

HOMELESS PLAN STRATEGIES

The following nine strategies are listed in order of community defined priority.

Prevention/Diversion/Discharge Planning: Strategies 1 & 2

Strategy 1 PREVENTION/ INTERVENTION	Increase housing stability for individuals and families at-risk of homelessness by supporting and expanding programs that provide housing payment assistance, eviction prevention services and other supportive services.
Description:	Identify households at-risk of homelessness, whose housing situation will stabilize long-term, if they receive assistance, such as rent/mortgage, rental arrears, utility, mediation, case management credit repair, etc. Provide resources through local service providers to meet the critical needs of persons in crisis.
Evidence of the Strategy's Effectiveness	The most economically efficient way to end homelessness is to prevent its occurrence in the first place. Financial assistance to prevent an eviction, mediation to address problems with a landlord or lender, and case management can all prevent individuals and families from becoming homeless.
Population to be Served	Individuals and families who are very low income and at-risk of homelessness.
Extent of Need	In 2009, 85% of rental households with incomes below 30% AMI were paying more than 30% of their income for housing (CHAS data). ⁵⁵ Clark County is only serving 35% of the need for homelessness prevention based on the turn-away numbers for the Emergency Shelter Assistance Program (ESAP).
Organizational Responsibility	Local government, Council for the Homeless, Coalition of Service Providers for the Homeless Planning Group and the Community Action Advisory Board.
Accomplished	<ol style="list-style-type: none"> 1. 795 additional households were able to stay in their homes because of new or strengthened programs. 2. United Way Community Relief Fund supported 143 households with rent and utility assistance. 3. The increased availability of supportive assistance funds prevented individuals and families from becoming homeless. Assistance included but was not limited to transportation, food, childcare, education, utility, medical and dental emergencies. 4. Funded 25 rental assistance vouchers for very-low income disabled individuals with supportive services. 5. Established funding to assist families at-risk of homelessness due to code enforcement. 6. Stabilized housing for households placed in "housing first" pilot for 1 year. 7. Added a Foreclosure Assistance Program that served 500 households. 8. Increased outreach and support services for families experiencing violence in north and east Clark County by having one SafeChoice staff available one day per week. 9. Established a Housing Justice Project to reduce eviction rates. 10. Created a Homeless Student Support Team to engage the community in meeting the needs of youth in a local school district.

⁵⁵ U.S. Census Bureau, 2009 American Community Survey 1-year estimates, Table B25074 Household Income by gross rent as a percentage of household income in the past 12 months, Clark County WA.

Best Practices	<ol style="list-style-type: none"> 1. Housing Subsidies are an effective prevention strategy and have been shown to help 80 percent of first-time homeless families sustain housing for a minimum of two years.⁵⁶ 2. Short-term housing subsidies had the greatest effect of several potential interventions in reducing homelessness.⁵⁷ 3. Housing subsidies are an effective prevention strategy and have been shown to help homeless families (80–85 percent retention over at least 18 months) in which a parent’s mental illness complicates housing stability, sustain housing.⁵⁸ 4. Housing subsidies for homeless families or chronically homeless single adults are effective in achieve housing stability.⁵⁹ 5. Prevention programs need to support households in decreasing their rent to income ratio.⁶⁰
Outcomes / Measures	<ol style="list-style-type: none"> 1. 70% of those who receive rental assistance maintain stable housing for 18 months. 2. 70% of chronically homeless single adults who receive rental assistance maintain stable housing for 18 months. 3. 75% of households who receive homeless prevention funds do not enter into a homeless housing program within two years. 4. Sustain and increase homeless prevention programs at 2009 (pre-ARRA) levels. 5. Number of newly homeless is 10% lower than the previous year.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Provide flexible funding for partial and full month rental or mortgage assistance and other supportive services for households with short-term needs. 2. Increase the availability of flexible assistance funds to prevent individuals and families from becoming homeless, including but not limited to transportation, food, childcare, education, utility, medical and dental emergencies. 3. Ensure families do not become homeless due to code enforcement actions by sustaining funds that can help relocate individuals and families to decent and safe housing. 4. Continue coordination with DSHS to assist families in rapidly accessing emergency income support and other services. 5. Integrate homelessness prevention screening and activities within intake sites for all housing programs to identify households who are most effectively served by homelessness prevention. 6. Establish an initial abbreviated prevention assessment system for referral to local agencies. 7. Increase flexibility of resources to allow programs to meet the varying needs of households, as identified by assessments. 8. Create culturally appropriate eviction prevention services to ensure diverse communities are not disparately impacted by displacement. 9. Connect those who receive eviction prevention assistance with available weatherization services to increase the energy efficiency in their home.

⁵⁶ Shinn et al., 2001, Stojanovic et al., 1999.

⁵⁷ Quigley et al. 2001.

⁵⁸ Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka , 1995.

⁵⁹ Strategies for Preventing Homelessness, U.S. Department of Housing and Urban Development Office of Policy Development and Research, May 2005.

⁶⁰Burt, Martha, Pearson, Carol & Montgomery, Ann Elizabeth, Community-wide strategies for preventing homelessness: Recent evidence: Results, Urban Institute, Washington DC, 2007.

<p>Intermediate</p>	<ol style="list-style-type: none"> 1. Move beyond one-time eviction prevention payments to providing time-limited housing subsidies and case management until families are stable in their housing situation. 2. Provide re-housing opportunities for those who are paying over 30% of their income to housing or those who are living doubled up. 3. Explore funding options for the Housing Justice Project. 4. Enhance coordination and information sharing among prevention providers to maximize existing prevention dollars and streamline services. 5. Create program(s) to help seniors (62+) sustain their housing. 6. Create a comprehensive resource referral list in partnership with the WorkSource Rapid Response Team for those who are being laid off or are underemployed. 7. Create new opportunities for youth to explore their post high school options and receive support as they plan for their future. 8. Work with schools to help them provide resource information to students or families about community services that might be relevant to their needs. 9. Target new homelessness prevention and emergency assistance efforts to neighborhoods and populations from which a disproportionate number of people are seeking shelter. 10. Advocate for DSHS to focus on housing stability as they work with their clients. 11. Provide advocacy support and self-advocacy opportunities through classes, drop-in options and/or a phone line for those in the middle of a potential eviction process to understand their rights and options. 12. Coordinate events or drop-in sites around foreclosure prevention and homeownership sustainability.
<p>Long-Term</p>	<ol style="list-style-type: none"> 1. Increase the availability of professionals and resource navigators to provide crisis intervention and case management to individuals and families in times of crisis. 2. Support free mental health services and medications for non-insured households. 3. With a focus on reducing re-user rates, extend case-management and supportive services for individuals and families that have completed programs, but find themselves still in need of services. 4. Ensure all person centered health care homes in the County have direct connections to prevention funds and housing programs for those who are at-risk of homelessness or homeless.

