A 10-YEAR BLUEPRINT TO SERVE EVERY HOMELESS CITIZEN IN THE PIKES PEAK REGION

Colorado Springs, CO

Coordinated through

Homeward Pikes Peak

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The Pikes Peak Region's 10-year Blueprint exists only because agencies banded together to discuss homelessness as a multi-sector problem with a multi-sector response. Without the dedication and input of dozens of dedicated staff and volunteers, this document and its solutions would not be possible. We gratefully acknowledge the following organizations and leaders for their tireless committee work.

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We dedicate this blueprint to the citizens of our rich and diverse community. Homelessness will never be eradicated but we are making significant strides in providing multi-layered options for everyone experiencing this difficult life.

Dr. Robert Holmes
Executive Director
Homeward Pikes Peak

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EXECUTIVE SUMMARY

Colorado Springs is relatively new in its effort to comprehensively deal with the homeless. Continuum of Care HUD data reveal approximately 1,100 homeless individuals in the Pikes Peak region. However, local homelessness experts (Homeward Pikes Peak, Peak Vista Homeless Clinic, the police department, etc.) estimate an additional 800 people remain uncounted. It is unrealistic to believe that homelessness can be eliminated. Instead, the agencies involved in creating this 10-Year Blueprint envision providing housing for every individual who wants it and optimizing solutions for the *causes* of homelessness in the Pikes Peak Region.

Homeward Pikes Peak serves as a coordinator for homeless services throughout the Pikes Peak region. The original Five-Year Blueprint to House Every Citizen of Colorado Springs was developed in 2003. The intervening years have brought significant change in the Continuum of Care as well as the working relationships between providers. Most important, planning together moved agencies from reactive to proactive mode. This change required anticipating conditions leading to homelessness and intervening with prevention resources. As most communities have found, prevention is significantly less expensive than re-housing.

To this end, key community agencies have outlined objectives and action plans in seven critical sectors: housing, healthcare, food, emergency services, veteran's services, prison re-entry, and access to services. An additional eight sectors will be added to the 10-Year Blueprint during 2009 and 2010. Together agencies are all working towards four common objectives:

#1: Coordinated resources and formalized networks among agencies.
#2: Outreach to unsheltered homeless individuals occurs on a regular basis.
#3: A continuum of services is available in seven key sectors.
#4: Measurable improvement of client's lives.

There is overlap between sectors and services, in part, because of the diligent community efforts to create a continuum of care with multiple entry and access points. Blueprint objectives are ambitious. They require more than the interagency collaboration of the past. They require a matrix of flexible communication and resource sharing unmarred by turf wars and characterized by blended funding and coordinated response.

As the multi-sector coordinator, Homeward Pikes Peak oversees coordination and data management between agencies. This effort includes comparing the community's response to homelessness with annual outcomes, comparing progress towards Continuum of Care end condition indicators with community quality of life indicators, and providing leadership for evidence-based practices and sustainable resources.

We acknowledge that life constantly changes and any document merely captures the dreams, desires and intentions of its constituents at one point in time. As such, this 10-Year Blueprint is just that - a blueprint, not a solid construct. It will be refined, expanded and improved through the lessons learned as our community meets the challenges of homelessness.

BACKGROUND

Homeward Pikes Peak serves as a coordinator for homeless services throughout the Pikes Peak region. Homeward Pikes Peak aims *to be the catalyst in the Pikes Peak region's commitment to eliminate homelessness by coordinating, facilitating and monitoring a strategic plan for homeless services and resource utilization.*

The original Five Year Blueprint to House Every Citizen of Colorado Springs was developed in 2003. The genesis of the plan came from the federal government's request to the Interagency Council on Homelessness to create a 10-year plan. A five-year blueprint seemed optimal given the ever changing economic environment. The intervening years have brought significant change in the Continuum of Care as well as the working relationships between providers. Most importantly, planning together moved agencies from reactive to proactive mode. This change required anticipating conditions leading to homelessness and intervening with prevention resources. As most communities have found, prevention is significantly less expensive than re-housing.

As the 2009-2018 10-year Blueprint is developed, the continuum of care community reflected on its accomplishments over the past five years.

- A broader spectrum of agencies became involved in the continuum of care. This led to the City of Colorado Springs and El Paso County maximizing Housing and Urban Development (HUD) federal funding for the past five years including Super NOFA Bonus Grants.

- The Comprehensive Homeless Assistance Providers (CHAP) organization was revitalized and expanded to include any interested community member. This task force has over 100 members and is chaired by Executive Director of Homeward Pikes Peak, the Continuum of Care Permanent Coordinating Organization. Education programs are sponsored on a regular basis, along with site visits to homeless service agencies. The average attendance has increased 400%.

    - Each year CHAP chooses a theme for concentrated effort and study. Past topics include developing a philosophy of helping the homeless, accessing mainstream resources, developing alternative delivery systems for food services, Gulf Coast Hurricane Relief, cooperative teaching for Life Skills classes, and developing an initiative to provide additional funding for substance abuse and mental health services.

- The HUD-mandated Homeless Management Information System (HMIS), called the Client Management System in our continuum, is up and running productively under the aegis of Pikes Peak United Way.

- Annual and semi-annual counts of the homeless plus the collection and processing of demographic information have been done on a regular basis since 2003. Through these efforts, the continuum generated accurate data and was able to dispel several demographic "myths" that had previously circulated throughout the region.

- A five-year effort now channels panhandling funds from individuals who would spend them on drugs and alcohol to homeless service agencies who use the funds to enhance homeless programs. The most recent effort is the parking meter project. Downtown residents and visitors can put spare change into meters which is then distributed to homeless service providers.

- An annual "Conference on Homelessness" has been held for the past six years. The event brings local and national experts to Colorado Springs to address topics germane to homeless services providers. Additionally, the "Annual Forum on Homeless" addresses specific topics in fields of interest. Both gatherings are open to service providers and the public alike.

- The continuum sponsors a "Small Mental Health Providers" monthly meeting on the same day as the CHAP meeting. This program serves as a mutual support and cooperative services group for mental health providers which operate on limited funds. It is heavily attended by faith-based organizations.

- Gulf Coast Hurricane Relief was coordinated, for the most part, by Homeward Pikes Peak on a *pro bono* basis. Colorado Springs and its environs received slightly over 2,000 Gulf Coast Hurricane evacuees who were housed and provided with social and support services. In addition, the community assembled a set of demographic information on each family equal to any other city's effort in the United States. Approximately half the evacuees likes the Pikes Peak region well enough to stay in the area long after aid ceased.

- Over the base five years, 60 new units for housing and case managing dual diagnosed chronically homeless individuals have been added to the continuum's inventory.

While the homeless continuum of care solidified, other sectors of the community also moved forward.

In 2006, Pikes Peak United Way invited more than 100 interested community leaders to join Vision Councils to address one of nine different areas. Leaders were drawn from the private, public and nonprofit sectors and represented diverse interests and passions. Together the councils established quantitative indicators that measure the quality of life in El Paso County. The nine categories cover a variety of issues that citizenry can improve through public decision making and action. 2006-2007 data provides the baseline for measuring progress during the next decade.[1] Linking the 10-Year Blueprint for Homelessness to community indicators and HUD Goals will provide a format for reviewing annual status and progress.

[1] Pikes Peak United Way. (2007). *Quality of Life Indicators for the Pikes Peak Region*. Colorado Springs, CO: Author

To quantify outcomes, particularly for the HMIS system, continuum of care leaders spent several sessions working with VisionLink, Inc between January and May 2008. The group completed a community self-assessment, defined ideal conditions, established indicators, and made progress on joint strategies. Four outcomes provide an overall measurement for the continuum of care sectors.

Outcomes:

#1: Coordinated resources and formalized networks among homeless provider agencies.

#2: Outreach to unsheltered homeless individuals occurs on a regular basis.

#3: A continuum of services is available across the continuum of care and needs are met in an optimized, cost effective manner.

#4: Measurable improvements in clients' lives.

Much has been accomplished in the past five years but much work remains to be done. The 10-Year Blueprint provides the direction, goals and benchmarks for that effort.

10-YEAR BLUEPRINT TO SERVE EVERY HOMELESS PERSON IN THE PIKES PEAK REGION

OVERVIEW OF CURRENT HOMELESS POPULATION

Colorado Springs anchors the Pikes Peak region of Colorado, 60 miles south of Denver. The city accounts for 63% of El Paso County's 587,272 residents. The county population increased 13.6% between 2000 and 2007.[2] With moderate housing costs and average employment rates, El Paso County attracts the hopeful seeking jobs, a temperate climate, and vibrant scenery. Colorado Springs centers on two main transportation routes - Interstate 25 (north-south from Mexico to Canada) and U.S. Highway 24 (east-west from Interstate 70 at Vail to Interstate 70 at Limon, CO). The result is easy access to a large city less sprawling than Denver. Approximately 80% of the population is white, 6.1% Black, 1% American Indian, 2.8% Asian, and 12.9% Hispanic. Twenty-seven percent of the county's population live in households with income below $25,000 per year and approximately 10% of county residents live in poverty. In 2004, 19.7% of the population had no health insurance and 7.4% was served through Medicaid.[3] Continuum of Care HUD data (2007)[4] collected by Homeward Pikes Peak reveal the following:

	Sheltered (emergency or transitional housing	Unsheltered	Total
General Homeless Pop.			
Individuals	434	328	762
Family members	259	56	315
Total Homeless	693	384	1,077
Subpopulations			
Chronically Homeless	101	94	195
Severely Mentally Ill	172	54	226
Chronic Substance Abuse	188	60	248
Veterans	122	62	184
Persons w/ HIV or AIDS	7	4	11
Victims of Domestic Viol.	12	*	12
Unaccomp. Youth < 18	17	1	18

* unknown

[2] U.S. Census. (2008). American fact finder. El Paso County, Colorado. Available at http://factfinder.census.gov
[3] El Paso County Department of Health and Environment. (2005, April 4). *Annual report for 2004: Initial results from the El Paso County community health survey.*
[4] U.S. Department of Housing and Urban Development. (2007). Colorado Springs, Colorado: 2006 Homeless Assessment Data. Available at http://www.hud.gov/offices/cpd/homeless/local/reports/2006_co_504_pop_sub.pdf

While the numbers shown are the official counts of homeless individuals through HUD surveys, local homelessness experts (Homeward Pikes Peak, Peak Vista Homeless Clinic, the police department, etc.) estimate an additional 800 people remain uncounted. They live in caves above Manitou Springs, camps hidden in the foothills, or are women and children who float from friend to friend. Credence is given to this estimate when examining Peak Vista's homeless patient count. Last year, the clinic registered 1,131 homeless individuals and provided 2,166 care visits for them.

An additional survey of homeless, unsheltered individuals was conducted during August 2006 by the Colorado Interagency Council on Homelessness.[5] This survey found:

- 71.3% of homeless were single.
- 22.5% were singles or couples with children under age 18.
- Males outnumber females (63.5% vs 36.5%).
- Nearly 17% identified themselves as Spanish/Latino/ Hispanic and slightly more than one-third (35.4%) were a minority ethnicity.
- Just 6.6% identified themselves a seasonal or year-round farm workers and only 3% were seasonal resort workers.
- Approximately 10% indicated that their homelessness was due to mental illness or medical problems.
- One in five (21.8%) had served in the U.S. military. This statistic is particularly significant since El Paso County is home to over 50,000 active military. The county is also home to over 76,000 veterans.

Other survey results include ties to the local community.

- Nearly 40% state the El Paso County was their last county of permanent residence.
- Housing continues to be an issue. Thirty-three percent of respondents were staying in time-limited transitional housing. Another 17.8% were staying in an emergency shelter or staying temporarily with family or friends (14.4%). Seventeen percent were unsheltered.

For the homeless, basic medical care, shelter, food, and clothing barriers are equally daunting. Mental illness often exacerbates underlying physical health ailments caused by the substance abuse. The most prevalent are pneumonia, bronchitis, acute pancreatitis, liver damage, cardiac dysrhythmias, chest pain, wounds, and gastrointestinal hemorrhaging. Medical treatment is confined to a few sites - the homeless medical services van (Peak Vista) and outreach and medical care through Catholic Charities and SET of Colorado Springs. Dental care is critical for positive interaction leading to housing, employment and community services. However, both Mission Medical and Peak Vista have long waiting lists. The lack of trained providers compound these barriers to delivering evidence-based integrated treatment. Few providers are anxious to work with homeless clients. Fewer still, know how or wish to work with individuals with serious mental illness and substance abuse. Qualified providers are rarely available beyond standard office hours, 8-5 Monday through Friday even at Peak Vista's Homeless Medical Clinic.

[5] Colorado Interagency Council on Homelessness. (2007). El Paso/Colorado Springs Continuum of Care.

The community currently has 39 housing slots available for homeless individuals including those with substance abuse issues. Another 53 slots are available through Shelter plus Care programs for individuals with mental health concerns. Both types of facilities have waiting lists. Community providers, supported by HUD surveys, estimate there are 300-400 homeless 18 - 64 year olds impacted by co-occurring substance abuse and mental health problems. Estimates also reflect that each homeless individual with a co-occurring condition costs the community $54,000 per year in untreated medical, emergency room, police and fire/ambulance services. During 2007, Homeward Pikes Peak, the El Paso County Co-Occurring Disorder Collaborative, and Harbor House moved 25 individuals into small apartments with wrap around services and treatment. The cost of housing and treatment for these individuals ranges from $12,000 - $18,000 per year - **one-third the cost of homelessness and non-treatment.**

COMMUNITY RESPONSE

HUD has established five national objectives:

- Create new Permanent Housing beds for chronically homeless persons.
- Increase the percentage of homeless persons staying in Permanent Housing over six months to at least 71.5%.
- Increase the percentage of homeless persons moving from Transitional Housing to Permanent Housing to at least 63.5%.
- Increase the percentage of homeless persons employed at exit to at least 19%.
- Decrease the number of homeless households with children.

