FREDERICK COUNTY
COALITION
FOR THE HOMELESS

ENDING HOMELESSNESS IN FREDERICK COUNTY – A STRATEGIC PLAN

Section 1: Introduction to the Strategic Plan and Goals

Section 2: OrgCode Recommended Update to the Strategic Plan

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Adopted September 15, 2015

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Introduction

Dorothy Day, the co-founder of the Catholic Worker movement, once wrote, "Over and over again we meet good people who are under the delusion that there is little poverty in the United States, that we are all enjoying a high standard of living, and when presented with such pictures as these they can scarcely believe them. 'It must be their own fault. They are shiftless, they drink, they go to moving pictures and do not save their money. Everyone can get a job these days.' These are the comments they make."

Other than the antiquated term of "moving pictures" those words could have easily been written last year, last month, or even yesterday, but Ms. Day wrote those words in April of 1943 when she was struggling, alongside Peter Maurin, to establish and operate a Catholic Worker House in New York City. Poverty, homelessness, disenfranchisement, and marginalization of the poor have continued, mostly unabated, over the ensuing 72 years. There have been successes like the New Deal and the War on Poverty, which were followed by reductions in poverty; but, recurring economic recessions and other social problems seemed to quickly and callously erode any progress. According to the U.S. Census Bureau, in 2013, there were an estimated 45.3 million Americans (14.5% of the U.S. population) living below the poverty level established by the federal government. In January 2014, the National Alliance to End Homelessness reported that 578,424 people experience homelessness on any given night in the U.S. and the National Student Campaign Against Hunger and Homelessness reports that more than 3.5 million people in the U.S. will experience homelessness each year.

In many respects Frederick County, Maryland is quite fortunate. Both the unemployment and poverty rates for Frederick County are lower than the rates for Maryland and the United States. The rate of homelessness is also lower than the national and statewide rates. OrgCode, the consultant group hired by the Frederick County Coalition for the Homeless (FCCH), reported, "Across the (Frederick County) Continuum of Care, the rate of homelessness – which is calculated as the number of homeless people per 10,000 – is 11.39. The national average is 20.26, and statewide average is 13.84. Thus, while the 275 people who are homeless would argue that homelessness is a problem locally, the scope of the homelessness problem is small relative to Frederick's population." **However, any level of homelessness is unacceptable in Frederick County and the FCCH is dedicating its efforts to ending homelessness.**

Rates of Homelessness in Selected Maryland Jurisdictions (2013 Point-in-Time Count)[1]			
Place	**2013 Total Population**	**2013 Homeless PIT Count**	**Rate of Homelessness Per 10,000 People**
Baltimore City	622,104	2,638	42.40
Charles/Calvert/St. Mary's Counties	352,981	833	23.60
Maryland	5,928,814	8,205	13.84
Washington County	149,588	192	12.84
Frederick County	**241,409**	**275**	**11.39**
Montgomery County	1,016,677	1,004	9.88
Carroll County	167,564	134	8.00

Source: OrgCode and Maryland State Homeless Data Warehouse

As reported by OrgCode, "Homelessness is an extremely rare event. At any given point in time, approximately 0.2% of the general population in the United States is homeless.[2] Over the course of one year, approximately 0.5% of the general population will experience homelessness.[3]

Even when considering poor households alone, homelessness is still a very rare event. Approximately 16% of the U.S. population lives below the poverty line,[4] and even if we were to assume that all homeless households are below the poverty line, this still demonstrates that only 3% of very poor households become homeless in a given year.[5]"

The following table depicts the Frederick County Point-in-Time (PIT) counts from 2008 through 2015, as well as the percentage of the Frederick County population counted as homeless during the PIT count.

Point-in-Time Counts for Frederick County – 2008 – 2015			
Year	**Total Number of People Counted (adults and children)**	**Population of Frederick County**	**Percentage of Population Counted as Homeless During the Annual PIT**
2008	302	226,525	0.133%
2009	324	227,980	0.142%
2010	303	233,385	0.129%
2011	280	237,293	0.117%
2012	285	239,520	0.118%
2013	275	241,409	0.113%
2014	246	243,675	0.100%
2015	311	243,692	0.127%

Source: Metropolitan Washington Council of Governments and U.S. Census Bureau

[1] One-day, statistically reliable, unduplicated count of sheltered and unsheltered homeless individuals and families in a geographic area.
[2] http://www.endhomelessness.org/pages/snapshot_of_homelessness
[3] http://b.3cdn.net/naeh/c29d84bf2a17bb608f_e9m6y5grp.pdf
[4] 2012 Census http://www.census.gov/prod/2013pubs/acsbr12-01.pdf
[5] http://b.3cdn.net/naeh/c29d84bf2a17bb608f_e9m6y5grp.pdf

The Process of Setting Goals and Developing a Strategic Plan

Established in 1983, the Frederick County Coalition for the Homeless (FCCH) is the oldest local coalition working to end homelessness in Maryland. The FCCH is a coalition composed of governmental and non-profit human service and community development organizations, religious institutions, for-profit businesses such as banks, local government officials, interested citizens, and homeless and formerly homeless persons. The FCCH meets monthly in order to coordinate the planning of local homeless services, discuss local needs and review new projects, and advocate for additional resources to address homelessness.

Under the leadership of Todd Johnson, FCCH Chairperson (2012-2015), the FCCH initiated the strategic planning process in 2013 by establishing a Strategic Planning Committee that was empowered to develop a strategic plan with regular reports back to the entire membership of the FCCH. Betsy Day, President/CEO of the Community Foundation of Frederick County agreed to serve as the chairperson of the FCCH Strategic Planning Committee. The committee set about collecting pertinent data and undertook an extensive asset mapping process. During March 2013, Ms. Day led the committee through a SWOT (strengths, weaknesses, opportunities, and threats) analysis which led to the development of four comprehensive goals for the Strategic Plan:

Goal 1: Increase Housing Options

Goal 2: Prevent Homelessness

Goal 3: Improve Leadership and Communication

Goal 4: Improve Services for Homeless People

The following is a list of key meeting dates and activities relating to the Strategic Planning process:

- March 2013 – SWOT analysis is performed and four strategic goals are established.
- April 2013 – February 2014 – Grant writing and fundraising efforts are initiated in order to raise approximately $20,000 to hire a consultant to further develop a comprehensive strategic plan. Committee efforts continue by refining the goals and conducting asset mapping of local resources.
- March 2014 – A Request for Proposals (RFP) is distributed to prospective consultants and posted on available websites.
- April 2014 – Proposals due back from prospective consultants.
- May 2014 – FCCH Strategic Planning Committee reviews submitted proposals and recommends contracting with OrgCode Consulting, Inc.
- June 2014 – FCCH approves contracting with OrgCode, effective July 1, 2014.

- August 2014 – OrgCode conducts phone interviews with FCCH Strategic Planning Committee members to obtain an understanding of the local Continuum of Care. A proposed project timeline is provided by OrgCode.
- September 2014 – Interim Report # 1 provided by OrgCode and a conference call is conducted to discuss the report.
- November 12, 2014 – Site visits to Frederick County shelters and transitional housing projects conducted by OrgCode.
- November 13, 2014 – A "Community Conversation" to gather community input on the strategic planning goals and process is conducted by OrgCode.
- November 14, 2014 – A "Focus Group for Persons with Lived Experience of Homelessness" is conducted by OrgCode.
- January 2015 – Interim Report # 2 provided by OrgCode and a conference call is conducted to review progress at mid-point through the consulting contract period.
- March 31, 2015 – A training session is conducted by OrgCode for FCCH Strategic Planning Committee members and other key partners.
- March 2015 – Final Report and DRAFT Strategic Plan provided by OrgCode.
- August 2015 – "Ending Homelessness in Frederick County – Recommended Update to Strategic Plan" is provided by OrgCode.
- September 2015 – FCCH Strategic Plan is presented to the membership of the Frederick County Coalition for the Homeless.

