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

August 29, 2022 | Webinar Transcript

LORI GERHARD: Hi, everyone! We will get started in a few minutes. I know we have folks joining the room right now.

Good morning, good afternoon, everyone. We are going to get started in a few minutes. There are a few more people joining today's webinar.

We have a very full agenda. I think we will go ahead and get started. I know there are still people going into the room.

Hello, and welcome to the Housing and Services Resource Center's webinar, Ending Homelessness – Developing Partnerships between HUD Continuums of Care and Disability, Aging and Health Services Providers.

Today we will learn about the HUD continuums of care, or CoC, and coordinated entry systems, and hear from colleagues in disability, aging, and health sectors who are part of continuums of care and the benefits of these partnerships. Thank you so much for joining us. Next slide.

My name is Lori Gerhard, and I'm the Director of the Office of Interagency Innovation at the U.S. Administration for Community Living, an agency within the U.S. Department of Health & Human Services. I will be serving as the facilitator for today's webinar. It's a privilege to have so many here with us.

Your active involvement with us is essential to have an engaging discussion, and I want to thank everyone for introducing themselves using the chat. We continue to learn from our presenters and all of you who participate in these webinars. It will take all of us working together to achieve our collective goal to increase housing stability, and help those who are experiencing, or at risk of, homelessness to be able to – or those who may be living in an institution – to obtain and maintain stable housing and the services they seek, to fully participate in the community.

Before we start, we would like to address a few housekeeping items. This meeting is being recorded, and by staying to participate, you are consenting to the recording. All attendees' microphones have been muted for audio quality. One hallmark of our webinars is active participation from attendees. Please frequently

use the chat to make comments, and submit your questions anytime in the Q&A feature in the Zoom dashboard.

You may email a question or comment to hsrc@acl.hhs.gov.

We have reserved time to address your questions during the session. If you are participating via the YouTube livestream, please submit your questions by emailing us at hsrc@acl.hhs.gov.

You can also use the chat, or email if you have a technical issue, or comment for other attendees. Next slide.

Before we start with the presentations, I would like to tell you about the Housing and Services Resource Center, or HSRC. It is a partnership between the U.S. Department of Health & Human Services, or HHS, and the U.S. Department of Housing and Urban development, also referred to as HUD.

Every state and community has a number of agencies, organizations, and programs helping people access housing, and supportive services, but the housing and services systems are often siloed. Stronger cooperation between these systems would enable more people with disabilities, older adults, and people experiencing homelessness to achieve housing stability, live with dignity and independence in the community, and avoid homelessness and costly institutional care.

The Housing and Services Resources Center, HSRC, brings together our federal agencies and technical assistance providers to cultivate, strengthen, and support cross-sector partnerships in communities, states, and across the federal government that bring together housing, homelessness services, aging and disability services, health, including physical health, behavioral and mental health, and public health services.

After the webinar, we hope you will look at the HSRC website at acl.gov/housingandservices.

At the end of the webinar, we will share an email address so you can be in touch with us and get periodic updates. Next slide.

The HSRC serves many sectors: each with its own unique terms, policies, and practices. Today's webinar brings together the homelessness continuums of care and coordinated entry systems and the disability agencies and health systems to share the approaches they have helped to work together, and talk about how these partnerships benefit the people we serve and their organizations.

It's been interesting developing this webinar as we are discovering the homelessness continuums of care and coordinated entry systems, and the Aging and Disability Resource Centers, no wrong door systems, Centers for Independent Living, Area Agencies on Aging, and community hubs are developing very similar systems.

Working to bridge together the array of housing options programs, funding streams and services to help those we serve obtain or maintain stable housing services and live full lives in the community.

Today we will focus on becoming familiar with homelessness continuums of care structures and coordinated entry systems, and identify opportunities in disability, aging, and health and other service networks to build and/or strengthen collaborations to reduce homelessness and increase housing stability among those we serve. We are in for a real treat today as we hear from national experts and colleagues in Florida and Virginia who will share their experiences and strategies about how they are working together to serve people who are experiencing homelessness or at risk of homelessness.

We will learn about the continuums of care from HUD and the Corporation for Supportive Housing, or CSH.