Colorado Springs agencies which serve the homeless strive to maintain even high standards than those delineated by HUD. During 2008, Colorado Springs

- Increased Permanent Housing beds by **45** (a 64% increase due to specialized funding streams)
- Increased the percentage of homeless persons staying in Permanent Housing over six months to **91%**
- Increased the percentage of homeless persons moving from Transitional Housing to Permanent Housing to **86%**

The percentage of homeless persons employed at exit from homelessness is already **18%** and all sectors are working diligently to incorporate education and employment supports into their service streams.

While the number of unsheltered families with children decreased from 75 to 56 (25%) during 2006, the difficult economic times in 2008 negatively impacted family housing. All agencies are working diligently to expand options and decrease wait times for family housing.

STRUCTURE OF THE 10-YEAR BLUEPRINT DOCUMENT

Vision

To house every citizen of Colorado Springs.

Goal

An optimized set of solutions for homelessness in the Pikes Peak Region.

The Pikes Peak region's continuum of care is characterized by 15 key sectors:

- Healthcare
- Housing
- Food
- Emergency Services
- Veterans' Services
- Prison Re-Entry
- Access to Services
- Clothing and Furniture
- Disability Services
- Discharge Policies and Process
- Daycare
- Youth Services
- Police
- Transportation
- Education

The first seven major areas will be considered in the 2009 10-Year Blueprint. Information is presented on each of the seven sectors. Background data, issues, barriers, strategies for reform, and action steps were developed by community agencies directly involved with service provision. Outcomes and indicators are tied to those developed in the continuum of care meetings with VisionLink. A culminating view of community challenges from the Homeward Pikes Peak perspective aligns goals, strategies and timelines with the community's Quality of Life Indicators.

The Blueprint is articulated so that each October a community-based team of homeless services providers, formerly homeless, business leaders, politicians, faith-based representatives, veterans, police, medical representatives, and other interested parties can meet to review, update and advance (by one year) the Blueprint. Additional service areas or amended goals and outcomes can be also considered.

CONTINUUM OF CARE SERVICES

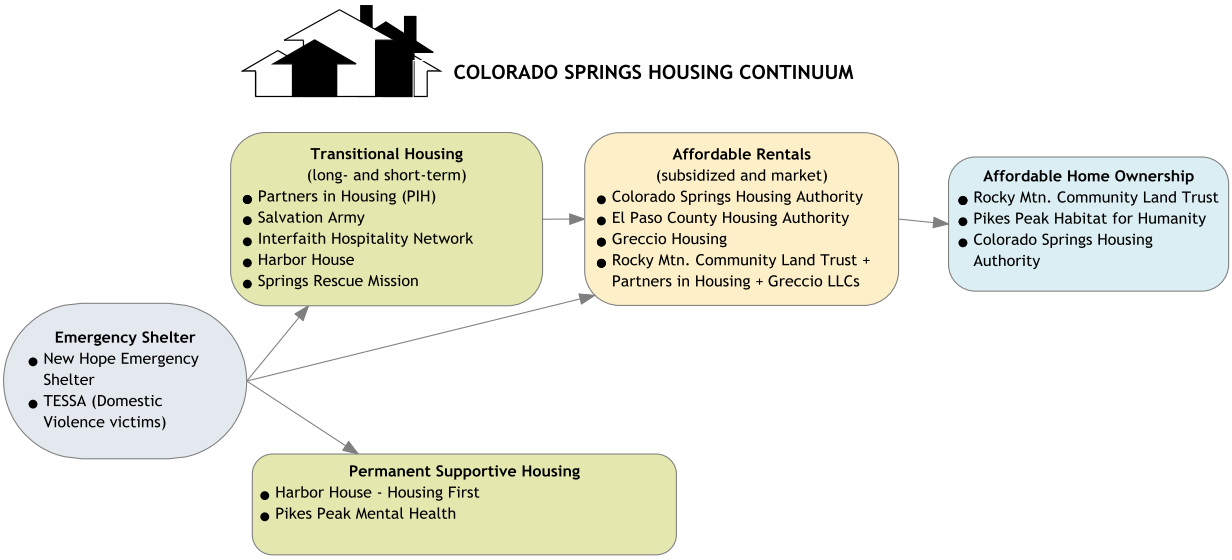
SECTOR 1: HOUSING

Overarching Goal

All individuals and families in the community have access to safe, decent, affordable housing along with appropriate support services, commensurate with their needs, to promote self-sufficiency and well-being.

Sector Description

Housing is a complex issue in any community and, for most communities, the lack of housing is a key contributor to homelessness. Colorado Springs provides a continuum of housing from emergency shelter to home ownership supported by an array of local agencies.



It should be noted that funding across the housing continuum is provided through various programs and at varying levels by the City of Colorado Springs, El Paso County, the Colorado Division of Housing and HUD. Additionally, the list of agencies reflected in the illustration above, as well as named throughout this plan, is not all-inclusive. There are other housing and homeless service providers not specifically called out in this document that contribute significant support across the continuum. Representative providers across the Colorado Springs housing continuum include the following agencies. Please note this is not an all-inclusive list, but is meant to provide a reasonable cross-section of major housing participants in the community. All figures and statistics are current as of January, 2009.

Emergency Shelter

- **Salvation Army**'s New Hope Emergency Shelter provides emergency shelter for men, women, and families. The New Hope Shelter is Colorado Springs only 24/7 emergency shelter and can accommodate up to 200 people. In cold weather, the Shelter can accommodate an additional 45 individuals. Residents receive a warm place to sleep, meals and access to shower and laundry facilities where all necessary provisions are supplied. The Center also collaborates with the City of Colorado Springs, serving as first-call shelter in its cold weather emergency plan. Counseling and resource advocacy are also available for those who wish to get off the streets. In addition, New Hope houses The Children's Discovery Center, a special developmental program for families with children living at the Center. The goal of The New Hope Center is to help lead residents out of the cycle of homelessness to self-sufficiency.

- **TESSA**, through its Safehouse, accommodates 32-42 women and children who are victims of domestic violence. TESSA is the primary agency dedicated specifically and solely to the issues of domestic violence and sexual assault in El Paso and Teller Counties in Colorado. The Safehouse provides food, clothing and shelter to women and children for up to six weeks. Victims have access to TESSA support groups, therapists and advocates.

Transitional Housing

- **Partners in Housing**'s Homeless Self-Sufficiency program serves eligible homeless families with children, adult childless couples, and adult single individuals by providing them with transitional housing for a period of up to two years, along with supportive services. As part of this program, ancillary services include individualized case management, life skills training, budget counseling, and educational and job counseling. Program goals include helping clients find permanent housing, further their education, find sustainable employment, improve family stability, and facilitate long-term goal achievement and self-sufficiency.

- **Salvation Army**'s Transitional Family Housing Program provides a stimulating and safe refuge for families with children to evaluate their lives after times of crisis. Transitional housing provides:
    - 13 two-bedroom and 5 one-bedroom apartments with private bathroom, kitchen, dishwasher, refrigerator, washer and dryer
    - A full-service commercial kitchen and cafeteria are available for lunch meals
    - School-aged childcare services available
    - Recreational facilities including playground, gym, basketball court and fitness
    - center
    - Wireless Internet access and Linkin'Labs computer check-out program
    - 24-hour staff on site

  The transitional Family Housing Program addresses physical, emotional, spiritual, and financial needs of the family while teaching clients the strategies that will permanently keep them on the road to self-sufficiency.

- **Harbor House** provides transitional housing, substance abuse treatment, and intensive case management to long-term homeless, chronic substance abusers in El Paso County. Harbor House places 20-30 individuals annually in its highly structured therapeutic environment. With a safe place to live and intensive services, chronic inebriates work towards health, sobriety and self-sufficiency. Outcomes include sobriety and comparisons of service utilization along with measurable improvements in six major life domains including employment, legal, family and social, psychiatric, and medical.

- **Interfaith Hospitality Network** realizes its mission by providing transitional short-term transitional housing, meals, and supportive services to homeless families with children and those at immediate risk to experience homelessness. IHN can accommodate 16 people in up to four families at a time for a negotiable maximum of three months per family. IHN's primary goal is to assist families with children to transition into safe, affordable housing. A secondary goal is meeting community transitional housing needs in the most cost-effective manner possible. Although it is a secular organization, the Interfaith Hospitality Network partners with congregations of diverse faiths and denominations to provide shelter and direct support to homeless families.

- **Springs Rescue Mission**'s one-year residential recovery program serves men suffering from chronic alcoholism, drug addiction, or those having difficulty functioning in society due to a lack of life skills. Housing is provided in conjunction with the Men's New Life Program. Men earn increased privileges as they progress through the program, learning appropriate tools of responsibility and community interaction. Ongoing one-on-one case management sessions are used to establish and meet personal and professional goals, and provide spiritual and cognitive counseling. Transitional beds will increase to 50 in 2009 with the completion of the Springs Rescue Mission's new Life Skills Center.

- Smaller organizations also offering transitional housing include, but are not limited to: Liza's Place (14 beds), Urban Peak (20 beds for homeless teens), Alano Recovery Homes (30 beds) and Colorado House (Up to 60 beds).

<u>Affordable Rentals</u>

- **Colorado Springs Housing Authority** manages over 700 affordable rental units in Colorado Springs, approximately 400 of which are family units, with the remainder provided as senior housing. In addition, CSHA manages over 2000 Section 8 housing vouchers under its own program, as well as managing Section 8 programs for the El Paso County Housing Authority and for the City of Manitou Springs. The affordable rentals are arranged on a scattered site basis. That is, the majority of the dwellings are single family houses with some duplexes, four-plexes, or six-plexes scattered throughout Colorado Springs. Participants in the program pay 30% of their adjusted gross income for the rent to the Housing Authority. Since 2006, Section 8 and public housing options have been full. Only seniors or disabled individuals can add their names to waiting lists. Housing Choice Vouchers are available to assist tenants in paying rent and utility payments on homes or apartments in the private market, per federal guidelines. The CSHA also offers comprehensive CHFA and HUD-certified first-time homebuyer education services open to the public (as does Partners In Housing).

- **El Paso County Housing Authority:** The EPCHA does not develop or manage public housing. However it holds 103 tenant-based Section 8 housing vouchers that are managed/contracted out to the Colorado Springs Housing Authority. These vouchers assist low-income individuals and families, the elderly, and the disabled in obtaining decent, safe, and sanitary housing in the private market. Voucher programs place the choice of housing in the hands of the individual or family; people that are issued housing vouchers are responsible for finding a suitable housing unit where the owner agrees to rent under the program. Because a family's housing needs change over time, such as changes in family size or job relocations, the voucher program is designed to allow families to move without the losing housing assistance. For this reason the number of vouchers that EPCHA holds may not all be currently used in El Paso County, however, the reverse is true. Vouchers from other areas, even other states, may be assisting people inside the County. The need for affordable housing greatly outweighs the supply; therefore a waiting list is in place for tenant-based Section 8 vouchers. As of the 2007 Audit Report of the EPCHA and CSHA there are currently 2,303 unduplicated applicants on the waiting list, and clients who applied in July of 2004 are now being served. No section 8 contracts are due to expire. However, as noted in the Colorado Springs Housing Authority paragraph above, the Section 8 waiting list has been closed as of as of May 2006.

- **Greccio Housing:** Greccio develops long-term affordable rental housing as opposed to temporary rental housing. It serves the working poor and disabled who have income, targeting a variety of persons in need, not just one population, and disperses its housing throughout the city to integrate its low-income residents into the community. Through public / private partnerships, donations and volunteer efforts, Greccio is able to purchase and rehabilitate rental properties at significantly lower cost than would otherwise be possible. Greccio passes on its up-front savings in the form of unsubsidized rents at below market rates to singles, couples and families with children. The agency currently owns and manages 193 affordable rental units.

- **Rocky Mountain Land Trust, Partners in Housing, and Greccio Housing's** various partnerships provide rental housing to lower-income working households at affordable rents. These units are income restricted and rent restricted, meaning that the rent is capped at a level considered to be affordable for a certain household income, and families must earn a certain income level or below in order to qualify to live in the housing. These partnerships own and operate close to 70 affordable units restricted to household earning at or below 30%, 40%, 50% and 60% of the Area Median Income (AMI).

Affordable Home Ownership

- **Rocky Mountain Community Land Trust** is a local 501(c)(3) non-profit organization that provides quality affordable housing opportunities for limited income families in the City of Colorado Springs and El Paso County through home ownership with families and collaborations with other non-profits. Homebuyers must be at or below 80% of the median income for El Paso County and the family must be a first time homebuyer (not having owned a home in the last three years). To date, 157 low-income families and individuals have become first-time homebuyers through the RMCLT program.

- **Pikes Peak Habitat for Humanity:** Through volunteer labor and tax-deductible donations of money and materials, Habitat builds and rehabilitates simple, decent houses in partnership with the community and prospective homeowners. Habitat houses are sold to partner families at no profit and financed with affordable, no-interest loans. The homeowners' monthly mortgage payments go into a revolving "Fund for Humanity" that is used to build more affordable houses. In addition to making a 1% down payment and their monthly mortgage payments, each homeowner family invests hundreds of hours of their own labor-sweat equity-into the building of their house and the houses of others. To date, Pikes Peak Habitat for Humanity has built 92 single-family homes.

- **Colorado Springs Housing Authority:** CSHA has assisted over 900 low-income (maximum 60% AMI) families and individuals become first-time homebuyers through its home-buyer education and "second deed of trust" (funding assistance) programs.

