Ending Homelessness in the Northern Shenandoah Valley in Ten Years

City of Winchester, and Counties of Clarke, Frederick, Page, Shenandoah, and Warren, Virginia

A Plan

November 2012

Table of Contents

Executive Summary

Our vision is that by 2024, every person in the Northern Shenandoah Valley – the City of Winchester, and Clarke, Frederick, Page, Shenandoah, and Warren Counties – will have access to a home, as well as the services and supports they need to thrive and achieve self-sufficiency. The common understanding of this ten year plan is that homelessness is solvable. However, we acknowledge the need for a renewed and focused effort that mobilizes the community to make ending homelessness a priority.

In autumn 2011, members of the Technical Advisory Network (TAN)[1] opted to begin the process of creating a ten year plan to prevent and end homelessness in the Northern Shenandoah Valley. The TAN, with support from the Northern Shenandoah Valley Regional Commission, contacted and then entered into a contract with the Virginia Coalition to End Homelessness to help facilitate and coordinate the planning process. A ten year plan is a community planning tool, used by over 300 urban, suburban, and rural communities across the nation and 14 communities in Virginia, which prescribes a concrete set of strategies designed to overcome the challenges to ending homelessness in the community.

The process itself, in addition to the end result, is critical. Already the ten year plan process has made a significant impact: it has generated dialogue on new ideas and data driven and research-focused best practices. It will be the continued dedication of existing and new partners that will make this plan a reality. *Ending Homelessness in the Northern Shenandoah Valley in Ten Years* is the result of insight, time, and dedication of members of the Technical Advisory Network who bring longstanding expertise and hands on experience to the cause of ending homelessness and creating a more coordinated and focused community effort in the Northern Shenandoah Valley.

The ten year plan includes concrete measurements of success to track the impact of the plan in reducing rates of homelessness. This plan has set the following goals:

1. Reduce homelessness by 10 percent each year for the next ten years.

[1] The Technical Advisory Network serves as the Continuum of Care for the Northern Shenandoah Valley. A 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. CoCs have taken on multiple roles in the community including coordination of resources, advocacy, and development of plans to end homelessness.

The 2011 Point in Time count[2] will serve as the baseline for achievement of this goal.

2. Prevent homelessness before it occurs.

   Prevent individuals and families from entering the homeless assistance system. Instead, help them stabilize in their existing housing and / or access housing of their own.

3. Create broad-based partnerships that will leverage new resources and talents.

   Cultivate relationships with leaders from local government, business, funders, faith communities, and others to galvanize community support for ending homelessness.

4. Help promote necessary services in the region that alongside housing opportunities will help eliminate and prevent homelessness and support housing stability.

5. Coordinate the existing services system to ensure a streamlined process of accessing services and housing supports and to reduce duplication and gaps in services.

   Develop processes for centralized intake and assessment of people entering the homeless services system to assure that people are assisted into permanent housing as quickly as possible and to assure that limited resources are used as efficiently as possible.

6. Ensure consistent and quality data collection to inform community stakeholders on the progress of the ten year plan.

7. Assess progress annually and update the ten year plan as needed to reflect current circumstances and opportunities.

We can and must reduce and end homelessness. Solving homelessness will require our leadership and focus as a community to implement and evaluate proven and innovative

[2] The Point-in-Time Count is a census, taken during a specific 24-hour period, of people living on the streets and in other homeless situations, including emergency shelter, and transitional housing. The Point-in-Time Count collects data on the number of people and households experiencing homelessness in a community, and surveys a sample of people to collect more in- depth information about them. Every Continuum of Care (see above for definition) is required by the United States Department of Housing and Urban Development to complete a point-in-time count.

solutions. It will require partnerships with those experiencing homelessness who desire better lives for themselves and commit to taking personal responsibility to make their dreams a reality.

The Goal to End Homelessness

Our goal is to prevent and end homelessness in the Northern Shenandoah Valley, comprised of Winchester City, and Clarke, Frederick, Page, Shenandoah, and Warren Counties.

Our Vision

By 2024, every person in the Northern Shenandoah Valley will have access to a home, as well as the services and supports they need to achieve self-sufficiency.