Strategy 2 DIVERSION/ RE-ENTRY	Increase coordination and linkages among mainstream programs that provide care and services to low-income people in order to consistently assess and respond to their housing needs to prevent homelessness, and ensure that public institutions (hospitals, prisons, jails, mental health facilities) discharge people into housing.
<p>Description: Most people who become homeless are eligible for assistance from mainstream systems of care, and many are or recently have been active clients of one or more of these systems. Studies focusing on where homeless people have lived immediately before becoming homeless show trends that suggest solutions. People involved in public systems or institutions, such as jails and prisons, hospitals, the child welfare system and mental health facilities are often released into the homeless system. One aspect of prevention is to stop these discharges into homelessness, through basic transition planning so that people leaving these institutions have stable housing and some means for maintaining it. Work to expand housing options for people being discharged from state psychiatric hospitals or residential treatment facilities, prisons, local jails, and local hospitals. Improve procedures for early planning and coordination of discharge. Procedures may include local community support, case management, re-entry counseling, education, training and employment opportunities, and identification of housing and gender responsive services. Diversion focuses on diverting households from shorter-term, expensive programs such as emergency shelter and quickly placing households into their own market rate home through rapid re-housing programs.</p> <p><i>Source: State of Washington 10-Year Homeless Plan</i></p>	
Evidence of the Strategy's Effectiveness	<p>Research indicates that offenders with disabilities or mental health challenges who are provided permanent supportive housing upon release and other offenders who are provided long-term transitional supportive housing, have lower rates of recidivism (up to 60%). A study found that prisoners participating in pre-release planning had a 54% lower rate of re-offending.</p> <p><i>Source: State of Washington 10-Year Homeless Plan</i></p>
Population to be Served	People with no income or very low-incomes, who are homeless or chronically homeless and are about to be released from correctional facilities, jail, institutions, residential treatment facilities and/or hospitals.
Extent of Need	Procedures are in place for state facilities to plan for discharge, but a lack of housing focused case management staff, appropriate structured housing, subsidies to support housing and resources for supportive services limits ability to implement.
Organizational Responsibility	Local Government, Law and Justice entities, Council for the Homeless and The Coalition of Service Providers for the Homeless Planning Group.
Accomplishments	<ol style="list-style-type: none"> 1. Established discharge planning and re-entry procedures from hospitals, jails, prisons, detox and other treatment programs. 2. Created the Re-Entry Housing Program of Clark County. This program is a collaborative program partnership with Second Step Housing, Community Services NW and the Department of Corrections and funded by United Way. The program supports offenders who are at high risk of homelessness and recidivism as they re-enter into the community and seek self-sufficiency. 3. Created the Clark Housing Engagement Collaboration (CHEC) program with Homeless Grant Assistance Funds (HGAP) funds. This program supports individuals coming from jails and state hospitals with rental assistance, landlord outreach, employment, medical and mental health/substance abuse treatment linkages to services for individuals. 4. Created a Housing Justice program to mediate between landlords and tenants during the eviction process. 5. State Legislature re-instated a three month voucher program for those being discharged from a correctional institute. 6. Acquired 50 Family Unification Program (FUP) vouchers which can be used to transition youth who have aged out of foster care into stable housing or provide housing assistance to families who are involved in the child welfare system.

	<ol style="list-style-type: none"> 7. Created a financial assistance and supportive services program for youth to help them attain and sustain housing. 8. Created a workgroup to update and maintain the housing inventory tool. 9. Convened a Task Force to explore opportunities for increased funding for homeless court and increased its capacity to serve clients.
Best Practices	<ol style="list-style-type: none"> 1. Permanent Supportive Housing for offenders reduces recidivism rates.^{61,62} 2. Therapeutic Specialty Courts lead to positive community impacts.⁶³ 3. Peer Supportive housing leads to greater housing stability.⁶⁴
Outcomes/ Measures	<ol style="list-style-type: none"> 1. 90% of those exiting institutions are discharged into housing. 2. 80% of those discharged into supportive housing remain housed for one year. 3. The recidivism rate or the rate at which an individual commits additional crimes after being placed in supportive housing, is below 30%. 4. 95% of those exiting Western State Hospital leave with discharge plans that include housing.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Create a rapid re-housing program to reintegrate youth who are transitioning out of foster care or who are being released from juvenile facilities into stable housing. 2. Work to establish additional discharge planning and re-entry procedures from hospitals, jails, prisons, mental health institutions, detox and other treatment programs. 3. Formalize integrated discharge plans between institutions and social service agencies, including housing programs. 4. Create a Veteran's Specialty Court. 5. Integrate planning with specialty courts: Domestic Violence, Mental Health, Veterans, Drug & Alcohol, Family Treatment and Homeless. 6. Identify and coordinate a coalition of multi-disciplinary service providers to create resources to help others navigate the housing programs for specific populations including male and female Veterans, domestic violence survivors, sexual minorities and people from diverse cultures. 7. Advocate for the sustainability of the offender, including sex offender, housing voucher programs. 8. Create additional rapid re-housing programs to divert or move households from emergency shelters into stable housing. 9. Increase the number of rapid re-housing opportunities for people who would do not need the long-term support of Permanent Supported Housing. 10. Provide one SOAR train the trainer per year to increase access to SSI/SSDI for those who are homeless or formerly homeless. 11. Assess the need for a human trafficking safe house in Clark County versus direct connections to Portland Metro area resources. 12. Provide rapid re-housing options for those exiting systems of care. 13. Engage in Veteran Administration efforts to support those reintegrating into the community after exiting the armed forces.
Intermediate	<ol style="list-style-type: none"> 1. Establish options for people who are medically fragile and being discharging from hospitals or other institutions. 2. Provide educational opportunities for landlords and community members to share the facts about housing people with sex offenses and parenting females with felonies.

⁶¹ Kendall Black and Richard Cho, "New Beginnings: The Need for Supportive Housing for Previously Incarcerated People," New York 2004, documents.csh.org/documents/pubs/full_new_beginnings.pdf.

⁶² Zhang, Roberts, & Callanan, 2005; The United States Interagency Council on Homelessness, 2008.

⁶³ Mosher, C., Drapela, L., & Mahon Haft, T. (September, 2002). Preliminary Report: Evaluation of Clark County Sales Tax Revenue for Chemical Dependency, Mental Health, and Therapeutic Courts. Washington State University Vancouver.

⁶⁴ Mead, S. & MacNeil, C. 2006. Peer support: What makes it unique? International Journal of Psychosocial Rehabilitation, 10 (2), 29-37, December 2004.

	<ol style="list-style-type: none"> 3. Sustain and develop population specific rapid re-housing programs to divert households from emergency shelters. 4. Support housing stability for those being released from jail or prison by advocating for offenders, including sex offenders to have their public benefits re-instated as soon as they are discharged. 5. Plan for housing assistance/case management and services for persons discharged from detox and other treatment facilities. 6. Reduce the household waiting time between filling out an application and obtaining stable housing within all rapid re-housing programs. 7. Create population focuses rapid re-housing programs to most effectively meet the needs of diverse populations. 8. Explore using HMIS to strengthen discharge procedures within agencies not currently entering data.
Long-Term	<ol style="list-style-type: none"> 1. Advocate for the criminal justice system to provide housing plans, long and short-term housing subsidies and case management for offenders. 2. Increase the supply of housing options for people moving out of treatment facilities. 3. Create housing plans for those transitioning into the community from Department of Corrections programs, including sex offenders. 4. Advocate for foster care and homeless youth to have housing plans and income support plans before exiting systems (foster care or school). 5. Create a peer navigator/mentor system to support those re-entering the community, including sex offenders.

