KCRHA
King County Regional Homelessness Authority

MEMORANDUM

Date: **December 12, 2022**

To: **KCRHA Implementation Board & Governing Committee**

From: **Marc Dones**

Subject: **Glossary of Terms**

To ensure shared understanding of terms of art within the homelessness response system, we are providing the following glossary to accompany our slides for the Five Year Plan.

Behavioral Health:

A term that covers the full range of mental and emotional well-being, from day-to-day challenges of life, to the treatment of mental illnesses, substance use disorders and other addictive behaviors.

By-Name List:

A By Name List (BNL) is a data set aimed at including information on everyone experiencing homelessness who are from a particular group or community. In addition to their names, specific data points about the circumstances of their situation and their desired resolution can be customized to the community's needs. By building a BNL we are able to quantify the number of people experiencing homelessness in the community of focus, articulate the circumstances of their homelessness at an aggregate level, and identify what is needed to re-house all of them.

Case Management:

Housing-focused case management uses individually tailored assistance to address an individual, couple, or family's immediate housing crisis. Staff works with clients to identify and refer them to other resources in the community (e.g., mainstream services, benefit services, food assistance programs, childcare resources, etc.) to support ongoing housing stability. Services are voluntary, housing-focused, person-centered and tailored to the needs of each household. Services can be increased through progressive engagement if more services are necessary for stabilization in housing.

Chronically Homeless:

There are three categories of people who meet the U.S. Department of Housing and Urban Development's definition of chronically homeless.

1. A homeless individual with a disability who:
    a. Lives in a place not meant for human habitation or in an emergency shelter; and
    b. Has been homeless (as described above) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months.
    c. Occasions separated by a break of at least seven nights.
    d. Stays in an institution of fewer than 90 days do not constitute a break.
2. An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Congregate Shelter

Traditional, temporary overnight sheltering in facilities with large open spaces in which many bunks, cots, or mats are placed for sleeping. Shelters may have limited hours with a curfew at night and a required time of exit in the morning. Connection to services may or may not be provided.

Continuum of Care (CoC):

A HUD designated geographic area designed to promote a coordinated community effort to end homelessness led by an organization that coordinates federal funding and ensures compliance with federal law. Our local CoC is WA-500.

The CoC lead entity and governing board was previously All Home, and is now the KCRHA. Our CoC is overseen by a CoC Board, the Advisory Committee, and carries out the primary responsibilities of a CoC as identified by the U.S. Department of Housing and Urban Development (HUD):

1. Ensure collection of homeless system performance data (a “Homeless Management Information System” or HMIS)
2. Establish and operate a coordinated needs assessment and referral process (“Coordinated Entry”)
3. Perform analysis to identify gaps in regional homeless services needs.

Coordinated Entry:

The Coordinated Entry System (CES) is a function of KCRHA’s homeless response system, encompassing Access, Assessment Prioritization, Referral, and Placement. The U.S. Department of Housing and Urban Development (HUD) mandates that each CoC have a CES.

Coordinated Entry serves all young adults, families, veterans, and single adults who are literally homeless according to the Category 1 HUD definition of homelessness, or fleeing/attempting to flee domestic violence according to the Category 4 HUD definition, and young adults (ages 18-24) who are imminently at risk of homelessness within the next 14 days.

Diversion:

A housing first, person-centered, and strengths-based approach to help households identify the choices and solutions to overcome their housing crisis with limited interaction with the crisis response system, often using flexible short-term interventions. For example, a service provider could use flexible financial resources for overdue rent, transportation, utilities, or deposits.

Emergency Housing

Temporary indoor lodging and accommodations for individuals or families who are experiencing homelessness or at imminent risk of becoming homeless, intended to address the basic health, food, clothing, and personal hygiene needs of individuals or families. Usually does not require occupants to enter into a lease or an occupancy agreement. See also RCW 35.21.683

Emergency Housing Voucher Program:

The Emergency Housing Voucher (EHV) program is available through the American Rescue Plan Act (ARPA). Through EHV, the U.S. Department of Housing and Urban Development (HUD) is providing 70,000 housing choice vouchers to local Public Housing Authorities (PHAs) in order to assist individuals and families who are homeless, at-risk of homelessness, fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking, or were recently homeless or have a high risk of housing instability. (HUD)

Functional Zero:

Functional Zero is achieved when there are enough services, housing and shelter beds for everyone who needs them. Functional Zero means that our system has reached a point where it is able to adequately serve the people who we are attempting to reach, by appropriately providing interventions based on their needs.

Functional Zero is *not* Absolute Zero, which would mean that there is no homelessness at all.

