HOPE Advisory Board

July 2023 Public Meeting

Meeting facilitated by HOPE Coordinator, Julie Arena

7/26/2023

Benton County

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Virtual Meeting Housekeeping

- **Please mute your microphone until it is your turn to share.**
- **All attendees can unmute themselves and choose to be seen visually by clicking "Mic" or "Camera" at the top right of the screen.**
- **Public comment:**
  - Type your name into the "Chat" area, say you want to make a public comment, and on what topic. Example: "Julie – public comment – crisis response."
  - For those on the phone, there will be an opportunity to comment, too.
- **Questions during the meeting:**
  - Type into the "Chat" area and send it to host, Julie Arena.

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Meeting Agenda

I. Welcome, Meeting Housekeeping, Overview of Agenda.....4:00pm

II. Public Comment (up to 10 minutes) 4:00pm

III. Roll call and approve May 2023 meeting minutes 4:10pm

IV. Educational Component: Creating Housing Coalition (CHC) Tiny Home Village.....4:15pm

V. Community Progress Updates and Discussion.....4:45pm

Situation Table implementation in Benton County

Community Engagement: HB 5019 Local Planning Groups and Community Plan

VI. HOPE Board feedback on the Strategic Plan Draft for HB 4123.....5:30pm

VIII. Next Steps 5:55pm

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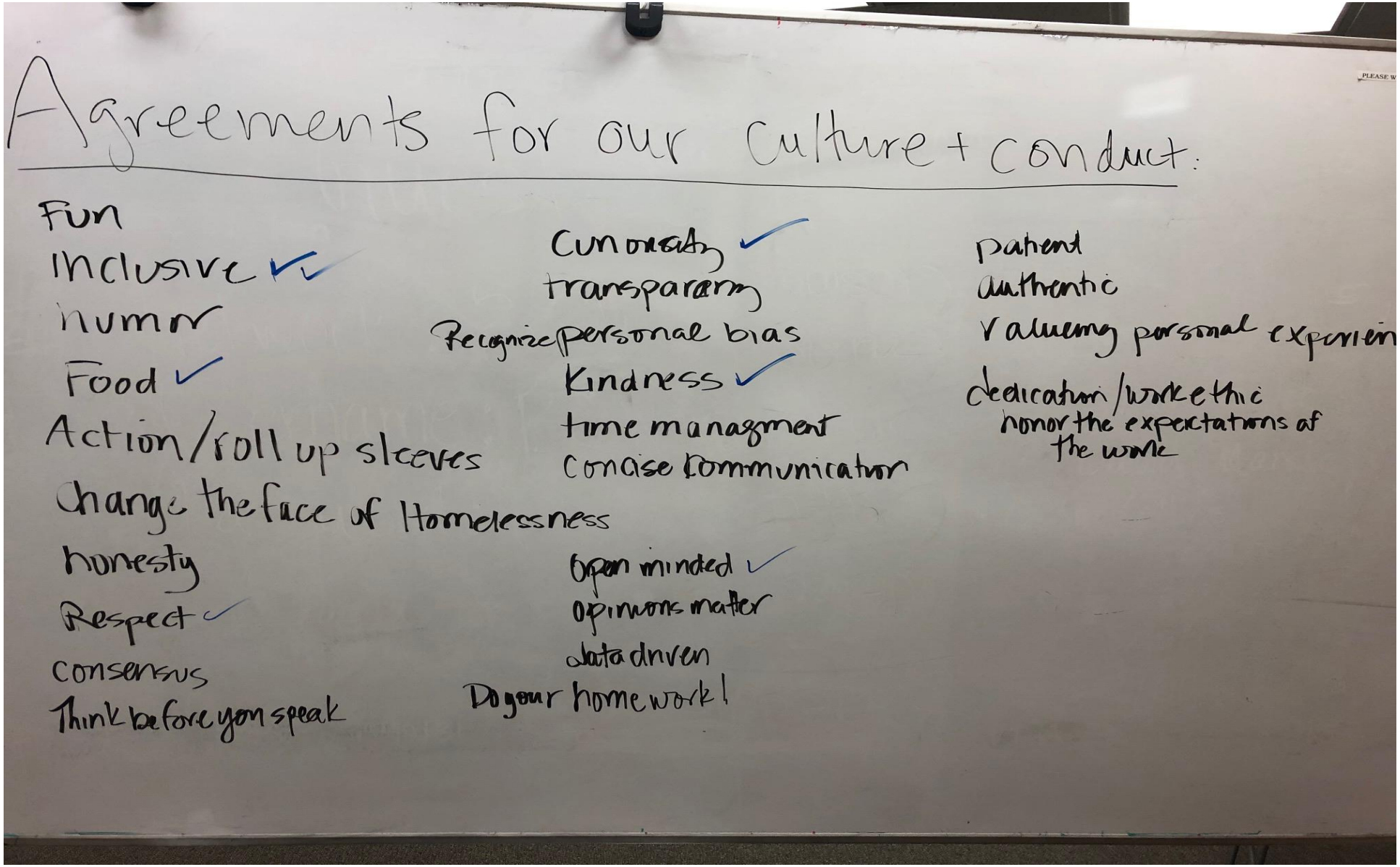