Housing Plus Supportive Services: Strategies 3-6

Strategy 3 PERMANENT SUPPORTED HOUSING	Provides housing which is intended to be the tenant's home for as long as they choose and appropriate supportive services for people, who for reasons outside of their control cannot support themselves independently in housing. Reasons could include mental health needs, physical health needs, and other unique circumstances. <i>Clark County 10-Year Homeless Housing Plan 2009 Report Card</i>
Description: Clark County is targeting households and individuals identified as high users of services such as substance abuse and mental health treatment, corrections systems, income assistance, hospitals, foster care, emergency shelter, and domestic violence/victim's services, then placing them into subsidized permanent housing with supportive services. This is being accomplished through numerous statewide, regional and local private-public efforts. Housing is being identified by the households or through partnerships with landlords and/or the local housing authority.	
Evidence of the Strategy's Effectiveness	<p>Families participating in the innovative local Bridges to Housing permanent supported housing program have benefited from increased and sustained stability and reduced risk of domestic violence. Most children in these families have demonstrated improved physical and mental wellbeing, are performing better in school and have sought increased opportunities for social and recreational activities.</p> <p>Studies examining the provision of flexible support services combined with permanent housing for persons with mental illness resulted in an 85% retention rate, a decrease in patient hospitalization, a decrease in both emergency room visits and incarcerations by 50%.⁶⁵</p>
Population to be Served	Households who are very low-income, at-risk of homelessness, living in housing with expiring federal contracts, mobile home parks, or transitioning from homelessness, including families, who for reasons outside of their control cannot support themselves independently in housing on a long-term basis.
Extent of Need	Estimated 122 households with an unmet need for permanent supported housing in 2009. ⁶⁶
Organizational Responsibility	Local Government, Council for the Homeless, Coalition of Service Providers for the Homeless (formerly Continuum of Care) Planning Group.
Accomplishments	<ol style="list-style-type: none"> 1. Increased the capacity of permanent supported housing in Clark County between 2005 and 2009 by a total of 526 households.⁶⁷ 2. Changed zoning laws to make it easier for homeowners to sublet 'mother-in-law' apartments in their homes.
Best Practices	<ol style="list-style-type: none"> 1. History of preserving expiring federal contracts provides housing stability for low-income tenants. Lack of permanent affordable housing is one of precipitating factors in causing homelessness, especially for high-needs families. Supported housing program outcomes indicate that providing services to people in permanent housing is an effective strategy to prevent and reduce chronic homelessness. Promising prevention strategies focus on people who are leaving hospitals, psychiatric facilities, substance abuse treatment programs, prisons, and jails.⁶⁸
Outcomes / Measures	<ol style="list-style-type: none"> 1. Create a 5% net increase in capacity for permanent supported housing annually until the need has been met. Current capacity (CoC 2009) for permanent supported housing is 791 households, and calculated need is 122 households. 2. Create a 10% net increase in capacity for permanent supported housing targeted at households identified as chronically homeless.

⁶⁵ State of Washington 10-Year Homeless Plan; Bridges to Housing Evaluation 2009 Year-End Report.

⁶⁶ 2009 Clark County Housing Inventory Chart.

⁶⁷ 2005 Housing Inventory; Clark County 10-Year Homeless Housing Plan 2009 Report Card.

⁶⁸ Services in Supported Housing; National Alliance to End Homelessness.

	<ol style="list-style-type: none"> Increase percentage of participants remaining in permanent supported housing projects for at least six months from the current 78% to at least 80% (CoC 2009).
Action Steps	
Short-Term	<ol style="list-style-type: none"> Sustain the existing housing and support services developed through HGAP/CHEC after funds expire in June 2011 by identifying community-based and alternative funding mechanisms. Continue to support components of Bridges to Housing with existing and alternative resources after funding expires in 2011. Apply annually for 'Bonus Funds' through the CoC to add rental subsidies to existing support service programs. Create access to at least 50 units of permanent supported housing targeted at homeless Veterans through either HUD/VASH vouchers or other resources. Promote and provide permanent supported housing training to mental health and alcohol and drug agencies. Advocate for a state organized housing task force to explore and reduce barriers that exist in the development of affordable housing projects. Identify the non-economic barriers those who are low-income experience when looking for housing and support proven strategies like tenant education, credit repair and guarantees that mitigate those barriers. Create and sustain programs to help alleviate barriers to housing for women and parenting veterans. Increase the number of permanent supported housing options for those transitioning out of systems of care. Assess opportunities for service integration, particularly with agencies that provide housing, but are outside the homeless system. Expand the number of housing first programs that place homeless individuals and families in housing with intensive services.
Intermediate	<ol style="list-style-type: none"> Explore the development of accessory dwelling units to provide needed low-cost rentals, but also to provide an income stream to low-income and first time homebuyers. Fund units of permanent supported housing located within housing developments that are easily accessible and close to services, with no debt and an annual operating and maintenance subsidy for households 0-30% MFI. Explore the development of cooperative communities or shared housing models focused on providing permanent supported housing for newly retired people who are facing a loss of income and are unable to maintain current homes. Re-program existing housing of aging population to allow for multiple dwellings. Link new permanent housing options with project based section 8 vouchers and services. Ensure participants are not rent burdened. Pursue grants that will benefit those who are homeless in collaboration with mental health providers or other non-traditional partners.
Long-Term	<ol style="list-style-type: none"> Affect policy to ensure no net loss of subsidized housing units. Create financial incentives to encourage builders to develop set-aside units in mixed income developments for very-low income homeless households currently receiving other services. Advocate for preservation of services which support high-needs homeless families and individuals, such as Medicare, Social Security, TANF, SNAP, mental health, and other services. Create, maintain and encourage housing programs that provide enough assistance to families so they are not rent burdened and continually at-risk of homelessness.

Strategy 4 TRANSITIONAL/ SUPPORTIVE HOUSING	Preserve and expand the supply of transitional (up to 2 years/time-limited) supportive housing for individuals and families.
Description:	Provide independent living opportunities for people who are homeless to help them move from short-term supportive housing (up to 2 years/time limited) to permanent housing with service supports, such as case management, child care, counseling and employment assistance, or to self-reliance.
Evidence of the Strategy's Effectiveness	Individuals in transitional housing programs benefited from educational and employment opportunities that help change life circumstances. Children benefited from having fewer moves and school changes. Families leaving transitional housing and moved to their own place and 60 percent remained in their homes 12 months later. ⁶⁹
Population to be Served	Households that are homeless, and that we can expect will have the capacity to move to self-reliance with moderate resources and supports. People whose needs are further assessed to be higher than this expectation may be moved to permanent supported housing as needed.
Extent of Need	Of the households who successfully completed a transitional housing program in 2008, 94% did not return to access any other services from the continuum in 2009. It is estimated by providers of transitional housing that approximately 50% of the people accessing transitional housing opportunities do so for lack of available permanent supported housing.
Organizational Responsibility	Local Government, Council for the Homeless, Coalition of Service Providers for the Homeless.
Accomplishments	<ol style="list-style-type: none"> 1. Created 106 (562 in 2005, increased to 668 in 2009) beds of transitional housing for homeless individuals and couples that include mental health and substance abuse treatment, and health care along with rental subsidy. Individuals have housing choice. Beds were created through the McKinney-Vento Continuum of Care Grant, Washington Families Funds, and VHA Project-Based Section 8 Vouchers. Share Aspire, Community Services Northwest, YWCA, Second Step Housing, and Open House Ministries have all added resources. 2. Participated in and accessed regional efforts, such as Washington Families Fund, and other comprehensive strategies, which provide housing and intensive support services. 3. Developed a Project-Based Section 8 program opportunity through 4 providers targeting households who by program assessment need a maximum of 18 months of support to attain self-sufficiency. 4. Collaborated with a local company, Holland Residential Services, to offer a 6 month transitional housing program that gives households whose only barrier to self-sufficiency is financial, an opportunity to develop a financial plan and build savings to develop assets.
Best Practices	<ol style="list-style-type: none"> 1. Supported Employment: is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities.⁷⁰ 2. Transitional Housing and Services: A Synthesis: Describes variations in the major approaches developed for homeless families and individuals in terms of differences in target populations, physical structures, service intensity, and other program characteristics that cluster along a continuum with "high-demand" service-intense facilities at one end and "low demand" programs with

⁶⁹ HUD's Office of Policy Development and Research, 2009.

