Southern Nevada/Clark County
Homeless Housing and Services

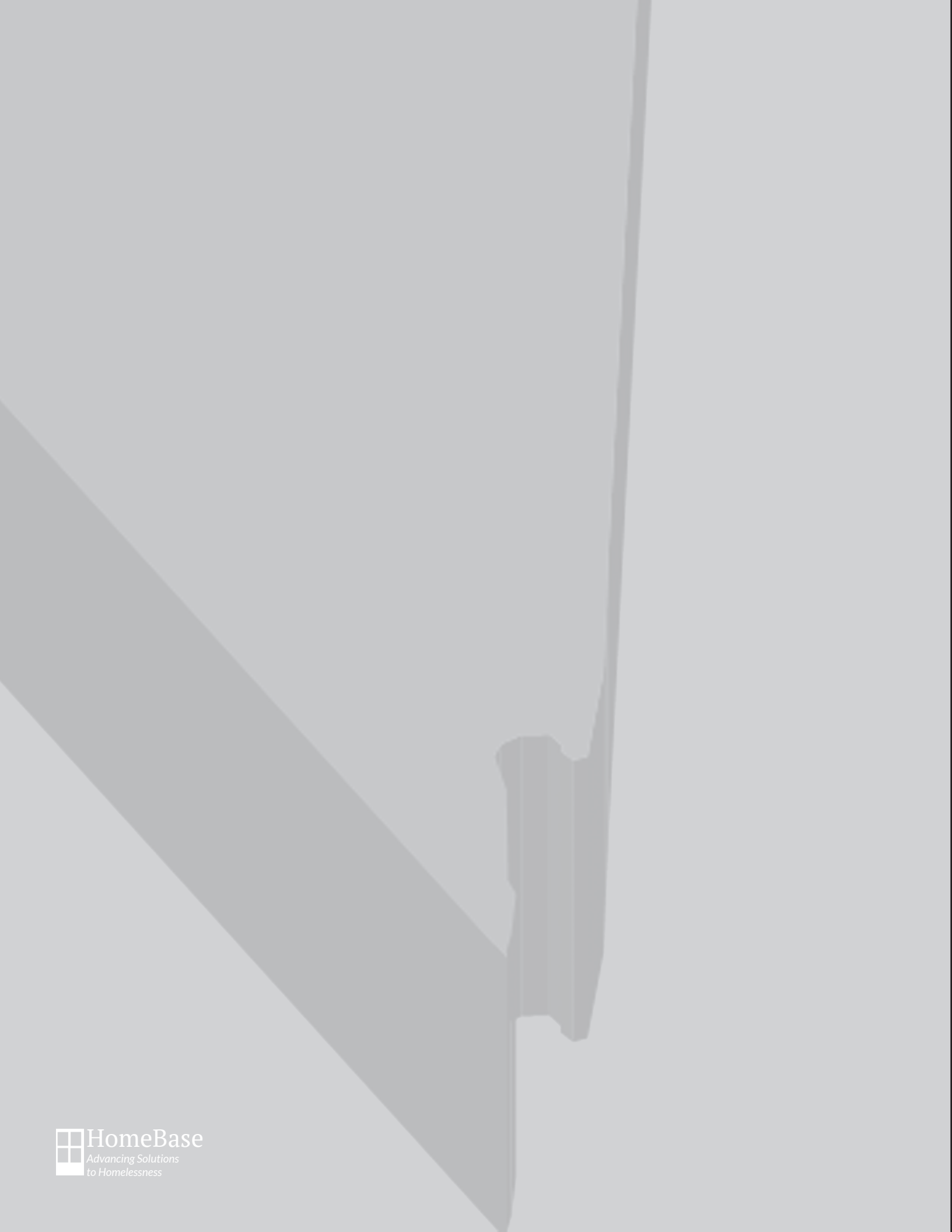
GAPS ANALYSIS

Southern Nevada Regional Planning Coalition
Committee on Homelessness

July 2013

Prepared By:

HomeBase
Advancing Solutions to Homelessness



HomeBase
Advancing Solutions to Homelessness

Southern Nevada/Clark County Homeless Housing and Services Gaps Analysis

Southern Nevada Regional Planning Coalition

Committee on Homelessness

Contents

Executive Summary

This gaps analysis was conducted as part of the ongoing efforts by the Southern Nevada Regional Planning Coalition Committee on Homelessness (CoH) to lead a regional response to homelessness. The goal of this gaps analysis is to help the region update its understanding of homeless need. The gaps analysis identifies key unmet needs in the housing and services system, focusing on overall needs as well as specific sub-population and geographic needs. It also considers the overall functioning of the system as a whole and identifies strategies to improve system-level effectiveness and efficiency.

