FL-513 Brevard County Continuum of Care 2023 – 2026 Strategic Plan

Prepared by:
The Brevard Homeless Coalition, Inc.

Our Journey

The Brevard Continuum of Care (CoC) 2023-2026 strategic plan represents a year-long process filled with focused conversations, workshops, research, and trend analysis of Housing and Urban Development (HUD)-required reporting such as the Point-In-Time Count (PITC). The update to our previous 3-year strategic plan began in earnest in May 2022. The Brevard Homeless Coalition (BHC), which serves as the Lead Agency for the Brevard CoC, began to hold focus group sessions within the existing CoC structure, including the General Membership and the Advisory Council members. Focus group sessions were also held with the BHC's Board of Directors. These conversations were invaluable and helped to guide further discussions with both member and non-member organizations. The BHC asked questions such as:

- What is the current strategic plan missing?
- What are our core community values relating to individuals and families experiencing homelessness?
- How is our population changing?
- What are the assets and gaps in our system of care?
- How do we align with national and state goals?

We then further honed in on seven key areas that warranted additional discussion, and again asked questions of providers working in these areas about gaps and barriers in the delivery of services. The seven key areas were:

1. Domestic violence and human trafficking
2. Healthcare services
3. Institutional discharge planning
4. Lived experience
5. Special populations, such as the elderly and the elderly with memory disorders
6. Street outreach
7. Youth homelessness

Holding a health equity forum, in November 2022, provided invaluable information in the development of the strategic plan through the lens of equitable access of our CoC services.
During this time, Brevard County spearheaded the development of the federal HOME-American Rescue Plan Act (ARP) Allocation Plan, in partnership with other HOME Consortium entities: the City of Cocoa, City of Melbourne, City of Palm Bay, and the City of Titusville. The County engaged the Cloudburst Group as consultants to hold focus groups with County and municipality staff and provider agencies, and to develop the Allocation Plan. We tapped into this robust process as well to gain additional learnings and to ensure consistencies as our respective plans were developed.

From all of these conversations, key themes and areas of need began to emerge:

- Expansion of the number of individuals and agencies serving as active members in the Continuum of Care to increase community-wide collaboration, resource generation, and visibility as a powerful voice for homelessness in the community. All sectors of the community will come to the table to make homelessness a rare, brief, and one-time experience.
- Increase the number of individuals with lived experience on CoC committees, provide pathways for leadership roles with other organizations and opportunities for employment and increased income.
- Prioritize case managers through on-going training in management best practices, and an industry-standard caseload in an effort to reduce turnover and burnout.
- Conduct GIS-based asset mapping to better understand our strengths and gaps.

- Develop more affordable housing units to keep pace with the growing needs of our community, especially for our most vulnerable to homelessness, and those in service and educational sectors, as a prevention strategy for staying stably housed.
- Collaborate with Brevard County, local city officials and staff, and private sector real estate/development companies to address health inequities within the community, including barriers to an efficient transportation network and affordable housing policies.
- Increase the number of shelters and housing units dedicated to special populations: the elderly, elderly with memory disorders, and individuals with intellectual and physical disabilities.
- Increase the number of agencies and users reporting in the Homeless Management Information System (HMIS) to accurately track in real-time performance measurements for communications to the community at large, advocacy, data gathering for funding opportunities, and to ensure adherence to HUD funding priorities.
- Finally, walk in partnership with the private sector real estate/development companies to facilitate the development of affordable housing.

No small tasks here!

These key themes led us down the path of viewing our strategic plan through our core values and belief statements:

We believe…

- *Housing is Healthcare.*
- In taking *A Whole Person Approach* – mentally, emotionally, physically, spiritually, and relationally.
- Providing *Care for Case Management*, both for the client and the case manager.
- In *Equity* with equitable access to all parts of the Continuum of Care.

With those core values, the *Housed & Healthy Brevard Strategic Plan 2023-2026,* came into focus. At the BHC, our mission is to make homelessness a rare, brief, and non-reoccurring event for our community friends and neighbors. Together with the Brevard CoC, five key goals will lay the foundation for our success:

Strengthen. Strengthening the existing foundation for our Continuum of Care through governance, funding, and community engagement. The CoC represents the ground floor from which all other priorities are supported.

