National Alliance to
End Homelessness

Recommendations for Implementation of the Federal HEARTH Act

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EXECUTIVE SUMMARY

HOMELESSNESS: A CHANGING LANDSCAPE

The federal approach to ending homelessness shifted as a result of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. The Act embodies much of the latest research and best practices for ending and preventing homelessness.

Broward County sought assistance to implement the new legislation from the National Alliance to the End Homelessness (the Alliance). The Alliance, founded in 1983, has long been considered a national expert in the movement to end and prevent homelessness because of its ability to influence policy, teach communities how to implement best practices, and disseminate relevant research.

The HEARTH Act dramatically increases the federal government's emphasis on performance and outcomes. As a result, communities will be expected to demonstrate that their homeless assistance achieves the following objectives:

- Return households to permanent housing as quickly as possible,
- Reduce new episodes of homelessness,
- Reduce the length of time households spend homeless (including time spent in homeless programs, such as in emergency shelter and transitional housing), and
- Reduce the number of people returning to homelessness.

The HEARTH Act charges communities with examining *system* outcomes, instead of just the outcomes of individual programs. A homeless assistance system encompasses all of the programs with a primary purpose of serving homeless individuals, including emergency shelters and transitional housing providers. Communities will be expected to show that their systems are coordinated and implement proven strategies to reduce homelessness. How well the system performs on the measures in the above list will influence how much funding Broward County receives from the federal government in the future.

HOMELESSNESS IN BROWARD COUNTY

Broward County has struggled with homelessness over the past few years. Homelessness is very visible in downtown Ft. Lauderdale, and Broward County has a relatively high percentage of households experiencing chronic (or long-term) homelessness. Several best practice strategies, particularly permanent supportive housing and rapid re-housing, are underutilized. However, Broward County's strengths, if used properly, can help propel it forward in the fight to end homelessness. These strengths include a significant commitment of County general funds toward homeless assistance, a sizeable amount of money from the U.S. Department of Housing and Urban Development (HUD), a plethora of local public and private financial resources, an evidence-based strategic plan in its Ten Year Plan to End Homelessness, *A Way Home*[1], and a well developed emergency housing infrastructure.

[1] Many communities adopted Ten Year Plans in the 2000s to set the course for how their community could work collaboratively to end homelessness. Broward's Ten Year Plan was released in October 2005. Recommendations in the plan relate to the issues of data, emergency prevention, systems change, street outreach, shortening the time people remain homeless, rapid re-housing, treatment and services, permanent affordable housing, and income to pay for affordable housing.

STAKEHOLDER FEEDBACK

The Alliance, in addition to evaluating HEARTH Act readiness and the County's strengths and weaknesses, was contracted to analyze the existing Continuum of Care (CoC)[2] and its level of functioning, propose strategies for increasing stakeholder engagement with the CoC, and examine the effectiveness of the current homeless assistance governance structure. To better understand these issues the Alliance gathered feedback from hundreds of stakeholders and dozens of organizations, advisory boards, cities, and County agencies. Feedback was collected for over a year through surveys, interviews, in-person meetings, site visits, emails, reports, strategic plans, and other informational papers provided by the County. The feedback provided by stakeholders was immensely insightful. As a result, this report contains a thorough analysis of Broward County's homeless assistance system and the flow of households through it. It also identifies improvements that would ensure that homeless assistance is delivered in compliance with the HEARTH Act and current best practice on preventing and ending homelessness.

SUMMARY OF RECOMMENDATIONS

The Alliance recommends the following steps to help Broward implement the HEARTH Act and reduce homelessness:

1. DEVELOP A MORE STREAMLINED COORDINATED ASSESSMENT PROCESS

The coordinated assessment process that currently exists, which is meant to make it easy for households to access the appropriate homeless assistance provider, is not as effective as it could be. Households currently experience unnecessarily prolonged wait times for services and are not necessarily being matched with the program best suited to return them to permanent housing. The more streamlined coordinated assessment process proposed in this report, beginning on page 21, creates a standardized process for determining the needs of people who become homeless that includes multiple levels of assessment, as well as a prioritization process that ensures the most vulnerable households (those most likely to end up on the streets or die) are prioritized. A coordinated assessment process will ensure that resources across Broward County are utilized more effectively and reduce the number of chronically homeless people residing on the streets.

2. IMPROVE THE CURRENT EMERGENCY SHELTER SYSTEM

Currently, much of the emphasis in the largest shelters in the County, the Homeless Assistance Centers (HACs), is on employment. The HACs also provide a variety of other supportive services focused on education, mental health needs, and substance abuse issues. While many of the services provided in shelter are helpful to clients, requiring people to participate in them while in shelter, and encouraging them to "work the program" and participate in a service curriculum slows the rate at which households exit, reducing shelter turnover, which in turn contributes to the number of unsheltered households. The consequences of this approach are reflected in the numbers - the

[2] The CoC is composed of a range of homeless assistance programs funded by HUD McKinney-Vento homeless assistance dollars that compete for these funds through the CoC application process.

HACs posted average lengths of stay for households exiting at 62, 78, and 71 days (according to the most recent quarterly data available). The Alliance recommends that shelters focus on permanent housing as the immediate goal for the households they serve and adopt a rapid re-housing approach (which is described below). When services for issues related to housing stability such as employment are needed, they should be provided once households are stable and in their own housing. These changes, described beginning on page 29, will make it easier to move households into permanent housing more quickly and free up more beds for those still on the street.

3. IMPLEMENT A ROBUST RAPID RE-HOUSING PROGRAM

The turnover in Broward's temporary housing (emergency shelter and transitional housing programs) is relatively low compared to other communities, which makes it more difficult for the County to move households off of the street. Many successful communities have incorporated a rapid re-housing approach into their homeless assistance systems to increase turnover and enable them to serve more households. The rapid re-housing model provides housing location and home-based case management services, often with a short- to medium-term rental subsidy. It requires strong relationships with private landlords. Broward County has underutilized this approach and should work to expand rapid re-housing by encouraging providers to convert their programs to a rapid re-housing model and training providers on how to more quickly help people move into permanent housing as described beginning on page 35.

4. EXPAND THE SUPPLY OF PERMANENT SUPPORTIVE HOUSING AND TARGET RESOURCES MORE EFFECTIVELY

Almost a quarter of all households in the County experience chronic homelessness, meaning they have serious health issues, mental health, or substance use disorders and either remain homeless constantly or cycle in and out of homelessness. Many of these consumers use a large amount of the system's resources without truly resolving their housing crises. Many of these households need permanent supportive housing, which provides a permanent housing subsidy and intensive wraparound services to break the cycle of homelessness. To ensure these units are being reserved for the households that need them the most, the Alliance recommends improved targeting of permanent supportive housing resources through the use of a vulnerability index to determine which households are in the greatest need of these supports. Additionally, the County should expand the supply of permanent supportive housing units for unaccompanied individuals through new development and conversions of other housing units and program types. Permanent supportive housing recommendations begin on page 41.

5. ENGAGE AND IMPROVE COORDINATION WITH OTHER SYSTEMS SERVING PEOPLE EXPERIENCING HOMELESSNESS

Many other systems in Broward County interact with households before, during, and after they experience a homeless episode, but do not necessary work with the homeless assistance system in a way that could streamline access to services for people experiencing homelessness and prevent future episodes of homelessness. The development of strong discharge plans that establish policies for preventing discharges from foster care, correctional facilities, hospitals, and other institutions into homelessness should be a top priority. The health care system is in a good position to support more households experiencing homelessness, especially if new Medicaid funding is used to pay for innovative services. The County and the Homeless Initiative Partnership (HIP) Board should work to engage and educate health providers about how collaboration could be of mutual benefit to both parties and the people they serve, using strategies beginning on page 44.

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6. CONSOLIDATE AND IMPROVE DATA COLLECTION

Broward County currently uses three different Homeless Management Information Systems (HMIS) to collect information on homeless households being served. HUD has recently released regulations that dictate all communities must use only one system for this purpose. Broward County has already made efforts to adopt one system, ServicePoint, and must continue down this path. It is recommended Broward acquire additional support through external consultants and additional staff to make the transition to one system a smoother one. Strategies for further improving data collection are described beginning on page 50.

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7. IMPLEMENT AN UPDATED PERFORMANCE MEASUREMENT AND IMPROVEMENT PROCESS

Broward County is currently unable to measure its performance on the HEARTH Act outcomes at a system level. To continue receiving funding, potentially increase its funding, and obtain feedback on how the system is doing in ending homelessness, it must resolve this issue. New suggested outcome measures in this report in Appendix P will give Broward a more accurate picture on how well the system and its programs are currently performing. Additionally, the Alliance recommends developing performance improvement plans for providers that are failing to meet the new performance standards. These plans will allow providers the opportunity to work collaboratively with the HIP Board to improve their performance before facing a potential funding loss. Performance-related recommendations begin on page 53.

8. REFORM GOVERNANCE STRUCTURE AND DECISION-MAKING PROCESSES

Currently, Broward County's performance measurement and governance capabilities are limited due to a small number of County staff dedicated to homelessness issues and a governance structure that sometimes lacks efficiency and transparency. More effective leadership is needed to guide the County's providers and stakeholders through the upcoming HEARTH Act change process. The Alliance recommends more staff for the County; more mainstream partners and changes to the seats on the HIP Board; and a clarified agenda and specific role for the Homeless Provider and Stakeholders' Council to ensure that leadership is diverse, focused, and representative. Governance recommendations begin on page 58.

9. UPDATE THE TEN YEAR PLAN

Broward County already has an exemplary Ten Year Plan to End Homelessness, though it is slightly outdated. The plan, once updated properly and reintroduced to the community, can be a guiding force for Broward County as it moves forward with implementing the recommendations described in this report. Recommendations for updating the plan begin on page 65.

Since the beginning of the Alliance's work with the County, things have already begun to change thanks to the initiative of Broward County HIP Section staff and various providers. The Alliance has incorporated much of that progress in this report. Moving forward, if Broward can implement these recommendations and continue to work toward developing a system built to adapt based on its performance outcomes, it will be in a much better position to end homelessness throughout the County.

INTRODUCTION

PROJECT OVERVIEW

The Alliance was contracted to provide guidance to the County on how to improve homeless assistance delivery and promote compliance and consistency with the HEARTH Act in Broward County and the Broward County/Ft. Lauderdale Continuum of Care (CoC)[3]. The scope of services requested by Broward County included the following:

- Analysis of the existing Broward County CoC structure, and provision of a summary of the analysis
- Recommendations for CoC partners
- Strategies for increasing stakeholder engagement in CoC
- Facilitation of meetings for the initial community HEARTH Act implementation planning processes to include scheduling meetings or conducting on-line surveys and/or telephone conferences to gather stakeholder input from community stakeholder groups
- Analysis of the CoC's readiness, and consultant's recommendations, for implementation of the HEARTH Act
- Analysis of the CoC's HUD funding application process
- Analysis of and recommendations for the functions and roles of County's HIP Advisory Board, and of Broward County's Homeless Provider and Stakeholder's Council (HPSC) and its partners, including Broward County's Housing Finance and Community Development Division (HFCD)
- Recommendations for changes to HIP to include an organizational chart showing how HIP should be staffed with specific job titles/realms of responsibility
- Provision of a comprehensive analytical report

The full scope of services is available in Appendix A of this report. It should be noted that some of the terminology and acronyms used within the report may be confusing: therefore, terms used throughout the report and their definitions in this context are in Appendix B. There are also some Broward-specific acronyms used throughout this report, including:

- *HIP*: Homeless Initiative Partnership Section of the Broward County Government
- *HIP Board*: Homeless Initiative Partnership Board
- *HPSC*: Homeless Providers and Stakeholders' Council

[3] The CoC is composed of a range of homeless assistance programs funded by HUD McKinney-Vento homeless assistance dollars that compete for these funds through the Continuum of Care application process.

ABOUT BROWARD COUNTY

Broward County has a large population (over 1.7 million people), a warm-weather climate, and more than 20 cities, towns, and villages that are part of the CoC but have distinct sets of laws, resources, and homeless assistance programs. All of these factors can combine to make developing a streamlined system of service delivery challenging. Additionally, relative to other communities, Broward County has a less well-developed data system and is less focused on rapid re-housing and permanent supportive housing for people experiencing chronic homelessness (both of which are considered best practices for ending homelessness). Unsheltered homelessness is also prevalent and visible.

Despite these barriers, several factors work in Broward County's favor. It invests a significant amount of its local County general revenue into homeless services and receives a relatively large allocation of money from HUD through the competitive CoC funding process. Additionally, rental housing in the area is relatively inexpensive compared to other large metropolitan areas, with the fair market rent for a one bedroom apartment in 2012 being $988. The rental vacancy rate was 10 percent and rising as of the end of 2010, which is about the same as in many other cities across the country, but high by historical standards. More information about Broward's housing market is available in Appendix C.

In terms of strengths within its homeless assistance system, Broward County has the beginnings of a coordinated assessment system, which is now a HUD requirement. Also, there is a focus on performance throughout the current County contracting process with providers, which will be key to making continued progress. Finally, Broward County's Ten Year Plan is very good and, with a few adjustments, can be a great guiding document for the County. A more thorough analysis of Broward County's strengths and weaknesses can be found in the Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis in Appendix D.

HOW BROWARD COUNTY COMPARES TO OTHER COUNTIES, FLORIDA, AND THE REST OF THE NATION

In its 2012 Point-in-Time count, Broward identified a total of 3,183 homeless households[4]. Comparison data from the State of Florida and the nation based on information from the 2012 HUD Annual Point-in-Time Count is detailed in Table 1.

[4] A point-in-time count is an unduplicated count on a single night of the people in a community who are experiencing homelessness that includes both sheltered and unsheltered populations. The 2012 count number includes the 2012 sheltered count information and the 2011 unsheltered count information, since no new unsheltered count was conducted in 2012. It is of note that Broward County has committed funding and entered into a contract with a local non-profit provider to conduct an annual sheltered and unsheltered Point in Time Count, which will occur January 2013. This will ensure a more consistent and comprehensive count that along with a Homeless Information Management system will likely improve data reliability and allow for trending over time.

TABLE 1: 2012 HOMELESSNESS DATA FROM BROWARD COUNTY, THE STATE OF FLORIDA, AND THE UNITED STATES

DATA POINT	BROWARD COUNTY	STATE OF FLORIDA	U.S.
2012 PIT Count	3,183	55,170	633,782
Change in Homelessness Between 2009 and 2012	-1.3%	-0.8%	-1.5%
Percent Adults Without Children	81.4%	64.8%	61.0%
Percent Chronic	23.6%	15.7%	15.8%
Percentage of Homeless People who are Unsheltered	39.8%	N/A *	38.4%
Emergency Shelter as a Percentage of All Beds	20.1%	27.1%	31.4%
Transitional Housing as a Percentage of All Beds	36.5%	34.5%	27.0%
Permanent Supportive Housing as a Percentage of All Beds	42.5%	37.1%	37.7%
Rapid Re-Housing as a Percentage of All Beds	0%	0.8%	3.5%

** Data not available because some CoCs in Florida used an incorrect methodology for their unsheltered counts.*

CHART 1: SHARE OF HOMELESS ASISTANCE BEDS BY BED TYPE (2012)

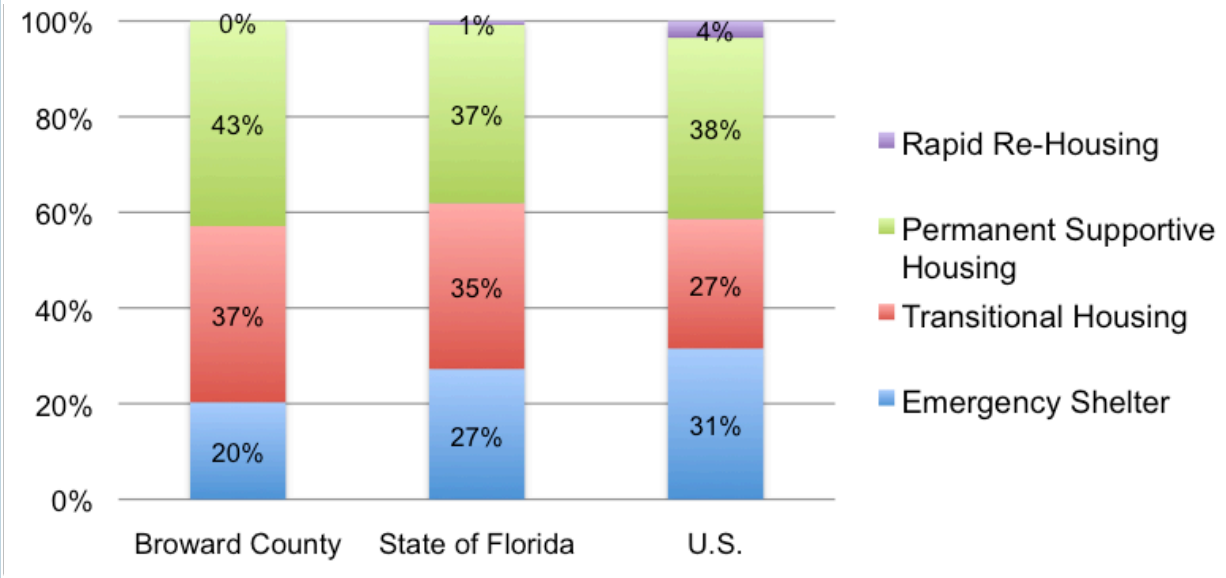
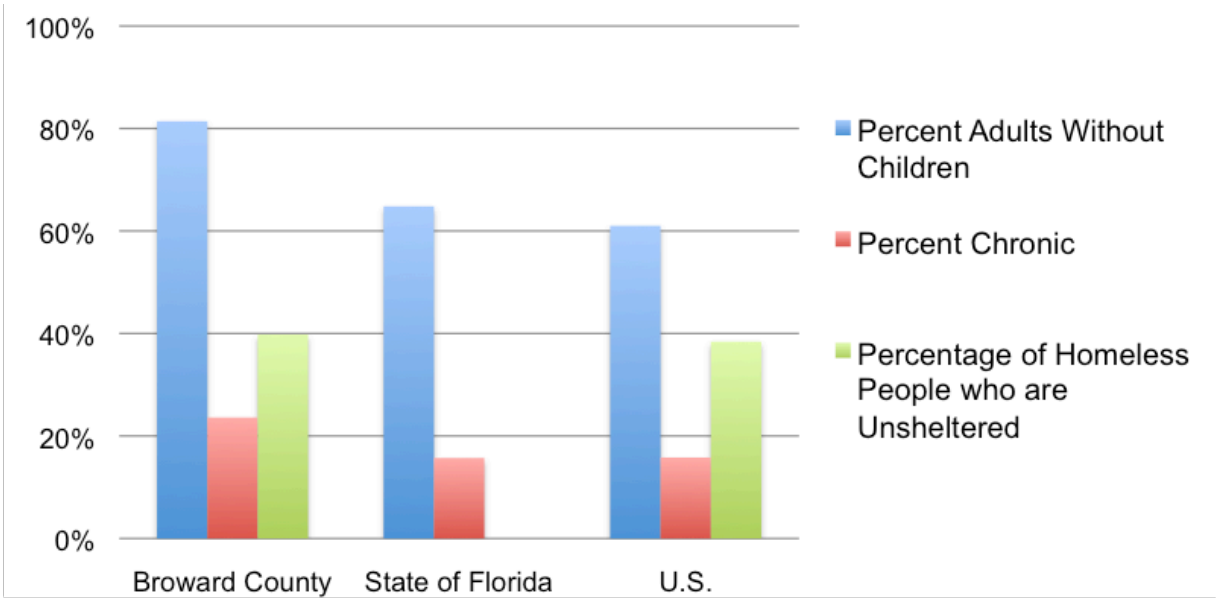


CHART 2: ADULTS, CHRONIC, AND UNSHELTERED AS A PERCENTAGE OF OVERALL HOMELESSNESS



NOTE: Data on unsheltered homelessness for the state of Florida is not available because some CoCs in Florida used an incorrect methodology for their unsheltered counts.

As Table 1 and the charts show, Broward County has a much higher percentage of homeless unaccompanied adults, a lower percentage of emergency shelter beds, and a higher percentage of transitional housing beds than Florida or the rest of the U.S. The percentage of people experiencing homelessness who are unsheltered is slightly higher in Broward County than it is in the rest of the U.S. on average, which is troubling.

TABLE 2: HOMELESSNESS DATA FROM BROWARD COUNTY AND COMPARABLE COUNTIES

DATA POINT	BROWARD COUNTY	ALAMEDA COUNTY, CA	TARRANT COUNTY, TX
Population in 2010 (from U.S. Census)	1,748,066	1,510,271	1,809,034
2012 Point-in-Time Count	3,183	4,257	2,123
Change in Homelessness Between 2009 and 2012	-1.3%	-1.9%	-2.7%
Percent Adults Without Children	81.4%	75.4%	59.2%
Percent Chronic	23.6%	24.5%	10.3%
Percentage of Homeless People who are Unsheltered	39.8%	52.0%	6.4%
Emergency Shelter as a Percentage of All Beds	20.1%	18.8%	34.0%
Transitional Housing as a Percentage of All Beds	36.5%	29.8%	24.2%
Permanent Supportive Housing as a Percentage of All Beds	42.5%	49.0%	40.9%
Rapid Re-Housing as a Percentage of All Beds	0%	2.4%	0.7%

CHART 3: SHARE OF BEDS BY BED TYPE: COMPARISON OF THREE COUNTIES

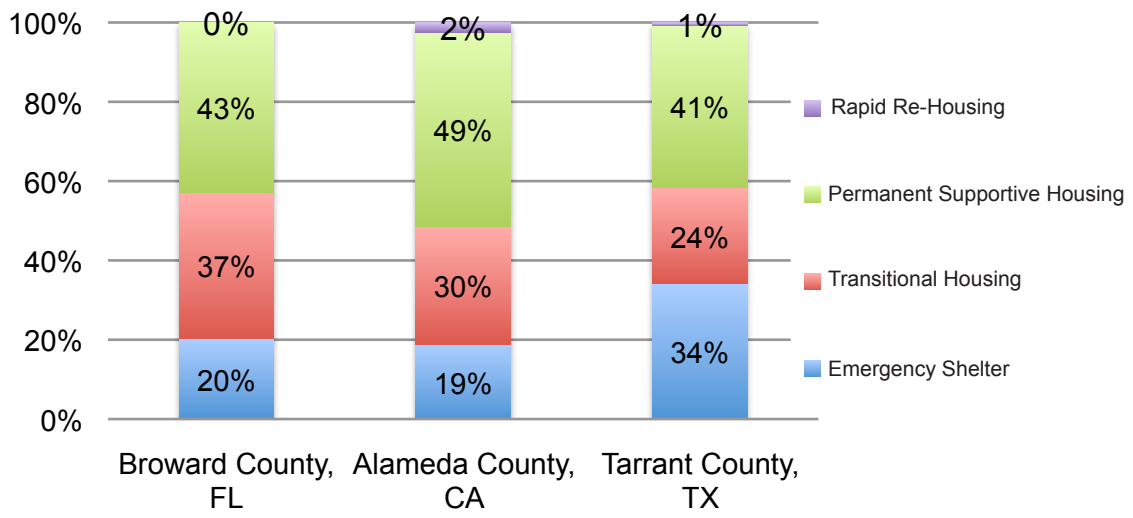
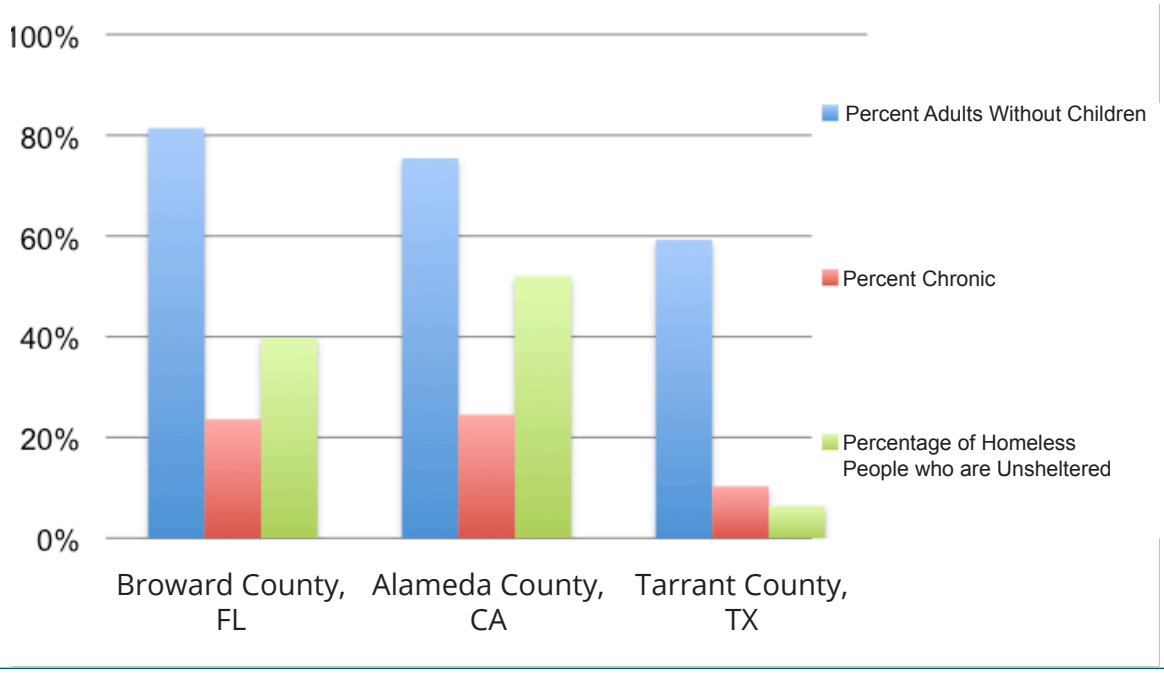


CHART 4: ADULTS, CHRONIC, AND UNSHELTERED: COMPARISON OF THREE COUNTIES



For additional comparison, the Alliance reviewed data on two counties that share some characteristics with Broward County: Alameda County, CA (which contains the city of Oakland) and Tarrant County, TX (where the largest city is Fort Worth). These communities were selected for comparison because they have large populations and have generally warm climates. Furthermore, both Tarrant County and Alameda County have implemented strategies consistent with the HEARTH Act that have helped reduce homelessness. Thus, they indicate a potential path forward for Broward County. Like Broward County, Alameda County struggles with jurisdictional issues, having dozens of jurisdictions in the county. Housing costs in Alameda County are higher (fair market rent for a one bedroom is $1,183) than in Broward. Alameda County once had a housing assistance infrastructure very similar to Broward County's, and has recently shifted toward a rapid re-housing model. This change has led to reductions in homelessness. Tarrant County has added a significant number of permanent supportive housing beds for single adults: nearly 500 beds were added between 2007 and 2011, and during that 4 year period, chronic homelessness declined 36 percent, while overall homelessness declined by 24 percent. Tarrant County was able to add permanent supportive housing even though the state of Texas provides less state funding for mental health substance abuse and other health services than nearly any other state.

When comparing data from Broward County with these communities, its relatively large ratio of homeless unaccompanied individuals to families stands out, as does, once again, its high ratio of transitional housing beds. Notably, although the share of bed inventory that is permanent supportive housing is similar across the communities, a higher percentage is devoted to single adults in both Tarrant (81 percent) and Alameda (49 percent) than in Broward (45 percent). The increase in permanent supportive housing beds devoted to chronic homelessness has been an important driver of decreases in chronic homelessness and in homelessness overall in both Tarrant and Alameda Counties.

ABOUT THE HEARTH ACT

The HEARTH Act reauthorizes the McKinney-Vento Homeless Assistance Act and creates incentives for communities to do more rapid re-housing, prevention, and targeted permanent supportive housing. The HEARTH Act also emphasizes meeting certain performance goals regarding entries into homelessness, length of homeless episodes, and repeat episodes of homelessness. These outcomes will be examined at the system level, meaning that the performance of all providers within Broward County, whether federally funded or not, will be assessed in an aggregate manner. Successfully implementing the strategies prescribed by the HEARTH Act will improve the homeless system's overall effectiveness, efficiency, and performance. Improving system performance will not only help people avoid housing crises or resolve them at a faster rate, but will also help Broward County use its resources more efficiently. Level of performance will also influence the amount of federal funding Broward County will receive in the future.

INFORMATION GATHERING PROCESS

To acquire a complete sense of the strengths and weaknesses of Broward County's homeless assistance system, the Alliance analyzed HUD reports, local data, County contracts, and grant materials provided by the County. Alliance staff also conducted several rounds of in-person informational interviews with providers and other stakeholders in Broward County's homeless assistance system. This feedback was gathered through seven in-person visits, phone calls, and emails between November 2011 and January 2013. Some of the partners the Alliance engaged with include the HIP Board and its subcommittees, who the Alliance met with approximately seven times, including some conference calls; County HIP Section staff, who the Alliance met with approximately eight times, which does not include countless phone calls, emails, and exchanges regarding the content of this report; and the operators of the Homeless Assistance Centers (HACs), who provided tours of each facility on the Alliance's initial visit, did extensive phone interviews with Alliance staff, and met with the Alliance on two additional occasions. Approximately 35 meetings in all were held on-site in the County with various organizations, agencies, and providers. At least 50 organizations, cities, and agencies were represented either through the surveys or in-person meetings with the Alliance.

Additional feedback was gathered through the use of a survey tool targeted to consumers (currently or formerly homeless individuals); service providers (front line staff or non-management staff at provider agencies who spend the bulk of their time working with people experiencing homelessness), including many who come from organizations the County contracts with; and community leaders (people involved with the administration of homeless assistance services and high level decision making, including government officials, agency executive directors, and HIP Board members). Over 120 surveys were collected by the end of the project. Most surveys were completed online; consumer surveys were administered through providers providing paper surveys or asking consumers the questions orally and then entering online. The surveys captured anonymous information on each stakeholder's experience, perception, and knowledge of Broward County's homeless assistance system.

Stakeholders provided valuable insight into Broward County's homeless assistance and had many important suggestions for moving forward. With few exceptions, their feedback was constructive and helped tremendously in the development of these recommendations.

Despite efforts to engage all of the community's stakeholders, there were some who were not responsive and who will need to be engaged in the homeless service delivery planning process moving forward. A list of stakeholders that participated in in-person feedback sessions, provided input via telephone, or identified their organization in the surveys (which were otherwise anonymous) is available in Appendix E.

SURVEY RESULTS AND AREAS OF CONCERN IDENTIFIED BY THE SURVEY

Generally speaking, survey respondents expressed a great amount of pride in different elements of the system, including the street outreach team. Service provider and front line staff responses to the survey were generally very positive, with many of them expressing that they felt knowledgeable, confident in their ability to serve consumers effectively, and accountable for placing consumers into permanent housing as quickly as possible.

Areas of concern that appeared to be common themes across the audiences of the community surveys are listed below. Summaries of all of the survey responses are available in Appendix F.

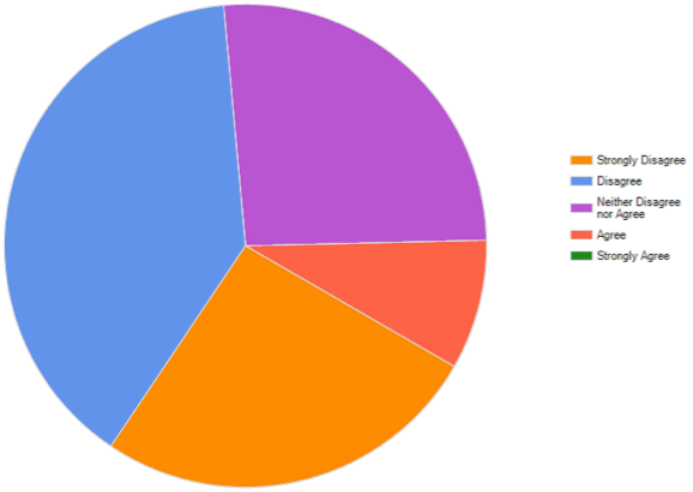
LACK OF RAPID RE-HOUSING AND PERMANENT HOUSING RESOURCES: The majority of service provider and community leader respondents did not believe that there were sufficient rapid re-housing resources in the community. Additionally, community leaders, by and large, did not feel that consumers were sufficiently helped to stabilize in their housing once placed. They were also unsure if the community had been successful engaging and sustaining landlords as part of a rapid re-housing program.

Consumers' responses reflect that they are experiencing issues as a result of this lack of resources. Out of those consumers surveyed, 66 percent were not housed within 30 days of becoming homeless. Of those respondents that had not been re-housed at the time of the survey, over a third did not have an idea of when they would be housed. Responses from consumers were mixed on whether or not the community had the resources needed to help households find and keep good housing.

GRAPHIC 1-1: RAPID RE-HOUSING/PERMANENT HOUSING SURVEY RESPONSES

COMMUNITY LEADER SURVEY RESPONSES

The community has sufficient rapid re-housing resources in place that assist consumers to be re-housed into permanent housing quickly (<45 days) should they become homeless.

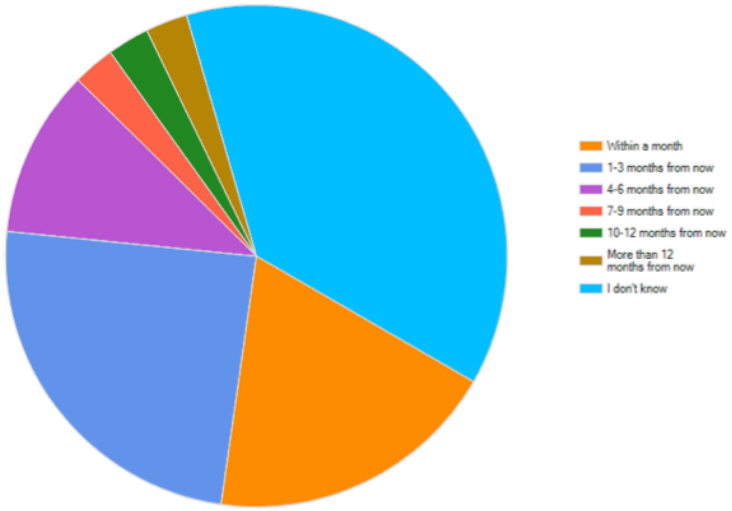


Number of respondents = 23

GRAPHIC 1-2: RAPID RE-HOUSING/PERMANENT HOUSING SURVEY RESPONSES

CONSUMER SURVEY RESPONSES

If you are not currently in permanent housing (a housing unit that is yours and that you never have to leave), when do you expect to be housed in such a unit?

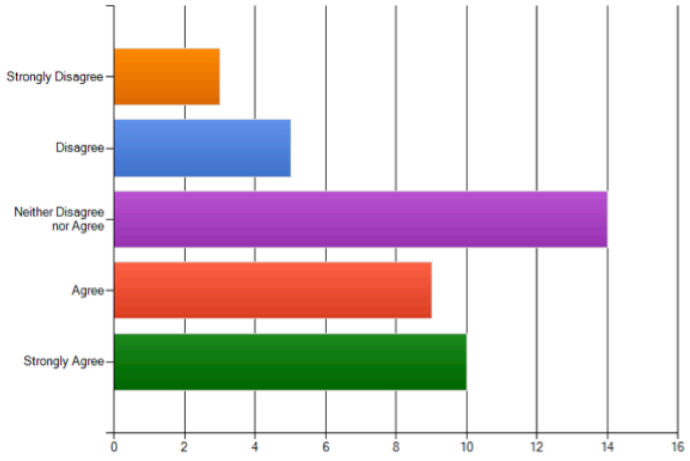


Number of respondents = 23

GRAPHIC 2-1: PERFORMANCE MEASUREMENT SURVEY RESPONSES

SERVICE PROVIDER SURVEY RESPONSES

As a community, we routinely reflect on data from either our HMIS or other case management software to understand who we are serving and not serving well and make adjustments to our service delivery accordingly.

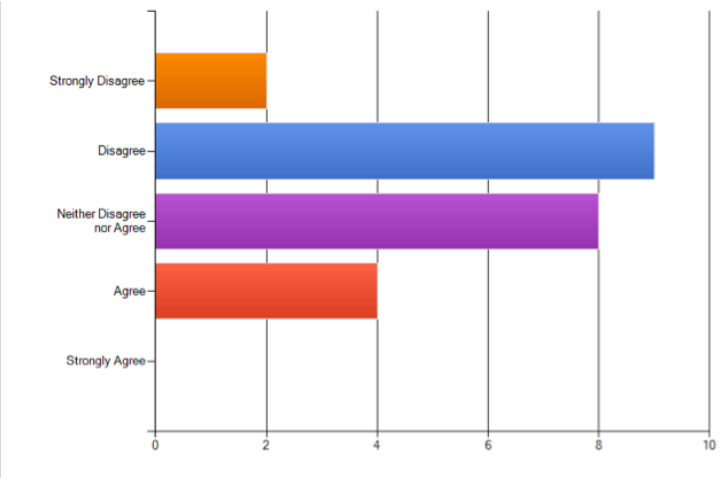


Number of respondents = 41

GRAPHIC 2-2: PERFORMANCE MEASUREMENT SURVEY RESPONSES

COMMUNITY LEADER SURVEY RESPONSES

Our community routinely reflects on data from either our HMIS or other case management software to understand who we are serving and not serving well and makes adjustments to our service delivery accordingly.



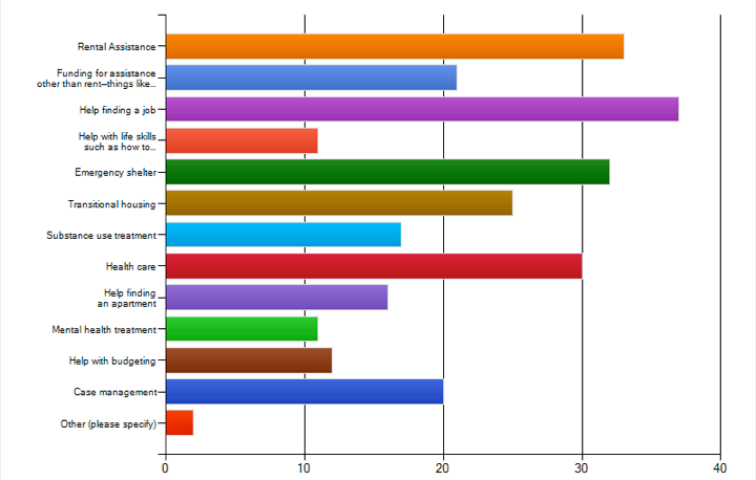
Number of respondents = 23

LACK OF CONSUMER VOICE: Consumers expressed that the services they needed the most when they were homeless included help finding a job (63 percent), rental assistance (56 percent), and emergency shelter (54 percent). However, only 31 percent surveyed reported receiving help finding a job and only 29 percent were offered rental assistance. These results imply that the system may not be providing enough of the services necessary for ending consumers' housing crises. Over half of consumers stated that to get help during their homeless episode, they had to do things they did not want to. Additionally, community leaders were somewhat unsure if consumers were satisfied with the services they were receiving (48 percent said they were, while 44 percent said they did not know) and also did not know whether or not the system was responsive to consumers. Half of consumers disagreed that they got to "call the shots" about how and when they received services. Overall, responses reveal that the continuum of services currently available may not be consumer driven or based on consumer need.

GRAPHIC 3-1: CONSUMER VOICE RESPONSES

CONSUMER SERVEY RESPONSES

What services or assistance do you or did you need the most when you were homeless? Check all that apply.

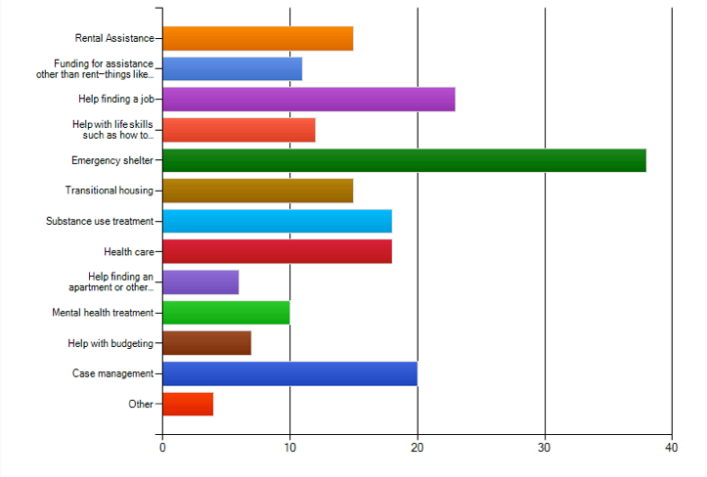


Number of respondents = 59
"Other (please specify)" responses included: no family supports, computer lab

GRAPHIC 3-2: CONSUMER VOICE RESPONSES

CONSUMER SERVEY RESPONSES

What services or help were you offered when you were homeless? Check all that apply.



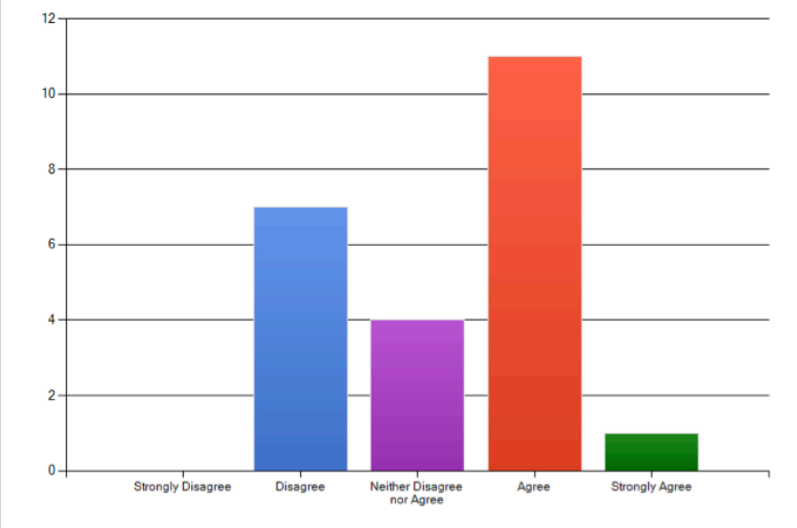
Number of respondents = 56
"Other" responses included: getting a mailing address, I'm still homeless, none

MISSING PARTNERSHIPS: Several community leaders noted that key partners from the health care sector were not active in working with the homeless assistance system or on the same page with the homeless assistance community when it came to sharing a vision to end homelessness. Private businesses and workforce were also mentioned more than once as partners whose participation in the system was desperately needed. This lack of workforce involvement is especially important to note, as consumers stated in their surveys that "help getting a job" was one of the services they needed the most. There were mixed responses among community leaders and service providers in response to the statement "The community has a comprehensive discharge plan that is being used and monitored for success on a regular basis," an issue that is discussed more later in the "other systems" recommendation in this report. Generally, this set of responses indicated that there is much room for improvement in terms of partnerships with agencies outside the homeless assistance system.

GRAPHIC 4-1: PARTNERSHIP RESPONSES

COMMUNITY LEADER SURVEY RESPONSES

All of the essential partners to end homelessness are around the table and share the vision of ending homelessness.

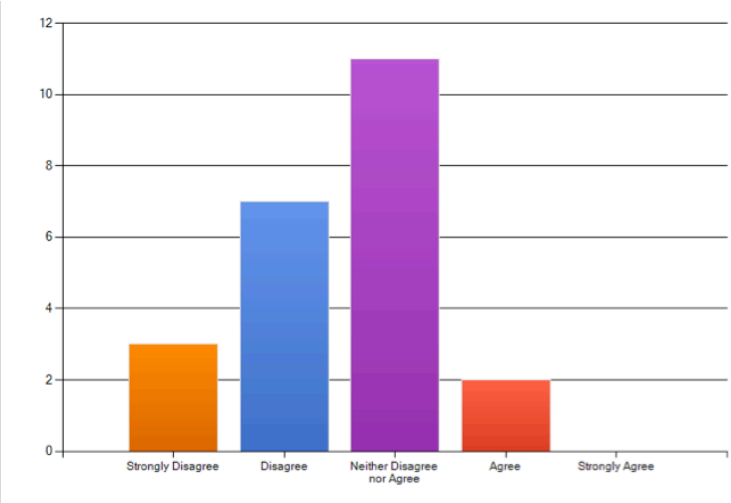


Number of respondents = 23

GRAPHIC 4-2: PARTNERSHIP RESPONSES

COMMUNITY LEADER SURVEY RESPONSES

The community has a comprehensive discharge plan that is being used and monitored for success on a regular basis.

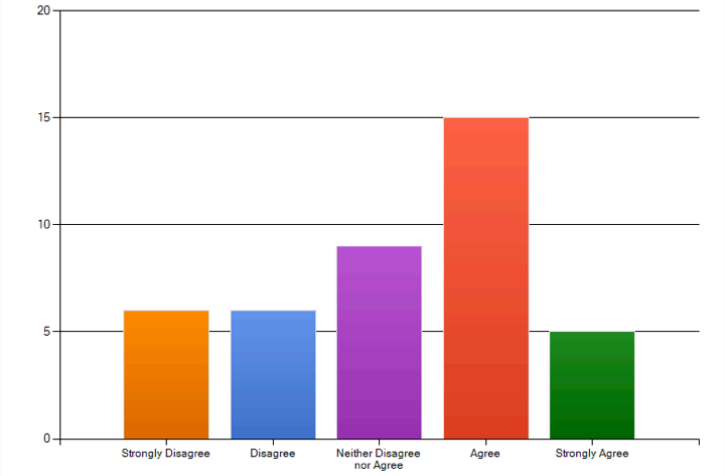


Number of respondents = 23

GRAPHIC 4-3: PARTNERSHIP RESPONSES

SERVICE PROVIDER SURVEY RESPONSES

I believe my community has a comprehensive and effective discharge plan.



Number of respondents = 41

RECOMMENDATIONS

RECOMMENDATION SUMMARY

Recommendations were made based on the results of the data analysis, both quantitative and qualitative; the current regulatory climate, specifically the HEARTH Act; and current promising and best practices as supported by measured reductions in homelessness. In addition, the Alliance has developed an extensive database and expertise in best practices across many types of communities. Evidence has emerged from dozens of these communities supporting the cost effectiveness and efficiency of rapid re-housing and permanent supportive housing. Across the country, this shift toward immediate placement in permanent housing and away from developing "housing readiness" in clients before helping them find housing is changing how communities everywhere use their homeless assistance system's resources. This necessary emphasis on permanent housing as a solution to ending homelessness is present throughout the recommendations in this report. Beyond the permanent housing focus, the shift from a program to a system view of success also shapes many of these recommendations. Because HUD will now be looking for success on a much wider scale – across all the homeless assistance programs in a community – the Alliance's recommendations are designed to create a more efficient, collaborative and unified set of programs that work together systemically to give Broward the best possible chance to successfully address the issue of homelessness.

The Alliance has developed the following nine recommendations for Broward County:

1. Develop a More Streamlined Coordinated Assessment Process
2. Improve the Current Emergency Shelter System
3. Implement a Robust Rapid Re-Housing Program
4. Expand the Supply of Permanent Supportive Housing and Target Resources More Effectively
5. Engage and Improve Coordination with Other Systems Serving People Experiencing Homelessness
6. Consolidate and Improve Data Collection
7. Implement An Updated Performance Measurement and Improvement Process
8. Reform Governance Structure and Decision-making Processes
9. Update the Ten Year Plan

Each remaining section of this report is focused on one of the Alliance's main recommendations for the improvement of the homeless assistance system in Broward County. Each recommendation contains specific sub recommendations with additional guidance on how the overall recommendation can be achieved. Each section also contains a timeline for how implementation would ideally be rolled out over the coming months and years. Most actions related to the recommendations are intended for County staff to address, though in some cases other agencies or organizations need to be involved. When the latter is the case, the Alliance has tried to clearly identify which organizations and stakeholders need to be involved.

1. RECOMMENDATION: DEVELOP A MORE STREAMLINED COORDINATED ASSESSMENT PROCESS

Broward County currently has various agencies that work together as part of a coordinated assessment process or entryway into the homeless assistance system, including a street outreach team; three very large County-funded emergency shelters, the HACs; an interfaith community-based shelter network; and a telephone-based Homeless Helpline. These organizations represent the most common and well-known ways that households can access homeless assistance services and housing opportunities.

Meetings with Homeless Helpline staff, the HACs, Hope South Florida (one of the providers of community-based shelter), and the outreach team revealed certain inefficiencies in the current assessment process. Households that need emergency shelter may have to make multiple calls or wait for many days to access services. The Homeless Helpline alone often has between 120 and 200 families on its wait list just to access shelter. Individuals waiting for assessment by the outreach team have to wait in designated places outdoors, and may have to come back multiple times before a placement is available for them. Providers' data systems are not connected, meaning that the availability of beds and services at some programs is unknown and that households may be referred to a place that has a bed at the time of their assessment but no longer has one by the time they arrive. Additionally, no system-wide criteria for prioritizing clients based on need is currently in place, so many providers operate on a first come, first served basis, potentially leaving the most vulnerable households without assistance.

For coordinated assessment to work effectively and improve both consumer and system outcomes, Broward County must make it easier for consumers to access services. This should be accomplished by making assessment locations clear and coordinating their activities; assessment and referral procedures standardized; data sharing easy and more prevalent; and through reducing consumer time spent searching for help; and prioritizing those households that have the most urgent needs for available beds. Additionally, the coordinated assessment process will be more effective if more providers participate in and only accept referrals from the coordinated assessment process. Coordinated assessment is now mandatory for HUD-funded providers; the County should attempt to entice non-HUD funded providers who offer homeless services in Broward to participate as well.

DEVELOP A COORDINATED ASSESSMENT STEERING COMMITTEE. The County will need a small core leadership group to ensure that a new coordinated assessment process is developed properly and in a timely fashion. A committee with similar purpose already exists in the County. A modified Coordinated Assessment Steering Committee should function as a committee under the HIP Board and its chair should designate the members. The Committee should consist of 6 to 9 individuals, including two non-County homeless assistance funders, a domestic violence provider, a HIP Board representative, an additional provider representative from HPSC, and a representative designated by the entity involved with the allocation of Emergency Solutions Grant (ESG) funds. This group should be tasked with:

- Ensuring all the tasks on the Coordinated Assessment Checklist (Appendix G) are completed;
- Delivering formal recommendations for a coordinated assessment tool and process to the County via the HIP Board;

- Securing input, feedback and support from providers around a new coordinated assessment process;
- Recommending written policies and procedures to govern the coordinated assessment process;
- Recommending an evaluation process for the coordinated assessment process; and
- Formulating and implementing a communication process to ensure that updates on coordinated assessment are regularly communicated to providers and the community at-large.

The evaluation process should take into account performance on HEARTH Act indicators, consumer feedback, HMIS data, and other indicators of system efficiency. Two tools to aid in the development of a coordinated assessment evaluation process are in Appendix H.

DESIGNATE SPECIFIC COORDINATED ASSESSMENT LOCATIONS FOR PEOPLE EXPERIENCING HOMELESSNESS. To streamline the process of assessment, the outreach team and case managers should assess households through a few select mainstream agencies (non-homeless specific County agencies that provide community services), the North and South HACs (the ordinance at the Central HAC would make walk-ups difficult), Women in Distress, a youth provider, and the Homeless Helpline (who may continue to use their current staff for assessment purposes). These should become the designated gateways to all of Broward County's homeless assistance programs, CoC-funded or otherwise. The County, through its HIP Section, should work to identify and investigate the potential use of County agency assessment locations that many consumers or at-risk households already access regularly, such as Elderly and Veterans' Services or the Broward Addiction Recovery Center. Trained staff will be needed at these locations to provide assessment services, and even those staff not participating in assessment should receive information and training on how coordinated assessment works specifically and what to do if someone they are serving is experiencing or at risk of homelessness. Having designated assessment locations and standardized processes (described below) will ensure that all households receive the same assessment and will increase the likelihood that every household is receiving the same opportunity to access all the County's services. Additionally, it will ensure efficient allocation and coordination of available resources.

FIGURE 1: Homeless Assistance Center

STANDARDIZE ASSESSMENT LOCATION HOURS. Business hours should be standardized across the HACs and other assessment locations as much as possible, and be extended as long as possible. Although a 24/7 option for many agencies may be nearly impossible due to local ordinances and neighborhood concerns, it is essential that flexible and expansive hours for assessment are available somewhere in the community. The Homeless Helpline should be accessible 24/7 for families. A 24-hour assessment option should also be available for individuals, either through the Homeless Helpline or through extending outreach team staff working hours.

DEVELOP AND INCORPORATE HUD-MANDATED WRITTEN STANDARDS FOR PRIORITIZATION AND ELIGIBILITY FOR HOMELESS ASSISTANCE PROGRAMS INTO THE COORDINATED ASSESSMENT PROCESS. Nationwide, all communities, according to the interim CoC legislation released by HUD, must have written standards that state prioritization and eligibility criteria for transitional housing, rapid re-housing, and permanent supportive housing programs. These written standards create an excellent opportunity to support targeting households for different interventions according to best practice, such as mandating that permanent supportive housing be targeted toward chronically homeless households. These guidelines also present an opportunity to further incentivize providers to respect the results of the referral process, which should be carefully aligned with the targeting ideas written into these standards. The County should develop the standards with the help of the Coordinated Assessment Steering Committee, the recommendations in this report, and the prioritization standards in Appendix I.

Create an outreach process that engages chronically homeless individuals living on the streets. People living on the streets often have mental health or substance use disorders or other serious illnesses. They are frequently viewed as a nuisance to the public, especially the business and law enforcement communities. Communities have experimented with different approaches, ranging from those that criminalize homelessness to efforts to house people experiencing chronic homelessness.[5] Unfortunately, many of the tactics used are not effective. For example, communities that outlaw encampments typically find that those laws have little long-term impact. The approaches that do have an impact are generally multi-pronged and focus on individuals with the most severe disabilities and longest experiences of homelessness. Of the many steps that Broward County could take to reduce the impact of street homelessness, the most important one is to prioritize permanent supportive housing units based on a vulnerability assessment (discussed in more detail in recommendation four). This would result in more chronically homeless individuals receiving permanent supportive housing, removing them from the streets, and engaging them in the recovery process. Two additional steps to take would be to create formal partnerships between law enforcement and homeless assistance providers (particularly outreach staff) and prioritizing chronically homeless individuals residing on the streets for emergency shelter and transitional housing beds. When law enforcement officials identify encampments or individuals sleeping on the streets who need assistance, outreach workers should be able to go to those locations and encourage those individuals to participate in an assessment and receive assistance. Having outreach workers that staff certain hotspot areas, such as churches that receive large numbers of homeless households and areas near libraries or train tracks is also helpful.

MODIFY THE ASSESSMENT AND REFERRAL PROCESS. Broward needs a consistent coordinated assessment, referral, and intake process that can salvage safe housing situations, if possible; preserve shelter beds for those with no other housing options; provide a consistent and best practice-based process for matching level of intervention to household need; and create a plan of action for helping a household return to permanent housing quickly. The process described below is designed to accomplish these tasks.

a. **PREVENTION AND DIVERSION SCREEN.** First, a prevention and diversion-oriented questionnaire should be administered to every household coming to an assessment location or calling into the Homeless Helpline. A sample prevention and diversion

[5] The U.S. Department of Justice has published a guide to dealing with homeless encampments, which describes some of these strategies and their relative effectiveness. The report can be found at http://cops.usdoj.gov/Publications/e011013251-HomelessEncampments.pdf. There is also a related report on Panhandling http://cops.usdoj.gov/Publications/e08032028.pdf.

assessment tool is in Appendix J. If eligible for receipt of prevention services according to that assessment, the household should be referred to the appropriate prevention provider in Broward County, most likely one of the Family Success Centers. Once at the Family Success Center, their degree of similarity to other households already in shelter should be used to determine a priority order for them to access prevention resources. A resource explaining how to target prevention assistance effectively is available in Appendix K.

If the household's current housing situation cannot be preserved, diversion may be an option. Shelter diversion involves assisting households relocate temporarily to living with friends, family, coworkers, or other situations outside of shelter while receiving assistance (financial or otherwise) to help them find a more permanent housing arrangement. It "diverts" the household from entering shelter unnecessarily while allowing them to access housing services similar to what they would receive while in shelter. Assessment staff at the HACs (outreach workers and HAC case managers) and Homeless Helpline staff should provide basic diversion screening and assist households to think through other housing options. Some diverted households will require financial or case management assistance, in which case they should be referred to the Family Success Centers for more intensive assistance.

b. **REFERRAL/ADMISSION TO EMERGENCY SHELTER.** Every household not eligible or appropriate for receipt of these prevention-oriented services should be admitted to emergency shelter in the homeless assistance system. All households should be referred to a HAC first, if there is space; if those beds are not available, they should receive a referral to another shelter option that is close to them. If there are no beds available in the HACs or any other shelters, then hotel or motel rooms should be the last resort until space at a HAC is available.

Broward County must ensure that no one is waiting on the street because the HACs are no longer accepting referrals for the day; there must be an alternative place for households seeking immediate shelter after the HACs or other shelters may have closed. Households calling the Homeless Helpline after HACs have closed should be assessed the same way as any other household. Those households that are eligible for prevention or diversion but cannot receive those services soon enough and households not eligible for prevention or diversion should be assigned to stay overnight at a community-based shelter or hotel or motel. These households should stay for one night with the understanding that they should go to whatever shelter they were referred to by the Homeless Helpline the following morning. Households that are in immediate danger due to domestic violence concerns should not be put through an assessment at that time but be urged to contact the police as well as go to Women in Distress or another domestic violence provider to be assessed there the next day. Other clients with safety concerns should call the police and also be referred to overnight shelter. All clients with safety concerns should be asked if they need to be transported to a provider or another safe place for the night and provided with

the transportation they need. Once they are out of a crisis state, they should call the Homeless Helpline or be assessed by an outreach worker. Eventually, community-based shelters willing to have their staff undergo coordinated assessment and rapid re-housing case management training and participate in the coordinated assessment system should be able to receive placements for longer than one night (in other words, receive the same type of referrals as the HACs).

Ideally, referrals to shelters by assessment staff should be handled through the HMIS. The assessment locations should send the household's information to the shelter they are being referred to, as well as document that a bed (or beds for couples or families) at that provider organization are "reserved" or filled in HMIS to ensure that bed availability information remains accurate. All providers should be using one HMIS (ServicePoint) and sharing information on availability through that system so that the Homeless Helpline and HACs can make informed referrals. Until all stakeholders in the homeless continuum are able to share available resource information in HMIS, the County will need to develop a system for shelter providers to update the assessment locations on their bed availability, perhaps through using a shared Google Drive document or spreadsheet. Domestic violence survivor information cannot be stored in HMIS, so an alternative system will be necessary to manage those beds and referrals.

c. **PRIORITIZATION, REFERRAL TO OTHER HOUSING PROGRAMS, AND HOUSING BARRIERS ASSESSMENT.** All households, once they have entered the shelter they were referred to, should receive a more intensive housing barrier assessment one week after entry. The week delay provides some time for households to figure out a potential housing situation on their own before receiving another more in-depth assessment. To support these new assessment responsibilities, providers may have to repurpose and reassign staff to fill new assessment and case management roles. Case managers and outreach workers that are experienced with administering more in-depth assessments should be used in this capacity. Additional suggestions for staffing are described in more detail in the emergency shelter section of this report.

This new assessment process will be used to identify the appropriate next step for the household that will help them return to permanent housing. Assessment staff should administer a questionnaire to help determine what intervention (likely either rapid re-housing, permanent supportive housing, or transitional housing) would be the best next step for each household. This process will not only be used to identify where a household would best be served, it will also help prioritize households to ensure that those households with the most urgent needs are served first. A tool that can be used for this purpose is available in Appendix L. Additional prioritization may occur through the use of a vulnerability index for chronically homeless households or a Housing Barrier Assessment for households entering rapid re-housing, available in Appendix M. For example, households that score higher on the Housing Barriers Assessment tool should be prioritized over those with lower scores. Transitional housing prioritization should be based on the number of barriers the household has from the list in the Housing Prioritization Tool in Appendix K.

To make this process work successfully, Broward County will need to maintain resource lists within each intervention type (e.g., transitional housing, rapid re-housing) with a rank order of households starting with those who scored with highest needs/priority down to lowest needs/priority. The process for making referrals with these prioritization standards in mind should unfold like this:

- When a space opens up, admissions should start at the top of the priority lists for that intervention and then move down, with considerations for differences among programs within each intervention. For example, men would not be referred to programs that only serve women with children, so if the person at the top of the list is a man when a space opens in one of these programs, the next woman with children after him on the list should receive the referral. Ideally, each household in the list would have a note on which programs within each intervention type they are eligible for to make this part of the process easier.

- An assessment staff member or case manager should be responsible for monitoring the priority lists and notifying the household and their shelter case manager that an opening has occurred within a program. The case manager should provide the household with the information necessary to get to the program they were referred to.