Information for the gaps analysis was gathered through a variety of strategies as outlined below:

1. A survey of homeless housing and service providers
2. Client focus groups
3. A meeting of providers
4. A meeting with law enforcement and hospitals focused on discharge planning
5. Key informant interviews
6. Review of documents, including the 2005 Gaps Analysis, 2011 Homeless Census and Survey, 2011-2013 Point-in Time Counts and Housing Inventory Counts, Homeless Management Information System (HMIS) data, Homeless Prevention and Rapid Re-Housing program (HPRP) Evaluation, and other data and information sources

2013 Housing and Shelter Inventory Analysis

- The current distribution of beds across sub-populations does not mirror the respective size of those sub-populations.
- Typical length of stay for emergency shelters has been dramatically reduced during the 2010 – 2012 time period. In 2012, most people stayed only 1-7 days.
- Typical length of stay for transitional housing has been reduced during the 2010 – 2012 time period. In 2012, fewer than one out of seven stayed more than 9 months.

System Level Gaps Analysis

Six key system level gaps were identified in the overall functioning of the Southern Nevada / Clark County homeless housing and services system. Two gaps are client focused, addressing people's ability to access the system of care and obtain coordinated assistance that results in ongoing stability. Three gaps are focused on system level capacity, including areas such as leadership, community engagement, planning and evaluation, and the need to promote ongoing quality improvement.

System level gaps included:

1. Improve Access to the System and its Services
    a. Establish centralized/coordinated intake and assessment
    b. Provide low threshold access to the system

2. Facilitate Coordinated Service Delivery and Follow-up after Housing Placement to Ensure Ongoing Stability
    a. Expand case management capacity
    b. Establish system-wide case management standards and tools and provide best practices training

3. Enhance System Level Capacity for Leadership, Planning, Oversight and Program Support
    a. Enhance staffing for the CoH
    b. Enhance the effectiveness of the CoH membership

4. Increase Community Engagement and Support for Preventing and Ending Homelessness
    a. Initiate a regional campaign to build public awareness and support for efforts to address homelessness

5. Support Provider Capacity-Building and Quality Improvement
    a. Commit resources to provider training and capacity

6. Engage in System Level Data Analysis and Performance Evaluation To Drive Resource Allocation
    a. Conduct a system-wide evaluation of emergency shelter, rapid re-housing, and transitional housing to inform resource allocation and policy and program development.

Program Level Gaps Analysis

Key gaps were identified in seven different program components within the system of care. Evaluation of gaps within each component considered what else is needed, including both new services as well as expansion of existing services, changes that would make these services more effective and accessible, and identification of underserved and high priority sub-populations.

Homeless Prevention and Rapid Re-Housing Services

1. Expand prevention and rapid re-housing services
2. Facilitate access to services through improved outreach and collaboration with other agencies, particularly mainstream agencies
3. Improve linkage of clients with additional support to foster ongoing stability

Basic Needs Services

1. Expand Availability of Transportation Assistance
2. Establish a Year-Round 24 Hour Drop-In Program

Health and Behavioral Health Services

1. Provide Dental and Vision Services for People with Low or No Income
2. Enhance Access to Health Care Services and Provide Appropriate Follow-Up
3. Provide More Mental Health Services
4. Offer Additional Substance Abuse Treatment

Shelter and Housing

1. Evaluate and expand shelter capacity
2. Provide centralized housing search assistance and explore master-leasing of units
3. Develop more permanent supportive housing and affordable housing, and including Housing First capacity

Outreach, Case Management, Referral, Advocacy and Legal Services

1. Expand Case Management Capacity and Quality
2. Use Peer-Mentoring to Supplement Case Management Support
3. Provide More Outreach and Engagement and Establish System-Wide Standards
4. Establish a Homeless Court

Children, Youth and Family services

1. Develop shelter and housing for youth, linked with intensive case management
2. Provide youth-targeted education and employment services
3. Expand affordable housing for families
4. Improve collaboration and communication between homeless services providers and Child Protective Services
5. Facilitate affordable childcare options for working families

Education, Skill Building and Employment Services

1. Facilitate homeless access and success in mainstream employment and training services
2. Identify employers who will hire homeless people, and provide follow-up and support to facilitate job retention

Introduction/Background

This gaps analysis was conducted as part of the ongoing efforts by the Southern Nevada Regional Planning Coalition Committee on Homelessness (CoH) to lead a regional response to homelessness. Understanding that having an impact on a social problem as complex as homelessness requires coordinated action across diverse sectors working towards a shared vision, the CoH is working to develop a collaborative approach for addressing homelessness among local governments, housing and service providers, local businesses and community leaders in the Southern Nevada region.

The 2007 "Help Hope Home: Southern Nevada's Regional Plan to End Homelessness" laid out a shared vision and strategies that have provided a blue print for regional efforts. The 2010 Plan Implementation Update provided further detail to guide continued implementation efforts and the Plan is currently being updated again in 2013.

Informed by the new federal vision for the response to homelessness as outlined in "Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness" and charged with the implementation of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act requirements for the Las Vegas/Clark County Continuum of Care, the CoH initiated this gaps analysis to help guide and target future action and strategic planning in the region regarding homelessness.

The goal of this gaps analysis is to help the region update its understanding of homeless need. The gaps analysis identifies key unmet needs in the housing and services system, focusing on overall needs as well as specific sub-population and geographic needs. It also considers the overall functioning of the system as a whole and identifies strategies to improve system-level effectiveness and efficiency. Based on this new understanding of program- and system-level needs, the Southern Nevada region will be able to better align its activities and investments across sectors and jurisdictions to achieve a collective impact on homelessness.