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Public Comment

10 minutes

- Comment limited to 2-3 minutes based on number of people wanting to comment
- Type into the “Chat” and say you want to make a public comment and on what topic.
- For those on the phone, I will ask if there are any public comments from callers.
- Can also submit written comments to the Board via email to Julie.Arena@co.Benton.or.us

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Vote on May 2022 minutes, roll call

Catherine Biscoe* (Co-Chair)

Karyle Butcher

Alice Carter (excused)

Ricardo Contreras

Bryan Cotter

Cade DeLoach

Anita Earl

Joel Goodwin

Aaron Lewis (excused)

Ari Grossman-Naples (excused)

Barbara Hanley

Melissa Isavoran (excused)

Briae Lewis* (Corvallis City Councilor)

Cindee Lolik* (Business Community) (excused)

Charles Maughan* (Corvallis Mayor)

Pegge McGuire* (CSC Director)

Andrea Myhre (excused)

Chanale Propst - resigning from HOPE

Nancy Wyse* (County Commissioner)

*Executive Committee Members

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Situation Table

Captain Joel Goodwin,
Corvallis Police Department

Eric Bowling, MSW, LCSW
Benton County Health Department

- Why the Situation Table (history)?
- What is the Situation Table?
- What is the four filter approach?
- How do we know it is successful?
- How does it compare to (or compliment) other models?
- Where are we now?
- What are the next steps?

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History and Process

- The HOPE Board researched best practices for care coordination and included a specific recommendation to adopt the Situation Table model.
  - HOPE Bylaws: prioritize community safety for all and our most vulnerable community members.
- Then we formed a group of community partners to discuss the situation table, FUSE, case conferencing. There was support from all community partners that there was a need for this model.

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What is the Situation Table model?

A Situation Table (ST) is a collaborative meeting where participants work together to reduce risk for individuals or families at an Acutely Elevated Risk.

Participants in ST meetings include people from a variety of entities that work together in a multi-disciplined team approach to solve problems.

The Situation Table model uses a four-filter approach to ensure consensus and formulate a plan for quick response.

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What is the four filter approach?

FILTER ONE: the initial contact (first responder, shelter worker, etc.) identifies the person as being at AER and refers the situation to the Situation Table

FILTER TWO: Members of the Situation Table review anonymized information to determine if the situation meets the criteria for AER.

FILTER THREE: The ST members receive additional information to better identify what services are available to reduce risk.

FILTER FOUR: ST members who have identified a role in reducing risk meet to formulate a response plan, and meet the person where they are.

