Guide to Stark County's Experience at the National Conference on Ending Homelessness 2016

Topics in alphabetical order. Notes provided by HCCSC attendees; names and email addresses listed in chart

Topic / Notes	Contact Person(s)
AFFORDABLE HOUSING	
• Affordable housing crisis is at the base of homelessness. Areas are struggling to increase affordable inventories to end homelessness. Many successful areas are turning to the "for-profit" industry to develop affordable housing and having non-profits partner with them, or step-aside. For profit developers are jumping on this model for the tax credits and new "boom" of an industry to sustain and grow their portfolios during an economy that hasn't fully returned to the success of the 1980's.	Shirene Starn-Tapyrik shirene@allianceforchildrenandfamilies.org
CHILD WELFARE AGENCIES, PARTNERING WITH	

• Overall, child welfare agencies that presented stated that they need to improve their assessments of families' housing needs. They often don't think of housing as something that can help them to achieve their goals for the family (i.e. preservation, reunification)
  ○ Child welfare agencies need to be educated on Housing First; shouldn't be using housing as a reward for achieving CW-related outcomes
  ○ Also need to be educated about harm reduction – this is a paradigm shift
• FUP vouchers can be effective when supports are provided at the front door; research showed that they helped families close their cases more quickly and helped preserved families to stay out of the system once exited
• One community identified their "frequently encountered families;" they had higher rates of caregiver DV, substance use, mental health disabilities, and inadequate housing
	Shannon McMahon Williams
	swilliams@scfcanton.org

CHRONIC HOMELESSNESS, ENDING and DOCUMENTATION	
• At time of intake, you can accept only have self-certification for homelessness. However, by 6 months after intake, 3rd party verification needs to be obtained. If you are not able to get the documentation by 6 months, that client will go into the "25% pool" that are self-certification only. • You only need 1 documented homelessness episode in a month to count the whole month for homelessness.	Lisa Snyder LisaS@ican-inc.org

• Accepted documentation: if a client reports to you every month for 3 months that they have slept under a bridge and you document that, it is accepted documentation. You cannot count months you don't know them (only from engagement forward). • 100% of homeless breaks can be documented by self-report. • 25% of total files that are only self-certification are designed for those individuals who have been "off-the-grid"	
• At least 9 months should be by 3rd party; up to 3 months by self-certification • No more than 25% assisted in project can have more than 3 months self cert. • https://www.hudexchange.info/resources/documents/Criteria-and-Benchmark-for-Achieving-the-Goal-of-Ending-Chronic-Homelessness.pdf • Can only count months you know. • If the client stays in an institution less than 90 days and was homeless prior, then the stay counts toward homelessness; if over 90 days, the stay in the institution counts as a break • You have 45 days to get Verification of disability • All States are now sharing their HMIS data since many travel around	Lisa Waikem lwaikem@starkmha.org
• Mainstream services and housing is key • Pro-active out and in reach partners • Prevent when possible • Immediate access to shelters and temp. arrangements • If deceased, no contact for 90+ days, institutionalized for 90+ days, can come off list • Don't lose individual accomplishments with group collaborations • Housing and services and cut system costs by 70% • Working towards housing in 90 days by 12/2016	Michelle Caldwell, MichelleC@Ican-Inc.org
CoC COMPETITION	
• In a "robust" reallocation process, new projects are solicited and the CoC rates all projects objectively, giving new projects as fair of a shot as reallocated projects get • Leveraging requirement has been eliminated	Shannon McMahon Williams swilliams@scfcanton.org

• HUD is releasing applications earlier to get in rapidly approved and awarded prior to change of our President and current administration changes, following the election in November. This will avoid any changes in approved budgets for homeless services, etc.	Shirene Starn-Tapyrik shirene@allianceforchildrenandfamilies.org
COORDINATED ENTRY	

• The greatest success was separating out low barrier needs from high barrier needs and not combining the populations. In many places across the US, the hotline and walk-in sites for these 2 populations are separate and distinct, to drive more successful outcomes for all.
  ○ Lowest barrier persons were triaged quickly and in one type of intake and shelter system. This population was integrated with health care (FQHC), BVR, education, employment for mild mental health/behavioral concerns.
  ○ Highest barrier persons were only referred and permitted in places with constant access to SOAR, BVR, medical care (FQHC) mental health & addiction services and funding exclusively from SMHA, Medicare/Medicaid, and Section 8 subsidy/vouchers.
	Shirene Starn-Tapyrik
	shirene@allianceforchildrenandfamilies.org

