Purpose of Training Guide

This guide is meant to facilitate the design and implementation of comprehensive Continuum of Care systems in localities throughout the country. The U.S. Department of Housing and Urban Development is committed to addressing the problem of homelessness by supporting communities in the strategic use of housing and service resources to move homeless individuals and families into stable permanent housing.

Use of Guide

This guide provides a comprehensive overview of the Continuum of Care planning process. It has been developed with a companion set of reference materials and worksheets to assist localities with the design and implementation of Continuum of Care systems.

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## Continuum of Care Planning Tasks and Outcomes

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1. **Organize an Annual Continuum of Care Planning Process**
   - Establish an effective community-based planning process
   - Create a core working group and encourage participation
   - Identify desired outcomes
   - Define the geographic area
   - Define roles and responsibilities and establish timetable and goals for the Continuum of Care planning process

2. **Collect Needs Data and Inventory System Capacity**
   - Consider strategies for collecting information
   - Select a methodology for collecting needs data
   - Inventory existing capacity dedicated to serving homeless people
   - Inventory mainstream resources
   - Compile information and validate findings

3. **Determine and Prioritize Gaps in The Continuum of Care Homeless System**
   - Organize Data: Continuum of Care Gaps Analysis
   - Establish a community process for determining relative priorities

4. **Develop Short- and Long-Term Strategies with an Action Plan**
   - Summarize priority gaps and create groupings which interrelate
   - Develop strategies and action steps
   - Link gaps to possible resources
   - Assign responsibilities and develop timelines
   - Adopt a written Continuum of Care Plan

5. **Implement Action Steps for the Continuum of Care Plan**
   - Establish a process for monitoring implementation of the Continuum of Care plan
   - Establish criteria for Continuum of Care Homeless Assistance Project selection

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**Continuum of Care Planning Cycle**
What is the Continuum of Care, and Why is it Important?

Purpose: This session is designed to provide the participants with an overview of the Continuum of Care concept and key principles for effective Continuum of Care planning. Since 1994, the U.S. Department of Housing and Urban Development (HUD) has been encouraging communities to address the problems of housing and homelessness in a coordinated, comprehensive, and strategic fashion. With input from practitioners throughout the country, HUD introduced the Continuum of Care concept to support communities in this effort. This concept is designed to help communities develop the capacity to envision, organize, and plan comprehensive and long-term solutions to addressing the problem of homelessness in their community.

What is the Continuum of Care?
The Continuum of Care is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.

Fundamental Components of a Continuum of Care System

HUD identified the fundamental components of a comprehensive Continuum of Care system to be:

- Outreach, intake, and assessment to (1) identify an individual's or family's service and housing needs, and (2) link them to appropriate housing and/or service resource.
- Emergency shelter and safe, decent alternatives to the streets.
- Transitional housing with supportive services to help people develop the skills necessary for permanent housing.
- Permanent housing and permanent supportive housing.

HUD’s Definition

“A Continuum of Care Plan is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.”

Components of a Continuum of Care Homeless System
An effective Continuum of Care system is coordinated. It not only includes the fundamental components identified by HUD, but also the necessary linkages and referral mechanisms among these components to facilitate the movement of individuals and families toward permanent housing and self-sufficiency. It balances available capacity in each of its key components and provides a framework that is both dynamic and responsive to changing needs over time.

In addition, a Continuum of Care system should include a focus on homelessness prevention strategies and services. Prevention services might include one-time emergency funds to keep families housed, crisis intervention services for people with mental illness living in the community, and peer networks for people in early recovery living in permanent housing.

What Sub-Populations Are Homeless?

- Single Men
- Single Women
- Families
- Youth
- Elderly
- Veterans
- People with drug or alcohol addictions
- People with mental illness
- Dually or multiply diagnosed
- Victims of domestic violence
- People living with HIV/AIDS

What Subpopulations Exist Among People Who are Homeless and What are the Best Ways to Serve Them?

A comprehensive Continuum of Care plan considers the needs of all people who are homeless. This means that in most communities there are different components of the Continuum of Care in operation that respond to the particular housing and service needs of different sub-populations of homeless people, such as homeless veterans or people who are homeless with mental illness, HIV/AIDS, victims of domestic violence, and/or histories of substance use.

Facilitate movement towards permanent independent living: The goal is to create and sustain sufficient capacity throughout the Continuum of Care system to facilitate movement of that sub-population toward permanent housing and independent living. However, not all people will need to access each component of a Continuum of Care or move through the Continuum of Care in a linear fashion.

Address multiple needs: It is important for a Continuum of Care plan to address the multiple needs and cross-over among homeless subpopulations. For example, there may be a need for substance abuse recovery services among people who are homeless and living with HIV/AIDS or there may be a need for bridge supports for youths graduating from state custody and lacking sufficient natural supports or life skills and are at risk of homelessness.

Anticipate new groups and issues: In order to develop a Continuum of Care system responsive to the range of housing and service needs among people who become homeless, it is important not only to understand who is homeless (including hard-to-serve homeless individuals such as street homeless with health, mental health, and/or substance abuse problems), but also to understand who might become homeless (such as women with children escaping domestic violence or people living with HIV/AIDS in overcrowded situations).
Key Characteristics of a Successful Continuum of Care Design

**Long-range:** The problems of homelessness are complicated and will need to involve long-range solutions and planning. It is important to recognize that to better serve homeless people and to create affordable permanent housing and supportive housing, considerable time, energy, and financial resources, as well as linkages to mainstream services and affordable housing, are needed.

**Comprehensive and collaborative:** A Continuum of Care system should address and deal with all major homeless populations and involve the breadth of housing and service options. The plan should be designed to meet the unique needs of subpopulations while also developing capacity to serve people who are homeless with multiple needs, such as people with histories of substance abuse or mental illness.

**Strategic:** A Continuum of Care plan should incorporate realizable strategies to move homeless individuals and families beyond shelter to permanent housing and self-sufficiency. Solutions to complex problems require carefully developed Action Plans to achieve the desired objectives. Further, these strategies should be grounded in community needs and priorities identified through a planning process which includes stakeholder input.

Why is a Continuum of Care Plan Important?

**Assess capacity and identify gaps:** Continuum of Care planning provides communities with an opportunity to step back, critically assess capacity, and develop solutions to move homeless people toward permanent housing and self-sufficiency.

**Proactive rather than reactive:** Continuum of Care planning helps communities look comprehensively at needs and to anticipate policy or demographic changes and develop the capacity to respond to these changes (e.g., new drug therapies for people living with HIV/AIDS which change the models of supportive housing most appropriate for this population).

**Common goals for which to advocate:** Continuum of Care planning helps communities develop a common vision and a set of common goals.

**Coordination and linkages:** Historically, homeless services have been fragmented at best. Continuum of Care planning helps providers identify ways of coordinating and linking resources to avoid duplication and facilitate movement toward permanent housing and self-sufficiency.
**Community “buy-in” and access to mainstream resources:** Continuum of Care planning ideally involves stakeholders outside of the traditional homeless system with the goal of educating these stakeholders and getting them to become part of the solution (e.g., the city housing department could include a set-aside of HOME funds for tenant-based rental assistance to transition homeless women and their children to permanent housing).

**Competitiveness for McKinney Homeless Assistance Funding:** Comprehensive and inclusive Continuum of Care planning makes communities highly competitive for receipt of McKinney Homeless Assistance funding through the Homeless SuperNOFA process. The plan will also be useful in leveraging other, non-McKinney resources needed to build a comprehensive system to address homelessness.
Step 1

Organize an Annual Continuum of Care Planning Process

Tasks

- Establish an effective community-based planning process
- Create a Core Working Group and encourage participation
- Identify desired outcomes
- Define geographic area
- Define roles and responsibilities and establish timetable and goals for the Continuum of Care planning process

Purpose: This session is designed to provide guidance on how to get started, including coordinating an effective planning process, defining the geographic area, defining the problem and articulating a vision, and establishing a meeting schedule timetable, and identifying expected outcomes for the Continuum of Care planning process.

Establish an Effective Community-based Planning Process

As a first step in the planning process, it is important for the planning body to understand the Continuum of Care concept, to develop a common vision for an ideal Continuum of Care, and to consider its desired outcomes. This process is an opportunity to get homeless providers and key stakeholders to step “out-of-the-box” and think broadly about what an ideal homeless system should include and what it could achieve.

This step in the planning process will differ slightly for communities which are embarking on a Continuum of Care planning process for the first time and those for whom a Continuum of Care planning process is conducted annually.

When embarking on a Continuum of Care planning process for the first time, it is particularly important for the Core Working Group to dedicate time to communicating the Continuum of Care concept. It is also important to create an opportunity for providers and other stakeholders to look at the homeless “system” as a whole, and develop a common understanding of homelessness (the problem) and a vision for the Continuum of Care. Depending on the size and diversity of the community, this initial visioning process may be best accomplished through a single community meeting or a series of smaller community meetings.