Permanent Supportive Housing

- **Harbor Housing First:** Harbor House initiated a new program in February 2007, in partnership with the City of Colorado Springs and Homeward Pikes Peak. Harbor House's Housing First provides immediate access to permanent living units and supportive services to the most under-served population in the community—homeless alcoholics and substance abusers. The "housing first" philosophy purports that housing is a basic human need and that all services can be offered with respect and compassion and in the spirit of hope and recovery. Housing First houses individuals and then develops relationships that will motivate them to get whatever help they need to lead more independent, self-sufficient lives. During 2007, Homeward Pikes Peak, the El Paso County Co-Occurring Disorder Collaborative, and Harbor House moved 25 individuals into small apartments with wrap around services and treatment. These are permanent supportive housing beds with five additional beds planned to be added per year. The cost of housing and treatment for these individuals ranges from $12,000 - $18,000 per year - one-third the cost of homelessness and non-treatment.

Progress in the Last Five Years

Over the past five years the face of housing for the homeless and the low income populations has changed significantly. Demand for affordable housing has increased but so have opportunities for collaboration. Partners acknowledge the need to work together and share resources to optimize their ability to meet the area's affordable housing needs. Thus collaboration has become the cornerstone an array of strategies employed across Colorado Springs' housing continuum.

As an example, Partners in Housing (PIH) increased its Transitional Housing inventory by 100% from 25 to 70 units. Total homeless served increased from 168 individuals (including 111 children) in 2003 to 302 individuals (including 188 children) in 2008. Expanded beds and services also meant that a more diverse population is reached. In 2003, services were confined to families with children. In partnership with the Rocky Mountain Community Land Trust, PIH developed the Colorado House and Resource Center. Partners In Housing now also serves homeless single adults and childless couples. Rocky Mountain Community Land Trust, Greccio Housing, and PIH also partnered to provide 74 affordable rental units for residents as low as 30% AMI.

Meanwhile, operation of the emergency shelter transferred from the Red Cross to the Salvation Army. The Salvation Army initiated a holistic transitional housing program to support families in gaining skills to move from homelessness to self-sufficiency. For more intensive support, Harbor House was founded by a community-wide taskforce dedicated to case management, treatment and housing for homeless individuals impacted by substance abuse. This effort added 34 Transitional beds. As stated above, these are permanent housing slots with five additional slots added per year. Harbor House is in the process of purchasing a dedicated 12-apartment property to house recovering substance abusers who are enrolled in the Harbor House program.

At the far end of the housing continuum, working both individually and in partnership, Pikes Peak Habitat for Humanity and the Rocky Mountain Community Land Trust (RMCLT) have continued to make home ownership affordable for low-income individuals and families. Since 1997, RMCLT has partnered with 157 low-income families (with 209 adults and 155 children) to help them become first-time homeowners. RMCLT currently has 127 families in homeownership and partners with approximately 15-20 additional families each year. Likewise, Pikes Peak Habitat for Humanity (PPHFH) has worked to bring affordable home ownership to 35 low-income families over the past five years. Currently, PPHFH and RMCLT are collaborating to develop a mixed-income neighborhood, comprised of 67 lots (36 owned by PPHFH and 31 by RMCLT). PPHFH will use its lots to build houses that will be sold to very low-income families. The RMCLT lots will be developed into a mix of affordable and market-rate homes. The two agencies plan to build six to 12 homes per year over the next three to fives years.

Clearly, communication and collaboration have been critical to progress. Providers discuss homeless housing as a community issue not an agency problem. Together they have worked diligently to move the homeless ***into and along*** the housing pipeline, providing more than simply a temporary refuge.

Current Gaps and Barriers

A wide array of inter-related factors, some positive, some negative, impact the housing continuum. The most prevalent of these factors include the following:

- The requirements of homeless individuals with special needs (physical or mental disabilities), the elderly (assisted versus independent), domestic violence victims (women, children, men), veterans (physical and mental injuries), and youth.

- Economic conditions, both local and national, including unemployment, interest rates, financing access, utilities costs, and changes in employment sectors. The major loss of "primary jobs" (e.g. high tech) changes both quantity and type of housing services required to meeting community needs. Coordination with other sectors is critical for developing long-term strategies (e.g., changes in post-secondary education) to offset negative impact.

- Housing market conditions, especially rental vacancies, Section 8 availability, and foreclosures.

- Affordable housing development conditions. This barrier is significant for long-term housing solutions and includes land availability (infill versus expansion), funding, proximity of services to available housing and development sites, land-banking obstacles, zoning, neighborhood attitudes, and growing "soft" costs such as development, impact, and tap fees.

- Ft. Carson expansion projects an estimated increase of 25,000 soldiers and family members (from 45,600 to 71,300 individuals) through FY 2013. The good news is that the expansion will also increase local secondary employment opportunities, particularly in the service/retail sector. That, in turn, helps reduce the potential homeless number. However, the increased demand for off-post housing, both rental and home purchases, drives up the cost of local housing. Since most job growth will be in the lower-income, hourly wage population, there will be less affordable housing available which drives up potential homeless numbers.

El Paso County is conducting a comprehensive community housing assessment. Due to be completed in 2009, the information should help delineate services gaps and provide a baseline for continued progress. A similar assessment of Ft. Carson expansion impact is critical. A number of the housing agencies are working closely with military liaisons to determine the impacts of troop expansion across all spectrums including behavioral and physical health, education, employment and as well as housing. Based on current market conditions, housing providers anticipate increasing gaps in emergency shelter capacity, transitional housing, and affordable rentals.

Strategies for Closing Sector Gaps

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Various types of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.3 Recurring (12-18 months) Homeless Service Agencies' Roundtable sessions to help define service gaps and develop collaborative strategies to close those gaps.	• Agencies meet to develop standardized format and realistic objectives for "Roundtable" sessions	Short	<u>Outputs</u> • Specific agreements are defined to meet the needs of clients with "cross-over" needs (i.e., needs that cannot be met by a single agency) <u>Outcomes:</u> • Hard to meet needs of "special" homeless populations are effectively addressed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	2.1 Housing providers will continue to coordinate outreach efforts to the maximum extent possible.	• Remain updated regarding community events where it is appropriate to disseminate information on housing opportunities	Ongoing	Outputs • # of providers sharing resources & reducing expense of outreach programs Outcomes • Public awareness of multiple agency relationships and services.	$
	2.2 Decrease the number of homeless households with children.	• Implement Rapid Re-Housing pilot program • Establish improvement baselines in income, employment, and education outcomes measures for TH families. • Determine 5 and 10 years goals based on first year performance.	Short	Outputs • # of homeless households at one point in time Outcomes • Continued trend of fewer homeless families with children	$$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Develop a methodology for meaningful assessment, analysis and projection of housing inventory versus need for: • Emergency shelter • Transitional Housing • Affordable rentals • Home ownership	• Acquire 2008 baseline housing data from El Paso County, city and housing authorities. • Annually, acquire impact projections from EDC, Colorado Dept. of Labor, and military • Create projection methodology to estimate community change and housing needs. o Share projections with other homeless sectors	1 Short Short	<u>Outputs:</u> • # of beds/dwellings available in each category identified • # of persons served in each category • # of affordable units needed in each category (acquisition or new construction) <u>Outcomes</u> • Projected need over the next 1-3 years • Forecasting tools for future housing/ homeless services needs	$$ $$ $$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner. **(continued)**	3.2 Ensure an array of strategies are available to move homeless persons from Emergency Shelter to Transitional Housing or Permanent Supportive Housing	• Improve coordination between emergency shelter and transitional housing providers to assess the needs of each client and determine the most appropriate transitional housing program and support services for their needs	Short/mid	Outputs • # of individuals and/or families moving from Emergency Shelter to TH or PSH Outcomes • % of people exiting from meets or exceeds HUD minimums • comparison of current year exit rates to trend data	$
	3.3 Ensure an array of strategies are available to move persons from Transitional Housing to Permanent Housing	• Increase bed coverage in all categories including all HUD funded programs plus as many non-HUD funded programs as possible. • Improve capture of exit information.	1, Mid, Long 1 1	Outputs • # of individuals and/or families moving from TH or PH Outcomes • % of people exiting from meets or exceeds HUD minimums • comparison of current year exit rates to trend data	$ $

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner. **(continued)**	3.4 Address homelessness by creating and preserving new housing units and beds.	• All Super NOFA funded housing-related programs will be integrated into and using HMIS • Housing sector agencies will monitor and report progress monthly via the HMIS system • Housing agencies will develop a corrective action plan if targets fall below the established HUD minimum	1, Mid, Long	<u>Outputs</u> • # of beds by housing type (ES, PSH, TH, PH) <u>Outcomes</u> • % of housing types meets or exceeds HUD minimums • comparison by housing type of current year data to trend data	$$
	3.5 Seek out existing distressed, foreclosed, and abandoned properties that have rehab potential and coordinate with government agencies and partners to develop the properties into affordable housing across the continuum.	• Housing agencies submit joint proposals to access HUD Neighborhood Stabilization Program Funds to acquire and rehab foreclosed and/or abandoned housing	Short	<u>Output</u> • # of existing properties with development potential are converted to meet affordable housing needs <u>Outcome</u> • % increase in properties over previous years <u>Cost/Benefit</u> • Acquisition/Rehab costs relatively low compared to benefit	$$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC	Housing	Action Steps	Timeframe*	Evaluation Indicators	Level of

Outcome	Sector Strategy		(1, short, mid, long)		Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner. **(continued)**	3.6 During Ft. Carson expansion, coordinate directly with military installations to assure affordable housing needs of both arriving military personnel and families and the existing local civilian population are met in a cost-effective manner.	• Local housing agencies actively participate as members of the Colorado Defense Mission Coalition. • Local housing agencies actively participate as members of the Military Community Collaborative (MCC).	1/Short 1/Short	<u>Outputs</u> • Local developers are kept informed regarding overall impacts of Ft. Carson expansion • MCC participants share critical information regarding all aspects of required services for both military and civilian populations <u>Outcomes</u> • How the housing sector is able to efficiently leverage resources for military and civilian populations.	$ $

CoC Outcome	Housing Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	4.1 Increase the stability of homeless in permanent housing through the development of personal resources.	• Develop and/or enhance life skills programs to better prepare clients for the move to higher levels of self-sufficiency. • Through collaboration between housing agencies, continue to grow "Housing First"-type resources including both housing and special supportive services ▪ Increase the number of providers tracking employment data. ▪ Develop semi-annual monitoring reports to track progress, quality and assess areas for improvement • Identify services from the CoC to support individual providers.	Short/Mid Short/Mid 1 Short/Mid Short/Mid	Outputs • # of persons employed when moving to PH • # of persons employed 12 months after entering permanent housing Outcomes • % increase in persons employed when they exit TH to permanent housing • % increase in persons staying in permanent housing for at least 12 months • % of persons employed at exit meets or exceeds HUD minimums	$$ $$$ $ $ $

Potential Barriers to Success

#1: The economy is experiencing a serious downturn. Human needs and the costs of meeting those needs are increasing while available funding from ALL sources is decreasing.

#2: Homelessness is a dynamic, multi-dimensional problem and forecasting models are challenging for even sophisticated economists. The Continuum of Care proposes to tackle housing assessments with economic, growth, labor, and industry projections. Sector members will need to remain focused on developing a simple, usable tool that provides a numerical basis for projecting housing needs over the next 3-5 years. The goal cannot be to create a perfect tool. The goal is to quantify a series of weighted factors that provide the basis for realistic projections and enables agencies to move forward proactively rather than reactively.

#3: No matter how "welcoming" the individual homeless and housing service providers wish to be to those in the community, resources and other limitations and restrictions on each agency almost always result in certain eligibility requirements for prospective clients. For example, some agencies can serve families while others can serve only individuals. Some agencies have special resources and expertise to deal with serious mental/emotional disorders and some do not. Some agencies can provide emergency short-term shelter only and some can provide longer but still time-limited housing. These constraints necessitate extensive coordination and cooperation among service providers. Agencies and funders need to combine resources, when possible, to meet the special needs of those clients who cannot be served by any one agency alone. Unfortunately, gaps remain, not only in the number of housing units available versus the number required but also in the types of services and support that can be provided even by collective cooperation.

Meeting HUD Priorities

The housing sector specifically supports the following HUD Priorities.

HUD Priority	
A	Providing increased homeownership and rental opportunities for low- and moderate-income persons, persons with disabilities, the elderly, minorities, and persons with limited English proficiency.
B7	Make communities more livable.
D	Providing full and equal access to grassroots, faith-based and other community organization to HUD program implementation.
F1	Creating affordable housing units, supportive housing, and group homes.
F2	Establishing set-aside of units of affordable housing for the chronically homeless.
F5	Establishing counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Providing supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Providing service coordinators or one-top assistance centers that will ensure that chronically homeless persons have access to a variety of social services.

H2	Building new or rehabilitate existing single-family homes to Energy Star standards for new homes, or include combined heat and power in multifamily properties.
H3	Meeting the requirements for Energy Star qualified New Homes for gut rehabilitation or new construction of low-rise multifamily housing.
I1	Providing low- and moderate-income households with information on FHA products as safe consumer alternatives to reduce costs and reliance on subprime lenders.
I2	Providing consumers with information on Fair Lending and discriminatory lending practices in languages appropriate to the clientele being served.

In addition to meeting HUD priorities, all agencies must work toward adjusting some of HUD's more restrictive policies that block providing timely and cost-effective help to the homeless. One of the more important of these is broadening HUD's definitions of "homelessness" so that service agencies can intervene earlier in the cycle leading to homelessness. These include loosening the restrictions regarding living in overcrowded conditions and allowing housing and services to families about to be evicted before they go to court. The goal is to allow for homeless prevention and earlier intervention thereby creating more positive results.