Reduce. Reducing the number and length of time people experience homelessness, including those who are chronically homeless and those fleeing domestic violence. To accomplish this, we must expand upon a diversified outreach approach to meet our most vulnerable populations where they are and grow our Coordinated Entry System for streamlined and efficient placement into housing. Utilizing our By Name List will ensure we are always keeping the client in the forefront of the process.

Prevent. Prevention is a first, best strategy. Preventing housing instability by increasing educational, social, health, and financial service supports to our most vulnerable populations, including

our veterans. Partnerships with area agencies will help us to achieve this with the goal of embedding programs and practices into our Coordinated Entry process. When we think about prevention, we also think about our system's case managers and the encompassing role they play in keeping clients stably housed and healthy through diversion and other efforts. As a CoC, we prioritize supporting our case managers through high quality educational opportunities, emotional support, and best practice caseloads to mitigate burn out and system turnover.

Build. Building upon and creating new multi-sector partnerships thereby increasing the number of affordable housing units, and shelter beds through innovative solutions. Our Continuum of Care and the Brevard Homeless Coalition as the Lead Agency place a special focus on those individuals who are elderly, elderly with memory disorders, those who are physically or cognitively disabled as well as individuals within our Coordinated Entry system. Building new units is a longer-term goal as the planning and development process takes time. But we can start developing the relationships now. More immediately, we can grow our number of shelter, rapid re-housing, and permanent supportive housing beds and have set an ambitious goal to do so.

Share. Sharing stories of homelessness and vulnerability within the CoC and to the broader community. Data is a powerful tool in storytelling. Documenting with fidelity in HMIS will allow the CoC and Lead Agency to turn data analytics into a compelling narrative. Sharing the human experience grounds the data on a personal level.

Our plan sets forth ambitious goals and objectives coupled with key measurements of success. These measurements are largely based on HUD's System Performance Measures, which are utilized to assess CoC's nationwide, the HUD Longitudinal Systems Analysis (LSA), the 2023 PITC, and the 2023 Housing Inventory Count. The plan also sets forth the structure for CoC committees and workgroups.
Finally, we'd like to thank all of our CoC members, the CoC Advisory Council, the BHC Board of Directors, and the many individuals who shared their vision for a *Housed & Healthy Brevard*.

Join us in making our vision a reality.

STRENGTHEN

Strengthening the foundation of our CoC.

Strengthen the existing foundation for our Continuum of Care (CoC) through governance, funding, and community engagement. The CoC represents the ground floor from which all other priorities are supported.

Objectives

- Committee structure guidance
- Lead agency support
- Homeless Management Information System (HMIS) participation
- Partnership growth and alignment

Measurements

Establishment of Committees	# of Households	New Partners in CoC
Committee structures are in place and approved by the CoC.	Increase # of HMIS participating agencies and projects.	Increase # of partner agencies addressing homelessness issues aligned with strategic plan.

Action Plan

Objective	Year 1 Action Items
Committee Structure Guidance	• The CoC Advisory Council shall evaluate and establish committees. • Develop guidelines and policies to formalize governance and other CoC operational structures. • Develop guidelines and policies to assist the CoC in recruitment of members for each committee based on experience, including those with lived experience. • Develop committee action plans based on a community approach to the end goals of the strategic plan.

Lead Agency Support	• Partner with the lead agency to identify funding opportunities benefiting the CoC. • Support CoC lead agency applications for funding by accurately documenting client services in the Homeless Management Information System (HMIS) to demonstrate community needs.
HMIS Participation	• Evaluate broader community support for document/access. • Conduct provider monthly checks. • Conduct quarterly data quality check in preparation of the annual Longitudinal Systems Analysis and Systems. Performance Measures report. • Track and report on By Name List in HMIS through a dashboard system.

Partnership Growth and Alignment	• Create matrix of aligned strategic plan elements with Brevard County Housing and Human Services plans:
	    • HOME-ARP Allocation Plan for HOME Consortium (Brevard County, Cocoa, Titusville, and Palm Bay)
	    • HOME Consortium 2022-2026 Consolidated Plan
	    • CAPER Report
	    • SHIP Program
	    • CDBG Program
	• Create matrix of aligned strategic plan elements with:
	    • Brevard County Health Department
	    • Area housing authorities
	    • Behavioral Health Needs Assessment
	    • Community Health Needs Assessment
	• Convene a workgroup consisting of CoC committee members and transportation provider leadership and staff focused on transportation issues related to accessibility of services.
	• Determine roles for the CoC and transportation providers in closing the transportation gap.
	• Create a working document between the CoC and transportation providers to address transportation gaps and needs.
	• Identify intersections for collaboration and pilot projects.