For communities that have previously engaged in a Continuum of Care planning process, this early community process is an opportunity to revisit the extent of the problem and refine the vision statement. (See W-1: Developing a Group Vision.)
Establish Effective Continuum of Care Planning Process

- Create a Core Working Group to begin the process
- Ensure that the major players in the homeless community are involved
- Seek involvement by all possible sectors of the community
- Enthusiastically communicate the need to undertake Continuum of Care planning to the community
- Ensure that the broader community is aware of the planning, particularly local government leaders
- Tie in with existing planning efforts in the community
- Take the time to do it right

Create a Core Working Group and Encourage Participation

There is not just one model for organizing a community’s planning process; each community has unique opportunities and constraints to developing and implementing a Continuum of Care plan. Any of the major stakeholders in the Continuum of Care—local jurisdictions, service providers, homeless people or their advocates—can take the lead to convene a community-based planning process. Regardless of the model used for organizing the process, there are certain principles that are important to an effective planning process and, ultimately, a comprehensive and meaningful plan. (See W-2: Organizational Structure.)

These principles are:

**Create a Core Working Group**: Creating a Core Working Group ensures that someone will be accountable to accomplish the tasks necessary to creating and implementing a Continuum of Care plan.

**Reach out to providers and stakeholders**: Who participates in this first meeting is very important. Outreach efforts should be inclusive and feasible to bring different elements of the homeless system together to create a common vision. For new and developing Continuum of Care systems, there should be ongoing efforts to include essential providers and stakeholders who might typically be viewed as “outside” the homeless system, such as affordable housing providers, community development policy-makers, mental health and/or substance abuse providers, and funders. (See W-3: Inclusive Process.)

**Include major players**: Maximize buy-in legitimacy by including such stakeholders as homeless providers, coalitions, social service networks, community development policy makers business leaders, housing agencies, and others in the planning process. (See W-4: Sample Invitee List.)

**Seek involvement of all possible sectors**: A comprehensive Continuum of Care planning process should especially include those agencies whose funding or policies impact the homeless communities but which may not be engaged already, e.g. a mental health service provider, HIV/AIDS organization, community leaders or public housing agency.

**Enthusiastically communicate the Continuum of Care concept**: It is important to create some momentum and common understanding by communicating the Continuum of Care concept and why it is important.

**Assure broader community awareness of planning**: Get the buy-in of policy makers and funders because much of the success of a Continuum of Care plan will rest on their cooperation.

**Tie to existing planning efforts**: Look to the Consolidated Plan, Ryan White CARE Act, AIDS Housing Plan etc. so as not to reinvent the wheel, and to link into existing priority activities or to advocate for changes in those priorities.

**Take the time to do it right**: A Continuum of Care plan takes time and effort, so communities undertaking a planning process should allow themselves the time to lay the right groundwork in terms of community process and data collection and analysis. Allow for a year-long process.
**Strong facilitation:** It is important to have a strong facilitator who is familiar with and can manage a group process. This could be a hired or “drafted” third party or someone from the Core Working Group who is particularly skilled or comfortable with facilitation. Colleges and universities or continuing education programs may be able to lend some expertise in this area. A strong facilitator will be especially important if the group anticipates friction or strongly divergent views among providers or key stakeholders regarding the homeless system. Getting people to move beyond historical barriers or strongly held opinions can be challenging, especially when negotiating gaps analysis and priority setting.

**Accessible meeting space and times:** Meetings should be held in buildings and rooms that are fully accessible to disabled persons. Accessibility may include the need for sight and foreign language interpreters. In addition, childcare availability and other potential barriers to participation by a broad range of community members should be considered.

**Preliminary information collection and analysis:** It is helpful to bring and distribute whatever information is available on the current system to provide people with a starting point from which to begin to discuss who is homeless and what capacity currently exists.

### Identify Desired Outcomes

It is important in the initial community planning process to identify desired outcomes. These will help create a common sense of purpose during the planning process and will help produce an action-oriented document. Below are four potential outcomes of the visioning step.

**Common understanding of the Continuum of Care and why it is important:** Participants should finish this step in the planning process with a common understanding of the Continuum of Care and why it is important, agreement on who is homeless (extent of the problem), and a shared vision for the Continuum of Care.

**Agreement on who is homeless:** This is important in deciding what sub-populations will be used as a base for analyzing needs and available resources in the plan. HUD’s Continuum of Care Homeless Assistance application provides a break out of sub-populations that must be considered in a Continuum of Care plan. It is also important to recognize that federal and state definitions of homelessness vary for housing and services, and therefore stakeholders’ understanding of who is homeless may vary and may necessitate some discussion.

**A group vision:** It is important for the Core Working Group to create a shared vision and a common purpose among the broader community as it moves forward with the planning process. This is often accomplished through the development of a mission statement and/or guiding principles that help focus the planning efforts as they progress.
**Identification of critical missing information:** These initial community meetings also offer opportunities, if time permits, to present what preliminary information is available on needs and capacity. The meetings allow the group to determine the validity of this information and to begin to identify methods and resources to more rigorously gather the data that is needed. (W-5: Sample Exercise on Defining the Problem.)

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**Sample Vision Statement**

*The Core Working Group is committed to assisting individuals and families who become homeless or are at risk of becoming homeless to regain housing stability and quality of life. Toward this end, over the next five years, the Core Working Group will implement and expand a comprehensive Continuum of Care to prevent and end the tragedy of homelessness among all individuals and families.*

**Define the Geographic Area**

A Continuum of Care system should comprise a logical geographic area. HUD provides a Geographic Area Guide of cities and counties as a basis for communities to define a geographic area. To compete for McKinney Homeless Assistance funding, a Continuum of Care area should be composed of one or more of the cities and counties listed in the Guide. Furthermore, one Continuum of Care system should not overlap with the service area of any other system.

Considerations for communities when defining a geographic area include:

- Clear rationale for its organization
- Consider jurisdiction of key agencies and providers to facilitate linkages and coordination (such as mental health, homeless coalitions, community action agencies)
- Consider jurisdiction of key resources needed to comprehensively respond to the needs of homeless people and facilitate linkages to mainstream resources (such as FEMA, ESG, CDBG, HOME)
- Include jurisdictions that are fully involved in the development and implementation of the strategy

**For example:**

A state should consider which cities and/or counties have their own Continuum of Care plans and ensure that the geographic area defined in the state's Continuum of Care plan does not overlap with these (though coordination is certainly encouraged). The state may want to encourage cities and/or urban counties to develop their own continuums if they have not yet done so, thereby leaving the role of the state to organize and plan for rural and ex-urban areas which would otherwise go underserved.

A multi-jurisdictional county may want to define the Continuum of Care plan's geography to include all cities within its borders. These cities and the county can then coordinate the planning process countywide. The result is that county and city resources can be more effectively deployed, thereby avoiding both duplication of effort and the funding of activities or policies that operate at cross-purposes. If a city within the county's jurisdiction chooses to develop its own Continuum of Care plan, then the county Continuum would cover the county outside the city's boundaries. Again, coordination and cross-referencing make a stronger plan.
Define Roles and Responsibilities and Establish Timetable and Goals for the Continuum of Care Planning Process

Finally, it is important for communities to make sure that participants understand what is expected of them and have a clear and active role (e.g., collecting needs data, reviewing data, assisting with strategy development, etc.).

To this end, the Core Working Group should develop a meeting schedule and timetable for the Continuum of Care process. This should carry through to writing and adopting the Continuum of Care plan. A timetable will provide participants with clear expectations of time commitment and steps necessary for the completion of the planning process.

Outcomes

- Core Working Group accountable for task completion
- Geographic area defined
- Defined roles and responsibility
- Establish planning process, timetable and goals

Example 1:

**Government Lead**

The City takes a leadership role in organizing the planning process and implementing the Continuum of Care. Two city agencies staff the effort and work in collaboration with the City’s Homeless Planning Committee. The Homeless Planning Committee includes homeless shelter and service providers, advocacy organizations, housing providers, a veterans group, homeless and formerly homeless people, and leaders from the business community. The Homeless Planning Committee is appointed by the Mayor and is responsible for recommending homeless policy.

A volunteer Homeless Planning Committee, with city staff support, takes the lead in organizing a community process to seek input from stakeholders regarding the Continuum and its effectiveness each year. In addition, the City conducts an annual census of street and shelter homeless, and inventories homeless system capacity. These data are used to update the Continuum of Care plan, identify gaps in the system, and set priorities. Identifying gaps and setting priorities is an iterative process led by the Homeless Planning Committee but involving community meetings to build consensus on priority activities and goals.

The Homeless Planning Committee meets monthly throughout the year to monitor implementation of the Continuum of Care plan and make policy recommendations. The Homeless Planning Committee also establishes subcommittees, as necessary, to focus on particular subpopulations or discreet system issues.