It is my distinct pleasure to introduce our national expert presenters, and with us today is Sharon Springer, who is a Senior Program Specialist at the Office of Special Needs Assistance Programs, also known as SNAPS, at the U.S. Department of Housing and Urban Development, and Marcella Maguire, who is the Director of Health Systems Integration at the Corporation for Supportive Housing, or CHS.

The floor is yours. Next slide.

MARCELLA MAGUIRE: Thank you, and thank you to the folks at ACL. We are so excited to have this conversation today and excited to set the ground here for what is our continuum of care program and what are the homeless systems for the aging partners in your community and give you key and basic information. Your partners on the housing side, if you're looking for local partners who address homelessness, older adults, and people with disabilities. These partnerships are really important, and we highlight the partnerships that overlap geographically. Some of them are working in Tallahassee. and the CoC is working in Tallahassee. We will highlight them.

And they have different skill sets and different funding streams they manage, and it's important to understand the complementarity of these partnerships here. And our goal here is to end homelessness for older adults and people with disabilities. Next slide, please.

We will talk about why people are experiencing homelessness and why it's more likely people who are aging or low income and people with disabilities are experiencing homelessness, and Permanent Supportive Housing and evidence-based practices to address their needs, and we will talk about what roles continuums of care play in creating supportive housing, and bringing together community-wide efforts around ending homelessness.

We will talk about why partnerships are necessary to end homelessness and why none of us can do this alone. We need partnerships, and we will hear from some successful partnerships locally about how they came into being.

Homelessness, I thought about it, and I've been in this field a long time, it's a game of musical chairs. There are 16 people out there and four chairs. That means only one in four of the low-income renters who need housing assistance can access that assistance.

The cost of living is going up, we said for ourselves and communities, it's far outpacing incomes and income supports, and we have a very limited number of affordable housing options for people on fixed or low incomes. That is the case for most people who are aging, many people who are aging or disabled.

We have a lack of social safety net and see people with domestic violence, histories of abuse, these have been challenged by their community and family members, and have these very separate systems that grew up in very different – what Lori said, homelessness is an issue, let's talk about the program we built there. All of you out there are experts on let's have services and supports for people who are aging and have disabilities, let's build a public health sector.

Though systems do not talk to each other and collaborate, we are here to talk about why that's important and support it to build these partnerships at the local level.

Who cannot access it? It's not random, people of color and aging have a difficult time navigating […] systems, and even if they cannot there is not housing out there, and just a word for folks who work in entitlement systems, Medicaid is an entitlement system and Medicare is an entitlement system. In theory if you can prove your disability to the state, you are entitled to services. There is no such entitlement on the housing side, when the budget is used up, the budget is used up and there are no more resources.

That builds a very different system. Next slide, please.

I want to center the conversation around equity and talk about how disproportionately impacted communities of color are by homelessness and housing instability, and increasing housing costs in our community. In people who identify as Black or African-American, 39% of all people are experiencing homelessness, and 53% of people experiencing homelessness are members of families with children, only 12% of the US population, […] clear equity issue and there has been a lot of research and certainly not ended over the last couple of years.

For Native American, Alaska Native, Pacific Islander, Native Hawaiian populations, each of those groups separately accounts for 1% of the U.S. population, yet they are 5% of the homeless population, 7% of the unsheltered population.

In contrast, 48% of people experiencing homelessness are white, rather than 70% of the U.S. population. You can see the vast inequities and the need for strategies that supposedly target the need and unique needs of these communities.

People identifying as Hispanic or Latino can be of any race, 23% of the homeless population are only 60% of our population overall. All non-white groups are overrepresented experiencing homelessness, and we need to center studies as we work to end homelessness and these long-standing disparities.

This really talks about how homelessness is increasing among those who are aging over the last couple of years. And chronic homelessness, we will talk a bit about that, it's a late Baby Boomer phenomenon and we see the Boomers are in the 58, 59 and up range, and how that's impacting.

Sheltered homelessness is increasing, the percentage of people increasing homelessness who are aging is increasing as well, lots of challenges. In this population we see people who have been homeless for a long time, chronic homelessness, and we are also seeing a lot of people homeless for the first time. They have been working low-wage jobs, not able to save, not able to meet the rising cost of housing in our communities.

