Black or African American	34.57%	41.44%	45.55%
Asian	2.60%	1.27%	0.88%
Native Hawaiian or Other Pacific Islander	1.53%	0.98%	1.22%
American Indian or Alaska Native	2.07%	1.54%	1.42%
Multi-racial	5.02%	2.88%	3.54%
Left Blank/Data Not Collected/Client Refused/Client doesn't Know	N/A	2.68%	0.71%

Ethnicity	Unsheltered & ES PIT Count	Persons Assessed	Persons Enrolled in PSH/RRH/TH
Non-Hispanic/Non-Latino	88.90%	87.19%	86.88%
Hispanic/Latino	11.10%	11.57%	12.83%
Left Blank/Data Not Collected/Client Refused/Client doesn't Know	N/A	1.24%	0.28%

REFERRAL AND PLACEMENT

APPROPRIATE REFERRALS

Time Spent on Community Queue	Referrals Made	Referrals Denied	Percent Referrals Denied
Less than a week:	633	460	72.67%
1 Week - 3 Months:	686	526	76.68%
3 - 6 Months:	145	95	65.52%
6 Months to 1 Year:	54	33	61.11%
1-2 years:	11	4	36.36%
2 years or more:	0	0	N/A

OUTCOMES

SUCCESS IN PLACEMENTS

Race	Clients Enrolled	Clients Housed
White	46.69%	49.81%
Black or African American	45.55%	44.21%
Asian	0.88%	0.85%
Native Hawaiian or Other Pacific Islander	1.22%	1.14%
American Indian or Alaska Native	1.42%	1.71%
Multi-racial	3.54%	2.18%
Left Blank/Data Not Collected/Client Refused/Client Doesn't Know	0.71%	9.00%

SOUTHERN NEVADA HOMELESSNESS CONTINUUM OF CARE

Ethnicity	Clients Enrolled	Clients Housed
Non-Hispanic/Non-Latinx	86.88%	91.75%
Hispanic/Latinx	12.83%	8.25%
Left Blank	0.00%	0.00%
Data Not Collected	0.20%	0.00%
Client Refused	0.08%	0.00%
Client Doesn't Know	0.00%	0.00%

Sample of Implementation and Evaluation Support Work Product Prepared by HomeBase

Santa Clara County State of Homelessness Report (2018)
Infographic: Causes & Impacts of Homelessness
Infographic: Supportive Housing System Progress

ENDING HOMELESSNESS

The State of the
Supportive Housing System
in Santa Clara County
2017

Ending Homelessness

The State of the Supportive Housing System in Santa Clara County
2017

Letter from the County Executive

In Santa Clara County's current housing crisis, safe and affordable housing is out of reach for many, especially those with the fewest resources, including the elderly and persons with a disabling condition. As a result, thousands of individuals and families experience homelessness in our county each year. The County, in collaboration with our city, nonprofit, business, and philanthropic partners, is dedicated to making homelessness rare, brief, and non-recurring for residents. The first of ten annual reports, this document highlights countywide efforts to prevent homelessness before it occurs, strengthen the supportive housing system to better serve those with the highest needs, and increase the community's stock of affordable housing.

As demonstrated in the following pages, our community has made significant progress toward the goals we set in 2015 when we collectively developed and committed to the Santa Clara County Community Plan to End Homelessness. Collaboration is essential to reaching our community goals; we must continue to build upon the strong partnerships that have been critical to our successes thus far.

We thank Destination: Home for its leadership in generating financial and community support for programs serving homeless individuals and families. We thank the City of San José for its commitment to funding both the development of supportive housing and services to support those most in need, highlighted by their multi-million dollar investment in Second Street Studios, the largest permanent supportive housing development in our county to date. We thank the Santa Clara County Housing Authority for its commitment of housing subsidies dedicated to supportive housing systems, such as 134 permanent subsidies for the homeless individuals moving into Second Street Studios this fall. And we thank the outreach workers, case managers, shelter staff, landlords, and hundreds of other partners who work every day toward the goal of preventing and ending homelessness in our county.

Thanks to the deep commitment of leaders from the County and its city, nonprofit, business, and philanthropic partners, our community has built far more than a continuum of services for homeless individuals — we have built a movement to end homelessness. As we look back at all that was accomplished in 2017, we are confident that our collective momentum will continue to push forward collaborative efforts to house those in our community who experience homelessness.

Sincerely,

Jeffrey V. Smith, M.D., J.D.
County Executive Officer
County of Santa Clara

Miguel Marquez, M.P.P., J.D.
Chief Operating Officer
County of Santa Clara

TABLE OF CONTENTS

A map of developments that include supportive housing is available at: www.supportivehousingscc.org/map

Gilroy Sobrato Studios. Photo courtesy of Eden Housing

EXECUTIVE SUMMARY

Each night, thousands of Santa Clara County residents face homelessness. Families with children, seniors, individuals with disabilities, veterans, and youth are all represented in the county's diverse homeless population, with nearly three-quarters going unsheltered – sleeping outside, in cars, or other places not meant for human habitation. Despite the prosperity associated with the region, a lack of affordable housing development and difficulty finding living-wage employment in Santa Clara County has resulted in many economically vulnerable households falling into homelessness, and countless more on the edge.
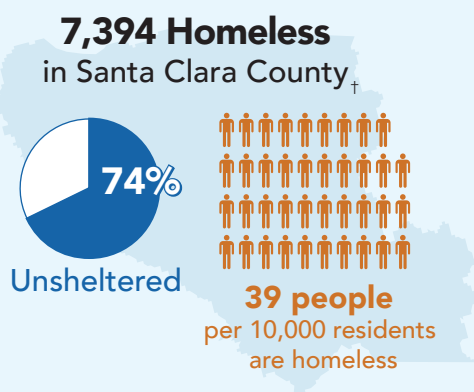
Data shows that for most, homelessness will be a brief and one-time occurrence, but for some it can last for years or become a repeating cycle. Often individuals who are homeless for longer periods of time make frequent use of emergency medical and psychiatric care, or get caught up in the justice system, resulting in high cost to the public. *Home Not Found*, a study of the cost of homelessness in Santa Clara County, reported that the County and service providers spend more than $520 million per year on such services.

In 2015, the community came together to create a roadmap to guide their efforts to end homelessness. Coordinated by the County of Santa Clara Office of Supportive Housing and nonprofit partner Destination: Home, the resulting Community Plan to End Homelessness set an ambitious goal of 6,000 new housing opportunities, and identified strategies to help the community achieve this shared vision. The community efforts to date represent significant progress toward these goals.
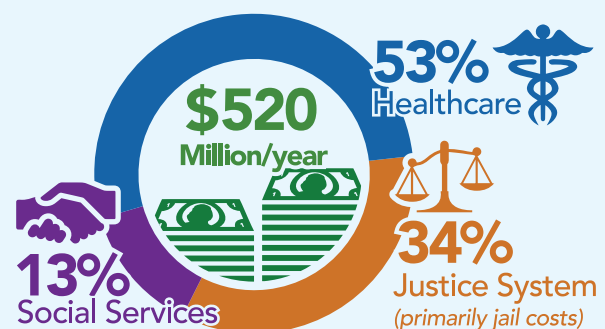
Building Affordable Housing

Responding to the high level of need for affordable housing and the desire to efficiently utilize scarce resources, the County has prioritized funding and development of housing for residents experiencing homelessness and extremely low-income households. Creating affordable housing for these priority populations requires substantial cooperation between the County of Santa Clara, its many agencies, and a range of municipal, nonprofit, philanthropic, and community partners. Key examples of the collaboration necessary to stably house the county's most vulnerable residents include:

- **Second Street Studios**, an innovative partnership between the County, the City of San José, and the Santa Clara County Housing Authority will result in a new service-enriched apartment community in September 2018. The development will improve the health and housing stability of 134 disabled individuals who have experienced long-periods of homelessness.

- **2016 Measure A**, the recently passed $950 million Affordable Housing Bond, will help to fill some but not nearly all of this need, by providing funding for approximately 4,800 units of affordable housing. The County has approved funding for six developments with housing designated for households exiting homelessness, and is working to support more than 100 additional developments over the next ten years.

7,394 Homeless
in Santa Clara County [†]

74%
Unsheltered

39 people
per 10,000 residents
are homeless

Cost of providing services to homeless residents in Santa Clara County

$520 Million/year

53% Healthcare

34% Justice System
(primarily jail costs)

13% Social Services

[†] U.S. Department of Housing and Urban Development, The 2017 Annual Homeless Assessment Report (AHAR) to Congress Part 1: Point in Time Estimates, Available at: https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

[‡] The universe for this measure (1,681 clients) includes all clients served in a permanent supportive housing program who were housed at least 12 months prior to the end of 2017. The universe is significantly lower than the total system capacity (2,846 households) because it does not include all clients served.

Progress Toward Goal of 6,000 New Housing Opportunities

1,449
New as of
December 31, 2017

946 🏠
503 🏠

804
Pipeline as of
Dec. 31, 2017

655 🏠
87 🏠
62 TBD

🏠 Permanent Supportive Housing   🏠 Rapid Rehousing

6,000
Goal for New
Opportunities

3,400 🏠
2,600 🏠

Santa Clara County's Supportive Housing System

Affordable housing is a critical tool of the supportive housing system in Santa Clara County, but it must be complemented by individualized services to help clients maintain stable housing and rigorous data evaluation to improve outcomes for families and individuals experiencing homelessness. Santa Clara County's supportive housing system provides a continuum of programs and services to meet the needs of the community's most vulnerable residents, including:

- **Homelessness prevention programs** help individuals and families on the verge of homelessness to remain housed and avoid extended shelter or transitional housing stays.

- **Targeted outreach programs** engage with people experiencing homelessness, especially the more than 5,000 county residents living in vehicles, encampments, and other public spaces.

- **Emergency shelters** provide a temporary place to stay, access to services, and other basic needs, for up to 1,146 people across the county each night.

- **Transitional housing programs** offer time-limited housing and services for up to 610 households at a time and are well-suited for populations such as youth or survivors of domestic violence, who may benefit from increased social supports and intensive onsite services.

- **Rapid Rehousing programs**, with a capacity to serve 619 households at a time, quickly move families and individuals into housing and provide financial assistance and services to help households stabilize, increase income, and eventually take over the cost of their rent. Of clients leaving the program in 2017, 72% had obtained permanent housing.

- **Permanent supportive housing programs** couple stable, long-term housing with wrap-around supportive services, such as case management and access to physical and behavioral healthcare, for up to 2,846 households at a time. Of those housed in permanent supportive housing programs by 2017, 90% of clients remained stably housed for at least 12 months.

- **Coordinated Assessment System**, which referred 1,401 households to housing programs in 2017, matches individuals and families experiencing homelessness with the county's transitional and permanent housing resources, and ensures that the community is serving those with the highest needs.

Obtained Permanent Housing
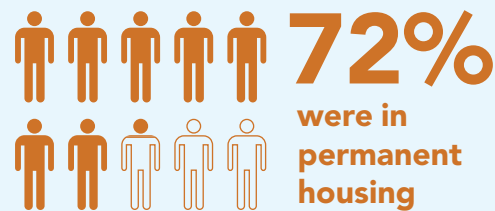
72% were in permanent housing

(884 of 1,232) of clients who exited rapid rehousing programs in 2017

Permanent Housing Retention

90% remained stably housed for at least 12 months

(1,205 of 1,343) of clients housed in PSH between July 2011 and the end of 2016 ‡

Innovative — and Cost Effective — Housing Programs

Though the County offers an array of programs and services, current capacity cannot meet the need of the county's significant homeless population. To efficiently utilize the limited resources available to assist individuals and families experiencing homelessness, the County seeks to target housing resources and close service gaps for its most vulnerable residents. Programs and strategies implemented by the Office of Supportive Housing and its partners include:

- **Re-envisioning the Community's Approach to Preventing Homelessness** — The Homelessness Prevention System Pilot brings together a network of community partners to provide flexible financial assistance and resources for households in crisis, targeting support to families and individuals most at risk of losing their housing and preventing them from entering the homeless system.

- **Facilitating Public Safety and Justice Housing Services** — County programs enhance public safety by helping homeless individuals overcome past criminal history and find safe and stable housing upon release, allowing them to reintegrate and contribute to the community.

- **Supporting Housing Stability to Promote Family Reunification** — The Bringing Families Home program, a collaboration between the Office of Supportive Housing and the Social Services Agency's Department of Family and Children Services, helps families involved in the child welfare system to attain housing stability and reunify.

These innovative programs, and many others that have been implemented or are in development, demonstrate the County of Santa Clara and its partners' commitment to working strategically and collaboratively to ensure that homelessness is rare, brief, and non-recurring. To achieve the collective goal of 6,000 new housing opportunities for individuals and families experiencing homelessness, the community must shift from relying on the private market to building enough affordable housing to meet the need in Santa Clara County. The Office of Supportive Housing is a leader in this movement, working across the region in a successful Collective Impact framework, as no one entity can address the issues of homelessness and poverty alone. As the many initiatives already in progress show, a community-wide effort to end homelessness requires the cooperation and collaboration of a range of stakeholders from our public/private sectors, including cities, state and county agencies, corporations, philanthropy and nonprofit partners.

Parkside Studios. Photo by Jeffrey Peters.

HOMELESSNESS IN SANTA CLARA COUNTY

Homelessness affects thousands of Santa Clara County residents each year. Individuals and families, adults and children, people with jobs, and those with severe disabling conditions all face challenges to finding and retaining safe and stable housing. Many live without habitable shelter, on streets, in parks, in vehicles, or in sheds or abandoned buildings, while others spend their nights in the community's emergency shelters and transitional housing programs. (See Appendix A: Defining Homelessness for more information about the definitions of homelessness used in this report.)

Home Not Found, a 2015 study on the costs of homelessness in Santa Clara County, identified 46,225 residents who experienced homelessness over the course of the year in 2012 and received some form of County medical, behavioral health, or other social services, or had contact with the criminal justice system.[i][ii] This population represents some of the county's most vulnerable residents, in no small part due to the instability, stigma, loss of resources, and physical vulnerability that accompany the experience of homelessness. The *Home Not Found*

study found that the majority of county residents with experience of homelessness between 2007 and 2012 had used the County of Santa Clara's medical and mental health services or had interacted with the criminal justice system, and many had contact with multiple County of Santa Clara departments or services.

The role of Santa Clara County's supportive housing system is to implement the most effective strategies to assist individuals experiencing homelessness in overcoming the barriers keeping them from stable housing, and to make homelessness rare, brief, and non-recurring across the county.

―――――――――

46,225 residents experienced homelessness over the course of the year in 2012

―――――――――

[i] The study identified homeless individuals based on records maintained by the County of Santa Clara Social Services Agency, the Santa Clara Valley Health and Hospital System (including Valley Medical Center and the Behavioral Health Services Department), the Santa Clara County Housing Authority, and the County of Santa Clara Criminal Justice Information Control, as well as information in the Homelessness Management Information System (HMIS), the community's central database for homeless housing and service providers. Due to variations in data collection and definitions of homelessness in the community, the study included some individuals who were couch surfing, without a permanent place to sleep, as well as individuals who meet the more strict federal definition of homelessness. See *Home Not Found: The Cost of Homelessness in Silicon Valley*, Methods Appendix pages 49-52 for more information on study methodology.

[ii] Economic Roundtable, *Home Not Found: The Cost of Homelessness in Silicon Valley*. 2015. Available at: https://destinationhomesv.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf
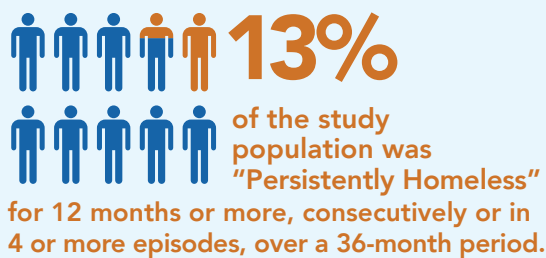
Patterns of Homelessness

The *Home Not Found study* analyzed six years of data from County homeless, health and justice system service databases, revealing patterns in duration, County service usage, and public cost.
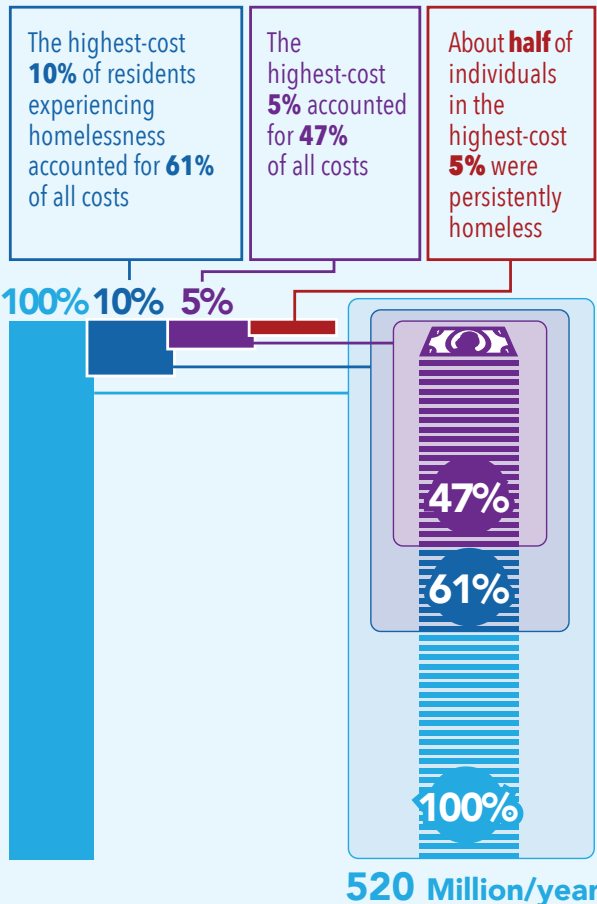
Duration

Out of the more than 100,000 people who experienced homelessness from 2007 through 2012, during those six years:

20% were homeless for 1 month

32% were homeless for 2-6 months

12% were homeless for 7-11 months

13% were homeless for 1 year - 23 months

were homeless for 2 years or more **22%**

YEARS OF HOMELESSNESS   1   2   3

While most individuals were able to make lasting exits from homelessness after shorter episodes, some fell into longer episodes or patterns of homelessness. In an average month from 2007 to 2012:
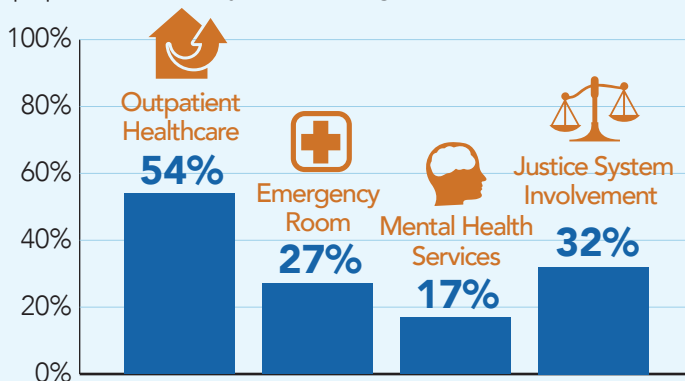
13% of the study population was "Persistently Homeless" for 12 months or more, consecutively or in 4 or more episodes, over a 36-month period.

On average, Santa Clara County service providers spent $520 million per year providing services for residents in years when they experienced homelessness during the six years covered by this study, with much of the costs accrued by a small number of frequent users. In 2012:

The highest-cost **10%** of residents experiencing homelessness accounted for **61%** of all costs

The highest-cost **5%** accounted for **47%** of all costs

About **half** of individuals in the highest-cost **5%** were persistently homeless

100% **10%** **5%**

Service Usage and Public Cost

Among the individuals in the *Home Not Found* study population, County service usage was common:

Outpatient Healthcare **54%**

Emergency Room **27%**

Mental Health Services **17%**

Justice System Involvement **32%**

Though the type of service usage and costs varied, the study found that mental illness, substance abuse, incarceration, and persistent homelessness all had a strong impact on overall public costs.

47%

61%

100%

520 Million/year

Santa Clara County Homeless Census & Survey [iii]

● Sheltered   ● Unsheltered

Homeless Persons

Year	Total	Sheltered	Unsheltered
January 2011	7,067	1,898	5,169
January 2013	7,631	1,957	5,674
January 2015	6,556	1,929	4,627
January 2017	7,394	1,946	5,448
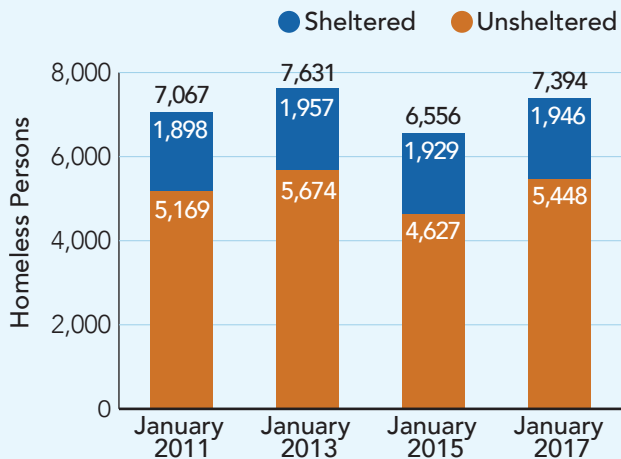
553,742 Homeless [iv]
in the United States

35% Unsheltered

17 people per 10,000 residents are homeless

134,278 Homeless [iv]
in California

68% Unsheltered

34 people per 10,000 residents are homeless

7,394 Homeless [iv]
in Santa Clara County

74% Unsheltered

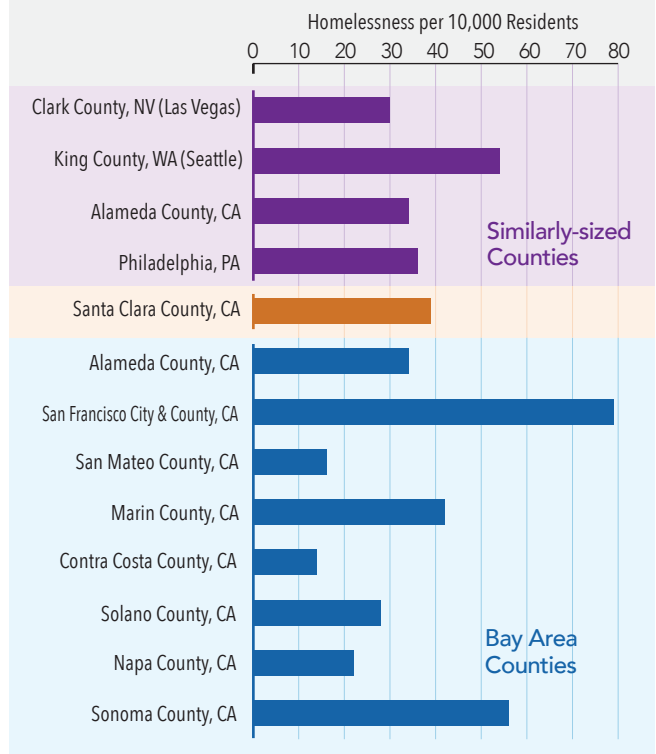**39 people** per 10,000 residents are homeless
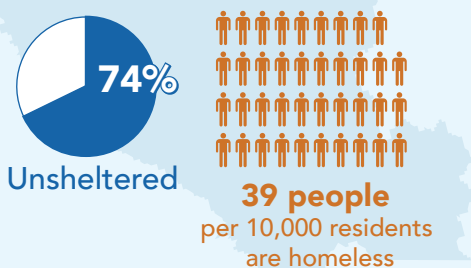
Homeless Population Change Over Time

Every other year in January, the County of Santa Clara Office of Supportive Housing and the local cities coordinate a countywide point-in-time count of people experiencing homelessness. This biennial Homeless Census and Survey provides the best data available on the size and characteristics of the county's homeless population over time, including numbers of people sleeping outside, in vehicles, or in structures not intended for human habitation (unsheltered), and in emergency shelters and transitional housing programs (sheltered). For more information about the Homeless Census and Survey, see Appendix B: Data Sources.

A Crisis in Context

Santa Clara County's housing and homelessness crisis is a local instance of a national epidemic, which is particularly acute in California's metropolitan areas. As of January 2017, local point-in-time counts similar to the Homeless Census and Survey reveal that the state of California is home to a quarter of the nation's homeless population. More than two-thirds of people experiencing homelessness in California are unsheltered – over twice the national rate. [iv]

How Santa Clara County's Homeless Population Compares to Other Communities [v vi]

Homelessness per 10,000 Residents

Similarly-sized Counties
- Clark County, NV (Las Vegas)
- King County, WA (Seattle)
- Alameda County, CA
- Philadelphia, PA
- Santa Clara County, CA

Bay Area Counties
- Alameda County, CA
- San Francisco City & County, CA
- San Mateo County, CA
- Marin County, CA
- Contra Costa County, CA
- Solano County, CA
- Napa County, CA
- Sonoma County, CA

247

Causes of Homelessness

In Santa Clara County, as in much of California and in many high-cost urban areas around the country, homelessness and housing instability are closely tied to the region's soaring housing costs and economic stagnation for low-income residents.

The Rental Market and Lack of Income are Primary Barriers to Regaining Housing

Top 3 barriers to obtaining permanent housing reported by 2017 Homeless Census and Survey respondents: [vii]

Can't Afford Rent
62%

No Job/Income
**56%**

No Money for Moving Costs
23%
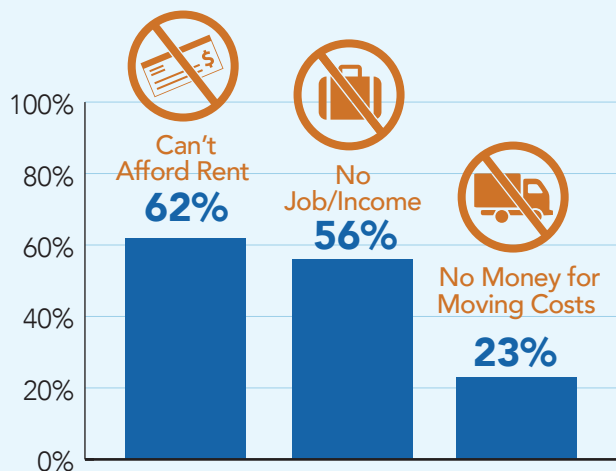
Job Loss and Eviction are Among the Leading Causes of Homelessness

Top 3 primary causes of homelessness reported by 2017 Homeless Census and Survey respondents:

Job Loss
37%

Alcohol or Drug Use
20%
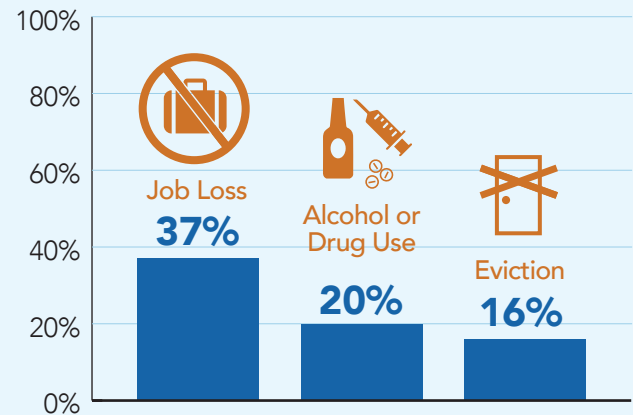
Eviction
16%

Homeless Census and Survey respondents reporting eviction as their primary cause of homelessness has increased by 11 percentage points between 2011 and 2017 (5% to 16%)

11%
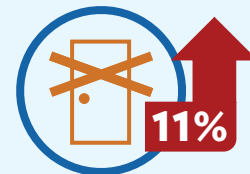
The number reporting evictions as the primary cause of homelessness increased by 11% points since 2011

[iii] Santa Clara County 2017 Homeless Census and Survey Comprehensive Report, https://www.sccgov.org/sites/osh/ContinuumofCare/ReportsandPublications/Documents/2017 Santa Clara County Homeless Census and Survey Report.pdf

[iv] U.S. Department of Housing and Urban Development The 2017 Annual Homeless Assessment Report (AHAR) to Congress Part 1: Point in Time Estimates, Available at: https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

[v] U.S. Census Bureau, American Community Survey data, 2016.

[vi] U.S. Department of Housing and Urban Development, 2007 – 2017 PIT Counts by CoC, Available at: https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/

[vii] Respondents were asked to identify the barriers preventing them from obtaining housing. Many identified more than one barrier and all responses were recorded.

The Housing Gap

In Santa Clara County, community-wide efforts have led to a number of robust and successful initiatives, but rates of homelessness remain persistently high. Although the county is among the most prosperous regions in the country, statewide economic trends and a severe housing shortage have left fewer and fewer residents able to afford the high cost of housing. Despite tremendous economic growth overall, median renter income in California declined by seven percent from 2000 to 2014. At the same time, annual median rent increased by 24 percent, overwhelming many renter households' purchasing power in the housing market.[viii]

Though Santa Clara County sits at the epicenter of the nation's technology sector, all residents have not shared in the wealth generated by this sector. For low-income households, decades of slow-paced housing development combined with stagnant wages and swiftly rising rents have displaced many and created an exceedingly tight rental market for those who have remained.

These economic and housing market trends have been challenging for many residents and have been particularly catastrophic for those lowest-income households without a financial safety net. In response, the County of Santa Clara is focused on building a supportive housing system to serve these most vulnerable residents. Priority populations for the County include those who are most impacted by the lack of affordable housing – people experiencing homelessness, disabled individuals, and extremely low-income, elderly, and fixed-income households. For these residents, safe and affordable housing is often a critical component to alleviate physical and mental health conditions, maintain housing stability, and mitigate the effects of poverty.
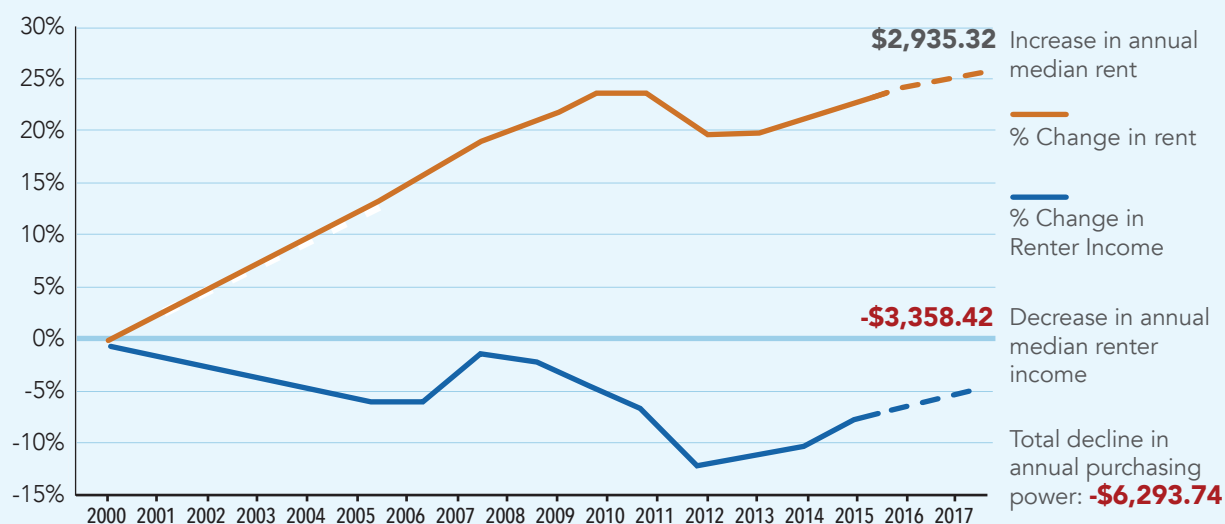

[viii] California Housing Partnership Corporation, "Confronting California's Rent and Poverty Crisis: A Call for State Reinvestment in Affordable Homes." April 2016. Available at: https://1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2016/04/State-Housing-Need-2016.pdf

[ix] Extremely low-income households comprise many of the county's most vulnerable renters, including low-wage service workers, and older adults and people with disabilities living on fixed incomes.