Southern Nevada Regional Planning Coalition Committee on Homelessness (CoH)

The Committee on Homelessness (CoH) is a cross-sector, cross-jurisdictional planning body tasked with developing and implementing a regional response to homelessness for the Southern Nevada region. Established in 2004 and staffed by the Clark County Social Service Department's Regional Initiatives Office, the CoH provides a forum for planning, policy and program development to prevent and end homelessness. It provides leadership and coordination for key regional efforts including:

- Implementation and evaluation of "Help Hope Home: Southern Nevada's Regional Plan to End Homelessness"
- Annual Homeless Census
- Homeless Management Information System
- Continuum of Care Coordination and Annual HUD Application
- Project Homeless Connect
- Regional Crisis Intervention Team
- Inclement Weather Shelter Program
- "No Wrong Door" Homeless Prevention System

The CoH membership includes:

- Clark County
- City of Boulder
- City of Henderson
- City of Las Vegas
- City of North Las Vegas
- Nevada Homeless Alliance
- Las Vegas Metropolitan Police Department
- Southern Nevada Adult Mental Health Services
- Clark County Social Service Department
- U.S. Veterans Affairs
- Local Businesses

HomeBase, a nationally known technical assistance provider on homelessness, was contracted to conduct the gaps analysis during Spring 2013.

Information for the gaps analysis was gathered through a variety of strategies as outlined below:

1. A survey of homeless housing and service providers
2. Client focus groups
3. A meeting of providers
4. A meeting with law enforcement and hospitals focused on discharge planning
5. Key informant interviews
6. Review of documents, including the 2005 Gaps Analysis, 2011 Homeless Census and Survey, 2011-2013 Point-in Time Counts and Housing Inventory Counts, Homeless Management Information System (HMIS) data, Homeless Prevention and Rapid Re-Housing program (HPRP) Evaluation, and other data and information sources

The appendices contain copies of the tools used and details on the individuals and agencies consulted through the survey, focus groups, meetings and interviews.

I. Overview of the Homeless Population and Nevada's Economic Context

While homelessness in Nevada has decreased in recent years, the numbers are still high, giving Nevada one of the highest rates of homelessness in the nation. In addition, a high proportion of the population is unsheltered, particularly among single individuals without children. With a backdrop of economic distress and high housing prices, Southern Nevada has growth in many of the factors that pose a risk of homelessness. The following sections provide an overview of the demographics of the homeless population and the economic and housing market trends that influence these numbers.

A Snapshot of Homelessness in the Southern Nevada Region

2011-2013 Point-in-Time (PIT) Count Data

Year	Total Persons	Singles			Persons in Families		
		Total	Sheltered*	Unsheltered	Total	Sheltered*	Unsheltered
2013	7355	6746	2920	4435	610	589	21
2012**			2358			724	
2011	9432	8536	2890	5646	896	872	24

* The Sheltered Category includes people in emergency shelters, transitional housing and safe havens.
** In 2012, an unsheltered point-in-time (PIT) count was not conducted. They are only required by HUD in odd years.

Most people who are homeless in Southern Nevada are single adults without children.

Most are living unsheltered – on the streets, in parks, vehicles, abandoned buildings, and/or in other places not meant for human habitation.

Highlights[1]

- There are 7,355 people homeless on any given night in the Southern Nevada region. This is a 22% reduction since 2011.
- 92% of the homeless population is single,[2] in households without children. The percentage of persons in families (8%) is much smaller than the percentage nationally (38%).
- More than half (60%) of people who are homeless are unsheltered, the same percentage as in 2011. This is significantly higher than the national percentage of people who are

1 Homeless population and sub-population data for Southern Nevada/Clark County are from the 2013 PIT Count. National homelessness data are from the National Alliance to End Homelessness's report: The State of Homelessness in America 2013. Available at: http://b.3cdn.net/naeh/bb34a7e4cd84ee985c_3vm6r7cjh.pdf.
2 Includes single adults and unaccompanied youth.

unsheltered (38%).

- Almost all of the unsheltered population (99.5%) are in households without children. 90% are single adults and 9% are unaccompanied youth under 18 years of age.
- 6% of the homeless population is unaccompanied youth under 18 years of age. 92% of unaccompanied youth are unsheltered.
- 9% of the homeless population is chronically homeless, less than the 16% who are chronically homeless nationally. Of those who are chronically homeless, 68% are unsheltered.
- 12% of the homeless population are veterans, much the same as the national rate of 10%. 53% of homeless veterans are unsheltered.
- 25% of the homeless population is estimated to have a severe mental illness. 65% are unsheltered.
- 9% of the homeless population is estimated to have a chronic substance abuse problem. 73% are unsheltered.
- 11% are victims of domestic violence, and of these, 57% are unsheltered.
- While only 1% of the homeless population are persons with HIV/AIDS, 86% of those with HIV/AIDS are unsheltered.
- In 2012, the rate of homelessness in Nevada was 36 homeless people per 10,000 in the general population, much higher than the national rate of 20/10,000. This was one of the highest rates in the nation, giving the state a ranking of 48 among the 50 states and the District of Columbia. In this same time period, the rate of homelessness in Clark County was 44/10,000.