The Different Definitions of Homelessness

There is often confusion about the definition of homelessness and the subsequent eligibility for various federally-funded homeless programs. In an effort to clarify the different definitions of homelessness used by the federal government, the following is reprinted from the website of the National Health Care for the Homeless Council:

"There is more than one 'official' definition of homelessness. Health Centers funded by the U.S. Department of Health and Human Services (HHS) use the following:

A homeless individual is defined in section 330(h)(4)(A) as 'an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing.' A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

An individual may be considered to be homeless if that person is 'doubled up,' a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously

homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice)

Programs funded by the U.S. Department of Housing and Urban Development (HUD) use a different, more limited definition of homelessness [found in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (P.L. 111-22, Section 1003)].

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- An individual or family who will imminently lose their housing [as evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days, having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause]; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing; and
- Unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who have experienced a long-term period without living independently in permanent housing, have experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

Hence different agencies use different definitions of homelessness, which impacts how various programs determine eligibility for individuals and families at the state and local level." Additional definitions of homelessness, including the federal definition of homeless students, can be found under the "Useful Links and Websites" section on page 8.

Understanding the Continuum of Care and Asset Mapping of Existing Resources

As described by HUD, "The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness."

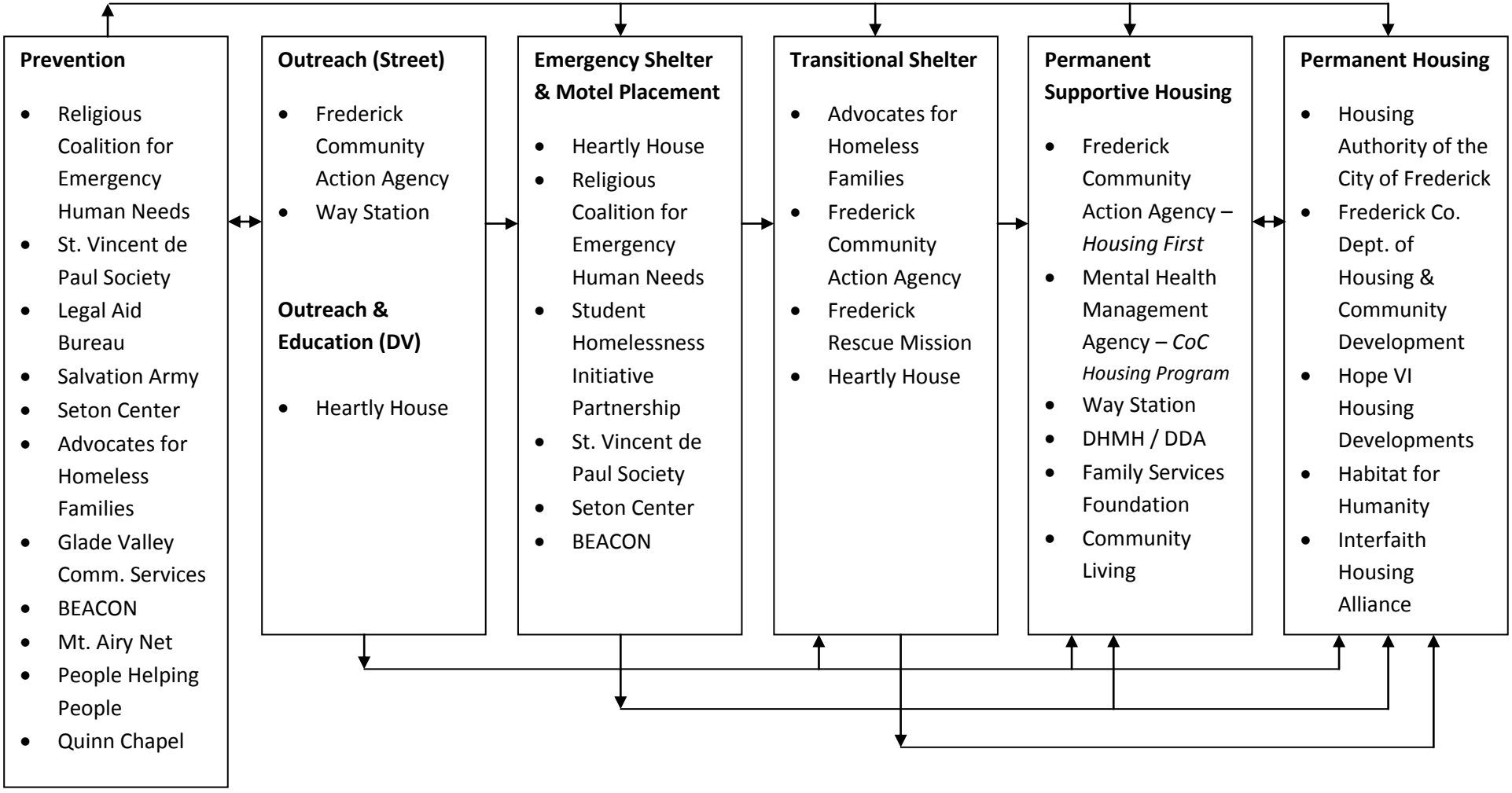
As part of the strategic planning process, the FCCH Strategic Planning Committee undertook an extensive asset mapping process and worked to catalog all services, programs, and resources that are available for homeless individuals and families. The committee found that the HUD CoC grant awards over $600,000 in federal funding on an annual basis for three Transitional Housing Programs that serve homeless families (one of the transitional shelters also serves physically- or medically-disabled individuals) and two Permanent Supportive Housing Programs. Of equal importance are "mainstream resources" such as permanent supportive housing programs operated by mainstream providers like Way Station, Community Living, and the Family Service Foundation. Without those mainstream housing providers in place, there could be thousands of additional people homeless and on the streets of Frederick County.

In summary, the FCCH Strategic Planning Committee found that a CoC can be described as: 1) an annual grant from HUD that funds transitional housing and permanent supportive housing programs; and 2) a system of care that starts at one end of the continuum with homelessness prevention and street outreach services, then moves to emergency shelter followed by transitional housing, and finally to permanent housing or permanent supportive housing; supportive services like case management are provided along the "continuum" and help people to move from one resource to the next. Graphically, the local "Continuum of Care" is depicted on the following page.

Next Steps – Strategic Plan Implementation

Ken Allread, Chairperson of the FCCH (2015-2016) stated, "Each strategic goal will have an FCCH member champion, responsible for ensuring the work progresses toward goal achievement. The OrgCode recommendations for the Strategic Plan to End Homelessness in Frederick County will be our roadmap. As we move forward with implementation of the plan, experience will guide and inform us as to any necessary changes or modifications needed to accomplish the goals. To ensure full and comprehensive reporting on the plan, goal champions will report monthly to the FCCH membership at regularly scheduled FCCH meetings, and any decisions needing to be put to a vote will be presented to dues-paying members of the FCCH. Community engagement and any concerns will be addressed at the FCCH meeting level, with FCCH committees subsequently being responsible for the implementation of the Strategic Plan."