[x] Fair market rent is the amount that the Department of Housing and Urban Development (HUD) calculates would be needed to pay rent and utilities for a modest, privately owned, and safe rental unit of that size. U.S. Dept. of Housing and Urban Development, Fair Market Rent. Available at: https://www.huduser.gov/portal/datasets/fmr.html#2018

[xi] City of San José, Housing Market Update Third Quarter 2017. http://www.sanjoseca.gov/DocumentCenter/View/73415

California's Median Rent Increased 24% while Median Renter Income Declined 7% from 2000 - 2014 [viii]

$2,935.32 Increase in annual median rent

—— % Change in rent

—— % Change in Renter Income

-$3,358.42 Decrease in annual median renter income

Total decline in annual purchasing power: -$6,293.74

Source: California Housing Partnership Corporation analysis of 2000-2014 Census and American Community Survey data. Median renter income and rent from 2001-2004 and 2015-2016 are estimated trends. Median rent and median renter income are inflation adjusted to 2014 dollars.
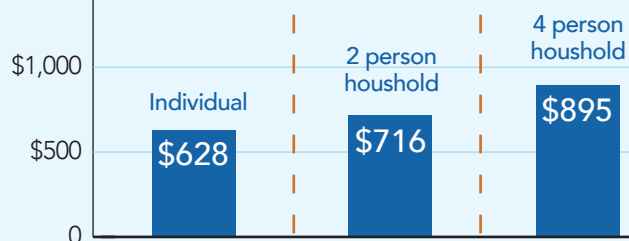
In 2017, annual income for an extremely low-income household earning 30 percent of the Area Median Income (AMI) in Santa Clara County was:[ix]

Annual Income for Extremely Low Income Renters

$25,100 Individual

$28,650 2 person houshold

$35,800 4 person houshold

Housing costs in Santa Clara County, however, far exceed what would be affordable for extremely low-income households:

An affordable unit for an extremely low-income renter – in which the household pays no more than 30 percent of their income for housing costs – in Santa Clara County would be:

Affordable Rent for Extremely Low Income Renters
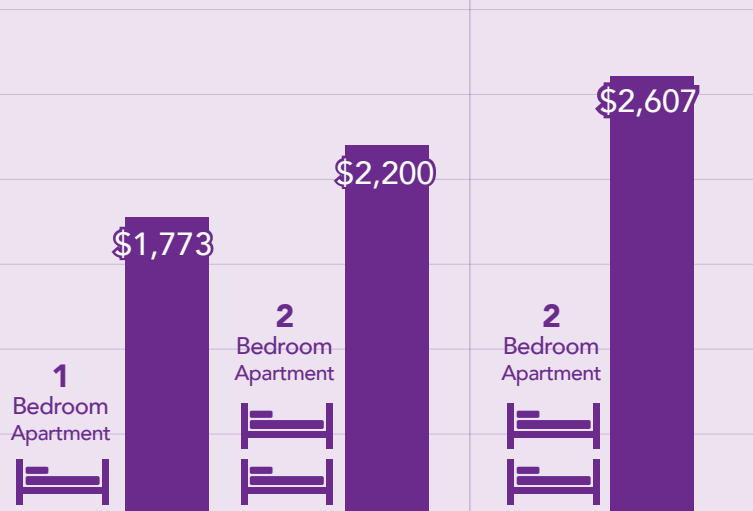
2017 Fair Market Rent[x]

Avgerage monthly rent[xi] in San José in 2017

Individual $628

2 person houshold $716

4 person houshold $895

1 Bedroom Apartment $1,773

2 Bedroom Apartment $2,200

2 Bedroom Apartment $2,607

Not All Housing is Created Equal

Addressing the affordable housing crisis for the county's most vulnerable residents is no small task. In Santa Clara County, the need for more affordable housing is extremely pressing for all but the highest-income households, and demand for housing for extremely low-income renters is most acute. These households face additional challenges to housing stability, as a larger proportion of their income often goes to rent, and there is a disproportionate lack of affordable housing options at their income level.

This deficiency is nothing new, however. In 2005, a San Jose State University study found that unmet need for affordable housing development for extremely low-income renters far surpassed that of households with higher incomes. The report predicted that an additional local investment of $3.8 billion would be required to create housing for just the county's extremely low-income households from 2005 to 2024.[xii]

Housing Need and Funding 2005-2024

	ELI (0-30% AMI)	VLI (31-50% AMI)	LI (51-80% AMI)	MOD (81-120% AMI)	Total
Gross/Total Need	42,483	12,978	13,260	22,187	**90,908**
Planned Production	8,119	10,148	16,237	19,089	**50,616**
Unmet Need	34,364	2,830	-	3,098	**40,292**
Funding Gap*	**$3,780,040,000**	**$198,100,000**	**$0**	**$154,900,000**	**$4,133,040,000**

*The funding gap is the additional local subsidy required over the next 20 years to develop a sufficient number of affordable units to meet the unmet need.

Source: *Housing Silicon Valley: A 20 Year Plan to End the Affordable Housing Crisis* (February 2007), SJSU prepared for Local Initiatives Support Corporation

Despite this urgent need, investment in and development of affordable housing for these most economically vulnerable households has not kept pace with the current or projected future need, even while development of housing for higher income households has exceeded demand. Through the state-mandated Regional Housing Need Allocation (RHNA) process, each region projects the total number of housing units necessary to meet the needs of people of all income levels in each county and city. Progress toward these targets is tracked annually based on permits issued.

Zero cities in Santa Clara County met their RHNA target for Very Low Income housing and the county as a whole produced just 27% of the goal. In contrast, ten cities exceeded their target for housing for households earning above moderate incomes, and the county as a whole met 139 percent of the goal.
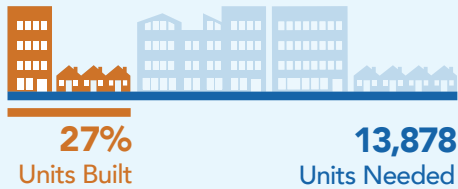
The trend of overproducing housing for higher-income households, while neglecting development for moderate-, low- and very low-income households, has continued under the county's new RHNA projections released for 2015-2023.[xiii]

[xii] Bay Area Local Initiatives Support Corporation and San Jose State University Institute for Metropolitan Studies, "Housing Silicon Valley: A 20 Year Plan to End the Affordable Housing Crisis." February 2007. Available at:
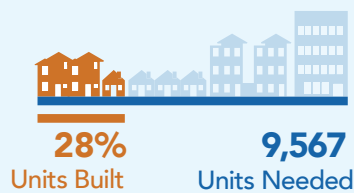http://scholarworks.sjsu.edu/cgi/viewcontent.cgi?article=1016&context=urban_plan_pub

[xiii] Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2015-2023 Regional Housing Need Allocation (RHNA)." April 2017. Available at: https://abag.ca.gov/planning/housingneeds/pdfs/2015-2023%20_RHNAProgressReport.pdf. See Appendix D for additional data.

2007-2014 Regional Housing Need Allocation (RHNA) Progress [xiv]

Very Low-income Household Units

27%
Units Built

13,878
Units Needed

Low-income Household Units

28%
Units Built

9,567
Units Needed

Moderate-income Household Units

22%
Units Built

11,007
Units Needed

Above Moderate-income Household Units

25,886
Aproximate Units Needed

139%
Units Built
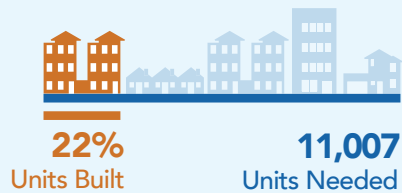
[xiv] Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2007-2014 Regional Housing Need Allocation (RHNA)." Sept. 2015. Available at: https://abag.ca.gov/files/RHNAProgress2007_2014_082815.pdf. RHNA does not track need and development of housing specifically for extremely low-income households, instead combining this population with very low-income households with incomes up to 50 percent of AMI. Development of housing affordable for these households likely lags even further. See Appendix D for additional data.

2015-2023 Regional Housing Need Allocation (RHNA) Progress as of 2015 [xv]

Very Low-income Household Units

3%
in Progress

16,158
Units Needed

Low-income Household Units

6%
in Progress

9,542
Units Needed

Moderate-income Household Units

1%
in Progress

10,636
Units Needed

Above Moderate-income Household Units

37%
in Progress

22,500
Units Needed

[xv] Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2015-2023 Regional Housing Need Allocation (RHNA)." April 2017. Available at: https://abag.ca.gov/planning/housingneeds/pdfs/2015-2023%20_RHNAProgressReport.pdf. See Appendix D for additional data.

Building Supportive – and Affordable – Housing in Santa Clara County

Currently, the county's supportive housing system relies heavily on the private market for available housing units, while the system provides rental subsidies to tenants to maintain affordability. This is not enough. An effective and sustainable supportive housing system requires many more units than are available in the private market, necessitating development of significant additional housing, and the cooperation of local, state, and federal partners.

To achieve this goal, the County of Santa Clara, city governments, and residents must make a deliberate shift in affordable housing policy, creating a movement to fund and develop the thousands of units and hundreds of development projects necessary to meet the needs of county residents of all income levels. In 2016, voters took a first and ambitious step toward this goal by passing bond Measure A, investing $950 million in affordable housing development over the next 10 years. Most of the funding will go toward the County of Santa Clara's key priorities of building housing for extremely low-income households, including permanent housing for people experiencing homelessness.

While the 2016 Measure A Affordable Housing Bond (Housing Bond) will fund development of many new homes, the bond funds alone are not enough to fill the gap left by the dramatic decrease in state affordable housing funding since FY 2008-2009.[xvi] Moreover, while more housing is being built, the system must also meet the basic needs of the county's homeless population, which is overwhelmingly unsheltered. Temporary housing interventions, including emergency shelters and transi-

tional housing, that seek to move people experiencing homelessness quickly into permanent housing, are a critical component of the supportive housing system. Meeting the current demand for temporary shelter and housing requires increased capacity and resources as well.

Along with its many partners in the public, private, and philanthropic sectors, the County of Santa Clara seeks to continue the momentum from the Housing Bond by further investing in housing that will support the county's most vulnerable residents achieve safe, affordable, and stable housing. Each step in the process relies on the collaboration of these stakeholders. Cities must first approve, and local communities must embrace and accept, new developments and the residents they will serve. Developers must engage the community in the development process, and service providers must work to support tenants to become an integrated part of the community.

This report seeks to highlight the many efforts the County and its partners are undertaking to support the county's most vulnerable residents and achieve the most impact with available resources. Poverty, income inequality, and affordable housing are among the biggest challenges facing residents of Santa Clara County and no single entity has the resources or authority to address these problems alone. As the many innovative and effective initiatives described in this report illustrate, community-wide solutions to ending homelessness require the cooperation and collaboration of a range of stakeholders, including cities, state and county agencies, and nonprofit partners.

[xvi] California Housing Partnership, "Confronting California's Rent and Poverty Crisis: A Call for State Reinvestment in Affordable Homes." April 2016. Available at:
https://1p08d91kd0c03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2016/04/State-Housing-Need-2016.pdf

A Movement to End Homelessness

The County of Santa Clara and its city, nonprofit, philanthropic, and other community partners share a vision for Santa Clara County in which homelessness is rare, brief, and non-recurring for all residents. This collective mission to prevent and end homelessness drives innovation and investment across public and private sectors, and is outlined in detail in the Community Plan to End Homelessness in Santa Clara County.

The Community Plan to End Homelessness in Santa Clara County

In 2014, the County of Santa Clara Office of Supportive Housing and Destination: Home, a public-private partnership dedicated to collective impact strategies to end homelessness, convened a series of community summits to develop a coordinated strategy to address homelessness across the county. Representatives of local cities, nonprofit advocacy groups, service providers, philanthropic organizations, elected officials, universities, and people with lived experience of homelessness participated in the planning process. The resulting Community Plan to End Homelessness has been formally endorsed by Santa Clara County's Board of Supervisors, Santa Clara County Housing Authority, Santa Clara Valley Water District, the majority of the county's 15 cities, and other stakeholder organizations.

The plan provides a roadmap for the community's work to end homelessness from 2015 to 2020, establishing goals and strategies within a three-part framework:

1 Disrupt Systems

The Community Plan calls for disruptive strategies and innovative programs that transform the systems related to housing homeless people.

- Deepen partnerships between local governments, nonprofit service providers, and the business sector to improve coordination
- Use data to implement outcomes-based decisions about the most effective programs and structures to meet community needs
- Coordinate housing and services through the Coordinated Assessment System to connect each individual with the right housing solution
- Ensure that all individuals have a plan for housing upon exit from criminal justice or medical institutions and are not discharged into homelessness

Above photo: A PATH outreach worker engaging with a community member experiencing homelessness. Photo by Jeff Bomberger

2 Build the Solution

To end homelessness, it is essential to secure the full amount of funding needed to provide affordable housing and services to those who are homeless and those at risk of homelessness.

The Community Plan sets a goal of 6,000 new affordable housing opportunities dedicated to people experiencing homelessness, including new physical homes and apartments and new rental subsidies. Tenants in each of these new housing opportunities will have access to case management, health care, employment programs, and other services to ensure they are able to remain housed.

3 Serve the Person

The Community Plan recognizes the need for client-centered strategies that target resources to each specific individual or household based on their unique and different needs. Goals under this section focus on increasing the system's capacity to serve the needs of veterans, children and youth, families, people with disabilities who have experienced long-term homelessness, and other specific subpopulations.

Since implementation of the Community Plan began in 2015, the supportive housing system has helped 5,154 people return to safe and permanent housing.

Total Permanently Housed — TOTAL 5,154

Year	People Permanently Housed
2015	1,212
2016	1,883
2017	2,059

The programs and initiatives described in this report represent significant progress toward Community Plan goals. The community's stock of affordable housing dedicated to people exiting homelessness has increased by over half (see **Closing the Housing Gap** on page 22 for more information about progress toward 6,000 new housing opportunities). Innovative partnerships with the community's healthcare, criminal justice, child welfare, and education systems are in place to disrupt cycles of homelessness for the county's most vulnerable residents (see **Supportive Housing Innovations** on page 29 for more information about cross-system partnerships). As it grows to meet the community's need, the supportive housing system will continue to focus on systemwide coordination and improved crisis response for all families experiencing homelessness (see **Crisis Response System** on page 47 for more information about system coordination and shelter programs).

SUPPORTIVE HOUSING SYSTEM MAP

Homelessness Prevention

- Helps individuals and families who are about to lose their housing to remain housed where they are or move to new permanent housing
- Acts as an access point to the Coordinated Assessment System

SEE PAGE 48

Outreach

- Engages with people experiencing homelessness on the street, in parks and other public spaces, and in vehicles
- Acts as an access point for the Coordinated Assessment System and for emergency shelter
- Locates people in the Coordinated Assessment System who have been referred to a housing program

SEE PAGE 49

Coordinated Assessment System

- Acts as a front door to the community's housing resources
- Matches people experiencing homelessness to the community's transitional housing, rapid rehousing, and permanent supportive housing programs

SEE PAGE 49

Emergency Shelter

- Provides a safe place to sleep for people experiencing homelessness
- Provides meals, showers, other basic needs, and connections to other community resources
- Acts as an access point to the Coordinated Assessment System

SEE PAGE 52

Permanent Supportive Housing

- Helps individuals and families with disabilities maintain permanent housing through long-term rental subsidies, connections to medical and behavioral health care, and other services.

SEE PAGE 30

Transitional Housing

Provides temporary housing and site-based services for people experiencing homelessness, a program model most effective for specific subpopulations, such as:
- Youth, especially Parenting Youth
- Veterans
- Homeless individuals and families enrolled in a permanent housing program and searching for apartments

SEE PAGE 54

Rapid Rehousing

- Provides supportive services and financial assistance to people experiencing homelessness
- Helps individuals and families obtain permanent housing and increase income so that they can remain housed independently.

SEE PAGE 38

A map of developments that include supportive housing is available at: www.supportivehousingscc.org/map

257

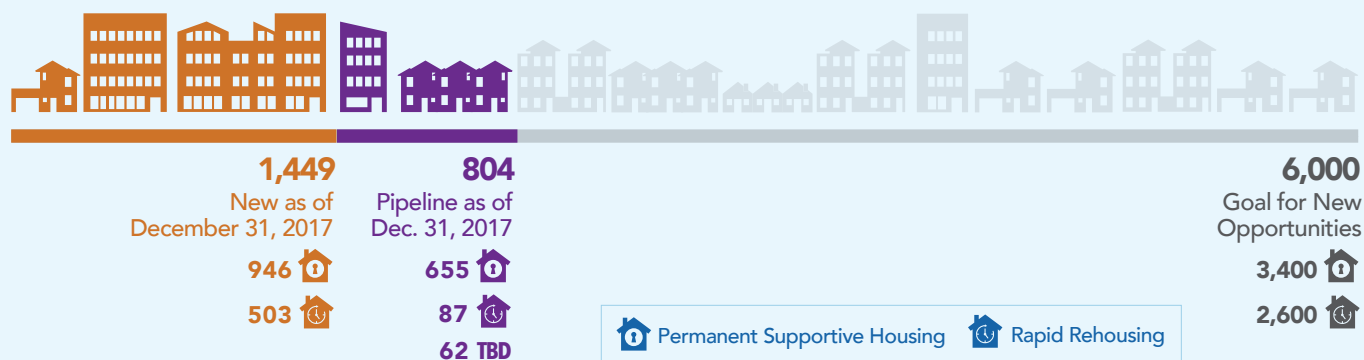Parkside Studios. Photo by Jeffrey Peters.

Closing the Housing Gap

For most individuals and families experiencing home-lessness, affordable housing is fundamental to achieving long-term housing stability. Since implementation of the Community Plan to End Homelessness began in 2015, Santa Clara County has made significant progress toward the central goal of 6,000 new affordable housing opportunities for individuals and families experiencing homelessness.

Under the Community Plan, new housing opportunities include both new housing stock and rental subsidies to assist households in exiting homelessness. This can take the form of new affordable housing development, commitments by property owners of existing housing for use by households exiting homelessness, and new funding streams to increase the community's capacity to subsidize rent payments for extremely low-income individuals and families.

Progress toward this goal is made possible by ongoing coordination of resources, expertise, and political will by city governments, County agencies, the Santa Clara County Housing Authority, community-based organizations, affordable housing developers, private funders, and other partners. Leaders have stepped up across the community with a shared commitment to building strong relationships, actively seeking out opportunities to work together toward common goals and generating a culture of collaboration that defines a growing movement to end homelessness in Santa Clara County.

Progress Toward Goal of 6,000 New Housing Opportunities

1,449
New as of December 31, 2017
946 🏠
503 🏠

804
Pipeline as of Dec. 31, 2017
655 🏠
87 🏠
62 TBD

🏠 Permanent Supportive Housing   🏠 Rapid Rehousing

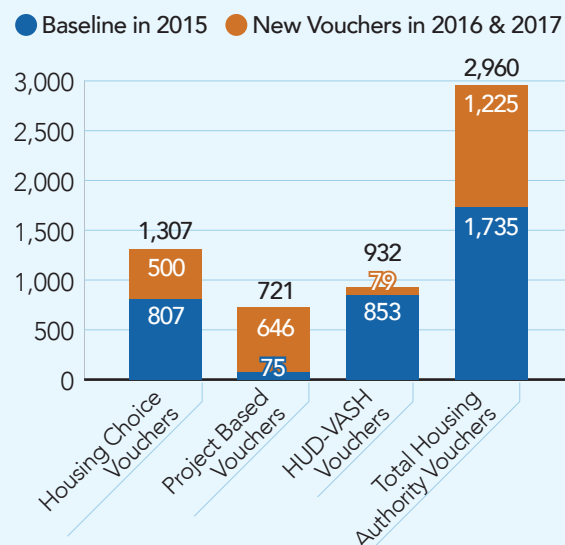**6,000**
Goal for New Opportunities
3,400 🏠
2,600 🏠

Santa Clara County Housing Authority Referral Programs

The Santa Clara County Housing Authority is a key partner in achieving the community's goal. Since 2015, the Housing Authority has dedicated 1,225 additional rental subsidies for households exiting homelessness through its Chronically Homeless Direct Referral Program, which serves individuals and families who have been homeless for a year or more and have a disabling condition (see Appendix A: Defining Homelessness for more information about chronic homelessness).[xvii]

In 2018, the Housing Authority and the County will launch the Special Needs Direct Referral program to serve individuals and families with medical or behavioral health needs, who may not meet the federal definition of "chronically homeless." Permanent supportive housing programs use Housing Choice vouchers to subsidize client rent, in combination with case management and supportive services funded through other sources. The Chronically Homeless and Special Needs Direct Referral Programs will provide increased supportive housing opportunities for the county's most vulnerable individuals and families experiencing homelessness.

Housing Choice Vouchers Committed to Homeless & Chronically Homeless Populations

● Baseline in 2015   ● New Vouchers in 2016 & 2017

Category	Baseline in 2015	New Vouchers in 2016 & 2017	Total
Housing Choice Vouchers	807	500	1,307
Project Based Vouchers	75	646	721
HUD-VASH Vouchers	853	79	932
Total Housing Authority Vouchers	1,735	1,225	2,960

[xvii] The Housing Choice Voucher Program (formerly known as Section 8) provides rental subsidies funded through the U.S. Department of Housing and Urban Development and administered by local housing authorities. Project-based vouchers subsidize rent in specific housing units, while Housing Choice vouchers are allocated to eligible households and can be used in any unit in the community. HUD-VASH vouchers combine HUD rental assistance with case management and medical services provided by the Department of Veterans Affairs.

The Veranda development's groundbreaking ceremony in Cupertino on April 19, 2018, Photo courtesy of Charities Housing

Rendering of Second Street Studios

Second Street Studios: A First-Rate Collaboration in Building Supportive Housing

"The design is very conducive to meeting people," said Michael Santero, Director of Asset Management at First Community Housing. "We want the space to be an asset to the client. We're doing everything we can to keep them housed and engaged in services."

Drive up South First Street towards downtown San José, and you might mistake the construction for one of many condo complexes springing up across Santa Clara County. In fact, one of the region's most innovative affordable housing developments is currently underway. Set to be completed in September 2018, Second Street Studios will provide 134 units of permanent supportive housing for some of Santa Clara County's most vulnerable residents.

Beginning in 2016, the County of Santa Clara Office of Supportive Housing enlisted several key partners, including the City of San José, the Santa Clara County Housing Authority, housing developer First Community Housing, property manager John Stewart Company, and supportive service provider Abode Services, with the goal of pioneering a new model for building permanent supportive housing. Although the partners were not unfamiliar to each other, in past collaborations there had been an uneasy tension between local governments working to create more affordable housing, developers seeking feasible projects, and service providers who serve a high-needs population. The Second Street Studios project challenged these partners to engage and collaborate in new ways.

Strong Commitment Builds Strong Communities

Like any successful partnership, the Second Street Studios project has required significant commitment and buy-in from all involved: the City of San José committed over $14 million in funding for the project; First Community Housing joined the partnership because it is committed to building high quality housing that meets the needs of the local community; the Santa Clara County Housing Authority will provide rental subsidies for all 134 units, allowing residents to stay as long as they have need; the County Office of Supportive Housing will provide ongoing funding for supportive services for clients; and, finally, Abode Services and the John Stewart Company have committed to locate staff on-site to provide wrap around support to ensure that residents are able to maintain their housing.

Housing First, a Client-Centered Model that Works

At the center of Second Street Studios will be its future tenants — 134 chronically homeless individuals, a vulnerable subset of the homeless population who have a disability and have been living on the streets for a year or more. (See Appendix A for more information about chronic homelessness.) Studies show that stable housing is critical to successful outcomes for chronically homeless individuals, and the Office of Supportive Housing and its Second Street Studios partners have seen first-hand how supportive housing can positively impact clients.

Embracing a Housing First philosophy, which quickly places people in housing and then provides supportive services, Second Street Studios' partners and services are focused on the stability and well-being of each client. From inception, Second Street Studios was envisioned as a safe, nurturing space for residents. The building was designed to minimize isolation while increasing opportunities for positive social interactions. There are shared community spaces, a green terrace for gardening, and a computer lab with free wireless internet. To foster a sense of community, Abode Services, with funding from the County, will offer client-centered programming and services focused on social interactions and celebrating successes. While moving in to permanent housing may be a transition for the new residents, many of whom have lived on the streets for years, the project has been a transformational process for the community and the many partners involved.

"We look at this as a team, and we're committed to providing an environment that ensures residents are receiving key supportive services," said Kathleen Kiyabu, Director at John Stewart Companies. "This is hard work, probably the hardest job I've ever done. It's a job that needs to be done, and it's the right thing to do."

2016 Measure A Affordable Housing Bond

In November of 2016, Santa Clara County voters approved a $950 million Affordable Housing Bond. The County of Santa Clara and its partners have moved quickly to utilize the bond funds, which are projected to fund 120 new affordable housing developments over ten years, including 4,800 new units dedicated to extremely low-income households and individuals, families exiting homelessness, and other underserved populations. A first round of funding has been approved for six developments, each of which includes supportive housing units dedicated to households exiting homelessness.

Villas on the Park

Location:
San José

Construction Completion Target:
December 1, 2019

Total Units:
84

PSH Units:
83

Housing Bond Funding:
$7.2 million

Villas on the Park is a 100 percent permanent supportive housing development consisting of 84 apartments on a 0.355-acre site in downtown San José, under development by Affirmed Housing Group Inc. and People Assisting the Homeless (PATH). PATH will provide on-site supportive services such as outreach and engagement, needs assessment, case management, mental health care, substance abuse treatment, life skills education, community building, eviction prevention, green education, and transportation planning.

The Veranda

Location:
Cupertino

Construction Completion Target:
May 1, 2019

Total Units:
19

PSH Units:
6

Housing Bond Funding:
$1 million

The Veranda is a 19-unit affordable senior housing development on a vacant 0.57-acre site, located in Cupertino and developed by Charities Housing Development Corporation of Santa Clara County. Six apartments will be reserved as permanent supportive housing units for formerly homeless or special-needs seniors. Catholic Charities will provide a service coordinator for all residents on site, offering a range of supports including referrals and assistance to access community-based services, financial literacy workshops, and organized social activities.

Gateway Senior Apartments

Location:
Gilroy

Construction Completion Target:
November 23, 2019

Total Units:
75

PSH Units:
37

Housing Bond Funding:
$7.5 million

Gateway Senior Apartments is a 75-unit affordable senior housing complex on a 1.86-acre site, developed by Danco Communities. Half of the apartments will be reserved for special needs seniors and the remaining apartments for income-qualifying seniors. LifeSTEPS will provide a service coordinator, who will offer residents referrals and assistance to access community-based services, financial literacy workshops, and organized social activities.

Leigh Avenue Senior Apartments

Location:
San José

Construction Completion Target:
March 1, 2020

Total Units:
64

PSH Units:
63

Housing Bond Funding:
$13.5 million

Leigh Avenue Senior Apartments is a 64-unit affordable senior housing complex, developed by First Community Housing. The development is 100 percent supportive housing, with all apartments set aside to serve homeless and special-needs seniors. Christian Church Homes Senior Housing, an organization with over 50 years of experience managing service enriched affordable senior communities, will serve as the resident services provider.

Quetzal Gardens

Location:
San José

Construction Completion Target:
February 1, 2021

Total Units:
71

PSH Units:
24

Housing Bond Funding:
$9.83 million

Quetzal Gardens is a 71-unit affordable housing development, developed by Resources for Community Development (RCD). Twenty-four of the apartments will be set aside for chronically homeless individuals or families, and the remaining units will be allocated to residents who are considered extremely low income and low income. RCD will take the lead in providing services for the family apartments. The building's service coordinator will offer individualized services to all residents and referrals to local community services.

Crossings on Monterey

Location:
Morgan Hill

Construction Completion Target:
October 31, 2019

Total Units:
39

PSH Units:
20

Housing Bond Funding:
$5.8 million

The Crossings on Monterey is a three-story affordable housing development consisting of 39 affordable housing units in Morgan Hill being developed by Urban Housing Communities. Approximately 20 apartments will be reserved for chronically homeless and homeless individuals and families. Resident services will be provided by Central Valley Coalition for Affordable Housing, including referrals and assistance to access community-based services.

A case manager from HomeFirst working with a client who has been housed in their program. Photo by Meadow Robinson.

Supportive Housing Innovations

The wide range of permanent housing programs that comprise Santa Clara County's supportive housing system form the core of the community's strategy to make homelessness rare, brief, and non-recurring. Embracing a Housing First philosophy, the supportive housing system considers every household ready for and deserving of safe and stable housing and is committed to providing the appropriate level of support for each client to achieve that goal.

This section describes some of the community's most innovative supportive housing initiatives, each of which pushes the boundaries of cross-system collaboration and reimagines the ways local government, nonprofit, and business partners work together to serve the county's most vulnerable residents.

TOOLS OF THE SUPPORTIVE HOUSING SYSTEM

The supportive housing system relies on three key elements to support participants as they obtain and retain stable housing: affordable housing, case management, and supportive services. Performance measurement is used to evaluate and improve the effectiveness of these tools.

Affordable Housing can take the form of rental subsidies, which cover part or all of a client's housing costs and may be short-term (1-3 months), medium-term (3-24 months), or long-term (over 2 years) used in physical housing units owned or leased by a housing program, in units that are part of the market-rate housing stock, or in affordable apartments developed and set aside for households exiting homelessness.

Case management involves one or more trained staff members working closely with a client to establish client-driven goals to attain and retain stable housing, including connecting the client to the best resources to help reach those goals.

Supportive services are a diverse array of resources that help clients obtain or maintain permanent housing, including assistance with public benefits applications, medical and behavioral health care, legal services, credit repair, childcare, job training and employment programs, assistance with housing location or rental applications, and help building relationships with landlords.

Performance measurement uses data collected by housing and service providers to evaluate the success of the supportive housing system and to improve outcomes for clients. See Appendix C: Measuring Success for more information about the performance metrics used.

Permanent Supportive Housing

Permanent supportive housing—which provides rental subsidies, medical and behavioral health, and other supportive services—is the most effective strategy for ending homelessness for long-term homeless and disabled individuals and their families. These programs target families and individuals with the highest barriers to finding or retaining housing and the longest time spent homeless. Often these clients are frequent users of County emergency medical, behavioral health services, and justice system services and most will need long-term or permanent support in order to remain stably housed. The County of Santa Clara Office of Supportive Housing partners with the Department of Behavioral Health to ensure that clients in permanent supportive housing have access to essential behavioral health services. The community's Housing First philosophy prioritizes swift permanent housing placements for these most vulnerable households as a necessary first step to stability.

At the core of Santa Clara County's permanent supportive housing system is the Care Coordination Project (CCP), a partnership of six permanent supportive housing providers, the County's Behavioral Health Services Department, and the County's Office of Supportive Housing. First implemented in 2011, this initiative brought the majority of the community's permanent supportive housing programs into a collaborative partnership, which agreed to standard data collection, shared performance measures, and a centralized client referral process. As of the end of 2017, Care Coordination Project partners have begun utilizing Continuum, a custom-designed data sharing system that integrates client records from the County's HealthLink medical services database and the Homeless Management Information System, allowing case managers to better coordinate wraparound services for each client.

With capacity to serve 1,322 households at a given time, representing 46 percent of the community's permanent supportive housing inventory, the Care Coordination Project continues to operate as a highly coordinated core of the supportive housing system and a model for systemwide performance measurement.

Total Unit Inventory (point-in-time capacity):

2,846 households

Measuring Success[xviii]

Permanent Housing Retention

90% remained stably housed for at least 12 months

(1,205 of 1,343) of clients housed in PSH between July 2011 and the end of 2016[xix]

Returned to Homelessness Within Two Years

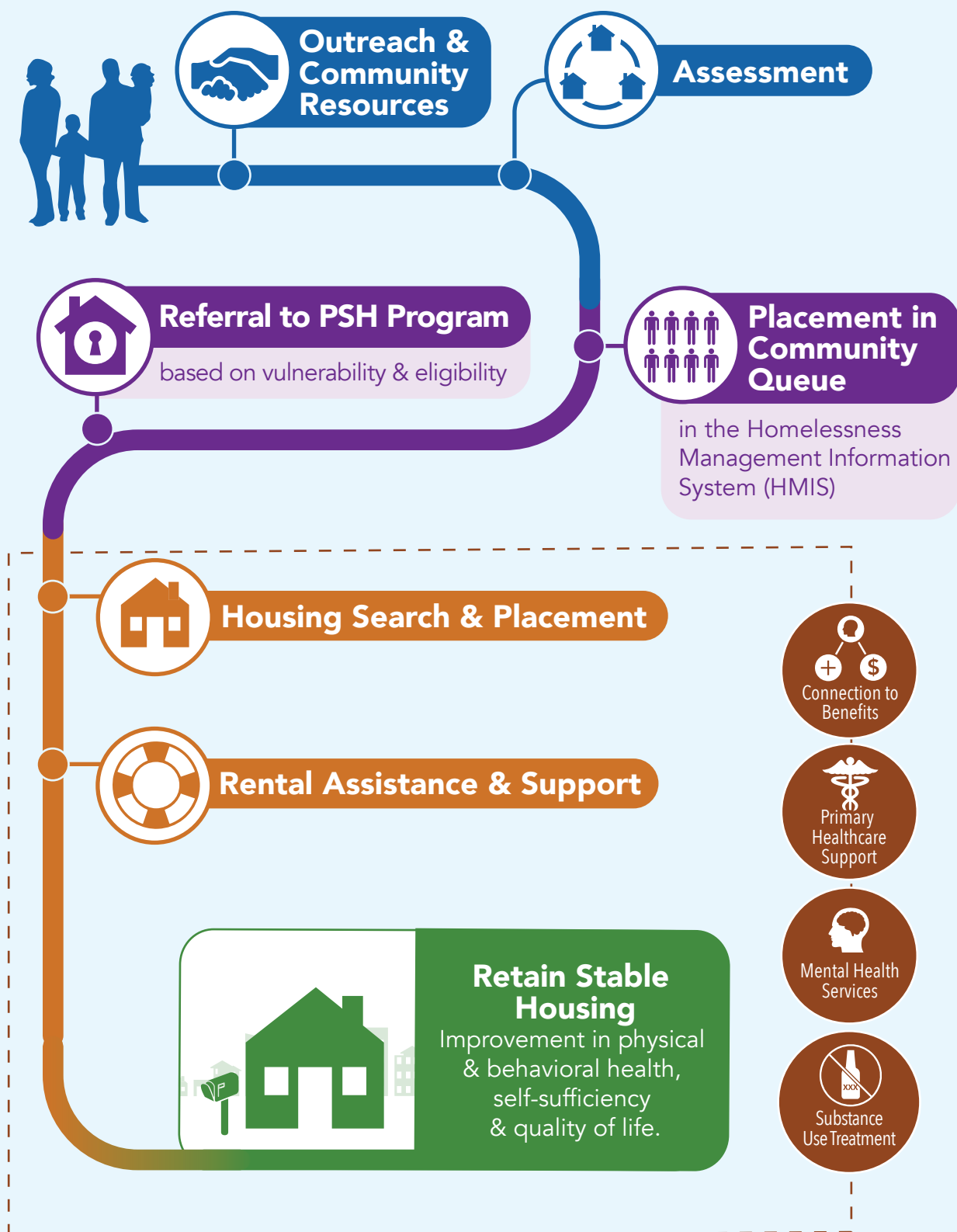**6%** returned to homelessness within 2 years

(4 of 65) of clients who exited permanent supportive housing for other permanent housing in 2015

[xviii] The Santa Clara County supportive housing system evaluates the overall success and impact of the system using data entered by supportive housing and shelter providers into the Homeless Management Information System. These performance measures are based on the national standards for performance measurement developed by the U.S. Department of Housing and Urban Development. For more information about the performance measures in this report, see Appendix C: Measuring Success.