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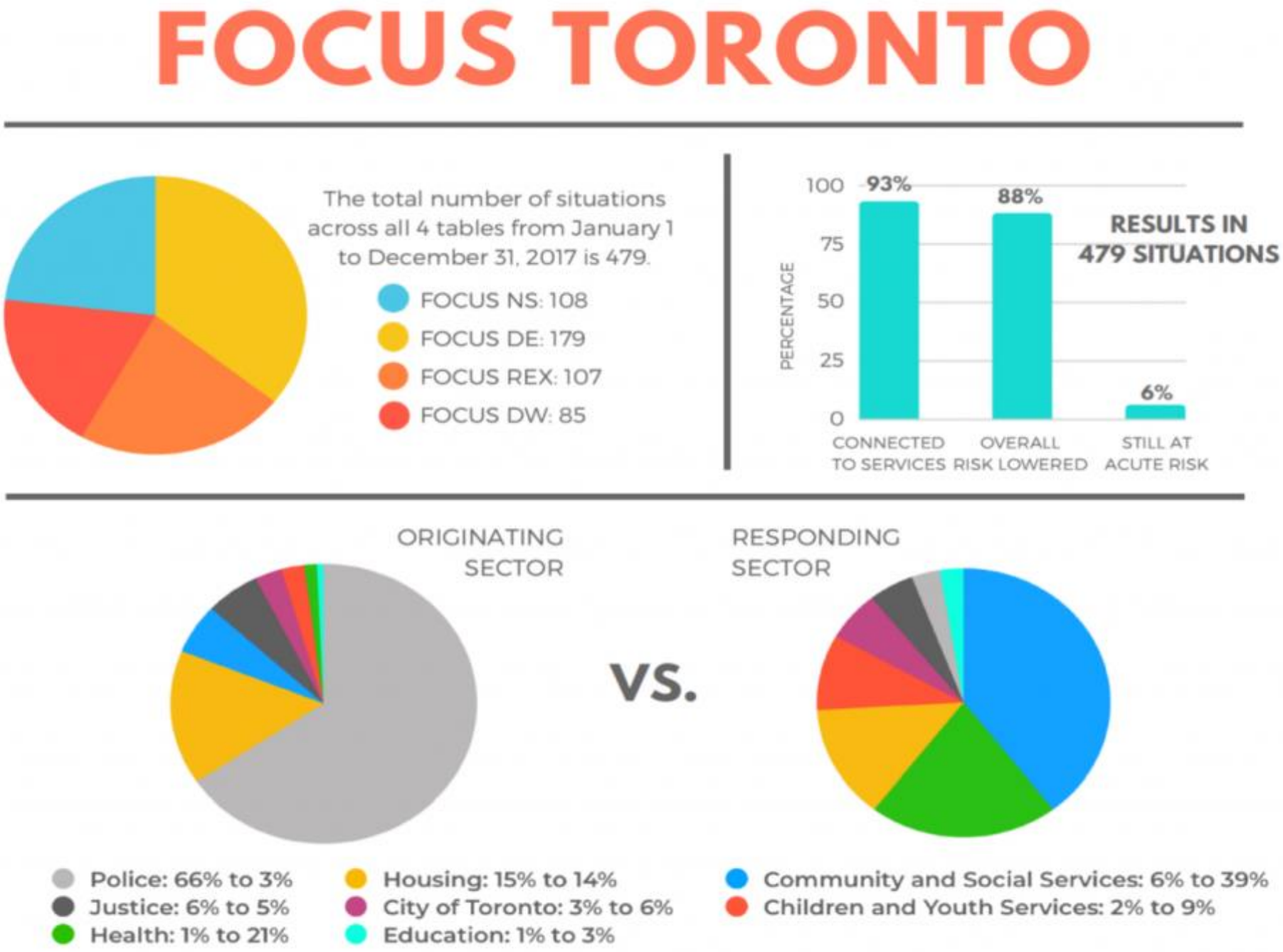
At a Glance: Situation Table Outcomes



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	Situation Table	FUSE	Coordinated Entry Case Conferencing
Risk Level	Acutely elevated risk (AER)	No	No
PSH need/end goal	No - lowering risk	Yes	Usually included, might be other housing
Condition (BH, Disability) prerequisite	No	Yes - BH	Usually included
Chronic Homelessness	No	Yes	Usually included
Population	All at AER	PSH qualifying	Homeless
Data sharing agreements needed?	No	Yes	Non-disclosure agreements for anyone who does not use HMIS. Release of Information needed for HIPAA covered entities like BH.
Timeline	Pending provider support, identifying ST facilitators, and funding for training.	Some amount of years for data sharing agreements. FTE.	FTE hiring process, figuring out the referral process and case conferencing, procedures for provider autonomy in accepting referrals. About 6 months to a year based on other counties experience.
Staff capacity	4 to 8 hours/week	?	.5 FTE

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Where are we now?

