**MID-WILLAMETTE HOMELESS INITIATIVE**

**CONTINUUM OF CARE ANALYSIS**

**March 28, 2019**

**EXECUTIVE SUMMARY**

Since 1994, the U.S. Department of Housing and Urban Development, Office of Special Needs Assistance Programs, has required communities to form a Continuum of Care to receive federal funds under the McKinney-Vento Homeless Assistance Act.

Marion and Polk counties originally formed a regional Continuum of Care, administered by the Mid-Willamette Valley Community Action Agency. In July 2011, members of the Mid-Valley Housing and Services Collaborative, the steering committee for the Salem/Marion/Polk Continuum of Care, voted unanimously to join the Rural Oregon Continuum of Care, a "balance of state" model.

Homelessness has become a more prominent community issue in recent years, with increasing numbers of visible homeless people and expectations from constituents that cities and counties take action. The Mid-Willamette Homeless Initiative Task Force discussed the region's membership in the Rural Oregon Continuum of Care in 2016 and recommended that the participating jurisdictions look at the issue.

This analysis considers four policy questions:

1. Should the region establish its own Continuum of Care?
2. What organizational structure is recommended for a new Continuum of Care?
3. What changes would need to occur from current and past practices?
4. What is the change process?

From this analysis, staff derives the following conclusions.

a. ***Outcomes.*** A regional Continuum of Care consisting of Marion, Polk, and possibly Yamhill counties offers the potential for improved planning, coordination, and outcomes for homeless individuals and families.
b. ***Funding.*** While there is no guarantee that federal funding will increase, and some speculation that funding could decrease in the short-term, there is a potential for increased funding over time. It will be necessary for the governmental jurisdictions to continue contributing to staffing costs and to assist currently-funded programs, if needed, so programs remain whole during the transition.
c. ***Systems Approach.*** A comprehensive systems approach is more likely to achieve the desired outcomes for homeless individuals and families than a programmatic approach. A systems approach requires cooperation and long-term commitment from the participating governmental jurisdictions.
d. ***Intergovernmental Relations.*** Governmental jurisdictions can play an important role in promoting intergovernmental relations and communication with HUD, Oregon Housing and Community Services, the Congressional delegation, state legislators, and other relevant federal and state agencies.
e. ***Models to Emulate***. The new Continuum of Care can look to tested models that have demonstrated success in prioritizing services based on community needs, used data to better understand the homeless population and drive service delivery, and held service providers accountable. Lane and Clackamas counties are two Oregon examples of successful continuums of care.

f. ***MWHI Foundational Work.*** The Mid-Willamette Homeless Initiative provides a solid foundation for the Continuum of Care transition. To date, the initiative has produced a Money Map financial analysis to demonstrate state and local leverage; a Resource Inventory mapping more than 500 programs as a basis for demonstrating strengths, gaps, and needs; a comprehensive strategic plan, created by a process that included hundreds of providers, advocates, community members, and homeless or formerly homeless individuals; an adopted list of metrics to measure success; and experience developing intergovernmental agreements outlining areas for cooperation. These products will be valuable resources, should the region decide to establish a new Continuum of Care.

g. ***Collaboration***. Inclusivity is a critical element of any governance structure. There are many nonprofits and existing collaborative groups that can add value and maximize coordination. This region has a strong track record of working together towards common goals, which can only benefit opportunities for success in creating a new Continuum of Care.

Staff recommends that the Marion-Polk or Marion-Polk-Yamhill region establish its own Continuum of Care beginning in 2020. To affirm this recommendation, staff recommends that each affected jurisdiction adopt a resolution that formalizes this direction, based on a template recommended by the Mid-Willamette Homeless Initiative Steering Committee.

**CONTINUUM OF CARE ANALYSIS**

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## I. Introduction

Since 1994, the U.S. Department of Housing and Urban Development, Office of Special Needs Assistance Programs, has required communities to form a Continuum of Care to receive federal funds under the McKinney-Vento Homeless Assistance Act.

Marion and Polk counties originally formed a regional Continuum of Care, administered by the Mid-Willamette Valley Community Action Agency. In July 2011, members of the Mid-Valley Housing and Services Collaborative, the steering committee for the Salem/Marion/Polk Continuum of Care, voted unanimously to join the Rural Oregon Continuum of Care, a "balance of state" model, now comprised of 28 counties including Marion, Polk, and Yamhill. The Rural Oregon Continuum of Care is administered by Community Action Partners of Oregon.

The issue was placed on the homeless initiative coordinator's work plan and was discussed at the October 2018 Steering Committee meeting in conjunction with a resource inventory and gaps analysis presentation. The Steering Committee reviewed the issue again in greater depth at the February 2019 meeting and, at this writing, presentations have been made to Marion and Polk county commissioners and to administrators representing Marion, Polk, and Yamhill counties and cities within the three counties.

The following analysis lays out federal expectations for a Continuum of Care and then considers the following four policy questions:

1. Should the region establish its own Continuum of Care?
2. What organizational structure is recommended for a new Continuum of Care?
3. What changes would need to occur from current and past practices?
4. What is the change process?

