VIRGINIA'S HOMELESS CRISIS RESPONSE SYSTEM

The State of Virginia's Continuums of Care • 2013

Virginia Coalition to End Homelessness
VCEH

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The State of Virginia's Continuum of Care • 2013

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Acknowledgements

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Purpose of Report

This report presents a snapshot of the homelessness response system in Virginia. It provides an overview of the local community planning entities — the Continuums of Care (CoC), presents aggregated goals and performance data, and highlights common challenges, strengths, and opportunities in order to inform systems level change efforts. This report is a resource for Continuums of Care, local community leaders, nonprofit and faith based service providers, policy makers, local and state governments, funders, and other interested partners working to end homelessness.

VCEH and our state and local partners have set the goal of reducing rates of homelessness and preventing homelessness before it occurs in the Commonwealth of Virginia. One individual or one organization cannot achieve this goal alone. Ending homelessness will require a strong local and state response that engages an entire SYSTEM of agencies, organizations, and individuals.

VCEH intends to use this report to guide our collective efforts to support and improve the local and statewide system that responds to the issue of homelessness. As the Continuums of Care are the local entities tasked with facilitating collaboration and serving as the central point for planning homeless services in the community[1], we seek to support CoC efforts to improve the system that responds to the issue of homelessness.

This report includes the following areas of information and analysis:

- **Need:** How many people are experiencing homelessness in Virginia? What are the challenges and gaps in the system?
- **Structure:** What are the CoCs? Where are they located? Who is involved?
- **Resources:** What are the sources and uses of homeless assistance funding? What shelter and housing resources are available? How are they targeted?
- **Performance:** How are CoCs and individual homeless assistance programs collectively performing to meet housing stability goals? What are the challenges CoCs identify to meeting key objectives?
- **Operations:** How are CoCs operating?

1 Some communities have other entities that also share responsibility for planning the community's response to homelessness, such as Ten Year Plan Governing Boards or Executive Committees. However, it is the CoC that is responsible to HUD and other funders for achieving community outcomes.

Key Findings

FINDINGS	RECOMMENDATIONS
Virginia CoCs are transitioning from temporary shelter-focused strategies to housing-focused solutions to homelessness. Homeless assistance programs that receive federal funding through the CoC are performing well in achieving housing stability for clients.	• Provide ongoing professional development opportunities to foster continuous improvement of housing-focused homeless assistance programs. • Expand the number of homeless assistance programs in the community that are reporting housing stability outcomes to better understand the impact of the entire system on efforts to combat homelessness.
Communities will soon have consistent and reliable data on key success indicators, enabling a better understanding of the impact of homeless programs and efforts. The key indicators are: • **Lengths of stay in homelessness** • **Returns to homelessness** • **New incidences of homelessness** **CoCs report on the inventory of emergency shelter, transitional housing, safe havens, permanent supportive housing, and rapid re-housing. Communities have only recently begun reporting data on the number of rapid-rehousing opportunities. The availability of data over multiple years on rapid re-housing programs and services will provide us with information on whether and how rapid re-housing opportunities are expanding.**	• Use data to drive program and policy decision making. • Adopt uniform statewide performance measurements to promote clear and more consistent statewide data.
Emergency shelters had a 76 percent overall utilization rate. Yet CoCs report that 1,022 individuals are living unsheltered — on the streets, under bridges, and in the woods.	• Increase street outreach efforts to better connect people in unsheltered situations with available emergency shelter beds and housing resources. • Review and revise emergency shelter program policies that may create unnecessary barriers to accessing emergency shelter.
The current pace of new permanent supportive housing development will not meet community goals.	• Continue to provide incentives within public and private funding for the creation of permanent supportive housing. • Explore opportunities to target federally-funded but locally-administered resources to permanent supportive housing. • Explore opportunities to partner with faith-based communities to leverage resources for permanent supportive housing.

Key Findings (continued)

FINDINGS	RECOMMENDATIONS
CoCs have primarily exceeded national minimum performance targets. However, some established higher targets than required and fell short in meeting these targets. Among the reasons cited for not meeting objectives was the delayed receipt of government funding for programs.	• Explore mechanisms to address cash flow shortages resulting from delayed payments from government funding sources. This could include low-interest lines of credit, establishment of fiscal agents with larger financial capacity, and opportunities for private funders to capitalize cash flow and operating reserves.
Communities report that accessing public and private funding and shifting funding from emergency shelter and transitional housing to housing first strategies are top factors that impact and challenge the local response to homelessness.	• Establish processes and mechanisms to coordinate and leverage funding, including establishing collective goals, in coordination with the CoC and public and private funders. • Focus funding on housing stability outcomes to provide service providers with maximum flexibility to achieve desired outcomes.
Federal resources make up the largest percentage of funding for homelessness assistance. Private funding is the second largest percentage.	
HUD has prioritized the reallocation of funds from services to housing, and communities are beginning to shift program dollars to housing.	
CoCs are mostly (64%) comprised of private sector organizations and members.	• Explore methods for state and local government to incentivize participation of missing partners in state and local homeless assistance efforts. These efforts may include establishing partnerships with national and statewide trade associations.
The largest gaps in private sector representation are the business community and health care providers, including hospitals.	
Local workforce investment boards are the least represented of the public sector entities in Virginia CoCs. Public housing authorities are the next lowest represented from the public sector.	
Half of the CoCs have dedicated staff to manage CoC functions. CoCs without dedicated staff allocate a portion of existing staff time or use volunteers who have other regular, full-time positions.	• Increase funds for community planning and coordination.
Communities are required by HUD to have policies in place that prevent the discharge into homelessness of people exiting institutions, including foster care, health care, mental health, and the corrections system.	• State and local governments should develop policies and put protocols in place to ensure that people being discharged from institutions are not discharged into homelessness.

FINDINGS	RECOMMENDATIONS
16 Virginia CoCs operate required data collection systems — the Homeless Management Information System (HMIS). CoCs reported collectively spending more than $1.7 million for HMIS.	• Match data from HMIS with data from other systems of care to identify the overlap of clients and reduce unnecessary duplication of services. This will enhance efforts to prevent homelessness before it occurs. • Explore methods of using HMIS funds more efficiently through collaborations and merging data systems to reduce administrative costs. • Collect statewide client level data to connect clients to appropriate resources, understand client service histories, and create unduplicated counts of the number of people experiencing homelessness across Virginia.

Background and Methodology

The United States Department of Housing and Urban Development (HUD) provides a significant percentage of the funding for homeless assistance efforts in Virginia. Therefore, it is critical that communities adhere to HUD funding requirements in order to be and remain competitive for HUD funding. HUD requirements have recently been altered by the federal 2009 HEARTH (Homeless Emergency Assistance and Rapid Transition to Housing) Act. HUD has not yet fully implemented the legislation, and communities are in the process of aligning with these requirements. This report includes an analysis of the status of community adherence to HEARTH.

The HEARTH Act seeks to radically transform the traditional system of delivering homeless services. HEARTH moves the focus of homeless services from temporary housing and emergency food and shelter to a crisis response system centered on permanent housing as the solution to homelessness — a model commonly referred to as "Housing First." Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible — and then providing services as needed. The HEARTH Act mandates that communities make changes to their service delivery systems in order to continue receiving federal homeless assistance funding. The local organizing bodies responsible for implementing these changes are called the Continuums of Care (CoC); currently there are 16 CoCs in Virginia. At the time of analysis, there were 19 CoCs in Virginia[2]. Each year communities submit an application to HUD for federal homelessness assistance. They report on CoC structure, operations, data collection, strategic planning, and performance towards HUD and local objectives. 2012 was the first year communities submitted their applications under the HEARTH Act Interim Rule. The information in this report, therefore, provides a baseline measuring progress towards meeting these HUD and best practice objectives.

The HEARTH Act seeks to radically transform the traditional system of delivering homeless services. [...] Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible — and then providing services as needed.

VCEH collected the 2012 competition applications submitted to HUD in January 2013. Relevant information was also gathered from the Point-In-Time Count, the Housing Inventory Chart, survey responses from CoC leaders, community funding information and other relevant sources to supplement the findings from the CoC compe-

2 Several CoCs merged, thereby reducing the total number of Virginia CoCs.

tition applications. In some cases, information pertaining to individual CoC responses has been de-identified.[3]

Information included in the common challenges and performance section of this report was collected and aggregated from FY12 CoC applications. This was the first time CoCs were required to report information on clients' lengths of time in homelessness. Guidance on how to calculate this data point was unclear. Therefore, communities used varied criteria to calculate length of stay. HUD has continued to issue guidance on how to calculate and utilize this performance measurement as part of ongoing implementation of the HEARTH Act which will help create uniformity and consistency of future data.

The analysis was informed through a participatory process. VCEH conducted outreach to CoC leadership to review and discuss the information presented in this report. Representatives from CoCs provided feedback either through webinar sessions held by VCEH or through written surveys administered by VCEH. This feedback was incorporated into the analysis and report.

Need

What is the extent of homelessness in Virginia?

The United States Department of Housing and Urban Development (HUD) requires Continuums of Care to conduct annual "point in time counts" in each January of people experiencing homelessness.[4] [5] The following information was collected and aggregated from community 2013 Point in Time counts.[6]

7,625 individuals experienced homelessness at one point in time.

Key Facts

7,625 individuals experienced homelessness at one point in time. This number represents 5,464 households, including 984 households with at least one child and 4,475 adult-only households.[7] During the course of the year, it is estimated that 3 to 4 times this number experience homelessness.

There are 1.5 times as many people in adult-only households that experience homelessness at one point in time versus people in family households with one or more dependent children.

13.4% (1,022) of people experiencing homelessness are living on the streets. Single adult households are much more likely to be unsheltered than families (21% compared to 3%.)

People experiencing chronic homelessness represent 17.7% (1,356) of the total homeless population. A person meets the definition of chronic homelessness when that individual has a disabling condition and has been

***Fig. 1.* Total Persons With At Least One Adult and One Child (Families)**

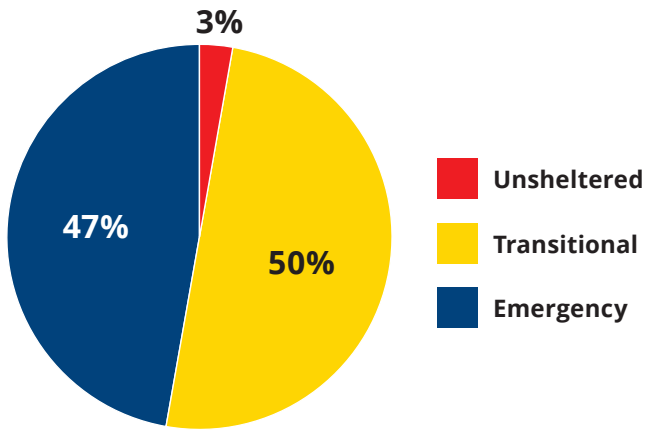
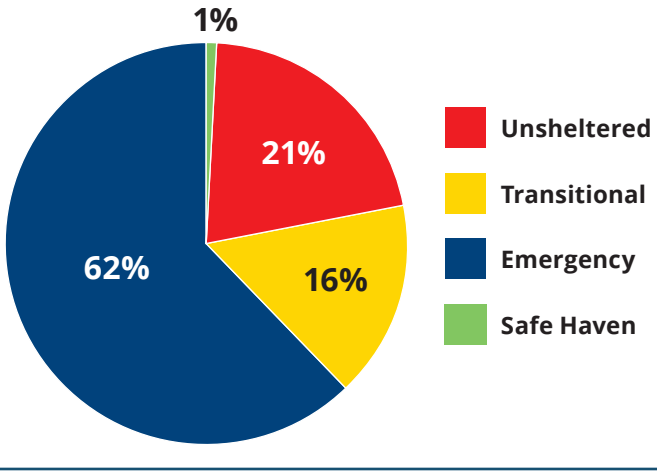


***Fig. 2.* Total Persons Without Children**



3 Information has been de-identified through an alphabetical coding system that is used in several of the report's graphs and charts.

4 HUD requires annual counts of people residing in sheltered situations but most communities, although not required, also conduct annual unsheltered counts.

5 See Appendix D for the definition of homelessness mandated by HUD and for use in defining homelessness during the point in time count.

6 As these numbers are a compilation of statewide data, community data may differ. For a breakdown by CoC, see Appendix A.

7 Five households with only children were also counted.

continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.[8]

Veterans make up 9.4% (719 persons) of the total homeless population.

Fig. 3. Chronically Homeless Individuals

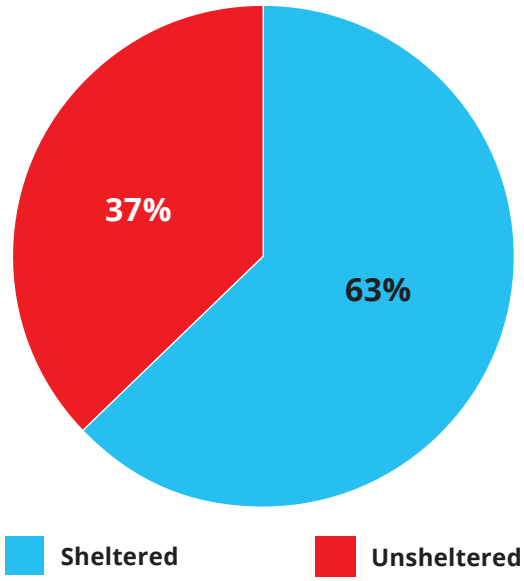
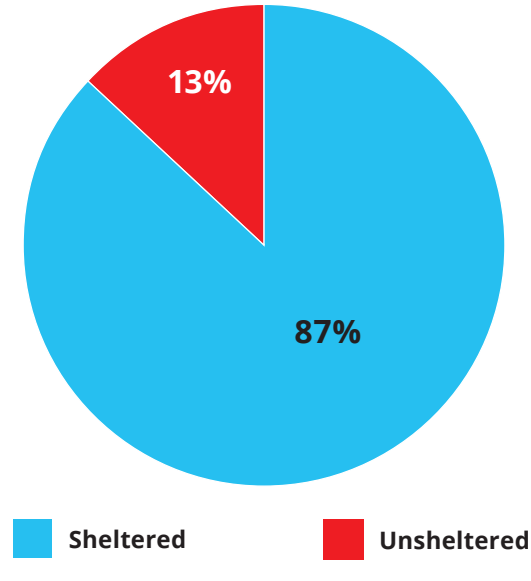


Fig. 4. Veterans Experiencing Homelessness



What are common challenges to combating homelessness at the local level?