Thank you for your time and participation

in the development of the Ten Year Plan

Bob Boulter, Faith Works
Mike Butler
Rebeka Carper
Phyllis Chamberlain, Virginia Coalition to End Homelessness
Stacey Clater, Northwestern Community Services
Kathleen Cooper, Shenandoah Alliance for Shelter
Debbie Dart, Choices of Page County
Carol De Garis
Melissa DeDomenico-Payne, Harmony Place
Maria Diaz, Access Independence
Keith Fluery, Faith Works
Jeanne French, Northwestern Community Services
Chairwoman Vanessa Gogia, Blue Ridge Legal Services, Inc.
Whitney Hamrick, Shenandoah Alliance for Shelter
Sigrid Hepp-Dax, House of Hope
Amanda Holsiner-Jenkins
Pat Hughes, Salvation Army
Kerry Keihn, Northern Shenandoah Valley Regional Commission
Tyler Klein, Northern Shenandoah Valley Regionl Commission
Pat Konshak, Winchester Area Temporary Thermal Shelter
Daphne Mize, People Incorporated of Virginia
Jennifer Morrison, Response
John Nagely, AIDS Response Effort
Shelia Orndorff, Shenandoah Alliance for Shelter
Garry Ostermeier, House of Hope
Donald Price, Access Independence
Emily Riehl, Virginia Organizing Project, Shenandoah Valley
Martha Shickle, Northern Shenandoah Valley Regional Commission
Robin Stevens, Choices of Page County
Valerie Taylor
Tom Thayer, AIDS Response Effort
Karin Vogel, Veterans Administration, Veterans Outreach Project
Sandra Webster

Our Planning Process

Why a Ten Year Plan?

In late 2011, leaders of the Technical Advisory Network (TAN) and the Northern Shenandoah Valley Regional Commission (NSVRC) set out to create a ten year plan to end homelessness, with assistance from the Virginia Coalition to End Homelessness. Ten year plans have been created by over 300 communities and 14 of Virginia's communities (including single cities or counties and regions). A ten year plan is a community planning tool that brings a diverse group of stakeholders together to utilize data and research to understand the needs of people experiencing homelessness, identify gaps in homeless prevention and assistance, coordinate and streamline existing services, and plan for new evidence-based practices. It prescribes a concrete set of strategies designed to overcome the challenges of ending homelessness.[3]

Research has documented that many communities across the nation have seen concrete results from the creation and proactive implementation of ten-year plans. These results include decreases in rates of homelessness across all populations and/ or among particular sub-populations, new funding resources, better coordinated and streamlined services, a community understanding of what it will take to end homelessness, and research and adoption of new strategies that have proven to improve outcomes for clients. In addition, the federal government, specifically the U.S. Department of Housing and Urban Development, encourages the creation of ten year plans and awards additional points to federal Continuum of Care[4] funding applications that are aligned with local ten year plans.

The belief underlying ten year plans is that homelessness is solvable and that the community can and must mobilize their energy and resources towards solving this tragedy.

Review of Best Practices

VCEH and TAN members researched and presented best practice and evidence-based solutions to homelessness. Members of the TAN provided feedback on suggested best

[3] Virginia Coalition to End Homelessness. 10 Year Plan Document.

[4] Communities that apply for federal McKinney-Vento Homeless Assistance Grants are required to form or join a local Continuum of Care to coordinate the community's response to homelessness, identify gaps in services, and collaboratively plan for how to fill these gaps.

practices that they felt would be most useful and successful in the Northern Shenandoah Valley.

Input from the Technical Advisory Network

Members of the TAN then provided additional guidance on suggested best practices to implement in the Northern Shenandoah Valley through a community survey that provided all members with the opportunity to respond.

Working Groups

TAN members formed the following four working groups, facilitated by VCEH, to further develop and refine ideas for inclusion in the ten year plan:

1. Supportive Services
2. Affordable Housing
3. Prevention
4. Outreach and Advocacy

The working groups formulated possible action steps for inclusion in the ten year plan. VCEH then synthesized the recommendations and the TAN provided further comments during two comment periods.

HEARTH Act

The TAN, with assistance from VCEH, reviewed new federal requirements and expectations of local ten year plans as outlined in the HEARTH Act – federal legislation that makes sweeping changes to the HUD Continuum of Care program.

The Planning and Implementation Process

The TAN Executive Committee established the following five committees to oversee the implementation of the ten year plan:

1. Affordable Housing
2. Prevention
3. Supportive Services
4. Community Outreach and Advocacy
5. Data and Information and HMIS

Further information about implementation of the ten year plan is included later in this document.

What We Know About Homelessness

Homelessness in the Northern Shenandoah Valley

186 people experienced homelessness in the Northern Shenandoah Valley during the January 2011 Point in Time Count. This included 73 people in families and 113 individuals without children. Data from the 2011 Point in Time Count will be used as the baseline to measure the success of the ten year plan.

There were 131 households who experienced homelessness at the Point in Time Count in January 2011, including 24 households with children and 107 households comprised of individuals without children.

The 2011 Point in Time identified the following subpopulations experiencing homelessness:

Chronically Homeless	39 people
Severely Mentally Ill	12 people
Chronic Substance Abuse	44 people
Veterans	16 people
Persons with HIV/ AIDS	0 people
Victims of Domestic Violence	51 people
Unaccompanied Youth (Under 18 years of age)	0 people

The TAN estimates that there are about 2,040 people (duplicated) who come in and out of shelter each year, based on a 2008 survey of shelter providers.