COORDINATION BETWEEN SYSTEMS	
• The most successful models were CoCs that had appointed representation on the board from local or state departments that could leverage political support and devote a staff to the mission as a full-time employee, or mandate other department chairs have a seat on the board. Once they were at the table, they took on the mission in their own areas of expertise (i.e. Dept. of Labor, BVR, Mayor's Office) and made the necessary changes or applied for the necessary grants within their fields to bring funding to the homeless population. In return, when the staff at the local employment source learned an applicant was homeless, they sent a referral to the homeless intake system and were given a priority. Much like the homeless intake referral received priority when referred to job openings.	Shirene Starn-Tapyrik shirene@allianceforchildrenandfamilies.org
CRIMINAL JUSTICE INVOLVEMENT AND HOMELESSNESS	
• Diversion techniques: Crisis intervention team (CIT), SOAR, TH beds • Jail in-reach • Coordinated discharge with prisons/jails	Lisa Snyder LisaS@ican-inc.org

CRIMINALIZATION OF HOMELESSNESS

- Loitering, pan handling, etc.—criminal acts
- Police, 911 dispatchers, ER staff get crisis intervention training dedicated to homeless
- Making homeless a crime is unconstitutional
- Interagency council-guidance on how to work with camps
- Data Driven Justice Initiative-divert low level offenders with MI, use data to help break cycle of incarceration
- SAMSHA has toolkit for law enforcement on positive outreach homeless models
- SAMSHA guide to outreach coming this summer
- Homeless impacts largely people of color with law enforcement

Michelle Caldwell,
MichelleC@Ican-Inc.org

EMERGENCY SHELTER

Learn the ways communities are re-designing their emergency shelter systems to align with community-wide goals to end homelessness.

Strategic Plan

- Clear assumptions
- Numerical targets
- Budget implications
- Transition strategy

Program Models/Framework

Front Porch Service	Short Term Placement	Permanent Housing
•Outreach •Prevention	•ES •TH	•RRH •PSH •Affordable Housing

System Modeling

- Establishing assumptions
- Shortest pathway of stops to PH
- Pathway through system, % of each population
- Length of stay at each stop
- HMIS/Coordinated Entry data used to inform assumptions

Tracey Lane
tlane@ywcacanton.org

• GOAL: Minimize number of stops in system on way back to PH • Use data to tell your story • ID leverage points • ID and involve allies	
EMPLOYMENT	
General Overview: • Demands placed on CoCs for incorporating an employment component to ending homelessness and tied to outcome measures, communities are using an assessment tool for "job readiness" and housing. However, they are two different tools, and NOT a service tool. Service tools are only being used for services. Consequently, NO tool was recommended and the term "HYBRID" was constantly used. I didn't hear anyone favoring any single instrument this year (first time in 4 years). When addressing services, the words "supportive services only" were used. All were quick to point out, not to determine housing referrals. Additionally, successful CoCs are embedding the social service world with workforce and have mandatory unified trainings. • Intakes were conducted with the referrals to the hotline by face-to-face and with BOTH an employment specialist and an intake assessor. In 3 of my courses, it was always the same model and is seen as separate and distinct roles and areas of expertise. In each model, the local government employment services provided a full-time staff devoted to this responsibility. Additionally, interagency referrals were made between the two entities. • Major funding sources for the models were started as pilot projects. Then they received grants from Workforce Development Board, Department of Labor, BVR, TANF, SNAP, SMHA, Medicaid, Medicare, SOAR, Section 8 and private funds. **Specific Programs:** **"All Home" – King Co, Seattle, WA. CoC:** Problem: Homeless PIT count up 19% in last yr., being blamed on the jump in rents for 1-bedroom apartments from $100/month to as high as $2,000/month in a 1-yr period. Hence, lack of affordable housing and gentrification. Solution: • Tied education and employment now to the "Front Door" and resources were acquired to have coordinated entry involve a highly specialized employment assessment piece (Not typical hotline worker	Shirene Starn-Tapyrik shirene@allianceforchildrenandfamilies.org

doing assessment. This is an employment specialist employee from the workforce development board. Two distinct roles, housing intake + employment intake that worked in conjunction with each other.)

- Pilot Project was a "connections project" that is now funded through DOL called "Home & Work", a 1-stop to get jobs for homeless job seekers. The project PRIORITIZES jobs to those who are already connected to homeless housing projects and gets them employed 1st! Model is a "Flow Chart" being creative, much like diversion from shelter flow charts. Various pathways relate to the amount of support needed to gain employment by the homeless applicant.

Funding: State Dept. of Labor/Workforce

"The Way Home," Houston, TX CoC:

Problem: Increasing numbers of homeless, lack of positive outcomes, repeated episodes of homelessness, and no improvement in the area of income once housed (neither through employment nor benefits).