⁷⁰ Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., et al., 2001, Implementing supported employment as an evidence-based practice, *Psychiatric Services*, 52, 313-322.

	<p>flexible requirements and optional services at the other. Available research assessing the major models indicates that scattered-site transitional housing programs that convert to permanent housing constitute one effective (and cost effective) approach to helping families and possibly individuals exit from homelessness.⁷¹</p> <p>3. Individualized Action Plans (IAP): Work or “actions”, which may be utilized in the course of action for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the recommendations/assessed needs.⁷²</p>
Outcomes / Measures	<p>1. There were 550 unique clients in Transitional Housing in 2008. In 2009 (12 months), 520 of those clients (94.55%) did not return to Emergency Shelter (HMIS). At least 80% of clients will remain in stable housing for 24 months measured annually.</p> <p>2. In 2009, 38% of adults exiting Transitional Housing were employed (CoC). At least 50% of successful graduates will be employed at exit annually.</p> <p>3. At least 8 youth and young adults remain stably housed for 18 months measured annually.</p>
Action Steps	
Short-Term	<p>1. Support current transitional housing programs with operating and maintenance resources.</p> <p>2. Support current transitional housing programs with service resources and case management.</p> <p>3. Develop short-term subsidy programs that accelerate households’ capacity to become self-sufficient and leave subsidized housing as early as possible.</p> <p>4. Identify and/or develop additional resources for those whose housing may be in jeopardy due to state budget cuts to safety net services.</p> <p>5. Increase transitional housing plus support options for Veterans.</p>
Intermediate	<p>1. Create additional permanent/transitional housing options with supportive services (including case management, long-term planning and tenant/credit/financial education) for youth, ages 16-24 years.</p>
Long-Term	<p>1. Maintain the current transitional housing programs until analysis shows it is feasible to transition housing to permanent supported housing. This is not a 1:1 trade of housing and services by program type.</p> <p>2. Coordinate local housing for individuals participating in employment or service oriented programs, training, apprenticeships, internships etc.</p>

⁷¹ SAMHSA National Registry for Evidence Based Programs and Practices.

⁷² SAMHSA National Registry for Evidence Based Programs and Practices.

Strategy 5 EMPLOYMENT/ INCOME SUPPORT	Increase access to educational and employment programs to increase earning potential for individuals who are homeless, or at-risk of homelessness, and lead to self-sufficiency.
Description: Increased self-sufficiency depends on opportunities for education and employment, as well as affordable housing. Pursue the development of community partners who work with employers to serve as a source of job training and employment. <i>State of Washington 10-Year Homeless Plan</i>	
Evidence of the Strategy's Effectiveness	Vocational programs for people who are homeless have demonstrated up to a 90% graduation and placement rate at positions earning more than double minimum wage. <i>State of Washington 10 Year Homeless Plan</i>
Population to be Served	People who are homeless, formerly homeless and at-risk populations, including youth.
Extent of Need	<ul style="list-style-type: none"> • 1,093 people who are homeless in Clark County during the annual 2010 Point in Time Count Homeless Count. • Unemployment Rate in Clark County is the highest in the state and throughout 2010, remained 4 points over the Washington State rate. • 27,290 people were unemployed during 2009 according to the American Community Survey. • Clark County's high unemployment rate is a contributing factor in the need to supported employment programs.
Organizational Responsibility	Local Government, Council for the Homeless, Coalition of Service Providers Group, Clark County
Accomplishments	<ol style="list-style-type: none"> 1. Increased the number of employment programs by creating the PIC women veteran employment program, two Columbia River Mental Health (CRMHS) homeless employment navigator (HEN) programs and the moving forward together (MFT) housing program. 2. From 2008-2010, 213 people who were unemployed and at-risk or temporarily homeless attained jobs. This was accomplished by developing supported employment opportunities for chronically homeless people through the HEN program. 3. Created a self-sufficiency program for those receiving section 8 vouchers and public housing. 4. Provided credit building and financial planning opportunities through the Community Housing Resource Center (CRHC) and their credit repair, debt management, credit counseling, mortgage default counseling and reverse mortgage counseling classes. 5. Developed a Clark County Asset Building Coalition (ABC). 6. 100 additional families were enrolled in employment and education programs through HEN and the Workforce Investment Act (WIA). 7. 20 chronically homeless people received supported employment through HEN. 8. 75 people completed credit building and financial planning training through CRHS, Tenant Education and Individual Development Accounts. 9. 10 families who are either homeless or at-risk increased their earning potential through education and micro enterprise support through the Share IDA program. 10. At least 762 households filed for the Earned Income Tax Credit (EITC) through CRHC and the AARP Tax Aide program at nine different sites during the 2010 tax season.

Best Practices	<ol style="list-style-type: none"> 1. Supportive Employment (SE), a SAMHSA Evidence Based Practice is a pathway out of homelessness.⁷³ 2. Supportive Employment (SE), a SAMHSA Evidence Based Practice has emerged as a model for providing rehabilitation to individuals with mental illness and co-occurring substance abuse disorders.⁷⁴ 3. Programs and individuals rooted in the Supportive Employment model and effective in helping people move out of homelessness.⁷⁵ 4. IDA's promote self-sufficiency.⁷⁶ 5. For children born to low-income parents, getting a college degree quadruples their chance of making it to the top of the income ladder as adults.⁷⁷
Outcomes / Measures	<ol style="list-style-type: none"> 1. 75% of those contacted from the shelters obtain employment (63% placement rate). 2. 60% of young adults who enter into an internship/mentorship of transitional employment program will obtain paid, at least part-time positions. 3. 40 households in who are homeless or formerly homeless increase their assets through programs like individual development accounts and SOAR. 4. 40% of those in shelters increase their income while their stay.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Increase employment opportunities for people in substance abuse and mental health treatment programs. 2. Implement micro-enterprise programs that support families as they increase their income through small business enterprise. 3. Ensure families who are eligible for mainstream employment and education services are enrolled. 4. Provide an annual retreat/training for homeless program case managers to learn about employment resources and program access and ways to support clients. 5. Increase the number of people participating in the IDA program who are formerly homeless. 6. Include employment and educational Resources for guests at the annual homeless connect. 7. Increase the coordination of short-term, work based housing/boarding opportunities by collaborating with the Workfirst Local Planning Area Board. 8. Create additional baseline tools in HMIS to increase outcome measurements. 9. Support veterans with disabilities in obtaining supportive employment. 10. Support programs that connect youth to GED programs, alternative high school education programs, and programs that help youth gain high school diplomas. 11. Provide documents into two non-English languages and provide interpreters, as necessary to all employment programs that serve people who are homeless. 12. Maintain services that provide people access to phone and answering services to link them with housing and job opportunities. 13. Coordinate SOAR certified advocates to be accessible by residents of all levels of the homeless system to help in their effort to apply for disability and attain stable income.
Intermediate	<ol style="list-style-type: none"> 1. Place youth in mentorship/internship or transitional employment programs that will move them toward readiness for employment. 2. Increase transportation options for those traveling to employment, the VA or social service programs.