This increase we talked about and the increases in housing costs, all of them were documented projections before COVID, and we expect with COVID the challenges will be even greater.

For people with disabilities experiencing homelessness, we know that they are significantly overrepresented among those experiencing homelessness or housing instability. They are more likely to experience it than a person without a disability. HUD requires local systems and continuums of care that Sharon will talk about to do a point-in-time count, counting them, we find 1/4 of them have a disability, when I say disability I made this public, this could be physical or intellectual, or people with serious mental illness and people with substance use disorders, people with any combination of all of those or at least one of those above.

People experiencing disabilities are more likely low income and therefore, especially with the rising costs, likely to be homeless. Next slide, please.

You heard me mention chronic homelessness, and this is a very specific term in HUD. There are many programs within the continuums of care that are only available to people experiencing chronic homelessness, and the definition includes a disability, again, all of those we talked about, as well as long-term homelessness.

This is a year, continuous, or four episodes in three years, each of those episodes has to add up to at least one year for homelessness. It can be a person who is living and […] a domestic violence situation, or a person living in shelter, or unsheltered living on the streets, cars, parks, other locations not meant for human habitation. I am proud to say 2007's the patterns of individuals with chronic

homelessness have decreased by 8% and that was in the earlier part of the decade between 2019 and 2020, this number increased by 15%.

We will talk about veterans. There is a decrease in veterans' homelessness in the middle of the last decade because resources were targeted to veterans or the Veterans Administration Supportive Housing Program.

Next slide, please.

So, what is the solution to affordable housing?

SHARON P SINGER: I think we are getting a lot of requests to slow down. It's a lot to take in. We are working very consciously of only having a few minutes, but I think you are definitely getting a number of asks.

MARCELLA MAGUIRE: Thanks for jumping in there. Permanent Supportive Housing is an intervention that combines affordable housing assistance and what makes that, and volunteer supportive services, that helps to address the needs of people with disabilities.

The services are housing-focused and designed to build independent living skills, tenancy skills, helping people budget and deal with landlords, helping people be good neighbors, and also connect people with community-based health care, treatment, employment, and other services.

Supportive housing services sees them very much as a whole person care coordination model. With the investments in permanent supportive housing, we have seen the decreases we talked about, and there is research, and always happy to share, that has demonstrated that supportive housing can increase housing instability and improve health.

We are talking specifically about people with disabilities and people who are aging, or the chronic homeless population, than the other people experiencing homelessness. Many just need an affordable housing option, for a lot of folks that are aging or have disabilities, Permanent Supportive Housing.

Acute-level services, shelters, hospitals, jails, prisons, nursing homes, and other institutions people are hoping to return to the community. Next slide.

Supportive housing is an evidence-based solution that is affordable and independent and aligns well with the *Olmstead* mandate and the letter and the spread of the law. And these services are flexible, voluntary, and tenant-centered and housing-focused, and there may be additional services, behavioral health services. Different programs target different operations, and you may need services there. From a values perspective they aligned very well with all of the work of home and community-based services and all the work you are doing out there.

Case management is a term that means different things to different people – case management in the housing world and homelessness world means a very low caseload, one to 10, one to 20, hands-on support, very focused on assisting the individual, very different from what case management means in many of the disability and waiver programs. Your caseloads are much higher there.

Next slide, please. With this, I pass it over to Sharon from the Department of Housing and Urban Development.

SHARON P SINGER: Thank you for setting the stage looking at the data that has been gathered to show where we are at this moment. I am from the Special Needs Assistance Programs Office, and if you look at the legislation, we are called the Homelessness Assistance Grants, and this is a quick snapshot of our programs. The largest, by far, is our continuum of care program.

Right now we have our competition, which is open. I have assumed people on the call who are very visibly working towards the September 30 deadline, that is $2.8 billion and the biggest competition in all of government, I believe.

We have block grant funds that are geared – it used to be called the Emergency Shelter Grant, it was changed to the Emergency Solutions Grant in 2009 with the HEARTH Act, which put into place more formally this continuum of care structure I will talk about.

Continuum of care is about funding Permanent Supportive Housing, which Marcella just talked about, Rapid Rehousing, for people who have less of a long-term need for support and with a few months of support could be stable and, in addition, supportive services.