VCEH conducted a survey[9] of CoC leaders to assess their perceptions of the impact and challenges related to homelessness in their communities. Survey findings detail that the following were the highest ranked factors affecting and creating barriers to the local response to homelessness:

- Accessing federal and state funding received the highest billing for the most impactful to the local response to homelessness. This was followed by issues around community coordination as an additional top factor.
- Shifting funds from emergency shelter and transitional housing to housing first strategies and accessing private funds were rated as the most challenging to the local response to homelessness. This was followed by accessing Continuum of Care funds and accessing local funds as additional top factors that presented challenges.

Overall, obtaining, managing, and increasing resources to support local homeless response systems is the top priority of Virginia communities.

Overall, obtaining, managing, and increasing resources to support local homeless response systems is the top priority of Virginia communities. While providing the resources to support local systems, public and private funding often requires or provides incentives for community coordination and the transition to more effective models of service delivery. Given the decline in public and private philanthropic support in recent years, funding is likely to remain a challenge for local communities and a major obstacle to achieving local, state, and federal policy goals to end homelessness.

With regard to gaps in housing and services, CoCs most often cited the following as unmet needs: permanent supportive housing; affordable rental housing / section 8 vouchers / low-income housing; and adequate funding for case management.

8 HUD definition of chronic homelessness

9 For a more detailed breakdown of these responses, see Figures A8, A9, and A10 in Appendix.

Nine CoCs indicated a need for better coordination with mainstream resources providers and programs in order to stabilize clients in housing. Most frequently mentioned were Social Security Income/Social Security Disability Income (SSI/SSDI), substance abuse services, mental health care, mainstream housing subsidies, and subsidized child care.

STRUCTURE

What is a Continuum of Care (CoC)?

The Continuum of Care (CoC) is a local collaborative of agencies that serve as that area's applicant for federal homeless assistance funding through the U.S. Department of Housing and Urban Development (HUD.) HUD requires agencies to create and participate in the CoC to apply for McKinney-Vento Homeless Assistance Grants. In addition, the Virginia Department of Housing and Community Development (DHCD) through which state and some federal funds are administered has begun to require that CoCs submit collaborative applications for state homeless prevention and assistance funding. CoCs have taken on multiple roles in the community including coordination of resources, advocacy, and development of plans to end homelessness. The CoC is generally viewed as the central place for coordinating and planning the local homeless service delivery response.

Where are the CoCs located in Virginia?

There are currently 16 active CoCs operating across Virginia, covering all jurisdictions (see Figure 5). For the purposes of this report, the table below includes 3 CoCs (509, 510, and 517) that merged with the Balance of State (521) in 2013.

What is the Balance of State?

The Balance of State CoC (VA-521) represents all jurisdictions in Virginia which are not part of a separate CoC and often do not share geographic boundaries (see Figure 6, page 9).

Who is involved in the CoCs?

1,013 organizations were reported as participating in CoCs across Virginia.[10] CoCs are mostly (64%) comprised of private sector organizations and members; nonprofits and faith based groups represent the majority of the private sector representatives.

The largest gaps in private sector representation are the business community, funders and advocates, and the health care system. Nearly 40% of CoCs did not report representation from these categories of private sector organizations.

***Fig. 5.* CoCs Operating in Virginia**

CoC #	JURISDICTIONS
500	Charles City, Chesterfield, Hanover, Henrico, Goochland, Richmond City, New Kent, and Powhatan
501	Chesapeake, Franklin City, Isle of White, Norfolk, Southampton, and Suffolk
502	Alleghany, Botetourt, Covington, Craig, Roanoke, Roanoke City, and Salem
503	Virginia Beach
504	Albemarle, Charlottesville, Fluvanna, Greene, Louisa, Nelson
505	Hampton, James City, Newport News, Poquoson, Williamsburg, and York
507	Portsmouth
508	Amherst, Appomattox, Bedford, Bedford City, Campbell, and Lynchburg
509	*Colonial Heights, Dinwiddie, Emporia, Greensville, Hopewell, Petersburg, Prince George, Surry, and Sussex*
510	*Augusta, Buena Vista, Highland, Lexington, Rockbridge, Staunton, and Waynesboro*
513	Clarke, Frederick, Harrisonburg, Page, Rockingham, Shenandoah, and Warren, Winchester
514	Caroline, Fredericksburg, King George, Spotsylvania, and Stafford
517	*Danville, Franklin, Henry, Martinsville, Patrick, and Pittsylvania*
521	Balance of State: See below chart for jurisdictions of Local Planning Groups
600	Arlington
601	Fairfax, Fairfax City, and Falls Church
602	Loudoun
603	Alexandria
604	Manassas, Manassas Park, and Prince William

10 Organizations may be counted multiple times if they participate in multiple CoCs.

Local workforce investment boards are the least represented of the public sector groups in Virginia CoCs. Public housing authorities are the next lowest.

Local government has the highest percentage of representation within the public sector. Local workforce investment boards are the least represented of the public sector groups in Virginia CoCs. Public housing authorities are the next lowest. More than 30% and 20% of CoCs, respectively, did not report any representation from these categories of public sector organizations.

Fig. 6. Balance of State Local Planning Groups

GROUP	JURISDICTIONS
LENOWISCO	Planning District (PD) 1: Dickenson, Lee, Scott, Wise and City of Norton
Cumberland Plateau	PD 2: Buchanan, Russell, Tazewell, Washington, City of Bristol
HOPE Interagency Council on Homelessness	PD 3: Bland, Carroll, Grayson, Smyth, Wythe, City of Galax
Housing Partnership for the New River Valley	PD 4: Floyd, Giles, Montgomery, Pulaski, City of Radford
Foothills Housing Network	PD 9: Culpepper, Fauquier, Madison, Orange, and Rappahannock
Southside	PD 13: Brunswick, Halifax, and Mecklenburg
Heartland	PD 14: Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward
Northern Neck/ Middle Peninsula Housing Partnership	PD 17: Essex, Gloucester, King and Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond, and Westmoreland
Community Partners of the Eastern Shore	PD 22: Accomack and Northampton

Consumer Representation

All CoCs in Virginia have homeless or formerly homeless representatives involved in decision-making. They include agency employees, community advocates, and advisors. They serve an important role in providing consumer input in the local planning process. Some communities also have consumer advisory councils which include a group of consumers that provide feedback to the CoC.

Fig. 7. CoC Membership by Sector

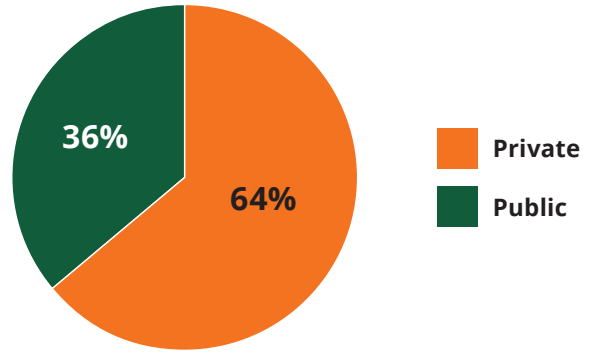


Fig. 8. CoC Private Sector by Group

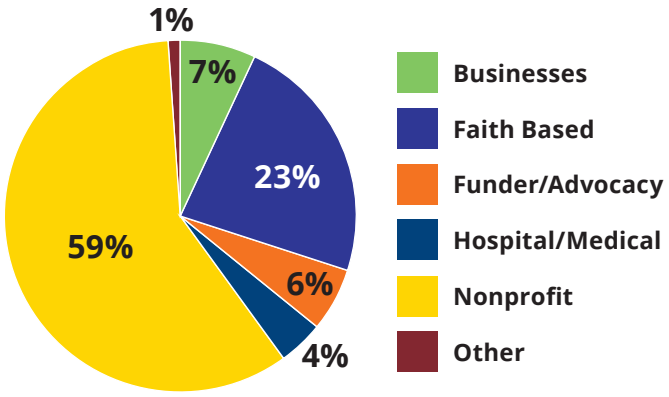
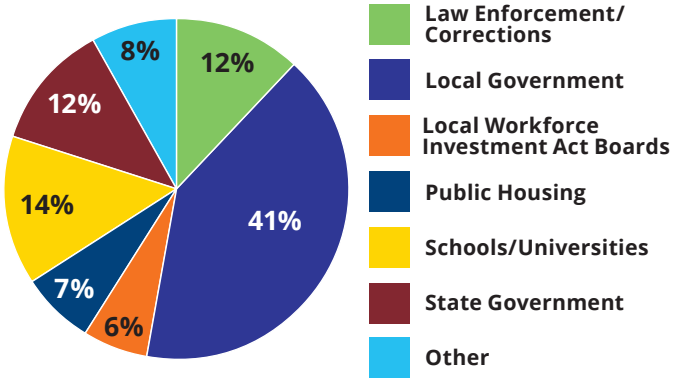


Fig. 9. CoC Public Sector by Group



Who staffs the CoCs?

Half of the CoCs have dedicated staff[11] that work primarily on managing the CoC. Some CoC staff may focus on administration such as submitting required reports. Other staff may focus more on convening and facilitating planning activities related to the local homeless response system, while some may do both. CoCs, without staff dedicated primarily to operating the CoC, allocate a portion of existing staff time or use volunteers. These volunteers are often staff from local nonprofit organizations that have other regular, full-time positions.

Adequate staffing to operate the CoC is a major challenge for many communities and an obstacle to implementing the major shifts in policy that state and federal governments are requiring.

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RESOURCES

What funding resources are available and from what sources?[12]

Federal sources[13] make up the largest percentage of funding for homelessness assistance. Private funding comprises the second largest percentage (see Figure 10).

Nearly half of current resources are allocated to permanent housing strategies (see Figure 11).

What is the inventory of shelter and housing?[14]

CoCs are shifting to permanent housing solutions and strategies. From 2010 to 2013 there has been a decrease in transitional housing and an increase in rapid re-housing and permanent supportive housing beds (see Figure 12, page 11).

Emergency shelter represents the largest type of inventory (43%) with 5,668 beds. The total number of beds includes 1,235 seasonal emergency shelter beds (see Figure 13, page 11).

Housing resources for people experiencing homelessness have utilization rates greater than 75%, although rates varied

***Fig. 10.* Current Funding Sources**

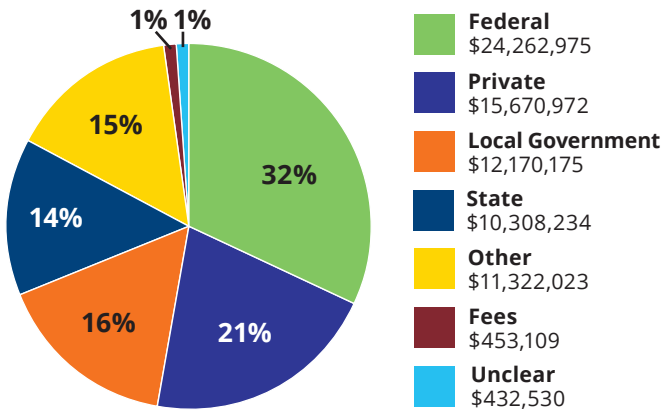
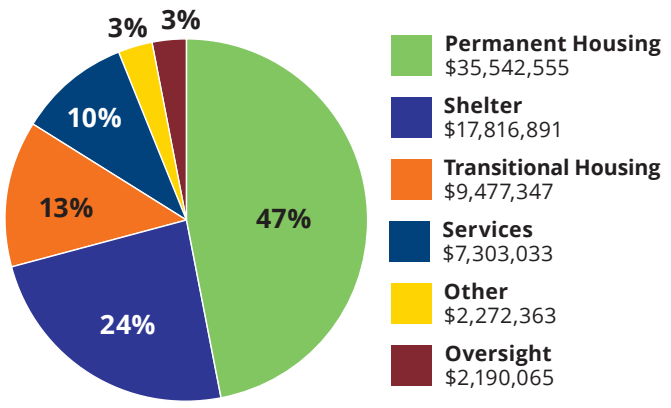


***Fig. 11.* Current Uses of Funding**



11 One state government, eight local governments, and ten nonprofits provide dedicated staff or allocate existing staff members to manage the CoC.