[xix] The universe for this measure (1,681 clients) includes all clients served in a permanent supportive housing program who were housed at least 12 months prior to the end of 2017. The universe is significantly lower than the total system capacity (2,846 households) because it does not include all clients served.

Permanent Supportive Housing (PSH) System Map

Outreach & Community Resources

Assessment

Referral to PSH Program

based on vulnerability & eligibility

Placement in Community Queue

in the Homelessness Management Information System (HMIS)

Housing Search & Placement

Rental Assistance & Support

Retain Stable Housing
Improvement in physical & behavioral health, self-sufficiency & quality of life.

Connection to Benefits

Primary Healthcare Support

Mental Health Services

Substance Use Treatment

Staff from HomeFirst meeting with a client in their housing program. Photo by Meadow Robinson

The High Cost of Homelessness

The County of Santa Clara Office of Supportive Housing and its many partners have been working diligently to fund and develop permanent supportive housing for the many long-term homeless and disabled residents who need it. However, with limited capacity, these intensive programs must be prioritized for those most vulnerable and with the most severe barriers to housing. This approach also helps to maximize the reach of the County's many other resources often utilized by long-term homeless and disabled individuals, including costly justice system, emergency psychiatric, and medical services.

Home Not Found, a 2015 study on the public cost of homelessness in Santa Clara County, found significant overlap between individuals who have been homeless for a year or more and those who incurred the highest public costs. In particular, public costs related to homelessness are heavily skewed toward a relatively small number of frequent users of justice system, emergency psychiatric, and medical services. While the average annual cost per person experiencing homelessness in 2012 was $5,148, individuals with costs in the top 5 percent had average costs of over $100,000 and accounted for 47 percent of all costs.[xx]

To address these cost disparities and ensure available resources and services are utilized most efficiently, the County has developed several programs, described in the following pages, that strategically target key populations that, when unhoused, use a disproportionate amount of county services. These programs recognize that stable housing is a vital component of the continuum of care for individuals with complex medical and behavioral health needs and those with significant justice system involvement. In addition, with an approximate cost of $30,000-35,000 per individual annually, permanent supportive housing for individuals with complex needs results a in significant reduction in the cost of services provided.

[xx] Economic Roundtable, *Home Not Found: The Cost of Homelessness In Silicon Valley*. 2015. Available at: https://destinationhomesv.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf

Valley Medical Center Permanent Supportive Housing - Whole Person Care

The Santa Clara Valley Medical Center (VMC) Supportive Housing Program, is an innovative cross-system collaboration that provides housing, case management, and high-quality health services to medically fragile individuals identified as high utilizers of County emergency health services. The program leverages California's Whole Person Care Program funding for medical care coordination and intensive case management provided by the County of Santa Clara Office of Supportive Housing and nonprofit partner Peninsula Healthcare Connections, as well as County funding to provide rental subsidies through Abode Services.[xxi] Enrollment began in November of 2017, and will serve 70 clients at full capacity. Seeking to serve the highest utilizers of emergency medical and mental health services, clients must be homeless or at risk of homelessness, disabled, between ages 18 and 65, and eligible for Medi-Cal.

Targeting the highest utilizers with the most acute needs

Potential clients are identified by VMC, which determines the highest utilizers of County emergency medical and psychiatric services, and by the Office of Supportive Housing, who confirms that potential clients are homeless or at risk of homelessness. To locate these individuals, the County has developed a highly-specialized multidisciplinary team including a public health nurse and a doctor to conduct targeted outreach for the program.

Bringing collaborative, nontraditional services to the highest utilizers

Combining intensive case management with data sharing between partners allows the program to fill in any gaps between service providers, with the goal of improving health outcomes for clients. Currently, VMC has access to the County's Homeless Management Information System (HMIS) to help caseworkers coordinate services. Soon this data sharing capacity will be improved by connecting multiple other County departments' data systems, including Mental Health and Custody Health, which provides mental health and medical services for incarcerated people.

[xxi] In 2016, the California Department of Health Care Services awarded funding to 18 communities to implement Whole Person Care Pilots, which provide coordinated medical, behavioral health, and other social services to individuals in the Medi-Cal program who are high utilizers of local medical services. Whole Person Care Pilots require collaboration between local government, medical care providers, housing providers, and other stakeholders to coordinate services and offer integrated care.

Permanent Supportive Housing for Public Safety and Justice

Through programming coordinated by the County of Santa Clara Behavioral Health Services Department, the County seeks to interrupt the complex feedback loop between homelessness and incarceration by connecting high-needs incarcerated individuals who would otherwise exit to homelessness with permanent supportive housing. The program employs a range of medical, behavioral health, and housing-related supports to reduce the rate of incarceration of individuals with serious mental illness and to address the social and health factors that can lead to further involvement with the justice system.

Commencing in April 2017, the County of Santa Clara Office of Supportive Housing and Behavioral Health Services Department fund and coordinate the program, which serves 90 individuals with serious mental illness and a history of chronic homelessness who would otherwise exit jail to the streets or emergency shelters. To identify participants, clinicians and staff from several county departments work closely with the local courts to ascertain which individuals may be most in need of mental health and housing services. Community Solutions, a nonprofit housing and service provider, supplies case management services, working with each individual prior to release to develop a plan for connecting to medical, behavioral health, and other services in the community and to secure housing after release. By connecting seriously mentally ill individuals to permanent supportive housing prior to discharge, the program prevents homelessness for individuals with complex health needs. As of December 2017, the program had already enrolled 35 participants, and placed four in stable housing. Additional components of this innovative approach include the following:

Anticipating Risk Factors to End Cycles of Incarceration and Homelessness

By ensuring that multi-disciplinary clinicians have access to and a consistent presence within the local courts, staff are able to observe and identify risk factors that lead individuals to repeat cycles of incarceration and homelessness to better anticipate how and when to intervene.

Coordinating and Prioritizing Interventions for the Most Vulnerable

The program uses evidence-based approaches to coordinate and prioritize participants for permanent supportive housing, by gathering information on individual service utilization and length of time homeless. This ensures that housing and services are connected to individuals most at risk of exiting to homelessness and eventual return to incarceration.

Streamlining Communication to Minimize Gaps in Housing

Through enhanced communication with local courts, case managers are aware of important dates for participants, and are able to arrange a "warm hand-off" where case managers provide transportation to interim housing for newly released participants.

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Kenya Rawls and Jorge Garcia Photo By Marianna Moles

CLIENT STORY
After Four Years on the Streets, Permanent Supportive Housing Provides Jorge a Home

Whomever visits Jorge at his studio apartment will most likely be introduced to his new friend, a kitten named Buddy, and hear about how much he loves his bathtub. It's no wonder, since for nearly four years Jorge was homeless and alone, working three jobs, without any way to regularly clean up while living in a tent in downtown Palo Alto.

Jorge was homeless until his case manager at Abode Services let him know he would be getting a studio apartment. "I like this place. I wasn't expecting this nice place. I really like the tub," said Jorge, sitting in a rolling office chair in his apartment. He leans back and mentions the medication he's taking, suggesting that he has struggled with severe depression. Without a pause, he goes on to talk about the interview he has on Friday with a restaurant in Willow Glen. He has always made a point to stay employed, working multiple jobs in downtown Palo Alto while he was homeless.

Jorge explains the importance of remaining employed, sharing that it allowed him to save money while homeless, so he could buy a tent. Unfortunately, it was one of eight tents he obtained that year because they kept getting stolen. Going to and from work, he would sneak around so he wouldn't be spotted by anyone, often waiting hours before returning to his tent hidden among the bushes. Sometimes when he got back, he'd find everything was gone.

He is no stranger to having his belongings disappear. In fact, the first time it happened was five years ago, when he became homeless at 26 years old. He returned home to the room he was renting for $800 a month, and he couldn't unlock the door. His landlord had changed the locks and everything he owned was inside. He says that a few days prior the landlord mentioned she was raising the rent $200 a month, and Jorge told her he couldn't afford the rent increase. After that, Jorge struggled to find a place he could afford, and when he could no longer

stay in the basement of the hookah lounge where he was working, he found himself with nowhere to go but the streets.

Jorge is one of thousands of people who have entered the Coordinated Assessment System, taking a brief survey to assess their immediate needs and prioritize them on a list for housing referrals. Jorge received a referral to a permanent supportive housing program funded by the County and operated by Abode Services.

Now that he is settled in his new home, he recalls the only thing he wanted to do when he moved into his apartment was sleep. "I hear that from a lot of people," said Kenya Rawls, Housing Services Coordinator with Abode Services. She's working with Jorge now that he's housed. She looks at him and says, "You've come so far. I am so proud of you." Jorge smiles and scratches Buddy behind the ears.

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Project Welcome Home

Project Welcome Home is a permanent supportive housing program designed to serve individuals with experience of long-term homelessness who are also among the highest utilizers of emergency medical and psychiatric services in the county. The County of Santa Clara Office of Supportive Housing refers clients to the program by using linked medical and homeless services data to identify clients with long-term homelessness and high rates of hospitalization, emergency department visits, or use of emergency psychiatric services. Clients that are able to remain stably housed through Project Welcome Home's intensive supportive services show dramatically reduced utilization of the County's safety-net services.

Project Welcome Home is the first permanent supportive housing program in California to operate under a Pay For Success model. It received $6.9 million in up-front investments from private funders, including The Sobrato Foundation, The California Endowment, The Health Trust, The Reinvestment Fund, Corporation for Supportive Housing, The James Irvine Fund, Google.org, the Laura and John Arnold Foundation, and Abode Services.[xxii] As the primary government sponsor, the County of Santa Clara repays those investments as the program demonstrates success by housing and improving the lives of the clients it serves. This innovative funding model ensures that program outcomes are closely tracked and that public funds are only expended when the program fulfills its purpose to stably house the County's highest utilizers.

Enrollment in the program began in May of 2015, and the total capacity will increase from 112 to 145 individuals in 2018. This program's ground-breaking approach to permanent supportive housing is evident in the following transformative strategies:

Setting the Standard in Cross-System Data Sharing

Continuum, the data platform that integrates the County's medical and behavioral health records with Homeless Management Information System data, was initially implemented as a tool for Project Welcome Home to identify the highest utilizers of crisis medical services with experience of long-term homelessness. Lessons learned through its implementation have laid the foundation for integration and alignment of data between other County, city, and nonprofit partners.

Offering intensive wraparound supports in an evidence-based treatment model

Abode Services employs an Assertive Community Treatment model, supporting clients with an inter-disciplinary team to offer housing case management, clinical psychiatric services, and counseling services, including alcohol and substance use counseling. Rather than connect clients to essential behavioral health supports through referrals and community-based services, the Project Welcome Home team provides those supports directly in a coordinated and highly responsive manner.
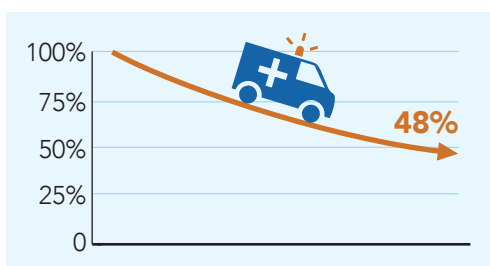
48%
Reduction in Emergency Medical Services Usage
by Tenants Housed > 12 months

[xxii] Funding from Abode Services was in the form of $500,000 in deferred fees for services provided as the primary rental assistance administrator and Assertive Community Treatment provider.

Onizuka Crossing. Photo by Bruce
Damonte courtesy of MidPen Housing.

Rapid Rehousing

Rapid rehousing is an evidence-based supportive housing strategy that quickly moves families and individuals who are experiencing homelessness into permanent housing and provides a time-limited rental subsidy and supportive services to obtain and maintain stable housing. This intervention is designed to support families and individuals experiencing episodic, rather than long-term, homelessness. Program staff help each household locate and secure an apartment, and clients typically receive 6 to 24 months of rental subsidy. During this time, clients have access to case management and supportive services, such as employment and training opportunities and childcare, aimed at increasing their income and addressing other barriers to housing stability. Rapid rehousing programs have regular client turnover, meaning that, as one household exits a program, funding can be redirected to help a new household entering the program.

While rapid rehousing offers a promising path to housing stability for large numbers of individuals and families, regional housing market and economic conditions make rapid rehousing program design and implementation challenging in Santa Clara County. For rapid rehousing clients, obtaining living-wage employment and finding an affordable apartment can make the difference between long-term housing stability and a continued risk of homelessness. Over the past six years, the County of Santa Clara has led an effort to increase rapid rehousing capacity and to improve outcomes for rapid rehousing clients through community standards for program design, training for program staff, targeted living-wage employment strategies, and County leadership in affordable housing development.

Total Unit Inventory (point-in-time capacity):

619 households

Measuring Success[xxiii]

Obtained Permanent Housing

72% were in permanent housing

(884 of 1,232) of clients who exited rapid rehousing programs in 2017

Returned to Homelessness Within Two Years
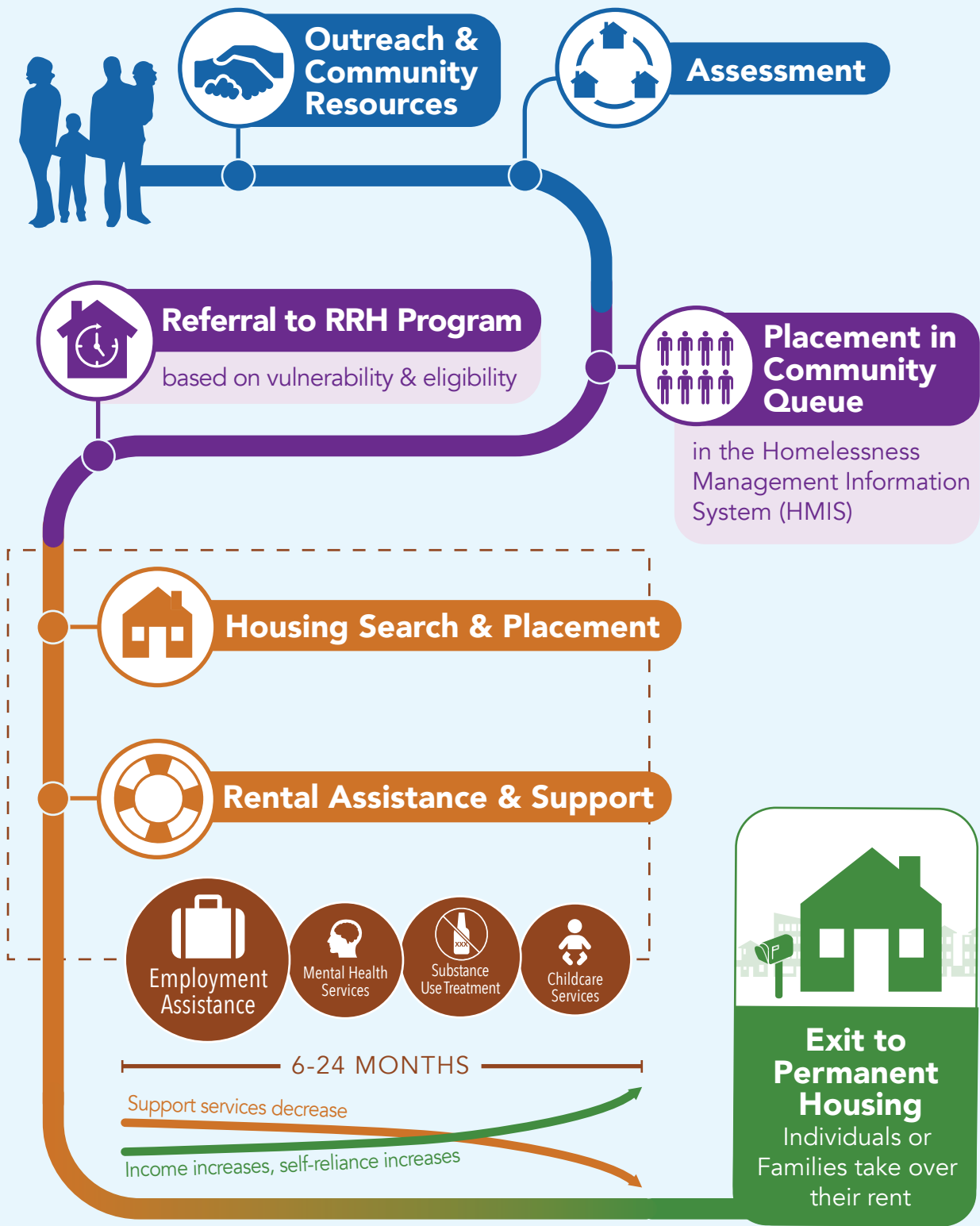
11% returned to homelessness within 2 years

(46 of 406) of clients who were in permanent housing when they exited rapid rehousing in 2015

[xxiii] The Santa Clara County supportive housing system evaluates the overall success and impact of the system using data entered by supportive housing and shelter providers into the Homeless Management Information System. These performance measures are based on the national standards for performance measurement developed by the U.S. Department of Housing and Urban Development. For more information about the performance measures in this report, see Appendix C: Measuring Success.

Rapid Rehousing (RRH) System Map

Outreach & Community Resources

Assessment

Referral to RRH Program

based on vulnerability & eligibility

Placement in Community Queue

in the Homelessness Management Information System (HMIS)

Housing Search & Placement

Rental Assistance & Support

Employment Assistance

Mental Health Services

Substance Use Treatment

Childcare Services

6-24 MONTHS

Support services decrease

Income increases, self-reliance increases

Exit to Permanent Housing

Individuals or Families take over their rent

Rapid Rehousing for Public Safety and Justice

In partnership with the County of Santa Clara Office of Reentry Services, the County of Santa Clara Office of Supportive Housing offers a rapid rehousing program to address a significant risk factor for long-term homelessness in Santa Clara County by providing much needed linkages to housing and case management for persons experiencing homelessness who are reentering society after involvement with the criminal justice system. The program has provided housing search assistance, case management, and time-limited rental subsidies to incarcerated and recently released individuals for the past six years, and in 2017 the program has seen significant expansion and enhanced interagency coordination and collaboration.

Initially implemented in 2012 with capacity to serve 25 clients, the program currently leverages $3.3 million in annual state and federal funding to serve up to 190 clients at a time. The County of Santa Clara Office of Reentry Services dedicates California Assembly Bill 109 (AB 109) funds to the program, which are supplemented by federal and state funding provided to the Office of Supportive Housing. Participants can access the program through the County's Reentry Resource Center, which acts as a coordinated service hub for formerly incarcerated residents. Multiple County departments and non-profit partners locate staff at the Reentry Resource Center to offer on-site counseling, public benefits application assistance, peer mentoring, medical care, health, housing, and other referrals, and a range of other resources in a one-stop-shop model. If a Reentry Resource Center client indicates housing is a need, the client receives an assessment of vulnerability and is prioritized for housing via the Coordinated Assessment System.

The program leverages collaboration across behavioral health, supportive housing, and criminal justice systems to reduce both homelessness and recidivism among prior serious offenders through the following strategies:

Ending Cycles of Homelessness and Criminal Justice Involvement

The program employs federal and state funding, to break the connection between homelessness and criminal justice involvement, whereby homelessness itself can lead to incarceration and criminal justice involvement can make it more difficult to obtain housing.

Employing Collaborative, One-Stop-Shop Program Design

The County of Santa Clara Offices of Reentry Services and Supportive Housing, in close collaboration with Abode Services, have designed the program to be client-centered, ensuring a clear path from housing needs assessment to connection to housing. By concentrating resources and case management services into one convenient location, the collaboration is maximized to best meet the housing needs of the Reentry participant.

Prioritizing Employment Partnerships

The program connects reentry clients with employment through partnerships with employment programs and referrals to the Destination: Work employment initiative, supporting participants to maintain housing stability and participate fully as members of the community.

Bringing Families Home

A common challenge among families involved in the child welfare system is the issue of housing instability. To be considered for family reunification, parents must be able to provide a safe and stable, though not necessarily long-term or permanent, living environment for the child. Temporary living arrangements, such as emergency shelters, transitional housing, and staying with friends and family, often cannot provide the type of stability that the child welfare system requires. This instability has been shown to cause stress within families, which can persist for at least six months following reunification, and can increase the risk factors resulting in reentry to the child welfare system.

In Santa Clara County, the Bringing Families Home program, a partnership between the Office of Supportive Housing and the Department of Family and Children Services, addresses these risk factors by providing stable housing to promote family reunification. Funded through a state legislative initiative targeted to families with connections to child welfare, the program provides rapid rehousing, including a rental subsidy and housing location services, to families at any point in the reunification process. This includes families with a child currently placed out of the home or families who have recently reunified who may be precariously housed, to assist them in achieving housing stability faster, exiting the child welfare system more quickly, and preventing re-entry.

After beginning enrollment in January 2018, the program will serve 46 families by July 2019. Families are referred to the program through the Coordinated Assessment System, which flags potentially eligible families that are currently experiencing homelessness or are at imminent risk of becoming homeless. After families are identified, the Department of Family and Children Services confirms that the family has a connection to the child welfare system, and a referral is made. Housing navigators from Abode Services work with the families to find housing, while Family and Children Services social workers continue to provide services, working in tandem to support families in their housing stability and reunification efforts. The program leverages the following innovations to aid its goal of providing stability to homeless families seeking reunification:

Enhancing Inter-Departmental Collaboration

County Office of Supportive Housing and Department of Families and Children Services staff work together to better coordinate services to families, respecting the unique roles each has to play in the success of the families' goals for reunification.

Addressing Causes of Instability with Wraparound Support

Abode Services provides wraparound support to families to address the causes of housing instability, including childcare, transportation, counseling, referral to financial and credit counseling, legal services, and developing individualized housing plans to guide families to permanent housing stability.

Delinking Housing Instability and Family Separation

By ensuring families have a safe, stable place to reunify, the Bringing Families Home program disrupts the cycle of housing instability that heightens the risk that children will experience homelessness in the future.

Rapid Rehousing for School-Age Children

According to the 2017 Homeless Census and Survey, 72 percent of families with children experiencing homelessness in Santa Clara County were residing in shelters or transitional housing programs. This is a significant decrease since 2013 when 95 percent of families experiencing homelessness in Santa Clara County were sheltered. Often, families that do not access shelters or other typical entry points for the County's supportive housing system, can be more challenging to engage, and risk falling through the cracks.

To reach these families, the Office of Supportive Housing has developed a rapid rehousing program targeting families with school-aged children who are not accessing the system through traditional access points, such as shelters or other community services. For this program, the County partners with the Bill Wilson Center and local school districts' McKinney-Vento Homeless Education liaisons to identify families experiencing homelessness. Eligible families with school-age children are referred to the program, which can serve 60 families annually, via the Coordinated Assessment System. Innovative approaches utilized by the program include:

Meeting Families Where They Are

To expand access to the program, the County is working to provide training to school liaisons and staff to administer the VI-SPDAT, a vulnerability assessment used by all homeless service providers across the county. Once the assessment is done, school staff can then connect families directly to the Coordinated Assessment System, providing a convenient and trusted access point to the community's supportive housing resources.

Forging New Partnerships to Better Serve Children and Families

To support clients in the program, the County of Santa Clara Office of Supportive Housing initiated several new partnerships, including with: local school districts; the federal Head Start program, which provides free preschool for low-income county residents and prioritizes services for homeless families; First 5 Santa Clara County, which operates and funds early childhood development programs for children up to 5 years of age; and Kids Connections, which offers access to developmental screening and early intervention services.

Creating Opportunities for Innovation

The three-year program, which started accepting referrals at the end of 2017, is funded solely by County general funds, which allows the flexibility to try new approaches, test alternative outreach strategies, and learn what works to better serve families with school-aged children in Santa Clara County.
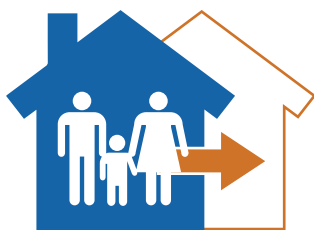
72% **of families with children experiencing homelessness** in Santa Clara County were residing in shelters or transitional housing programs

Amanda & Daniel. Photo by Crystal Pretel-Ritter.

CLIENT STORY
Rapid Rehousing—and Hard Work— Helps A Family Buy Their "Forever Home"

"Regardless of the situation, this roof is the most important thing in the world," said Amanda, stretching her arms out, as she sits in her new home in Manteca, California, which she and her fiancé Daniel recently purchased. "I don't care if we don't have anything in this home…this roof is all that matters."

Amanda, Daniel, and their four children, all under the age of 10, know the value of having a stable home after becoming homeless for nine months when a string of events led them to leave their home of four years in San Jose's Willow Glenn neighborhood. They bounced between family and friends' homes until they were accepted at Family Supportive Housing's shelter, where they took budgeting classes and developed a plan to purchase a home within five years. They hit the

ground running, all while caring for four kids, and met their goal in just three years.

Abode Services worked with Amanda and Daniel through their rapid rehousing program to secure an apartment with a new landlord who was flexible with the family's needs. Until they successfully took over the rent, Abode provided financial assistance to cover the deposit, a rental subsidy for the first three months, and nine months of continued support. This financial support helped create a stable environment which allowed them to continue working toward their plans to purchase their own home.

Amanda and Daniel worked with numerous other organizations, including: Employment Connection and CalWORKS, which helped

Amanda search for jobs and tweak her resume; Downtown Streets Team helped gather home essentials for their first apartment; and Catholic Charities assisted with professional attire. Within three months, Amanda secured fulltime work with an accounting firm, where she continues to work today.

In one year, they turned around their bad credit and were approved for a first-time home loan. While their new life will be built in the Central Valley, their path to housing stability began in Silicon Valley. "Life was not meant to be lived alone," said Amanda. "Knowing the significance of our forever home is power and motivation to keep us putting one foot in front of the other every single day!"

Rapid Rehousing for Survivors of Domestic Violence, Sexual Assault, and Human Trafficking

Homelessness itself can be traumatic for individuals and families, and often those experiencing homelessness have coped with other traumatic events in their lives. National studies show that 80 percent of women with children experiencing homelessness have also experienced domestic violence, and one in five of all homeless women report that domestic violence was the immediate cause of their homelessness.[xxiv][xxv]

In many communities, service providers working with survivors operate independent of the supportive housing system; however, since 2015, the County of Santa Clara Office of Supportive Housing, YWCA of Silicon Valley, The Health Trust, and the City of San José have partnered to develop several rapid rehousing programs to support survivors of domestic violence, sexual assault, and human trafficking who are experiencing homelessness. These programs serve individuals and families coming from the streets, emergency shelters, or directly fleeing domestic violence, and bring together the expertise of domestic violence service providers with evidence-based supportive housing strategies.

The YWCA-SV works with survivors to locate safe and secure housing options, and the programs currently have the capacity to serve 77 households at a time, receiving referrals through a confidential process within the Coordinated Assessment System. The County and the City of San José provide local funding for the programs, which is combined with federal dollars. The programs utilize the following evidence-based and effective strategies:

Providing Client-Centered, Trauma-Informed Services

YWCA provides trauma-informed and client-driven services to promote healing and empowerment. Initial support is intensive and focused on collaborating with the client to create a housing retention plan and address barriers to attaining housing.

Ensuring Ongoing and Individualized Support

Once housed, clients continue to receive the wraparound support necessary to maintain housing, including regular case management meetings, counseling, childcare, connections to benefit programs, education and employment opportunities, and access to legal services.

80% of women with children experiencing homelessness **have also experienced domestic violence**
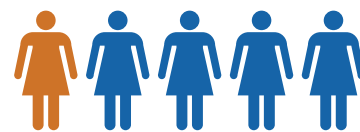
1 in 5 of all homeless women report that **domestic violence was the immediate cause of their homelessness.**

[xxiv] Aratani, Y. (2009). Homeless Children and Youth, Causes and Consequences. New York, NY: National Center for Children in Poverty. Available at: http://www.nccp.org/publications/pdf/text_888.pdf

[xxv] Wilder Research Center (2004). Homeless in Minnesota, 2003, 22; Center for Impact Research (2004). Pathways to and from Homelessness: Women and Children in Chicago Shelters, 3; National Center for Homelessness & Health Care for the Homeless Clinicians' Network (2003). Social Supports for Homeless Mothers, 14, 26; Inst. for Children & Poverty (2004). The Hidden Migration: Why New York City Shelters are Overflowing with Families; Homes for the Homeless and Institute for Children & Poverty (1998). Ten Cities 1997-1998: A Snapshot of Family Homelessness Across America, 3.

Destination: Work

For many individuals and families experiencing homelessness, one or even multiple low- or minimum-wage jobs is simply not sufficient to cover housing costs and other basic necessities in Santa Clara County. Employment that provides a living wage can be the key to long-term housing stability, particularly for families receiving time-limited rental subsidies in rapid rehousing programs.

The new "Destination: Work" employment initiative, coordinated by Destination: Home and the County of Santa Clara Office of Supportive Housing, aims to provide opportunities for living-wage employment for individuals and families experiencing homelessness. Through partnerships with programs offering job training, professional certifications, and paid work experience in high-growth industries, Destination: Work supports each client to identify pathways to increasing income and long-term career opportunities.

Destination: Work forges new and more meaningful collaboration between employment and supportive housing programs that prioritize client-led problem solving and continual improvement in system design. Key strategies of this collaborative approach include the following:

Maximizing Impact by Tracking Outcomes

Destination: Work partner organizations use standard outcome measures and a shared data system to evaluate the initiative's impact and to inform strategic decisions about how it is implemented. Key metrics include rates of job placement and retention, attainment of living wage, and transition into self-sufficiency by program participants.

Deepening Partnerships with Employment Partners

Employment partners and rapid rehousing case managers attend bimonthly meetings to discuss housing and employment opportunities, strategies, and outcomes. Meeting regularly and in person allows Destination: Work partners to operate as a cross-system service team to coordinate resources and address barriers to employment and housing for individual clients.

As of the end of 2017, Destination: Work served 44 individuals:

39 completed an employment training program

24 obtained full-time employment

Health Care Employment Partners[xxvi]
- LeadersUp
- Silicon Valley Children's Fund/Teen Force

Building & Construction Trades Employment Partners
- Building Trades Council
- Goodwill of Silicon Valley
- Working Partnerships

Advanced Manufacturing Employment Partners
- Work2Future

Technology & Professional Employment Partners
- Center for Employment Training
- REDF

[xxvi] All partners are listed alphabetically.

CRISIS RESPONSE SYSTEM

While supportive housing programs—and building more units to increase the system's capacity—are central to the community's mission to end homelessness, the reality remains that individuals currently experiencing homelessness need programs and services that address their immediate needs. The supportive housing system includes a range of crisis response strategies, which help to identify and engage with at-risk or homeless households, prevent homelessness before it begins whenever possible, and provide shelter and other basic needs to individuals and families experiencing homelessness. For many households, these programs are the first step back to stable housing, and each component of this housing crisis response system works in alignment with the community's supportive housing programs and other permanent housing resources to help clients achieve long-term housing stability.

Casa Feliz. Photo by Bernard Andre.

Homelessness Prevention System Pilot

Under the leadership and coordination of Destination: Home, the Homelessness Prevention System pilot re-envisions the community's approach to preventing homelessness. With a combined $4.2 million dollars from public and private sources, this 27-month pilot program streamlines access to essential resources for families in crisis, targets resources to those most at risk of homelessness, and uses data to measure the collective impact of the prevention system.

The Emergency Assistance Network, a group of seven nonprofit organizations based in different areas of the county, has long been the community's primary provider of homelessness prevention services. In contrast with most existing funding sources for prevention, this pilot funding allows the Emergency Assistance Network agencies to provide more than one-time financial assistance, so that case managers can work with clients to identify and resolve immediate crises, including financial, legal, and other service needs. Financial support can be targeted to the needs of each household, ranging from one-time moving costs to multiple months of back-rent or rental assistance. Case managers continue to check in with each household after assistance has been provided to identify ongoing challenges and ensure long-term housing stability. This flexibility allows the agencies to provide the assistance needed to keep families and individuals from entering the homeless system. Since the program started, the average cost of financial assistance provided was $2,913 per household, significantly less costly to the County than an extended shelter or transitional housing stay.

The agencies participating in the Homelessness Prevention System pilot use a standard assessment tool to target resources to households with the highest risk of homelessness. The use of a single intake assessment allows the system to better identify which households are most likely to experience homelessness, and to prevent it. As a coordinated system with standardized data collection requirements, the Homelessness Prevention System pilot will provide a rich source of information about the nature of housing crises in Santa Clara County and which tools are most effective at permanently stabilizing housing for at-risk families.

The seven agencies began serving families at risk of homelessness under the Homelessness Prevention System pilot in July 2017. In the first six months of the pilot, 30 households received prevention services.

87 percent of families and individuals served (26 of 30) remained housed while receiving homelessness prevention services

90 percent of families and individuals served (9 of 10) were stably housed when they stopped receiving homelessness prevention services

Funding Partners[xxvii]
- City of Morgan Hill
- City of San José
- City of Santa Clara
- County of Santa Clara
- The David and Lucile Packard Foundation
- Google.org
- Sunlight Giving

Coordinating Partners
- County of Santa Clara Office of Supportive Housing
- Destination: Home
- Sacred Heart Community Services

Legal Services Partner
- Law Foundation of Silicon Valley

Emergency Assistance Network Partners
- Community Services Agency of Mountain View & Los Altos
- LifeMoves
- Sacred Heart Community Services
- Salvation Army
- St. Joseph's Family Center
- Sunnyvale Community Services
- West Valley Community Services

[xxvii] All partners are listed alphabetically.

