ANNUAL PLANNING POLICY

Lakeland/Winter Haven Polk County
Continuum of Care
Homeless Coalition of Polk County
Lead Agency
107 Morningside Drive, Unit C
Lakeland, FL 33803

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PURPOSE

This policy and procedures manual defines the Polk County Continuum of Care annual planning process. It explains the Continuum of Care planning cycle and the Continuum of Care system components.

CONTINUUM OF CARE PLANNING

Continuum of Care planning is a year-round activity to ensure the Continuum of Care system meets the needs of the homeless by identifying types of services needed, the location where services are needed, the capacity that must be met by the services, and identifying approaches to providing those services. The Continuum of Care annual planning cycle consists of the six steps shown in Figure 1--Continuum of Care Planning Cycle with products developed in step 6 being used in step 1 of the next year's planning process.

The planning committee will determine specific schedule and responsibilities for Continuum of Care planning. The following actions, at a minimum, should be included during the months indicated.

Step 1--Review the Annual CoC Planning Process and Point-in-Time Count

Target date: January/February

Actions:

- Review the effectiveness of the community-based planning process.
- Review the membership on working groups to ensure the correct organizations are participating.
- Update previously identified desired outcomes for the new planning cycle.
- Update roles and responsibilities.
- Update goals for the Continuum of Care planning process and establish timetable for the new planning cycle.
- Determine the number of homeless to be served and identify their needs for service.
- Homeless survey of State of Florida, Office of Homelessness.

Step 2--Collect Needs Data and Inventory System Capacity

Target date: March/April

Actions:

- Consider strategies for collecting information.
- Select a methodology for collecting needs data, capacity data, and mainstream resources.
- Add new capacity to the inventory of existing capacity dedicated to serving homeless people and delete any capacity no longer available.
- Add any new mainstream resources to the inventory and delete any mainstream resources no longer available.
- Compile information and validate findings.

Step 3--Determine and Prioritize Gaps in the Continuum of Care Homeless System

Target date: May/June

Actions:

- Organize Data: Continuum of Care gaps analysis.

- Review the community process for determining relative priorities updating as needed.

Step 4--Develop Short-and Long-Term Strategies with an Action Plan

Target date: July/August

Actions:

- Summarize priority gaps and create groupings which interrelate.
- Develop strategies and action steps.
- Link gaps to possible resources.
- Assign responsibilities and develop timeframes.

Step 5--Implement Action Steps for the Continuum of Care Plan

Target date: September/October

Actions:

- Obtain participation agreements for the upcoming year.
- Select a Lead Agency for the upcoming year.
- Ensure an Annual Conflict of Interest Statement is completed by each director, principal officer, and member of a committee with Board delegated powers.
- Review and update the Polk County Continuum of Care Application Ranking Criteria .for Continuum of Care Project selection.
- Finalize written plan and the CoC Application.
- Monitor implementation of the Continuum of Care plan.

Step 6—Project Ranking and Homeless Provider selection

Target Date November/December

Actions:

- Nominate and select panel for project application review.
- Following the CoC Application Review procedures and the updated Polk County Continuum of Care Application Ranking Criteria determine project rankings.
- Develop the CoC Project Listing.
- Publicize selection of provider agencies.
- Complete application documentation.

CONTINUUM OF CARE SYSTEM COMPONENTS

A Continuum of Care is a coordinated set of services to address the needs of the homeless. The U. S. Department of Housing and Urban Development defines a Continuum of Care as consisting of the following components:

Prevention and Diversion

Prevention is the first key to reducing homelessness by keeping families in their home. Homeless prevention activities include income supports, rental assistance, and advocacy. They may include stabilization services such as one-time emergency funds to prevent eviction and crisis intervention assistance to those at risk of becoming homeless to maintain their housing. Diversion services occur after an individual or family becomes homeless. The goal is to keep clients out of emergency shelters by

rapidly rehousing them. Diversion activities are often the same as prevention activities, but can also include intervening with family members to persuade them to house the client or working with landlords to persuade them to let the client come back.