12 It is estimated that, for all of the CoCs and BoS Planning Groups, there was $39,847,544 in federal homeless assistance funding awarded in FY2011 but expended in 2012-2013, and $12,041,243 in state homeless assistance funding awarded for the July 1, 2012 - June 30, 2013 program year. Information was collected and aggregated from "Spending Plans" submitted to the Virginia Department of Housing and Community Development as part of the FY14 Emergency Solutions Grant (ESG) competitive grants program. This was the first year the spending plan was required and not all CoCs/BoS Planning Groups applied for funding. Information for some CoCs is not included because the entire CoC receives a direct allocation of ESG funding and is therefore ineligible for state ESG funding. This includes Virginia Beach, Fairfax, and Prince William CoCs. Spending plans for five additional CoCs/BoS planning groups were also unavailable. The category "unclear" includes reported spending that could not be categorized with the available information.

13 Federal sources includes federally-funded, but state- and locally-administered Emergency Solutions Grants or ESG.

14 The following information was collected and aggregated from Housing Inventory Charts of emergency, transitional, safe haven, rapid re-housing and permanent supportive housing stock available across Virginia. For breakdown by CoC, see Figures C2 through C6 in Appendix C.

by type of inventory and geography (Figure 14, page 12). Emergency shelters had the lowest utilization rate at 76%.

Communities have more permanent supportive housing and rapid re-housing units new and/or under development than other types of housing inventory (Figure 15, page 12). This reflects the shift in communities towards permanent housing interventions as well as the shift in public and private funding away from shelter and transitional housing.

Communities have more permanent supportive housing and rapid re-housing units new and/or under development than other types of housing inventory.

Communities and organizations may *designate* and/or *target* housing inventory beds in order to better meet the needs of prevalent subpopulations.

Designating means that the bed is only available to an individual that meets the criteria of a specific population, e.g. a person with a disability. Targeting means that while there is a preference for a specific population, the bed may be used by other populations.

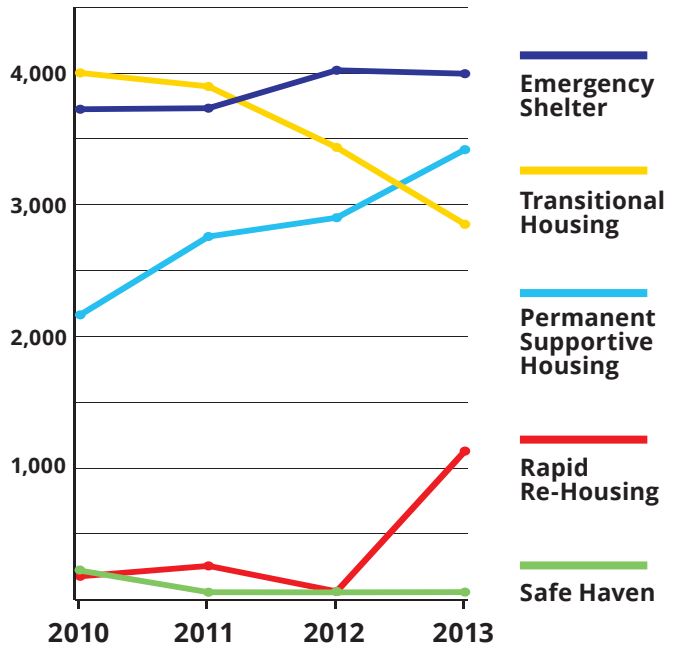
The largest percentages of beds that are designated within an inventory type are permanent supportive housing (PSH) beds designated for veterans (26% of total PSH beds; see Figure 16, page 12). This reflects the influx of federal and state resources to address veterans' homelessness in recent years.

Emergency beds targeted to victims of domestic violence are the largest group of all targeted beds (34%).

Permanent supportive housing beds targeted to veterans represent the second largest group of targeted beds (33%). This likely reflects the influx of new resources for veterans experiencing homelessness, including the HUD-VASH program.

CoCs are encouraged by HUD to designate permanent supportive housing beds to people experiencing chronic homelessness. However, beds may be targeted to the chronically homeless but not officially designated. Therefore, Figure 18 (page 12) likely underestimates the number of units targeted to people experiencing chronic homelessness in existing permanent supportive housing.

Fig. 12. Year-Round Beds 2010-2013



PERFORMANCE

How long do people experience homelessness?

A major goal of the HEARTH Act is that no individual or family experiences homelessness for longer than 30 days. This is commonly referred to as the length of stay in homelessness.

For emergency shelter programs, **seven** CoCs reported average stays of less than 30 days and **twelve** have aver-

Fig. 13. Total Beds By Program Type

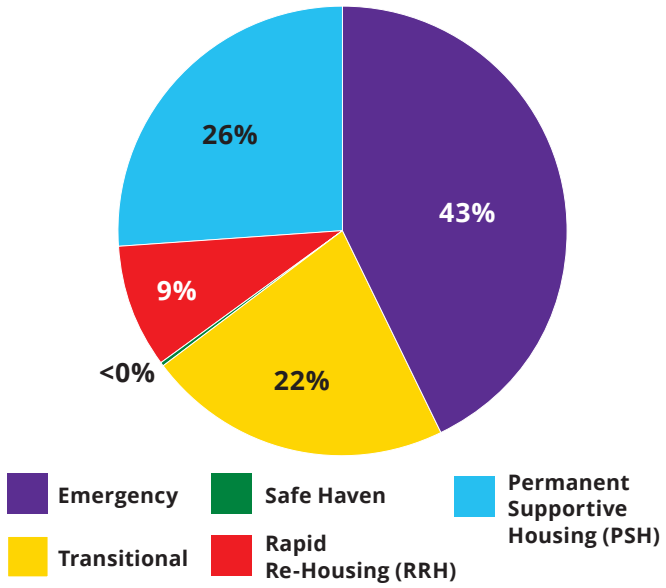


Fig. 14. Total Beds and Average Utilization Rates by Type of Inventory

	ES		TH		SH		PSH	
	Beds	Utilization	Beds	Utilization	Beds	Utilization	Beds	Utilization
TOTAL	5,668	76%	2852	82%	58	86%	3419	84%

Fig. 15. Total Beds New and Under Development by Type of Inventory

	ES		TH		SH		PSH	
	New	Under Development	New	Under Development	New	Under Development	New	Under Development
TOTAL	77	14	35	0	734	89	155	126

Fig. 16. Beds *Targeted* to Specific Populations by Program Type

	ES				TH				SH				PSH			
	DV	% of Beds	VET	% of Beds	DV	% of Beds	VET	% of Beds	DV	% of Beds	VET	% of Beds	DV	% of Beds	VET	% of Beds
TOTAL	925	16%	100	18%	292	10%	188	7%	117	10%	48	4%	121	4%	894	26%

Fig. 17. Total *Targeted* Population Beds by Program Type

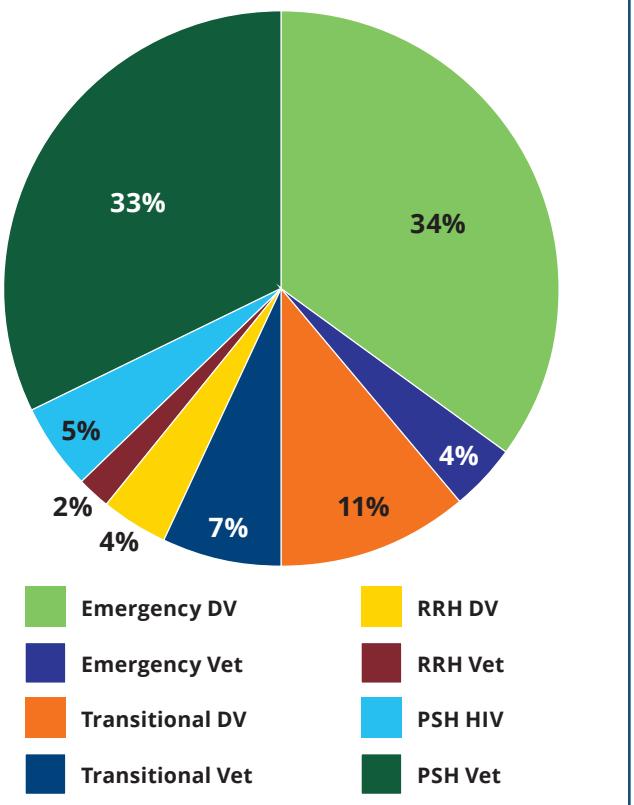


Fig. 18. Total PSH Beds and Designated Chronically Homeless Persons (CH) PSH Beds

# of PSH Beds	# of PSH Beds Designated for CH	% PSH Beds Designated for CH
3,419	974	28%

age stays longer than 30 days. Of the twelve, **four** reported stays between 30 and 60 days, **five** reported stays between 60 and 90 days, and **three** reported stays of longer than 90 days (see Figure 19, page 13).

Average lengths of stays are longer in transitional housing facilities, with many programs allowing clients to stay up to 24 months.[15] Many CoCs have taken steps to reduce length of stay in transitional housing — **four** CoCs have average lengths of stay of five or fewer months and **nine** have average lengths of stay of less than one year (see Figure 20, page 13).

Data on the average length of homelessness for those individuals that are unsheltered — living on the streets, under bridges, and in the woods — is unknown.

15 Traditionally, transitional housing has been defined as a stay of up to 24 months.

How are homeless assistance programs performing?

The following objectives highlight best practices in responding to homelessness. As part of the HUD CoC FY12 application process, CoCs were required to identify current and future plans to meet the following HUD objectives[16]:

- **OBJECTIVE 1:** Create new permanent housing beds for chronically homeless persons.

  Seven out of the nineteen CoCs met the goal to create new permanent housing beds designated for chronically homeless persons, creating 75 new beds for chronically homeless persons from 2011-2012. The CoCs have plans to nearly double permanent housing units designated for persons experiencing chronic homelessness in ten years (Figure 21).

- **OBJECTIVE 2:** Increase the percentage of participants remaining in permanent housing projects for at least six months to 80% or more.

  Currently, **fourteen** CoCs are meeting or exceeding this goal. **Six** CoCs are meeting the goal to increase the percentage of participants remaining in permanent housing projects to at least 80%, and **eight** are exceeding this goal.

- **OBJECTIVE 3:** Increase the percentage of participants in transitional housing that move into permanent housing to 65% or more.

Fig. 19. **Emergency Shelter Average Length of Client Stay (Months)**

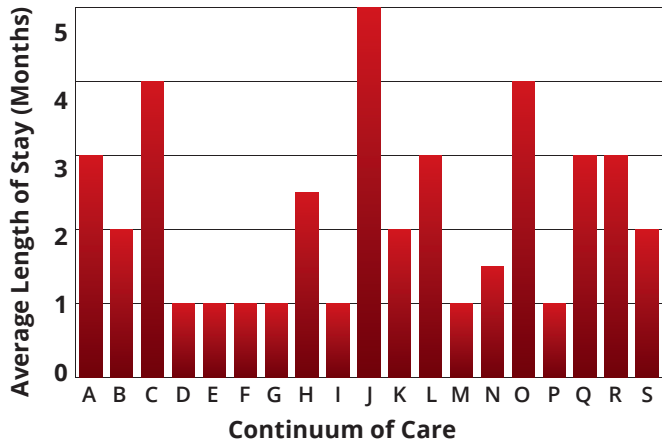


Fig. 20. **Transitional Housing Average Length of Client Stay (Months)**

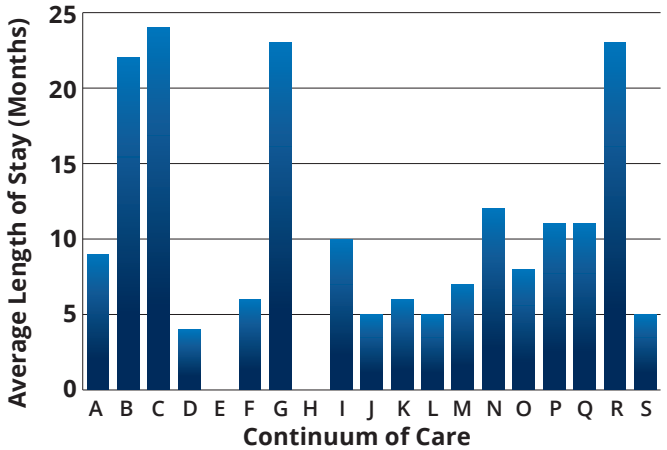


Fig. 21. **Obj. 1: Plan for Permanent Housing Beds Designated for Chronically Homeless Persons**

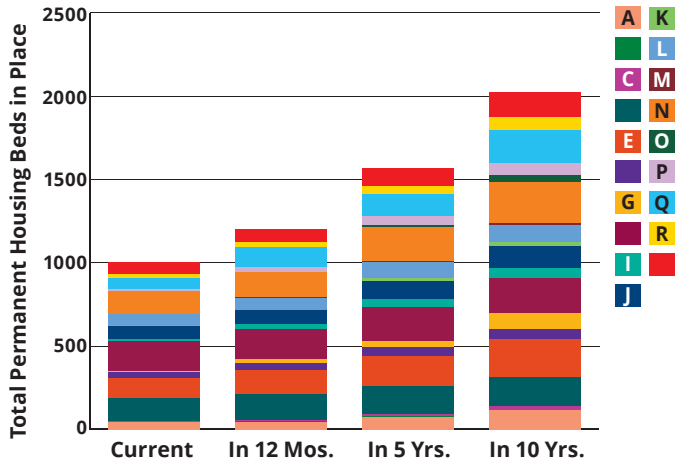
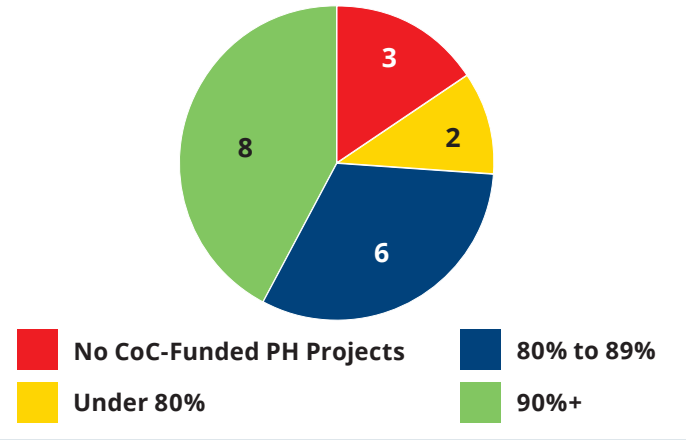


Fig. 22. **Obj. 2: Continuum of Care Percentage of Participants Remaining in CoC-Funded Permanent Housing (PH) Projects for at Least Six Months**



16 This information only includes programs that receive funding through the CoC. Therefore, this information does not include data on programs that do not receive HUD funding. This applies to objectives 2-6.