Defining Homelessness and At Risk of Homelessness

This plan uses the definition of homelessness and at risk of homelessness adopted by the U.S. Department of Housing and Urban Development (HUD) as revised by the HEARTH Act. It defines an individual or family as experiencing homelessness if they fall into one of four categories:

1. An individual or family living in a.) A place not meant for human habitation (including a car, park, abandoned building, bus/train station, airport, or camping ground) or b.) Emergency shelter or transitional housing. A person is also considered homeless if he or she is discharged from an institution where he or she has resided for 90 days or less and the person resided in emergency shelter (but not transitional housing) or place not meant for human habitation immediately before entering that institution.
2. An individual or family being evicted within 14 days from their primary residence and a.) No subsequent residence has been identified and b.) The household lacks the resources or support networks (i.e. family, friends, faith-based or other social networks) needed to obtain other permanent housing.
3. Families with children and unaccompanied youth (up to age 24) experiencing housing instability who have not had a lease in the last 60 days, have moved at least twice in the last 60 days, and who have one or more of: chronic disabilities, chronic physical or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, a child with a disability, or two or more barriers to employment (lack of a high school diploma or GED, illiteracy, low English proficiency, history of incarceration or detention for criminal activity, or history of unstable employment).
4. An individual or family fleeing domestic violence, dating violence, sexual assault, stalking, or life-threatening conditions that relate to violence and have no other residence and lack the resources and support networks to obtain other permanent housing.

HUD defines the term "at risk of homelessness" to apply to an individual or family who meets the following criteria:

1. Has an income below 30 percent of Area Median Income;
2. Has insufficient resources immediately available to attain housing stability; and
3. Has one or more of the following:
    a. Has moved frequently because of economic reasons;

b. Is living in the home of another because of economic hardship;
c. Has been notified that their right to occupy their current housing or living situation will be terminated;
d. Lives in a hotel or motel;
e. Lives in severely overcrowded housing;
f. Is exiting an institution within 90 days; or
g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.

4. Includes all families with children and youth defined as homeless under other Federal statutes.

The Tools: Research that Shows Success in Ending Homelessness

There are many current and new tools that the community will utilize to achieve the intended goal of preventing, reducing, and ending homelessness over ten years. The information below provides brief information on each model.

Data Collection

HEARTH Act – The TAN will collect data that aligns with the HEARTH Act performance measurements to show progress in the following areas:

- Reduce rates of homelessness
- Reduce length of stay in shelter
- Reduce rates of return into homelessness
- Increase income either through access to benefits and / or through employment.

The TAN, through the ten year plan, has set out targets for the number of permanent supportive housing units to be created each year and the number of people experiencing homelessness who will be permanently housed to reduce and eliminate homelessness in the Northern Shenandoah Valley over the next decade.

Homeless Management Information System (HMIS) – The HMIS is a computerized data collection application in place for the Northern Shenandoah Valley. It can be used to measure the majority of the performance indictors called for by this ten year plan.

HMIS is designed to capture client-level, system-wide information over time on the characteristics, service needs, and history of those experiencing homelessness. It provides an unduplicated count of clients served within the community's system of homeless services. HMIS can provide data on client characteristics and service utilization. Analysis of HMIS data increases understanding of the local extent and scope of homelessness, identifies service gaps, and informs systems design and policy decisions.

Point in Time count and survey – The Point in Time count and survey is also a tool in place in the Northern Shenandoah Valley. The Point in Time count documents whether rates of homelessness in the community are increasing, decreasing, or remaining the same. The Point in Time count a one night count held semi-annually in January and July of sheltered and unsheltered people experiencing homelessness. It indicates an estimated number of people experiencing homelessness on any given night, according to the federal definition of homelessness used by HUD. HUD requires that those communities submitting Continuum of Care applications for federal homeless assistance funds conduct biennial count, although many communities, including the Northern Shenandoah Valley, conduct the count at least annually.

The Point in Time survey is used to understand the characteristics of those experiencing homelessness – including demographics, employment history, and mental health status – and can identify service needs of those experiencing homelessness.

Supportive Services

Coordination of Services – The Technical Advisory Network is in the process of implementing Central Intake and Common Housing Barrier Assessment tools to assist people experiencing homelessness access housing and eliminate the frustration of people in need of assistance who do not know how to access services. Each approach will streamline existing services and identify gaps and overlap of services. A Common Housing Barrier Assessment will assist agencies to have a common understanding of the challenges to accessing permanent housing for people experiencing homelessness. A Winchester-based Homeless Resources Center will serve provide central intake on a part time basis.

SSI/ SSDI Outreach, Access, and Recovery (SOAR) – Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that generally also include either Medicaid and/ or Medicare health insurance to individuals who are eligible.