SECTOR 2: HEALTHCARE

Overarching Goal

The sector will be a streamlined healthcare system comparable to any in the United States. An integrated and seamless continuum of physical and mental health services will offer timely access for all homeless regardless of ability to pay. Open access and an integrated model of care will lessen the burden of caring for the homeless in Colorado Springs by decreasing Emergency Department visits and hospital admissions. This goal will be achieved by providing comprehensive evidence-based treatment, increased availability of specialty services, effective healthcare screening, and preventative measures in the homeless setting.

Sector Description

The healthcare sector provides physical and mental healthcare to the homeless population. A comprehensive primary care system should include prevention services, screening, immunizations, assessment, psychiatric services, individual and group therapy, paraprofessional and peer support services, medication and med monitoring services, service coordination, comprehensive service planning, support groups, education groups, and advocacy services.

Acute care reflects the need for immediate action and services should include testing and assessment, medication provision, short-term care or hospitalization. Behavioral health acute care includes short-term rehabilitation or stabilization services which may include hospitalization and detox services (5 to 10 days), community liaison services and discharge planning, and follow-up, partial hospitalization/day-treatment programs, community stabilization units, outreach services, psychosocial rehab services, supported employment, and mobile crisis response teams.

Many homeless suffer with chronic diseases such as diabetes, chronic obstructive pulmonary disease, and alcoholism. These diseases require long-term care and monitoring. Treatment of the chronically ill should include case coordination, paraprofessional services, consumer run drop-in services, self-help groups/services, outreach services, psychosocial rehab services, supported employment, advocacy services, social/recreational support services, Integrated Dual Disorder Treatment teams, psychiatric services, individual and group therapy, paraprofessional and peer support services, medications, and medication monitoring services.

Hospital Emergency Departments currently provide much of the emergent medical care and admissions. Walk-in clinics (e.g., Peak Vista Homeless Health Center, SET of Colorado Springs, Mission Medical) provide quick care and assessment based on complexity and are generally free to the homeless. The Criminal Justice Center provides basic care when homeless clients are jailed. There are some private practice clinics that will see the occasional patient for free but service does not usually include access to specialists. The Peak Vista Community Health Center's Homeless Health Center provides comprehensive medical care and specialty referral. Extended outreach for homeless patients exists directly on the streets and via a nighttime mobile clinic. Specialty services for eating disorders, neuropsychiatry psychology, developmental

disability services, geriatric services, veteran, and youth are almost nonexistent. Communication regarding heath care and treatment plans between agencies is inconsistent. Key medical sector providers include the following agencies.

Provider	Services
Peak Vista Homeless Health Center	Physical and dental health care
SET of Colorado Springs	Chronic and acute medical care
Mission Medical Clinic	Physical and dental health care
The Collaborative	access to co-occurring disorder treatment
Harbor House	substance abuse/mental health treatment
Pikes Peak Behavioral Health	mental health/substance abuse treatment
Bridge to Awareness	Substance abuse and co-occurring disorders

Three in five (40%) of survey respondents reported having a serious medical condition in the 2006 Colorado point-in-time homeless count. Based on statistics from the Peak Vista Homeless clinic over half of the 2,300 unduplicated clients seen at the clinic have a physical disorder and a co-occurring behavioral health disorder which frequently interferes with their ability to successfully participant in their health care treatment. An estimated additional 20% of homeless are seen at CATCH (Safety net) Clinics and Emergency Rooms for unmet behavioral health issues.

Progress in the Last Five Years

A significant attempt has been made to provide medical outreach to homeless individuals that cannot access clinics during their collectively limited hours of operation. The fact that many homeless are, in fact, employed, makes afterhours access critical to decreasing hospitals' Emergency Department burden. Some walk-in clinics are trying to adapt to a more primary model of care adopting effective practices from other parts of the country.

Current Gaps and Barriers

Behavioral health service for the homeless have suffered multiple set backs in the last five years. With the loss of the homeless grant in 2004, respite care services were eliminated and the Homeless Outreach team services were slashed. Until 2007, there were no dedicated psychiatric or therapy services available. In 2007, the Health Department announced the elimination of the substance abuse services they offered which eliminated outreach services to over 600 homeless individuals and substance abuse treatment services to over 250.

Currently the Safety Net clinics provide limited behavioral health services and are only willing to treat those without severe mental health issues. Outreach and case management services are provided the by RAP (Resource Advocacy Program) for approximately 100 individuals with co-occurring mental health and substance abuse disorders. Pikes Peak Mental Health has one licensed mental health professional providing services, annually, to 25 individuals with severe mental illness, woefully inadequate for the estimated 400 homeless with debilitating behavioral health issues.

Colorado Springs is relatively new in its effort to comprehensively deal with the homeless. There is ignorance regarding the homeless condition by many in the medical field. This lends itself to the following gaps.

- A lack of formal interagency communication and referral processes. For example, when a homeless individual has been an inpatient at a local hospital there is no respite facility at which to continue the healing process upon release. For other homeless with significant medical issues, there is limited access to specialty services such as neurology or orthopedics. The lack of direct interagency communication is also revealed in the shortage of case management/social services, care coordination and outreach services.

- Limited clinic hours due, primarily, to static funding. This exacerbates the Emergency Department revolving door when the homeless use hospitals for primary care.

- A well-constructed, community-wide pain management program for the addicted patient.

- Dental services which are limited to extractions only. There are no reparative or restorative services available to the homeless.

- A lack of community-wide, concerted effort to retro-access benefits for qualifying patients (e.g., Medicaid, Medicare). In addition, the benefits application process is cumbersome and difficult for the homeless with behavioral health challenges (the current Medicaid application is 28 pages long).

- Homeless are frequently unsuccessful in traditional behavioral and co-occurring disorder treatment programs.

- Lack of training for behavioral health professionals in El Paso County on how to work with the homeless. In addition, many health professionals have limited experience working with chronic inebriates and those with severe mental health illnesses.

- Community shortages of psychiatric physicians, Nurse Practitioners and uninsured patient access to psychotropic meds.

- Limited access to transportation services, bus and cab vouchers impact medical service provision.

- Fragmented and restrictive funding streams which could be leveraged to better serve this population (HUD, Medicaid, Mental Health Block Grant, Federal PATH and ADAD).

While the healthcare sector is improving, member agencies are less experienced than communities that have been providing services and developing policy on homelessness for decades. The following pages outline the sector's strategies and action steps for closing gaps.

Strategies for Closing Sector Gaps

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants	• Continued monthly meetings	ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Types of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.3 Establish a medical provider network to enhance communication between agencies on complex patients.	• Identify key stakeholders in medical community • Organize first meeting • Develop mission of group and rotate meeting facilitation responsibilities	Mid	<u>Outputs</u> • # of agencies/ partnerships in the network • # of points of entry	$
	1.4 Partner with VA Administration & CJC to ensure discharged patients are not lost to follow-up.	• Develop patient discharge protocol	Short	<u>Outputs</u> • # of homeless individuals receiving follow up care upon discharge- baseline then ongoing	
	1.5 Integrate a preventative medicine model into healthcare for the homeless.	• Work with medical provider network to identify current community healthcare prevention measure • Assess needed prevention efforts • Develop strategic plan to address gaps in prevention efforts • Implement Plan	Long	<u>Outputs</u> • # of homeless individuals receiving prevention health care services <u>Outcomes</u> %/type of change from baseline information	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.6 Increase the number of professionals with the skills and knowledge to work effectively with the homeless population	• Develop comprehensive training plan including MI, cultural comp., psych. First aid, trauma • Access education and formal training in providing healthcare for the homeless (per NHHC)	Mid	Outcome # of persons trained to provide effective treatment services	$
	1.7 Acquire good data on the unmet physical health needs of the homeless including screening and assessment.	• Develop comprehensive data collection and reporting capacity	Short	Output • Baseline of all community health indicators Outcome • % homeless receiving services	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	2.1 Increase outreach (mobile van) and clinic access.	• Increase funding and staff	Short	Outputs • # of homeless contacted Outcomes • % increase in contacts • % increase in services provided	$$
	2.2 Extend outreach to include peers and paraprofessionals	• Identify funding to support expansion of RAP services	Mid	Outputs • # of contacts Outcomes • % of contacts engaged in community services within 4 months of initial contact	$
	2.3 Use resources to develop best-practice services, such as outreach, which meet the unique needs of the homeless rather than through traditional programming.	• Develop wish list of programs/services • Prioritize list for funding • Develop quality review process	1	Outputs • # of outreach efforts/worker • # of evidence-based behavioral health programs • Cost of moving one person from outreach to recovery	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner. **(continued)**	3.1 Establish full dental services to the homeless	• Increase funding and staff for PV dental • Increase outreach and clinic access community-wide	Short Short	Outputs • # patients served Outcomes • Decreased ED visits • Increased employment	$$
	3.2 Establish respite care for inpatient discharges and chronic disease management.	• Securing funding and staff for at least one community respite center	Long	Outputs • # of patients Outcomes • % transitioned to housing	$$$
	3.3 Develop and implement an integrated treatment plans for physical and behavioral health care.	• Organize task force to design a community service plan • Get buy-in from providers	Mid and Ongoing	Outcomes • Service plan • % of agencies using integrated service plan	$
	3.4 Increase the number of homeless individuals who have access to behavioral health treatment and services.	• Increase funding levels and partnerships	Mid	Outputs • # accessing behavioral health services Outcomes • Change in individuals accessing services	$$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Healthcare Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	4.1 Outreach to secure benefits for those that qualify (SSI, SSDI, Medicaid, Colorado Indigent Program).	• Qualify homeless during medical intake process.	1	Outputs • # of successful applications Outcomes • % increase in qualifying homeless receiving benefits	$
	4.2 Work with state and local officials to advocate for dedicated funding to address the behavioral needs of the homeless.	• Advocacy at state and local levels	Short Mid	Outcomes • % increase in funding • Service utilization pre-& post- • ROI to community	$$ $$$
	4.3 Increase collaborative funding of homeless services	• Develop list of community priorities through continuum of care • Identify major funders • Coordinate funding efforts/requests	Long	Outcomes • Decreased duplication of work • Decreased paperwork • % of leveraged funding	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

The economy, political change and the success of various nonprofit and government organizations often dictates the success of strategic planning. Beyond these, the medical sector agencies identified several additional barriers. First, the local and state funding mechanisms are fragmented for homeless services as well as behavioral and substance abuse treatment. Funding distribution can be skewed towards the loudest advocate rather than the most effective services. Second, there is a lack of coordination among leaders regarding planning, prioritization and spending. This arena is the one most fraught with territorial tensions and where the **community-wide** continuum-of-care must work hardest. Third, funding is often constrained by regulations that limit blended funding streams and creative solutions. Finally, community integrated medical services (planning and treatment) must work within HIPAA restrictions. Colorado Springs is lucky to have five years of experience with HealthTrack, a HIPAA compliant web-based software system, that provides a virtual medical home for the under- and uninsured. HealthTrack helps healthcare providers and community agencies understand who the uninsured are, where and when they go for care, and what services they most often seek. Lessons learned from operating this system should ease barriers to community-wide service plans and treatment.

Meeting HUD Priorities

The medical sector specifically supports the following HUD Priorities.

HUD Priority	
F3	Establish substance abuse treatment programs targeted to the homeless population.
F5	Establish counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Provide service coordinators or one-stop assistance centers that will ensure that chronically homeless persons have access to a variety of social services

SECTOR 3: FOOD

Overarching Goal

To provide food for every homeless person in the Pikes Peak region in need of emergency food assistance.

Sector Description

Food for the homeless falls into two categories - meals and bulk food sources. Meals are provided daily at several locations. The **Springs Rescue Mission** serves breakfast and lunch six days a week for the homeless men in its New Life Program. The Mission then opens its kitchen to the low-income and homeless public to serve dinner Monday through Saturday. During 2007, 244,000 meals were served. This translates into over one million meals during the last decade. More than 14,000 lunches were delivered to children through the Kids Café program and 2,000 meals were provided at the Peak Addiction Recovery Center.

Catholic Charities' Marian House Soup Kitchen is the largest soup kitchen in the region and serves lunch to an average of 424 guests every day without stipulations. In 2007, volunteers served over 149,955 hot, nutritious meals to low-income, disabled and homeless adults and families. Local grocery stores, dairies, and prominent hotels and restaurants donate more than an estimated 200,000 pounds of food annually, an amount sufficient to run the soup kitchen, stock the Marian House Community Outreach Program food pantry and frequently to supply other, smaller soup kitchens that serve evening meals. In FY 2007-2008, community outreach delivered 365 food boxes averaging 50 pounds each. In the same year, the Catholic Charities' Life Support Center gave out 1,537 cans of formula and 10,128 jars or boxes of baby food and cereal.

Care and Share Food Bank of Southern Colorado acquires food from national regional and local food industry sources, the US Department of Agriculture, food purchasing sources (e.g., good brokers, manufacturers, wholesalers), and the local community. In turn, Care and Share distributes that food to approximately 435 partner agencies across southern Colorado. Nearly 75% of partner agencies are food pantries rather than meal preparation sites. Thus most distribution is in consumer-size rather than bulk packaging. Care and Share also distributes various produce, breads and dairy products by the pound. In 2007, an estimated 61,000 individuals in El Paso County received 4,453,000 pounds of food. Approximately 2,440 (4%) of these individuals were homeless.