Twelve CoCs are meeting or exceeding this goal, and **six** are exceeding it (see Figure 23).

- **OBJECTIVE 4:** Increase percentage of participants in all projects employed at time of program exit to 20% or more.

  Six CoCs are meeting this goal and **eight** are exceeding it (see Figure 24).

- **OBJECTIVE 5:** Increase the percentage of participants in all projects obtaining mainstream benefits at time of program exit to 20% or more.

  Eighteen CoCs are exceeding this objective, including **six** CoCs with performance rates of greater than 75% (see Figure 25).

- **OBJECTIVE 6:** Decrease the number of homeless families.

  Eleven CoCs reduced the number of homeless households with at least one child under the age of 18 as reported on the annual Point in Time Count from 2011-2012.

  These CoCs collectively reduced the number of homeless households with at least one child by 94. The net reduction in the number of homeless households with at least one child across all CoCs was 51.

  CoCs have plans to reduce the number of families with children experiencing homelessness by half in the next 10 years (see Figure 26, page 15).

- **OBJECTIVE 7:** Intent of the CoC to reallocate Supportive Services Only (SSO) and Transitional Housing (TH) projects to create new Permanent Housing (PH) projects.

  HUD has made reallocation of funds from services to housing a priority. **Five** CoCs reallocated funding in the FY12 competition.[17]

About Income

The most common source of cash income is earned income (40% of those exiting CoC homeless assistance programs with cash income are receiving it from earned income.)

For participants who exited from CoC funded projects with non-cash benefits, the most common sources of non-cash benefits included SNAP and Medicaid health insurance.

Fig. 23. **Obj. 3: Continuum of Care Percentage of Participants in CoC-Funded Transitional Housing (TH) Projects Moved to Permanent Housing**

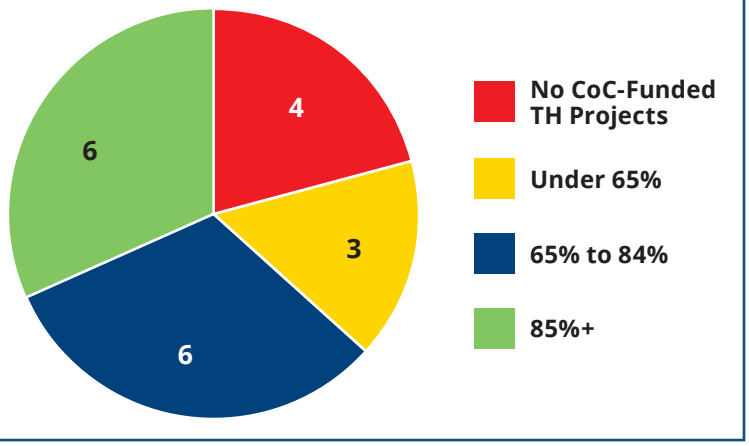


Fig. 24. **Obj. 4: Continuum of Care Percentage of Participants in All CoC-Funded Projects That Are Employed at Program Exit**

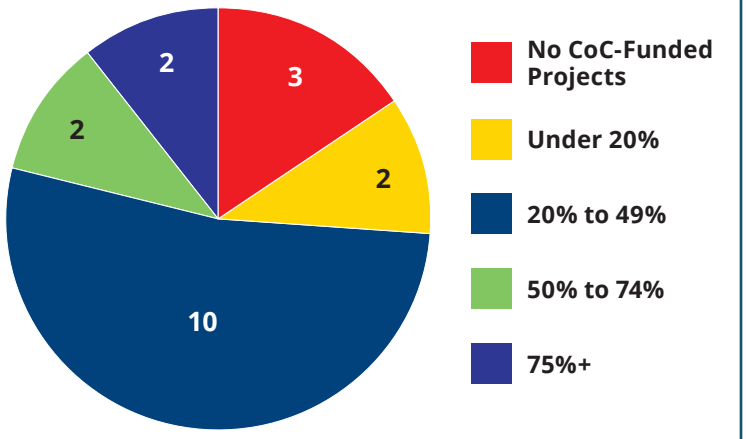
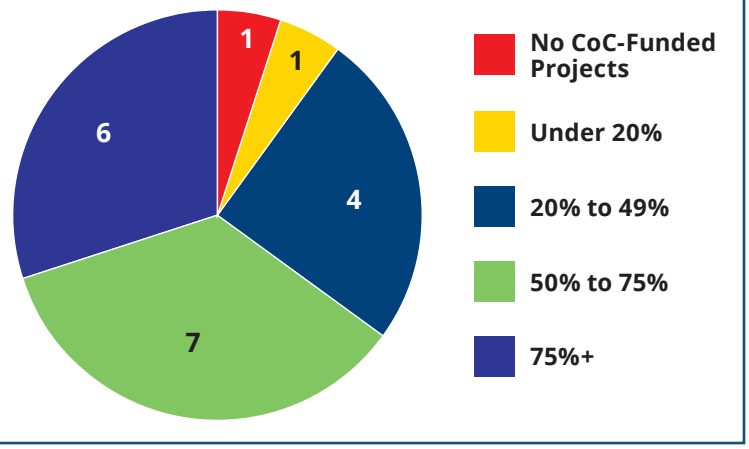


Fig. 25. **Obj. 5: Continuum of Care Percentage of Participants In All CoC Funded Projects That Receive Maintstream Benefits At Program Exit**



17 It should be noted that some CoCs do not have Transitional Housing or Supportive Services Only grants through the CoC, therefore this objective does not apply to all CoCs.

Fig. 26. Obj. 6: Plans to Decrease Number of Households With At Least One Child

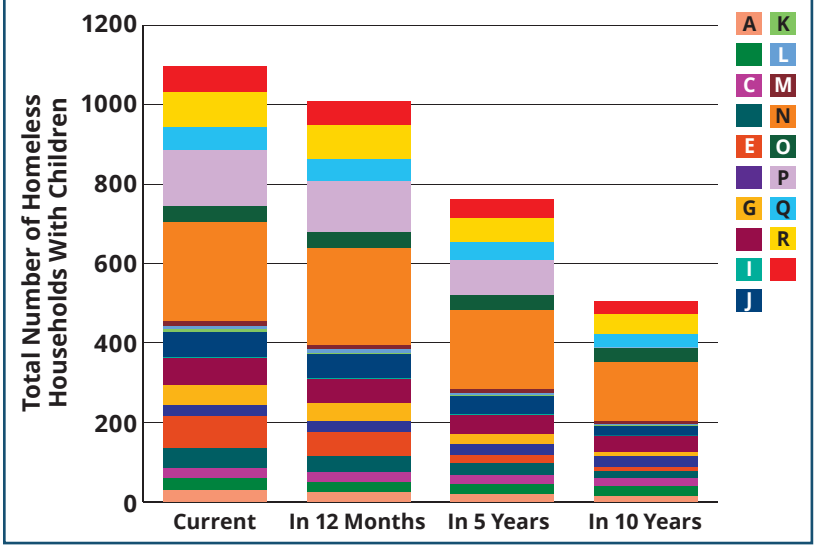


Fig. 27. Participants in CoC-Funded Projects Exiting With Cash Income By Type of Cash Income

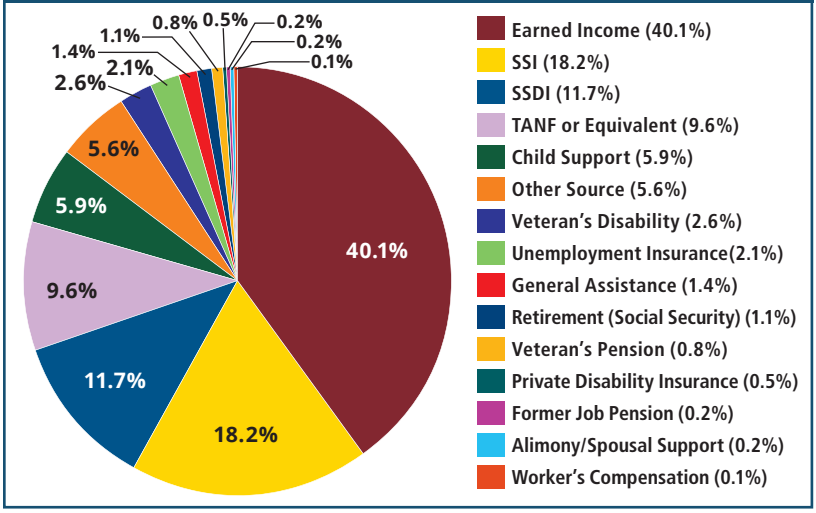
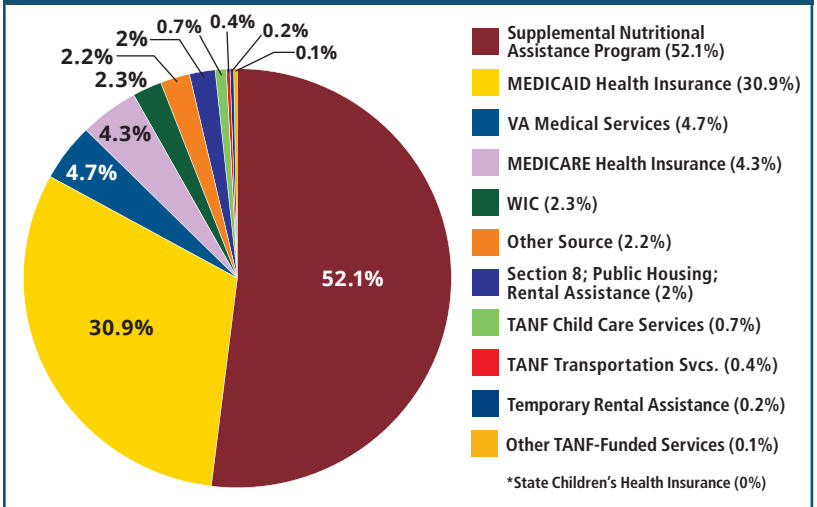


Fig. 28. Obj. 6: Participants in CoC-Funded Projects Exiting With Non-Cash Benefit Sources by Type of Source



What challenges impact performance?

CoCs in Virginia primarily exceeded HUD national minimum performance targets. In some cases where CoCs established higher targets than required, they sometimes fell short in meeting their own locally established objectives. One-third of CoCs identified delays in anticipated openings of permanent supportive housing or receipt of state and federal resources for programs as challenges to meeting objectives.

CoCs also identified the following factors as contributing to falling short of their stated objectives:

- Access to employment opportunities was frequently identified as a major factor in meeting objectives for exits to permanent housing and exits with earned income. CoCs expressed difficulty in securing employment for clients with high barriers such as mental illness and disability. Single parents with children were also identified as having employment challenges due to lack of available and affordable child care.
- Inadequate public housing resources was identified as a factor in lower exits to permanent housing as well as lengthier times in homelessness. Underfunding of vouchers as well as the administration of vouchers was identified as a major challenge to quickly housing clients.
- Lack of affordable housing in general was identified as a major barrier to meeting objectives to exit clients to permanent housing, specifically for large families.
- Economic conditions were identified as a contributor to increases in family homelessness especially for large families.
- Adequate staffing to implement the programs effectively was identified as a factor in lease up rates for permanent supportive housing as well as objectives to increase earned income and meet overall HUD objectives.

OPERATIONS

The following section explores how CoC operations align with HUD requirements for: discharge planning; community coordination including access to mainstream programs and centralized/coordinated assessment; specific program models and programs targeted to specific sub-populations; governance; program monitoring; program rating and ranking for funding priority; and data collection via the Homeless Management Information System (HMIS).

What are key elements of CoC operations?

DISCHARGE PLANNING		
Foster Care Discharge	National experts have identified inadequate discharge planning as a significant factor contributing to homelessness. Many clients experiencing homelessness have received services prior to their homeless episodes from other systems of care, including foster care, health care, mental health and the corrections system. If these other systems of care put in place policies and protocols to identify and address housing instability, we can prevent homelessness before it occurs. HEARTH requires state and local governments to put policies in place to prevent discharge into homelessness.	• 79% have state mandated policies. • 16% have CoC mandated policies. • 5% have local department of social services (DSS) mandated policies.
Health Care Discharge		• 26% have state mandated policies. • 32% have CoC mandated policies. • 42% have other forms of mandated policies (This includes federally mandated discharge planning of veterans or areas that do not have public hospitals within their CoCs.)
Mental Health Discharge		• 79% have state mandated policies. • 16% have CoC mandated policies. • 5% have community level discharge planning created by the community service board.
Corrections Discharge		• 58% have state mandated policies. • 21% have CoC mandated policies. • 21% have other forms of mandated policies. (This includes existing policies within the Virginia Department of Corrections or County Adult Detention Centers.)