## II. Background

### a. What is a Continuum of Care?

The U.S. Department of Housing and Urban Development (HUD) stated that the purpose of the Continuum of Care program is to "promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effective utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness."[1] HUD's interim rule further defined a Continuum of Care as "the group organized to carry out the responsibilities required under this part [Part 578] and that is composed of representatives of organizations, including nonprofit homeless

[1] 24 CFR Part 578 Interim Rule: Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program, Office of the Assistant Secretary for Community Planning and Development, p. 4. https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate."[2]

In short, the intent of the Continuum of Care program is to stimulate communitywide planning and coordination to improve outcomes for individuals and families who are homeless, while involving the many sectors that affect this population.

There are five ways that HUD allows communities to define the geographic reach for a Continuum of Care: (1) urban city boundaries (9% of the nation's continuums were defined by cities in 2009); (2) single county boundaries (52%); (3) regional continuums comprised of at least two counties (30%); balance of state continuums, intended for large areas not covered by regional, county, or city continuums (7%); and statewide continuums in six states with relatively small populations: Delaware, Rhode Island, Montana, Wyoming, North Dakota, and South Dakota (2%).

In Oregon, Multnomah, Washington, Clackamas, Lane, and Jackson counties each are defined by single county continuums of care. Oregon now has one regional continuum of care in Central Oregon that includes Deschutes, Jefferson, and Crook counties. The remaining 28 Oregon counties form the "balance of state" continuum known as the Rural Oregon Continuum of Care, or ROCC. These 28 counties are: Baker, Benton, Clatsop, Columbia, Coos, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Josephine, Klamath, Lake, Lincoln, Linn, Malheur, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, and Yamhill.

HUD describes the advantages of a regional or balance of state approach as:

- Increases visibility of homeless persons' needs and ensures critical coverage in rural communities;
- Creates a "critical mass" that boosts funding prospects;
- Leverages additional assistance from state governments; and
- Facilitates communities with more experience sharing their expertise with less experienced communities.

Disadvantages of a regional or balance of state approach include:

- States, counties, and participating localities coming up with efficient organizational structures that allow participatory involvement in all aspects of the continuum of care process, from forming local planning groups to setting priorities; and
- Challenges with assembling meaningful data in a large geographic area that is often non-contiguous.[3]

[2] 24 CFR Part 578 Interim Rule: Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program, Office of the Assistant Secretary for Community Planning and Development, p. 54. https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

[3] U.S. Department of Housing and Urban Development, Office of Community Planning and Development: *Continuum of Care 101*. HUD: Washington, D.C., pp. 47-49. https://www.hudexchange.info/resource/1187/continuum-of-care-101/

### b. Why is a Continuum of Care important?

In addition to preparing an annual application for McKinney-Vento funds, continuums of care play an important role in bringing stakeholders together to identify community needs and gaps around homelessness, in setting priorities for multiple funding sources (federal, state, local), coordinating diverse services for homeless individuals and families, collecting and interpreting data, and assuring that programs and services are performing well.

Federal Continuum of Care funds include Supportive Housing, Shelter Plus Care, and Section 8 Single Room Occupancy programs.[4] For Marion and Polk counties, the 2018 preliminary pro rata need was calculated at almost $946,000.[5] HUD described the planning process envisioned for Continuum of Care as "strategic" and "year-round," so that services funded with Continuum of Care funds meet identified community needs and are "well integrated" with mainstream services, such as public housing; Section 8 housing choice vouchers; programs funded by HOME, Community Development Block Grant; Social Services Block Grant; Workforce Investment and Opportunity Act; Community Mental Health Services Block Grant; and Substance Abuse Prevention and Treatment Block Grant, among others. In addition, HUD anticipated Continuum of Care planning would coordinate with programs for runaway and homeless youth, veterans, and victims of domestic violence.[6]

A *Money Map* compiled by the Mid-Willamette Homeless Initiative coordinator identified more than $107 million in federal, state, county, and local funds targeted at addressing and preventing homelessness in Marion and Polk counties alone. An inventory of related programs and services identified 550 programs that touch this population.[7]

Continuums of care create opportunities to bring stakeholders together to work on housing supply for low-income individuals and families. In fact, in *Continuum of Care 101*, HUD explained that the original intent for homeless assistance funding was to support permanent housing projects. In 1999, Congress began requiring HUD to spend at least 30% of McKinney-Vento homeless assistance funds on permanent housing. Then in 2002, HUD began offering a bonus to applications that ranked a new permanent housing project as a first priority for funding and awarding points to requests for higher percentages of funds for housing-related activities, rather than service activities.

The Continuum of Care Program funds two types of permanent housing: permanent supportive housing and rapid re-housing. Permanent supportive housing is permanent housing paired with supportive services to help homeless persons with a disability achieve housing stability. Families with an adult or child member with a disability also qualify. Rapid re-housing moves homeless individuals and families into permanent housing as rapidly as possible through housing search, relocation, and rental assistance.