285

Outreach

During the 2017 Homeless Census and Survey, 5,448 people were unsheltered in Santa Clara County. Street outreach teams provide essential resources, information, and service connections for this population and are often the only contact some have with the broader system of care. For individuals experiencing homelessness who are unsheltered, contacts with outreach teams are an essential first step to connecting with housing resources. Outreach by multiple service providers covers the entire geographic area of Santa Clara County,

A member of PATH's outreach team in San Jose. Photo by Jeff Bomberger.

including targeted outreach to veterans, youth, LGBTQ+ populations, and households living in encampments. In addition, the Santa Clara Valley Health and Hospital System's Valley Homeless Healthcare Program brings healthcare services directly to people living outside.

Coordinated Assessment System

The Coordinated Assessment System, administered by the County of Santa Clara Office of Supportive Housing, is a streamlined system for matching the community's most vulnerable households to the appropriate housing resources. In Santa Clara County, Coordinated Assessment operates with a "no wrong door" access model, so that a household presenting at any access point across the county will receive the same brief assessment, the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), to determine their relative vulnerability and priority for the community's supportive housing. Access points for Coordinated Assessment include street outreach teams, emergency shelters, County benefits offices, drop-in and community centers, the County's Reentry Resource Center, community medical clinics, and many other community resources.

Once an individual or family has been assessed, they are placed on a single community queue in the County's Homelessness Management Information System.

Coordinated Assessment staff use this database to identify the most vulnerable individuals and families for referral to supportive housing, as vacancies become available. Because the Coordinated Assessment System is informed of all vacancies in participating housing programs, it is able to connect assessed households to a countywide inventory of supportive housing, prioritizing people with the most need first.

Based on VI-SPDAT score, each household is prioritized for either permanent supportive housing, rapid rehousing, or referral to other resources such as emergency shelters, legal aid, government benefits, or employment programs.[xxviii] When a vacancy occurs in a participating housing program, the Coordinated Assessment System refers the household with the highest assessed vulnerability who is prioritized for that program type. Once a household is contacted and accepts the offered vacancy, the supportive housing program begins working with their new client to find housing.

Standard Assessment & Prioritization	Referral to the Best Available Resource	Contact & Confirmation of Eligibility	Supportive Housing Program Enrollment
5,600 Households Entered Coordinated Assessment for the First Time in 2017	**1,401 Households** Received Referrals in 2017		**828 Households** Enrolled in a Housing Program in 2017

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xxviii Beginning in 2018, some households will be prioritized for transitional housing vacancies.

Client Engagement Team

The goal of Coordinated Assessment is to connect the community's most vulnerable individuals and families to case management and other housing-focused services as quickly as possible. In 2017, housing providers and the County of Santa Clara Office of Supportive Housing identified one of the primary challenges in the housing process was locating clients to offer them referrals to programs.

To reach and house clients more swiftly, the Office of Supportive Housing committed its Client Engagement Team, an outreach team with expertise in locating and building relationships with individuals experiencing homelessness, to take on this role. Under this novel approach, the Client Engagement Team mobilizes immediately to make contact with households as they are referred through Coordinated Assessment, to explain the available housing opportunity and help put them in contact with the supportive housing program. To further streamline the Coordinated Assessment System, the County's Client Engagement Team ensures that households meet all eligibility criteria before they attempt to enroll in a housing program.

By centralizing the process of client location and verifying eligibility for the majority of individuals and families referred through Coordinated Assessment, the Client Engagement Team increases the efficiency of supportive housing referrals throughout the county and connects hard-to-reach individuals with scarce housing resources.

Client is highest priority for housing referral

Client Engagement Team locates client

Client Engagement Team confirms client's eligibility

Client accepts housing referral

Warm hand-off to housing case manager

Michael -Rambo- Renteria. Photo By Marianna Moles.

CLIENT STORY
Street Outreach Saved Rambo's Life

Rambo — a nickname Mike earned for wearing camo and a bandana around his head while he was homeless on and off for over 30 years — is relieved to be housed. "I wanted to be a normal, responsible person. I was counting the weeks to get housed," he said recently.

Prior to being housed last year, Rambo could be found sleeping underneath a tarp in Saint James Park in downtown San José, wearing all five of his coats so they would not be stolen. For most of his life, Rambo has battled addictions and mental illness, suffered from severe hearing impairment since he was a baby, and often felt that people would give up on him. With assistance from the Office of Supportive Housing and its partners, he got sober in February of 2017 and moved into his current apartment in July of that year with help from a rental subsidy funded by the County. On his first night in his new home, he enjoyed a three-hour long bath, and cooking "meals that really fill me up, like soup," he said, has become one of his favorite pastimes.

Finding the normalcy Rambo had long desired is the result of a collaborative effort, one that exemplifies the individualized approach clients need to stay success-fully housed. Years of consistent street outreach also played a key role in getting Rambo off the streets and into permanent housing. Aiko, the case manager at PATH who reached out to Rambo in October of 2015 can attest to that. To more easily communicate with him, she wrote down her questions and was diligent about making sure he kept important appointments by texting him, rather than calling. Many other organizations have worked with Rambo to help him navigate the judicial system, find counseling services, obtain a reliable phone, and get hearing aids through Medi-Cal.

His current case manager at The Health Trust reports that the supportive services Rambo receives are essen-tial to him successfully staying housed. Rambo said, "I may be 62 and a half, but I want to be able to enjoy the rest of my life. I feel good, like a normal human being. Got back on my own two feet. I'm happy."

1585 Studios. Photo by Bernard Andre.

Emergency Shelter

Emergency shelters play an essential role in the supportive housing system. Of 7,394 people experiencing homelessness on the night of the January 2017 Homeless Census and Survey, 1,140 spent the night protected from the elements in a bed provided by a shelter program.

Santa Clara County's emergency shelters follow diverse program models, but most provide more than just a place to sleep. When available, on-site services such as showers, laundry, and meals support the health and well-being of shelter guests. Some emergency shelters are able to offer case management services, connecting guests to healthcare, benefits advocacy, employment programs, or other supportive services in the community. All emergency shelters act as access points for the Coordinated Assessment System, administering the standard assessment used to prioritize households for the community's permanent and transitional housing opportunities. For families and individuals experiencing homelessness, emergency shelter is often the first step in a path to stable housing.

Emergency Shelter Unit Inventory (point-in-time capacity):

1,146 households
1,400 people

Measuring Success[xxix]

Obtained Permanent Housing

19% went to permanent housing

(693 of 3,631) of clients who exited emergency shelter in 2017

Returned to Homelessness Within Two Years

20% returned to homelessness within 2 years

(133 of 678) of clients who exited emergency shelter for permanent housing in 2015

[xxix] The Santa Clara County supportive housing system evaluates the overall success and impact of the system using data entered by supportive housing and shelter providers into the Homeless Management Information System. These performance measures are based on the national standards for performance measurement developed by the U.S. Department of Housing and Urban Development. For more information about the performance measures in this report, see Appendix C: Measuring Success.

Expansion of the Cold Weather Shelter Program

During the winter months, the County of Santa Clara opens additional emergency shelters in the community to provide increased capacity and allow more of the county's unsheltered population to come indoors during cold and inclement weather. In 2017, the County took steps to significantly expand the Cold Weather Shelter Program. Historically operating from the first Monday after Thanksgiving through the end of March, the Cold Weather Shelter Program now runs from mid-October through mid-April, offering shelter during some of the county's wettest and coldest months. Bed capacity also increased during 2017, with increased funding allowing the North County Winter Shelter in Sunnyvale to welcome 15 additional individuals each night. The County Office of Supportive Housing partnered with the City of Mountain View, Hope's Corner, and the Trinity United Methodist Church to open a new Cold Weather Shelter location in Mountain View. The Trinity United Methodist Church Winter Shelter will provide warm beds for up to 50 individuals each night during cold weather months and is the city's first emergency shelter program for residents experiencing homelessness.

HomeFirst operates four Cold Weather Shelter Program locations, including the Gilroy Winter Shelter at the National Guard Armory; the North County Winter Shelter in Sunnyvale; the Boccardo Reception Center in San Jose; and the Trinity United Methodist Church Winter Shelter in Mountain View. St. Joseph's Family Center operates the Ochoa Winter Family Shelter in Gilroy.

LGBTQ-Focused Emergency Shelter

Twenty-nine percent of individuals interviewed during the 2017 Homeless Census and Survey self-identified as LGBTQ, mirroring a national trend of overrepresentation of LGBTQ individuals in the homeless population. In 2017, the County of Santa Clara Office of Supportive Housing and Office of LGBTQ Affairs began conducting outreach and gathering information to support the design of an emergency shelter program focused on LGBTQ-identified residents experiencing homelessness. In January of 2018, the County of Santa Clara Board of Supervisors directed the Office of Supportive Housing to begin work to open the county's first LGBTQ-focused emergency shelter. The new shelter is expected to open in 2018.

Transitional Housing

Transitional housing programs provide time-limited housing for individuals and families experiencing homelessness and can fill specific gaps in a comprehensive supportive housing system. For some experiencing homelessness, longer-term transitional housing (up to 24 months) can offer a uniquely supportive environment. For example, youth who are pregnant or parenting may elect to enroll in a transitional housing program that provides a built-in social network and parenting supports, while individuals or families fleeing domestic violence or sexual assault may seek out the security of housing with on-site services and trauma-informed programming. Typically, transitional housing clients receive housing assistance in an apartment owned or leased by the program, and, when assistance ends, the individual or family moves out of the program's housing. During their stay in the program, clients have access to services designed to address barriers to housing, including counseling, financial management training, job and housing search assistance, and connections to medical and behavioral health care.

In Santa Clara County's competitive rental market, a housing search for a client who is already enrolled in a permanent housing program can take weeks or months. When designed around shorter one- to three-month stays, transitional or interim housing programs offer stability while supporting the client in an active search for permanent housing. Regardless of program design, a primary goal of transitional housing is to support clients in their transition into safe and stable permanent housing.

Integrating Transitional Housing into Coordinated Assessment

In 2017, the County of Santa Clara Office of Supportive Housing worked closely with transitional housing providers for youth and veterans to integrate these housing resources into the Coordinated Assessment System. Through a collaborative process including the Department of Veterans Affairs, LifeMoves, HomeFirst, the Homeless Veterans Emergency Housing Facility, and Bill Wilson Center, the Office of Supportive Housing adopted policies for transitional housing referrals from Coordinated Assessment to be implemented in 2018.

Total Unit Inventory (point-in-time capacity):

610 households
1,026 people

Measuring Success[xxx]

Obtained Permanent Housing

 55% **went to permanent housing**

(602 of 1,098) of clients who exited transitional housing in 2017

Returned to Homelessness Within Two Years

 20% **returned to homelessness within 2 years**

(94 of 482) of clients who exited transitional housing for permanent housing in 2015

[xxx] The Santa Clara County supportive housing system evaluates the overall success and impact of the system using data entered by supportive housing and shelter providers into the Homeless Management Information System. These performance measures are based on the national standards for performance measurement developed by the U.S. Department of Housing and Urban Development. For more information about the performance measures in this report, see Appendix C: Measuring Success.

CONCLUSION

In Santa Clara County, a booming economy and high median income contrast starkly with one of the nation's largest populations of people experiencing homelessness. In 2017, nearly 7,400 individuals were living on the streets, in shelters or transitional housing across the county. For many more low-income households, Santa Clara County's high cost of housing and lack of living wage employment opportunities put stable and affordable housing out of reach.

The Santa Clara County supportive housing system provides shelter, supportive housing, and homelessness prevention services in furtherance of the goal of making homelessness rare, brief, and non-recurring. However, the need for affordable housing and services in Santa Clara County far exceeds current capacity.

In 2015, major stakeholders of the county's supportive housing system established the Santa Clara County Community Plan to End Homelessness, a roadmap to increasing resources and ending homelessness through innovative strategies. Since implementation began in 2015, the County of Santa Clara has made substantial progress, working toward the goal of 6,000 new affordable housing opportunities for individuals and families experiencing homelessness.

The number of people housed each year has increased since 2015. The efforts of the County and its partners have been particularly successful at addressing chronic homelessness and veteran homelessness, two areas in which they have focused resources in recent years. The increased funding and support for Permanent Supportive Housing for people experiencing chronic homelessness lead to an 18 percent reduction in this population from 2011 to 2017. The focus on ending veterans homelessness has resulted in housing 990 veterans since November 2015.

Though the road to ending homelessness presents numerous challenges, the County of Santa Clara and its many partners are committed to ensuring safe and affordable housing for every household experiencing or at risk of homelessness.

Appendix A: Defining Homelessness

Homelessness and housing instability take many forms, and these challenges affect individuals and families with a diversity of life experiences. To understand the scope of the community's need and to develop the right systemic responses, it is necessary to rely on clear definitions of "homelessness." This report primarily uses the following components of the definition of homelessness developed by the U.S. Department of Housing and Urban Development (HUD) for its Continuum of Care and Emergency Solutions Grants housing programs.[xxxi] Under this definition, a household who falls into any one of the following criteria is considered homeless:

I. An individual or family who lack a fixed, regular, and adequate nighttime residence, including households living outside, in cars, emergency shelters, transitional housing, and some short institutional stays;

II. An individual or family who will imminently lose their primary nighttime residence; or

III. An individual or family who is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

This report also references the definition of homelessness used by the County Office of Education and the public school system. This definition includes a household that lacks a fixed, regular, and adequate nighttime residence, children under 18 waiting for foster care placement, and individuals and families who are living "doubled up" or in hotels.[xxxii]

Chronic Homelessness

HUD has defined a subset of households experiencing homelessness as "chronically homeless." These households are most likely to have intensive medical, mental health, and other service needs that cannot be met while they remain unhoused and are a priority population within supportive housing systems nationally and locally.

The definition of chronically homeless includes both a disability requirement and a length of homelessness component. Under this definition, a household who meets all of the following criteria is considered chronically homeless:

I. A homeless individual with a disability, who lives in a place not meant for human habitation, a safe haven, or an emergency shelter;

II. Who has been homeless and living in any of the situations described above continuously for at least 12 months or on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months.

While a longer stay in an institution such as a jail, hospital, or drug treatment facility will not count as living in a homeless situation, institutional stays of fewer than 90 days do count as time spent homeless. If a family's head of household, generally an adult family member, but occasionally a minor who is the head of a family with no adults, is chronically homeless under this definition, then the entire family meets the definition of chronic homelessness.[xxxiii]

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xxxi Code of Federal Regulations, Continuum of Care Program, Title 24, sec. 578.3. This report does not use Category 3 of HUD's homeless definition, which includes unaccompanied youth or families who are homeless under other federal definitions of homelessness.

xxxii U.S. Department of Education: Education for Homeless Children and Youth Program Non-Regulatory Guidance, March 2017. Accessed on 10/2/17: https://www2.ed.gov/policy/elsec/leg/essa/160240ehcyguidance072716updated0317.pdf

xxxiii Code of Federal Regulations, Continuum of Care Program, Title 24, sec. 578.3.

Appendix B: Data Sources

The two most common methods for estimating the number of persons experiencing homelessness in a community are point-in-time counts and data collected by housing and services programs. This report draws on both of those methods to establish the scope and characteristics of homelessness in Santa Clara County, and each is described below.

Homeless Management Information System (HMIS)

The County of Santa Clara Office of Supportive Housing operates the community's HMIS, a countywide database used by the majority of programs providing housing or services for homeless populations within the county. Providers request consent from each person they serve to enter standard information into HMIS, including demographic information, services provided, and data about income and housing status. This results in a large set of data that includes nearly all individuals who had contact with outreach teams, emergency shelters, homeless housing programs, and other services.

Because HMIS is focused on service data, it does not include individuals who are currently homeless but are not accessing services. It also does not include persons who receive services or housing designed for survivors of domestic violence or human trafficking, as many programs providing those services are prohibited from entering information into HMIS for privacy and safety reasons. Most significantly, since the individuals in HMIS are limited to those who have received services, the total number of persons recorded as homeless in HMIS increases as the system serves more people.

To estimate the total number of persons experiencing homelessness over the course of a year using data from HMIS, communities use the number of persons who have spent at least one night in emergency shelter or transitional housing. As the size and capacity of the community's emergency shelter and transitional housing system increase, the total persons identified in HMIS as experiencing homelessness will also increase.

Homeless Census and Survey

Every two years, the County of Santa Clara and the region's fifteen cities conduct a Homeless Census and Survey. Trained volunteers tally the number of people observed living or sleeping outside at a single point in time and survey a sample of those counted. To cover the entirety of the county's extensive geographic area, the count occurs over the course of two days during the month of January, with roughly half of the county enumerated on each day. Data is also collected from emergency shelter and transitional housing programs, as households in shelter and temporary housing are considered homeless for purposes of the count.

The Homeless Census and Survey employs consistent methods from year to year, providing a useful data set for tracking changes in the homeless population. Because the count enumerates people who are currently living outside or in vehicles, including those who may not engage in services, it incorporates a population that may not be represented in HMIS data.

Notably, a point-in-time count will only provide a snapshot of homelessness on the nights selected for the count, which is not easily extrapolated to a total annual number of people who experience homelessness. This also means that the number of individuals counted each year is affected by weather conditions, the number of shelter beds open on the night of the count, natural disasters, and other temporary conditions that cause fluctuations in the visibility or size of the homeless population. It is expected that point-in-time methods will undercount individuals and families who shelter in locations that are not visible to volunteer teams, including vehicles, garages, and other structures not built to be lived in.

Appendix C: Measuring Success

To ensure that each component of Santa Clara County's supportive housing system effectively advances the goal of ending homelessness, system stakeholders have identified standard, data-based indicators of success. These indicators track the system's ability to help individuals and families permanently exit homelessness by obtaining and retaining housing.

These metrics are based on data entered by the community's housing and shelter programs into the Homeless Management Information System (HMIS), the primary community-wide database for collecting information about homeless housing and services, to evaluate the overall success and impact of the community's response to homelessness. See Appendix B: Data Sources for more information about the HMIS.

Permanent Housing Retention

How successful are the community's housing programs at helping individuals with disabilities who exit homelessness to remain in the permanent housing situations that they have obtained for at least 12 months, while they continue to receive support from the housing program?

Program type: Permanent Supportive Housing

Universe: All individuals served by the program during the measurement period who were housed with program support at least 12 months ago.

Measure: The percentage of the universe who remained housed for at least 12 months.

Obtained Permanent Housing

How successful are the community's housing and shelter programs at helping individuals experiencing homelessness to obtain permanent housing?

Program type: Emergency Shelter, Transitional Housing, Rapid Rehousing

Universe: All individuals served by the program who exited the program (stopped receiving services) during the measurement period.

Measure: The percentage of the universe who were in a permanent housing situation when they exited the program.

Returns to Homelessness

How successful are the community's housing and shelter programs at ensuring that individuals who exit homelessness do not return to homelessness once they stop receiving services?

Program type: Emergency Shelter, Transitional Housing, Rapid Rehousing, Permanent Supportive Housing

Universe: All individuals served by the program who exited the program (stopped receiving services) two years prior to the measurement period, and were in a permanent housing situation when they exited.

Measure: The percentage of the universe who were served by another homeless housing or services program in Santa Clara County's HMIS within 2 years of the date they exited the program to a permanent housing situation.

Appendix D: Santa Clara County Regional Housing Need Allotment

The Regional Housing Need Allocation (RHNA) is a state-mandated process Bay Area counties use to identify and project the total number of housing units necessary to meet the needs of people of all income levels in each county.

2007-2014 Regional Housing Need Allocation (RHNA) Progress

Jurisdiction	Very Low Income up to 50% AMI			Low Income 51% to 80% AMI			Moderate Income 81% to 120% AMI			Above Moderate Income more than 120% AMI			Total		
	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met
Campbell	199	32	16%	122	300	246%	158	67	42%	413	217	53%	892	616	69%
Cupertino	341	38	11%	229	31	14%	243	58	24%	357	657	184%	1,170	784	67%
Gilroy	319	29	9%	217	70	32%	271	65	24%	808	1,262	156%	1,615	1,426	88%
Los Altos	98	23	23%	66	22	33%	79	12	15%	74	784	1059%	317	841	265%
Los Altos Hills	27	25	93%	19	10	53%	22	5	23%	13	76	585%	81	116	143%
Los Gatos	154	2	1%	100	41	41%	122	5	4%	186	180	97%	562	228	41%
Milpitas	689	336	49%	421	109	26%	441	264	60%	936	6,442	688%	2,487	7,151	288%
Monte Sereno	13	6	46%	9	12	133%	11	3	27%	8	14	175%	41	35	85%
Morgan Hill	317	98	31%	249	100	40%	246	43	17%	500	1,286	257%	1,312	1,527	116%
Mountain View	571	237	42%	388	28	7%	488	4	1%	1,152	2,387	207%	2,599	2,656	102%
Palo Alto	690	156	23%	543	9	2%	641	128	20%	986	787	80%	2,860	1,080	38%
San Jose	7,751	1,774	23%	5,322	1,038	20%	6,198	144	2%	15,450	13,073	85%	34,721	16,029	46%
Santa Clara	1,293	412	32%	914	111	12%	1,002	198	20%	2,664	5,952	223%	5,873	6,673	114%
Saratoga	90	-	0%	68	13	19%	77	5	6%	57	20	35%	292	38	13%
Sunnyvale	1,073	572	53%	708	402	57%	776	1,204	155%	1,869	2,403	129%	4,426	4,581	104%
Unincorporated	253	58	23%	192	396	206%	232	166	72%	413	422	102%	1,090	1,042	96%
County Totals	13,878	3,798	27%	9,567	2,692	28%	11,007	2,371	22%	25,886	35,962	139%	60,338	44,823	74%

Source: Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2007-2014 Regional Housing Need Allocation (RHNA)." Sept. 2015. Available at: https://abag.ca.gov/files/RHNAProgress2007_2014_082815.pdf.

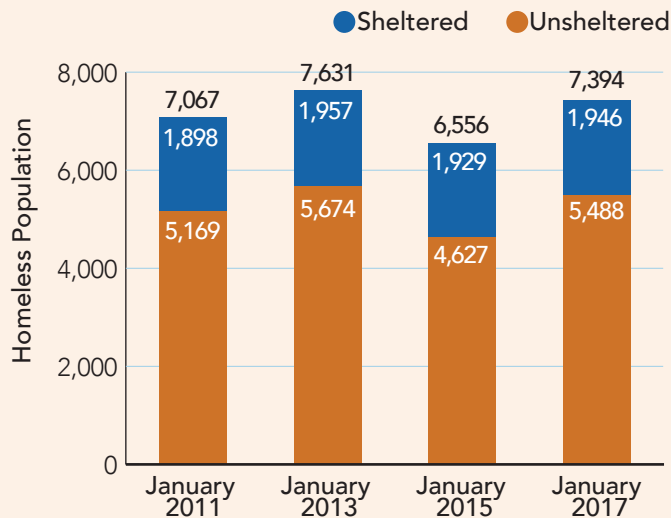## 2015-2023 Regional Housing Need Allocation (RHNA) Progress as of 2015

Jurisdiction	Very Low Income up to 50% AMI			Low Income 51% to 80% AMI			Moderate Income 81% to 120% AMI			Above Moderate Income more than 120% AMI			Total		
	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met	RHNA	Permits Issued	% Met
Campbell	253	0	0%	138	4	3%	151	2	1%	391	43	11%	933	49	5%
Cupertino	356	0	0%	207	0	0%	231	4	2%	270	174	64%	1,064	178	17%
Gilroy	236	26	11%	160	249	156%	217	7	3%	475	398	84%	1,088	680	37%
Los Altos	169	0	0%	99	0	0%	112	0	0%	97	48	49%	477	48	10%
Los Altos Hills	46	5	11%	28	5	18%	32	0	0%	15	11	73%	121	21	17%
Los Gatos	201	0	0%	112	0	0%	132	2	2%	174	24	14%	619	26	4%
Milpitas	1,004	10	1%	570	0	0%	565	0	0%	1,151	0	0%	3,290	10	0%
Monte Sereno	23	4	17%	13	0	0%	13	1	8%	12	2	17%	61	7	11%
Morgan Hill	273	0	0%	154	12	8%	185	6	3%	316	331	105%	928	349	36%
Mountain View	814	0	0%	492	9	2%	527	0	0%	1,093	237	22%	2,926	246	8%
Palo Alto	691	20	3%	432	58	13%	278	7	3%	587	153	26%	1,988	238	8%
San Jose	9,233	345	4%	5,428	231	4%	6,188	0	0%	14,231	5,904	41%	35,080	6,480	17%
Santa Clara	1,050	0	0%	695	0	0%	755	19	3%	1,593	212	13%	4,093	231	5%
Saratoga	147	0	0%	95	0	0%	104	0	0%	93	0	0%	439	0	0%
Sunnyvale	1,640	43	3%	906	0	0%	932	18	2%	1,974	799	40%	5,452	860	15%
Unincorporated	22	0	0%	13	0	0%	214	0	0%	28	65	232%	277	65	23%
County Totals	16,158	453	3%	9,542	568	6%	10,636	66	1%	22,500	8,401	37%	58,836	9,488	14%

Source: Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2015-2023 Regional Housing Need Allocation (RHNA)." April 2017. Available at: https://abag.ca.gov/planning/housingneeds/pdfs/2015-2023%20_RHNAProgressReport.pdf.

CAUSES & IMPACTS OF HOMELESSNESS

Santa Clara County Homeless Census & Survey

● Sheltered ● Unsheltered

Homeless Population

	January 2011	January 2013	January 2015	January 2017
Total	7,067	7,631	6,556	7,394
Sheltered	1,898	1,957	1,929	1,946
Unsheltered	5,169	5,674	4,627	5,488

Cost of providing services to homeless residents in Santa Clara County

520 Million/year

53% Healthcare

34% Justice System *(primarily jail costs)*

13% Social Services
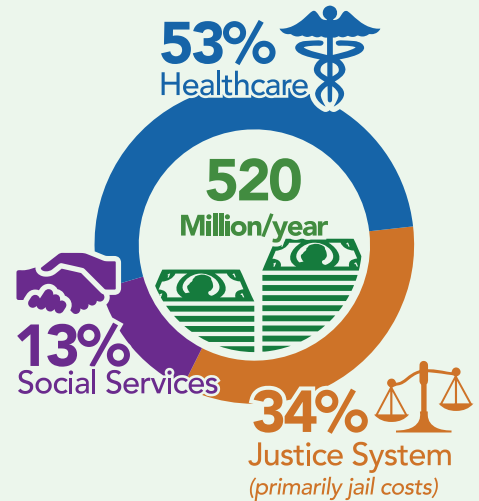
Duration of Homelessness

Out of the more than 100,000 people who experienced homelessness from 2007 through 2012, during those six years:

20% were homeless for 1 month

32% were homeless for 2-6 months

12% were homeless for 7-11 months

13% were homeless for 1 year - 23 months

22% were homeless for 2 years or more

YEARS OF HOMELESSNESS   1   2   3

2007-2014 Regional Housing Need Allocation (RHNA) Progress

Above Moderate-income Household Units

25,886 Aproximate Units Needed

139% Units Built

Very Low-income Household Units

27% Units Built

13,878 Units Needed

Association of Bay Area Governments, "San Francisco Bay Area Progress in Meeting 2007-2014 Regional Housing Need Allocation (RHNA)." Sept. 2015. Available at: https://abag.ca.gov/files/RHNAProgress2007_2014_082815.pdf. RHNA tracks local need and development of housing by affordability, based on the federal Area Median Income (AMI) calculation. Very low-income households have income at or below 50% of AMI for Santa Clara County, and above moderate-income households have income over 120% of AMI.

Ending Homelessness: The State of the Supportive Housing System in Santa Clara County **2017**
Read the full report at: www.supportivehousingscc.org/report

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SUPPORTIVE HOUSING SYSTEM PROGRESS

Total Permanently Housed

TOTAL 5,154

2015	1,212
2016	1,883
2017	2,059

891 Veterans Housed

Obtained Permanent Housing

72% were in permanent housing

(884 of 1,232) of clients who exited rapid rehousing programs in 2017

Permanent Housing Retention

90% remained stably housed for at least 12 months

(1,205 of 1,343) of clients housed in PSH between July 2011 and the end of 2016

Progress Toward Goal of 6,000 New Housing Opportunities

1,449 New as of December 31, 2017	804 Pipeline as of Dec. 31, 2017	6,000 Goal for New Opportunities
946 🏠	655 🏠	3,400 🏠
503 ⏱	87 ⏱	2,600 ⏱
	62 TBD	

🏠 Permanent Supportive Housing   ⏱ Rapid Rehousing

2016 Measure A Production Goals & Progress

	PSH* to Assist Homeless Persons with Disabling Conditions & their Families	RRH* to Assist Homeless Working Families & Individuals Regain Permanent Housing	Housing Affordable to ELI* Individuals & Families	Housing Affordable to VLI* Individuals & Families	Total
Housing Goal	1,800	1,600	800	600	4,800
Approved Units	489	0	91	134	714**
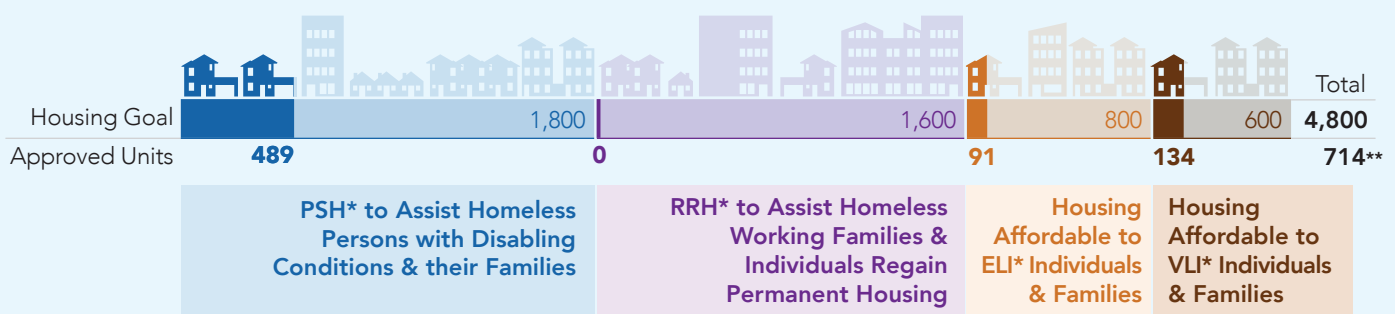
*PSH (Permanent Supportive Housing), RRH (Rapid Rehousing), ELI (Extremely Low Income), VLI (Very Low Income)
**103 additional units approved for Median Income households and building managers' apartments to bring the total to 817 new apartments approved within Year 1

Ending Homelessness: The State of the Supportive Housing System in Santa Clara County **2017**
Read the full report at: www.supportivehousingscc.org/report

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THE COUNTY OF SANTA CLARA 1850

Sample of Community-wide Written Standards Prepared by HomeBase

Santa Clara County's CoC Quality Assurance Standards (last updated 2019)

Santa Clara Countywide Quality Assurance Standards for Homeless Housing & Service Programs

Santa Clara County Continuum of Care

Table of Contents

How to Use the Quality Assurance Standards

The quality assurance standards were developed with the expectation of providing quality, standardized services to persons who have become homeless, to facilitate their successful re-entry back into their communities.

Applicability

Quality Assurance Standards

All Santa Clara County Collaborative on Affordable Housing and Homeless Issues member agencies should use the Quality Assurance Standards as a benchmark and model for agency- and program-level policies and procedures.

Standards demarcated as "Preferred Practice Recommended Standards" represent preferred community practices above and beyond the basic quality assurance standards. Programs are encouraged to implement Preferred Practice Recommended Standards whenever possible.

Local funders are encouraged to use the Quality Assurance Standards to assess agency and program capacity, operations, and performance.

Standards for Continuum of Care and Emergency Solutions Grant Recipients

The following sections serve as the Continuum of Care's written standards for providing assistance, as required under Continuum of Care Program Interim Rule section 578.7(a)(9):

- Section C. Permanent Supportive Housing

- Section D. Rapid Re-Housing

- Section E. Transitional Housing

- Section J. Coordinated Assessment Policies and Procedures

Certain sections of the Quality Assurance Standards are required policies of the Continuum of Care (CoC) for the CoC and Emergency Solutions Grant (ESG) Programs, and apply only to activities funded under the CoC or ESG programs. These sections are identified in the section and subsection headings.

The "Emergency Solutions Grant Monitoring" section outlines the Santa Clara County CoC's procedures for monitoring the performance of ESG recipients, as required under Continuum of Care Program Interim Rule section 578.7(c)(5).

Definitions

RESIDENT OR CLIENT

The terms "RESIDENT" OR "CLIENT", as used in the ensuing standards, refer to individuals or families who reside in a shelter, transitional housing, rapid re-housing or permanent supportive housing, as defined below, or participate in programs offered by homeless shelter, housing, or service providers.

SHELTER

The term "SHELTER", as used in the ensuing standards, includes all three types of shelters, temporary, basic and service-enriched, as defined below. When the standards apply only to a certain type of shelter, specific language is used to clarify the designation.

TEMPORARY OR WINTER SHELTER

The terms "TEMPORARY SHELTER" OR "WINTER SHELTER", as used in the ensuing standards, refer to all temporary or seasonal emergency shelters, including rotating church shelters, that provide shelter in a non-

permanent location, for a limited period of time, to individuals and families having neither a home nor the means to obtain a home or other temporary lodging. These shelters may be set up in response to natural disasters, harsh climactic conditions, or other emergencies. The programs and/or facilities are temporary and are not meant to exist beyond the length of the emergency or winter season.

BASIC SHELTER

The term "BASIC SHELTER", as used in the ensuing standards, refers to facilities providing shelter in a permanent location, for a limited period of time, to individuals and families having neither a home nor the means to obtain a home or other temporary lodging.