⁷³ Supportive Employment, The Evidence, October 2009 <http://store.samhsa.gov/shin/content/SMA08-4365/SMA08-4365-05.pdf>.

⁷⁴ Supportive Employment, The Evidence, October 2009 <http://store.samhsa.gov/shin/content/SMA08-4365/SMA08-4365-05.pdf>.

⁷⁵ Permanent Supportive Housing, The Evidence, July 2010, <http://store.samhsa.gov/product/SMA10-4510>.

⁷⁶ Assets for Independence Act Evaluation, Impact Study: Final Report, Mills, Lam et al. February 22, 2008.

⁷⁷ Economic Mobility Project, *Renewing the American Dream: A roadmap to enhancing economic mobility in America*, Burkhauser, Richard, Kosters, Marbin, Haskins, Ron et. al, page 3, November 2009.

	<ol style="list-style-type: none"> 3. Assess employment programs on a fidelity scale annually to ensure best practice model is being followed. 4. Create an employment toolkit for case managers who work with people who are homeless or formerly homeless. 5. Create new intentional partnerships between entities with varying focuses to support those who are homeless or unstably housed in attaining employment. 6. Assist the county's unbanked and underbanked residents in achieving greater economic prosperity by connecting them to financial mainstream services, products, and financial education. 7. Support the aging population (55-70) in finding and sustaining employment to retirement. 8. Strive to maintain components of stimulus funded programs. 9. Create internship/mentor opportunities including transitional employment sites for youth who have minimum or no work experience.
Long-Term	<ol style="list-style-type: none"> 1. Explore the need to increase the capacity to ensure eligible families can access mainstream employment and education. 2. Create college transition or vocational support plans for homeless youth and young adults.

Short-Term Emergency Response: Strategies 6 & 7

Strategy 6 OUTREACH/ ACCESS/ LINKAGE	Maintain effective outreach programs for persons who are homeless or chronically homeless and are not engaged in the homeless service system. Linkages should be created to easily connect those who are homeless to mainstream resources, and create simple access points for comprehensive housing, physical and mental health services, and chemical dependency treatment
Description: Expand outreach efforts to unsheltered populations and those who are chronically homeless, to encourage entry into housing and services. Provide early assessment and case management at intake with a focus on rapid re-housing and stability.	
Evidence of the Strategy's Effectiveness	A Center for Mental Health Policy and Services Research (U. of Pennsylvania) study shows that homeless persons receiving outreach on the street experience improvements in almost all outcome measures equivalent to clients who were contacted in shelters. The report shows that over a 5-year period mentally ill people living in services-enriched housing reduced their use of publicly funded services by an average of \$12,145 per year. <i>State of Washington 10-Year Homeless Plan</i>
Population to be Served	People who are homeless or chronically homeless, are living in places not meant for human habitation and struggle or resist engaging in services like emergency shelter, housing programs mental health treatment, and/or chemical dependency treatment.
Extent of Need	In 2005, 558 people were unsheltered at the Point In Time Count, 194 of which were chronically homeless. In 2010, 209 people were unsheltered at the PIT count, 50 of which were chronically homeless.
Organizational Responsibility	Local governments, Council for the Homeless, Coalition of Services Providers, Community Action Advisory Board, Clark County
Accomplished	<ol style="list-style-type: none"> 1. Created resources for chronically homeless individuals that provide emergency intervention, showers, mail service, laundry facilities, credit reports and access and information regarding other services through Share Outreach and Janus, The Perch programs. 2. Developed an enhanced system to establish eligibility and enroll homeless individuals in Medicaid, Veterans' benefits, GAU, Social Security, or TANF through HGAP Outreach Team and Share Outreach and Janus, The Perch. 3. Engaged police, Department of Transportation and sheriff to develop protocols to identify and engage homeless people on the street including those previously or currently incarcerated through the CHEC program. 4. Hired 2 FTE outreach staff people to identify and engage homeless or at-risk youth and provide them with information/contact with ongoing services through Janus Youth Yellow Brick Road program. 5. Created an outreach plan for chronically inebriated individuals through the CHEC program. 6. Explored the establishment of a Sobering Center. 7. Dedicated substantial resources to preventing homelessness through HPRP and EFSP ARRA funds. 8. Created youth outreach center through Janus Youth called The Perch.
Best Practices	<ol style="list-style-type: none"> 1. A coordinated entry and assessment process makes it easier for those who are homeless to access appropriate services and creates a more efficient use of the community's resources.⁷⁸ 2. Outreach must have the ability to connect people who are homeless to housing and services.⁷⁹

⁷⁸ National Alliance to End Homelessness, Ending Family Homelessness, Lessons from the Communities, July 2010.

⁷⁹ National Alliance to End Homelessness, Ten Essentials, August 15, 2003.

	<ol style="list-style-type: none"> 3. To End Youth Homelessness the community should have an outreach and engagement system designed to reduce barriers and encourage homeless youth so that they enter appropriate housing linked with appropriate services.⁸⁰ 4. The SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative is effective in helping people who are homeless with disabilities access benefits through the Social Security Administration.⁸¹ 5. The extent to which SOAR initiative outcomes were achieved depended on how much time and resources stakeholders invested in the initiative.⁸²
Outcomes / Measures	<ol style="list-style-type: none"> 1. At least 75 people who are homeless receive increase their income while in shelter. 2. At least 25 people who are homeless receive detox, mental health, and medical services. 3. At least 75 people who are homeless are treated at the free clinic annually. 4. At least 60 people who are homeless are provided treatment instead of jail annually through treatment courts. 5. At least 250 youth annually will receive information about resources. 6. At least 20 individuals who are chronically homeless will be enrolled in the drug and alcohol system's detox and residential programs. 7. At least 3 providers/clinics provide reduced cost health care to youth and young adults. 8. Train at least 20 SOAR certified advocates in the community and implement a SOAR initiative. 9. At least 300 individuals are served annually through project homeless connect.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Build on the existing shelter entry system to include coordinated access to all housing opportunities, including those for youth, families, elderly, veterans, and those who are chronically homeless or at-risk of homelessness. 2. Support and engage services for people who are homeless in County efforts around creating Person Centered Health Care Homes. 3. Create direct connections between substance abuse, mental health, dental health and medical services within person centered health care homes and agencies that serve people who are low-income and/or Medicaid recipients. 4. Work with person centered health care homes to increase the capacity to serve people who are low-income and at-risk of homelessness or homeless. 5. Provide training to staff and providers within person centered health care homes to help them provide culturally competent services to people who are at-risk of homelessness or homeless. 6. Create a direct link between VA programs for veterans who are homeless, the homeless system. 7. Increase availability of staff to provide crisis intervention and case management to individuals and families in times of crisis, including. 8. Develop a direct link between the county detox center and the shelter system. 9. Increase the support for people who are homeless and applying for SSI/SSDI by offering SOAR training to volunteers, peers and homeless system professionals annually. 10. Provide consumer focused resource access fairs or drop-ins such as, project homeless connect and Veterans Stand Down on an annual basis. 11. Engage the fire department in developing protocols to refer people who are homeless to available resources and expand their capacity to respond, beyond the Emergency Room.