Solutions:

- Collaborative leveraged system that provides systems-wide training on homeless culture, special needs employment of homeless and housing first targeting homeless with a **variety** of barriers.
- "Earn While You Learn" system approach that is client centered, combined with supportive housing placements.
- System change began with appointment of board members in January 2016 from Mayor's Office & State Workforce Development agency with mandated participation. Having the Director of the Workforce board in a mandatory seat on the CoC board, the employee from the Mayor's Office, the representatives' collaborative designed how this coordinated access to system of housing and employment would work. Once they created it, they ensured their employees would implement through their intimate knowledge, their respective knowledge of their own systems, and having bought in from their leadership teams. They named their project "Income Now".
- 3-Pronged System: SOAR, Supported Employment, and Public Workforce System are all included.
- Planning team, leadership team, design team, and implementation team were all utilized and headed by CoC appointed board members for subcommittee. Began their work in 2012 and by 2016 had a 50% reduction in homelessness. All attributed to restructure and participation of CoC board members, Mayor's Office, and design model of Income Now, using coordinated access by both hotline intakes and employment intake specialist.
- Embedded social service world trainings with workforce trainings. Shared trainings on an on-going basis are necessary and have resulted in "shared goals/outcomes."
- Now have internal referral process, if employment application discloses homelessness, employment

specialist immediately makes referral to homeless hotline and vice versa and shows both systems can meet people wherever they present. This is especially useful for capturing "street outreach" subpopulation. The employment specialist goes to them wherever they present in those situations. Funding: • Started with a small pilot project grant initiative with 2 workers. Through State Dept. of Labor/Workforce Development Grant • Then with successful outcomes and reduction in homelessness, they were able to receive funding and increase to what are now grants for 14 staff positions for employment and staff has locations at shelters, intake assessment location (hotline) and satellite offices. Insist on face-to-face interviews in this "Employment 1st Model" **Central City, Washington, DC, CoC:** Problem: 13,000 homeless persons annually. Major causes have to do with a lack of affordable housing units, major medical health issues, unemployment, mental health concerns and addictions. Solution: Integrated systems: • FQHCs • Employment – assess each candidate with appropriate supports by barriers • Lowest barriers get triaged FIRST with traditional employment • Quad morbidity get most wrap around intensive service (even those with addictions are employable with supports) • CoC pairs rental assistance with employment. CoC engages City officials to participate on board and commit to funds through prioritizing funding to end homelessness Funding: • SNAP, TANF, WIA, Section 8, Section A, SAMHSA, BVR, USDA, Medicaid/Medicare, Private Funds, Grants, CDBG, etc.	
• SNAP Employment and Training (E&T) program is not well utilized locally; they get funding returned to them each year. Becoming a SNAP E&T provider is rather arduous (must go through the State) but the funding is flexible; can be used for employment, training, admin, support services • In Seattle, coordinated entry asks about income and employment and workforce navigators joined RRH teams. Zero exclusion program ○ CE question: "are you interested in seeking employment for income?" If no: "are you concerned about your benefits?"	Shannon McMahon Williams swilliams@scfcanton.org

• In Chicago, CoC and workforce board dollars are matched
• Misc. examples: Chicago Farmworks, Massachusetts Grandeis Secure Jobs program
• One community's suggestions:
  ○ In RRH, financial assistance could be extended for participants who are engaged in short-term, job-driven training
  ○ Employment-focused support services (childcare, transportation) should ideally be part of the RRH model
  ○ Financial empowerment should be "baked into" the RRH model
• Potential resource: livingwage.mit.edu
• Simultaneous housing and employment search needed in RRH programs
• Subsidized Employment and On-the-Job Training models can be successful, especially if the employer is willing to hire the client full-time after the initial period
• How are CoCs supposed to balance the pressure to limit rental assistance in RRH with the demand to help clients (who may not have employment history or any income) secure livable wages?
  ○ Extend subsidy when the client is in on-demand training
  ○ Don't expect RRH case manager to do it all – pair with a workforce staff
  ○ Advocate for higher minimum wage in your state	

Veterans Focused Employment
• HVRP helps with training, counseling, placement service
• American Job Center: they can assist with services and brings job seekers and employers together
  ○ Core services: needs little guidance
  ○ Intensive Services: really in need
  ○ Training Service: on the job training
• Points of Collaboration: dedicated funds for training, flexibility in employment, access to supportive services
• VA Employment Center and the Employment Coordinator serve as the advocate on behalf of the veteran with members of the employment collaborative and community employers. There are workshops that they can attend in preparation of employment.
  ○ They hold hiring events and bring in employers to do mock interviews
• Start the employment conversation from day one, stress the importance of employment
• Severe barriers can be overcome; always remember, just because they have severe issues doesn't mean they don't want to work
• Stages of change: Pre-contemplation, Contemplation, Preparation, Action, Maintenance
• HUD-VASH participants should be working with their case workers on the employment piece and
	Lisa Waikem
	lwaikem@starkmha.org