SERVICE-ENRICHED SHELTER

The term "SERVICE-ENRICHED SHELTER", as used in the ensuing standards, refers to facilities that provide shelter and services in a permanent location, for a limited period of time, to individuals and families having neither a home nor the means to obtain a home or other temporary lodging. Service-enriched shelters are distinguished from basic shelters by the provision of services, such as case management, substance abuse treatment, and/ or mental health counseling, which support residents' transition to stability.

TRANSITIONAL HOUSING

For the purposes of these standards, "TRANSITIONAL HOUSING" must comply with the standards of service-enriched shelters except where existing law requires a different standard. Transitional housing programs offer housing combined with an array of support services, for an extended, but not permanent length of time where clients may pay a percentage of their income towards their housing cost. Transitional housing is designed to provide people with the structure and support they need to address critical issues contributing to their homelessness and to teach the skills necessary to maintain permanent housing and maximum self-sufficiency.

BEDROOM

The term "BEDROOM", as used in the ensuing standards, refers to a room furnished with a bed and intended primarily for sleeping.

FACILITY

The term "FACILITY," as used in the ensuing standards, refers to a building, buildings, or part of building used to provide site-based services, shelter, or housing to persons experiencing homelessness or participating in Permanent Supportive Housing or Rapid Re-Housing. The definition of "FACILITY" does not include units occupied by participants in Rapid Re-Housing or Permanent Supportive Housing programs.

DROP-IN CENTER

"DROP-IN CENTER" refers to a program which provides services, including information and referral, food, bathrooms, seating accommodations and telephones, in a safe, welcoming, minimally intrusive environment that is designed to foster trust and personal engagement. Drop-in centers are not residential programs.

INTERNAL GRIEVANCE PROCEDURE

The term "INTERNAL GRIEVANCE PROCEDURE", as used in the ensuing standards, refers to a mechanism for clients to file official complaints about inadequate shelter conditions or improper staff behavior.

INTERNAL APPEAL PROCESS

The term "INTERNAL APPEAL PROCESS", as used in the ensuing standards, refers to a mechanism for clients to appeal the results of the internal grievance procedure or to appeal unfavorable admissions or eligibility decisions, shelter rules, sanctions or expulsions.

OUTREACH SERVICES

"OUTREACH SERVICES" refer to street outreach or mobile outreach teams that are designed to bring the existing service delivery system to the person or family served. These services are offered to persons and families who have unmet needs and who are not served or are under-served by existing service delivery mechanisms in the community.

PERMANENT SUPPORTIVE HOUSING

"PERMANENT SUPPORTIVE HOUSING" refers to a type of permanent housing that is organization sponsored and which provides housing linked with supportive services. Permanent supportive housing is designed to encourage maximum independence among its residents.

PERSONS WITH SPECIAL NEEDS

The term "PERSONS WITH SPECIAL NEEDS", as used in the ensuing standards, refers to individuals with a disability, whether mental, physical or developmental, who desire services relevant to their disability.

PREFERRED PRACTICE

The term "PREFERRED PRACTICE", as used in the ensuing standards, refers to those provisions and activities that are beyond basic standards of care. All programs are encouraged to implement Preferred Practices whenever possible.

PROGRAM

The term "PROGRAM", as used in the ensuing standards, refers to the entity that is providing the housing or services, which may include shelter, permanent supportive housing, prevention and support services, outreach services, drop-in center, or any other social services whether they are provided in a residential or non-residential setting.

RAPID RE-HOUSING

The term "RAPID RE-HOUSING" refers to a type of permanent housing program, which offers time-limited rental subsidies and case management. The aim of Rapid Re-Housing is to move individuals and families into permanent housing as rapidly as possible, and to provide supports necessary for clients to achieve independence and long-term housing stability.

REASONABLE ACCOMMODATION

The term "reasonable accommodation" refers to a change in a shelter or service provider's usual rules, policies, or practices when a change is necessary and reasonable for a participant with a disability to fully use and enjoy the program. The accommodation has to be directly related to the individual's disability.

SERVICE ANIMAL

The term "service animal," under the Americans with Disabilities Act and as used in the ensuing standards, refers to a dog that is individually trained to do work or perform tasks for people with disabilities. A service animal's training does not have to be documented or certified.

ASSISTANCE ANIMAL

The term "assistance animal," under the Fair Housing Act and Section 504 of the Rehabilitation Act of 1973 and as used in the following standards, refers to any animal that works, provides assistance, or performs tasks for the benefit of a person with a disability, or provides emotional support that alleviates one or more identified symptoms or effects of a person's disability. Assistance animals do not need to be individually trained or certified.

References

Americans with Disabilities Act: http://www.ada.gov/pubs/adastatute08.htm See Titles II and III

Federal Fair Housing and Amendments Act: http://www.justice.gov/crt/fair-housing-act-2 See §804

California Fair Employment and Housing Act http://www.dfeh.ca.gov/Publications_FEHADescr.htm See Chapter 6, Article 2

Unruh Civil Rights Act http://www.dfeh.ca.gov/Publications_Unruh.htm See Section 51

A. General Standards for Program Management

All programs must comply with the following standards, except where the standard is designated as applying to only certain program types.

I. Management and Oversight

A. Program management is planned, coordinated, monitored, and evaluated on a continuous basis.

B. Program operation is overseen by a County or City agency or a non-profit corporation with an independent oversight typically a Board of Directors. It is professionally run with appropriately trained staff.

II. Hours of Operation

A. The program posts its hours of operation in a conspicuous location.

Preferred Practice Recommended Standards

B. Reasonable accommodations are made outside of normal hours of operation for special circumstances such as illness, inclement weather, disabilities, etc.

III. Staff

A. For site-based programs, the program has trained, on-site staff persons (paid or volunteer), available and accessible in sufficient number to provide a safe environment during all hours that a facility is open to clients.

B. Appropriate criminal background checks will be conducted on all staff members that work with children.

C. Programs must have a policy prohibiting staff from establishing sexual relationships with program clients.

Preferred Practice Recommended Standards

D. Site-based programs should have sufficient staff on duty at each facility to provide for the safety and security of clients and of the facility. The ideal staff/client ratio should be determined based on the population(s) served, physical plant configuration (per building/site), and number of clients served.

IV. Staff Training

A. All programs must ensure that staff receive regular, high-quality training

B. For site-based programs, there is at least one staff person on-site at each facility at all times who has had training and orientation on the following topics. In temporary or winter shelters, staff receive at minimum a one-time training per season/year on these subjects.

1. CPR;

2. First Aid;

3. Crisis intervention and de-escalation techniques;

4. Cultural sensitivity;

5. Sexual harassment;

6. Sensitivity to wider issues of homelessness;

7. Universal Precautions (disease transmission prevention);

8. Child abuse/neglect reporting laws (if shelter provides services to children);

9. Search and Seizure/Probable Cause (shelter programs only);

10. TB Prevention (shelter programs only);

11. Medication handling (shelter programs only if shelter handles medication).

Preferred Practice Recommended Standards

C. For uniform and widespread communication of information and for economy, trainings should be sponsored by the Service Providers Network, the CoC, and/or local agencies and conducted jointly. Thereafter, staff attending the training should disseminate the training information to their co-workers.

V. Admission Procedures, Eligibility, & Documentation

A. The program's admission process must include written eligibility criteria that are fair and objective, and verbal or written notification in all appropriate languages or in a fashion readily accessible to accommodate non-hearing and sight impaired individuals, upon request, of reasons for non-acceptance.

The eligibility information must be made available to clients at intake and staff must provide answers to questions about the admission criteria and process.

B. The Santa Clara Continuum of Care and its housing and service providers are committed to fostering equal access to housing and services. Programs may not discriminate on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, age, familial status, or disability. Programs must provide notice of this non-discrimination policy to participants and prospective participants.

C. Programs must have formal appeal procedures through which clients may appeal unfavorable admission or eligibility decisions. Programs must provide clients with a copy of the policy for appeals at intake in a fashion readily accessible to accommodate non-hearing and sight impaired individuals. (See "Procedures to Protect Participant Rights, Section B")

D. Programs that condition services on particular criteria, such as treatment for current substance abuse, must document such criteria in writing in all appropriate languages or in a fashion readily accessible to accommodate non-hearing and sight impaired individuals and make these criteria clear to all clients at intake.

E. *CoC- and ESG- Funded Programs*: The Santa Clara County Continuum of Care funds Permanent Supportive Housing, Rapid Re-Housing, and Transitional Housing. Eligibility and documentation requirements for CoC-funded programs are outlined in Section D. Permanent Supportive Housing, Section E. Rapid Re-Housing, and Section F. Transitional Housing.

VI. Rules, Policies and Procedures

Programs are encouraged to adopt a low-barrier, housing first approach in their written policies and procedures, by limiting the grounds for expulsion from the program as much as is reasonably possible (see Section B.IV. Protection of Client Choice).

A. The program has reasonable rules for clients that are appropriate for the program model, target population, and services provided. Such rules clearly inform clients of the obligations upon which their continued participation in the program depends and the sanctions for non-compliance.

B. The program provides clients with a copy of the rules at intake in all appropriate languages or in a fashion readily acceptable to accommodate non-hearing and sight impaired individuals. In addition, it posts the rules in a location readily accessible to clients and visitors in all appropriate languages or in a fashion readily acceptable.

C. The program rules specify the rights of clients (See "Procedures to Protect Participant Rights, Section B") and the procedures in place to protect their rights and dignity. Clients must be permitted to exercise these rights without fear of reprisal.

D. The program rules must be equally applied to all clients, unless a client has asked for a reasonable accommodation due to his/her disability.

E. The program rules specify the reasons or conditions for which a client may be sanctioned or expelled, including those behaviors which constitute gross misconduct and are grounds for immediate discharge from the program and those which would prompt a written warning if violated and potential discharge if violated repeatedly. This information is provided in a manner which is clear and easily understood by clients.

F. The program rules describe the formal appeal procedures through which clients may appeal program regulations, sanctions or expulsions. (See "Procedures to Protect Participant Rights, Section B")

G. The program rules include the policy and procedures governing how and when searches of clients' private possessions may be conducted. (See "Procedures to Protect Participant Rights, Section B")

Basic & Service Enriched Shelter Standards:

H. The program rules require that clients and staff respect the personal rights and private property of the other clients. This includes abstaining from disorderly conduct, the use of threatening or abusive language and excessive noise.

I. The program rules specify that clients who have visitors are responsible for ensuring that their visitors comply with all shelter rules pertaining to the behavior of guests.

J. The program rules specify any normal housekeeping services required of clients.

K. Shelter rules make clear when and under what circumstances maintenance personnel or contractors can enter a room or apartment without the client's permission. Clients must be given reasonable advance notice when possible if such access is required in non-emergency situations.

VII.   Domestic Violence Policies

All efforts shall be made to protect the privacy and safety of survivors of domestic violence, dating violence, sexual assault or stalking (hereinafter "domestic violence survivors"). The following procedures are required for any CoC-funded programs.

A. Privacy and Safety

1. Programs which are primarily for survivors of violence ("victim service providers") are prohibited from contributing client-level data into the HMIS System. However, these programs must record client-level data within a comparable internal database and be able to generate aggregate data for inclusion in reports.

2. Victim service providers should ask incoming households experiencing homelessness whether they want their HMIS record to be deidentified in HMIS if such a record exists. If deidentification is desired, the victim service provider should have the survivor sign a letter stating the request. The victim service provider must then send the request to the Bitfocus Help Desk. The Help Desk

can be reached via email at sccsupport@bitfocus.com, by phone at 408-596-5866 Ext. 2, or by going to scc.hmis.cc and opening a Support Ticket.

3. If a non-victim service provider becomes aware that a household being served is fleeing or attempting to flee violence, the provider should:

   a. Immediately offer the household a warm referral to a victim service provider; and

   b. Check the HMIS System to see if there is an existing record for the household and proceed as follows:

      i. If there is no existing HMIS System record for the household, explain the Release of Information and offer the household the option to have their information entered into HMIS anonymously. The provider should explain the process for housing referrals if entered anonymously (referral would be processed through the service provider entering the record into HMIS, who would then attempt to locate the client if a referral is made).

      ii. If there is an existing HMIS System record for the household that includes the household's identifying information (non-anonymous), offer the household the option to make this existing HMIS profile anonymous. The provider should immediately notify the Bitfocus Help Desk if they change a previously existing profile from non-anonymous to anonymous so that other providers serving the household are notified of this change.

      iii. If the DV survivor is part of a household in HMIS that includes their abuser, offer the survivor the option to remove their identity from the existing household and create a new and separate anonymous client profile. The provider should notify the Bitfocus Help Desk by following the procedure in subsection (2) above.

4. The location of Domestic Violence shelters/programs shall not be made public.

5. Staff responsible for coordinated assessment shall receive training on protecting the safety and privacy of individuals who are fleeing, or attempting to flee violence.

6. No CoC-funded program will deny or terminate assistance or evict a participant solely because she or he is a domestic violence survivor.

7. For each program participant who moved to a different Continuum of Care due to imminent threat of further violence under § 578.51(c)(3), the CoC program must retain:

   a. Documentation of the original incidence of violence. This may be written observation of the housing or service provider; a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has sought assistance; medical or dental records; court records or law enforcement records; or written certification by the program participant to whom the violence occurred or by the head of household.

   b. Documentation of the reasonable belief of imminent threat of further violence, which would include threats from a third-party, such as a friend or family member of the perpetrator of the violence. This may be written observation by the housing or service provider; a letter or other documentation from a victim service provider, social worker, legal assistance provider, pastoral counselor, mental health provider, or other professional from whom the victim has sought assistance; current restraining order; recent court order or other court records; law enforcement report or records; communication records from the perpetrator of the violence or family members or friends of the perpetrator of the violence, including emails, voicemails,

text messages, and social media posts; or a written certification by the program participant to whom the violence occurred or the head of household.

B. Certification of homelessness

For victim service providers:

1. An oral statement by the individual or head of household seeking assistance that states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers:

1. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; and

2. Certification by the individual or head of household that no subsequent residence has been identified; and

3. Self-certification, or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

    a. These requirements apply to all CoC-funded PSH, RRH and TH programs funded through the 2017 CoC Program Notice of Funding Availability (NOFA) and all subsequent CoC Program NOFAs.

    b. Required Forms and Notices

        i. All CoC-funded PSH, RRH and TH must provide each household applying for assistance with a Notice of Occupancy Rights and Certification Form at the following times:

            1. The household is denied assistance;

            2. The household is admitted to the program;

            3. The household receives notification of eviction; and/or

            4. The household is notified of termination of assistance.

        ii. The Notice of Occupancy Rights must include:

            1. VAWA protections, including survivor rights of confidentiality and the prohibited bases for denial or termination of assistance or eviction; and

            2. Limitations of VAWA protections, including a housing provider's compliance with court orders and right to evict or terminate assistance to tenants for any violation not premised on an act of domestic violence, dating violence, sexual assault, or stalking.

        iii. The Certification Form must be approved by HUD, and provide space for the applicant to state:

            1. That they are a survivor of domestic violence, dating violence, sexual assault or stalking;

            2. That the incident that is the ground for protection meets the applicable definition for such incident under 24 CFR 5.2003; and

            3. The name of the individual who committed the violent act, if the name is known and safe to provide.

    c. Contracts between recipients/subrecipients and property owners/landlords must include the following provisions to ensure the owner/landlord is complying with requirements under VAWA in any leases with program participants:

        i. A statement that the "owner/landlord will comply with 24 CFR part 5, subpart L";

        ii. A provision ensuring that if the owner/landlord is to have a lease with a participant, the owner/landlord will include in the lease the provisions in 24 CFR 5.2005(b) and (c);

iii. If assistance is not TBRA, a provision ensuring that any lease, sublease or occupancy agreement with a program participant will permit the program participant to terminate the lease, sublease or occupancy agreement without penalty if the recipient determines the participant qualifies for an emergency transfer;

iv. Landlord/owner may include a provision that these protections only apply while the participant receives assistance through the CoC program.

d. Leases, subleases and occupancy agreements between recipients or subrecipients and program participants must include:

i. A provision that the program will comply with 24 CFR part 5, subpart L;

ii. The provisions in 24 CFR 5.2005(b) and (c);

iii. If the participant is not receiving TBRA, any lease, sublease, or occupancy agreement with a participant must permit the participant to terminate the lease, sublease, or occupancy agreement without penalty if the recipient determines the participant qualifies for an emergency transfer;

iv. The recipient or subrecipient may also include a provision stating that the protections under 24 CFR part 5, subpart L, will apply only during the period of assistance under the CoC Program.

e. Lease Bifurcation

i. Housing providers may bifurcate tenant-based rental assistance leases to evict, remove, or terminate assistance to a household member who engages in domestic-violence related criminal activity without evicting, removing, or terminating assistance to, or otherwise penalizing, a victim of such criminal activity who is also a tenant or lawful occupant.

ii. Tenant-based rental assistance and any utility assistance shall continue for the family member(s) who are not evicted or removed.

iii. If the lease is bifurcated for a family residing in permanent supportive housing and the family's eligibility for housing was based upon the evicted or removed family member's disability or chronic homeless status, the remaining family members may stay in the project as provided by 24 CFR 5.2009(a).

VIII.   Education Policies

Consistent with the CoC Program Interim Rule 24 CFR §578.23, all CoC and ESG programs assisting families with children or unaccompanied youth must:

A. Take the educational needs of children into account when placing families in housing and will, to the maximum extent practicable, place families with children as close as possible to their school of origin so as not to disrupt such children's education.

B. Inform families with children and unaccompanied youth of their educational rights, including providing written materials, help with enrollment, and linkage to McKinney Vento Liaisons as part of intake procedures.

C. Not require children and unaccompanied youth to enroll in a new school as a condition of receiving services.

D. Allow parents or the youth (if unaccompanied) to make decisions about school placement.

E. Not require children and unaccompanied youth to attend after-school or educational programs that would replace/interfere with regular day school or prohibit them from staying enrolled in their original school.

F. Post notices of student's rights at each program site that serves homeless children and families in appropriate languages.

G. Designate staff that will be responsible for:

    1. Ensuring that homeless children and youth in their programs are in school and are receiving all educational services they are entitled to; and

    2. Coordinating with the CoC, the Department of Social Services, the County Office of Education, the McKinney Vento Coordinator, the McKinney Vento Educational Liaisons, and other mainstream providers as needed.

IX. Family Admission and Separation Policies

a. Consistent with CoC Program Interim Rule §578.93:

    i. CoC and ESG providers that serve families may not use the age or gender of a family member under 18 as the basis for denying admission to a family. CoC and ESG providers that serve families may not deny admission to any member of a family that is being served by the program. "Family member" means any member of a household as defined or identified by the household, and is not limited to persons related by birth, adoption, or marriage.

    ii. The CoC will work closely with providers to ensure that placement efforts are coordinated to avoid involuntary family separation, including referring clients for the most appropriate services and housing to match their needs.

b. Continuing efforts will be made among cold winter shelters to ensure that families are not separated and the 211 telephone system will be used to help identify the needs of families and keep them together.

X. Injury Prevention

A. The program has a Workplace Injury and Illness Prevention Program, in compliance with Cal/ OSHA guidelines in Title 8 of the California Code of Regulations, and posts recommended practices regarding on-site injury prevention as well as guidelines for response to on site injury.

B. All entrance and exit ways at program facilities are clear of blockages and tripping hazards.

C. Clients are not locked in any portion of a program facility without a means of exit.

XI. Emergency Procedures

Standards for Program Facilities

A. The program promptly and appropriately responds to the medical problems of clients and staff.

B. The program has first aid equipment and supplies for medical emergencies available at all times. These supplies must be checked regularly to ensure they are up to date and their location in the facility must be clearly marked.

C. The program has written protocols to guide staff response to shelter crises including, but not limited to, physical injury, client suicide attempts, overdoses, and domestic or other violence.

D. The program has a phone available 24 hours per day to contact the fire department, paramedics, police and site supervisor personnel, and posts a list of such emergency numbers.

E. There should be posted policies and procedures for responding to emergencies. The program has at least one designated individual person on site at all times who has had training and orientation on emergency procedures.

F. Universal precaution practices are used to prevent transmission of diseases and are implemented under the presumption that blood and body fluids from any source are to be considered potentially infectious. Supplies necessary for maintaining universal precautions, such as sharps containers, must be available.

G. The program has a fire safety system including a posted evacuation plan and map in each room and all items required by building, safety, and health codes.

Preferred Practice Recommended Standards

H. The program should develop written, site-specific emergency response protocols with local police, fire department and other agencies. The protocols should address personnel and client-centered emergencies such as overdoses and violence, and should sensitize police and fire departments to the special needs of the program, its population and its environment. The protocols should outline the way in which police and fire departments should enter the facility, what they can expect of clients and staff when they enter the facility, and which staff to interact with. This document should be created in cooperation with the police and fire departments and should be part of an ongoing relationship with these departments. Shelters should develop these protocols in addition to developing a plan, based on the Standardized Emergency Management System, which will address facility and environmental emergencies.

XII. Disaster Preparedness and Response

A. Agencies should participate in community-wide disaster preparedness efforts, including training and drills.

Standards for Program Facilities

B. The program mitigates earthquake hazards by anchoring cases and file cabinets and eliminating falling hazards.

C. **Basic & Service Enriched Shelter Standard:** The program has a plan based on the Standardized Emergency Management System (SEMS) - a local, state, and federally-mandated system to respond to earthquakes, fires, floods, and other disasters.

XIII. Food Services

All programs that provide food services on site must comply with the following standards.

A. If a program provides meals, they must be well-balanced and nutritious. The meals may be provided either directly or through a contractual arrangement.

B. All health codes will be observed in the preparation and storage of food.

Preferred Practice Recommended Standards

C. Programs providing food services should make a reasonable effort to meet medically appropriate dietary needs of all clients as prescribed by appropriate medical or dental personnel.

D. Programs providing food services on-site should provide food buying and menu planning by a staff member, consultant or volunteer knowledgeable in nutrition.

XIV.   Transportation Services

All programs providing transportation services with agency vehicles must comply with the following standards.

A. The program has written policies and procedures that guide the use and maintenance of agency motor vehicles used for client transportation.

B. If the program serves people with children, it must have sufficient car seats and booster seats for infants and toddlers, and children 6 years or younger and/or 80 pounds or below and must use them in a manner complying with existing law when infants, toddlers, and children are being transported.

C. All vehicles (personal and agency) used for transportation are fully and adequately insured, operated only by licensed drivers, and have up-to-date registration. All drivers and passengers must use seat belts, as required by law.

D. Mass transport vehicles receive, at a minimum, an annual safety inspection by qualified individuals. Documentation of immediate completion of safety repairs is kept on file.

E. Programs that provide transportation make provisions for clients who need vehicles that are wheelchair accessible.

B. Procedures to Protect Participant Rights

I.   Basic Rights

A. Providers of shelter, housing, and services to the homeless must protect the rights and dignity of the individual or family served in all phases of service delivery. At a minimum, providers must afford each client the following rights and protections. Clients must be permitted to exercise these rights without fear of reprisal.

B. All shelter clients are entitled to enjoy a safe and healthful environment in the shelter or program.

C. All program clients are entitled to be treated in a manner that respects their dignity and individuality.

D. All program clients with disabilities are entitled to reasonable accommodations under fair housing laws when such accommodations are necessary because of their disability.

E. All clients are entitled to remain in the program and not be involuntarily removed without reasonable notice, good cause, and just procedures.

F. All program clients are entitled to just and standardized procedures for determining eligibility, admissions, sanctions and dismissals, and resolving grievances

G. All program clients are entitled to reasonable privacy and confidential treatment of personal, social, financial, medical, mental and behavioral health records, except as necessary to further treatment, information and referral services and in compliance with the client's consent to release information.

H. All program clients are entitled to the full exercise of their civil, constitutional, and legal rights.

II.   Opportunities for Participants in Program Administration

A. Programs shall provide clients with on-going opportunities to voice opinions, to participate in program operation and programming, and to make suggestions regarding programming and rules.

B. Programs shall respect clients' right to exercise their civil, constitutional and legal rights in regard to access to shelter, housing and services.

III. Protection Against Discrimination

A. Clients' rights must be protected against all forms of discrimination, including those based on race, religious creed, color, national origin, ancestry, language, disability (physical or mental health), medical condition, marital status, familial status, age, sex or gender identify, sexual orientation, source of income, or political affiliation.

B. Programs must have a written policy that harassment of clients and staff on the basis of race, religious creed, color, national origin, ancestry, language, disability (physical or mental health), medical condition, marital status, familial status, age, sex or gender identity, sexual orientation, source of income, or political affiliation will not be condoned nor tolerated. Programs must post this policy in a conspicuous place and in all appropriate languages.

C. Programs must have a written policy regarding the religious freedom of clients and staff. Programs that receive federal funding cannot require clients, staff or guests to participate in religious worship or instruction and cannot proselytize to clients, staff or guests.

D. Clients and staff have the right to report any acts of harassment or discrimination in violation of the program's policy without fear of retaliation.

E. Programs must take immediate action up to and including disciplinary action and/or termination against any person who violates the program's policy against harassment and/ or discrimination. Programs must adopt and follow written procedures for responding to violations of the program's policy against harassment and/or discrimination, if such violations are not covered by the program's grievance and termination procedures.

F. Program staff must respect and reasonably accommodate personal and cultural differences associated with race, religious creed, color, national origin, ancestry, language, disability (physical or mental health), medical condition, marital status, familial status, age, sex or gender identity, sexual orientation, source of income, or political affiliation.

G. At no point shall program access be denied because of an individual's disability. Moreover, a program may not apply different rules to individuals because of their disabilities, unless the different rules are a result of granting a reasonable accommodation request made by an individual with a disability.

H. Clients with disabilities are entitled to reasonable accommodations. If a client requests a change in a program's policy or procedure as an accommodation of his/her disability, the program should grant the accommodation when the accommodation is both reasonable and necessary because of the individual's disability. Such an accommodation request must be considered during any stage in the provision of a program, including at intake, during services, and during discharge proceedings. When a reasonable accommodation request is made, the program supervisor may request medical verification of the individual's disability.

I. Service Animals

   a. Programs providing emergency shelter and/or services must allow service animals to accompany people with disabilities in all areas of a program facility where clients are normally allowed to go. This includes but is not limited to publicly accessible areas, common areas, areas used to provide services or case management, and sleeping accommodations in emergency shelters. Persons with service animals cannot be isolated from other clients, treated less favorably than other clients, or asked to pay a fee in connection with their service animal.

   b. All programs administered by the state of California, by a local government, or by a state or local public agency such as a public housing authority, must allow people with disabilities to have service animals in all areas of a program facility where clients are normally allowed to go, which includes but is not limited to publicly accessible areas, common areas, areas used to provide services or case management, sleeping accommodations in emergency shelters, and in a client's

housing unit. Persons with service animals cannot be isolated from other clients, treated less favorably than other clients, or asked to pay a fee in connection with their service animal.

    c. In programs that are required to allow service animals, program staff may not ask a person with a service animal to prove or document that the animal is trained, that the person needs the animal to assist them, or that the person has a disability. If, and only if, it is not readily apparent that the animal is trained to perform tasks for a person with a disability, programs may ask the person with the service animal the following two questions:

        i. Is this a service animal that is required because of a disability?

        ii. What work or tasks has the animal been trained to perform?

    d. Programs that are required to allow service animals may ask persons with service animals to keep the animal harnessed, leashed, or tethered, unless that would interfere with the service animal's work or the person's disability prevents the use of a harness or leash. In that case, the program may require the person to maintain control of the animal through voice, signals, or other controls.

    e. In programs that are required to allow service animals, person with a service animal can be asked to remove their service animal from a program facility or housing unit for the following reasons, only:

        i. The animal is out of control and the owner takes no effective action to control it, or

        ii. The animal is not housebroken.

J.   Assistance Animals

    a. Programs providing emergency shelter, transitional housing, or permanent housing must evaluate any request for a reasonable accommodation to possess an assistance animal using the same principles and process applied to all reasonable accommodations requests. Upon receiving a request to live with an assistance animal, the program must consider the following:

        i. Does the person making the request have a disability?

        ii. Does the person making the request have a need for the assistance animal that is related to their disability?

    b. When considering a request to possess an assistance animal, the program may ask the person making the request to provide reliable documentation of a disability, unless the person's disability is apparent or is already known to the housing provider.

    c. If an animal meets the definition of "assistance animal" and of "service animal," and the program is of a type required to allow service animals, then the animal must be treated as a service animal.

K. Programs must have a written policy to ensure equal access to shelter, housing and services regardless of actual or perceived sexual orientation, gender identity, or marital status. Where appropriate, program policies will comply with the Department of Housing and Urban Development's Equal Access Rule and Notice CPD-15-02 on Appropriate Placement for Transgender Persons in Single-Sex Emergency Shelters and Other Facilities.

    a. If bathroom or shower facilities are single-sex, transgender clients should have access to bathroom and shower facilities based on their gender of identification. People who identify outside of the male/female gender binary should have access to whichever bathroom and shower facilities help them feel safest.

    b. Single-sex shelter and transitional housing programs will place clients in shelter or housing that corresponds to the gender with which that person identifies or, if the client does not identify with either binary gender, in the shelter or housing situation that makes the client feel safest.

     c.   Programs must provide notice and training to all program staff to ensure compliance with written policies regarding equal access and client intake.

IV.   Protection of Client Choice

A.   Generally, the use of services beyond the provision of food and shelter should be encouraged and tailored to the level and type of need of each client; however, programs are encouraged to adopt a low barrier, housing first approach and to refrain from requiring participation in services as a condition to housing, to the extent possible.

    1.   The following are recommended as the minimum standard for a housing first approach in all programs:

       i.   Income is not a requirement for program entry or participation.

       ii.   Sobriety and treatment compliance are not requirements for program entry or participation.

       iii.   Compliance with a service or treatment plan is not a condition or tenancy, and lack of compliance is not grounds for eviction.

    2.   Programs are strongly encouraged to align with the following housing first standards:

       i.   During the admission/screening and acceptance process, applicants are considered and acceptance without regard for sobriety or use of substances, completion of treatment, and/or participation in supportive services.

       ii.   Participants are not required to participate in drug tests as a condition of program entry or participation.

       iii.   Accept applicants with poor credit or financial history, low or no income, poor or lack of rental history, minor criminal convictions, history of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement), or behaviors that indicate a lack of "housing readiness."

       iv.   Accept housing referrals from shelters, street outreach, drop-in centers, and other parts of crisis response system frequented by vulnerable people experiencing homelessness.

       v.   Explicitly state in their policies that clients will not be terminated from the program for any of the following reasons: use of alcohol or drugs; failure to participate in supportive services; loss of income or failure to improve income; being a victim of domestic violence; and any other activities not typically covered in lease agreements in the program's geographic area.

       vi.   Provide client-centered service plans and explicitly state in their policies that clients will not be terminated from the program for lack of participation or lack of progress with a service plan, or non-compliance with program requirements. (Note that rapid re-housing programs may require case management as condition of rental assistance.)

    3.   Programs should aspire to meet the following exemplary housing first standards:

       i.   Follow a tenant selection plan that includes prioritization of eligible tenants based on criteria other than "first come, first serve," such as duration or chronicity of homelessness, vulnerability, or high utilization of crisis services.

       ii.   Provide tenants reasonable flexibility in paying their tenant share of rent on time and offer special payment arrangements for rent arrears, assistance with financial management, including payment plans, or representative payee arrangements.

iii.   Train and assist case managers and service coordinators to actively employ evidence-based practices for client and tenant engagement, such as motivational interviewing and client-centered counseling.

iv.   Utilize a harm reduction model where tenants are engaged in non-judgmental communication regarding drug and alcohol use and are offered education regarding how to avoid risky behaviors and engage in safer practices.

v.   Provide units that accommodate disabilities, reduce harm, and promote health among tenants. Examples include elevators, stove-tops with automatic shut-offs, wall-mounted emergency pull-cords, ADA wheelchair compliant showers, etc.

V.   Protection of Privacy

A.   Clients are entitled to enjoy the maximum amount of privacy under the circumstances.

B.   Clients have the right to have private written and verbal communications, including the right to meet with legal representatives and legal counsel.

C.   Clients are entitled to receive and send mail or any other correspondence without interception or interference, where mail service is available.

VI.   Protection Against Unreasonable Searches and Seizures

A.   **Programmatic or Routine Searches:** Routine or programmatic searches are searches or inspections that do not target individual clients or residents, but are conducted for all clients on a routine basis according to a program's written policies and procedures. Programmatic or routine searches include routine bag checks when clients enter program facilities, and room inspections for purposes of pest control.

1.   Searches may only be conducted on a programmatic or routine basis when the program has a sufficiently compelling policy reason to conduct such searches, and the search is the least intrusive means to accomplish the goal.

2.   Programmatic or routine searches are permitted only within program facilities, or as a condition to entry to a program facility.

3.   Programs must have written policies and procedures regarding when and how program staff will conduct routine searches and what will be done with items of client property that are not permitted in the program facility.

4.   Clients must be informed of the program's policies and procedures regarding routine searches, including storage of items not permitted in the program facility, treatment of illegal or dangerous items, and any consequences to the client, at or prior to entry into the program.

5.   Clients must be permitted to refuse to consent to a routine search and elect to exit the program.

6.   If a client possesses items not permitted in the program facility, the client must be given the option to retain the items and decline to enter the facility.

7.   Where feasible, programs should offer to retain and store items for the client, and return the items when the client exits the facility.

8.   If the client chooses to surrender items not permitted in the facility, and the program cannot legally or safely store items (e.g. weapons, illegal drugs), program staff should contact law enforcement or other appropriate authority to arrange for storage or disposal. The program may not disclose information regarding the client's possession of illegal or dangerous items, without the client's prior written consent. Clients must be informed of this course of action prior to surrendering the item.