⁸⁰ National Alliance to End Homelessness, Ten Essential Strategies to Ending Youth Homelessness, August, 10, 2005.

⁸¹ Dennis, D., Perret, Y., Seaman, A., & Wells, S. M. (2007). Expediting Access to SSA Disability.

Benefits: Promising Practices for People Who Are Homeless. Delmar, NY: Policy Research Associates, Inc.

⁸² Kauff, Jacqueline, Brown, Jonathan, Altshuler, Norma, Denney-Brown, Sama Martin, Emily and Mathematica Policy Research, Inc, Findings from a study of the SSI/SSDI Outreach, Access and Recovery Initiative, Fall 2009, <http://aspe.hhs.gov/hsp/10/SOAR/>.

	<ol style="list-style-type: none"> 12. Create a system to help people at-risk of homelessness or homeless, self triage into the most appropriate resource. 13. Support coordination of community information and referral. 14. Increase linkages with community landlords through landlord outreach education and networking. 15. Support shared housing programs in Clark County and provide outreach and information to system providers.
Intermediate	<ol style="list-style-type: none"> 1. Reduce barriers to youth accessing culturally and developmentally appropriate mental health and drug and alcohol treatment by exploring options where a health care providers will offer medical care to youth at a reduced fee or no-cost. 2. Establish additional opportunities for people who are homeless to meet their basic needs and access services through collaboration and coordination. 3. Create direct connections from outreach programs for permanent supportive housing options. 4. Ensure the main focus of community outreach programs are on housing stability. 5. Increase linkages between systems to enhance holistic planning and case management.
Long-Term	<ol style="list-style-type: none"> 1. Support free mental health services and psychiatric medications for non-insured individuals. 2. Develop a full SOAR initiative to effectively engage and efficiently move those who are homeless and have disabilities onto SSI/SSDI. 3. Develop a peer navigator program to support those who are at-risk of homelessness or homeless. 4. Develop access centers for those who are homeless and for specific populations. 5. Move toward a person centered model linking mental health, substance abuse, physical health and social services together in one holistic space. 6. Explore utilizing low-cost and/or no cost advocates (AmeriCorps/VISTA, Work Study, Intern) to further the SOAR initiative and other community based efforts.

Strategy 7 ACCESS TO SHELTER	Ensure availability and access to staffed emergency shelter and services in the existing shelter system.
Description: Clark County’s homeless and housing plans call for a “housing first” model. The system is in the process of evolution and there is currently not an adequate supply of permanent or supported housing for homeless individuals or families. The emergency shelters in Vancouver serve as a short-term urgent option for those who are on the streets, or are waiting to obtain transitional or permanent housing. Shelter staff provides a supportive environment, assess needs and eligibility for mainstream resources, and refer the households to appropriate resources and programs. The number of people turned away from emergency shelter in Clark County (about 65% of those who request shelter) exhibits the need for continued emergency response.	
Evidence of the Strategy’s Effectiveness	Clark County has a one-stop resource for directing people who are in urgent need of housing to available shelter. The clearinghouse model, a National Alliance to End Homelessness best practice, does a daily assessment of demand and provides vital information for planning efforts. The model screens callers and diverts appropriate household to more appropriate housing or prevention options.
Population to be Served	People who are homeless.
Extent of Need	Based on Emergency Shelter Homelessness Prevention (ESHP) turnaway numbers for emergency shelter and emergency assistance, Clark County turns away 65% of those who request shelter.
Organizational Responsibility	Local Government, Council for the Homeless and The Coalition of Homeless Service Providers.
Accomplishments	<ol style="list-style-type: none"> 1. Studied the need for an intermediate shelter (3-6 months) for youth and young adults 16-24 years of age with attached staff and case management including credit and financial education. The process determined transitional housing is needed for youth. 2. Committed 2 years of funding to current programs to assist people to move out of homelessness.
Best Practices	<ol style="list-style-type: none"> 1. Coordinated access to resources.⁸³ 2. Single point of contact system, with linkages to community shelter resources, for households experiencing a housing crisis.⁸⁴
Outcomes / Measures	<ol style="list-style-type: none"> 1. ESHP turnaway numbers are reduced to below 50%. 2. All shelters are ADA compliant. 3. Those who are homeless have options to house themselves and their domestic pets. 4. Length of stay in shelters is less than 14 days or 10% less than the previous year.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Continue to fund and increase coordinated access to current shelter and outreach programs. 2. Strengthen linkages between the shelter access point, outreach programs and housing programs. 3. Ensure all shelters have consistent access to funding for interpreter services to better meet the language needs of immigrants and refugees, and other clients, with limited or no English language skills.
Intermediate	<ol style="list-style-type: none"> 1. Reduce barriers to shelter that make it challenging for consumers to access or sustain housing. 2. Create shelter options for those with domestic pets.

⁸³ National Symposium on Homelessness Research, People Who Experience Long-Term Homelessness: Characteristics and Interventions, Caton, Carol L. M.; Wilkins, Carol; Anderson, Jacquelyn, March 1, 2007

⁸⁴ Columbus and Franklin County, Ohio, Rebuilding Lives Plan Best Practice Research Summary, March 3, 2008

	<ol style="list-style-type: none"> 3. Identify deficiencies in shelters related to ADA compliance. 4. Incorporate Domestic Violence prevention information, classes and resources into all shelters and veteran programs.
Long-Term	<ol style="list-style-type: none"> 1. Create a system to divert households from shelters to most appropriate housing options. 2. Create ADA accessible shelters by determining deficits and identifying funding opportunities to ensure shelter is accessible to all. 3. Increase urgent access to emergency shelter and decrease need, by increasing permanent supported housing and homelessness prevention options.

