CONTINUUM OF CARE AND UNDERSTANDING COMMUNITY NEED
WHAT IS A CONTINUUM OF CARE?

The Continuum of Care is a community plan and planning group deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and self-sufficiency. (HUD, 2001)

It includes action steps to end homelessness and prevent a return to homelessness. (HUD, 2001)
COMPONENTS OF A CONTINUUM OF CARE

Building an effective housing response system
There are 8 Continuums statewide
• McKinney Act – 1987
  • Established or modified programs in federal agencies to target homelessness; Established the US Interagency on Homelessness (USICH)

• HUD-1996
  • Began requiring Communities to develop a Continuum of Care (CoC) to apply for federal housing funding
  • Required CoCs to coordinate services and conduct community planning to address homelessness in partnership with municipal governments
THE HOMELESS EMERGENCY ASSISTANCE AND RAPID TRANSITION TO HOUSING (HEARTH) ACT (2009)

- Emphasis on Performance
- Consolidated Programs
- Made the Definition of Homelessness more consistent with other Federal Agency Definitions
- Codified the Continuum of Care Planning Process
  - Municipalities and Continuums coordinate CDBG Consolidated Plans & funding with Continuum plans to end homelessness
- Focused on Families & Rural Homelessness
LOCAL COORDINATION BETWEEN CDBG AND CONTINUUM PLANNING

• The Hearth Act requires **measureable goals and progress in addressing homelessness in the Consolidated plans for CDBG funding**
  
  • A community’s homeless plan is evaluated to determine how homelessness is reduced.
  
  • Communities are evaluated on responsiveness to need and the quality of outcomes

• The HEARTH Act requires **goal setting, performance outcomes**, data sharing, and coordination between Municipal CDBG Consolidated plans and Continuum plans.
THE NEWEST FEDERAL STRATEGIC PLAN

All In: Vision for the Future

This plan is built upon our vision of a nation in which no one experiences the tragedy and indignity of homelessness—and everyone has a safe, stable, accessible, and affordable home.

GOAL: Reduce homelessness 25% by 2025
QUICK FACTS

• Nationally, about 1.25M people experience homeless in a year, and 580,000 people experience on a single night in January.

• In St. Charles County, approximately 1100 households become homeless in a year; approximately 425 are homeless on any day.

• About 30% of the total homeless population in our county is part of a family; about 5% are veterans; 16% have experienced domestic violence.
QUICK FACTS

Coordinated Entry received over 10,000 calls for housing assistance in 2022.

Our CoC receives 4% of the regional CoC funding, although we have 25% of the regional homeless population, and 36% of the regions unsheltered homeless

90% of the households that are rehoused do not become homeless again within 2 years

It takes an average of 212 days to rehouse a homeless household in our community
For a fragile family, a single instance of instability can trigger a cascade of additional events that cause further instability:

*When families face multiple forms of instability, stress can become overwhelming and prevent a family from accessing sufficient resources to buffer the impact on their child’s well-being.*
IMPACT OF INSTABILITY AND POVERTY

➢ **Induces stress** and a loss of resources which affect parent’s ability to buffer against consequences on child well-being.

➢ **Chronic instability** is associated with toxic stress and **leads to the most adverse child outcomes**

➢ **Affects kinship & social support systems**, including the ability of “anchor” institutions (such as schools, childcare, health care) and public safety net programs to effectively reduce negative outcomes.
RESPONSIBILITIES OF THE CONTINUUM OF CARE, IN PARTNERSHIP WITH COUNTY GOVERNMENT AND THE CAB BOARD:

• Assess community need, gather data to address needs, and develop plans to address homelessness in coordination with state and federal plans.

• The CAB Board oversees and allocates Homeless and Indigent Funding to support community, municipal, and Continuum goals.

• The Continuum of Care coordinates other Federal, State and Local funding available at the community level to address homelessness.
COORDINATION OF HOMELESS PLANNING & FUNDING WITH OTHER GOVERNMENT PROGRAMS

PLANNING
- Continuum of Care
  - Monthly meetings
  - Point in Time Count
  - Community Information Sharing System (HMIS)

DOCUMENTATION
- Collaborative Application
  - HMIS
    - Documents the community process to address homelessness
    - Provides data quarterly to federal, state and local govt.

