Ending Homelessness – Developing Partnerships Between HUD Continuums of Care and Disability, Aging, and Health Services Providers

August 29, 2022
Webinar
Welcome

Webinar is hosted by the Housing and Services Resource Center (HSRC)

Facilitator

Lori Gerhard, Director of the Office of Interagency Innovation at the Administration on Community Living
Instructions for Zoom

Audio Options
• Use your computer speakers, OR dial in using the phone number in your registration email.
• All participants are muted.

Questions and Comments
• Please actively use chat throughout the meeting, especially for your comments.
• To ask a presenter a question, please use the Q&A function.

Or, send your question or comment via email to HSRC@ACL.HHS.GOV
Housing and Services
Resource Center
acl.gov/HousingAndServices #HousingResources
Partnerships to address the needs of people experiencing or at risk of homelessness
National Experts

• **Sharon P. Singer**, Office of Special Needs Assistance Programs (SNAPS), U.S. Department of Housing and Urban Development (HUD)

• **Marcella Maguire**, Director, Health Systems Integration, Corporation for Supportive Housing (CSH)
The Continuum of Care (CoC) program:

CoCs as Local Partners to Address Homelessness for Older Adults and People with Disabilities
You will learn...

• Why do people experience homelessness
• About homelessness for those who are aging and/or living with disabilities
• Why Permanent Supportive Housing (PSH) is the best practice to meet their needs
• What are Continuums of Care (CoCs) and what role they play in addressing homelessness
• Why partnerships are needed to address community needs related to homelessness
Why do people experience homelessness?

• Cost of renting/homeownership far outpacing incomes
• Limited affordable housing options for people on fixed or low-incomes
  • Only 1 in 4 low-income renters who need housing assistance can access that assistance
• Lack of a social safety net (or have burned through supports)
• Domestic violence and/or history of abuse
• Lack of collaboration between service systems attempting to serve the same people—e.g. health care, public health, mental health, aging and disabilities systems
Disproportionate representation by race

- People identifying as **Black or African American** accounted for **39%** of all people experiencing homelessness and **53%** of people experiencing homelessness as members of families with children but are **12%** of the total U.S. population.

- Together, **American Indian, Alaska Native, Pacific Islander and Native Hawaiian** populations account for **1%** of the U.S. population, but **5%** of the homeless population and seven percent of the unsheltered population.

- In contrast, **48%** of all people experiencing homelessness were **white** compared with **74%** of the U.S. population.

- People identifying as **Hispanic or Latino** (who can be of any race) are about **23%** of the homeless population but only **16%** percent of the population overall.

Aging and Homelessness

Figure 2: Sheltered Homelessness is Increasing Among Older Adults

- **Number of Sheltered Homeless (Thousands)**

- **Share of Sheltered Homeless (Percent)**
  - 51–61: 2007 – 10%, 2017 – 12%
  - 62 and Older: 2007 – 2%, 2017 – 4%


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Joint Center for Housing Studies of Harvard University
People with disabilities and homelessness

• People with disabilities are disproportionately likely to experience homelessness.
• Annual point-in-time counts (i.e., counts of the people in a community experiencing homelessness on a single night required by HUD) suggest that nearly one quarter of individuals experiencing homelessness have a disability, including physical, intellectual, and developmental disabilities, as well as mental health and/or substance abuse disorders.

On one night in January 2020, there were 110,528 homeless individuals with chronic patterns of homelessness. That is 27% of the total population of homeless individuals. 66% of chronically homeless individuals were living on the street, in a car, park, or other location not meant for human habitation. Since 2007, the number of individuals with patterns of chronic homelessness has decreased 8%. However, between 2019 and 2020 this number increased by 15%.
Permanent Supportive Housing (PSH)

• PSH is an intervention that combines affordable housing assistance with voluntary support services to address the needs of people with disabilities (many of whom are chronically homeless).
• Services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment.
• Investments in PSH have helped decrease the number of chronically homeless individuals by 8 percent since 2007.
• Research has demonstrated that permanent supportive housing can also increase housing stability and improve health.
• A cost-effective solution, PSH has been shown to lower public costs associated with the use of crisis services such as shelters, hospitals, jails and prisons.

https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/
Supportive Housing is an Evidenced Based Solution

Supportive housing combines affordable housing with services that help people who face the most complex challenges to live in their own homes and communities.