- Once the consumer has accepted the referral, the shelter should then share data they have collected on the household, including the assessment information, through HMIS with the program they will be entering and call that provider to let them know to expect the household.

- More information on the referral process can be found in the emergency shelter section of this report.

d. ENTRANCE INTO A PROGRAM. Once households are referred and admitted into a program after emergency shelter, or once a household has proven to be eligible for rapid re-housing in one of the HACs, that provider's case managers should use information from the previous assessments and conduct further assessment if necessary to craft a housing plan. The plan should help focus staff around how to help the household get into permanent housing and how to support them once a housing unit has been identified and obtained.

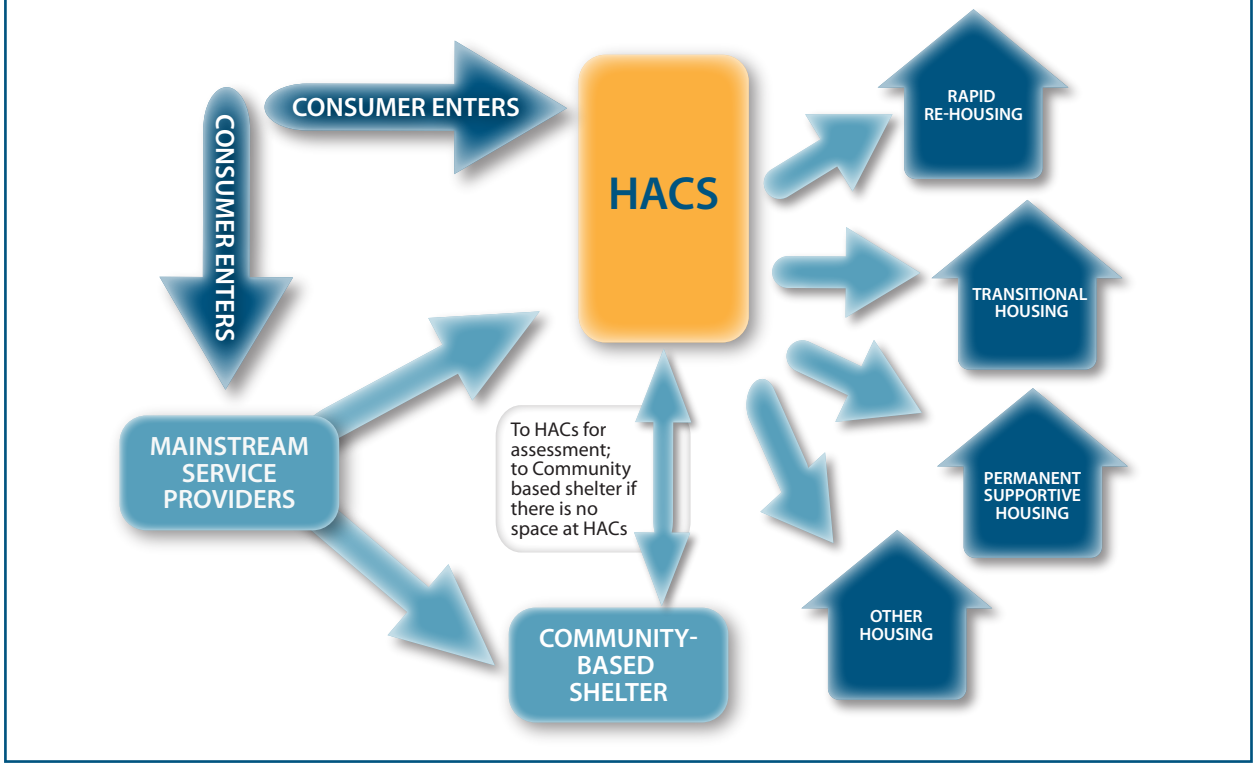
This model for assessment, referral, and intake will apply to coordinated assessment for both individuals and families, but there are some differences in the model for each population, as described in more detail below.

PROPOSED SYSTEM FOR INDIVIDUALS

For unaccompanied individuals, outreach workers stationed at the North and South HACs and other mainstream social service agency offices frequented by at-risk and homeless individuals, such as the Family Success Centers, will be responsible for conducting the initial prevention and diversion screening, at least for now. If the unaccompanied individual is eligible for shelter and requires assistance with transportation,

the outreach staff should escort them to the HACs (or other shelters, if necessary). For unaccompanied individuals who present as chronically homeless, outreach workers or case managers will need to conduct an additional vulnerability assessment during the assessment process.

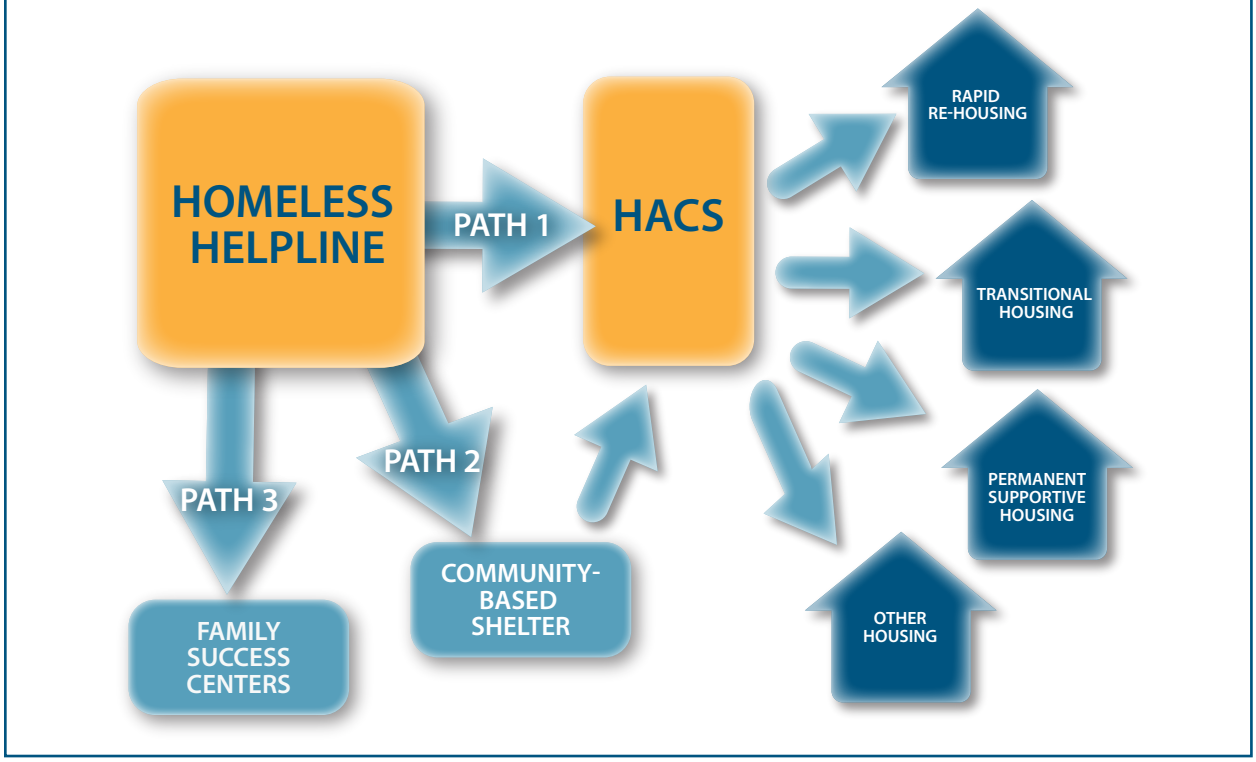
DIAGRAM 1: PROPROSED COORDINATED ASSESSMENT SYSTEM FOR UNACCOMPANIED ADULTS



PROPOSED SYSTEM FOR FAMILIES

The family system will still rely on the Homeless Helpline for initial prevention and diversion screenings. Any consumers coming directly to the HACs for assistance should call the Homeless Helpline to complete these assessments. If a household cannot be served by prevention or diversion, they should first be referred to a HAC, where, if they are deemed eligible for rapid re-housing, they can continue to stay as a participant in the rapid re-housing program. Families needing overnight shelter because they cannot immediately access a HAC should stay at a community-based shelter instead. Families staying at a community-based shelter should receive the same assessments and access to rapid re-housing assistance as if they were staying at the HAC. Those households who are assessed as being a better fit for transitional housing, permanent supportive housing, or any other program should be prioritized according to the process describe above and then referred when an appropriate slot is available.

DIAGRAM 2: PROPOSED COORDINATED ASSESSMENT SYSTEM FOR FAMILIES



SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• HIP Board calls for first meeting of modified Coordinated Assessment Steering Committee
4-6 months	• County completes HUD written prioritization standards • Coordinated Assessment Steering committee designates new assessment centers • Assessment locations begin new hours of operation (standardized) • Coordinated Assessment Steering committee finalizes assessment, prioritization, and housing barrier assessment tools • New protocols are developed for law enforcement and outreach partnerships
7-12 months	• Assessment locations begin implementing new assessment, referral, and intake processes • (Six months after implementation) County conducts first evaluation of new coordinated assessment process
13-24 months	• (One year after last assessment) County conducts evaluation of new coordinated assessment process
After 24 months	• County continues evaluating new coordinated assessment process

2. RECOMMENDATION: IMPROVE THE CURRENT EMERGENCY SHELTER SYSTEM

Most emergency shelter beds in Broward County are within the three HACs, with smaller contributions from a network of independent and faith-based providers. Despite the presence of these shelter beds, many people in Broward County remain unsheltered. It appears a lack of turnover in these shelter beds, due to the absence of rapid re-housing and permanent housing focus within the shelters, is contributing to unsheltered homelessness. The HACs provide a vast array of services including employment-focused services, support groups, childcare, educational opportunities, and mental health services. However, trends around the country show these services are best provided to households once they have been helped to locate permanent housing to help them stabilize in housing, when households are more receptive to receiving them. Additionally, consumers tend to have an easier time becoming employed once they have stabilized in housing. Strategies that have been successful in other communities in helping households move into permanent housing again quickly, including short-term rental subsidy provision, help locating housing, and help approaching landlords are not being provided at all or are provided almost as an afterthought. By increasing the number of households exiting shelter and decreasing the amount of time they spend in the HACs, the County could maximize existing shelter beds and increase shelter capacity even without increasing the number of emergency shelter beds. In concert with a streamlined assessment process, such as the one described in the coordinated assessment section, the County can also ensure that fewer households are unnecessarily entering the HACs if they have alternate housing options.

EMERGENCY SHELTER CASE MANAGEMENT

Shelters with short lengths of stay and good permanent housing outcomes typically are permanent housing-focused and provide housing-related case management, in addition to providing temporary financial assistance to help households with start-up housing costs. Recommendations on how to shift to a permanent housing focus when providing case management services are below.

REVISE CASE MANAGEMENT RESPONSIBILITIES. Currently, staff job descriptions in the HACs are focused on providing clinical and employment services. Additionally, case managers' roles and responsibilities vary from shelter to shelter. Each shelter should have case managers with at least two sets of distinct roles: crisis intervention and intake, and housing location and rapid re-housing service provision. Shelters will need dedicated staff for rapid re-housing that are not also focused on day-to-day shelter operations. Staff for these new positions could potentially be repurposed from employment, educational, or other support positions at the shelters.

> **CRISIS-INTERVENTION AND INTAKE SERVICES.** Some case managers should be specifically designated for onsite shelter operations duty, which would include managing any crisis situations and doing an intake with households (which differs from the housing barriers assessment described below). Intake would simply require gathering any additional information on the household needed to admit them into the shelter once they arrive, which might include additional HMIS data or health information. Crisis situations may include violence or a severe mental health episode that endangers the client or the people around them. These staff will need basic training in deescalating violent situations and the requirements of a basic shelter intake.

HOUSING-FOCUSED CASE MANAGEMENT, ON SITE OR AT THE CLIENT'S UNIT, AND HOUSING LOCATION SERVICES. Depending on fiscal and staff resources, shelters may have case managers perform all these tasks or divide them between a housing case manager and a housing location specialist. If they choose the latter, the housing location specialist should provide housing location services and work to build landlord relationships, and the case manager should work on developing housing plans and conducting home visits with clients. There are advantages and disadvantages to dividing these responsibilities; having two positions makes it less likely that staff will become overburdened and forced to work out of their comfort zone in terms of skill set; however, dividing the work between two positions makes it extremely important that case managers and housing location specialists work collaboratively and may be more challenging to implement financially. A sample job description for the housing location specialist is available in Appendix N.

- **Administering a standardized housing barrier assessment**. The coordinated assessment process recommended for the County (described in more detail in the coordinated assessment section of this report) creates many changes to how households are assigned to a particular intervention and program. It will be the responsibility of the case management staff at the HACs, and, in some cases, outreach staff, to assess households for more specific housing-related needs within a week of their entry into shelter using the Housing Prioritization Tool, which is available in Appendix L. Based on these needs and the prioritization process described in the coordinated assessment section, households will receive a referral to another program. Many households will be deemed a good fit for rapid re-housing, in which case they would stay in shelter while working with their case manager to find a permanent housing unit. Some households may need to be referred to a domestic violence provider or other specialized program to meet specific safety or other needs. Currently, those households who are deemed to have fewer barriers to re-entering housing or service needs are, in some instances, referred to transitional housing programs. This creates a backlog in the homeless assistance system as these households would likely be good candidates for rapid re-housing, which is a much shorter and less intensive intervention. Having a stronger coordinated assessment process and standardized tool should largely solve this issue, but training shelter staff will also help.

- **Providing housing search and location services.** For households eligible for rapid re-housing, housing location specialists should take information from the housing barrier assessment as well as information on the household size, location of household jobs and schools, and information on any safety concerns to help find the household suitable housing options. Options explored should include privately-owned apartments, shared housing opportunities, living with family or friends, and rented rooms in single-family homes. Existing landlord relationships will also influence what kinds of units are available for households requiring rapid re-housing.

- **Building landlord relationships.** Housing location specialists, aside from helping individual households find housing, will also need to develop positive relationships with local landlords and be knowledgeable of available units and housing stock. Building landlord relationships will include putting together events for landlords in concert with County staff, engaging landlords through local landlord associations, engaging the Housing Authorities, marketing rapid re-housing programs, and cold-calling landlords with available units. More information on building landlord relationships can be found in the rapid re-housing recommendation in this report.

ADOPT SYSTEM-WIDE STANDARDS FOR CASE MANAGEMENT PROVISION. The adoption of system-wide standards for case management practice in emergency shelters will ensure that services are focused on permanent housing and aligned across the homeless assistance system. It will create a consistency in delivering assistance, ensure that all households are getting assistance finding permanent housing, and relieve providers of the burden of developing their own individualized case management standards.

The following housing-focused case management goals should be incorporated into shelter policies, procedures, and job descriptions:

- The primary goal of case management is helping households return to permanent housing.
- Housing goals must be clear, measurable, and attainable.
- A housing-focused case management plan should be developed by the second week of shelter stay.
- The case management process is designed to get households ready to move to permanent housing, help them manage change, and empower them to take control of their own lives and their housing stability.
- The case management process is a partnership between the household and case manager in which housing decisions and plans are mutually developed with the household actively involved in all phases of the process: assessment, planning, problem solving, and finding resources.
- Case management plans should be client-centered and reflect needs and goals that are specific to and appropriate for the household.
- Case management practice is rooted in the belief that clients are capable of taking control of their lives and their ability to be stably housed; it recognizes that persons experiencing homelessness are like anyone else with strengths and resources as well as weaknesses and barriers.
- The case manager's role is not to be the "end all be all" for the household, but rather a facilitator to facilitate the resources and solutions the household needs to meet their housing goal. Their role is to encourage the household to connect the with other identified service needs that affect their housing and financial stability once housed, including employment and job training programs, childcare, income, and medical assistance programs.
- For households involved with other agencies, every attempt must be made to coordinate case management plans, with the shelter case manager requesting a copy of all other case management plans to ensure coordination of plans and avoid duplication of services. It is also important that a primary case manager is identified.

PROVIDE AND REQUIRE TRAINING OF ALL CASE MANAGERS. The County should identify or potentially develop trainings for all provider case managers working in the emergency shelter system. These trainings should focus on best practice case management principles, rapid re-housing case management best practices, and identification of community-wide resources and supports. It is critical for case managers to have an understanding of the populations they are serving and to demonstrate qualifications specific to their clientele and program criteria. Training can also ensure standards, ethics, and codes of conduct are understood and in practice.

Training should be offered at times that are accessible to both day and night shift shelter case managers. Each case manager should be required to participate in 10 to 20 hours of training annually. Training may include the following:

- Basic housing-focused case management
- Best practices in rapid re-housing including:
  - Basics of home visiting and voluntary service provision
  - Assessing for subsidy needs
  - Developing financial literacy
  - Empowering households to connect with other mainstream service providers to meet housing stabilization needs (employment, education, etc.)
- Core competencies of case management with homeless households, including:
  - Culturally appropriate interventions for mental health issues, addictions, and other behavioral health needs
  - Addressing multiple client needs and heterogeneity
  - Engaging people and developing trusting relationships
  - Activities and processes of case management
  - Administering and analyzing assessment tools
- Conflict resolution and de-escalation
- Cultural competence (based on diversity of populations served)
- Record keeping and HMIS data recording
- Community housing and supportive service resources[6]

OPERATIONAL RECOMMENDATIONS

Standardize shelter operations. The County should use its funding as leverage to incentivize shelter providers to use the same standards for their operations. Standards should be written into County contracts. These standards should include participating in the County's coordinated assessment process; using the same cleanliness and safety standards, operating hours, and adopting the same residents' rights policies; employing the case management and operational recommendations in this report; and measuring progress on the outcomes recommended in this report if adopted by the County. The County, the City of Ft. Lauderdale (as the primary ESG stakeholders), and the HIP Board should convene a series of three to four meetings to work collectively with shelter providers and other relevant stakeholders to develop policies and procedures to guide shelters in the implementation of these efforts. Shelters that operate independently of County or HUD funds should be encouraged to adopt these procedures as well.

REDUCE OR RESTRUCTURE PROVISION OF OTHER SERVICES OFFERED AT EMERGENCY SHELTERS. If there are resources and funding available for other services such as mental health support groups and computer classes after the above case management and housing location needs have been addressed, these services should be made available to a larger group of Broward County residents who could use the services based on referrals from mainstream agencies or used voluntarily by households in shelter or rapid re-housing clients. No program requirements or incentives should be attached to using these services.

[6] These recommendations stem from information on case management standards from the Calgary Homeless Foundation Case Management Accreditation Manual (http://calgaryhomeless.com/agencies/accreditation/) and Council on Accreditation website (http://coanet.org/).

PROVIDE ACCESS TO FINANCIAL ASSISTANCE TO CONSUMERS AT THE HACS. Case managers at emergency shelters will need financial resources to assist each household's movement to permanent housing. This assistance will be used to provide temporary rental assistance, utility assistance, security deposits, and money for moving costs. Having financial resources easily accessible will allow case managers to quickly distribute funds to landlords and households and incentivize landlords to take on rapid re-housing clients. Potential sources of funding for rapid re-housing subsidies are listed in the rapid re-housing recommendation section of this report.

DISCONTINUE SYSTEM OF REWARD BEDS. Currently, some of the HACs reward residents of their shelters for participation in services by moving them to rooms with fewer beds and more personal space. Sleeping space should be allocated based on need, and not used as an incentive or award for performance. Rooms with more privacy might be used for families, people with health problems, those who work at night and need to sleep in the day, youth, etc.

ACCOMMODATE TRANSGENDER INDIVIDUALS BASED ON HOW THEY IDENTIFY, NOT BIOLOGICAL SEX. To comply with best practice and policies that promote inclusivity and non-discrimination, transgender households should be permitted to lodge with whatever gender they identify with, rather than being forced to use bathrooms and beds associated with their biological sex.

REFOCUS SHELTER OUTCOME MEASURES. Providing incentives for emergency shelters to shift their focus to permanent housing will be the key to making real change in terms of how shelters operate. Changing the outcomes required of shelters, and therefore changing how they are funded, can create the momentum necessary for change. Columbus, OH has a high performing homeless assistance system with an average length of stay of 25 days in shelter. Performance measures for emergency shelter in Columbus are focused on serving more households, shortening length of stay, and improving the volume of positive exits (exits to permanent housing, including permanent supportive housing). Columbus's outcomes are available in Appendix O. The County should consider adopting similar outcomes in order to encourage emergency shelters to focus on rapid re-housing and other permanent housing strategies. In terms of their rapid re-housing efforts, shelters should also be focused on getting high housing retention rates for households after six months and one year. Suggested outcome measures for emergency shelters and other interventions are in Appendix P of this report. More information on incentivizing good performance is available in the performance measurement and improvement section of this report.

The system-wide shift toward a permanent housing focus will require a shift in how shelters do business, from their general operations to their case management services. However, this new emphasis will help shelters serve more people, reduce the number of people forced to live on the street, and reduce the amount of time households spend homeless.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• Shelters shift policies on transgender individuals • County begins providing at least quarterly staff trainings for case management staff
4-6 months	• Shelters end system of "reward beds" • Shelters provide intensive training for staff on new rapid re-housing model • Shelters begin shifting resources away from additional educational and employment services toward case management • Shelters write new case management job descriptions • Shelters begin shifting current staff roles • County establishes and formally adopts new system-wide standards for emergency shelters • Shelters sign pledges to adopt new system-wide standards • Coordinated Assessment Steering committee introduces final housing barrier assessment tool for shelter case managers to use • County collaborates with Ft. Lauderdale to develop and release policy and procedures document for shelters
7-12 months	• Shelters begin hiring new case management staff (if necessary) • Shelters begin providing financial assistance to re-house clients • Shelters begin conducting assessments with housing barrier assessment tool
13-24 months	• County revisits, and, if necessary, revises case management standards • County begins holding shelters to new performance outcomes
After 24 months	• County revisits, and, if necessary, revises case management standards

3. RECOMMENDATION: IMPLEMENT A ROBUST RAPID RE-HOUSING PROGRAM

Perhaps the most important change that Broward County should make to its homeless assistance system is expanding its use of a rapid re-housing model. The County's current homeless assistance system experiences numerous bottlenecks that limit the turnover of shelter beds, leaving many households unsheltered and prolonging episodes of homelessness for many others. This is not only happening in shelters: as reported on the County's 2011 CoC Application, only 45 percent of participants in transitional housing moved to permanent housing, which is far below HUD's standard of 65 percent. This may partially explain why unsheltered homelessness increased over 58 percent between 2009 and 2011.

To alleviate this bottlenecking, Broward County must focus on "opening the back door" out of homelessness and rapidly re-housing households into permanent housing as quickly as possible. Getting people out of temporary housing programs more quickly will increase those programs' capacity to serve other people in need of their services. Once in permanent housing in a rapid re-housing program, households receive case management and other services to improve their long-term housing stability. The biggest difference between this and other interventions, such as emergency shelter or transitional housing, is that the household's homeless status is addressed immediately, with voluntary services being administered after the household has returned to permanent housing. Abode Community Services in Alameda County has been quite successful rapidly re-housing unaccompanied individuals by setting up roommate situations and using shorter-term subsidies as a "bridge" to longer subsidies.

There is compelling evidence that supports the efficiency and effectiveness of rapid re-housing. Many localities used funds from HPRP (Homelessness Prevention and Rapid Re-housing Program), which began in 2009 as part of the American Recovery and Reinvestment Act, to fund their rapid re-housing efforts. Ninety-one percent of families served with rapid re-housing assistance through HPRP exited rapid re-housing for permanent housing, and more than half did so with just one month of financial assistance. The Alliance has additional data supporting rapid re-housing gathered from fourteen diverse communities. In this dataset, compared to emergency shelter and transitional housing, rapid re-housing had the lowest average cost for exits to permanent housing per household served, the lowest rate of return to homelessness among families with children, and the highest percentage of exits to permanent housing. Compared to transitional housing, rapid re-housing programs housed families for one-fifth the cost and housed unaccompanied individuals for one-third the cost. Examples of individual communities with positive results from rapid re-housing initiatives include Salt Lake City, Utah, where providers re-housed over 600 families between October 2009 and May 2011 with only 8 percent returning to shelter. In Palm Beach County, FL, providers rapidly re-housed 154 homeless families at an average cost of $5,900. The majority (96 percent) of households in Palm Beach were re-housed directly from an emergency shelter or domestic violence program and most (69 percent) were re-housed within 30 days of entering shelter. One year after exiting the program, 75 percent of families remain housed.

Rapid re-housing is a viable solution to many of Broward County's homeless assistance system's problems. Currently, however, very few of the County's financial and programmatic resources are devoted to rapid re-housing programs. Broward County has a much smaller proportion of rapid re-housing beds than other large warm-weather counties, as evidenced in Table 1; in fact, Broward had no rapid re-housing beds reported

[7] Each year, CoCs submit a Housing Inventory Chart (HIC) to HUD that captures all of the homeless assistance beds in emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing in the CoC.

on its 2012 Housing Inventory Chart[7]. The County must work to not just reverse this trend, but to develop more rapid re-housing resources than ever. This will require, in addition to the reorientation of emergency shelter discussed in the shelter section of this report, that:

- Current providers introduce new services as part of their current programs;
- Providers shift their financial and staff resources toward rapid re-housing; and
- that the County engages with private funders, advocates, the business and faith communities, and other stakeholders to encourage the funding and support of rapid re-housing.

REPROGRAM TRANSITIONAL HOUSING BEDS. One way to expand rapid re-housing beds is to reprogram some of the existing transitional housing stock into permanent housing beds. Broward County has .7 percent of all the transitional housing beds in the country, which is an excessive amount. Having this many transitional housing program beds has consequences in terms of meeting HEARTH Act outcomes, as many of these programs serve participants for up to two years while they are still considered homeless by HUD standards. While many of these programs provide excellent services, they often lack the permanent housing focus that is needed to move households quickly back into permanent housing. Converting these beds into either rapid re-housing or permanent supportive housing beds will allow clients to receive the services they need while living in their own permanent housing unit. Transitional housing providers who wish to convert to a more permanent approach serving unaccompanied individuals should convert their units to permanent supportive housing (discussed more in the expansion of permanent supportive housing recommendation): providers serving families should convert their units to rapid re-housing.

For rapid re-housing, scattered site units (units that are dispersed throughout the community instead of in a single building) generally work the best. Thus, providers who currently use a facility-based model and are interested in converting should look into divesting themselves of ownership of their buildings and moving toward a scattered-site model to make this transition easier. Transitional housing units that utilize leased apartments can more easily shift to a rapid re-housing model[8]. Households in transitional programs making these shifts have their housing subsidized for a period of time, much as they would have in a transitional housing setting. If possible, the leases should be in the households' name from the time they move in; when that is not possible, providers may master lease and then use a sublease for the homeless household that is functionally similar to a regular lease. The key factor in moving to this rapid re-housing approach is that the household has the same rights and responsibilities as a tenant in the community would normally have, even if they are under a sublease agreement. This also means that tenancy is not contingent on participation in services but rather based on adherence to the terms of a standard tenancy lease. Once assistance has been provided for a period of time, preferably less than 12 months, and the lease has been converted to the tenant (if it is not already in the tenant's name), the provider begins the process again with a new unit and another household. This model allows for the continuation of services that transitional housing providers are used to offering, but allows for a more permanent housing-focused program.

Many communities are still in the beginning stages of making the aforementioned changes, and there are some that have made progress. Between 2003 and 2006, Chicago, IL replaced 2,800 emergency shelter and transitional housing beds with 2,200 "interim shelter" beds. Interim shelter operates like 24-hour emergency shelter focused on helping people move into permanent housing within 120 days. Approximately 65 to 70 percent of people who entered interim housing were moving to permanent housing within 120 days according to the last figures available.

[8] This kind of conversion is often described as a conversion to a "transition in place" or "rolling stock" transitional housing model.

IDENTIFY RESOURCES TO USE FOR SHORT AND MEDIUM-TERM SUBSIDIES. Transitional housing beds are not the only resources available to the community that could be reprogrammed to expand rapid re-housing. Funding for providers that have been consistently low performing and whose funds would otherwise be recaptured by HUD, have failed to improve according to the parameters of their performance improvement plan, or are willing to shift some or all of their resources to a different model to improve their performance could be used to provide resources for rapid re-housing programs. Before embarking on any funding reallocation, the County should follow through on the performance improvement process described later in this report in the performance measurement section to ensure contracted providers have a chance to improve performance before facing any larger changes.

Beyond repurposing programmatic resources, the County should ensure it is maximizing available federal, state, and local funding resources. ESG funding, which is currently administered through the HFCD Division, can be used to fund rapid re-housing. The County is already using HOME program funds for one rapid re-housing project, and the City of Hollywood has also allocated HOME funding for a tenant-based rental assistance project. There are other potential funding sources as well, including:

- CoC competition funds;
- Supportive Services for Veterans and their Families (SSVF) program;
- Temporary Assistance for Needy Families (TANF);
- Community Development Block Grant (CDBG) funds;
- HOME funds; and
- Emergency Food and Shelter Program (EFSP) funds.

Different stakeholders, including Broward County and the State of Florida, control different resources, and not all of them will be available for rapid re-housing. However, determining the focus and size of current funding streams will assist in discovering potential funds available for rapid re-housing, therefore allowing Broward County to get a better sense of its resource portfolio. This identification of financial resources should be one of the primary tasks of the County and be passed on to the CoC Coordinator (a new position described later in the governance recommendation section).

ENGAGE WITH POTENTIAL FUNDERS. Expanding rapid re-housing is one of the most vital needs of Broward County's homeless assistance system, and funders need to hear this message. The County should begin an education campaign with the stakeholders within the County as well as faith-based, private, and for-profit organizations in the community. Using national data, the language in the HEARTH Act regulations, this report, and the newly modified Ten Year Plan, the County should lay out a vision for the homeless assistance system moving forward and highlight the role of rapid re-housing.

The County should also offer information to funders on the kinds of outcomes to expect from rapid re-housing programs. Unlike how homeless assistance was funded in the past, which tended to be focused on a provider's activities (e.g., providing case management services and filling a certain number of shelter beds), HUD is now prioritizing permanent housing-related outcomes. Funders of rapid re-housing should be looking at housing placement rates, quick turnarounds from program entry to housing placement, and high housing retention rates in the programs they fund. They should also be educated on how targeting harder-to-house populations might affect expected outcomes. For example, providers who try to rapidly re-house people with more barriers to housing should be expected to achieve differently on certain outcomes (for example, housing retention rates may be lower or return rates may be higher than programs that serve households with fewer barriers to re-entering housing).

The County cannot engage funders all on its own, and therefore should also work to engage local and state advocacy partners to spread the word about rapid re-housing. These advocates may have more time and more influence over certain partners, as well as more flexibility in how to approach them.

SHIFT ORGANIZATIONAL AND CULTURAL FOCUS TOWARD RAPID RE-HOUSING. The County should be leading the charge in terms of furthering the cause of rapid re-housing amongst its providers. It should ensure continued funding resources for rapid re-housing, track technical assistance needs for providers across the County, educate funders about the importance of rapid re-housing, and designate a Transitioning to Rapid Re-Housing committee to be formed under the HIP Board. The HIP Board and the County Government must also be vocal about the need for rapid re-housing and be prepared to support the efforts of providers to shift toward a permanent housing focus within their organizations.

Providers should incorporate a rapid re-housing focus in all of their staff functions. Executive directors should become champions of a rapid re-housing approach. Case managers should understand the importance of a housing-focused assessment process and development of case plans for households that address housing barriers. All front line staff should be working to gain expertise in locating appropriate permanent housing situations for their clients, whether those are private apartments, shared housing situations, or a different arrangement. Data and higher-level staff should be trained on how to track housing outcomes in HMIS.

DETERMINE A COMMUNITY-WIDE SUBSIDY MODEL AND STRUCTURE. There are numerous models for providing short and medium-term subsidies, including providing a declining subsidy (the subsidy is gradually reduced over time), an income-based subsidy (the household pays a share of their income toward housing with the subsidy making up the difference), or a flat subsidy (the household receives a set amount, such as $500, each month). So far, there is little national evidence about which subsidy model works best. The County should use whatever subsidy model is easiest to implement given the funding sources that are or would be available and evaluate its effectiveness.

The duration of subsidies is also an important decision. The duration in other communities ranges from one month to two years, with some communities varying the subsidy length on a household-by-household basis. Based on the Alliance's evaluation of different programs, we recommend using a three-month base subsidy model with an allowance for extending subsidies for a small portion of highest risk households. Although housing stability for a person served may be slightly less than for longer-term subsidies, the fact that a shorter-term subsidy would be able to serve far more households makes it a superior model for reducing homelessness in Broward County.

BUILD PARTNERSHIPS WITH LANDLORDS. Successful rapid re-housing programs rely on comprehensive outreach to, and positive relationships with, private landlords. Communities with successful rapid re-housing programs find that landlords actually start coming to them directly when they have vacancies to fill. Good relationships with landlords can ensure continued unit availability as well as decreased overall costs of leasing due to waived credit checks, background fees, and other costs.

Some providers in Broward County may already have relationships with landlords and be willing to work with other programs by either sharing the names of these landlords or sharing their landlord recruitment techniques. Techniques that other communities use include cold calling, distributing brochures about

rapid re-housing to landlords with personalized letters, going to landlord association meetings to educate landlords about their programs, and organizing informational events for landlords that include free food or other incentives for program participation. Broward County should work with providers to organize informational events for landlords. At each of these events, the County should have sign-in sheets to collect landlord information and have a brochure or other written material that includes contact information for someone the landlord can follow up with to learn more. Additionally, the County should be following up with landlords after each event to see if they have any questions and providing further information on how to become involved with rapid re-housing.

The most important incentive any provider can offer to landlords, besides a rental subsidy for clients and the opportunity to give back to their community, is the support of a third party (usually a case manager) in working with the household and ensuring lease compliance. Once a landlord has agreed to take a household from a rapid re-housing program, providers should be prepared to deliver continuing support to both the landlord and the tenant. The landlord should have a name and contact number of a case manager or other staff member in case they have any issues with the tenant. Having someone available to help mediate disputes or someone to call if the landlord has concerns or has not received payment has often proven to be the most enticing part of working with a household in a rapid re-housing program for a landlord. Providers should be clear about any restrictions that exist on contacting a case manager (e.g., only available during certain hours). Case managers should also be actively checking in with their tenants' landlords to make sure things are going smoothly. Other ways to encourage landlords to house rapid re-housing clients include offering services to the landlord's current tenants who are having trouble paying their rent and marketing and advertising on behalf of the landlord's properties.

Trainings on landlord engagement and partnership development are available in a wide variety of formats, including online trainings, webinars, papers, and in-person trainings. The Alliance has provided a list of some of these resources to providers previously. The County should continue to seek out these resources and make them available to providers. Additionally, the County should connect with providers in similar counties that have done rapid re-housing successfully, such as Abode Services in Alameda County, CA, and utilize their expertise in the development of their own rapid re-housing program.

ESTABLISH A LANDLORD DATABASE. A task related to landlords where the Broward County Housing Council could be particularly helpful is establishing a landlord database. A database of landlords with affordable units who are willing or have already leased to rapid re-housing program participants in the past would be very helpful for housing specialists or locators and would aid greatly in the expansion of rapid re-housing across Broward County. The Housing Council could host this service through their existing website. Programs that are already delivering rapid re-housing could submit names of landlords they have worked with successfully in the past. As programs build new relationships, they should update the landlord information in the database. Additionally, landlords should be informed of the database and encouraged to participate with the knowledge that it will help them fill any vacancies and attract households that will come with rental subsidies and a case manager attached.

ACQUIRE TECHNICAL ASSISTANCE. The County should request technical assistance through its CoC Check-up process from HUD on implementing rapid re-housing. If this is not sufficient, Broward County should seek other technical assistance opportunities through other consulting firms. Many Broward County providers will likely need hands-on assistance to reshape their programs and learn how to run a rapid

re-housing program effectively. Training on how to conduct a housing barrier assessment, provide housing location services (which surveys showed most front line provider staff that responded either did not believe were being offered or were unsure if they were being offered in the County currently), proper targeting, and program evaluation would be extremely beneficial.

Successful rapid re-housing also requires home-based, voluntary case management as well as referrals to mainstream organizations. From the beginning, services provided in a rapid re-housing program need to be focused on addressing the barriers the household has to entering housing rather than building general life skills, a focus that many providers may currently have. Providers becoming involved with rapid re-housing will have to help their front line staff transition to this new philosophy of service provision and distinguish which issues have the most impact on a household's housing. Trainings on voluntary case management, which are also discussed in the emergency shelter section of this report, would be extremely helpful for case management staff.

Though many of these changes will be difficult and take time, they will reposition Broward County's homeless assistance providers to better meet the goals of the HEARTH Act, reduce the number of people who experience homelessness at a given point in time, and reduce the number of unsheltered households.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County inquires about potential technical assistance needs around rapid re-housing providers may have • County seeks out technical assistance from HUD
4-6 months	• County adds additional staff (CoC Coordinator) • County completes inventory of state and local financial resources for rapid re-housing • HIP Board Performance, Outcomes, and Needs and Gaps committee identifies and gathers list of both low-performing programs and programs that are interested in converting to rapid re-housing • County and Broward Housing Council begin gathering resources for landlord database from providers and advertising database
7-12 months	• County holds first series of landlord education events about rapid re-housing • HIP Board makes final recommendations on program conversions to rapid re-housing • Selected programs begin conversion process • County holds educational event for funders on rapid re-housing • County holds educational event for state and local advocates on rapid re-housing • Landlord database on Broward County Housing Council website goes live
13-24 months	• County continues with conversions and expansions of rapid re-housing units
After 24 months	• County continues with conversions and expansions of rapid re-housing units

4. RECOMMENDATION: EXPAND THE SUPPLY OF PERMANENT SUPPORTIVE HOUSING AND TARGET RESOURCES MORE EFFECTIVELY

In Broward County, of the 3,183 unaccompanied individuals experiencing homelessness found in the 2012 Point in Time count, some 23 percent were chronically homeless. Chronically homelessness households, as defined by HUD, are those where an unaccompanied individual (or the head of household for families) with a disability has experienced homelessness four times in the past three years or for more than one year continuously. These households include the most vulnerable people in Broward, and often consist of individuals who end up living on sidewalks, in parks, under bridges, and other places not fit for human habitation. Prolonged street living further contributes to poor health status and increases the incidence of injury and disease. In addition to severe and persistent mental illness and substance use disorders, chronically homeless people have high incidence of HIV/AIDS, diabetes, and cardiovascular disease.

Permanent supportive housing is the best solution for moving chronically homeless households off the streets and out of shelters and into permanent housing. It is especially effective for people that are considered resistant to shelter or other services. Permanent supportive housing is largely responsible for a decrease in chronically homeless individuals nationally over the past six years. A brief that demonstrates the cost savings of permanent supportive housing is located in Appendix Q[9]. By pairing subsidized housing (usually provided through a permanent rental subsidy, such as a Housing Choice Voucher) with services suited to the needs of people experiencing chronic homelessness, permanent supportive housing provides a stable housing environment and reduces costs to the homeless assistance system as well as other institutions, like hospitals and jails. Broward County has already developed a supply of permanent supportive housing units, most of which are designated for families. The recommendations below, if implemented properly, can expand the number of available permanent supportive housing units and ensure these units are being used as effectively as possible.

DEVELOP A PRIORITIZATION PROCESS FOR PERMANENT SUPPORTIVE HOUSING. The County does not have a consistent, targeted method of identifying households that would most benefit from or need permanent supportive housing. Currently, permanent supportive housing providers determine eligibility for their own permanent supportive housing units. This screening process is detrimental to the system and to consumers, as it results in many chronically homeless individuals being "screened out" of permanent supportive housing programs because they are perceived as too difficult to serve.

Participation by permanent supportive housing providers in the coordinated assessment process that will make eligibility and prioritization determinations based on system-wide criteria, which will be mandatory for all HUD-funded programs, can help rectify this selection issue. The coordinated assessment process should include the adoption of an additional assessment tool that can prioritize those households eligible for permanent supportive housing. Good prioritzation tools at multiple factors, such as current physical health and health history, mental health, substance abuse history, and time spent living outdoors to determine which households are most in need of permanent supportive housing based on their risk of mortality, continued homelessness, and other factors. The results are used to create a list where the most vulnerable are prioritized for the first available permanent supportive housing units. The prioritization list should be maintained in HMIS by coordinated assessment staff, if possible. No additional assessments by permanent supportive

[9] Additional studies on the cost effectiveness of permanent supportive housing are available here: http://www.endhomelessness.org/pages/springhrinewsletter#LETTER.BLOCK11.

housing providers are needed before housing these individuals. This process, based on objective criteria, will ensure that the most vulnerable households are the ones to receive permanent supportive housing.

One example of a prioritization tool is the one used by the 100,000 Homes Campaign, which has worked with communities across the country, including other communities in Florida. They have resources for assisting in the development of vulnerability assessments, identifying the most vulnerable individuals, and housing them quickly. There is no fee for signing on with 100,000 Homes. It is strongly suggested that the County utilize this organization's expertise to help increase the capacity and develop resources in Broward County.

INCREASE THE SUPPLY OF PERMANENT SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS INDIVIDUALS. Approximately 55 percent of Broward County's permanent supportive housing beds are designated for families. Evidence for the effectiveness and cost effectiveness of permanent supportive housing is greatest for chronically homeless people. Given the low level of chronic homelessness among families, and the over-allocation of existing supportive housing units to families, in the short run the focus should be on development of permanent supportive housing for chronically homeless individuals. After a new Point-in-Time count is available, Broward County should revisit the mix of family and unaccompanied individual beds and see if family permanent supportive housing units can and should be converted to serve chronically homeless individuals when those units turn over.

The County should set a target number for the number of units to be developed over the next five years using its Point-in-Time count and information on the current permanent supportive housing supply. There are numerous sources that could be utilized to fund these units, including HUD homeless assistance funding and HUD-VASH. However, the most potent financing mechanism will be to utilize housing choice vouchers for the housing subsidy combined with Medicaid reimbursement for supportive services (discussed in more detail below). The County should begin working with housing authorities and service providers who have experience with Medicaid reimbursement to develop a strategy for creating the needed units.

INCREASE AVAILABLE SERVICES FOR PERMANENT SUPPORTIVE HOUSING. Broward County has a willing partner for funding permanent supportive housing units in the Broward County Housing Authority, which has Shelter Plus Care vouchers available that require a service match to be activated[11]. However the lack of adequate required service match for those vouchers has reduced the utilization of permanent supportive housing units. The County should, through the Permanent Supportive Housing committee of the HIP Board, work to identify funding and service resources that will unlock this valuable housing resource. The County should leverage the fact that chronic homelessness affects many other systems to pull in other partners to aid in funding or providing match supportive services. Some of these partners are already engaging with many of the households that could be eligible for permanent supportive housing and might be interested in expanding their role. For example, the North Hospital District, through the Health Care for the Homeless program, already provides case management and health care to its clients. Case management services continue even after the household is no longer homeless by the federal definition standards. With some adjustments to their service model and added training on housing location, they could provide many of the services needed for chronically homeless households. The United Way and other foundations could also be crucial partners in ensuring more service resources are made available through the programs they fund. State funding for mental health and substance abuse services, currently managed by a Managing Entity, and County funding also need to be aligned to contribute to development of permanent supportive housing services. Additionally, current transitional housing funds, specifically those provided through the Supportive Housing Program (a formerly

[10] If a family of three resides in a permanent supportive housing unit, that unit is considered to have three permanent supportive housing beds. This report refers to permanent supportive housing beds because that concept is frequently used in HUD reports.
[11] Shelter Plus Care is a HUD program that provides a rental subsidy if the grantee matches with services equivalent to the dollar value of the rental subsidy.

distinct program under the CoC funding umbrella), could be shifted to provide services for supportive housing. The Permanent Supportive Housing committee should be tasked with identifying other potential partners and resources and reporting to the HIP Board with recommendations about who to reach out to. More information about working with mainstream partners on permanent supportive housing is available in the next recommendation.

SUPPORT "GRADUATION" WHEN APPROPRIATE. Some recipients of permanent supportive housing no longer need the intensive services offered with these units, especially households who were not among the most vulnerable when they entered their unit. These residents may be interested in moving to a different location with fewer supports. They should be assisted in finding other options, both to increase their independence and to free up permanent supportive housing units for people experiencing chronic homelessness. Permanent supportive housing providers should provide training to their staff on how to assist households that may be ready to transition and develop a process for helping them move on. In some other communities, housing authorities have made housing choice vouchers available to help permanent supportive housing tenants move out of their units or transition off supportive services. This model would work well in Broward County.

INCREASE THE USE OF MEDICAID AND STATE FUNDED SERVICES IN PERMANENT SUPPORTIVE HOUSING. The Affordable Care Act dramatically changes Medicaid. It makes many more people who are experiencing homelessness eligible, and it creates and expands new options that can make most of the services in permanent supportive housing reimbursable. Additionally, Florida has now designated a Managing Entity to administer its mental health and substance abuse funding that also can serve homeless individuals with behavioral health needs. The County, through its Intergovernmental Affairs Office, should attempt to influence state Medicaid policy and state mental health and substance abuse funding to ensure that organizations that can provide services in permanent supportive housing utilize Medicaid and State mental health and substance abuse funds. The HIP Board's Permanent Supportive Housing committee should pull in other experts and Florida communities as necessary to determine how to best use Medicaid resources in the County. This committee should also start meeting at least bimonthly to tackle these important issues. A sample agenda for the first two meetings the committee should hold on Medicaid is attached in Appendix R.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County explores working with 100,000 Homes for a "Registry Week" or other methods of prioritization • County begins inventory of programs and units that could become permanent supportive housing • County set goal for number of new/converted permanent supportive housing units for unaccompanied individuals to develop each year • County begins discussions with housing authorities and service providers on a permanent supportive housing funding strategy
4-6 months	• County carries out 100,00 Homes "Registry Week" or other vulnerability assessment effort and creates initial vulnerability list • County settles on and begins using vulnerability assessment • HIP Board Permanent Supportive Housing committee holds first meeting on Medicaid
7-12 months	• County develops goal number of new units of permanent supportive housing available for unaccompanied individuals • County develops a funding strategy to meet the goal number
13-24 months	• County and partners develop new units of permanent supportive housing for unaccompanied individuals

5. RECOMMENDATION: ENGAGE AND IMPROVE COORDINATION WITH OTHER SYSTEMS SERVING PEOPLE EXPERIENCING HOMELESSNESS

Homeless and at-risk households, especially those experiencing chronic homelessness, interact with many other mainstream service systems, including hospitals, mental health providers, foster care, law enforcement, corrections, and VA. Often when they exit these systems, for example when they are discharged from a hospital, they become homeless. Better coordination between homeless assistance providers and mainstream systems can help prevent or end a homeless episode. In conversations with stakeholders and the community surveys, it was made abundantly clear that these systems are oftentimes disconnected. Better collaboration between systems is necessary in order to make accessing services easier for providers and consumers, save money at the County level, prevent or reduce the length of homeless episodes, and make it simpler to gather data on frequent users of all systems and reform County policies and procedures accordingly.

COMMUNITY-WIDE RECOMMENDATIONS

INCREASE ACCESS TO BENEFITS FOR HOMELESS HOUSEHOLDS. While a household is waiting in emergency shelter to move on to another program, case managers should be working with them to ensure they are connected to all potential benefits that they are eligible for. Additional benefits income can be the difference between a household being able to move into permanent housing quickly and maintaining that housing or not. Assessment for eligibility for benefits can be built into HMIS, an option that Broward County should explore. Benefits to prioritize would include Social Security Disability Income (SSDI) and Temporary Assistance for Needy Families (TANF). Providing SOAR (SSI/SSDI Outreach, Access, and Recovery) training for providers that may work with chronically homeless households could increase access to SSI (Social Security Income) and SSDI benefits dramatically.[12] According to a 2011 SOAR Outcomes report released in partnership with the Substance Abuse and Mental Health Services Administration, SOAR-assisted applications were approved 71 percent of the time versus 10 to 15 percent of the time for households that did not receive assistance from a SOAR-trained worker.[13]

Once case managers have identified eligibility for benefits within a particular household, they should begin working with them immediately to file the necessary paperwork to receive the benefits or check on the status of any pending requests. Any efforts or progress made on this front should be recorded in HMIS so that any future providers the household is referred to have this information on hand.

START A PILOT PROJECT TO BEGIN DATA MATCHING ACROSS SYSTEMS. Corrections, primary health care/hospital emergency room, and homeless assistance providers are all likely to have information on who uses their systems. Broward County should design and implement a pilot program to identify, prioritize, and house homeless unaccompanied individuals who are the biggest users of emergency and urgent-care services within the County. This will require using the various data systems to identify common users, as espoused by the Corporation for Supportive Housing's (CSH) Frequent Users System Engagement (FUSE) model, discussed more in Appendix S. Beyond being used to identify and prioritize households for permanent supportive housing units, having this information available also has the potential to reduce the costs that the County incurs through providing momentum for more effective collaboration between the various systems.

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[12] SOAR is a government-sponsored program specifically designed to increase access to SSI/SSDI resources for homeless and at-risk of homelessness individuals with mental health and substance abuse issues.

[13] The 2011 SOAR Outcomes Report is available here: http://www.prainc.com/cms-assets/documents/52889-944292.2011-outcomes-summary-031212.pdf.

REENERGIZE STAKEHOLDERS, PARTICULARLY IN CORRECTIONS AND LAW ENFORCEMENT, AROUND DISCHARGE PLANNING. Currently, the County does not have a formal, coordinated plan or plans around handling clients exiting other institutions that are at high risk of homelessness. As noted in the introduction to this report, most community leaders surveyed for this report either disagreed or were unsure about whether or not Broward County had a comprehensive discharge plan that was being used and monitored for success on a regular basis. Jails in the County are often overcrowded and cost the County upwards of $100 per night for each individual being detained, inflating the costs of caring for individuals experiencing homelessness who may be in jail for minor issues. All Broward County's partners must work together to ensure they are not discharging people into homelessness, whether on the streets or in a shelter, if possible. The County needs to develop a plan or plans with corrections, the primary health systems, foster care, and mental health institutions that will address:

- Who will assess the household's housing needs before they exit an institution? How will these needs be assessed?
- Are there ways to avoid having homeless households enter the jail system for a minor offense, and instead report to either the courts or a housing provider? Alternatively, is there a way to more quickly discharge them from jail into a program more suited to help them meet their housing needs? Could implementing such strategies reduce jail overcrowding in the County?
- How will each household's housing needs be met? Who will ensure they connect with their best housing option upon program exit, or beforehand whenever possible?
- If entering another system (e.g., going from jail to the homeless assistance system), when and where will data on that entrance be collected? How will any housing leads be shared between those providers?

If possible, households should receive assessment services before exiting institutions so that they have a plan of where to go upon exit. It is recommended that the Sheriff's Office, other corrections stakeholders, hospitals and Hospital Districts and mental health institutions follow these recommendations from the October 2008 issue of Healing Hands, published by the National Health Care for the Homeless Council:

- Ensure household stability prior to discharge;
- Base the decision to discharge on medical, not financial considerations;
- Encourage the household (or surrogate) to participate in discharge planning;
- Give the household (or surrogate) written notice of the intent to discharge and allow for an appeal of the discharge determination;
- Involve social work, pastoral care, legal counsel, ombudsman, ethicist, and a multidisciplinary care team in discharge planning;
- Provide information about community resources to clinicians and households; and
- Dedicate a clinical social worker to all homeless discharges.

The *Healing Hands* document, in addition to other resources on discharge planning, can found in Appendix T.

The County should convene key stakeholders from each system to discuss the need for and secure commitment to developing a discharge plan that will clearly delineate the responsibility for each system in ensuring people are not exiting institutions into homelessness. The work done in the Ten Year Plan around discharge planning should be used as a starting point to be discussed and elaborated on in a set of quarterly meetings with the final goal of creating and finalizing discharge plans for each major system that can be signed off on and implemented.

PRIMARY CARE, MENTAL HEALTH, AND BEHAVIORAL HEALTH RESOURCES

Many homeless households, especially chronically homeless households, will require access to affordable health care to retain their housing. Because they tend to have multiple health care conditions and co-occurring behavioral health issues, chronically homeless households need treatment and evaluation across health care disciplines and specialties. Currently, homeless households in Broward County access health care in the HACs, hospital emergency rooms, and at behavioral health treatment sites, if they access health care at all. Generally, these services are financed in the County through local Hospital Districts, the federal-state Medicaid program, and County general revenue. Federal homeless assistance programs also play a financing role, including a Health Care for the Homeless-funded project that works closely with street outreach. There is no provider in the community that serves to manage or coordinate health care services. To improve access to health services, reduce costs to the system due to the frequent use of urgent and emergency care facilities, and improve consumer outcomes, Broward County will need to expand health care access by creating more flexible ways of receiving services and carefully coordinating its housing and health related responses to the needs of households.

EDUCATE MAINSTREAM HEALTH CARE PROVIDERS AND FUNDERS ABOUT BEST PRACTICE IN SIMULTANEOUSLY ADDRESSING CONSUMER HEALTH AND HOUSING NEEDS. It will be vital that Broward County continue engaging and educating mainstream providers about the most successful operational and business models about best practices in serving people experiencing homelessness. The goal of this engagement should be aligning homeless households' access to health care with access to permanent supportive housing to help healthcare providers identify how to become involved in and contribute to improving coordination and care for households experiencing homelessness. The Medicaid Task Group and Permanent Supportive Housing committee of the HIP Board should work with HPSC to integrate best practice content on this topic into quarterly "providers plus" meetings, as well as provide other educational events on implementation strategies and outcomes of each model to local funders, Hospital Districts, permanent supportive housing providers, government officials, and other stakeholders. Bringing in presenters from Palm Beach County and other adjacent areas, as well as technical assistance experts from organizations like CSH to these events would be especially helpful, as they can provide Florida-specific examples of success.

USE MEDICAL HOMES TO IMPROVE ACCESS TO HEALTH CARE. Initiatives like managed care in Medicaid and the "patient-centered medical home" concept seek, in various ways, to create more incentives for local provider networks to improve coordination and be more accountable for health care and cost outcomes. A medical home or health home is a separate intervention or service from a clinician who leads

an interdisciplinary team to which a high-risk household is assigned. Medical homes and health homes are not necessarily confined to a specific office or treatment setting; the term "home" refers to a central locus of assessment, coordination, monitoring, and evaluation, in non-institutional settings. This new benefit is a source of funding for care coordination activities that are frequently not covered in Medicaid programs. A health home can help improve behavioral and physical outcomes for vulnerable homeless households, which in turn are proven to reinforce positive housing outcomes. Medicaid payments for health homes can also increase safety net capacity for health care and housing at the community level. Broward County should identify and engage a federally qualified health center (FQHC) and the Hospital Districts who are the primary providers of primary care to serve as a medical home for high-risk unaccompanied individuals that are currently, or have formerly experienced homelessness who need health care services to remain safely housed. Palm Beach County already does good work with medical homes and could provide a good model for Broward County. More information on the medical home model can be found in Appendix U.

ESTABLISH MOBILE TEAMS TO BETTER SERVE HOUSEHOLDS IN PERMANENT SUPPORTIVE HOUSING. Many communities use an approach that utilizes an interdisciplinary team with a lead provider who coordinates services under an individualized plan of care to serve chronically homeless households in their permanent supportive housing units. These teams, if used in Broward County, could help fill the gap in the required service match for permanent supportive housing units. A good model in Florida is the community partnership emerging in Palm Beach County between a housing provider (Our Lord's Place) and a FQHC (Genesis Community Health). This partnership, funded by the United Way, supports an Assertive Community Treatment (ACT) Team to house and stabilize homeless households with severe mental illness. Program managers have reported positive health- and housing-related outcomes after just a year of operation. Caseloads for interdisciplinary teams that have been shown to be effective are in the range of 10:1 to 12:1. A local County provider has advised the County that it is potentially interested in funding an ACT team pilot, and it is recommended the County explore this possibility. More information on this model can be found in Appendix V.

CO-LOCATE AND COORDINATE HEALTH CARE FOR THE HOMELESS AND OTHER COMMUNITY HEALTH SERVICES. In the County, Health Care for the Homeless (HCH) funding is received and administered by Broward Health. HCH grants provide funding for primary health, oral health, recuperative care, case management, and other health services to people experiencing homelessness. HCH-funded services are provided through sites throughout the County, including two of the HACs and all of the Broward Health Primary Care Centers. In most places around the country, households lose their eligibility to be served by Health Care for the Homeless providers after being housed for a certain length of time (usually 12 or 24 months). If the HCH-funded provider is not working closely with community health providers, households are at a higher risk of failing to transition to a new provider and ending up with health problems that lead to more homeless episodes. To improve coordination, the County should develop a collaborative approach with health providers so that households can move as seamlessly as possible from HCH-funded coverage to receiving services at community health centers or primary care clinics. One way to accomplish this is to co-locate the providers (e.g., an HCH-funded provider and regular FQHC grantee) so that consumers can more easily physically transition between providers and communication between providers becomes

easy and convenient. Another solution is to have clear protocols among providers that are centered on the client's continued access to services and care coordination, the development of which should be a goal of the County's in partnership with community health care providers and HCH-funded providers.

SUBSTANCE ABUSE TREATMENT RESOURCES

EXPLORE THE EXPANDED USE OF BROWARD ADDICTION RECOVERY CENTER BEDS AND RESOURCES. The substance treatment abuse resources available at Broward's Addiction Recovery Center (BARC) could be extremely useful to numerous homeless assistance providers and households experiencing homelessness. Recommendations for making these resources more readily available include:

- The coordinated assessment locations and emergency shelters should be able to make referrals to BARC when it meets the household's needs, particularly for services like detoxification.
- Households being referred to permanent supportive housing, or currently in permanent supportive housing, should have easy access to BARC's services, which include a treatment center and services for people with co-occurring disorders. Permanent supportive housing providers and their staff should build utilization of these services into their client's service plans rather than providing substance abuse services themselves.
- Households that wish to participate in one of BARC's residential programs should be able to receive a referral from one of the HACs or another shelter and be prioritized for these beds based on their lack of other housing options.

The County should develop protocols that contain suggestions for how permanent supportive housing providers, coordinated assessment staff, emergency shelter staff, and BARC can work together to implement these policies.

JUDICIAL RESOURCES

WORK WITH THE MENTAL HEALTH AND DRUG COURTS TO CREATE CLEAR PATHS TO HOUSING. Broward County already operates two courts that interact with people experiencing homelessness – a Mental Health Court and a Drug Court. Some representatives from these courts lamented that they struggled to help people find housing programs and struggled with a lack of overall system coordination within the homeless assistance system. The judges on each court should meet with the County, the Sheriff's Office, and other relevant stakeholders to discuss if there are any ways to increase the number of clients reaching the Courts instead of going to jail and ease their clients' paths into an appropriate housing program, perhaps through utilization of the new coordinated assessment process.

Though improved functioning within the homeless assistance system will improve Broward County's outcomes, increased collaboration within the County and with partners outside of it that work with people at risk of and experiencing homelessness will be necessary to maintain and grow this success.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County identifies any possible resources for SOAR training for additional providers • County schedules meeting with judges, corrections, and other stakeholders to discuss use of Drug and Mental Health Courts • County selects stakeholders for and convenes first discharge planning meeting • County schedules meetings with stakeholders regarding integrating substance abuse treatment services with the homeless assistance system • County explores local provider's interest in funding and implementing ACT Team pilot • County begins investigating FQHC that could serve as medical home lead
4-6 months	• County schedules second meeting with stakeholders and issues memo around increasing collaboration for substance abuse services • HCH-funded and community health providers discuss possibilities for co-location • County selects medical home lead • County holds discharge planning meeting
7-12 months	• County identifies and gathers stakeholders for discharge planning meeting • County analyzes ServicePoint for opportunities to build in mainstream benefits eligibility assessments • County holds discharge planning meeting • County meets with HCH and community health providers to discuss co-location or begin creation of coordination protocol • County begins ACT Team pilot project • Providers begin implementing medical home model
13-24 months	• County holds discharge planning meetings • Before Year 2: County releases finalized discharge plan
After 24 months	• County evaluates success of discharge plan

6. RECOMMENDATION: CONSOLIDATE AND IMPROVE DATA COLLECTION

Currently, providers in Broward County use the following data systems to capture information on households served by the homeless assistance system: a homegrown Client Services Management System (CSMS/HMIS), Broward County's ServicePoint, Palm Beach County's ServicePoint, and Provider Enterprise. Provider Enterprise is only used by Housing Opportunities for Persons with AIDS (HOPWA) grantees. The majority of providers use ServicePoint or CSMS. Because different systems are being used, none of them can produce comprehensive performance data on all of the different programs and program types (e.g., emergency shelter and transitional housing). Bed coverage rates (which represent the percentage of beds within each program type that enter information into one HMIS) for transitional housing and permanent supportive housing programs in Broward County's Client Services Management System are below HUD standards as of the 2011 CoC application (with bed coverage rates of 0 to 50 percent in each case). New legislation from HUD requires CoCs to use one singular HMIS for the entire geographic area, which makes it all the more imperative that Broward County focus its energy on consolidating its data systems and improving future data collection capabilities.

