**NY-603 Governance Board Meeting Minutes**

**July 21, 2023**

**Zoom**

**Recording:** [**https://clipchamp.com/watch/FldJTVscmig**](https://clipchamp.com/watch/FldJTVscmig)

**Attendees listed at end of document**

Recent & upcoming meetings

* June – overview of draft governance charter
* July – discussion on 2023 HUD funding round principles
* August – finalization of governance charter & vote

2023 CoC Funding Round Guiding Principles

* Slides saved in Governance Board Minutes folder
* Guiding principles for 2022 funding round:
  + Project expectations:
    - All projects must be Housing First
    - Increasing PSH greatest priority with any additional funds
    - Reallocation is voluntary
  + Values:
    - Equity
    - Inclusion of people with lived experience
    - Involvement of marginalized communities
  + Ranking:
    - HMIS and Coordinated Entry guaranteed Tier 1 placement (HUD requirement)
    - Ranking Committee reviews, scores, & ranks all applications
* Summary of 2022 Competitive debrief
  + Score in range to lose funds
  + Most points lost for not leveraging housing and healthcare, lack of coordination with PHAs, and HUD System’s performance measures, especially length of time homeless
  + Gained 1 program in 2022 – DV RRH
* Expectation for 2022
  + Expecting to lose SPM points for increase in homeless numbers
  + Likely to lose funds if not leveraging housing and or healthcare
* Leveraging housing
  + Must be 25% of funds for housing from non-CoC or ESG source, including PHAs. Documentation of commitment required
  + Easiest way to do this is through set aside vouchers through partnership with PHAs
  + Does HUD require PHAs to cooperate with this or have incentives to partner?
    - Although HUD funds PHAs, the onus and accountability for partnership seems to be on CoCs
    - Federal entities seem careful not to tell one another what to do
    - Historically there has been a lot of pushback PHAs as they want to use local discretion
    - EHVs make a good argument for having homeless preference for vouchers and on a state level there does seem to be interest in this
    - CDCLI just took over Nassau County and Hempstead vouchers, and it looks promising to get set asides from them
    - For smaller PHAs things can be challenging as they may have a small total amount of vouchers to begin with and they already have challenges with utilization rates, making them more risk averse
    - EHVs and stability vouchers were required by HUD to have to work with CoCs to receive all of their referrals through Coordinated Entry. Not a lot has been done to change housing choice voucher (HCV) requirements, but it does seem that new programs are changing. Youth independence vouchers are strongly but not required to work with CoCs.
    - EHV shows that having homeless preferences can be successful, making PHAs more willing to work with CoCs in the future.
    - Local PHAs such as CDCLI had state vouchers pass through that were dedicated according to a state, not local administrative plan.
    - Connie Bruno has moved from CDCLI to the state level Section 8 and has included language into a state amendment about set asides
    - A few years ago, a bunch of vouchers came into Suffolk County because of a set aside. This could happen again through CDCLI where we could potentially have a lot of new vouchers
* Leveraging healthcare
  + Contributions from public or private healthcare provider of up to 25% for points
  + Healthcare provider eligibility cannot restrict eligibility for the housing program
  + How might this work locally? Would this work if there was an agreement between a program and healthcare provider for their participants to receive services at the health care provider site?
    - Yes, this would probably work similar to a match component, where 25% of the grant amount can be reimbursed through Medicaid or an insurance provider as long as HUD is not paying
  + For specific healthcare services, such as substance abuse, you must consider whether there are enough individuals in need of those services to serve 25% of participants
    - For example, HIV services may not be applicable
* Bonus funds
  + Bonus could be up to $1 million, or we could lose 7% for programs that are not in Tier 1 (93%). We could potentially lose anything that falls into Tier 2, up to $1 million.
  + This emphasizes importance of prioritizing leveraged program
  + We might not want to be too aggressive in telling people not to apply without leveraging, because we don’t want to lose providers.
    - Leveraging refers to new programs only.
    - If we get leveraged programs, we can likely keep everything that we have and get new funds.
    - We are not suggesting cutting any existing programs, but given the ranking some programs may be cut if we lose funds
* Do we follow up with specific providers about submitting applications
  + We have been working on identifying agencies that may be able to leverage given what we have in house over the past year
* It seems as though including applications that include leveraging would get us the points. By prioritize, are you suggesting prioritize over other new programs or over all other programs? Including renewals?
  + Seems like we get the points for applying, regardless of where they are included in the ranking
  + It is up to GB and RC to decide where it would be prioritized
  + So much of score is data-driven now, we are close to line to lose funds. If we don’t leverage, we are unlikely to get any new funds