The unsheltered homeless population is composed of:

- People with severe mental illnesses (27%)
- People with chronic substance abuse problems (11%)
- People who are chronically homeless (11%)
- Veterans (10%)
- Victims of domestic violence (10%)
- Unaccompanied youth under age 18 (9%)
- People with HIV/AIDS (1%)

Note: People may be represented in more than one category.

The State of Nevada has one of the highest rates of homelessness in the nation.

The Economic Context in the Southern Nevada Region

While homelessness has decreased in recent years, the economic indicators for Nevada paint a picture of continuing hardship and risk for those with the lowest incomes. The following section provides information on three factors typically identified as key causes of homelessness: poverty, low wages and lack of employment, and high housing costs. Additionally, data is provided on the increase in vulnerable households with characteristics that may pose a risk for homelessness.

The December 2012 Hunger and Homelessness Survey by the U.S. Conference of Mayors cited lack of affordable housing, poverty and unemployment as the main causes of homelessness.

Poverty

- The median household income in Nevada was $48,927 in 2011, less than the national median of $50,502. Median household income in Nevada has been steadily falling since it peaked in 2007 at $59,727.[3]
- 22% of the population in Nevada is uninsured, compared to 16% for the nation overall.[4]
- One out of every five Nevada children lives in poverty, and Nevada is ranked 48th of all the states on overall child well-being. This rank was developed considering data in four domains: economic well-being, education, health, and family and community.[5]
- An increasing number of households in Nevada are food insecure, meaning that they do not have "access at all times to enough food for an active, healthy life for all household members."[6]
    - » 15% of Nevada's households are food insecure. This is a 50% increase since 2007.
    - » 16.5% of Nevada's seniors face the threat of hunger, surpassing the national average of 14.85%. This is the tenth highest senior hunger rate in the nation.
- Between February 2008 and February 2013, Nevada had a 156% increase in SNAPS (Supplemental Nutritional Assistance Program) participation, the largest five-year increase in the nation.[7]
- 19% of individuals ages 65 or older in Nevada have incomes below 100% of the supplemental poverty threshold 2009-2011, as compared to the national average of 15%.[8]

Wages and Employment

- 30.7% of workers age 18 and over are in low wage jobs, giving Nevada a ranking of 45 out of all the states.[9]
- 18.8% of jobs in Nevada are in occupations paying below the poverty level.[10]
- 37.4% of working families are below 200% of the poverty level, giving Nevada a ranking of 42 out of all the states.[11]

3 Department of Numbers, Nevada Household Income. Available at: http://www.deptofnumbers.com/income/nevada.
4 The Kaiser Family Foundation. Health Insurance Coverage of the Total Population. Available at: http://kff.org/other/state-indicator/total-population/
5 Annie E. Casey Foundation. 2012 KIDS COUNT Data Book: Overall Child Well Being in Nevada. Available at: http://kidscount.unlv.edu/newsletters/2012KC_state_profile2_NV.pdf.
6 Nevada Department of Health and Human Services (DHHS) Grants Management Unit (GMU). "Food Security in Nevada: Nevada's Plan for Action. February 2013. Available at: http://dhhs.nv.gov/Grants/Documents/2013-02-04_FoodSecurity-NevadaPlan.pdf.
7 Food Research and Action Center. SNAP/Food Stamp Participation, February 2013 Participation Tables. Available at: http://frac.org/wp-content/uploads/2011/01/snapdata2013_february.pdf.
8 The Kaiser Family Foundation. A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure. May 2013. Available at: http://kff.org/medicare/issue-brief/a-state-by-state-snapshot-of-poverty-among-seniors.
9 The Working Poor Families Project. Annual Data and Sources: Conditions of Employment. Available at: http://www.workingpoorfamilies.org/indicators.
10 Occupational Employment Statistics, BLS 2011 cited in Working Poor Families Project State Data Snapshot. Available at: http://www.workingpoorfamilies.org/states/popups/nevada.html.
11 The Working Poor Families Project. Annual Data and Sources: Conditions of Low Income Working Families. Available at: http://www.workingpoorfamilies.org/indicators.

- Nevada's unemployment rate has been falling, but in April 2013 it was still the highest in the country at 9.6%.[12]

Housing Affordability

- The Nevada housing wage is $19.69 – this is the hourly wage a household must earn in order to be able to afford a two-bedroom apartment at Fair Market Rent ($1,024) without paying more than 30% of their income on housing.[13] The Clark County housing wage is even higher at $20.46. This is much higher than the Nevada minimum wage of $8.25 and higher than the estimated average wage for a renter of $14.40 in Nevada and $14.63 in Clark County.[14]
- 88.6% of Nevada working families below 100% of the poverty level spend more than 33% of household income on housing, giving Nevada a ranking of 48 out of all the states.[15]
- The Nevada foreclosure rate in April 2013 was one foreclosure for every 360 housing units – the highest rate in the nation.[16]

Households At-Risk of Homelessness

- Statewide, there has been an increase in the number of households with characteristics that may pose a risk for homelessness. While national trends also show an increase in these vulnerable households, for most groups, the increase in Nevada was greater than nationwide.