EXPAND USE OF SERVICEPOINT AS THE SOLE HMIS FOR BROWARD COUNTY. Broward County is moving toward using Broward County's ServicePoint as the sole HMIS for the area, which is a positive shift. All providers not currently in ServicePoint should begin preparing to make that shift by identifying what assistance they will need and what steps need to be taken to complete the process. The County should set a reasonable target date within the next year for a completed phase-out of the other data systems. The date and phase-out process should be based on reports from providers on what they will need to accomplish before a transition can be made and HUD's finalized HMIS regulations, which have not yet been released. The County should mandate use of ServicePoint for all County and HUD funded providers and strongly encourage it for all other providers of homeless services in Broward County.

SEEK HMIS TECHNICAL ASSISTANCE FROM A HUD TECHNICAL ASSISTANCE PROVIDER TO HELP FACILITATE THE PROCESS OF CONSOLIDATING DATA SYSTEMS. Shifting to one data management system will not be a simple process. Broward County should get expert assistance from a HUD-approved technical assistance provider to help with the transition process. If this assistance is not available through HUD's CoC Check-up process, Broward County should acquire help through other means. Providers outside of Broward County that have an expertise in HMIS can also be brought on to aid in the transition process. The County could explore using a portion of its Emergency Solutions Grant allocation to pay for HMIS training for providers, data consolidation, and other forms of preparation.

INCREASE DEDICATED COUNTY HMIS STAFF. Currently, Broward County uses the services of provider staff, several part-time, and only one full-time staff member to help coordinate and run their HMIS system. However, to make the shifts described and ensure a smooth transition, more staff time should be dedicated to consolidating data, data clean up, data migration, and staff training, at least in the short term. This may mean bringing a part-time employee, or several, to full-time status or shifting the role of other positions in the County. The County should work with the consultant they hire to provide HMIS technical assistance to determine if additional staff needs to be hired and what their responsibilities should be.

PROVIDE HMIS TRAINING FOR PROVIDER STAFF. Some providers already participating in the ServicePoint pilot project going on in the County voiced concerns over how transition from the previous system was handled, feeling that they did not receive proper training on how to use the system, specifically when it came to creating needed reports. The County should work on identifying problem areas for providers and training resources for provider staff working in ServicePoint. HPSC should compile a list of issues providers have had with ServicePoint and provide this to the County to assist in securing the appropriate technical assistance. The County should then use their technical assistance consultant to provide trainings on HMIS for providers around solutions to their identified problem areas.

Additionally, the County should use the expertise of providers already using ServicePoint who feel comfortable working with it to train other providers. Informal brown bag training events where providers can show how they complete certain tasks or reports in HMIS can save money as well as create more opportunities for cooperation between providers. One of these events (either a consultant training or brown bag) should be held quarterly.

The County should ensure that data training is open to all providers, including those who serve specific subpopulations and may not be able to use HMIS due to federal regulations (e.g., agencies serving domestic violence survivors).

CREATE THE NECESSARY ELEMENTS AND REPORTS IN HMIS. The Performance, Outcomes, and Needs and Gaps committee of the HIP Board and new Performance Measurement and Improvement Coordinator (described in the governance recommendation section of this report) should work with County data staff to ensure that ServicePoint includes the specific data elements and reports that are needed to measure performance on HEARTH Act outcomes. This will likely not be a problem with respect to the data elements; however, reporting has proven to be a challenge in the past, so the committee should ensure that the appropriate reports are built into ServicePoint as soon as possible. This is an area where technical assistance would also be useful.

FOCUS ON IMPROVING THE COLLECTION OF ZIP CODE OF LAST PERMANENT ADDRESS. In the County's 2011 CoC Application, it was reported that 49 percent of records in HMIS had a missing value for the field Zip Code of Last Permanent Address. This field provides information on where the household last resided before becoming homeless. Knowing where a household came from in Broward County and having a sense of how many households are coming from each area can be powerful information. Without providing this data back to municipalities within Broward County to help them understand the extent of homelessness in their area, the County will continue to struggle to create strong municipality-based partnerships and bring entitlement city stakeholders and resources to the table. HMIS staff and Broward County should work with providers to find out why they have struggled to fill out this particular field and strategize around how to improve its completion rate.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County looks into HMIS technical assistance opportunities through HUD • County sets target date for all HUD-funded and County providers to move to ServicePoint • County gathers feedback from HPSC on ServicePoint issues • Providers begin receiving HMIS technical assistance (if consultant has been identified)
4-6 months	• County provides ServicePoint technical assistance brown bag for providers • County and consultant build needed report templates into ServicePoint • County identifies any potential resources for new HMIS staff
7-12 months	• County provides ServicePoint technical assistance brown bag for providers • County completes phase out of other data management systems (unless HUD dictates that it must be done sooner) • County begins interviewing and hiring new HMIS staff based on technical assistance recommendations
13-24 months	• County provides ServicePoint technical assistance brown bag sessions for providers
After 24 months	• County measures whether at least 75 percent of records have completed Zip Code at Last Permanent Address data field • County provides ServicePoint technical assistance brown bag sessions for providers

7. RECOMMENDATION: IMPLEMENT AN UPDATED PERFORMANCE MEASUREMENT AND IMPROVEMENT PROCESS

The ability to measure performance and produce good outcomes will be crucial in improving the system's overall performance and maximizing the financial resources the County will have available for homeless assistance in the future. While having adequate data systems, as discussed in the data recommendation, will address one piece of this issue, the County will also have to change what outcomes it measures, the incentives it uses to obtain good program and system outcomes, and the consequences for poor outcomes as well. Each of these areas is addressed below.

PERFORMANCE MEASUREMENT RECOMMENDATIONS

Based on Broward County's Outcomes Report from 2010, the outcomes that it is measuring do not align with the outcomes that are required by the HEARTH Act. The HEARTH Act measures include number of new entries into homelessness, length of stay in homelessness, and number of repeat entries into homelessness. The County should ensure that it is measuring performance on these specific outcomes. Providers will need to modify their current service and housing offerings in a way that will allow them to perform well on these measures as well as others related to moving households to permanent housing.

To support this shift in the system toward outcome measurement, funding decisions should be made based on a program's performance related to reducing homelessness (as measured by the HEARTH Act outcomes). The transition to this performance-based funding approach should be phased in over a period of two to three years. The County in conjunction with its HIP Board should issue a memo and hold meetings for providers that make clear that performance on these outcomes will be the new basis for funding decisions and that providers worried about their performance should work with the HIP Board to find ways to improve it.

REDEFINE OUTCOMES. The County should agree on a set of outcome measures for providers, program types, and for the homeless assistance system as a whole. Suggested outcome measures for each program type and for the system are attached in Appendix P.

As requested by the County, below are specific changes recommended to current expected contractual outcomes and activities in the current Annual Broward Outcomes Report:

> **FOR ALL PROGRAMS:** There are many cases where something is presented as an outcome in the report when it is actually an activity. Outcomes are changes that result in the household or, more accurately, the household's housing situation as a result of services received. Activities are simply what the provider does in attempting to help clients reach these outcomes. The following is an example of an activity that was reported as an outcome in the 2010 Outcomes Report for the TaskForce fore Ending Homelessness: "100% of clients engaged and assessed will have their information collected and placed in the client database." Entry into a database does not represent a change for the household; rather, it is something provider staff should do in order to help households make their way through the system and back to housing.

The County should identify other activities incorrectly listed in this report as outcomes and remove them to avoid confusion about the primary goals providers should focus on. These activities can still be tracked, but should be tracked in a separate report, document, or format. The number of people accepted to a program should no longer be measured as an outcome, both because it is an activity and because this will no longer be something entirely controlled by the provider controls once a coordinated assessment process is established.

FRONT DOOR AND HOMELESS HELPLINE: Most of the current "outcomes" for the Homeless Helpline are in fact activities. There should be no positive value associated with how many people are linked with shelter; non-entry into the system (due to prevention, diversion, and mainstream referrals) is often a good outcome for people and should not be viewed negatively.

HOMELESS OUTREACH: Outreach outcomes should be based on the number of vulnerable households connected with permanent supportive housing or other permanent housing opportunities, as well as reducing the number of households sleeping on the street or other places not fit for human habitation.

EMERGENCY SHELTER, MEDICAL RESPITE, TRANSITIONAL HOUSING, AND RAPID RE-HOUSING: Entering shelters not always a good outcome (for example, for households that may have other housing options outside of shelter, diversion is better). Obtaining and retaining permanent housing should be separate outcomes, and each of these should have a goal percentage higher than 50 percent. Good housing outcomes – quick exits tp permanent housing, reduced lengths of stay, and high housing retention rates - should be considered of higher priority to attain than outcomes around treatment plan goals, sobriety, or increasing level of functioning. Performance on income and employment outcomes are also outcomes of particular interest in the HEARTH Act.

ALL OTHER PROGRAMS: All other programs being funded by the CoC should be helping households address barriers that will ultimately help them obtain housing or retain housing (e.g., outstanding legal issues that may affect their ability to pay rent) . Court outcomes are acceptable as-is

SET BENCHMARKS FOR EACH PROGRAM AND PROGRAM TYPE. The HIP Board, in concert with HMIS staff, should set specific benchmarks for each program, program type, and the system as a whole. The numeric benchmarks should set percentage or absolute number targets for each outcome and be established based on a baseline set of data from the most recent year the needed data is available. Benchmarks will need to be adjusted based on the level of barriers faced by the population served by that particular program or intervention. The Columbus, OH outcomes in Appendix O provide an example of the kinds of outcomes that could be measured and reported on for each different program type and the system as a whole. Although the actual benchmarks used in this model may not currently be appropriate for use in Broward County, the process by which benchmarks are set and used would be a good one to follow. Another more similar county with a good performance measurement structure is Alameda County, CA. Their performance report, attached in Appendix W, offers a sense of what other warm weather, large population counties are doing and have done in terms of performance measurement.

PRODUCE A QUARTERLY REPORT CARD. A new Performance Measurement and Improvement Coordinator County staff member (described in detail in the governance section), or, until this person is hired, the Performance, Outcomes, and Needs and Gaps committee of the HIP Board, should take the primary responsibility for reviewing the outcomes achieved within Broward County on a quarterly basis. A report should be run out of ServicePoint that shows the performance of each program, program type, and the system as a whole. This report should be made available to all homeless assistance stakeholders and the public. Having this information available will keep everyone up to date on the performance of the system and whether or not there is the need for improvement or adjustments.

PERFORMANCE IMPROVEMENT RECOMMENDATIONS

Once Broward County has established appropriate benchmarks for each intervention, programs that are below standard should be identified. These are the programs that will be considered "low performers" and should be obligated to go through a performance improvement process to continue receiving funding. The obligation to undergo a performance improvement process if performance is subpar should be written into all future contracts between the County and providers of homeless assistance. Many of the responsibilities related to performance improvement will be tasked to a new County staff position, the Performance Measurement and Improvement Coordinator, described in the governance recommendation.

ENGAGE LOW PERFORMERS IN A PERFORMANCE IMPROVEMENT PLAN. The reasons for poor performance may vary. County staff should meet one-on-one with the provider's leadership to discuss the areas where their performance is subpar and provide an opportunity for them to explain what they think the causes of their poor performance are. County staff should work collaboratively with providers to create a program that makes sense to them and does not impose an undue burden on the provider. County staff should suggest some or all of the following strategies, in addition to others that are appropriate to address the specific causes of poor performance:

- **ADOPTING A PROVIDER MENTOR:** Some providers struggling with performance may benefit from learning from higher performing providers. Setting up a system where higher performing providers can mentor low performing ones by talking to them about their strategies and models through one-on-one meetings, site visits, and informal learning opportunities like brown bags can help improve performance. These brown bags could also be offered to a larger community of providers as a way of disseminating best practice information more widely.

- **REQUIRING MORE FREQUENT DATA REVIEWS:** If providers are struggling, having them report their data more frequently – without consequences for poor data or data quality - may make it easier to catch data or program issues before they compound. Data requests may be made monthly of these programs, or more if required, and each report release should trigger a meeting between County staff and provider staff to review the data, discuss any inaccuracies, and troubleshoot any issues.

- **OFFERING TECHNICAL ASSISTANCE:** If the provider is unable to capture data well or perform well due to limitations in staff training or knowledge, offering them technical assistance may be helpful. County staff should help connect the provider with any technical assistance resources that are available. Providers may also be required to view online trainings, attend conferences, or participate in other educational opportunities that will help them improve their performance.

- **ENCOURAGING PROGRAM CONVERSION:** Some providers may be performing well by their perception, but their outcomes and goals may not match those of the rest of the County. In cases like these, it may be that the program model itself needs to change. This kind of change may require more time and more intensive help than the other strategies, so the expectations in terms of a timeline for performance improvement should be adjusted accordingly.

- **OTHER INDIVIDUALIZED STRATEGIES:** One of these strategies, a combination of some or all of them, or none of them may be what's best for a particular provider. The County should consult with other communities to get input on other possible strategies, as well as rely more heavily on what providers say they would need most to improve their performance.

The County should put a specific improvement plan into writing for the provider to sign off on. The plan should include timelines and milestones for providers to meet and describe what the consequences will be if they are unable to improve within an allotted period of time, which in most cases should be six months to two years. Providers that do not improve their performance within a specific timeframe should have their funding reallocated.

INCENTIVIZE GOOD PERFORMANCE. Providers that are performing well should receive rewards for their performance. One way to do this is through performance-based contracting. Performance-based contracting pays providers bonuses for good outcomes. The Performance, Needs, Gaps and Outcomes Committee of the HIP Board should create and recommend a set of higher performance benchmarks that would result in financial bonuses. The County should create and expand performance-based incentives in individual contracts upon their expiration. The first year of these contracts could simply require providers to begin measuring performance on the agreed-upon outcomes; the second year could provide financial incentives for meeting the high performance benchmarks. Outcomes can be measured on a quarterly basis with payments awarded over the next quarter. Samples of performance-based contracts from Columbus, OH are available in Appendix X.

Other ways to incentivize good performance may include preference in terms of ranking for new projects on the CoC application or countywide recognition through provision of a non-financial award. These kinds of incentives will help maintain good performance and hopefully inspire others to perform at a higher level. The County should come up with a list of additional possible incentives to propose to the HIP Board for final approval.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• HIP Board Performance, Outcomes, and Needs and Gaps Committee meets to finish developing new outcomes and performance standards and develop initial benchmarks • •County meets with providers to introduce new outcome measures and timeline for their adoption • (At earliest opportunity) County modifies CoC and county contracts to include performance-based contracting measures
4-6 months	• County allocates additional resources to hire Performance Measurement and Improvement Coordinator dedicated to performance improvement in the homeless system • The Performance Measurement and Improvement Coordinator proposes incentives for high performing programs • County meets with providers to introduce new performance improvement procedures • County develops template for and produces first quarterly report card
7-12 months	• County produces quarterly report cards
13-24 months	• After Year 1: County starts performance improvement plans with providers interested in improving performance on a voluntary basis • After Year 2: HIP starts performance improvement plans as mandatory requirements for low performing providers; start providing financial incentives based on performance-based contracting measures • Performance Measurement and Improvement Coordinator continues producing quarterly report cards • County through its Performance Measurement and Improvement Coordinator evaluates effectiveness of performance improvement process
After 24 months	• County through its Performance Measurement and Improvement Coordinator evaluates effectiveness of performance improvement process • Performance Measurement and Improvement Coordinator continues issuing quarterly report cards

8. RECOMMENDATION: REFORM GOVERNANCE STRUCTURE AND DECISION-MAKING PROCESSES

To move forward with the changes in this report, Broward County will need strong leadership to set and enforce a housing-focused direction for the homeless assistance system, measure and regulate performance, and fund the system in a way that supports good outcomes. Currently, Broward County's governance capabilities are limited due to a small number of County staff dedicated to homelessness issues and a governance structure that sometimes lacks efficiency and transparency. The small number of staff currently in the HIP Section may make it exceedingly difficult or impossible to carry out the tasks mandated by the HEARTH Act, making regulatory compliance an issue. Additionally, decisions about funding and system design are often made based on a set of criteria that are not aligned with HEARTH Act outcomes.

The current governance structure includes four main bodies: the HIP Board; HPSC; Broward County's HIP Section, which is part of the County Community Partnerships Division/Human Services Department; and the Broward County Board of Commissioners (Board of Commissioners). The HIP Board primarily works as the CoC decision making body; the HPSC is the official planning body for the CoC, as well as the local coalition; the County's HIP Section does much of the day-to-day work in terms of administration and funding of homeless assistance and the CoC; and the Board of Commissioners oversees these operations and approves any major decisions taken by either the HIP Section or the HIP Board. The recommendations below are meant to further define the functions of each of these groups in a way that will make the decision making process more inclusive and effective, as well as improve the efficiency with which the entire system operates.

RECOMMENDATIONS FOR THE HIP BOARD

CREATE NEW HIP BOARD SEATS. HUD is now requiring in the interim CoC regulations that CoCs have boards with members that are representative of the homeless subpopulations in the CoC and include a formerly homeless or currently homeless individual. Additional regulations may be added that require a chair or co-chair for the board; an uneven number of members serving staggered terms; inclusion of members from the public and private sectors; and a member from at least one ESG recipient agency. The HIP Board meets some of these requirements, but needs to more specifically target certain sectors of the homelessness arena, as well as key mainstream stakeholders, in order to meet them completely and maximize input, resources, and cooperation from key partners. Having more mainstream partners aiding in decision making and engaging with homeless assistance issues will likely make it easier to gain their buy-in, confidence, and collaboration when it comes to making their own programs more accessible to people experiencing homelessness. To ensure that the HIP Board contains the right stakeholders from each sector, it is recommended that the current HIP Board ordinance be revised to include the designated seats listed below. The HIP Board should be composed of the following 19 members:

- 1 County Housing Council representative designated by Housing Council Chair
- 1 Housing Authority board representative from one of the following: Broward County Housing Authority, Ft. Lauderdale Housing Authority or Hollywood Housing Authority (this seat should rotate between the three housing authorities annually to ensure full representation)

- 1 Hospital District representative
- 1 United Way representative
- 1 corrections or law enforcement representative (this seat should rotate between the Sheriff's Office, the Ft. Lauderdale, and Hollywood Police Departments)
- 1 representative from the judicial sector designated by the Chief Judge (e.g., Mental Health Court judge)
- 1 Broward County Commissioner
- 1 domestic violence provider representative
- 1 elected official from local jurisdictions/entitlement cities designated by the City Manager (this seat would rotate between three different entitlement cities annually to ensure full representation)
- 1 provider representative (the current HPSC chair)
- 1 homeless advocate
- 1 person who is currently or has formerly experienced homelessness
- 1 Chamber of Commerce representative
- 1 WorkForce One representative
- 1 BARC Advisory Board representative
- 1 mental health services provider representative
- 1 Veterans Affairs representative designated by the Miami Veterans Affairs Healthcare System Director
- 2 Community leaders that have extensive knowledge or experience with homelessness but don't fit into other categories

Each representative on the HIP Board should be made aware that the expectation is that they will voice the concerns and speak for the interests of the group they represent. For example, the provider representative will be expected to speak for the interest of all providers, which makes it all the more important that the members of the HSPC provide targeted feedback to their chair to bring back to the HIP Board.

The CoC Coordinator, Performance Measurement and Improvement Coordinator (new positions described later in this section), and the County HIP Administrator should work to coordinate the activities of the HIP Board, ensure important items are prioritized and brought to their attention, and that items needing further action are brought back to the County and Board of Commissioners.

REFINE COC APPLICATION PROCESS. The County is not yet maximizing the funds it could receive through the CoC application process. Analysis of the CoC's previous applications and ways it could improve its score are detailed in Appendix Y. The most important improvement to make for the sake of receiving more funding and improving system performance is to allocate the funds available to programs based primarily on performance, then level of need among the population each program serves and utilization of current funds. As discussed in the performance measurement and improvement recommendation, the HIP Board should develop new benchmarks for projects to meet and circulate and present on these standards so that providers are aware of them.

To allow providers time to adjust to the new standards, the HIP Board should give providers two competition cycles (two years) to make changes to their programs before taking any action of programs that are not able to meet these standards. Low performing renewal projects should be put on performance improvement plans (described in more detail in the performance measurement recommendation). A tool to help Broward score the performance of projects when making decisions about CoC funds is available in Appendix Z.

ALTER COMMITTEE STRUCTURE. The HIP Board should revise its committees to reflect Broward County's most immediate concerns and needs. Committees should be led by current HIP Board members but need to include non-HIP Board members as well.

COORDINATED ASSESSMENT STEERING COMMITTEE. (described in the coordinated assessment section on page 21).

PERFORMANCE, OUTCOMES, AND NEEDS AND GAPS COMMITTEE. This committee should be responsible for determining appropriate outcome measures and benchmarks across programs and begin the process of restructuring the current annual outcomes report to better reflect HEARTH Act outcomes. They will also be responsible for identifying low and high performing programs, and be the primary committee responsible for reviewing project applications from programs during the CoC competition cycle. Their recommendations for which programs to fund will be forwarded to the HIP Administrator for approval. This committee should be coordinated by the Performance Measurement and Improvement Coordinator (described below).

TRANSITIONING TO RAPID RE-HOUSING COMMITTEE. This committee should be responsible for tackling the system-wide cultural and resource changes necessary to support a robust rapid re-housing program. It should include several representatives from transitional housing programs in Broward County. This group should also be responsible for mapping out the process by which transitional housing programs and other resources might be shifted toward rapid re-housing. Additionally, this group would be responsible for identifying funding sources for short- and medium-term subsidies and determining which agencies will provide services and housing for rapid re-housing. It would also provide support to providers and help them find training and technical assistance opportunities as they develop their rapid re-housing programs. The CoC Coordinator (described below) should coordinate this group.

PERMANENT SUPPORTIVE HOUSING COMMITTEE. This group would be in charge of developing targeting criteria and a vulnerability assessment for permanent supportive housing, identifying service providers that could provide supportive services, and preparing to take advantage of changes to Medicaid. This committee should include providers that have billed services to Medicaid in the past, staff from Henderson Behavioral Health, staff from the North and South Hospital districts, and a representative from the one of Broward County housing authorities.

RECOMMENDATIONS FOR THE HOMELESS PROVIDER AND STAKEHOLDERS' COUNCIL

CHANGE THE ROLE OF THE HPSC. By introducing specific tasks for the HPSC to tackle and using it as a forum to discuss any provider and community issues and increase communication the Broward County and providers, its efficiency can be improved.

The HPSC should meet monthly. At each meeting, the HPSC Chair should report on any issues on which the HIP Board is seeking input or that might be relevant to providers. Then, any HPSC members on HIP Board committees should report on the work they are doing. Any additional pressing concerns among providers

should be discussed, documented, and presented to the HIP Board at their next meeting by the HPSC chair. Any actions taken by the HIP Board or other comments made about the providers' concerns should be shared with providers at the next HPSC meeting. Additionally, providers should rotate discussing one of these topics at each meeting: coordinated assessment, rapid re-housing, permanent supportive housing, performance measurement, and HMIS. The chair should start the conversation by sharing any relevant information from the HIP Board meetings on these topics, and then the providers should discuss any challenges or questions on the topics; ways they think implementation of these strategies could be improved; and any information or assistance they need in implementing any of these strategies. Minutes should be taken at each meeting and then distributed so that all providers can easily access them. Before each meeting, the HPSC chair should set a specific agenda that includes which topic will be discussed.

HPSC should also have a set schedule of special meetings. Once a quarter, a member of the HIP Board, preferably the CoC Coordinator, should come to a HPSC meeting to update them directly on important issues around the CoC and the CoC application process. Having this direct face-to-face interaction will help ensure that the relationship between the HIP Board and the providers remains open and communicative, and also creates transparency. This should also be used as an opportunity to address any concerns about the CoC directly with the HIP Board.

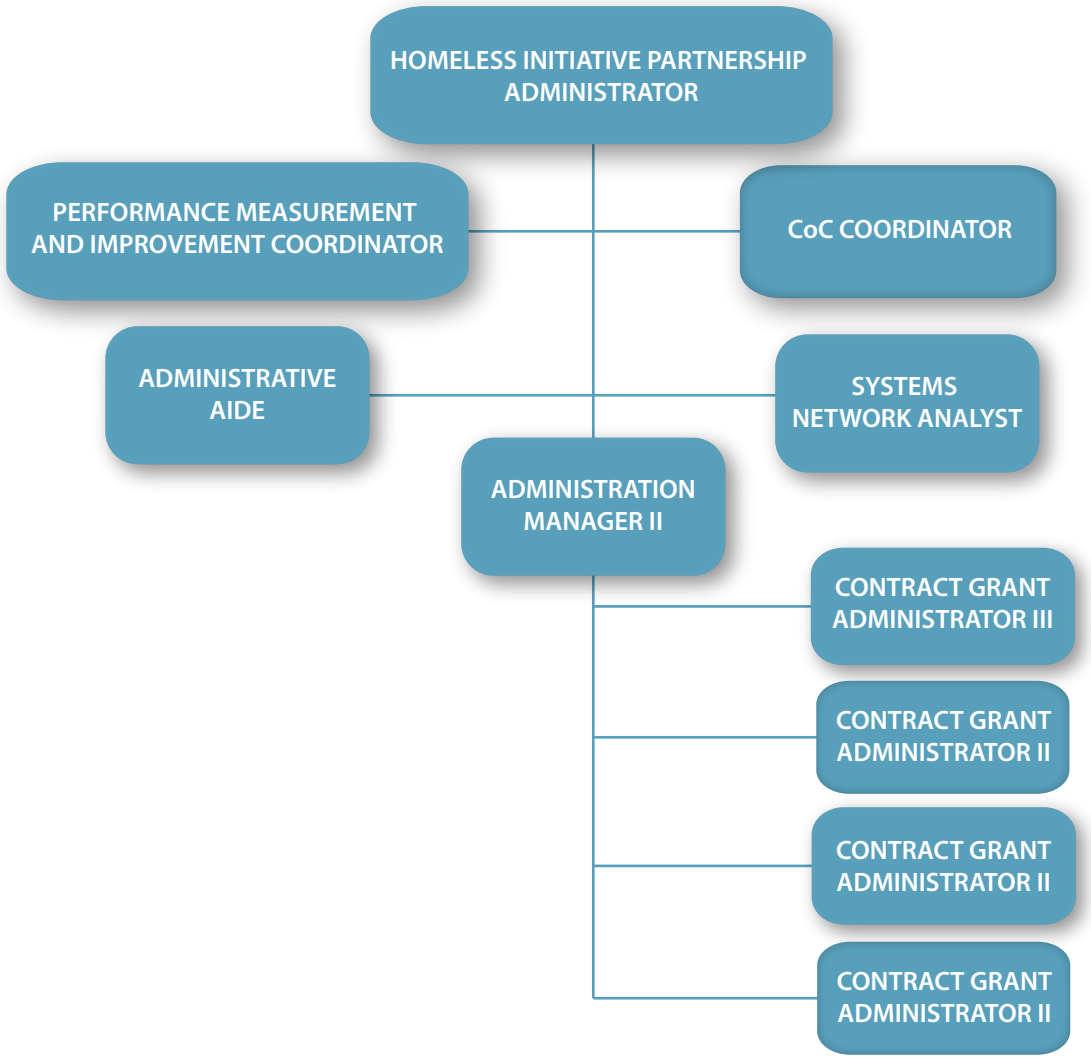
Another quarterly meeting should be a "providers plus" meeting where all other mainstream services/ providers are invited and welcome, including funders, education representatives, faith-based organizations, employment organizations, the libraries, substance abuse organizations, mental health organizations, and housing authorities. These meetings can be used to discuss potential collaborations between these mainstream providers and the homeless assistance system and areas where connections can be improved. Having one or two mainstream providers do a presentation at each of these meetings on the resources they provide or how they interact with consumers would also be helpful.

Once in place, the new structure of the HPSC should be advertised so that providers are aware of the changes and potentially reenergized about participating. The new HIP Board structure should also be discussed, with an emphasis being placed on the importance of providers participating and sharing feedback with the chair in order to ensure their representation when decisions are being made. A new push should be made to get new providers, from front line staff to executive directors, involved in HPSC and increase the range of provider voices in this forum.

RECOMMENDATIONS FOR THE COUNTY'S STAFFING STRUCTURE

HIRE ADDITIONAL STAFF. Currently, the HIP Section lacks sufficient staffing to maximize its effectiveness or to take on the additional tasks that would be required under the HEARTH Act. The County should create additional staff positions to assume these increasing responsibilities. As a frame of reference, the Community Shelter Board, the guiding organization behind Columbus, OH's high-performing CoC,

PROPOSED HIP STAFFING CHART



has 20 full time staff members with diverse functions to oversee funding for its CoC, as well as other funding for homeless assistance available through private sources. The HIP Board has already secured resources for an additional position through their advocacy funding. However, this position is a temporary one ending June 30, 2013 and would be funded through state-designated local coalition funding that is not in the state budget at this time. Additional staff beyond this one potential person to work on HMIS and help with system

management, particularly around data and HMIS, performance measurement, and system assessment would be especially beneficial. Recommended positions to be added by the County and supervised by the HIP Administrator include:

CoC Coordinator, responsible for:

- Disseminating information about best practices, especially rapid re-housing, through policy briefs, training, and brown bags;
- Coordinating the Transitioning to Rapid Re-Housing committee of the HIP Board;
- Identification of financial resources for rapid re-housing;
- Coordinating the discharge planning process;
- Reporting happenings at the HIP Board to the HPSC each quarter;
- Producing and sharing the annual Ten Year Plan update (described in the Ten Year Plan recommendation);
- Coordinating the annual Ten Year Plan update meeting; and
- Advertising the Ten Year Plan in the community.

Performance Measurement and Improvement Coordinator, responsible for:

- Producing quarterly report cards on program, program type, and system performance;
- Identifying low performing programs;
- Working with low performing programs to create a performance improvement plan;
- Monitoring progress on performance system wide and updating the HIP Board with this information;
- Working closely with HMIS staff to ensure data systems can produce information on desired outcomes;
- Chairing the Performance, Outcomes, and Needs and Gaps committee of the HIP Board.

WAIT AT LEAST ONE FUNDING CYCLE BEFORE BECOMING A UNIFIED FUNDING AGENCY. HUD introduced the concept of a new funding authority, called a Unified Funding Agency (UFA), as part of the new HEARTH Act regulations. The UFA would receive the entire amount of the CoC grant directly instead of individual providers receiving their own funding. To become a UFA, the collaborative applicant must have financial systems that meet HUD standards and a demonstrated ability to monitor subrecipients. If designated a UFA, the applicant would be responsible for entering into legally binding agreements with subrecipients and requiring them to establish appropriate fiscal controls and accounting procedures. The primary benefit of becoming a UFA for Broward County is that it would allow the County to more easily shift resources from low performing programs to higher performing programs. It would also make it much easier for providers to make adjustments to or resolve problems with their grants.

However, because of funding constraints at the federal level, there will be no additional funding available for performing the tasks required of a UFA, at least not right away. Right now, it is best for the County that any uncommitted resources be focused on strengthening data systems, regularly assessing performance,

and facilitating a transition of resources to rapid re-housing and permanent supportive housing. Additional milestones Broward County should attempt to meet before applying to become a UFA include:

- Having most providers transitioned to using Broward County ServicePoint only,
- Having hired at least one new HIP Section staff member, and
- Having introduced the new performance measures to the provider community and established a date when they will go into effect.

It is best that Broward County have a better HMIS infrastructure, accurate information on performance, more staff, and more time to make more urgent revisions to the homeless assistance system before taking on the additional responsibility of becoming a UFA. However, the HIP Division is well placed to take on the duties of a UFA eventually, and should apply for that designation in the next one to three years.

STREAMLINE ESG AND COC FUNDING AND IMPLEMENTATION. Both the ESG and CoC regulations released by HUD mandate that communities ensure whatever entities administer their ESG and CoC funding streams are coordinated, communicating, and working toward the same goals. Currently, the County HFCD Division administers County ESG funding, while the HIP Division does much of the work with CoC administration. Right now, communication and coordination around how these funding sources are being used is insufficient. As these funding sources are becoming more closely tied together, it will be necessary that coordination be improved through increased meetings, joint planning around the Ten Year Plan, Consolidated Plan, and CoC, and even the movement of the administration of the funding streams into a single division. Initial conversations around adding ESG administration to the HIP Division's responsibilities have already begun and should continue. If the HIP Division does not take over responsibility for administering ESG, a robust level of collaboration will have to be established.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County develops or revises HIP Board committees • County approves additional staffing and develops functional job descriptions for additional County staff • County discusses recommended changes to HPSC with providers • (As soon as possible) HIP Board shifts to a model using designated seats • Conversations regarding the administration of ESG by the HIP Division continue
4-6 months	• County recruits new County staff • Providers hold first revamped HPSC meeting • County hires new HIP Section staff
7-12 months	• Providers hold first HPSC meeting with HIP Board representative present • HPSC holds first "providers plus" HPSC meeting
13-24 months	• County begins holding providers to new CoC performance standards for the CoC Notice of Funding Availability (NOFA) and all other federal and county funding • County evaluates performance of new staff and effectiveness of new staff positions and makes any needed adjustments • County applies to become UFA (after one year at the earliest)

9. RECOMMENDATION: UPDATE THE TEN YEAR PLAN

Broward County already has a strong Ten Year Plan to End Homelessness, A Way Home.[15] The Ten Year Plan contains proven strategies for ending and preventing homelessness, lays the foundation for a telephone-based coordinated assessment process for the homeless assistance system, and lays out specific objectives that the community should strive to meet. Though the plan predates the enactment of the HEARTH Act, it does contain the beginnings of similar standards and outcome measures. The plan also identifies opportunities to work with, draw in, and connect with mainstream partners. An additional area of emphasis is the need to be proactive in terms of homelessness prevention.

Having a strategic Ten Year Plan that is being used actively to guide homeless assistance efforts can ensure that the system develops in a consistent way and stays connected to best practice. Additionally, it can ensure that the goals and structure of the system are transparent and clear to all stakeholders. The recommendations below are meant to ensure that the plan is fulfilling these purposes and is still relevant under the new federal legislation.

HOLD A COMMUNITY CHARRETTE. Though this report provides recommendations on Broward County's homeless assistance system, a community-wide process that results in a comprehensive update to the Ten Year Plan is recommended. Several communities, including Hillsborough County, FL, have used the charrette process to update their plans.[16] These charrettes bring together local and national experts to discuss issue areas that the community has selected as priority areas to address. Over the course of two days, the larger community has the opportunity to listen to these experts and then provide their own feedback. The week after the charrette, an updated Ten Year Plan is released to the public. It is noted that the County has already secured grant funding to conduct a charrette and efforts to facilitate this planning process in the early spring of 2013 are already underway.

UPDATE CONTENT AREAS. Areas in which the Ten Year Plan could be expanded or improved are listed below.

- **PREVENTION:** Prevention assistance should be targeted to households based on shelter data, not eviction data. Many households that receive eviction notices do not end up becoming homeless. The relevance of receiving an eviction notice or actually being evicted in terms of eligibility for prevention assistance should be determined based on how many households in shelter became homeless immediately following an eviction. More information on how to target prevention funds effectively is available in Appendix K. The homeless assistance system should delegate mortgage assistance provision to other partners.

[15] A Way Home: Broward County, Florida's Ten Year Plan to End Homelessness can be found here: http://www.broward.org/HumanServices/CommunityPartnerships/Documents/TenYrPlanEndHomeless.pdf

- **TRANSITIONAL HOUSING:** County funders, providers, and other stakeholders will have to think carefully about how transitional housing can be reshaped to meet the outcomes mandated by the HEARTH Act. Life skills training classes should not be mandatory for households in transitional housing programs. Services provided should be based around the household's barriers to returning to permanent housing and tailored to the household's specific strengths and weaknesses. Additionally, under the new CoC regulations, no CoC programs, including transitional housing programs, are allowed to require participation in substance abuse services if they are not primarily a substance abuse treatment program, and can no longer require participation in any disability-related servicess.

- **RAPID RE-HOUSING:** The current Ten Year Plan states that recently homeless households should be targeted for rapid re-housing programs. However, rapid re-housing has been successfully used to serve moderate and high-barrier homeless households as well, which may include more households than just those that became homeless for the first time recently. Indeed, targeting those with more housing barriers for this assistance may be more cost effective in the long run. Explicit recognition of the fact that these additional households should be targeted for rapid re-housing assistance should be in the Ten Year Plan.

- **DATA:** The County should consider building in a screening tool for various benefits into ServicePoint. Additionally, Broward County should attempt to get data on the number of homeless households served by mainstream agency partners to strengthen the case for collaboration and the sharing of resources.

- **EMPLOYMENT:** The Ten Year Plan does not identify the Workforce Investment Board as a partner. This group could be key in connecting homeless or formerly homeless households to job opportunities. The County should continue to pursue opportunities with apprenticeship programs as well as partnerships with businesses and Business Improvement Districts.

- **INVOLVEMENT OF CURRENTLY AND FORMERLY HOMELESS HOUSEHOLDS:** The involvement of currently and formerly homeless households in contributing to and implementing the Ten Year Plan was not discussed at length. The plan should describe the role of these households in the development of the plan as well as their role in the homeless assistance system.

- **AFFORDABLE HOUSING:** Affordable housing development is an important long-term strategy for preventing and ending homelessness. However, housing can be made more affordable and more accessible through other more short-term means, including provision of short-term subsidies and strong relationships with landlords. These strategies should be highlighted in the plan as other ways of creating affordable housing solutions that allow households to move into housing quickly.

- **FUNDING SOURCES:** Some of the funding sources listed in the plan are out of date.

[16] The Corporation for Supportive Housing (CSH), a technical assistance provider and consulting firm, organizes these charrettes.

- **DO AN ANNUAL PLAN UPDATE.** Doing an annual progress report on the Ten Year Plan is one way to keep the document active and current with any new information gained from the field or new regulations. A structured opportunity to discuss the plan each year can also serve to keep stakeholders engaged, refresh the community on the goals of the system, and resolve any issues around specific strategies in the plan.

Each year a meeting, similar in format to the quarterly provider meetings recommended in the governance section of this report, should be held where discussions around needed updates and solutions to any implementation issues should be addressed by a mixed group of consumers, providers, and government officials. The meeting should be open so that any interested parties can join. A sample agenda and other materials from a community that holds similar meetings (and has been successful as a system with the implementation of targeted prevention and rapid re-housing), Hennepin County/Minneapolis, MN, is in Appendix AA. The results of this meeting, and any resulting changes to the Ten Year Plan, should be provided to all relevant stakeholders and the community at large.

SUGGESTED ACTIVITY TIMELINE

TIMEFRAME	ACTIVITY
0-3 months	• County organizes and conducts community charrette • County makes updates recommended at the charrette to the Ten Year Plan • County makes additional aforementioned recommended updates (listed in the report) to the Ten Year Plan
4-6 months	• County releases information about updates made to the Ten Year Plan to the media • County advertises annual Ten Year Plan update meeting
7-12 months	• County holds first annual Ten Year Plan update meeting • County holds annual Ten Year Plan update meeting
13-24 months	• County holds annual Ten Year Plan update meetings each year

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION: DEVELOP A MORE STREAMLINED COORDINATED PROCESS	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• "Bottlenecking" at the front door of the system • Lack of access to services • Prolonged lengths of stay in homelessness • New entries into homeless assistance system	• Develop a Coordinated Assessment Steering committee • Designate specific assessment locations for people experiencing homelessness • Standardize assessment location hours • Develop and incorporate HUD-mandated written standards for prioritization and eligibility for homeless assistance programs into the coordinated assessment process • Create an outreach process that engages chronically homeless individuals living on the streets • Modify the assessment and referral process

RECOMMENDATION: IMPROVE THE CURRENT EMERGENCY SHELTER SYSTEM	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Lack of shelter capacity • Unsheltered homelessness • High number of homeless households • Bottlenecks within the homelessness system • Prolonged lengths of stay in homelessness	• Revise case management responsibilities • Adopt system-wide standards for case management provision • Provide and require training of all case managers • Standardize shelter operations • Reduce or restructure provision of other services offered at emergency shelters • Provide access to financial assistance to consumers at the HACs • Discontinue system of reward beds • Accommodate transgender individuals based on how they identify, not biological sex • Refocus shelter outcome measures

RECOMMENDATION: IMPLEMENT A ROBUST RAPID RE-HOUSING PROGRAM	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Bottlenecking" in emergency shelters and transitional housing programs • Prolonged lengths of stay in homelessness • Unsheltered homelessness	• Reprogram transitional housing beds • Identify resources to use for short and medium-term subsidies • Engage with potential funders • Shift organizational and cultural focus toward rapid re-housing • Determine a community-wide subsidy model and structure • Build partnerships with landlords • Establish a landlord database • Acquire technical assistance

RECOMMENDATION: EXPAND THE SUPPLY OF PERMANENT SUPPORTIVE HOUSING AND TARGET RESOURCES MORE EFFECTIVELY	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Prolonged lengths of stay in homelessness • Unsheltered homelessness	• Develop a prioritization process for permanent supportive housing • Increase the supply of permanent supportive housing for chronically homeless individuals • Increase available services for permanent supportive housing • Support "graduation" when appropriate • Increase the use of Medicaid and State funded services in permanent supportive housing

RECOMMENDATION: ENGAGE AND IMPROVE COORDINATION WITH OTHER SYSTEMS SERVING PEOPLE EXPERIENCING HOMELESSNESS	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Unsheltered homelessness • Lack of services in permanent supportive housing • Lack of coordination between stakeholders serving people experiencing homelessness	• Increase access to benefits for homeless households • Start a pilot project to begin data matching across systems • Reenergize stakeholders, particularly in corrections and law enforcement, around discharge planning • Educate mainstream health care providers and funders about best practice in simultaneously addressing consumer health and housing needs • Use medical homes to improve access to health care • Establish mobile teams to better serve households in permanent supportive housing • Co-locate and coordinate Health Care for the Homeless and other community health services • Explore the expanded use of Broward Addiction Recovery Center beds and resources • Work with the Mental Health and Drug Courts to create clear paths to housing

RECOMMENDATION: CONSOLIDATE AND IMPROVE DATA COLLECTION	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Low bed coverage rate in HMIS • Multiple HMIS systems utilized • Missing data values • Lack of compliance with upcoming HMIS regulations	• Expand use of ServicePoint as the sole HMIS for Broward County • Seek HMIS technical assistance from a HUD technical assistance provider to help facilitate the process of consolidating data systems • Increase dedicated County HMIS staff • Provide HMIS training for provider staff • Create the necessary elements and reports in HMIS • Focus on improving the collection of *Zip Code of Last Permanent Address*

RECOMMENDATION: IMPLEMENT AN UPDATED PERFORMANCE MEASUREMENT AND IMPROVEMENT PROCESS	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Lack of relevant outcome data for each program when making funding decisions • Lack of common goal or vision for each program and program type	• Redefine outcomes • Set benchmarks for each program and program type • Produce a quarterly report card • Engage low performers in a performance improvement plan • Incentivize good performance

RECOMMENDATION: REFORM GOVERNANCE STRUCTURE AND DECISION-MAKING PROCESSES	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Lack of common goal or vision across the community • Lack of structured feedback process for providers	• Create new HIP Board Seats • Refine CoC application process • Alter committee structure • Change the role of the HPSC • Hire additional staff • Wait at least one funding cycle before becoming a Unified Funding Agency • Streamline ESG and CoC funding and implementation

RECOMMENDATION: UPDATE THE TEN YEAR PLAN	
PROBLEM AREAS ADDRESSED	**SPECIFIC RECOMMENDATIONS**
• Lack of common goal or vision across the community	• Hold a community charrette • Update content areas • Do an annual plan update

CONCLUSION

Since the evaluation process for this report has started, Broward County has already made progress in several of its biggest issue areas. Changes to the HIP Board committees have already been made, the County has looked into ways to fund the expansion of ServicePoint using local and HUD dollars, and performance measurement efforts have begun. Over the course of its work with the County, Alliance staff have had many conversations with providers who were curious about the new changes and who were interested in being at the forefront of change.

However, without substantial changes to how homeless assistance operates in the County, it may prove difficult to stem the flow of households into homelessness and to help those who do become homeless exit homelessness in a timely manner. The County, its HIP Board, and other stakeholders must reexamine Broward County's homeless assistance system from entry to exit, first by looking at opportunities to divert households from entering the system, then by making sure people and programs are properly matched through coordinated assessment and better discharge planning, then by reducing lengths of stay in homelessness through a new rapid re-housing culture, and finally through reconfiguring targeting criteria and mainstream system integration with permanent supportive housing programs.

The structure and gauge of success for the homeless assistance system must also change. Developing a cleaner governance structure that clearly defines the roles of the County, the HIP Board, and HPSC and how they should use data and outcomes to make decisions must be a priority.

Next steps are written under each recommendation, but no matter how bold the vision, nothing will be achieved without much improved communication. Broward County must communicate to providers, funders, households experiencing homelessness, and other stakeholders what the system's focus will be moving forward; how agencies can work together better to achieve these goals; what the new goals, as communicated through outcomes, must be for each provider; what the expectations will be of each provider; and what will happen if providers cannot meet those expectations. Communication must be ongoing with ample opportunities to revisit, provide feedback, and adjust as data becomes available on how well the County is performing. Implementing these recommendations in Broward within a system that can adapt and change based on its performance will be essential to Broward's success.

APPENDIX A:
SCOPE OF SERVICES

EXHIBIT A
REVISED SCOPE OF SERVICES

Services to be Provided

I. CONSULTANT agrees to provide the services of a consultant(s) knowledge about changes to Housing and Urban Development(HUD) Homeless Continuum of Care programs pursuant to the Feeral Homeless Emergency and Rapid Transition to Housing (HEARTH) Act. CONSULTANT shall work with COUNTY's Human Service Department, Community Partnership Division Homeless Initiative Partnership (HIP) staff to assure compliance with the Act. The services shall include:

A. Analysis of the existing Broward County Continuum of Care (CoC) structure, and provision of a summary of the analysis.

B. Recommendations for CoC partners.

C. Propose strategies for increasing stakeholder engagement in CoC.

D. Facilitation of meetings for the initial community HEARTH Act implementation planning processes to include scheduling meetings or conducting on-line surveys and/or telephone conferences to gather stakeholder input from community stakeholder groups which includes:

1. Broward County Residents
2. Homele3ss Initiatie Partnership (HIP) Advisory Board
3. Homeless CoC Planning Body (Stakeholder and Provider's Council)
4. Fifteen (15) Community Development Block Grant (CDBG) Entitlement Communities (as authorized under Title 1 of the Housing and Community Development Act of 1974, Public Law 93-383, as amended; 42 U.S.C.-5301 et seq.), which includes Broward County and the cities of Coconut Creek, Coaral Springs Town of Davie, Deerfield Beach, Fort Lauderdale, Hollywood, Lauderhill, Margate, Miramar, Pembroke Pines, Pompano Beach, Plantation, Sunrise and Tamarac.
5. Hi-Level Staff from the major ntitlement cities of Fort Lauderdale, Pompano Beach and Hollywood
6. Hi-Level Staff from entitlement and non-entitlement cities of Coconut Creek, Coaral Springs, Town of Davie, Deerfield Beach, Lauderhill, Margate, Miramar, Pembroke Pines, Plantation, Sunrise and Tamarac;
7. Cooper City, Dania Beach, Hallandale Beach, Hillsboro Beach, Lauderddale-By-The-Sea, Lauderhill, Village of Lazy Lake, Lighthouse Point, North Lauderdale, Oakland Park, Parkland, Pembroke Park, Sea Ranch Lakes, Southwest Ranches, Weston, Pwest Park and Wilton Manors
8. State Department of Children and Families (Office on Homelessness, Etc.)
9. Business community
10. Law enforcement (County and Municipal)
11. Homeless services providers (funded and unfunded) all sub populations
12. Tax supported and private hopitals
13. Homeless youth advocates
14. Mental health providers and Substance Abuse Providers
15. Broward County HSD Divisions (BARC, FSAD and EVSD)
16. Broward County School Board
17. Medicaid/managed care organizations (MHO's)
18. Coordinating Council of Broward County
19. Funding Agencies (Florida Department of Children and Families Southeast Region, Children's Services Council, Florida Department of Health, ChildNet, Inc., WorkForce One and United Way of Broward County)
20. Broward County Housing Finance and Community Development Division
21. Mental Health Taskforce
22. Judiciary (Drug Court, Veterances Court)
23. Faith Based organizations of various denominations
24. Broward Health Healthcare for the Homeless
25. Local Public Housing Authorities
26. Veterans Administration (Miami)

This list is not all inclusive and additional stakeholder groups may be added

E. Analysis of the CoC's readiness, and CONSULTANT's recommendations, for implementation of the HEARTH Act.

F. Analysis of the CoC's HUD Homeless Continuum of Care funding application process.

G. Analysis of and recommendations for the functions and roles of COUNTY's Homeless Initiative Partnership Advisory Board, and of Broward County's Homeless Provider and Stakeholder's Council and its partners, including COUNTY's Housing Finance and Community Development Division.

H. Recommendations for Changes to HIP to include an organizational chart showing how HIP should be staffed with specific job titles/realms of responsibility.

I. Provision of a comprehensive analytical report that contains:

1. Proposed by-laws and/or policies/procedures for COUNTY's Homeless Initiative Partnership Advisory Board; Homeless Provider and Stakeholder's Council and its partners

2. Proposed changes to existing CoC strategies to include an analysis and recommendations relating to CoC Services based on best practice for street outreach, emergency shelter services, other supportive services, transitional housing and permanent supportive housing services

3. Analysis of COUNTY's currnt homeless funding and recommendatioins, based on best practice, to assist COUNTY to maximize funding for leverage/match for HUD Supportive Housing Program (SHP) and HUD Shelter Plus Care (SPC) projects in anticipation of HEARTH act requirements

4. Proposed goals for the CoC

5. Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis

6. Analysis of the CoC's "Ten Year Plan to End Homelessness" to include an assessment identifying areas in the plan that are best practice and recommendations on areas that need revision and items needing to be added to the plan

7. Outline of plan to align the Homeless Helpline as a coordinated intake process based on HEARTH Act guidelines and best practice

8. Analysis of performance measures and outcomes in HIP's contractual agreement and recommendations on changes to align them with HEARTH act requirements and HUD goals

9. A detailed listing of the stakeholders and the number of stakeholders, for each category, that participated in the process

10. Targeted strategies, based on best practice, on how to deal with homeless congregating in public places

11. Proposed recommendations for establishing system-wide performance goals and outcomes for CoC funded homeless housing and supportive services, including programs funded under HUD McKinney-Vento and other resources.

12. Recommended actions for COUNTY to become a Unified Funding Agncy (UFA) to include essential elements that should be in place prior to the County becoming a UFA.

II. CONSULTANT shall provide these services in five (5) phases as sescribed in Paragraph III below. The first four (4) phases shall include a minimum of three (3) trips by CONSULTANT to Broward County for initial information gathering, for presentation and feedback regarfing draft recommendations, and for presentation of final recommendations; the fifth (5^{th}) phase shall include a minimum of one (1) additional trip by CONSULTANT to Broward County to facilitate initial planning meetings. Recommendations shall focus on identifying the governance structure and an implementation plan that will help meet the following goals:

A. Align COUNTY and community initiatives with the HEARTH Act, "Opening Doors, the Federal Strategic Plan to Prevent and End Homelessness," the federal Ten Year Plan to End Chronic Homelessness, and other national plans or best practices as identified by COUNTY.

APPENDIX B:
GLOSSARY OF ACRONYMS AND KEY TERMS

Acronyms

HUD: The United States Department of Housing and Urban Development
HEARTH Act Amendment: Homeless Emergency Assistance and Rapid Transition to Housing Act
CoC: Homeless Continuum of Care
APR: HUD Annual Performance Report
AHAR: HUD Annual Homeless Assistance Report (HMIS Driven)
ES: Emergency Shelter
ESG: Emergency Solutions Grant
PIT: Point in Time Count (Sheltered and Unsheltered)
HIC: Housing Inventory Chart
BCHSD: Broward County Human Services Department
HIP: Homeless Initiative Partnership Section (Continuum Lead Agency)
HIP Advisory Board: Continuum of Care Primary Decision Making Body
DCF: The State of Florida Department of Children & Families
FMR: Fair Market Rent
HMIS: Homeless Management Information System
HOPWA: Housing Opportunities for People with AIDS
HQS: Housing Quality Standards
LOS: Length of Stay
PHA: Public Housing Authority
RRH: Rapid Re-housing
SHP: Supportive Housing Program
S+C: Shelter Plus Care
SSI: Supplemental Security Income, a federal disability benefits program
SSDI: Social Security Disability Insurance (SSDI)
TH: Transitional Housing

Key Terms

At risk of homelessness: A household who identifies themselves as imminently homeless.

Chronically homeless: An unaccompanied homeless individual or family head of household with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

Continuum of Care (CoC): HUD (see below) introduced the CoC concept to encourage and support local organizations in coordinating their efforts to address housing and homeless issues. CoC committees at the city, county and state level coordinate their efforts to produce plans that identify the needs of local homeless populations, the resources that are currently available in the community to address those needs, and additional resources needed to fill identified gaps. The CoC process is a community-based approach

that encourages the creation of collaborative, comprehensive systems to meet the diverse of needs of local homeless populations. HUD also refers to the group of service providers involved in the decision making processes as the "Continuum of Care."

Disabling Condition: A disabling condition is defined by HUD as (1) A disability as defined in section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes an individual's ability to live independently, and of such a nature that the disability could be improved by more suitable conditions; (3) a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.

Emergency Housing: A temporary housing program meant to sustain someone through a housing crisis but that they must eventually exit (e.g., an emergency housing or transitional housing program).

Fair Housing: The Federal laws and regulations that provide for equal access to housing and determine what is considered illegal discrimination in the provision of housing.

Fair Market Rent: The basis for the payment standard in the Section 8 program and other HUD-funded housing programs. The current definition used is the 40th percentile rent, the dollar amount below which 40 percent of the standard-quality rental housing units are rented.

Family: Any number of adults that have related children with them as part of their household.

Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act): On May 20, 2009, President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. The HEARTH Act amends and reauthorizes the McKinney-Vento Homeless Assistance Act with some substantial changes.

- *Homelessness:* The definition of homelessness in this report is consistent with the HUD definition, which includes:
  - People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided if they were in shelter or a place not meant for human habitation before entering the institution.
  - People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing.
  - Families with children or unaccompanied youth who are unstably housed and likely to continue in that state, such as families with children or unaccompanied youth (up to age 24) who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
  - People who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening situations related to violence; have no other residence; and lack the resources or support networks to obtain other permanent housing.[1]

[1] More information on the HUD definition of homelessness and how it has recently changed can be found in this Alliance summary document: http://www.endhomelessness.org/library/entry/changes-in-the-hud-definition-of-homeless.

Household: Any number of individuals, related by blood or not, whether bound legally or not, that compose a unit (e.g., travel together, enter homelessness together).

Housing Opportunities for People with AIDS: The HOPWA Program was established by HUD to address the specific needs of persons living with HIV/AIDS and their families. HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons medically diagnosed with HIV/AIDS and their families.

Housing First: A programmatic approach to assisting homeless people that places primary importance on securing housing before addressing other areas of need.

Housing Quality Standards: A HUD- authorized inspection standard for determining whether a rental housing unit is decent, safe and sanitary.

Master lease: A lease between a property owner and a program which permits the program to sublease the unit to persons selected by the program.

McKinney-Vento Act: The McKinney-Vento Homeless Assistance Act was the first major federal legislative response to homelessness. The McKinney-Vento Act provides federal money for homeless assistance grants programs.

Medicaid / Florida: Medicaid provides Medical coverage to low income individuals and families. The state and federal government share the costs of the Medicaid program. Medicaid services in Florida are administered by the Agency for Health Care Administration.

Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients).
DCF determines Medicaid eligibility for:

- Low income families with children
- Children only
- Pregnant women
- Non-citizens with medical emergencies
- Aged and/or disabled individuals not currently receiving Supplemental Security Income (SSI)

Source: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid

Payment standard: A maximum rent amount, by bedroom size, over which a program will not provide housing subsidies.

Permanent housing: Housing where the resident has the rights and obligations of tenancy and may remain for as long as the terms of the tenancy are met.

Rental subsidy: A payment to a property owner on behalf of an eligible program participant to cover a portion of the participant's rent.

Security deposit: A payment required by a property owner to ensure that a tenant pays rent on time and keeps the rental unit in good condition. If the tenant damages the property or leaves owing rent, the property owner can use the security deposit to cover what the tenant owes.

Shelter Plus Care Program (S+C): The Shelter Plus Care Program is a HUD Continuum of Care program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters.

Social Security Disability Insurance (SSDI): pays monthly benefits to workers who are no longer able to work due to a significant illness or impairment that is expected to last at least a year or to result in death within a year. It is part of the Social Security program that pays retirement benefits to the vast majority of older Americans. Benefits are based on the disabled worker's past earnings and are paid to the disabled worker and to his or her dependent family members. To be eligible, a disabled worker must have worked in jobs covered by Social Security.

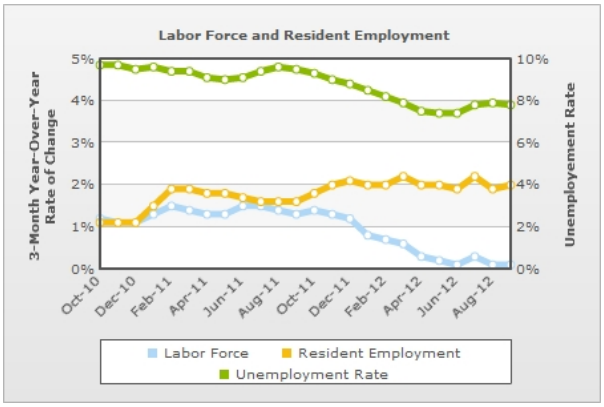
Supportive Housing Program (SHP): The Supportive Housing Program was formerly a HUD Continuum of Care program (and is now a collection of eligible activities) designed to develop supportive housing and services that will allow homeless persons to live as independently as possible. Eligible applicants are States, units of local government, other governmental entities such as PHAs, and private nonprofits.

Temporary housing: A housing location, including a hotel or emergency shelter, where the participant is expected to be for a short period of time while a more permanent housing situation is developed, and where the participant generally does not have the rights of tenancy.

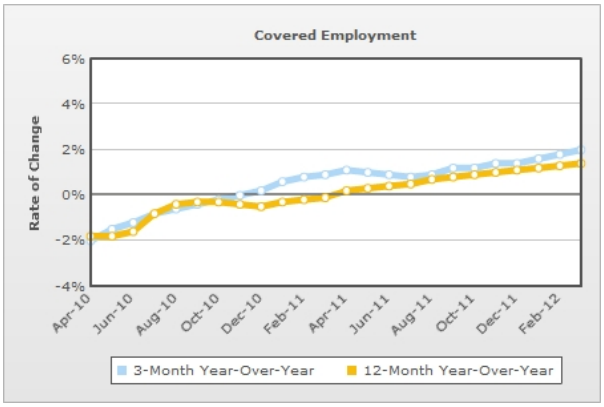
Unaccompanied Individual: An adult (over age 25) that enters the homeless assistance system alone (e.g., is not currently part of a couple or family with children).