connecting them to services	
EVALUATION OF PROGRAMS	
Basic Evaluation – Identify main measures for program examination and improve performance based on these measures. • All RRH programs should look the same no matter what organization. Potential program participants should not be able to shop around for the best package. • CoCs should establish rental policies; even if the participant has $0.00 they should be responsible or accountable for something towards their rent. Everyone has some type of resource and identifying resources enables the participant to work on their strengths. If we are not tapping into their available or potential resources, we are enabling them. • Every $$ we spend at 100% minimizes families we can assist. RRH will not end poverty, the goal is to end homelessness. • Understanding it is not our job to keep the participant in housing, it is the participant's job to maintain their housing. • Do not use RRH $$ for Sect. 8 clients, use these funds to house other potential participants. • We need to establish a program that works around the client, all clients are not available from 9-5 p.m. We have to establish evening and non-traditional hours that keep the client engaged. • Identify supports that already exist within the household, what are your strengths? What have you done? Education? Training? • The development of a strengths assessment changes the conversation from what do you need to here are your strengths, let's start here. • Client choice; They can move to a community even if we don't think it's a good idea. Take the case management into the community. • Look at those who have been homeless longer because it effects systemic measurement.	Tracey Lane tlane@ywcacanton.org
GENERAL ANNOUNCEMENTS FROM HUD/NAEH	
• Pay attention to the upcoming election! NAEH is nervous about what changes it may bring for resources for the homeless system. Projects can educate their clients about the voter process but are prohibited from engaging in partisan politics • HUD has had problems with communities not spending down their ESG funding • Updated prioritization guidance is coming; CoCs will need to update their written standards for PSH in accordance with this new guidance • It was suggested that there be a monthly CoC Lead call, like there is a monthly HMIS Lead call	Shannon McMahon Williams swilliams@scfcanton.org

• There is a notice out for comment on the revised PPRN formula	
HARM REDUCTION	
• Key component of intervention at all levels of consumer engagement • Comes out of HIV/Aids movement • Should be helping people towards safer use, not deadly use • Homeless Healthcare, LA • Fundamental principles-low threshold, integrated approach, account for impact of past experience on present, trauma informed, welcome people who present difficult barriers • Make informed decisions, think things we do everyday	Michelle Caldwell, MichelleC@Ican-Inc.org
HMIS (see also POINT-IN-TIME COUNT)	

• 2017 PIT Count: guidance coming soon. Will serve as the youth baseline, so make sure to have a complete youth count!
• Final HMIS Rule is with the attorneys right now, will be released later this year
• Three draft notices also coming out soon: (1) Governance, (2) Functionality, and (3) Privacy and Security
• Critical changes coming to the data standards; will be renamed "2017 HMIS Data Standards"
• Privacy plans: need to be in line with agency's plans first, then the whole CoC's plans
• Data Sharing
  ○ Conversations took place about Business Associate Agreements and methods for ensuring privacy and security when multiple agencies are involved
  ○ Allegheny County, PA, has a data warehouse accessible from several agencies. They are just now making data on clients' multi-system use available to providers (providers need to "claim" the client to be able to see their records in other systems). The county is both the CoC and HMIS Lead.
  ○ Statewide systems in Michigan and New York can show whether or not clients have been offered different types of services (several limitations to this model)
	Shannon McMahon Williams
	swilliams@scfcanton.org

• Las Vegas gave a card to each of the people on the waitlist in order to track and it is linked to their HMIS profile. So if outreach personnel see them, they can scan their card for location purposes. Less than 5% lose the card. It's called the Clarity card: it has their identifier on it, picture and name. • VA representatives are entering HMIS data. • Hayward, CA: HMIS data shows what programs are working and where funding should be. • What services are needed, the reports measure performance, length of stay and returns	Lisa Waikem lwaikem@starkmha.org
LANDLORD ENGAGEMENT	
Focus – Landlord engagement and how to best market Rapid Re-Housing (RRH) to them. Learning and developing effective strategies for recruiting and engaging landlords for your program. - **4 things a landlord wants:** 1. Good Neighbor – Home visits as well as active communication with landlords establishes a relationship as well as assists the resident in understanding expectations. 2. On-time rent – Providing case management and home visits prior to rent becoming due to determine if there are any challenges with rent payments. If there is a gap, how are you going to fill that gap? Supportive services? 3. Long term renter – Refill vacancies with other renters, program participants 4. Property care – Home visits **Diversifying methods** – Build relationships, cold calls, host a landlord event, networking meetings, direct mail and word of mouth. **Landlord roundtables/focus groups** – Builds relationships and creates a platform to understand challenges and address concerns. Locate landlords with empty units and understand their housing needs. Creates an opportunity to discuss program participants as well as supportive services available throughout the duration of the lease term. Minimize financial liability by developing landlord relationships to prevent eviction costs and property damages. **Landlord incentives** – Respond to landlord concerns about rent, lease, damages and landlord/tenant conflict. o Home visits o Assist with tenant move out without eviction filing. o Fill vacancies with program participants. o Possible implementation of a contingency fund to pay for unpaid rents and damages to properties. o Program consistencies – All RRH programs should be doing the same thing to create awareness and understanding of the program across the board. o Development of a Business Case – Landlord understands what we have paid him/her over the past xx years and the contribution to his/her bottom line.	Tracey Lane tlane@ywcacanton.org