Objective	Year 2 Action Items
Committee Structure Guidance	• CoC Advisory Council will provide guidance to identified CoC committees. • Implement guidelines and policies to continue recruitment of members for each committee based on experience, including those with lived experience. • Implement committee action plans.
Lead Agency Support	• Partner with the lead agency to identify funding opportunities benefiting the CoC. • Support CoC lead agency applications for funding by accurately documenting client services in HMIS to demonstrate community needs,
HMIS Participation	• Adjust HMIS written standards based on learnings from evaluation of broader community support for document/access. • Conduct provider monthly data quality checks. • Conduct quarterly data quality check in preparation of the annual Longitudinal Systems Analysis and Systems Performance Measures report. • Track and report on By Name List in HMIS through a dashboard system.
Partnership Growth and Alignment	• Convene workgroup consisting of CoC committee members and local government officials and staff to discuss identified alignment of strategic plan goals. • Create shareable outcomes between the CoC and local government and other entities. • Develop a measurement and tracking system for shareable outcomes. • Implement working document between the CoC and transportation providers. • Expand upon existing transportation resources. • Communicate resources to providers. • Begin to develop pilot projects with local government/other entities and transportation providers.

Objective	Year 3 Action Items
Committee Structure Guidance	• Continue to implement guidelines and policies to continue recruitment of members for each committee based on experience, including those with lived experience. • Continue to implement committee action plans. • Evaluate current committee structures and operations. • Evaluate guidelines and policies of CoC operational structures. • Evaluate the guidelines and policies that assist the CoC in recruitment of members for each committee. • Evaluate committee action plans.
Lead Agency Support	• Partner with the lead agency to identify funding opportunities benefiting the CoC. • Support CoC lead agency applications for funding by accurately documenting client services in HMIS to demonstrate community needs.
HMIS Participation	• Conduct provider monthly data quality checks. • Conduct quarterly data quality check in preparation of the annual Longitudinal Systems Analysis and Systems Performance Measures report. • Track and report on By Name List in HMIS through a dashboard system.
Partnership Growth and Alignment	• Continue to meet as a workgroup to implement potential pilot projects and ensure connections for existing resources. • Implement a measurement and tracking system for shareable outcomes. • Continue to implement working document between the CoC and transportation providers. • Implement and evaluate, if applicable, pilot projects/plans to address transportation gaps and barriers. • Expand upon existing transportation resources. • Communicate resources to providers.

REDUCE

Reducing homelessness for vulnerable populations.

Reduce the number and length of time of people experiencing homelessness, including those who are chronically homeless, and those fleeing domestic violence. This priority area calls for the expansion of diversified outreach to our most vulnerable populations and of the Coordinated Entry system.

Objectives

- Coordinated Entry
  - Diversified outreach and access
  - Expand participating agencies
  - Increase successful program enrollment & engagement
- Reduce the number of chronically homeless individuals
- Reduce the number experiencing homelessness due to fleeing domestic violence

Measurements

of Households

Reduce the # of households and people served in the homeless system. **2023 is expected to reflect an increase in this # before a decrease in years 2 & 3 due to expanded diversified outreach and implementation of ERA funding.

2023:	2026:
1732 Households 2675 Individuals	1300 Households 2000 Individuals

of Days

Reduce the average # of days homeless.

2023:	2026:
188 Avg.	141 Days

% Exits

Increase the percentage of successful permanent housing placements and/or retention.

2023:	2026:
48%	73%

Action Plan

Objective	Year 1 Action Items
Coordinated Entry - Diversified Outreach & Access	• Reduce HMIS System Performance Measure 1 (Length of time persons remain homeless) by at least 5% in Year 1. • Maintain HMIS System Performance Measure 3 (Number of homeless persons) in year 1. • Increase HMIS System Performance Measure 7 (Successful placement from diversified outreach into or retention of permanent housing) by 5% each year. • Report on action items at each CoC General Membership meeting.
Coordinated Entry - Expand Participating Agencies	• Utilize the By Name List to ensure the process is client-provider specific. • Widely distribute a de-identified By Name List as a provider and community engagement tool. • Identify additional resources for provision of housing options for those on the By Name List.
Coordinated Entry - Increase Program Enrollment and Engagement	• Identify provider program requirements, capacity, and strengths to better match client referrals. • Create strategy for higher provider engagement level in Coordinated Entry placement. • Reflect participation in Coordinated Entry in the Monthly Data Report Card. • Expand HMIS referral process to include 211 Eligibility Module tool for screening/verification for programs.