Housing: Affordable Permanent Independent

Support: Flexible Voluntary Tenant-centered Coordinated Services

80+% of Supportive Housing residents stay housed.
Snapshot—Homeless Assistance Grants

- **Continuum of Care (CoC) Program**—(FY22 $2.8 billion due 9/30/22) awarded through annual competition. Projects are ranked and awarded as part of a community entity also called a CoC. Program components include Permanent Supportive Housing (PSH), Rapid-Rehousing (RRH), Supportive Services (SS)

- **Emergency Solutions Grants (ESG)**—(FY22 $300 million) Distributed by formula to states and localities. Program components include street outreach, emergency shelter, homelessness prevention (HP), RRH, and HMIS; as well as administrative activities

- **ESG-CV**—($3.96 billion CARES Act funding in 2020) Same program components as ESG including non-congregate shelter and other COVID related activities

- Special NOFO for Unsheltered and Rural Homelessness—($332 million due 10/20/22)

- **Youth Demonstration Project**—6 rounds of funding (approx. $70 million annually)
FY22 CoC NOFO

Priority #1: *End homelessness for all persons experiencing homelessness.*

Priority #2: *Use a Housing First approach.*

Priority #3: *Reduce unsheltered homelessness*

Priority #4: *Improve system performance.*

Priority #5: *Partner with housing, health, and service agencies*

Priority #6: *Advance racial equity and address racial disparities.*

Priority #7: *Improving assistance to LGBTQ+ individuals*

Priority #8: *Engage persons with lived experience of homelessness*

Priority #9: *Support local engagement to increase supply of affordable housing.*
Role of the local Continuum of Care (CoC)

- **A CoC is a state, regional or local planning body** that coordinates housing and services funding for homeless families and individuals.
- CoCs are required to bring together government and nonprofit partners across the community representing different populations and community systems to work towards ending homelessness. People experiencing or with lived experience of homelessness must be included in the CoC work.
- HUD is to COCs, as ACL is to Area Agencies on Aging, Aging and Disability Resources Center (ADRCs) and Centers for Independent Living (CIL)
- Large/medium size communities have their own COCs and smaller/rural communities are represented at state level called Balance of State (BOS) COC
- COCs may be led by a department within government, or a local nonprofit with strong ties to the community and government
• System leadership and allocation of limited resources in the best way possible to address homelessness in their communities.
• CoCs have a similar role to an AAA, ADRC or CIL role but for a different lens on the population.
• They manage funding and performance for a variety of programs (funded both by HUD and likely state, local and private funding) including:

1. Unsheltered outreach (CoC and ESG)
2. Shelter (ESG)
3. Transitional Housing (CoC)
4. Rapid Re Housing (CoC and ESG)
5. Permanent Supportive Housing (PSH) (CoC)

HUD reports annually on Housing Inventory by CoC as well as a Point in Time Count of Homelessness by CoC—volunteers can participate in the count!
What are the four categories of the homeless definition (§ 578.3)?
Within the homeless definition there are four categories of homelessness:

1. Literally Homeless
2. Imminent Risk of Homelessness
3. Homeless Under Other Federal Statutes
4. Fleeing/Attempting to Flee Domestic Violence

Separate definition for “At-Risk of Homelessness”
HUD requires CoCs to establish and operate a Coordinated Entry System with the goal of increasing the efficiency of local housing crisis response system and improving fairness and ease of access to shelter, services and housing, including mainstream resources.
How does CE change the process?

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<tr>
<th>BEFORE COORDINATED ENTRY IMPLEMENTATION</th>
<th>AFTER COORDINATED ENTRY IMPLEMENTATION</th>
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<tbody>
<tr>
<td><strong>Should we accept this person into our project?</strong></td>
<td><strong>What housing and service assistance strategy among all available is best for this household?</strong></td>
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<tr>
<td>• Project-centric</td>
<td>• Person-centric</td>
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<tr>
<td>• Different forms and assessment for each organization or small subgroup of projects</td>
<td>• Standard forms and assessment used by every project for every participant</td>
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<td>• Project-specific decision-making</td>
<td>• Community agreement on how to triage based on the household’s needs</td>
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<td>• Ad hoc referral process between projects</td>
<td>• Coordinated referral process across the CoC’s geographic area based on written standards for administering CoC assistance</td>
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<td>• Uneven knowledge about available housing and service interventions in the CoC’s geographic area</td>
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Coordinated Entry Core Elements

ACCESS

ASSESSMENT

1. Initial Triage
2. Diversion
3. Intake
4. Initial Assessment
5. Potential Eligibility Assessment
6. Comprehensive Assessment

PRIORITIZATION

REFERRAL
Values and Principles to Guide CES Assessment Processes & Policies

- Tested, valid, and appropriate
- Reliable
- Equitable
- Comprehensive
- Person-centered
- User-friendly
- Strengths-based
- Housing First–oriented
- Sensitive to lived experiences
- Locally-specific
- Transparent
Community Experts

- **Jackie Fortmann**, Assistant Director, Ability1st (FL)
- **Johnna Coleman**, Executive Director, Big Bend Continuum of Care (FL)
- **Joshua Gemerek**, Senior Vice President, Housing, Bay Aging (VA)
- **Angie Alley**, Assistant Director, Housing Services, Bay Aging (VA)
Ability1st maintains a Homeless Services Department consisting of a director and two full-time staff members dedicated to Street Outreach. The staff’s mission is to engage and build trust with homeless individuals to hopefully get them into housing and provide them with necessities while they are unsheltered. The Leon County 2021 Point in Time count identified 91 unsheltered individuals, with 52 of them chronically homeless. With the current spike in rental costs and inflation, unfortunately, it is likely that more and more people will become homeless.
Our population target are individuals with disabilities who are homeless or unsheltered

How we help:

**Food:** Provide ready made meals, snacks and drinks.

**Basic Necessities:** Provide clothing, shoes, sleeping bags, portable showers, hygiene items, backpacks, flashlights, etc.