Multiple meetings have been held to ensure consensus with community partners that the ST should move forward.

The Benton County/Corvallis PD CORE Team has been identified to facilitate ST meetings.

IHN-CCO has committed to funding the training and initial implementation of the ST in our community.

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Next steps:

- Planning training for this Fall with community rollout by the end of 2023.
- Contact Joel or Eric if you are a community service provider interested in participating.
- Questions or discussion

- Additional information at: https://www.publicsafety.gc.ca/cnt/cntrng-crm/crm-prvntn/nvntr/dtls-en.aspx?i=10015

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Creating Housing Coalition

Creating Housing Coalition

Stacey Bartholomew, Executive Director

- With a successful groundbreaking on June 10, Hub City Village is officially on its way to becoming Albany's first tiny house village, dedicated to providing a home and community for our unhoused neighbors.
- If all goes smoothly, residents will begin moving into the 27 tiny homes in the spring of 2024.

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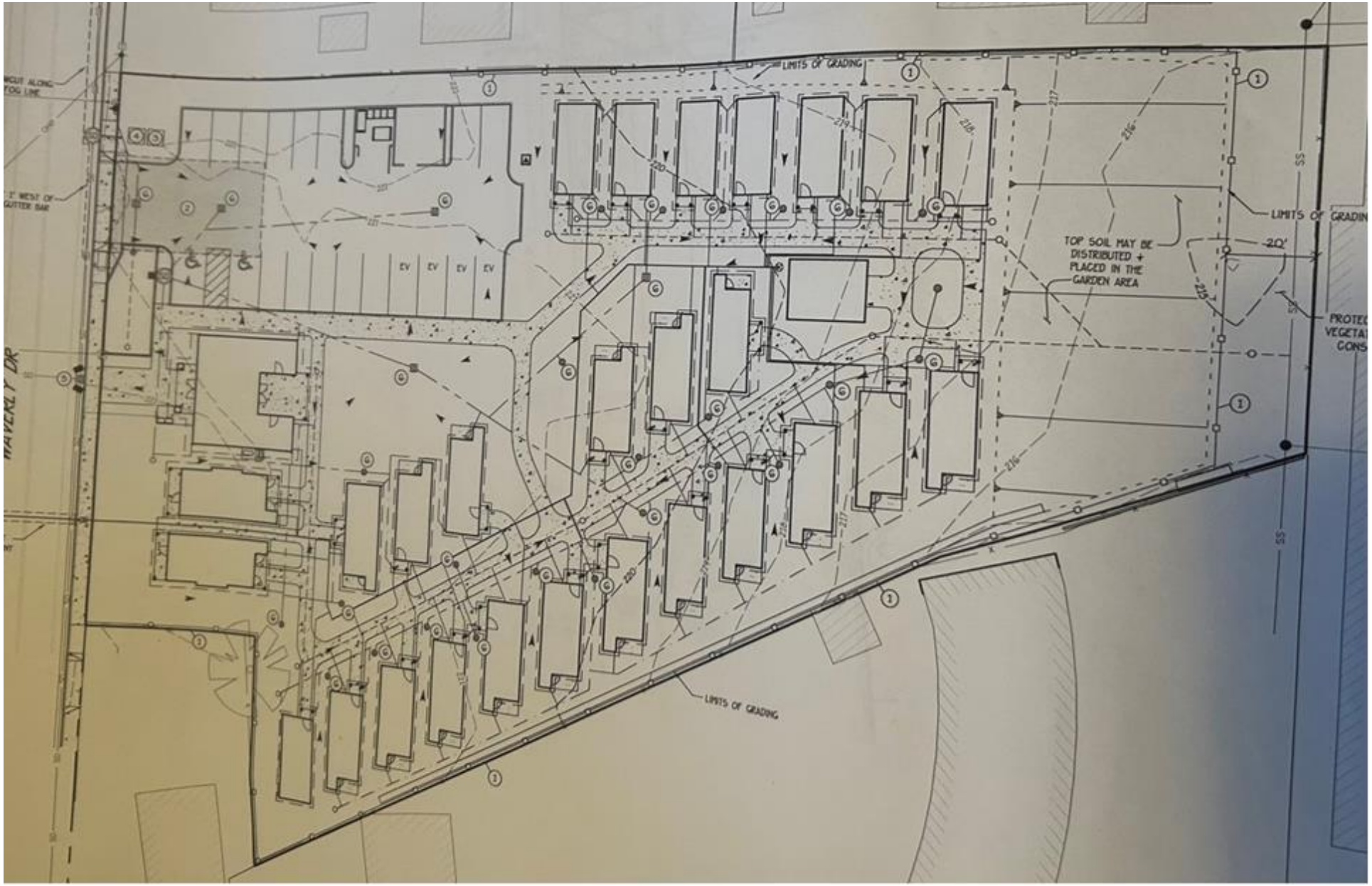
Draft plans for the village