Reduce the Number of Chronically Homeless Individuals	• Collaborate with the CoC lead agency to bring federal funding, including the Emergency Solutions Grant (ESG) funding, into our community. • Expand outreach efforts to identify those who are chronically homeless and enroll them in the HMIS. • Expand partnerships with the non-profit, for-profit business and organizations, healthcare, faith-based institutions, local government, law enforcement, and others to strengthen the safety net of services and communication around homelessness issues and solutions to chronic homelessness.
Domestic Violence - Reduce the Number Experiencing Homelessness	• Identify resources for those individuals and families fleeing domestically violent situations through the asset mapping process.

Objective	Year 2 Action Items
Coordinated Entry - Diversified Outreach & Access	• Reduce HMIS System Performance Measure 1 (Length of time persons remain homeless) by at least 5%. • Reduce HMIS System Performance Measure 3 (Number of homeless persons) by 5%. • Increase HMIS System Performance Measure 7 (Successful placement from diversified outreach into or retention of permanent housing) by 5%. • Report on action items at each CoC General Membership meeting.
Coordinated Entry - Expand Participating Agencies	• Continue to utilize the By Name List to ensure the process is client-provider specific. • Continue to widely distribute a de-identified By Name List as a provider and community engagement tool. • Continue to identify additional resources for provision of housing options for those on the By Name List.

Coordinated Entry - Increase Program Enrollment and Engagement	• Monitor participation in Coordinated Entry in the Monthly Data Report Card.
Reduce the Number of Chronically Homeless Individuals	• Continue to collaborate with the CoC lead agency to bring federal funding, including the Emergency Solutions Grant (ESG) funding, into our community. • Continue to expand outreach efforts to identify those who are chronically homeless and enroll them in the HMIS. • Continue to expand partnerships with the non-profit, for-profit business and organizations, healthcare, faith-based institutions, local government, law enforcement, and others to strengthen the safety net of services and communication around homelessness issues and solutions to chronic homelessness.
Domestic Violence - Reduce the Number Experiencing Homelessness	• Develop additional safe housing beds in partnership with local governments and community partners. • Develop a comparable database and coordinated entry process for those feeling domestic violence in partnership with domestic violence providers.

Objective	Year 3 Action Items
Coordinated Entry - Diversified Outreach & Access	• Reduce HMIS System Performance Measure 1 (Length of time persons remain homeless) by at least 5%. • Reduce HMIS System Performance Measure 3 (Number of homeless persons) by 5% in year 3. • Increase HMIS System Performance Measure 7 (Successful placement from diversified outreach into or retention of permanent housing) by 5%. • Report on action items at each CoC General Membership meeting.
Coordinated Entry - Expand Participating Agencies	• Continue to utilize the By Name List to ensure the process is client-provider specific. • Continue to widely distribute a de-identified By Name List as a provider and community engagement tool. • Continue to identify additional resources for provision of housing options for those on the By Name List.
Coordinated Entry - Increase Program Enrollment and Engagement	• Continue to monitor participation in Coordinated Entry in the Monthly Data Report Card.
Reduce the Number of Chronically Homeless Individuals	• Continue to collaborate with the CoC lead agency to bring federal funding, including the Emergency Solutions Grant (ESG) funding, into our community. • Continue to expand outreach efforts to identify those who are chronically homeless and enroll them in the HMIS. • Continue to expand partnerships with the non-profit, for-profit business and organizations, healthcare, faith-based institutions, local government, law enforcement, and others to strengthen the safety net of services and communication around homelessness issues and solutions to chronic homelessness.

Domestic Violence - Reduce the Number Experiencing Homelessness	• Develop additional safe housing beds in partnership with local governments and community partners. • Implement a comparable database and coordinated entry process for those feeling domestic violence.

PREVENT

Preventing housing instability through education, healthcare, case management.

Prevent housing instability by increasing educational, social, health, and financial service support to our most vulnerable populations including our veterans. Prevention is a first, best strategy. Case management holds the key to providing the support and connections needed to guide people toward stability. In turn, we hold the key to supporting our Case Managers through high quality educational opportunities, emotional support, and case management best practices.