Frederick City and County Homeless Resources – Continuum of Care Model
September 2015



Commonly Used Abbreviations and Acronyms

The following are some common or standard abbreviations and acronyms used by homeless service providers:

AFHF ..... Advocates for Homeless Families
AHAR ..... Annual Homeless Assessment Report
AMI ..... Area Median Income
BEACON ..... Brunswick Ecumenical Assistance Committee on Need
CM ..... Case Manager or Case Management
CoC ..... Continuum of Care
CSA ..... Core Service Agency
DHCD ..... Maryland Department of Housing and Community Development
DHHS ..... U.S. Department of Health and Human Services (also referred to as HHS)
DHMH ..... Maryland Department of Health and Mental Hygiene
DHR ..... Maryland Department of Human Resources
ESG ..... Emergency Solutions Grant
FCAA ..... Frederick Community Action Agency
FCAHC ..... Frederick County Affordable Housing Council (also referred to as AHC)
FCBHS ..... Frederick County Behavioral Health Services
FCCH ..... Frederick County Coalition for the Homeless
FCDC ..... Frederick County Detention Center
FCDHCD ..... Frederick County Department of Housing and Community Development
FCDSS ..... Frederick County Department of Social Services
FCHD ..... Frederick County Health Department
FCPS ..... Frederick County Public Schools
FCSAS ..... Frederick County Substance Abuse Services
FMH ..... Frederick Memorial Hospital
FRM ..... Frederick Rescue Mission
HACF ..... Housing Authority of the City of Frederick
HCHP ..... Health Care for the Homeless Program
HFP ..... Housing First Program
HIC ..... Housing Inventory Count (or Chart)
HMIS ..... Homeless Management Information System
HUD ..... U.S. Department of Housing and Urban Development
IHA ..... Interfaith Housing Alliance
LAB ..... Legal Aid Bureau
MA ..... Medical Assistance (Medicaid)
MSDE ..... Maryland State Department of Education
PIT ..... Point-In-Time (Survey or Count)
PSH ..... Permanent Supportive Housing
RCEHN ..... Religious Coalition for Emergency Human Needs
SBHC ..... School-Based Health Center
SHIP ..... Student Homelessness Initiative Partnership

SNAP.....Supplemental Nutrition Assistance Program (previously Food Stamps)
SNAPS..... HUD Special Needs Assistance Programs
SRO.....Single Room Occupancy
TANF..... Temporary Assistance to Needy Families (Federal Title)
TCA..... Temporary Cash Assistance (State Title)
USDA..... U.S. Department of Agriculture
WSI..... Way Station, Inc.

Useful Links and Websites

Definitions of Homelessness for Federal Program Serving Children, Youth, and Families:
https://www.acf.hhs.gov/sites/default/files/ecd/homelessness_definition.pdf

HEARTH Act – Continuum of Care Program Interim Rule:
https://www.hudexchange.info/resource/2033/hearth-coc-program-interim-rule/

HUD Continuum of Care Dashboard Reports:
https://www.hudexchange.info/manage-a-program/coc-dashboard-reports/

HUD Defining Chronic Homelessness: A Technical Guide for HUD Programs:
https://www.hudexchange.info/resources/documents/DefiningChronicHomeless.pdf

HUD Exchange Homelessness Assistance:
https://www.hudexchange.info/homelessness-assistance/

HUD Family Options Study:
http://www.huduser.gov/portal/family_options_study.html

HUD Resources for Chronic Homelessness:
https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/

Maryland Department of Housing and Community Development:
http://www.dhcd.maryland.gov/Website/Default.aspx

Maryland Department of Human Resources:
http://www.dhr.state.md.us/blog/

National Alliance to End Homelessness: Changes in the HUD Definition of "Homeless":
http://www.endhomelessness.org/library/entry/changes-in-the-hud-definition-of-homeless

The McKinney-Vento Education for Homeless Children and Youth Act of 2001:
http://center.serve.org/nche/downloads/mv-full-text.docx (definition of homeless students)

Strategic Plan Goals and Champions

Goal Number	Goal Title	Champion
1	Increase Housing Options	Frederick County Department of Housing and Community Development and Frederick County Affordable Housing Council
2	Prevent Homelessness	Religious Coalition for Emergency Human Needs and United Way of Frederick County
3	Improve Leadership and Communication	FCCH Executive Committee and FCCH Standing Committees
4	Improve Services for Homeless People	FCCH Strategic Planning Committee

HUD CoC and ESG Grantees in Frederick County

Homeless Service Providers serving Frederick County that recently received HUD CoC or ESG funding	
HUD Continuum of Care (CoC) – 2014 Program Year Grantees	
Advocates for Homeless Families, Inc.	Friends for Neighborhood Progress, Inc.
City of Frederick / Community Action Agency	State of Maryland Department of Health and Mental Hygiene Behavioral Health Administration & Mental Health Management Agency, Inc.
HUD Emergency Solutions Grant (ESG) – State Fiscal Year 2015 Grantees	
Advocates for Homeless Families, Inc.	Heartly House, Inc.
City of Frederick / Community Action Agency	Religious Coalition for Emergency Human Needs, Inc.

ENDING HOMELESSNESS IN FREDERICK COUNTY

RECOMMENDED UPDATE TO STRATEGIC PLAN

August 2015

ORG CODE

Ending Homelessness in Frederick County

Recommended Update to Strategic Plan

Consultation, report writing, and layout by OrgCode Consulting, Inc.

http://www.orgcode.com/

Errors and/or Omissions

Every effort has been made to provide factual commentary relative to the information provided and researched in the course of this assignment, as well as in analyzing and interpreting the results of the survey and commentary provided during the facilitated retreat. Any errors and/or omissions are the responsibility of OrgCode Consulting, Inc.

August 2015

Contents

Who We Are

The Frederick County Coalition for the Homeless comprises individuals, government, religious, business, corporation and community organizations that share a common concern for the needs of Frederick County's homeless. The Coalition identifies the needs of our County's homeless, investigates best practices in meeting those needs, advocates for resources and coordinates services to meet these needs.

What We Believe In

- Passionate commitment to bringing self-sufficiency to all Frederick County residents and to providing adequately for those not able to achieve self-sufficiency
- Respect and dignity for all persons
- All residents have access to housing, healthcare, and employment opportunities, and other essential services
- The community working together to address social needs
- A significant return on investment made by the community in the provision of care
- Community caregivers investing in lasting human accomplishments and gain
- Honesty, integrity, transparency, and good governance among homeless service providers
- Being champions for the disenfranchised and marginalized
- A strong partnership with socially responsible elected officials

Where We Want To Be

By 2020...

With strategic leadership and the adoption of evidence informed practices and processes dedicated to ending episodic and chronic homelessness, the incidence of homelessness and the average duration of homeless episodes will be significantly reduced. Annual Point in Time counts will demonstrate an annual reduction in the number of individuals and families experiencing homelessness, especially for those who are chronically homeless. Data is being collected from all agencies and the needs of the homeless population are well understood. Overall shelter usage has declined, and average length of stay in shelters has decreased significantly. Housing programs, including Housing First and Rapid Re-Housing, will not only be in place with resource investment aligned to meet the local needs, but program outcomes demonstrate a reduction in episodic and chronic homelessness. The impact of such investments is that most people who have experienced homelessness and have been housed, remain stably housed.

Agencies will be connected to the common Homeless Management Information System (HMIS) and use the findings of this HMIS to strategically plan services. Common intake procedures

are being adopted by most agencies and some agencies have strong linkages and common assessment tools. Referral processes and linkages between homeless service agencies and such mainstream service agencies as mental health, addictions, employment are improving with clients able to access the services they need through formalized service pathways.

The availability of affordable housing options will be improved, with zoning and regulatory enhancements ensuring increased diversity in housing, including Single Room Occupancy (SRO) units.

By 2025...

Although housing crises will always exist, homelessness will be a uncommon event that is of short duration. Annual Point in Time counts will demonstrate that the rate of homelessness is below 10 people per 10,000 of the general population. No one will be chronically homeless. The average shelter stay will be less than one month, and systems will be in place to rapidly connect people experiencing homelessness with permanent, affordable housing.

Services for homeless people will be seamlessly integrated. All agencies that assist individuals and households experiencing homelessness use the same Homeless Management Information System (HMIS), and have common intake procedures and assessment tools. Decisions regarding service provision are made as a system and available resources are prioritized based on which individual or household across the County needs those resources the most. Referral processes and linkages between homeless serving agencies and partner agencies (i.e. mental health, addictions, employment) are streamlined ensuring clients are able to access the services they need through formalized client-centered processes.

Longer Term

We will continually strive for improvements in the number, variety, and quality of available affordable housing units, including specialized options for vulnerable populations such as low-income seniors.

We will also continue to advocate for poverty alleviation strategies, including enhancements in education and job training, increases to welfare and disability allowances and food stamps, and supporting other programs that promote improvements in the quality of life of people living in poverty.