○ Landlord hotline or establish (1) person to call, information is distributed the same	
LEVERAGING PUBLIC AND PRIVATE DOLLARS	
• Presentation from LA with Hilton Foundation leading • Private funders were brought to the table first and discussed how their funding could be used to leverage a lot of public funding (estimated that $5M from them could leverage $35M in public) • Public officials did not want to hear about "blending" funding – wanted to hear about "aligning" funding ○ Private foundations then made their deliverables/measures the same as public funders so that providers could report on the same outcomes. Private funding was more flexible.	Shannon McMahon Williams swilliams@scfcanton.org
MERGING CoCs	
• HUD is moving to larger CoC units to streamline effectiveness, duplication in services, avoidance of local politics, and remove a fiscal burden to communities. They realize and anticipate their demands on CoCs are over burdensome and will cause a "joining of forces" and merging of CoCs and would not be surprised if states move to an entire state model. HUD will be encouraging and rewarding this model as effective and efficient. However, HUD will be asking for more regional representation on the larger or statewide CoCs. This model is already in place in smaller states and larger states are pulling in more CoCs under 1 or 2 larger ones. (Personally, it sounded like the model used for National & State Trust Fund Dollars.)	Shirene Starn-Tapyrik shirene@allianceforchildrenandfamilies.org
PERMANENT SUPPORTIVE HOUSING	
• Jericho Project, New York, Bronx—Amazing Example • Pay it forward attitude for graduates • Encourage moving on for independence, lose sense of institutionalization, no case management • Challenges-lack of affordable housing, landlord reluctance, tenant opting not to move • 3 most important things-comprehensive/individualized/holistic services, patience/persistence, have expectations • Moving on Initiative (Philly)-services most important and need to be flexible, all about choice, partner with everyone, won't know what is needed to client into they have moved in (can be considered the "sickest day") • Be flexible, what worked in past may not work today	Michelle Caldwell, MichelleC@Ican-Inc.org

POINT-IN-TIME COUNT 2017 (see also HMIS)	
• Refer to email HUD sent regarding changes for 2017 count • 2017 used as baseline year for tracking our progress towards ending youth homelessness • Congress paying attention to youth is "huge" • Data used for Presidents budget, NAEH • Resources-primary site for HUD's PIT and HIC resources, PIT and HIC Guides, Tools and Webinars • Extrapolation Tool-fills in gaps where we can't for demographics • Use different strategies for different populations • Discussions on preparing, project management and PIT count planning • Youth count needs to fit seamlessly into PIT without duplication • Use peer to peer strategies • Have incentives • Andrea-Winston/Salem NC PIT, very informative	Michelle Caldwell, MichelleC@Ican-Inc.org
PREVENTION/DIVERSION	

• Diversion
  ○ Needs to be built into coordinated entry, located at the front door, not really a separate program
  ○ In other communities, diverted cases are recorded in HMIS
  ○ Piloted with families using a strengths-based approach
  ○ Diversion work extends up to 30 days
  ○ Other communities divert people who are already literally homeless
  ○ Cost per family: a little over $1,000
  ○ Over 50% success rate in keeping families housed either with others or in their own housing
• Prevention
  ○ Consensus that there is little evidence that traditional prevention works (HPRP)
  ○ One researcher stated that eviction prevention services should be targeted to highest need people; this will mean more failures, but also more actual prevention because most severe needs are being met (for some people)
  ○ Funding should be targeted into communities where the need is the greatest
  ○ Minneapolis has great public resources; able to identify specific population that is most likely to enter shelter and target prevention to them
  ▪ Panelist stated that prevention funding should be used for people who have been homeless before
	Shannon McMahon Williams
	swilliams@scfcanton.org