Example 2:

**Homeless Consortium or Coalition Lead**

A coalition of homeless providers coordinates the Continuum of Care planning process. In its first year, the coalition included just provider members in the Continuum of Care planning efforts, but in subsequent years it has recruited additional members to include representation
from area foundations, corporations, and homeless and/or formerly homeless people. Both city and county government have a seat at the table and support the process, but they are not leading it.

The coalition advocated for joint funding by the city and county for a comprehensive needs assessment and planning process over the course of the year to develop a Continuum of Care plan. Committees were organized to address specific aspects of the Continuum of Care, including membership development, research and information, advocacy, and interagency planning. Other than using paid researchers from a local university to conduct the needs assessment, responsibility for developing the plan and monitoring its implementation is provided through the volunteer time of member agencies by committee assignments.
Step 2

Collect Needs Data and Inventory System Capacity

Tasks

- Consider strategies for collecting information
- Select a methodology for collecting needs data
- Inventory existing capacity dedicated to serving homeless people
- Inventory mainstream resources
- Compile information and validate findings

Purpose: This session is designed to (1) assist with understanding the importance of deciding on a methodology for collecting needs data, and (2) introduce and discuss possible data collection and inventory strategies.

Consider Strategies for Collecting Information

An important next step in the planning process is the identification of sources and methods for collecting data on the needs of homeless people. Each community will need to decide its strategy for determining who has this responsibility. The goal is to ensure that the data collected are as comprehensive as feasible, that providers and key stakeholders agree with the methodology and results they present, and that any shortcomings in the data are agreed upon as acceptable. Before deciding on a methodology, there are some principles to keep in mind when undertaking the significant and labor-intensive planning task of collecting and analyzing needs data.

They are:

Identify who has capacity: Collecting and analyzing needs data are labor-intensive and time-consuming tasks. Be realistic about who has the capacity to follow through and what methods would be least taxing on providers and the system, while at the same time yielding reasonably accurate and comprehensive data. There may be resources outside of the homeless provider network that can be tapped. For example, universities or metropolitan planning councils often have the capacity and interest to assist in data collection and analysis, though their assistance may not be pro bono.
Establish accountability: Ensure that someone or group is accountable for data collection and follow through, and is prepared to analyze and document the data collected in a user-friendly format for community review and input. (Communities may want to use a format similar to that of the Consolidated Plan.) This may be the Core Working Group or other designees.

Cast a broad net: Make sure data collection captures all sub-populations identified among homeless individuals, including veterans, people with mental illness, and people living with HIV/AIDS. In addition, there should be specific methods explored for capturing information on people who are homeless and are not engaged in any service or shelter system, such as people living on the street, in cars, in parks, or under bridges. A comprehensive Continuum of Care plan should include methods for quantifying and assessing the needs of this segment of the homeless population.

Provide for community input: Plan a formal iterative process (such as community meetings) to solicit ideas on sources of data and methodology of collection to ‘reality test’ data. This should include some discussion before and/or during data collection to solicit ideas for, and cooperation on, methods and sources.

Acknowledge shortcomings: Acknowledge any shortcomings of the accumulated data and identify strategies to collect additional data needed for planning (this may include plans for more rigorous and ongoing data gathering as part of the Continuum of Care plan implementation in subsequent years).

Build consensus: Ensure that there is consensus on the data collected, including acknowledgement of acceptable shortcomings in the data.

Possible Sources of Needs Data

- Homeless and ancillary service providers: HIV/AIDS, youth, mental health, addictions
- Consolidated Plan, Others (Ryan White, strategic plans)
- Existing homeless needs assessment, e.g. by a homeless coalition, city/state-sponsored census, local university
- Statewide organization, i.e. homeless or low income housing coalitions

Select a Methodology for Collecting Needs Data

An essential foundation of a Continuum of Care plan is an assessment of the extent and types of need experienced by people who are homeless in the community. There is not just one correct way to collect needs data, but the Core Working Group, in coordination with the broader community of providers and stakeholder, must decide on a methodology and identify the resources and capacity to carry out needs data collection.

Sources and methods that different communities employ will vary depending on the size of the community, complexity of homeless populations, capacity of providers, and whether there are established mechanisms for collecting needs data, such as using data consistent with your homeless census or the community’s Consolidated Plan.

Decisions that will need to be made in deciding on a methodology for collecting needs data include the following:

- How will point-in-time data be collected on who is homeless and what their housing and service needs are?
- How will sheltered and unsheltered homeless be counted?
- How will duplication be avoided?
- How will the data be analyzed and who will do it?
• How will the data be documented and the methodology described?
• How often will it be collected?
• Over time, how will changes in the data (demographics, numbers) be captured and used?

Participants should complete this step of the planning process with general agreement on the soundness of the most recent data and any acceptable shortcomings. This information, together with the inventory described below, forms the basis of the discussion of gaps in the Continuum of Care system. Without consensus on this base line data, the gaps analysis may lack legitimacy and will make building consensus on unmet needs and priority gaps more challenging. (See W-6: Exercise to Develop an Inventory of Need and Resources, W-7: Sample Needs Survey, W-8: Sample Community Survey, W-9: Sample Provider Survey.)

**Inventory Existing Capacity Dedicated to Serving Homeless People**

In addition to assessing the extent of homelessness, participants need to inventory the existing capacity available to meet the needs of homeless people. This assessment should be conducted in the context of the Continuum of Care concept (i.e., outreach, emergency shelter and services, transitional programs, permanent housing, and permanent supportive housing).

The initial community meeting(s) are an opportunity for providers and stakeholders to think about the homeless system in the context of a Continuum of Care framework. The inventory is an opportunity to look at existing capacity within the framework of a Continuum of Care system.

The approach used to inventory capacity will vary depending on the size and complexity of the homeless services system. As with the collection of homeless needs data, the Core Working Group may want to take the lead in conducting an inventory and then present its findings for community input and reality testing. Larger communities may want to use subcommittees to look at particular components of the Continuum of Care system. Smaller communities may want to use a community meeting to solicit this information and then supplement it with follow-up phone calls.

**Inventory Mainstream Resources**

**Comprehensive inventory:** A comprehensive inventory of capacity and resources for a Continuum of Care plan should include a look at resources that lie outside of the traditional homeless system and its providers. It should include “mainstream” affordable housing resources, such as conventional public housing, Section 8 and other rental subsidy programs, and other affordable housing and community development resources available in the community. The Consolidated Plan is a good source for this information, as well as key housing providers, such as Public Housing Authorities and non-profit housing agencies.

Communities should ensure that this inventory includes service capacity and resources that could be available to people who are homeless, such as mental health services and substance abuse treatment. Discussions with and/or surveys of funders and providers of these services can help provide this information.
**Leverage mainstream resources:** A comprehensive Continuum of Care plan should include strategies to leverage and engage “mainstream” housing and service resources. Accessing mainstream housing and services is important to Continuum of Care development and implementation because the addition of these resources will:

- Better support people's movement out of homelessness
- Avoid the creation of parallel systems of care
- Ensure that new resources, such as McKinney Homeless Assistance funding, are used to meet the unique needs of a homeless population where no other resources exist

For example, under welfare reform, it may become more necessary to support women in job training and placement while in shelters and transitional housing programs. Though this is identified as a priority “gap” in existing services, the solution may not be new targeted funding for this service, but rather facilitated access to state and federal programs already available to families receiving transitional assistance.

**Link with other planning processes:** Finally, there may also be other planning processes underway (Ryan White Care Act, Empowerment or Enterprise Zones, or Neighborhood Revitalization planning efforts) that should be looked at for information on available and current use of resources in areas such as health care, job training and placement, and child care.

**Compile Information and Validate Findings**

As with the needs data, it is important that the inventory of resources and capacity in the homeless system and the inventory of mainstream resources be compiled and synthesized in a manner from which an analysis can begin. This will likely be the task of the Core Working Group or some appointed subset of the Core Working Group.

Once compiled and synthesized, these findings should likewise be available for community review and input to ensure that the inventory accurately and sufficiently reflects different stakeholders' understanding of what capacity and resources exist.

It is important to finish this step of the planning process with consensus on the data because these needs and inventory data form the basis of the gaps analysis.

**Outcomes**

- Collection of quantitative and qualitative information on homelessness
- Inventory of existing capacity/mainstream resources
- Consensus on data, including acceptable shortcomings
Step 3

Determine and Prioritize Gaps in the Continuum of Care Homeless System

Tasks

- Organize data: Continuum of Care Gaps Analysis
- Establishing a community process for determining relative priorities

Purpose: This session is designed to assist localities with quantifying unmet needs and determining and prioritizing gaps in the Continuum of Care in order to develop strategies to address these unmet needs.