How We Will Do That

Goal 1. Increase Housing Options

In order to increase housing options, first we must develop an understanding of the current status of affordable permanent housing options. Then, we will explore options and promote initiatives to increase the supply of affordable housing units. We will pursue and promote a variety of types of housing, including transitional and permanent, rented and owned, independent and supported, large and small, shared and separate.

OrgCode has a proprietary housing model that allows us to investigate 24 different data points to determine housing targets for communities. Based on an exploration of such data, it is projected that there is a need in Frederick County for 352 additional affordable housing units over the next five years. A summary of the breakdown of these units is provided below. For further detail, see "Appendix B: Affordable Housing Targets" on page 24.

Although the Coalition cannot solely be responsible for the building and/or conversion of such units or the generation of rental supplement programs, the Coalition can play a leadership role in advocacy and to assist in planning.

	Singles	Families	Total # of Units
Permanent Supportive Housing	116	32	148
Non-Supportive Housing	115	89	204
Affordable	*57*	*44*	*101*
Deeply Affordable	*58*	*45*	*103*
Total	**231**	**121**	**352**

Indicators to Measure Progress

In order to monitor our success with regards to this goal, we will monitor:

- The absolute number of units that meet our definition of affordable permanent housing;
- The number of units that fit into identified subcategories, including accessible, SROs, and PSH units
- The number of building permits issued for rental housing
- Our progress relative to the housing targets (see also "Appendix B: Affordable Housing Targets" on page 24).

For all of these indicators, we will strive for a year-over-year improvement, by implementing the following strategies:

Strategy 1.1. Regularly update our knowledge of local availability of permanent affordable housing options

Action Items:

1.1.1) Develop a working definition of affordable permanent housing.

1.1.2) Break down the housing need by household characteristics, such as family size and composition, income, accessibility, and other factors.

1.1.3) Measure and monitor the change in affordable permanent housing stock.

1.1.4) Identify gaps between affordable housing demand and availability, and focus efforts on those gaps.

Strategy 1.2. Foster opportunities for affordable housing growth

Action Items:

1.2.1) Collaborate with government entities to encourage inclusion of affordable housing options in land use and development.

1.2.2) Examine current laws and regulations to identify barriers to affordable housing and provide recommendations.

1.2.3) Contact county and municipal housing, planning, and community development staff to introduce Affordable Housing Council (AHC) members and establish a relationship.

1.2.4) Work with staff to examine regulations and explore best practices from around the state, county and internationally.

1.2.5) Identify specific regulations with input from staff that act as an impediment to affordable development.

1.2.6) Draft recommendations with input from staff on regulation or law changes.

1.2.7) Advocate for specific changes through contact with elected officials and civic and community groups.

1.2.8) Review effectiveness of the altered laws and regulations, the methods used to achieve the aforementioned changes, and the AHC as a whole.

Strategy 1.3. Build partnerships and engage stakeholders

Action Items:

1.3.1) Participate with public and private planning entities, community groups, and other agencies that are involved in housing services, housing counseling and education, and economic support opportunities.

1.3.2) Collaborate with the business community to identify commercial properties with potential for affordable residential components for development and rehabilitation of affordable housing.

1.3.3) Identify Coalition members to attend meetings of housing related entities and groups such as Golden Mile Alliance, Frederick County Coalition for the Homeless, Commission on Aging, Chamber, Business Development Board, Downtown Frederick Partnership, etc. to advocate for and learn of potential affordable housing opportunities.

1.3.4) Conduct assessment of developers' needs/ideas relative to increasing affordable housing options.

1.3.5) Conduct assessment of potential projects.

1.3.6) Conduct an assessment of local resources and needs for affordable housing, also utilizing information from others that have been developed.

1.3.7) Identify and provide advocacy for the highest level needs as determined by the needs assessment, focusing on creative partnerships with entities that can leverage land/sites.

1.3.8) From the assessment, identify developers and community/government entities to work together with the AHC to meet action item 1.3.2, focusing on a limited number of properties/areas.

1.3.9) Review effectiveness of AHC's efforts.

Strategy 1.4. Promote economically viable and livable communities

Action Items:

1.4.1) Advocate for planning policies that support mixed-use development that includes diverse housing stock, multi-modal transportation networks, energy conservation and efficiency, open spaces, and similar principles.

1.4.2) Identify, encourage, and advocate for projects that foster community development.

1.4.3) Attend meetings of Planning Commissions to advocate for planning policies that support and entice mixed use mixed income affordable housing development.

1.4.4) Research potential sites, such as dilapidated downtown buildings.

1.4.5) Review and update AHC Strategic Plan at the annual meeting of the AHC.

1.4.6) Promote alternative housing types and forms, including Single Room Occupancy (SRO) units, Tiny Homes, prefabricated dwellings, secondary suites and accessory suites.

1.4.7) Identify zoning regulations for SROs.

1.4.8) Understand barriers for SROs and work through them.

1.4.9) Develop SROs, including investigate available structures, funding and management.

1.4.10) Determine availability and possible expansion of Moderately Priced Dwelling Units for transitional housing stock.

Goal 2. Prevent Homelessness

In order to prevent homelessness, we will adopt a two-pronged approach. First, we will improve the targeting and efficiency in programs geared specifically towards preventing homelessness. Second, we will support the identification and adoption of best practices in poverty alleviation.

Indicators to Measure Progress

In order to monitor our success with regards to this goal, we will monitor:

- The absolute number of people, on an annual basis, who enter the homeless service delivery system for the first time;
- The number and percentage of the people discharged from institutions including jails/prisons, hospitals, and child welfare services, who are discharged directly into homelessness;
- The number and acuity (severity of need) of people applying for homelessness prevention assistance, both eligible and ineligible;
- The percentage of households below the poverty line; and
- The number of working households spending 30% or more of their income on housing.

For all of these indicators, we will strive for a year-over-year improvement, by implementing the following strategies:

Strategy 2.1. Prevent people experiencing housing crises from losing their housing

Action Items:

2.1.1) Create a map or service matrix of resources available in the community for households experiencing a housing crisis.

2.1.2) Improve the accessibility of these resources and services. Improve clarity on the available services and supports dedicated to preventing homelessness.

2.1.3) Implement a common assessment tool to be used at identified access points when a household applies for prevention assistance.

2.1.4) Recognizing the challenges of predicting which households will become homeless without prevention services, prioritize prevention dollars for applicants that have the most characteristics in common with the existing chronically homeless population.

2.1.5) Follow up with recipients of prevention services after the housing crisis has passed to ensure that a housing crisis will not reoccur.

2.1.6) In the long term, follow-up with prevention recipients to ensure that the prevention assistance did have its intended effect.

2.1.7) Use the results of this long term monitoring of the impact of prevention services when making future funding allocations to agencies interested in delivering homelessness prevention initiatives.

Strategy 2.2. Improve discharge planning to ensure zero discharge to homelessness

Action Items:

2.2.1) With the collaboration of representatives of medical, psychiatric, correctional, and children's welfare services, design and implement a discharge planning strategy that will formalize the connections between the housing and homelessness system and these mainstream sectors.

2.2.2) Collaborate to ensure a zero discharge to homelessness policy by mainstream systems. This will ensure that proactive discharge planning processes incorporate a plan for stable housing and ongoing supports.

Strategy 2.3. Implement a shelter diversion program

Action Items:

2.3.1) Train shelter intake workers on evidence informed diversion practices.

2.3.2) Train 211 operators on diversion practices.

2.3.3) Using the HMIS or comparable data process, track shelter diversion attempts, by acuity levels (severity of need), and ensure that those diverted are followed up with to determine impact of that diversion activity.

2.3.4) Measure the number of people who can be successfully diverted from entering the homeless system.

Strategy 2.4. With the goal of enhancing long term housing stability, establish a collaborative and coordinated service delivery system to identify and reach the target audience that will benefit from the services of the Prosperity Center

Action Items:

2.4.1) Using acuity levels (severity of need) and/or case management goals, identify individuals and families that would benefit from the services provided by the Prosperity Center.

2.4.2) Connect households with a "coach" to help establish goals.

2.4.3) Track progress and results through standardized reporting.