Obviously, with COVID, I would say there's probably a lot of new examples of collaboration that has happened between the health system and housing, and homelessness.

Our ESGCB fund was almost $4 billion in the CARES act and is still being spent. Right now, we have a special NOFO which is for people who are unsheltered or in rural areas. We have a youth demonstration project.

There is a lot going on in our office, lots of new acronyms for you to learn. You can go to the next slide.

Just taking a quick look at the slide, just talks about the priorities of this year's NOFO and usually it is pretty similar, last year's was pretty similar.

And using a Housing First approach, making sure people do not have to jump through hoops to get to housing. That had historically been the way a lot of programs approached getting into shelters, being sober, being compliant with medication, and that shift away from setting – being a low barrier to entry and helping people to get into housing, and address whatever needs are there.

I would also point out Priority Five as partnering with housing, health, and service agencies, which is many of the groups on the call today.

There are nine priorities on there you can see. These will be shared with you afterwards. You can go to the next slide.

So, it's a little confusing. A continuum of care is the body that helps to apply for those funds that are also called continuum of care. It is a little confusing. This body is a group of local government, non-profit, and other entities that work on a range of housing and services, as well as – and it's really required to bring community partners together.

That is written into the rule, the Continuum of Care Rule from 2012, which is requiring that they bring together the hospitals, the health providers, the veterans groups, people with the lived experience being part of these conversations. So, it is really meant to bring people together. Thank you for spelling out NOFO there are a lot of acronyms on both sides.

As mentioned, there are a lot of parallels to how this work is being done in a community setting. It's meant to be collaborative. It does not have to be a local government body, it could be a non-profit that is the collaborative applicant that pulls people together, both about the CoC funding but about addressing homelessness as a community.

What are your non-sheltered numbers? What are your numbers of people with disabilities? What are the gaps in services and housing and how can you work with these local partners to address them? We can go on to the next slide.

I will skip this, but I will say there are different activities. For example, unsheltered outreach can be done through different funding sources. There are a range of funding sources, ours, although it's a large amount, there are local, state, local, and non-profit partners that fund these projects and are required to be partners in terms of match and in terms of collaboration.

What I would say is, annually, HUD does require that communities gather what they call a "point-in-time count" and if you are interested in getting involved in your community, that is a great place to start. It is one or two nights in January, where they both look at who is in the shelter that night, but also, who is out on the street to try and engage them for housing and services, and to understand those needs.

Obviously, January 2021, it was not a requirement to do these outreach, unsheltered counts. So, our data is little bit off for last year.

Let's go on to the – and just to say back to the continuum of care and collaboration is if you are not already a partner with your continuum of care, please reach out. On our website, on the HUD website, you can easily find who the leader is and to contact them to be invited to meetings, and to find ways to collaborate more fully.

If you could go to the next slide... Very quickly, I know we are running over, there are different categories of homelessness across the federal government that can be challenging to navigate.

To enter Permanent Supportive Housing, for example, or to enter shelter, you would need to be either literally homeless, living on the street, in shelter, someplace not meant for human habitation like a car, or at imminent risk of homelessness, which is 14 days out. We do talk about other federal statutes, and each community has some flexibility as to whether or not to use those, again, the CoC should be partnering with the schools, with the hospitals, with the Area Agencies on Aging, to try and find ways to work together.

Obviously, people who are attempting to flee domestic violence are -- automatically pulled into the system regardless of where they have come from. We do have a separate definition for at risk of homelessness that is rather lengthy. I did put this in the notes. When you get slides, you can see more detail.

For example, to come into Permanent Supportive Housing, as Marcella said, you need to have a disability. And to be prioritized by your community. That will be my last slide. The next one.

I am the lead for the Office on Coordinated Entry, and this is a policy that was put into place in 2017, and asked communities by 2018 to have this in the works.

HUD requires communities to have this system of inflow, both to try and prevent people from coming into homelessness and divert them to stable housing through other resources, often what we call "mainstream resources," but when people come through the info of the system, there are different stages.

Historically, this has been very disorganized and random as to who got into housing.

The goal is to be more equitable and make sure it is person centered and people are getting these services and housing that they need. And that works within the system.