APPENDIX C:
MARKET AT A GLANCE

ECONOMIC CONDITIONS



Data Source: U.S. Bureau of Labor Statistics



Data Source: U.S. Bureau of Labor Statistics

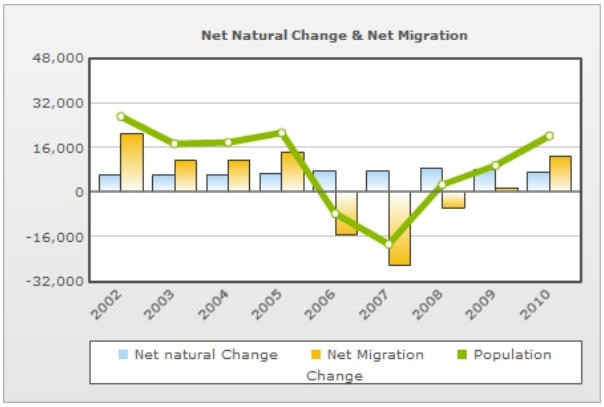
	3-Month Average			3-Month Year-Over-Year Change			
	September 2010	September 2011	September 2012	September 2010 to September 2011		September 2011 to September 2012	
				Number	Percent	Number	Percent
Labor Force	986,901	999,806	1,000,680	12,905	1.3	874	0.1
Resident Employment	890,157	904,518	922,281	14,361	1.6	17,763	2
Unemployment Rate (%)	9.8	9.5	7.8	n/a	n/a	n/a	n/a
	March 2010	**March 2011**	**March 2012**	**March 2010 to March 2011**		**March 2011 to March 2012**	
Covered Employment	676,336	682,729	696,541	6,393	0.9	13,812	2

Data Source: U.S. Bureau of Labor Statistics

POPULATION & HOUSEHOLDS

	Decennial Census				ACS & Population Estimates Program						
	April 2000	April 2010	Average Annual Change 2000 to 2010		July 2008	July 2009	July 2010	2008 to 2009		2009 to 2010	
			Number	Percent				Number	Percent	Number	Percent
Population	1,623,018	1,748,066	12,505	0.8	1,723,633	1,733,310	1,753,578	9,677	0.6	20,268	1.2
Households	654,445	686,047	3,160	0.5	667,220	651,477	658,025	-15,743	-2.4	6,548	1

Data Source: 1 - 2000 Census; 2010 Census; U.S. Census Bureau Population Estimates
2 - 2000 Census; 2010 Census; 2008, 2009 and 2010 American Community Surveys (1 - Year)



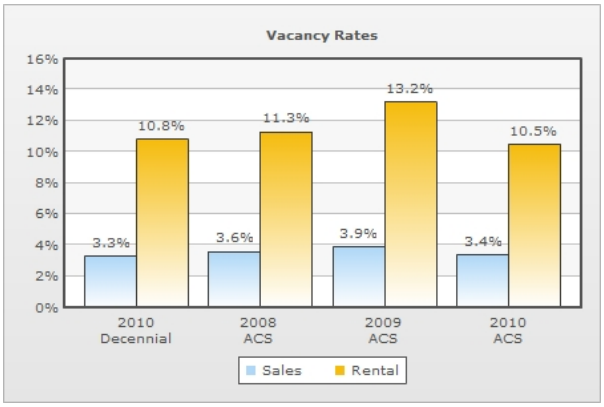
Data Source: U.S. Census Bureau Population Estimates

Notes: 1 - Values in chart reflect July year-to-year changes
2 - Net Migration includes residual population change

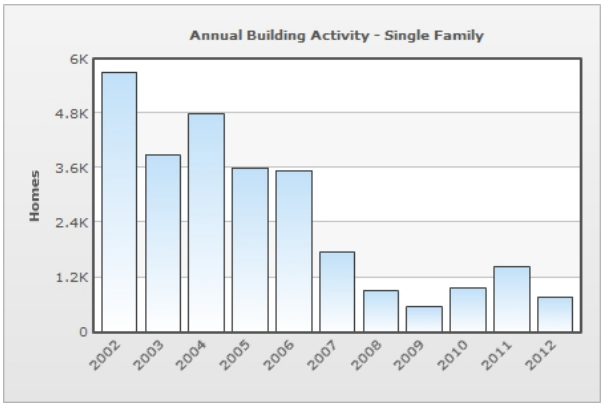
Economic Trends and Population and Household Trends

Economic conditions in the Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Metropolitan Division, which is coterminous with Broward County, improved slightly during the past year. During the 12 months ending April 2012, nonfarm payrolls increased by 5,000 jobs, or 0.7%, from the previous 12-month period to total 712,300. The 3-month average also increased as nonfarm payrolls increased by 4,700 jobs, or 0.7%, during the past 3-month period ending April 2012 compared with the average during the same period a year ago. From 2007 through 2010, nonfarm payrolls lost an average of 28,300 jobs, or 3.7%, annually. Payrolls increased in 2011 by 6,100 jobs, or 0.9%, from 2010. The education and health services sector had the highest growth during the past 3 months, increasing by 2,700 jobs, or 2.8%, from the same period last year. The manufacturing sector increased by 2,400 jobs, or 9.5%. The construction sector had the greatest decline, losing 2,800 jobs, or 9.4%. The government sector declined by 700 jobs, or 0.7%. The unemployment rate decreased during the past 12 months to 8.7% from 9.5% during the previous 12-month period. As of May 1, 2012, the population of Broward County was estimated at 1,805,000, with an annual increase of 26,850 people, or 1.5%, since April 1, 2010. Net in-migration accounted for approximately 75 percent of growth during this time period. Households increased from 686,000 in 2010 to a current estimate of 701,200, an increase of 7,275, or 1.1%, annually.

HOUSING MARKET CONDITIONS



Data Source: 2010 Census; 2008, 2009 and 2010 American Community Surveys (1 - Year)

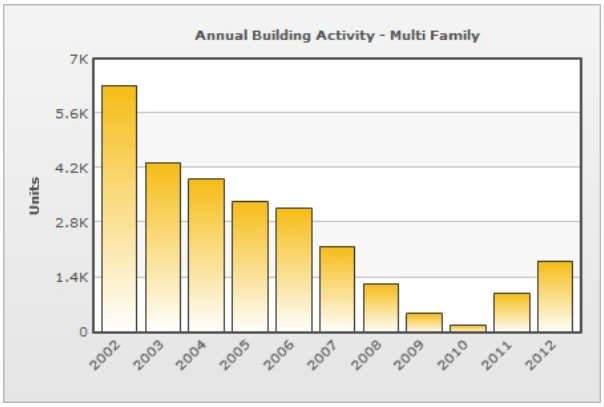


Data Source: U.S. Census Bureau, Building Permits Survey; adjustments by analyst

Note: Data for 2012 is preliminary, through September 2012

Housing Inventory by Tenure	2010 Decennial	2008 ACS	2009 ACS	2010 ACS
Total Housing Units	810,388	805,807	807,137	810,410
Occupied	686,047	667,220	651,477	658,025
Owners	456,732	469,738	445,958	435,488
% Owners	66.6	70.4	68.5	66.2
Renters	229,315	197,482	205,519	222,537
% Renters	33.4	29.6	31.5	33.8
Total Vacant	124,341	138,587	155,660	152,385
Available for Sale	15,687	17,529	17,891	15,303
Available for Rent	27,753	25,045	31,239	26,163
Other Vacant	80,901	96,013	106,530	110,919

Data Source: 2010 Census; 2008, 2009 and 2010 American Community Surveys (1 - Year)



Data Source: U.S. Census Bureau, Building Permits Survey; adjustments by analyst

Note: Data for 2012 is preliminary, through September 2012

Housing Market Conditions Summary

Housing market conditions in Broward County improved during the last year, but remain soft. The sales and rental vacancy rates are currently estimated at 3% and 8.1%, respectively, down from 3.3% and 10.8% recorded in 2010. According to CoreLogic, approximately 6,000 existing single-family homes were sold during the past 3 months ending March 2012, an increase of 500 homes, or 9%, from the same period a year prior. An average of 21,650 existing single-family homes were sold annually from 2007 through 2011. The median sales price increased by 10% from $90,750 in March 2011 to $100,000 in March 2012. According to preliminary data, during the past 3-month period ending April 2012, approximately 1,000 total building permits were issued, more than triple the 310 permits that were issued during the same period a year ago. An average of 2,150 permits were issued annually from 2007 through 2011. Approximately 210 single-family homes were permitted during the past 3-month period, an increase of 20 homes, or 11%, from the same period a year earlier. Approximately 800 multifamily units were permitted during the past 3 months, compared with 120 units permitted during the same period in 2011. One Plantation Place Apartments with 321 units is currently under construction in Plantation, FL. Construction is expected to be completed in the third quarter of 2013. Approximately 500 single-family homes and 1,650 multifamily units are under construction.

Rental Housing Supply	
Under Construction	1650
In Planning	

Data Source: Estimates by analyst

Note: Units in Planning have not been permitted, but are expected to be completed within 3 years

For additional information, please contact: Robyn Bowen
robyn.e.bowen@hud.gov
404-331-5001

APPENDIX D:
SWOT ANALYSIS

STRENGTHS	WEAKNESSES
Many elements of a coordinated assessment process are in place **County contracting includes performance measures** **Ten Year Plan is focused on the correct strategies** HIP Board provides a structure for initiating systemic changes Large supply of permanent supportive housing for families with children	**Outcomes are not aligned with the HEARTH Act or best practices** **Few resources for rapid re-housing** **Poor data systems and reporting capability** **Little consensus among providers about rapid re-housing** Large supply of transitional housing Little supply of permanent supportive housing for single adults
OPPORTUNITIES	**THREATS**
High rental vacancy rate **Modest rental housing costs** **Changes to Medicaid provide a new resource for permanent supportive housing** New ESG funding HEARTH Act Implementation	**Federal, State, and local budget pressures** **Increased Federal emphasis on rapid re-housing** Inter-jurisdictional disagreements Poor economy and high unemployment

APPENDIX E: PARTICIPATING AND INVITED COMMUNITY STAKEHOLDERS

PARTICIPATING STAKEHOLDERS

NAME OF ORGANIZATION OR GROUP	# OF TIMES MET WITH NAEH OR ATTENDED MEETING	# OF STAKEHOLDERS THAT MET WITH THE ALLIANCE
COUNTY GOVERMENT		
County Administrator	1	1
Broward County Human Services/Community Partnerships Division	12	6
Broward Addiction Recovery Center (BARC)	1	1
Familiy Success Administration Division (FSAD)	1	2
Elderly and Veterans Services Division (EVSD)	1	1
Broward Health - Healthcare for the Homeless	2	3
Health Care Services Section	1	1
Broward County Housing Finance and Community Development Division	1	1
STATE GOVERNMENT		
State Department of Children and Families - Office on Homelessness	3	2
Florida Department of Health	1	1
BROWARD COUNTY ENTITLEMENT AND ENTITLEMENT CITIES		
Broward County	1	2
City Coral Springs	1	1
City of Fort Lauderdale	5	3
City of Hollywood	1	1
City of Lauderhill	1	1
City of Margate	1	1
City of Pompano Beach	1	1
City of Tamarac	1	1
Town of Davie	1	1
City of Coconut Creek (Represented by CRA FL)	1	1
City of Pembroke Pines (Represented by CRA FL)	1	1
City of Miramar (Represented by CRA FL)	1	1
City of Deerfield Beach (Represented by CRA FL)	1	1
HOMELESS ADMINISTRATIVE AND GOVERNANCE BODIES		
Homeless CoC Planning Body (Provider and Stakeholders Council): includes representation from The Salvation Army, HOPE South Florida, State Department of Children and Families - Office on Homelessness, Family Central Inc, Covenant House, Volunteers of America of Florida, Broward County Housing Authority, TaskForce Fore Ending Homelessness, Broward Outreach Center/Miami Rescue Mission, Susan B. Anthony Center, HOPE South Florida, Broward House, 2-1-1 Broward, Broward Regional Health Planning Council, Archways, Broward Housing Solutions, Feeding South Florida, Department of Veterans Affairs, Broward Partnership for the Homeless, Inc., Second Chance Society, Help 4 Homeless, Pathways to Freedom, Pairs, LifeNet 4 Families, Good Growth Homes Inc., Carrfour Supportive Housing	4	15
Homeless Initiative Partnership (HIP) Advisory Board: includes representation from Legal Aid Service of Broward County, Broward Outreach Center/Miami Rescue Mission, HOPE South Florida, Broward County Board of Commissioners, Broward County School Board, KIDS Inc., United Way of Broward County, Broward Partnership for the Homeless, Inc., State Department of Children and Families - Office on Homelessness, Coalition to End Homelessness, People Helping People Outreach Center, Lauderhill Law Enforcement, The Salvation Army	5	15
LAW ENFORCEMENT		
Broward County Sheriff's Office	1	1
Fort Lauderdale Police Department	1	1
Hollywood Police Department	1	2
PUBLIC HOUSING AUTHORITIES		
Broward County Housing Authority	2	3
FOUNDATIONS		
Jim and Jan Moran Foundation	1	1
COMMUNITY PROVIDERS		
Memorial Health Care	2	2
Broward Community Health and Family Health Centers, Inc.	1	1
Archways	1	1
Care Resource	1	2
Health Choice Network	1	1
Family Central Inc	1	1
The Salvation Army	2	3
Women in Distress	1	1
CeC, Inc. Hollywood	1	1
TaskForce Fore Ending Homelessness	2	2
Legal Aid Service of Broward County	1	1
Hope Outreach Center	1	1
Broward House	1	1
Broward Regional Health Planning Council	1	1
Henderson Behavioral Health	2	4
Broward Outreach Center/Miami Rescue Mission	4	3
Broward Housing Solutions	2	2
HOPE South Florida	2	2
Covenant House Florida	1	1
2-1-1 Broward	3	2
Broward Partnership for the Homeless, Inc.	4	4
OTHER STAKEHOLDERS		
United Way of Broward County	2	4
Judiciary Sector (including Drug Court, Mental Health Court)	2	2
Homeless youth advocates	1	1
TOTAL	**96**	**117**

* All numbers are approximate and based on best information available. Numbers include in-person meetings attended and phone interviews and meetings.

SURVEY RESPONDENTS

NAME OF ORGANIZATION OR GROUP	# OF RESPONDENTS
Susan B. Anthony Recovery Center	1
Legal Aid Service of Broward County	1
Broward Health	1
Volunteers of America of Florida	3
Take Him to the Streets	1
Henderson Behavioral Health	3
TaskForce Fore Ending Homelessness	4
Women in Distress	1
Broward County	1
Broward Housing Solutions	1
HOPE South Florida	1
Veterans New Life Haven	1
Coalition to End Homelessness	2
Broward Outreach Center/Miami Rescue Mission	13
Covenant House Florida	1
2-1-1 Broward	1
Jireh Outreach & Community Development, Inc	1
Broward Housing Options	2
Broward County Housing Authority	1
Catholic Charities of the Archdiocese of Miami	1
TOTAL	**41**

* This list includes only the names of organizations service provider respondents listed as their place of employment when completing the survey.
**Surveys were made available to the Broward Housing Council. **Surveys were made available to the Broward Housing Council.

INVITED STAKEHOLDERS

NAME OF ORGANIZATION OR GROUP	
SChildNet, Inc.	Margate Police Department
Children's Services Council	Miramar Police Department
City of Plantation	Pembroke Pines Police Department
City of Sunrise	Plantation Police Department
Coordinating Council of Broward County	Wilton Manors Police Department
City of Parkland	Fort Lauderdale Housing Authortiy
Town of Pembroke Park	Dania Beach Housing Authority
Village of Sea Ranch Lakes	Deerfield Beach Housing Authority
Town of Southwest Ranches	Hollywood Housing Authority
Village of Lazy Lake	Pompano Beach Housing Authority
City of West Park	Medicaid/managed care organizations
City of Weston	Mental Health Taskforce
Coconut Creek Police Department	Veterans Administration (Miami)
Coral Springs Police Department	Veterans Court
Davie Police Department	WorkForce One Employment Solutions, Inc.
Hallandale Beach Police Department	Health Care Network
Lauderdale by the Sea Police Department	Board of Health
Lighthouse Point Police Department	
	TOTAL: 35

* This list includes stakeholders who were invited to meetings held during this project but did not attend.

APPENDIX F:
SURVEY RESULTS SUMMARIES
COMMUNITY LEADERS

1. I believe my organization is committed to the community plan to end homelessness.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	0.0%	0
Neither Disagree nor Agree	4.3%	1
Agree	26.1%	6
Strongly Agree	**52.2%**	**12**
We don't have a community plan to end homelessness.	8.7%	2
	answered question	**23**
	skipped question	**0**

2. Funding and service decisions in our community are focused on getting consumers into permanent housing as quickly as possible.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	30.4%	7
Neither Disagree nor Agree	13.0%	3
Agree	**39.1%**	**9**
Strongly Agree	8.7%	2
	answered question	**23**
	skipped question	**0**

		Percent	Count
to develop self-sufficiency in our clients		**47.8%**	**11**
to end poverty for the people we serve		0.0%	0
to end homelessness by providing housing		34.8%	8
to end homelessness by providing services		17.4%	4
		answered question	**23**
		skipped question	**0**

4. Various systems of care participate in the planning and coordination of services to end homelessness.

		Response Percent	Response Count
Strongly Disagree		0.0%	0
Disagree		8.7%	2
Neither Disagree nor Agree		4.3%	1
Agree		**56.5%**	**13**
Strongly Agree		30.4%	7
		answered question	**23**
		skipped question	**0**

5. All of the essential partners to end homelessness are around the table and share the vision of ending homelessness.

	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	30.4%	7
Neither Disagree nor Agree	17.4%	4
Agree	**47.8%**	**11**
Strongly Agree	4.3%	1
	answered question	**23**
	skipped question	**0**

6. If you "strongly disagree" or "disagree" that all of the essential partners to end homelessness are around the table and share the vision of ending homelessness, who or what organization is missing in your community? (write "N/A" if you did not select either of these choices)

	Response Count
	23
answered question	**23**
skipped question	**0**

7. All providers of shelter and other homeless assistance participate in data collection and planning.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	17.4%	4
Neither Disagree nor Agree	13.0%	3
Agree	**47.8%**	**11**
Strongly Agree	13.0%	3
	answered question	**23**
	skipped question	**0**

8. There is one or more organization(s) in our community—a governmental body, health care provider, service provider, landlord, faith group, etc.—that is a barrier to ending homelessness in our community.

	Response Percent	Response Count
Yes	**43.5%**	**10**
No	13.0%	3
I don't know	**43.5%**	**10**
	answered question	**23**
	skipped question	**0**

9. Our community planning process and discussions result in tangible actions to end homelessness through new programs, program amendments, pilot projects, refined/improved policies, new funding, etc.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	17.4%	4
Neither Disagree nor Agree	8.7%	2
Agree	**60.9%**	**14**
Strongly Agree	4.3%	1
	answered question	**23**
	skipped question	**0**

10. The community has a comprehensive discharge plan that is being used and monitored for success on a regular basis.

	Response Percent	Response Count
Strongly Disagree	13.0%	3
Disagree	30.4%	7
Neither Disagree nor Agree	**47.8%**	**11**
Agree	8.7%	2
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

11. Our system is set up so that service providers and programs with the best performance on outcomes are rewarded and praised.

		Response Percent	Response Count
Strongly Disagree		4.3%	1
Disagree		**43.5%**	**10**
Neither Disagree nor Agree		30.4%	7
Agree		21.7%	5
Strongly Agree		0.0%	0
		answered question	**23**
		skipped question	**0**

12. Staff and volunteers in our community are qualified and trained to provide the services they deliver.

		Response Percent	Response Count
Strongly Disagree		0.0%	0
Disagree		13.0%	3
Neither Disagree or Agree		17.4%	4
Agree		**69.6%**	**16**
Strongly Agree		0.0%	0
		answered question	**23**
		skipped question	**0**

13. Providers are held accountable for their outcomes.

	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	21.7%	5
Neither Disagree nor Agree	**34.8%**	**8**
Agree	30.4%	7
Strongly Agree	13.0%	3
	answered question	**23**
	skipped question	**0**

14. Please list the outcomes for which providers are held accountable.

	Response Count
	23
	answered question	**23**
	skipped question	**0**

15. The community uses a standardized process and/or tool for intake/assessment that helps us determine the most appropriate resources based for each consumer based on his/her/their needs.

	Response Percent	Response Count
Yes	**52.2%**	**12**
No	21.7%	5
I don't know	26.1%	6
	answered question	**23**
	skipped question	**0**

16. In my opinion, the intake process is standard and consistent for all organizations in my community serving the same type of consumer.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	26.1%	6
Neither Disagree nor Agree	26.1%	6
Agree	**39.1%**	**9**
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

17. The community has a periodic review process to evaluate its targeting strategy as well as the overall assessment and resource allocation process.

	Response Percent	Response Count
Yes	34.8%	8
No	**39.1%**	**9**
I don't know	26.1%	6
	answered question	**23**
	skipped question	**0**

18. Consumers are prioritized for housing, financial assistance, and services based on need instead of first come, first served.

	Response Percent	Response Count
Strongly Disagree	13.0%	3
Disagree	13.0%	3
Neither Disagree nor Agree	**39.1%**	**9**
Agree	30.4%	7
Strongly Agree	4.3%	1
	answered question	**23**
	skipped question	**0**

19. Choices are provided to consumers about where they can be housed based on their preferences and income.

	Response Percent	Response Count
Yes	**43.5%**	**10**
No	26.1%	6
I don't know	30.4%	7
	answered question	**23**
	skipped question	**0**

20. Permanent housing needs are assessed within one week of entry into any community shelter.

		Response Percent	Response Count
Yes		26.1%	6
No		17.4%	4
I don't know		**56.5%**	**13**
		answered question	**23**
		skipped question	**0**

21. Whenever possible, our community employs strategies that prevent people from losing their housing and divert them away from needing shelter or other housing assistance.

		Response Percent	Response Count
Strongly Disagree		8.7%	2
Disagree		17.4%	4
Neither Disagree nor Agree		26.1%	6
Agree		**47.8%**	**11**
Strongly Agree		0.0%	0
		answered question	**23**
		skipped question	**0**

22. The community has sufficient rapid re-housing resources in place that assist consumers to be re-housed into permanent housing quickly (<45 days) should they become homeless.

	Response Percent	Response Count
Strongly Disagree	26.1%	6
Disagree	**39.1%**	**9**
Neither Disagree nor Agree	26.1%	6
Agree	8.7%	2
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

23. Most consumers served in the community are successfully supported in stabilizing in permanent housing.

	Response Percent	Response Count
Yes	17.4%	4
No	**47.8%**	**11**
I don't know	34.8%	8
	answered question	**23**
	skipped question	**0**

24. The community has been successful engaging landlords and finding new ones that are amenable to housing formerly homeless persons.

	Response Percent	Response Count
Strongly Disagree	4.3%	1
Disagree	21.7%	5
Neither Disagree nor Agree	**65.2%**	**15**
Agree	8.7%	2
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

25. The community has staff dedicated to providing permanent housing location services to consumers.

	Response Percent	Response Count
Yes	**47.8%**	**11**
No	21.7%	5
I don't know	30.4%	7
	answered question	**23**
	skipped question	**0**

26. Landlords that house consumers are actively supported through regular communication and a check-in to ensure that rent is paid in full and on time each month.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	8.7%	2
Neither Disagree nor Agree	**65.2%**	**15**
Agree	17.4%	4
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

27. Homeless assistance programs have appropriate staff to consumer ratios for the type of work delivered to homeless and recently housed people.

	Response Percent	Response Count
Strongly Disagree	4.3%	1
Disagree	**26.1%**	**6**
Neither Disagree nor Agree	21.7%	5
Agree	17.4%	4
Strongly Agree	4.3%	1
I don't know	**26.1%**	**6**
	answered question	**23**
	skipped question	**0**

28. Our community routinely reflects on data from either our HMIS or other case management software to understand who we are serving and not serving well and makes adjustments to our service delivery accordingly.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	**39.1%**	**9**
Neither Disagree nor Agree	34.8%	8
Agree	17.4%	4
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

29. The community implements system-wide data collection on HMIS.

	Response Percent	Response Count
Yes	**47.8%**	**11**
No	30.4%	7
I don't know	21.7%	5
	answered question	**23**
	skipped question	**0**

30. Tracking of the community's outcomes includes the following:

	Yes	No	I don't know	Response Count
Number of people who become homeless	**87.0% (20)**	4.3% (1)	8.7% (2)	23
Average time of homeless episodes (not necessarily the average stay in a shelter)	**47.8% (11)**	17.4% (4)	34.8% (8)	23
Rate of returns to homelessness	34.8% (8)	21.7% (5)	**43.5% (10)**	23
			answered question	**23**
			skipped question	**0**

31. Our community strives to eliminate the unnecessary duplication of services.

	Response Percent	Response Count
Strongly Disagree	4.3%	1
Disagree	17.4%	4
Neither Disagree nor Agree	17.4%	4
Agree	**60.9%**	**14**
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

32. The community has a data driven approach to targeting prevention resources.

	Response Percent	Response Count
Strongly Disagree	8.7%	2
Disagree	13.0%	3
Neither Disagree nor Agree	30.4%	7
Agree	**47.8%**	**11**
Strongly Agree	0.0%	0
	answered question	**23**
	skipped question	**0**

33. The community successfully leverages resources and funds from the public and private sectors.

		Response Percent	Response Count
Strongly Disagree		4.3%	1
Disagree		17.4%	4
Neither Disagree nor Agree		26.1%	6
Agree		**52.2%**	**12**
Strongly Agree		0.0%	0
		answered question	**23**
		skipped question	**0**

34. Please answer the following questions based on your knowledge of the status of services in your community:

	Yes	No	I don't know	Not applicable	Response Count
We use a methodological approach to collect information from our consumers regarding their impressions of our program's specific services.	**47.8% (11)**	26.1% (6)	26.1% (6)	0.0% (0)	23
Consumers are satisfied with the services that they are receiving.	**47.8% (11)**	8.7% (2)	43.5% (10)	0.0% (0)	23
Our system is responsive to feedback from consumers.	39.1% (9)	13.0% (3)	**47.8% (11)**	0.0% (0)	23
				answered question	**23**
				skipped question	**0**

APPENDIX F:
CONSUMER SURVEY RESULTS

1. Are you currently living in permanent housing? If you are not currently living in permanent housing, please skip to question #5.

	Response Percent	Response Count
Yes	23.7%	14
No	**76.3%**	**45**
	answered question	**59**
	skipped question	**0**

2. If you are currently living in permanent housing, when did you move in?

	Response Percent	Response Count
Within the last month	12.5%	2
1-3 months ago	0.0%	0
4-6 months ago	**31.3%**	**5**
7-9 months ago	12.5%	2
10-12 months ago	25.0%	4
More than 12 months ago	18.8%	3
	answered question	**16**
	skipped question	**43**

3. If you are in permanent housing now, are you satisfied with your housing?

	Response Percent	Response Count
Yes	**100.0%**	**14**
No	0.0%	0
	answered question	**14**
	skipped question	**45**

4. If you are in permanent housing now, what resources or services do you need to keep your housing? Check all that apply.

	Response Percent	Response Count
Rental Assistance	**64.3%**	**9**
Funding for assistance other than rent—things like deposits, utilities, rental applications, or other financial assistance	28.6%	4
Help finding a job	50.0%	7
Help with life skills such as how to care for an apartment	14.3%	2
Substance use treatment	0.0%	0
Health care	0.0%	0
Mental health treatment	21.4%	3
Help with budgeting	28.6%	4
Case management	14.3%	2
Other (please specify)	7.1%	1
	answered question	**14**
	skipped question	**45**

5. If you are not currently in permanent housing (a housing unit that is yours and that you never have to leave), when do you expect to be housed in such a unit?

	Response Percent	Response Count
Within a month	18.9%	7
1-3 months from now	24.3%	9
4-6 months from now	10.8%	4
7-9 months from now	2.7%	1
10-12 months from now	2.7%	1
More than 12 months from now	2.7%	1
I don't know	**37.8%**	**14**
	answered question	**37**
	skipped question	**22**

6. Within your first 30 days of being homeless, were you placed into permanent housing?

	Response Percent	Response Count
Yes	20.3%	12
No	**66.1%**	**39**
I am currently homeless and I have been homeless less than 30 days	13.6%	8
	answered question	**59**
	skipped question	**0**

7. If you were not housed permanently within a month of staying in a shelter, why do you think it took so long?

	Response Count
	36
answered question	**36**
skipped question	**23**

8. Do you currently have a paying job?

	Response Percent	Response Count
Yes	16.9%	10
No	**79.7%**	**47**
Don't want to answer	3.4%	2
answered question		**59**
skipped question		**0**

9. If you answered "yes" to the question above, is your job part-time or full-time?

	Response Percent	Response Count
Part-time	**60.0%**	**6**
Full-time	40.0%	4
answered question		**10**
skipped question		**49**

10. What services or assistance do you or did you need the most when you were homeless? Check all that apply.

		Response Percent	Response Count
Rental Assistance		55.9%	33
Funding for assistance other than rent—things like deposits, utilities, rental applications, or other financial assistance		35.6%	21
Help finding a job		**62.7%**	**37**
Help with life skills such as how to care for an apartment		18.6%	11
Emergency shelter		54.2%	32
Transitional housing		42.4%	25
Substance use treatment		28.8%	17
Health care		50.8%	30
Help finding an apartment		27.1%	16
Mental health treatment		18.6%	11
Help with budgeting		20.3%	12
Case management		33.9%	20
Other (please specify)		3.4%	2
		answered question	**59**
		skipped question	**0**

11. What services or help were you offered when you were homeless? Check all that apply.

	Response Percent	Response Count
Rental Assistance	26.8%	15
Funding for assistance other than rent—things like deposits, utilities, rental applications, or other financial assistance	19.6%	11
Help finding a job	41.1%	23
Help with life skills such as how to care for an apartment	21.4%	12
Emergency shelter	**67.9%**	**38**
Transitional housing	26.8%	15
Substance use treatment	32.1%	18
Health care	32.1%	18
Help finding an apartment or other permanent housing	10.7%	6
Mental health treatment	17.9%	10
Help with budgeting	12.5%	7
Case management	35.7%	20
Other	7.1%	4
	(please specify)	3
	answered question	**56**
	skipped question	**3**

12. It was easy for me to find services to help me when I became homeless.

		Response Percent	Response Count
Strongly Disagree		13.6%	8
Disagree		20.3%	12
Neither Disagree or Agree		20.3%	12
Agree		**32.2%**	**19**
Strongly Agree		13.6%	8
		answered question	**59**
		skipped question	**0**

13. I am satisfied with the quality of services I received while homeless.

		Response Percent	Response Count
Strongly Disagree		16.9%	10
Disagree		1.7%	1
Neither Disagree or Agree		8.5%	5
Agree		**54.2%**	**32**
Strongly Agree		18.6%	11
		answered question	**59**
		skipped question	**0**

14. I am satisfied with how I was treated by service providers in my community while homeless.

	Response Percent	Response Count
Strongly Disagree	15.3%	9
Disagree	8.5%	5
Neither Disagree or Agree	10.2%	6
Agree	**42.4%**	**25**
Strongly Agree	23.7%	14
	answered question	**59**
	skipped question	**0**

15. My community has all the services needed to help someone find and keep good permanent housing.

	Response Percent	Response Count
Strongly Disagree	18.6%	11
Disagree	20.3%	12
Neither Disagree or Agree	20.3%	12
Agree	**22.0%**	**13**
Strongly Agree	18.6%	11
	answered question	**59**
	skipped question	**0**

16. I felt that the services I received while homeless were focused on helping me get into permanent housing as quickly as possible.

	Response Percent	Response Count
Strongly Disagree	13.6%	8
Disagree	16.9%	10
Neither Disagree or Agree	22.0%	13
Agree	**28.8%**	**17**
Strongly Agree	18.6%	11
	answered question	**59**
	skipped question	**0**

17. The different agencies/organizations in my community work well together.

	Response Percent	Response Count
Strongly Disagree	10.2%	6
Disagree	13.6%	8
Neither Disagree or Agree	23.7%	14
Agree	**33.9%**	**20**
Strongly Agree	18.6%	11
	answered question	**59**
	skipped question	**0**

18. To get help, I was sometimes asked to do things that I didn't want to do.

	Response Percent	Response Count
Strongly Disagree	11.9%	7
Disagree	15.3%	9
Neither Disagree or Agree	18.6%	11
Agree	**33.9%**	**20**
Strongly Agree	20.3%	12
	answered question	**59**
	skipped question	**0**

19. I felt that I got to "call the shots" about when and how I received services.

	Response Percent	Response Count
Strongly Disagree	15.3%	9
Disagree	**35.6%**	**21**
Neither Disagree or Agree	16.9%	10
Agree	20.3%	12
Strongly Agree	11.9%	7
	answered question	**59**
	skipped question	**0**

20. Homelessness in this community can be ended some time within the next 10 years.

	Response Percent	Response Count
Strongly Disagree	25.4%	15
Disagree	18.6%	11
Neither Disagree or Agree	18.6%	11
Agree	**27.1%**	**16**
Strongly Agree	10.2%	6
	answered question	**59**
	skipped question	**0**

21. Thinking about the most recent time you became homeless, what could have PREVENTED you from becoming homeless? Check all that apply.

	Response Percent	Response Count
Rental Assistance	**54.2%**	**32**
Funding for assistance other than rent—things like deposits, utilities, rental applications, or other financial assistance	40.7%	24
Help finding a job	49.2%	29
Help with life skills such as how to care for an apartment	22.0%	13
Substance use treatment	23.7%	14
Health care	23.7%	14
Help finding another apartment	28.8%	17
Mental health treatment	15.3%	9
Help with budgeting	22.0%	13
Case management	22.0%	13
Other (please specify)	13.6%	8
	answered question	**59**
	skipped question	**0**

22. Do you think that you may become homeless in the future?

	Response Percent	Response Count
Yes	13.6%	8
No	**54.2%**	**32**
I don't know	32.2%	19
	answered question	**59**
	skipped question	**0**

23. Did you feel any pressure to complete this survey or did anyone force you to take this survey?

	Response Percent	Response Count
Yes	0.0%	0
No	**100.0%**	**59**
	answered question	**59**
	skipped question	**0**

APPENDIX F:
SERVICE PROVIDER SURVEY RESULTS

1. Name of the organization I work/volunteer for:

	Response Count
	41
answered question	**41**
skipped question	**0**

2. What is the mission of your organization?

	Response Count
	38
answered question	**38**
skipped question	**3**

3. Our community has a plan to end homelessness within a defined period of time.

		Response Percent	Response Count
Yes		**75.6%**	**31**
No		14.6%	6
I don't know		9.8%	4
	answered question		**41**
	skipped question		**0**

4. Our plan to end homelessness is consistent with or can be aligned with the HEARTH Act and the Federal Strategic Plan to Prevent and End Homelessness.

	Response Percent	Response Count
Yes	**61.0%**	**25**
No	4.9%	2
I don't know	29.3%	12
We don't have a community plan to end homelessness	4.9%	2
answered question		**41**
skipped question		**0**

5. I believe my community has a comprehensive and effective discharge plan.

	Response Percent	Response Count
Strongly Disagree	14.6%	6
Disagree	14.6%	6
Neither Disagree nor Agree	22.0%	9
Agree	**36.6%**	**15**
Strongly Agree	12.2%	5
answered question		**41**
skipped question		**0**

6. Our community uses a universal process and/or tool at intake that helps us assess the most appropriate resources for each consumer's needs.

	Response Percent	Response Count
Yes	**75.6%**	**31**
No	9.8%	4
I don't know	14.6%	6
	answered question	**41**
	skipped question	**0**

7. Our community has a periodic review process to evaluate our targeting strategy as well as the overall assessment and resource allocation process.

	Response Percent	Response Count
Yes	**75.6%**	**31**
No	7.3%	3
I don't know	17.1%	7
	answered question	**41**
	skipped question	**0**

8. Consumers are prioritized for housing, financial assistance, and services based on their needs instead of first come, first served.

		Response Percent	Response Count
Strongly Disagree		4.9%	2
Disagree		7.3%	3
Neither Disagree nor Agree		17.1%	7
Agree		**56.1%**	**23**
Strongly Agree		14.6%	6
		answered question	**41**
		skipped question	**0**

9. Please answer the following questions as they pertain to housing consumers (unless otherwise indicated, you should assume the question is being asked about your organization).

	Yes	No	Unsure	Response Count
Choices are provided to consumers about where they can be permanently housed based on their preferences and income.	**67.5% (27)**	10.0% (4)	22.5% (9)	40
Permanent housing needs are assessed within a week of a consumer's entry into any community shelter.	35.9% (14)	17.9% (7)	**46.2% (18)**	39
Most consumers are successfully supported in stabilizing in permanent housing.	**50.0% (20)**	32.5% (13)	17.5% (7)	40
The community has an updated listing of available affordable housing units within its boundaries.	**65.9% (27)**	17.1% (7)	17.1% (7)	41
The community has staff dedicated specifically to providing permanent housing location services to consumers.	**47.5% (19)**	37.5% (15)	15.0% (6)	40
			answered question	**41**
			skipped question	**0**

10. Please answer these additional questions about housing consumers.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Response Count
Whenever possible, our community employs strategies that prevent people from losing their housing and divert them away from needing shelter or other housing assistance.	2.4% (1)	17.1% (7)	22.0% (9)	**46.3% (19)**	12.2% (5)	41
The community has sufficient rapid re-housing resources in place that assist consumers in being re-housed into permanent housing quickly (<45 days) should they become homeless.	10.0% (4)	**45.0% (18)**	25.0% (10)	17.5% (7)	2.5% (1)	40
The community has been successful engaging landlords and finding new ones who are amenable to housing formerly homeless people.	9.8% (4)	14.6% (6)	**43.9% (18)**	29.3% (12)	2.4% (1)	41
We have an adequate supply of affordable permanent and permanent supportive housing in our community that can accommodate each person's place in the life cycle with the needed level of support.	22.0% (9)	**41.5% (17)**	14.6% (6)	19.5% (8)	2.4% (1)	41
Community wide, landlords who house consumers are actively supported through regular communication and a check-in to ensure rent is paid on time and in full each month.	7.3% (3)	12.2% (5)	**48.8% (20)**	29.3% (12)	2.4% (1)	41
					answered question	**41**
					skipped question	**0**

11. Please answer the following questions pertaining to your qualifications, training and expertise.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Response Count
I am knowledgeable of the essential elements of diversion/prevention programs.	0.0% (0)	9.8% (4)	14.6% (6)	**51.2% (21)**	24.4% (10)	41
I am knowledgeable of the essential elements of rapid re-housing programs.	4.9% (2)	9.8% (4)	14.6% (6)	**56.1% (23)**	14.6% (6)	41
I am knowledgeable of the essential elements of permanent supportive housing programs.	4.9% (2)	4.9% (2)	7.3% (3)	**61.0% (25)**	22.0% (9)	41
I understand the Stages of Change and how the various stages apply to my work with consumers.	7.3% (3)	7.3% (3)	12.2% (5)	**51.2% (21)**	22.0% (9)	41
I comprehensively understand strength-based support strategies.	2.6% (1)	7.7% (3)	10.3% (4)	**48.7% (19)**	30.8% (12)	39
I am comprehensively trained in Motivational Interviewing.	5.0% (2)	15.0% (6)	5.0% (2)	**42.5% (17)**	32.5% (13)	40
I am comprehensively trained in data storage and rules of disclosure including legal requirements pertaining to confidentiality and privacy.	2.4% (1)	0.0% (0)	4.9% (2)	43.9% (18)	**48.8% (20)**	41
I am comprehensively trained and/or have experience to address life changes, including: new partner, return of children, relationship break-up, etc.	2.4% (1)	4.9% (2)	12.2% (5)	**46.3% (19)**	34.1% (14)	41
I have an understanding of cognitive impairments such as brain injuries, Fetal Alcohol Spectrum Disorders, severe and persistent mental illness,etc.	0.0% (0)	2.4% (1)	9.8% (4)	**58.5% (24)**	29.3% (12)	41
I have a strong understanding of the effects of trauma.	0.0% (0)	0.0% (0)	9.8% (4)	**56.1% (23)**	34.1% (14)	41

I have a strong understanding of the impact and behaviors associated with sexual abuse.	0.0% (0)	2.5% (1)	15.0% (6)	**55.0% (22)**	27.5% (11)	40
I have expertise in how to access and navigate income supports and benefits systems.	4.9% (2)	9.8% (4)	19.5% (8)	**46.3% (19)**	19.5% (8)	41
I have expertise in other community services available to the consumers with whom I work.	0.0% (0)	2.4% (1)	2.4% (1)	**65.9% (27)**	29.3% (12)	41
I have received appropriate cultural competency training.	2.5% (1)	2.5% (1)	2.5% (1)	**50.0% (20)**	42.5% (17)	40
					answered question	**41**
					skipped question	**0**

12. I do not attempt to provide services that I am unqualified or untrained to deliver.

		Response Percent	Response Count
Yes		**78.0%**	**32**
No		22.0%	9
		answered question	**41**
		skipped question	**0**

13. There are appropriate staff to consumer ratios in my organization for the type of work that we deliver.

	Response Percent	Response Count
Strongly Disagree	14.6%	6
Disagree	9.8%	4
Neither Disagree nor Agree	19.5%	8
Agree	**36.6%**	**15**
Strongly Agree	19.5%	8
	answered question	**41**
	skipped question	**0**

14. Our organization supports and participates in joint meetings/case conferences regarding specific consumers in order to coordinate our efforts with other service providers in our community.

	Response Percent	Response Count
Strongly Disagree	2.4%	1
Disagree	2.4%	1
Neither Disagree nor Agree	4.9%	2
Agree	43.9%	18
Strongly Agree	**46.3%**	**19**
	answered question	**41**
	skipped question	**0**

15. I strive to help consumers connect with other resources, services and organizations to best meet their needs.

		Response Percent	Response Count
Strongly Disagree		9.8%	4
Disagree		0.0%	0
Neither Disagree nor Agree		2.4%	1
Agree		19.5%	8
Strongly Agree		**68.3%**	**28**
		answered question	**41**
		skipped question	**0**

16. As a community, we routinely reflect on data from either our HMIS or other case management software to understand who we are serving and not serving well and make adjustments to our service delivery accordingly.

		Response Percent	Response Count
Strongly Disagree		7.3%	3
Disagree		12.2%	5
Neither Disagree nor Agree		**34.1%**	**14**
Agree		22.0%	9
Strongly Agree		24.4%	10
		answered question	**41**
		skipped question	**0**

17. In our community, consumers who are entering or already engaged in a crisis are quickly identified and assisted.

	Response Percent	Response Count
Strongly Disagree	4.9%	2
Disagree	9.8%	4
Neither Disagree nor Agree	17.1%	7
Agree	**43.9%**	**18**
Strongly Agree	24.4%	10
	answered question	**41**
	skipped question	**0**

18. Our community separates crisis responses from longer-term support or case management responses.

	Response Percent	Response Count
Yes	**63.4%**	**26**
No	12.2%	5
I don't know	24.4%	10
	answered question	**41**
	skipped question	**0**

19. Services are distributed across the community so consumers can effectively access services in different locations.

		Response Percent	Response Count
Yes		**73.2%**	**30**
No		7.3%	3
I don't know		19.5%	8
		answered question	**41**
		skipped question	**0**

20. Programs and services have been implemented that respect and serve the needs of identified sub-populations, including: survivors of domestic violence, veterans, youth, seniors, immigrants, etc.

		Response Percent	Response Count
Strongly Disagree		7.3%	3
Disagree		0.0%	0
Neither Disagree nor Agree		19.5%	8
Agree		**53.7%**	**22**
Strongly Agree		19.5%	8
		answered question	**41**
		skipped question	**0**

21. The services we offer the clients we serve—either in-house or through direct referrals to other services in the community—include the following: (check all the services that apply)

	Response Percent	Response Count
Rental Assistance	53.7%	22
Funding for assistance other than rent—things like deposits, utilities, rental applications, or other financial assistance	46.3%	19
Help finding a job	73.2%	30
Help with life skills such as how to care for an apartment	68.3%	28
Emergency shelter	73.2%	30
Transitional housing	78.0%	32
Substance use treatment	75.6%	31
Health care	70.7%	29
Help finding an apartment	61.0%	25
Mental health treatment	82.9%	34
Help with budgeting	75.6%	31
Case management	**87.8%**	**36**
Other Services (please specify)	29.3%	12
	answered question	**41**
	skipped question	**0**

22. I believe that I am accountable for getting consumers into permanent housing as quickly as possible.

		Response Percent	Response Count
Strongly Disagree		4.9%	2
Disagree		12.2%	5
Neither Disagree nor Agree		22.0%	9
Agree		**39.0%**	**16**
Strongly Agree		22.0%	9
		answered question	**41**
		skipped question	**0**

23. We use a methodological approach to collect information from consumers regarding their impressions of our programs and services.

		Response Percent	Response Count
Strongly Disagree		2.4%	1
Disagree		7.3%	3
Neither Disagree nor Agree		14.6%	6
Agree		**48.8%**	**20**
Strongly Agree		26.8%	11
		answered question	**41**
		skipped question	**0**

APPENDIX G:
COORDINATED ASSESSMENT CHECKLIST

This checklist, developed by the Alliance, is meant to help communities conceptualize what issues they should begin considering early on in the coordinated assessment planning process. It also offers a timeline within which these actions might take place, though this timeline will vary by community.

PHASE I: PLANNING AND PREPARATION (30-60 DAYS)

€ Establish Planning Committee

The committee should have 5 to 10 people, including key stakeholders. The planning committee oes not necessarily have to do all the work, but it should have input and a lot of influence over the outcome. Key participants include the following:

- One to two shelter operators;
- Government officials, including the person responsible for Emergency Solutions
- The Continuum of Care (CoC) lead agency; and
- Other major funders (foundation, United Way, etc.).

€ Identify Target Population

Will the coordinated assessment process begin by serving everybody who becomes homeless, or will it start with one population (e.g. families with children) and then expand to serve other populations?

€ Decide on the Structure of Coordinated Assessment

Evaluate the possibilities, including one centralized location, multiple intake locations (a decentralized model), and a "no wrong door" approach (where any agency can conduct the evaluation and make a referral). Decide whether assessments will be done in person, by phone, or both. Decide whether and how the assessment process will be integrated with 2-1-1 or other call centers.

€ Integrate Prevention and Shelter Diversion

Identify prevention and diversion resources that should be available at the coordinated assessment center(s).

€ Map out the Existing Assessment and Intake Process

Create a map of the existing assessment, intake, and referral process and how people move through the system within it. What are the flaws with this process and how can they be addressed with a more coordinated approach? What are the good aspects that should be included in the new model?

€ Sketch out a Preliminary Needs Assessment/Screening Tool

Identify questions to be asked and begin mapping how referrals will work. This should be very basic and will be modified as the process moves forward.

PHASE II: IMPLEMENTATION (4-6 MONTHS)

€ Identify the Organization(s) That Will Host Coordinated Assessment

Which organizations have the space, staff capacity, and availability to host the intake, if any? Will there need to be multiple organizations or just one? What changes need to be made to enable the organization to take on multiple responsibilities? Communities may have different organizations for each different subpopulation (families, unaccompanied youth, etc.).

€ Identify Additional Staffing and Resource Needs
Think about what staff you will use at the coordinated assessment points and how many you will there need to be multiple organizations or just one? What changes need to be made to enable the organization to take on multiple responsibilities? Communities may have different organizations for each different subpopulation (families, unaccompanied youth, etc.).

€ Identify Additional Staffing and Resource Needs
Think about what staff you will use at the coordinated assessment points and how many you will need based on anticipated intake volume. Trained case managers will be crucial to the success of the assessment process. Technological needs, including computers and the necessary data management programs, access to information on community resources, etc. will all be necessary.

€ Obtain Resources
Obtain the resources needed by either pulling them from elsewhere in the community (e.g., having providers agree to "share" case management staff with the coordinated entry points) or hiring new staff.

€ Identify Data and HMIS Needs
Make sure the current HMIS system can collect and report out on the outcomes relevant to coordinated assessment. Create capacity to identify bed availability in real time.

€ Train People on the Data and HMIS Procedures Involved in Coordinated Assessment Process
Staff should be trained on when to start entering data, what data must be entered, and how to share data with referral organizations.

€ Begin Changing Contract Language to Ensure That as Many Partners as Possible Are Participating in the Coordinated Assessment Process
The community should offer strong incentives to providers to participate in coordinated assessment, including tying receipt of funds to participation. This could be accomplished through the advent of a performance-based contracting process.

€ Create a Plan for How the Coordinated Assessment Will Be "Switched On"
A firm plan should be established that includes dates, times, and contingency plans in case anything should go wrong.

€ Finalize the Version of the Screening/Assessment Tool That Will Be Used When the Coordinated Intake Goes Into Effect
Make sure that intake staff is familiar with the assessment tool and how to make referrals based on the information within it before the new coordinated assessment process goes into effect.

€ Create a Specific Referral Process
What constitutes a referral? How does the referral get made? When must an organization accept a referral? When can it be denied, and what happens when referrals are denied?

€ Identify a Process for Evaluating and Making Adjustments to the Coordinated Assessment Process
This may involve having a version of the planning committee that continues to oversee the coordinated assessment process. How often will evaluation meetings occur? How will changes to the intake process be decided upon? What are the key outcome measures?

€ Create a Communications Plan

Key partners in the community, including mainstream service partners, government officials, consumers, and the general public will need to be notified about how the new coordinated assessment works. Social media, brochures, and informational meetings are just some of the avenues communities could use to make this happen.

€ Identify Additional Staffing and Resource Needs

Think about what staff you will use at the coordinated assessment points and how many you will need based on anticipated intake volume. Trained case managers will be crucial to the success of the assessment process. Technological needs, including computers and the necessary data management programs, access to information on community resources, etc. will all be necessary.

PHASE 3: FLIP THE SWITCH: BEGIN UTILIZING THE COORDINATED ASSESSMENT SYSTEM (ONGOING)

€ Evaluate Coordinated Assessment

Evaluate the new process on the following metrics:

- Are there long waiting lists, if so what adjustments need to be made in the referral process?
- Is the evaluation tool working? Are there questions that should be eliminated or different questions that should be asked?

The community should also use the tools in this toolkit when evaluating their success:

Coordinated Assessment Questionnaire

Coordinated Assessment Evaluation Tool

APPENDIX H:
COORDINATED ASSESSMENT EVALUATION TOOL

Coordinated Assessment Evaluation Tool

Communities can use this tool as a quick way to assess how well their coordinated assessment system is functioning. The tool has two parts: one part should be completed before a coordinated assessment process has been implemented, and one part should be completed six months to a year after implementation. Embedded in the tool are instructions explaining how communities can gather the information needed for the evaluation. As with the other tools, communities should feel free to modify this tool as they see fit.

More detailed instructions on how to use this evaluation tool are in red.

Part I: Before Implementing Coordinated Assessment

Choose a six month reporting period to answer the following questions. Fill in as much information as you can.

1. Number of organizations currently doing assessments and referrals: _____
   Any organization doing assessments of consumer need, including individual programs and designated assessment centers, and making referrals or admitting households to other homeless or housing programs should be included.

2. Program Table

Type of Organization	Number of Organizations in Each Program Type	Total Number of Entries into Each Program Type	Rate of Exits to Permanent Housing*
Prevention/Diversion			
Emergency Shelter			
Transitional Housing			
Rapid Re-housing			N/A
Permanent Supportive Housing			N/A
Other Types of Housing/Programs			

   *Rate of Exits to Permanent Housing equals the number of people that exit each program type in the given six month period for permanent housing divided by the total number of people that exited each program type within that six month period.

3. System Outcomes

   Average Length of Stay in Emergency Shelter Programs

   Singles: _____ Families*: _____ Youth: _____

Average Length of Stay in Transitional Housing Programs

Singles: _____ Families: _____ Youth: _____

New Entries into Homelessness

Singles: _____ Families: _____ Youth: _____

* Communities should define 'family' in a way that makes sense to them.

4. Coordinated Assessment Questionnaire

List the most popular response to each question from the Coordinated Assessment Questionnaire, which is part of the Coordinated Assessment Toolkit.

Question 2. Where did you go to get help when you became homeless?

Question 3. When you became homeless, was someone able to place you into emergency shelter, permanent housing, or another housing program immediately?

Question 4. After intake, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

Question 6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

5. Longer Qualitative Assessment Tool Responses

Survey for Consumers
Survey for Community Leaders/Executive Directors
Survey for Direct Service Provider/Front Line Staff
Analyze using the **Survey Analysis Sheet.**

Document any general trends present in the surveys, especially areas of concern.

6. Does the community have a system-wide wait list for services?

☐ Yes ☐ No

7. Size of the wait list for homeless assistance (system-wide; if no system numbers available, use program type numbers)

_____ waiting for shelter

_____ waiting for transitional housing

_____ waiting for rapid re-housing

_____ waiting for permanent supportive housing

_____ waiting for other interventions

_____ total

We recommend adding a space on your assessment tool to document where the person was ultimately sent (their "secondary referral") and where they would've ideally been sent based on the results of your assessment ("primary referral") had that resource been available. For example, if the assessment indicated that a person should receive prevention assistance but no funds were available and they had to go to shelter, you would write 'prevention' as the primary referral and 'shelter', along with the name of the shelter, as the secondary referral. If they were eligible for rapid re-housing and were referred to the appropriate rapid re-housing program, that program would be listed as both the primary and secondary referral. Both the program type and name of the program the person was referred to should be noted.

Part II: After Coordinated Assessment (six months – one year after implementation and every six months thereafter)

1. Number of organizations currently doing assessment and intake: _____
   Any organization doing assessments of consumer need, including individual programs and designated assessment centers, and making referrals or admitting households to other homeless or housing programs should be included.

   How many "side doors" does your community have (organizations that participate in the coordinated assessment model but admit clients coming from places other than the coordinated assessment centers into their programs)? _____

   How many organizations are there that do not participate in the coordinated assessment process and do their own intake and assessment? _____

2. Program Table

Type of Organization	Number of Organizations in Each Program Type	Number of Primary Referrals Made to Program Type*	Number of Secondary Referrals Made to Program Type**	Rate of Exits to Permanent Housing
Prevention/Diversion				
Emergency Shelter				
Transitional Housing				
Rapid Re-housing				N/A
Permanent Supportive Housing				N/A
Other Types of Housing/Programs				

   *Number of Referrals (Primary): Number of referrals made because this housing option was determined to be the best choice for the client.

   **Number of Referrals (Secondary): Number of referrals made because this housing option had bed availability at the time of intake (secondary referrals would only be made if first choice option wasn't available). If a community does not separate primary and secondary referrals, communities should insert the number of referrals made to this program type in this column.

3. System Outcomes

   Average Length of Stay in Emergency Shelter Programs

Singles: _____ Families: _____ Youth: _____

Average Length of Stay in Transitional Housing Programs

Singles: _____ Families: _____ Youth: _____

New Entries into Homelessness:

Singles: _____ Families: _____ Youth: _____

4. Coordinated Assessment Questionnaire

List the most popular response to each question from the Coordinated Assessment Questionnaire, which is part of the Coordinated Assessment Toolkit.

Question 2. Where did you go to get help when you became homeless?

Question 3. When you became homeless, was someone able to offer you prevention assistance or place you into emergency shelter, permanent housing, or another housing program immediately?

Question 4. After intake, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

Question 6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

5. Qualitative Assessment Tool Responses

Survey for Consumers
Survey for Community Leaders/Executive Directors
Survey for Direct Service Provider/Front Line Staff
Analyze using the **Survey Analysis Sheet.**

Document any changes since the first survey administration.

6. Does the community have a system-wide wait list for services?

☐ Yes ☐ No

7. Size of Wait List (system-wide; if no system numbers available, average among programs)

_____ waiting for shelter

_____ waiting for transitional housing

_____ waiting for rapid re-housing

_____ waiting for permanent supportive housing

_____ waiting for other interventions

_____ total

To determine success:

The following factors might indicate success with coordinated assessment:

- The number of organizations doing individual intake and assessment decreased
- There are no "side doors" in the community
- Average length of stay in homelessness is decreasing
- Rate of exits into permanent housing for every intervention has increased
- New entries into homelessness have decreased
- Consumers are most often naming the designated intake point(s) as a response to question number two on the Coordinated Assessment Questionnaire
- There is a centralized wait list now (if there wasn't before) or no wait list at all
- The number of organizations consumers had to work with before getting into permanent housing has decreased (Coordinated Assessment Questionnaire question number six)
- Most referrals are being made under the "primary" category

Consider making adjustments to your system (such as modifying program types or changing who receives Continuum of Care funding if):

- Primary and secondary referrals are not matching up
- The same consumer concerns are coming up in the surveys pre- and post-implementation of a coordinated assessment

Coordinated Entry Assessment Questionnaire

For Survey Administrators:

This survey of consumers (people experiencing homelessness or that formerly experienced homelessness) can be used as an evaluation tool to determine if coordinated assessment is creating a shorter path for consumers between homelessness and a return to permanent housing. The questionnaire ties into the **Coordinated Assessment Evaluation Tool**, but can be used independently.

It is crucial that as communities move forward they include consumers in the evaluation process; after all, coordinated assessment systems are meant to serve them more efficiently. The questionnaire should be administered at consistent intervals before and after a coordinated assessment has been implemented; suggestions and responses should be taken seriously and used to aid in the process of making adjustments or changes to the assessment system. Consumers should never be pressured or mandated to take the survey. Communities should feel free to develop their own system for how the survey is administered, change the questions in the survey, and make decisions about how the consumers to be surveyed are selected.

For Consumers:

Thank you for taking this survey about your experiences. Everything you say here will be anonymous. We will use these surveys to improve the way we serve people experiencing homelessness in our community.

There may be some terms in the survey that you are unfamiliar with. To help, here is how we define the following words in the survey:

Permanent Housing: Housing that you live in and can stay in or leave whenever you want. It may be an apartment with your name on the lease or a house. It may also be a place where you are staying with somebody else, but are allowed to stay or leave whenever you want. An emergency shelter or other program bed (described below) would **not** be considered permanent housing.

Program Bed: A bed or apartment-like unit in an emergency shelter, transitional housing, recovery program, or other program where you can only live temporarily (NOT permanent housing).

Homeless Assistance Organization or Program: Any program or organization that offers services or housing to someone who is about to lose their housing or has already become homeless.

1. What category below would best have described the last time you were homeless (or describes you now if you are currently homeless)?

☐ Single Adult

☐ Unaccompanied Youth (18 to 24 years old)

☐ Adult in a homeless family (that includes children)

☐ Child in a homeless family (that is 18 years old or younger)

☐ Adult in a homeless couple

☐ Other _____

2. Where did you go to get help when you became homeless?

Write name of organization here: _____

3. When you became homeless, was someone able to place you into emergency shelter, permanent housing, or another housing program immediately?

☐ Yes ☐ No

4. After you were assessed for your needs related to your homeless episode, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

☐ Directly to permanent housing

☐ Sent somewhere else first

☐ I was not assessed/asked questions about what I needed when I asked for help with my homeless episode

5. Are you currently housed in permanent housing?

☐ Yes ☐ No

6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ More than four

7. (If you are currently housed in permanent housing): How much time passed between the first time you went to get homeless assistance and the day you got into permanent housing?

- ☐ Less than a month
- ☐ One to three months
- ☐ Four to six months
- ☐ Seven to nine months
- ☐ Ten to twelve months
- ☐ More than a year
- ☐ Between a year and two years
- ☐ Between two years and three years
- ☐ Other _____

8. (If you are NOT currently housed in permanent housing): How much time has passed since the first time you went to get assistance at the organization you listed in question two?

☐ Less than a month

☐ One to three months

☐ Four to six months

☐ Seven to nine months

☐ Ten to twelve months

☐ More than a year

☐ Between a year and two years

☐ Between two years and three years

☐ Other _____

9. (If you are NOT currently housed in permanent housing): When do you expect to be permanently housed?

☐ Within one month

☐ Within two months

☐ Within three to six months

☐ More than six months from now

☐ I don't know

10. (If you are currently housed in permanent housing): Do you think that you may become homeless again in the future?

☐ Yes ☐ No

11. (If you answered yes to question 10): When do you think that will happen?

☐ Within three months

☐ Three to six months from now

☐ Six to twelve months from now

☐ Over a year from now

12. (If you think that you will become homeless again in the future): Why do you think that might happen?

13. (If you are in permanent housing now): Are you satisfied with your housing?

☐ Yes ☐ No

14. (If you answered 'No' to question 13): If you are not satisfied with your current permanent housing, how can your housing needs be better met?

15. Did you feel any pressure to complete this survey or did anyone force you to take this survey?

☐ Yes ☐ No

APPENDIX I:
PRIORITIZATION STANDARDS

DEVELOPING WRITTEN STANDARDS FOR COORDINATED ASSESSMENT: SUGGESTED PRIORITIZATION CRITERIA		
INTERVENTION	**CURRENT KEY ELEMENTS OF PROGRAMS**	**PRIORITIZATION CRITERIA**
Transitional Housing	• Intensive services and housing, usually including employment/ education focus • Lasts for up to two years • Housing in a unit owned or otherwise controlled by the program • May offer a completely sober or "dry" living environment	For families and individuals: Multiple previous episodes of homelessness, In a transitional stage of life (e.g., recent dramatic life change) and *at least one of the following characteristics:* For individuals: • Re-entering from prison or jail • In recovery seeking a supportive or sober living environment • A young adult under the age of 18 that cannot be reunified with family For families: • Child welfare involvement
"Light" Rapid Re-housing	• Rapid movement from state of housing crisis into an apartment where they are on the lease (or have all the rights and responsibilities of a tenant) • One-time financial assistance or up to subsidy three months • Sample assistance program: ◦ Deposit and first months' rent if on their own lease, first months' rent if moving in with someone else; for families, more money or a longer subsidy upfront may be necessary ◦ Households should receive a shallow subsidy (approximately $300-$500 per month) and be reassessed for need at 3 months; if they are falling behind, subsidy should be extended ◦ Follow-up case management services tailored to household need, likely to last around six months or less (possibly up to 24 months) ◦ Linkages to mainstream resources and services	• Any first-time homeless individuals or families

DEVELOPING WRITTEN STANDARDS FOR COORDINATED ASSESSMENT: SUGGESTED PRIORITIZATION CRITERIA		
INTERVENTION	**CURRENT KEY ELEMENTS OF PROGRAMS**	**PRIORITIZATION CRITERIA**
"Heavy" Rapid Re-housing	• Rapid movement from state of housing crisis into an apartment where they are on the lease (or have all the rights and responsibilities of a tenant) • Sample assistance program: ◦ Deposit and first months' rent if on their own lease, first months' rent if moving in with someone else; for families, more money or a longer subsidy upfront may be necessary ◦ Households should receive a rental subsidy and be reassessed for need at 3 months; will most likely need subsidy for a total of 6-12 months, and possibly for up to 24 months ◦ Average cost of approximately $3000-$5000 per household • Follow-up case management services tailored to household need, likely to last around a year (possibly up to 24 months) • Linkages to mainstream resources and services	For individuals and families: Previous episodes of homelessness that lasted six months or more or Previously unsuccessful with "light" rapid re-housing once
Permanent Supportive Housing	• Wraparound services, often including a focus addressing on mental health, substance abuse, and behavioral health needs • Subsidized housing available for the entire lifetime of the household, usually through provision of a permanent subsidy	For individuals and families: Scores high on vulnerability index tool and For individuals: (if chronic homelessness is effectively nonexistent in the community) returned to homelessness from rapid re-housing more than once For families: prioritize according to number of episodes of prior homelessness

AMOUNT OF RENTAL SUBSIDIES:

Beyond what is mentioned in the section above, communities should establish a policy that allows them to be flexible depending on a household's needs. The goal in providing rental assistance should be to provide just enough to stabilize the household in housing. Thus, it's important that communities begin with an amount based on the models above and consistently re-evaluate the household's situation, preparing to increase or decrease the amount as needed. Communities should also be prepared to alter the amount based on the number of people it the household.