**Transportation:** Provide bus passes so people can attend appointments as necessary.

**Referrals:** Refer in house for assistance with social security and other benefits. Provide information regarding local shelters, food banks, career source, mental health and substance abuse treatment, etc..

**Case management**- Assessing housing and service needs, arranging, coordinating and monitoring the delivery of individualized services to meet the needs of the program participant. Use in house rapid rehousing funds and assist individuals with documentation for permanent supportive housing.
The Big Bend Continuum of Care (BBCoC) is a membership, planning and oversight body for the homeless service system of care serving Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla counties of the Big Bend area in Florida. The purpose of the CoC is to develop and implement strategies to prevent and end homelessness. The active participation of individual and organizational members is critical to the success of the CoC. Members of the CoC are asked to attend general membership meetings and participate in any committees of interest throughout the year.

Other local partners include:
- Capital City Youth Services
- The Kearney Center Homeless Shelter
- HOPE Community Shelter
- Big Bend Homeless Coalition
- The Refuge House

Ability1st and other partners use a Homeless Management Information System to make sure we are providing the best level of service while not duplicating efforts – this way the individual is receiving comprehensive assistance.
BAY AGING
DIGNITY AT EVERY AGE

BAY HEALTH
A DIVISION OF BAY AGING

BAY HOUSING
A DIVISION OF BAY AGING

BAY TRANSIT
A DIVISION OF BAY AGING
Integrated Array of Services (1)

**Health & Wellness**
- Adult Day Care
- Active Lifestyle Centers
- Care Coordination
- Chronic Disease Self-Management
- Dementia Friendly Communities
- Fall Prevention
- Home & Personal Care
- Insurance Counseling
- Meals on Wheels
- Prevention Education
- Transitional Care
- Veterans-Directed Home and Community Based Services

**Advocacy & Outreach**
- Advance Care Planning
- Community Action Program
- Community Integrated Health Network
- Ombudsman
- Options Counseling
- Retired & Senior Volunteer Program
- Senior Medicare Patrol
- Senior Employment Title V
Integrated Array of Services (2)

**Housing**
- Age- and Income-Restricted Service-Enriched Rental Housing
- Community Development Block Grants
- Emergency Home Repair
- Homeless Solutions
- Housing Choice Voucher Program
- Indoor Plumbing Rehabilitation
- Maintenance Technicians
- Resident Service Coordination
- Rural Development 504 Loan
- Weatherization Assistance

**Transportation**
- Demand-Response
- Deviated Fixed-Routes
- Expanded App-based Service
- MedCarry
- New Freedom
- Seasonal Trolleys
Continuum of Care (CoC)
Regional collaboration and uniform assessment for people experiencing a housing crisis

- Community Based Organizations
- Community Services Board
- Departments of Social Services
- Department of Veterans Affairs
- Domestic Violence Providers
- Emergency Shelters
- Faith-Based Community
- Foundation, State, & Federal Funders
- Health Department
- Hospital Systems
- Landlords & Housing Managers
- Legal Aid
Panel Discussion

Q&A
Welcome to the Housing and Services Resource Center!

The Housing and Services Resource Center was created for people who work in the organizations and systems that provide housing resources and homelessness services, behavioral and mental health services, independent living services and other supportive services, and others who are working to help people live successfully and stably in the community.

Our goal is to foster collaboration and cross-sector partnerships, in order to streamline access to services, better leverage resources, and ultimately make community living possible for more people.

acl.gov/HousingAndServices
Upcoming HSRC Event

• **Training on Homelessness for Public Health Providers** available through CDC Train, an affiliate of the TRAIN Learning Network powered by the Public Health Foundation. The training is available to anyone serving people who are experiencing homelessness and can be accessed by creating a free account at [www.train.org](http://www.train.org). This course will provide trainees with the knowledge and skills needed to (i) ensure public health protections reach people experiencing homelessness and (ii) recognize and respond to public health emergencies among people experiencing homelessness. Upon completion of this course, participants will be able to:
  o Take action to form partnerships with homeless service organizations
  o Ensure that people experiencing homelessness are represented in public health data and analyses
  o Tailor public health interventions and measures for people experiencing homelessness
Access the most recent case studies to discover approaches for housing stability and addressing homelessness

• **Bay Aging** Partnerships Bring Help and Hope to People Experiencing Homelessness

• **AgeSpan** Partnerships Bring Housing and Services Together

• Visit the Housing and Services Resource Center’s **What’s New page**!
Resources for Continuums of Care

HUD landing page on COCs

HUD on Point In Time Counts

HUD's Housing Inventory Chart (HIC) - homeless related housing programs and units in your community

HUD on COC boards
Help Us Improve

Please complete our short feedback form:

https://www.surveymonkey.com/r/HHLR2GN
We want to hear from you!

Please email us at hsrc@acl.hhs.gov
Acknowledgment

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