  + Prioritizing program to likely to get funded with leveraging will help us not be in the same position next year.
  + Weight of those programs in ability to help entire CoC is significant. We also do not want to discourage partners such as PHAs which are already difficult to get on board.
  + Retention rates for PSH for people coming off the street is lower than RRH and single adult homelessness is the number one negative impact on systems performance. If new leveraged application can meet a greater need objectively than existing programs, there is an argument that program should be prioritized
    - For example HCV for long-term homeless families with 5+ year homeless
    - Single adult program with leveraged healthcare when programs often do not have services to meet needs
    - Might be based on specifics, such as population served
    - Could make sense to rank above existing programs
* For current providers looking to apply, it would have to be an expansion or new project to get the leveraging points
  + Why? Based on HUD is specifically asking us to add new capacity
  + Existing program could expand in number of units or participants served
  + There are some advantages to doing small expansion, because demonstrated to be able to operate. Small expansion means small number of units leveraged
  + Can still receives points for leveraging less than 25% - **could require new applicants to leverage something as not to discourage new applications because can get partial points**
  + Existing programs are likely already leveraging housing and healthcare
    - SPA would not count because additional requirements are in place to access the healthcare
  + Aging adults is one of greatest needs with data and with survey – leveraging medical care for this population could be very helpful to the CoC
  + Providers can leverage services within own agency, may be very viable. Follow up meetings can help problem solve together
  + A new program could leverage both housing and healthcare and we could get even more points – does not need to be an either/or
    - Couldn’t have percentage of each total to 25%, percentages are looked at separately
  + No timelines have been put out yet?
    - We did not want to put out local application without discussing with GB and RC about what we wanted to consider and guiding principles
    - If we decide we are limiting or not, this would impact ranking tools that we send out
    - Application due to HUD at end of September, everything needs to be in and ranked and finalized by 30 days before that
  + Prioritizing – anytime you do that for new programs, there is a situation of comparing data at outcomes with narratives and plans
    - There is a risk of new programs not delivering
    - The idea is not to rank above every existing program, but there are poorer performing programs in our region. Could make sense to put in bottom of Tier 1
    - We also have new programs that are not yet operating or have data to compare
* We need to look at guiding principles – change, add, remove
  + Ranking Committee can make detailed prioritization decision
  + Will accept new projects that are PSH and RRH, but prioritize PSH over RRH
  + Vote: Limit new applications to those will leverage some percentage
    - Passed
  + Add narrative to meet the needs of LGBTQ+ households on renewal & new applicants?
    - Renewal application has already gone out in finalized form. Are we looking to amend? Or add to scoring criteria?
      * Something to be considered for scoring next year
    - New programs – scoring on non-gender restricted units, speak to unit configurations “meeting participant needs”
    - How do we get around single gender units for mental health, given the trauma that people have experienced?
      * Not meeting needs of nonbinary individuals
    - Often not restricting beds, but trying to figure out what works in the house
    - SPA – all beds are gender typed, can change after the fact. Bigger conversation with OMH is needed
    - **Ask all applicants about** **efforts to include LGBTQ+ individuals – won’t be scored for renewals, scored for new programs**
    - Develop standard operating procedure for future
  + Prioritization of sub-populations
    - People with disabilities – already aligned with PSH
    - Re-entry – critical time is after leaving incarceration, PSH is out off the bat because beds must be chronic dedicated
    - **Points included for new programs that** **serve under served populations in ranking review**
  + DV bonus still available? If so, would we consider these programs?
    - **DV must also meet leveraging requirement**
      * Healthcare service easy to leverage
      * DV providers could not apply for PSH due to lack of need
    - New DV programs least likely to be funded given inability to demonstrate the need & requires additional work
    - There is a significant DV waitlist, but HUD wants to see households that are literally homelessness for demonstrating the need
    - Realistically, we are unlikely to get DV bonus funds whether there are applicants are not – based on regional competitive score
      * Turnaround window will be 3 weeks, less time for completing additional application questions for DV

Attendees

Donna O’Hearon, Mercy Haven

Vicki McGuinn, Suburban Housing

Stephen Brazeau, Hope House Ministries

Deirdre Trumpy, MOMMAS House

Allison Covino, Options

Greta Guarton, LICH

Terray Gregoretti, The Safe Center LI