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Benton County Coordinated Homeless Response Office Update

HOPE Advisory Board

7/26/2023

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Community Progress Update and Discussion: House Bill 5019

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- HB 5019 Balance of State Funding and Community Planning.
- Community Engagement and Local Planning Efforts
- Next steps

Oregon Balance of State
HB 5019
State Sponsored. Locally Driven.

- **Benton County's HB 4123 Coordinated Homeless Response** structure and staff to develop Community Plan to be incorporated into grant agreements.
- **Local Planning Groups** to include culturally specific and responsive organizations, cities, counties, coordinated care organizations, mental health providers, and other critical partners supporting the needs of people experiencing unsheltered homelessness when developing plans.
- Plans will outline **specific strategies** that a community plans to use to reach their goals.

Benton County's Goal: Rehouse 33 people by June 30, 2025.

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HB 5019 Oregon Balance of State Funding

Formula Based: Rapid Rehousing ~$19.5M across 26 counties

- # of people experiencing homelessness
- Rate of unsheltered Homelessness
- # of students experiencing homelessness
- # of severe rent burdened households with income below $35k.
- # of people in poverty

Benton County to receive ~$1.4M. Goal to rehouse 33 people.

Competitive Based: Sheltering Projects ~$6.6 across 26 counties

Competitive RFP funding process:

- **Readiness**: Demonstrate ability create and operate shelter sites or additional shelter beds by 6/25/2025.
- **Operations:** Demonstrate low barrier operational plan.
- **Support:** Demonstrate local support for project from community leaders and regional partners.

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Benton County Community Plan Development Process

June 30
Local Planning Group Invitation
- Culturally specific organizations, coordinated care org., mental health providers, and partners supporting people experiencing homelessness.

July 7-11
Distribute Survey for Qualitative Data Collection
- Factors increasing risk of experiencing homelessness and barriers to housing

July 12, Local Planning Group Meeting #1
-Review Baseline and Qualitative Survey Data

-Identify Populations Most likely to Experience Homelessness

July 12-18 Sheltering and RRH Focus Groups meet
- Identify action items for 2-year plan to rehouse 33 people.

- Prepare draft Community Plan

July 19, Local Planning Group Meeting #2
- Review Draft Community Plan

- Discuss inclusion of qualitative and quantitative data

July 19-21
Sheltering and Focus Groups meet
- Finalize community Plan
- Outcome metrics
- Partner roles
- Plan signed by Contract Manager*

Plan due to OHCS July 21, 2023

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*To Be Determined

Equity

A critical component of the plan is that groups who have experienced disparities in homelessness within our community are prioritized.

OHCS requests that we identify three subpopulations most likely to fall into unsheltered homelessness and face the highest barriers to return to housing.

What does the data say?

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Context for Existing Data

- Point in Time (PIT) Count – one-day snapshot, limited to who responds at that time, volunteer run, 2023 not yet HUD-approved
- Homeless Management Information System (HMIS) and Coordinated Entry (CE) - detailed data, limited to those who chose to and have the time to complete assessment
- McKinney-Vento – school-age children, no demographic data
- Unity Shelter and Corvallis Daytime Drop-in Center - includes sheltered and unsheltered; Unity includes Men's Shelter, Room at the Inn, 3rd St., Safe Place, Hygiene Center, and Emergency Hotel Shelter

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Data Overview

Key numbers for size of unsheltered population:

- 168 unsheltered individuals (45.2%) out of 372 total homeless population. (PIT 2023)
- 102 unsheltered individuals have a current CE assessment (HMIS)
- 17 unsheltered students (McKinney-Vento)
    - 62 unaccompanied homeless youth

Provider numbers show about 1,000 total homeless individuals.