B. **Targeted Searches and Seizures:** The following standards apply to congregate living facilities, including site-based emergency shelters and site-based transitional housing. Programs and program staff should not conduct targeted searches of clients or seize client property in other types of facilities (e.g. program offices, facilities providing supportive services), or in permanent housing units occupied by residents. All programs and program staff must respect tenants' rights and protections, when they apply.

1. Programs must have a policy and procedure governing when and how searches of clients' private possessions may be conducted. These policies and procedures must be in writing and shall be in all appropriate languages or in a fashion readily accessible to accommodate sight impaired individuals. These policies and procedures either shall be given to clients at intake or conspicuously posted.

2. The program rules include the policy and procedures governing how and when searches of clients' private possessions may be conducted. Unless the law requires otherwise, searches will only be conducted when there is "probable cause" to believe that the person has in his or her possession something which may jeopardize the safety of other clients or staff, including a weapon, or illegal material, including illegal drugs. The search policy must include specific factors to be considered in determining "probable cause." The least intrusive means to search will be utilized. The more intrusive the search, the more compelling the circumstances must be to justify the search.

3. Searches must be made in a reasonable manner with respect for the individual's dignity and privacy. Searches may only be conducted to the extent required in order to find a weapon, illegal material, drugs or alcohol. (For example, if a gun is suspected to be in a person s possession, a locker may be searched but not a wallet.)

4. Before a search is conducted, the client must be given an opportunity to voluntarily consent to a search.

5. If the person does not consent to the search, and "probable cause" exists to search, the person must be given the choice of being discharged or being searched.

6. Whenever possible, the individual must be given an opportunity to be present during all inspections of his or her belongings.

7. If a search is conducted, the following information must be documented in the person's record or if individual records are not kept, in the shelter's daily log:

    i. the facts establishing reasonable grounds for the search;

    ii. whether the client consented to the search or was discharged;

    iii. the scope of the search and the manner in which it was conducted; and

    iv. the individuals' name(s), gender(s) and role(s) who were present at the search.

8. Unless only one staff person is present at the program, searches must be conducted in the presence of at least two program staff members.

9. Searches of an individual's body must be made by a program staff member of the same gender as the individual being searched.

10. Illegal contraband confiscated during a search may be turned over to law enforcement. Oral information identifying from whom the contraband was confiscated may not be communicated to law enforcement unless in response to a subpoena. Written information identifying from whom the contraband was confiscated may not be turned over to law enforcement unless in response to a warrant or subpoena. When the circumstances permit, senior management should supervise interactions with law enforcement.

11. Any search policy must include specific factors to be considered in determining "probable cause" to search.

12. Before a search is conducted, the program's written search policy shall be given and explained to the person to be searched.

VII.   Confidentiality

A. Programs must respect clients' right to confidential treatment of personal, social, financial, and medical records. Programs must develop and follow written policies and procedures regarding the confidentiality of information about clients.

B. HMIS participating agencies must comply with all confidentiality, privacy, and security standards in the "Santa Clara HMIS Standard Operating Procedures."

C. Without a client's lawful consent to disclose information, all information and records obtained in the course of providing behavioral health services must be kept strictly confidential, even as to other program staff. Information gathered in the course of other, non-mental health related support services is also kept confidential unless otherwise necessary, following all application privacy, confidentiality, and data security laws and regulations for those services.

D. Programs must ensure that their procedures conform with all applicable legal and statutory requirements including, but not limited to, laws governing health care records and information, information about behavioral health consumers, victims of domestic violence, the federal drug and alcohol confidentiality law, and laws and regulations pertaining to the confidentiality of HIV information. When appropriate, programs should obtain legal counsel regarding the confidentiality of records and the general conditions under which they may be subpoenaed. Additional legal counsel is sought, if necessary, when courts, public officials, investigative units, or law enforcement bodies seek special or unusual information about a client.

E. Programs must comply with mandatory reporting laws, and protect clients and the community when a client may be dangerous to self or others. To this end, programs must establish and follow written policies regarding disclosure of sensitive information about the client. Internal policies and procedures are developed for recording and periodically reviewing these cases to determine that appropriate disclosure takes place.

F. When programs receive a valid request for the release of confidential information, programs must obtain the informed, written consent of the client as required by law. Programs shall provide a copy of the signed consent to the person giving consent and place a copy in the case record. Documentation of a client's consent should include the following elements as well as any other elements that may be required by applicable law:

1. the signature of the person whose information will be released, or the legal guardian of a client who is not able to provide such informed consent;

2. the specific information to be released;

3. the purpose for which the information is sought;

4. the date the consent takes place;

5. the date the consent expires;

6. the identity of the person to whom the information is to be given;

7. the identity of the person within the organization who is releasing the confidential information; and

8. a statement that the person or family served may withdraw their consent at any time.

G. In the absence of a subpoena or other legal requirement, programs and program staff will not provide information about clients to law enforcement or other outside entities without written consent of the client.

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H. Programs shall protect the confidentiality and privacy of clients by prohibiting participation in public performances against the wishes of the client or without informed consent of that person (and, for a minor, of the client and the client's parent or guardian); the required or coerced use of public statements that express gratitude to the organization; and the use of identifiable photographs, videotapes, audio-taped interviews, artwork, or creative writing for public relations purposes without the informed consent of that client (and, for a minor, of the client and the client's parent or guardian).

VIII. Grievance Procedures

A. Programs must have an internal grievance process that clients can use to resolve conflicts within the program. Programs must have written policies and procedures for resolving grievances, including a statement regarding the client's right to request reasonable accommodation, and must post them in a place conspicuous and accessible to clients. In addition, each client shall receive a copy of the grievance policies and procedures, upon intake and upon receiving a warning or discharge notice, in all appropriate languages or in a fashion readily accessible to accommodate non-hearing and sight impaired individuals.

B. The grievance process focuses on preventing the escalation of conflicts, resolving conflicts, and improving program environments for clients and staff. To this end, programs must strive to maximize the use of informal avenues for resolving disputes whenever possible.

C. The program's grievance procedures must allow clients the opportunity to be represented by a third-party advocate in the grievance process. Reasonable efforts must be made to coordinate with the client's advocate in order to schedule the appeal.

D. The program's grievance procedures must provide clients the opportunity to present their case before a neutral decision-maker.

E. To the extent possible, the goal of grievance procedures should be conflict resolution, rather than determining or assigning fault or blame.

IX. Procedures for Expulsion or Sanction

A. Programs must have written policies detailing formal procedures for addressing behaviors, conditions, and circumstances that may necessitate a client's eviction or discharge from the program. At a minimum, program policy must explicitly state the specific conditions under which a client may be sanctioned, evicted, or terminated from the program; the formal procedures that will be followed in sanctioning or expelling a client; and clearly specified conditions for a client's re-acceptance after sanction or expulsion.

B. A client's disability cannot be used as grounds for discharge or sanction.

C. At a minimum, the program's procedures for sanctioning or expelling a client must include the following elements:

    1. Clients must be informed at intake of the specific reasons or conditions for which a client may be sanctioned or expelled, including those behaviors which are grounds for immediate discharge from the program and those which would prompt a written warning if violated and potential discharge if violated repeatedly. This information must be provided to clients in writing and must be clear and easily understandable by clients.

    2. Timely due process provisions.

    3. Notice of, and access to, formal appeal procedures.

    4. Notice of the conditions or process for re-admission to the program.

    5. Reasonable efforts to provide an appropriate referral to another facility.

D. Timely due process provisions include:

1. Two warning notices for violations which do not result in immediate discharge prior to issuance of a discharge notice;

2. Opportunity for a case conference after warning is issued to the client;

3. Discharge notices in writing which are initiated by staff or program supervisor and which state the grounds for discharge, the client's right to request a reasonable accommodation, the client's right to file an appeal, and the client's right to bring an advocate to the appeal, if the client so chooses;

4. The establishment of an internal appeal process before a program supervisor, other than the staff or supervisor who initiated the discharge;

5. Denial of services requires the signature of the supervisor;

6. The establishment of an external appeal process before a neutral party if the decision from the internal appeal process is unfavorable; and

7. The implementation of a policy whereby a client has the right to retain residence or services in the program during the appeal process when the discharge is based on a violation that does not result in immediate discharge.

C. Permanent Supportive Housing (PSH)

The following standards will govern the CoC-funded PSH projects in the Santa Clara County CoC. Each program may focus or operate a little differently, but will align with the overall standards.

I. Target Populations for Assistance

The Santa Clara County CoC-funded PSH programs will target the following populations:

1. Chronically homeless individuals and families

2. Homeless individuals with disabilities

3. Homeless families with a disabled head of household

4. Homeless youth with disabilities

5. Elderly homeless adults

II. Structure of Permanent Supportive Housing Assistance

PSH is community-based permanent housing with intensive case management, and is the most intensive housing intervention available under the CoC Program.

1. **Goals of Assistance:**

   a. After entering the PSH program, the household remains stably housed, either remaining in PSH or exiting to another permanent housing location.

   b. Some participants in PSH may choose to move into other subsidized housing, with a lower level of supportive services. While clients will be supported to move to other subsidized housing when appropriate, this will not be a goal for every PSH client.

2. **Duration/Subsidy Amount/Client Contributions:**

   a. There can be no predetermined length of stay in a PSH program.

b. *CoC-Funded Programs*: Total rent shall equal the sum of the monthly rent for the unit per the lease agreement plus, if the tenant pays separately for utilities, the monthly allowance for utilities (excluding telephone) established by the public housing authority in the area in which the housing is located.

c. *CoC-Funded Programs*: CoC-funded PSH programs must comply with CoC Program requirements regarding client portion of rent, FMR and Rent Reasonableness.

d. *CoC-Funded Programs*: Each participant in CoC-funded PSH programs must enter into a lease for an initial term of at least one year. The lease must continue automatically upon expiration on a month-to-month basis and be terminable only for cause.

III.   Eligibility Requirements

In order to qualify for PSH, households must satisfy the following criteria:

A. Be the highest priority household available within the target population served by the program, as identified through Coordinated Assessment.

B. Other eligibility criteria created at the program level.

C. *CoC-Funded Programs*: For CoC-funded PSH programs, participants must meet the following eligibility requirements:

1. The individual or household must meet the definition of homeless in the CoC Program Interim Rule, under Category 1 or Category 4.

2. Participants who are homeless under Category 1 and are entering transitional housing must have entered the transitional housing program from emergency shelter or a place not meant for human habitation.

3. The individual or at least one member of the household must have a disability of long duration, verified either by Social Security or a licensed professional that meets the state criteria for diagnosing and treating that condition.

All PSH programs are encouraged to dedicate some or all of their beds that become available through turnover to persons who meet the HUD definition of Chronically Homeless.

PSH programs will adopt a housing first approach and take all reasonable steps to reduce barriers to housing, including working with landlords to limit the criteria used to exclude applicants or evict participants. Unless required by law or as a condition of a particular source of funding, programs will not screen out or exclude participants based on any of the following:

1. Failure to participate in supportive services or make progress on a service plan

2. Having too little or no income

3. Refusal to participate in drug tests

4. Active or history of substance abuse

5. Experience of domestic violence (e.g. lack of a protective order, period of separation, etc.)

6. Credit or eviction history

7. Failure to participate in a probation or parole program

IV. Documentation Requirements

CoC-Funded Programs: For participants in CoC-funded PSH programs, documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates eligibility as follows. For more detailed guidance, please consult the Documentation Checklist: Homelessness Verification form on the CoC website.

A. **Category 1: Literally Homeless (in order of preference)**

1. Third Party Verification (HMIS print-out, or written referral/certification by another housing or service provider); or

2. Third Party Verification via written observation by an outreach worker; or

3. Certification by the intake worker whose only encounter with the program applicant is at the current point at which they are seeking assistance; or

4. Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter;

If the provider is using anything other than Third Party Verification, the case file must include documentation of due diligence to obtain third party verification.

B. **Category 4: Fleeing/Attempting to Flee DV**

For victim service providers:

1. An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers:

1. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified by an individual or organization from which the individual or head of household has sought assistance; and

2. Certification by the individual or head of household that no subsequent residence has been identified; and

3. Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

Additional documentation requirements apply to CoC-funded programs with beds dedicated to chronically homeless households. Please consult the Chronic Homelessness Documentation Checklist on the CoC website for more guidance.

V. Housing Requirements for Permanent Supportive Housing

A. All housing supported by CoC-funded PSH resources must meet all HUD requirements, including, but not limited to, Housing Quality Standards, rent reasonableness standards, FMR (as relevant), as well as other requirements including local regulations and community standards regarding occupancy limits based on unit size.

B. PSH programs will endeavor to offer as much client choice as possible regarding type and location of housing.

C. PSH programs will provide a living environment that is safe and accessible, offer supportive services, and encourage maximum independence.

D. Where possible, PSH services will be provided in community settings that are readily accessible by public transportation and convenient to shopping and other community services.

VI. Service Requirements for Permanent Supportive Housing

A. Case Managers will provide intensive case management services throughout each participant's stay in PSH to assist households to maintain housing stability. Services may be provided at the program offices, and Case Managers will conduct home visits when appropriate.

B. PSH programs, through collaborative arrangement or by referral, must offer services to all clients that are tailored to each client's needs. The level and type of services offered should fully meet each client's identified needs, including but not limited to any of the following:

1. Housing Support

a. Intake and assessment

b. Rental assistance

c. Legal assistance

d. Assistance with housing applications

e. Information and training regarding tenants' rights and responsibilities

f. Education and assistance around landlord-tenants' rights and responsibilities

g. Mediation and negotiation with landlords

2. Socialization & Daily Function

a. Daily living skills training

b. Budgeting and money management skills and training

c. Skills and training in maintaining a household

d. Eligibility screening for, and assistance applying for and retaining mainstream resources (SSI, CalWORKS, MediCal, Veterans benefits, etc.)

e. Vocational and employment assistance or training and referral

f. Supportive employment and referral for employment

g. Interpersonal communication skills

h. Transportation, including accompaniment to appointments, home visits

i. Child care

j. Parenting information and education

k. Conflict resolution and crisis intervention

l. Helping clients connect to meaningful daily activities

m. Social, cultural, or recreational activities

n. Opportunities for peer-to-peer education and support

o. Support groups and other services to maintain, preserve, and promote independence, including optimal physical, social, and psychological development and functioning

3. **Wellness**

    a. Service coordination

    b. Mental health counseling and education

    c. Substance abuse education and counseling

    d. Effective use of health care (medical/dental/mental health/psychiatric)

    e. Preventive health services

4. **General**

    a. Verification of progress towards achievement of short and long-term client objectives

C. Case managers will offer case management contact with clients at least four (4) times per month.

D. PSH programs are encouraged to maintain a client to case manager ratio at or below twenty clients to one FTE case manager.

VII. Procedures for Transfer Between Permanent Supportive Housing Programs

A. Transfers Within the Continuum of Care and Across Continuum of Care Geographic Borders

1. Requests for transfer between Permanent Supportive Housing (PSH) programs will be reviewed by the Office of Supportive Housing (OSH) staff responsible for facilitating matches to housing opportunities within the Coordinated Assessment system.

2. *CoC-Funded Programs:* An individual or household is eligible for transfer between CoC-funded PSH programs only if they met all eligibility requirements of the destination PSH program, prior to entry into the transferring PSH program.

B. Transfers Related to Domestic or Intimate Partner Violence or Stalking

1. When a resident of Permanent Supportive Housing requests a transfer related to domestic or intimate partner violence or stalking, OSH staff will prioritize that transfer.

2. Program staff of the transferring program will ensure that the person who experienced domestic or intimate partner violence has access to appropriate services in accordance with the Domestic Violence Policies (see Section B.IX, Domestic Violence Policies).

D. Rapid Re-Housing (RRH)

The following standards will govern the CoC- and ESG- funded RRH projects in the Santa Clara County CoC. Each program may focus or operate a little differently, but will align with the overall standards.

I. Target Populations for Assistance

The Santa Clara County CoC- and ESG- funded RRH programs will target the following populations:

1. Veterans

2. Youth and families with children

3. Individuals and families fleeing domestic violence

4. Non-Chronically Homeless individuals

5. Chronically Homeless not requiring permanent supportive housing

II. Structure of Rapid Re-Housing Assistance

The structure of rapid re-housing assistance is guided by a philosophy that encourages providers to provide the least amount of assistance to individuals and families to ensure their housing stability. Providers, together with the client, determine how long or often to provide a subsidy (unless determined by specific grant requirements, regulations, etc.) while at the same time ensuring that program resources are used as efficiently as possible.

1. **Goals of Assistance:**

   a. After receipt of assistance, household is able to remain stably housed.

   b. At the conclusion of assistance, providers are encouraged to follow-up with household for up to 6 months to monitor and/or evaluate whether household has remained stably housed.

2. **Duration/Subsidy Amount/Client Contributions:**

   a. Rental subsidies are provided for a maximum of 24 months based on client income and decline in steps based upon a fixed timeline, determined by the program. Providers may revise the fixed timeline as needed to accommodate the client's circumstances.

   b. Initial assistance can be as much as 100% of rent depending on client income. Client will pay a percentage of their income in rent based on the program's assessment of the client's financial and family situation, with rental assistance decreasing monthly over time (schedule to be determined by program).

   c. *CoC-Funded Programs*: Total rent shall equal the sum of the monthly rent for the unit per the lease agreement plus, if the tenant pays separately for utilities, the monthly allowance for utilities (excluding telephone) established by the public housing authority in the area in which the housing is located.

   d. *CoC-Funded Programs*: CoC-funded RRH programs must comply with CoC Program requirements regarding FMR and Rent Reasonableness.

   e. *CoC-Funded Programs*: Each participant in CoC-funded RRH programs must enter into a lease for an initial term of at least one year. The lease must continue automatically upon expiration on a month-to-month basis and be terminable only for cause.

   f. The goal is for households to "graduate" from the program once they no longer meet the eligibility requirements of the program's funding source and/or a Case Manager determines assistance can be terminated, whichever comes first.

   g. An assessment tool is used to determine the need for ongoing assistance every 90 days. Additionally, CoC-funded RRH programs must re-evaluate, not less than once annually, that a program participant lacks sufficient resources and support networks necessary to retain housing without CoC assistance and that the participant is receiving the types and amounts of assistance that they need to retain housing.

   h. If the household does not attain any of these goals, assistance ends at 24 months (or earlier time as set by the program).

3. **Move-In Assistance:**

   a. Move-In Assistance will be targeted to households who are assessed as able to maintain their unit after the assistance. The amount of move-in assistance is determined by the program, within the limits set by the program's funding source.

b. Move-In Assistance may be provided as one-time assistance or in tandem with Rental Assistance/Rental Subsidies.

c. Grant funds may be used for security deposits in an amount not to exceed 2 months of rent. An advance payment of the last month's rent may be provided to the landlord, in addition to the security deposit and payment of first month's rent.

d. Move-In Assistance only households must show proof of tenancy (e.g., named on the lease agreement or have a verifiable, valid sublease agreement, letters of verification).

III. Eligibility Requirements

In order to qualify for RRH, households must satisfy the following criteria:

A. Be the highest priority household available within the target population served by the program, as identified through Coordinated Assessment.

B. Other eligibility criteria created at the program level.

C. *CoC-Funded Programs*: For CoC-funded RRH programs, the individual or household must meet the definition of homeless in the CoC Program Interim Rule, under Category 1 or Category 4, consistent with the program's grant agreement with HUD. Additionally, the individual or household assisted in a CoC-funded RRH program must meet eligibility requirements identified in the NOFA for the grant year in which the program is funded.

It should be noted that if a client has entered multiple rapid re-housing programs and not found success with this service model, the provider is encouraged to assess and identify whether rapid re-housing is the best approach.

RRH programs will adopt a housing first approach and take all reasonable steps to reduce barriers to housing, including working with landlords to limit the criteria used to exclude applicants or evict participants.

Unless required by law or as a condition of a particular source of funding, programs will not screen out or exclude participants based on any of the following:

A. Failure to participate in supportive services or make progress on a service plan

B. Having too little or no income

C. Refusal to participate in drug tests

D. Active or history of substance abuse

E. Experience of domestic violence (e.g. lack of a protective order, period of separation, etc.)

F. Credit or eviction history

G. Failure to participate in a probation or parole program

Regarding Income

Households must demonstrate at point of program enrollment their ability and/or willingness to increase their income and/or decrease expenses and transition off the subsidy within the specified timeframe.

Regarding Rent to Income Ratio

Taking into account a household's total income and expenses, all Move- In Assistance only households should be able to demonstrate their permanent housing unit will be sustainable going forward.

Regarding Other Eligibility Requirements

Rapid re-housing targeted toward families with children may assist qualifying CoC applicant families who do not currently have physical custody of their child(ren), if documentation from CPS verifies that housing and/or other services is the only remaining barrier to reunification and if the funding source allows for it, that reunification will occur after housing is obtained, and the household demonstrates compliance with CPS, court orders, etc.

IV.   Documentation Requirements

CoC-Funded Programs: For participants in CoC-funded rapid re-housing programs, documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates eligibility as follows. For more detailed guidance, please consult the Documentation Checklist: Homelessness Verification form on the CoC website.

A. **Category 1: Literally Homeless (in order of preference)**

1. Third Party Verification (HMIS print-out, or written referral/certification by another housing or service provider); or

2. Third Party Verification via written observation by an outreach worker; or

3. Certification by the intake worker whose only encounter with the program applicant is at the current point at which they are seeking assistance; or

4. Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter;

If the provider is using anything other than Third Party Verification, the case file must include documentation of due diligence to obtain third party verification.

B. **Category 4: Fleeing/Attempting to Flee DV**

For victim service providers:

1. An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers:

1. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified by an individual or organization from which the individual or head of household has sought assistance; and

2. Certification by the individual or head of household that no subsequent residence has been identified; and

3. Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

V.   Housing Requirements for Rapid Re-Housing

A. All housing supported by CoC-funded RRH resources must meet all HUD requirements, including but not limited to, Housing Quality Standards, rent reasonableness standards, FMR (as relevant), as well as other requirements including local regulations and community standards regarding occupancy limits based on unit size.

B. RRH programs will endeavor to offer as much client choice as possible regarding type and location of housing.

C. RRH programs will provide a living environment that is safe and accessible, offer supportive services, and encourage maximum independence.

VI. Best Practices for Rapid Re-Housing

In addition to the requirements related to receiving RRH resources, the CoC encourages providers to implement best practices when locating and securing housing for applicant families.[1] Best practices include:

A. Overall Best Practices

1. Set Goals – From the start, identify and set goals with the household to determine what they want.

2. Set Expectations – Review the various rules and regulations related to housing – from noise levels to cleanliness to respect for neighbors. Stress the benefits. Differentiate between the household's wants versus their needs (e.g. studio serves the purpose rather than a one-bedroom).

3. Set Up Support – Have in place counseling and case management during housing process to assist with necessary changes as household transitions into housing (e.g. modifying behaviors that may be viewed negatively in residential settings).

4. Listen to Household – Meet regularly, view apartments together, recognize household's ability to decide where they want to live. Have household take an active role on the search.

5. Recognize What Landlords Want – Know what landlords are looking for in prospective tenants (tenants who pay on time, maintain property, get along with others).

6. Address Credit, and Criminal History Issues – Educate household on their credit report. Obtain it and review it with household, encourage payment arrangement on utilities to correct discrepancies. Same with criminal history – obtain police records to ensure information is accurate. Identify resources to assist household with cleaning up their criminal record.

7. Work with Landlords – Work closely with landlord to provide simple, straightforward explanations of a household's credit/criminal history (face-to-face is best). Once household accepted have landlord and household meet. Prepare household for this first impression (e.g. specific questions the landlord may ask). If household not accepted maintain positive attitude and motivation for possible future opportunity.

8. Understand the Purpose of the Security Deposit – Educate the household that the security deposit is a guarantee against damage not unpaid rent. Meet with the landlord and the client to do an inspection and document/photograph any existing damage and include in household's file.

9. Review the Lease – Review the lease with the household. Emphasize sections on rent, alteration of the apartment, lease violation, rules relating to guests and pets. Identify who is responsible for paying the utilities and any additional charges. Encourage the household to ask questions. Ensure that initial leases are for a term of at least one year, automatically renewable on a month-to-month basis, and terminable only for cause.

10. Anticipate Challenges – Provide and identify support for household who may be experiencing a major transition and adjustments in routines now that they are housed.

B. Financial Assistance Best Practices

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[1] Compiled from *Helping Clients to Help Themselves Through the Housing Process*, Evans, Bobbi Jo, http://homeless.samhsa.gov/resource/helping-clients-to-help-themselves-through-the-housing-process-49727.aspx and How to Give a Helping Hand Toward Housing, Evans, Bobbi Jo, http://homeless.samhsa.gov/resource/How-to- Give-a-Helping-Hand-Toward-Housing-46281.aspx

1. Service Providers should not issue rental checks to anyone other than a property owner or property management company. A check or payment should not be made to the household or another party unless a utility reimbursement is to be paid. In which case, the following must be followed:

   o Direct payment to the program participant; or

   o Payment to the utility company on behalf of the participant so long as:

      ▪ Written permission is obtained from the program participant

      ▪ Written notification to the participant of the amount paid to the utility company

2. Service Providers should verify property ownership by calling the Santa Clara County Tax Assessor. Provide the Assessor with the address of the unit the provider is interested in renting and verify the name of the property owner.

3. Service Providers should call the landlord to verify the rental agreement.

4. Service Providers should mail payment to the property owner and/or property management company. Should the landlord, property owner and/or property management company need the check immediately they may pick it up from the service provider. The household should not pick-up or deliver the payment to the property owner and/or property management company.

   Service Providers should consider requiring two signatures for amounts over an identified threshold. All other standard financial procedures should apply including review of canceled checks and review of stale checks that have not been cashed.

VII. Service Requirements/Components for Rapid Rehousing

A. Case Managers will provide intensive case management services throughout each participant's stay in RRH to assist households to successfully retain housing and move off the subsidy and into self-sufficiency. Services may be provided at the program offices, and Case Managers will conduct home visits when appropriate. Services may include, but are not limited to:

1. **Housing Support**

   a. Intake and assessment

   b. Rental assistance

   c. Legal assistance

   d. Assistance with housing applications

   e. Information and training regarding tenants' rights and responsibilities

   f. Education and assistance around landlord-tenants' rights and responsibilities

   g. Mediation and negotiation with landlords

   h. A minimum of one monthly face-to-face case management meeting

   i. A minimum of one quarterly home visit

2. **Socialization & Daily Functions**

   a. Daily living skills training

   b. Budgeting and money management skills and training

    c.   Skills and training in maintaining a household

    d.   Eligibility screening for, and assistance applying for and retaining mainstream resources (SSI, CalWORKS, MediCal, veteran's benefits, etc.)

    e.   Vocational and employment assistance or training and referral

    f.   Supportive employment and referral for employment

    g.   Interpersonal communication skills

    h.   Transportation, including accompaniment to appointments, home visits

    i.   Child care

    j.   Parenting information and education

    k.   Conflict resolution and crisis intervention

    l.   Helping clients connect to meaningful daily activities

    m.   Social, cultural, or recreational activities

    n.   Opportunities for peer-to-peer education and support

    o.   Support groups and other services to maintain, preserve, and promote independence, including optimal physical, social, and psychological development and functioning

3. Wellness

    a.   Service coordination

    b.   Mental health counseling and education

    c.   Substance abuse education and counseling

    d.   Effective use of health care (medical/dental/mental health/psychiatric)

    e.   Preventive health services

4. General

    a.   Verification of progress towards achievement of short and long-term client objectives

B. During the clients' participation in the program, client must meet with a case manager not less than once per month to assist the program participant in ensuring long-term housing stability. The project is exempt from this requirement if the Violence Against Women Act of 1994 (42 U.S.C. 13925 et seq.) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services.

C. All clients may receive follow-up services for up to 6 months to ensure stability and assess the effectiveness of RRH programs.

E. Transitional Housing

I.   Target Populations for Assistance

Santa Clara County Continuum of Care transitional housing (TH) programs serve a range of populations, including single adults, youth and families with children. Regardless of target population, program design and services should further the goal of transitioning participants to permanent housing. In alignment with national

priorities and evidence-based practices, the Continuum of Care encourages TH programs to prioritize and target the following populations:

1. Transitional age youth, including single youth, pregnant youth, and/or youth-led households

2. Persons with experience of domestic violence or other forms of severe trauma

3. Individuals and heads of household struggling with substance abuse, or early in recovery from substance abuse

II. Structure of Transitional Housing Assistance

1. Goals of Assistance

    a. Upon exit from the program, participants move into a permanent housing situation and are able to maintain housing stability.

    b. Transitional housing may serve as a bridge to permanent housing for households that have been accepted into a permanent housing program but do not yet have a unit.

2. Subsidy Amount/Length of Time/Calculation:

    a. Transitional housing facilitates the movement of homeless individuals and families to PH within 24 months of entering transitional housing.

    b. CoC-funded TH programs must comply with CoC Program requirements regarding client portion of rent, occupancy charges, FMR and Rent Reasonableness.

    c. Rents collected from residents of TH may be reserved in whole or in part to assist the residents to move to permanent housing.

    d. All participants in CoC-funded TH programs must enter into a lease or occupancy agreement, so that participants retain full tenants' rights during their residency in the program.

III. Eligibility Requirements

In order to qualify for transitional housing, households must satisfy the following criteria:

A. For CoC-funded programs and others participating in the Coordinated Assessment System, be the highest priority household available within the target population served by the program, as identified through Coordinated Assessment.

B. For Veterans Affairs (VA) Grant Per Diem (GPD) programs, be among the highest priority households that is within the target population served by the program and approved by the VA, if applicable.

C. Other eligibility criteria created at the program level.

D. For CoC-funded programs, meet the HUD definition of homeless in the CoC Program Interim Rule under Category 1, Category 2, or Category 4.

IV. Documentation Requirements

CoC-Funded Programs: For participants in CoC-funded transitional housing programs, documentation must be included in the case file, and/or scanned into the HMIS client record that demonstrates eligibility as follows:

A. **Category 1: Literally Homeless (in order of preference)**

1. Third party verification (HMIS print-out, or written referral/certification by another housing or service provider); or

2. Written observation by an outreach worker; or

3. Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter;

If the provider is using anything other than a) Third Party Verification, the case file must include documentation of due diligence to obtain third party verification.

B. **Category 2: Imminent Risk of Homelessness**

4. A court order resulting from an eviction action notifying the individual or family that they must leave within 14 days; <u>or</u>

5. For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay; <u>or</u>

6. A documented and verified written or oral statement that the individual or family will be literally homeless within 14 days; <u>and</u>

7. Certification that no subsequent residence has been identified; <u>and</u>

8. Self-certification or other written documentation that the individual lacks the financial resources and support necessary to obtain permanent housing.

C. **Category 4: Fleeing/Attempting to Flee DV**

For victim service providers:

1. An oral statement by the individual or head of household seeking assistance which states: they are fleeing; they have no subsequent residence; and they lack resources. Statement must be documented by a self-certification or a certification by the intake worker.

For non-victim service providers:

1. Oral statement by the individual or head of household seeking assistance that they are fleeing. This statement is documented by a self-certification or by the caseworker. Where the safety of the individual or family is not jeopardized, the oral statement must be verified; <u>and</u>

2. Certification by the individual or head of household that no subsequent residence has been identified; <u>and</u>

3. Self-certification or other written documentation, that the individual or family lacks the financial resources and support networks to obtain other permanent housing.

V. Service Requirements/Components for Transitional Housing

Case Managers will provide case management services at a level that meets the needs of each participant, in order to assist households to exit the program into permanent housing and achieve self-sufficiency.

VIII. Transitional housing programs are encouraged to adopt a low-barrier, housing first approach. Unless required by law, a condition of a particular source of funding, or necessary to serve a target population in recovery from substance abuse, programs will not screen out or exclude participants based on any of the following:

a. Failure to participate in supportive services or make progress on a service plan;

b. Having too little or no income;

c. Refusal to participate in drug tests;

d. Active or history of substance abuse;

e. Experience of domestic violence (e.g. lack of a protective order, period of separation, etc.); or

f. Failure to participate in a probation or parole program.

IX. Transitional housing programs are characterized by:

1. Client-centered services, by directly providing a range of services or by serving as part of a network that provides a range of services, tailored to each participant's level and type of need;

2. Immediacy, by providing for timely intervention and avoidance of delays in implementing a workable plan for transition to a permanent housing situation; and

3. Continuity and linkage to after care (to the extent possible when funding is available), by providing services in cooperation with other resources and ensuring appropriate follow-up after the child, adult, or family has left the program.

X. Transitional housing programs must develop service plans with participants and provide or offer referrals for identified services that address each participant's ongoing needs. Service planning should be initiated at intake, and focuses on identifying and transitioning participants to the most appropriate permanent housing situation.

XI. Ongoing assessment of progress on the participant's service plan should be conducted throughout the individual's or family's term of residence in the program.

XII. Transitional housing programs, either directly or by referral, must make services available to all clients that are tailored to support each client in transitioning to permanent housing. The level and type of services offered should meet each client's identified needs, including but not limited to any of the following:

1. Crisis intervention;
2. Legal assistance;
3. Service coordination;
4. Emergency and ongoing identification of medical and health needs and referral for care;
5. Public benefits eligibility assessment and application assistance;
6. Educational and employment assistance;
7. Exit planning, housing search, and relocation assistance;
8. Education related to activities of daily living (life skills);
9. Preventive health education, including information about prevention of HIV/AIDS, Tuberculosis and Sexually Transmitted Disease;
10. Substance abuse and mental health counseling;
11. Support groups;
12. Structured social/recreational activities;
13. Parenting education;
14. Job referral and placement;
15. Child care;
16. Transportation;
17. Domestic violence counseling; and
18. Other appropriate services as necessary for the service population.