APPENDIX J:
PREVENTION AND DIVERSION ASSESSMENT TOOL

SAMPLE PREVENTION & DIVERSION ASSESSMENT TOOL

**Includes questions adapted from Hennepin County and Columbus YWCA assessment tools*

This assessment tool, based on Minneapolis/Hennepin County, Minnesota's and Columbus, Ohio's assessment forms, will be of use to communities attempting to determine if a household needs prevention or diversion assistance. This should be administered as soon as a household enters an assessment center to determine if they will need shelter or if they can be assisted and housed without having to enter the homeless assistance system. The prevention segment of this tool should be tweaked based on the community's data on its sheltered population. Prevention assistance should be targeted to those households that most closely resemble the households already in shelter. For more information on prevention targeting, please see the Alliance's paper, **Prevention Targeting 101**. For more on what shelter diversion is and what the benefits of it are, please read **Closing the Front Door: Creating a Successful Diversion Program for Homeless Families.**

Instructions for the person administering the tool are in red.

Start by gathering required data to begin HMIS entry and creating an identifier for the household/household members.

Introductory Questions

1. **Are you homeless (living on the street, staying in an emergency shelter or transitional housing program, fleeing domestic violence) or at-risk of homelessness?**

   ☐ Yes ☐ No
   If the household is not homeless or at-risk, refer to other mainstream resources.

2. **Where did you stay last night?**

   ☐ With a friend/family member/other doubled up situation
   Skip to Diversion Questions.

   ☐ A hospital

   ☐ Jail/prison

   ☐ Juvenile detention facility

   ☐ In a hotel/motel

☐ In a foster care/group home

☐ In a substance abuse treatment facility

☐ In my own housing – rental
Skip to Prevention Questions.

☐ In my own housing – owned
Refer household to foreclosure prevention resources if necessary.

☐ In a car, on the street, or in another place not meant for human habitation

☐ In other housing _____
Ask household to define "other housing."

3. What brought on your housing crisis?

☐ Problems with landlord
If yes, ask what specific issues are. Interpersonal? Disputes about the unit? Problems being caused by the tenant? Not paying rent? Make a note of the answer. Use this answer to determine what kind of mediation or conflict resolution is necessary.

☐ Have rental or utility arrears (circle which)
If yes, list amount owed: $_____

☐ Evicted or in the process of being evicted from a private dwelling or housing provided by family or friends

☐ Victim of foreclosure on rental property
If yes, skip to Diversion Questions.

☐ Living in housing that has been condemned
If yes, skip to Diversion Questions.

☐ Unable to pay rent

☐ Experiencing high overcrowding
If yes, determine extent of overcrowding in the unit. If situation seems untenable, skip to Diversion Questions.

☐ Violence or abuse occurring in the family's household
If the household is in immediate danger, refer them to law enforcement and/or the appropriate domestic violence provider.

☐ Other _____
Ask household describe "other."

Diversion Questions

4. **Are you safe in your current living situation?**

   ☐ Yes ☐ No
   If no, but household is otherwise eligible for diversion, divert them to a location other than where they are currently staying and make sure that it is somewhere where the household feels safe.

5. **Is there anyone else you and your family could stay with for at least the next three (3) to seven (7) days if you were able to receive case management services/transportation assistance/limited financial support?**

   ☐ Yes ☐ No
   Help family think through potential places – with family, friends, co-workers. Have them identify what barriers they think exist to staying in a certain location and how they might be overcome.

   If answer to this question is yes, household qualifies for diversion assistance. Skip to Concluding Questions.

   If answer to this question is no and shelter diversion has therefore been ruled out, go to Prevention Questions.

Prevention Questions

6. **Are you safe in your current living situation?**

   ☐ Yes ☐ No
   If no, admit or refer to emergency shelter.

7. **Do you believe you will become homeless within the next seven (7) days?**

   ☐ Yes ☐ No
   At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

8. **Have you ever been to a shelter or another homeless assistance program before?**

   ☐ Yes ☐ No
   At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

9. **If you answered yes to the previous question, what was the name of the program?**

   _____

   When were you last there? ____/____/_____

10. **Household income is at or below 30 percent of AMI**

    ☐ Yes ☐ No
    If the community has data on sheltered households, they should adjust the percentage accordingly. At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

11. **Has household experienced homelessness in the last 12 months?**

    ☐ Yes ☐ No
    At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

***If community has data on sheltered households available, it should use this data to shape the development of this assessment tool and add more questions as more information on sheltered households becomes available. In every case that the household being assessed matches a sheltered household, one point should be added (e.g., if most households entering shelter are exiting jail or prison, and the household being assessed is exiting jail or prison, they should receive one additional point). The total points needed to be eligible for prevention should be adjusted accordingly as additional questions are added to this tool. Some examples of questions to be added:

- Prior living situation matches most common prior living situation of sheltered households (look at response to question two)
- Trigger of housing crisis matches most common housing crisis for sheltered households (look at response to question three)
- Household composition matches that of sheltered households (singles vs. families, age of head of household, number of children, etc.)

Total Prevention Points: _____

Provide prevention assistance if household has at least three points (remember to adjust the number of points necessary if adding additional questions).

Concluding Questions – Case Manager Only

1. **Does client qualify for diversion assistance?**

   ☐ Yes ☐ No
   If no, attempt to make appropriate referrals to other available community/mainstream resources.

2. **If so, what kind of assistance do they need initially to be successfully diverted?**

   ☐ Landlord mediation

   ☐ Conflict resolution with potential roommate

   ☐ Rental assistance (Amount _____)

   ☐ Utility assistance (Amount _____)

   ☐ Other financial assistance (Amount _____)

☐ Other assistance (Define: _____)

3. **Does client qualify for prevention assistance?**

   ☐ Yes ☐ No
   If no, attempt to make appropriate referrals to other available community/mainstream resources.

4. **If so, what kind of assistance do they need initially to be successfully diverted?**

   ☐ Landlord mediation

   ☐ Conflict resolution with potential roommate

   ☐ Rental assistance (Amount _____)

   ☐ Utility assistance (Amount _____)

   ☐ Other financial assistance (Amount _____)

   ☐ Other assistance (Define: _____)

This concludes the assessment.

See next page for the follow-up form.

Follow-Up Form (Case Manager/Assessment Staff Only)

1. **Was the household diverted from entering shelter? (If no, skip to question two).**

   ☐ Yes ☐ No

   If yes, to where:

   ☐ Friend's house

   ☐ Family member's housing

   ☐ Previous housing

   ☐ Other (please describe): _____

   How long were they in this housing? Number of days: _____

2. **Did the household receive prevention assistance?**

   ☐ Yes ☐ No

   What type?

   ☐ Utility assistance in the amount of $_____

   ☐ Rental assistance in the amount of $_____

   ☐ Security deposit in the amount of $_____

   ☐ Moving costs in the amount of $_____

   ☐ Other $_____

   <u>After 30 Days…</u>

   1. **Did they find permanent housing?**

   ☐ Yes ☐ No

   <u>After 90 Days…</u>

   1. **Have they come back to shelter/the homeless assistance system since being diverted?**

   ☐ Yes ☐ No

   2. **Are there whereabouts known?**

      ☐ Yes ☐ No

      3. **If they are known, where do they live currently?**

      ☐ Remained in initial housing

      ☐ Relocated to different permanent housing unit

      ☐ In homeless assistance system

      4. **If they "remained in initial housing" or "relocated to different permanent housing unit," how long have they been there? Number of Days: _____**

APPENDIX K:
PREVENTION TARGETING 101

INTRODUCTION

Programs aimed at preventing homelessness have become increasingly popular in communities due to new funding sources, a desire to reduce costs to the homeless assistance and other systems, and the belief that providing short-term financial assistance upfront can prevent a homeless episode. Many communities used Homelessness Prevention and Rapid Re-Housing Program (HPRP) funds to create their prevention programs. Under HPRP, communities were advised to serve the households that would become homeless without the receipt of this assistance and would also be completely stable in permanent housing afterwards. Communities faced a daunting task in accurately identifying households that fit this description. An additional hurdle to figuring out proper targeting techniques was that determining the success of prevention efforts was difficult due to the need to follow up with recipients.[1] It should come as no surprise, then, that communities have struggled to find the most effective targeting threshold. While good targeting may seem difficult, it is possible. By using an approach driven by local data, communities can use their prevention funds more efficiently to resolve housing crises. This brief is a concise "how-to" guide on how communities can begin or improve efforts to identify and effectively assist the households who are most likely to become homeless and serve them appropriately.

HOW TO TARGET

Use Data on Households in Emergency Shelter to Target Prevention Assistance
Communities can improve their ability to prevent homeless episodes by using the characteristics of their sheltered population as the criteria for determining if a household should receive prevention assistance. If the goal of prevention assistance is to prevent people from losing their housing and needing to enter shelter, it follows that homeless assistance systems should be targeting people that have the same profile as people who have entered shelter in the past. Usually, a Homeless Management Information System (HMIS) or similar data collection system can provide all the data that a community needs. Some factors to look at include:

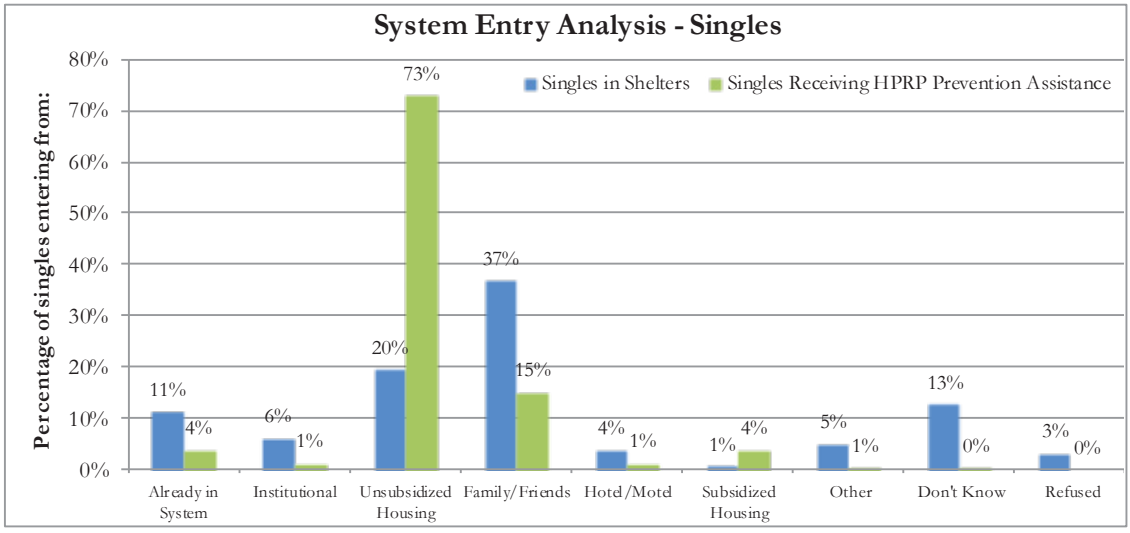
- Household income
- Disabilities in the household
- Criminal records

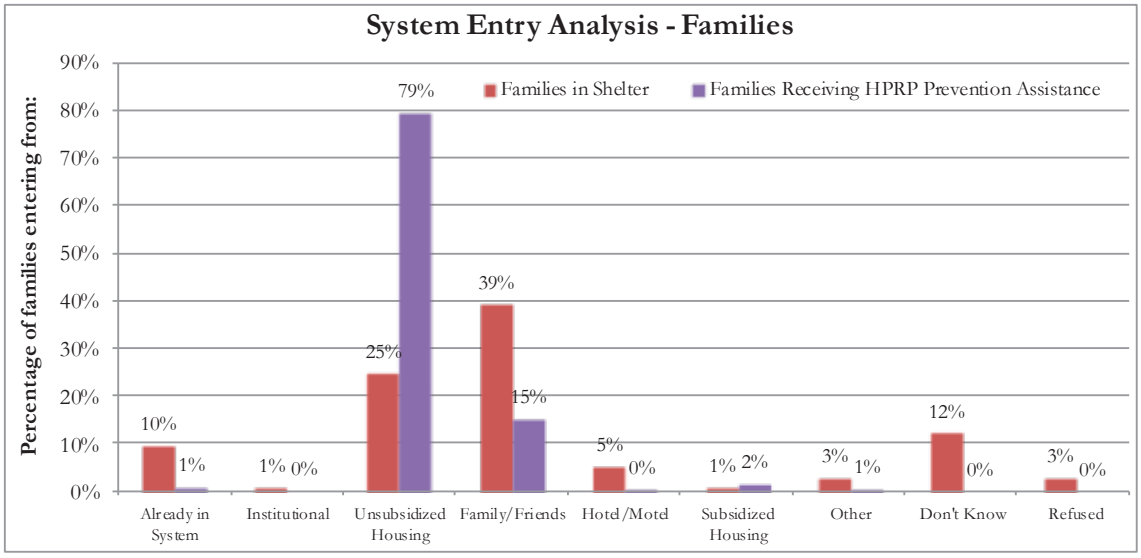
[1] Shinn, Marybeth Ph.D. and Jim Bauhmohl D.S.W. (1999, August). *Rethinking the Prevention of Homelessness.* National Symposium on Homelessness Research: What Works. Department of Housing and Urban Development (HUD) and Department of Health and Human Services (HHS). http://aspe.hhs.gov/progsys/homeless/symposium/13-Preven.HTM

- Past evictions
- Pregnancy
- Benefits received (Temporary Assistance for Needy Families, etc.)
- Number of and length of previous homeless episodes
- Living situation prior to coming to the homeless assistance system
- Employment status
- Household size and membership (presence of children, their ages, etc.)

Without using shelter data in selecting prevention assistance recipients, communities may run a much higher risk of inadvertently serving people who would never have become homeless in the first place, limiting the resources available to households that truly need them. The graphs in Figure 1 below illustrate this point by comparing data on prior living situations for households served by HPRP prevention assistance and households entering shelter in a community that participated in the Center for Capacity Building's HEARTH Academy. The differences between these groups in terms of prior residence are typical for many communities the Alliance has worked with that have not used shelter data in their targeting strategy; most prevention assistance ended up going to households coming from their own unsubsidized housing, even though most people entering shelter were coming from a doubled up situation with family or friends.

Figure 1: Prior Living Situations for Singles and Families
Source: Center for Capacity Building HEARTH Academy data





Discrepancies are also typical in factors other than prior living situation. For example, in another city the Alliance worked with, there was a $1,000 difference in monthly income between households receiving prevention assistance funds and households in shelter. When analyzing its prevention efforts in this way, Hennepin County, MN, found that 63 percent of families in their shelter system had been homeless before, while only 36 percent of families receiving prevention assistance had been. They also found that while 33 percent of sheltered families had a head of household under the age of 22, only 1 percent of families receiving prevention assistance did. It is obvious in these cases that the households entering shelter – the ones who likely needed prevention assistance the most – and the people actually receiving prevention assistance were often quite different, and that the households needing prevention assistance the most had many more housing barriers than the households receiving it.

Although providers may have concerns about a high-barrier household's ability to retain their housing after being assisted, as the Alliance describes in the brief, *What is 'sustainable' housing cost burden? Implications for HPRP*, only about 10 percent of impoverished people end up becoming homeless over the course of a year. Providers must focus on identifying and serving the small subset of households who are truly on the immediate edge of homelessness in order to maximize the effectiveness of prevention funds. To further improve the chances of success for the households served, prevention programs should consider offering services to help households maximize whatever income they have, including linking them with additional benefits they qualify for and referring them to education and employment programs.

Prioritize Households with the Most Imminent and Intense Housing Crises

Targeting closer to a household's anticipated separation from housing increases the chances they will actually need financial assistance from the homeless assistance system in order to stay out of shelter. The more time a household has until their housing situation falls apart, the more likely it is they will find a workable solution for their current situation that does not require the

homeless assistance system to intervene. For this reason, households that have come seeking emergency shelter but may still be in their own housing situation are often good candidates for receiving prevention assistance. Other factors, including oral confirmation from current roommates/leaseholders that the person in question must leave their housing and has nowhere else to go, are also useful in determining how likely it is the household will need assistance. At the same time, an eviction notice on its own is not close enough to homelessness for targeting purposes, as many people may still be able to find other resources to help them resolve the situation before they are forced to leave their unit.

Communities Without Data

For communities that do not have reliable shelter entry data or any data at all, the factors listed below can be used as an initial guide on who to target for receipt of prevention assistance until a proper data collection system has been developed. The interim ESG regulations also provide some guidance by defining people considered at risk of homelessness (and who are eligible to receive HUD-funded prevention services). Some criteria to consider from the regulations and other Alliance resources are listed below. Generally speaking, households with multiple risk factors should be prioritized for assistance.

Factors to consider using include:

- Household has no income
- Household has moved frequently for economic reasons (at least two times within a 60 day period)
- Household lives in an unstable housing situation
- Household is currently experiencing a housing crisis (dangerous living conditions, eviction)
- Household is a secondary tenant (doubled up)
- Household is exiting an institution
- Household lives in overcrowded housing
- Household lives in a hotel or motel that is not paid for by the government or a charitable organization
- Household includes a young child under the age of two
- Head of household is under the age of 24 and was in foster care at some point
- Household has had a prior homelessness episode

Next Steps

After identifying the characteristics of sheltered households and carefully examining the extent of the household's housing crisis, the next step is to create or modify an assessment tool. Assessment tools should include questions that determine how a household compares to sheltered households and include a scoring or rating system that makes it more likely households that are the most similar to sheltered households receive assistance. Hennepin County, in reaction to its community's findings, updated its prevention screening tool (available on the Alliance's website) and scoring system. Now households with the same characteristics as

their sheltered population, including ones with extremely low incomes, multiple barriers to housing, previous homeless episodes, and pregnant mothers under 30 are more likely to qualify to receive prevention assistance.

Assessment of eligibility for and provision of homeless prevention funds best happens through the homeless assistance system's "front door(s)," or system entry point(s). Homeless assistance systems with coordinated entry systems should use their intake center(s) to assess for prevention needs as well as any other housing and service needs. Systems without coordinated entry should train individual providers on what kinds of questions to ask to see if a household coming them for help is eligible for prevention assistance. Providers should be instructed to ask these questions and only admit a household to their program if prevention has been eliminated as a possibility in solving their housing crisis. They should also be trained on where to send households who need prevention funds if their organization does not have access to this resource.

Systems should also be aware of mainstream agency resources that could be tapped to provide prevention support. Mainstream agencies are organizations outside of the homeless assistance system that provide funds or other forms of support to certain populations. Mainstream resources that might be able to provide utility, rental, or other financial assistance include:

- Temporary Assistance for Needy Families (TANF) programs
- Emergency Food and Shelter Program (EFSP) funds
- Community Development Block Grant (CDBG) funds
- Faith-based organizations
- Foundations
- Public Housing Authorities (PHAs)
- Community Action Programs (CAP)
- The United Way
- Supplemental Security Income (SSI) programs

The homeless assistance system should be aware of the eligibility requirements households must meet to receive assistance from these other organizations and work questions about these requirements into their assessment tools. Households that may qualify for assistance under the criteria of these others funds should be referred to the correct agency for assistance.

EVALUATION

There are two things that communities will want to evaluate to measure success with prevention targeting: one is their success in reaching people that would have become homeless without some kind of intervention or assistance, and the second is how well they have prevented homelessness for the households served. First though, communities will need to develop proper performance measurement standards.

Developing a Performance Standard

Measuring the outcomes of prevention assistance requires a performance measurement system that sets reasonable expectations for success and adjusts for the risk of households being served. Having unrealistic expectations for prevention program outcomes may have consequences for consumers needing assistance. When prevention assistance programs are expected to achieve unrealistically high outcomes, they frequently assist people who have the lowest risk of becoming homeless, commonly referred to as "creaming." A prevention program with a very high success rate that has never used shelter data in the past to aid in targeting efforts is probably targeting its resources to people who would never have become homeless in the first place. Programs experiencing these high success rates should be extra careful to ensure that they are serving households whose profiles match those of the households in the shelter system.

Risk adjustment, the process by which the definition of a positive outcome is adjusted based on who is being served, is one way that programs can figure out what level of success they should reasonably expect. Risk adjustment might include setting a lower benchmark for certain households: for example, a program might be expected to achieve success preventing homelessness for 60 percent of households served when those households have a high number of risk factors but may also be expected to achieve a success rate of 80 percent for households with fewer risk factors. More information about benchmarking and risk adjustment can be found in the Alliance guide *What Gets Measured Gets Done: A Toolkit for Performance Measurement for Ending Homelessness*.

Successfully Reaching Would-Be Homeless Households

As noted earlier, it can be difficult to know who would become homeless without a homeless assistance system intervention. Communities should continue to monitor the characteristics of households entering shelter and modify their requirements for prevention assistance accordingly. Another way to ensure the right households are being reached is to follow a comparison group of people who qualified for prevention assistance but did not receive it. The comparison group approach should only be used in cases where it does not raise serious ethical concerns. A natural way to do this is to look at people that have been turned away from prevention programs in the past due to a lack of available program funds.[2] If this control group of unserved households is becoming homeless at a higher rate than those who receive assistance, this is a good indicator that the community's targeting criteria are on point. If the comparison group is **not** becoming homeless at a higher rate, the community will have to modify their targeting efforts.

Successfully Preventing Homeless Episodes for Households Served

Outcomes for households receiving prevention assistance should be tracked over time at set intervals (e.g., one month after being assisted, three months after been assisted, etc.). Tracking the return rate of persons served with prevention assistance to the homeless assistance system

[2] Gale, Katharine. "Do Conventional Prevention Programs Really Prevent Homelessness? Considerations for Using Local Data in Prevention Planning."

will provide good information on how effective current prevention interventions are or have been.

CONCLUSION

Prevention offers one way communities can reduce the number of households entering the homeless assistance system. Because funds are limited, communities must be strategic in committing funds to households that are the most likely to become homeless: these are usually higher barrier households with imminent housing crises who mirror those households already in shelter. By targeting those households most similar to the ones already in emergency shelter for assistance, communities maximize their chances that homeless assistance resources will return maximum results in terms of preventing future episodes of homelessness.

APPENDIX L:
HOUSING PRIORITIZATION TOOL

Housing Prioritization Tool

A – Transitional Housing/Transitional Living Program
B – Light Rapid Re-housing
C – Heavy Rapid Re-housing
D– Permanent Supportive Housing

Instructions: A trained case manager or other clinician should ask the questions in italics. Additional italicized instructions within each question are meant for the staff member administering the tool. If the household's answer has a letter next to it, the staff member should place that letter on the score line in the question and prepare to tally the number of each letter at the end. If an answer has multiple letters next to it, both of those letters should be entered onto the score line. If no letter is associated with their answer, leave the score line blank.

PREVIOUS HOMELESS EPISODES

1. Is this your first episode of literal homelessness in the past five years?
(Explain definition of literal homelessness – staying in emergency shelter, transitional housing, other place not fit for human habitation, etc.).

Yes (B) No

Score (letter): _____

IF YES, SKIP TO END OF QUESTIONNAIRE (SCORING SECTION).

2. Does household meet HUD definition of chronic homelessness?

Ask household:

- *Do you (if an individual) or the head of household (if a family) have a disability?*
- *Have you been homeless for longer than a year?*
- *Have you been homeless four times in the past three years?*

Explain any documentation that will be necessary.

If household answers yes to questions 1 and 2 or 1 or 3, answer to question is "yes."

Yes (C, D) No

Score (letter): _____

IF YES, SKIP TO END OF QUESTIONNAIRE (SCORING SECTION). Apply vulnerability index and use score to help determine eligibility. Offer choice between permanent supportive housing and heavy rapid re-housing. See additional directions at the end of questionnaire.

3. How many episodes of homelessness have you experienced?

Two (C) Three or more (A, D)

Score (letter): _____

4. How long was the longest of your previous episodes of homelessness?

Less than six months Six months – less than a year (A, C)

A year or more (D)

Score (letter): _____

5. Have you ever become homeless after being served by a rapid re-housing program?

Yes, once (C) Yes, more than once (D) No

Score (letter): _____

HOUSEHOLD CHARACTERISTICS

1. For youth 24 or younger: What is preventing you from being able to reunite with your family/legal guardian?

_____
_____
_____
_____
_____
_____

Case manager or other trained staff should engage the youth and make the final judgment if youth truly appears to be unreunifiable with family, then answer the question below.

Can the youth be safely reunified with their family or other guardian?

Yes No (A)

Score (letter): _____

2. For staff to answer for youth 24 or younger: Is the youth too young to legally sign their own lease?

Yes (A) No

Score (letter): _____

3. For families: Are you currently working with Child Welfare/Childrens' Services/Family and Childrens' Services?

Yes (A) No

Score (letter): _____

4. Are you currently recovering from substance abuse issues and seeking a sober environment to recover in?

Yes (A) No

Score (letter): _____

5. Are you re-entering society from prison or jail?

Yes (A) No

Score (letter): _____

6. Does you have any safety concerns (e.g., related to domestic violence)?

Explanation of different program types and program set-ups may be necessary. Information about data or information required, data sharing, etc. should also be shared with the client.

Yes No

List concerns here:

_____

_____

_____

_____

Call the police if necessary. Refer to domestic violence provider if applicable.

SCORING

1. ENTER TOTAL SCORE:
Take any question weights into account.

Number of (A)s: ___
Number of (B)s: ___
Number of (C)s: ___
Number of (D)s: ___

Scored For *(Choose intervention that matches the letter that showed up the most):*

_____

If the household scores for "D", apply vulnerability index to determine their place on the vulnerability list. For families, prioritize according to score, then prior number of episodes of homelessness.

2. LOOK AT LIST OF PROGRAMS AND CRITERIA
Use individual program criteria list (separate – should be created by community) to determine which program within the scored-for intervention the household should be referred to. Decisions should be made based on population served, services offered, bed availability, and proximity.

3. INCORPORATE CONSUMER CHOICE

Read the following script (modify as necessary):

Based on your answers, I would recommend (insert program) for you. This program offers these services (e.g., case management, rental subsidies, employment training, etc). Current average length of stay in the program is ____. ___% of people exit this program for permanent housing. Right now, the current wait list is ____ many people long, which means you might have to wait ___ days before you are admitted. Are you interested in this program? (If no data is available, use national data.)

If no, move to second choice program.

If the consumer not interested in intervention at all, go back to #1, choose second-choice intervention, then choose best program within that.

Placed In: _____

APPENDIX M:
HOUSING BARRIERS ASSESSMENT

Rapid Re-housing Triage Tool

This tool may be helpful for the purposes of determining what services and level of subsidy a household eligible for rapid re-housing needs. Communities would ideally use this tool only after prevention or diversion had been ruled out as options as part of the coordinated assessment process and before or very shortly after admitting a household to an emergency shelter program if they have no place else to stay. This tool should be used as a starting point; communities are encouraged to refine the tool to reflect local data and system outcomes.

Level of Assistance	Tenant Screening Barriers (Barriers to Obtaining Housing)	Retention Barriers (Barriers to Sustaining Housing)
Level 1— The **household** will need minimal assistance to obtain and retain housing. The Rapid Re-Housing (RRH) program offers the following for most Level 1 households: ❖ Financial assistance for housing start-up (e.g. first month's rent, security deposit, utility deposit) ❖ Initial consultation related to housing search (e.g. where to find rental information, how to complete housing applications, documentation needed) ❖ Time-limited rental assistance, per client Housing Plan ❖ Home visit/check-in after move-in ❖ Offer of services (at tenant request) for up to 3 months. **Landlord** assistance will likely include only program contact information for tenancy concerns	Household has no criminal history Rental history: an established local rental history. No evictions, landlord references are good to fair Credit history is good, with the exception of a few late utility and credit card payments	No significant barriers except financial: very low income, insufficient emergency reserves
Level 2— The **household** will need routine assistance to obtain and retain housing. The RRH program offers the following for most Level 2 households: ❖ Financial assistance for housing start-up	Household has no serious criminal history, but may have a few minor offenses such as moving violations, a DUI, or a misdemeanor Rental history is limited or	Financial barriers include very low income, may have inconsistent employment, poor budgeting skills No serious mental illness or chemical dependency that affects

Level of Assistance	Tenant Screening Barriers (Barriers to Obtaining Housing)	Retention Barriers (Barriers to Sustaining Housing)
❖ Time-limited rental assistance, per client Housing Plan ❖ Initial consultation and ongoing assistance with housing search, including bus tokens as needed ❖ Development of Housing Plan to work on any identified retention barriers ❖ Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met. ❖ Services available for up to 6 months, depending on housing problems and progress toward Housing Plan goals. **Landlord** assistance: ❖ 6 month availability: landlord can call with tenancy issues and program will respond. ❖ Program will check in with landlord periodically for updates. ❖ RRH program will relocate household if landlord is considering eviction.	out-of-state. May have 1-2 explainable evictions for non-payment. Prior landlords may report a problem with timely rent. Credit history shows pattern of late or missed payments	housing retention. May have some level of depression or anxiety or problems responding to conflict May lack awareness of landlord-tenant rights/responsibilities. May have minor problems meeting basic household care/cleaning. May have been homeless once before.
Level 3— The **household** will need more intensive and/or longer assistance to obtain and retain housing. The RRH program offers the following for most Level 3 households: ❖ Financial assistance for housing start-up ❖ Time-limited rental assistance, per client Housing Plan ❖ Initial consultation and ongoing assistance with housing search, including bus tokens as needed. Staff may accompany client to the landlord interview. ❖ Development of Housing Plan to work on any identified retention barriers ❖ Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met. Include unannounced drop-in visits.	Household may have some criminal history, but none involving drugs or serious crimes against persons or property Rental history includes up to 3 evictions for non-payment. Prior landlord references fair to poor. Partial damage deposit returned. Some complaints by other tenants for noise Credit history includes late payments and possible court judgments for debt, closed accounts	Household is very low income, has periods of unemployment, no emergency reserves, lacks budgeting skills Problems with mental health or alcohol/substance use that somewhat impacts compliance with tenancy requirements. May have deficits in care of apartment, landlord-tenant rights/responsibilities, communications skills with landlord and/or other tenants Conflict may exist in household May have lost housing and been homeless several times in past

Level of Assistance	Tenant Screening Barriers (Barriers to Obtaining Housing)	Retention Barriers (Barriers to Sustaining Housing)
❖ Services available for up to 9 months, depending on housing problems and progress toward Housing Plan goals. **Landlord** assistance: ❖ 9 month availability; landlord can call with tenancy issues and program will respond even after services end. ❖ Program will check in with landlord periodically for updates. ❖ RRH program will relocate if an eviction is being considered. If household will not leave, program may pay court costs. ❖ Program may pay or repair damages.		
Level 4— The **household** will need more intensive and longer assistance to obtain and retain housing. The RRH program offers the following for most Level 4 households: ❖ Financial assistance for housing start-up ❖ Time-limited rental assistance, per client Housing Plan ❖ Initial consultation and ongoing assistance with housing search, including bus tokens as needed. Staff may accompany client to the landlord interview. ❖ Development of Housing Plan to work on any identified retention barriers ❖ Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met. Include unannounced drop-in visits. ❖ Services available for up to 12 months, depending on housing problems and progress toward Housing Plan goals. **Landlord** assistance: ❖ 12 month availability; landlord can call	Criminal history, violations may include drug offense or crime against persons or property Rental history includes up to five evictions for non-payment and/or lease violations. Landlord references poor. Security deposit may have been kept due to damage to unit. Credit history is poor, late payments, may include judgment for debt to a landlord, closed accounts	Extremely low income, no emergency reserves, bank accounts closed, lacks budgeting skills. May be using drugs/alcohol and/or has mental health problems. May have conflict with child/ren or partner. May lack ability to care for apartment or communicate appropriately with landlord and other tenants. Has likely been homeless multiple times or for more extended periods

Level of Assistance	Tenant Screening Barriers (Barriers to Obtaining Housing)	Retention Barriers (Barriers to Sustaining Housing)
with tenancy issues and program will respond; ongoing option to call even after Rapid Re-Housing services are ended can be offered or negotiated on a case-by-case basis. ❖ Program will check in with landlord monthly (or more often if landlord prefers) for updates/issues. ❖ May pay an additional damage deposit and/or last month's rent in addition to normal start-up costs. ❖ RRH program will relocate household if an eviction is being considered. If household will not leave, program may pay court costs of eviction. ❖ Program may pay or repair damages.		
Level 5— Household needs longer or more intensive services; may need staff with more professional training. RRH program refers household to appropriate program, such as intensive case management, permanent supportive housing or other local resources.	Extensive criminal background Extremely poor rental history, multiple evictions, serious damage to apartment, complaints Credit history includes multiple judgments, unpaid debts to landlords, closed accounts	Active and serious chemical dependency or mental illness Unable to comply with lease requirements or interact positively with landlord/tenants; poor apartment management skills, out-of-control behaviors by adult or child/ren May have experienced chronic homelessness (multiple and/or extended periods of homelessness)

APPENDIX N:
HOUSING LOCATION SPECIALIST JOB DESCRIPTION

Broward Partnership for the Homeless, Inc.
Job Description

Work Location:	Fort Lauderdale Florida
Title:	Housing Location Specialist
Reports To:	Case Management Supervisor
Program:	Rapid Re-Housing
Exempt/Non-Exempt Status:	Exempt
Position Status:	Full Time
Funding Source:	

I. Job Summary

The Rapid Re-Housing Program serves homeless individuals and families who are participating in existing continuum of care programs at the Central Homeless Assistance Center. Clients are referred to the Rapid Re-Housing Program for housing relocation and stabilization services. The Rapid Re-Housing Program moves homeless individuals and families into permanent rental housing *as quickly as possible*, in conjunction with case management, workforce and support services being provided simultaneously. After relocation the clients will move into aftercare case management to provide on-going support and assistance to prevent homelessness in the future.

The Housing Relocation Specialist assists program participants in locating and securing permanent housing as quickly as possible through outreach to landlords, property managers and housing authorities. In addition, the Housing Relocation Specialist collaborates closely with landlords and Case Managers to mediate landlord-tenant issues and ensure successful tenancies.

II. Agency Expectation of Employee

- Adheres to Agency Policy and Procedures
- Acts as a role model within and outside the Agency
- Dresses appropriately in attire consistent with the position image
- Performs duties as workload necessitates
- Maintains a positive and respectful attitude
- Communicates regularly with supervisor about Department issues
- Demonstrates flexible and efficient time management and ability to prioritize work load
- Consistently reports to work on time prepared to perform duties of position
- Meets department productivity standards

III. Essential Duties and Primary Responsibilities

1. Conduct initial housing assessment of participants enrolled in the program.

2. Conduct research, outreach, education and public relations to build a pool of landlords and property management companies willing to rent to program participants.

3. Help program participants identify potential neighborhoods where they wish to live, conduct housing searches in said areas and negotiate with potential landlords on behalf of the participants.

4. Establish and maintain relationships with landlords, property management companies.

5. Assist in the processing and submission of applications for housing (subsidized and unsubsidized).

6. Conduct inspections of potential permanent housing units where program participants will reside.

7. Work collaboratively with after-care case managers to assist participants as needed during their move into permanent housing. Such assistance may include accessing rental assistance monies, moving costs, donated furnishings and other basic household items for the clients.

8. Collaborate with program participant's assigned case manager to insure seamless services and solve any potential issues.

9. Provide tenant education including: tenant rights and responsibilities, housing discrimination and communication with landlords.

10. Maintain a regular and open line of communication with landlords in order to assess the landlords' satisfaction with the programs and address any questions or concerns that landlords may have.

11. Document and maintain up-to-date information on services provided to participants in the Homeless Management Information System (HMIS).

12. Participate in staff meetings and attend trainings as assigned.

13. Prepare service activity reports.

14. Respond to complaints from landlords and participants related to housing conditions and provide mediation as needed.

15. All job requirements listed indicate the minimum level of knowledge, skills, and/or ability deemed necessary to perform the job proficiently. This job description is not to be construed as an exhaustive statement of duties, responsibilities, or

requirements. Employees will be responsible to perform any other job-related instructions given by their supervisor, subject to reasonable accommodations.

IV. Qualifications

1. Bachelor's degree (B.A.) in social work or related field;
2. Two to three years experience working in the field of homelessness;
3. Effective verbal and written communication skills;
4. Effective time management skills;
5. Proficient use of computers, basic office software and any other database software(s) used to track service delivery;
6. Strong ability to effectively resolve and cope with immediate conflict and/or crisis situations;
7. Ability to develop relationships with a wide variety of housing stakeholders;
8. A valid FL driver’s license, and safe driving record;

V. WORK ENVIRONMENT:

Work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

APPENDIX O:
COLUMBUS MODEL OUTCOMES

communityshelterboard

Program Performance Standards (in alpha order)

Based on CSB Governance Ends Policies, HUD standards, CoC local standards and best practices program performance.
Bolded measurements denote CSB Board established Ends Policies.

Direct Housing/Rapid Re-housing/Rolling Stock

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on program capacity, prior year(s) attainment and funds
	New households served (#)	Set based on program capacity, prior year(s) attainment and funds
	Average length of participation	Based on program design
Access to resources/services to move to and stabilize housing	Usage of CSB Direct Client assistance ($)	Average DCA amount will be consistent with prior performance and /or program design.
	Usage of CSB Direct Client Assistance (%)	% of households that receive CSB DCA will be consistent with prior performance and /or program
	Average length of shelter stay	Average stay at Tier 1 Shelter not to exceed 13 days.
	Housing Affordability at Exit (%)[1]	At least 50% of successful households have their housing affordability ratio, measured as cost of housing (rent and utilities) divided by the household's income at exit, lower than 50%. Monitored but not evaluated during FY2011.
	If Applicable, Completed Vocational/Other Training (%)	70% of households complete vocational or other training by their exit from the program.
	If Applicable, Employment Status at Exit (%)	65% of households have employment at exit from the program.
	If Applicable. Employment Status at Exit (#)	Calculated based on the Employment Status at Exit % measurement.
Basic needs met in a non-congregate environment	Successful housing outcome (%)	At least 90% successful housing outcomes.
	Successful housing outcome (#)	Calculated based on the Successful housing outcomes %
Not re-enter the emergency shelter system	Recidivism (%)	≤5% of those who obtain housing will return to shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Pass program certification	Provide access to resources and services to end homelessness

Emergency Shelter – Centralized Point of Access

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on, system demand and capacity.
Access to resources to address immediate housing need	Successful diversion outcome[2] (%)	At least X% of those contacting the central point of access will be diverted to other community resources.
	Pass program certification	Provide access to and coordination with community resources and services to prevent homelessness.
	Shelter Linkage[2] (%)	At least 70% of those referred for intake into an emergency shelter will enter shelter.
Not re-enter the emergency shelter system	Diversion Recidivism[2] (%)	<X% of those diverted will enter shelter.
Efficient and effective use of a pool of community resources	Cost of overflow	Cost of overflow is reduced compared to overflow cost in a non-centralized environment.
	Pass program certification	Provide access to resources and services to end homelessness.

Emergency Shelter – Tier I

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment, fair share of system demand, facility capacity, and funds available to program.
Access to resources to address immediate housing need	Successful outcomes (%)	Obtain housing at standard below or greater if prior year(s) achievement was greater: • At least 25% for adult shelters • At least 70% for family shelter • At least 15% for inebriate shelter.
	Successful outcomes (#)	Calculated based on the Successful outcomes % measurement.
	Successful housing outcomes (%) (YWCA Family Center Only)	Set based on prior year(s) attainment. Excludes exits to Tier II
	Successful housing outcomes (#) (YWCA Family Center Only)	Calculated based on the Successful housing outcomes % measurement
	Usage of CSB Direct Client Assistance (%)	% of households that receive CSB DCA will be consistent with prior performance and /or program design.
	Usage of CSB Direct Client Assistance (#) (YWCA Family Center Only)	# of households that receive CSB DCA will be consistent with prior performance and /or program design.
	Pass program certification	Provide access to and coordination with community resources and services to prevent homelessness.

[2] Metric will be benchmarked in FY2010 and measured in FY2011

	Successful diversion outcome[3] (%) (YWCA Family Center only)	At least 39% will be diverted to other community resources.
Basic needs met in secure, decent environment	Pass program certification	Provide secure, decent shelter.
Temporary, short-term stay	Average length of stay	Not to exceed standard below or average for prior year(s) if less than standard below: • 30 days for adult shelters • 20 days for family shelter • 12 days for inebriate shelter.
	Average FHC Transition Time (YWCA Family Center Only)	Not to exceed standard based on the FHC policies and procedures (less or equal to 7 days)
Not re-enter the emergency shelter system	Recidivism	≤5% of those who obtain housing will return to shelter.
	Movement[4] (%) (Single Adult Shelters only)	<15% of those who exit the emergency shelter will immediately re-enter another shelter.
	Detox exits (Inebriate shelter only)	At least 10% of inebriate shelter exits will enter a detoxification
	Diversion Recidivism[3] (%) (YWCA Family Center only)	<5% of those diverted will enter shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Pass program certification	Provide access to resources and services to end

Emergency Shelter – Tier 2

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment, fair share of system demand, facility capacity, and funds available to program.
	New Households served (#)	Set based on program capacity and prior year(s) attainment.
Access to resources to address immediate housing need	Successful housing outcomes (%)	At least 70% will obtain permanent or transitional housing.
	Successful housing outcomes (#)	Calculated based on the Successful housing outcomes % measurement
	Usage of CSB Direct Client Assistance (%)	% of households that receive CSB DCA will be consistent with prior performance and /or program design.
	Usage of CSB Direct Client Assistance (#)	# of households that receive CSB DCA will be consistent with prior performance and /or program design.

	Housing Affordability at Exit[5] (%)	At least 50% of successful households have their housing affordability ratio, measured as cost of housing (rent and utilities) divided by the household's income at exit, lower than 50%. Monitored but not evaluated during FY2011..
Basic needs met in a non-congregate environment	Pass program certification	Provide secure, decent shelter.
Temporary, short-term stay	Average Length of Stay	Average stay not to exceed 80 days.
Not re-enter the emergency shelter system	Recidivism (%)	≤5% of those who obtain housing will return to shelter.
Efficient and effective use of a pool of community resources	Program Occupancy Rate (%)	At least 95% occupancy rate.
	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Pass program certification	Provide access to resources and services to end

Homelessness Prevention

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on program capacity, prior year(s) attainment and funds
	New households served (#)	Set based on program capacity, prior year(s) attainment and funds
Access to resources and services to maintain and stabilize housing	Successful housing outcomes (%)	At least 90% will maintain or obtain housing.
	Successful housing outcomes (#)	Calculated based on the Successful housing outcomes %
	Housing Affordability at Exit (%)	At least 50% of successful households have their housing affordability ratio, measured as cost of housing (rent and utilities) divided by the household's income at exit, lower than 50%. Monitored but not evaluated during FY2011.
	If applicable, usage of CSB Direct Client Assistance ($)	Average DCA will be consistent with program design.
	If applicable, usage of CSB Direct Client Assistance (%)	% of households that receive CSB DCA will be consistent with prior performance and /or program design.
	If applicable, usage of other community resources (%)	% of households that receive other community resources will be consistent with prior performance.
Not enter the emergency shelter system	Recidivism (%)	≤5% of those who have successful housing outcomes will enter
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.

[5] New measurement for change in income from entry to exit to be benchmarked during FY2010. Housing Affordability at Exit

	Pass program certification	Provide access to and coordination with community resources and services to prevent homelessness.
	Average length of participation	Based on program design.

Increase Access to Benefits and Income

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment and funds available. . Count of all households with an application end date that occurs either within the report period or is
	New households served (#)	Set based on prior year attainment and funds available. Count of all households with an application start date that occurs within the report period.
Access to resources and services to move to and stabilize housing	Submitted SSI/SSDI Applications (#)	The number of SSI/SSDI applications submitted will be consistent with program design. At least 58% of the households served will have their SSI/SSDI applications submitted[6].
	Submitted Other Applications (#)	The number of other benefits applications submitted will be consistent with program design. At least 58% of the households served will have their other benefits applications submitted[6].
	Successful SSI/SSDI Applications (%)	At least 70% of the submitted SSI/SSDI applications have a favorable resolution[7].
Not re-enter the emergency shelter system	Recidivism (%)	≤5% of those who have successful applications will return to shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful applicant	Cost per successful applicant will be consistent with budget.
	Pass program certification	Provide resources and services to end homelessness.

Outreach Specialist

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment and funds available.
	New households served (#)	Set based on prior year attainment and funds available.
Access to resources to address immediate housing need	Usage of CSB Direct Client Assistance (%)	At least 25% will receive CSB DCA.
Basic human needs met in secure, decent environment	Successful outcomes (%)	At least 70% successful housing/shelter
	Successful outcomes (#)	Calculated based on the Successful outcomes % measurement.
	Successful housing outcomes (%)	At least 75% of successful outcomes obtain housing.
	Successful housing outcomes (#)	Calculated based on the Successful housing outcomes %
	Exited Households to PSH (#)	Set based on anticipated vacancies for the critical access to housing initiative.
Do not re-enter the emergency shelter system	Recidivism (%)	≤5% of those who obtain housing will return to shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Pass program certification	Provide access to resources and services to address immediate housing need.

Supportive Housing[8]

PSH – Permanent Supportive Housing; TH = Transitional Housing; SPC = Shelter Plus Care

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment and program capacity.
	If applicable, CAH Households served (#)	Set based on prior year(s) attainment and program capacity.
Access to resources/services to move to and stabilize housing	Housing Stability[11]	At least standard below or greater if prior year(s) achievement was greater • At least 12 months for PSH (goal to be set not to exceed 24 months, actual attainment may be greater than goal) • Up to 4 months for TH • At least 12 months for SPC
	Housing Affordability at Exit (%)[9]	At least 50% of successful households have their housing affordability ratio, measured as cost of housing (rent and utilities) divided by the household's income at exit, lower than 50%. Monitored but not evaluated during FY2011.

[8] HUD and local CoC required outcomes must be met by all programs that receive HUD funding.

[9] New measurement for change in income from entry to exit to be benchmarked during FY2010. Housing Affordability at Exit

Ends	Measurement	Annual Metrics
	Employment status at exit[10,12] (%)	At least 20% of households exiting will have employment.
Basic needs met in a non-congregate environment*	Successful housing outcomes (%)	At least 90% successful housing outcomes.
	Successful housing outcomes (#)	Calculated based on the Successful housing outcomes %
	Successful housing exits (%)	At least X% of exits are successful housing outcomes. To be benchmarked in FY2011, measured in FY2012.
Not re-enter the emergency shelter system	Housing Retention[11] (%)	≤5% of those who obtain housing will return to shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Cost per unit	Cost per unit will be consistent with budget.
	Program Occupancy Rate[11] (%)	Full occupancy (>95%).
	Turnover Rate (%)	Set based on prior year(s) attainment, an annual 20% turnover rate is desirable.
	Pass program certification	Provide access to resources and services to end homelessness.
Standards[6, 7]	Negative Reason for leaving[11] (%)	Less than 20% leave for non-compliance or disagreement with rules
	Successful housing outcome (%)[10, 12]	At least standard below or greater if prior year(s) achievement was greater • At least 80% for PSH and SPC • At least 77% for TH
	Interim housing stability[10, 12] (%)	• At least 81% of persons remain in permanent supportive housing for at least 6 months
	Increase in income from entry to exit[11] (%)	• At least 45% of tenants in PSH and SPC • At least 50% of clients in TH

Transition Program Direct Client Assistance

Ends	Measurement	Annual Metrics
Efficient number of households served	Households served (#)	Set based on prior year(s) attainment and funds available to program
Access to resources/services to move to and stabilize housing	Usage of other community resources related to housing stability (%)	% of households that receive other community resources will be consistent with prior performance.
	Usage of CSB Direct Client Assistance (%)	At least 95% will receive financial assistance
	Usage of CSB Direct Client assistance ($)	Average DCA amount will be consistent with prior performance, funds available and /or program design.

[10] Goal approved for the 2009 HUD Application, Exhibit 1, by the CoC Steering Committee. Applicable to all HUD funded programs.
[11] Local goal approved by the CoC Steering Committee. Applicable to all HUD funded programs.

Basic needs met in a non-congregate environment	Successful housing outcomes (%)	At least 98% successful housing outcomes.
	Successful housing outcomes (#)	Calculated based on the Successful housing outcomes %
Not re-enter the emergency shelter system	Recidivism (%)	≤5% of those who obtain housing will return to shelter.
Efficient and effective use of a pool of community resources	Cost per household	Cost per household will be consistent with budget.
	Cost per successful housing outcome	Cost per successful housing outcome will be consistent with budget.
	Pass program certification	Provide access to resources and services to end homelessness.

APPENDIX P:
SUGGESTED OUTCOME MEASURES

Program Type	Efficiency Measures	Output Measures	Quality Measures	Outcome Measures
Coordinated Assessment (CA)/Prevention (P) /Diversion (D) (programs intended to prevent homelessness for people who are seeking shelter assistance)	Average length of time per assessment (CA) Average cost per household served (P/D)	Number of people assessed (CA) Percent of assessed households receiving diversion assistance (D) Number of assessed households receiving diversion assistance (D) Percent of assessed households receiving prevention assistance (P) Number of assessed households receiving prevention assistance (P)	Average number of days from referral to program admission (CA) Number of cases where a program referral is sent back to assessment point (CA)	Percent of households diverted but requesting shelter placement within 12 months (D) Number of households diverted but requesting shelter placement within 12 months (D) Percent of households receiving prevention assistance but requesting shelter placement within 12 months (P) Number of households receiving prevention assistance but requesting shelter placement within 12 months (P) Percent of households exiting to permanent housing (CI/D/P) Number of households exiting to permanent housing (CI/D/P)

Emergency Shelter and Safe Havens (SH)	Average cost per household served	Number of households connected to rapid re-housing opportunities Number of households connected to permanent supportive housing opportunities Percent of households engaged in treatment (SH)	Average barrier level of new entries	Percent of households exiting to permanent housing Number of households exiting to permanent housing Average length of stay for households who exit to permanent housing Percent of households exiting to permanent housing who return to homelessness within 12 months Number of households exiting to permanent housing who return to homelessness within 12 months
Transitional Housing and Other Non-Permanent Residential Programs	Average cost per household served	Number of households who receive follow-up case management services after exiting to permanent housing	Average increase in household income between program entry and exit	Percent of households exiting to permanent housing Number of households exiting to permanent housing Average length of stay for households who exit to permanent housing Percent of households exiting to permanent housing who return to

Transitional Housing and Other Non-Permanent Residential Programs	Average cost per household served	Number of households who receive follow-up case management services after exiting to permanent housing	Average increase in household income between program entry and exit	Percent of households exiting to permanent housing Number of households exiting to permanent housing Average length of stay for households who exit to permanent housing Percent of households exiting to permanent housing who return to homelessness within 12 months Number of households exiting to permanent housing who return to homelessness within 12 months
Rapid Re-housing	Average cost per household served	Number of landlords participating in the rapid re-housing program Percent of high barrier households served (households with zero income, previous evictions, substance use disorders, criminal	Average length of time between program admission and placement into permanent housing Average number of months a	Percent of households exiting to permanent housing Number of households exiting to permanent housing Percent of households permanently housed in 30 days or less Number of households permanently housed in 30 days or less Average length of stay for people

Permanent Supportive Housing	Average annual cost per household served	Percent of new tenants experiencing chronic homelessness at time of entry Percent of tenants engaged in treatment Average barrier level of new tenants	Average increase in income during first year of tenancy	Percent of chronically homeless people placed into permanent supportive housing (PIT Count of CH households is denominator) Number of chronically homeless people placed into permanent supportive housing (PIT Count of CH households is denominator) Percent of tenants who exit for positive reasons Number of tenants who exit for positive reasons Percent of new entrants who remain housed after 12 months Number of new entrants who remain housed after 12 months Percent of program participants exiting to permanent housing who return to homelessness within 12 months Number of program participants exiting to permanent housing who return to homelessness within 12 months

Permanent Supportive Housing	Average annual cost per household served	Percent of new tenants experiencing chronic homelessness at time of entry Percent of tenants engaged in treatment Average barrier level of new tenants	Average increase in income during first year of tenancy	Percent of chronically homeless people placed into permanent supportive housing (PIT Count of CH households is denominator) Number of chronically homeless people placed into permanent supportive housing (PIT Count of CH households is denominator) Percent of tenants who exit for positive reasons Number of tenants who exit for positive reasons Percent of new entrants who remain housed after 12 months Number of new entrants who remain housed after 12 months

Note: System level outcome reports will also be prepared consolidating data from program-level reports.

APPENDIX Q:
SUPPORTIVE HOUSING COST BRIEF

Supportive Housing is Cost Effective

January 2007

Three studies show that the net public cost of providing permanent supportive housing for homeless people with mental illness and/or addictions is about the same or less than the cost of allowing them to remain homeless.

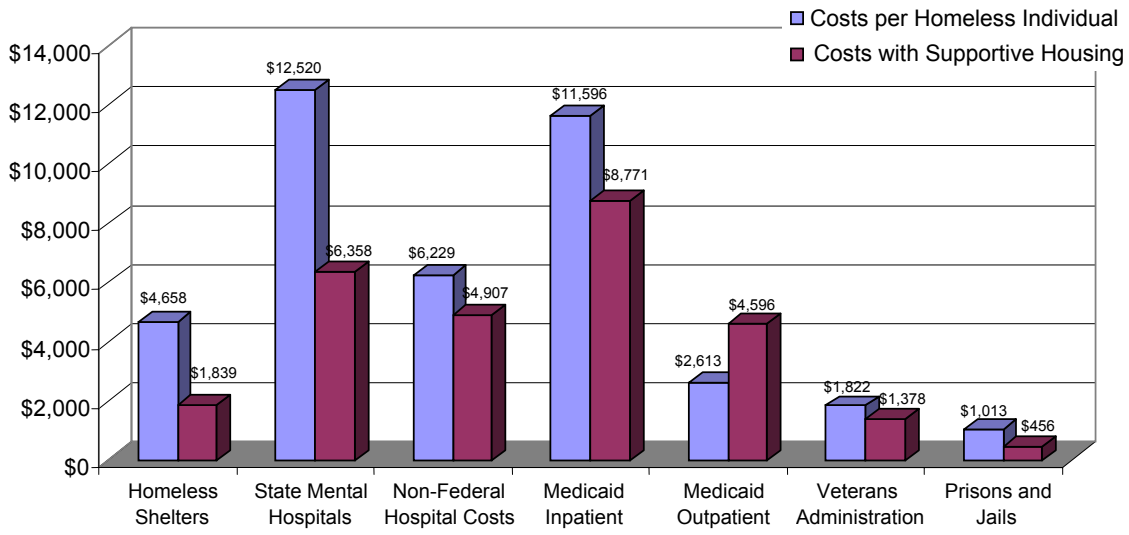
Homelessness causes illnesses and makes existing mental and physical illnesses worse, leading to expensive treatment and medical services. Permanent supportive housing improves physical and mental health, which reduces the need for these services, particularly expensive inpatient mental health care and hospitalization.

Permanent supportive housing helps tenants increase their incomes, work more, get arrested less, make more progress toward recovery, and become more active and productive members of their communities.

New York, NY

In New York City, each unit of permanent supportive housing saved $16,282 per year in public costs for shelter, health care, mental health, and criminal justice. The savings alone offset nearly all of the $17,277 cost of the supportive housing.

Exhibit 1: Annual Cost of Supportive Housing vs. Homelessness

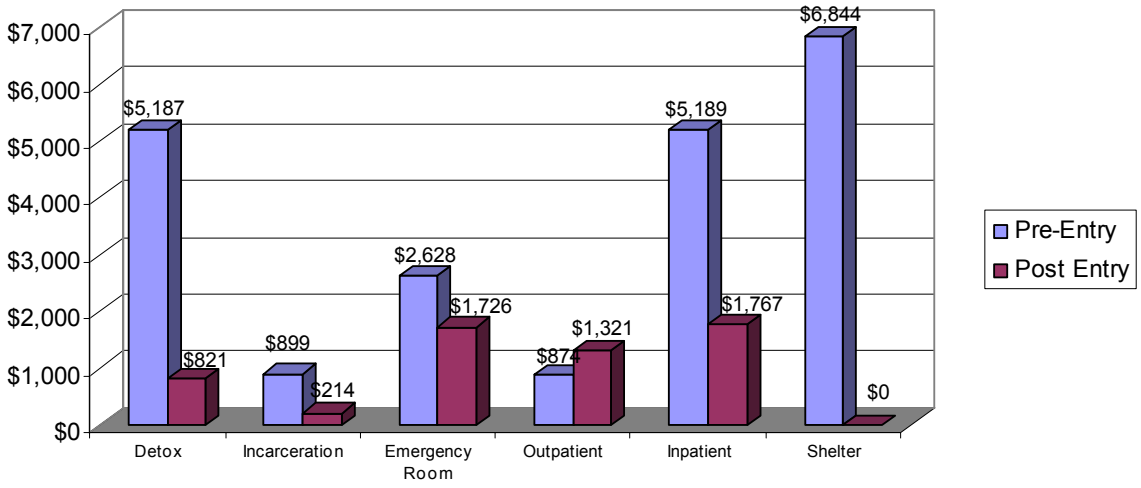


Source: The *Impact of Supportive Housing on Services Use for Homeless Persons with Mental Illness in New York City.* Dennis Culhane, Ph.D., Stephen Metraux, M.A., Trevor Hadley, Ph.D., Center For Mental Health Policy & Services Research, University of Pennsylvania. Data from 4,679 NY/NY placement records between 1989-97.

Denver, CO

The Denver Housing First Collaborative targets people who have been homeless for long periods of time, many of whom live on the streets, and moves them into permanent housing. The program reduced the public cost of services (health, mental health, substance abuse, shelter, and incarceration) by $15,773 per person per year, more than offsetting the $13,400 annual cost of the supportive housing.

Exhibit 2: Annual Costs Before and After Entering Supportive Housing

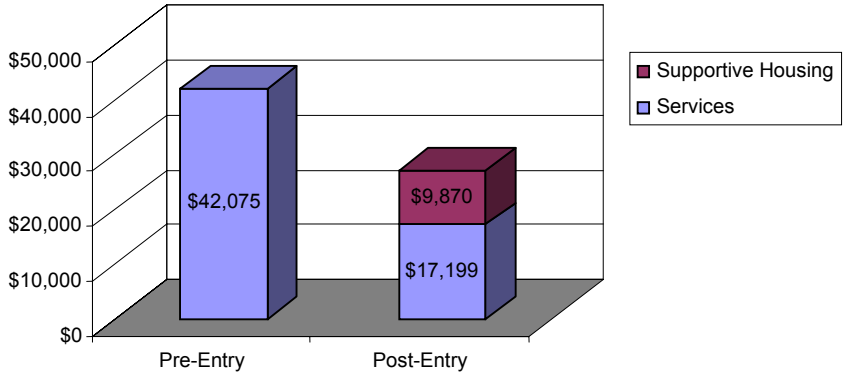


Source: *Denver Housing First Collaborative: Cost Benefit Analysis And Program Outcomes Report*. Jennifer Perlman, PsyD, and John Parvensky. Colorado Coalition for the Homeless. December 2006.

Portland, OR

Portland's Community Engagement Program provides housing and intensive services to homeless individuals with mental illness and addictions. The program reduced the cost of health care and incarcerations from $42,075 to $17,199. The investment in services and housing during the first year of enrollment was averaged to approximately $9,870. This represents a 35.7% ($15,006 per person) annual cost saving for the first year following enrollment in CEP.

Exhibit 3: Annual Cost Before and After Entering Supportive Housing



Source: *Estimated Cost Savings Following Enrollment In The Community Engagement Program: Findings From A Pilot Study Of Homeless Dually Diagnosed Adults.* Thomas L. Moore, PhD. Portland, OR: Central City Concern. June 2006.