Objectives

- Grow partnerships
- System performance measurement
- Support case management through best practice training & education
- Communicate clear pathways for support
- Identify funding

Measurements

First Time
Prevent first-time homelessness by reducing the # of individuals accessing the CoC.

2023:	2026:
1442	1081

Household Stability
Increase job and income growth for the CoC Program participants.

2023:	2026:
Employment Income: 24% Non-earned Income: 7%	Employment: 49% Non-earned: 34%

Returns
Prevent returns to homelessness after permanent Placement within year one and year two.

2023:	2026:
Within Year 1 -11% Within Year 2 – 26%	Year 1 -8% Year 2 -10%

Action Plan

Objectives	**Year 1 Action Items**
Grow Partnerships	• Identify ways to integrate CareerSource Crosswalk with Coordinated Entry process • Expand healthcare resources and collaborate with state and local public health agencies to develop policies and procedures to respond to and prevent infectious disease outbreaks. • Create discharge planning protocols with state and local entities to ensure that those discharged do not become homeless.
System Performance Measurement	• Reduce System Performance Measure 5 (Number of persons who become homeless for the first time) by 5%. • Reduce HMIS System Performance Measure2 (Persons who exit homelessness to permanent destination and returns to homelessness) by 5%.
Support Case Management - Training	• Consider resuming Monthly Provider meetings for ongoing education/trainings. • Provide high quality, educational training opportunities for case management.
Support Case Management - Education	• Provide education for the community surrounding housing stability resources. • Share information related to public health measures to ensure providers are equipped to prevent or limit infections disease outbreaks.
Communicate Clear Pathways for Support	• Identify strategies to support long term case management of 24+ months. • Support case managers through emotional support, and case management best practices.

Identify Funding	• Identify funding specifically to address housing stabilization and long-term case management. • Identify funding specifically to address healthcare.

Objectives	**Year 2 Action Items**
Grow Partnerships	• Begin integration of CareerSource Crosswalk with Coordinated Entry process • Continue to expand healthcare resources and collaborate with state and local public health agencies and finalize policies and procedures to respond to and prevent infectious disease outbreaks. • Implement discharge planning protocols with state and local entities to ensure that those discharged do not become homeless.
System Performance Measurement	• Reduce System Performance Measure 5 (Number of persons who become homeless for the first time) by 5%. • Reduce HMIS System Performance Measure2 (Persons who exit homelessness to permanent destination and returns to homelessness) by 5%.
Support Case Management - Training	• Consider resuming Monthly Provider meetings for ongoing education/trainings. • Provide high quality, educational training opportunities for case management.
Support Case Management - Education	• Continue to provide education for the community surrounding housing stability resources. • Share information related to public health measures to ensure providers are equipped to prevent or limit infections disease outbreaks.

Communicate Clear Pathways for Support	• Implement strategies to support long term case management of 24+ months. • Support case managers through emotional support, and case management best practices.
Identify Funding	• Pursue funding specifically to address housing stabilization and long-term case management. • Pursue funding specifically to address healthcare.

Objectives	**Year 3 Action Items**
Grow Partnerships	• Integrate CareerSource Crosswalk with Coordinated Entry process. • Continue to expand healthcare resources and collaborate with state and local public health agencies and implement policies and procedures, when applicable, to respond to and prevent infectious disease outbreaks. • Implement discharge planning protocols with state and local entities to ensure that those discharged do not become homeless.
System Performance Measurement	• Reduce System Performance Measure 5 (Number of persons who become homeless for the first time) by 5%. • Reduce HMIS System Performance Measure2 (Persons who exit homelessness to permanent destination and returns to homelessness) by 5%.
Support Case Management - Training	• Consider resuming Monthly Provider meetings for ongoing education/trainings. • Provide high quality, educational training opportunities for case management.

Support Case Management - Education	• Continue to provide education for the community surrounding housing stability resources. • Share information related to public health measures to ensure providers are equipped to prevent or limit infections disease outbreaks.
Communicate Clear Pathways for Support	• Continue to implement strategies to support long term case management of 24+ months. • Support case managers through emotional support, and case management best practices.
Identify Funding	• Continue to identify and pursue funding specifically to address housing stabilization and long-term case management. • Continue to identify and pursue funding specifically to address healthcare.