Systemwide Improvements: Strategies 8 & 9

Strategy 8 PLANNING/ COORDINATION	Plan and coordinate countywide and systemwide to efficiently manage limited resources for ending homelessness.
Description: A planning group, which includes local government, provides coordination of planning efforts to end homelessness.	
Evidence of the Strategy's Effectiveness	Clark County's Coalition of Service Providers has been recognized as an effective collaborative planning group that identifies priorities and recommends resource allocations.
Population to be Served	People who are homeless.
Extent of Need	At the inception of the 10-Year Homeless Plan in 2005 the population of people without homes was 1578 people, and in 2010 that population has been reduced to 1093. As compared to total population this translates to a reduction from 39 per 10,000 to 25. The expectation is to eliminate the population of people without homes, and by 2015 reduce the population by 50%.
Organizational Responsibility	Local governments, Council for the Homeless, Coalition of Services Providers for the Homeless, Community Action Advisory Board, Clark County.
Accomplished	<ol style="list-style-type: none"> 1. Updated the Clark County Plan by incorporating additional objectives, strategies, activities, and outcomes to insure consistency with State Plan. 2. Clark County 10-Year Plan group meets bi-monthly and monthly as needed to update strategies and review outcomes to reduce homelessness. 3. Community stakeholders meet annually to review progress on implementing the plan's strategies and develop new initiatives as needed. 4. Clark County 10-Year Plan meets state guidelines. 5. Clark County 10-Year Plan accurately reflects local needs and priorities. 6. Reported on progress toward meeting goals, and updates to 10-Year plan every 2-3 years.
Best Practices	<ol style="list-style-type: none"> 1. Successful Planning and coordination leads to high Performing Communities.⁸⁵ 2. Interdisciplinary, interagency and intergovernmental action is required to effectively create comprehensive responses to the complex problem of homelessness.⁸⁶ 3. Coordination with Mainstream agencies is an effective strategy for ending homelessness.⁸⁷
Outcomes / Measures	<ol style="list-style-type: none"> 1. A 10 year plan report card or an update will be published annually. 2. The plan will clearly identify action areas that are measured and analyzed. 3. A Collaborative Applicant, as defined by the HEARTH ACT, will be identified. 4. Clark County will become a high performing community on at least one outcome according to the HEARTH Act. 5. At least five in-depth assessments focusing on the housing and supportive service needs of specific populations will be conducted. 6. 90% of community funds contracts will meet or exceed stated outcomes. 7. Less than 5% of individuals/families who were homeless within the past two years become homeless again. 8. Average length of homeless episode is less than 20 days.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Develop baselines for new outcome measures incorporated in 2011 plan

⁸⁵ National Alliance to End Homelessness, Summary of HEARTH Act, July 14, 2008.

⁸⁶ Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, U.S. Interagency Council on Homelessness, Poppe et al., 2010.

⁸⁷ National Alliance to End Homelessness, Summary of HEARTH Act, July 14, 2008.

	<p>update.</p> <ol style="list-style-type: none"> 2. Measure and report on existing outcome expectations and disseminate the information to the community. 3. Align all outcomes with those presented in the HEARTH Act. 4. Engage the Coalition of Service providers in the creation and revisions of the Consolidated Housing and Community Development Plan. 5. Consciously work to meet the needs of diverse populations through culturally specific outreach, translated materials, interpretation options, encouraging diverse staff, staff trainings and more. 6. Study the impact of community ordinances that negatively affect those who are homeless and restrict where social service non-profits can locate. 7. Develop a plan to change or strike ordinances that create unnecessary barriers for social service organization and/or people who are homeless. 8. Develop or identify a workgroup to enhance cultural competency across the system to ensure access to quality services for all current and emerging populations. 9. Incorporate criteria in contracts that consider actual performance in serving diverse communities within applications for funding. 10. Ensure all homeless system service providers are trained to identify and work with those dealing with PTSD and traumatic brain injury. This is of particular importance for those working with Veterans in any capacity. 11. Survey the needs of people who are homeless and utilize this information in planning and funding allocations. 12. Assess the housing and supportive services needs of at least five different specific populations who may be underserved by the homeless system including people with developmental disabilities, survivors of domestic violence and youth aging out of foster care.
Intermediate	<ol style="list-style-type: none"> 1. Coordinate with the Federal Opening Doors Homeless Plan including the use of national measurement outcomes. 2. Coordinate with WA State 10-Year Homeless Plan updates as they become available. 3. Coordinate among Local, State, and Federal governments to identify and respond to emerging needs and trends. 4. Assess the cost effectiveness of rental subsidies versus the building of new rental units. 5. Incorporate outcomes focusing on specific populations within each community funds contract. 6. Utilize the recommendations of the Aging Task Force to effectively meet the needs of the aging population.
Long-Term	<ol style="list-style-type: none"> 1. Plan for outcome expectations beyond 2015 based on outcomes and trends as identified.

Strategy 9 DATA ANALYSIS	Build on successful implementation and expansion of Homeless Management Information Services (HMIS) in Clark County.
Description:	Clark County's HMIS system's comprehensive unduplicated data is essential for planning and coordination of services, as well as for allocation of resources. HMIS provides local data to all levels of government to assess progress towards goals and priorities.
Evidence of the Strategy's Effectiveness	Data is needed in order to determine program effectiveness and determine modifications in plans and activities to more effectively work toward ending homelessness.
Population to be Served	People who are accessing homeless services and homeless service providers.
Extent of Need	In order to receive homeless service funds organizations must enter accurate and complete data into HMIS. In 2005, at the inception of the 10 Year Plan to End Homelessness, 1,392 people, according to the annual point in time count were homeless in Clark County and six agencies were entering data into the system. In 2010, there were 1,093 individuals who were homeless, according to the annual point in time count and 13 agencies entering data into the system. Data Analysis should be the central source for determining achievement of program outcomes. 100% coverage is necessary to provide accurate and complete data to ensure system design is data driven.
Organizational Responsibility	Council for the Homeless, Coalition of Service Providers for the Homeless and Clark County
Accomplished	<ol style="list-style-type: none"> 1. Implement an effective annual point-in-time count of people who are homeless by engaging organizations in every community within Clark County serving people who are homeless to participate in the point in time count. 2. Funding for data collection and analysis has been adequately developed. 3. A committee to develop policy and procedures for collection and analysis of HMIS data has been developed. 4. Purchased and incorporated the ART report writing system into the HMIS system.
Best Practices	<ol style="list-style-type: none"> 1. Timely, accurate and complete data is central and critical to the success of HMIS.⁸⁸ 2. Take an "Everyone affects the quality of HMIS data" approach.⁸⁹ 3. Establish benchmarks for data timeliness, accuracy and completeness.⁹⁰ 4. HMIS data should be viewed as a valuable tool for the community and for ending homelessness.⁹¹ 5. Conduct long-term data analysis on the re-user rate within the homeless system.
Outcomes / Measures	<ol style="list-style-type: none"> 1. At least 95% of available beds on the Homeless Inventory Chart will provide data. 2. All partner agencies will show positive annual progress on the established data assessment tool.
Action Steps	
Short-Term	<ol style="list-style-type: none"> 1. Develop regularly scheduled trainings for new and experienced HMIS users. 2. Develop service specific HMIS entry instructions. 3. Common Intake form will be implemented for partner agencies. 4. Translate the intake/assessment form into three different languages. 5. Establish a data quality assessment tool for all HMIS partner agencies.

⁸⁸ Taylor, Patrick, *From Intake to Analysis: A Toolkit for Developing a Continuum of Care Data Quality Plan*, October, 2009.

⁸⁹ *ibid*

⁹⁰ *ibid*

⁹¹ *ibid*

	6. Exceed National AHAR scoring standards and increase score annually.
Intermediate	<ol style="list-style-type: none"> 1. Develop a regional data system with the Portland Metro area. 2. Conduct long-term data analysis on the number of children who are homeless system. 3. Translate intake/assessment form into additional languages, as appropriate. 4. Expand on the current data analysis regarding the re-user rate within the homeless system.
Long-Term	<ol style="list-style-type: none"> 1. Analyze data available through HMIS to determine where additional inquiry/exploration is needed to fully understand homelessness in Clark County. 2. Create an HMIS dashboard for presentation and analysis of key data on the web. 3. Analyze HMIS data from a regional perspective and create regional outcomes.