To make sure that the most vulnerable are assisted first, and that people exit to the type of services that match them. At the bottom, the outflow might be Permanent Supportive Housing, Rapid Rehousing, some very few transitional housing programs but that could be one, or for the housing may be with a Section 8 voucher, it may be some – or a low-income tax unit, or a senior program for low-income seniors.

There are a range of possible places for people to come out. There are other slides we have hidden but will be available to you to talk more about this. This is meant to be not just about housing, but also about services.

If someone is potentially coming into Permanent Supportive Housing, they may need assistance from a range of community partners. It is to make sure those partnerships are lined up. So that the household is successful in that housing and can remain there for as long as needed.

I know there's a lot more to say, but I will pass it off. I think you will hear from some local communities that can talk more in detail about how to make this work.

LORI GERHARD: Thank you, Sharon and Marcella, for that exciting overview of homelessness, continuums of care, our CoCs, and coordinated entry systems.

We'll change to our Florida and Virginia partners to talk about the benefits of these partnerships. It is my privilege to introduce Jackie Fortmann and Johnna Coleman, who is the Executive Director at Big Bend Continuum of Care in Florida.

Joshua Gemerek, who is the Senior Vice President of Housing at Bay Aging, and Angie Alley, who is the Assistant Director for Housing Services at Bay Aging, an Area Agency on Aging in Virginia.

We will ask them to provide backgrounds on partnership efforts, and we will turn it over to Jackie to get started.

JACKIE FORTMANN: I am Jackie… this is a Center for Independent Living in North Florida. We have a bunch of programs. The one we are focused on today is our Homeless Services Department. This is a pretty new department for us. That consists of a director, which is me, and two full-time staff members who are dedicated to street outreach and identifying unsheltered individuals experiencing homelessness.

Their mission is to engage and build trust with homeless individuals with the hopes of getting them into housing, and in the meantime, provide them with necessities while they are unsheltered. The 2021 point-in-time count identified 91 unsheltered individuals, and 52 is a typo, it's actually 197 chronically homeless individuals in 2021.

I did pull the 2022 stats for that, too. There is 164 unsheltered, with 153 of them being chronically homeless for the 2022 point-in-time count.

With the current cost of rentals and inflation, it's more and more people that will become homeless. Next slide.

Our population target are individuals with disabilities who are homeless or unsheltered, and we help by providing food such as ready-made meals, snacks, and drinks; those basic necessities that I mentioned, which are clothing, shoes, sleeping bags, portable showers, hygiene items, backpacks, flashlights, etc. Transportation, bus passes, they can get to where they need to go and attend the appointments that we all need to go to.

Referrals. We refer in-house assistance with Social Security, and other benefits, and we provide information regarding local shelters, food banks, CareerSource, mental health, substance abuse treatment, and so on.

We provide case management, assessing their housing needs, (Indiscernible), coordinating, and monitoring the delivery to meet the needs of the program participant.

We have Rapid Rehousing funds to assist people with documentation and assist people with individuals to move, whether that's to, you know... regular housing, or prepare them for Permanent Supportive Housing, which was mentioned before, too.

Johnna, were you going to go over the slide?

JOHNNA COLEMAN: We partnered with several programs, and Ability1st.

We are working with them through our CoC, which has the largest – we have the largest... not population with the largest area coverage, I'm sorry, for Florida. We do cover eight counties.

The majority of individuals experiencing homelessness are located within Lyon County, Tallahassee area. I have seen people talk about the rural areas that they just do not have the resources, and hopefully we are able to address some of those through our NOFO and partnerships with agencies such as Jackie's program. Being able to reach those people in those rural counties for us will be critical.

We do partner with other – specifically other agencies such as our Capital City Youth Services, that services youth; the Kearney Center, which is our largest emergency shelter; our homeless coalition, they service our Rapid Rehousing; and emergency shelter for families; and the refuge house, which is our domestic violence shelter, and they also offer transitional housing.

And also, some crisis support lines. We have Ability1st working with our systems and we work with them through a CoC, HUD CoC-funded for individuals who have chronic homelessness with the PHS program, and we have a PHS programs for families.

Our partnership is unique, and we definitely know there is a need for us to partner with agencies that specialize in assisting individuals with disabilities. Next slide.