The **Springs Rescue Mission** has the second largest food pantry in the city. It receives 28% of its food resources from Care and Share with the remaining 72% from wholesale and retail markets and individuals. Over 5,500 food boxes were given out to the general public last year, a 32% increase over 2006. Bulk food from both Care and Share and the Springs Rescue Mission is distributed through to local food banks such as those at **Westside CARES, Northern Churches CARES, and Tri-Lakes CARES.**

The El Paso County Department of Human Services' (EPCDHS) primary food distribution to the homeless is through the Supplemental Nutrition Assistance Program (SNAP) funded by the US Department of Agriculture. EPCDHS currently has 16,000 approved households in El Paso County to which is distributes $43,000,000 in federal food assistance funds. SNAP funds enable families to purchase food with an electronic benefits transfer (EBT) card. EPCDHS caseworkers and technicians actively refer clients to community resources for food assistance and other supportive services such as:

- 2-1-1 to connect families with community resources;
- Women, Infant and Child (WIC) program through the El Paso County Department of Health and Environment;
- Food Stamp Job Search program for individuals able to work;
- Feed the Children, an event that distributes 2,000 boxes of food to 1,300 families;
- Care and Share and other agencies receiving county Community Partner funding; and
- Youth assistance for young adults exiting the foster care system to prevent homelessness.

Progress in the Last Five Years

Successful capital campaigns over the past 24 months have proven the community's support for the continuum of care's food sector. The Springs Rescue Mission currently serves 120 meals plus prepares 30-40 bag dinners per night. New kitchen facilities, scheduled to open in 2009, will allow the agency to feed 350 meals daily. In addition, the SRM opened a new building on its campus that enables staff to better serve clients needing food boxes or The Emergency Food Assistance Program (TFAP).

A decade ago, Marian House served just over 100,000 guests annually. Last year it served 155,000 guests reflecting the dramatic population growth in El Paso County. Growing meal service coupled with an aging facility resulted in the construction of a new facility with general dining hall seating 150-175 people and the family dining area that seats up to 50. Improvements will include a larger, commercial grade kitchen, centralized food storage and expanded office space. A basement underneath the dining area provides ample storage for both the soup kitchen and the Community Outreach Program.

Five years ago, Care and Share's annual food distribution was 4.5 million pounds. Today it is 7.3 million pounds per year. The agency now serves all 31 counties in its service area, up from 21 counties in FY 2004. The new branch facility in Pueblo doubled storage capacity. A successful capital campaign resulted in a warehouse that triples the Colorado Springs storage capacity. The delivery fleet of trucks has increased from two to nine vehicles. Most importantly, Care and Share has nearly doubled the number of people served annually.

EPCDHS continues to see increases in the number of applicants and families approved for food assistance. Two satellite offices at Sand Creek (eastern Colorado Springs) and the Lorraine Center (Fountain, CO) process food applications easing service access issues. Expedited food assistance is a priority to help those with the greatest needs. The agency's

Services Integration initiative promotes staff training and support the utilization of both internal and external resources to assist clients.

Current Gaps and Barriers

For meals programs, service providers agree that there are three major service gaps.

- A significant percentage of the community (homeless, donors, and social service agencies) lack information about meal availability and ancillary services such as showers, communication tools, and clothing available at meal sites.

- The community is experiencing Increasing numbers of homeless and the economically disadvantaged. For the Springs Rescue Mission, direct emergency services have increased 16% since August 2008. Individuals who used to donate to the Mission are now clients.

- Lack of communication with other agencies in the continuum of care, leads to a disjointed services system and unmet client needs.

Care and Share faces a similar struggle in finding quality partners willing to distribute quality food in adequate quantities. Securing adequate donations of nutritious food **on a year round basis** is a constant struggle for all food pantries.

EPCDHS works diligently to process applications in a timely manner. Accurate data entry to ensure accurate benefits is an ongoing issue. Lack of funding for additional staff as well as staff recruitment and retention issues are evidenced by crowded lobbies and long wait times.

Strategies for Closing Sector Gaps

CoC Outcome	Food Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Types of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Food Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.3 Increase awareness of meal and food distribution options in other social services agencies.	• Site visits to social service agencies • Grow food distribution base to 1 quality site per every 440 people in poverty. • Continue development and deployment of Care & Share's Member Campus program to increase partner/member agency capacity	Mid Mid Mid	<u>Outputs</u> • Pounds of food/ meals distributed • # of people served <u>Outcomes</u> • Decrease gap in access to 3 meals/day by 25% <u>Cost/Benefit</u> • # of pounds/meals distributed per budget $	$$ $$ $$
	1.4 Increase awareness of meal and food distribution networks with the general public	• Increase annual fund raising and food donation efforts.	1	<u>Outputs</u> • # of contacts • # of donors • # of $ raised <u>Outcomes</u> • Change in contact: donation ratio • % of first-time donors • % of donors increasing level of donation	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Food Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	Increase outreach connections through Urban Peak (homeless youth) and Catholic Charities of Colorado Springs.	• Continue daily connectivity to homeless serving organizations • Meet with key agency staff to ensure smooth referral processes	Ongoing	Outputs • Types of outreach • Types of referrals Outcomes • % increase/ decrease in number of individuals and families served	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Food Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Annually, ensure the distribution of 85 pounds of food per homeless/low income person in El Paso County through bulk food and meals (to ensure 3 meals per day/person).	• Grow food distribution base to 1 quality site per every 440 people in poverty. • Coordinate meal service between agencies to ensure homeless or those in crisis have access to 3 meals per day	Mid Short, Mid	<u>Outputs</u> • Pounds of food/ meals distributed • # of people served <u>Outcomes</u> • Decrease gap in access to 3 meals/day by 25% <u>Cost/Benefit</u> • # of pounds/meals distributed per budget $	$$ $$
	3.2 EPCDHS will process Food Assistance applications within federal timeliness rules to assure access to food benefits.	• Assure a sufficient number of appointments are available to meet the homeless applying for benefits. • Train staff to obtain all required information at the initial intake • Implement Training to Unit to ensure qualified staff can move into vacant positions	1 Ongoing 1	<u>Outputs:</u> # of available appoints that increase in response to # of applicants <u>Outcomes:</u> At least 80% of applications will be processed in a timely manner <u>Cost/Benefit</u> • Decreased need to seek food banks • Increased federal food funds for EPCounty	$ $ $

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Food Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	Provide access to bulk food and meals that enables individuals and families to move past their current crisis.	• Support interagency coordination • Support planning for self-sufficiency post-crisis	Ongoing	Outputs • Pounds of food/ meals distributed • # of people served Outcomes • Decrease gap in access to 3 meals/day by 25%	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

For county, federal, and nonprofit agencies, the economic downturn is a considerable concern. Funding cuts for training, recruitment and retention of staff directly impact the ability to serve clients in a timely manner and with sufficient resources.

Meeting HUD Priorities

The food sector specifically supports the following HUD Priorities.

HUD Priority	
B7	Make communities more livable.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.

SECTOR 4: EMERGENCY SERVICES

Overarching Goal

The community will provide appropriate crisis and emergency services and support to chronically and acutely homeless clients while referring them to the best sources to help them move toward achieving dignity and self-sufficiency.

Sector Description

The Emergency Services sector of the continuum of care provides:

- short-term food allotments and pet food;
- financial assistance for medical needs and prescriptions;
- mental health crisis assistance;
- hygiene (e.g., haircuts, 38 showers daily);
- clothing;
- bedding;
- backpacks;
- emergency transportation assistance (e.g., bus tokens, gasoline vouchers);
- access to identification (e.g., birth certificates);
- legal and tax assistance;
- housing referrals;
- a resources room for job placement, educational programs, and access to other social service agencies; and
- spiritual encouragement.

Approximately 20% of the 30,000 annual client visits to **Ecumenical Social Ministries** (ESM) are individuals experiencing homelessness. These homeless were living in another's home (n=329), halfway houses (n=135), hotels (n=286), shelters (n=259), or were homeless and on the street (n=551). For homeless with co-occurring disorders, ESM provides a valuable link to medical treatment and housing. Pikes Peak Behavioral Health clinicians are co-located at Ecumenical Social Ministries and Peak Vista Homeless Medical Clinic. Clinicians serve approximately 25 homeless consumers at any given time and about 75 annually. About half of the consumers treated are placed in to permanent housing situations or acquire the benefits for which they are eligible.

Springs Rescue Mission helps an average of 4,000 families every year with services similar to ESM. The Springs Rescue Mission is the region's largest provider of clothing and furniture to the low-income and homeless. Recently, it furnished 10 apartments for the Housing First program. Emergency Services needs are increasingly critical for women and children. El Pomar Foundation Fellows are working with Springs Rescue Mission to develop a women's shelter as well as a women's self-sufficiency program. Equally important, the agency works with Northern Churches CARES' Adopt-a-Child Program to attract funds to keep families in their homes and preventing homelessness.

Smaller agencies such as Westside CARES, Northern Churches Cares, Tri-Lakes Cares, Gods Pantry, Manna Ministries, Crossroads, and Grace Be Unto You Ministires also provide homeless intervention through food pantries, clothing, healthcare referrals, and referrals to other continuum-of-care agencies. Their goals are to provide temporary crisis services and connect the homeless with community resources that help them meet long-term basic needs.

Progress in the Last Five Years

During the past five years new and increased funding has supported an overall increase of the types and quantity of services available to the homeless. Showers, the "clothes closet," haircuts and food purchases reflect service expansion. The Co-occurring Disorder Collaborative has been particularly instrumental in coordinating multi-agency, multi-sector emergency/crisis services for homeless clients with mental health and substance abuse issues. Funding has also enabled ESM and the Springs Rescue Mission to improve physical facilities making them more welcoming and accessible. The advent of the 2-1-1 referral system and recent continuum of care efforts have greatly improved emergency services coordination and interagency collaboration.

Current Gaps and Barriers

Emergency services providers agree that the community needs additional emergency shelter and housing, food, access to medications, counseling (mental health and substance abuse), job assistance, and access to hygiene (e.g., showers, haircuts) in order to better serve the homeless. However, certain segments of the homeless population are more critically underserved than others. These are:

- families with children, especially single mothers;
- the chronically homeless, many of which have mental health and substance abuse issues; and
- ex-offenders, especially those recently released with no identification or documentation.

Strategies for Closing Sector Gaps

CoC Outcome	Emergency Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers.	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants.	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Types of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Emergency Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.3 Match the most appropriate service to chronically homeless with mental health and/or substance abuse issues.	• Improve the accuracy of tracking systems databases. • Improve volunteer training to help with appropriate direct services • Advocate with member churches and the community for improved and increased shelter and medical support	1 Short Mid and Ongoing	<u>Outputs</u> • # clients served • types of resourced utilized <u>Outcomes</u> • Improvement in matching client needs with appropriate resources	• $ - current staff, IT consultants, funding • Credible outside expert training • Creating community leadership advisory groups and partnerships
	1.4 Any and all homeless families will be served in a manner that ensures short term basic needs are met while providing opportunities for long-term stability and self-sufficient.	• Raise community awareness for increased and appropriate emergency shelter for families with children	Mid and Long	<u>Outputs</u> • Agencies and leaders involved in Advisory councils <u>Outcomes</u> • Changes in service types, provision method, access	$ - Cultivation and support of community leaders & key communicators

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Emergency Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	2.1 Increase information and networking with congregations.	• Meet with congregations located outside the downtown corridor • Create avenues for suburban/non-downtown congregations to support emergency service provision	1, Short	<u>Outputs</u> • # of churches contacted • type of information provided <u>Outcomes</u> • change in involvement level/type after outreach	$ $
	2.2 Continue working with current and potential referral sources.	• Continue work to increase the array of services available • Continue working to increase the quantity of services available • Continue working to ensure coordination with other agencies to prevent homelessness.	Short, Mid, Long	<u>Outputs</u> • # and types of referrals (in and out) • # and type of services <u>Outcomes</u> •Changes in service types, provision method, access •Changes in service level	

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Emergency Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Match the most appropriate service to chronically homeless with mental health and/or substance abuse issues.	• Improve the accuracy of tracking systems databases. ○ Train current staff, ○ Secure IT consultants, funding • Improve volunteer training to help with appropriate direct services ○ Develop/contract credible outside expert training • Advocate with member churches and the community for improved and increased shelter and medical support ○ Create community leadership advisory groups and partnerships	1 Short Mid and Ongoing	<u>Outputs</u> • # clients served • Types of resourced utilized <u>Outcomes</u> • Improvement in matching client needs with appropriate resources	$ $ $

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Emergency Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	4.1 Any and all homeless/near-homeless families and individuals will be served in a manner that ensures short term basic needs are met while providing opportunities for long-term stability and self-sufficient.	• Provide short-term survival/crisis support on-site • As appropriate, refer to transitional or affordable rental housing agencies	1 Ongoing	Outputs • # of families served • Types of services accessed Outcomes • Improved options for homeless children/families • Changes in service types, provision method, access	$ $
	4.2 All homeless ex-offenders in Colorado Springs will receive emergency services plus employment support and assistance.	• Solve ID issues ○ Collaboration with public and private agencies and employers • Facilitate employment assistance ○ Cultivate temporary agencies • Quantify and implement long-term employment supports ○ Engage and involve major employers	1 and Ongoing Short Ongoing	Outputs • # served • types of services Outcomes • % reduction in recidivism • Improved employability • Improved employment stability	$ $ $

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

As with all sectors, economic challenges impact agency and community financial support. The economic climate also increases unemployment decreasing the number and types of jobs available for the homeless and ex-offenders. Many ex-offenders would benefit from job training or re-training programs. Opportunities are limited and require significant coordination with local employers.

Community attitudes show a propensity for contributing food for the homeless but there is less awareness and/or interest in providing shelters and other key services. The need for children's and women's services is particularly hard hit. Homeless clients are difficult to track and their needs are often difficult to quantify and prioritize. Improving the sector's access to accurate data would not only validate current services but would document gaps, unresolved issues and support effective public relations.

Meeting HUD Priorities

The emergency services sector specifically supports the following HUD Priorities.