For people who are homeless with mental health problems that impair cognition, or who are returning to the community from institutions (jails, prisons, or hospitals), access to these programs can be extraordinarily challenging. The application process for SSI/SSDI is complicated and difficult to navigate. Nationally, about 37 percent of individuals who apply for these benefits are approved on initial application. Appeals take an average of two years to complete. Yet, accessing these benefits is often a critical first step in recovery.

SOAR is a solution to this challenge. SOAR provides strategic planning and training to increase access to Social Security benefits for people experiencing homelessness. These benefits can increase access to permanent housing, treatment, and supports. Many, but not all, people experiencing homelessness have disabilities and are eligible for benefits. It is difficult to obtain these benefits, however, and many are rejected multiple times in the application process.

SOAR has resulted in success rates of 71 percent on initial SSI/SSDI applications as compared to the usual 10-15 percent for applicants experiencing homelessness.

Employment – The goal of all programs is to assist people to achieve increased self-sufficiency, recognizing that self-sufficiency may be different from one individual to the next. Employment is key to increasing income and increasing self-determination. The ten

year plan sets employment as a key strategy and outlines several options to increase employment and jobs skills of persons experiencing and at risk of homelessness.

Affordable Housing Options

Permanent Supportive Housing – Permanent supportive housing has been identified as a solution to homelessness for a sub-set of the population – those who experience homelessness for long periods of time (chronic homelessness[5]) with multiple barriers to housing stability, including mental disabilities, chemical dependence, and other chronic health conditions. Permanent supportive housing provides first a home and then continuing supportive services to help individuals maintain a home. These support services either directly provide or connect individuals to services in the community. Support services include direct or coordinated care in the areas of mental health, substance abuse, health care, dental care, education, employment, and access to benefits.

Rapid Re-Housing – Rapid re-housing is a strategy to assist families and individuals experiencing homelessness to access housing as quickly as possible and then deliver uniquely tailored services to help them maintain stable housing. If follows a "housing first" philosophy which says that individuals and families experiencing homelessness need housing first, and then they need services.

Rapid re-housing differs from traditional homeless assistance in that it does not require a family or individual to live in emergency shelter or transitional housing for a certain length of time prior to returning to permanent housing. It can, however, be delivered in an emergency shelter or transitional housing setting and is not mutually exclusive from emergency shelter and transitional housing settings.

Services are consumer-driven in that the person, with the help of a case manager, determines the services that she or he needs to maintain their housing. Services are critical to help a family maintain their housing, access and maintain employment, and increase

[5] The U.S. Department of Housing and Urban Development defines a person who is chronically homeless as an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or more, or has experienced at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitations (e.g., living on the streets) and/or in an emergency homeless shelter. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, or developmental disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living. Recent changes to federal law have expanded the definition of chronic homelessness to include families with a head of household who meets the above defined criteria.

their self-sufficiency and well-being. It is the housing *and* services that make rapid re-housing an effective permanent solution to homelessness.

Partnering with Landlords – Many agencies and community organizations have developed partnerships with landlords, and these partnerships have resulted in access to affordable housing options for those experiencing and at risk of homelessness. The partnership is an agreement that the landlord will rent to this population and, in some cases, the service agency agrees to maintain contact and provide services to help the household remain stably housed. It is a win-win situation for all parties in that the person accesses affordable housing, the service agency helps to house their clients, and the landlord has a source of support if any problems with the tenant arise.

Partnering with Affordable Housing Developers – Non-profit and for-profit affordable housing developers can be important partners in the financing and development of affordable, subsidized, and permanent supportive housing that can serve as a resource to homeless assistance agencies who wish to increase housing available to people experiencing homelessness.

Partnering with Veterans Administration Medical Centers to access HUD VASH vouchers – Case managers at Veterans Administration (VA) Medical Centers may refer eligible veterans experiencing homelessness to receive vouchers for supportive housing. To end veteran homelessness it is therefore imperative to partner with case management staff at the Martinsburg VA Medical Center to assure veterans experiencing homelessness in Northern Shenandoah Valley receive HUD VASH vouchers to which they are eligible.

Preventing Homelessness

Discharge Planning – It has been documented that those exiting institutions – including state and private hospitals, jails and prisons, nursing homes, and foster care – are at higher risk of homelessness. The ten year plan calls for the creation and evaluation of the impact of discharge plans for individuals exiting these institutions. Discharge plans include a realistic housing plan for each individual, ideally linked to housing and service supports as needed.

Outreach and Advocacy Efforts

Advisory Committee – The TAN is committed to forming a broad-based advisory committee comprised of members throughout the community, including elected officials, representatives of local government, the United Way, community and health foundations,

and other influential community leaders who are dedicated to ending homelessness. The advisory committee will assist the TAN to raise awareness of the problem of and solutions to homelessness in the community as well as to increase and leverage resources to achieve the goals of the ten year plan. The TAN will seek out a prominent community leader to serve as a chairperson of the committee and act as a community spokesperson for the cause of solving homelessness in the Northern Shenandoah Valley.