Organize Data: Continuum of Care Gaps Analysis

The first step for determining gaps in the Continuum of Care is to quantify unmet needs. This involves a calculation between the estimated amount of need (based on the needs data collected) and the current capacity by Continuum of Care component (based on the inventory) to meet the need. The Core Working Group (or a designee) can use the Gaps Analysis worksheet from the Continuum of Care Homeless Assistance application to organize this information.

Establish a Community Process for Determining Relative Priorities

Determining gaps and their relative priority are fundamental steps in the Continuum of Care planning process. Decisions regarding the relative priority of gaps (i.e., low, medium, and high) are the basis for developing strategies to deploy new resources or re-deploy existing resources to best assist people who are homeless to obtain and maintain permanent housing and self-sufficiency.

Again, based on the size of the community and the complexity of the homeless system, there will need to be a process for involving homeless providers and other stakeholders in the decision-making to determine and prioritize gaps. In general, this step is best accomplished through one or more community meetings.

The process should be logical and fair, and the ground rules for participation and influencing the decision-making should be clear to everyone involved. For example, determine: how and what information will be presented; who will provide input and how they will do it, who can vote, and how.
The outcome of this process should be a list of housing, service, and system gaps. This list of gaps will then need to be prioritized with the involvement of the broader community of homeless providers and stakeholders.

**Qualitative criteria**

In order to help prioritize among this list of gaps, the Core Working Group can propose and build consensus on a set of qualitative criteria. This overlay of qualitative criteria will help homeless providers and key stakeholders agree on how to place a relative priority on gaps throughout the system (i.e., whether a gap gets a low, medium, or high priority). This process should be described clearly in the Continuum of Care plan and in the application for HUD Continuum of Care Homeless Assistance funding.

It is important to note that low priority does not mean that there is not an unmet need. Rather, it means that relative to other unmet needs or gaps, it is less of a priority. These qualitative criteria should focus on the ultimate goal of assisting people who are homeless to obtain and maintain permanent housing.

### Possible qualitative criteria to use when prioritizing unmet needs

- Look at relative need among sub-populations
- Consider the vulnerability of the population (age, diagnosis)
- Identify groups not yet served versus those with some housing resources in place
- Determine whether the need is growing, and if so, how rapidly
- Look at users of high-end services (e.g., hospitalization, detoxification)
- Generate other criteria

### For example:

A community that is committed in its guiding principles to emphasizing permanent solutions to homelessness may not place a high priority on the need for emergency shelter, even if the unmet need or gap is large. Instead, they might prioritize permanent supportive housing and engagement services to move people off the street and into permanent housing.

The goal is to identify and build consensus on the relative priority among gaps. There are different methods for accomplishing this.

### For example:

Some communities may utilize a one-person one-vote system after a full discussion at a community meeting. After identifying a list of gaps to address critical unmet needs, each person or provider gets to choose their three priority gaps. The gaps that get the most votes get highest priority.

Alternatively, communities may not want a one-person one-vote (or one-provider one-vote) approach. Instead, a representative committee could be established (appointed...
or nominated) to analyze the data, identify gaps, and prioritize among gaps. The results of this decision-making could then be processed in a larger community forum for final input or comment.

Regardless of the method, the process must be considered legitimate to those participating both directly and indirectly. The Core Working Group should finish this step in the planning process with consensus among the broader community of homeless providers and stakeholders on the relative priority among the gaps identified. (See W-10: HUD Gaps Analysis, W-11: Prioritizing Unmet Needs, W-11 (a): Sample Worksheet, W-11 (b): Emergency Shelter, W-11 (c): Transportation, W-11 (d): Permanent Housing, W-11 (e): Permanent Supportive Housing, W-11 (f): Supportive Services Only.)

### Outcomes

- Quantitative analysis of unmet needs
- Determination and relative prioritization of gaps in the Continuum of Care based on critical unmet needs
Houston/Harris County - Planning Process

Houston/Harris County’s planning process was initiated in 1992, before HUD developed its Continuum of Care approach to planning. Yet Houston/Harris County, under the guidance and coordinating efforts of the Coalition for the Homeless and the Homeless Services Coordinating Council, had put into place precisely the model that HUD encourages. The Council, formed by the Coalition to unify the activities of all stakeholders in the county, plays the key role in coordinating the county’s HUD application processes, identifies program development needs among service providers, fosters information sharing, identifies service delivery and funding priorities, and develops its own Continuum of Care model. Focusing on assisting clients to “exit” homelessness, Houston/Harris County developed a structured Continuum of Care process that enables individuals and families to be brought into the system and move through emergency shelter or transitional housing into permanent independent or supportive housing.

Implementation

HUD’s Continuum of Care initiative noticeably improved several aspects of the process, most notably coordination among service providers. This improvement has made it easier to implement programs at all stages of the continuum. HUD’s approach also made it easier for smaller organizations to get funding for innovative approaches to assisting hard-to-reach homeless populations. In addition, the ability of smaller organizations to integrate their services within the broader system has grown. Meanwhile, larger service providers are less isolated from each other, thereby becoming more aware of the range of services to which they can refer their clients.

Current Operation of Continuum of Care

The current HUD funded Continuum of Care approach in Houston/Harris County combines the following critical components: computerized homeless network, quality assurance, prevention, outreach/intake/assessment, emergency shelter, transitional housing, supportive services, permanent independent housing, and permanent supportive housing.

Step 4

Develop Short- and Long-term Strategies with an Action Plan

Tasks

- Summarize priority gaps and create groupings which interrelate
- Develop short- and long-term strategies
- Link gaps to possible resources
- Assign responsibilities and develop timeframes
- Adopt a written Continuum of Care Plan

Purpose: This session will assist communities with the process of crafting and building consensus on strategies based on the identified gaps in housing and services and the proposed changes to the homeless system. These strategies should include the identification of financial and non-financial resources needed to support proposed strategies.

Summarize Priority Gaps and Create Groupings Which Interrelate

After determining and prioritizing gaps, it is important to look at how these gaps interrelate to assist with strategy development. The Core Working Group or designee should summarize the quantitative and qualitative information used to reach decisions regarding relative priority. This summary is an informational document for the larger Continuum of Care groups and will provide a basis for the strategy development.

In addition, the Core Working Group or designee should propose some possible “groupings” or linkages among priority gaps as a way to get stakeholders to begin to think of gaps in the context of a homeless system of care. Major gaps in housing and services should be looked at as they interrelate to each other, for example mental health street outreach, transitional housing for people with mental illness, and permanent supportive housing for people with mental illness are related. This should also help identify where there are “systems” issues rather than just capacity issues. For example, a lack of transitional housing capacity may best be addressed by the addition of supports to encourage more movement out of transitional housing and into permanent housing rather than by increasing transitional housing capacity. (See W-12: Group Exercise to Develop Strategies, W-13: Strategy Statement Worksheet.)
Develop Strategies and Action Steps

Strategy development may occur through a series of community meetings, or the Core Working Group could facilitate the creation of subcommittees, each of which would be responsible for developing strategy statements and preliminary action steps for grouped priority gaps. These subcommittees may enlist the expertise of other community members in the process of developing strategies. The length of time and number of meetings necessary for this step in the process will vary based on the size and experience of the community, but will likely involve 2 to 3 community meetings.

- Using the priority gaps identified (i.e. mental health counseling, transitional housing for families, etc.), consider the relationship between and among gaps.
- Group these linked needs into major gaps, where possible, and develop a draft long-range strategy for each.
- Consider strategies that do not require funding but which call for changes in policies, procedures, or re-allocation of existing resources.
- Assess the availability of federal, state, local and private resources that might be used to fund the implementation of identified strategies.
- Make “ball-park” estimates of costs and identify potential sources of funding.
- Seek assistance concerning mainstream and other non-HUD resources as needed.

Link Gaps to Possible Resources

The Core Working Group should organize the inventory of homeless capacity and mainstream resources by the groupings created from the exercise above. This is necessary to assist with strategy development by looking at gaps alongside existing capacity and possible mainstream resources.

This capacity and resources list (based on the inventory developed earlier in the planning process) can be reorganized to be consistent with the relative priority gaps identified. In addition, further fact finding or information gathering may be necessary regarding possible or potential resources.

This review of possible resources is an informational document for the larger Continuum of Care group and will help ensure that participants develop strategies in the context of existing homeless and mainstream capacity. Furthermore, it will help ensure that strategies address necessary changes in the use of resources as well as any need for new resources in the system.