Outreach and Engagement

This component acknowledges that some homeless persons are unable or unwilling to accept shelter services. Outreach efforts include such things as street outreach to people residing in places not fit for human habitation, identifying and addressing a person's immediate needs, and providing a link for the individual to ongoing support. Engagement is the more long-term process of building a trusting relationship so that more than immediate needs may be addressed.

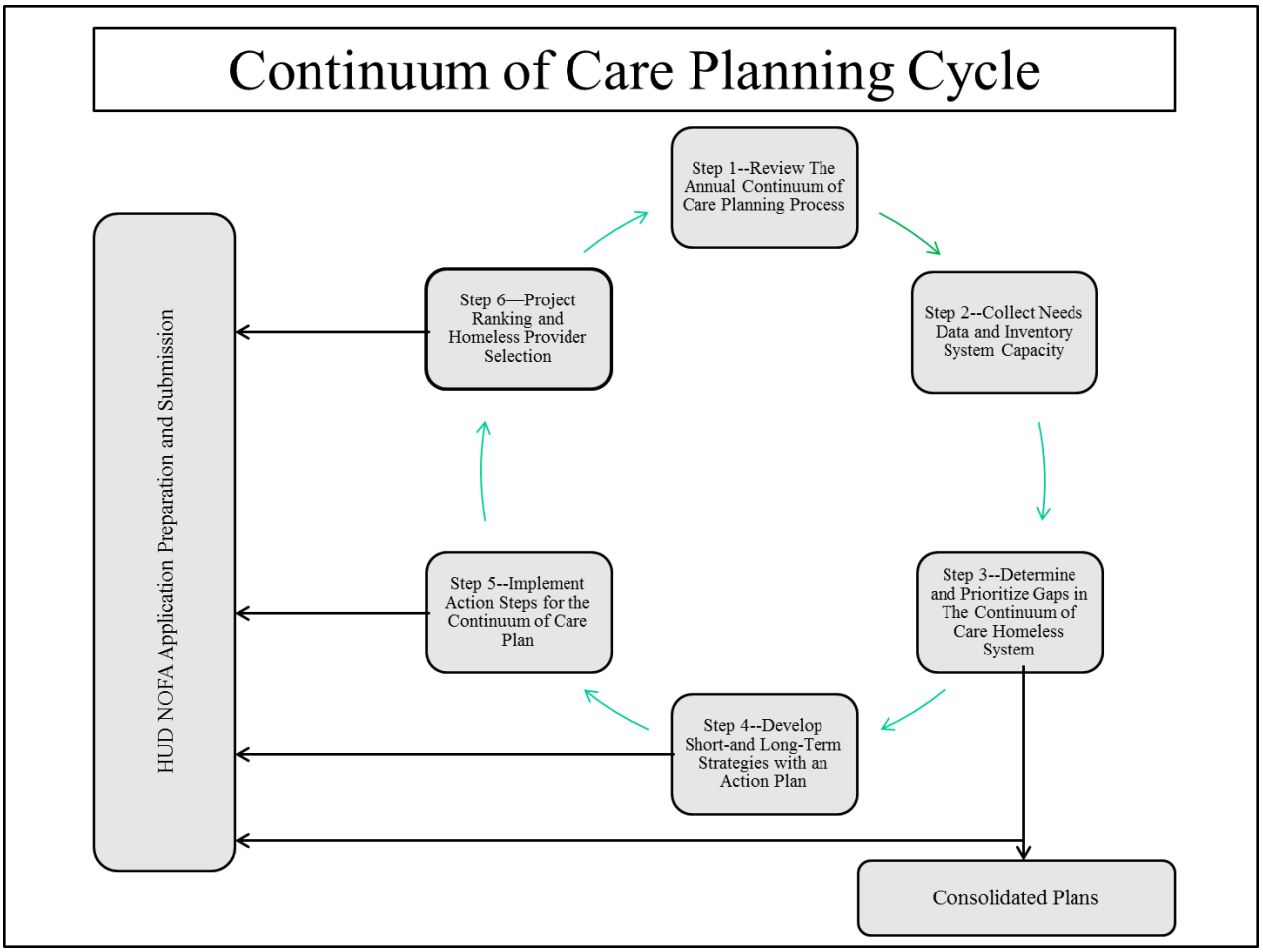

Figure 1—Continuum of Care Planning Cycle

Coordinated Assessment

Coordinated assessment is a powerful tool designed to ensure that homeless persons are matched with the right intervention, among all of the interventions available in the CoC, as quickly as possible. It standardizes the access and assessment process for all clients and coordinates referrals across all providers in the CoC. When providers intake and assess clients using the same process, and when

referrals are conducted with an understanding of all programs, including their offered services and bed availability, participants can be served with the most appropriate intervention and not with a "first come, first served" approach.

Emergency Shelter

Emergency shelter offers a safe, secure, temporary place for individuals and families to reside while they prepare to move into more stable housing. Emergency Shelter, along with assessment and case management, is typically provided for 90 days, or until specific goals are accomplished.

Transitional Housing

This is longer term (generally up to 24 months) housing with varying degrees of support services to provide a period of stability while treating the underlying causes of homelessness. Transitional housing programs are designed to enable people to successfully transition to and maintain permanent housing.

Permanent and Permanent Supportive Housing

These components provide long-term, safe, decent and affordable housing for individuals and families. Permanent housing is the ultimate goal of the Continuum, and may be provided in one structure or at scattered sites. Permanent supportive housing enables homeless persons with disabilities to live as independently as possible.

Supportive Services

Supportive services are often needed to help homeless people move towards self-sufficiency and independent living. Services such as substance abuse treatment, employment education and job readiness, budgeting workshops, parenting classes, childcare, transportation, etc., may be provided as part of an emergency shelter or transitional housing program, or independently, as supportive services only program.