HUD Priority	
B7	Make communities more livable.
F4	Establish job training programs that will provide opportunities for economic self-sufficiency.
F5	Establish counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Provide service coordinators or one-stop assistance centers that will ensure that chronically homeless persons have access to a variety of social services

SECTOR 5: VETERANS' SERVICES

Overarching Goal

To end homelessness among veterans in southern Colorado.

Sector Description

Colorado Springs is home to five military installations: Peterson Air Force Base, Fort Carson, U.S. Air Force Academy, NORAD, and Schriever Air Force Base. They bring not only active military but many retirees who chose to stay on for the area's scenic beauty and access to veteran's services. Unfortunately, being a veteran brings its own set of challenges. The local Veteran's Administration staff is dedicated to ensuring that even homeless veterans receive the housing and services critical for stability. Veterans are estimated to comprise 22% of the local homeless population.

Established by a small group of veterans, Crawford house provides a supportive living environment for veterans facing physical, mental or substance abuse challenges. Fifteen beds are available for emergency housing. An additional 10 beds are available next door in Crawford House's transitional facility. Here the house director and health professionals help veterans gain back their self-sufficiency. Veteran's services also accesses 14 Shelter Plus Care and 35 HUD-VASH slots for long-term supportive care. Financial resources include employment, VA disability, Social Security, state Old Age Pension, and state Aid to Needy Disabled.

Progress in the Last Five Years

Over the past five years, homeless veteran's services have made significant strides. The percentage of veterans housed upon discharge has increased from 44% in 2003 to 86% in 2008. The percentage of veterans accessing financial resources (benefits) upon discharged was 58% in 2003 and is 84% in 2008. Finally, the new HUD-VASH program was added in 2008 bringing 35 new housing vouchers to the community.

Current Gaps and Barriers

Most homeless veterans struggle with mental health and/or substance abuse issues. The greatest needs are for increased access to case management, medical care (i.e., medical treatment, mental health treatment, and substance abuse treatment) and employment. The VA plans to increase staff. However, the local facility has physically reached maximum capacity. To quantify needs and service gaps, Veterans Services is in the process of comparing the cost of medical care for veterans before being housed and after being housed. Preliminary data indicate that there is a significant reduction in the cost of care between veterans who are housed compared to veterans who are living in shelters or on the streets.

Strategies for Closing Sector Gaps

CoC Outcome	Veterans' Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers.	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants.	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Types of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Veterans' Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	Continue outreach among veterans and homeless serving agencies	• Meet regularly with other agencies • Ensure VA case managers have information on homeless services	Ongoing	Outputs • # of meetings • types of outreach information provided Outcomes • Changes in referral sources	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Veterans' Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Improve case management.	• Employ additional case managers • Attempt to find space for graduate student interns to assist with case management • Participate in management team planning for a new VA clinic to accommodate additional staff	1, Mid, and Long 1 1, Mid, and Long	Outputs •# of veterans housed at discharge •# of veterans with financial resources Outcomes •% veterans housed at discharge •% veterans with financial resources	$ $ $
	3.2 Improve access to care including medical treatment, mental health treatment and substance abuse treatment.	• Participate in management team planning for a new VA clinic to accommodate additional staff	1, Mid	Outputs •# of veterans housed at discharge •# of veterans with financial resources Outcomes •% veterans housed at discharge •% veterans with financial resources	

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Veterans' Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	Increase access to employment services	• Regular collaborative meetings focused on resource development, education, & employment • More effective communication with employers by promoting re-entry as a referral and pre-screening process. • Increase the number/type of apprenticeship programs and job training programs	Short Short, Mid Short, Mid	<u>Outputs</u> • # of veterans employed or in training program <u>Outcomes</u> • % increase in #/type of training programs • Change in access to apprenticeship, training and employment programs	$ $ $$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

Virtually all funding for this sector is derived from federal funds. Changes in the new administration and Congress will have as yet unknown impact on local resources.

Meeting HUD Priorities

The veterans' services sector specifically supports the following HUD Priorities.

HUD Priority	
B7	Make communities more livable.
F1	Create affordable housing units, supportive housing, and group homes.
F2	Establish set-aside of units of affordable housing for the chronically homeless.
F3	Establish substance abuse treatment programs targeted to the homeless population.
F5	Establish counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Provide service coordinators or one-stop assistance centers that will ensure that chronically homeless persons have access to a variety of social services

SECTOR 6: PRISON RE-ENTRY

Overarching Goal

To have enough resources to offer the programs, training, housing, medical services and employment options to assist ex-offenders gain self-sufficiency.

Sector Description

The prison re-entry sector falls, primarily, under the purview of the Colorado Department of Corrections. Services are those traditionally identified with community reintegration, transitional services, and aftercare services and are provided through state and federal agency partnerships, faith and community based collaborations, case management, and direct support services. Local services include:

- transportation;
- clothing
- tools appropriate for employment (and verified by the employer);
- housing and some rent assistance;
- identification assistance;
- job search/employment assistance (e.g., application and resume preparation);
- child support;
- education;
- backpacks with hygiene items;
- medical access (including SSI, Vocational Rehabilitation, and prescription assistance);
- community services referrals; and
- financial budgeting.

Community Re-Entry Specialists work with facility case managers, education staff and community parole officers to support implementation of offender transition plans. These plans use the "case management model" in which multiple services are delivered and/or programs are utilized to assist the offender successfully transition back to the community. The goals are to ensure the offender can function successfully on his or her own and to enhance public safety through decreased recidivism.

During FY 2007, the local re-entry program served 402 offenders on parole. Success is measured by having ex-offenders staying out of the system for three or more years. The savings to the community is the cost of $7 to $90 per day for incarceration and the loss of a productive, taxpaying citizen.

Progress in the Last Five Years

Offender re-entry can be a lengthy and difficult process. The past five years have seen increased stability within the state's re-entry program ensuring a continuum of support and connected services. Funding has increased moderately but rarely keeps pace with client need. Transitional housing has been secured through a local landlord for ex-offenders who have been "red carded" from the New Hope Shelter or who are not eligible due to past crimes. Increasingly, more support services are available due to improved communication between agencies.

Current Gaps and Barriers

One of the largest, and continuing gaps, is the need for affordable and permanent housing. Many landlords will not rent to individuals with criminal records. Housing agencies have admissions criteria that excludes many ex-offenders. Expanded outreach and education is also needed in the employment sector as many are reluctant to hire felons. Additional training and apprenticeship programs could provide opportunities for ex-offenders to learn trade skills and workplace expectations. At the same time, they would provide employers the opportunity to gain confidence in ex-offenders as trustworthy employees.

Community resources, from basic supplies to basic skills, are critical for all ex-offenders. However, part of the re-entry process is enabling these individuals to give back to their community. Volunteering or a barter system (we will give you 'x' if you can follow-through with 'y') helps the ex-offender demonstrate that he/she is serious about personal success.

Strategies for Closing Sector Gaps

CoC Outcome	Prison Re-entry Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: Coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers.	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants.	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Types of CoC collaborations developed	$
	1.3 Coalesce community groups into one overarching collaborative to coordinate services for individuals re-entering the community after jail or prison	• Outreach from State Dept. of Corrections re-entry staff to faith and community-based organizations. • Regular collaborative meetings focused on resource development, education, & employment	1	Outputs Regular meetings with consistent membership Outcomes • Expanded resources • Coordinate basic services & life skills	$

CoC Outcome	Prison Re-entry Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	2.1 Street-based outreach to unsheltered homeless	• Meet with unsheltered homeless regularly	Short	<u>Outputs</u> # of outreach contacts # of plans developed and implemented # of offenders employed within 30 days # of offenders housed	$
	2.2 Regular case management and resource coordination with decreasing contact as offender stabilizes	• Develop individualized steps for sheltering and employment • Work with landlords on initial weekly payment schedule (rent, utilities, phone) shared between Department of Corrections and the offender. • Continued coordination between DOC and community/ faith-based re-entry programs	Mid, Long	<u>Outcomes</u> % of offenders employed 90 days post-contact % of offenders house 90 days-post contact	$$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Prison Re-entry Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Continue honing referral processes between agencies to decrease duplicative services.	• Offenders are immediately referred to Dept. of Corrections (DOC) staff for planning. • DOC staff provide written referrals to community service agencies to meet specific offender needs • Community agencies provide updates and data on how/when offenders access services. • Continued and improved communication between DOC and local/faith-based prison re-entry programs	Short	<u>Outputs</u> • # of offenders with service plans • # of community agency referrals • types of referrals <u>Outcomes</u> • Increase/decrease in service levels • Increase/decrease in ability to case manage offenders towards self-sufficiency	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Prison Re-entry Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	4.1 Improve housing options.	• Increase number of landlords and housing agencies willing to house offenders. • Work with landlords and housing agencies on flexible rent/utilities payments that align with individual intervention plans	Short, Mid	Outputs • # of offenders housed within 30 days of release • # of landlords/housing agencies willing to take offenders Outcomes • % of offenders still housed after 90 days • % increase in number of employers with flexible payment plans for offenders	$ $
	4.2 Improve employment options	• More effective communication with employers by promoting re-entry as a referral and pre-screening process. • Increase the number/type of apprenticeship programs and job training programs	Short, Mid	Outputs • # of offenders employed or in training program with 30 days of release Outcomes • % increase in #/type of training programs • % of offenders employed 90 days post-release	$$ $$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

Currently, this sector is significantly underfunded and understaffed. Several church-based programs exist to facilitate prisoner re-entry. Ongoing work and coordination between groups will be critical for increasing sector resources.

Meeting HUD Priorities

The prison re-entry sector specifically supports the following HUD Priorities.

HUD Priority	
B7	Make communities more livable.
F3	Establish substance abuse treatment programs targeted to the homeless population.
F4	Establish job training programs that will provide opportunities for economic self-sufficiency.
F5	Establish counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Provide service coordinators or one-stop assistance centers that ensure chronically homeless persons have access to a variety of social services

SECTOR 7: ACCESS TO SERVICES

Overarching Goal

Individuals and families who are homeless or imminently at risk of becoming homeless can find and access services easily.

Sector Description

Ensuring that people can find and access services easily can be viewed from three perspectives: clients, providers, and continuum of care (which represents the community).

- Clients: Individuals and families should be able to easily determine if services are available to meet their specific needs. They should be directed to the providers, programs, and/or services that best match their most critical concerns. Ideally, clients should be able to receive most if not all of their needed services through a minimum number of site visits. Where it is necessary to access multiple providers, it is beneficial to have coordination between the providers so that conflicting demands do not burden the client. It is also helpful to minimize the number of times clients must provide the same information to different organizations. Any system of sharing data must provide for approval/consent by the client.

- Providers: Providers need to know where there are gaps, both in their own services as well as across the entire continuum. Providers can better coordinate services and expectations/requirements if they can view (have access to) the entire client picture. Shared data serves individual clients more effectively while also ensuring better distribution of services to all clients reducing overlaps and redundancy. Finally, access to high quality comprehensive data assists providers with grant writing and reporting which, in turn, expands funding sources.

- Continuum of Care: To ensure clients have access to services, the Continuum of Care needs to have a broad picture of what is available and where there are gaps (both missing services and inadequate availability). The Continuum of Care also benefits from unduplicated population data from which create a community-wide perspective of services. The Continuum of Care must be able to measure the effectiveness of programs and services in order to effectively allocate resources and measure progress.

Progress in the Last Five Years

Five years ago, access to care focused on how homeless individuals received services when they found their way to social service agencies – a process which was complicated and full of obstacles. One of the long time barriers to access was the lack of a coordinated information and referral process. Every organization had its own resource list or "sticky note system" which rapidly became outdated and required duplicative effort to maintain. The outcome for clients

was that information given with the best of intentions often caused inconvenience for both clients and providers. A second barrier was the lack of coordinated data collection and reporting. This barrier hampered even the best efforts to coordinate care, made it difficult for providers to report on clients served and services provided (both for internal management and for fund development and reporting), and precluded any data-driven focus on performance outcomes or determination of gaps and needs.

Today, access to care has evolved into a systemic approach to data collection/reporting and improved service coordination. Progress has been made on several key fronts.

- **2-1-1:** 2-1-1 is the national abbreviated dialing code for free access to health and human services information and referral. 2-1-1 is an easy-to-remember and universally recognizable number that makes a critical connection, via referrals, between individuals and families in need and the appropriate community-based organizations and government agencies. In 2001, Pikes Peak United Way joined the effort to bring a coordinated Information & Referral system to the Pikes Peak Region by joining the Colorado 2-1-1 Collaborative in the kick-off stage.

  The local center was launched in June 2004, making 2-1-1 available to El Paso, Teller, Park, Chaffee, Lincoln, and Cheyenne counties (5 other centers provide the service to 37 additional counties). Since that time, the database of resources in El Paso County has expanded to cover nearly 400 providers and 2,000 services (statewide it includes 3,600 providers and 13,000 services). The data is maintained regularly to ensure a high degree of accuracy, and it encompasses not only name, address, phone number, and hours of operation, but also includes such information as eligibility, intake procedures and requirements/limitations, need for appointment, accessibility to bus routes, and much more. The database greatly improved matching client need to provider thus reducing the frustration for both. Since 2004, local call volume has tripled from under 8,000 to 24,373 in 2008 (statewide call volume was 220,000 for 2008).

- **Homeless Management Information System (HMIS):** In 2003, Homeward Pikes Peak contracted with Pikes Peak United Way to be the System Administrator for the local HMIS. This met both the community and provider need for a data system and HUD's requirement that every Continuum of Care create an HMIS. Tapestry software was chosen primarily because it was already in use for the statewide 2-1-1 system thus offering coordination with the Metro Denver and Balance of State Continuums of Care. The objective was to have a fully integrated and statewide 2-1-1 and HMIS system (one of only a few in the country). Local Continuum of Care agencies were an integral part of the software design, working with the vendor to develop and implement software that would meet both HUD and community requirements. Since the pilot implementation in December 2005, the following has been accomplished.