Assign Responsibilities and Develop Timeframes

- To ensure that the Continuum of Care plan is outcome oriented, each strategy should include action steps, point(s) of accountability, and a time frame.
- Determine appropriate time frames needed (i.e. 5-10 years) to demonstrate significant improvements over time.
- Identify which organization(s) should be responsible for each “next step”.
- Once developed, strategies and action steps should be made available for community input and comment. (These action steps will provide the community with a road map for implementing the Continuum of Care plan.)
(See W-14: Questions to Use to Assess Your Draft Plan before Finalization)

For example, youth system (county or state) discharge planning (or lack there of) may result in growing numbers of young people falling into homelessness upon discharge, particularly those who lack existing natural supports in the community. Engaging policy makers and advocating for changes in discharge planning and procedure may be an appropriate long-term strategy to prevent this sub-population from becoming homeless.

**Adopt a Written Continuum of Care Plan**

Once the decision-making is completed, the Core Working Group, perhaps with help from designees, drafts the Continuum of Care plan. Much of the outline for the plan has been developed as part of the planning process.

- Many communities seek the endorsement of the plan from key public officials to lend it clout and legitimacy, especially in the areas of policy changes and leveraging main-stream resources.
- The Core Working Group may want to disseminate the plan to key stakeholders and policy-makers to publicize its vision and articulated strategies.

**Outcomes**

- Prioritized gaps summarized and groupings created
- Strategies, action steps and time lines established
- Vision statement and written plan for Continuum of Care development
Case Study

Boston - Planning Process

Since 1993, the City has coordinated a solid strategic planning and systems implementation approach, involving the Emergency Shelter Commission, Public Facilities Department, and the Homeless Planning Committee. The Homeless Planning Committee, whose 84 public and private members include homeless shelter and service providers, advocacy organizations, housing providers, homeless and formerly homeless persons, a veterans group, and local business leaders, meet monthly to discuss policy and to further the development of systems for implementation. The committee is well linked to other related strategic planning processes within the City and to providers and entities outside of the homeless continuum. Boston's Continuum of Care process is a truly collaborative process, stressing community-based involvement with strong leadership from the City and the Homeless Planning Committee.

Implementation

The implementation of all aspects of the Continuum of Care plan has been strengthened by the support of HUD's Homeless Assistance contract and award process. The result is that while current resources are still not adequate to meet the needs of each homeless person in the city, Boston's homeless assistance system now addresses all phases of the housing and services continuum.

Boston's homeless service planning is well organized and coordinates an extensive range of services that reflect the goals of HUD’s Continuum of Care model, utilizing a community-based process to implement a system-oriented housing and services delivery model. In addition, the City has contracted with a local university to assist Supportive Housing Programs with data management, monitoring, and evaluation, representing a major step toward the further development of outcome-oriented assessment methodologies.

Current Operation of Continuum of Care

As a result of the Continuum of Care planning process, homeless persons living in Boston have more options in their efforts to re-enter the economic mainstream, largely as a result of increased and improved linkages among homeless service providers and entities outside of homeless services. Collaboration and communication among city agencies and homeless service providers has improved through this process, with the result being that each member of the housing assistance system in Boston can focus on their specific role in the continuum while also coordinating their efforts to reach common objectives.

Another result of the planning process was that homeless providers in the city “buy in” to a systems approach to homelessness assistance—the coordinating agencies believe that the front, middle, and back end of the continuum are of equal importance. Finally, the continuum process encouraged the integration of planning for homeless services and housing into the more comprehensive community economic development process, thereby providing more efficient and cost-effective planning and better coordination of city and state housing and service resources to the homeless population.

Step 5

Implement Action Steps for the Continuum of Care Plan

Tasks

- Establish a process for monitoring implementation of the Continuum of Care Plan
- Establish criteria for Continuum of Care Homeless Assistance Project selection

**Purpose:** This session is designed to outline the importance of establishing a formal and regular process for monitoring the implementation of the Continuum of Care plan, and in particular how to rank and select projects for McKinney Homeless Assistance funding in the future.

**Establish A Process for Monitoring Implementation of the Continuum of Care plan**

Successful Continuum of Care implementation necessitates that communities establish who will be responsible for ensuring that tasks are accomplished, and progress is monitored.

- In communities where the city or county government has taken the lead in the planning process, it will likely be city or county staff who are responsible for monitoring the implementation of the action steps in the Continuum of Care Plan.
- Many communities also create a monitoring committee or establish regularly scheduled community meetings where progress on the plan’s implementation is reported.

Regardless of who is responsible, roles and responsibilities must be clear and a regular meeting schedule established to ensure an ongoing, year-long planning process.

**Establish Criteria for Continuum of Care Homeless Assistance Project Selection**

A primary action step for the Continuum of Care plan will be application for Continuum of Care Homeless Assistance funding. Communities should develop some selection and ranking criteria for prioritizing projects for McKinney Homeless Assistance funding. This is especially important for larger communities that may have multiple potential projects competing for funding, or may be confronting competition among renewal requests and new projects.

The single most important factor is that projects requesting McKinney Homeless Assistance funding address priority gaps in relationship to the community’s identified relative priorities.
In addition, communities will need a mechanism for ranking and selecting projects for Continuum of Care Homeless Assistance funding. Any mechanism would need to demonstrate that decisions were based on pre-established selection criteria that are logical and fair.

- Criteria might include capacity to implement and manage the proposed project, experience working with the target population, cost effectiveness, etc.
- Communities should emphasize and even rank projects based on the project’s ability to articulate achievable outcome measures against which the project can be evaluated in future years. This is especially important as projects come up for renewal funding and communities must try to assess performance.
- Communities should ensure a fair and efficient process. This might include the formation of a selection committee, use of a standing committee on homelessness, or use of staff of a lead agency (city or homeless coalition).

**Outcomes**

- On-going oversight, monitoring and accountability for Continuum of Care implementation
- Fair process for McKinney project selection consistent with priority gaps
Case Study

**Kentucky - Planning Process**

Prior to 1993, metropolitan areas and rural counties developed their own relationships with HUD and other funding sources, operating separately from one another. Then the Kentucky Housing Corporation, the state housing finance agency, coordinated a statewide planning process. The state was divided into 15 geographic Area Development Districts (ADD) to enhance regionalized planning for homeless services and funding. Each ADD in turn formed a Local Homeless Planning Board to assess existing resources, identify gaps in services, and develop priorities for project proposals, to be submitted to the State Continuum of Care Planning Board. The local and state boards have both benefited from the opportunity to work collaboratively—bringing urban and rural groups together, sharing information, discovering hidden resources, and, through a consensus-building process, coming to agree on needs and priorities.

**Implementation**

The statewide Continuum of Care planning process forced participants to take a closer look at resources and needs and to fill service gaps with the priorities identified and has brought forth new systems of communication and decision-making that are likely to continue to leverage other dollars and assure that limited resources are used efficiently. Providers throughout the state have acknowledged the benefits of maximizing what each does well and developing collaborative planning strategies to fill in service delivery gaps without duplicating services. The process of planning for integrated and coordinated services has also strengthened the network of housing and services funded by an array of other HUD funds.

The local and state planning boards continue to meet on a regular basis to plan, share resources, review cases and address systems problems.

**Current Operation of Continuum of Care**

Across the state, public and nonprofit providers of homeless services, for the most part, have had positive experiences in developing a planning process for the Continuum of Care applications—new relationships have been forged, resources have been discovered and shared, duplication of services has been minimized, and statewide and regional goals and priorities have been established. While differences in philosophy and priorities emerged during the planning process, most participants were satisfied with using a consensus-building process to resolve differences and solve problems.

Creating formal structures that encourage communication and collaboration has reduced the sense of isolation that many rural providers had experienced and has encouraged smaller organizations to join forces in advocating for system-wide improvements. Key to the planning and implementation of the Continuum of Care approach was the support and involvement of political, governmental, and media players.

Developing a Group Vision

This is an exercise for a planning group to use with providers and stakeholders to begin to develop and articulate a shared vision for a Continuum of Care system.

In a group, brainstorm answers to the following questions:

- What should the Continuum of Care system include?

- How would it operate?

- Whom would it help?

- What relationships should exist?

Use the answers to these questions to help develop a Vision Statement and goals for the Continuum of Care system.

Sample Vision Statement

“The Core Working Group is committed to assisting individuals and families who become homeless or are at risk of becoming homeless to regain housing stability and quality of life. Toward this end, over the next five years, the Core Working Group will implement and expand a comprehensive Continuum of Care to prevent and end the tragedy of homelessness among individuals and families.”

Goals for a Continuum of Care System

1).

2).

3).
This worksheet may be helpful in documenting your community’s Continuum of Care planning process. In Exhibit 1 of the application for Continuum of Care Homeless Assistance funding, HUD will want to see that you have organized and can specifically document the organizational structure (i.e., roles and responsibilities) and desired outcomes of the planning process.

For example:

**Core Working Group**

<table>
<thead>
<tr>
<th>Member</th>
<th>Affiliation</th>
<th>Phone</th>
<th>Fax</th>
<th>E-Mail</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Inclusive Process

This sample format can be used while you are organizing your Continuum of Care planning process. It will help ensure that you have documented the process that your community has gone through to reach out to all categories of potential participants during the planning process.