XIII. If the program provides referrals for mental health, substance abuse, health care, or developmental disability services, this same referral information must be offered to every client. Then, the program

providing these services may separately ask questions about the issues relevant to the provision of that service.

XIV. Any services related to an individual's disability may not be required as a condition of receiving shelter unless the shelter is specifically designated for individuals with disabilities and has a mandatory service component according to its funding criteria.

F. Other Services and Services-Only Programs

X. Information and Referral and Case Management Services

A. Information and Referral

At a minimum, programs providing Information and Referral services offer the following:

1. A basic assessment of client needs (could be informal/verbal);

2. Information about community resources and referrals to local partners;

3. Assistance in acquiring services, including access to phones to make local calls, letters of introduction, lists of required documents, blank applications/forms, coaching regarding appropriate language to use when asking for services to get the desired outcome, etc.;

4. Advocacy on behalf of individual clients.

B. Case Management

At a minimum, programs providing Case Management services offer all Information and Referral services, as well as the following:

1. Client-centered goal development focused on managing the practical problems of daily living;

2. Individualized support in identifying and completing action steps toward goals;

3. Encouragement and support toward goal achievement through regular meetings in an ongoing relationship;

4. For each case managed client or household, programs must maintain a separate case file including registration and assessment paperwork (including any community-wide assessments) and case notes;

5. For each case managed client, HMIS participating programs must record a Program Entry and Exit in HMIS and ensure that HUD Universal Data Elements are completed.

C. Intensive Case Management.

At a minimum, programs providing Intensive Case Management services offer all Information and Referral and Case Management services, as well as the following:

1. Education about basic living skills, health care, getting the most out of treatment, and understanding the stages of change;

2. Assistance with access and coordination between medical, mental health, and substance abuse services, if needed;

3. Assistance in the development of new informal support systems to sustain the client's improving recovery patterns;

4. Response to client crises and assistance in stabilizing the situation;

5. Available to meet with clients outside of program offices (attend court with client, transport client to important appointments, home visitation, etc.)

6. Maintain low caseloads of no more than 15-20 active clients.

XI. Outreach Services

All programs providing outreach services, street outreach or mobile outreach teams must comply with the following standards.

A. Outreach workers providing outreach services through street outreach or mobile outreach teams will receive on-going training in best practices generally accepted in the community designed to engage homeless persons on the street at the first point of contact in a manner in which they are willing and able to connect as below. Training should be held at least once per season/year in this area.

1. Use of assertive outreach techniques such that the team(s) will actively work to make contact with clients and engage them at the level and in the manner in which they are willing to connect;

2. Interventions carried out in the field, at locations where clients congregate and are comfortable rather than in traditional mental health settings;

3. High staff-to-client ratio of approximately one direct service staff to every ten clients;

4. Direct service provision that includes assistance in meeting basic survival needs (food, showers, a place to come in from the streets) as well as clinical services;

5. Referrals, advocacy and intensive case management without time limits in order to address the client's full range of needs, including linkages with medical, psychiatric, and alcohol and drug treatment services; benefits programs; and emergency, transitional, supportive, and/or permanent housing.

B. Outreach services are provided by a team of professionals or paraprofessionals. For reasons of safety for both personnel and persons served, street outreach teams consist of at least two personnel.

C. Outreach services are designed to bring the existing service delivery system to the person or family served. These services are offered to persons and families who have unmet needs and who are not served or are under-served by existing service delivery mechanisms in the community.

D. Outreach service provision is flexibly tailored to the unique needs and characteristics of each person or family served. It is characterized by:

1. flexibility;

2. voluntary acceptance of services by the person or family served, except in those cases where the outreach team has the authority to commit individuals against their will and without their consent;

3. a team approach; and

4. linkage to, or direct provision of a full range of readily accessible prevention,

5. support, and treatment services.

E. During the provision of outreach services, the engagement and assessment of the client is characterized by:

1. sensitivity to the willingness of the person or family to be engaged;

2. a non-threatening manner;

3. maximum respect for the autonomy of the person or family being engaged; and

4. persistence.

B. Outreach services provide linkages to, or directly provide, a full range of prevention, support, and treatment services, including but not limited to:

1. screening and assessment;

2. harm reduction;

3. basic needs intervention;

4. crisis intervention;

5. help accessing public assistance;

6. advocacy;

7. legal assistance;

8. case management;

9. housing assistance;

10. social support services;

11. informational services;

12. service planning;

13. medical/ dental evaluation and care;

14. counseling and/ or treatment; and

15. other services necessary to serve the target population.

XII.   Drop-In Centers

All programs operating Drop-In Centers must comply with the following standards.

A. In programs operating drop-in centers, staff should receive annual training on counseling skills, techniques for handling conflicts or crises in a non-violent manner, cultural sensitivity, sexual harassment, and sensitivity to wider issues of homelessness at a one-time training per season/year on these subjects.

B. Drop-in centers provide services in a safe, welcoming, minimally intrusive environment that is designed to foster trust and personal engagement.

C. Drop-in centers provide:

1. Information and referral;

2. Food or snacks;

3. Bathrooms;

4. Seating accommodations; and

5. Access to telephones.

D. S4.4   Drop-in centers may also provide, either directly or by referral:

1. Crisis intervention;

2. Emergency services;

3. Legal and advocacy services

4. Mental health services

5. Case management;

6. Facilities for personal hygiene: showers and laundry;

7. Employment and housing services;

8. Classes in living skills;

9. Community space;

10. Meeting space;

11. Linkage to medical service;

12. Mail, voice mail, computer access;

13. Clothing, and;

14. Client storage.

E. Personnel are available during drop-in center operating hours to provide ongoing services and overall supervision.

F. Drop-in centers have written policies and procedures for expelling an individual or family from the facility that:

1. Are clear and simple, avoiding overly rigid and bureaucratic rules;

2. Require that all reasonable efforts are made to provide an appropriate referral;

3. Are clearly posted in all appropriate languages or in a fashion readily accessible to accommodate non-hearing and sight impaired individuals or are otherwise provided to persons using the service;

4. Include a definition of the reasons or conditions for which an individual or family may be expelled;

5. Delineate a clearly defined process for expulsion including due process provisions; and

6. Describe the conditions or process for re-admission to the facility.

XIII.   Prevention and Support Services

All programs providing prevention and support services must comply with the following standards as appropriate to the population served.

A. General Requirements

1. Prevention and support services are provided to persons and/or families who are at risk of developing problems in physical, mental, social or economic functioning. They are designed to provide individuals and/or families with information and new or enhanced skills to:

    a. Ameliorate a problem or condition that can lead to individual, family and social displacement or dysfunction, prior to its onset; or

    b. Stabilize a problem or condition so that the problem or condition does not worsen; and/or

    c. Maintain the highest level of functioning possible within their community.

2. Prevention and support services focus on realistic, attainable, and measurable goals and they are provided within the context of broad community, state, and federal prevention efforts.

3. Prevention and support service programs publicize their services utilizing a variety of methods to inform the target population, the general public, and other referral sources of:

    a. The types of service that are offered;

    b. Service availability; and

    c. How individuals can access the program's resources.

4. Prevention and support service programs maintain linkages with a wide variety of services, programs and systems, including other community, state and federal prevention efforts, hospitals, schools, the criminal justice system, legal services, advocacy services, and mental health services, as well as other organizations that are likely sources of referrals.

5. Programs offer one or more of the following prevention and support services:

    a. Direct financial assistance;

    b. Mortgage/ rent assistance, security deposit, emergency financial aid, utility

    c. Assistance, rent arrearage;

    d. Legal assistance;

    e. Mediation;

    f. Education on tenants' rights and responsibilities

    g. Vocational training or rehabilitation;

    h. Employment assistance and/or counseling services;

    i. Transportation;

    j. Budgeting and financial management skills building;

    k. Remedial education and literacy programs;

    l. Nutrition education and counseling;

    m. Pregnancy prevention and support;

    n. Child care;

    o. Drug and alcohol education;

    p. Health promotion;

    q. Life skills education programs;

    r. Mental health education;

    s. Parenting and child development education;

    t. Housing assistance, including counseling;

    u. Housing maintenance and repair;

    v. Furniture/appliance provision or warehousing;

    w. Clothing provision/laundry;

    x. Food pantry and/or meals;

    y. Mental health or other counseling services; and

z. Other services to maintain housing or to promote optimal social, psychological, and physical development and functioning.

G. Emergency Shelter Services

I. Temporary and Basic Shelter Services

All temporary and basic shelters must comply with the following standards, except where the standard is designated as applying to only a certain shelter type.

A. Temporary and basic shelters provide services coordinated to meet the immediate safety and survival needs of the individual or family served, including shelter, food, clothing and other support services. These services are provided in a minimally intrusive environment.

B. At a minimum, temporary and basic shelters provide the following services directly on-site:

1. sleeping accommodations;

2. personal hygiene supplies and facilities, including toilets and wash basins;

3. showers and/ or bathtubs (temporary shelters may provide referrals to other facilities for these services).

C. In addition to the services listed in Section D.VI.B, temporary and basic shelters provide either directly or by referral the following services:

1. food;

2. information and referral;

3. crisis intervention;

4. mailing address;

5. linkage to medical services;

6. clothing; and

7. laundry facilities, either on-site or located within walking distance.

D. The use of services beyond the provision of food and shelter should be encouraged.

E. Basic shelters may require as a condition of admission that the individual or family be clean from drug use and sober.

II. Service-Enriched Shelter Services

Service-enriched shelters must comply with the following standards.

A. In addition to meeting basic needs, service-enriched shelters are designed to increase the client's coping and decision- making capacities and assist in planning for the client's reintegration into community living.

B. Service-enriched shelter programs are characterized by:

1. comprehensiveness, by directly providing a range of services or by serving as part of a network that provides a range of services;

2. immediacy, by providing for timely intervention and avoidance of delays in implementing a workable plan; and

3. continuity and linkage to after care (to tile extent possible when funding is available), by providing services in cooperation with other resources and ensuring appropriate follow-up after tile child, adult, or family has left the program.

C. In addition to providing the services of a basic shelter (See Section D.VI Temporary and Basic Shelter Services), service- enriched shelters make available, either directly or by referral, the following services:

1. crisis intervention;

2. assessment for child abuse and/ or neglect (in family shelters);

3. service coordination;

4. emergency and ongoing identification of medical and health needs and referral for care;

5. public assistance eligibility assistance;

6. educational and employment assistance; and

7. exit planning and relocation assistance

D. In addition to the services listed in Section D.VII.C., service-enriched shelters also provide some or all of tile following services, as indicated by tile service population:

1. education related to activities of daily living (life skills);

2. preventive health education, including information about prevention of HIV/AIDS, Tuberculosis and Sexually Transmitted Disease;

3. substance abuse and mental health counseling;

4. support groups;

5. structured social/recreational activities;

6. parenting education;

7. job referral and placement;

8. child care;

9. transportation;

10. domestic violence counseling; and

11. other appropriate services as necessary for the service population.

E. If the shelter provides referrals for mental health, substance abuse, health care, or developmental disability services, this same referral information must be offered to every client. Then, tile program providing these services may separately ask questions about the issues relevant to the provision of that service.

F. Any services related to an individual's disability may not be required as a condition of receiving shelter unless tile shelter is specifically designated for individuals with disabilities and has a mandatory service component according to its funding criteria. (See R3.9)

G. Programs serving all homeless people may require non-disability related services (e.g., money management or employment training) as a condition to housing, so long as the requirement is communicated to all clients at intake.

H. Ongoing assessment of adjustment to community living arrangements is conducted throughout the individual's or family's term of residence in the program.

I. Service-enriched shelters develop exit plans with the individuals served and l provide or offer referrals for identified services that address their ongoing needs. Exit planning is initiated at intake.

H. Emergency Shelter Facility Management

All shelters, temporary, basic, and service-enriched, must comply with the following standards, except where the standard is designated as applying to only certain shelter types.

I. Codes and Ordinances

A. The shelter conforms to all applicable state and local building, fire and health regulations, including wheelchair accessibility standards.

B. The shelter does not exceed the maximum occupancy issued to it by the Fire Department for the entire shelter nor for the individual rooms used as sleeping quarters.

C. The shelter conspicuously posts the maximum occupancy issued to them by the Fire Department for the entire shelter and for the individual rooms used as sleeping quarters.

D. The shelter conforms to all pertinent requirements of the Americans With Disabilities Act (ADA), the Federal Fair Housing Amendments Act (FHAA), the California Fair Employment and Housing Act (FEHA), and the Transitional Housing Misconduct Act (THMA).

II. Shelter Location

A. The shelter provides clients with reasonable access to public transportation.

Preferred Practice Recommended Standards
B. New shelter construction should be located to facilitate the use of community-based services.

III. Shelter Layout and Floor Plan

A. The shelter is well arranged and carefully planned to provide as safe and secure an environment as possible.

B. If the shelter provides residents with separate rooms with doors, residents must be able to secure the door while in the room, and staff must have keys to all rooms.

C. In shelters that separate resident sleeping accommodations by gender, transgendered clients should be sheltered according to their gender of identification, regardless of physical characteristics.

D. Basic & Services Enriched Shelter Standard: If a shelter provides food on-site, the sleeping area must be separate from the dining area.

E. Service-Enriched Shelter Standard: The shelter includes rooms for providing on-site services, as applicable.

Preferred Practice Recommended Standards
F. The shelter provides adequate separation of families, couples and single adults, and adequate separation of single women and single men.

G. Room accommodations, bathrooms, lounges and other common spaces in the shelter should be wheelchair accessible. Wheelchair access should be provided to all common areas and to not less than 10% of the sleeping units.

H. The shelter should provide a private/ quiet space that allows children to do their homework and clients to study and work.

I. The shelter includes some outdoor space for client-use only. The outdoor area is enclosed and appropriately screened to ensure privacy.

IV. Protection of the Family Unit

Preferred Practice Recommended Standards

A. Shelters should attempt to provide accommodations which protect the family unit whenever possible, allowing parents and children to be accommodated together.

V. Visitors

A. Shelters may permit residents to have visitors as appropriate to the shelter population and type of facility.

B. Shelter residents are responsible for the behavior of their visitors and may experience the consequences of their guests' negative behaviors as specified in the shelter rules.

VI. Security

A. The building and grounds are routinely and regularly monitored.

B. Building or shelter security is maintained, and when appropriate to the population served and the type of facility, residents are encouraged to form resident patrols.

VII. Storage of Personal Possessions

A. Shelters which hold funds or possessions on behalf of residents have a written policy and established procedure for securing and returning residents' belongings. The policy specifies how the stored items will be safeguarded, the shelter's liability for items that are lost or stolen, and the length of time funds or possessions will be held. Shelters must explain this policy to clients before holding any funds or possessions for them, and shelters must post this policy in a conspicuous location in all appropriate languages.

B. Security deposits may be used to compensate the program for a resident's failure to pay program fees, to repair damages, exclusive of ordinary wear and tear, caused by the resident or resident's guest or for the cleaning of the premises. Security deposits, less deductions, shall be returned, and an itemized statement of deductions made, shall be provided to the departed resident within three weeks after the resident has left the program.

C. If the shelter holds funds (other than Security Deposit) or possessions on behalf of a resident, those funds or possessions are returned the same day if possible, and no later than two weeks after the demand for return.

Preferred Practice Recommended Standard

D. In shelters, bedrooms should have individual, separate lockable storage lockers for the adult resident's belongings. Each locker should be large enough to accommodate winter clothing.

E. Service Enriched shelters and Transitional Housing Programs should allow residents to store personal belongings for up to 72 hours after residents have left the shelter or housing.

VIII. Smoking, Drugs & Alcohol, and Weapons

A. The program prohibits possession and use of illegal drugs and alcohol on the premises.

B. The program prohibits smoking indoors.

C. The program prohibits possession of weapons by everyone (clients, staff, volunteers, guests, etc.) at the facility. The program posts its policy regarding the discovery of weapons, including a list of items considered to be weapons.

IX. Medication: Storage, Access & Distribution

A. The program complies with laws and regulations regarding the storage of record- keeping concerning medications.

B. The program has established procedures for preserving clients' confidentiality in the storage of and keeping of records concerning medications.

X. Shelter Maintenance

A. The shelter has a written building maintenance policy that includes a clearly identified person to whom the residents can report maintenance problems.

B. Routine maintenance is performed by qualified personnel or qualified personnel supervise maintenance work performed by residents.

XI. Housekeeping Policies

A. The shelter has a housekeeping plan to ensure a safe, sanitary, clean and comfortable environment. The plan includes:

1. a cleaning schedule for all parts of the facility, including, but not limited to, the floors, walls, windows, doors, ceilings, fixtures, equipment, and furnishings;

2. a schedule for collecting and discarding trash inside the facility;

3. a clearly identified person(s) responsible for the tasks on the housekeeping plan.

B. Trash inside the facility is contained in appropriate trash receptacles. Trash receptacles are emptied on a regular basis.

C. Adequate, properly maintained supplies and equipment for housekeeping functions are available. These supplies are properly labeled, and supplies and equipment are kept in a separate cabinet away from any food and out of the reach of children.

D. A Material Safety Data Sheet is maintained where the chemicals that the sheets apply to are stored for all chemical products used on site. An additional copy of the sheets must be maintained in a location that can be accessed easily by staff and clients in the event of an emergency and must be available upon request.

XII. Communicable Diseases

A. In compliance with Cal/ OSHA Interim Tuberculosis Control Enforcement Guidelines, shelters must:

1. annually test employees for Tuberculosis (TB), in accordance with current criteria recommended by the Centers for Disease Control and Prevention;

2. have written criteria to identify individuals who are suspected of having infectious TB;

3. have written TB exposure control procedures;

4. provide employees and residents with proper medical evaluation and preventative therapy;

5. provide TB prevention training to employees; and

6. maintain proper documentation of employee TB prevention training, TB exposure incidents, and diagnosed TB cases.

B. Staff use "universal precautions" when disposing of child/infant items such as diapers, tissues, band-aids, etc. Gloves and plastic bags are used when handling and disposing of these items.

C. The program notifies clients anytime there is a possibility that they were exposed to a communicable disease that is spread through casual contact. Notification must include posting a written warning about possible exposure in a conspicuous location and in all appropriate languages or in a fashion readily accessible to accommodate non-hearing and sight impaired individuals. The warning includes the date of the exposure, the disease, the onset time of the disease, its symptoms and how it is treated.

D. The program consults a medical professional when deciding if a client or potential client is infected with a contagious communicable disease that might endanger the health of other clients.

E. The program maintains written policies regarding mandatory implementation of universal precautions, control of tuberculosis, (per the California Department of Health Service's guidelines), and notification of clients of possible exposure to a communicable disease.

F. The program maintains written policies on client confidentiality issues regarding communicable diseases, including HIV/AIDS.

G. Program admission and exit policies and daily operation procedures adhere to protocols established by the Center for Disease Control.

Preferred Practice Recommended Standard
H. All shelter clients should be tested for TB within 30 days of their intake. Afterwards, they should receive a TB test card that should be accepted at other shelters.

I. All shelter clients should be given information about and if appropriate referred to County-sponsored disease testing (e.g. for TB and HIV/AIDS) and child immunizations.

XIII. Pest Control

A. The shelter works actively to prevent insect and rodent infestations and to eliminate them if they occur. In kitchen, dining areas, and food storage areas, the shelter takes precautions such as wiping up spills and crumbs frequently; storing food at least 6 inches off the floor and away from the walls; checking incoming boxes for insects and rodents excluding clients' personal belongings; filling in all crevices and cracks in walls; elevating garbage containers off the floor; having annual pest control inspections; and installing self-closing doors, where appropriate, on the outside of the facility.

B. The shelter notifies residents of any pest-control maintenance activities.

C. Notification must be given 24 hours in advance. The Material Safety Data Sheets are requested from any exterminators hired and kept on file.

Preferred Practice Recommended Standard
D. Shelters should have monthly pest control inspections.

XIV.   Heating and Ventilation

A.   The shelter has a heating and ventilation system that is in proper working order and maintains a minimum temperature appropriate for the population served.

XV.   Interior/Exterior Lighting

Preferred Practice Recommended Standard

A.   Natural lighting is provided wherever possible. Windows should allow a natural lighting ratio of 1 foot of window space to every 10 square feet of room area. Exceptions allow for the kitchen to be provided with adequate artificial light.

XVI.   Electricity, Gas and Water

A.   A map designating the location of the gas main will be conspicuously posted and known to the shelter's on-site emergency response designee. A gas shut- off tool must be attached near the gas main. Instructions for using the gas shut-off tool must be posted next to the tool in all appropriate languages.

XVII.   Heaters Bath & Toilet Facilities

A.   The shelter has a sufficient supply of functional, clean, and reasonably private toilets and wash basins.

B.   The shelter has functional, clean, and reasonably private bathing facilities for residents. (Temporary or winter shelters may provide referrals to places that have bathing facilities on site.)

C.   The shelter provides separate bathrooms for male and female in ratios appropriate to the capacity of the shelter. Temporary or winter shelters may have unisex bathrooms.)

D.   Transgender clients have access to bathrooms based on their gender of identification, regardless of physical characteristics. People who do not clearly identify as male or female should have access to whichever toilet/ shower facility helps them feel safest. Where there are single-use showers and bathrooms in the facility designated for residents, transgender residents will be told about them and welcome to use them.

E.   The shelter provides toilets and wash basins accessible to residents with disabilities.

F.   *Basic & Services Enriched Shelter Standard*: If the shelter provides services to persons with infants and young children, it must provide adequate space and equipment such as bathtubs, portable tubs, and basins for the bathing and changing of infants and young children.

G.   Toiletries

1.   The shelter provides toilet tissue, soap, and a means for washing and drying hands.

2.   If the shelter provides showers on site, towels and soap must be provided.

3.   The shelter provides containers for disposal of feminine hygiene products.

Preferred Practice Recommended Standard

4.   Shelters should supply deodorant, shampoo, toothbrushes, toothpaste, condoms, feminine hygiene products, and diapers.

XVIII.   Telephones

A.   The shelter takes incoming emergency phone messages and messages from other service providers such as case manager or advocates, for residents during business hours and has a process for making these

messages available to them. Messages are taken without confirming whether or not the individual is a client of the agency.

B. *Basic and Service-Enriched Shelter Standard:* The shelter has or provides access to a phone that residents can use within reasonable limits. This phone is made as private as possible.

XIX.   Furnishings

A.   General

1.   The shelter provides the necessary equipment and furnishings to support shelter activities.

2.   All shelter equipment and furnishings are maintained so they are clean, safe and appropriate for their intended function.

B.   Dining Area

1.   Basic &Service-Enriched Shelter Standard· If a shelter provides food on site, tables and chairs must be provided in the dining area.

C.   Bedroom/Sleeping Area

1.   At a minimum, basic and service-enriched shelters provide residents with a bed or a cot. Winter shelters and rotating church shelters, at a minimum, provide residents with a mat.

2.   Each resident is supplied with sheets, a pillow and pillowcase and at least one blanket.

3.   Bed linens, blankets and towels are laundered as often as necessary for cleanliness and freedom from odors. The shelter has sufficient numbers of each item to allow for changes when necessary.

4.   Clean bed linens are to be provided to new residents at intake. Residents are expected to maintain cleanliness of linens when facilities are available onsite, otherwise clean linens will be provided by the facility at least once a week.

5.   The shelter implements routine procedures for disinfecting the bed, mat, or cot and its cover with each change of client.

Preferred Practice Recommended Standards

6.   The shelter should furnish each resident, whether an adult or child, with a clean bed (or crib for infants) that is a minimum of 27 inches in width, or a double bed for an adult couple.

7.   The shelter should use vinyl mattress covers or mattresses that are resistant to bacteria, fluids, and pests and sanitize them between clients.

8.   In shelters, bedrooms should have individual lockable storage lockers for the resident's belongings. Each locker should be large enough to accommodate winter clothing.

XX.   Provisions for Babies and Young Children

A.   If the shelter provides services to people with infants, it must provide refrigeration and cooking equipment capable of being used for the storage and preparation of infant formula, baby food and milk. (Winter Shelters can apply for a one-time, one-year waiver).

B.   All children's furniture and equipment meets national safety standards. Donated furniture and equipment also must meet these same standards.

C.   *Basic & Service-Enriched Shelter Standard*: If the shelter provides services to people with children, it must provide age appropriate cribs or beds, storage space for toys, and appropriate feeding equipment for infants and young children.

D. *Basic & Service-Enriched Shelter Standard*: If the shelter provides services to people with children, it must have/provide appropriate feeding equipment for infants and young children.

I. Inter-Organizational Collaboration

I. HMIS

A. All agencies providing shelter, housing and services to the homeless and those at risk of becoming homeless should participate in the Homeless Management Information System designated by the Continuum of Care in order to collect, track, and report uniform information on client needs and services and enhance community-wide service planning and delivery.

B. All agencies participating in the Homeless Management Information System will abide by the countywide system administrator's policies and procedures, including the "Santa Clara County Continuum of Care HMIS Governance Agreement" and the "Santa Clara HMIS Standard Operating Procedures", and adhere to the current HUD data standards.

C. Assessments will be conducted according to the policies, procedures, and confidentiality rules of each individual program, of the Homeless Management Information System countywide administrators, and of the Coordinated Assessment system.

D. All users of the Homeless Management Information System must be trained according to the standards of the HMIS system administrators, including End User Training, and Confidentiality Training.

E. All agencies, regardless of participation in the Homeless Management Information System, are required to keep their Program Descriptor Data Elements current and accurate at all times. This information should be updated at least annually by agency HMIS administrators or reported to the county wide system administrators.

II. Coordinated Assessment

A. All agencies participating in HMIS will serve as Coordinated Assessment Access Points, in accordance with Section J, Coordinated Assessment Policies and Procedures (See Section K.III, Access Points).

III. Continuum of Care (CoC) Participation

A. All agencies providing shelter and services to the homeless should be participants in the Santa Clara County Continuum of Care.

B. To the extent possible, member organizations of the Santa Clara County CoC will participate in community wide efforts endorsed by the CoC Board.

J. Coordinated Assessment Policies & Procedures

I. Background

A. What is Coordinated Assessment?

Coordinated assessment (also known as coordinated entry) is a consistent, community wide process to match people experiencing homelessness to community resources that are the best fit for their situation. In a community using coordinated assessment, homeless individuals and families complete a standard triage assessment survey that identifies the best type of services for that household. Participating programs accept referrals from the system, reducing the need for people to traverse the county seeking assistance at every

provider separately. When participating programs do not have enough space to accept all referrals from the system, people are prioritized for services based on need.

B. HUD Requirement

Under the interim rule for the U.S. Department of Housing and Urban Development's (HUD) Continuum of Care (CoC) program, each CoC must establish and operate a centralized or coordinated assessment system (24 CFR 578.7(a)(8)). HUD defines a centralized or coordinated assessment system as "a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3).

Participation in the coordinated assessment system is required for grantees receiving HUD CoC and Emergency Solutions Grant (ESG) funds.

C. Community Vision

Our community vision for coordinated assessment is that we have a fully engaged coordinated assessment system with standardized assessment and all transitional housing, permanent supportive housing, and rapid rehousing placements made through the system. Coordinated assessment will encompass all populations and subpopulations within the CoC's geographic area and prioritize and place people effectively and efficiently, quickly matching people to the housing type and services that are most likely to get them permanently housed.

D. Benefits of Coordinated Assessment

Coordinated assessment will benefit our community by:

1. Using existing resources effectively by connecting people to the housing programs that are the best fit for their situations.

2. Reducing the need for people to call around to multiple housing programs and fill out multiple applications to join waitlists. Coordinated assessment will assess people for all participating programs at the same time.

3. Providing clear communication about what housing and services are available.

4. Collecting information about how many people in Santa Clara County need different types of housing and services. This information will help us advocate for more resources to support people experiencing homelessness in Santa Clara County.

II.   System Overview

In Santa Clara County's Coordinated Assessment system, all homeless individuals and families will complete a standard triage assessment survey that considers the household's situation and identifies the best type of housing intervention to address their situation. The standard triage assessment survey that will be used in Santa Clara County is the Vulnerability Index-Service Prioritization Decision Assistance Tool 2.0 (VI-SPDAT) created by OrgCode Consulting and Community Solutions. The VI-SPDAT will be integrated into the standard HMIS intake for people experiencing homelessness and conducted at HMIS partner agencies, including shelters, service centers, transitional housing programs, and outreach programs: anywhere that people who are homeless first encounter our system of care.

Permanent housing programs, including permanent supportive housing and rapid rehousing, and transitional housing programs will fill spaces in their programs from a community queue of eligible households generated from HMIS. The queue will be prioritized based on length of time homeless and VI-SPDAT scores to ensure that we house those with the greatest need first. This coordinated process will reduce the need for people to traverse the county seeking assistance at every provider separately.

III. Non-Discrimination Policy

The Santa Clara County CoC does not tolerate discrimination on the basis of race, color, national origin, ancestry, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or expression, marital status, source of income, genetic information, or other reasons prohibited by law. The CoC and all agencies participating in the coordinated assessment process must comply with applicable equal access and nondiscrimination provisions of federal and state civil rights laws during every phase of the coordinated assessment process.

The Santa Clara County CoC is committed to making its coordinated assessment process available to eligible individuals and families, who will not be steered toward any particular housing facility or neighborhood because of the above-listed characteristics or for any other reason prohibited by law. Some programs may limit enrollment based on requirements imposed by funding sources and/or state or federal law. All such programs will avoid discrimination to the extent allowed by their funding sources and authorizing legislation.

The Santa Clara County CoC is committed to adopting a Housing First approach and reducing barriers for accessing housing and services. Individuals are not screened out of the assessment process due to perceived or actual barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability or related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

All locations where persons are likely to access or attempt to access the coordinated assessment system will include signs or brochures displayed in prominent locations informing participants of their right to file a non-discrimination complaint and containing the contact information needed to file a non-discrimination complaint. The requirements associated with filing a non-discrimination complaint, if any, will be included on the signs or brochures.

To file a non-discrimination complaint, contact

Kathryn Kaminski
Acting Continuum of Care Quality Improvement Manager
Office of Supportive Housing
County of Santa Clara
3180 Newberry Drive, Suite 150
San Jose, CA 95118
408-793-1843
kathryn.kaminski@hhs.sccgov.org

IV. Access Points

A. Requirements for Access Points

Access points are locations where people experiencing homelessness can complete the assessment survey to participate in coordinated assessment. In Santa Clara County, all HMIS partner agencies will serve as access points and the triage assessment survey (VI-SPDAT) will be incorporated into the standard HMIS intake.

Access points are sited in proximity to public transportation and other services to facilitate participant access, but a person with a mobility or other impairment may request a reasonable accommodation to complete the coordinated assessment process at a different location. Reasonable accommodations requests should be made to the Housing and Homeless Concerns Coordinator at OSH, who will arrange alternative transportation or an alternative location for people who have disabilities or who are otherwise unable to reach any CoC provider.

In order to participate as an access point, organizations must have a current, signed HMIS partner agency agreement and meet the following requirements:

1. Participate in HMIS and follow all HMIS user agency requirements *(domestic violence victim service providers are exempt from this requirement).*

2. Maintain at least one regular staff person who is trained and authorized to conduct the VI-SPDAT and only allow trained and authorized staff or volunteers to conduct the VI-SPDAT.

3. Agree to follow the community guidelines for completing the assessment and communicating about the coordinated assessment system.

4. Agree to provide additional referrals to other community services, as appropriate, to people completing the assessment.

5. Be accessible to individuals with disabilities, including individuals who use wheelchairs, as well as people in the CoC who are least likely to access homeless assistance.

6. Ensure effective communication with individuals with disabilities and provide appropriate auxiliary aids and services necessary to ensure effective communication (*e.g.*, Braille, audio, large type, assistive listening devices, and sign language interpreters).

B. Emergency Services

The coordinated assessment system will maintain connections with the emergency care system using the following techniques:

1. Encouraging emergency service providers to operate as coordinated assessment access points.

2. Encouraging emergency service providers that do not operate as access points to promptly forward information about homeless residents who have been served at night or on the weekend to an appropriate coordinated assessment access point, so that those residents can be integrated into the coordinated assessment system as soon as the access point opens for business.

3. Ensuring that all emergency services connected with the CoC, including all domestic violence hotlines, emergency service hotlines, drop-in service programs, emergency shelters, domestic violence shelters, special population shelters, and other short-term crisis residential programs, can receive and care for residents even during hours when coordinated assessment access points may be closed for business.

4. Arranging meetings between homeless service providers and emergency medical or behavioral health care providers at least once per year to discuss strategies for reducing barriers to communication between the health care system and the homeless system of care.

C. Communication and Frequently Asked Questions

As the original point where people connect with the coordinated assessment system, access points are likely to receive questions from people asking about their status on "the list" and when they will get referred to housing. Organizations should be able to:

1. Check HMIS to determine if the individual or household has a current (less than one year old) VI-SPDAT entered in HMIS.

    a. If so, communicate to the individual or household that they are current in the system and will be contacted if services that are a good fit for them become available.

    b. If the individual/household does not have any record of a VI-SPDAT in HMIS, work with them to complete the standard HMIS intake and VI-SPDAT.

    c. If the individual's/household's VI-SPDAT is over one year old, have them complete an annual update.

2. Check to make sure that the individual's/household's contact information is current and update it if needed.

Organizations should not communicate the individual's or household's number or place in the community queue in HMIS as this placement may change frequently as new assessments are entered into the system. See the *Santa Clara County Coordinated Assessment FAQs* for more information.

D.   Outreach and Marketing

The CoC will affirmatively market housing and supportive services to eligible persons in the CoC's geographic area who are least likely to apply in the absence of special outreach, including the following sub-populations: people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence. Coordinated assessment outreach will be designed to ensure the coordinated access process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Coordinated assessment outreach and any marketing materials will clearly convey that access points are accessible to all sub-populations.