Key Goals and Implementation Strategies

Goals

The ten year plan sets out the following goals to prevent, reduce, and end homelessness in the Northern Shenandoah Valley by 2024.

1. Reduce homelessness each year for the next ten years.

   The 2011 Point in Time count will serve as the baseline for achievement of this goal.

2. Prevent homelessness before it occurs.

   Prevent individuals and families from entering the homeless assistance system. Instead, help them stabilize in their existing housing and / or access housing of their own.

3. Create broad-based partnerships that will leverage new resources and talents.

   Cultivate relationships with leaders from local government, business, funders, faith communities, and others to galvanize community support for ending homelessness.

4. Help promote necessary services in the region that alongside housing opportunities will help eliminate and prevent homelessness and support housing stability.

5. Coordinate the existing services system to ensure a streamlined process of accessing services and housing supports and to reduce duplication and gaps in services.

   Develop processes for centralized intake and assessment of people entering the homeless services system to assure that people are assisted into permanent housing as quickly as possible and to assure that limited resources are used as efficiently as possible.

6. Ensure consistent and quality data collection to inform community stakeholders on the progress of the ten year plan.

7. Assess progress annually and update the ten year plan as needed to reflect current circumstances and opportunities.

Implementation Strategies

The ten year plan sets out the following implementation strategies to achieve the goals of the ten year plan to prevent, reduce, and end homelessness by 2024. Implementation strategies have been identified for the first five years of the plan. Proposed activities will be reevaluated and revised on an annual basis.

Increase Affordable Housing in the Northern Shenandoah Valley

GOAL	*STRATEGIES*
Create Affordable Housing Opportunities	
Year 1	Identify possibility of accessing HUD-VASH vouchers by partnering with the VA Medical Center.
Year 1	Utilize the NSVRC Needs Assessment to make the case for need for additional affordable housing opportunities.
Years 1-2	Expand programs and staffing to conduct outreach to landlords to develop relationships that assist clients in accessing affordable housing
Years 1-2	Explore the need for a landlord contingency fund to mitigate real and perceived concerns of landlord that tenants will create a cost burden due to needs to repairs to units.
Years 1-5	Pursue opportunities to develop permanent supportive housing, including but not limited to 8-unit development by Shenandoah Alliance for Shelter and a development by People Inc. in Woodstock
Years 1-5	Continue efforts to improve the CoC score (and apply for bonus funds) to obtain federal funding for permanent supportive housing programs
Years 1-5	Implement Rapid Re-Housing programs for families experiencing homelessness, including through Salvation Army, Response, Community Transitional Housing Program and

	others
Years 3-5	Expand programs to reach out to housing developers to create affordable housing.
Years 3-5	Identify concrete incentives for housing developers to prioritize housing for people experiencing homelessness and / or set aside units for housing developers. To the extent necessary, involve political leaders.

Prevent Homelessness Before It Occurs

GOAL	*STRATEGIES*
Prevent homelessness of people being discharged from hospitals and mental health institutions	
Year 1	Review best practice models for hospital discharge plans that discharge people to appropriate housing options (if the group has not already done so).
Year 1-2	Make connections and develop relationships with patient advocates and social workers to determine what they do and how they plan for discharge.
Year 2	Host a meeting with hospital partners (local hospital systems and the VA) to identify possibilities for working together to develop a discharge plan.
Year 2	Begin implementing best practice discharge plan that discharges people to appropriate housing.
Prevent homelessness of people exiting jails	
Year 1	Review best practice models for discharge plans that discharge people from jails and prisons to appropriate housing options (if the group has not already done so).
Year 2	Host a meeting with partners from local jails to identify possibilities for working together to develop a discharge plan.
Year 2	Begin implementing best practice discharge plan that discharges people to from jails to appropriate housing.
Prevent homelessness of youth being discharged from foster care	
Year 1	Review best practice models for discharge plans that discharge youth exiting foster care to appropriate housing options (if the

	group has not already done so).
Year 2	Host a meeting with partners from DSS to identify possibilities for working together to develop a discharge plan.
Year 2	Begin implementing best practice discharge plan that discharges youth exiting foster care to appropriate housing options.
Prevent homelessness of unaccompanied youth	
Years 1-2	Identify the need for programs for unaccompanied youth. Review models to house unaccompanied youth.
Year 2	Host a meeting with partners to identify possibilities to work together to develop a plan to house unaccompanied youth experiencing homelessness.