For example:

<table>
<thead>
<tr>
<th>Date</th>
<th>Category of Participants</th>
<th>Key Actions to Involve</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 26, 1999</td>
<td>Mental Health Providers</td>
<td>• Contact city or county mental health providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify key players</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Invite key players to participate in the Continuum of Care planning process</td>
</tr>
</tbody>
</table>
General Invitation List for Continuum of Care Planning*

- Local homeless coalitions and networks
- Homeless service providers and agencies
- Nonprofit housing developers
- Local government representatives (City and County)
- Key civic leaders
- Homeless and formerly homeless people and homeless advocates
- Housing authorities
- Mental health service funders and service providers
- Substance abuse service funders and providers
- Local job councils
- Colleges and vocational education institutions
- Veterans service agencies
- Persons representing special needs populations such as people with mental illness, people with addictions, people with HIV/AIDS, and families fleeing from domestic violence
- Religious leaders
- Business community
- Key members of local planning groups
- Major employers
- Political leaders
- Police officers
- School district officials
- Local universities, such as Community Initiatives or Sociology Departments

*Excerpted from the Guidebook for Developing Local Continuum of Care Plans for Homeless People, Low Income Housing Institute, December 1996.*
**Sample Exercise on Defining the Problem**

This exercise is designed to help structure a brainstorming session among a planning group in order to begin to define the problem that the Continuum of Care is trying to address. It also helps the group begin to identify some of the policy and context issues that affect who is homeless and who is at risk of homelessness.

<table>
<thead>
<tr>
<th>Who is Homeless?</th>
<th>How many people are homeless?</th>
<th>Where are they from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working poor families</td>
<td>Increasing</td>
<td>Lost housing in community</td>
</tr>
<tr>
<td>Families fleeing domestic violence</td>
<td>Increasing, or increased visibility</td>
<td>Lost housing in community</td>
</tr>
<tr>
<td>Individuals with dual diagnosis</td>
<td>Increasing, or recently identified as such</td>
<td>Lost housing in community</td>
</tr>
<tr>
<td>Individuals with substance abuse problems</td>
<td>80% of single adult shelter residents – increasing younger residents</td>
<td>Treatment, state systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is at risk of homelessness?</th>
<th>How many people are at risk?</th>
<th>Where are they from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families losing welfare benefits</td>
<td>Increasing (%)</td>
<td>Housing in community, doubled up</td>
</tr>
<tr>
<td>Young people discharged from DSS (aging out and kicked out)</td>
<td>Increasing (%)</td>
<td>State systems</td>
</tr>
</tbody>
</table>

**Policy and Funding Context:**

<table>
<thead>
<tr>
<th>Issue or Problem?</th>
<th>Current or likely impact?</th>
<th>Possible impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost and escalating rental market</td>
<td>Limited or no access to affordable housing; declining ability to use tenant-based rental assistance</td>
<td>Need for permanent housing production to expand supply</td>
</tr>
</tbody>
</table>
Exercise to Develop an Inventory of Needs and Resources*

This is a simple, two-step method for creating inventories of needs and available resources.

• First, post large sheets of blank paper around the walls of a room, each one titled for a key type of housing or supportive service.

• Participants are given marker pens and asked to walk around the room and identify gaps in each type of housing or service. They should indicate:
  1) the **number of units** of housing or services needed, and, if possible,
  2) the **specific sub-populations or geographic areas** which are currently underserved.

• After all have finished, the facilitator reads off the results to generate further clarification of the information on the sheets.

• In a second round, another set of blank paper is posted around the room, one sheet for each key type of service or housing need/gap, as identified above.

• Participants are asked to walk around the room with their marker pens and respond to three questions regarding existing housing and services:
  1) Which agencies provide this type of housing and/or service?
  2) What is their capacity (# of beds, length of stay, treatment slots, etc.)?
  3) Who is the contact person and what is their telephone number?

• After all have finished, the facilitator reads off the results to generate further clarification of the information on the sheets.

• Both sets of sheets should be typed up for discussion at the next meeting. If necessary, Core Working Group members can make follow-up phone calls to the contacts listed to obtain more complete information and then synthesize the findings.

*Taken from the Guidebook for Developing Local Continuum of Care Plans for Homeless People, Low Income Housing Institute, December 1996.
Sample Needs Survey Administered to People who are Homeless

(From the Alameda County-Wide Homeless Continuum of Care Plan)

To try and serve you better, and its service providers want to ask you some questions about your situation. Please do not provide your name or anything that identifies who you are.

Have you filled out this survey before?  ___No  ___Yes (If Yes, please do not fill out again.)

Are you:  ___Female  ___Male

Are you a Veteran?  ___ No  ___Yes

How old are you? ________

Are you disabled?  ___No  ___Yes

If yes what is your disability?

___ Physical/medical  ___ Mental health
___ HIV/AIDS  ___ Substance abuse
___ Developmental  ___ Other

Are you currently homeless?  ___No  ___Yes

If homeless, check your reason(s) why:  (Check all that apply)

___ Domestic violence
___ Family break-up
___ Fire/other disaster destroyed my home
___ Unable to pay rent
___ Evicted due to non-payment of rent
___ Evicted for other reason
___ Discharged from an institution (please describe):  __________________________________________

___ Other reason (please explain):  __________________________________________________________

Could not maintain income or stay housed due to:

___ Job lost
___ Mental illness
___ Medical problems or medical costs
___ Alcohol or other drug use
___ Money management problems
___ Temporary living situation ended (please explain) ____________________________________________

___ Discrimination as a result of:

___ Race/Ethnicity/Nationality
___ Family size
___ HIV status
In what city did you most recently become homeless?

How long had you lived there?

How long have you been homeless?

How many times have you been homeless in the past 5 years?

What would have prevented you from becoming homeless?

Are you homeless with a spouse or life partner?  No  Yes

Do you have any dependent children living with you?  No  Yes
  If Yes,  
  Number of Children needing services  Ages of Children  
  Number of Children elsewhere  Ages of Children  

Over the last 6 years in what city/cities have you lived?

How big an apartment/house do you need?
  Studio, 1 bdrm, 2 bdrm, 3 bdrm, 4+ bdrm

What city or neighborhood do you want to live in? (list three choices)
  1)
  2)
  3)

What have your source(s) of income been in the last 6 months (Check all that apply):
  Employment  full time  part time  day laborer
  AFDC/TANF
  General Assistance (GA)
  Unemployment Compensation / SDI
  Vocational Programs
  Social Security
  Food Stamps
  Relatives/partner/friends
  Panhandling/Vouchers
  Other sources of income (please describe):  

If unemployed, are you seeking work?  No  Yes

If Yes, how long have you been homeless?
In the last month, what services have you used (check as many as apply)? If you are on the waiting list for any of these services, please check under “waiting list.”

<table>
<thead>
<tr>
<th>Received</th>
<th>Waiting List</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food/ Hot Meals</td>
<td></td>
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<tr>
<td>Health Care</td>
<td></td>
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<tr>
<td>Job Help</td>
<td></td>
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<tr>
<td>Showers</td>
<td></td>
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<tr>
<td>Drop-in Center</td>
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<tr>
<td>Alcohol/Drug</td>
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<tr>
<td>Rehab</td>
<td></td>
<td></td>
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<tr>
<td>Section 8</td>
<td></td>
<td></td>
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<tr>
<td>Permanent Housing</td>
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<tr>
<td>Shelter</td>
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<tr>
<td>Domestic Violence</td>
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<tr>
<td>Services</td>
<td></td>
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<tr>
<td>Storage</td>
<td></td>
<td></td>
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<tr>
<td>Transitional Housing</td>
<td></td>
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<tr>
<td>Respite Care</td>
<td></td>
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<tr>
<td>Bus Ticket</td>
<td></td>
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<tr>
<td>Shelter Plus Care</td>
<td></td>
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<tr>
<td>Rental Assistance</td>
<td></td>
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<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
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</tr>
</tbody>
</table>

If relevant, in what cities do you use services the most?

1. 
2. 
3. 

In the last month, how did you mostly get around? (check two answers only)

- [ ] Walked
- [ ] Wheelchair or other mobility device
- [ ] Bus
- [ ] Bus Tickets
- [ ] Taxi scrip
- [ ] Bicycle
- [ ] Received rides from friend or family
- [ ] Own vehicle

How did you pay for the fare on your last ride on Public Transit?

- [ ] Cash
- [ ] Scrip
- [ ] Bus Tickets

What services do you need that you are currently not getting?
**Community Survey on the Needs and Resources of Homeless People**

Service providers, public officials, civic and business leaders, and other community organizations are undertaking a strategic planning process to develop long range plans to better meet the needs of homeless people. The purpose of this survey is to obtain information on the needs of homeless people in our community and to determine existing resources. The planning group can then make informed decisions on steps to expand housing services.