AGENCIES
- Federal
  - HUD
  - VA
  - HHS

- State
  - MHDC
  - DSS

- Local
  - County, St. Charles, O’Fallon
  - Comprehensive Planning

- NonProfits
  - Apply directly to HUD

PUBLIC FUNDS
- MHTF, ESG & Housing First
- CDBG & CAB
- Potential CoC funding from HUD
THE COC EXECUTIVE COMMITTEE LEADS PLANNING AND MONITORS COMMUNITY PROGRESS TO END HOMELESS

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### Summary of Key metric results 6-12

<table>
<thead>
<tr>
<th>Key result</th>
<th>Metric</th>
<th>Community System Performance</th>
<th>Target Result</th>
<th>Annual Result 10/1/20-9/30/21</th>
<th>Q1 10/1/21-12/31/21</th>
<th>Q2 1/1/22-3/31/22</th>
<th>Q3 4/1/22-6/30/22</th>
<th>Q4 7/1/22-9/30/22</th>
<th>Annual Result 10/1/21-9/30/22</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>1st QM 5.1</td>
<td>% of people experiencing homelessness</td>
<td>30</td>
<td>20</td>
<td>80%</td>
<td>80.4% (644)</td>
<td>80%</td>
<td>81%</td>
<td>80%</td>
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<tr>
<td>2</td>
<td>2nd QM 5.2</td>
<td>Average length of time persons remain homeless (in ES)</td>
<td>24 days</td>
<td>23 days</td>
<td>25 days</td>
<td>26 days</td>
<td>35 days</td>
<td>32 days</td>
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<tr>
<td>3</td>
<td>3rd QM 5.3</td>
<td>Average length of time homeless for families</td>
<td>24 days</td>
<td>23 days</td>
<td>25 days</td>
<td>26 days</td>
<td>35 days</td>
<td>32 days</td>
<td></td>
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<tr>
<td>4</td>
<td>4th QM 5.4</td>
<td>% of households in permanent housing retaining permanent housing</td>
<td>90%</td>
<td>89%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
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<tr>
<td>5</td>
<td>5th QM 5.5</td>
<td>% of persons/household returning to homelessness over a 12 month period</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
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<tr>
<td>6</td>
<td>6th QM 5.6</td>
<td>% of persons/household returning to homeless over a 6 month period</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>3%</td>
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<tr>
<td>7</td>
<td>7th QM 5.7</td>
<td>% of adult leavers with increased earned income</td>
<td>22%</td>
<td>21%</td>
<td>13%</td>
<td>13%</td>
<td>10%</td>
<td>10%</td>
<td>11%</td>
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<tr>
<td>8</td>
<td>8th QM 5.8</td>
<td>% of adult leavers with increased non-employment cash income</td>
<td>22%</td>
<td>21%</td>
<td>16%</td>
<td>13%</td>
<td>20%</td>
<td>0%</td>
<td>18%</td>
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<td>9</td>
<td>9th QM 5.9</td>
<td>% of households prevented from becoming homeless</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>10</td>
<td>10th QM 5.10</td>
<td>% of households rehoused</td>
<td>200</td>
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<td>200</td>
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### Key Results

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<th>Label</th>
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<tbody>
<tr>
<td>1</td>
<td>Executive</td>
<td>Reduce and Prevent homelessness among households in a housing crisis.</td>
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<tr>
<td>2</td>
<td>Community Development</td>
<td>Develop COC strategies to best capture and use federal funding available. (AEC, COC, etc.)</td>
</tr>
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<td>3</td>
<td>Promote Need</td>
<td>Promote need for funding for shelter, housing, prevention, and transportation needs of persons in a housing crisis.</td>
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<tr>
<td>4</td>
<td>Set Target Production Goals</td>
<td>Set target production goals to increase shelter and affordable housing capacity.</td>
</tr>
<tr>
<td>5</td>
<td>Strengthen Capacity</td>
<td>Strengthen COC capacity through targeted monthly Even planning meetings, leadership information sharing meetings, and leadership development.</td>
</tr>
<tr>
<td>6</td>
<td>Engage New Community Partners</td>
<td>Engage new community partners.</td>
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### MO-003 Continuum of Care Progress Report 2021-2022

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<th>Year</th>
<th>Result</th>
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<td>Q1</td>
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<tr>
<td>Q2</td>
<td>1145</td>
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<td>Q3</td>
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<td>Q4</td>
<td>961</td>
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<td>Annual</td>
<td>3158</td>
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*MO-003 Continuum of Care Progress Report 2021-2022*
COORDINATED ENTRY

➢ Captures unmet need
➢ Allow people seeking assistance to complete one intake for all housing programs in the community
➢ Screen for program eligibility for all publicly funded community housing programs
➢ Since client information is collected at one housing intake, persons needing help make one call to access all services that they may be eligible for, and agencies spend less time on intake and eligibility screening.
IN SUMMARY...WE ARE ALL IN THIS TOGETHER!

• “Stable housing is the foundation on which people build their lives. Absent a safe, decent, and affordable place to live, it is next to impossible to achieve good outcomes or reach one’s economic potential.”

- US Interagency to End Homelessness