(continued on next page)

COMMUNITY COORDINATION		
Centralized / Coordinated Assessment	Centralized or coordinated assessment is a coordinated process for clients to receive homeless resources that ensure widespread access, common assessments, and assignment of clients to the intervention that will most likely end their homelessness. Characteristics of current Virginia systems vary widely. Some CoCs have common intake processes and shared assessment tools. Some have a central intake in place for specific populations (i.e. families) or for specific services (i.e. emergency shelter.) Many use hotlines for central intake and referral. A few indicate that diversion is a key component of their coordinated / central intake system.	• 74% have centralized assessment. • 26% will work to implement within the next year.
Collaboration with Local Education Authorities	The McKinney-Vento Act ensures educational rights and protections for children and youth experiencing homelessness.	100% coordinate with Project HOPE-Virginia, the statewide McKinney-Vento funded education program for children and youth experiencing homelessness.
Access to Mainstream Programs	There are multiple federal resources that do not specifically target homeless populations but can be used to serve clients experiencing homelessness. Communities can tap into mainstream programs in a variety of ways.	• 100% have specialized staff to identify, enroll, and follow up on participation in mainstream programs. • 84% provide training on access to mainstream programs. • 79% received SOAR training. • 21% use HMIS to screen for eligibility to mainstream programs.
Local 10 Year Plans to End Homelessness	The ten year plan to end homelessness is a tool that has been developed and used in hundreds of communities across the country. It brings together a diverse group of community stakeholders to identify the causes of and solutions to homelessness. It outlines clear and concrete goals and strategies for improving the local response to homelessness.	• 74% have 10 Year Plans in place and review and update them. • 16% are planning to develop a 10 Year Plan.
Incorporation of Federal Strategic Plan into CoC Goals	The federal government unveiled Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness in 2010. The plan set goals to end chronic and veteran homelessness by 2015, and family, child, and youth homelessness by 2020.	100% incorporate elements of the Federal Strategic Plan into local goals and priorities.

SPECIFIC PROGRAM MODELS OR SUB-POPULATIONS		
Rapid Re-Housing	The Homelessness Prevention and Rapid Re-Housing Program (HPRP) was created under the American Reinvestment and Recovery Act of 2009 and provided approximately $25 million in funding for prevention and rapid re-housing to Virginia communities. The funds were quickly spent and communities needed to identify how to replace this funding.	• 100% indicate intention to provide continued prevention and / or rapid re-housing assistance. • 90% report continued or increased rapid re-housing programs. • 84% report continued or increased prevention programs. • 90% report receipt of state resources for prevention and rapid re-housing programs. • 26% report receipt of local resources for prevention and rapid re-housing programs.
Veterans	Programs specifically for veterans are a priority in many CoCs and for the federal and state government. Benefits are available to veterans through the Veterans Administration (VA) that are not available to non-veterans, and therefore efforts to access and coordinate these benefits to promote housing stability is a priority.	• 74% coordinate with the closest VA Medical Center through participation in CoC meetings and through formal partnerships to provide assistance. • 11% have formal partnerships with the closest VA Medical Center to provide outreach. • 37% have formal partnerships with the closest VA Medical Center to provide housing vouchers to veterans through the HUD VASH program. • 26% have formal partnerships with the closest VA Medical Center to provide Supportive Services for Veterans Families (SSVF) assistance. • 11% have formal partnerships with closest VA Medical Center to provide grant and per diem programs. • 53% coordinate with local Wounded Warrior offices. • 32% have targeted employment programs for veterans experiencing homelessness through the Virginia Employment Commission and other groups. • 26% have transitional shelter and permanent supportive housing specifically targeted for veterans experiencing homelessness.
Outreach	Outreach is a key strategy to helping individuals access services and become aware of available programs.	• 69% have dedicated staff that conduct street outreach. • 47% report that PATH workers provide street outreach in their communities. • 11% report that VA staff conduct street outreach.

GOVERNANCE		
Governance	Effective governance includes the creation of written policies and procedures, code of conduct for the board, a process for board selection, and a governance charter.	• 90% have written and approved policies and procedures. • 79% have written and approved codes of conduct for the CoC board. • 90% have written processes for board selection. • 84% have written and approved governance charters among collaborative applicant, HMIS lead, and participating agencies.

How do communities create funding priorities?

CoCs are required to rate and rank projects to determine CoC funding priorities. Rating and ranking processes vary across Virginia CoCs. The following were identified as being a part of the rating process:

- Organizational capacity;
- HMIS use and data quality;
- CoC participation;
- Performance towards HUD and/or CoC established outcomes;
- Cost efficiency;
- Quality of presentation to CoC;
- HUD and CoC monitoring results;
- Audited financials;
- Experience;
- Objective scoring criteria;
- Project readiness; and
- Budget – including match and leverage.

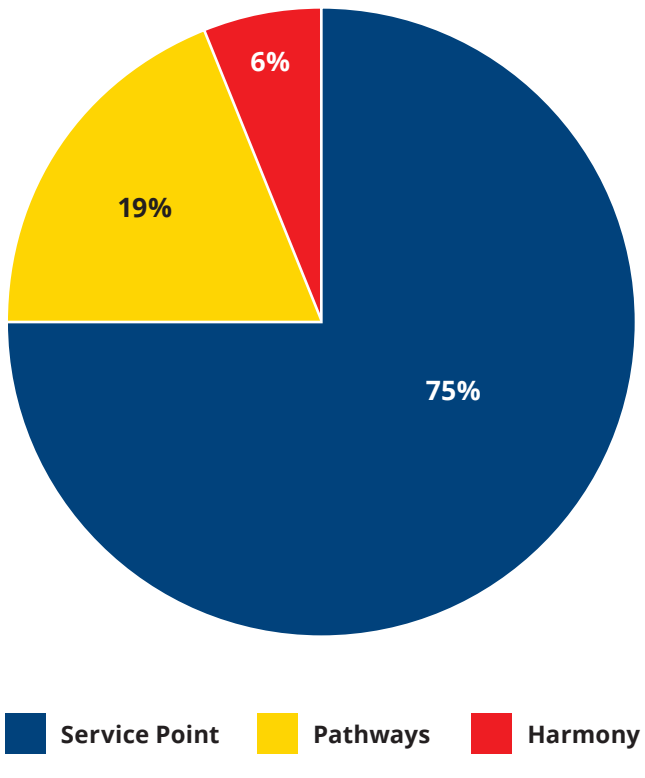
CoCs use the following processes to review and rank projects:

- Past participation/membership in CoC required to be eligible to apply;
- Letters of Interest for new projects;
- Supplemental/Pre-applications;
- Presentation requirement;
- Objective scoring process conducted by leadership group or technical assistance/staff person;
- Independent ranking committees, Leadership/Governing group, and CoC wide approval of ranking;
- Majority vote to approve ranking; and
- Consensus decision to approve ranking.

What do we know about data collection systems?

CoCs began keeping records and statistics with HMIS systems an average of eight years ago. The majority of Virginia CoCs use the vendor Service Point for HMIS. **Twelve** CoCs use Service Point, **three** use Pathways, and **one** uses Harmony.

Fig. 28. **CoC HMIS Vendors**



Budget

Together, CoCs reported budgets of more than $1.7 million for HMIS. The average HMIS budget is approximately $105,000. HMIS budgets range from $0 to $283,138. The majority of CoCs have HMIS budgets between $25,000 and $100,000 with an average of just over $65,000.

Fig. 29. **Budget**

	# of CoCs	Avg. Annual Budget
0 – $10,000	3	$3,267
$25,000 – $100,000	9	$65,658
$100,001 – $283,138	7	$200,334

CONCLUSION

Virginia communities are shifting towards more effective housing crisis response systems and are working to comply with new funding requirements. CoCs are leading this shift. VCEH believes that increased funding and support of CoC-level systems change efforts is critical to continuing this shift and meeting local, state, and federal objectives to prevent and end homelessness. Action is required at the local, state, and federal levels to identify administrative and policy opportunities to streamline processes and prioritize people experiencing homelessness. Continued evaluation of local system needs and local, state, and federal activities that will improve the local system is essential.