▪ Can provide Hennepin County Eviction Study if we're interested ○ In DC, prevention services include minimal financial supports, budgeting, intensive case management, housing location, housing plan	
• Prevent already housed from homelessness by keeping them housed • The "Worthy Poor" trap-giving services to people who are worthy but not at risk • What works-Deep housing subsidies, eviction prevention, home based prevention • Think works-universal screening for vets, shallow housing subsidies, supportive services with MI, mediation for eviction prevention • Instead of asking what doing to end homelessness, ask what issues do you face? • Coordinated entry • Example-Washington DC Homeless Prevention Program—launched 2015, right to shelter city, single entry point, all services connected (em. Shelter, TANF, etc.), use Westat Tool Assessment (began in 2016, 500 completed, 300+ prevention, -200 mediation	Michelle Caldwell, MichelleC@Ican-Inc.org
PROGRESSIVE ENGAGEMENT	
• (Provider: The Road Home) Progressive engagement weekly meetings with other provider to assess RR cases that may need PSH. • (Cuyahoga County) 4 months' rent paid at 100% for everyone. This has a 65-75% success rate. Their NOFA provides an additional 8 months and if the client needs more assistance, they look for PSH.	Lisa Snyder LisaS@ican-inc.org
RAPID REHOUSING	
Goals – Implementation of an effective rapid re-housing model or the improvement of an existing rapid re-housing program. • Eligibility – people who are homeless, literally homeless meaning on the street or in a shelter or fleeing domestic violence. • During this transition the participant does not lose their chronic eligibility status for purposes of remaining eligible for PH placements dedicated to chronically homeless (HUD FAQ). • Implementation of a strengths as opposed to needs assessment • Core Components – rent/move in assistance, housing ID and case management. • Case managers should transition into rapid case managers. Case management should not be long term, get them out and referred to long term services. • Rapid re-housing does **NOT** do the following:	Tracey Lane tlane@ywcacanton.org

→ Eliminate poverty → Assure people will have affordable housing → Protect people from life losses or bad choices → Eliminate housing mobility **Hearth Act Goal – 30 days or less from housing into permanent housing** **Progressive engagement** – *No cookie cutter or package deals*, everyone does not get the same supportive services or length of assistance. It's harder to be successful when everyone is wrapped into the same package because everyone's strengths and needs are not the same. • When utilizing the progressive engagement model statistics have shown only 16% singles, 15% families, 7% TH and 9% RRH return to homelessness. • Financial assistance should be for 6 months in order to serve more people. If you are utilizing a 12-24-month model you can only provide services to a select number of those in need. Adopting a 6-month model with the concept of rapidly rehousing people demonstrates success because you are more focused on their strengths as opposed to their needs. **Housing First –** Is not a program, this is a system-wide orientation and response. Everyone is ready for housing regardless of the severity of their needs.	
SCHOOLS, PARTNERING WITH	

• In Southern Nevada, there is close collaboration between the school district (very large – 356 schools) and the CoC
  ○ Quarterly meetings held with youth/family service providers, child welfare agencies, CoC
  ○ Youth providers go into the schools (including at staff meetings) to discuss services
  ○ School district is involved with Project Homeless Connect
  ○ PIT – "Youth Census" where schools distribute youth-specific surveys. Schools schedule meetings with students who identify as homeless
	Shannon McMahon Williams
	swilliams@scfcanton.org

SINGLE ADULT HOMELESS POPULATION	
• Solutions are outreach, low barrier shelter, diversion (innovative diversion ideas) • Intervention opportunities: income, services, housing (short term rental assistance with short term supportive services CTI) • VI SPDATS are done in emergency rooms to target high cost Medicaid uses and those accessing shelter	Lisa Snyder LisaS@ican-inc.org

• If you can prevent crisis homelessness, you may keep someone from becoming chronically homeless	
STREET OUTREACH	

• Collaborate with EMS, police, jails, courts, medical providers, hospitals, legal defenders
• Having access to medical data is a helpful component to reaching homeless and identifying those in crises
• Ratio for street outreach is
  ○ 50-100:1 street outreach
  ○ 25-30:1 in the navigation stage
  ○ 1:10 chronically homeless very vulnerable
  ○ 1:20 case management in supportive housing units
	Lisa Snyder
	LisaS@ican-inc.org