Growth in Households with Characteristics Posing a Risk of Homelessness*		
Characteristic	State of Nevada Change 2010-2011	United States Change 2010-2011
# of poor renter households with severe housing cost burdens	+9%	+5.5%
# of poor people living double up	+21%	+9.4%
# of poor adults accessing safety net benefits	+22%	+11.5%
# of poor single person households	+11%	+5.8%
# of poor family households headed by a single adult	+5.7%	+3.8%

* National Alliance to End Homelessness: The State of Homelessness in America 2013. Available at: http://b.3cdn.net/naeh/bb34a7e4cd84ee985c_3vm6r7cjh.pdf

12 Bureau of Labor Statistics, Local Area Unemployment Statistic. Available at: http://www.bls.gov/web/laus/laumstrk.htm.
13 HUD defines a household as having a housing cost burden if monthly housing costs (including utilities) exceed 30% of monthly income. Households have a severe cost burden if monthly housing costs (including utilities) exceed 50% of monthly income.
14 National Low Income Housing Coalition. Out of Reach 2013: Nevada State Data. Available at: http://nlihc.org/sites/default/files/oor/2013-OOR-NV_0.pdf.
15 The Working Poor Families Project. Annual Data and Sources: Conditions of Low Income Working Families. Available at: http://www.workingpoorfamilies.org/indicators.
16 National Real estate Trends and Market Info: http://www.realtytrac.com/statsandtrends/foreclosuretrends.

II. Overview of the Current Southern Nevada / Clark County Homeless Housing and Services System

2013 Housing and Shelter Inventory Analysis

2013 Housing and Shelter Inventory*					
Type	Total Beds	% of Total Inventory	Beds for HH w/o Children	Beds for HH w/ Children	Beds for Unaccompanied Youth
Year Round Emergency Shelter	2207**	41%	1393	383	24
Transitional Housing	1074	20%	750	278	46
Safe Haven	25	0.5%	25	0	0
Permanent Supportive Housing	2032	38%	1475	557	0
Total Beds	5338		3643	1218	70

* 2013 Housing Inventory Count (HIC). Numbers do not include beds under development
** Includes year round beds plus 347 seasonal beds and 60 overflow beds.

See Appendix 1 for a detailed list of 2013 programs, organized by type (emergency shelter, transitional housing, safe haven and permanent supportive housing).

This inventory includes beds for specific sub-populations as follows:

- Survivors of Domestic Violence: There are 128 emergency shelter beds, 89 for households with children and 39 for households without children. This is much less than is needed for the 11% of the homeless population[17] that identified as survivors of domestic violence. 57% of domestic violence survivors were unsheltered.
- Persons Living with HIV/AIDS: There are 8 permanent supportive housing beds for households without children. 71 people who identified themselves as having HIV/AIDS were counted in the 2013 PIT Count, 86% were unsheltered.
- Veterans: There are 1,271 beds of all types. This includes 57 emergency shelter beds (2 for households with children and 55 for households without children), 328 transitional housing beds (all for households without children), and 886 permanent supportive housing beds (268 for households with children and 618 for households without children).
- While beds for veterans make up 26%[18] of the overall inventory, veterans are only 12% of the overall homeless population.[19] Despite the seeming over-inventory of beds for veterans, 53% of veterans were unsheltered.
- The inventory contains a disproportionate number of beds for persons in households

17 This percentage refers only to the 777 adults who identified as victims of domestic violence in the 2013 PIT Count. Any children who are with them are not included in these numbers.
18 Calculation is based on the total number of emergency shelter, transitional housing safe haven bed and permanent supportive housing beds, excluding seasonal and overflow beds.
19 866 individuals identified as veterans in the 2013 PIT Count.

with children, while the percentages of beds for individuals without children and for unaccompanied youth (under age 18) are smaller than their respective proportions of the overall population.[20]