HUD went on to say, "With the emphasis placed on permanent housing, less funding is available under HUD's annual CoC competition to fund other components of the CoC system. … As a result, it is *critical*

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[4] U.S. Department of Housing and Urban Development, Office of Community Planning and Development: *Continuum of Care 101*. HUD: Washington, D.C., pp. 24-28.
[5] FY 2018 Continuum of Care (CoC) Preliminary Pro Rata Need (PPRN) Report. https://www.hudexchange.info/resources/documents/FY-2018-Geographic-Codes-with-PPRN.pdf
[6] U.S. Department of Housing and Urban Development, Office of Community Planning and Development: *Continuum of Care 101*. HUD: Washington, D.C., pp. 28-43. https://www.hudexchange.info/resource/1187/continuum-of-care-101/
[7] Documents can be found at https://www.mwvcog.org/programs/homeless-initiative/

that continuums seek out other resources to ensure that adequate housing and supportive services can be provided at every stage in the homeless service system and beyond."[8]

**c. What is the history of the Continuum of Care in the mid-Willamette region?**

Marion and Polk counties formed one of Oregon's continuums of care (Oregon 504) that operated with staff support from Mid-Willamette Valley Community Action Agency until 2011. The continuum operated as a consortium model, with representation from many area nonprofit organizations. In 2011, the Rural Oregon Continuum of Care approached the Marion-Polk continuum about merging efforts.

The rationale offered for joining the balance of state continuum included concerns by Oregon 504 partner organizations about increasing federal expectations, particularly around data collection, and the capacity of Community Action to continue to provide staff support, given those expectations; a belief that the Marion-Polk region would become more successful to compete for bonus dollars in a continuum of care with greater overall population; and assurances by Rural Oregon Continuum of Care representatives that the Marion-Polk region's projects would be held harmless in the first year and would be supported to be successful in future years. Consortium partners voted unanimously to move the entity to ROCC in July 2011.

In reviewing the meeting minutes, it is apparent that governmental jurisdictions were not active participants in this decision. Only City of Salem had a representative at the table at the meeting. Neither Marion nor Polk County, nor any other cities in the two counties were involved in the decision, and the decision was not communicated to governmental leadership, including elected officials or senior staff at the City of Salem.

**d. Why the impetus to consider changing structures?**

In 2016, the issue of Rural Oregon Continuum of Care membership was raised at subcommittee meetings of the Mid-Willamette Homeless Initiative Task Force. As a result, the initiative's strategic plan included the following objective: "Examine ways to best position the region for future funding, including but not limited to a) Examining HMIS participation rates to determine the degree of community coordination in future cooperative applications; and b) Assessing local inclusion in the Rural Oregon Continuum of Care (ROCC) to understand how best to address the problems of homelessness and needs of people experiencing homelessness."[9] Other task force recommendations pointed to the need for enhanced service coordination.

This analysis begins to respond to these strategic plan objectives. Since 2011, homelessness has become a more prominent community issue, with increasing numbers of homeless people and homelessness becoming more visible to area residents. In conducting standardized assessments of nearly 6,000 individuals between October 2016 and January 2019 in Marion and Polk counties, Community Action identified 2,628 homeless individuals, with significant numbers of children, chronically homeless individuals, families, and veterans. "Chronically homeless" is defined as an individual who (i) is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living in said conditions for at least one year or on at least four separate occasions in the last three years; and (iii) can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder,

[8] Ibid., pp. 17-18.

[9] https://www.co.marion.or.us/BOC/MWHI/Documents/MWHI%20Strategic%20Plan%20FINAL%202.8.17JC-JC%20FINAL.pdf

cognitive impairments resulting from brain injury, or chronic physical illness or disability."[10] In 2018, Oregon's balance of state continuum had the tenth highest number of chronically homeless individuals in the nation.[11]

DHM Research conducted a Residential Satisfaction Survey for the City of Salem in September 2018. The methodology was a statistical sample of 450 residents contacted by telephone. The survey found that action around homelessness was the top priority for Salem residents and the percentage of residents listing it as such increased dramatically from the two prior years. The city's recently-published policy agenda stated: "While homelessness was a top concern in both 2017 (26%) and 2016 (17%), more residents (33%) list it as the most important issue for Salem to do something about in 2018."[12]

The numbers of homeless individuals and families continue to rise, along with a growing public awareness and expectations that governments act. Yet there is no designated entity that is viewed as having the lead responsibility to address the problem. Multiple task forces and studies have been done. Networking groups continue to meet. For Salem's homeless population, Marion and Polk counties provide mental health services; three housing authorities operate within the two counties; and homeless individuals move back and forth from downtown Salem to unincorporated East Salem and across the Willamette River to Polk County. It is also important to recognize that homelessness is not exclusively a Salem concern. Smaller cities and unincorporated areas in the region have also seen increases in homeless individuals and are seeking solutions.