BUILD

Building homes, shelter beds, resources, and partnerships.

Build upon and create new multi-sector partnerships to increase the number of affordable housing units, and shelter beds through innovative solutions. The CoC and Lead Agency place a special focus on those individuals who are elderly, elderly with memory disorders, those who are physically or cognitively disabled as well as individuals as established by the Coordinated Entry process.

Objectives

- GIS asset mapping
- Flow process from shelter beds into PSH/RRH units
- Increase supply of shelter beds and permanent housing units to include affordable housing, rapid rehousing, and permanent supportive housing

Measurements

# of Homes
Increase the number of Rapid Rehousing and Permanent Supportive Housing Beds available. Increase 25% each year.

2023:	2026
RRH – 920	R.R.H. 1800
PH/PSH – 207	P.S.H. 400
PH/OPH – 236	O.P.H.

# of Shelter Beds
Increase the number of Shelter Beds available. Increase 25% each year. 2022 HIC Total #: 615

2023:	2026:
ES – 221	1200
SH – 21	
TH – 373	

Action Plan

Objectives	Year 1 Action Items
GIS Asset Mapping	• Identify the GIS asset mapping tool. • Research existing GIS data for inclusion: County, City consolidated plans; transportation partners; providers to identify unit locations. • Create database layers geared toward those in economic transitions or by economic strata. • Identify consultant or BHC staff to conduct the asset map process.
Flow Process - Shelter Beds to PSH/RRH	• Develop a flow process with providers to streamline clients transition from shelter into permanent housing. • Increase capacity to provide housing focused shelter beds. • Identify opportunities for the development of new drop in and overnight shelters with non-profit and for-profit organizations, and local/state government partners. • Conduct barrier assessment for accessing shelter beds to ensure the beds meet needs of different demographics, such as seniors and gender-neutral individuals.
Increase Supply of Shelter, PSH, and RRH Beds	• Partner with Public Housing Agencies (PHAs) on admission preferences for households experiencing homelessness, including move-on strategies. • Identify opportunities for the development of new PSH units with non-profit and for-profit organizations, and local/state government partners. • Identify shelter housing opportunities for transition-age youth and for those aging out of the foster care system. • Finalize landlord risk mitigation program to provide security for landlords.

Increase Affordable Housing Supply	• Identify current affordable housing supply. • Work with County and Cities to reform zoning and land use policies to reduce regulatory barriers to development and permit more housing development. • Support shared accommodations for elderly populations through existing County and non-profit efforts. • Build upon and create new partnerships to increase the number of affordable housing units for the general population including a focus on the elderly, elderly with dementia/Alzheimer's, and individuals with physical and cognitive disabilities. • Expand partnerships with proprietors willing to provide affordable housing units. • Seek opportunities to leverage funding in partnership with opportunity zones, Community Redevelopment Agencies (CRAs) and bring more opportunity zones into the County. • Engage business community regarding generation of resources for new and existing employees. • Engage with Chambers of Commerce and realtors' association.

Objectives	**Year 2 Action Items**
GIS Asset Mapping	• Begin to conduct GIS asset mapping of CoC. • Based on asset mapping data, ensure at least 85 percent of the beds in the CoC's geographic area are covered in HMIS.
Flow Process - Shelter Beds to PSH/RRH	• Begin implementation of flow process with providers to streamline clients transition from shelter into permanent housing. • Continue to increase capacity to provide housing focused shelter beds. • Continue to identify opportunities for the development of new drop in and overnight shelters with non-profit and for-profit organizations, and local/state government partners. • Analyze barrier assessment for accessing shelter beds to ensure the beds meet needs of different demographics, such as seniors and gender-neutral individuals.

Increase Supply of Shelter, PSH, and RRH Beds	• Continue to partner with Public Housing Agencies (PHAs) on admission preferences for households experiencing homelessness, including move-on strategies. • Continue to identify opportunities for the development of new PSH units with non-profit and for-profit organizations, and local/state government partners. • Continue to identify shelter housing opportunities for transition-age youth and for those aging out of the foster care system. • Begin implementation of landlord risk mitigation program to provide security for landlords.
Increase Affordable Housing Supply	• Continue to identify affordable housing supply. • Continue to work with County and Cities to reform zoning and land use policies to reduce regulatory barriers to development and permit more housing development. • Continue to support shared accommodations for elderly populations through existing County and non-profit efforts. • Continue to build upon and create new partnerships to increase the number of affordable housing units for the general population including a focus on the elderly, elderly with dementia/Alzheimer's, and individuals with physical and cognitive disabilities. • Continue to expand partnerships with proprietors willing to provide affordable housing units. • Continue to seek opportunities to leverage funding in partnership with opportunity zones, Community Redevelopment Agencies (CRAs) and bring more opportunity zones into the County. • Continue to engage business community regarding generation of resources for new and existing employees. • Continue to engage with Chambers of Commerce and realtors' association.