- 10 providers are actively using HMIS and over 9,000 client records have been created.

- Data drawn from the HIMS was an integral part of the 2008 SuperNOFA application charts.

- The community has achieved or exceeded required bed coverage in four of six categories (three of the four required categories and one of the two optional), and have total bed coverage of 59% (goal is 75%).

- During 2008, the Continuum of Care voluntarily participated in the Annual Homeless Assessment Report in 3 of 4 categories.

- Colorado Springs used the HMIS for the January 2009 Point-In-Time survey.

- The Continuum of Care has worked with the vendor to implement many system improvements and expansions.

HMIS now has the ability to provide the information necessary to quantitatively examine how homeless services are provided in the community and justify appropriate action steps. Data elements to inform these indicators have been incorporated into each sector's action plans. Aggregated, they will convey a point-in-time snapshot of homelessness in the Pikes Peak region. Over time, the data elements will delineate progress and remaining gaps. Both will be used to update annually the 10-year plan as part of the region's Conference on Homelessness. The HMIS Advisory Committee meets monthly, and establishes policies and procedures as well as provides oversight for HMIS usage in the Continuum of Care.

- **Point-In-Time Surveys:** In 2002, Catholic Charities of Colorado Springs undertook the region's first point-in-time count of homeless persons. Since then, Homeware Pikes Peak and Pikes Peak United Way have facilitated 7 subsequent counts: March 2004, January and August 2005, January and August 2006, January 2007, and January 2009. The semi-annual counts in 2005 and 2006 allowed the community to examine seasonal differences. The August 2006 and January 2007 counts were part of a coordinated statewide effort to measure homelessness, the first in 17 years. All survey results are an integral part of HUD SuperNOFA application and reporting, and are one of the components of the needs assessment process. Results are provided on demand and are used regularly in grant applications and reports.

- **Housing/Bed Inventory:** As part of the point-in-time process, Pikes Peak United Way annually updates the Housing/Bed Inventory and HMIS Participation chart. The chart encompasses Emergency Shelter, Transitional Housing, and Permanent Supportive Housing, and includes individual and family beds, special populations, HMIS participation, and bed utilization rates. This, too, is an integral part of the HUD SuperNOFA application and reporting, and is another major component of the needs assessment process.

- **Needs Assessment:** Housing and service needs are assessed annually by CHAP participants, HMIS Advisory Committee, Homeward Pikes Peak, and the city's Housing and Community Development Division. This year, El Paso County is conducting a comprehensive, county-wide housing needs assessment which will additional comprehensive data to the 2009 assessment process. One of the Access Sector's action steps (see page 78) is to improve this process through service gaps/needs data.

- **Annual Homeless Assessment Report (AHAR):** The AHAR is HUD's annual report to Congress on the state of homelessness in the United States. Data must be drawn from the HMIS and covers four categories: Emergency Shelter Individuals and Families, and Transitional Housing Individuals and Families. The data includes year-long data as well as quarterly snapshots of duplicated and unduplicated number of people (in several demographic breakdowns), length of homelessness, frequency of use and cross-category use, and bed utilization rates. Colorado Springs became a voluntary, contributing Continuum of Care for the October 2007 – September 2008 reporting period in 3 of the 4 categories. It is currently expected that AHAR participation will be mandatory in 2010.

- **Rapid Reader Card System:** In July of 2007, Colorado Springs began working with the HMIS vendor and a sub-vendor to develop a card printer/reader system to facilitate data collection and service delivery. The system consists of a camera to capture a picture of the client, a printer to produce a card with the client's picture and bar code of a Personal Identification Number (PIN), and a scanner to record services delivered to clients. In the short term, the system will assist clients and providers of high-volume services such as shelters, soup kitchens, and emergency services by facilitating service enumeration. In the long run, it will facilitate client access to services through a streamlined intake process and data sharing if/when allowed by clients. The Continuum of Care is currently completing testing of the pilot implementation at the New Hope Center and will complete at least two more pilot sites in 2009.

- **Rapid Re-Entry pilot:** Homelessness, particularly for families, is often situational. Loss of employment, catastrophic illness, or divorce can plunge adults and children alike into crisis. The 2008 SuperNOFA application provided funds for pilot Rapid Re-Entry programs. These programs rely on early identification and resolution of a family's or individual's housing barriers and provide the supportive service assistance necessary to facilitate their speedy return to permanent housing. Interfaith Hospitality Network has outlined a Rapid Re-entry pilot program for this community. Upon approval from HUD, the pilot will be initiated with clients in Interfaith Hospitality Network programs.

Current Gaps and Barriers

Access to care continues to be confounded by the lack of centralized intake tools and coordinated case management. Client data is inherently difficult with the homeless population as individuals move between service providers, friends, and relatives. Client data sharing, particularly related to healthcare, is governed by HIPAA regulations. Currently, the HMIS system does not generate unduplicated counts or Continuum of Care-wide reports automatically. Data must be manipulated manually - a time and labor-intensive process. HMIS staff are working with a volunteer to build a more responsive reporting mechanism and working with the vendor to build more serviceable reporting tools.

As this 10-Year Blueprint evolved, data specificity became more critical. Not all agencies, even within a sector, quantify process outputs or measure outcomes using the same data elements. During 2009, HMIS staff will meet with each sector to delineate the specific measurement tools and data most relevant to outcome measurement. These outcome indicators will also be important for evaluation of program effectiveness. Examples of outcome indicators to be examined include:

- Percentage or rate of people seeking serves able to access those services.
- Measurable improvement in one or more key areas such as housing stability, income, employment, education.
- Point in time decrease in homelessness as a proportion of the population.
- Reduction in time individuals and families are homeless.
- Reduction in services sought over time in the continuum of care.

Ensuring sector data reflects sector priorities will hone HMIS requirements and help refine the next iteration of the 10-Year document.

Strategies for Closing Sector Gaps

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: There are coordinated resources and formalized networks among homeless provider agencies.	1.1 Empower and assist Homeward Pikes Peak in its mission to coordinate and optimize efforts of homeless service providers.	• Agencies join to seek sustained, alternative funding sources for Homeward Pikes Peak and other collaborative programs and projects	1	Outputs: • Funds/resources to develop, maintain, and enhance formalized, coordinated networks are in place Outcomes: • Strategic, effective resource coordination among agencies without diverting direct services funds	$
	1.2 Comprehensive Homeless Assistance Providers (CHAP) group continues to enable top-level information exchange and helps determinate potential collaborations among group participants.	• Continued monthly meetings	Ongoing	Outputs • Monthly meetings with consistent membership Outcomes • Range of CoC collaborations developed	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#1: There are coordinated resources and formalized networks among homeless provider agencies. **(continued)**	1.3 Establish coordinated client intake and case management	• Convene providers • Determine options • Work with software vendor to implement client sharing • Refine data sharing requirements including client permissions across agencies • Finalize system policies and procedures • Ensure 2-1-1 has complete and current information	1 1 Short Short Short Ongoing	<u>Outcomes</u> • Clients only provide intake information once • Clients avoid conflicting demands • Providers have ability to share relevant client data and coordinate services • Information and data improve client services • Information and data improve cross-agency coordination	$$
	1.4 Ensure broad agency participation in HMIS	• Continue meetings with Advisory group • Ensure all HUD mandated providers are using HMIS • Encourage all other key providers to participate (see also Outcome #5 on page 80)	Ongoing 1 Short	<u>Outputs</u> • All required and necessary providers participate in HMIS <u>Outcomes</u> • Better coordination among providers improves services for clients	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#2: Outreach to unsheltered homeless individuals and families occurs on a regular basis.	2.1 Annual homeless point-in-time survey	• Coordinate annual homeless point-in-time survey (January) • Expand reach of survey to encompass all of El Paso County • Expand focus to include clients' needs (rather than just a head count)	Ongoing Short Mid	Outputs • Annual Point-In-Time count Outcomes • Accurate portrayal of homelessness • Ability to use data illuminate client needs and drive services	$$
	2.2 Create feedback mechanism for clients	• Convene providers • Develop and implement instrument and/or mechanism for clients to provide feedback on services received and needed	Short Short	Outputs • Client feedback for community planning purposes Outcomes • Ability to use data to illuminate client needs and drive services	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#3: A continuum of services is available to all homeless across the continuum of care and needs are met in an optimized, cost effective manner.	3.1 Use data to identify needs and gaps	• Convene providers • Develop/implement consistent method for gathering needs/gaps information • Develop reporting mechanism for communication needs, gaps, and progress • Improve current needs assessment process • Aggregate data from agencies, AHAR, and Point-In-Time surveys • Provide quarterly and annual reports • Work with CoC to analyze data trends and service gaps	Short Short/Mid Short/Mid Short Mid Mid/Ongoing Mid/Ongoing	<u>Outputs</u> • #, type of reports available • # of participating organizations <u>Outcomes</u> • Data driven decisions on allocation of resources (services and funds) • Impact of accurate timely data on service provision	$
	3.2 Implement Rapid Reader/Card system	• Complete pilot installation • Work with vendor to integrate Rapid Reader system with HMIS • Develop plan for including additional providers • Implement across additional providers	1 1 1 Short	<u>Outputs</u> • # of agencies & homeless participating in project <u>Outcomes</u> • Improved service delivery for clients • Improved data for providers	$$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#4: Clients' lives are measurably improved.	4.1 Develop outcomes measurements	• Convene providers • Identify set of program/service outcomes • Identify data elements needed in order to measure the outcomes • Develop needed reports	1 1, Short 1, Short Short, Ongoing	<u>Outputs</u> • Set of data elements and reports <u>Outcomes</u> • Ability to measure program effectiveness	$$
	4.2 Develop reporting and analysis tools	• Convene providers to determine needs • Work with software vendor to develop necessary tools • Purchase and implement additional tools as necessary	1 Short 1, Short	<u>Outputs</u> • Set of reports and analysis tools <u>Outcomes</u> • Array of measurement and analysis tools aligned with sector needs • CoC has access to and participates in data analysis	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#5: Meet all HUD Continuum or Care and HMIS requirements	5.1 Meet HUD agency participation requirements (75% bed coverage in all categories) and our community needs (inclusion of other key providers)	• Work with agencies to help them understand the importance and benefits of HMIS participation • Train all "required" providers • Identify other providers as needed to achieve bed coverage; train them • Identify other desired providers; train them	1, Ongoing 1 1 1, Short	Outputs • # of agencies trained • # of agencies participating Outcome • Non-required providers actively participate in HMIS • Availability of inclusive and longitudinal data	$
	5.2 Meet HUD HMIS software requirements	• Ensure alignment of software with new data standards • Identify software gaps and solutions to close those gaps • Generate accurate and unduplicated housing inventory • Generate APR and AHAR reports	Short 1, Short Ongoing Ongoing	Outputs • Housing inventory, APR and AHAR reports Outcome • Ability to generate HUD required reports directly from HMIS	$$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

CoC Outcome	Access to Services Sector Strategy	Action Steps	Timeframe* (1, short, mid, long)	Evaluation Indicators	Level of Resources ($, $$, $$$)
#5: Meet all HUD Continuum or Care and HMIS requirements **(continued)**	5.3 Meet HUD CoC structure requirements.	• Evaluate new CoC structure requirements • Work with Homeward Pikes Peak to ensure compliance	1 Short	<u>Outcomes</u> • Compliance with HUD requirements	$
	5.3 Develop a threshold mechanism to alert the CoC should progress fall below HUD minimums	• Work with software vendor to create an alert mechanism coordinated with monthly agency reports and HUD requirements	1	<u>Outcome</u> • Reporting system responsive to HUD and CoC needs	$

* 1 = Year 1; short = years 2-4; mid = years 5-7; long = years 7-10

Potential Barriers to Success

Economic realities are significantly impacting the Colorado Springs city budget. Impact has been and will continue to be felt by governmental and service agencies alike. While access to services drives the community's response to homelessness, the need for reports, client data sharing and a central/coordinated intake may not be perceived as top priority. Participation in CHAP and HMIS Advisory Committee meetings will be crucial to sustaining a community-wide response.

In addition, the HMIS system has significant software gaps plus HUD will issue new standards sometime in 2009. It is not yet known whether the vendor will be able to meet the requirements in a timely fashion or whether we will have sufficient funds to close the gaps. If the Continuum of Care must change software providers, the funds needed will be significantly greater.

Centralized/coordinated intake requires broad and willing participation from providers and clients. There is considerable motivation to accomplish this, but the confidentiality and peace of mind considerations will have to be addressed with extensive planning, participation, and education.

Meeting HUD Priorities

The access to services sector specifically supports the following HUD Goals and Policy Priorities.

HUD Goal	
C4	End chronic homelessness and move homeless families and individuals to permanent housing
E2	Improve HUD's management and its internal controls to ensure program compliance and resolve audit issues
E3	Improve accountability, service delivery, and customer service of HUD and its partners
E4	Capitalize on modernized technology to improve the delivery of HUD's core business functions
F2	Conduct outreach and provide technical assistance to strengthen the capacity of faith-based and community organization to attract partners and secure resources

HUD Policy Priority	
B7	Make communities more livable.
F6	Provision of supportive services, such as health care assistance that will permit homeless individuals to become productive members of society
F7	Provision of service coordinators or one-stop assistance centers that will ensure that chronically homeless persons have access to a variety of social services

SYSTEMIC RESPONSE AND SERVICES: HOMEWARD PIKES PEAK

Homeward Pikes Peak's role is to step back from the service sectors to evaluate the community's capacity to serve the homeless. Beyond aggregating and assessing HMIS data, Homeward Pikes Peak must work with the Continuum of Care on the following issues.