Fig. A1. Households With At Least One Adult and One Child (Families) by CoC

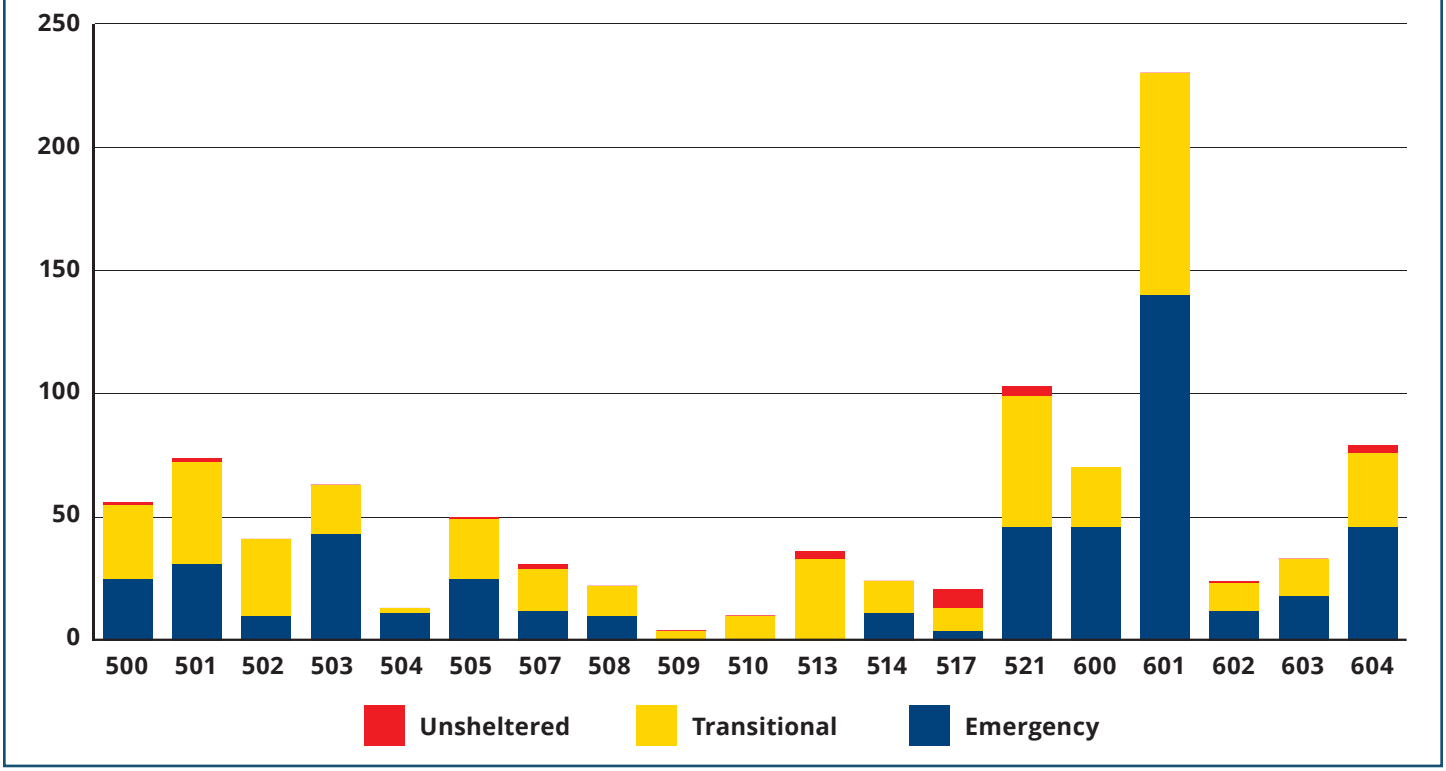


Fig. A2. Households Without Children by CoC

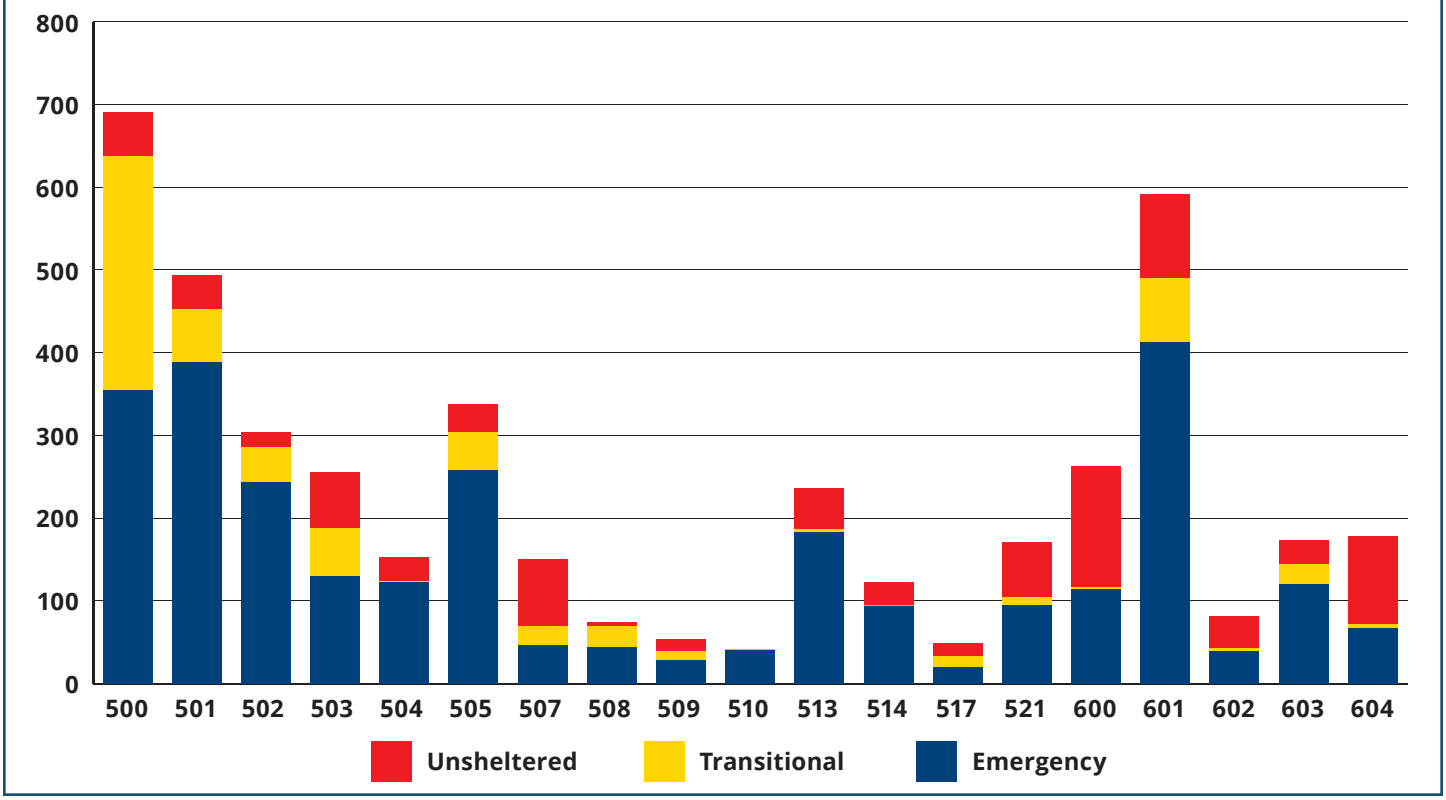


Fig. A3. Chronically Homeless Individuals by CoC

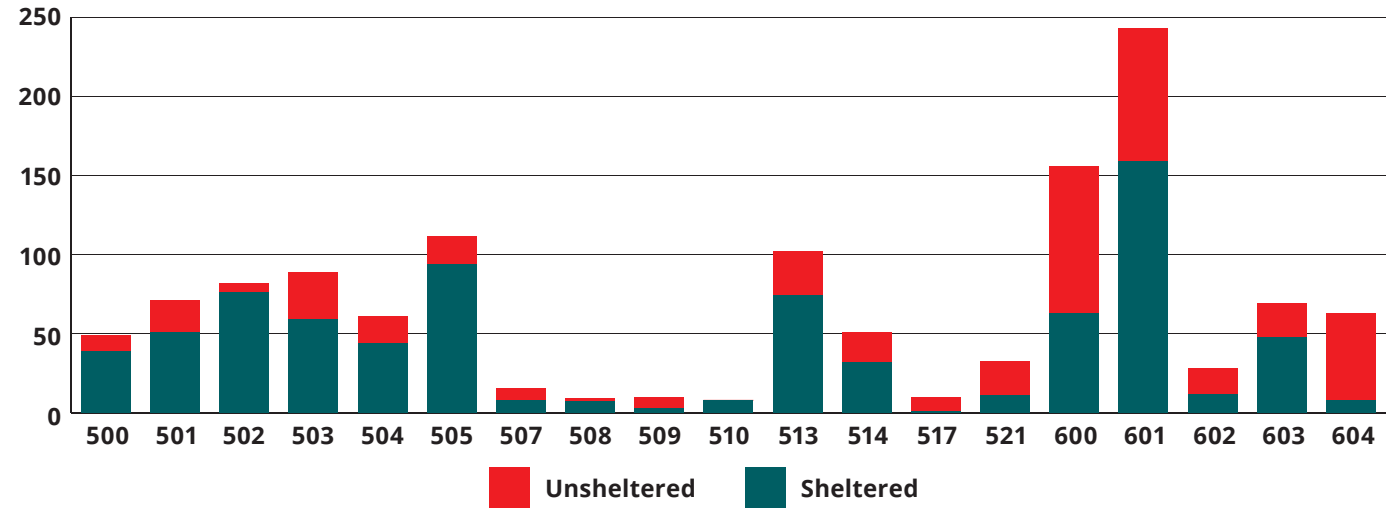


Fig. A4. Chronically Homeless Families by CoC

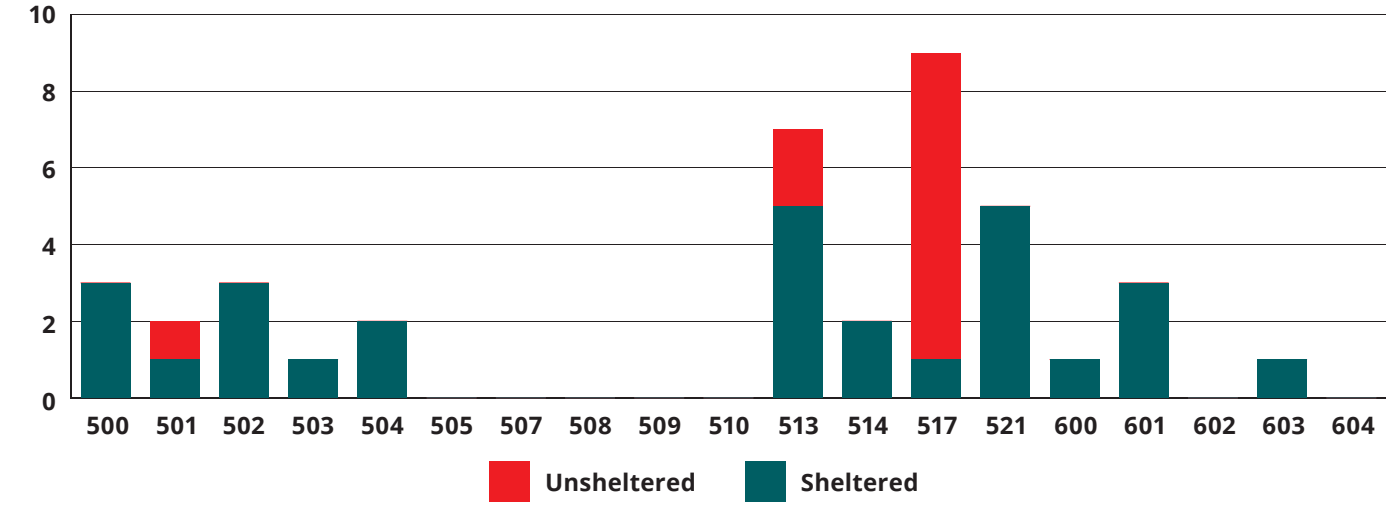


Fig. A5. Homeless Veterans by CoC

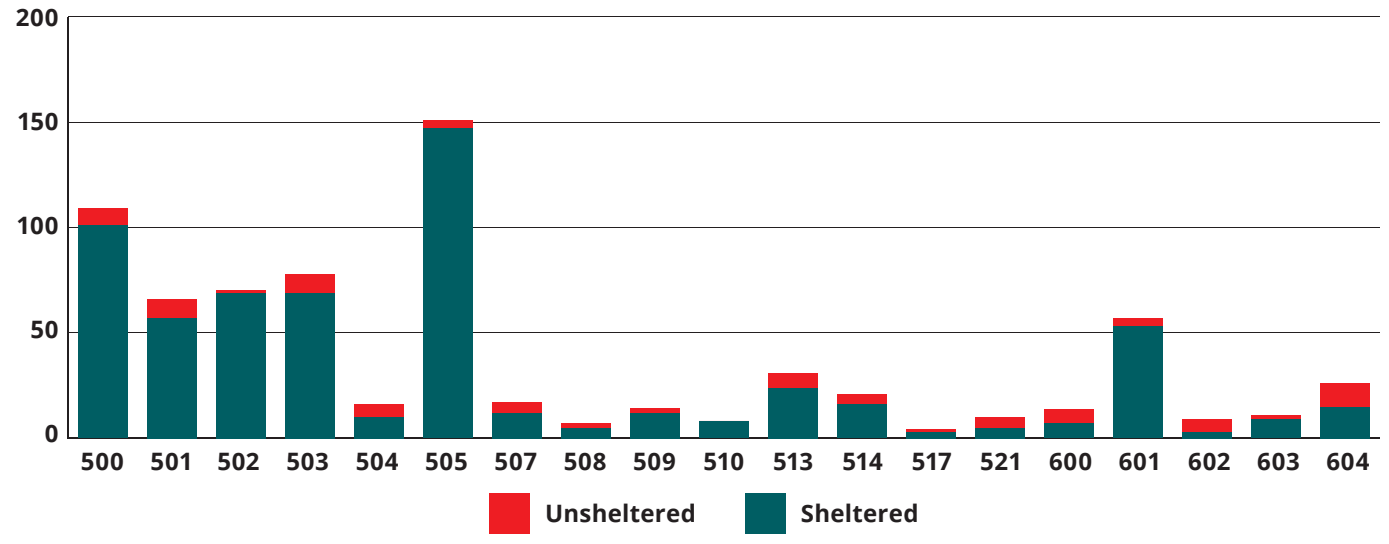


Fig. A6. Subpopulations of Sheltered Persons by CoC

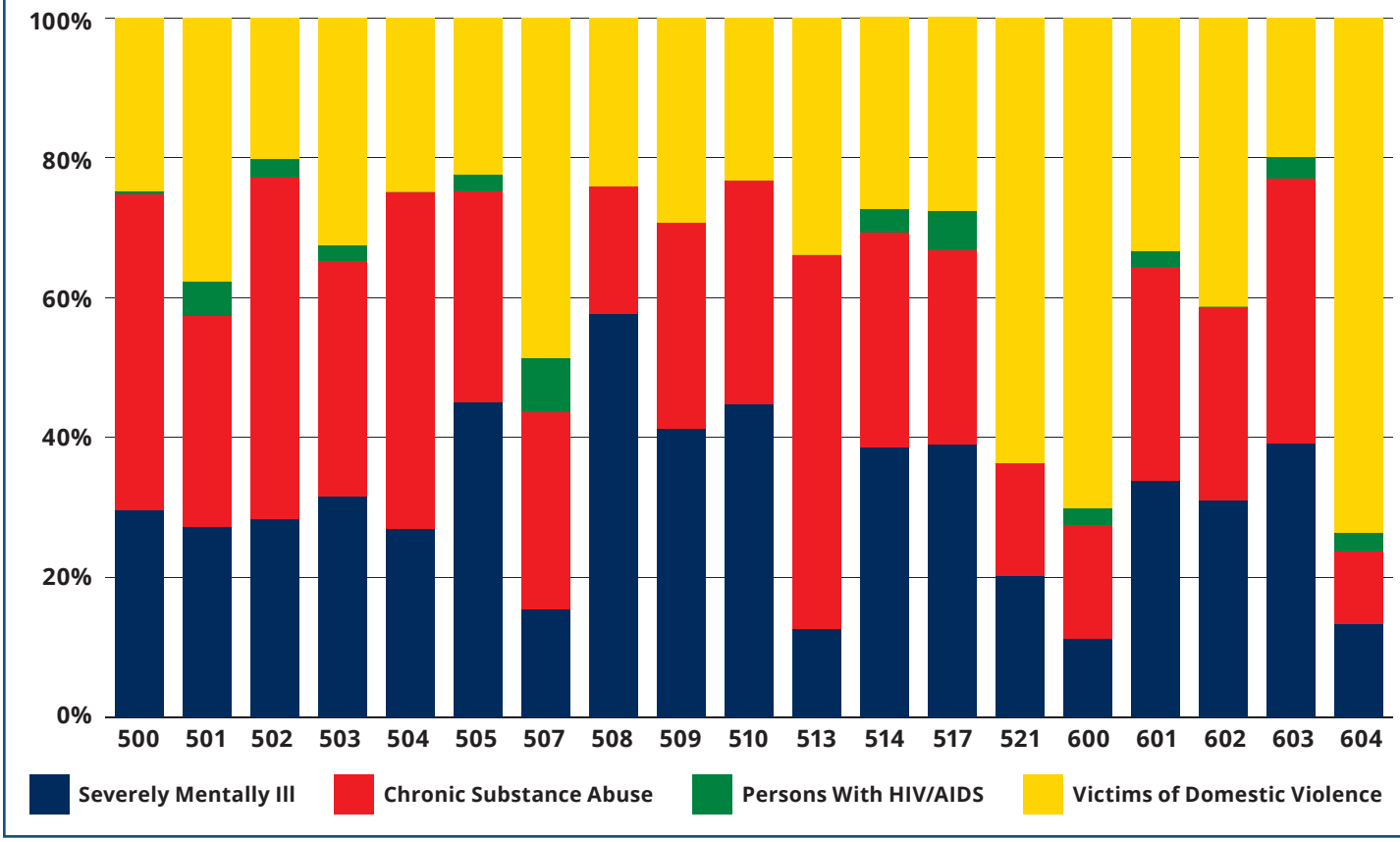
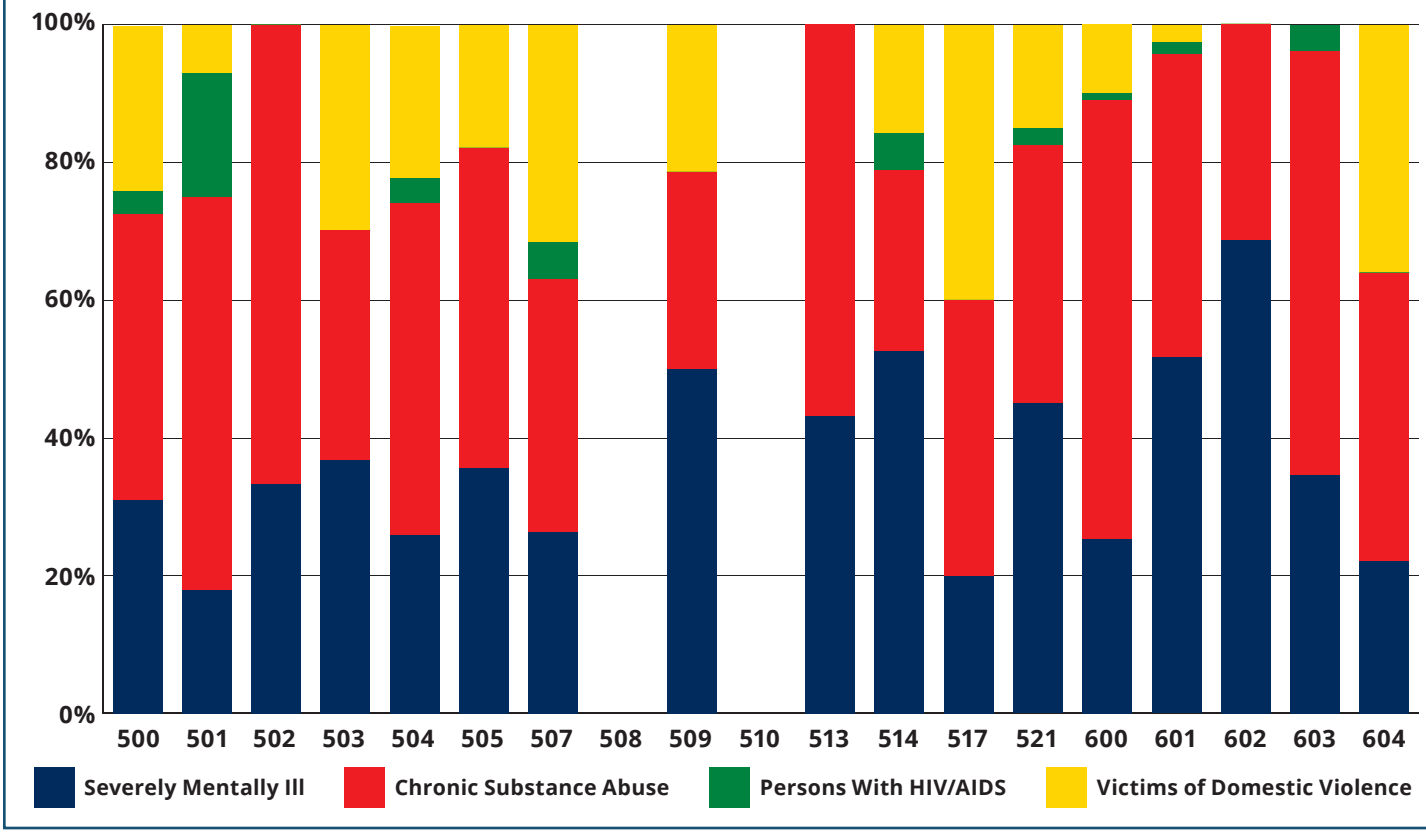