SUBSTANCE USE DISORDERS WITHIN THE HOMELESS POPULATION	
• Overdose deaths quintupled since 2001, opioid and benzo. • Systems need to work together to address all issues together-housing, mental health, substance use, etc. • Not much evidence antibuse helps with alcohol • Meth effects similar to cocaine • Homeless 9Xs more likely to die from overdose • Veterans are 10Xs more likely • Bi-directional problem-housing should be point of entry to treatment, this can and will reduce relapse • UPCOMING-Mental health reform, S 2680 and HR2646-wrap around mental health, substance use and medical • New and emerging threats-rise of “synthetics” on the market, non-pharm. Fentanol on the streets (20-40Xs more potent than heroin and cheaper than heroin) • Local challenges-low priority for homeless, limited money and resources, stigma • Responses-LOCAL- naloxone, education programs, good Samaritan laws, expanding access to housing FEDERAL-needle exchange laws, Drug Court, Comprehensive Addiction Recovery Act, • Starting to recognize peer supporters are critical to recovery • States have to comply with all new rules (Medicaid) by 2017 • Technical Assistance Collaborative Inc.—Great Examples!	Michelle Caldwell, MichelleC@Ican-Inc.org

• Methadone and buprenorphine as treatments do continue the patient's dependence on opioids but do not trade one addiction for another • Clinical treatment should be point of entry for the homeless system • Comprehensive Addiction and Recovery Act (CARA) bill is providing grants to communities experiencing the opioid epidemic; provides access to Naloxone for FQHCs and community-based organizations • Some housing models for people with substance use disorders face challenges in delivering; specifically, in dedicated units, participants feel disconnected from family/friends/network – projects should emphasize activities and provide physical spaces dedicated to gathering • In project-based housing, projects need to recognize and embrace that relapse is part of recovery and does not compromise other participants' recovery • Managed Care Organizations have health navigators and FQHCs are sources of mental health and substance use services	Shannon McMahon Williams swilliams@scfcanton.org

• Housing stability is essential for long term recovery from SUD. It reduces relapse.
• Best practices:
  ○ Establish stable housing ASAP
  ○ Address social co-morbidities
  ○ Patient centered harm reduction approach
  ○ Having treatment readily available
	Lisa Snyder
	LisaS@ican-inc.org

SYSTEM PERFORMANCE MEASUREMENT	

HUD's seven performance measures designed to help communities gauge how well you are doing in preventing and ending homelessness. How the HUD measures connect and interact with each other, and the difference between system and program level measurement.
• Intersection of measure
• Desired outcomes
• Why measure system level performance?
• Using data in a meaningful way, people represented by a number #.
• Data is used to analyze the efficiency of serving the homeless.
  ○ ID gaps in the system
  ○ Inform system change
  ○ Inform rating/ranking process
	Tracey Lane
	tlane@ywcacanton.org

HUD – Right now there are no targets of length of time homeless
HUD – Has no data from communities

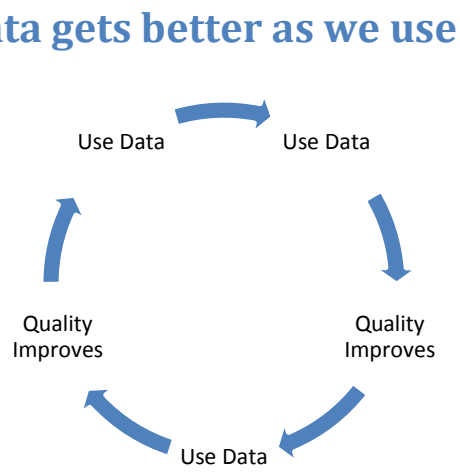
- CoC will be judged from your CoC past i.e., Canton v. Canton
- You have a lot of flexibility, don't be arbitrary
- What's going on, who are you trying to serve
- As a CoC you have the authority to think through how you set your targets

HUD – Knows measures, does not set targets
HUD – Understands the data is not perfect, submit data, allow time to correct and re-submit
Data Quality – Attack those problems and work on fixing them… Why did I have these problems? How do I fix them?

- Data quality hurdle will be pretty big at first
- Many parts, doing things different
- Work towards a common goal, work together

Performance Measures – Systematically evaluate whether your program is making an impact on clients you serve.

- Helps provide efforts to improve results
- Start meetings with what do we know, stop guessing
- Reference Montgomery Co. PA ending and preventing homeless reports



UNSHELTERED HOMELESS IN ENCAMPMENTS

• Option is to create a low barrier pathway to housing	Lisa Snyder LisaS@ican-inc.org
VETERANS	
• Look at usich.gov • Quickly identify, engage, intervene, prevent, divert, access to shelter/crisis, no barriers • Quick access for permanent housing • Criteria and benchmarks should be measured together to see how entire system is functioning • Have to be federally approved to say ended veteran chronic homelessness, it is a process	Michelle Caldwell, MichelleC@Ican-Inc.org

• Bridge housing, GPD
• Federal criteria for ending veteran homelessness:
  ○ Identify all homeless veterans
  ○ Link them with immediate shelter if they want it
  ○ Use transitional housing in limited cases
  ○ Community has capacity to quickly move veterans to permanent housing
  ○ The community has resources, plans, and capacity for future homeless veterans
	Lisa Snyder
	LisaS@ican-inc.org