Below are a series of questions and an inventory of needs and resources. Please complete this survey and return by: ____________________________ to the following address: ____________________________

---

**General Assessment of Existing Housing and Services**

<table>
<thead>
<tr>
<th>Name:</th>
<th>E-mail:</th>
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<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Agency:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

When answering the following questions, please refer to the Continuum of Care System in the Participant Guide.

1. Which part of the existing system serving homeless people works best?

2. Which parts of the existing system have the greatest need for expansion?
   a. __________________________________________
   b. __________________________________________

3. Which parts of the existing system have the greatest need for improvement?
   a. __________________________________________
   b. __________________________________________
4. What actions would you take to expand or improve these two parts of the system?
   a. 
   
   b. 

5. What two actions would you take to meet the most pressing needs of the sub-population that you serve, or are most knowledgeable about?
   Identify Sub-populations: 
   a. 
   
   b. 

6. What wouldn’t you do?
   a. 
   
   b. 

**Thank you for your time and assistance with this survey.**

---

*Excerpted from the Guidebook for Developing Local Continuum of Care Plans for Homeless People, Low Income Housing Institute, December 1996.*
Sample Provider Survey

Name of housing program: ____________________________________________________________

Note: Please complete separate surveys for each housing and support service programs you operate. If a particular program serves both individuals and families, please complete one survey for individuals and one for families served by that program.

Agency Name: ________________________________________________________________
Completed by _________________________________________________________________
Phone # ________________________________________________________________

Type of housing:
_____ permanent independent  _____ permanent supportive  _____ transitional
_____ emergency  _____ support services only  _____ individuals  _____ families

1. **Daily capacity:** how many homeless can be served on any one day?

<table>
<thead>
<tr>
<th></th>
<th>Females (% or #)</th>
<th>Males (% or #)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abusers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriously mentally ill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dually diagnosed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic violence victims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Annual capacity:** how many homeless can be served in a year?

<table>
<thead>
<tr>
<th></th>
<th>Females (% or #)</th>
<th>Males (% or #)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abusers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriously mentally ill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dually diagnosed</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Veterans</td>
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<tr>
<td>Domestic violence victims</td>
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<tr>
<td>Youth</td>
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<tr>
<td>General population</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Supportive services provided in this program.

In the first column write the number of your daily caseload capacity for each service provided by your program. In the second column check ✓ if the service is provided by another agency. In the third column ✓ check if your participants access the service outside of your program, and for any ✓ in columns 2 and 3 list the agencies that provide the services.

<table>
<thead>
<tr>
<th>Supportive Service</th>
<th>Daily case load capacity</th>
<th>✓ if service is provided by another agency</th>
<th>✓ if your participants access the service outside of your program</th>
<th>List agencies that provide service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job training (skill development)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment access</td>
<td></td>
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</tr>
<tr>
<td>Employment assessment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Supported/transitional employment</td>
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<tr>
<td>Case management &amp; advocacy</td>
<td></td>
<td></td>
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<tr>
<td>Substance abuse treatment/recovery support</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mental health treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical care</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Housing search/placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life skills training</td>
<td></td>
<td></td>
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<tr>
<td>Intake/assessment</td>
<td></td>
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<tr>
<td>Outreach</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Basic needs (food, clothing, transportation)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
4. Please list any restrictions your program has for participants.
   a. Drug or alcohol free
   b. Age of participants
   c. Accessibility of facility
   d. Lengths of stay
   e. Other restrictions

5. Participant flow.
   a. Where do they come from?
   b. Where do they go after an unsuccessful tenancy?
   c. What percentage doesn’t successfully remain in housing after 1 year?
   d. What is the average length of stay?
   e. Is there a maximum length of stay?

Thank you for completing this survey!
### Continuum of Care: Gaps Analysis

<table>
<thead>
<tr>
<th></th>
<th>Estimated Need</th>
<th>Current Inventory</th>
<th>Unmet Need</th>
<th>Relative Priority</th>
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</thead>
<tbody>
<tr>
<td><strong>Individuals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beds/Units</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>115</td>
<td>89</td>
<td>26</td>
<td>M</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Total</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Estimated Supportive Service Slots</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Job Training</td>
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<tr>
<td>Case Management</td>
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<tr>
<td>Substance Abuse Treatment</td>
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<tr>
<td>Mental Health Care</td>
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<tr>
<td>Housing Placement</td>
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<tr>
<td>Life Skills Training</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Estimated Sub-Populations</strong></td>
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<tr>
<td>Chronic Substance Abusers</td>
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<td></td>
</tr>
<tr>
<td>Seriously Mentally ill</td>
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<td>Dually Diagnosed</td>
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<td>Veterans</td>
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<tr>
<td>Persons with HIV/AIDS</td>
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<td>Youth</td>
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<td>Other</td>
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<tr>
<td><strong>Persons in Families with Children</strong></td>
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<tr>
<td><strong>Beds/Units</strong></td>
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<td><strong>Estimated Supportive Service Slot</strong></td>
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<tr>
<td><strong>Estimated Sub-Populations</strong></td>
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<td>Youth</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Prioritizing Unmet Needs

The following worksheets (11a-11f) were developed to assist the work group in prioritizing the unmet needs in the Continuum of Care system. Through your data collection process the group will have identified a number of unmet needs. These sheets can help the Continuum of Care group prioritize among those needs using both quantitative and qualitative information.

Each worksheet represents a component of the Continuum of Care including:

- Emergency Shelter
- Transitional Housing
- Permanent Supportive Housing
- Permanent Housing
- Supportive Services only

A sample worksheet for **Permanent Supportive Housing** has been filled out in order to illustrate how these worksheets can be used.

**Directions**

For each identified gap, pick the sub-population and the part of the system where the gap has been identified (i.e. the unmet needs of persons with mental illness for permanent supportive housing). Using the data that you have previously collected, enter the quantifiable need (i.e. 1,000) in column B. Then proceed to answer the questions in columns C, D, and E across under the following headings.

- Organizational Capacity
- Relative Need
- Vulnerability of Population

*NOTE: In addition to these categories, the group may determine that other qualitative factors are also important to consider. If this is the case, the worksheets can be modified to include additional factors.*

The group should answer each question in columns C, D, and E with a response of **High**, **Medium** or **Low**.

⇒ Keep in mind that a qualitative analysis to prioritize unmet needs is a **subjective** process, and opinions may differ. However, it is important to try to reach some consensus when answering the questions. Once the number of high, medium, and low responses are totaled in column F, the group can consider both the qualitative data in column B and the qualitative data summarized in column F. This process will help give the group a sense of the relative priority needs within the Continuum of Care System.
For the category of permanent housing serving homeless persons with a mental illness, under column C, Organizational Capacity, the group was asked to consider and respond to the following qualitative factors:

- Expertise in serving this population – The group determined that there were providers within the Continuum of Care system who serve this population, but that none had experience in housing. Based on this analysis, a medium response was assigned to this qualitative factor.

- Readiness to proceed with developing permanent supportive housing for homeless individuals with mental illness. The group determined that, within the Continuum of Care provider network, there was a non-profit organization willing and able to develop this type of housing. However, the organization had not yet formulated a development plan. Based on this analysis, the group assigned a medium response to this qualitative factor.

- Feasibility of developing permanent housing for homeless individuals with mental illness in the community. The group determined that the community opposition that had delayed other supportive housing projects would impact the feasibility of any new effort, and assigned a low response to this qualitative factor.

⇒ Keep in mind that qualitative factors are designed to raise issues that should be considered in assigning priorities to identified gaps within the Continuum of Care. However, a ranking of low for any qualitative factor does not necessarily mean that a project cannot be done. Rather, it identifies one or more important issues to keep in mind if the Continuum of Care group prioritizes this type of project.
## Sample Worksheet: Permanent Supportive Housing

<table>
<thead>
<tr>
<th>A. Sub Populations</th>
<th>B. Number of Unmet Need</th>
<th>C. Organizational Capacity</th>
<th>D. Relative Need</th>
<th>E. Vulnerability of Population</th>
<th>E. Priority (total H, M, and L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental illness</td>
<td>1,000</td>
<td>Expertise in serving this population? M</td>
<td>Any existing housing for this population? M</td>
<td>Is the Population &quot;at risk&quot;? M</td>
<td>High 3</td>
</tr>
<tr>
<td>Single women in recovery with children</td>
<td>1,500</td>
<td>Expertise in serving this population? M</td>
<td>Any existing housing for this population? M</td>
<td>Is the Population &quot;at risk&quot;? M</td>
<td>High</td>
</tr>
<tr>
<td>Expertise in serving this population? M</td>
<td>Any existing housing for this population? M</td>
<td>Is the population &quot;at risk&quot;? M</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
</tr>
</tbody>
</table>