Outreach will be conducted by existing outreach teams and programs in the community that act as coordinated assessment access points, including outreach resources that specifically target people experiencing chronic homelessness, veterans, families with children, youth, LGBTQ youth, and survivors of domestic violence and human trafficking. Culturally competent outreach resources with strong existing ties to the community's most vulnerable populations will serve as coordinated entry access points to ensure that all subpopulations access coordinated assessment. Outreach will be available in the following languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP): Spanish, Vietnamese, Tagalog and Mandarin.

V.   Assessments

A.   The VI-SPDAT

Santa Clara County uses the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) created by OrgCode Consulting, Inc. and Community Solutions as the standard triage assessment tool. This assessment will be used for all homeless individuals and households in Santa Clara County. There are five versions of the VI-SPDAT in use for different populations:

1. Individuals

2. Families

3. Transition Age Youth

4. Justice Discharge

5. Prevention

The VI-SPDAT is to be completed by all individuals and families who are homeless under Category 1 (Literally Homeless) and Category 4 (Fleeing Domestic Violence) of HUD's definition of homelessness. The VI-SPDAT will be conducted as part of the standard HMIS intake.

The Prevention VI-SPDAT is used by the Homelessness Prevention System (HPS) pilot to assess eligibility for participation. Emergency Assistance Network agencies administer the Prevention VI-SPDAT to households at risk of losing their primary residence. All assessed households that fall within the eligible score range for the HPS pilot are offered HPS prevention services.

B.   Training and Authorization of Users

The VI-SPDAT can only be conducted by staff or volunteers who have successfully completed training and been authorized by OSH. The CoC will provide training opportunities at least once quarterly to organizations and/or staff people at organizations that serve as access points or administer assessments. The purpose of the training is to provide all staff who administer assessments with access to materials that clearly describe the

methods by which assessments are to be conducted with fidelity to the CoC's coordinated assessment written policies and procedures.

OSH staff will monitor the quality and consistency of assessments entered into HMIS and provide feedback, training, and adjustments to policies and procedures as necessary to address issues that may arise. Additionally, OSH may revoke the right of any individual user or agency to participate in HMIS and/or coordinated assessment if the individual or agency violates user agreements or policies and procedures.

Administering the VI-SPDAT

OSH will provide Coordinated Entry and VI-SPDAT training, which will include training on how to conduct the assessment, guidelines for communicating with people about coordinated assessment, Coordinated Assessment Policies and Procedures, and frequently asked questions.

All persons administering the VI-SPDAT must also be trained HMIS users or trained users of a comparable database used by a victim service provider or program serving survivors or domestic violence or human trafficking.

CoC Policy

Staff conducting assessments must also complete a training curriculum that will cover each of the following topics:

1. Review of the CoC's written coordinated assessment policies and procedures, including any adopted variations for specific subpopulations;

2. Requirements of use of assessment information to determine prioritization;

3. Non-discrimination policy as applied to the coordinated assessment system; and

4. Criteria for uniform decision-making and referrals.

Cultural Competence

All assessment staff must be trained at least once on how to conduct a trauma-informed assessment of participants, with the goal of offering special consideration to survivors of domestic violence and/or sexual assault to help reduce the risk of re-traumatization.

All assessment staff must be trained at least once on safety planning and other next-step procedures to be followed in the event that safety issues are identified in the process of conducting an assessment.

All staff administering assessments use culturally and linguistically competent practices in order to reduce barriers for underserved populations, including but not limited to immigrants and refugees, youth, individuals with disabilities, and LGBTQ individuals. The CoC shall further these practices by:

1. Incorporating cultural and linguistic competency training and person-centered approaches into the required annual training protocols for participating projects and staff members;

2. Using culturally and linguistically competent questions for all persons that reduce cultural or linguistic barriers to housing and services; and

3. Providing staff access to and training in the procedures for obtaining interpretation and accessibility services.

HMIS

All staff and volunteers who enter data into HMIS or access data from HMIS must be trained in current HMIS policy and procedures.

C. Confidentiality and Releases of Information

The VI-SPDAT is covered under the standard HMIS Release of Information (ROI). The ROI authorizes HMIS partner agencies to conduct the HMIS intake and the VI-SPDAT, enter the information in HMIS, and share the individual's or household's information with other participating organizations in order to facilitate connecting the household with housing and services. The ROI *MUST* be completed and uploaded into HMIS before any other information, including the VI-SPDAT, can be entered into HMIS.

D. Conducting the Assessment

The VI-SPDAT will be conducted as part of the standard intake for HMIS and as part of annual updates in HMIS. It may be directly entered into HMIS or completed on paper and then entered into HMIS.

The VI-SPDAT should be conducted in a setting that promotes privacy and confidentiality. The staff member or volunteer conducting it must follow the community guidelines for explaining what the assessment is and how coordinated assessment works.

All of the questions on the VI-SPDAT are designed to be answered with one-word "yes" or "no" answers. There is no need for respondents to go into detail describing their situation or past history. Respondents should be told that it is important to answer the questions honestly and accurately in order to match them to the best services for them.

The CoC will not deny services to any participant based on that participant's refusal to allow their data to be stored or shared unless a Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information as a condition of program participation. All CoC coordinated assessment participants are free to decide what information they provide during the assessment process, to refuse to answer assessment questions, and to refuse housing and service options without retribution or limiting their access to other forms of assistance. The assessment process does not require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

The VI-SPDAT and HMIS standard intake must be conducted in person and the release of information must be uploaded into HMIS.

After completing the assessment, the volunteer or staff member should provide the individual/household with referrals to meet immediate needs. It is very unlikely that a housing placement will be available immediately or even in the near term, due to the overwhelming need in our community. Thus, it is important to provide information about resources that can meet immediate needs, such as shelter, food, and health care.

Individuals and households that score in the low acuity range should be provided with referrals to other resources to meet their housing needs, since they will not be matched with permanent supportive housing or rapid rehousing. Referrals should be based on the individual's/household's specific situation, and could include referrals to the Emergency Assistance Network, emergency shelters, or transitional housing programs.

E. Use of SPDAT

All providers are encouraged to use the SPDAT as a case management tool to assess clients on entry to a program and on an ongoing basis.

To ensure continuity of service and provide the appropriate level of supports to clients, rapid rehousing programs are strongly encouraged to administer the SPDAT for all clients and to collect disability documentation within 45 days of intake for clients with long-term disabilities. The rapid rehousing program should re-administer the SPDAT quarterly thereafter.

F. Updates to Assessments

As long as individuals/families remain homeless, they should complete the VI-SPDAT annually to capture changes in their circumstances. In addition, individuals/households may complete an update whenever they

experience a life event or change in circumstances that substantially impacts their vulnerability. This may include, but is not limited to, a significant change in:

- Amount of income or benefits,

- Health or disabling condition,

- Ability to care for oneself or dependents,

- Family composition, and/or

- Exposure to imminent danger or risk of severe physical harm.

The update would include an HMIS update and a new VI-SPDAT. Referrals to the community queue will become inactive after 390 days if there is no activity in HMIS for that client. While a community queue referral is inactive, no housing referrals will be made for that individual/household. Any of the following will re-activate a referral to the community queue:

1. Completion of a new VI-SPDAT assessment in HMIS;

2. Entry into a program in HMIS;

3. A record in HMIS of services provided;

4. Any other evidence in HMIS of contact with the individual/household.

VI.   Community Queue

Santa Clara County maintains a community queue in HMIS based on the VI-SPDAT scores and intake records in HMIS. HMIS also contains the inventory and eligibility criteria for each transitional and permanent housing provider, including permanent supportive housing and rapid rehousing programs.

Each CoC project must establish specific eligibility criteria that the project will use to make enrollment determinations, and these criteria must be made available to the public. Determining eligibility is a different process than determining prioritization. Eligibility refers to limitations on who can be accepted into a program based on the program's funding sources, the program's authorizing regulations, the program's real estate covenants or rental agreements, and the program's capacity to provide necessary services. Prioritization refers to the order in which eligible persons will be referred to a project based on factors such as need and vulnerability.

A.   Housing Program Inventory
All participating housing providers will enter their program inventory and eligibility criteria in HMIS. Program staff will work with the HMIS system administrator and OSH to make sure program information stays up to date. Additional eligibility criteria will be used to pre-screen individuals and households on the queue for basic eligibility.

B.   Match to Program Type
Santa Clara County uses the VI-SPDAT to determine the best type of housing intervention for the individual or household being assessed.

1. Those who are identified to have high acuity are referred to permanent supportive housing.

2. Those with moderate acuity are referred to rapid rehousing or transitional housing. Recognizing that client choice is a central concern around transitional housing placements and that some households (*e.g.*, DV survivors or persons in recovery) may prefer transitional programs while others may prefer rapid rehousing, individuals will be asked specific questions relating to interest in specific programs (*e.g.*, "Would you be interested in a transitional housing program?" or

"Would you prefer sober housing?") and their preferences will be integrated into the referral process.

3. Those who are assessed to be low acuity most likely will be able to resolve their homelessness without a housing intervention. Since Santa Clara County has limited housing capacity, housing interventions will be prioritized for those who most need it. Individuals and households with low acuity will be referred to prevention and diversion services, which could include deposit assistance from an Emergency Assistance Network provider, making sure they are connected to public benefits, and referring to other services in the community.

C. Prioritization

Santa Clara County has a significant shortage of housing opportunities compared to the need. Thus, the coordinated assessment system will triage people and house those who are most in need first. Permanent Supportive Housing placements will be prioritized for those who have been homeless on the streets or in emergency shelter for at least a year and with the highest acuity, thus serving those who are most in need and most at risk if they remain on the streets first. In addition, households fleeing domestic violence that are qualified for an emergency transfer will have priority for CoC-funded programs under the circumstances detailed in the Emergency Transfer Plan. (*See Section VIII. Safeguards for Survivors of Domestic Violence*).

Using VI-SPDAT scores, individuals/households are assigned to the most appropriate type of housing intervention (permanent supportive housing, rapid rehousing or transitional housing, or no housing intervention). Within those groups, individuals and households will be prioritized based on the following criteria.

Permanent Supportive Housing Prioritization Criteria
1. VI-SPDAT Score – Those who have been on the street, in emergency shelter, and/or places not meant for human habitation for at least a year with the highest acuity will be served first.

2. Length of Time Homeless – Among those with the same VI-SPDAT score, individuals/households who have been homeless the longest will be prioritized first.

3. High Use of Services – Among those with the same VI-SPDAT score and the same length of time homeless, individuals/households will be prioritized based on the level of utilization of County services, with those with the highest utilization served first.

To reflect our commitment to serve those most in need and most at risk, the CoC will work with all CoC-funded permanent supportive housing projects to phase in turnover beds to be dedicated or prioritized for people experiencing chronic homelessness.

Rapid Rehousing and Transitional Housing Prioritization Criteria
1. VI-SPDAT Score – Those with the highest score within the rapid rehousing range will be served first.

2. Risks Score – Among those with the same VI-SPDAT score, individuals/households with the highest Risks sub-score in the VI-SPDAT will be prioritized first.

3. Length of Time on the Community Queue – Among those with the same VI-SPDAT score and the same Risks score, individuals/households will be served in the order they completed the assessment.

Other Housing and Services
Services that are needed for an emergency crisis response, such as entry to emergency shelter, will not be prioritized through coordinated assessment. Instead, all persons who qualify for and require emergency services will receive those services on a first-come, first-serve basis, or through referrals from partner organizations and other providers.

VII.　Housing Referrals

A.　Matches to Housing Opportunities

Matches are facilitated by OSH staff. When a housing program has a space available, the designated OSH representative will use the community queue in HMIS to identify the household or individual to be referred by:

1. Filtering the community queue based on the type of housing intervention (transitional housing, permanent supportive housing or rapid rehousing) so that it pulls a list of individuals/households that have matched to that type of housing;

2. Filtering the community queue based on the eligibility criteria of the housing program; and

3. Prioritizing the community queue based on the prioritization methodology described above.

The OSH representative will then make a referral in HMIS to the housing program.

OSH staff will provide human judgment and discretion in making referrals based upon the prioritization and match-making methodology laid out in this document. Discretion may include taking into account a client's known preferences when making matches, avoiding referrals to programs where an individual/household has had a serious violation in the past, and addressing inconsistencies or concerns in the assessment or eligibility information entered in HMIS. Any match that requires some flexibility outside the methodology described here requires approval from an OSH senior manager.

B.　Provider Responsibilities

When a permanent housing program receives a referral in HMIS, the provider will follow these steps:

1. **Locate the individual/household**: It is expected that the provider will **make at least 3-5 reasonable attempts** to find the individual/household. In addition to trying the contact information in the person's HMIS account, attempts should include seeking the person out in locations and at other service providers that they are known to frequent.

2. All attempts to find the individual/household must be documented in HMIS.

3. **Verify eligibility:** Information in the individual's/household's HMIS account (including the VI-SPDAT) is primarily self-reported. Providers will need to conduct their own program intake and documentation of eligibility.

4. **Enter the individual/household into the program in HMIS**.

If the individual/household cannot be located, the provider will notify the OSH representative who made the match. Together, the OSH staff and the provider will determine if additional attempts should be made. If the individual/household still cannot be located, they will be referred back to the community queue and OSH staff will initiate a new match.

If the individual/household turns out to be ineligible for the program, they will be referred back to the community queue and OSH staff will initiate a new match. The program should provide information regarding why the individual/household was not eligible and a note will be made in HMIS. Depending on the reason for ineligibility, OSH staff may initiate a review of the client's information and/or request that the client complete an updated assessment (for example, if inaccurate or out of date information on the assessment led OSH to believe the client would be eligible).

If the individual/household declines a referral, they will be referred back to the community queue and OSH staff will initiate a new match. Individuals/households have the right to decline any and all referrals. OSH staff will continue to offer referrals as many times as it takes to match the individual/household with housing. However, OSH will follow some basic guidelines:

1. OSH staff will not re-refer an individual or household to the same program multiple times if the person/household has communicated that they are not interested in that program. Instead, the individual/household will be referred to other programs in the community.

2. If an individual/household declines 3 referrals, OSH staff will wait three months before making the next referral.

3. If an individual/household declines 6 referrals, OSH staff will communicate with the individual/household that they will not be given any new referrals until they inform OSH that they are interested in receiving a new referral.

C. Transfers from Rapid Rehousing to Permanent Supportive Housing

While it may be possible to transfer a RRH participant to a PSH program, it generally cannot be done immediately and often PSH spots are not available for the client. The following steps should be followed in this situation:

1. Do not complete a new VI-SPDAT unless there have been significant changes and you do not plan to enroll the client in the RRH program.

2. Enroll the household in the RRH program and work with them to achieve housing stability.

3. Complete chronic homelessness documentation within 45 days of enrollment in the RRH program, including chronic homelessness certification and disability documentation.

4. Complete the SPDAT assessment every three months to evaluate the household's progress. Extend RRH assistance if needed.

5. At the end of the standard period of the RRH program (six months, nine months, etc.), if the participant has not made progress and may still need PSH, contact the RRH Matchmaker. The Matchmaker will work with the RRH program to determine whether the participant is eligible for and can be placed in a PSH program. If it is determined that the household needs PSH and there is available capacity in an appropriate PSH program, the Matchmakers may be able to make a referral to PSH. However, there may not be any available spots in PSH programs.

6. Extend the RRH assistance as long as needed, up to two years, while the household is attempting to gain housing stability.

D. Project-Specific WaitLists

One of the benefits of coordinated assessment is that it simplifies the path to housing by replacing the multitude of existing project-specific wait lists with a shared community queue. However, some projects have requirements from their funders that may conflict with coordinated assessment. In those situations, OSH will work with the provider to determine the best possible way to participate in coordinated assessment.

VIII.   Safeguards for Domestic Violence Survivors

Families and individuals will not be denied access to the coordinated assessment process on the basis that they are survivors of domestic violence, dating violence, sexual assault, stalking, or trafficking. Such individuals will have safe and confidential access to the coordinated assessment process and victim service providers, and immediate access to emergency services such as domestic violence hotlines and shelter, as well as full access to other housing and services through the coordinated assessment process.

A separate, confidential process is available within the coordinated assessment system for domestic violence survivors who are receiving services from designated domestic violence service providers in the community. This process allows service providers to maintain confidentiality and safety for their clients, while also ensuring that homeless survivors have access to the full array of housing opportunities in the community.

A. Access

All staff conducting assessments at DV-dedicated and non-DV-dedicated access points will be trained on the complex dynamics of domestic violence, privacy and confidentiality, and safety planning, including how to handle emergency situations.

B. Assessment

1. Victim Service Providers
    i. The participating domestic violence service providers will conduct the VI-SPDAT triage assessment with the individuals and families staying in their shelters and transitional housing programs. These service providers are prohibited by law from using HMIS, so the VI-SPDAT and additional eligibility criteria that is usually included in the HMIS standard intake will be completed on a paper form. This modified intake form will only include the minimum information necessary to determine eligibility and prioritization and it will specifically exclude personally identifying information, including: name, date of birth, social security number, and last permanent address. The service provider completing the form will include the name of the agency, the appropriate staff contact, and an alternate staff contact. All communication about the assessment and any possible placements will be conducted through the service provider to maintain client confidentiality. The domestic violence service provider will include an internally generated ID number that the agency can associate with the client, but that cannot otherwise be identified with the client. OSH staff will use this number to identify the client when communicating with the service provider.

2. Non-Victim Service Providers
    i. Prior to initiating the VI-SPDAT, access points that are not victim service providers will screen all incoming households to determine whether they are DV survivors at risk of harm by using the "DV Screening Tool," available on the Office of Supportive Housing website.
    ii. If a household indicates that they are DV survivors at risk of harm, the assessor must offer them the choice of:
        1. An immediate warm handoff to a victim service provider for services, including safety planning and the VI-SPDAT; or
        2. Continuing to receive the VI-SPDAT from the non-victim service provider who will enter the household's information into the community queue in HMIS anonymously; or
        3. Continuing to receive the VI-SPDAT from the non-victim service provider who will enter the household into the community queue in HMIS.
    iii. If a DV survivor is already in the community queue because they have undergone a Family VI-SPDAT with their abuser, the survivor should be given the option to be re-assessed without the abuser. See subsections (ii)(1)-(3) above for how to proceed regarding the re-assessment.

C. CommunityQueue

OSH will maintain a separate Community Queue outside of HMIS for survivors referred by domestic violence service providers. No client data will be entered into HMIS, in order to maintain confidentiality and safety for survivors and compliance with federal law. Anytime there is an opening in a transitional or permanent housing program, OSH staff will reference both the HMIS community queue and the community queue outside of HMIS to determine the most highly prioritized eligible individual/household.

D. Housing Referrals

When an anonymous client from a domestic violence service provider receives a housing referral, OSH staff will contact the service provider. It is the responsibility of the service provider to reach out to the client and

connect them with the housing provider. The standard policies regarding the length of time to look for someone and the individual's/household's right to decline a referral still apply.

E. Emergency Transfer Plan

1. Emergency Transfer Qualifications

A client in a CoC- or ESG-funded project qualifies for an emergency transfer if:

a) The client is a survivor of domestic violence, dating violence, sexual assault or stalking;

b) The client expressly requests the transfer; *and*

c) Either:

  i. The client reasonably believes there is a threat of imminent harm from further violence if the client remains in the same dwelling unit; or

  ii. If the client is a survivor of sexual assault, the sexual assault occurred on the premises during the 90-calendar-day period preceding the date of the request for transfer.

2. Emergency Transfer Process

Participants may submit an emergency transfer request directly to program staff. The program must communicate with the Coordinated Assessment System matchmaker at the Office of Supportive Housing to inform them that an emergency transfer request has been made and whether the request is for an internal transfer (a transfer where the client would not be categorized as a new applicant), external transfer, or both. Participants may seek an internal and external emergency transfer at the same time if a safe unit is not immediately available. If the participant receives TBRA, the program will take reasonable steps to support the participant in securing a new safe unit as soon as possible and a transfer may not be necessary.

Residents of PSH who do not meet the Emergency Transfer criteria may request a transfer under section C.VII.B. "Transfers in Permanent Supportive Housing."

Internal Transfer

Where the participant requests an internal emergency transfer, the program should take steps to immediately transfer the participant to a safe unit if a unit is available. Requests for internal emergency transfers should receive at least the same priority as the program provides to other types of transfer requests.

If a safe unit is not immediately available, program staff will inform the participant that a unit is not immediately available and explain the participants' options to:

(1) wait for a safe unit to become available for an internal transfer,

(2) request an external emergency transfer, and/or

(3) pursue both an internal and external transfer at the same time in order to transfer to the next available safe unit in the CoC.

External Transfer

If a participant requests an external emergency transfer, the participant has priority over all other applicants for CoC-funded housing assistance, provided the household meets all eligibility criteria required by HUD and the program. After the agency communicates the participant's emergency transfer request to the

Coordinated Assessment System matchmaker, the matchmaker will facilitate referral of the participant to the next available appropriate unit through the Coordinated Assessment System.

The household retains their original homeless or chronically homeless status for purposes of the transfer.

3. Documentation and Record Keeping

To request an emergency transfer, the participant should submit a written request to program staff, certifying that they meet the emergency transfer qualification requirements. The program may – but is not required to – request additional documentation of the occurrence for which the participant is requesting an emergency transfer. No other documentation is required.

CoC-funded programs must retain records of all emergency transfer requests and their outcomes for a period of 5 years following the grant year of the program in which the household was a participant and report them to HUD annually.

4. Emergency Transfer Confidentiality Measures

Programs will ensure strict confidentiality measures are in place to prevent disclosure of the location of the client's new unit to a person who committed or threatened to commit an act of domestic violence, dating violence, sexual assault, or stalking against the client.

5. Family Separation

Where a family receiving TBRA separates as part of the emergency transfer, the family member(s) receiving the emergency transfer will retain the TBRA assistance when possible. The program will work with the CoC and the household to support an effective transfer in situations where the program is not a good fit for the family member(s) receiving the emergency transfer.

IX.   Administrative Structure

A.   System Oversight

Oversight of the coordinated assessment system, including implementation of the VI-SPDAT, community queue, prioritization and match-making, will be provided by OSH. OSH serves as the Santa Clara County CoC's collaborative applicant and HMIS Lead and staffs the CoC Board and the CoC Coordinated Assessment Work Group. The CoC board delegated authority to OSH, as the collaborative applicant, to approve and implement operational policies for coordinated assessment (See Delegation of Authority Table approved in April 2015). OSH will staff implementation of coordinated assessment and report back on progress to the CoC Board Executive Committee.

B.   Evaluation

At least once per year, OSH will consult with each participating project, and with project participants, to evaluate the intake, assessment, and referral processes associated with coordinated assessment. OSH will solicit feedback addressing the quality and effectiveness of the entire coordinated assessment experience for both participating projects and for households. All feedback collected will be private and must be protected as confidential information.

OSH will employ multiple feedback methodologies each year to ensure that participating projects and households have frequent and meaningful opportunities for feedback. Each year, OSH will use at least two of the following methods:

1. Surveys designed to reach at least a representative sample of participating providers and households;

2. Focus groups of five or more participants that approximate the diversity of the participating providers and households; or

3. Individual interviews with enough participating providers and households to approximate the diversity of participating households.

As part of the evaluation process, OSH will examine how the coordinated assessment system is affecting the CoC's HUD System Performance Measures.

The feedback will be collected and presented to the Coordinated Assessment Work Group, which will meet within 60 days of when the feedback is collected to consider what changes are necessary to the coordinated assessment system's processes, policies, and procedures in light of the feedback received.

C. Grievance Procedures

Any person participating in the coordinated assessment process has the right to file a grievance. Grievances related to a particular service provider (for example, a grievance related to how an assessment was conducted at a particular provider) should be resolved through that provider's grievance procedure. Grievances specific to discrimination or the coordinated assessment system (for example, a grievance related to the match-making process), should be forwarded to OSH.

D. Revisions to Policies and Procedures

The Policies and Procedures document will be reviewed and, if necessary, updated at least annually by the Coordinated Assessment Work Group and OSH staff.

E. Participating Providers

All CoC- and ESG-funded service providers must participate in the coordinated assessment system. For permanent housing providers (both rapid rehousing and permanent supportive housing) and transitional housing providers that means working with the coordinated assessment system to take referrals from the community queue. The CoC strongly encourages all other housing providers with housing dedicated to people who are homeless to participate, as well.

X. Definitions

ACCESS POINT

Locations where people can complete the triage assessment survey to participate in coordinated assessment. Access points often include emergency shelters and drop-in service centers.

CHRONIC HOMELESSNESS

HUD's definition of chronically homeless is an individual (or a family with an adult head of household) who:

- Is homeless and lives in a place not meant for human habitation, a safe haven, or an emergency shelter;

- Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years; AND

- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and who met all of the criteria above before entering that facility is also considered chronically homeless (24 CFR 578.3).

COLLABORATIVE APPLICANT

The eligible applicant that has been designated by the Continuum of Care to apply for a grant for Continuum of Care planning funds on behalf of the Continuum. The collaborative applicant for Santa Clara County is the Office of Supportive Housing.

COMMUNITY QUEUE

A prioritized list in HMIS of people who have completed the triage assessment survey and are in need of permanent or transitional housing. The list can be sorted by basic eligibility criteria and is prioritized so that individuals and families with the greatest need are housed first.

CONTINUUM OF CARE (COC)

The Santa Clara County Continuum of Care carries out the responsibilities required under HUD regulations, set forth at 24 CFR 578 – Continuum of Care Program. The CoC is comprised of a broad group of stakeholders dedicated to ending and preventing homelessness in Santa Clara County. CoC membership is open to all interested parties and includes representatives from organizations within Santa Clara County. The over-arching CoC responsibility is to ensure community-wide implementation of efforts to end homelessness and ensuring programmatic and systemic effectiveness of the local Continuum of Care program.

EMERGENCY SOLUTIONS GRANT (ESG)

ESG is a grant program of the U.S. Department of Housing and Urban Development (HUD) that funds emergency assistance for people who are homeless or at risk of homelessness. ESG grantees are required to participate in Coordinated Assessment.

HOMELESS

HUD's definition of homelessness (24 CFR 578.3) has four categories:

Category 1 – Literally homeless individuals/families.

Category 2 – Individuals/families who will imminently lose their primary nighttime residence with no subsequent residence, resources, or support networks.

Category 3 – Unaccompanied youth or families with children/youth who meet the homeless definition under another federal statute.

Category 4 – Individuals/families fleeing or attempting to flee domestic violence.

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

A local information technology system used to collect data on the provision of housing and services to homeless individuals and families.

HOUSING AND URBAN DEVELOPMENT (HUD)

The United States Department of Housing and Urban Development.

LITERALLY HOMELESS

Category 1 of HUD's definition of homelessness. Literally homeless means an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation, the individual or family is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs), or the individual is existing an institution where s(he) has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

OFFICE OF SUPPORTIVE HOUSING (OSH)

An office within the County of Santa Clara's Department of Behavioral Health Services. OSH serves as the collaborative applicant for the Santa Clara County Continuum of Care, staffs the Coordinated Assessment Work Group, and serves as the lead agency for implementation of coordinated assessment in Santa Clara County.

PERMANENT SUPPORTIVE HOUSING (PSH)

A type of permanent housing designed for chronically homeless and other highly vulnerable individuals and families who need long-term support to stay housed. Permanent supportive housing provides housing linked with case management and other supportive services. Permanent supportive housing has no time limitation, providing support for as long as needed and desired by the resident.

RAPID REHOUSING (RRH)

A type of permanent housing program that provides short-term financial assistance and support to quickly re-house homeless households in their own independent housing. The goal is to quickly move households out of homelessness and back into permanent housing, providing the lightest level of service necessary to assist the household.

RELEASE OF INFORMATION (ROI)

The consent form that individuals/households complete and sign to grant consent for their personal information to be entered into HMIS and used for coordinated assessment. Signing the release of information is not required to participate in coordinated assessment and receive referrals for housing; however, it is required to for information to be entered into HMIS.

SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (SPDAT)

An assessment tool developed by OrgCode Consulting, Inc. that is designed to help guide case management and improve housing stability outcomes.

TRANSITION AGE YOUTH (TAY)

Young adults ages 18 – 24 years old.

VULNERABILITY INDEX – SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

A pre-screening tool designed by OrgCode Consulting, Inc. and Community Solutions that can be conducted to quickly determine whether a client has high, moderate, or low acuity.

K. Emergency Solutions Grant Monitoring

The CoC is responsible for monitoring projects that receive ESG funds to ensure that the projects are performing adequately, operated effectively, managed efficiently, and in compliance with HUD requirements.

The Santa Clara County CoC Operations Committee will be responsible for monitoring project performance.

I. Monthly

A monthly monitoring report regarding performance will be generated by the HMIS Administrator and shared with the Committee monthly.

The monthly monitoring report will be shared with all ESG recipients and programs. ESG recipients and ESG-funded programs will be encouraged to participate in the Committee and invited to attend all Committee meetings at which ESG performance is discussed.

The report will include community-wide performance on the following objectives using the benchmarks set for each objective:

A. From HMIS, the percentage who:
1. Obtain permanent housing

2. Maintain/retain permanent housing (1 year)

3. Maintain/retain permanent housing (3 years)

4. Exit with earned income *I* employment

5. Exit with mainstream benefits

6. Have adequate resources to meet needs (calculated just like CCP)

7. Return to homelessness after report start

8. Exit to Known Destination

B. Also from HMIS:
1. Average Nightly Occupancy

2. Time (in days) from program entry to permanent housing for those obtaining permanent housing

C. Data Quality
HMIS data quality will be evaluated for each program on a monthly basis.

II. Quarterly

The CoC Providers Advisory Committee will review program-level performance to identify poor performers, taking into account populations served. To the extent that technical assistance and training is needed, the committee will provide recommendations to the Collaborative Applicant and the CoC Board.

ESG recipients and ESG-funded programs will be encouraged to participate in the Committee and invited to attend all Committee meetings at which ESG performance is discussed.

Poor performers may be selected for more intensive, on-site monitoring. This may include site visits, client feedback, and/or grant records. Ongoing poor performers may be selected for targeted technical assistance or other response.

III. Annually

In addition to the monthly and quarterly reports, the CoC Providers Advisory Committee may include a review of the HUD Annual Performance Report (APR) as well as other local sources to ensure compliance with HUD requirements.

Collaborative Applicant will coordinate with the ESG recipient to share any agency capacity policies.

List of Selected Clients from Past Three Years

Contra Costa County, CA
Lavonna Martin
Health, Housing, and Homeless Services Director
Contra Costa Health, Housing and Homeless Services Administration
(925) 608-6709

El Dorado, CA
Daniel Del Monte
Deputy Director, Community Services Division, CoC Coordinator
El Dorado County
(530) 295-6931

Fresno-Madera Continuum of Care, CA
Doreen Eley
Continuum of Care Coordinator
Senior Manager, Fresno Housing Authority
(559) 443-8400 ex. 4431

Maricopa Association of Governments (Arizona)
Anne Scott
Human Services Planner III
Maricopa Association of Governments
(602) 452-5006

Marin County, CA
Ashley Hart McIntyre
Homelessness Policy Analyst
Marin County
(415) 473-3501

Missouri Housing Development Corporation
Samantha Gamble-Kintz, MSW
Program & Policy Analyst
Missouri Housing Development Commission
(816) 759-6636

San Francisco, CA
Hugo H. Ramírez
Mayor's Office of Housing and Community Development
(415) 701-5516

San Mateo County, CA
Brian Eggers
Human Services Analyst, Center on Homelessness
San Mateo County Human Services Agency
(650) 802-5083

Santa Clara County, CA
Kathryn Kaminski
Continuum of Care Quality Improvement Manager
Office of Supportive Housing
County of Santa Clara
(408) 793-1843

Solano County Continuum of Care, CA
Dawn La Bar
Vice Chair, CAP Solano Joint Powers Authority
Special Projects Coordinator, City of Fairfield
(707) 428-7749

Southern Nevada CoC
Michele Fuller-Hallauer, MSW, LSW
Social Service Manager
Clark County Social Service
(702) 455-5188

Stanislaus County Continuum of Care, CA
Francine DiCiano
President/CEO
United Way of Stanislaus County
(209) 523-4562

Tulsa Continuum of Care, Oklahoma
Patrice Pratt
Division Director, Housing and Homelessness
Community Service Council
(918) 699-4236

References

A. CoC Governing Body Members

Teri House
CDBG/Housing/Homeless Consultant
City of Antioch Community Development Dept.
925-779-7037
CDBG@ci.antioch.ca.us
Relationship: Teri House has worked with HomeBase for many years and serves on the Contra Costa County CoC Board.

B. CoC Provider/Recipient

Vivian Wan, MSW
Chief Operating Officer
Abode Services, Allied Housing
HIP, Community Working Group
 (510) 657-7409 ext 212
vwan@abodeservices.org
Relationship: Vivian Wan has worked with HomeBase on multiple projects in Santa Clara and Napa Counties.

C. CoC Collaborative Applicant

Kathryn Kaminski
Continuum of Care Quality Improvement Manager
Office of Supportive Housing
County of Santa Clara
408-793-1843
kathryn.kaminski@hhs.sccgov.org
Relationship: Kathryn Kaminski is CoC staff in Santa Clara County.

8. Specific Staff and Percentage of Time

HomeBase

Staff Name / Title	Percentage of Time Dedicated to this Project
Nikka Rapkin / Executive Director	1% FTE
Bridget Kurtt DeJong / Managing Director and Team Lead	9% FTE
Meadow Robinson / Project Coordinator	13% FTE
Tara Clancey Ozes / Project Assistant	15% FTE
Colin Sorenson / Project Assistant	14% FTE

LeSar Development Associates

Staff Name / Title	Percentage of Time Dedicated to this Project
Jamie Taylor/Senior Principal	2% FTE
KrisKuntz/Principal	2% FTE