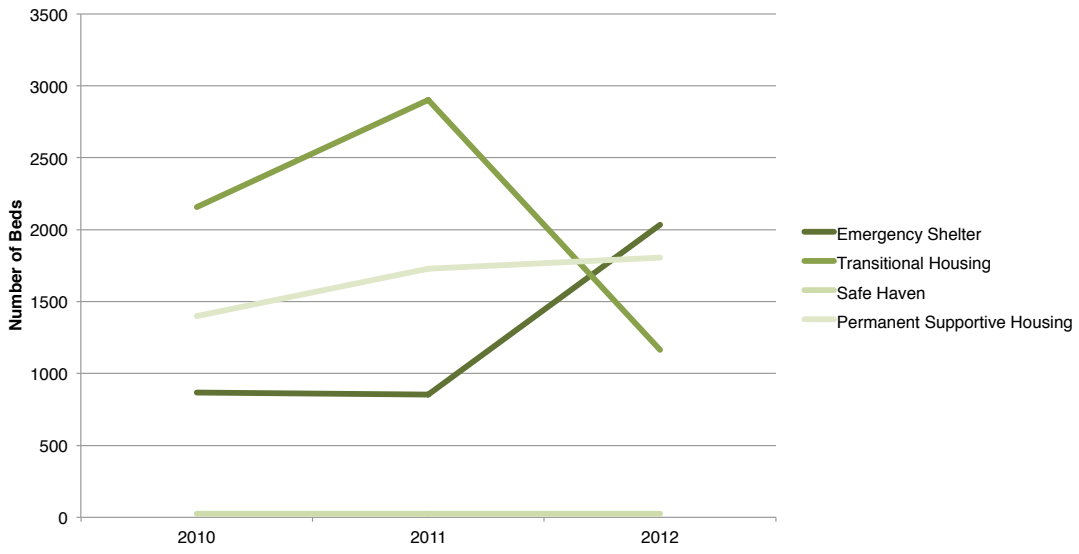
- 25% of emergency shelter, transitional housing, safe haven and permanent supportive housing beds are for households with children. This sub-population makes up 8% of the overall homeless population.
- 74% of beds are for adults without children. Single adults make up 92% of the overall homeless population.
- 1% of beds are for unaccompanied youth (under age 18). These youth are 6% of the overall homeless population.

Housing and Shelter Inventory Trends 2010-2013

Since 2010, there has been a 14% increase in total inventory, despite a 1% loss in the last year. This increase is due to overall growth in the number of emergency shelter beds (despite a 6% loss in beds in the past year) and annual growth in the number of permanent supportive housing beds. Transitional housing inventory has been cut in half during this time period. This is consistent with national trends, where CoCs are reducing transitional housing to fund more cost-effective interventions such as permanent supportive housing and rapid re-housing.

Housing and Shelter Inventory Trends*		
Type	**% Change 2012-2013**	**% Change 2013-2010**
Year-Round Emergency Shelter	-6%	+101%
Transitional Housing	-11%	-50%
Safe Haven	0%	0%
Permanent Supportive Housing	+13%	+45%
Total Beds (ES, TH, SH & PSH)	-1%	+14%

* Does not include beds under development in the calculation. For emergency shelter, includes seasonal and overflow beds.



20 Calculations are based on the total number of emergency shelter, transitional housing, safe haven and permanent supportive housing beds, excluding seasonal and overflow beds.

Trends in Length of Stay & Bed Usage Efficiency

Emergency Shelter

The Continuum of Care has significantly reduced the length of stay for people in emergency shelter in the 2010 – 2012 time period. However, bed usage efficiency has dropped, as evidenced by a decrease in the bed turnover rate and a drop in the average bed utilization rate for emergency shelter programs.

Trends in Emergency Shelter Length of Stay % Staying for Each Time Period*						
	Individuals / Households without Children			Households w/ Children		
Days**	2012	2011	2010	2012	2011	2010
1-7 days	81%	54%	49%	78%	42%	49%
8-30 days	11%	24%	28%	18%	39%	35%
1-3 months	4%	12%	15%	2%	16%	15%
3-6 months	2%	4%	4%	1%	2%	2%
6-9 months	3%	3%	3%	0%	0%	0%
9-12 months	0.5%	3%	2%	0%	0%	0%

* HMIS data
** Emergency shelters allow clients to stay for one night at a time and clients must return to check in for their bed again each day they want to stay. The bed is not reserved for more than a single night.

- For individuals in emergency shelter, the typical length of stay has dropped dramatically in the 2010-2012 time period due to both a significant increase in the percentage of people staying 1-7 days and a large decrease in the percentage of people staying 8 days – 3 months.
  - » 65% increase in the percentage of those staying 1-7 days.
  - » 67% decrease in the percentage of those staying 8 days - 3 months.

- For families/households with children, the typical length of stay has decreased significantly in the 2010 – 2012 time period due to both a large increase in the percentage of people staying 1-7 days and an equally strong reduction in the percentage of people staying 8 days – 3 months.
  - » 59% increase in the percentage of those staying 1-7 days.
  - » 60% decrease in the percentage of those staying 8 days – 3 months.

Typical length of stay for emergency shelters has been dramatically reduced during the 2010 – 2012 time period. In 2012, most people stayed only 1-7 days.

- The emergency shelter bed turnover rate[21] – the average number of times that a bed is turned over each year -- has decreased 38% during this time period.
  - » In 2010, each emergency shelter bed was turned over on average 8.4 times.
  - » In 2012, each emergency shelter bed was used on average 5.2 times.

- In addition, the average bed utilization rate[22] for emergency shelter programs dropped during this same time period.
  - » In 2010, the average emergency shelter bed utilization rate was 89%.
  - » In 2012, the average emergency shelter bed utilization rate was 73%.
  - » In 2013, the average emergency shelter bed utilization rate is 79%.