In addressing Veterans Homelessness, the U.S. Department of Housing and Urban Development says that functional zero is reached when the number of veterans experiencing homelessness within a community is less than the average number of veterans being connected with permanent housing each month.

High Acuity:

A combination of two or more of the following:

- High behavioral health needs including psychotic spectrum disorders (schizophrenia, bipolar disorder, Dissociative Identity Disorder)
- Substance Use Disorder (Using opioids, methamphetamines)
- Physical Health challenges (chronic disease, disability)

Homeless Management Information System (HMIS):

A web-based software application designed to record and store person-level information regarding the service needs and history of households experiencing homelessness throughout a Continuum of Care jurisdiction, as mandated by the U.S. Department of Housing and Urban Development (HUD).

Housing First:

Housing First is an evidence-based approach that connects people to permanent housing quickly while reducing preconditions and barriers in the housing process. A Housing First approach prioritizes the most impactful need first – safety and stability – through housing placement, and then connects people to voluntary supportive services to address medical, mental and behavioral health, substance use, employment, and education needs that can build towards self-sufficiency. Programs in a housing first system seek to eliminate typical preconditions or barriers to housing like poor financial or rental history, criminal convictions, income requirements, sobriety, and mandatory participation in services.

Lengths of Stay:

Measured as the number of days from program enrollment to program exit.

Lived Experience / Expertise:

An individual who has experienced housing instability, barriers to obtaining housing and/or difficulty navigating health, housing, or service systems due to their design.

Low Barrier:

Low barrier minimizes barriers such as paperwork, waiting lists, eligibility requirements and assessments that can stand in the way of clients getting their needs met.

A low barrier shelter is an emergency shelter that does not require any of the following for a client to stay at the shelter: criminal background checks; credit checks; income verification; program participation; sobriety or identification.

Non-Congregate:

A type of housing and/or shelter in which each individual or family has living space that offers a level of privacy such as a hotel or motel.

Ombuds Office:

The Office of the Ombuds responds to questions about RHA services, individuals' rights within the system, and connects people to resources to resolve their needs. The Ombuds Office also handles and investigates complaints, collects data, issues reports, and gathers feedback to improve the homeless system's operations and outcomes. Community members, employees, services providers, and other agency contractors who use, interact with, or implement services and activities funded or overseen by the RHA may contact the Ombuds Office. Through working with the community to address concerns, the Ombuds Office's aim is to promote accountability and public confidence in RHA's ability to serve people experiencing homelessness effectively, efficiently, and equitably.

Outreach:

Outreach meets people experiencing homelessness where they are, in order to build trust and create a bridge to services. Outreach workers engage face-to-face with people living unsheltered in places like cars, RVs, parks, encampments, and abandoned buildings, making frequent attempts to establish a relationship in a flexible, empathetic, respectful, non-judgmental and trauma-informed way. Outreach workers often have lived expertise, and may also be specially trained in trauma-informed care and de-escalation techniques. Outreach workers help ensure that basic needs are met and connect people to shelters, housing, and supportive services. However, outreach workers are not case managers.

Permanent Supportive Housing (PSH):

Permanent Supportive Housing combines low-barrier affordable permanent housing and supportive services for individuals and families who have experienced long-term homelessness and often have a disabling condition. Permanent housing usually includes long-term leases or rental assistance. Supportive services can include things like case management, food, child care, education services, employment assistance and job training, legal services, health services, behavioral health services, substance use disorder services, and transportation.

Prevention:

Interventions, policies, and practices such as emergency financial assistance that reduces the likelihood that a household will experience homelessness or to ensure it does not happen again.

Rapid Rehousing (RRH):

A low-barrier, time-limited intervention connecting households experiencing homelessness to permanent housing through low-barrier short-term rental assistance and tailored support services, without any pre-conditions or requirements. RRH includes three core components: 1) Housing Identification. 2) Move-in and Rental Assistance, and 3) Housing-Focused Case Management Services and Supports.

Service Match:

Service matching is the process of matching a housing intervention to a person's particular circumstances so that person's needs are met with judicious use of public resources.

Trauma Informed Care:

Trauma-informed care is a framework that involves:

- Understanding the prevalence and recognizing the effects of trauma and adversity on health and behavior;
- Training leadership, providers, and staff on responding to patients with best practices in trauma-informed care;
- Integrating knowledge about trauma and adversity into policies, procedures, practices and treatment planning; and
- Avoiding re-traumatization by approaching patients who have experienced ACEs and/or other adversities with non-judgmental support. (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014)