The Rural Oregon Continuum of Care has struggled to meet HUD performance expectations. The continuum is currently recruiting for two staff positions and has been receiving assistance from Oregon Housing and Community Services. Finally, while regional stakeholders have acknowledged that money cannot be the sole driver for change, and that building regional continuum capacity is a long-term endeavor, an analysis of funding finds that Marion and Polk counties have been receiving diminishing amounts of funding, even though the overall Rural Oregon Continuum of Care allocation has steadily increased.

The following chart illustrates what HUD calls the "preliminary pro rata need" for Salem, Marion County, and Polk County that serves as the basis for Continuum of Care allocations.

**HUD Preliminary Pro Rata Need Calculation (FY 2018)[13]**

| Geo Code | Name | FY 2017 Preliminary Pro Rata Need |
|---|---|---|
| 411200 | Salem | $357,682 |
| 419047 | Marion County | $470,239 |
| 419053 | Polk County | $117,681 |
| | **REGION TOTAL** | **$945,602** |

[10] 24 CFR Part 578 Interim Rule: Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program, Office of the Assistant Secretary for Community Planning and Development, pp.53-54. https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

[11] HUD Homeless Annual Assessment Report, 2018. https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

[12] https://www.cityofsalem.net/Pages/survey-says-salem-residents-remain-satisfied-with-city-services.aspx

[13] FY 2018 Continuum of Care (CoC) Preliminary Pro Rata Need (PPRN) Report. https://www.hudexchange.info/resources/documents/FY-2018-Geographic-Codes-with-PPRN.pdf

This chart illustrates how Marion and Polk counties have fared prior to and after the Rural Oregon Continuum of Care merger in 2011.

**Marion-Polk Continuum of Care Funding: 2005-2018[14]**

| Marion-Polk CoC | | | Marion-Polk Within Balance of State CoC | | |
|---|---|---|---|---|---|
| 2005 | $ 726,979 | | 2011 | $ 920,350 | $2,654,586 |
| 2006 | $ 726,978 | | 2012 | $1,059,253 | $2,873,713 |
| 2007 | $ 726,978 | | 2013 | $ 953,529 | $2,750,204 |
| 2008 | $ 886,927 | | 2014 | $ 668,126 | $3,164,408 |
| 2009 | $ 953,574 | | 2015 | $ 643,989 | $3,081,444 |
| 2010 | $ 954,195 | | 2016 | $ 615,384 | $3,134,740 |
| | | | 2017 | $ 779,982 | $3,165,384 |
| | | | 2018 | $ 696,819 | $3,233,919 |

By comparison, Eugene, Springfield, and Lane County's preliminary pro rata need for 2018 was $769,403, $177,199 less than Marion-Polk's allocation. Lane County's overall population and homeless population is very similar to that of Marion and Polk counties. However, through adopting a systems approach, with strong coordination among the county and its major cities, Lane County has been able to grow its Continuum of Care funding allocation to significantly more than that of the Rural Oregon Continuum of Care encompassing Marion, Polk, and Yamhill counties and 25 more. In 2016, a homeless person in Lane County was allocated $2,398 in continuum dollars, while a homeless person in a Rural Oregon Continuum of Care county was allocated received $549.[15]

**e. What are the opportunities and risks for changing the current structure?**

Any change brings potential opportunities and risks. Creating a new Continuum of Care offers the following opportunities for this region:

1. Improves the Continuum of Care's capacity to identify regional and local needs and gaps and to prioritize and coordinate services for homeless individuals and families;
2. Identifies and leverages state, county, and local dollars already being invested to impact homelessness (i.e., funds listed in the Money Map and programs considered in the Resource Inventory[16]);
3. Better connects the Continuum of Care planning and prioritization with mainstream federal housing and homelessness programs;
4. Engages and expands local partnerships around the Continuum of Care table, including existing collaborations on health and mental health care, workforce development, economic development, addictions, service integration, public safety, and early learning;
5. Collects and reports local data to better understand the homeless population and to improve provider performance;

[14] Figures provided by Mid-Willamette Valley Community Action Agency. Calculations are based on the 2016 Point-in-Time County. See page 8 of this document for further detail.
[15] Figures provided by Mid-Willamette Valley Community Action Agency.
[16] http://www.mwvcog.org/programs/homeless-initiative/

6. Gains autonomy for local governmental and nonprofit leaders to make decisions affecting homeless people within the region; and
7. Creates a greater likelihood that outcomes intended by HUD through the Continuum of Care program are achieved.

Potential risks associated with changing the current structure include the following:

1. If funds decrease, local programs relying on Continuum of Care funds may experience lose program capacity;
2. Governmental leadership may disagree, change direction, or disengage from the Continuum of Care, leaving the governance model to be carried out by nonprofit organizations without adequate support;
3. Rural Oregon Continuum of Care may become even less stable without this region's dollars, creating a situation where HUD and Oregon Housing and Community Services Department are not inclined to look favorably upon the change; or
4. The newly-created Continuum of Care may fail to change from a programmatic approach to a systemic approach and the status quo would continue, albeit in a smaller footprint.