APPENDIX R:
MEDICAID AGENDAS FOR PSH COMMITTEE

First Meeting
Goal: Getting on the same page

- Develop consensus on mission statement or other brief, simple set of objectives for group. Two examples:
    - Plan for efficient leveraging of Medicaid and other indigent-care funding to bolster PSH as an effective solution to chronic homelessness in Broward County.
    - Improve integration of funding for supportive housing and health care services to permanently house the most vulnerable individuals in the county.
- What are the Medicaid resources in Broward County?
    - Medicaid demographics in county
    - Expenditures
    - Providers
- What are the Medicaid and other health care resources relevant to services in PSH?
    - Sources of health care funding to serve homeless population (including behavioral health interventions for individuals with the highest/most intense needs)
    - Key providers of health care services
- Currently, what are the most serious funding and service gaps affecting the most vulnerable people in or eligible for placement in PSH?
    - Could filling these gaps through a different PSH service strategy result in lower costs in other areas of safety net, e.g., hospitals, emergency services, episodic public safety interventions?
- What further data/analysis is needed to move forward?
- Are additional stakeholders needed at the table?
- Consensus on next steps, timelines, follow-up responsibilities

Second Meeting
Goal: Formulating state policy agenda

- Introduce and brief any new stakeholders on initial meeting/decisions
- Briefing on the future of Medicaid in Florida – independent outside speaker, e.g., from State government or in-state academic institution
- What statewide changes are in progress or close to implementation that can significantly benefit Broward's PSH agenda?
- What policy changes are necessary to drive the PSH agenda further?
- Assess opportunities and barriers to effect necessary Medicaid changes

Later Meetings
Goals: Progress, monitoring, trouble-shooting

Annual Meetings
Goals: Assess outcomes and identify needed action, with reference to mission; engage county political and administrative leadership

APPENDIX S:
FUSE MODEL INFORMATION

BLUEPRINT FOR FUSE

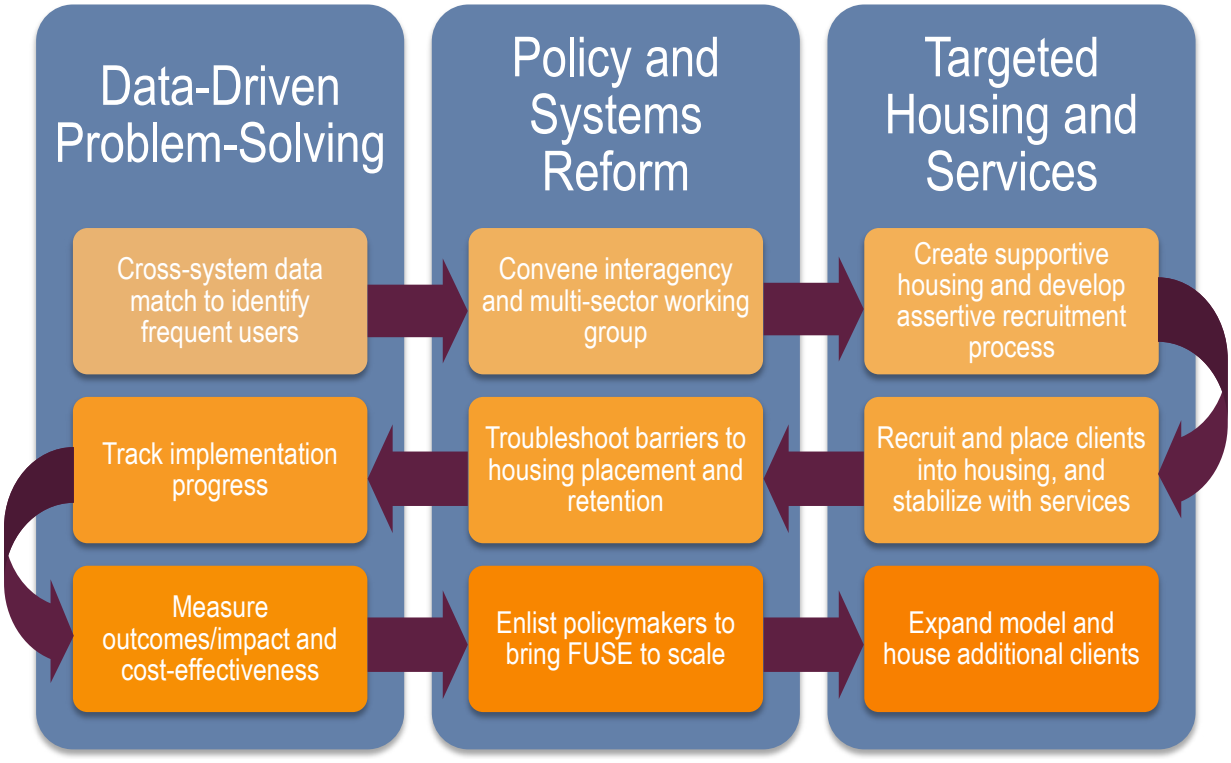
THREE PILLARS AND NINE STEPS

CSH's Frequent Users Systems Engagement (FUSE) model is being used as part of our *Returning Home Initiative* to help communities to break the cycle of incarceration and homelessness among individuals with complex behavioral health challenges who are the highest users of jails, homeless shelters and other crisis service systems. FUSE increases housing stability, reduces recidivism and breaks the cycle of multiple crisis service use, resulting in public cost offsets. While CSH has helped each of the communities implementing FUSE to adapted the model to suit its unique local contexts and conditions, at the core of FUSE are three essential pillars:

- **Data-Driven Problem-Solving** Data is used to identify a specific target population of high-cost, high-need individuals who are shared clients of multiple systems (jails, homeless shelters and crisis health services) and whose persistent cycling indicates the failure of traditional approaches. Data is also used to develop a new shared definition of success that takes into account both human and public costs, and where the focus is on avoiding institutions altogether, as opposed to simply offloading clients from one system to another.

- **Policy and Systems Reform** Public systems and policymakers are engaged in a collective effort to address the needs of shared clients and to shift resources away from costly crisis services and towards a more cost-effective and humane solution: permanent housing and supportive services.

- **Targeted Housing and Services** Supportive housing—permanent housing linked to individualized supportive services—is enhanced with targeted and assertive recruitment through in-reach into jails, shelters, hospitals and other settings, in order to help clients obtain housing stability and avoid returns to costly crisis services and institutions.



These three pillars also contain the nine key steps involved in the adoption of FUSE. It should be noted that the real-life process for implementing FUSE is not always linear. For instance, some communities will form their interagency working groups prior to conducting a cross-system data match, and the data match itself may bring new willing partners to the table. Also, while outcome measurement takes place during and after implementation, the design of the evaluation or outcome tracking methods takes place prior to implementation. However, while the specific sequence may vary, these steps represent the basic blueprint to guide communities in their replication of FUSE. First and foremost, communities should contact CSH to obtain assistance in pursuing these steps.

1 Conduct Cross-System Data Match to Identify Frequent User Cohort

Match administrative data across corrections, homeless services and other crisis public services to develop a list of shared clients who meet specified thresholds of high service use (e.g. 4 jail and 4 shelter admissions in last 3 years).

2 Convene Stakeholders & Create Interagency, Multi-Sector Working Group

Convene key public agencies, policymakers, and community stakeholders into a working group to help adapt the model, assemble resources, track and troubleshoot process, oversee outcomes, and advocate for the expansion of the model.

3 Design and Assemble Resources for Supportive Housing and Assertive Recruitment through In-Reach into Jails, Shelters and Other Services

Work with partners to design the intervention—supportive housing coupled with assertive client engagement and recruitment through in-reach into jails, shelters, and other settings—assemble the resources needed for the intervention (e.g. rent subsidies, unit set-asides, services funding), and select participating providers.

4 Recruit and Place Clients into Housing and Stabilize with Services

Work with and train selected supportive housing providers to proactively recruit frequent user clients from the data-generated list by conducting in-reach into jails, shelters, and other crisis service settings. Providers engage and build motivation among clients and place them into supportive housing rapidly. Once placed, clients are assisted in developing and meeting service goals to increase housing stability and prevent returns to jails, shelters, and other services.

5 Troubleshoot Barriers to Facilitate Housing Placement and Retention

Through routine oversight meetings, the working group reviews and troubleshoots barriers to housing placement and retention, especially barriers that stem from bureaucratic approval processes.

6 Track Recruitments, Placements and Avoidance of Crisis Services

Systems and procedures are created to conduct real-time tracking of client recruitment, housing placement, and client use/avoidance of jail, shelter, and other services.

7 Measure Reductions in Crisis Services and Cost-Effectiveness of Model

Outcomes and impact are measured either through a formal evaluation or informal outcomes tracking process, which measures reductions in jail, shelter and other crisis services used and attendant cost offsets. These cost offsets are compared against the cost of supportive housing.

8 Enlist Policymakers to Bring FUSE to Scale

Based upon the success of the model in reducing crisis services use and costs, the working group engages key policymakers to commit additional resources to bring the model to full scale, that is, enough units to reach the full set of individuals identified in the data match.

9 Expand the Model, Participating Providers and House New Clients

With newly committed resources, expand capacity of current providers and recruit and train new providers to recruit and house new frequent user clients.

APPENDIX T:
DISCHARGE PLANNING RESOURCES

Preventing Homelessness: Discharge Planning from Corrections Facilities

August 2002

Community Shelter Board
115 West Main Street, LL
Columbus, Ohio 43215
(614) 221-9195 phone
(614) 221-9199 fax
www.csb.org

Preventing Homelessness:
Discharge Planning
Community Shelter Board
August 2002

Why Prevention?

"The homeless assistance system ends homelessness for thousands of people every day, but they are quickly replaced by others. People who become homeless are almost always clients of public systems of care and assistance. These include the mental health system, the public health system, the welfare system, and the veterans system, as well as the criminal justice and the child protective service systems (including foster care). The more effective the homeless assistance system is in caring for people, the less incentive these other systems have to deal with the most troubled people – and the more incentive they have to shift the cost of serving them to the homeless assistance system." (National Alliance to End Homelessness [NAEH], 2000)

"Prevention holds hope as a sensible and cost effective way to stop the growth of homelessness. Given scarce public and private resources, the continual entry and re-entry of people into the homeless population makes it difficult to move beyond an emergency response to the problem. Were we to stop this flow, we could more effectively provide assistance to those who are currently homeless and begin to reduce the size of the homeless population. Only when this is done will the end of homelessness truly be in sight." (NAEH, 1992)

HOMELESSNESS AND PRIOR INSTITUTIONALIZATION

- Almost 25% of the homeless population have been in a mental institution before they became homeless.
- 29% of homeless individuals were in some kind of treatment program before their current episode of homelessness.
- Over half of all homeless have previously been in local jails and about 20% have been in prison.
- Between 29% and 47% of homeless adult males have served in the armed forces prior to becoming homeless.
- Somewhere between 14% and 39% of the homeless population have been involved with foster care (compared with 2%-3% of the general population).

Lindblom, 1991

Why Discharge Planning?

The mental health systems, alcohol and drug treatment providers, and correctional facilities regularly release individuals back into society with little or no support upon exiting. The lack of support and/or proper planning increases the likelihood of individuals returning to jail, mental health facilities, or relapse into addictive behaviors.

U.S. Department of Justice, 2000

- Nearly 600,000 inmates arrive yearly at the doorsteps of communities nationwide (591,000 are state prisoners). By comparison, fewer than 170,000 were released in 1980.
- Inmates have always been released from prison, and officials have long struggled with helping them to success. But the current situation is different. The numbers of returning offenders dwarf anything known before, the needs of released inmates are greater, and corrections has retained few rehabilitation programs.
- Determinate sentencing means automatic release. Indeterminate sentencing lost credibility in part because it is discretionary use. But most corrections officials

believe some power to individualize sentences is necessary, since it is a way to take into account changes in behavior or conditions that occur during incarceration.

- Increased dollars have funded operating costs for more prisons, but not more rehabilitation.
- The Office of National Drug Control Policy reported that 70-85 percent of State prisoners need treatment; however, just 13 percent receive it while incarcerated.
- Nearly 1 in 5 inmates in U.S. prisons report having a mental illness.
- Eighty percent of returning prisoners are released on parole and assigned to a parole office. The remaining 20 percent (about 100,000 in the 1998), including some who have committed the most serious offenses, will "max out" (serve their full sentence) and leave prison with no postcustody supervision.
- Fully two-thirds of all parolees are rearrested within 3 years. The numbers are so high that parole failures account for a growing proportion of all new prison admissions. In 1980, they constituted 17 percent of all admissions, but they now make up 35 percent.
- Recycling parolees in and out of families and communities has a number of adverse effects. It is detrimental to community cohesion, employment prospects and economic well being, participation in the democratic process, family stability and childhood development, and mental and physical health and can exacerbate such problems as homelessness.

NATIONAL CORRECTIONAL POPULATION REACHES NEW HIGH -- GROWS BY 126,400 DURING 2000 TO TOTAL 6.5 MILLION ADULTS

The nation's combined federal, state and local adult correctional population reached a new high of almost 6.5 million men and women in 2000, having grown by 126,400 men and women during the year, the Justice Department's Bureau of Justice Statistics announced in late August 2001. The total represented 3.1 percent of the country's total adult population, or 1 in every 32 adults.

The total adult correctional population includes incarcerated inmates as well as probationers and parolees living in the community. On December 31, 2000, there were 3,839,532 men and women on probation, 725,527 on parole, 1,312,354 in prison and 621,149 in local jails. The 2 percent increase last year was half the average annual increase of 4 percent since 1990.

During the past decade the total correctional population increased 49 percent. There were 2.1 million more men and women under correctional supervision in 2000 than in 1990.

AUGUST 8, 2001 - OHIO

- 45,833 incarcerated, a 2.2% reduction from 1999.

What is Discharge Planning?

Discharge planning is a process that occurs while the individual is still incarcerated, which prepares the individual for her or his re-entry into the community. Discharge planning is a formal function of corrections administrations in several states, and occurs informally in others via correctional health providers, community-based social services providers, or other prison-based social services staff. Discharge plans usually include an estimated discharge date, programs that the individual has completed in prison, and medical records, and attempt to line up a post-release residence, medical and mental health care providers, and other community-based services for the individual.

Preventing Homelessness:
Discharge Planning
Community Shelter Board
August 2002

Housing is Major Barrier to Successful Reentry

- With no income immediately upon release, ex-offenders lack resources for rent and other housing costs, which limits housing options.
- Offenders convicted of drug offenses are barred from public and assisted housing.
- Screening for criminal history is common by landlords.
- Siting of halfway houses and supportive housing for ex-offenders is very contentious with prospective neighbors.

People with Mental Illnesses Often Lack Benefits Upon Release

- Growing numbers of men and women with severe mental illnesses are in jail or prison. Many cycle through corrections facilities repeatedly, costing criminal justice systems and communities significant resources and causing pain to the individual and their families.
- 284,000 men and women in jail have a severe mental illness such as schizophrenia or manic depression.
- Generally, the length of time a person is in jail determines whether, or when, federal SSI benefits will be affected.
- SSDI benefits are suspended following a conviction and confinement in jail for 30 days or longer.
- Medicaid and Medicare are suspended when someone is incarcerated. Medicare resumes when SSDI payments resume. Depending on length of incarceration, Medicare may be resumed upon release but may require redetermination of eligibility.
- Inmates not receiving benefits when sent to jail can apply for SSI or SSDI while incarcerated, in anticipation of their release. They usually need assistance, however, to obtain the appropriate forms and gather the necessary evidence.

SUPPORTIVE HOUSING DEVELOPERS FACE CHALLENGES TO DEVELOP HOUSING FOR EX-OFFENDERS:

Challenges unique to the criminal justice context may complicate involvement by supportive housing providers. These include challenges related to:

1) the unique service needs of ex-offenders;
2) working with the criminal justice system who tends to seem highly bureaucratic and whose case-management style differs from that of supportive housing providers;
3) involvement and coordination of new and diverse kinds of partners; and
4) new project models (more programmatic models than typical supportive housing).

A Guide to Re-Entry Housing
Corporation for Supportive Housing
2002

This country has made a decision to make a commitment, not in prevention, not in treatment, but in incarceration. There's a huge re-entry problem that policy-makers are just waking up to.

JoAnne Page, Executive Director
Fortune Society
SwissInfo News, August 21, 2002

What Can Be Done?

Innovative community programs

Improved public policy (federal, state, and local)

Sampling of Innovative Programs

Fortune Society, a New York non-profit organization staffed primarily by ex-offenders, provides housing and services to former prisoners. Operates the Castle, a 59-bed center on the western edge of Harlem.

Druid Heights Transitional Housing for Ex-Offenders, Baltimore, Maryland, started with a grant from the Enterprise Foundation. The project is part of an overall neighborhood revitalization strategy.

Safer Foundation, Chicago, provides education, employment and supportive services to ex-offenders and offenders. Manages secured residential centers.

Project Return, New Orleans, is a 90-day program that provides drug counseling, education, and job training. Incorporates non-traditional methods for grief counseling such as tribal rituals.

ELEMENTS OF SUCCESSFUL DISCHARGE PLANNING

1. The plan should prevent consumers from falling into homelessness.
2. Identification of appropriate housing is critical.
   - Discharges to emergency shelters are inappropriate for any situation.
   - Discharges to homeless programs who have 24-hour transitional program may be made on a case by case basis.
   - Discharges to supportive housing and/or halfway houses are beneficial.
3. Planning must be individualized, comprehensive, and coordinated with community based services.
4. Consumers must participate in the planning.
5. Institution staff (inclusive of professional staff) and community partners should be included.
6. For consumers who abuse substances, appropriate treatment must be included.

Essential Resources for Discharge Planning
National Health Care for the Homeless Council
2002

Sampling of Policy Initiatives

Federal Initiatives

The **Reentry Partnership Initiative**, sponsored by the U.S. Department of Justice's Office of Justice Programs and National Institute of Justice, provides new models for offenders returning to the community in eight sites: Baltimore, Maryland; Burlington, Vermont; Columbia, South Carolina; Kansas City, Missouri; Lake City, Florida; Las Vegas, Nevada; Lowell, Massachusetts; and Spokane, Washington.

The Serious and Violent Offender Reentry Initiative was developed by the U.S. Department of Justice Office of Justice Programs (OJP), in conjunction with other federal partners. The Reentry Initiative is a comprehensive effort that addresses both juvenile and adult populations of serious, high-risk offenders. It provides funding to develop, implement, enhance, and evaluate reentry strategies that will ensure the safety of the community and the reduction of serious, violent crime. This is accomplished by preparing targeted offenders to successfully return to their communities after having served a significant period of secure confinement in a state training school, juvenile or adult correctional facility, or other secure institution.

THREE PHASES OF REENTRY

Phase 1—Protect and Prepare: Institution-Based Programs. These programs are designed to prepare offenders to reenter society. Services provided in this phase will include education, mental health and substance abuse treatment, job training, mentoring, and full diagnostic and risk assessment.
Phase 2—Control and Restore: Community-Based Transition Programs. These programs will work with offenders prior to and immediately following their release from correctional institutions. Services provided in this phase will include, as appropriate, education, monitoring, mentoring, life skills training, assessment, job skills development, and mental health and substance abuse treatment.
Phase 3—Sustain and Support: Community-Based Long-Term Support Programs. These programs will connect individuals who have left the supervision of the justice system with a network of social services agencies and community-based organizations to provide ongoing services and mentoring relationships.

Examples of potential program elements include institution-based readiness programs, institutional and community assessment centers, reentry courts, supervised or electronically monitored boarding houses, mentoring programs, and community corrections centers.

The Reentry Initiative represents a new way of doing business for federal, state, and local agencies. Instead of focusing the Initiative on a competition for a limited amount of discretionary funds, the federal partners are coming together to help state and local agencies navigate the complex field of existing state formula and block grants and to assist them in accessing, redeploying, and leveraging those resources to support all components of a comprehensive reentry program. The discretionary funding available through this Initiative will be provided only to fill any gaps in existing federal, state, and local resources.

Communities selected to participate in the Reentry Initiative will have the opportunity to develop state-of-the-art reentry strategies and to acquire knowledge that will contribute to the establishment of national models of best practices. The Reentry Initiative allows communities to identify the current gaps in their reentry strategy and present a developmental vision for reentry that seeks to fill those gaps and sustain the

overall strategy. Additionally, communities can enhance existing reentry strategies with training and technical assistance that will build community capacity to effectively, safely, and efficiently reintegrate returning offenders.

The Serious and Violent Offender Reentry Initiative is supported by the U.S. Department of Justice, Office of Justice Programs and National Institute of Corrections, and their federal partners: the U.S. Departments of Education, Health and Human Services, Housing and Urban Development, and Labor.

Massachusetts

In January 2000, the Massachusetts Executive Office for Administration and Finance established the Working Group on Discharge Planning. The group was charged with examining the discharge planning policies and systems within correctional facilities and the Commonwealth's human service agencies and identifying initiatives to improve these systems.

> *Among the many objectives to be achieved by discharge planning,* ***the goal of preventing releases into homelessness should appropriately be identified as one priority****. This should include a discussion of discharge planning as both a public safety issue, as it relates to the potential reduction of recidivism, and a cost containment opportunity. In evaluating the success of discharge planning conducted by both Commonwealth employees and contracted vendors, prevention of releases into homelessness should be included as a performance standard. This is not to argue that discharge planning in the context of correctional facilities can, or should, be understood as guaranteeing stable housing arrangements or supportive services for every released inmate. Consistent with their mission to promote public safety, however, these institutions can be expected to act on behalf of the general public in assisting inmates who are in their custody and are preparing to transition back into the general public*

Current Massachusetts Best Practices

- **Needs assessment** of inmates to be discharged are conducted.
- Through the **Triage Team system**, appropriate parties likely to possess vital information regarding post-release needs are brought together.
- The **five-day workshops** and the **reintegration program for substance abusers** associated with the Correctional Recovery Academy both involve the inmates extensively in the process of planning for their own post-release conditions.
- The Department of Correction's recently established collaborative efforts with both the Department of Public Health and Department of Mental Health provide **specialized discharge planning services for targeted populations.**
- The Department of Corrections, in collaboration with other agencies, appears to be in the process of expanding the **involvement of community-based service providers** within their facilities. By contracting for services with community-based providers who will continue interacting with the inmate in the post-release period, these efforts promise to offer some continuity of service to those passing through the transition

period. This type of continuity is an important characteristic of effective discharge planning.

- The **Transitional Intervention Plan** also promises to provide feedback to discharge planners regarding the success and appropriateness of their discharge planning, which is another important characteristic of effective discharge planning.

Planned Massachusetts Initiatives

1. The Department of Correction is in the early implementation stages of a **system-wide discharge planning process**. As part of this process, the Department will clearly articulate the role of discharge planning in its overall mission. The Department will also establish a method to monitor the operational success of the new process and its various components. Such an evaluation will be designed to identify both the potential benefits and the limits of discharge planning as a means of promoting successful reintegration and, by extension, furthering the goal of protecting public safety.
2. As the Department of Correction makes housing referrals, it will compile an **inventory list of transitional and supportive housing** programs being utilized by inmates released from its facilities. Without such an inventory, it is nearly impossible to evaluate the needs that exist or the reallocation of resources that might be possible and desirable.
3. As discharge planning becomes a more prominent aspect of the Department's work, **appropriate training for those staff** carrying out these responsibilities will be provided. The Department will develop a systematic training process by which staff members learn to locate and identify the community resources available to released inmates.
4. The Department will **catalogue its collaborative efforts** with other state agencies and departments and identify those that are regularly serving its released inmates. Such identification will serve as a first step in identifying potential areas of further collaboration to strengthen the safety net of services available to these vulnerable populations and thus reduce recidivism and higher long-run costs to the Commonwealth.
5. While utilizing community-based resources for services during the pre-discharge period poses a greater challenge for the Department's facilities than it does for the more geographically-specific, county correctional facilities, linkages will be actively pursued wherever possible. To date, the Department has experienced limited involvement of community-based resources providing services to inmates within its facilities. This type of **continuity of care** can provide important community links and help minimize the disruption of the transition period.
6. The Department will establish procedures to **gather information** on the appropriateness of its placement practices. As the Department increases its interaction with community-based service providers, it will have an ongoing system

compromising the privacy rights of ex-offenders, the Department will collect information from community-based providers about the general and ongoing suitability of its referrals and placements. The Transitional Intervention Plan will be closely monitored as a model in this regard. Although TIP is designed to serve a limited population (AIDS/HIV positive inmates), the lessons learned from its design and operation will be closely observed and shared with the Department's policy-makers.

7. The Department will adopt low-cost procedures to be followed for the one-third of its inmates who chose not to participate in discharge planning workshops. For example, the Department is preparing **resource packets** to provide certain inmates upon their release. There will always be non-participating or disengaged inmates who, nevertheless, have needs related to their reintegration**.** Contingency plans, such as the distribution of resource packets, are not in place at this time. While transition planning is ultimately the responsibility of the released inmate, the potential community costs of failed reintegration dictate that some minimal level of useful information should be provided to all inmates being released.

8. The Department will **identify those inmates most likely to be at high risk of homelessness beyond those suffering from substance abuse and mental illness**. The Working Group on Discharge Planning heard anecdotal evidence of the unique challenges facing some types of offenders in their attempt to secure housing in the post-incarceration period. The Department will attempt to quantify this problem and articulate the need for discharge planning and community reintegration programs appropriate to these types of special populations. Such an assessment should include a realistic evaluation of the potential and limits of pre-release discharge planning.

9. Over the past several months, the Department of Correction has undertaken "reentry initiatives" with two separate Commonwealth communities. The initiatives involve **working with local law enforcement and community representatives** to support an inmate's transition into the community. Specifically, the Department is working with the City of Lowell and Hampden County. These two programs will be closely monitored as pilots that can potentially be expanded statewide in the future.

10. The Department will formally seek definitive word from the Headquarters Office of the U.S. Department of Housing and Urban Development (HUD) on **inmate eligibility for McKinney-funded transitional housing resources**. Having done so, the Department will then ask the Executive Office of Public Safety (EOPS) to circulate this information to all those involved with discharge planning from correctional facilities in order to make sure there is universal understanding of the eligibility requirements. EOPS will then solicit the support of parties responsible for overseeing the funding and operation of such transitional resources to make them aware of the HUD regulations.

Illinois

Congressman Danny K. Davis, 7th District of Illinois, introduced new legislation entitled "Public Safety Ex-offender Self Sufficiency Act of 2002" (H.R. 3701) into the House of Representatives on February 7, 2002. It provides for *transitional housing* for ex-offenders, with on-site delivery of **employment placement** and **supportive services** to facilitate successful ex-offender re-entry and promote public safety.

H.R. 3701 amends the IRS code of 1986 to reflect an ex-offender low-income housing credit to encourage the provision of housing, job readiness training, and other essential services delivered in structured living environments designed to assist ex-offenders in becoming self-sufficient.

This comprehensive legislative initiative addresses the United States' lack of a systematic, comprehensive approach to re-integrating the increasing number of returning ex-offenders. It seeks to decrease recidivism rates and the cost of crime to victims, and increase public safety.

This legislation addresses needs and solutions identified by the 7th District of Illinois Ex-Offenders Task Force, a broad group of representatives from national and local civil rights organizations, community-based organizations, ex-offenders, academicians, law-enforcement officials, elected officials, community activists, faith-based organizations, block club residents, businesses and community residents who collaborated with the ex-offender population to find solutions.

The Task Force identified safe and affordable housing for ex-offenders as a key barrier and critical as a stabilizing force. But since the issues are far broader than housing alone, this legislative initiative addresses the re-integration of ex-offenders from a more holistic perspective.

Among the support services identified in the legislation are: job readiness training, employment counseling and placement, entrepreneurial training, financial management, substance abuse counseling, anger management, healthcare services, educational assistance and family and crisis management. The ex-offender resident must enter a written agreement to attend and participate in the supportive services program and may not default on this agreement.

For a copy of the bill and its status, go to Thomas: Legislative Information on the Internet (http://thomas.loc.gov) and type in H.R. 3701 or contact Congressman Davis' office at 773/533-7520.

Minnesota

Minnesota Department of Corrections has undertaken an effort to develop housing options for ex-offenders. The initial report (March 2001) recommended the following housing services:

- Guaranteed emergency bed access
- Transitional housing
- Supportive housing
- Access to market rate and affordable housing

Additional recommendations focused on improved system coordination and communication, improved transitional services and earlier release planning, as well as, increased public education and awareness of needs.

Ohio

Ohio Department of Rehabilitation and Corrections

The Ohio Department of Rehabilitation and Corrections (ODRC) plans to develop and implement the Ohio Community-Oriented Reentry (CORE) Project, which will target adult offenders who are returning to Ohio's two largest urban areas, Cuyahoga and Franklin Counties, and the suburban/rural area of Allen County. Through the CORE Project, the Department will partner with various service agencies to address the challenges of recidivism, substance abuse, and physical and mental health issues and to support education, workforce participation, housing, family reunification, faith-based issues, and mentoring. (Amount of DOJ grant: $1,998,014)

Local contact: Horst E. Gienapp, 614–752–1607.
OJP contact: Adam Spector, 202–307–0703.

ODRC has established a designated liaison to the Community Shelter Board and the Continuum of Care's 10-Year Plan to End Homelessness. She will be touring supportive housing developed under the Rebuilding Lives Plan on September 5, 2002.

Ohio Supreme Court

Ohio Supreme Court Justice Eve Stratton has a statewide task force to develop sentencing options and diversion programs. The Community Shelter Board has provided background is a resource to the court.

Franklin County

Judge Scott Vanderkaar, and Judge Jennifer Brunner have convened a task force to address issues of mental illness and the local criminal justice system. Sub-committees are working on the following: Crisis Intervention Team Training, Mental Health Courts, Jail Assessment and Referral and Public Awareness. Tom Albanese, Program Director at the Community Shelter Board, is a member of the Task Force

CSB staff met with Gayle Dittmer, Chief Probation Officer, Franklin County Adult Probation, on August 28, 2002.

Next Steps for CSB

Cultivate relationship with ODRC

- Develop understanding of discharge practices
- Request participation in CORE initiative
- Explore feasibility of cooperation to facilitate development of supportive housing
- Explore options to decrease discharge to shelter

Participate in ongoing planning groups

- Franklin County Mental Health Court Task Force
- Ohio Supreme Court

Cultivate relationship with Franklin County Probation and Sheriff's Office

- Develop understanding of discharge and supervision practices

Develop understanding of local impact and resources

- Explore feasibility of determining extent of ex-offenders receiving homeless services via HMIS data match with ODRC and/or sample survey of shelter residents.
- Establish point of contact at all local human service organizations which work with ex-offenders

Develop state advocacy strategy

- Meet with local faith-based organizations to understand advocacy and programming activities related to criminal justice
- Meet with COHHIO to determine feasibility of joint advocacy efforts to develop coordinated discharge planning and adequate resources to assure re-entry without utilization of homeless services
- Meet with Columbus Coalition for the Homeless members to determine feasibility of joint advocacy efforts to develop coordinated discharge planning and adequate resources to assure re-entry without utilization of homeless services

Provide support to CSB partners

- Share information about all of the above
- Determine needs of providers to better divert ex-offenders who are being released from corrections facilities

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APPENDIX T:
DISCHARGE PLANNING RESOURCES

A PUBLICATION OF THE HCH CLINICIANS' NETWORK

HEALING HANDS

Vol. 12, No. 5 ■ October 2008

Tools to Help Clinicians Achieve Effective Discharge Planning

Too many people without financial resources and social supports cycle among hospitals, mental health facilities, foster care or group homes, correctional institutions, shelters, and the streets. These insidious "revolving doors" exacerbate homelessness and call for clinicians and communities to find coordinated solutions that are humane and cost effective. First steps often involve creative adaptation of existing interventions. The following articles discuss discharge planning strategies and focus on individuals who are leaving health care institutions, jails and prisons, protective youth services, or the armed forces.

In 2006–2007, one in five homeless individuals admitted to shelter programs came from either in-patient medical facilities (12%) or correctional institutions (9%).[1] Those figures do not include unsheltered individuals or those living in domestic violence shelters or doubled up with family members or friends.

Discharge Planning: The process—beginning on admission—to prepare a person in an institution for return into the community and the linkage of the individual to essential community services and supports.

— Massachusetts Housing and Shelter Alliance

Regardless of which institution an individual may be leaving, some form of discharge planning is imperative to assure a successful transition to independent or assisted living. Without a stable home environment and family or peer support, people recovering from illness, surgery or physical injury; those without health insurance and income; and those newly emancipated from protective or correctional institutions are especially vulnerable to the harsh realities of homelessness. Many homeless shelters provide a place to sleep at night but close their doors in the morning, leaving residents to depend on soup kitchens, drop-in centers or public places, or to walk the streets without a safe place to rest or heal.[2]

Poignant case histories illustrate what can happen without adequate discharge planning. **Brooke Doyle**, Vice President of Homeless Services and Intensive Addiction Services at Community Heathlink's HOAP project in Worcester, MA, oversees facilities that provide medical and mental health case management at multiple service sites. Recently, she relates, "One of our clients was released from prison to an emergency shelter where our staff provides health care services. He had an open wound from recent surgery for a spinal cyst. His health risk was too high for shelter living, and he was unable to manage on the streets during daytime hours." In addition, as a former sexual offender, he was barred from subsidized housing and nursing homes.

HOAP has two respite beds that are staffed 24/7 at its primary site. The staff was able to establish wound care through their hospital partner; but this patient will occupy 50% of the center's medical respite capacity for an extended period of time—perhaps 12 months—before he is sufficiently healed to be discharged to a shelter. "Clearly, this case illustrates a lack of coordinated and humane planning," observes Doyle. "It is understandable that when an inmate's sentence has been completed, he or she needs to be released. But individuals with no income and no family don't have a lot of choices."

Ted Amann, MPH, RN, Director of Healthcare and Improvement at Central City Concern in Portland, OR, reminds us that "adapting to the changing fiscal and healthcare landscape while maintaining essential social benefits requires foresight, innovation, and new sources of revenue. Together, hospitals, states, the broader health care community, insurers, and patients must craft solutions that are financially viable and compassionate so that medically underserved populations, including rural communities, receive adequate healthcare now and far into the future."[3] That means hospitals, substance abuse treatment facilities, medical respite care providers, prisons, jails, and protective programs for youth all need to be skilled in the principles and practice of discharge planning.

Discharge Planning Guidelines for Health Care Institutions[4]

- Provide physical and mental/cognitive assessment at intake.
- Work with the patient on treatment adherence issues.
- Ensure patient stability prior to discharge.
- Base the decision to discharge on medical, not financial considerations.
- Encourage the patient (or surrogate) to participate in discharge planning.
- Give the patient (or surrogate) written notice of the intent to discharge and allow for an appeal of the discharge determination.
- Involve social work, pastoral care, legal counsel, ombudsman, ethicist, and a multidisciplinary care team in discharge planning.
- Provide information about community resources to clinicians and patients.
- Dedicate a clinical social worker to all homeless discharges.

The Health Care Link in Discharge Planning

On July 14, 2008, representatives of major homeless continuums of care in Cook County, IL met with county, state and federal officials to discuss how discharge policies of health, mental health, youth services, and correctional institutions were impacting homelessness. This Countywide Forum on Discharge Planning and Homelessness resulted in the formation of seven subcommittees representing agencies and subpopulations affected by discharge planning: Veterans Affairs, Health Care, Mental Health Care, Substance Abuse Treatment, the Cook County Jail, Youth Protective Services, and the Illinois Department of Corrections.

Kathleen Kelleghan, Associate Director of Health Outreach Services for Heartland Health Outreach in Chicago, chairs the Health Care subcommittee. "The forum inspired hope that this collaborative effort will engender necessary systems change to assure better care for vulnerable people," said Kelleghan, who has already seen how important it will be for her group to interact with the other six.

Nancy Radner, Chief Executive Officer of the Chicago Alliance to End Homelessness, told forum participants: "We are finding that people who leave the mental health, corrections, or child welfare systems can end up in the homeless [service] system. [It is important to] highlight how effective planning and coordination among these systems [can be] the key to preventing homelessness for so many people."

REVOLVING DOORS In the mid-1980s, caregivers nationwide began to notice the often cyclical inter-relationships among institutions that provide medical or behavioral health care, child protective services, and correctional facilities, and to realize their collective impact on homelessness. Clients tended to move from one institution to another without careful screening or resources, as if through revolving doors.[5,6] As more and more homeless individuals were caught in this vortex, financial burdens for institutions increased, public budgets inflated, and pressure was exerted on clinicians, administrators, and government agencies to look for creative solutions.

The U.S. Department of Housing and Urban Development (HUD) published a bibliography on discharge planning in 2005, noting that "good discharge planning is the lynchpin of a comprehensive homelessness prevention strategy."[7] Ensuring an individual's successful transition from institutions to the community "requires continuity of care and linkages to appropriate housing and community treatment and support" following discharge.[5-7] Research emphasizes that without permanent housing options even the most effective discharge planning will fall short.[5,8,9]

The National Health Care for the Homeless Council finds the linkage between ineffective discharge planning and homelessness unacceptable and recommends:[10]

- Development of explicit discharge planning policies;
- Prohibition of institutional discharge into homelessness from all publicly funded institutions including hospitals, treatment facilities, jails, prisons, and the foster care system;
- Effective discharge into stable housing as an imperative outcome measure for any residential program; and
- Requirement that publicly funded institutions help residents secure all available entitlements prior to discharge.

ZERO TOLERANCE In 1994, the State of Massachusetts mandated zero tolerance for discharge to homelessness in response to pressure generated by the Massachusetts Housing and Shelter Alliance (MHSA). Research conducted by MHSA identified state systems that were discharging clients without stable housing options.[11] As a result, state agencies eventually adopted common discharge planning procedures.

With the assistance of its 87 member agencies, including the Boston HCH Program, MHSA introduced innovative procedures to prevent homelessness through better discharge planning.[11] MHSA contends that discharge planning

- must be tailored to meet different needs of different consumers;
- should be comprehensive;
- must create a system that is continuous and coordinated;
- must prevent consumers from falling into homelessness; and
- should begin at admission.

The HUD McKinney Act requires states, counties, and city governments that apply for continuum of care funds to certify that their communities have policies and protocols in place to prevent the discharge of individuals into homelessness. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has required hospitals to practice discharge planning since 2003.[5] Nevertheless, discharge planning processes are far from uniform, ranging from minimalist to comprehensive practices. It is hoped that emerging evidence-based practices will validate preventive models and encourage their adoption by service organizations nationwide.

TRAINING FOR CLINICIANS There are 79,000 homeless people and 5,240 emergency shelter beds in Los Angeles County. Inappropriate hospital discharges to the streets have increased dramatically and documented cases have been prosecuted, resulting in large monetary settlements. Homeless Health Care Los Angeles (HHCLA) conducted a detailed survey about the experiences of clients discharged from area hospitals and follow-up practices, with support from the Kaiser Permanente Foundation. In response to survey results, HHCLA developed an innovative training model that is designed to help clinicians improve their skills. The training targets social workers, discharge planners, nurse case managers, and selected emergency department personnel.

Director of Discharge Planning Services **Linda Rodriguez, MSW**, explains that HHCLA's training curriculum focuses on

- Clinicians' roles in discharge planning and legal and regulatory responsibilities;
- Community resources including social services;
- Values inherent in the delivery of discharge planning services;

- Assessment as a continuous process on which planning criteria are based; and
- Strategies to reduce avoidable inpatient days through better discharge planning.[4]

HOSPITAL CONSULT SERVICE
Operation Safety Net in Pittsburgh, PA, has implemented a hospital consult service for homeless people. "The consult program serves both clients and hospitals by providing ongoing clinical communication and filling the reality gap that exists when the client leaves the hospital," explains Medical Director **Jim Withers, MD**. "We are called to visit clients at admission, which allows us to share background information with hospital staff and facilitates inpatient assessment. The patient sees a familiar face, and we know how to follow up with client care after discharge. This enables us to remain in the care loop."

MEDICAL RESPITE CARE Some urban areas including Washington, DC, and Boston have operated medical respite care facilities for homeless people since the 1980s.[12] Others are seeing the need to begin or expand such programs in the face of shorter hospital stays and a growing need for recuperative services and continuity of care after clients move back into the community. There are currently over 40 medical respite centers in the U.S. and Canada (http://www.nhchc.org/Respite/2008-2009RespiteCareProgramDirectory100708.pdf).

Homeless people are known to experience higher rates of physical and mental illness than the general population. A study by the Stroger Hospital of Cook County in Chicago suggests that medical respite care improves health outcomes and reduces health care costs. The cost of respite care provided to the study cohort was approximately half the per diem rate for hospital care and resulted in a 36% decrease in emergency department (ED) usage.[13]

"Interfaith House, a 64-bed facility in Chicago established in 1994, often fills an essential gap between a homeless person's hospital discharge and complete recovery," says Kathleen Kelleghan. "But there just aren't enough beds—3 of every 4 patients must be turned away. One of our needs is to find alternatives for medical respite care, perhaps by using established clinic sites."

During the 2008 National HCH Pre-conference Institute on Respite Care and Hospitals, **Adele O'Sullivan, MD**, Medical Director of the Maricopa County Public Health Department's HCH project, spoke passionately about the drive to build a homeless respite center in Phoenix, AZ that will open with 25 beds. What had been a dream for the future became a front-burner issue for Phoenix after an egregious example of a hospital discharge to the streets was caught on the homeless center's security videotape. People from across the community have contributed time, talent, skills, and money to bring the new facility closer to reality.

Benefits of Medical Respite Care[2]

- Stabilization of acute health conditions and a care plan to address chronic conditions
- Help getting required documentation to qualify for public benefits: Food Stamps, SSI/SSDI, Medicaid
- Help getting stable housing and employment
- Linkage to community service agencies offering ongoing support
- Better self-management of health following discharge from respite care

These initiatives are important because acute and chronic illnesses can be extremely difficult to treat when patients do not have a stable living situation in which to receive recuperative or convalescent services. Mental illness, substance dependence, HIV, and tuberculosis require regular, uninterrupted treatment and are exacerbated by exposure to the elements, poor diet, lack of health insurance, and irregular access to primary care. Medical respite programs can:[2]

- Prevent patient readmission to the hospital by providing a clean living area where wounds can heal;
- Provide patient referrals for medical evaluations;
- Initiate case management services that facilitate documentation of eligibility for health insurance or other disability benefits; and
- Protect existing relationships with case managers while building patients' readiness to address mental health issues and seek more permanent housing.

PARTNERING WITH HOSPITALS
Across the country, many tertiary care hospitals affiliated with universities are finding the economics of health care unmanageable. Oregon Health & Science University Hospital (OHSU) in Portland serves some of the state's most vulnerable citizens who are unable to pay for their care. In 2007, the hospital sustained uncompensated costs totaling $53 million.[3]

Central City Concern (CCC) in Portland, which operates a continuum of affordable housing integrated with health care, addictions treatment, recovery support, and employment services, is partnering with OHSU to help reduce some of these costs. CCC's medical respite care program, which is supported by a grant from OHSU, serves high utilizers of the hospital's ED whose complex health problems and unstable living conditions often result in longer inpatient stays and frequent readmissions.[3]

This collaboration between CCC and OHSU has resulted in more effective care management. The respite program has:[3]

- Reduced the length of homeless patients' hospital stays;
- Improved patient flow and capacity management;
- Provided cost-effective care of high quality by trained staff familiar with the needs of homeless people; and
- Managed other care functions such as utilization review, discharge planning, and social services.

This partnership has also resulted in better fiscal outcomes and resource management for OHSU:

- Patients moving to the respite program required shorter hospital stays;
- Respite care protected medically stabilized clients and added social stability that helped decrease the likelihood of readmission; and
- Engagement in primary care through the respite program provided client education about how best to use the health care system and discouraged unnecessary dependence on the hospital emergency department.

Discharge Planning for Re-entry after Incarceration

Kushel and colleagues conducted a study of homeless and marginally housed adults in San Francisco that illustrates the bi-directional association between homelessness and imprisonment. Acknowledging that "the intersection of substance abuse, unemployment, imprisonment, and homelessness is potent and lasting," they concluded that "high rates of imprisonment among homeless populations may be the end result of a system that does not provide access to timely services—including access to housing, health care, mental health care, and substance abuse treatment—and systems that have obstacles preventing receipt of these services by people exiting prison." [14]

Jails and prisons are mandated to provide health care, but are allowed to use their own staff, private contractors, or community health centers as providers. Traditional approaches have often been slapdash; many inmates are discharged with even worse medical problems than they had at intake.

Each year, over 9 million people spend hours, days, or months in the United State's 3,300 jails; 80% of inmates are incarcerated less than a month and as many as 60% are awaiting trial or arraignment.[15] Because inmates are generally incarcerated for a limited period, many of these individuals (mostly men) cycle back into their communities, bringing a host of communicable and chronic diseases with them. Over a third of inmates report medical problems more serious than a cold; 17% were homeless before being jailed; and 64% have mental health problems.[15] In addition, most inmates have little education, are poor, and lack social support.

CONTINUITY OF CARE During the 1990s, doctors from a clinic in Hampden County, MA, wanted to track patients with HIV during incarceration. When the Sheriff's Department allowed medical staff into the jails to provide treatment, a new model of care was born. That model resulted in many ex-offenders with medical or mental health problems who after release continued to see providers they had met in jail.

In 2006, the Robert Wood Johnson Foundation allocated $7.5 million to fund a new nonprofit organization, the Community Oriented Correctional Health Services (COCHS), to encourage replication of the Hampden experience nationwide. Since then, in addition to the ongoing project in Hampden County, COCHS has added similar projects in the District of Columbia and Ocala County, FL.

Community-based approaches to ensure continuity of care have often relied on the APIC Model: assess, plan, identify, coordinate.[16] The COCHS approach goes further, allowing inmates to establish a health care "home," to learn about their health conditions and how to keep from infecting others in their communities after release, and to leave jail with prescriptions that can be filled at their community health center. The model uses new computerized systems to produce electronic medical records that can be accessed by community health clinics after discharge.

Diana Lapp, MD, Deputy Chief and Medical Director of Correctional Health Facilities for Unity Health Care, the HCH grantee in Washington, DC, is tremendously proud of her staff's accomplishments. "Unity has 11 discharge planners who begin working with inmates soon after incarceration, often the same day, by developing an individualized plan of care that will connect the inmate back to the community," she says. "All inmates receive primary care in jail from 'half and half providers', who spend half time at the correctional facility and half time at one of Unity's 28 health sites. At discharge, over 95% of those released receive a seven-day supply of medications and are connected to the DC Healthcare Alliance; those infected with HIV receive a 30 day supply of meds funded by the AIDS Drug Assistance Program (ADAP) [which provides free medications for the treatment of HIV/AIDS and opportunistic infections]."

EMR "From intake to discharge, we use electronic medical records (EMR) that can later be viewed by providers outside the correctional health system," explains Lapp. "Corrections officials and court officials see the value of our discharge planning, and everyone is helping to make the process seamless." She attributes the program's success to the person-to-person connection between inmates and discharge planners. The planners give inmates their pager numbers along with a packet of information that includes a pamphlet with resources and referrals to facilitate early access to health care sites. The DC Department of Corrections (DOC) gives every person discharged from jail an ID upon release and tokens for food to help encourage successful reintegration into the community.

The DOC–Unity Health Care program is working so well that in July 2008, the National Commission on Correctional Health Care (NCCHC) recognized this remarkable partnership with the "Program of the Year Award," which is presented annually to only one of its 500 accredited prisons, jails, and juvenile detention facilities.

INFECTION CONTROL Prison terms are longer than jail terms, and imprisoned individuals are often located farther from their home communities. Although longer sentences provide an opportunity to work on treatment adherence, infection control is especially problematic in prisons where people from diverse backgrounds and communities are housed in close proximity.

The Centers for Disease Control and Prevention (CDC) have issued guidelines to correctional and detention facilities for the control of HIV/AIDS, viral hepatitis, STD, and TB prevention.[17] Similar to the COCHS programs, the guidelines call for early assessment and identification of infection, completion of prescribed treatment, appropriate use of isolation and environmental controls to minimize transmission of airborne infection, comprehensive discharge planning, and efficient and thorough contact investigation, as well as continuing education for inmates and facility staff.

DISCHARGE PLANNING GUIDE In New Jersey, the DOC's Office of Transitional Services strives to provide a systemwide continuum of care based on proven practice

while trying to prepare the 14,000 offenders it discharges each year for any eventuality. Director **Darcella Sessomes** has created linkages to resources including health care, employment, housing, and family support services.

The department spearheaded development of *The Smart Book: A Resource Guide for Going Home* for New Jersey counties. Recognized nationally as a top-tier discharge planning guide, these booklets leave nothing to chance.

Topics include:

- Getting Started: ID and Other Documents
- First Steps After Release: Where Do I Go to Find . . .
- Taking Care of Yourself: Getting Support and Health Care Resources
- Finding a Job: Employment Assistance and Training Programs
- Reconnecting with Family
- The Game Plan

(http://liberty.state.nj.us/corrections/OTS/news_ots.html)

"These are vital skills for all ex-offenders," says **James Comstock, MSW**, Senior Social Worker at Project HOPE in Camden, NJ. He recently retired after 25 years as a correctional counselor and knows the difference that the Smart Books make for positive discharge planning. "The step-by-step entries give individuals a guidewire to resources for success."

Discharge Planning for Youth in Foster Care

Statistics that describe youth who are aging out of foster care paint a grim picture. These young people suffer disproportionately from physical and mental health problems, may be involved in illegal activities, are isolated from the community at large, and face a life of poverty. Scared, lonely, and angry, they often act out in response to cumulative trauma, making placement in a supportive environment difficult.

Of the 750,000 young adults estimated to experience homelessness each year, 20,000 have a history of foster care. Four years after emancipation, 46% of these individuals have not finished high school, 42% have become parents, 25% have been homeless, and 20% are still not able to support themselves.[18,19]

Research shows that youngsters leaving foster care are hindered by missing social supports, incomplete education, poor employment opportunities, and the inability to access health care and housing.[18,19] While the 1999 Chafee Foster Care Independence Program was enacted to provide a safety net of programs for youth leaving care systems, states are required to add a 20% match to the federal dollars. Flexible funding allows them to design programs for specific groups as needed. Foundations, government agencies, and clinicians are increasingly aware that available funds are insufficient to provide a comprehensive assistance program.[18]

Foster children whose birth parents were themselves in foster care are particularly disadvantaged, both socially and economically. Conservative estimates indicate that 49% of birth parents of children entering foster care have experienced homelessness.[20]

Best Practices for Young People Aging Out of Foster Care

- Preventive rather than reactive practices
- Adequate dollars to fund consistent programs
- Automatic support systems: a health insurance card that travels with young adults through age 25; employment and housing assistance
- Foster care programs designed at the national level and applied consistently across all states
- Mentors for all youth in foster care
- Educational and peer group support for pre-teens so that they learn preparation skills when they are still receptive

— Cheryl Zlotnick, RN, DrPH

PREPARATION & SUPPORT Although young adults who have episodes of homelessness after emancipation may have more trouble accessing health care than do those without a history of foster care, they do not seem to experience worse health outcomes.[21] The key to successful transitions from foster care to the community is preparation for independent living coupled with strong relationships, education, housing, life skills, identity, youth engagement, and adequate financial support.[22]

ONGOING ASSESSMENT **Cheryl Zlotnick, RN, DrPH**, Project Director of the Center for the Vulnerable Child, an HCH project at Children's Hospital and Research Center in Oakland, CA, says that "for children who have experienced trauma and have mental health problems, ongoing psychological assessments and treatment are very important. More time in care, more placements and trauma lead to more mental health problems in later life." It is well-established that young children living in foster care have higher rates of social and psychological problems, notes Zlotnick. In addition, newly emancipated 18 year olds encounter high rates of unemployment and homelessness.

MENTAL HEALTH SERVICES Because childhood history of foster care appears to be linked to later mental health problems, effective statewide interventions for children in foster care could reduce the development of psychosocial problems in adulthood.[23] "Mental health services are very important for children in foster care," Zlotnick emphasizes. "And a constant adult who cares about the child and can be part of his or her life consistently—even a birth mom who is not living with the child—is wonderful."

MENTORING RELATIONSHIPS Ahrens and coworkers' recently published study demonstrates that youth in foster care engaged in mentoring relationships with nonparental adults during adolescence have significantly better outcomes than do nonmentored youth. The establishment of such relationships within existing social networks seems to promote stronger and longer lasting relationships.[24]

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For more information about Discharge Planning, see
the National Health Care for the Homeless Council's website: www.nhchc.org/dischargeplanning.shtml

Communications Committee
Jan Caughlan, LCSW-C (Chair); Bob Donovan, MD (Co-Chair); Tina Carlson, APRN, BC;
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Barbara Wismer, MD, MPH; Sue Bredensteiner (Writer); Pat Post, MPA (Editor)

This publication was developed with support from the Health Resources and Services Administration.
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

APPENDIX U:
MEDICAL HEALTH HOME

Medicaid health homes serve as the center of decision-making by interdisciplinary teams – consisting, for example, of a physician, psychiatrist, nurse, and social worker. Care management activities are reimbursed separately from the discrete health care services provided. The health home role can be assumed within a doctors' practice, an outpatient clinic, or a behavioral health organization, among other providers. Typically, only patients and clients with a threshold level of health care needs are assigned to a health home.

States can offer (but are not permitted to require) the health home benefit to a high-risk person in Medicaid who meets one of three criteria in federal law, specifically one of the following:

Having two or more chronic conditions; or
Having one serious and persistent mental health condition; or
Having one chronic condition and being at risk of developing a second chronic condition.

States can tailor a health home benefit within these eligibility guides. For instance, a state can limit a health home program to people with serious and persistent mental health conditions.

States are also allowed wide latitude to set the package of services that health homes can provide. In guidance, CMS offered the following examples of services: Comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate. [3]

Implications—Medicaid Health Homes
Health home services, such as care coordination, can be key to supporting people in supportive housing who have experienced chronic homelessness or otherwise need help achieving housing stability. Such individuals tend to have intensive behavioral and physical health needs and may be receiving ongoing treatments from a range of providers. Coordination adds value to their care. Yet advocates often cite gaps in funding for coordination as a barrier to successful housing interventions. The separate Medicaid reimbursement under the health home benefit can also contribute to the bottom line of housing and service providers.

EMERGING HEALTH HOME MODELS IN MEDICAID

As Medicaid health home models come on line, features and components relevant to ending chronic homelessness have become apparent. Current models can inform approaches homeless advocates may take now in their states to influence health home designs. The Alliance reviewed state Medicaid plan amendments approved by CMS as of October 1, 2012 (the first year of implementation), with particular attention to target population, provider designations, and payment policies.[4] These design elements can have significant implications for the goals of supportive housing providers and homeless assistance in a given state.

POPULATION FOCUS: BEHAVIORAL HEALTH

All the health home models reviewed focus on at-risk behavioral health populations to varying degrees. For example, Missouri's plan specifies four distinct groups of enrollees eligible for health home services based on a behavioral health need. The groups range from those with a serious and persistent mental health condition, to those with a "substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, development disability, overweight)." For comparison, Rhode Island developed a health home benefit solely for individuals with "one serious mental illness," with no additional qualifying criteria. Ohio is another example of a

state targeting high-risk behavioral health populations with its Medicaid health home benefit. Other states, such as North Carolina and Iowa, offer health homes to individuals with chronic mental illness co-occurring with chronic physical conditions, but do not specifically target behavioral health populations for health home programs.

Implications—Behavioral Health Focus

One of the core advantages of health homes is the ability to integrate behavioral and physical health, while also addressing related problems of housing stability – all within Medicaid. For this reason alone, the implications for supportive housing capacity are significant. Given the prevalence of co-occurring disorders, strategies to address chronic homelessness are best served by health homes that meet the broadest range of behavioral needs. It is important to set eligibility criteria so as not to exclude high-risk homeless groups, e.g., those with primary diagnoses related to substance use. Further, for flexibility to co-locate health home providers within supportive housing, it would be most helpful for health home eligibility to fit clearly the health profiles of people in recovery and with experience of chronic homelessness.

HEALTH HOME PROVIDER TYPES

States designate their Medicaid health home providers according to general federal guidance and the additional criteria they may set. Under core federal standards, providers must have integrated medical staff and the ability to organize and supervise interdisciplinary teams. States so far have taken different approaches to defining or limiting the type of provider that can be designated as a Medicaid health home. The Missouri and Rhode Island programs deem their established community mental health centers (CMHCs) to be health home providers for behavioral health populations in their catchment areas. Ohio, which is also focusing on its high-risk behavioral population, includes private non-profit behavioral health agencies in a broader pool of potential health home designees.

Oregon and New York, to compare, are more flexible in defining the types of providers that may serve as Medicaid health homes. This may be because their programs also reach populations with complicated, non-behavioral medical and physical health conditions. In Oregon, the program designates current Medicaid providers such as community health centers and physicians' practices, in addition to behavioral health organizations that have medical capacity. New York's design would permit any Medicaid provider to apply for the designation, assuming health home service capacity is demonstrated.

Implications—Provider Type

State decisions on health home provider type can have significant implications for homeless assistance and supportive housing capacity. The flexibility in New York's approach, for example, indicates that housing providers already billing Medicaid are in a position to apply for the designation and be reimbursed for health home services to residents. This type of open model also allows community partnerships to form across safety net silos of housing, health care and social services. The built-in flexibility allows for local collaboration and innovation in housing and serving vulnerable homeless people.[5] Depending on the community, however, a more closed model may also be suited to local plans to end chronic homelessness. In states where behavioral health agencies are strong funders and operators of supportive housing, integrating health homes through those agencies makes strategic sense. As always, the key for homeless coalitions is to advocate for and support local priorities to identify and house the most vulnerable. The added service capacity of health homes in public agencies can inform that strategy.

APPENDIX V:
ACT TEAM INFORMATION

Information on ACT teams from the Assertive Community Treatment Association (http://www.actassociation.org/actModel/)

P.O. Box 2428 · Brighton, MI 48116

810.227.1859 · Fax: 415.382.0664 · acta@actassociation.org

ACT Home
Join ACTA
ACT Model
Origins of ACT
Model Fidelity Standards
Annual Conference
Board of Directors
ACTA Trainings
News
Resources
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ACT Model

Assertive Community Treatment is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia.

The ACT model of care evolved out of the work of **Arnold Marx, M.D.**, **Leonard Stein**, and **Mary Ann Test, Ph.D.**, in the late 1960s. ACT has been widely implemented in the United States, Canada, and England. The Department of Veterans Affairs has also implemented ACT across the United States.

A team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry provide **Assertive Community Treatment** services. Among the services ACT teams provide are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual's ability to live successfully in the community. **ACT services are available 24 hours per day, 365 days per year.**

An evidence based practice, ACT has been extensively researched and evaluated and has proven clinical and cost effectiveness. The Schizophrenia Patient

Recent Updates

Click Here to go to the ACT Conference page
and
Access the 2012 ACT Conference Brochure Online

Conference Registration Fees

2013 ACT Association Training Calendar

Address

The ACT Association
P.O. Box 2428
Brighton, MI 48116

Other Contact Information:
Phone: 810.227.1859
Fax: 415.382.0664
acta@actassociation.org

Outcomes Research Team (PORT) has identified ACT as an effective and underutilized treatment modality for persons with serious mental illness.

PERSONS SERVED BY ACT

Clients served by ACT are individuals with serious and persistent mental illness or personality disorders, with severe functional impairments, who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Persons served by ACT often have co-existing problems such as homelessness, substance abuse problems, or involvement with the judicial system.

PRINCIPLES OF ACT

Assertive Community Treatment services adhere to certain essential standards and the following basic principles:

- **PRIMARY PROVIDER OF SERVICES:** The multidisciplinary make-up of each team (psychiatrist, nurses, social workers, rehabilitation, etc.) and the small client to staff ratio, helps the team provide most services with minimal referrals to other mental health programs or providers. The ACT team members share offices and their roles are interchangeable when providing services to ensure that services are not disrupted due to staff absence or turnover.
- **SERVICES ARE PROVIDED OUT OF OFFICE:** Services are provided within community settings, such as a person's own home and neighborhood, local restaurants, parks and nearby stores.
- **HIGHLY INDIVIDUALIZED SERVICES:** Treatment plans, developed with the client, are based on individual strengths and needs, hopes and desires. The plans are modified as needed through an ongoing assessment and goal setting process.
- **ASSERTIVE APPROACH:** ACT team members are pro-active with clients, assisting them to participate in and continue treatment, live independently, and recover from disability.
- **LONG-TERM SERVICES:** ACT services are intended to be long-term due to the severe impairments often associated with serious and persistent mental illness. The process of recovery often takes many years.
- **EMPHASIS ON VOCATIONAL EXPECTATIONS:** The team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly.
- **SUBSTANCE ABUSE SERVICES:** The team coordinates and provides substance abuse services.
- **PSYCHOEDUCATIONAL SERVICES:** Staff work with clients and their family members to become collaborative partners in the treatment process. Clients are taught about mental illness and the skills needed to better manage their illnesses and their lives.
- **FAMILY SUPPORT AND EDUCATION:** With the active involvement of the client, ACT staff work to include the client's natural support systems (family, significant others) in treatment, educating them and including them as part of the ACT services. It is often necessary to help improve family relationships in order to reduce conflicts and increase client autonomy.
- **COMMUNITY INTEGRATION:** ACT staff help clients become less socially isolated and more integrated into the community by encouraging participation in community activities and membership in organizations of their choice.
- **ATTENTION TO HEALTH CARE NEEDS:** The ACT team provides health education, access, and coordination of health care services.