2.4.4) Establish a "fee for service/savings incentive" system.

2.4.5) Track "drop-outs" and "graduates" and identify recidivism response.

Strategy 2.5. Work with low-income households to increase financial stability

Action Items:

2.5.1) Provide job training and placement and advancement programs.

2.5.2) Provide tax time credits and savings opportunities.

2.5.3) Provide free tax preparation services.

2.5.4) Provide Credit Repair/Counseling Services.

2.5.5) Provide assistance to obtain income supports/entitlements/special subsidies.

2.5.6) Manage and eliminate barriers for underemployed through child care, transportation, and training supports.

2.5.7) Improve access to traditional banking services.

2.5.8) Improve individuals and families budgeting and savings skills.

2.5.9) Increase access to savings and investment tools.

2.5.10) Deliver financial literacy training/workshops/seminars.

2.5.11) Connect families with emergency financial assistance providers to help maintain current assets.

2.5.12) Direct families to economically accessible housing.

2.5.13) Promote and enroll families in incentive based savings programs.

Goal 3. Improve Leadership and Communication

We will raise community awareness about homelessness and housing challenges experienced by residents of Frederick County. For the community at large, we will focus on disseminating information about these issues and combating stigma. For community leaders, including funders and elected officials, we will take a more direct approach, which will include lobbying and educating about best practices to alleviate homelessness and other social issues. Finally, with direct service providers, we will identify and overcome barriers to collaboration and seek ways to better integrate services through common language, tools, and practices.

Indicators to Measure Progress

In order to monitor our success with regards to this goal, we will monitor:

- The number of agencies using Service Point;
- The number of agencies using a common assessment tool;
- The number of agencies using a common intake process;
- The number of clients on Service Point accessing services from multiple agencies;
- The number of client referrals to other agencies, and the percentage of these referrals that are 'actioned';
- Performance of agencies relative to service targets established by the Coalition;
- Promotion and circulation of an annual report card as a communication and strategic tool.

For all of these indicators, we will strive for a year-over-year improvement, by implementing the following strategies:

Strategy 3.1. Promote the Frederick County Coalition for the Homeless as a leadership body

Action Items:

3.1.1) Establish the Coalition as the Continuum of Care lead agency.

Strategy 3.2. Increase opportunities for inter-agency collaboration, data sharing and improved communication

Action Items:

3.2.1) Implement a dedicated centralized triage approach, ideally with one access point, or coordinated access with consistent implementation/ management policies.

3.2.2) Identify and implement an evidence informed common assessment tool.

3.2.3) Increase participation in ServicePoint by primary service providers by offering training and support for new ServicePoint users.

3.2.4) Encourage secondary service providers to begin using ServicePoint.

Strategy 3.3. Support and promote forums/meetings/other sessions for community members, including business, landlords, non-profits, government, and the faith community to address issues around homelessness and encourage collaboration and change

Action Items:

3.3.1) Sponsor an annual forum for all facets of the community to increase awareness on issues around homelessness and to encourage collaboration and positive change.

3.3.2) Hold forums on homelessness and related issues involving community leaders.

3.3.3) Support prayer walks for Hunger/Homeless Awareness month.

Strategy 3.4. Increase awareness/understanding by leaders who control funding

Action Items:

3.4.1) Testify at local government budget hearings and public meetings.

3.4.2) Communicate, in person and in writing, with government leaders about homelessness over the course of the year.

3.4.3) Meet with county and municipal commissions.

3.4.4) Work with local, state and national funders to develop meaningful indicators that focus on outcomes, not outputs.

Strategy 3.5. Develop ways to inform public of successes and positive outcomes as the result of service provider efforts

Action Items:

3.5.1) Develop contact information and personal relationships with media outlets.

3.5.2) Document events and projects with photos and press releases.

3.5.3) Develop presence in social media.

3.5.4) Synthesize collected data into a mass media format for targeted audiences.

3.5.5) Identify talking points from annual reports and HMIS data.

Strategy 3.6. Build community acceptance and support for a range of housing options

Action Items:

3.6.1) Enhance and/or develop opportunities for education and outreach within the community.

3.6.2) Engage with civic, business, and neighborhood groups to promote the communitywide benefits of affordable housing.

3.6.3) Research community benefits of affordable housing and compile statistics to support those benefits.

3.6.4) Research and adopt best practices for counteracting negative stereotypes often associated with affordable housing.

3.6.5) Identify and form relationships with civic, business, and neighborhood groups as well as social service providers operating in the affordable housing arena.

3.6.6) Develop a community-oriented, Frederick County-specific presentation.

3.6.7) Determine most appropriate audiences and make public presentations.

3.6.8) Publicize wider grassroots support for affordable housing in the community.

Goal 4. Improve Services for Homeless People

Champion: Coalition Strategic Planning Committee

We will improve the quality and efficiency of services available for individuals and households experiencing homelessness. Our services will focus on quickly ending episodes of homelessness and connecting homeless persons with permanent, affordable housing.

In addition, we will develop an understanding of the acuity (severity of need - see "Appendix A: Glossary of Terms" on page 18) of each client accessing services, and connect the right clients to the right services. However, it is important to first ensure that program eligibility is satisfied before acuity, prioritization and matching occurs.

Indicators to Measure Progress

In order to monitor our success with regards to this goal, we will monitor:

- The number of people experiencing homelessness at any given point in time and over the course of a year;

- The average duration of a shelter stay or episode of homelessness;
- The acuity of people who experience homelessness;
- The occupancy and usage rates of shelters and housing programs;
- The housing retention rate of individuals and families in Permanent Supportive Housing Programs;
- The recidivism rate (return to homelessness) of people supported through funded programs.

For all of these indicators, we will strive for a year-over-year improvement, by implementing the following strategies:

Strategy 4.1. Complete system design activities to identify and implement strategies to address homelessness as a unified system of care

Action Items:

4.1.1) Create a comprehensive, realistic and collaborative system map of available services and supports to demonstrate the client-centered pathways from homelessness to housing stability.

4.1.2) Develop guiding principles for the functioning of a unified housing and homelessness system with an emphasis on evidence informed practices and policies.

4.1.3) Make decisions system-wide regarding effective programming/service types and levels of service required to meet local needs.

4.1.4) Where appropriate, consolidate funding streams at the Coalition and make strategic decisions as to where to allocate funds.

Strategy 4.2. Establish clear service targets for approved populations and subpopulations with outcome analyses used to determine future funding allocations

Action Items:

4.2.1) Develop service targets for each type of program.

4.2.2) Develop program monitoring and performance management processes and develop policies for addressing low performance.

4.2.3) Ensure that ongoing funding is allocated to high performing programs demonstrating the outcomes needed to end homelessness for the target population served by that programming stream.

Strategy 4.3. Increase system accountability throughout Coalition members and funded programs

Action Items:

4.3.1) Identify expectations, approaches and tools to monitor fidelity to practice for funded programs.

4.3.2) Encourage homeless-serving programs to self-evaluate, on an annual basis, and identify ways to become more successful at ending homelessness.

4.3.3) Produce an annual report on homelessness, focusing on outcomes achieved and trends.

Strategy 4.4. Provide the right supports to the right people at the right time to end their homelessness

Action Items:

4.4.1) Adopt a common assessment tool so that individuals and households experiencing homelessness can be prioritized system-wide and matched to the program/support most suited to end their homelessness.

4.4.2) Prioritize services, supports, and resources for people with the highest needs.

4.4.3) Engage all community service providers in system design discussions regarding common assessment tools, service prioritization and referrals for openings and supports.

4.4.4) Ensure that each service participant accepted into housing programs will be served by evidence informed housing based case management practices, including individualized service planning.

4.4.5) Ensure that a loss of housing by a supported household does not result in a loss of supports dedicated to re-housing and increased stability.

Strategy 4.5. Ensure that the available shelter options meet the needs of individuals and families experiencing homelessness in Frederick County

Action Items:

4.5.1) Monitor the shelter system to ensure that the number and type of shelter beds is adequate and appropriate to meet local needs.