Each of these risks underscores the imperative nature of regional collaboration before, during, and after the transition. Should any of these risks occur, the jurisdictions will need to work closely together to mitigate potential harm to existing programs, the governance structure, partnerships, and state and federal relationships.

## III. Policy Question 1. Should the region establish its own Continuum of Care?

This is the preeminent question that this analysis must explore. In conducting the analysis, staff considered the following factors: (1) funding, (2) planning and coordination, and (3) autonomy or local control.

### a. Funding

As outlined on page 8 above, a review of Continuum of Care allocations over more than a decade found that the region initially benefited from joining the Rural Oregon Continuum of Care, but that funds allocated to programs serving the Marion-Polk region steadily declined since 2013. Additionally, the dollars per homeless person in the balance of state Continuum of Care at $549 per homeless individual are significantly lower than per person allocations in other large Oregon counties, including Lane County at $2,398 per homeless individual.

The following chart illustrates the divergence between the Rural Oregon Continuum of Care funding per homeless person, based on the 2016 Point-in-Time Count, and the funding per homeless person in other Oregon continuums of care.

**Where We Stand: Continuum of Care Dollars Per Person based on 2016 Point-in-Time Count[17]**

| | | | | | |
|---|---|---|---|---|---|
| 1. | OR-506 Washington | $5,897 | | 5. OR-500 Lane | $2,398 |
| 2. | OR-501 Multnomah | $5,531 | | 6. OR-503 Central OR | $ 993 |
| 3. | OR-507 Clackamas | $4,956 | | **7. OR-505 Balance of State/ROCC** | **$ 549** |
| 4. | WA-508 Vancouver | $2,527 | | 8. OR-502 Jackson | $ 502 |

If the region establishes its own Continuum of Care, participating governments and nonprofits cannot expect an immediate, significant increase in federal funds. It took Lane County's Continuum of Care almost two decades to build its current allocation level, with strong collaboration among Lane County, Eugene, and Springfield.

That said, there is a likelihood that funds for this region will grow over time, through allocated funds, competitive grants and bonus funds. This potential for growth assumes that the new regional Continuum of Care has strong staff support so that it is well managed. It also assumes that the new Continuum of Care views its role broadly in addressing homelessness across the region, leveraging not only federal, but also state and local dollars in planning for increased housing supply and supports for homeless individuals and families.

**b. Planning and Coordination**

When the Marion-Polk Continuum of Care merged into the Rural Oregon Continuum of Care, the region lost a central planning entity for issues surrounding housing and homelessness. Many groups attempted to fill the void. These included the Mid-Willamette Homeless Initiative Task Force, city-led task forces and, to an extent, the Emergency Housing Network and the Health and Housing Committees that continue to meet as networking groups.

A regional Continuum of Care for Marion, Polk, and possibly Yamhill counties presents an opportunity to again create a central entity tasked with coordinated, strategic planning. It would allow other planning and networking groups, such as Salem's Emergency Housing Network and the Health and Housing Committee, to examine their roles and functions vis a vis the central planning entity. It would reduce duplication of effort and align resources across cities and counties within the region, and among private, nonprofit, and public stakeholders.

However, to achieve its full potential, the new Continuum of Care will need to align funding beyond CoC Program dollars. This will require governmental jurisdictions to work closely together on an ongoing basis. It will also require greater connections among homeless services, the region's coordinated care organizations, housing authorities, behavioral health organizations, workforce development councils, public safety councils, education organizations, and social services, regardless of whether or not an organization receives Continuum of Care or other federal funding.

**c. Autonomy/Local Control**

A new Continuum of Care will allow this region to focus on its own unique circumstances, rather than be constrained by the needs of 25 or 26 other counties. A two or three-county region could make decisions

[17] Figures provided by Mid-Willamette Valley Community Action Agency.

to apply for competitive grants from HUD or to seek private or foundation resources without negotiating with 25 or 26 other counties. The balance of state structure has created a situation where smaller counties across Oregon have become reliant on the larger county dollars for financial stability. While efforts have been made locally to create a sub-regional coordinating structure, and while Rural Oregon Continuum of Care staff made efforts in the past year to assist Marion County with youth homelessness, these efforts still did not mitigate the fundamental barriers of operating within a 28-county region, with counties spread across the state.

## IV. Policy Question 2. What organizational structure is recommended for a new Continuum of Care?

Should the governmental jurisdictions signal that the region create its own Continuum of Care, the next step is to select an organizational structure or lead organization, create a governance structure, and appoint staff.

### a. Organizational Structure

HUD described three preferred organizational structures to lead a continuum of care. These are: (a) a coalition, (b) a governmental entity, and (c) a nonprofit organization. HUD laid out the pros and cons for each of these organizational structures.[18] HUD noted that "a lead organization that has strong leadership, access to resources, and high visibility in the community can provide a continuum with the credibility needed to attract broad-based participation in the community."[19] Each organizational structure has advantages and disadvantages.