Transitional Housing

The Continuum of Care has improved the efficiency in the use of transitional housing, reducing the average length of stay and increasing the bed turnover rate in the 2010-2012 time period. Despite a 44% drop in number of transitional housing beds, there was an 8% increase in the number of people served (10% increase in individuals and a 3% increase in persons in families).[23]

Trends in Transitional Housing Length of Stay % Staying for Each Time Period						
	Individuals / Households without Children			Households w/ Children		
Days	2012	2011	2010	2012	2011	2010
1-7 days	8%	8%	8%	4%	8%	6%
8-30 days	17%	16%	13%	18%	14%	15%
1-3 months	26%	20%	21%	21%	21%	22%
3-6 months	19%	14%	17%	15%	19%	12%
6-9 months	17%	16%	19%	29%	14%	25%
9-12 months	13%	26%	23%	13%	24%	21%

- For individuals in transitional housing, there has been a decrease in the typical length of stay during the 2010-2012 time period due to an increase in the percentage of individuals staying less than 6 months and a decrease in those staying more than 6 months.
  - » 31% increase in the percentage of those staying 8-30 days.
  - » 18% increase in the percentage of those staying 1-6 months.
  - » 29% decrease in the percentage of those staying 6-12 months.

Typical length of stay for transitional housing has been reduced during the 2010 – 2012 time period. In 2012, fewer than one out of seven stayed more than 9 months

21 Annual number of persons served in emergency shelter divided by the total emergency shelter beds (including seasonal and overflow). From HMIS, in 2012, 11,470 persons were served in emergency shelter (9,766 individuals and 1,704 persons in families), and in 2010, 9,248 persons were served (7490 individuals and 1,758 persons in families). In 2010, the HIC shows an inventory of 1097 emergency shelter beds (including seasonal and overflow beds and excluding those under development).

22 From Housing Inventory Counts (HIC), averaging the program utilization rate.

23 From HIC, 1,206 transitional housing beds in 2012 and 2,156 beds in 2010. From HMIS, in 2012, 2,623 persons were served in transitional housing (1,834 individuals and 789 persons in families), and in 2010, 2,432 persons were served (1663 individuals and 769 persons in families).

- For families/households with children, there has been an increase in the number of families staying 3-9 months and a decrease in those staying longer.
  - » 19% increase in the percentage of those staying 3-9 months.
  - » 38% decrease in the percentage of those staying 9-12 months.

- The transitional housing bed turnover rate[24] – the average number of times that a bed is turned over each year—has doubled during this time period.
  - » In 2010, each transitional housing bed was turned over on average 1.1 times.
  - » In 2012, each transitional housing bed was turned over on average 2.2 times.

- The average transitional housing bed utilization rate[25] has stayed largely the same during the 2010 – 2012 time period. However, it dropped in 2013.
  - » In 2010, the average transitional housing bed utilization rate was 88%.
  - » In 2012, the average transitional housing bed utilization rate was 86%.
  - » In 2013, the average transitional housing bed utilization rate is 77%.

System Entry / Prior Residence Analysis

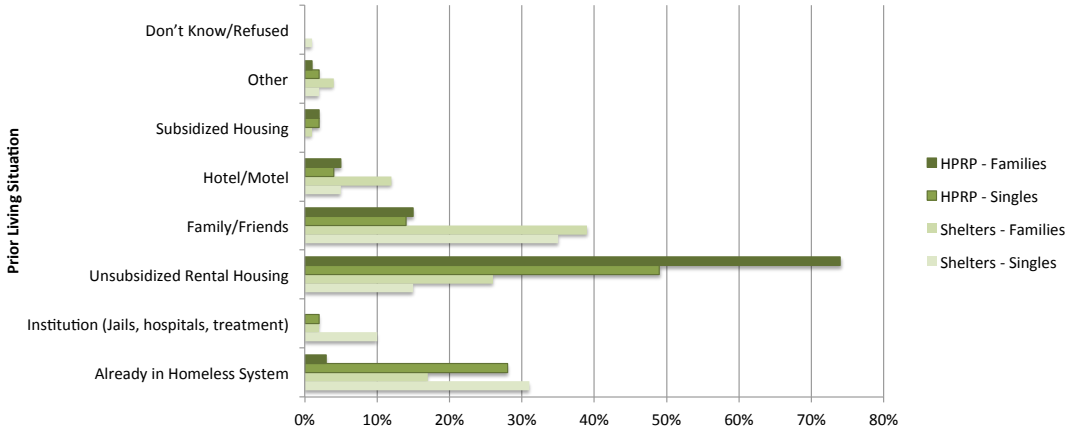
Emergency Shelter and Homeless Prevention and Rapid Re-Housing Program (HPRP)

Overall, most people enter emergency shelter or HPRP after staying with friends or family, directly from unsubsidized housing, or from another program in the homeless system. However those entering emergency shelters are most likely to come from staying with family or friends while those accessing HPRP are most likely to have been in unsubsidized housing.

System Entry Analysis*				
Prior Living Situation	Shelters		HPRP	
	HH without Children	HH with Children	HH without Children	HH with Children
Already in Homeless System	31%	17%	28%	3%
Institution (Jails, hospitals, treatment)	10%	2%	2%	0%
Unsubsidized Rental Housing	15%	26%	49%	74%
Family/Friends	35%	39%	14%	15%
Hotel/Motel	5%	12%	4%	5%
Subsidized Housing	0%	1%	2%	2%
Other	2%	4%	2%	1%
Don't Know/Refused	1%	0%	0%	0%

* From HMIS data for 2012. Note: not all emergency shelter programs were entering data into the HMIS in 2012; this analysis is based only on data from programs participating in the HMIS.