4.5.2) Wherever possible, remove access barriers at shelters to ensure that every person experiencing a housing crisis can access emergency shelter options, when diversion is not a safe and appropriate option.

4.5.3) Enhance the role of the shelter as a connection to permanent housing solutions with a service orientation dedicated to ending homelessness.

4.5.4) Investigate best practices and standards for shelter services, including innovative funding models and eligibility requirements for guests.

4.5.5) Ensure that all activities conducted in shelters have a housing focus.

4.5.6) Use common assessment tools to ensure that clients are matched to re-housing programs that are most appropriate for their needs.

Strategy 4.6. Develop, implement, and expand housing programs

Action Items:

4.6.1) Educate service providers about Housing First, as a philosophy and an intervention.

4.6.2) Ensure that existing and new Housing providers are operating according to best practices and achieving mandated service targets for the population they serve.

4.6.3) Expand the number and diversity of housing programs.

4.6.4) Promote funding for housing programs that align with best housing practices.

4.6.5) Within the targeted population served by each funded program, clients with the highest acuity are prioritized for available openings in the county.

4.6.6) Monitor the acuity and housing stability of clients in funded housing programs over time, and celebrate successes.

4.6.7) Create a housing locator position dedicated to engaging partners such as local property management companies and the Realtor's Association to recruit landlords interested in leasing units to individuals and families. The adoption of evidence informed business practices to this recruitment and liaison work will be essential for success.

Appendix A: Glossary of Terms

Acuity – a condensed term used to describe the depth of need or the severity and complexity of issues being experienced by an individual. Where a pre-screen identifies the presence of an issue, a full assessment identifies acuity. The determination of the level of acuity and how this impacts an individual's ability to successfully find and maintain housing identifies the type of program that will quickly and permanently end someone's homelessness.

Affordable Housing – for the purpose of this report, rental housing is deemed to be affordable when a household at or below the median income of its local community can consistently meet all of its basic needs (food, utilities, clothing, transportation, telephone, school supplies) and also cover the cost of the rental accommodation. In most instances, a household at or below the median income should not be spending more than one-third of its gross (before tax) monthly income on housing costs – if both housing and basic needs are to be sustainable.

Deeply Affordable Housing - housing that is affordable (see Affordable Housing) for households at or below 50% of the median income of its local community.

Assertive Community Treatment (ACT) – a model of case management where a multidisciplinary team of professionals is responsible for providing services to clients. Caseloads are small and shared among the team (typically staff to client ratio of 1:10). Most services are delivered on an outreach basis and there is often 24-hour coverage. The inclusion of psychiatrists and nurses in this service means that the former may prescribe medications while the latter may administer them.

Assertive Engagement – is a proactive approach to the delivery of outreach, engagement and follow-up services that maintains strong connections with individuals and families. When applied properly, Assertive Engagement assists in effectively moving clients towards change that is self directed and sustainable.

Assessment – the use of a reliable, valid tool designed to determine acuity of individuals and families is a critical step in the process when clients access services. Unlike the triage process that uses a brief pre-screen tool to identify issues that may be present, assessment tools measure acuity or the depth of presenting issues.

Client-centered – sometimes referred to as "person-centered", is an orientation to service delivery that considers what the individual or family needs and wraps supports around to meet those self-defined needs, as opposed to stipulating a pre-determined direction or course of action for the individual or family. A client-centered approach uses the Stages of Change model to help the individual or family track their progress from their current state to a future improved state through motivation, information sharing and empowering service participant decision-making. Client-centered services are based on client choices and do not use coercion, nor do they prescribe a particular order of service access.

Diversion – a homelessness prevention strategy that occurs at the "front door" of the homeless serving system with a focus on connecting people with alternatives to shelter, exhausting all possible other supports first. The goal of diversion is to find a housing solution - even if temporary - that stabilizes housing without shelter access.

Fidelity – is the extent to which the Housing First Program — in all of its elements — is reliably delivered in accordance with the original, trained and tested program design.

Harm Reduction – an approach aimed at reducing the risks and harmful effects associated with substance use and risky behaviours, for the person, the community, and society as a whole, without requiring abstinence.

Homelessness – when an individual/family lacks a safe, fixed, regular and adequate place to reside, or regularly spends the night in an emergency shelter, institution, or a place not intended for human habitation. Homelessness can also be discussed using the following categories:

Absolute Homelessness - When an individual/family is without a residence and sleeps in indoor or outdoor public places not intended for habitation (e.g. streets, parks, abandoned buildings, stairwells, doorways, cars, or under bridges).

Sheltered Homelessness – When an individual/family is without a residence and spends the night in an emergency shelter or similar institution, including having no fixed address and staying overnight in a hospital, jail or prison.

At-Risk of Homelessness – When an individual/family is spending 50% or more of its gross monthly income on housing or when the condition of the housing, either because of state of repair or number of occupants, is inadequate for ongoing habitation.

Chronic homelessness – When an individual/family experiences continuous homelessness for a period of one year or greater, or, experiences four or more episodes of homelessness within a three-year period. Most often chronically homeless persons also have complex, co-occurring and frequently disabling conditions.

Episodic homelessness – When an individual/family experiences homelessness for less than a year and no more than three instances of homelessness within a three-year period.

Cyclical homelessness – When an individual/family moves in and out of various states of homelessness and housing such as moving from a motel to a low-cost rental to a point of incarceration to a shelter to a hospital stay. The cycle suggests that this is a pattern of housing status that has some consistency in the movement between a homeless and housed state, even though the exact types of housing or homelessness may change.

Hidden Homelessness - When an individual/family does not access emergency shelters or sleep in visible public areas, usually because they have temporary shelter by staying with friends or family.

Homeless Family – A unit comprising one or more adults accompanying at least one minor, usually but not always a blood relative, who are homeless.

Homeless Youth – A youth who is between the ages of 16-24, without adult supervision, and is homeless.

Homeless Management Information System (HMIS) – a software application designed to record and store client-level information on the characteristics and service needs of homeless

persons. An HMIS is typically a web-based software application that homeless assistance providers use to coordinate care, manage their operations, and better serve their clients.

Homelessness Prevention – a targeted process completed by a solution focused professional that is dedicated to preventing homelessness before the individual or family loses their housing. However, to make the most effective use of available resources for prevention, funds should be targeted at individuals and families who are most likely to become homeless if they do not receive such assistance.

Housing Based Case Management – in a housing first approach, case management is a collaborative structure of care that is used to support service participants to achieve housing and life stability. Assessments are conducted to determine service options that may be suitable for the service participant, based upon the individual needs and the availability of resources. Case Management is then involved in planning, facilitating and brokering access to those services best able to meet those defined needs, documenting all aspects in this regard. Priorities are established to sequence activities, and intended outcomes are pre-defined so that progress can be measured against fixed points. Case Management is not treatment, nor is it therapy or counselling. It is also important to note that it is the case that is being managed, not the person. As such, case management does not require, coerce or direct a particular approach or order with which service participants must engage with services.

Housing First Philosophy – includes an approach and programming that focuses on helping people experiencing homelessness to have access to housing before providing support for other life issues that contributed to their homelessness.

Housing First Program – is a program model based on an evidence-based intervention that is best suited for homeless people who have complex and co-occurring issues, and serves those with the highest acuity first with minimal pre-conditions, such as "housing readiness". Prior to entering the program, the person agrees to have their support workers visit them in the home, pay rent on time, and to avoid eviction by not disrupting others.

Housing First Program Staff – is an employee of a funded agency contracted to deliver Housing First programming. These trained professionals are involved in the delivery of support services to service participants, most often in the form of Case Management that is delivered in accordance with a written Case Plan.

Housing Readiness – refers to standards and expectations of housing providers before independent housing is offered. Expectations can include psychiatric treatment, sobriety and/or life skills such as cooking. Using a "housing readiness" approach to service is not in alignment with the Housing First Philosophy.