To meet these needs, HUD administers grants programs for Emergency solutions and Continuum of Care. These programs, combined with the programs administered by the other members of the United States Interagency Council on Homeless, provide comprehensive support for individuals and families experiencing homelessness or in danger of becoming homeless.

The continuum of care system components are shown in Figure 2—CoC System Components.

CONTINUUM OF CARE SYSTEM INTERVENTIONS

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 as implemented in the 2012 rule published as 24 CFR Part 578, Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program; Interim Final Rule, referred to as the Interim Rule mandates the use of three new interventions in the CoC system. These are Housing First, Rapid Re-Housing, and the Voluntary Services Model.

Housing First

Housing First is a specific type of service delivered through Intensive Case Management. Housing First is specifically not a "first come, first served" intervention. It intentionally seeks out chronically homeless

individuals that have complex, and most often co-occurring issues. Participation in Housing First is voluntary – people cannot be forced or coerced to participate in a Housing First intervention. Individuals who consent to receive a Housing First intervention are provided assistance with accessing housing and supports for at least 12-18 months.

There is no expectation of sobriety, treatment, compliance or mandated service. The only real expectations of Housing First, which the individual agrees to prior to starting with the program, is to agree to have their support workers visit them in their home – usually multiple times per week in the early days of program participation, to pay their rent on time and in full (or agree to third party payment of their rent), and to work hard to avoid disrupting the reasonable enjoyment of other tenants in the same building that would cause their eviction. Services in Housing First are offered through a harm reduction philosophy, in a non-judgmental manner and from a client-centered position.

Rapid Re-Housing

Rapid Re-Housing is a support intervention intended to serve longer-term episodically homeless people with mid-range acuity; these clients typically have co-occurring issues that are at the core of their frequent returns to homelessness. The individual or family usually has two or three life areas where assistance in accessing community-based resources should improve their life and housing stability. Rapid Re-Housing recipients usually receive supports for a minimum of six months, with possibility of renewal of service in three month increments based upon traction in sustainably meeting needs that will enhance housing and life stability.