Fig. A7. Subpopulations of Unsheltered Persons by CoC



NOTE: *CoCs 508 and 510 did not report unsheltered persons in the above subpopulation categories.*

Fig. A8. Issues Having the **Most Impact** on the Local Response to Homelessness

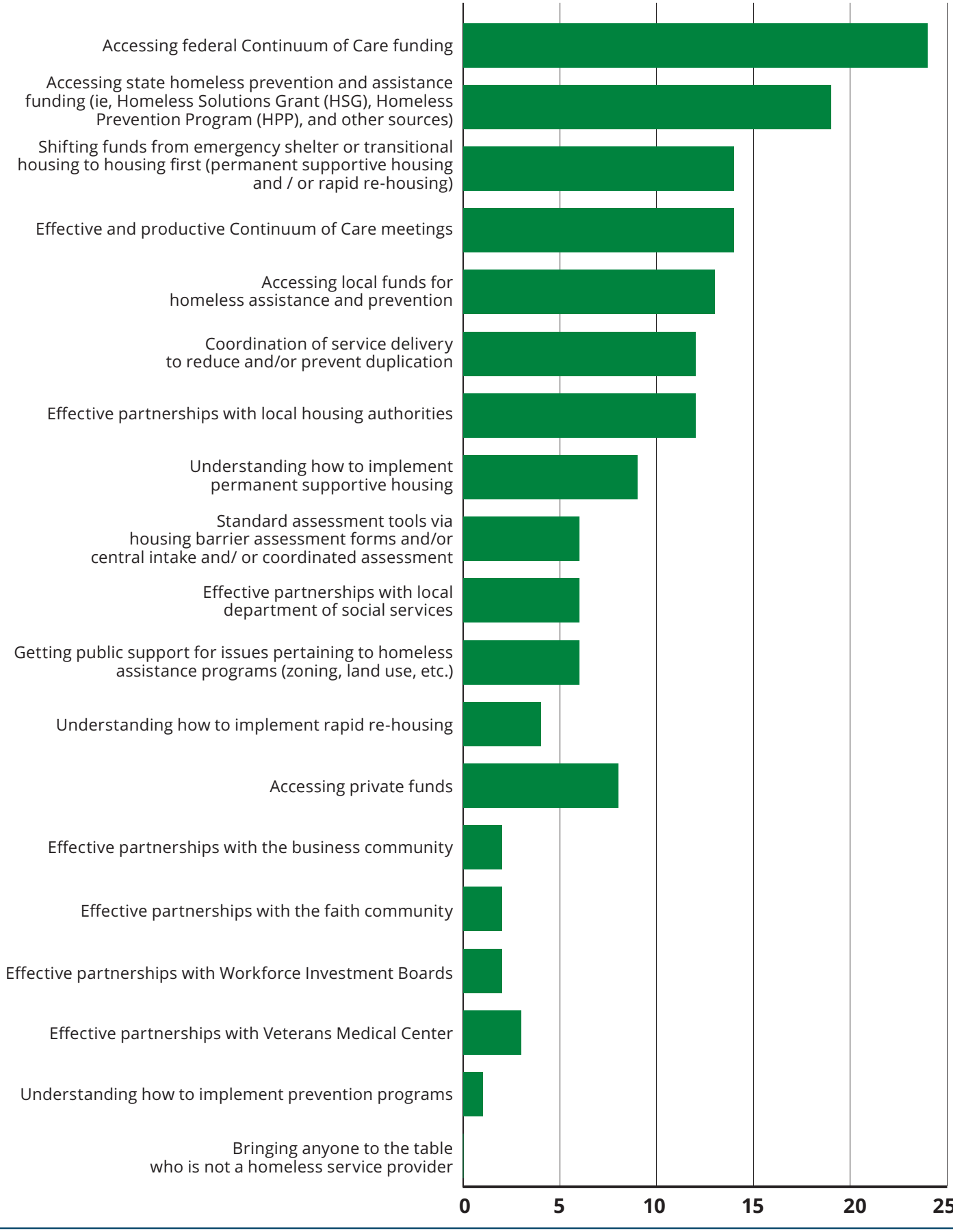


Fig. A9. **Most Challenging Issues in the Local Response to Homelessness**

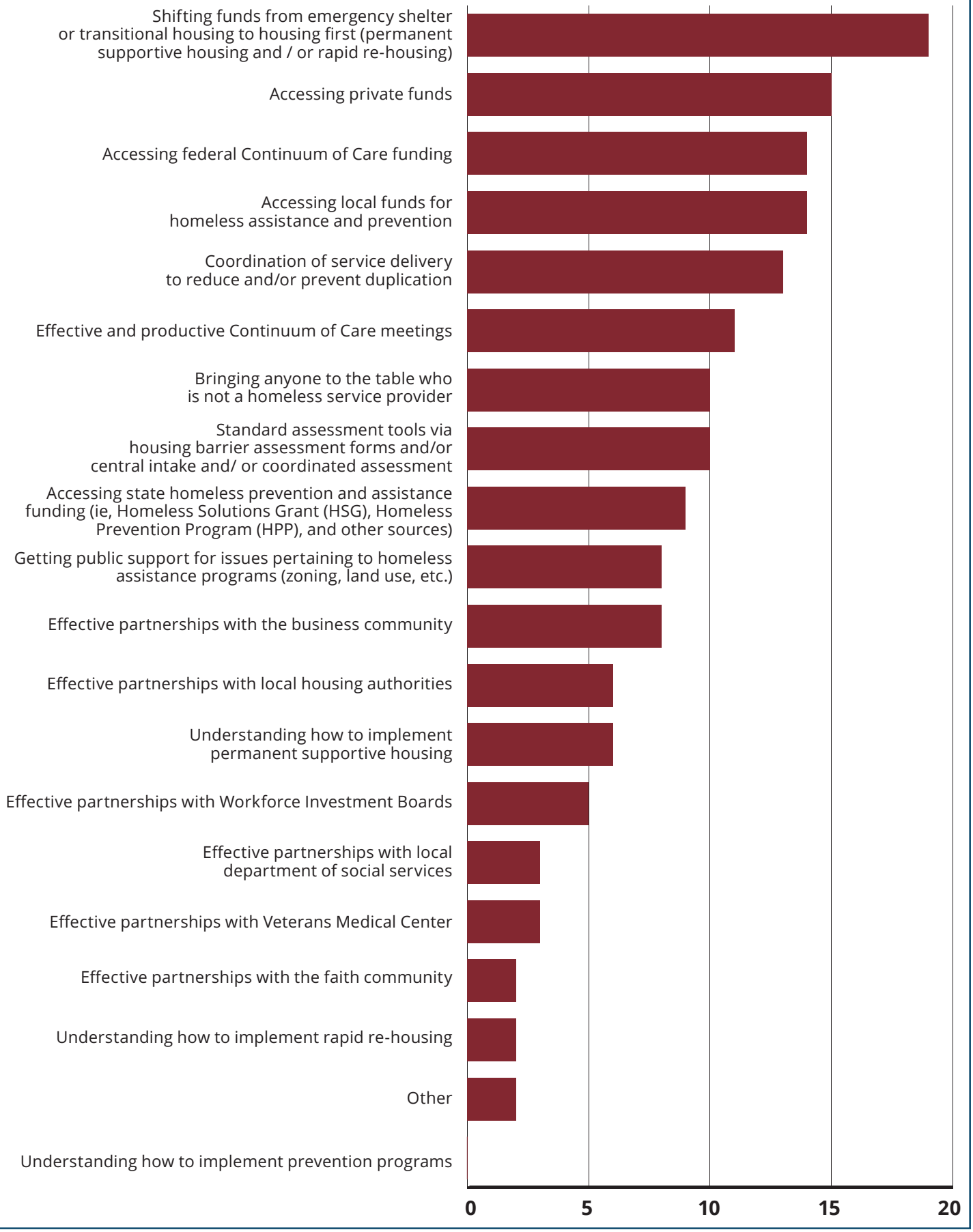


Fig. A10.

In your opinion, what has the most impact on the local response to homelessness?

MOST → LEAST

	1	2	3	4	5	Rating
Funding	26	4	2	1	0	4.67
Community coordination among homeless service providers	12	14	4	1	2	4.00
Partnering with stakeholders that are NOT homeless service providers	9	9	5	7	3	3.42
Shifting to new models of service delivery	9	5	9	7	3	3.30
Public and community support for efforts	3	7	10	3	7	2.79

MOST ↓ LEAST

In your opinion, what is most challenging in your local response to homelessness?