JOSHUA GEMEREK: Thank you very much. I'm Joshua Gemerek. Can we go back to the previous slide? If you do not mind, thank you. Just to give folks the overview.

Bay Aging is a 501(c)(3) non-profit corporation, and we are headquartered in the town of Urbana in the northern peninsula region of eastern Virginia. I wanted to give you a geographical scope there or idea, or context.

Formed in 1978, for 44 years, we have been providing services with the mission of -- serving clients, and you can see Bay Health, Bay Housing, and Bay Transit here.

We are an Area Agency on Aging and Community Action Agency certified by the state of Virginia.

This puts us in a unique position to provide services to older adults and alleviate issues of property. For the health, housing, and transportation, and how those interact, and preserving this independence, it's very important. Next slide, please.

So, not gonna go through all the services, but I do want you to have an idea of the scope of the services that we offer, because they all achieve this theme of independence. In our in-house services department, we are offering things like Meals on Wheels delivery, home care, adult day care, active lifestyles centers with congregate dining and nutrition opportunities, and a Veteran Directed Care program that operates at a multiple state area, helping veterans stay – nursing home eligible – stay independent. Next slide, please.

With the transportation and housing, the transportation is public transportation. It's important for securing and preserving independence for folks experiencing homelessness, folks in-house and everyone in the community.

It's available because it's public transportation and available for everyone at a low cost. As you can see on the list, we offer transportation that allows people to go to medical appointments, and we are an on-demand response. They pick you up at your door, and they take you to work, you may be shopping, anywhere you would like in the area.

We have fixed routes. We have a variety of single-family and multifamily housing programs that are integrated and work in a variety of levels to prevent homelessness.

On the single-family housing side, we are making low-income homeowners' homes more energy-efficient for weatherization assistance. We have an emergency home repair program. It can cover and make repairs to low-income homeowners' homes, critical repairs.

We partner with local governments and Community Development Block Grants fixing up whole neighborhoods and providing new housing to low-income owners.

We are the Housing Choice Voucher Program Section 8 administrator for many local governments in our local areas in every service region.

We have developed and currently operate numerous mental health communities that are mostly age restricted, not exclusively, but for the most part they are age restricted and income restricted, and this supportive housing we have developed is important in preventing homelessness.

We have close to 400 units under management at 12 distinct properties. We have a menu of homeless solutions programs, Rapid Rehousing, homelessness prevention, housing navigation, for recruiting landlords and engaging with landlords, and we are the coordinated entry point of contact and operate that hotline.

That is an important entry point for all of our services. We manage HMIS data, that is Homeless Management Information Systems, and we act as the lead agency for what we call the Local Planning Group, but it operates like a continuum of care, or CoC. We fall underneath the state of Virginia Department of Housing & Community Development. We fall under that and operate our local planning group.

It really operates the same way as any other CoC. Quickly I will say, we have implemented a number of homelessness prevention add-ons, possibly, or augmentations to our programs. We have a homeless preference for all of our rental housing, a system that HUD approved formally, very proud of that.

We offer emergency housing vouchers and Voucher Choice program, and we have a team of managers that will handle the folks and get them set up in the housing we are operating.

To give you a flavor of the services we offer, we have embraced that.

We will talk more about that a little bit more.

ANGIE ALLEY: Good afternoon, I'm Angie Alley. In the essence of time, since most everything has been covered, the Bay Aging service team provides coordinated entry and works with these partners. The list of potential examples of partners that we have in our continuum of care are on the slide right here.

Josh mentioned our homeless preference, and that's been really successful for placing our senior folks into Permanent Supportive Housing, and another thing we found was necessary is we had folks having difficulty assimilating once they were placed in our apartment communities.

We formed a transitions team and that's comprised of our case managers and service coordinators who work on-site at our apartment communities.

Sometimes, folks need a little extra help and a team of folks that can come up with some creative ways to help them out. That has been a successful program for us.

I wanted to make sure we added that to our list. Thank you!