The supports delivered in Rapid Re-Housing are typically case management supports delivered in the community. Importantly, Rapid Re-Housing comes with the expectation that the client will engage with support services. Support services are provided at the client's request. They are not required or mandated. Like Housing First, Rapid Re-Housing is offered through a harm reduction philosophy, in a non-judgmental fashion and from a client-centered position.

Rapid Re-Housing is almost exclusively delivered through scattered site apartments. Participants sign a standard tenancy agreement. Nowhere in the lease does it stipulate that an individual has to participate in programming or will be evicted. For all intents and purposes, the housing is permanent. So long as the individual follows the lease and pays their rent they have the same security of tenure as any other renter.

Voluntary Services Model

The voluntary services model is the model for services provision in Housing First and Rapid Rehousing. In the traditional model services are determined by a case manager and are mandatory to continue in the transitional housing program. In the voluntary services model services are voluntary and housing focused. They are client driven with the focus on client needs and client choice. The model usually includes a Housing Plan which addresses barriers to obtaining housing and staying housed, home visits, and links to mainstream and community services.

With the voluntary services model the role of case managers is redefined. There is a shift from what you need to do to stay in the program successfully to what is needed to do move out quickly and sustain housing. The role is not to counsel or fix but to connect clients with the services identified on the supportive service and permanent housing plans. Case managers typically spend more time out in the community developing partnerships with other providers.