- 950 guests at CDDC (2022, unduplicated)
- 1,004 guests at Unity Shelter (July 2022 – June 2023, unduplicated)

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Data by Race and Ethnicity

	PIT	CE		Unity	CDDC		Census
	(Unsheltered)			(All Guests)			(Benton)
African American, Black	3%	3.92%		7%	8%		1.4%
Native American, Alaska Native, or Indigenous	5.4%	7.8%		11.8%	13%		0.7%
Hispanic/Latino/a/x	9.5%	6.9%		8.8%	9.4%		8.2%
Two or more races/Multi-racial	3%	--		12%	15%		8.7%

- PIT and CE data represent percentages of the unsheltered population.
- Unity and CDDC data represent percentages of the unduplicated number of people served annually by each organization.

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Data for Contributing Factors for Homelessness

	PIT	CE	Unity	CDDC	Census
	(Unsheltered)		(All Guests)		(Benton)
Aging (55 years+)	29.9%	20.6%	44 yrs	40 yrs	28.1%
Youth (18-24 years) *PIT 0-24 yrs: 14.9%	8.9%	7.8%	--	--	38.4%
Serious Mental Illness	97.6%	44.1%	31.3%	33%	--
Substance Use Disorder	38.5%	29.4%	28.8%	20%	--
Domestic Violence Survivor	20.6%	38.2%	31.2%	4%	--
Chronically Homeless	52%	--	--	--	--

*Unity and CDDC data are for guests that chose to disclose information. For CDDC, guests were asked what needs they hoped CDDC would support.

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Notable Data

- Data on disabilities is complicated. It can include physical disability, mental health, chronic health conditions, substance use, and developmental disability, depending on the source.
- 100% of the multi-racial homeless population is unsheltered – 9 individuals. (PIT 2023)
- 97.6% of Serious Mental Illness homeless population were unsheltered - 41 of 42 individuals. (PIT 2023)
- We recognize the intersections among different identities and factors and the limits of the data to tell that story.

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Key Questions for Community Plan

3 Subpopulations	5 Top Barriers
Who is most likely to experience unsheltered homelessness? What factors are contributing to folks becoming homeless?	What barriers are keeping people from getting into a safe place to live? What specific barriers are these subpopulations facing in finding and securing housing?

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Overrepresented Groups:

1. Black and Native American communities
2. Families with children
3. High & complex needs: mental wellness, substance use, physical needs, aging
4. People with high needs who don't qualify for specific programs

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Black and Native American communities are most overrepresented in the data.

- **Specific Barriers**
  - BIPOC communities with conviction histories, specifically felonies, and/or not accessing shelter.
  - Felony conviction – housing barrier, and program ineligible.
  - Stigma in accessing help.
  - Culturally specific outreach, connection, trust in the messenger.
- **Addressing Barriers**
  - Technical Assistance (TA) to build organizational capacity to do housing and sheltering for culturally specific orgs.
  - Partnership and training between agencies
  - Staff training
  - Strategic planning to move towards housing supports

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Families with children

- **Specific Barriers**
  - Fear of government and systems – needs to not be a government employee, fear of losing child.
  - Finding locations that fit large families – advocacy with landlords for specific units.
  - Cost of a unit that fits the family = big barrier.
- **Addressing Barriers**
  - Coordination of partners and housing navigation for families.
  - Understanding and awareness of families experiencing homelessness.
  - Funding for larger units – higher levels of rent assistance for large families.

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High & complex needs: mental wellness, substance use, physical needs, aging

- Specific barriers
  - Culturally responsive and high levels of training for assessing needs
  - Connecting the person with the right level of care: SUD residential, MH treatment, group housing
  - Capacity/space in any of those treatment or living situations
- Addressing barriers
  - Increasing staff capacity at community organizations for various skill levels, cultural responsiveness, and training.