Increase Supportive Services Available for People Experiencing Homelessness

GOAL	*STRATEGIES*
Increase income through employment	
Year 1	Review strategies for increasing income and employment.
Year 1	Determine a model for increasing income and employment that the group would like to recommend. Consider whether a partnership with the Virginia Employment Commission would meet the goals of the ten year plan in increasing access to employment.
Years 1-2	Partner with Lord Fairfax Community College to increase educational opportunities.
Years 1-2	Partner with People Inc. to determine ways that Workforce Investment Act One Stop Career Centers could support creating employment opportunities. Determine ways to partner with People Inc. to provide employment for youth through Youth Workforce Investment Act and Youth Build programs.
Year 2	Host a meeting with workforce and employment services partners to identify possibilities for working together
Year 2	Begin implementing the model for increasing income and employment.

Years 3-5	Encourage the prioritization of people experiencing and at risk of homelessness in Workforce Investment Board programs.
Year 5	Explore and encourage small-scale entrepreneurship among formerly homeless people.
Create System of Centralized Intake and Assessment	
Year 1	Finalize and implement centralized intake process with common intake, assessment and housing placement protocols across all CoC agencies
Year 1	Develop centralized Homeless Resource Center one day per week in Winchester.
Year 3	Expand centralized Homeless Resource Center.
Increase Access to Disability and Other Benefits for Those Who Are Eligible	
Year 1	Utilize Common Help Portal, the new system implemented by Virginia Department of Social Services, to help clients apply for and access benefits.
Year 1	Contact the Virginia Department of Behavioral Health and Developmental Services regarding the availability of training on the SOAR program – a program that drastically reduces the time it takes to receive a SSI / SSDI disability application approval.
Increase Access to Supportive Services	
Year 3	Explore opportunities for funding for transportation including micro loans and savings programs that allow for the purchase or repair of cars.

Strengthen community wide data collection and performance measurement.

GOAL	*STRATEGIES*
Increase participation of service providers, including government units that provide direct assistance, in the Homeless Management Information System (HMIS) to understand the needs of those experiencing homelessness in the community.	
Year 1	Advertise to those agencies that are not participating in the Homeless Information Management System (HMIS) that there is an option for them to not have to pay for user licenses.

Year 1	Conduct outreach to agencies not participating in HMIS and host two meetings to review benefits of participating in HMIS.
Year 1	Identify a mechanism to aggregate HMIS data with data from domestic violence service agencies. (Domestic violence providers are prohibited from using the HMIS data for their clients.)
Increase awareness of the agencies providing services in the region and the services that they provide.	
Year 1	Utilize nsvcommunity.org, hosted by the NSVRC, to create a web portal to list agencies and the services provided.
Utilize data to determine the programs that are achieving results.	
Year 1	Agree on standard performance measurements for all agencies in the Continuum of Care.
Year 2	Request that all agencies report on their outcomes quarterly to create a community snapshot of the results of homeless programs.
Better disseminate data to use as a tool with local government, policy makers, and other stakeholders.	
Years 2 - 10	Create and disseminate a report to be issued to local government, policy makers, and other stakeholders on the impact of homeless programs and the need for increased focus on homelessness.

Increase Outreach and Advocacy Efforts to End Homelessness

GOAL	*STRATEGIES*
Develop a broad-based advisory committee that can support the TAN to raise awareness in the community, debunk myths about homelessness, increase funding and resources, fight NIMBY, and attract volunteers.	
Year 1	Identify a prominent community leader (for example, an elected official, prominent business person or religious leader) to serve as chairperson of the committee
Years 1-2	Meet with and work to engage leaders from among the following: Chambers of Commerce, Local Government, United

	Way, Community Foundations, Business (including realtors, landlords), colleges and universities, churches and faith communities, law enforcement, social service agencies, mental health agencies, hospitals, schools, affordable housing developers, immigrant Advocacy Groups, and veterans' service groups.
Years 1-5	Partner with local and state elected officials to bring about policy changes necessary to implementing the ten year plan.
Years 1-5	Speak to community groups about issue of homelessness
Years 1-5	Utilize local media (distribute regular news releases; develop relationships with local reporters)
Years 1-5	Share success stories from agencies making progress to end homelessness
Years 1-5	Use statistics on the costs of homelessness to jails, hospitals, and shelters to show cost effective housing first alternatives that reduce homelessness

Implementation Structure

The TAN has adopted the following committees to oversee the implementation of the ten year plan:

1. Affordable Housing and Prevention

   This committee is responsible for:

   - Overseeing strategies that increase permanent supportive housing;
   - Overseeing strategies that increase rapid re-housing;
   - Overseeing strategies that increase affordable housing.

2. Prevention

   This committee is responsible for:

   - Overseeing strategies that prevent the homelessness of people being discharged from hospitals and mental health institutions;
   - Overseeing strategies that prevent the homelessness of people exiting from jails;
   - Overseeing strategies that prevent the homelessness of youth aging out of foster care;
   - Overseeing strategies that prevent the homelessness of unaccompanied youth.