MARCELLA MAGUIRE: Thank you, everyone, for this. I want to acknowledge in the chat, there is a lot of discussion and people who are both people themselves experiencing homelessness, and challenged, and cannot meet the needs, cannot find housing, cannot find services; also people who run programs, who are also trying to assist with far too few resources. You will not have the answer to all of

those questions here, etc. Please keep putting them in chat and making your voices heard.

We will work through all the questions we can to answer them. I wanted to acknowledge that.

Our first question is a basic one: How did your partnership start? How did your partnership build? Josh, you are a AAA as well as CoC. I hear incredible partnerships happen in Tallahassee with the Big Bend CoC. How does this all start? Let's start with Jackie and John.

JACKIE FORTMANN: I've only been with Ability1st for two years. Johnna has been with the CoC as long as I've known her. Maybe she will have more insight on how Ability1st, how that partnership started. I originally – ever since I got my degree, I worked in homelessness.

I initially started working at the CoC to make sure my clients were on the supportive housing list and getting them housed. That is initially how I met Johnna. Maybe they can speak to how the relationship originally formed.

JOHNNA COLEMAN: Long before me, I came in 2016, long before me they were working with Big Bend Homeless Coalition with the collaborative applicants. They worked to form our first program, and they first took over a program, was an individual program and there was a need for where Ability1st... (Static) and therefore, apply for PSH.

They brought on a family program for PSH and to house 13 families through PSH, and since Jackie and I have been on, we have worked to develop with them a Rapid Rehousing program, as well as street outreach. That is how we connected.

MARCELLA MAGUIRE: For Josh and Angie, what about up in Virginia?

JOSHUA GEMEREK: Thanks for asking. For me, it's a story that always excites me. I always like talking about it. Our partnership really began about 10 years ago in our region. It went from no activity with any programs serving those experiencing homelessness, and there was a real void.

One of our big 10 service areas, one of our counties had a Resource Council meeting monthly. We had a subcommittee, and I was a member at the time, and it was really a discussion thing. From that, we had some key folks at different domestic violence shelters, the Department of Social Services, the Community Services Board, a couple of smaller community-based organizations. We began talking and talking.

We received a grant from the National Coalition on Homelessness, the Community Change grant that allowed us to hire a consultant. We developed bylaws, we became – we went to the – we covered the 10-county region, and we gained

approval from the Department of Housing & Community Development to be seen, or by Bay Aging, to act as the lead agency.

It was an interesting concept at the time. Everyone was reluctant to jump – we want to be the agency; nobody had a burning desire to do that. It was a new thing and new direction.

Bay Aging was serving the 10-county area already through all those other programs I spoke about: transportation, health, and housing.

A lot of folks in the room were looking at us – tacitly approving us, seeking that leadership role, and we do take that very seriously. We did acknowledge the need existed, and then it would – it would complement the existing programs and all that housing I was talking about the rental housing communities, and folks were already moving into those properties that had previously been homeless.

Were not necessarily making it a formal thing. All that happened, and now Bay Aging is the lead agency, and we manage the point-in-time, coordinated entry, HMIS. I am very proud of that history. I hope that helps! Angie, if you have anything...

ANGIE ALLEY: I think you covered it, Josh. Thank you.

MARCELLA MAGUIRE: Let me ask one question here – what qualities do you each look for in your potential partners, and what you need to successfully collaborate and/or create the change you are each working towards making? I saw a lot of comments in the chat where people said, I'm from the homeless system and try to reach out to s, I cannot get a response, I'm in the aging, and trying to reach out to the homeless district, and I cannot get a response.

From the homeless world, please, they are in the middle – Johnna, I'm shocked and thrilled you are with us, they have a competition for their funding due in September and have another NOFO, notice of funding opportunity for unsheltered and […] due in mid October.

On the homeless side, keep trying and calling – I want to hear from you all, what do you need from those partners?

JOHNNA COLEMAN: I am answering my emails and getting tons of questions and we have things to do tomorrow.

I can say that what we look for in a partner is someone who is actually serving our population. We will look for a mission that aligns with our mission, and making sure the agencies we partner with have the ability to provide low-barrier, and housing focused – Housing First focused programs.

So, those are largely the things we are doing. At this time, we are definitely looking into capacity building, as we have noticed a lot of our agencies are kind of over it.

(Laughs) To have reached a point where they have just come to the end of their capacity, and we are looking to build some capacity within our community.