1. **Coalition**. Coalitions can promote broad-based participation and buy-in by relevant organizations. However, capacity and accountability can be compromised in this model. Without dedicated staff, continuum members must share the workload. Without prominent community members acting as champions, the coalition may not have the clout needed to achieve outcomes. And there is no mechanism in a coalition-led model that ensures accountability. The former Marion-Polk Continuum of Care was governed by the Mid-Valley Housing and Services Collaborative, a coalition that experienced some of these challenges.

2. **Government**. Governments, such as cities and counties or intergovernmental organizations, usually have greater capacity to provide staff support, hold entities accountable, gather and interpret data, and conduct planning, and write grants. Conversely, governments can be subject to political agendas and can also stifle innovation if they create rigid process requirements.

3. **Nonprofit**. Nonprofit organizations are very sensitive to community needs and, depending on the nonprofit organization's size and financial position, can dedicate staff and resources to the planning effort. Disadvantages of this model include the burden that can be placed on a single nonprofit organization responsible for administering a continuum of care, as was experienced by Community Action in leading the former Marion-Polk Continuum of Care. A nonprofit leadership model can also result in bias, as those steering the initiative are often also those that are receiving Continuum of Care dollars.

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[18] U.S. Department of Housing and Urban Development, Office of Community Planning and Development: *Continuum of Care 101*. HUD: Washington, D.C., pp. 49-51. https://www.hudexchange.info/resource/1187/continuum-of-care-101/

[19] Ibid., p. 49.

If the lead agency applies as a Unified Funding Agency, then HUD funds will be disbursed to the lead agency, which then contracts with program providers as sub-recipients of the federal funds. This process will enhance the Continuum of Care's capacity to hold service providers accountable.

**b. Governance**

In addition to selecting a lead organization, the region will determine which geographic footprint is included in the region (Marion-Polk? Or Marion-Polk-Yamhill?) and create a governance structure. The lead agency and governance structure need the capacity to execute federal planning requirements, assure service delivery achieves outcomes, and holds service providers accountable. Federal expectations include outreach, engagement, and assessment; supportive services; prevention strategies; a Point-in-Time Count, conducted biennially at a minimum; gaps analysis; consolidated plan; performance targets; centralized or coordinated assessment system, including a system for individuals and families fleeing domestic violence; and operation of a single Homeless Management Information System, or HMIS.[20]

HUD established expectations for Continuum of Care boards, including a written process to establish the board; conflict of interest requirements that board members not participate in or influence discussions or decisions concerning grant awards; at least semi-annual meetings; appointed committees and workgroups; and a governance charter. HUD also has a long list of sectors that need to be represented in the Continuum of Care process.[21]

Lane County[22] achieved these requirements by merging its Community Action program with the county's Human Services Commission to create a Poverty and Homeless Board. The board oversees issues related to homelessness, including the county's Continuum of Care, and adopted a charter that designates dollars that each governmental jurisdiction delegates to the board.

Charter language declares that Lane County's board seeks "action-oriented" people to serve. Voting positions on the board represent business, direct services, education, faith-based organizations, homeless or formerly homeless consumers, health care, mental health, philanthropic interests, homeless youth, and victim services. Voting members may not be recipients of funds overseen by the board. Non-voting positions include representatives from public housing, veterans, training and employment, Oregon Department of Human Services, grant co-applicants, emergency shelter services, and the county's coordinated care organization.[23]

Eight workgroups or committees engage multiple stakeholders in various aspects of the work. These workgroups focus on the topics of youth, employment, shelter and supportive housing, evaluation, strategic planning, lived experience, health care, and membership.

In Clackamas County, the governance structure consists of a Steering Committee that serves as the Continuum of Care's governing board. A Continuum of Care/Homeless Council, comprised of experts

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[20] [20] U.S. Department of Housing and Urban Development, Office of Community Planning and Development: *Continuum of Care 101*. HUD: Washington, D.C., pp. 9-13. https://www.hudexchange.info/resource/1187/continuum-of-care-101/

[21] See pages 2-3 of this document for a list of required participants.

[22] Interview with Steve Manela, Lane County, February 14, 2019.

[23] https://www.lanecounty.org/government/county_departments/health_and_human_services/policy___advisory_boards/poverty___homelessness_board/poverty___homelessness_board_resources

providing services, meets often to coordinate programs, operations, and activities addressing homelessness, identify unmet needs, recommend bonus projects, and strengthen best practices and data-driven responses. A Homeless Policy Committee was formed to raise awareness of homelessness, advocate for funding, coordinate the community response, and expand the system outside of traditional providers. Each of the three bodies interacts with or feeds into the other bodies.[24]

A regional governance structure created for a new Continuum of Care must be inclusive of leadership from the two (or three) participating counties. Yet the governance structures should also be sized to efficiently manage prioritization and decision making. Should the jurisdictions decide to move forward, staff will develop governance structure options for consideration.