Original Planning Body Members-2005

Name	Agency	Representing
Sherri Bennett	YWCA SafeChoice	Domestic Violence Provider
Diane Christie	Share	Homeless Services Provider
Pam Clark	Clark County Corrections	Corrections
Kim Conner	Council for the Homeless	Coordinating Entity
Julie DeSmith	YW Housing	Housing Provider
Alice Doyle	Vancouver Housing Authority	Housing Provider
Sondra Dudley	Community Action Advisory Board (CAAB)	Community Services
Karen Evans	Clark County, Dept. of Community Services	County
Renee Holmes	Open House Ministries	Homeless Person
Erin Kelleher	Affordable Community Environments	Housing Provider
Patrick Kelly	Council for the Homeless Volunteer	Volunteer
Trina King	Columbia River Mental Health Services (CRMHS)	Mental Health/Housing Provider
Bridget McLeman	Children's Home Society of Washington	Family Services
Charlie Mitchell	Northwest Justice Project/CAAB	Legal Services
Dennis Morrow	Janus Youth	Youth Provider
Pete Munroe	Clark County, Dept. of Community Services	County
Erin Nolan	Clark County Sheriff's Office	Law Enforcement
Melodie Pazolt	Columbia River Mental Health Services (CRMHS)	Employment Services
Cheryl Pfaff	Community Choices, 2010	Community Health
Karen Read	Council for the Homeless	Coordinating Entity
Gregory Robinson	Columbia River Mental Health Services	Mental Health/Housing Provider
Steve Rusk	Salvation Army	Homeless Services Provider
Vicki Salsbury	Columbia River Mental Health Services (CRMHS)	Mental Health Services/Options Youth
Peggy Sheehan	City of Vancouver	Largest City
Mary J. White	Vancouver Police Department	Law Enforcement
John Wiesman	Clark County Health Department	Public Health
David Wilde	Open House Ministries	Homeless Services Provider
Nancy Wilson	Inter-Faith Treasure House	Homeless Services Provider

Planning Process Participants-2005

Name	Agency	Representing
Sherri Bennett	YWCA SafeChoice	Domestic Violence Provider
Diane Christie	Share	Homeless Services Provider
Pam Clark	Clark County Corrections	Corrections
Kim Conner	Council for the Homeless	Coordinating Entity
Julie DeSmith	YW Housing	Housing Provider
Alice Doyle	Vancouver Housing Authority	Housing Provider
Sondra Dudley	Community Action Advisory Board (CAAB)	Community Services
Karen Evans	Clark County, Dept. of Community Services	County
Renee Holmes	Open House Ministries	Consumers
Erin Kelleher	Affordable Community Environments	Housing Provider
Patrick Kelly	Council for the Homeless Volunteer	Volunteer
Trina King	Columbia River Mental Health Services (CRMHS)	Mental Health/Housing Provider
Bridget McLeman	Children's Home Society of Washington	Family Services

Charlie Mitchell	Northwest Justice Project/CAAB	Legal Services
Dennis Morrow	Janus Youth	Youth Provider
Pete Munroe	Clark County, Dept. of Community Services	County
Erin Nolan	Clark County Sheriff's Office	Law Enforcement
Melodie Pazolt	Columbia River Mental Health Services (CRMHS)	Employment Services
Cheryl Pfaff	Community Choices, 2010	Community Health
Karen Read	Council for the Homeless	Coordinating Entity
Gregory Robinson	Columbia River Mental Health Services	Mental Health/Housing Provider
Steve Rusk	Salvation Army	Homeless Services Provider
Vicki Salsbury	Columbia River Mental Health Services (CRMHS)	Mental Health Services/Options Youth
Peggy Sheehan	City of Vancouver	Largest City
Mary J. White	Vancouver Police Department	Law Enforcement
John Wiesman	Clark County Health Department	Public Health
David Wilde	Open House Ministries	Homeless Services Provider
Nancy Wilson	Inter-Faith Treasure House	Homeless Services Provider

Additional Planning Process Participants-2007

Name	Organization
Alina Aaron	Human Service Council
Barb Baldus	Board Council for the Homeless
Jeri Balsley	Share
Sarah Bowens	YW Housing
Larry Brennan	Veterans Affairs
Pam Brokaw	Affordable Community Environments
Kate Budd	Council for the Homeless
Victoria Clevenger	YW Housing
John Collins	Community Member
Debby Dover	YW Housing
Jennifer Gallagher	Community Member
Martin Greenlee	City of Vancouver
Christine Hermann	Columbia Nonprofit Housing
David Herrington	City of Vancouver
Jim Just	VA Housing
Sandy Kendrick	Clark County Public Health
Beth Kennard	The Salvation Army
Tom Lasher	Clark County
Anne Glavas Lydiard	Vancouver School District
Carol Mackey	Community Member
Bobi Magill	Share
Lindsey Morris	Share

Name	Organization
Crystal Nebeker	Community Member, RAP
Gelinda Nell	Clark County
Megan Newell	YW Housing
Valerie Norris	YW Housing
Teresa Olson	Community Services Northwest
Laura Plymale	Janus Youth
Amy Reynolds	Share
Jim Robison	Consumer Voices are Born
Dee Sanders	Share
Keith Scheff	Veterans Affairs
Bonnie Scott	Clark County
Connie Sherrad	Vancouver Housing Authority
Duane Sich	Friends of the Carpenter
Tina Smith	Vancouver Comm. Library
Karen Steffen	Council for the Homeless
Denise Stone	Community Services Northwest
Maureen Taylor	Clark County Public Health
Tom Tucker	Greater Vancouver Interfaith Association
Audrey Warfel	Community Member
Lisa Watts	YWCA SafeChoice
Mary White	Vancouver Police Department
Lorie Wood	Community Member

APPENDIX A: HOMELESS POPULATION AND SUBPOPULATIONS

The Homeless Populations and Subpopulations chart presented below was prepared for and included in the Clark County, Washington 2005 Continuum of Care Application, and reflects information gathered during the January 27, 2011 sheltered and unsheltered street count.

Exhibit I: 2011 Continuum of Care Chart HUD 40076 COC – I Homeless Populations and Subpopulations Chart

Part 1: Homeless Population	Sheltered		Unsheltered	Temporarily Living with Family/Friends
	Emergency	Transitional		
Number of Families with Children (Family Households):	37	103	18	173
Number of Households without Children	139	208	93	35
Number of Households without Adults (no one over 17 years old)	11	9	4	65
a. Number of Persons in Families with Children:	72	427	105	504
b. Number of Single Individuals and Persons in Households without Children:	126	126	133	66
c. Number of persons in Households without Adults (no one over 17 years old)	7	8	2	58
Total Persons: (Add Lines Numbered a & b)	239	411	187	834
Part 2: Homeless Subpopulations				
	Sheltered		Unsheltered	Temporarily Living with Family/Friends
	Emergency	Transitional		
a. Chronically Homeless Individual	25	NA	44	15
b. Chronically Homeless Family	2	NA	3	2
c. Mentally Disabled	36	31	45	20
d. Persons with alcohol and/or other drug problems	22	46	33	16
e. Veterans	35	28	32	12
f. Persons with HIV/AIDS	0	7	0	0
g. Victims of Domestic Violence	48	90	20	2
h. Unaccompanied Youth (Under 18)	7	10	2	51
i. Physically Disabled	59	70	33	24
j. Seasonal Agricultural Workers	0	0	0	0
k. Persons with both substance use and mental health problems	9	10	16	5
l. Senior citizens (aged 65 or older)	1	2	3	2