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Last Revised: Wednesday, 21-Mar-2007 04:59:14 EDT

APPENDIX W:
ALAMEDA OUTCOMES REPORT

Measuring Progress -

Achieving Outcomes

2011 Progress Report on
Ending Homelessness in Alameda County, CA

April 2012

by

EveryOneHome
Ending Homelessness
in Alameda County

hcd

Alameda County
Housing and Community Development Department
HMIS - InHOUSE

Aspire Consulting LLC

Acknowledgements

This is Alameda County, California's second annual *Measuring Progress – Achieving Outcomes* report. It evaluates the performance during calendar year 2011 of individual programs and the system as a whole in achieving outcomes that we believe will bring an end to homelessness. Last year's report on 2010 outcome performance was published in July 2011. This year we committed to moving the publication date up three months to April 2012 in order to allow providers a longer lead time to adjust program practices and thereby impact their performance in 2012. The staffs of EveryOne Home and HMIS are planning to continue a spring release of this data in future years.

The data in this report is extracted from the local Homeless Management Information System (HMIS), known as InHOUSE, and supports our efforts to improve the system of care and bring about an end to homelessness by using local HMIS data for strategic planning and as an evaluation tool.

EveryOne Home wishes to acknowledge the work of the many people and organizations responsible for ensuring this report's publication, especially:

Agencies and Jurisdictions Using InHOUSE HMIS System
See Attachment A for a complete list

EveryOne Home Performance Management Committee
See Attachment A for a full list of members

EveryOne Home Leadership Board
See Attachment A for a full list of members

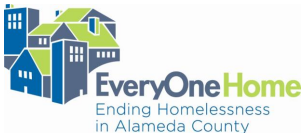
HMIS Staff who designed the InHOUSE performance reports and generated the data for this report
Patrick Crosby, System Administrator
Jeannette Rodriguez, HMIS Coordinator

Co-Authors of this Report
Kathie Barkow, Elaine de Coligny, and Allison Millar

Funders of the InHOUSE HMIS System
City of Alameda
City of Albany
City of Berkeley
City of Dublin
City of Emeryville
City of Fremont
City of Hayward
City of Livermore
City of Newark
City of Oakland
City of Piedmont
City of Pleasanton
City of San Leandro
City of Union City
County of Alameda, Housing and Community Development Department

EveryOne Home looks forward to continuing to provide data and similar reports that help this community understand its impact on ending homelessness.

Please contact EveryOne Home with questions or requests for further information:
(510) 670-5933
everyonehome@acgov.org
224 West Winton Avenue, Room 108, Hayward, California 94544



Introduction and Background

The EveryOne Home Plan to prevent and end homelessness in Alameda County by the year 2020 was published in 2006 and an organization by the same name launched in 2007 to lead implementation. Since then EveryOne Home and community stakeholders have worked hard to honor the Plan's charge to "measure success and report outcomes," the fourth of the Plan's five major strategies.

The data presented in this report reflects the performance of the system of care from January through December 2011 on outcome measures related to housing, income, and system efficiencies such as how quickly housing is obtained. It includes some comparisons to 2010 data, and identifies noteworthy trends. The measures discussed in this report represent the community's best thinking on how to evaluate our progress toward ending homelessness through achieving the outcomes expressed in both the federal HEARTH Act and the EveryOne Home Plan. The EveryOne Home systemwide outcomes first adopted in 2008 are:

1. 15,000 homeless households obtain permanent housing by January 2020;
2. The amount of time between disclosure of a housing crisis/homelessness and stabilization or residence in permanent housing is reduced from months, even years, to weeks;
3. 85% of those that obtain permanent housing will maintain it for at least one year and 65% will maintain their housing for at least 3 years.

The goals included in the HEARTH Act passed in 2009 are similar:

1. Reduce the length of time individuals and families remain homeless (the federal goal is 30 days);
2. Reduce the rate at which individuals and families who are housed return to homelessness;
3. Ensure all homeless individuals and families in a given region are served;
4. Grow jobs and income for homeless individuals and families;
5. Reduce the number of individuals and families who become homeless; and
6. Reduce the overall number of homeless individuals and families.

At the federal level, communities will be evaluated on their progress toward these goals as a system rather than individual agencies, and our performance will affect the amount of federal homeless assistance dollars available to Alameda County in the years to come. As HEARTH regulations are released later this year, some means of measuring local outcomes may be revised to comply with the new information about implementing and reporting on HEARTH goals.

To meet HEARTH Act and EveryOne Home Plan expectations, individual programs must perform well on outcome measures that are appropriate to their role in the system of care. The standardized outcomes and performance benchmarks adopted in 2010 for our system sorts programs into the following sectors:

- Emergency Shelter (ES)
- Transitional Housing (TH)
- Permanent Supportive Housing (PSH)
- Rapid Re-Housing (RRH)
- Prevention (Prev)
- Drop In Center (DIC)
- Outreach (Outreach)
- Employment Programs (Emp. Prog.)
- Services Only programs tied to Permanent Housing (SO-tied to Perm)
- Services Only programs with Case Management not tied to permanent housing (SO-CM)

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This report uses these sector names and their abbreviations as labels on the charts and in the narrative throughout this report. Some outcomes or performance measures such as "exiting with income" or "exiting to known destinations" apply to all sectors. Others are specific to one or several sectors. For example, the outcome "avoiding exits to streets or shelter" applies to Emergency Shelters, Employment Programs, and Services Only-Case Management sectors. Benchmarks, the rate at which outcomes measures are to be achieved (i.e. 65%, 40%, etc.), were established based on the sector's actual performance in 2009. In most cases 25% of agencies were already performing at that benchmark rate. In addition, the community determined that programs demonstrating an increase of at least 10 points above their prior year's performance would be viewed as meeting the improvement benchmark even if they had not yet reached the performance benchmark. See Attachment B for a chart of outcome measures and benchmarks by sector.

The ultimate goal of the EveryOne Home outcomes initiative is for all providers to be performing at or above the benchmarks. The community anticipated it would take several years to meet that goal because the established benchmarks were a stretch for many programs, data collection and reporting capacity were still under development, technical assistance would be required, and programs needed time to realize the impact of any changes to their service delivery approach. There was also concern that programs which targeted specific populations (i.e. families versus single adults) or had differing program models (i.e. winter versus year-round shelter) might perform differently over time and need different benchmarks. Several factors including but not limited to those noted above that could influence performance rates were statistically analyzed and accounted for during the process of creating the benchmarks. Such factors and their impact on performance will continue to be monitored over time. This report does explore the potential impact of program size on outcome performance, but not target populations or program design. Subsequent reports will address these issues.

YEAR TWO PRIORITIES

Having successfully boosted the quality of the data set in the first year by improving rates of exit to known destinations, agencies and programs concurrently achieved an increase in the rate of persons exiting to permanent housing. **For year two, the goals built on year one successes and included:**

- Further increasing the rates of exits to known destinations
- Improving rates of obtaining permanent housing
- Reducing the length of time between program entry and acquiring permanent housing
- Expanding report to include program stayers as well as leavers
- Improving incomes through earnings or the obtaining of benefits

EveryOne Home can report substantial progress on year two priorities:

- Exits to known destinations continued to improve in all sectors, with all but two sectors exceeding last year's systemwide average of 82%
- The system demonstrated a 30% increase in the rate of persons exiting programs with permanent housing from 33% in 2010 to 43% in 2011
- Both transitional housing and emergency shelter providers reduced the length of time between program entry and acquiring permanent housing by 8% and 6% respectively
- This report still includes only data for those persons exiting our system. It does not yet include data for those staying in programs. EveryOne Home expects to issue an expanded 2011 report

that includes stayers in late 2012. Any programs not identified individually in this report will be included in the expanded 2011 report.

- Finally, providers increased the numbers of persons exiting with some income who entered the system with none. Helping people to secure earned income remained a challenge for our system.

This communitywide effort to understand, direct and improve performance is a work in progress. This report puts local performance data in front of the community to support our growth and learning as we seek to better serve those in our community facing homelessness.

Housing

➢ Obtain Permanent Housing (Figure 1)

Overall the system has improved the rate of exits to permanent housing (PH) from 28% in 2009, to 33% in 2010, to 43% in 2011. The Emergency Shelter, Rapid Re-Housing, Drop In Center, and Outreach sectors met their performance benchmarks in 2011, with all four sectors demonstrating improvement since 2010. The Employment Program sector held steady at 23% for the third year in a row; the Transitional Housing and Services Only-Case Management sectors both had slight declines from 2010.

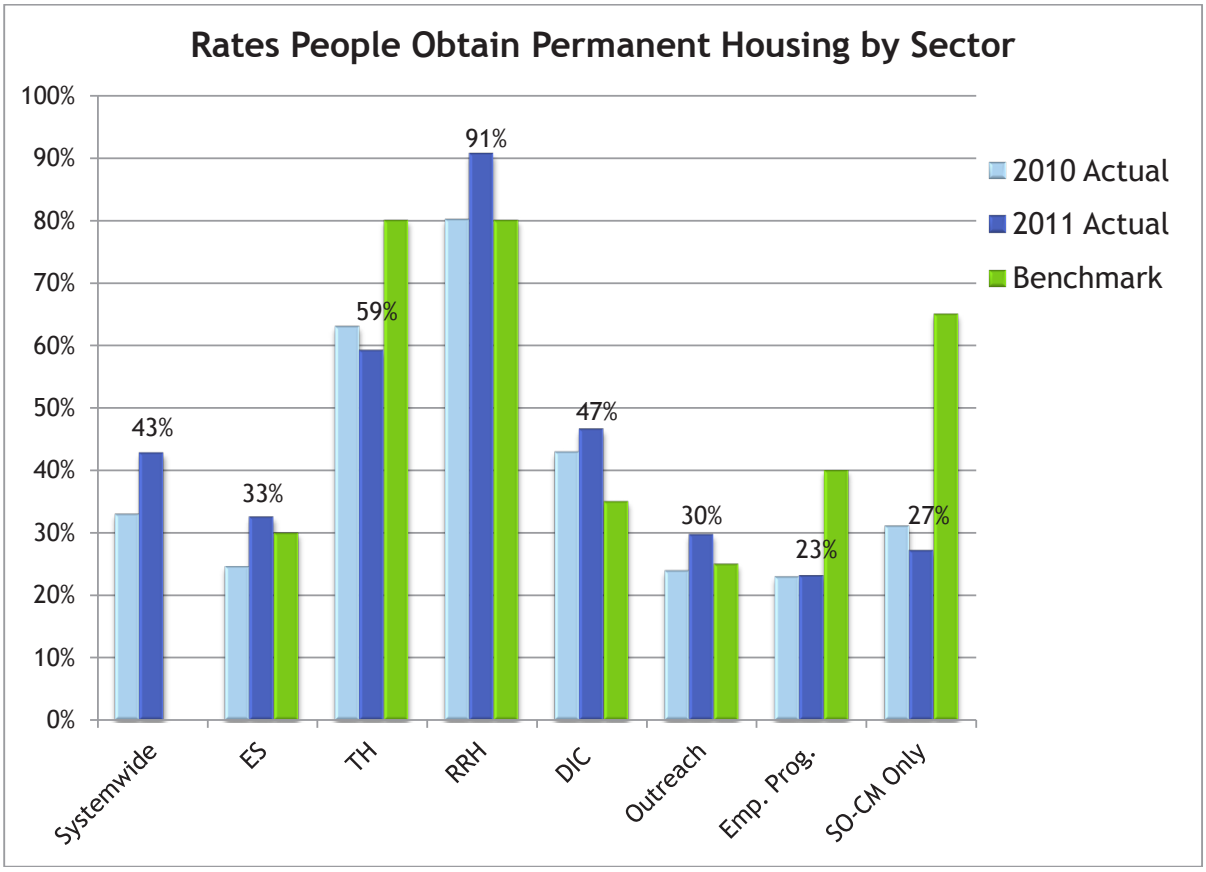
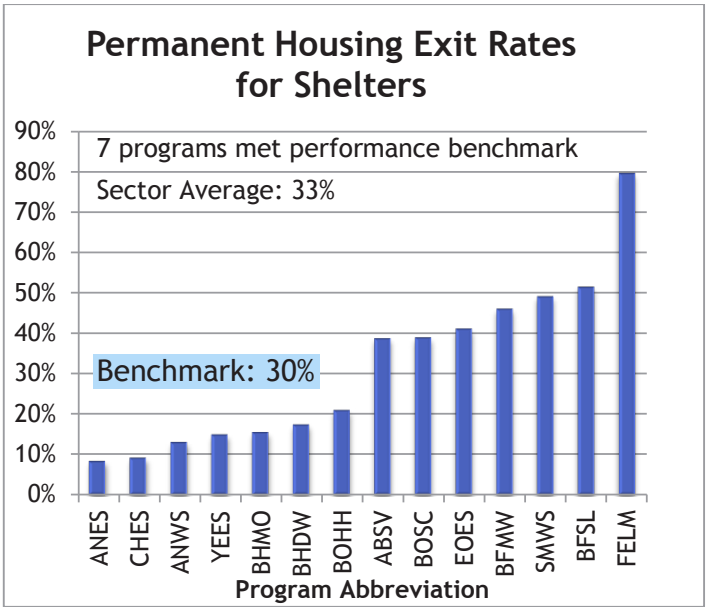


Figure 1 Percentage labels indicate 2011 actuals. Source for Systemwide data: 2011 APR run systemwide without HPRP. Sources for Sector data: InHOUSE Outcomes Report 2/3/12, run for each sector, 2011 Alameda County.

Emergency Shelter (ES) Sector (Figures 2 - 4)**:** Fourteen emergency shelters in Alameda County exited 2,561 people from their programs in 2011.

The tables below display the rates of exits to permanent housing for each shelter in the sector labeled by an abbreviated shelter name (see Attachment C for a index of program names).



Highlights

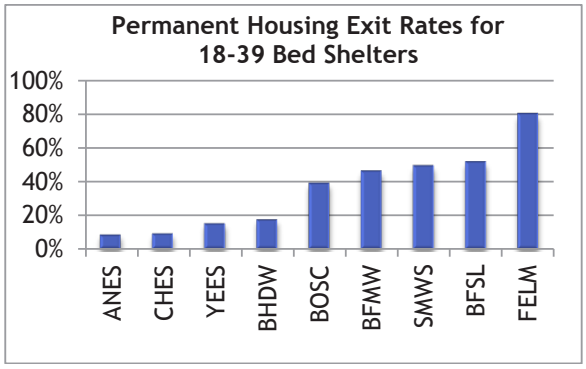
Eleven of 14 shelters improved their performance rate, one stayed the same, and only two saw slight decreases of 2% and 4% respectively.

Four programs improved their rates by double digits, FELM from 30% to 80%. For EOES an increase from 25% to 41% meant they met the benchmark for the first time.

Last year BFMW and BFSL had more than 50% of their exits to permanent housing occur within 60 days. This year they are joined by YEES, SMWS, and FELM.

Figure 2 **Source: InHOUSE Report "Outcomes " 2/3/2012 (run for Shelter sector and combined programs), 2011 Alameda County.**

For the second year, results indicate that the bed capacity of a program may not correlate to outcomes in emergency shelters. The figures below examine the permanent housing exit rates in shelters by bed capacity of each program, Figure 3 for smaller facilities and Figure 4 for larger facilities. In Figure 3, nine shelters have 18-39 bed capacity with a wide range of permanent housing exit rates from 8% to 80%. The larger facilities range from 40 to 125 beds and demonstrated a similarly wide range of exit rates to permanent housing (13% to 41%). This analysis by shelter size is unlikely to be included in subsequent reports, but future reports will instead examine if exit rates to permanent housing are influenced by program design or target population.



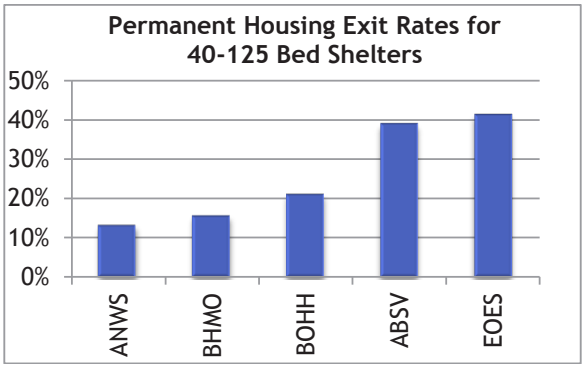


Figure 3 Figure 4

Source: InHOUSE Report "Outcomes" 2/3/2012 (run for Shelter sector and combined programs), sorted by capacity, 2011 Alameda County.

Transitional Housing (TH) Sector (Figures 5 - 6)**:** Thirty transitional housing programs had 735 people exit in 2011. Six percent of those people had more than one exit from TH in the year. Programs labeled with an * have met the improvement benchmark by increasing their performance by 10 percentage points or more over the prior year, but have not yet achieved the performance benchmark of 80%.

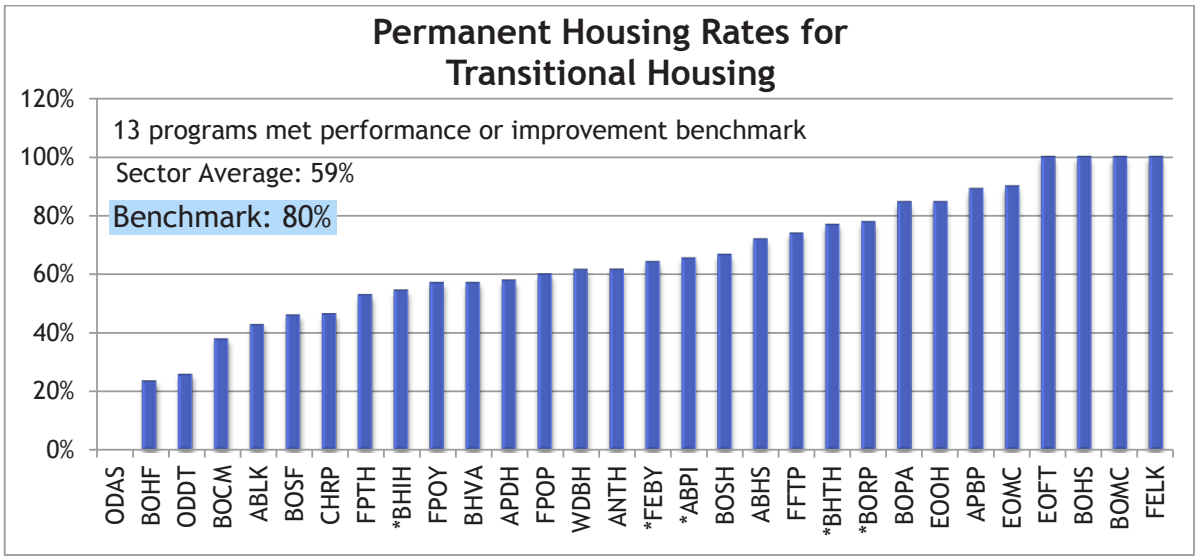


Figure 5 **Source: InHOUSE Report "Outcomes "2/3/12" run TH sector, 2011 Alameda County.**

Highlights

The current HUD national goal is for transitional housing programs to exit 65% of their participants to permanent housing. Fourteen programs (47%) met the national standard, down from 61% in 2010.

Two of the four programs with 100% exits to PH rates are subsidy-based projects where participants remain in the rental unit at exit and transition off the subsidy. Two programs are facility-based where participants must move at exit, which also achieved the same 100% outcome rate.

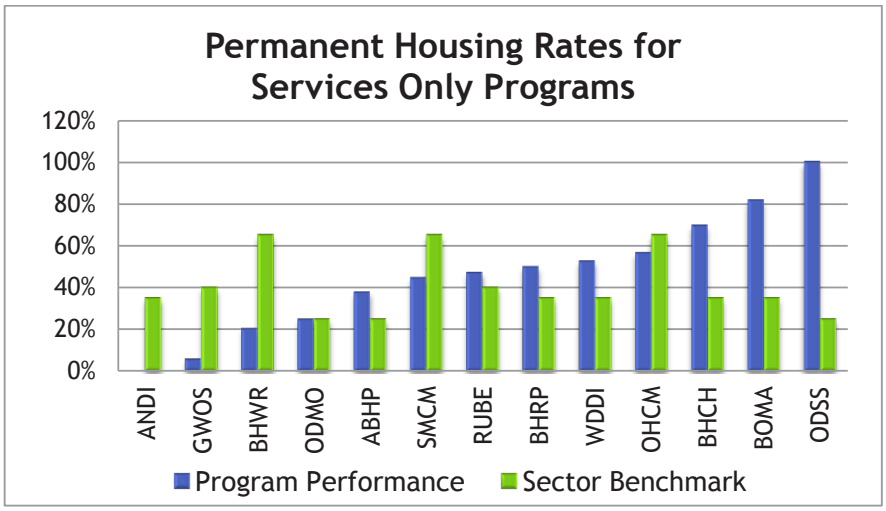
Eight programs surpassed the 80% performance benchmark, while five additional programs met the improvement benchmark by increasing 10 percentage points or more.

As the following chart indicates, bed/program capacity is smaller for transitional housing than emergency shelters in Alameda County. In smaller programs an increase or decrease of just a few people can have a substantial impact on performance rates. Fewer of the 1-19 person capacity programs met the benchmark in 2011 when compared to their larger counterparts. More analysis is needed over time before concluding how size of programs correlates to rates of exit to permanent housing. In 2011 all four programs with 100% exit rates to permanent housing had capacities of 20-39 persons.

Size	Number of Programs	Range of 2011 PH Exit Rates	# Programs with 100% Exit to PH	% (#) Programs Meeting Goal
1 – 19 person capacity	13	0% - 85%	0	31% (4)
20 – 39 person capacity	11	24% - 100%	4	55% (6)
40 + person capacity	6	53% - 90%	0	50% (3)

Figure 6 **Source: InHOUSE Report "Outcomes" 2/3/2012 (run for TH sector), sorted by capacity, 2011 Alameda County.**

Services Only Sectors (Figure 7): The programs presented below combine four sectors: Outreach, Drop In Centers, Employment, and Services Only–Case Management. Each sector has a different permanent housing benchmark. These are small sectors with only two to four programs in each. They often work in tandem with emergency shelter or transitional housing programs, helping participants with income supports and other service needs, while the housing program works on permanent housing. Figure 7 presents each program's performance beside the benchmark for its sector. The expanded 2011 report will include additional programs and will present each sector separately instead of this combined format.



Highlights

8 out of 13 Service Only programs met their sector's benchmark.

All 4 Drop In Centers, BHCH, BHRP, BOMA, and WWDI met their sector's benchmark of 35% exits to permanent housing.

Figure 7 Source: InHOUSE Report "Outcomes" 2/3/12 (run for each program), 2011 Alameda County.

Types of Permanent Housing Obtained (Figure 8): As in 2010, two-thirds of persons who exit the system to permanent housing do so to unsubsidized permanent housing, which includes rental housing with no subsidy (43%), family or friends on a permanent basis (21%), and ownership (2%). From 2010 to 2011 the percentage of people exiting to permanent rental housing with a subsidy increased by 4 points, while the number exiting to permanent supportive housing fell by 4 points.

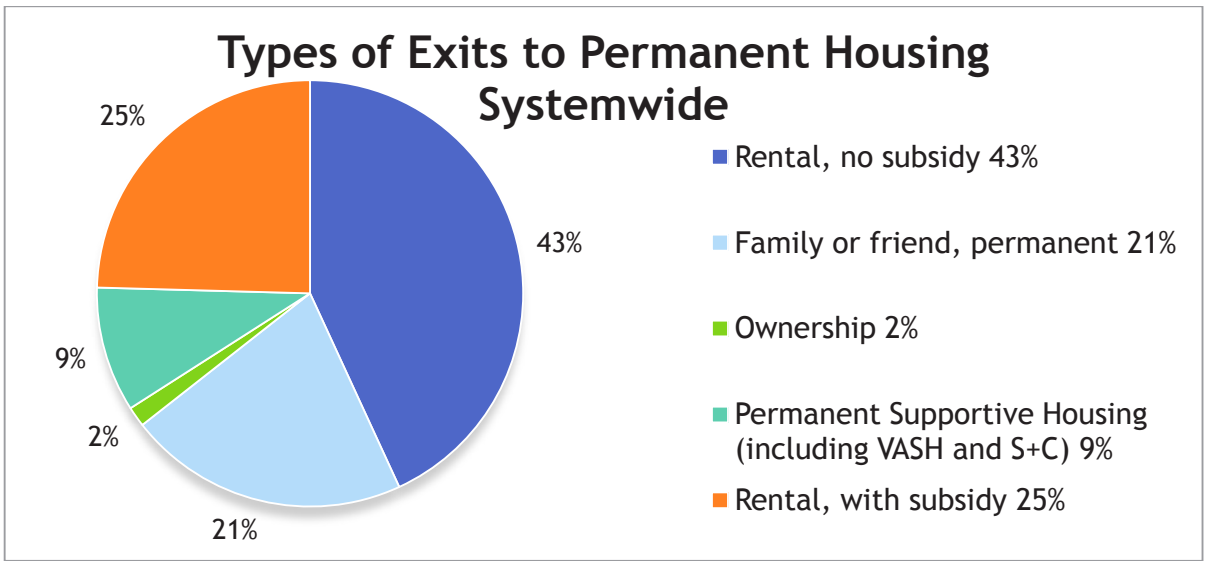


Figure 8 Source: InHOUSE Report APR v4.06.087 2/6/12 (run system wide without HPRP), 2011 Alameda County.

- Return to Homelessness (Figure 9)

In 2011 the systemwide rate of return to homelessness was once again 7%. This rate is the percentage of people exiting to permanent housing that subsequently reenter HMIS as homeless within the following twelve months, for the average of the months April 2010, July 2010, October 2010, and January 2011. Homeless is defined as entering a shelter or transitional housing program or entering any other program with a housing status of "literally homeless". Rates vary from a high of 27% for emergency shelters to a low of 3% for Rapid Re-Housing (RRH) programs. The federal and local goal is that less than 10% of those who exit to permanent housing subsequently return to homelessness. Despite a slight increase within three sectors, the systemwide rate remains level because it includes prevention program.

Future reports may calculate this outcome measure differently based on guidelines expected to be issued by HUD later this year. EveryOne Home is also interested in examining return to homelessness from various exit destinations (rental with subsidy, rental without subsidy, family and friends, and home ownership) to assess whether some destinations are more likely to result in a return to homelessness than others.

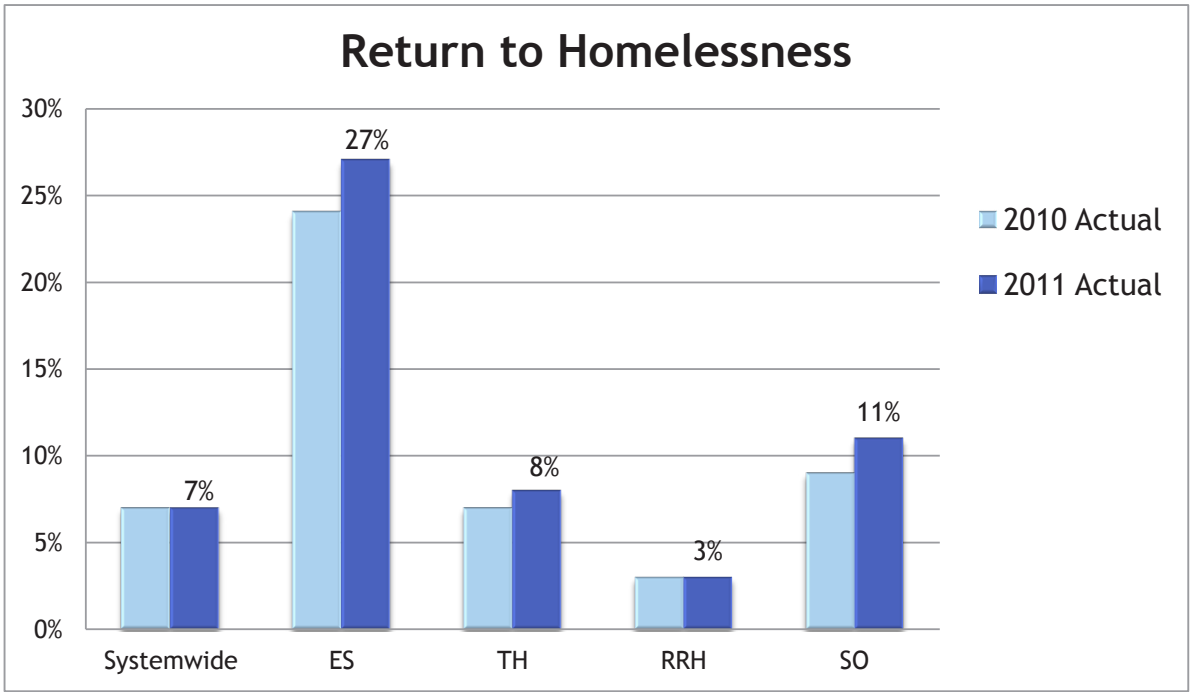


Figure 9 **Source: InHOUSE Report "Returns to Homelessness v 12.02.03", run by systemwide with HPRP and by sector for each quarterly increment, 2011 Alameda County.**

➢ Retain Permanent Supportive Housing (PSH) (Figure 10)

Housing retention is measured at six months, twelve months, and three years to comply with local and federal outcome measures. The federal department of Housing and Urban Development expects 72% of persons moving into permanent supportive housing to maintain it for at least six months. Alameda County PSH programs exceed that federal benchmark as well as the local goals indicated in Figure 10 below. Locally this outcome is measured by excluding tenants who had moved in more recently than the time period being measured; for example, not counting tenants who had moved in less than six months ago for the first benchmark of six months.

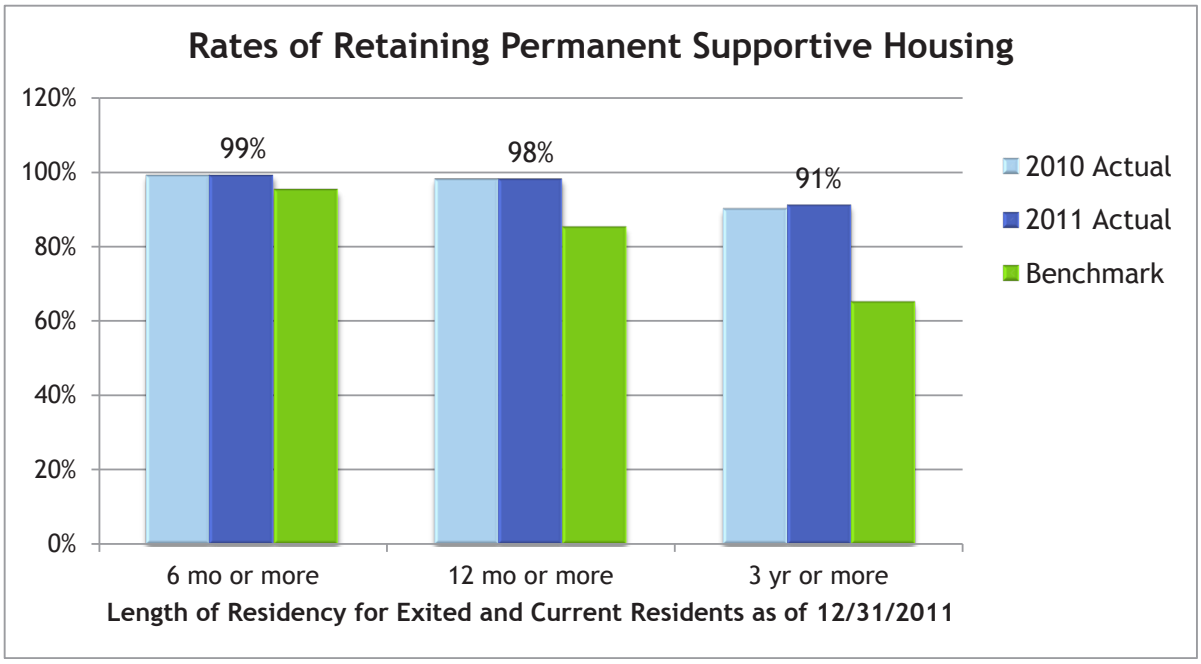


Figure 10 **Percentage labels indicate 2011 actuals. Length of Residency for Exited and Current Residents as of 12/31/2011 Source: InHOUSE CoC APR , 2/17/2012.**

➢ Turnover In Permanent Supportive Housing Programs (Figure 11)

Permanent supportive housing is a very cost-effective solution for chronically homeless, disabled persons when compared to the high expense of hospital stays and criminal justice involvement incurred by the community for people living in places not meant for human habitation. It is critical to target this deeply subsidized, service-rich resource to those who need it most. EveryOne Home and community stakeholders recognize that people with disabilities stabilize while in permanent supportive housing and may not always need the level of service and subsidy provided in such programs. When it is in the best interest of a participant, programs are encouraged to help people move to other less costly, less service-rich permanent housing. This strategy increases availability of PSH to currently homeless, disabled individuals. Approximately 11% of PSH tenants exited their units in 2011, the same percentage as 2010. Of the 230 people who exited PSH in 2011, 49% exited to some other form of permanent housing. Over one third (37%) exited to permanent housing other than PSH which is less expensive to the system of care, including rental housing with subsidy, rental housing without subsidy, and staying with a friend or

family on a permanent basis. These positive exits from PSH to less expensive housing and services help ensure the system's ability to target the right resources to the right people, at the right time.

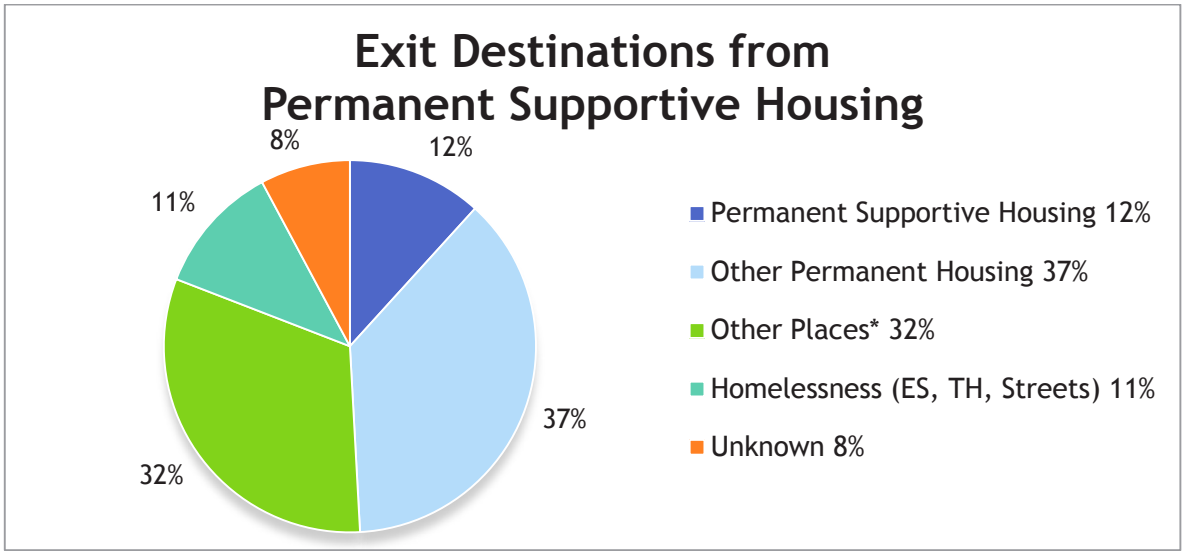


Figure 11 Source: InHOUSE Report "Outcomes" 2/3/12 (run for PSH Sector), 2011 Alameda County.
***** "Other places" includes staying with friends or family on a temporary basis, hospitals, jail or prison, substance abuse treatment or detox, hotel or motel without an ES voucher, Safe Haven, and deceased**.**

Income

- Change From No Income To Some Income (Figure 12)

Eight sectors now meet their benchmark, whereas in 2010 only four did. Those same eight sectors also saw improvements in their performance on this outcome; two sectors improved by over 30%. The following programs successfully assisted 100% of their clients who entered with no income to exit with some: Abode Services Lorenzo Creek SHP, Bonita House HOST S+C, City of Berkeley S+C TRA, LifeLong Medical Care BIST UA Homes, Alameda Point Collaborative Service Center, LifeLong Medical Care Project Respect, Second Chance RISE, and ANKA Drop In Center.

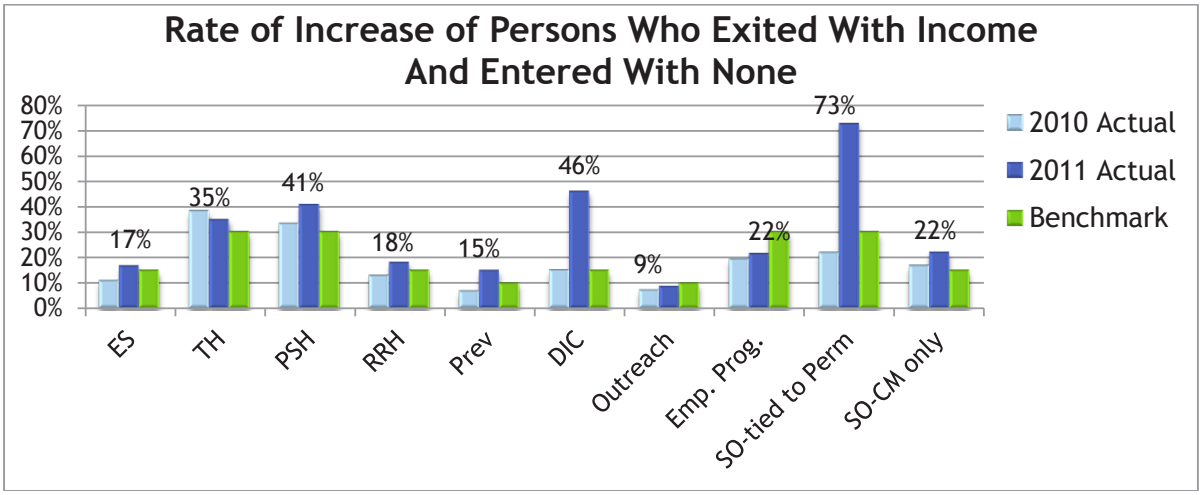


Figure 12 Percentage labels indicate 2011 Actuals. Source: InHOUSE Report "Outcomes" 2/3/2012 (run by sector), 2011 Alameda County.

- Earned Income (Figure 13)

Rate of exiting with earned income is a federal outcome and therefore has been adopted locally. From 2010 to 2011 all sectors increased the percentage of people exiting with earned income. Only one sector, Services Only- Case Management, surpassed its benchmark.

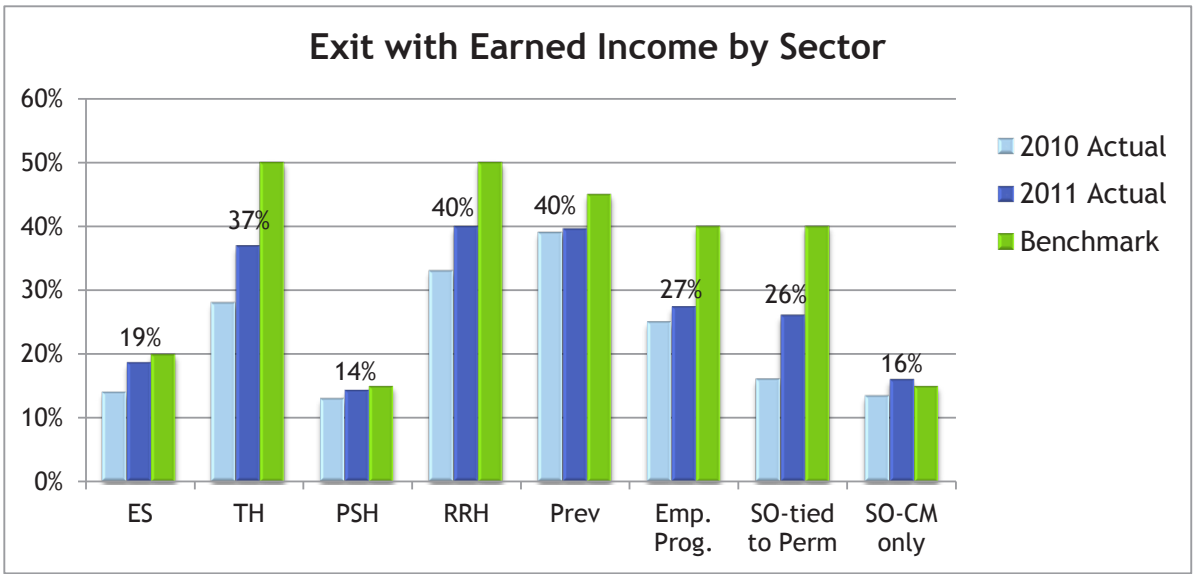


Figure 13 **Percentage labels indicate 2011 Actuals. Source: InHOUSE Report "Outcomes" 2/3/2012 (run by sector), 2011 Alameda County.**

Employment Programs Sector (Figure 14): In addition to exiting people to permanent housing, exits with employment are also essential to the stabilization of homeless households. Currently the reporting of this outcome only captures persons who exit the employment program, not those who obtained employment and are still participating in the program. The expanded 2011 report will include outcomes for persons remaining in programs, which will provide a more complete picture of employment programs' performance helping participants gain earned income. In 2011 the range of persons who exited from employment programs with earned income was 21% and 35%. The performance benchmark for Employment Programs is 40%.

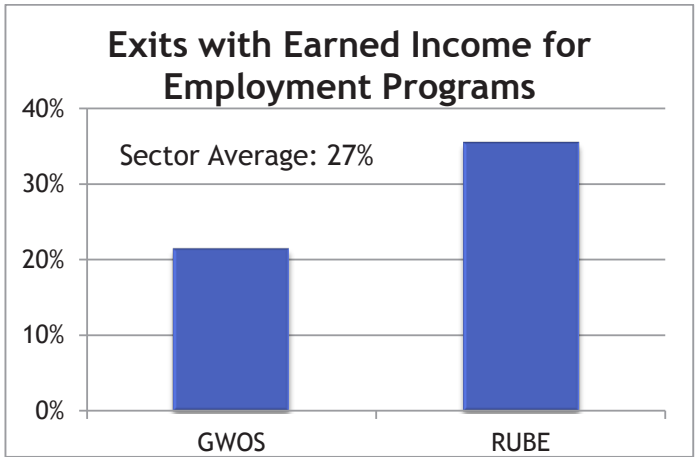


Figure 14 **Source: InHOUSE Report "Outcomes" 2/3/2012 (run by sector), 2011 Alameda County.**

System Efficiencies

- Rate of Exiting to Known Destinations (Figure 15)

Known destinations include all exit destinations other than "don't know", "refused", or null (unanswered). Improving this rate was an intentional focus at most agencies and within the system to ensure that all analysis was based on robust data sets. Drop In Centers and Outreach Programs showed the greatest rates of improvement on this measure for the second year in a row. All but one sector, Services-Case Management Only, met or came within a few percentage points of meeting this benchmark.

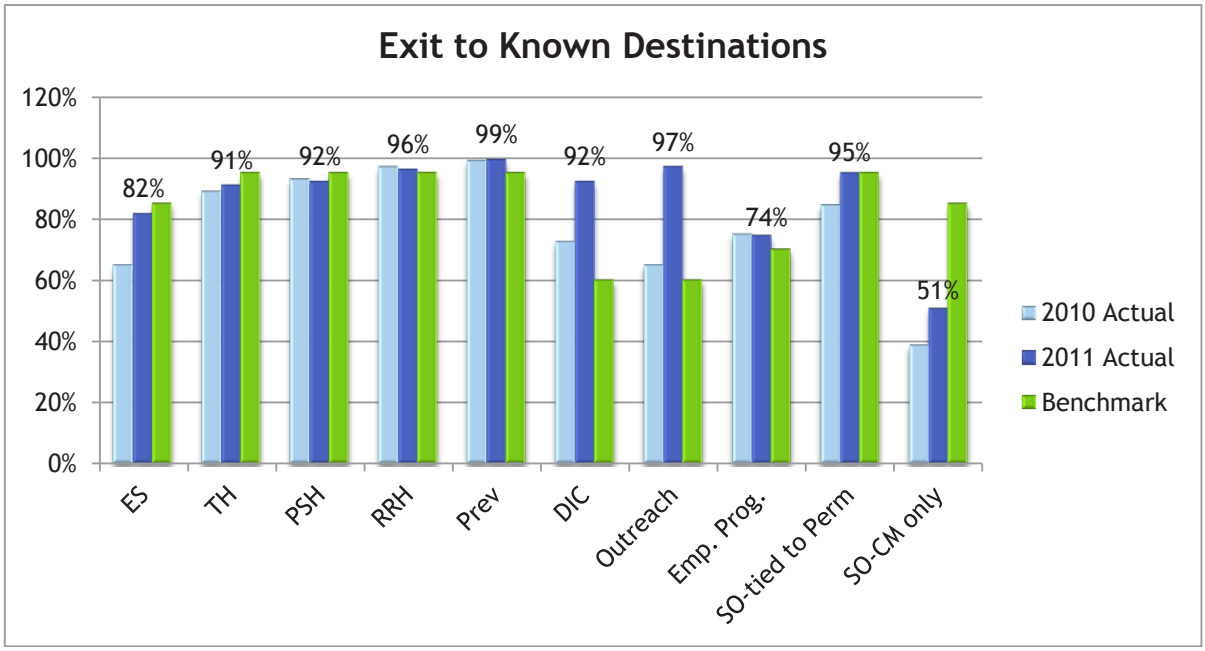


Figure 15 **Percentage labels indicate 2011 Actuals Source: InHOUSE Report "Outcomes" 2/3/12 (run by sector), 2011 Alameda County.**

- Reducing exits to streets or shelter (Figure 16)

EveryOne Home and community stakeholders aim for reductions in the rate of exits from Shelters, Employment, and Services Only-Case Management Programs back to the streets or other shelters. All three sectors met their goal with fewer exits to the streets or shelter than the benchmark rate; however, 2011 showed significant increases for both Emergency Shelters and Services Only-Case Management programs.

Exits to Streets or Shelter	ES	Emp. Prog.	SO-CM only
2011 Actual	29%	12%	14%
2010 Actual	17%	13%	2%
2009 Actual	10%	18%	1%
Benchmark	less than 30%	less than 40%	less than 20%

Figure 16 **Source: InHOUSE Report "Outcomes" 2/3/2012 (run by sector), 2011 Alameda County.**

- Length of Stay (Figure 17)

Measuring the length of stay in a given program is the best proxy EveryOne Home and community stakeholders currently have for measuring length of time homeless. Emergency shelters and transitional housing are encouraged to reduce the amount of time between program entry and exit to permanent housing.

Program Type	Average Length of Stay (LOS) in days for Exited Persons		Average LOS per Exit to Permanent Housing		% of those exiting to PH who do so within 60 days	
	2010	2011	2010	2011	2010	2011
Shelter	60	56	84	79	59%	54%
Rapid Re-Housing	124	138	129	137		
Transitional Housing	346	288	383	351		

Figure 17 Source: InHOUSE Report "Length of Stay - Averages v 12.03.15" (run for ES, RRH, and TH sectors) and ES Sector "Outcomes" Report 2/3/2012, 2011 Alameda County.

Shelters and transitional housing programs noted a drop in both the average length of stay for all persons exiting and a marked decrease in the length of time to exit to permanent housing: a 5 day decrease in shelters (6%) and a 32 day decrease in transitional housing programs (8%). These reductions in lengths of stay contribute to a lower cost per person served within that sector, and more turnover within the programs to serve more homeless people over time.

As anticipated, rapid re-housing programs experienced increases in average length of stay for all persons exiting and those exiting with permanent housing (11% and 6% respectively). Given that the program can subsidize participants for up to 18 months (547 days) and 2010 was the first full year of rapid re-housing in Alameda County, an increase in lengths of stay was expected. Even with these increases, the program remains a short-term intervention with an average length of stay of under four months, nowhere near the maximum allowed by federal regulations.

Conclusion

On April 25th, 2012, an EveryOne Home Community Meeting was held to solicit stakeholders' input to determine the key successes of 2011 and further refine the priorities for 2012 and mandates for future work, including repurposing parts of the system of care to produce the greatest results in ending homelessness. Some work is already underway such as the exploration of a coordinated intake process and the assessment of our current use of transitional housing resources. Additionally, EveryOne Home will continue providing technical assistance, facilitating the sharing of best practices from local agencies and national models and supporting data driven refinements to our system of care in order to ensure we achieve the outcomes to which our community is committed. To that end, EveryOne Home is excited to award cash prizes in 2013 for outstanding attainment of outcomes in 2012 and to offer the EveryOne Housed Academy to further the improvement in outcomes performance. While this work is underway, the outcomes achieved in 2011 uniquely guide the implementation of these activities as providers and investment replicate what is working best and devotes attention to more improvement in 2012.

EveryOne Home and community stakeholders celebrate the ongoing improvements in performance and in capacity to collect and analyze data across the system. Especially noteworthy are:

- the increases in exits with permanent housing
- the increased rates of people exiting the system with some income who entered with none,
- the retention rates in permanent supportive housing,
- the reduced lengths of stay in shelters and transitional housing, and
- a return to homelessness rate lower than the national average.

This progress propels the conversation about how to better the services we deliver and the outcomes we achieve for persons facing homelessness. The anticipated release of HEARTH regulations and new HMIS standards this year will also drive efforts in data collection, reporting, and defining successful outcomes.

A focus of 2012 will be on further improving reporting capabilities. In addition to generating data about both stayers and exiters from programs, community members want to see the results as real numbers as well as percentages, and more detail about exits from permanent housing and returns to homelessness. Community stakeholders praised the system's progress in collaboration, while calling for further coordination as well as increased understanding of the interconnectedness of the outcomes, programs and sectors in our system.

2012 will also emphasize achieving greater rates of obtaining permanent housing and increasing income and jobs. Participants asserted the need for continued Rapid Re-Housing resources in light of their demonstrated effectiveness. Given the rate of improvements on many performance benchmarks, community members expressed an interest in exploring whether those should be raised for future years.

Attachment A

EveryOne Home would like to thank all entities and individuals who assisted with making this report possible in addition to those noted at the beginning of this report, including:

Members of the
Performance Management Committee
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Patrick Crosby (InHOUSE)
Jeannette Rodriguez (InHOUSE)

Agencies and Jurisdictions Using
InHOUSE HMIS System
Abode Services
Affordable Housing Associates
Alameda County HCD
Alameda Co. Behavioral Health Care Services Dept.
Alameda Point Collaborative
Anka Behavioral Health, Inc.
Ark of Refuge
Bay Area Youth Center
Berkeley Drop-in Center
Berkeley Food & Housing Project
Bonita House, Inc.
BOSS
Building Futures with Women and Children
City of Berkeley
City of Oakland
Covenant House
Davis Street Family Resource Center
East Bay Community Law Center
East Bay Community Recovery Program
East Oakland Community Project
Eden I&R, Inc.
FESCO
First Place Fund for Youth
Fred Finch Youth Center
Goodwill Industries, Inc.
Housing Resource Centers and their Partners
LifeLong Medical Care
Oakland Homeless Families Program
Operation Dignity
Rubicon Programs
Second Chance
St. Mary's Center
Volunteers of America
YEAH!
Women's Daytime Drop-In Center

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Attachment B Systemwide Outcomes and Efficiency Measures

Progress Measure: For all outcome and efficiency goals, programs can meet or exceed the numerical benchmark or show an improvement of 10 percentage points over past year's outcome rates.

Outcomes	**Shelter** (winter and year round shelters)	**Transitional Housing** (site based, scattered site, and subsidy-based programs, e.g., Linkages & Project Independence)	**Permanent Supportive Housing** (site-based and subsidy-based programs [e.g. Shelter + Care and HOST])	**Rapid Rehousing** (programs w/financial assistance and/or supp. services)
Obtain permanent housing	*30% or greater*[2]	*80%*	Increase exits to other perm hsg by 10% over prev year	*80%*
Maintain/retain permanent housing			95% > 6 mos 85% > 12 mos 65% > 3 years	
Exiting to streets or shelter	*<30%*			
Exiting to permanent *OR* interim housing				
Exit with earned income	20%	50%	20%	50%
Of those adults entering with no income, an increase in those who exit with an income	*15%*	*30%*	*30%*	*15%*
Return to homelessness in 12 months				<10%
Efficiency/Process Measures				
Occupancy	90% single/mix 85% families	90%	95%	
Exit to Known Destination	85%	95%	95%	95%
Time from entry to permanent housing for those obtaining permanent housing	50% of those who gain permanent housing do so within 60 days	Reduce by 10% length of time from entry to permanent housing for programs with ave. stays over 12 mos		Average of 45 days
Other				

Systemwide goal: Returns to Homelessness (as measured by a new entry in HMIS) within 12 months of exit to permanent housing are less than 10%.

[1] For prevention, persons with Housing Status other than "Literally Homeless" are included.
[2] All italicized, underlined numbers are benchmarked on actual performance and subject to annual updating.

Prevention (programs with financial assistance and/or supportive services)[1]	**Drop-In Centers** (material support and services for homeless or unstably housed, e.g. WDDC, MASC, MSC)	**Street Outreach** (intended to address housing, e.g. HOPE & MOP)	**Service Only- Employment Programs** (programs targeted to homeless or housing stability)	**Service Only- Services tied to perm. Housing** (e.g. Lifelong HHISN or APC Service Center fpr PH residents)	**Services Only- Case mgmt tied to other housing** (e.g. RISE, OHFP, APC Service Center for Trans Housing clients)
	35%	*25%*	*40%*	Increase exits to other perm hsg by 10% over prev year	*65%*
90%	90% of those who have housing at entry			95% > 6 mos 85% > 12 mos 65% > 3 years	
			<40%		*<20%*
	50%	50%			
45%			40%	40%	15%
10%	*15%*	*10%*	*30%*	*30%*	*15%*
95%	60%	60%	70%	95%	85%
Average 45 days for those who move; 14 days to first payment for those who stay	50% of those who gain permanent housing do so within 6 months	50% of those who gain perm. housing do so within 6 months	50% of those who gain permanent housing do so within 6 months		Reduce by 10% length of time from entry to permanent housing for programs with average stays over 6 months
			50% of those who gain employment do so within 13 weeks		

Attachment C
Program Abbreviations and Data Contributors

In this report, tables and charts within six sectors identify the achievements of specific programs within that sector (Emergency Shelters, Transitional Housing, Drop In Centers, Outreach, Employment Programs, and Service Only-Case Management not tied to permanent housing). Program names are identified in the report using the four letter abbreviations noted in the tables below. The first two letters represent the agency, the second two represent the program. Any of these programs making a 10 point improvement in an outcome area and thereby meeting the improvement benchmark will be noted by an asterisk preceding the program abbreviation.

Other programs' data is included in the findings for a sector but is not specifically identified program by program for the permanent supportive housing, rapid re-housing, prevention, and services only – tied to permanent housing sectors. Following the tables showing the program abbreviations is a list showing which program data is included in these four sectors.

New programs or those programs not included in this report will be included in the expanded 2011 report anticipated for late fall 2011.

Shelters

Abbreviation	Program Name
ABSV	Abode Services Sunrise Village
ANES	Anka Behavioral Health Emergency Shelter
ANWS	Anka Behavioral Health Winter Shelter
BHDW	Berkeley Food and Housing Project Dwight Way Shelter
BHMO	Berkeley Food and Housing Project Men's Shelter
BOHH	BOSS Harrison House Shelter
BOSC	BOSS South County Homeless Project
BFMW	Building Futures with Women and Children Midway Shelter
BFSL	Building Futures with Women and Children San Leandro Shelter
CHES	Covenant House Emergency Shelter
EOES	East Oakland Community Project Crossroads Emergency Shelter
FELM	FESCO Les Marquis Emergency Shelter
SMWS	St. Mary's Center Winter Shelter
YEES	YEAH! Emergency Shelter

Employment

Abbreviation	Program Name
GWOS	Goodwill Industries One Stop Employment Program
RUBE	Rubicon Berkeley Employment Program

Transitional Housing

Abbreviation	Program Name
ABHS	Abode Services Housing Scholarship
ABLK	Abode Services Linkages Program
ABPI	Abode Services Project Independence
APBP	Alameda Point Collaborative Barbers Point
APDH	Alameda Point Collaborative Dignity Housing West
APUV	Alameda Point Collaborative Unity Village
ANTH	Anka Behavioral Health Transitional Housing
BHIH	Berkeley Food and Housing Project Independent House
BHTH	Berkeley Food and Housing Project Transitional House
BHVA	Berkeley Food and Housing Project VA Transitional Housing
BOCM	BOSS Casa Maria
BOHF	BOSS Harrison House Family Transitional Housing
BOHS	BOSS Housing Stabilization
BOMC	BOSS McKinley House
BOPA	BOSS Pacheco Court
BORP	BOSS Rosa Parks House
BOSF	BOSS Sankofa House
BOSH	BOSS South County Sober Housing
CHRP	Covenant House Rites of Passage
EOFT	East Oakland Community Project Families In Transition
EOMC	East Oakland Community Project Matilda Cleveland
EOOH	East Oakland Community Project Our House
FEBY	FESCO Banyan House
FELK	FESCO Linkages Project
FPOP	First Place For Youth Oakland PATH
FPOY	First Place for Youth Oakland Youth Housing Collaborative
FPTH	First Place For Youth THP Plus
FFTP	Fred Finch Turning Point
ODAS	Operation Dignity Ashby House
ODDT	Operation Dignity Dignity Commons Transitional Housing
WDBH	Womens Daytime Drop-In Center Bridget House

Outreach

Abbreviation	Program Name
ABHP	Abode Services HOPE Project
ODMO	Operation Dignity Mobile Outreach
ODSS	Operation Dignity Mobile Outreach Season of Sharing

Drop In Centers

Abbreviation	Program Name
ANDI	Anka Behavioral Health Drop In Center
BHRP	Berkeley Food and Housing Project MSC Representative Payee
BHCH	Berkeley Food and Housing Project Multi-Service Center Housing
BOMA	BOSS MASC Multi-Agency Service Center
WDDI	Womens Daytime Drop-In Center DIC

Services Only -CM

Abbreviation	Program Name
BHWR	Berkeley Food and Housing Project Womens Resource Center
OHCM	Oakland Homeless Families Program Case Management
SMCM	St. Mary's Center Case Management

The sectors below do not report program-specific data within the report. The programs listed below the sector heading denote the programs whose data contributes to the sectors' performance.

Permanent Supportive Housing

- Abode Services Bridgeway Permanent Supportive Housing, Carmen Avenue, Concord House, HOPE Housing, Lorenzo Creek S+C and SHP, STAY Well Housing
- Alameda County Housing and Community Development PRA, SRA, SRO, and TRA
- Alameda Point Collaborative Non-Subsidized, Barbers Point, Dignity Housing West, Mariposa, Miramar, Unity Village, Perm APP, Spirit of Hope 1
- Ark of Refuge Walker House
- Berkeley Food and Housing Project Russell Street Residence CCL
- Bonita House HOST
- BOSS Peter Babcock House, Regent Street
- City of Berkeley Shelter + Care Alameda City Collaborative, Bonita House SRA, COACH, RCD-SRA, TRA, Square One
- LifeLong Medical Care Erna P. Harris Court, UA Homes, Dellums, Hamilton, Oaks

Prevention Sector

- Bay Area Youth Center Hayward Housing Stabilization
- Bay Area Youth Center Private Housing Stabilization
- East County HRC Dublin/Unincorporated County Housing Stabilization
- East County HRC State Livermore/Pleasanton Housing Stabilization
- Mid County HRC Alameda Housing Stabilization

- Mid County HRC Hayward Housing Stabilization
- Mid County HRC State San Leandro Housing Stabilization
- North County HRC Berkeley Housing Stabilization
- North County HRC Urban County Housing Stabilization
- Oakland Downtown HRC Housing Stabilization
- Oakland Eastmont HRC Housing Stabilization
- Oakland Eastmont HRC Pathway Home Housing Stabilization
- Oakland TAY Housing Stabilization
- South County HRC Fremont Housing Stabilization
- South County HRC State Union City Housing Stabilization
- South County HRC Urban County Housing Stabilization

Rapid Re-Housing Sector

- Bay Area Youth Center Hayward Housing Stabilization
- Bay Area Youth Center Private Housing Stabilization
- East County HRC Dublin/Unincorporated County Housing Stabilization
- East County HRC State Livermore/Pleasanton Housing Stabilization
- Mid County HRC Alameda Housing Stabilization
- Mid County HRC Hayward Housing Stabilization
- Mid County HRC State San Leandro Housing Stabilization
- North County HRC Berkeley Housing Stabilization
- North County HRC Urban County Housing Stabilization
- Oakland Downtown HRC Housing Stabilization
- Oakland Eastmont HRC Housing Stabilization
- Oakland Eastmont HRC Pathway Home Housing Stabilization
- Oakland TAY Housing Stabilization
- South County HRC Fremont Housing Stabilization
- South County HRC State Union City Housing Stabilization
- South County HRC Urban County Housing Stabilization

Services Only – Tied to Permanent Housing

- Abode Services RISE Project
- Alameda Point Collaborative Service Center
- BOSS RISE Project
- LifeLong Medical Care Project Respect
- Second Chance RISE Project

APPENDIX X:
PERFORMANCE BASED CONTRACT SAMPLES

PERFORMANCE BASED CONTRACTS
EXAMPLES FROM COLUMBUS, OHIO

Columbus, Ohio has consistently performed well on outcomes in the HEARTH Act, including reducing length of homelessness, new, repeat, and overall homelessness. The community's lead Continuum of Care agency, the Community Shelter Board, uses several approaches to achieve these results including performance-based contracting. The following examples include contract language that may be used by any community wishing to encourage provider partners to improve and/or sustain a high level of performance.