MOST → LEAST

	1	2	3	4	5	Rating
Funding	23	6	3	1	0	4.55
Community coordination among homeless service providers	8	2	3	11	9	2.67
Partnering with stakeholders that are NOT homeless service providers	6	6	6	13	2	3.03
Shifting to new models of service delivery	5	9	7	7	5	3.06
Public and community support for efforts	4	11	7	8	3	3.15

MOST ↓ LEAST

Fig. B1. Private Sector Composition by CoC

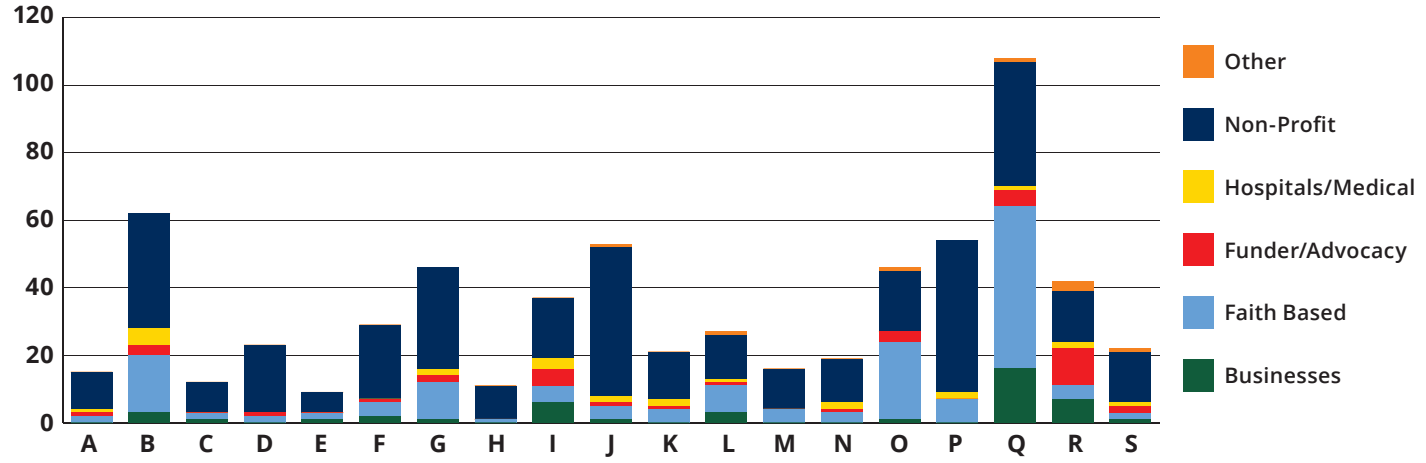


Fig. B2. Virginia Private Sector CoC Membership Across CoCs

	Businesses	Faith Based	Funder/Advocacy	Hospitals/Medical	Nonprofit	Other
Total	43	153	38	24	386	8
Mean	2	8	2	1	20	0
Median	1	4	1	1	15	0
Mode	0	4	1	0	13	0
Min	0	1	0	0	6	0
Max	16	48	11	5	45	3

Fig. B3. Public Sector Composition by CoC

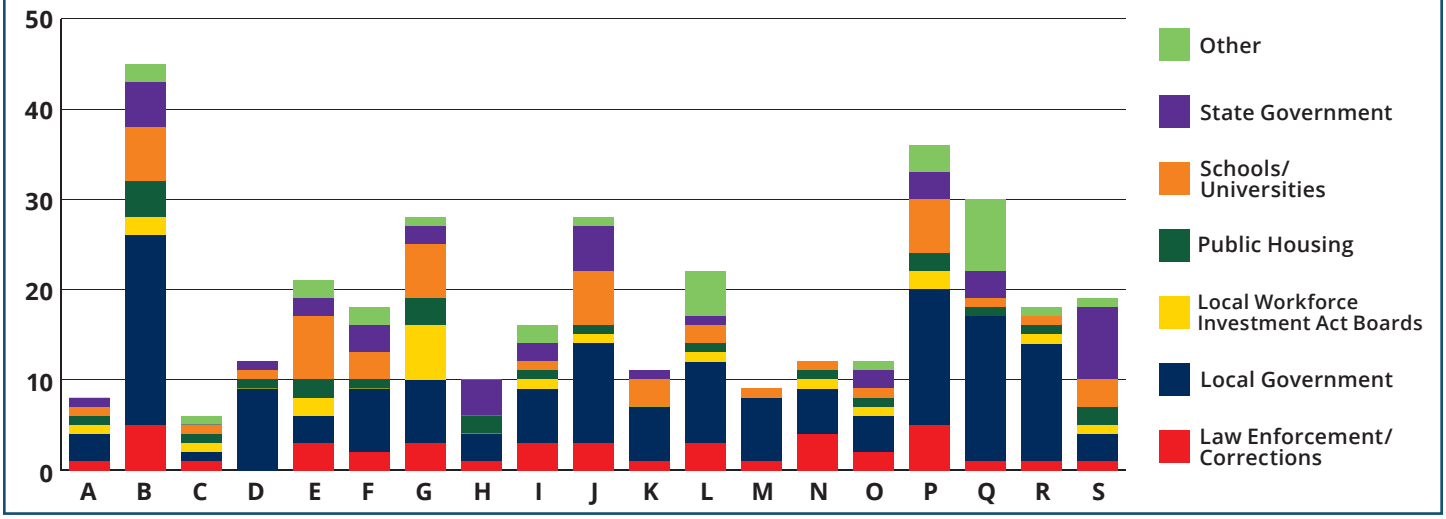


Fig. B4. Public Sector Representation

	Law Enforcement/ Corrections	Local Gov't	Workforce Investment Act Boards	Public Housing	Schools/ Universities	State Gov't	Other
Total	41	149	21	26	51	43	30
Mean	2	8	1	1	3	2	2
Median	2	7	1	1	1	2	1
Mode	1	3	1	1	1	1	1
Min	0	1	0	0	0	0	0
Max	5	21	6	4	7	8	8

Appendix C: RESOURCES

Fig. C1. Current Uses of Funding – Detail

Temporary Housing	
Emergency Shelter	
Motels or motel vouchers	267,323
Overflow/Seasonal Shelter	1,122,028
Year-Round Shelter	16,427,540
Transitional Housing	
Site-Based Programs	6,737,735
Scattered-site Transition in Place (TIP)	2,178,151
Scattered-Site (not TIP)	561,461
Permanent Housing	
Permanent Supportive Housing	18,311,344
Rapid Re-Housing	6,765,546
Homelessness Prevention	10,465,665
Site-Based Programs	6,737,735
Services	
Employment	265,280
Outreach	2,667,954
Child Care	34,630
Health/Medical/Clinic	1,447,149
Substance Use Treatment/Services	1,786,289
Mental Health Treatment/Services	1,101,731
Oversight	
Data/HMIS	911,329
Coordinated Assessment	763,472
Coordination/Planning	515,264
Oversight	
Other	2,272,363
Unclear	17,764

Fig. C2. Total Beds by Type of Program

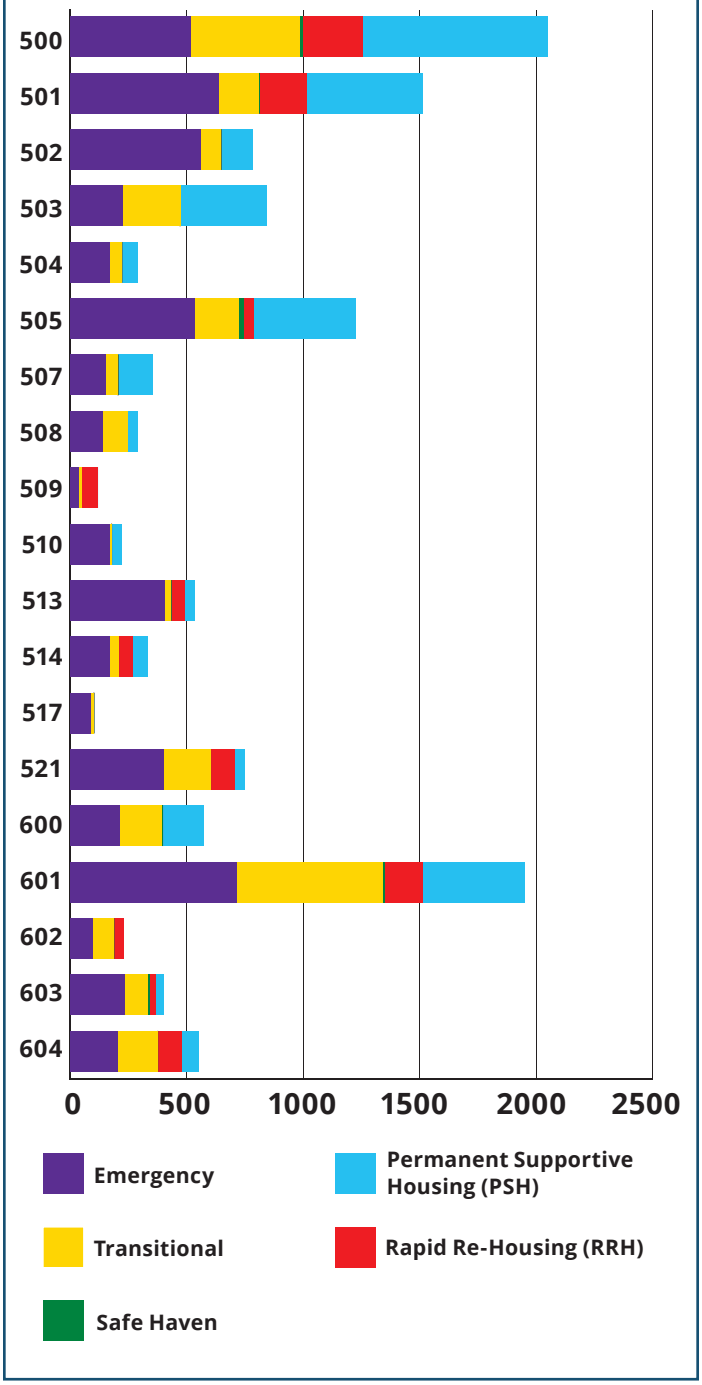


Fig. C3. Total Beds and Average Utilization Rates by Type of Inventory

CoC	ES		TH		SH		RRH		PSH	
	Beds	Utilization	Beds	Utilization	Beds	Utilization	Beds	*Utilization*[a]	Beds	Utilization
500	518	90%	469	70%	10	80%	259	*99%*	796	80%
501	637	76%	176	92%	0		205	*100%*	497	87%
502	561	70%	87	97%	0		0		136	73%
503	227	70%	245	83%	0		0		371	94%
504	171	65%	51	83%	0		0		67	97%
505	533	74%	190	84%	22	100%	42	*100%*	438	94%
507	152	75%	54	140%	0		0		149	91%
508	138	59%	108	49%	0		0		46	68%
509	37	100%	11	100%	0		70	*101%*	0	
510	170	28%	8	0%	0		0		46	86%
513	404	70%	30	27%	0		60	*100%*	42	81%
514	170	85%	38	82%	0		62	*100%*	64	100%
517	86	70%	16	100%	0		0		0	
521	400	66%	203	76%	0		103	*100%*	43	80%
600	214	98%	177	71%	6	50%	0		176	13%
601	715	97%	628	91%	8	100%	163	*100%*	438	93%
602	97	69%	91	55%	0		40	*100%*	2	100%
603	233	72%	99	68%	12	100%	23	*100%*	35	94%
604	205	91%	171	93%	0		102	*100%*	73	98%
TOTAL	**5668**	**76%**	**2852**	**82%**	**58**	**86%**	**1129**	***100%***	**3419**	**84%**

Fig. C4. Total Beds *New* and *Under Development* by Type of Inventory

CoC	ES		TH		RRH		PSH	
	New	Under Development	New	Under Development	New	Under Development	New	Under Development
500					170	89		21
501								56
502								
503	24						7	15
504								
505		4	4		28			8
506								**15**
507								
508								
509					22			
510								
513					60			
514		10			62		17	11
517	24							
521	13				103		25	
600							6	
601	12		28		163		53	
602					40			
603	4				23			
604			3		63		47	
TOTAL	**77**	**14**	**35**	**0**	**734**	**89**	**155**	***126***

a Utilization rates for rapid re-housing are counted based on the number of persons enrolled in a rapid re-housing program on the night of the Point-In-Time Count. Therefore, utilization rates should be 100%.

Fig. C5. Beds Designated to Specific Populations by Program Type

CoC	ES				TH				RRH				PSH			
	DV	% of Beds	VET	% of Beds	DV	% of Beds	VET	% of Beds	DV	% of Beds	VET	% of Beds	HIV	% of Beds	VET	% of Beds
500	51	10%	10	2%	30	6%	43	9%							323	41%
501	62	10%			31	18%			33	16%			46	9%	89	18%
502	76	14%					25	29%							70	51%
503	63	28%			47	19%	32	13%					7	2%	128	35%
504	25	15%			9	18%							2	3%		
505	49	9%	90	17%	63	33%	55	29%					24	5%	182	42%
507	42	28%														
508	50	36%														
509											45	64%				
510	40	24%														
513	110	27%							39	65%			42	100%		
514	32	19%							36	58%						
517	32	37%														
521	187	47%			20	10%	5	2%	9	9%					6	14%
600																
601	60	8%			92	15%	28	4%			3	2%			49	11%
602	12	12%														
603	17	7%														
604	17	8%													47	64%
TOTAL	**925**	**16%**	**100**	**2%**	**292**	**10%**	**188**	**7%**	**117**	**10%**	**48**	**4%**	**121**	**4%**	**894**	**26%**

Fig. C6. Total PSH Beds and Designated CH PSH Beds

CoC	# of PSH Beds	# of PSH Beds Designated for CH	% PSH Beds Designated for CH
500	796	186	23%
501	497	216	43%
502	136	18	13%
503	371	77	21%
504	67	65	97%
505	438	50	11%
507	149	46	31%
508	46	0	0%
509	0		
510	46	0	0%
513	42	4	10%
514	64	49	77%
517	0		
521	43	37	86%
600	176	52	30%
601	438	146	33%
602	2	1	50%
603	35	2	6%
604	73	25	34%
TOTAL	**3419**	**974**	**28%**

Appendix D: DEFINING HOMELESSNESS

The National Alliance to End Homelessness provides this summary of the most recent changes to the HUD definition of homelessness. Some federal agencies use other definitions of homelessness.

This summary can be found at:
http://www.endhomelessness.org/library/entry/changes-in-the-hud-definition-of-homeless

This is a summary of HUD's final regulation to implement changes to the definition of homelessness contained in the Homeless Emergency Assistance and Rapid Transition to Housing Act. The definition affects who is eligible for various HUD-funded homeless assistance programs. The new definition includes four broad categories of homelessness:

- **People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.** The only significant change from existing practice is that people will be considered homeless if they are exiting an institution where they resided for up to 90 days (it was previously 30 days), and were in shelter or a place not meant for human habitation immediately prior to entering that institution.
- **People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing.** HUD had previously allowed people who were being displaced within 7 days to be considered homeless. The proposed regulation also describes specific documentation requirements for this category.
- **Families with children or unaccompanied youth who are unstably housed and likely to continue in that state.** This is a new category of homelessness, and it applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
- **People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.** This category is similar to the current practice regarding people who are fleeing domestic violence.

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