**c. Staff**

To effectively administer the new Continuum of Care organization, participating jurisdictions and the lead organization would be best served by three staff positions: (1) a staff leader position; (2) a technical staff position; and (3) a Homeless Management Information System (HMIS) data entry position.

The staff leader position will require a person with passion for the issue of homelessness and excellent communication skills to convene partners, develop community relationships, promote excellence in services that support homeless individuals and families; leverage resources, and supervise the technical staff. The technical staff position will bring analytical and numerical skills to monitor and evaluate programs, review and analyze data, conduct gaps analyses, and write applications. The HMIS data entry position is a key position and the incumbent must be proficient in accurately entering and accessing data in the system to create meaningful reports. Community Action employs staff that currently performs the HMIS data entry function.

The Rural Oregon Continuum of Care employs two staff positions. The first position is a combination of staff leader and technical position; the second, an assistant that conducts data entry. However, while its staffing model is smaller and therefore a lower cost than the three positions proposed here for the new Continuum of Care, it is important to understand that the Rural Oregon Continuum of Care has struggled with performance and has not had strong capacity with its staffing model.

Assuming that Community Action continues to contribute the HMIS data entry function during the transition, estimated overall costs for the senior level and technical positions range from $208,500 to $261,700 per year. This assumes an annual salary for the senior level position of $68-78,000, $57,000 for the technical position, and full family medical benefits, along with materials and services and indirect costs. If the technical position were contracted, rather than a full-time employee, the cost for the technical staff would be reduced.[25]

HUD allows continuums of care to apply ten percent of an annual allocation to administration and an additional three percent to planning. HUD also allows the lead agency to include federally-approved indirect costs to be included as administrative costs.[26]

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[24] https://www.clackamas.us/communitydevelopment/cchp.html

[25] Salary estimates were compared with similar positions at Marion County. Personnel and agency costs were obtained from COG. Contracting for technical support at $85 per hour for an average of 48 hours a month is $69,815 per year, or $53,000 less annually than employing a full-time technical staff position. This cost estimate includes agency indirect costs and materials and services.

[26] 24 CFR Part 578 Interim Rule: Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program, Office of the Assistant Secretary for Community Planning and Development, p. 75-76, 87-89. https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

## V. Policy Question 3. What changes would need to occur from current and past practices?

The former Marion-Polk Continuum of Care had a strong program focus, as was customary during the 1990s and early 2000s. Many of the programs addressing homelessness that are operating today in the region were generated from early Continuum of Care planning and grant awards. However, over the past decade, HUD has become much more focused on comprehensive and systemic approaches. Yet it appears that the approach within the Rural Oregon Continuum of Care continues to be program-focused. Furthermore, people representing Marion and Polk counties on the Rural Oregon Continuum of Care committee that prioritizes the federal funds represent local organizations that also receive Continuum of Care funding.

A new Continuum of Care for the region would benefit from a systems approach to homelessness. The Mid-Willamette Homeless Initiative Strategic Plan could offer a springboard for this approach, with identified recommendations about increasing housing supply, expanding shelter and transitional housing resources, better coordinating education and social services, and developing strategies that respond to the characteristics of unique target populations; e.g., veterans, youth, seniors, and domestic violence victims. The new Continuum of Care would also benefit from forging strong connections with other coalitions that plan and coordinate around issues related to homelessness.

With this systems approach, the Continuum of Care could be viewed by governmental jurisdictions and nonprofit partners as the legitimate, "go to" organization for issues related to homelessness. In this role, the new Continuum of Care could also serve as a neutral convener and coordinator of local and regional homeless strategies.

Even within a smaller geographic footprint, participating counties and encompassed cities face unique needs and resource issues. Issues facing Salem are not the same as those facing the Santiam Canyon, or McMinnville, or Independence. The new Continuum of Care will need to build the capacity to address HUD requirements for the region, while retaining a laser focus on diverse local issues within that regional context.

## VI. Policy Question 4. What is the change process?

The next opportunity to submit a Continuum of Care application to HUD is in the spring of 2020. Once the jurisdictions formally express a willingness to move forward, staff will draft a preliminary Memorandum of Understanding where the jurisdictions designate a geographic footprint, a lead organization to develop and submit the application, and a governance structure that assures inclusivity and engages partners in the Continuum of Care's work.

A conference call with HUD officials William Snow, Sid Nilakanta, Brian Fitzmaurice, and James Akin on March 22 explored HUD's process steps and criteria. Prior to the 2020 registration, HUD will require that the region provide five items for HUD review. If approved, HUD then will establish the region's new Continuum of Care and generate a new CoC number. The five items are as follows.

a. Evidence the region has acquired a Homeless Management Information System (HMIS) that covers the region's geographic footprint and has the staff capacity to run the system.
b. Evidence that the region has notified the Rural Oregon Continuum of Care of the region's intent to establish a new Continuum of Care, with the notice including denoting which jurisdictions are included in the new structure.
c. Evidence, such as meeting minutes, of a local stakeholder vote approving the formation of a new Continuum of Care. The vote need not be unanimous but should demonstrate a

preponderance of support. The concept of voting presumes an initial governance structure has been created for the region.

d. An approved governance charter that demonstrates the region can meet Continuum of Care responsibilities, and that names proposed Continuum of Care committees.
e. Documentation that a Coordinated Entry process has been implemented for the region. If a Coordinated Entry committee is listed in the new governance charter, the charter can serve as evidence of this item.