At this point, it's a pivotal time to start building those new relationships with agencies and organizations that you have not already been working with.

MARCELLA MAGUIRE: Jackie, what about from your end? What do you need from a partner?

JACKIE FORTMANN: For us, learning from our partners, what services they have to offer, you know, identifying gaps in our services, and how that can help us.

And learning about all the specialties so that we can give that information to our staff, and they can be aware of all the resources so when they get a client, they know, here, here, here. They know exactly where to send that client for everything that they need.

Definitely keep communicating with those partners, because things are always changing. But just making sure that we have the resources to give to our staff, to give to the consumers.

MARCELLA MAGUIRE: Josh and Angie, we have two minutes before have to hand it back to Lori to close us out. What do you look for in partners?

JOSHUA GEMEREK: Angie, do you want to say anything on those? What do you think?

ANGIE ALLEY: Think the other ladies did a great job in covering the types of things that we look for in partners. I want to add something that might be of interest to folks, something we do to keep our partners engaged. We do a weekly newsletter and a once-a-month landlord newsletter. That can be anything from hot topics, or housing information, and just keeps us engaged and in touch with them on a regular basis.

That has been helpful for us in maintaining those relationships over the long-term.

MARCELLA MAGUIRE: Maintaining the relationships over the long term. So true! With that, Lori, back to you.

LORI GERHARD: Thank you very much. Thank you for all the questions, and we will respond back with a frequently asked questions document to respond to these questions. We are sorry we are getting a little short on time, but it's clear, there is so much interest in this topic that we need to develop a few webinars and opportunities for technical assistance.

Watch your emails and newsletters for that. If we move on to the next slide – we want to announce information about a free training our colleagues at the Centers

for Disease Control and Prevention, CDC, have made available. This is available for anyone who serves people who are experiencing homelessness.

You can access this training. There is a link on the slide. You can also access it by creating a free account at www.train.org, and the course provides trainees with the knowledge and skills needed to ensure public health protections and recognize and respond to public health emergencies among people experiencing homelessness.

Upon conclusion of the course, those who take the course will be able to take action to form partnerships with homelessness organizations and ensure people experiencing homelessness are represented in public data and analysis, and tailor public health interventions and measures for people experiencing homelessness.

We want to thank our colleagues at CDC for developing this training, and it's an excellent training, and encourage everyone to take it. If we move on to the next slide, we would like to highlight two key studies we released today. These case studies feature Bay Aging in Virginia and various partners and include approaches to promote housing stability and strategies to address homelessness, and we encourage you to visit our website and look at the What's New section to view these key studies.

If you registered for today's webinar, we will send out the links to this information. We have additional resources on the slide here. They are the HUD landing page for the continuums of care or CoCs, there is a link to the HUD point-in-time counts, and a link to the HUD Housing Inventory Chart, or HIC, which is a homeless-related program, and in your community.

And the HUD Continuum of Care Board. You can see where your continuum of care might be in your community. If we move on to the next slide... these learnings will be put into the chat, and we also make them available in the materials you will receive from this webinar.

We would like to ask you to take a few minutes to respond to our five questions, and rate different aspects of today's webinar, for your feedback is so important. We have a lot of information to cover and getting as much to everyone as possible. And help you facilitate partnerships. Let us know how we can do this better. We read all the comments we receive.

Please take time to fill out the survey form. On the next slide, we want to hear from you, the Housing and Services Resource Center, it is all of our Housing and Services Resource Centers.

Email us at hsrc@acl.hhs.gov about what your technical assistance needs might be, website suggestions, and tell us about your own cross-sector partnerships. We use this information to help develop our faculty for future technical assistance materials.

Next slide. Finally, we want to thank today's speakers, our colleagues at HUD, thank you so much, Sharon, for your presentation, and your preparation. The ACL housing team, especially our colleague who at the last second put together the YouTube livestream. Thank you so much.

We want to thank Mission Analytics and USAging, who are the contractors for HSRC, […], our interpreter, and Nick, our CART specialist, and their role in today's webinar. We are grateful for everyone for joining us. Thank you for sharing all of your information in the chat; it encourages us to work together to help people get stably housed.

Thank you, and have a wonderful afternoon!