3. Supportive Services

   This committee is responsible for:

   - Overseeing the implementation of strategies that increase income through employment;
   - Overseeing the creation of a system of centralized intake and assessment;
   - Overseeing the implementation of strategies that increase access to disability and other benefits for those who are eligible;
   - Overseeing increased access to supportive services.

4. Community Outreach and Advocacy

   This committee is responsible for:

- Developing a broad-based advisory committee;
- Supporting the TAN to raise awareness in the community, debunk myths about homelessness, increase funding and resources, fight NIMBY, and attract volunteers;
- Identifying a prominent community leader to serve as the chairperson of the committee;
- Advocating with local and state public officials.

5. Data and Information and HMIS

   This committee is responsible for:

   - Informing the development of the Consolidated Plan's housing and homeless needs assessment and special needs and non-housing community development needs assessment (same as current);
   - Promoting and giving leadership to conducting the annual homeless Point in Time Count (same as current);
   - Gathering information for the annual Housing Inventory (same as current);
   - Encouraging participation in the Homeless Management Information System and Annual Homeless Assessment Report (same as current);
   - Evaluating the quality of current data;
   - Assessing progress in achieving the goals of the ten year plan to end homelessness.

6. Program Project and Initiatives Committee (as needed)

   This committee is responsible for:

   - Reviewing and ranking proposals for the annual Continuum of Care Application;
   - Completing final review and interviewing agency requesting funds;
   - Making final decision on the applications for which the Continuum of Care with seek funding.

In addition, ad hoc committees will occasionally be formed as needed.

Metrics and Evaluation

10 Year Plan Targets for Reducing Homelessness in the Northern Shenandoah Valley 2014 – 2024

	2009	*2010*	*2011 (Baseline)*	*2012*	**2014 Goal**	**2015 Goal**	**2016 Goal**	**2017 Goal**	**2018 Goal**	**2019-2024 Goals**
Total Number of persons	*97*	*264*	*186*	*183*	168	150	132	114	96	0
Number of households	*72*	*160*	*131*	*142*	118	105	92	79	66	0
Number of households (less chronically homeless)	*41*	*113*	*92*	*109*	83	74	65	56	47	0
Number of People Entering and Exiting Shelter (duplicated)			*2,040** (*2008)		1,836	1,632	1,428	1,224	1,020	
Chronically Homeless	*31*	*47*	*39*	*33*	35	31	27	23	19	0
Veterans	*4*		*16*	*12*	8	0	0	0	0	0
Persons with HIV/ AIDS	*17*	*4*	*0*	*0*	0	0	0	0	0	0
Victims of Domestic Violence	*23*	*49*	*51*	*17*	46	41	36	31	26	0

Un Accompanied Youth (Under Age 18)	*5*	*0*	*0*	*0*	0	0	0	0	0	0

10 Year Plan Targets for Creating Housing Opportunities for People Experiencing Homelessness in the Northern Shenandoah Valley 2014 - 2024

	2009	*2010*	*2011*	*2012*	**2014 Goal**	**2015 Goal**	**2016 Goal**	**2017 Goal**	**2018 Goal**	**2019-2024 Goals**
New PSH Beds			4		4	4	4	4	4	20
Rapid Re-Housing and Affordable Housing Placements					204	204	204	204	204	1,020

Appendix A: Glossary

Barriers to Housing – People who experience homelessness have multiple barriers and challenges that make it more difficult for them to access and maintain housing of their own. For example, criminal history is a barrier to housing because those with criminal histories are often barred from renting housing in the private market. Poor credit is another example of a barrier to housing because landlords screen out people with poor credit.

Best Practice – A best practice approach or strategy is one that has been shown to have better results than alternative programs. In the field of homelessness, the best practice approaches of permanent supportive housing and rapid re-housing demonstrate outcomes that show greater success in preserving housing stability and do so more cost-effectively than traditional interventions such as emergency shelter and transitional housing.

Case Management – Case management refers to the coordination of a variety of services (mental health, substance abuse recovery, employment assistance, etc.) on behalf of and with a person or household who is experiencing homelessness. Case management is generally delivered by a social worker.

Chronic Homelessness – The U.S. Department of Housing and Urban Development defines a person who is chronically homeless as an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or more, or has experienced at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitations (e.g., living on the streets) and/or in an emergency homeless shelter. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, or developmental disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living. Recent changes to federal law have expanded the definition of chronic homelessness to include families with a head of household who meets the above defined criteria.

Consumer Choice – Consumer choice recognizes self-determination and self-direction as the foundations for service provision as individuals and families define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence by leading, controlling, and exercising choice over the services and supports that assist them in achieving housing stability. In doing so, they are empowered and provided the resources to make informed decisions, initiate recovery, build on strengths, and gain or regain control over their lives.