HUD officials recommended that these five items be submitted before December 2019. In the application, the region will also need to demonstrate capacity to measure system performance and to submit a Longitudinal System Analysis. It was also recommended that the region prepare for these two items early on.

With regard to funding, HUD officials clarified several issues. First, if the new Continuum of Care registers in the spring of 2020, Continuum of Care dollars will likely not arrive until sometime between late February and April of 2021. However, because program awards are currently being sent from HUD directly to service providers in our region, the transition will likely not involve a handoff from the Rural Oregon Continuum of Care to the new Continuum of Care. Rather, once the 2020 dollars are received by the new Continuum of Care, then the agency will need to be prepared to enter into contracts with service providers awarded through the Continuum of Care's prioritization process that will be reflected in the 2020 collaborative application for funds.

Second, while HUD continues to publish the preliminary pro rata need by formula, pro rata need has been less influential in determining a region's allocation than performance since 2012. The preliminary pro rata need formula includes factors such as population, poverty, and overcrowding, and is based on the Community Development Block Grant formula.[27] If the calculated pro rata need is higher than the region's current allocation, HUD may consider a review. However, HUD officials noted that there are many regions across the nation that receive less than their pro rata need, and the amount of funds available for continuums of care largely depends on Congressional appropriations.

Third, the allocation amount that the new region would receive for 2020 will, in large part, be determined through a negotiation with the Rural Oregon Continuum of Care. The negotiation will focus on the programs that currently serve Marion, Polk, and Yamhill counties. HUD assumes that the dollars currently allocated to programs serving this region will transfer to the new region. If there are difficulties that cannot be resolved in the negotiations, HUD will conduct a historical look and help resolve disputes. Planning funds can also be part of negotiation discussions.

HUD officials offered to provide technical assistance to the new region during this transition process.

Since Oregon Housing and Community Services will also play a role in supporting the Rural Oregon Continuum of Care through this transition, the state agency will need to be communicated with in the upcoming months.

## VII. Conclusions

From this analysis, staff derives the following conclusions.

[27] The July 25, 2016 Federal Register describes in detail how the formula is developed and proposals for adjusting the formula factors. See https://www.hudexchange.info/resource/5092/coc-program-notice-for-further-comment-on-the-pprn-formula/.

a. ***Outcomes.*** A regional Continuum of Care consisting of Marion, Polk, and possibly Yamhill counties offers the potential for improved planning, coordination, and outcomes for homeless individuals and families.
b. ***Funding.*** While there is no guarantee that federal funding will increase, and some speculation that funding could decrease in the short-term, there is a potential for increased funding over time. It will be necessary for the governmental jurisdictions to continue contributing to staffing costs and to assist currently-funded programs, if needed, so programs remain whole during the transition.
c. ***Systems Approach.*** A comprehensive systems approach is more likely to achieve the desired outcomes for homeless individuals and families than a programmatic approach. A systems approach requires cooperation and long-term commitment from the participating governmental jurisdictions.
d. ***Intergovernmental Relations.*** Governmental jurisdictions can play an important role in promoting intergovernmental relations and communication with HUD, Oregon Housing and Community Services, the Congressional delegation, state legislators, and other relevant federal and state agencies.
e. ***Models to Emulate***. The new Continuum of Care can look to tested models that have demonstrated success in prioritizing services based on community needs, used data to better understand the homeless population and drive service delivery, and held service providers accountable. Lane and Clackamas counties are two Oregon examples of successful continuums of care.
f. ***MWHI Foundational Work.*** The Mid-Willamette Homeless Initiative provides a solid foundation for the Continuum of Care transition. To date, the initiative has produced a Money Map financial analysis to demonstrate state and local leverage; a Resource Inventory mapping more than 500 programs as a basis for demonstrating strengths, gaps, and needs; a comprehensive strategic plan, created by a process that included hundreds of providers, advocates, community members, and homeless or formerly homeless individuals; an adopted list of metrics to measure success; and experience developing intergovernmental agreements outlining areas for cooperation. These products will be valuable resources, should the region decide to establish a new Continuum of Care.
g. ***Collaboration***. Inclusivity is a critical element of any governance structure. There are many nonprofits and existing collaborative groups that can add value and maximize coordination. This region has a strong track record of working together towards common goals, which can only benefit opportunities for success in creating a new Continuum of Care.

Staff recommends that the Marion-Polk or Marion-Polk-Yamhill region establish its own Continuum of Care beginning in 2020. To affirm this recommendation, staff recommends that each affected jurisdiction adopt a resolution that formalizes this direction, based on a template recommended by the Mid-Willamette Homeless Initiative Steering Committee.