Integrated Service Model – integration refers to collaboration within and between professionals from different sectors to increase information sharing, cross-training, improve services, reduce gaps in service, duplication of services and costs and to improve outcomes for service participants. The highest level of integration is achieved through cooperation between professionals who work together as a team to deliver case management services and supports to quickly meet the needs of service users.

Intensive Case Management (ICM) – similar to ACT, this model also provides case management and outreach services by professional staff. Lower caseload ratios and coverage outside of regular working hours are key components of ICM. The main differences between ICM and ACT is that ICM services are not delivered by multidisciplinary teams and ICM ratios are higher, usually 1 staff to 20 clients.

Interim Housing – is housing that can be accessed on a temporary basis that a Homeless Services Worker can make available to a service participant while permanent housing solutions are pursued or when a service participant is being re-housed. Interim Housing has no rights of tenancy.

Outcomes – are the result of service inputs, activities and outputs. Long-term housing stability, changes in skills and behaviour, increased knowledge and awareness and improved wellness are examples of measurable outcomes.

Permanent Housing – any housing arrangement where the tenant can continue to live at the same address indefinitely, as long as the tenant pays rent on time and follows the terms of the lease. Permanent housing can take many different forms, from rental units in the private market to permanent supportive housing. It can also include rooming houses and boarding homes, with secure tenancy, if the client chooses these housing options. However, in all of these types of rentals, the lease cannot stipulate a prescribed length of stay (other than a standard lease length), nor can it be conditional on participation in programming.

Permanent Supportive Housing – Permanent Supportive Housing (PSH or "supportive housing") is for people who need long-term housing assistance with supportive services in order to stay housed. Individuals and families living in supportive housing often have long histories of homelessness and face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder, or a chronic medical problem. Many supportive housing tenants face more than one of these serious conditions.

Point-In-Time Homeless Count (PIT) – Sometimes referred to as a Point-In-Time Count, PIT Count, or simply a PIT, it is a one-day, statistically reliable, unduplicated count of sheltered and unsheltered homeless individuals and families in a geographic region.

Pre-screen – an initial and brief assessment tool that identifies the presence of issues. Valid pre-screen tools prove to be valuable in the initial identification of issues that may need to be addressed to gain and maintain housing stability in the future. These are particularly helpful in busy environments and can identify those individuals and families who would benefit from a full assessment.

Professional Services – a service delivered by individuals that have the education, training and/or experience to make them conversant and qualified to deliver services in accordance with the requirements of a specific intervention. In almost all instances, the individuals performing the professional service receive remuneration consistent with other professionals performing similar work. In a professional service, people are expected to not cause harm due to negligence or ignorance related to the service that they are providing, exercise professional boundaries and have a skill set that is specialized related to the tasks required. In the delivery of a professional service, it is possible to monitor fidelity to the intervention and note

compliance and shortcomings in practice. Professional services stay current with evidence-based, main currents of thought and practices in service delivery.

Progressive Engagment – a strategy of starting off offering a small amount of assistance initially, and adding more if needed to help each household reach stability. This strategy uses the lightest touch possible for each household to be successful, knowing more assistance can be added later if needed.

Rapid Re-Housing – is a support intervention intended to serve homeless persons with mid-range acuity, often with co-occurring issues. Persons and families in a Rapid Re-Housing program usually receive supports for a period of 6-9 months with the option of renewal in 3-month increments. Services include housing based case management supports but these are less intense than those offered in a Housing First intervention.

Rent-Geared-to-Income (RGI) Assistance – RGI assistance is a form of rent supplement that is based on a tenant's income.

Scattered Site Housing – refers to housing that is "scattered" throughout the community in which some units in a residential complex are independent, private, market rate housing, and other units are designated as supportive or supported housing or Rent-Geared-to-Income. Participants often use rent subsidies to afford housing from private landlord and supportive services may be provided through home visits.

ServicePoint – A Homeless Management Information System used in Frederick County.

Service Prioritization Decision Assistance Tool (SPDAT) – is an instrument created by OrgCode Consulting, Inc. that examines 15 components and the acuity of each to help determine if an individual or head of household is a candidate for Housing First programming. The tool is used to assist with setting priorities and effective case management delivery. The SPDAT is a "decision assistance tool" and staff requires training to use the SPDAT effectively.

Subsidized housing – government assistance programs aimed at alleviating housing costs and expenses for people in need with low to moderate incomes. Forms of assistance may include housing subsidies, non-profit housing, public housing, etc. In the United States, subsided housing is often called "affordable housing".

Supported Housing – a term often used to describe permanent housing that includes the provision of supports on an as-needed basis, as determined through the case management process. Often these supports are provided through home visits and are designed to maintain housing and stability. Supported housing can benefit service users that are experiencing mid-range and high acuity with the frequency and intensity of the support determined through an assessment of the depth of need. Supported housing is normally offered in a scattered site housing model.

Supportive Housing – is permanent housing that is attached to the provision of supports designed to maintain housing and stability, often these supports are available on-site on a 24-7 basis. Supportive housing is one housing option that is available for those who face the most complex challenges such as individuals and families confronted with homelessness and who

also have very low incomes and/or serious, persistent issues that may include addictions, mental illness, HIV/AIDS, or other serious challenges.

Strength-Based – is an approach to service delivery that focuses on the strengths that a service participant has rather than focusing on their deficits. Using the natural and learned strengths that a service participant has, the intent is to leverage these strengths to help the service participant positively impact other areas of their life.

Transitional Housing – housing that normally comes with a specified time limitation for tenancy and often with requirements to comply with rules such as sobriety, curfew and/or participation in training or employment programming, in addition to the tenancy agreement.

Vulnerability Index – The Vulnerability Index (VI) is a tool based on medical research that helps communities identify homeless individuals who may face an elevated risk of death on the streets. Community Solutions is the owner of this triage tool.

Appendix B: Affordable Housing Targets

Goal #1 of the Frederick County Coalition for the Homeless identifies the need for more affordable housing.

Using its proprietary housing affordability model, OrgCode Consulting, Inc. projected housing demands and affordability over the next 5 years. There are a range of indicators, based upon trends, that most impact the conclusions reached by the affordability model, including, but not limited to:

- City and County population
- Understanding anticipated population changes and characteristics of population change (in-migration, age, participation in labor force, income levels, gender, birth and death rates, etc.)
- Incidence of low-income, and characteristics of low-income households
- Mean and median household income, and characteristics of households by income brackets
- Breakdown of industries, with attention paid to propensity of lower-wage industry sectors
- Rates of unemployment, as well as length of unemployment and other unemployment trends
- Rates of income assistance (TANF, SNAP, Medicaid, etc.) relative to rental market affordability
- Minimum wage income relative to rental market affordability
- Availability of affordable rental units within current and historic rental market by type of unit and range of affordability
- Trends in household composition
- Mobility of households
- Service use patterns within homeless shelters (occupancy rates, average lengths of stay, household characteristics of shelter users, etc.)
- Development patterns
- Loss and changes in composition of rental market housing stock

Like any forward-looking projection, both current and historic data, as well as an understanding of current initiatives to address known issues become important factors in breaking down anticipated levels and types of affordability within affordable housing.

Using this approach, it is recognized that over the next 5 years, a total of 352 affordable units would need to be created in Frederick City and County to fully address the need. Although the need is there for these units, its development is not fiscally achievable by the Coalition alone. Instead, these targets should be used by the Coalition to advocate and assist in planning.

In addition, these units do not need to be new constructions. Some can be acquired, such as by purchasing and/or converting existing housing or other structures. Also, housing vouchers are an excellent way to immediately increase the supply of affordable housing.

Breakdown by Household Type

Although some units should be for families, the greatest demand is for single units, as illustrated on the table below.

	Total # of Units
Families	121
Singles	231
Total	**352**

Breakdown by Supports

Some of the units required should be permanent supportive housing units – housing that is not only affordable but also has supports attached to help tenants most in need stabilize their housing and maintain housing tenure. Permanent supportive housing is key to the success of ending chronic homelessness.