Continuum of Care – 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. CoCs have taken on multiple roles in the community including coordination of resources, advocacy, and development of plans to end homelessness.

Emergency Shelter – An emergency shelter provides short-term overnight housing for people who experience homelessness. While it differs from community to community, generally people who experience homelessness sleep on beds or cots together in one room.

Evidence-Based Practice – An evidence-based practice has been shown to be successful based on studies conducted using theoretical, quantitative, or qualitative research. Permanent supportive housing is an evidence-based practice, as documented through a toolkit created by the United States Substance Abuse and Mental Health Services Administration (SAMHSA.)

Harm Reduction – A harm reduction approach does not create rules and regulations around sobriety and treatment as a condition to receiving housing. This approach recognizes that once a person has housing of his or her own, housing provides the stabilizing force which increases the client's own motivation to participate in services.

Homeless Management Information System – A Homeless Management Information System (HMIS) is a database that tracks outcomes for programs assisting people who experience homelessness and demographic data about people participating in homeless assistance programs.

Housing First – The Housing First philosophy recognizes permanent housing as the first and primary solution to homelessness. Housing First places a person or household experiencing homelessness in permanent housing as quickly as possible, regardless of physical, mental health, or substance use disability, or other barrier to housing. Such issues can and should be addressed only after permanent housing is established.

Length of Stay – Length of stay describes the duration of a single stay in a homeless assistance program such as emergency shelter or transitional housing. Best practices suggest that the length of stay in emergency shelter should be as short as possible. In new regulations, the U.S. Department of Housing and Urban Development is urging communities to reduce the average stay in emergency shelter for families to under 30 days.

Low-Barrier Shelter –A low barrier shelter is a form of congregate housing where a minimum number of expectations are placed on people who wish to stay there. The aim is to have as few barriers and rules as possible to allow more people to access services. This often means that people staying in low-barrier shelter are not expected to abstain from using alcohol, forced to adhere to time limits, or other rules. Low barrier shelters follow a harm reduction philosophy.

Motivational Interviewing – Motivational interviewing is a form of collaborative conversation for strengthening a person's own motivation and commitment to change. It is a person-centered counseling style addressing the common problem of ambivalence about change. It is designed to strengthen an individual's motivation and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. (Definition from the Motivational Interviewing Network of Trainers)

Permanent Supportive Housing – Permanent supportive housing (PSH) is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. A permanent supportive housing unit is intended for a person or family whose head of household is homeless or at risk of homelessness and has multiple barriers to housing and housing stability, which may include mental illness, chemical dependency, and/or other disabling or chronic health conditions. The tenant household ideally pays no more than 30% of income towards rent and utilities, holds a lease with no limits on length of tenancy, and any member of the household may access flexible and comprehensive support services designed to assist the tenant in achieving housing stability. Service providers proactively seek to engage tenants in these on-site and community-based services, but participation by the tenant in such services is not a condition of ongoing tenancy. The unit's operations are managed through a partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants. Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance abuse, relapse, and mental health crises, with a focus on housing stability.

Point-in-Time Count – The Point-in-Time Count is a census, taken during a specific 24-hour period, of people living on the streets and in other homeless situations, including emergency shelter, and transitional housing. The Point-in-Time Count collects data on the number of people and households experiencing homelessness in a community, and surveys a sample of people to collect more in- depth information about them. Every Continuum of Care (see above for definition) is required by the United States Department of Housing and Urban Development to complete a point-in-time count.

Progressive Engagement – Progressive Engagement is a best practice strategy of providing services and financial assistance that preserves the most intensive and expensive interventions for households with the most need in order to preserve resources and provide assistance to the widest number of people. In progressive engagement, all households receive a minimum level of assistance and many will be successful. Only those households who need additional assistance will receive it. For example, all households who enter a rapid re-housing program may receive assistance with housing startup costs, but

only those families determined to need additional assistance may receive ongoing short term rental assistance. If then a few households are determined to have even greater needs, they may be considered for additional resources.

Rapid Re-Housing – Rapid Re-Housing is a housing first strategy for preventing and ending homelessness that places a family or individual experiencing homelessness in permanent housing as quickly as possible, or prevents a family from experiencing homelessness, by providing temporary financial assistance and targeted supportive services to assist a household to become stably housed.

Transitional Housing – Transitional Housing is temporary housing, often for up to two years. Transitional housing also provides supportive services to address the issues that may have contributed to a person's homeless episode.

Voluntary Services – A voluntary services approach makes acceptance of services for participants optional rather than a requirement. Consumers of homeless housing programs who are empowered to make their own decisions have been shown to have greater success dealing with the issues that may have caused their homelessness.