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People with high needs who don't qualify for specific programs

- **Specific Barriers**
  - Eligibility/requirements
  - Physical and mental wellness needs without meeting severely and permanently mentally ill (SPMI) or activities of daily living (ADL) threshold
  - Nursing home care needed but don't qualify
- **Addressing Barriers**
  - Flexible funding for needs outside of program eligibility
  - Care coordination across programs to connect people with any program where they are eligible. Coordinating across multiple providers to help person with all needs.

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Other Factor: Prevention support

- **Specific Barriers**
  - Help can't be given because they don't qualify yet, but they are going to become unhoused without help immediately.
- **Addressing Barriers**
  - Flexible funding to help people

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Funding and Goals

Total Award for Benton County: $1,480,946 through June 2025.

Goals:

- Benton County: Rapidly rehouse 33 people experiencing unsheltered homelessness by June 2025.
- Statewide: Add a minimum of 100 emergency shelter beds by June 2025.

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Funding Categories – 2 year

Category	Amount
Street Outreach	$86,600
Emergency Shelter	$86,600
Rapid Re-housing	$976,800
HMIS	$50,000
Administration	$222,141
Not yet categorized	*$58,805*
TOTAL	**$1,480,946**

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Funding Calculations

- Rapid Re-housing: $14,800/person/year x 33 people x 2 years= $976,800
- Administration: set by OHCS - $222,141 (approx. 15%)
- HMIS: based on input from CSC - $50,000
- Remainder ($173,200): split evenly between Street Outreach and Emergency Shelter

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Benton County Coordinated Homeless Response Office:

Strategic Plan Draft Community Engagement

HOPE Advisory Board meeting

7/26/2023

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Update and Q&A

In March and May we covered:

- The work and history that got us where we are today in Benton County
- HOPE Policy Recommendations Integration
- Organization by 10-year plan categories
- HB 4123 Coordinated Office Strategic Plan
- Reviewed a draft strategic plan
- Heard HOPE Board feedback

Today: HB 4123 Coordinated Office Strategic Plan

- Updates on organization for understanding draft strategic plan
- Partner engagement and coordination

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From Policy to Progress…

What are we hoping to achieve today with the HOPE Board?

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Strat Plan purposes:

- Goal 1: Strategic Plan communicates our local work to the State within the framework they are funding.
- Goal 2: Strategic Plan guides staff work to implement policy recommendations.
- Goal 3: Community Roadmap

HOPE Feedback Purpose:

Help us effectively communicate our local work to the State and to Benton County communities.

Development since the March HOPE meeting:

We are organizing our 5-year strategic plan with the same broad priority areas from the 10-year plan to accomplish the following:

- Strategic priorities that are inclusive and relevant for community partners working on urban and rural solutions.
- Showing alignment for collective impact.
- Community roadmap of all the work beyond HOPE recs and HB 4123 requirements.
- Holding space for countywide and even regional approaches.

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Strategic Plan Revised formatting: 5-year Timeline with integrated metrics

The Work: Actions – Projects – Progress	**Partners**	**Timeline**				
		FY23	**FY24**	**FY25**	**FY26**	**FY27**
1. Solicit projects and allocate housing and community development funding annually.	**Lead:** City of Corvallis	Annually				
2. Support coordination and additional funding for affordable units and shelter capacity.						
3. Modify county code language to allow vehicle camping and micro-shelter options.	**Lead**: Benton County Coordinated Office **Collaborators:** Unity Shelter, City of Corvallis	2021				
4. Support funding and coordination for the Navigation Center to add more 24/7/365 sheltering for all populations.	**Lead:** Benton County Coordinated Office					
5. Maintain partner commitments and program models that can be scalable to site availability and funding. (e.g. Project Turnkey 2.0)	**Convenor**: Benton County Coordinated Office **Collaborators:** All community partners					
6. Provide affordable housing technical support to rural areas and smaller cities.	**Lead**: City of Corvallis	As needed				
7. Determine appropriate metrics for affordable housing production at various area median income (AMI) levels	**Leads:** City of Corvallis **Collaborators:** All community partners	2023 – 2024				
8. Supporting community partners in sustaining the retention of affordable housing efforts						
9. Increasing access to units by working in partnership with landlords to better serve marginalized populations.	Lead: Coo					