	Units for Singles	Units for Families	Total # of Units
Non-Supportive Housing	115	89	204
Permanent Supportive Housing	116	32	148
Total	**231**	**121**	**352**

Breakdown by Household Income

All PSH units will be geared to income, but non-supported units will be most likely a fixed rental price. In order to put this into context, first the Area Median Income (AMI), reported by the Department of Housing and Urban Development, must be analyzed.

For FY 2015, the AMI for Frederick County is $109,200 (for a family of four).[1] Typically, households are considered to have low income if they have less than 80% of AMI. Units are considered affordable if a household would spend 30% or less of their income on housing costs, so affordable rent for a low-income household is $1,700 per month, or $1,190 for singles.

These units, while considered affordable according to federal definitions, do not help individuals in very low (50% of AMI) or extremely low (30% of AMI) income. For these groups, deeply affordable units are needed. Families in this range could afford units ranging from $819-1365 per month, while singles could only afford units from $574-$965 per month.

1 For more information about AMI and Income Limits, visit http://www.huduser.org/portal/datasets/il/il15/index_il2015.html

Thus, it is important, when developing affordable housing, to ask how affordable the unit is. When adding affordable housing stock, it is recommended that at least 50% of (non-supportive) housing units are deeply affordable.

	Total # of Units
Affordable	50% of total
Deeply Affordable	50% of total or more
Total Non-Supportive Housing	**204**

Overview

	Singles	Families	Total # of Units
Permanent Supportive Housing	116	32	148
Non-Supportive Housing	115	89	204
Affordable	*57*	*44*	*101*
Deeply Affordable	*58*	*45*	*103*
Total	**231**	**121**	**352**

Appendix C: Service Delivery Models

Sector of Service: Homelessness Prevention

Homelessness Prevention Programs

Problem Statement

Some episodes of homelessness can be prevented, if prevention assistance is targeted to those households that are most likely to become chronically homeless should they lose their housing.

Service Delivery Model

- The acuity of clients is determined when assistance is requested
- Prevention assistance resources are prioritized for clients with higher acuity
- Clients who receive assistance receive follow-up care once family is no longer in crisis mode to prevent future housing crises

Indicators

- # of households that apply for prevention assistance
- % of applications that are high, moderate, and low acuity
- # of households served, by acuity level
- % of households remaining stably housed at 6 and 12 months after receiving prevention assistance, by acuity level

Intended Outcomes

- Prioritized access for services based upon acuity level
- Households that receive prevention assistance maintain housing and do not become homeless

Shelter Diversion Programs

Problem Statement

Individuals/families that have safe and appropriate alternatives to homeless services, including shelters, should be supported in achieving those alternatives.

Service Delivery Model

- Safety determination
- Understanding of previous night's location of stay
- Return if safe and appropriate to do so

- Alternative locations that may be safer or more appropriate
- Underlying presenting issues
- Housing plan upon entry to services if no alternatives

Indicators

- # of households presenting for services
- # of households where diversion is implemented
- # and % of households initially diverted that subsequently return for future diversion
- # and % of households initially diverted that subsequently return and enter into homeless services system

Intended Outcomes

- 30% of households seeking homeless services can have their needs safely and appropriately met through other means

Sector of Service: Connection to Long-Term Solutions

Coordinated Access & Common Assessment

Problem Statement

Without coordination across programs and organizations at a system level, the individual/family getting to the right service to address his/her needs is difficult and inefficient, enhances trauma and may inadvertently prolong homelessness.

Service Delivery Model

- Common assessment tool across all types of services
- Decentralized approach to being assessed - walk-in and phone-based
- Typologies and priorities established based upon acuity, not first come, first served
- Safety screening put in place
- Assessment follows the person without unnecessary secondary assessments

Indicators

- # of households identified as higher acuity, moderate acuity, and lower acuity
- # of households assigned to programs by program type and acuity level

Intended Outcomes

- Prioritized access for services based upon acuity level
- Service planning based upon gaps and opportunities in system - emerging from assessment data

- "Side doors" and access to services based upon feelings of readiness are eliminated

Outreach Programs

Problem Statement

Some individuals/families are not connected to services or are not connected in such a manner that it is ending her/his homelessness.

Service Delivery Model

- Geographically based with set hours of services
- By name registry of people being sought for engagement
- Housing solution is primary purpose of engagement
- No coercion or threats
- Acuity determined "in the field"

Indicators

- # of households identified as higher acuity
- # of higher acuity households accessing shelter
- # of higher acuity households accessing housing
- # and % of higher acuity households that return to homelessness

Intended Outcomes

- Decreased acuity
- 80% remain housed and do not return to homelessness

Shelter Programs

Problem Statement

Individuals/families experiencing homelessness require safe and appropriate overnight shelter.

Service Delivery Model

- Safety assessment
- Provision of basic material needs (bedding, hygiene, food) - Additional services may be provided so long as they do not incentivize homelessness

Indicators

- # of households accessing shelter
- Average length of stay by type of household

- # and % of households experiencing recidivism
- Acuity range of those staying longer than 14 days
- Average number of homelessness episodes per person within last three years
- Average cumulative duration of homelessness

Intended Outcomes

- Year over year decreased length of stay
- Year over year improved rates of recidivism (fewer returns to homelessness)
- Year over year decrease in cumulative duration of homelessness

Sector of Service:Housing Services

Housing First/Permanent Supportive Housing

Problem Statement

Individuals/families with higher acuity may benefit from permanent supportive housing/ Housing First to assist with housing and life stability while integrating into community, otherwise will cycle in and out of homelessness.

Service Delivery Model

- Scattered Site Assertive Community Treatment
  - Participation based upon higher acuity and more complex, co- occurring, intensive issues
  - Recovery-oriented ACT implementation
  - Brokering and advocacy along with direct service supports
  - Case management supports are permanent
- Scattered Site Intensive Case Management
  - Participation based upon higher acuity and more complex, co- occurring, intensive issues
  - Home based case management
  - Brokering and advocacy to community resources
  - Case management supports are permanent
- Congregate Intensive Case Management
  - 24/7 on-site supports
  - Participation based upon higher acuity and more complex, co- occurring, intensive issues
  - Home based case management
  - Advanced, specialized access to supports such as mental wellness, physical wellness
  - Case management supports are permanent

Indicators

- # of people housed
- % that remain housed at 6 months and 12 months # and % of unknown and unsuccessful exits

Intended Outcomes

- Decreased acuity
- Improved quality of life
- 80% remain housed

Rapid Re-Housing

Problem Statement

Individuals/families with moderately acute needs require case management supports to assist with housing and life stability, otherwise will cycle in and out of homelessness.

Service Delivery Model

- No mandatory program prerequisites
- Participation based upon consent and acuity
- Home based case management
- Each case manager has their own case load
- Moderate level acuity results in focused attention on 2-3 primary issues
- Case management supports usually for 3-6 months

Indicators

- # of people housed
- # of families housed
- % that remain housed at 6 months
- # and % of unknown and unsuccessful exits

Intended Outcomes

- Decreased acuity
- Improved quality of life
- 85% remain housed throughout duration of support

Sector of Service: Ancillary Services

Drop-ins and Day Centers

Problem Statement

Individuals/families experiencing homelessness and/or under housed require safe and appropriate places to go during the day for respite and to meet basic material needs.

Service Delivery Model

- Provision of basic material needs (hygiene, food)
- Additional services may be provided - by day center staff or external parties - so long as they do not incentivize homelessness

Indicators

- # of households accessing drop-in/day center
- # of days visited by unique individuals and her/his housing status

Intended Outcomes

- Improved quality of life of service participants

Employment & Education

Problem Statement

Individuals/families previously experiencing homelessness may require assistance to access employment and/or education opportunities in order to achieve greater independence over time.

Service Delivery Model

- "Employment first" model of supported employment
- Direct access to employers and job supports
- Access to educational opportunities that will increase job opportunities

Indicators

- # of people accessing employment programs
- # and % of people that access paid employment through engagement with employment programs
- # and % of people that lose employment after achieving it
- # of people accessing educational opportunities
- # and % of people completing their educational opportunity

Intended Outcomes

- Improved income of participants