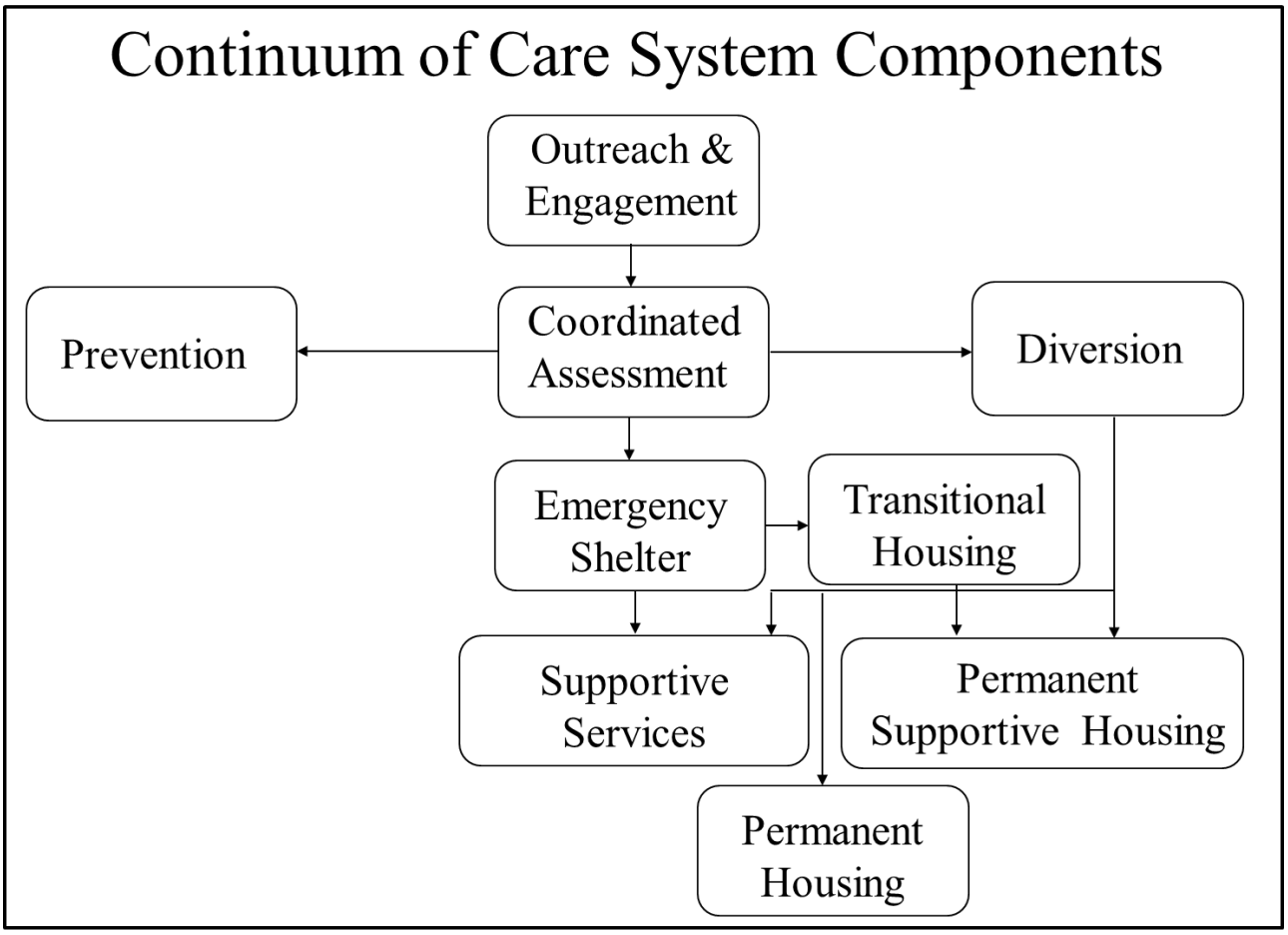

Figure 2—CoC System Components

CONTINUUM OF CARE GOALS AND OBJECTIVES

Polk County CoC annual planning is guided by the goals and objectives set by HUD. Each annual planning process must move the CoC forward in achieving these goals and objectives.

The United States Interagency Council on Homelessness has developed Opening Doors: Federal Strategic Plan to Prevent and End Homeless. This plan has four major goals:

- End chronic homelessness in 5-years
- End veteran homelessness in 5 years
- End family & youth homelessness in 10-years
- Set a path to ending all homelessness.

HUD has committed to achieving these goals and is including required actions to that end in both the CoC and ESG solicitations.

Additionally, HUD has stated five performance and strategic planning objectives. Progress of CoCs in meeting each objective is measured in each year's continuum of care program competition. HUD usually weighs this performance heavily in scoring consolidated applications. These performance and strategic planning objectives are:

1. Increase progress toward ending chronic homelessness;
2. Increase housing stability;
3. Increase project participants Income;
4. Increase the number of participants obtaining mainstream benefits;
5. Using Rapid Re-Housing as a method to reduce family homelessness.

HUD NATIONAL PERFORMANCE MEASURES

HUD has announced national performance measures. The HEARTH Act requires HUD to use data from the performance measures as part of its selection criteria for awarding grants under the CoC Program. HMIS vendors are required to implement these performance measures in their products. Until the phase-in of these measure is completed, HUD has said narrative questions addressing these selection criteria may be included as part of the annual CoC Program Competition until HUD believes it can request communities to provide numerical data on system-level performance measures. Polk County CoC annual planning must consider and support CoC grant recipients' performance against the measures.

The performance measures are:

Measure 1: Length of Time Persons Remain Homeless;

Measure 2a: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6 to 12 Months;

Measure 2b: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 2 Years;

Measure 3: Number of Homeless Persons;

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects;

Measure 5: Number of Persons who Become Homeless for the First Time;

Measure 6: Homelessness Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects;

Measure 6a: Preventing Returns to Homelessness within 6 and 12 Months among This Subset of Families and Youth;

Measure 6b: Preventing Returns to Homelessness within 24 Months among This Subset of Families and Youth;

Measure 6c: Successful Housing Placement among This Subset of Families and Youth;

Measure 7a: Successful Placement from Street Outreach;

Measure 7b: Successful Placement in or Retention of Permanent Housing.