1) Align sector-based services to evidence-based practices.
   Action: Arranging site visits to successful programs in similar communities.
   Action: Distributing and discussing information on evidence-based practices at CHAP meetings.

2) Conduct an annual evaluation of homelessness care coordination.
   Action: Homeward Pikes Peak will facilitate annual performance plans from each sector.
   Action: Homeward Pikes Peak will track cost/benefit and return on investment data on each community sector.
   Action: Homeward Pikes Peak will aggregate HMIS and annual performance data to create a report on the Continuum of Care's contribution towards the following Community Quality of Life Indicators.
      - Growing a Vibrant Economy:
        - Employment rate
        - Poverty rate
        - Self-sufficiency income
      - Promoting Social Wellbeing
        - Affordable housing
        - Homelessness
        - Drug and alcohol use
      - Sustaining a Healthy Community
        - Access to Care
        - Mental Health
        - Oral Health

   Action: In conjunction with the annual 10-year plan update, Homeward Pikes Peak will oversee appropriate "course corrections" on how the Continuum of Care serves the public through evidence-based practices, interagency coordination, and service access.

3) Continue leadership in developing sustainable financial resources for service providers.
   Action: Continue working with city and county agencies to coordinate Super NOFA homelessness funds.
   Action: Serve as a local, state and national advocate for increased funds and resources for the Continuum of Care.
   Action: Promote interagency collaboration and blended resource streams to accomplish community homelessness goals.

4) Coordinate public relations opportunities regarding homelessness and interventions.
   Action: The Homeward Pikes Peak Executive Director will continue community outreach and education through speaking engagements and committee work.
   Action: The Homeward Pikes Peak website will be updated to serve as a resource and link to homeless services and service providers.
   Action: A Public Relations packet including key elements of the 10-Year Blueprint and progress towards community indicators will be developed and made available to community leaders and the press.
   Action: The annual Conference on Homelessness will serve as a key conduit for information on homelessness, evidence-based practices and progress towards community indicators.
   - The conferences will provide opportunities for Continuum of Care and government agencies to reflect and celebrate progress at least annually.
   - The conference will provide a "look forward", aligning progress preventing homelessness with community quality of life indicators.
   - Homeward Pikes Peak will publicize cost/benefit and return on investment data on each community sector.

Incorporating 8 Additional Continuum of Care Sectors

Eight additional sectors contribute vital services to the homeless:

- Outreach;
- Clothing and Furniture;
- Disability Services;
- Discharge Policies/Processes;
- Daycare;
- Youth Services;
- Police;
- Transportation; and
- Education.

Over the next two years, these sectors will be incorporated into the 10-Year Blueprint. Representatives from each sector have been involved in the VisionLink planning and CHAP meetings during 2008.

CONCLUSION

The last five years focused a spotlight on homelessness and homelessness issues throughout the region. Agencies began a concerted effort to discuss mutual problems, efficiencies and strengths. Developing this 10-Year Blueprint served to emphasize progress and the ongoing need for improvement. As one Executive Director said, "We want to change how the matrix of services functions, not just move the same pieces around the chess board."

Sector coalitions now meet regularly. Progress indicators have a continuity between agencies and sectors including the following:

- The percentage or rate of people seeking services who are able to access services.
- Measurable improvement in client status.
- Reduction in the time individuals spend homeless.
- Reduction in services sought over time in the Continuum of Care.

As important, Homeward Pikes Peak and CHAP serve as ongoing forums which facilitate coordination between sectors. Agencies view their actions, needs and concerns as part of a *viable* Continuum of Care. Their collective vision for the next 10 years reaches beyond progress indicators to deliberate change.

- Any homeless person seeking services receives them.
- Any homeless person who needs case management receives it.
- There is reduced incidence of recidivism, relapse and re-use of services.
- Homeless individuals demonstrate movement toward self-sufficiency.
- The community has developed sustained funding and programs.
- Systems are increasingly effective in preventing homelessness.
- The community has sufficient housing to meet the needs of the homeless.

Given the current economic climate, homelessness may actually increase during the next 12 months. Job loss and business failure will lead many families to the brink of disaster. Now, it is even more critical for the Pikes Peak region to move forward deliberately, ensuring rapid access to services and rapid exit to housing. Innovation, collaboration and multi-dimensional solutions are the watchwords to ensure our community is a great place to overcome homelessness, but a difficult place to be intentionally homeless.

ADDENDUM 1:

GLOSSARY OF TERMS

Throughout this document many terms have been used that may be unfamiliar to the general public or to professionals outside the service delivery system for the homeless. This glossary provides definitions as agreed upon for this document by the Continuum of Services agencies in the Pikes Peak region.

Area Median Income (AMI): The median divides the income distribution into two equal parts: one-half of the cases falling below the median income and one-half above the median. HUD uses the median income for families in metropolitan and non-metropolitan areas to calculate income limits for eligibility in a variety of housing programs. HUD estimates the median family income for an area in the current year and adjusts that amount for different family sizes so that family incomes may be expressed as a percentage of the area median income. For example, a family's income may equal 80 percent of the area median income, a common maximum income level for participation in HUD programs.

Community Access to Coordinated Health (CATCH): CATCH is a community system of health care for low income, uninsured residents. Common qualifying criteria and forms have been established for use by faith-based clinics and by volunteering providers. Memorial and Penrose Hospital systems have donated lab and diagnostic tests to CATCH clients. Peak Vista has signed an agreement to "fast track" CATCH patients with chronic diseases from local free clinics into Peak Vista. Pikes Peak Mental Health is working with CATCH to identify the mental health needs of CATCH clients. The El Paso County Medical Society is increasing the number of physician volunteers willing to provide care for the uninsured. HealthTrack allows partners to electronically track CATCH eligibility, print CATCH cards allowing clients access to required services (such as lab and imaging) and make referrals from the list of volunteers.

Chronic Homelessness: The Department of Housing and Urban Development defines a "chronically homeless" person as an unaccompanied individual who has been homeless for a period of one year or more, or has experienced four or more episodes of homelessness over a three year period, and has some sort of disabling condition (e.g., mental and/or emotional disorder, substance abuse, etc.).

Emergency Housing: Short-term housing provided in response to a housing crisis offered either in emergency shelters (congregate facilities used for this purpose) or motel rooms funded as emergency housing by either a public or not-for-profit agency.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"): The HIPAA Privacy Rule standards address the use and disclosure of individuals' health information as well as standards for individuals' privacy rights to understand and control how their health information is used. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

HealthTrack: A HIPAA compliant web-based software system, that provides a virtual medical home for the under- and uninsured. Through the visit history summary, HealthTrack helps improve quality of care by informing providers of recent visits to other safety-net providers, including diagnoses, tests and treatment provided. It has helped organizations re-bill for services provided once benefits, such as Medicaid, are approved, determine if benefit applications have been submitted, understand who the uninsured are, where and when they go for care, and what services they most often seek.

Homeless Management Information System (HMIS): HMIS systems are developed locally to record client level data from a community's homelessness service providers. In addition, HMIS presents communities with an opportunity to re-examine how homeless services are provided in their community, make informed decisions, and develop appropriate action steps.

Homelessness: This blueprint uses the HUD definition of homelessness which is as follows:

- sleeping on the streets or places not meant for human habitation;
- sleeping in an emergency shelter (or a motel room funded as emergency housing);
- living in transitional housing after having been on the streets or in emergency shelter;
- staying for a period of up to 30 days in a hospital or other institution after having been on the street or in an emergency shelter;
- being threatened with an eviction within one week from a private dwelling unit; or
- begin discharged within one week from an institution in which the resident has been a resident more than 30 days and not appropriate housing has been identified.

Housing Choice Voucher Program: The current name for the Section 8 Housing Program.

"Housing First" Model: A model focused on securing permanent housing coupled with intensive supportive and treatment services. The housing is secured as quickly as possible after individuals or families have become homeless.

Low-Income Housing: Housing that is affordable to those who are at or below 30% of the median income for the area in which they live. This is housing for very impoverished persons many of whom are reliant on Supplemental Security Income (SSI) or temporary assistance through the Department of Social Services as their only income.

NOFA/SuperNOFA: Notice of Funding Availability/Super Notice of Funding Availability is the federal program announcement for HUD program. Funding is available to communities throughout the United States and covers ten (10) Economic Development and Empowerment Programs operated and managed by the following HUD Offices: Community Planning and Development (CPD), Housing-Federal Housing Administration (FHA), Public and Indian Housing (PIH), and the Office of Lead Hazard Control (OLHC).

Permanent Housing: Housing that can be occupied for an indefinite period as long as the tenant complies with lease requirements. One type of permanent housing is *permanent supportive housing* which is permanent housing accompanied by ongoing supportive and treatment services. Many persons with disabilities require permanent supportive housing in order to remain stably housed.

Poverty: The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the U.S., this level is determined by the Department of Health and Human Services. Federal Poverty Level varies according to family size. The number is adjusted for inflation and reported annual in the form of poverty guidelines.

President's Interagency Council on Homelessness: Congress established the Interagency Council on Homelessness in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act. The Council is responsible for providing Federal leadership for activities to assist homeless families and individuals.

Public Housing: Housing, usually operated by public housing authorities, established to provide decent and safe rental units for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single-family houses to high-rise apartments for the elderly.

Section 8 Housing Program (now called the Housing Choice Voucher Program): Housing assistance secured from a local housing authority or other authorized provider in the form of direct payments to landlords that low-income people can use to rent apartments and homes on the private market.

Single Room Occupancy (SRO): Permanent housing providing an individual a single room in which to live. These units may contain food preparation or sanitary facilities or these may be shared with others.

Social Security Disability Insurance: A federally-funded wage-replacement program, administered by the Social Security Administration, for those who have a disability meeting Social Security rules and who have paid FICA taxes. SSDI is financed with Social Security taxes paid by workers, employers, and self-employed persons. SSDI benefits are payable to disabled workers, widows, and children or adults disabled since childhood who are otherwise eligible.

Supplemental Security Income: A Federal income supplement program funded by general tax revenues and designed to help aged, blind, and disabled people who have little or no income. The program provides cash to meet basic needs for food, clothing, and shelter.

Transitional Housing: Housing coupled with supportive and treatment services that is provided on a time-limited basis (in most cases, not exceeding 24 months). The primary distinction between transitional housing and permanent housing is that in transition housing the program, not the participant, determines the length of stay.

U.S. Department of Housing and Urban Development (HUD): A cabinet-level agency of the federal government whose mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination. HUD is the primary federal funder of low-income housing for homeless persons.

ADDENDUM 2:

Continuum of Care Member Organizations

Colorado Coalition for the Homeless
Colorado Springs City Council
Colorado Division of Housing
Colorado Department of Human Services
Colorado Springs Housing and Community Development
Colorado Springs Fire Department Public Sector
El Paso County Department of Human Services
El Paso County Department of Health and Environment
Social Security Administration
Colorado Springs Housing Authority
Colorado Springs School Districts 2, 11,12, 14, 20
Colorado Springs Christian School
Colorado College
University of Colorado at Colorado Springs
Pikes Peak Community College
Diocese of Colorado Springs Schools
Colorado Springs Police Department
El Paso Sheriff's Department
El Paso County Correctional Facility
Manitou Springs Police Department
Fountain Police Department
Green Mountain Falls Police Department
Pikes Peak Workforce Center
Veterans Administration Public
Alano Recovery Homes
Assistance League of Colorado Springs
Care and Share Food Bank for Southern Colorado
Colorado House
Colorado Legal Services
ComCor
FirstChoice Services
Goodwill Industries
Bijou Community
Greccio Housing
Collaborative for Co-Occurring Disorders
Colorado Springs Child Nursery Center
Habitat For Humanity Private Sector Nonpro..
Harbor House
Homeward Pikes Peak Private
Billie Spielman Center
Colorado Veterans Resource Coaltion
Centro De La Familia
Family Life Services
Good News Foundation
Ithaka Land Trust ..
Grace Be Unto You Private Sector Faith
Liza's Place
Mesa House
Meadows Park Community Center
Lighthouse Recovery
Mercy Housing
National Association of Mental Health - Local Chapter
Partners In Housing
Pikes Peak Behavioral Health Group
Pikes Peak Community Action Agency
Peak Vista Health Centers
Pikes Peak Mental Health Center
Rocky Mountain Land Trust
Silver Key Senior Services
Salvation Army
Southern Colorado Aids Project
Springs Rescue Mission
TESSA (formerly the Center for Prevention of Domestic Violence)
Urban Peak Colorado Springs
Women Partnering
Womens Resource Agency
Westside CARES
Catholic Charities Private Sector Faith
Ecumenical Social Ministries
Emmanuel Missionary Baptist Church
Interfaith Hospitality Network

Lutheran Family Services
Manna Ministries
Mission Medical Clinic
Northern Churches Care
Open Bible Medical Clinic
Pulpit Rock Church
The Safe Harbor
Payne Chapel A.M.E. Church
Business Improvement District
Center for Nonprofit Excellence
Council of Neighbors and Organizations
The Daniels Fund
The Downtown Partnership
El Pomar Foundation
Joseph Henry Edmondson Foundation
Marson Foundation
Pikes Peak Community Foundation
Pikes Peak Peace and Justice Commission
Pikes Peak United Way
Aspen Grove Properties
The Colorado Springs Greater Chamber of Commerce
The Colorado Springs Gazette
Concept Restaurants
Lockheed Martin
Platinum Group Realty
Wells Fargo Bank
Memorial Hospital Private Sector
Penrose-St. Francis Hospital
St. Francis Counseling
S.E.T. of Colorado Springs
Apartment Managers Association of Southern Colorado
Dia Didario Homeless Individual
Michelle Duda Homeless Individual
Gaylord Goll Homeless Individual
Matt Parkhouse Homeless Individual
Robert Heller Homeless Individual