Overview

In Columbus, performance-based contracts are used to encourage a high level of performance by providers, increase capacity to implement effective strategies to end homelessness, and shape the system's performance to meet specific system needs. Community Shelter Board (CSB) allocates money for performance-based funding each year when it creates its programs and services budget.

While performance-based agreements could be used for many programs and services, Columbus uses them primarily for emergency and short-term/transitional shelter programs. Agreements also tend to focus on shortening length of homelessness and helping households access permanent housing more quickly and efficiently. For example, if Columbus experiences an increase in family homelessness and needs to increase the number and pace of families moving from shelter to housing, CSB may use performance-based contracts to "purchase" a higher number of "successful housing outcomes," "successful exits," or "new admissions" (defined below) from the relevant agencies. This practice ensures that performance payments are linked to relevant outcomes when they are most critical for system needs.

In general, CSB-funded agencies receive 80 to 100 percent of base operating funds in 12 monthly payments. At the beginning of each month, each agency receives its base funding for the current month's operations (i.e., food, shelter, etc. but not the outcome-related intervention itself). Using the remaining operating funds, CSB purchases a certain number of desired outcomes and pays each month for the sum total of successful outcomes achieved in the previous month. For agencies, performance-based awards fill their remaining budget "gap" up to 100 percent of the overall contract amount if the agency received 80 percent of base operating funds, or up to 120 percent if the agency received 100 percent of base operating funds. Performance "bonuses" – funding that is greater than 100 percent of operating funds – are typically used when there is a higher than usual demand or need for a specific resource or activity in the homeless system (e.g. housing placement).

Base operating funds are paid as long as the agency meets the standards outlined in CSB's Administrative and Program Standards and its contract, excluding the performance-based portion of the contract. If the agency fails to meet these standards, the agency has breached its contract and all funding is stopped. On the other hand, performance-based payments are capped to ensure that payments do not exceed the budget CSB previously set aside for performance awards. Performance is tracked in the CoC's HMIS, and each agency agrees to an action plan to meet the goals outlined in its contract in a Performance Outcome Plan, which is appended to the contract. Contracts are negotiable.

Downloadable Tools
1. Columbus Performance Outcome Plan (POP) Overview
2. Columbus Performance Outcome Plan (POP) – Blank Sample
3. Columbus & Community Shelter Board Administrative and Program Standards

Additional Resources
Community Shelter Board Website

Example 1: Successful Housing Outcomes	
Summary This excerpt is from a contract for short-term transitional shelter. The contract allocates 80 to 100 percent of funds for base operations and purchases performance-based "successful housing" outcomes with the remaining funds. [1] The goal of this portion of the contract is to incentivize the shelter to help their clients access permanent housing quickly. How it works (a) This agency receives its base funding at the beginning of each month for the current month's operations. (b) Performance-based payments are also paid at the beginning of each month for the previous month for all households that were placed into permanent housing with a lease in their name. Performance payments are made until the agency reaches its Maximum Performance Amount (i.e., 100 percent of the contract). (c) "Bonus" performance-based payments are awards over and above 100 percent of total operating/performance payments outlined in sections (a) and (b). This payment is used when there is an usually high demand for this outcome based on the homeless population size and need. It is capped. Other uses This contract can be modified to pay for performance on housing stability. For example, during the first 3 months after housing placement (or initial stabilization	Section 3. Award of Funds. (a) Base Funding. During the Initial Term of this Partnership Agreement and subject to the terms and conditions set forth herein, CSB hereby awards the Provider the sum of XXX (the "Base Amount"). The specific sources and designations of the Base Amount are set forth in the funding chart attached hereto as Schedule 1. If the Provider fails to successfully operate XXX units monthly during the Term, the Base Amount awarded shall be reduced by CSB proportionately to the number of units actually operated monthly by the Provider. CSB shall pay to the Provider the aggregate sum of the Base Amount in monthly installments in accordance with the attached Schedule 1. CSB shall pay to the Provider any Base Amount not paid in monthly installments pursuant to monthly invoices in substantially the form found in the Guide to CSB. Notwithstanding Section 17(a) of the Master Provider Agreement, (i) CSB may modify the specific sources and designations of the Base Amount set forth on Schedule 1 at any time in its sole discretion and will promptly notify the Provider of any such modification and (ii) CSB may, in its sole discretion, reduce that portion of the Base Amount not used by the Provider within the period designated for use of such portion of the Base Amount set forth in the attached Schedule 1 and will promptly notify the Provider of any such reduction. The Provider agrees to promptly return to CSB any portion of the Base Amount it receives but has not used that is the subject of a subsequent reduction pursuant to the foregoing clause (ii). (b) Performance-Based Funding The Provider shall be entitled to receive funding in an amount equal to XXX per "successful housing outcome" (as defined below) (the "Performance Amount"); provided, however, that in no event shall the Provider be entitled to receive a Performance Amount greater than XXX (such amount, the "Maximum Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(b) for a maximum amount of XXX successful housing outcomes). For purposes of this Section 3(b), a "successful housing outcome" means the transfer of a household from Provider into a successful housing outcome. Each month, CSB will determine the number of successful housing outcomes completed by the Provider for the preceding month, and the payment of such Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Performance Amount. If, at any time after CSB has paid the Provider a Performance Amount, CSB determines that the Provider was paid an amount in excess of what it was entitled to receive (such amount, the "Excess Amount"), CSB shall notify the Provider of the same, and the Provider agrees either (i) to promptly return to CSB the Excess Amount, or (ii) that CSB may withhold an amount equal to the Excess Amount from any future Performance Amount due the Provider.

[1] Columbus defines "Successful Housing Outcome" as a household that exited shelter or transitional housing for

Example 1: Successful Housing Outcomes	
for prevention and diversion programs), many clients remain in the program and receive case management and services to stabilize them in housing. Performance payments could be paid fractionally for each of the following successful outcomes: • Housing placement • Housing stability in months 1, 2 and 3 This contract can also be modified for employment or education programs. For example, an agency may be paid for each client's enrollment in and/or completion of a program or class. Performance payments or bonuses may be given for each client that becomes employed or increases his/her employment income by a certain amount.	(c) Additional Performance-Based Funding. In addition to the Performance Amount provided pursuant to Section 3(b) and after the Provider has received the Maximum Performance Amount pursuant to Section 3(b), during the Term of this Program Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive additional funding in an amount equal to nine XXX per "additional successful housing outcome" (as defined below) (the "Additional Performance Amount"); provided, however, that the Provider shall not be entitled to receive an Additional Performance Amount greater than XXX (such amount, the "Maximum Additional Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(c) for a maximum amount of XXX additional successful housing outcomes). For purposes of this Section 3(c), an "additional successful housing outcomes" is any successful housing outcome over and above the XXX successful housing outcomes. Each month (after the Provider has received the Maximum Performance Amount), CSB will determine the number of additional successful exits completed by the Provider for the preceding month, and the payment of any Additional Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Additional Performance Amount.

Example 2: New Program Admissions and Successful Exits	
Summary This excerpt is from a contract for a short-term transitional shelter program. The contract allocates 80 to 100 percent of funds for base operations and purchases performance-based outcomes related to new admissions and successful exits with the remaining funds. [2] The goal of this portion of the contract is to incentivize this agency to take on a greater and fairer share of homeless households in the system, relative to other agencies in the system. In order for this agency to take on its fair share of system capacity it must move clients from its transitional shelter program and into permanent housing (i.e. achieve a "successful housing outcome") more quickly. For each household that "successfully	Section 3. Award of Funds. (a) Base Funding. During the Initial Term of this Partnership Agreement and subject to the terms and conditions set forth herein, CSB hereby awards the Provider the sum of XXX (the "Base Amount"). The specific sources and designations of the Base Amount are set forth in the funding chart attached hereto as Schedule 1. CSB shall pay to the Provider the aggregate sum of the Base Amount in monthly installments in accordance with the attached Schedule 1. CSB shall pay to the Provider any Base Amount not paid in monthly installments pursuant to monthly invoices in substantially the form found in the Guide to CSB. Notwithstanding Section 17(a) of the Master Provider Agreement, (i) CSB may modify the specific sources and designations of the Base Amount set forth on Schedule 1 at any time in its sole discretion and will promptly notify the Provider of any such modification and (ii) CSB may, in its sole discretion, reduce that portion of the Base Amount not used by the Provider within the period designated for use of such portion of the Base Amount set forth in the attached Schedule 1 and will promptly notify the Provider of any such reduction. The Provider agrees to promptly return to CSB any portion of the Base Amount it receives but has not used that is the subject of a subsequent reduction pursuant to the foregoing clause (ii). (b) Performance Based Funding. The Provider shall be entitled to receive funding in an amount equal to XXX per "new admission"

[2] A "new admission" is defined as a household that enters the program. A "successful exit" is the transfer of the household from shelter to a "successful housing outcome" as defined above.

Example 2: New Program Admissions and Successful Exits	
exits" this program, a "newly admitted" household can be served in its place. How it works (a) This agency receives its base funding at the beginning of each month for the current month's operations. (b) Performance-based payments are paid at the beginning of each month for the previous month for all the new households admitted into the program and all the households that were placed into permanent housing with a lease in their name. Performance payments are made until the agency reaches its Maximum Performance Amount (i.e., 100 percent of the contract). (c) "Bonus" performance-based payments are awards over and above 100 percent of total operating/performance payments outlined in sections (a) and (b). This payment is used when there is an usually high demand for this outcome based on the homeless population size and need. It is capped. Other uses This language can be inserted into an updated contract and used in conjunction with a Quality Improvement Intervention. It can also be used with a prevention or diversion program. If the performance payments are benchmarks or outcomes achieved only during the time the household is with the program.	(as defined below) and XXX per "successful exit" (as defined below) (the "Performance Amount"); provided, however, that in no event shall the Provider be entitled to receive a Performance Amount greater than XXX (such amount, the "Maximum Performance Amount"). For purposes of this Section 3(b), a "new admission" is a family that enters the "program", and a "successful exit" means the transfer of a household from the "program" into a successful housing outcome. Each month, CSB will determine the number of new admissions and successful exits completed by the Provider for the preceding month, and the payment of such Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Performance Amount. If, at any time after CSB has paid the Provider a Performance Amount, CSB determines that the Provider was paid an amount in excess of what it was entitled to receive (such amount, the "Excess Amount"), CSB shall notify the Provider of the same, and the Provider agrees either (i) to promptly return to CSB the Excess Amount, or (ii) that CSB may withhold an amount equal to the Excess Amount from any future Performance Amount due the Provider. (c) Additional Performance Based Funding. In addition to the Performance Amount provided pursuant to Section 3(b) and after the Provider has received the Maximum Performance Amount pursuant to Section 3(b), during the Term of this Program Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive additional funding in amount equal to XXX per "additional new admission" and XXX per "additional successful housing outcome" (as defined below) (the "Additional Performance Amount"); provided, however, that the Provider shall not be entitled to receive an Additional Performance Amount greater than XXX (such amount, the "Maximum Additional Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(c) for a maximum amount of XXX new admissions and a maximum amount of XXX successful housing outcomes). For purposes of this Section 3(b), an "additional new admission" is any new admission over and above the XXX new admissions and an "additional successful housing outcome" is any successful housing outcome over and above the XXX successful housing outcomes. Each month (after the Provider has received the Maximum Performance Amount), CSB will determine the number of additional successful exits completed by the Provider for the preceding month, and the payment of any Additional Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Additional Performance Amount.

Example 3: Successful Transition Applications & Successful Housing Outcomes	
Summary This excerpt is from a contract for a shelter program. The contract allocates 80 to 100 percent of funds for base operations and purchases performance-based outcomes related to successful transition applications and successful housing outcomes with the remaining funds. [3] The goal of this portion of the contract is to incentivize this agency to achieve "successful housing outcomes," as defined above. The agency will be able to achieve this by speeding up its process for helping clients complete their applications for rental assistance with CSB. CSB pays its portion of the rent or other financial assistance to the landlord directly, which helps provider agency achieve a successful housing outcome. Additionally, this incentive will help the agency avoid keeping clients in shelter too long in order to resolve non-housing related barriers. How it works (a) This agency receives its base funding at the beginning of each month for the current month's operations. (b)(i) Performance-based payments are paid at the beginning of each month for the previous month for all households that successfully completed a transition application and, separately, all households that were placed into permanent housing with a lease in their name.	Section 3. Award of Funds. (a) Base Funding. During the Initial Term of this Partnership Agreement and subject to the terms and conditions set forth herein, CSB hereby awards the Provider the sum of XXX (the "Base Amount"). The specific sources and designations of the Base Amount are set forth in the funding chart attached hereto as Schedule 1. CSB shall pay to the Provider the aggregate sum of the Base Amount in monthly installments in accordance with the attached Schedule 1. CSB shall pay to the Provider any Base Amount not paid in monthly installments pursuant to monthly invoices in substantially the form found in the Guide to CSB. Notwithstanding Section 17(a) of the Master Provider Agreement, (i) CSB may modify the specific sources and designations of the Base Amount set forth on Schedule 1 at any time in its sole discretion and will promptly notify the Provider of any such modification and (ii) CSB may, in its sole discretion, reduce that portion of the Base Amount not used by the Provider within the period designated for use of such portion of the Base Amount set forth in the attached Schedule 1 and will promptly notify the Provider of any such reduction. The Provider agrees to promptly return to CSB any portion of the Base Amount it receives but has not used. (b) Performance Based Funding (i) Application Payments. In addition to any other funding received pursuant to this Section 3, during the Initial Term of this Partnership Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive funding in an amount equal to XXX per "successful transition application" (as defined below) (the "Application Performance Amount"); provided, however, that in no event shall the Provider be entitled to receive an Application Performance Amount greater than XXX (such amount, the "Maximum Application Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(b)(i) for a maximum amount of XXX successful transition applications). For purposes of this Section 3(b)(i), a "successful transition application" is an application that has been approved and paid by CSB in its sole discretion. Each month, CSB will determine the number of successful transition applications completed by the Provider for the preceding month, and the payment of such Application Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Application

[3] A "successful transition application" is an (housing-related) application for financial assistance (e.g. first month's rent and security deposit) that has been approved and paid by CSB in its sole discretion. By focusing on approvals that are decided solely by CSB, CSB avoids penalizing the agency for processes over which neither CSB nor the provider shelter has control.

Example 3: Successful Transition Applications & Successful Housing Outcomes	
Performance payments are made until the agency reaches its Maximum Performance Amount (i.e., 100 percent of the contract). (b)(ii) "Bonus" performance-based payments are awards over and above 100 percent of total operating/performance payments outlined in sections (a) and (b). This payment is used when there is an usually high demand for this outcome based on the homeless population size and need. It is capped. <u>Other uses</u> This contract can be modified for other income-benefits related applications or housing-related applications in circumstances where the agency forwarding the application and the agency managing the application are both managed or overseen by the same entity. For example, a local Department of (Health and) Human Services may manage both the homeless assistance system and TANF benefits. This contract could be modified to incentivize family shelters to help clients complete their applications for TANF benefits more quickly (and correctly). In a slightly different model, in cases where the lead CoC agency shares a strong relationship with the housing authority, the mental health agency, or the social security administration, this language could be inserted into a contract to help programs and partner agencies process housing and benefits applications more quickly. (This works only in cases where there is clear accountability for the application	Performance Amount. If, at any time after CSB has paid the Provider an Application Performance Amount, CSB determines that the Provider was paid an amount in excess of what it was entitled to receive (such amount, the "Excess Amount"), CSB shall notify the Provider of the same, and the Provider agrees either (i) to promptly return to CSB the Excess Amount, or (ii) that CSB may withhold an amount equal to the Excess Amount from any future Application Performance Amount due the Provider. (ii) <u>Performance Based Payments.</u> The Provider shall be entitled to receive funding in an amount equal to XXX per "successful housing outcome" (as defined below) (the "Performance Amount"); provided, however, that in no event shall the Provider be entitled to receive a Performance Amount greater than XXX (such amount, the "Maximum Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(b)(ii) for a maximum amount of XXX successful housing outcomes). For purposes of this Section 3(b)(ii), a "successful housing outcome" means the transfer of a family from Provider into a successful housing outcome. Each month, CSB will determine the number of successful housing outcomes completed by the Provider for the preceding month, and the payment of such Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Performance Amount. If, at any time after CSB has paid the Provider a Performance Amount, CSB determines that the Provider was paid an amount in excess of what it was entitled to receive (such amount, the "Excess Amount"), CSB shall notify the Provider of the same, and the Provider agrees either (i) to promptly return to CSB the Excess Amount, or (ii) that CSB may withhold an amount equal to the Excess Amount from any future Performance Amount due the Provider. (c) <u>Additional Performance-Based Funding</u>. In addition to the Performance Amount provided pursuant to Section 3(b)(ii) and after the Provider has received the Maximum Performance Amount pursuant to Section 3(b)(ii), during the Term of this Program Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive additional funding in an amount equal to XXX per "additional successful housing outcome" (as defined below) (the "Additional Performance Amount"); provided, however, that the Provider shall not be entitled to receive an Additional Performance Amount greater than XXX (such amount, the "Maximum Additional Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(c) for a maximum amount of XXX additional successful housing outcomes). For purposes of this

Example 3: Successful Transition Applications & Successful Housing Outcomes	
process and in systems where the application processes are well-integrated.)	Section 3(c), an "additional successful housing outcomes" is any successful housing outcome over and above the XXX successful housing outcomes. Each month (after the Provider has received the Maximum Performance Amount), CSB will determine the number of additional successful exits completed by the Provider for the preceding month, and the payment of any Additional Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Additional Performance Amount.

Example 4: Successful Exits	
Summary This excerpt is from a contract for a rapid re-housing program. The contract is 100 percent performance-based; therefore, the agency does not receive any "guaranteed" base payments for daily operations. The goal of this portion of the contract is to incentivize this agency to successfully exit households from the program to a successful housing outcome, as defined above. How it works (a) Performance-based payments are paid at the beginning of each month for the previous month for all households that were placed into permanent housing with a lease in their name. Performance payments are made until the agency reaches its Maximum Performance Amount (i.e., 100 percent of the contract). Performance-based payments cover all operational expenses for this program (e.g., units, food, rapid re-housing, etc.) (b) "Bonus" performance-based payments are awards over and above 100 percent of total operating/performance payments outlined in sections (a) and (b). This payment is used when there is an usually high demand for this outcome based on	Section 3. Award of Funds. (a) Performance Based Funding During the Initial Term of this Partnership Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive funding in an amount equal to XXX per "Successful Exit" (as defined below) (the "Performance Amount"); provided, however, that in no event shall the Provider be entitled to receive a Performance Amount greater than XXX (such amount, the "Maximum Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(a) for a maximum amount of XXX Successful Exits). For purposes of this Section 3(a), a "Successful Exit" is a successful exit from the shelter to The Provider program. Each month, CSB will determine the number of successful exits for the preceding month, and the payment of such Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Performance Amount. If, at any time after CSB has paid the Provider a Performance Amount, CSB determines that the Provider was paid an amount in excess of what it was entitled to receive (such amount, the "Excess Amount"), CSB shall notify the Provider of the same, and the Provider agrees either (i) to promptly return to CSB the Excess Amount, or (ii) that CSB may withhold an amount equal to the Excess Amount from any future Performance Amount due the Provider. (b) Additional Performance Based Funding. In addition to the Performance Amount provided pursuant to Section 3(a) and after the Provider has received the Maximum Performance Amount pursuant to Section 3(a), during the Term of this Program Agreement and subject to the terms and conditions set forth herein, the Provider shall be entitled to receive additional funding in amount equal to nine XXX per "additional successful exit" (as defined below) (the "Additional Performance Amount"); provided, however, that the Provider shall not be entitled to receive an Additional Performance Amount greater than XXX (such amount, the "Maximum Additional Performance Amount") (e.g., the Provider can receive funding pursuant to this Section 3(b) for a maximum amount of XXX additional successful exits). For purposes of this Section 3(b), an "additional successful exit" is any successful housing outcome over and above the XXX successful exits permitted by Section 3(a). Each month (after the Provider has received the Maximum Performance Amount), CSB will

the homeless population size and need. It is capped. <u>Other uses</u> One-hundred percent performance- based contracts should be used only for programs in which the program can fully control its performance outcome (e.g., rapid re-housing programs). No program will meet 100 percent of its performance goals 100 percent of the time; however, this funding model has been used successfully in Columbus for three years.	determine the number of additional successful exits completed by the Provider for the preceding month, and the payment of any Additional Performance Amount due the Provider will be made by CSB on the last day of the month in which such determination is made, until the time in which the Provider has received the Maximum Additional Performance Amount.

APPENDIX Y: BROWARD COUNTY COC REVIEW AND RECOMMENDATIONS

Broward County Exhibit 1 2011 Continuum of Care Completion Scoring Analysis

OVERVIEW

A review of the Broward County competitive scoring over the past 3 years indicates that the Exhibit 1 application has consistently scored below the national average as exhibited on Chart 1.

Chart 1: Broward County Exhibit 1 Scores 3 Year Comparison

Scoring Category	Maximum Score	2011 Score	2010 Score	2009 Score
CoC Housing, Services and Structure	14	13.75	12	12.25
Homeless Needs and Data Collection	26	15.5	14.25	14.75
CoC Strategic Planning	22	18.75	16	15.5
CoC Performance	32	19.25	23	24
Emphasis on Housing Activities	6	0	0	4
Total FL-601 CoC Score	**100**	**67.25**	**65.25**	**70.50**
National Median Scores		**74.22**	**75.42**	**75**
National Funding Line		**65**	**65**	**71.25**

A comparison to national standards indicates that this year's score shows some improvement compared to national standards with the national high score and median score falling slightly, while Broward County's score increase slightly from the previous two years as exhibited in Chart 2 . However, the score continues to be 23 percentage points below the national high score and 7 percentage points below the national median score. With the coming HEARTH regulations increased focus on outcomes, competition for funding is expected to increase with HUD's emphasis on system wide performance standards.

National Scoring Standards	2011	2010	2009
Broward County Score	**67.25**	**65.25**	**70.5**
High Score	90.25	91.25	91.25
Low Score	44.5	38.5	43
Median Score	74.22	75.42	75
Funding Line	65	65	71.25

In review of the scoring and the 2011 application, it appears that there are three for that need the most improvement. Those areas include Part II: Homelessness Needs and Data Collection with the application only receiving 15.5 out of a possible 26 points, Part IV: CoC Performance with the application receiving only 19.25 out of a possible 32 points, and Part V: Emphasis on Housing Activities with the application receiving 0 out of a possible 7 points.

PART II REVIEW: HOMELESS NEEDS AND DATA COLLECTION

This portion of the application reflects the communities HMIS usage and coverage, including timely and accurate counts and data quality. In our review of the Broward County Exhibit 1, the following areas were noted that showed deficiencies that would appear to impact the score based on HUD's CoC Debriefing Summary:

1. *HIC inventory (1G)*– in several places the narrative referred to 2012 inventory, yet the question was in regards to 2011 inventory.

2. *HMIS (2A)* – The narrative regarding the specific steps and timelines to improve HMIS was not clear with precise steps and timelines; for example, while the CoC identified poor data quality as an issue, the only reference to improving data quality was to issue standards, but no mention of training regarding the quality standards for providers.

3. *HMIS Bed Coverage (2C)* – low bed coverage reported for TH and PSH; HUD expectation is that bed coverage for all sections be higher than 50%; narrative did not mention a plan to increase TH coverage, only focusing on PSH. Also, narrative refers to applying for a bonus project for 2012 to improve data when an application could have been made for 2011 showing more intent on improving. It does not appear from the narrative that there is a clear plan for increasing the bed coverage in both areas by the next application.

4. *Data Quality (2D)*– application showed significant areas of high null values (6 out of 10 areas showing 20% or higher); Review of data quality only semi-annually when there are clearly data quality issues that could be addressed if data was reviewed more often. The answer to the question asking to describe the existing policies and procedures used to ensure valid exit and entry dates does NOT respond to the question. Instead of describing the specific policy and procedure (i.e. what are the standards required for entry and exit dates), it instead describes the dissemination of the information, but not the actual standards.

5. *Data Usage (2E)* - Point-in-time count of sheltered persons: At least Annually; while HUD provides this option, the fact that Monthly is an option for all answers in this section indicates that higher performing CoC perform these functions more often and in fact, usage of data on a more regular basis improves performance standards for communities (the other area that Broward scored low).

6. *Data Technical Standards and Training (2F&G)* – Again, increased frequency of these activities more often indicates better performing CoC's. Particularly the number of Null Values in the data indicates that technical standards and training need to be more intensive for higher performance in this area.

7. *Sheltered Homeless Methods, Data Collection and Data Quality (Section 2I, J, K)* – Each of these sections had a distinct difference, yet the narrative for all three sections is similar and does not clearly address the distinction between the method used (2I), the data collection for an accurate count (2J), and the data quality (2K). According to the HUD instructions, it is important to make the clear distinction. For example, we would suggest that 2I could why the particular methods were used and why they work in your community; 2J would address how the data was then collected, what efforts were made to engage all providers including trainings etc. and 2K address specific measure to ensure accurate i.e. providers reviewing counts for accuracy, etc.

8. *Unsheltered* – see above for any suggestions

NAEH summary and recommendations for Part II

It is recommended that Broward County:

1. Increase HMIS participation to over 50% for each population; develop a clear plan of action to increase participation included a plan to engage non HMIS providers; articulate this plan clearly in future applications
2. Decrease NULL values in all categories to less than 5%
3. Increase emphasis in data standards and training for all providers; articulate specific tools and steps to increase data quality in narrative in all sections regarding data quality, standards and training for providers

PART IV REVIEW: Continuum of Care Performance

CoC's were asked to propose numeric achievements for each of HUD's five national objectives related to ending chronic homelessness and moving individuals and families to permanent housing and self-sufficiency through employment in 2010 and this section compares their actual accomplishments since FY2010 versus the proposed accomplishments.

The scoring in this section specifically correlates to the CoC meeting or exceeding the previous year's projections with primary focus on 1) increasing PSH beds for the chronically homeless, 2) making progress towards eliminating the chronically homeless and 3) CoC funded transitional housing program participants' success in obtaining permanent housing. Broward County falls significantly short on all of these 3 areas. In our review of the Broward County Exhibit 1, the following areas were noted that showed deficiencies that would appear to impact the score based on HUD's CoC Debriefing Summary

1. *Increase in PSH beds for the chronically homeless* - 317 were projected, but only 272, (15% less) were actually created
2. *Progress towards decreasing the chronically homeless* – Broward County reports a significant increase of chronically homeless persons, and shows no increase (in fact a decrease) in beds for that population.

Year	CH Person	CH Beds
2010	377	292
2011	816	274

3. *CoC funded transitional housing program participants' success in obtaining permanent housing* – While the HUD goal is 65% and the proposed Broward County goal was 55%, the actual achievement was only 45%. This score is 20 percentage points below the HUD objective and 10 percentage points below the local objective. Of importance is to know that many communities are exceeding the HUD goal, many reporting over 80% exiting to permanent housing.

HUD debriefing further indicates that many CoC's did not provide responsive summaries as to why objectives were not met. It is critical to have clear explanations. For example, the narrative regarding PSH beds did not detail the reason for the lack of creation of 45 beds, but only addressed 18 beds. The narrative on the TH exits to permanent housing did not clearly address what is happening across the system. Even if one provider is significantly low, this narrative can talk about the other providers.

It is also important to align this section with section 3:CoC Planning in addressing the specific steps that will be taken to meet the performance objectives including precise plans and timelines to deal with low performers.

NAEH summary and recommendations for Section 4

It is recommended that Broward County:

1. Place special emphasis and resources towards reducing chronically homeless persons in the CoC, including clear identification of the most vulnerable and targeting any available PSH beds in the CoC for those persons
2. Aligning existing resources with the development of permanent housing solutions for the chronically homeless
3. Developing performance based contracting for all funded transitional housing providers with a system wide goal of at minimum meeting the HUD performance standard of 65% of exits to permanent housing; evaluate and provide technical assistance to low transitional housing performers to meet the 65% goal. If the goal is not met within a specified time, reallocate resources to high performing strategies.

PART V: Emphasis on Housing Activities (6 total points available)

Emphasis on Housing Activities was only scored on eligible new project requests; this included those new projects created under the Hold Harmless Reallocation process. Points were awarded based on the relationship between new funds requested for housing activities and new funds requested for supportive service activities.

NAEH Summary and Recommendations for Part V

Broward County did not submit a new PSH project for the Housing Bonus this year. This automatically cut 6 points from the overall score.

In light of the fact that the numbers of unsheltered and chronic homelessness increased significantly, coupled with the fact that no new PSH units were added for that population, it is recommended that the community leverage this bonus every year to apply for projects to increase the housing options for reducing homelessness. Any project should focus on use of housing dollars (leasing/operating costs) vs. supportive services. A model used by some communities is to partnering with another community service provider who can provide the services and SHP funding provides leasing and operating dollars.
Applying for this bonus will not only increase the housing options to help meet other community goals, but will increase the score each year by adding points.

SUMMARY

Focusing the community's efforts to increase HMIS participation and data quality, and improved performance specifically in reducing chronic homelessness, increasing PSH units and meeting the HUD goal of exits from TH to PH will increase the competitiveness of the Exhibit 1 application.

APPENDIX Z:
BROWARD COC APPLICATION SCORING TOOL

MAX POINTS	SCORE	CATEGORY *(factors that apply to new projects are italicized)*
		Participation in Community Planning Efforts (Applies to Provider)
0		Attended <50% of Quarterly meetings
1		Attended 50%-74% of Quarterly meetings
2		Attended 75%-100% of Quarterly meetings
0		Attended <50% of Provider Council meetings
1		Attended 50%-74% of Provider Council meetings
2		Attended 75%-100% of Provider Council meetings
		Participation in ServicePoint (Applies to Specific Project)
5		98% beds/persons entered and updated monthly (Universal Data Elements and Program Specific Data Elements entered and up to date) into Broward County HMIS
3		98% of beds/participants entered into Broward County HMIS– Missing data/NULLS
2		50% to 97% of beds/participants entered at either level into Broward County HMIS
1		Participated in HMIS training but <50% of beds/participants entered at either level into Broward County HMIS
0		Did not participate in training, 0 beds entered into Broward County HMIS
2		Enter data into other types of HMIS and share information consistently with Broward County
4		*New project that commits to full participation in HMIS (Project must commit to be considered for CoC funding)*
4		Average score of A on Quarterly Data Report Card
2		Average score of B or C on Quarterly Data Report Card or New Project
1		Average score of D on Quarterly Data Report Card
0		Average failing score on Quarterly Data Report Card
		Projects program model aligns directly with goals and objectives of the County Ten year Plan and other strategic planning efforts
10		Program is already utilizing ten year plan strategies and aligned with recognized best practice or *new project is aligned with ten year plan strategies*
5		Program has made efforts to align with the yen year plan and recognized best practice
		Percentage of program funds allocated to housing (Applies to project, *including new projects)*
3		80-100%
2		60-79%
1		Less than 60%
		Project Performance
5		Project is at 95% capacity or higher
5		Project is at 95% capacity or higher
4		Project is at 85-94% capacity
2		Project is at 75-84% capacity
0		Project is below 75% capacity
3		At least 20% of clients are employed upon exit
3		At least 50% of clients have health insurance upon exit
3		90% or more of annual budget is being expended

MAX POINTS	SCORE	CATEGORY *(factors that apply to new projects are italicized)*
3		50% of clients or more report increase in income between program entry and exit
10		New projects (*in lieu of points for past performance*)
5		Has not returned money to HUD or the County (*applies to new projects*)
10		At least 90% of program participants are referred from Coordinated Assessment
5		At least 50% of program participants are referred from Coordinated Assessment
7		New Project that commits to only receiving program participants from Coordinated Assessment
		Program Type Specific Performance on Outcomes
		Transitional Housing
7		At least 75% exiting to permanent housing
10		At least 85% exiting to permanent housing
3		Average length of stay for households is under 120 days
5		Average length of stay for households is under 90 days
7		Average length of stay for households is under 60 days
5		New Transitional Housing Project (*in lieu of points for past performance*)
		Rapid Re-housing
8		90% of program participants exit to permanent housing
5		80% of program participants exit to permanent housing
6		Less than 5% of households exiting the program return after 6 months
4		Less than 5% of households exiting the program return after 12 months
6		Average length of stay before exiting to permanent housing is 30 days or less
4		Average length of stay before exiting to permanent housing is 45 days or less
15		*New Rapid Re-housing Project (in lieu of points for past performance)*
		Permanent Supportive Housing
6		90% of clients served are chronically homeless households
4		Use Medicaid funding in their program
6		Fewer than 15% of tenants negatively exit
6		At least 70% percent of new entrants that remain housed after 12 months
8		At least 90% of new entrants remain housed after 12 months
15		New Permanent Supportive Housing Project to serve Chronically Homeless (in lieu of points for past performance)
		Performance Risk Adjustment
TBD		*Risk adjustment factor for projects that serve households with higher barriers. Bonus points are awarded for projects that meet pre-agreed benchmarks for the share of program participants at certain barrier levels. Possible bonus points are negotiated with HIP staff at the beginning of contracts.*

Additional Points will be awarded based on criteria and incentives HUD includes in its Continuum of Care Notice of Funding Availability

APPENDIX AA:
HENNEPIN TYP MEETING AGENDA AND NOTES

Agenda for HHH Community Meeting
September 20, 2012

Welcome and brief update on where we are, 9:30 – 9:50

Updates from Community providers, 9:50 – 10:15

Community Feedback Sessions, 10:20 – 11:45

This is a chance for you to help guide the priorities for Heading Home Hennepin in the coming years. As we have limited time, please focus on Gaps in services, any new trends you are seeing, and discuss new or developing opportunities.

Session 1, 10:20 – 10:45

Homeless Children - Jackman Room (downstairs)*

What are the gaps in services for homeless children? How do we successfully fill those gaps? Are there programs/service models that are showing promising results?
Facilitator: Dawn Horgan

Youth – Guild Hall, Back

All things youth. What is working, what do we need to do more of? Employment/training strategies, shelter, improvements to the OC, other systems change that needs to happen?
Facilitator: Andrea Simonett

Downtown Issues - Guild Hall, Front

What unique issues face downtown Minneapolis? How do we improve livability while delivering service to those who are homeless? What partners need to be involved? How can outreach be improved? What new opportunities are on the horizon?
Facilitator: David Jeffries

Housing – Lenmark Room (downstairs)*

-A discussion of all things housing. How do we develop more opportunities for families, what is working currently, what works for singles, what do we need to do more of, what do we need to change, what policies stand in the way of developing housing opportunities?
Facilitator: Mike Manhard

*To get to the **Jackman** and **Lenmark** Rooms, walk to the back of Guild Hall, and take a right, both rooms are immediately at the bottom of the stairs.

Session 2, 10:50- 11:15

Young Families – Lenmark Room (downstairs)
An opportunity to discuss how to better serve the needs of young parents and their families, and to identify practices that are working well with this population.
Facilitator: Jenny Geris

Suburban Specific issues - Jackman Room (downstairs)
What issues are affecting people in the suburbs disproportionately? What works for people who are homeless in suburban Hennepin? What are we missing?
Facilitator: Anita Perkins

Targeting housing resources - Guild Hall, Front
How do we best use the housing resources we have? How can we create targeted programming?
Facilitator: Wendy

Healthcare - Guild Hall, Back
What opportunities are on the horizon considering the changes to health care under the Affordable Care Act? What gaps in services are still present? How do we more closely connect housing and medical outcomes? How can we better integrate behavioral health and medical care?
Facilitator: Stephanie Abel

Session 3, 11:20-11:45

FHPAP – Lenmark room (downstairs)
Provide feedback that will help guide the creating of the new FHPAP RFP, expected next March.
Facilitator: Kristi Olzeske

Employment, Education, and Income – Jackman room (downstairs)
What works and what do we need more of in education and employment for homeless adults. Some topics to promote thought and dialogue: Employment: training programs; income supplement programs; integration of "mainstream" employment and income support programs; work incentives; integration of housing and employment; financial education; innovative and non-traditional employment and training models; disparities & closing gaps. Education: access; secondary and post-secondary programs; integration with housing; linking education with employment outcomes.
Facilitator: David Browne

Criminal Justice - Guild Hall, Back
What is lacking in discharging people from Criminal justice institutions? How do Criminal Justice issues affect folks who are homeless, what can we do about it?
Facilitator: Steve Horsfield

Immigrant/Refugee/Undocumented – Guild Hall, Front
How do we best serve refugees? Undocumented households? How do we develop cultural competence to serve them better? What resources are we missing? What resources do we have that we could use to target these folks?
Facilitator: Rachele King

Wrap up and Next Steps, 11:45-11:55

Minneapolis / Hennepin County Office to End Homelessness
Research, Planning and Development Department
A-2308 Government Center
300 S. 6th Street
Minneapolis, MN 55487-0238

10/5/2012

Dear Heading Home Hennepin Community,

A huge thanks to each of you who were able to make it to the Heading Home Hennepin annual community meeting at Plymouth Church on September 20, 2012. We had a huge and enthusiastic turnout, with well over 200 people from 66 different agencies in attendance. We spent a little time updating folks on what has been done in the past year, as well as looking what indicators are affecting our ability to find housing for people. We then heard from providers about new programs and initiatives in the community. Some information that was presented is available on our website (http://www.headinghomeminnesota.org/hennepin/Meeting).

The bulk of the community meeting was spent in small groups discussing gaps in services and new opportunities for a variety of subjects ranging from youth and families to employment and refugee specific issues. This document serves as our report to the community on the meeting. We have arranged each section into a)What we heard in the session b)what are next steps, c) what the Office to End Homelessness will do next, and d) what we need help from the community with. Please take some time to read these notes, and let us know if we missed anything. For each action step we will be following up with the either direct action from our office, or with a working group to help guide work around a specific topic.

The main complaint we heard at the meeting was that the sessions were not long enough to full capture the current problems or opportunities, as well as come up with solid and clear next steps. Due to this, the Office to End Homelessness is planning to start a "Community Conversations" series where we will pull in experts and policy makers as well as community providers to continue these discussions and gain more input from various stakeholders. We anticipate these sessions will begin after the New Year, and would ideally include one conversation a month. We will keep you informed as we solidify this series.

Thank you all for your ongoing support and commitment to ending homelessness,

Sincerely,

Cathy ten Broeke
Matthew Ayres
Lisa Thornquist
Danita Banks

Homeless Children
Facilitator: Dawn Hogan

What we heard:

What are the Gaps:
- Children are losing access to early childhood education upon leaving the shelters.
- Continued growth in numbers of children & youth who are homeless and little to no increase in resources to meet their needs
- Lack of Family housing
- Need for more funding for children: Most funding mechanisms are geared toward adults and thus creates a gap when it comes to child funding. Difficult to find funding for children.
- There is a lack of awareness of the needs of children outside of the urban core areas.
- Lack of affordable childcare needs to be addressed.

What's Working
- Wrap around services
- Success when families are covered under an umbrella of services (life skills, parenting classes)
- Services for children in shelters/head start
- Some school districts fully following the McKinney Vento Education law
- Greater success for children in school when educational advocates are included in housing supports.

Next Steps:
- Engage a discussion with programs such as PICA/Head Start to ensure the continuation of early childhood education after children/families leave shelters
- Streamline funding sources. Families often receive funding from multiple sources which makes it difficult to identify a single funding source for housing.
- Work with cities to relax zoning restrictions for low income family housing.
- Need to work with state and federal decision making bodies to push for more funding for affordable family housing

What the Office to End Homelessness will do next:
- Connect with Head Start to identify ways to ensure continuity in service when a family leaves shelter for housing.
- Convene a group of funders to discuss the gap in housing opportunity development in Hennepin County for families.
- Create a list of supportive services in the suburban communities in which families are being housed. (Each family could get an individualized list of informal and formal supports in their new community. Including child care, food supports, youth programming, parenting support, etc.)
- Work with County officials, suburban school districts, and initiatives to encourage full implementation of M-V education laws.

What we need help from the community with:
- Help creating the resources booklet, work to target communities where most families are housed.
- Lobby legislators to fund affordable Family appropriate housing in our community, as well as housing subsidies for families.
- Work with the MN Coalition (www.mnhomelesscoalition.org) to help move their legislative agenda forward.

Youth
Facilitator: Andrea Simonett

What we heard:

What Are the Gaps:
- Young people need driver's training, but no access to the training or licensing process.
- Longer and deeper rent subsidies
- Kids leaving Corrections with mental health needs – those case managers don't know much about housing. Specifically supportive housing.
- Life skills are as needed as academic skills. Invest in those in greater depth.
- Supporting people through program transitions. What happens when one program ends?
- Creative youth employment opportunities. Can we build on the Step Up summer program?
- What to do for young people 18-24 who do not want to go to shelter.
- Increasing need for clinical services related to trauma and mental health.
- How to support families in continuing to try to work with their children. Education and training.
- Suburban youth outreach and services.
- Funding for age range 12-18 has unique needs that are underfunded.
- Concept of emerging adulthood has unique needs that need to be addressed in specific ways – 14 to 24.

What's working:
- Host Home Model is creating some great opportunities for youth.
- The expanded hours at the Youth Opportunity Center have provided new learning and access to previously unsupported youth. Youth shelter is working as well, what little there is of it.
- Youth Opportunity Center is working – multiple partners. One stop
- A model of engagement is emerging that catches kid's eyes – a leadership or learning opportunity that also comes with housing.
- Providing kids with "Life Coaches" versus "case managers" or "staff". This manner of engaging youth has improved outcomes for youth
- Contracting with YMCA and The Bridge for Life Coaches
- Working with local police and local community members has allowed for some training and education on youth related issues in the suburbs. This has led to specific positions within the department that are sensitive to youth needs.
- Pilot in Mpls and Hennepin County, DHS funded youth under 19.5 age on MFIP get connected to a Public Health Nurse who then works as their MFIP case manager. This has improved outcomes for these youth.
- People Serving People state youth in shelter are isolated, bored and disconnected. PSP has designed youth programming with input from the youth and are finding it successful to engage youth using digital media and design technology to do meaningful work in their community.
- Anoka Hennepin food shelf has been expanded to most of the middle and high schools. The kids were able to get many needs met at fall resource fairs.

Next Steps:
Explore employment opportunities, including a summer step-up like program.
Explore continued expansion of Host Home model

What the Office to End Homelessness will do next:
What we need help from the community with:

Downtown issues/Outreach
Facilitator: David Jeffries

What we heard:
- Nicollet is a corridor for the homeless.
- Criminalizing homelessness. Businesses are angry. People are talking about removing benches outside downtown Target.
- Young people are sitting and congregating and selling cigarettes, looking for food. With GoTo passes being given by MPS, a lot of young people are transferring downtown.
- Suggestions for a Central Library partnership because many librarians are not educated on homeless issues. The library is a free and quiet place to stay so it attracts a transient population. Someone to connect people with services could be at Central for a couple of hours a day.
- Inform public that homeless need more than leftover lunch. They need help from facilities.
- People are being kicked out of HCMC because there have been cuts in mental health staff.
- There are issues of race and class in how homelessness is visible to people. St. Stephens received 10 calls in one day about a 24 year-old white woman with 3 kids. Stigmas prevent us from changing homelessness. Many homeless do not panhandle and are indistinguishable from the next person.
- Guide the conversation away from closing down public spaces because of fear. Fight "pay-to-play."
- Some young teens are looking for opportunities. Focus on solutions. Don't give money.
- Outreach teams drop info to businesses. They want to try to educate people through the business.

Next steps
- Expand on partnerships that will encourage downtown businesses to avoid just calling police, and to call outreach instead.

What the Office to End Homelessness will do:
- Work with Youth Coordinating Board to help train and coordinate their new outreach workers with Streetworks.
- Work with Library to expand on existing trainings for library staff.

What we need help from the community with:
- Inform public that homeless need more than leftover lunch, public awareness about panhandling and services.
- Continue education of businesses and downtown residents through Street Outreach Teams

Housing

Facilitator: Mike Manhard

What we heard:

- We have a lot of good strategies (like Housing First, shelter plus care, etc) but we need to target the right people into those opportunities and we need to have an exit strategy when people don't need that level of service anymore. Also need to allow people to improve their situation without losing their housing (i.e., earning income, going back to school).
- We need more affordable housing linked to services (open up more building to GRH).
- We need more affordable housing that isn't linked to services (SROs).
- Booklet to describe housing resources.
- Extend Rapid Exit services beyond 6 months so it can play a role in preventing a repeat of homelessness.
- We need housing accessible to people with criminal histories.
- We need to push the federal government to expedite social security claims process.

Next steps:

- Look to GRH/Housing First group to develop a practical growth strategy and plan. How much larger can/should the program grow? Any room to move on percent of apartments in a single building?
- Work with Mpls and suburbs – how can we support more housing development to ease the vacancy rate?
- As a state, can we push Social Security (thru DHS) to expedite claims? Can we work with local office to develop priority for people in shelter?

What the Office to End Homelessness will do:

- Organize a meeting with the county's Housing First staff and management and community advisory group to identify a sustainable growth strategy for GRH.
- Bring the issue of housing development to the City and County Funders Council for ideas on how to generate/support more housing development and how to turn existing vacant housing into affordable, rentable housing.
- Connect with Social Security staff to see if there are efficiencies
- Explore coordinated access to housing resources (part of the work that is currently being done around central intake)

What we need help from the community with:

- Work as a community on central intake/central exit to best target resources. Work as a "system."
- Community education/dialogue on the need to make room in our community for all our citizens, including those who paid their debt to society and are now back in our community.
- Continue the community discussion around housing to identify more action steps and efficiencies

Young Families and Children
Facilitator: Jenny Geris

What we heard:
Gaps/Opportunities:

- Good service provision must include the parent/guardian *and* each child as equal, primary participants.
- Intentional and effective father involvement is frequently overlooked or not considered.
- Navigating Hennepin County systems can be difficult for many young families.
- Families lose access to quality early childhood education upon leaving shelter.
- The community needs more affordable, appropriate, and adequate family housing.
- The community needs more affordable quality child care.
- Providers would benefit from a comprehensive clearinghouse of resources and referrals specific to this population.
- It is difficult to find funding to support children and their families.
- There is a perceived gap in supports and understanding of families and children living outside the urban areas of Hennepin County.
- Transportation continues to be a barrier for homeless families when accessing services.

Existing Strengths:

- Wraparound services (that include but are not limited to life skills education, parenting classes and support, visiting in family's home)
- Opportunities for community building, specifically with young mothers.
- Existing collaborations among agencies. Other agencies may learn from prior experience.

Next steps:

- Begin discussion with shelter partners (i.e., PICA Head Start) about possibilities for families to continue access to appropriate early childhood education after leaving shelter.
- Encourage programming and supports that focus on the child as a primary recipient of services.
- Design and implement programming and supports that are mindful of young parents' needs.

What the Office to End Homelessness will do:

- Restart Young Family workgroup.
- Continue to develop Stable Family Initiative project, with involvement of interested community partners.
- Connect with Head Start to identify ways to ensure continuity in service when a family leaves shelter for housing.

What we need help from the community with:

- Work to clarify possible funding sources for families and family housing. Streamline process if possible.
- Consider how zoning and building restrictions impact low-income family housing.
- Increase funding and collaboration for affordable, appropriate, and adequate family housing.
- Determine how healthcare and MFIP funding sources and related services may be used to improve services and supports for children and young families.
- Continue avid and intentional participation in state policy affecting homeless children. Seek connection with similar ties at the federal policy level.
- Create allies in related Hennepin County systems that understand and advocate for the needs of young parents.

Suburban Issues
Facilitator: Anita Perkins

What we heard:
- There is a lack of affordable and transitional housing in the suburbs
- More expensive in the Western Suburban area and even less transportation
- GRH works well
- Rapid exit not working well for some suburban families
- Suburban landlords often will require additional security deposits
- Transportation can be a major barrier, and there is no help for people who have cars but need repairs
- Travelling downtown to receive services is time consuming, difficult and expensive
- Bus routes are not helpful or too hard to get to get to Services downtown
- Drivers education and drivers licenses are unaffordable
- No outreach for people who are unsheltered
- No shelters in the Suburbs
- Shelters downtown: Bussing or cabbing children to home schools can be stigmatizing,
- Host Homes work well for youth, suburbs is a good place for youth, fewer distractions
- There can be a disconnect between suburban providers and resources
- There is often a lack of communication and collaboration among different suburban providers
- There is a lack of awareness around resources that exist in the suburbs
- HPRP worked well for people in the Suburbs
- 3 month or more extended assistance with the HPRP was really helpful and stabilized more families
- Guide to Human Services that NWHHSC prints and has on the website might be helpful to connect to services

Next steps:
- Expand Suburban provider groups to encourage collaboration.
- More Host homes
- Develop resources guide that is geared toward people who are experiencing homelessness
- Create a list of supportive services in the suburban communities in which families are being housed. (Each family could get an individualized list of informal and formal supports in their new community. Including child care, food supports, youth programming, parenting support, etc.)

What the Office to End Homelessness will do:
- Work to spread the word about Hennepin County's new family services center in Brooklyn Park.

What we need help from the community with:
- Create a list of supportive services in the suburban communities in which families are being housed.
- Expand Suburban provider groups to encourage collaboration.

Targeting Housing Resources
Facilitator: Wendy Weigmann

What we heard:
- High-end users targeting
- Housing First collaborative relationships with landlords and Housing First baseline service delivery.
- Nicollet Square flat rent for youth and their HIRED partnership.
- Opportunity Center
- Catholic Charities Tenant Education Seminar
- Partner funding for GRH resources and Heading Home Hennepin work groups
- We need both a coordinated intake system and more coordination in housing.
- We need housing for young moms and people in school or in job programs.
- We need access for everyone including those with limited English proficiency and outreach for traveling youth.
- We need to target families and youth to meet goals. Family diversion should be stressed to keep families out of shelter. We need to target rapid rehousing and prevention in schools.
- We need to pay attention to ideas and best practices from other states.
- We need incentive programs for landlords.
- We need to be mindful of the entire homeless population not just subpopulations.
- There are 5 programs and 4,000 scenarios which results in not enough flexibility. To help, we need to be able to get people services before they are in shelter.
- There are no places for chronic inebriate women. Something like a Higher Ground for women would be helpful as well.
- We need programs and housing outside the city of Minneapolis.
- The long-term homeless often struggle after being housed because they have lost their routine and community. We need to understand that a quick shift to independent housing will not work for all.

Next steps:
- Bring MPHA on board to assist with specific populations
- Create and pilot a coordinated housing intake and referral program

What the Office to End Homelessness will do:
- Work to create a coordinate assessment and Intake system
- Work with providers to identify the best ways to centralize housing waitlists

What we need help from the community with:
- Identify and implement ways to coordinate and centralize housing applications and waitlists

FHPAP

Facilitator: Kristi Olzeske

What we heard:

- People are not happy with the system as it exists but no consensus on what niche FHPAP should fill. We need more prevention dollars while at the same time we need more RE money for longer-term subsidies and case management. Should we target prevention to higher income families so it can be successful or do we move money to rapid rehousing for hardest to serve families and give them deeper services? Compromising in the middle by giving tough families just a little bit of help doesn't work.
- We need to better target RE better. Tier clients and target the right amount of resources for each tier. See an increase in higher barrier families and RE needs to be able to stay with them long enough to make it work.
- We need to re-imagine shelter, prevention, and rapid exit. For families, the children need to enter into the discussion.
- We need to look at more neighborhood based services. Combine RE and prevention dollars with neighborhood agencies that can provide wrap around services.

Next steps:

- Hennepin County and MN Housing are re-issuing RFPs for FHPAP dollars in 2013. This is an opportunity to reshape FHPAP.

What the Office to End Homelessness will do:

- OEH is pulling together a planning process – Stable Families – to look at a more comprehensive set of services and housing supports for the most difficult to serve families.

What we need help from the community with:

- Identify multiple models of addressing homelessness. A spectrum of interventions need to be designed:
  - Prevention
    - Consider multiple levels of assistance based on AMI? Consider all cash comes with some case management/budgeting.
  - Basic Rapid Exit
  - Rapid Exit Plus
  - Intensive Support Model
- Getting the right people to the right level of support and then determine which of these models is FHPAP best positions to support.

Immigrants/Refugees/Undocumented
Facilitator: Rachele King

What we heard:
- Shelter staff are seeing many immigrants. Mary's Place families are over ½ Somali. 1 in 4 people are undocumented at Simpson.
- There are many homeless undocumented Hispanic men without English skills.
- Immigrants often don't know who to trust, and worry if they are going to be helped or sent back to their home country.
- Many undocumented are still long-term homeless even after getting jobs.
- Undocumented families are split up at Harbor Lights and children will go with a family friend.
- It is hard to advocate for the undocumented. Because of private shelters and those flying under the radar, the count for these populations is low. Latinos will also often double up.
- There needs to be better interpreter education from the Hennepin County Multicultural Center and more people at Hennepin County in general with language skills.
- We need trauma-informed services for refugees. There needs to be a resources list for trauma education instead of winging it with each new family.
- Utilize services that cater to specific nationalities.
- Refugee specific economic assistance team to work with only refugees.
- We need to have a continuance of funding and coordination between front-end and crisis services.
- Inform libraries where immigrants can go for help.
- Ask for development centers, churches, and schools' help with the undocumented. We also need agencies that help these populations to share information with the shelters.
- More community health workers are needed. There are refugee mental health issues and interpreters need to be versed in mental illnesses. There are little to no mental health services for the undocumented.
- Communicating eligibility status requirements and reducing changes in status.
- Inform frontline workers of geographic barriers because of refugees' experience with past political conflict.

Next steps:
- Create a resources list for Trauma-based education
- Explore creation of Refugee specific EA team at Hennepin County
- Look at current interpreter training in OMS at Hennepin County
- Create a resource list for refugee and immigrant households; get it out to the community.
- Look to mainstream resources to connect single undocumented men with. Create resources list.

What the Office to End Homelessness will do:
- Explore creation of Refugee specific EA team at Hennepin County.
- Look at current interpreter training in OMS at Hennepin County.
- Explore creating a Homelessness 201 training for staff on history and context of conflicts that many refugees in MN experienced.
- Look at reforming the HHH undocumented working group

What we need help with:
- Create a resource list for refugee and immigrant households; get it out to the community.
- Look to mainstream resources to connect single undocumented men with. Create resources list.
- Create a resources list for Trauma-based education. (Center for Victims of Torture?)

Employment, Education, Income
Facilitator: David Browne

What we heard:
- We should broaden the concept of employment; encourage structured activities during the day.
- Create more subsidized employment
- Focus more attention on accessing employment
- Engage more employers and bring them to the table
- Need more support groups for individuals looking for jobs
- Change the mindset that if you are employed, you will not lose benefits or healthcare
- More collaboration needed with employers beyond the Workforce Center(s) to find ways to engage employers and provide them support
- Encourage individuals to volunteer more and think beyond just finding employment
- Some people have difficulty obtaining a Social Security card for various reasons
- We need a training for those seeking employment with criminal backgrounds
- More educational classes designed to teach individuals how to look for and retain employment
- More training for specific types of jobs
- Education Opportunity Center and the work program through Pillsbury House/Internship are successful

What are the next steps:
- Find new or different job and training programs
- Find employers who provide child care for employees
- Recruit felony friendly employers (can we replicate the Housing First collaborative model?)
- Explore building capacity in the provider community to find and secure employment
- Work to find a solution for obtaining ID and Social Security cards

What the Office to End Homelessness will do:
- Continue this conversation in the community. Host a dedicated conversation on this topic.
- Restart the HHH Employment workgroup to:
    - look at ways we can encourage staff and clients to thing about employment as a viable option
    - explore bringing employers to the table as partners
    - provider training and resources to providers on how to help clients access employment and keep benefits
- Explore other productivity options for those who are housed but cannot work (volunteering, community activities)
- Expand ID vouchers to employment programs

What we need help with:
- Identify more employment - on the job training opportunities
- Provider engagement on Employment working group

Health Care
Facilitator: Stephanie Abel

What we heard:
- Problems exist with continuity of care after hospital release
- SPMI individuals are being released after a 72 hour hold without a proper follow up plan
- How can a chemical dependency harm reduction program/model be implemented for families, safety issue for children
- Traditional services alone don't work because they will also drop the client if they are not present for an appointment.
- Transportation can be problematic – clinics drop clients who are late or miss appointments. Public transportation is unreliable.
- Residents being released from hospitals after surgical procedures into homelessness
- Appropriate healthcare training needed
- DART is harm reduction not sobriety, a model that works in reducing use
- Community healthcare worker's assist residents to navigate systems
- Smaller clinics work better to navigate systems
- Transportation continues to be problematic causing residents to miss scheduled appointments
- Brain Injuries can impact treatment. We need to screen better.
- More aggressive commitment to harm reduction tools and training for providers. How to talk to someone about their drug use without judgment.
- Look at the food we serve in shelters. There is a noticeable trend that people gain weight in shelter.

Next steps:
- Funding needed to provide transportation for scheduled appointments
- Need more Care Coordination and Coordinators
- Housing and Healthcare support, expand funding and case management
  Education needed on the various drugs (cocaine, heroin, meth etc.), chemical health is a epidemic, make sobriety a requirement
- Communication with healthcare providers (hospitals, clinics) to discuss ongoing care once released
- More and easier to access TBI and DD testing
- Examine a healthy food campaign in shelters
- Training for staff (and clients?) on who to properly use the healthcare system

What the Office to End Homelessness will do:
- Continue this conversation in the community. Host a dedicated conversation on this topic, and develop workgroup if there is sufficient interest.
- Explore more Harm Reduction training and training on how to use the healthcare system appropriately
- Look into incorporating TBI screening in program intakes

What we need help with:
- Provide State and Local discussion to expand healthcare to include housing support as a service.
- Educational dialogue on the importance of healthcare by healthcare providers

Criminal Justice
Facilitator: Stephen Horsfield

What we heard:

- Felons: sex offenders, arsonists and defined violent crime offenders have a extremely difficult time securing
- Crimes from years past remain on record
- Employment restrictions exist for ex-offenders
- Find safe environments to have open dialogue/conversations regarding chemical use.
- Homelessness is a crime, more advocacy needed in the courts
- Reunification of families upon, assistance needed
- There is a "Going Home" guide for re-entry created by the Dept. of Corrections located in the Corrections Library
- Employment, Housing needed immediately upon release
  Educating the community to give ex-offenders a second chance
- Connecting ex-offenders to a mentor
- Available community resources
  Housing resource data base needed for sex offenders and arsonists
- Create a Bonding program similar to Employers for Landlords
- Definition of homelessness needed for a ex-offender (incarceration period does not apply)
- More engagement needed with Law Enforcement
- Continue mental health treatment if treated while incarcerated
- Regional housing solutions needed to allow for a fresh start

Next steps:
- Work with Public Housing Authority regarding ex-offenders who are not sex offenders or arsonist being restricted from housing
- Need more housing advocates within the criminal justice system
- Neighborhood discussion regarding housing for ex-offenders
- Work on expungements
- Develop a Mentor program for ex-offenders
- Develop a housing data base for sex offenders and arsonists
- Define LTH screening for ex-offenders
- Find Landlords willing to rent to ex-offenders

What the Office to End Homelessness will do:
- Continue to communicate with the Department of Corrections, attend Transition Coalition meetings and provide resource in-service sessions at Shakopee Prison .Pre-Release classes
- Develop a Resource List for ex-offenders

What we need help with:
- Establish ongoing meetings with Law Enforcement Officials to discuss (ex-offender /homelessness /employment/ mental-chemical health issues)
- Work as a community to find how to prevent recidivism
- Employment - Housing needed for ex-offenders

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