Ending Veteran Homelessness
• Make sure that all Veterans are in the HMIS system
• The VA should have access to HMIS
• The hard to engage: at least 8 attempts over 2 months, Veterans who refuse: at least 4 attempts
• For permanent housing: prioritize all Veterans, coordinate with all landlords, do a security deposit program
• Tracking: Outreach/VA to have read-only HMIS Access
• Connecticut: ended veteran homelessness 2015; they had 766 Veterans in 2015, average 78 days from ID to housed
  ○ Sustainability: HMIS up to date, Add HUD VASH and have them graduate to Section 8 voucher
  ○ Renewed focus on Employment during Intake
• New Orleans ended veteran homelessness, 18 months maintained
  ○ All Veterans were given PH between 6/14 to 1/15; 227 veterans housed, 9 had said no but out of those 9, 5 have now said yes
	Lisa Waikem
	lwaikem@starkmha.org

- 1/16 to present: 217 veterans now housed, avg is 30 days, median is 25
- 4% of 217 have relapsed and they scoop them back up and try again
- Every newly discovered veteran is provided PH within 90 days, unless they choose to enter a longer term treatment program. SSVF quickly performs assessment, VA confirms status, if not eligible for SSVF they go to Rapid Rehousing.
- They prioritize veterans over all
- Outreach/Prioritize/Housing are their top 3

Federal Criteria and Benchmarks

- 27 Communities in 2 States ended veteran homelessness
- Federal Criteria: 1) Identify all Veterans, 2) quick access to Shelters, 3) Sufficient PH Capacity, 4) Committed to housing first and provide services: intensive, transitional resources, plans and system capacity
- All key players must sign off on applying for Functional Zero, then you apply to either USICH, HUD – submit all of your data and complete template. The review team will look over the list and may contact with question; if confirmed we will receive a letter, if not confirmed they will offer guidance/tech support
- Does the VA have Transitional housing? If so it can be used as a bridge to PH

CoC and VA Partnerships

- Shawn Liu: Prevention: Outreach HCHV outreach with Community resource and referral
- Document goals, performance measures, CRRC having access to add data to HMIS, make sure all veterans sign release at Intake
- HOMES report has and shows if veteran is chronic
- Effectively ending homelessness means having the leadership of the Governor, state agencies, Board of Mental Health, HUD and CoC and the Mayor on board.
- Assist veterans with obtaining PH within 90 days
- 60% will not connect with the VA
- Ensure all veterans are in the HMIS: VA to have access to HMIS, SSVF/CRRC access HMIS and they report veteran status
- Prevention: Housing stability: employment and benefits, SSVF: prevention/eviction, Diversion: SSVF training on shelter diversion
- Sustainability: Keep list up to date: Access to SSVF, employment and into housing within 90 days

CoC and Veterans Service Organizations Partnerships

- Working together with your VFW's, Amvets, Service Organizations, Employment Assistance
- GPD program, SOAR is a national program focused on expediting access to SSI/SSDI, HVRP= Homeless

Veteran Reintegration Project • Outreach person connects with Veteran being discharged from Jail/prison to assist with housing • Case management is very critical ***Vets @ Home Convening*** • Make sure supports stay consistent even when housed • Changes are coming to GPD • Big on Data Sharing; access to HMIS • Engage more landlords • President just announced veteran homelessness is down 50% • USICH has new things coming out soon • Share your success w/ NCHU • SSVF & GPD is being pushed to help other than honorable • They recommending in looking at these two websites: ○ https://www.hudexchange.info/news/announcement-vets-home-technical-assistance-opportunity/ ○ https://www.hudexchange.info/resource/4711/vets-at-home-toolkit-identifying-and-engaging-homeless-veterans/ *****See also "Employment" for notes on a veteran-focused employment session***	

Other Resources:

Michelle shared: I also picked up a lot of information on Social Security, Journal of Children and Poverty, 2016 Affordable Housing GAP Analysis, The National Network for Youth, Trauma Interventions, HUD *Evidence Matters* Summer 2012 booklet and Fall 2014 booklet, HUD Rem*oving Barriers to Affordable Housing* booklet, HUD *Worst Case Housing Needs 2015 Report to Congress* book, HUD *What Happens to Low-Income Housing Tax Credit Properties at Year 15 and Beyond* book, HUD *Strategies for Improving Homeless People's Access to Mainstream Benefits and Services and the Institute for Children*, Poverty and Homelessness's *American Almanac of Family Homelessness* book. All of these resources I obtained from the various booths at the conference.