Is risk increasing? M

Is population high-end users? M

Is the need much greater than current capacity? M

Is population high-end users? M

Is the need much greater than current capacity? M

Is population high-end users? M

Is the population "at risk"? M

Is population high-end users? M

Is the need much greater than current capacity? M

Is population high-end users? M
## Emergency Shelter

<table>
<thead>
<tr>
<th>A. Sub Populations</th>
<th>B. Number of Unmet Need</th>
<th>C. Organizational Capacity</th>
<th>D. Relative Need</th>
<th>E. Vulnerability of Population</th>
<th>E. Priority (total H, M, and L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental illness</td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>High ___ Medium ___ Low ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td></td>
<td>Is risk increasing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single women in recovery with children</td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>High ___ Medium ___ Low ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td></td>
<td>Is risk increasing?</td>
<td></td>
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<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>High ___ Medium ___ Low ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td></td>
<td>Is risk increasing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>High ___ Medium ___ Low ___</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td></td>
<td>Is risk increasing?</td>
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<td></td>
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<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td></td>
<td></td>
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</tbody>
</table>
### Transitional Housing

<table>
<thead>
<tr>
<th>A. Sub Populations</th>
<th>B. Number of Unmet Need</th>
<th>C. Organizational Capacity</th>
<th>indicate L, M, or H</th>
<th>D. Relative Need</th>
<th>indicate L, M, or H</th>
<th>E. Vulnerability of Population</th>
<th>indicate L, M, or H</th>
<th>E. Priority (total H, M, and L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with mental illness</td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>Low ___</td>
<td>High ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td>Is the need much greater than current capacity?</td>
<td>Is risk increasing?</td>
<td>Medium ___</td>
<td>Medium ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td>Low ___</td>
<td>Low ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single women in recovery with children</td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>Low ___</td>
<td>High ___</td>
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<tr>
<td></td>
<td>Readiness to proceed?</td>
<td>Is the need much greater than current capacity?</td>
<td>Is risk increasing?</td>
<td>Medium ___</td>
<td>Medium ___</td>
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<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td>Low ___</td>
<td>Low ___</td>
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</tr>
<tr>
<td></td>
<td>Expertise in serving this population?</td>
<td>Any existing housing for this population?</td>
<td>Is the population &quot;at risk&quot;?</td>
<td>Low ___</td>
<td>High ___</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Readiness to proceed?</td>
<td>Is the need much greater than current capacity?</td>
<td>Is risk increasing?</td>
<td>Medium ___</td>
<td>Medium ___</td>
<td></td>
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<tr>
<td></td>
<td>Feasibility?</td>
<td></td>
<td>Is population high-end users?</td>
<td>Low ___</td>
<td>Low ___</td>
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</tbody>
</table>
# Permanent Housing

<table>
<thead>
<tr>
<th>A. Sub Populations</th>
<th>B. Number of Unmet Need</th>
<th>C. Organizational Capacity</th>
<th>D. Relative Need</th>
<th>E. Vulnerability of Population</th>
<th>E. Priority (total H, M, and L)</th>
</tr>
</thead>
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A Group Exercise to Help with the Development of Strategies*

This exercise is designed to facilitate a group process to begin to develop strategies to respond to priority gaps identified in the Continuum of Care system.

1. Have a person write down the major gaps identified through the earlier processes. There should be between 10-20 gaps. If there are more, and they are not yet prioritized, determine the top 4-5 gaps in each element identified. These major gaps should then be transcribed in short phrases: “mental health counseling,” “transitional housing for families,” “outreach to youth and people with mental illness,” and so on, and should then be written in felt pen on 8x10 pieces of paper (linkage cards). (NOTE 1: To speed the process, have an individual prepare the cards as decisions on each of the elements are completed so that the cards are ready at the beginning of this step.)

2. Spread the linkage cards out on a large table (or tables) so that the participants can see them and move them around the table freely. Have extra paper available to make duplicates when needed. Invite participants to gather around the table to view the cards.

3. Ask the participants to consider the connections between the various gaps. Ask them to look at how they might be linked and to place them in logical piles. For instance, “Mental Health Counseling”, “Outreach to Youth and the Mentally Ill” and “Permanent Housing for the Chronically Mentally Ill” are well related. Some cards cannot easily be placed with others and may stand alone. Others might need to be split (i.e., “Outreach to Youth and the Mentally Ill” could be split into outreach to youth and outreach to the mentally ill) or duplicated so that they may be placed in more than one pile. Allow time for everyone to become comfortable with the groupings and to discuss possible rearrangements. These piles represent the first step in designing long-term (5-10 year) strategies.

4. Depending upon how much time remains in the meeting and how many piles there are (try to keep the number of piles below 10), divide the participants into small groups of 3-6 persons, including those who are knowledgeable about the particular subject matter. Ask them to take a pile and draft a proposed Long-Range Strategy Statement to address the gaps identified. Ask them not to be constrained by funding considerations at this point and to also think in terms of strategies that do not involve funding. The Long-Range Strategy Statement may consist of a broad description of the strategy and individual bullets describing the concept. If appropriate, identify in the statement who is targeted, what type of housing or services are involved, any inter-related aspects and any location issues. The form of the statement is not important. The goal is to describe the basic concept so that the Core Working Group may draft a more complete strategy statement for review at the next meeting.
NOTE: In the development of both strategies and action steps, be certain that the participants are not just focused on projects and activities that require financial assistance. Many strategies developed by communities do not entail any financial assistance. These may include changes in policies, procedures, and reallocation of existing resources, program changes, and so on. For example, a change in the program may include modifying the length of stay in a shelter, setting aside units for a particular sub-group within an existing facility, or developing cooperative links with employment training resources.

*(Adapted from the Guidebook for Developing Local Continuum of Care Plans for Homeless People, Low Income Housing Institute, December 1996.)*
## Strategy Statement and Action Plan Worksheet

**Strategy Statement**  

---

### Gaps to be Impacted | Description / Components of Strategy
--- | ---

### Action Steps | Timeline | Outcomes
--- | --- | ---

### Proposed Responsibilities | Lead
--- | ---

### Resources Required for Implementation | Potential Barriers to Strategy
--- | ---
The questions outlined below will help localities self-assess their current Continuum of Care planning process to encourage a process that is inclusive and strategic, and supports the locality in implementing its Continuum of Care homeless system to maximize the movement of people who are homeless to permanent housing and increased self-sufficiency.

- Is your Continuum of Care process a year-round planning and assessment process? Is it well organized and does it efficiently use participants’ time?

- Does the process meaningfully include a broad cross-section of stakeholders (e.g., homeless or formally homeless people, local and state government representatives, housing and service providers serving homeless people, elected officials, the business and civic community and advocates)? Do people participate in the process mostly because it’s a HUD requirement or is there a sense of ownership of the planning process by the community of stakeholders?

- Is there a shared understanding of the structural causes of homelessness? Is there a locally-based vision and strategy for a Continuum of Care system (i.e., a seamless system of housing, services and opportunities to meet the needs of homeless people)? Is the vision a long-term strategic one or is it crisis or project-driven?

- Is there shared agreement about the methodology for identifying existing resources, needs, gaps in services and housing, and priorities for both long-term strategies and annual action plans? Is this information available in usable form? Is there an effective and ongoing process to re-assess these and regularly update these parts of the plan?

- Are the identified priorities based on the identified needs of homeless people? (Are there examples of “I have a hammer, so it looks like a nail” syndrome?)

- Is there currently a continuum of housing and services that balances emergency housing and services (tertiary) with permanent / supportive housing (primary)? Is the system seamless? If not, does the plan prioritize strategies to achieve that balance? Is there duplication of efforts in your system due to historical funding and turf issues?

- Does the process include an assessment process for the components of the system? Is there shared understanding of standards of quality and best practice? Are systems in place to monitor and report on these?
• Have new programmatic strategies and partnerships emerged as a result of the planning and collaboration process? Has your community been successful in getting additional “mainstream” (non-homeless specific) resources for permanent housing and services? Have you gotten new sources of funding or created innovative funding partnerships?

• Has the process promoted and/or enhanced collaboration and coordination among all the stakeholders in the system? Is there an effective way of building consensus and dealing with conflict?

• Does your annual action plan serve as a guide throughout the year?

• Does your community have an effective process for ranking competitive projects? Are decisions made according to the priorities identified through the planning process? If existing projects (that are still meeting current needs) are not prioritized, are other resources identified to support them? Does a cross-section of stakeholders participate in the ranking process?

• Are your homeless program planning and activities integrated within broader community development strategies (i.e., integrated within the HUD Consolidated Plan)?

Does your community need assistance working through any of the above issues? If so, HUD provides technical assistance to local communities on Continuum of Care planning. The training can be customized to your community’s specific needs. If you are interested in finding more about this resource, please contact your local HUD field office staff in Community Planning and Development.