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Community Partner Strategic Priorities

- **Already reviewed in May:**
  - Intercommunity Health Network Coordinated Care Organization (IHN-CCO) – Medicaid insurance for tri-county
  - Community Services Consortium (CSC) – community action agency (CAA) for tri-county
- **New items to share today:**
  - Cascade West Council of Governments (COG) – senior and disability services, area agency on aging (AAA)
  - Casa Latinos Unidos (CLU) – culturally specific organization for our Hispanic community
  - NAACP for Linn and Benton Counties
- **Yet to come:**
  - United Way for the tri-county area – meeting in August
  - Linn Benton Housing Authority – planning for August

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Cascade West Council of Governments (COG)

- Senior and disability services
- Area agency on aging
- **Aging and disability resource connection (ADRC)**
- Do assessments and connect eligible people with personal care attendants

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System Change:

- *New Housing Coordinator* will streamline referral process for the ADRC.
- Improving coordination, referrals, and engagement between CSC and COG.

Care Coordination:

- *New Housing Coordinator* will connect folks to any benefits they need that COG offers, such as programs beyond housing.
- *New Housing Navigator* will coordinate with providers outside of the COG on other supportive services or programs.

Housing:

- *New Housing Navigator* will connect clients to long term housing, monitor follow up and coordination for 90 days, make referrals to mitigate potential eviction.

Casa Latinos Unidos (CLU)

Culturally specific organization for our Hispanic community

- Housing: Farmworker housing. Working to add direct referrals to affordable housing.
- Outreach: new outreach coordinator. Door-to-door at housing developments. Going to businesses. Farmworker outreach services at the location of the farm. Bringing services to the individuals.
- Communication and Outreach: Educational videos. Culturally appropriate skits about healthy Oregon. CLU get outdoors day, Latinx representation.
- Care Coordination: enrolling clients with OHP.
- Prevention:
  - Financial literacy
  - Emergency assistance fund (provide a small part of first month rent)

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NAACP of Linn & Benton

Culturally specific organization for our Black, Indigenous, and communities of color (BIPOC)

- Keys for the People event – planning to host annually with LBHEA, CSC, and other community partners to connect BIPOC folks with resources on housing, landlord/tenant rights, Black professionals and realtors speaking.
- Creating resources about tenant rights and discrimination, including contacting the local NAACP to make connections or advocate.
- Researching best practices for improving access to housing and sustaining housing for communities of color (2023-2024).
- Planning phase: there are talks of reparations across the nation – leadership is deciding if this committee should focus on that – under discussion in year 2023.

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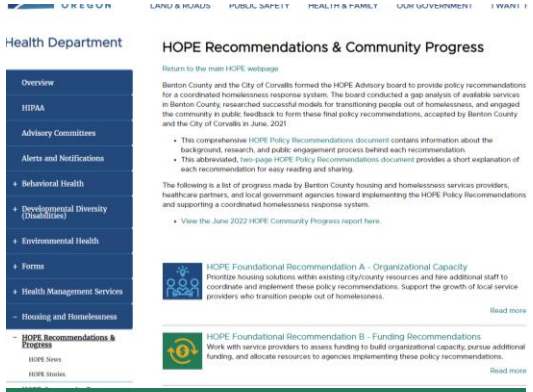
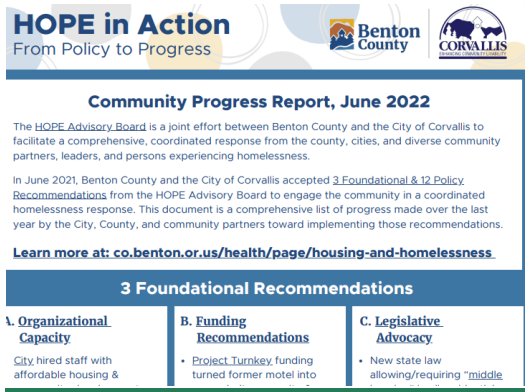
Central Point of Communications



HOPE Website

- Central point of communication



Graphics & Visuals

- Storytelling

e-Newsletter

- Subscribe to HOPE News & Updates

Social Media

- Amplifying aligned messaging through partner engagement

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