Objectives	Year 3 Action Items
GIS Asset Mapping	• Conduct GIS asset mapping of CoC. • Based on asset mapping data, ensure at least 85 percent of the beds in the CoC's geographic area are covered in HMIS.
Flow Process - Shelter Beds to PSH/RRH	• Continue to work with County and Cities to reform zoning and land use policies to reduce regulatory barriers to development and permit more housing development. • Develop pilot projects/plans with new partnerships to increase the number of affordable housing units for the general population including a focus on the elderly, elderly with dementia/Alzheimer's, and individuals with physical and cognitive disabilities. • Continue to expand partnerships with proprietors willing to provide affordable housing units.
Increase Supply of Shelter, PSH, and RRH Beds	• Continue to increase capacity to provide non-congregate shelter beds. • Develop action steps to create identified opportunities for the development of new drop in and overnight shelters with non-profit and for-profit organizations, and local/state government partners.
Increase Affordable Housing Supply	• Continue to grow partnership with Public Housing Agencies (PHAs) on admission preferences for households experiencing homelessness, including move-on strategies. • Develop pilot projects/plans for the development of PSH units with non-profit and for-profit organizations, and local/state government partners.

SHARE

Sharing our story through data.

Share stories of homelessness and vulnerability within the CoC and to the broader community. Data is a powerful tool in storytelling. Documenting with fidelity in HMIS will allow the CoC and Lead Agency to turn data analytics into a compelling narrative. Sharing the human experience grounds the data on a personal level.

Objectives

- Data analytics
- Community dashboard
- Communicate stories of homelessness

Measurements

System Performance Measurement SPMs reflect Strategic Plan goals.	**Dashboard** Dashboard provides data/measurements for use by providers and media.	**Communication** # of articles and social media posts on providers and homeless issues.

Action Plan

Objectives	**Year 1 Action Items**
Data Analytics	• Analyze key data metrics from providers monthly via an agency scorecard. • Analyze quarterly checks of LSA data quality components for annual submittal to HUD. • Analyze System Performance Measures on quarterly basis.
Community Dashboard	• Select a vendor to assist with the creation of a community dashboard on the BHC website.

Communicate	• Partner with media outlets to share stories of individuals and families experiencing homelessness. • Provide educational materials and share stories from individuals and families on the impact of mental health and substance use in homelessness. • Develop a 1-pager for use by providers on the role of the CoC.

Objectives	**Year 2 Action Items**
Data Analytics	• Analyze key data metrics from providers monthly via an agency scorecard. • Analyze quarterly checks of LSA data quality components for annual submittal to HUD. • Analyze System Performance Measures on quarterly basis.
Community Dashboard	• Create community dashboard on BHC website • Share the website dashboard with the community at large.
Communicate	• Partner with media outlets to share stories of individuals and families experiencing homelessness. • Provide educational materials and share stories from individuals and families on the impact of mental health and substance use in homelessness.

Objectives	**Year 3 Action Items**
Data Analytics	• Analyze key data metrics from providers monthly via an agency scorecard. • Analyze quarterly checks of LSA data quality components for annual submittal to HUD. • Analyze System Performance Measures on quarterly basis.
Community Dashboard	• Continue to share the website dashboard with the community at large.
Communicate	• Partner with media outlets to share stories of individuals and families experiencing homelessness. • Provide educational materials and share stories from individuals and families on the impact of mental health and substance use in homelessness.

Prevent
Reduce
Build
Strengthen
Share
Housed & Healthy Brevard
Brevard CoC Strategic Plan 2023-2026
Strengthening the foundation of our CoC
Reducing homelessness for vulnerable populations.
Preventing housing instability through education, healthcare, case management.
Building homes, shelters, resources, partnerships.
Sharing our story through data.