24 Annual number of persons served in transitional housing divided by the total transitional housing beds. See Footnote 22.
25 From HIC, averaging the program utilization rates.



- For emergency shelter:
  - » Two-thirds of individuals without children enter emergency shelters after staying with family or friends (35%) or from somewhere else in the homeless system (31%). 15% were in unsubsidized housing and 10% come from an institutional setting.
  - » 39% of persons in households with children enter emergency shelters after staying with family or friends and 26% come directly from unsubsidized housing. 17% were already in the homeless system and 12% were staying in a hotel or motel.

- For HPRP:
  - » Almost half (49%) of individuals without children who access HPRP identify their prior living situation as unsubsidized housing. 28% come from within the homeless system and 14% have been staying with family or friends.
  - » Almost three-quarters (74%) of persons in households with children who access HPRP were living in unsubsidized housing. 15% were staying with family or friends.

Transitional Housing and Permanent Supportive Housing[26]

The most common prior living situations for people entering transitional housing and permanent supportive housing are a homeless situation or living with friends or family.

- For transitional housing:
  - » 56% of individuals in households without children enter transitional housing from a homeless situation, most often an emergency shelter. 17% have been living with friends or family and 9% come from an institutional setting.

26 Based on data from 16 APRs from 2011-2012 for transitional housing and permanent housing programs.

» 34% of persons in households with children enter transitional housing from a homeless situation, most often an emergency shelter or another transitional housing program. 24% have been living with friends or family and 14% come from unsubsidized housing.

- For permanent supportive housing:
  - » 77% of individuals in households without children enter permanent supportive housing from homeless situations, most often places unfit for human habitation or an emergency shelter. 12% have been staying with friends or family.
  - » 49% of persons in households with children come from homeless situations, including emergency shelter, transitional housing or places unfit for human habitation. 28% have been staying with friends or family and 13% have been in unsubsidized housing.

System Performance

Exit Destination Rates*				
	Shelters		Transitional Housing	
Destination	Individuals	Persons in Households w/ Children	Individuals	Persons in Households w/ Children
Permanent Housing	18%	34%	52%	58%

Average Length of Stay By Destination*				
	Shelters		Transitional Housing	
Destination	Individuals	Persons in Households w/ Children	Individuals	Persons in Households w/ Children
Average Length of Stay (LOS)	35 days	43 days	175 days	182 days
Average LOS per Permanent Housing Exit	30 days	44 days	238 days	250 days

* From HMIS data for 2012. Note: not all emergency shelter programs were entering data into the HMIS in 2012; this analysis is based only on data from programs participating in the HMIS.

Emergency Shelter

For those who exit to permanent housing, more than 90% have a timely exit of under 60 days.

- 18% of individuals in households without children leave emergency shelters for permanent housing, and of these, 91% have a length of stay less than 60 days.
- 34% of persons in households with children leave emergency shelter for permanent housing, and of these, 97% have a length of stay less than 60 days.
- The average length of stay for individuals children is 35 days and for households with

children, it is 43 days.

Transitional Housing

More than half of those in transitional housing exit to permanent housing.

- 52% of individuals in households without children leave transitional housing for permanent housing, and of these, 13% have a length of stay less than 60 days.
- 58% of persons in households with children leave transitional housing for permanent housing, and of these, 21% have a length of stay less than 60 days.
- The average length of stay for persons in transitional housing is approximately 6 months: for individuals, it is 175 days, and for households with children, it is 182 days.

System Costs

- Emergency shelter costs $1,100/month/household.[27]
- The average cost of a permanent housing exit from emergency shelter for individuals in households without children is $1,100 (based on average length of stay for a permanent housing exit of 30 days.) The average cost of a permanent housing exit from emergency shelter for households with children is $1,613 (based on average length of stay for a permanent housing exit of 44 days).
- Transitional housing costs $972/month/household. [28]
- The average cost of a permanent housing exit from transitional housing for individuals in households without children is $7,711 (based on average length of stay for a permanent housing exit of 238 days.) The average cost of a permanent housing exit from transitional housing for households with children is $8,100 (based on average length of stay for a permanent housing exit of 250 days).
- The average annual bed cost for permanent supportive housing is $11,277 or $940/month.[29]
- The HPRP program prevented homelessness at a cost of less than $1,200 per individual or $3,240 per household (based on an average length of rental assistance of 3 months).

For a detailed analysis of services offered by provider, please see 2013 Services Inventory Analysis

27 From Clark County Department of Social Service. Homeless Prevention and Rapid Re-Housing Program Evaluation, 2012, page 23.
28 Ibid.
29 Calculated from the 2011-2012 APRs for 6 permanent supportive housing programs. Total SHP and cash match or S+C and supportive services match expenditures for the 6 programs divided by the total number of beds.

III. System Level Gaps Analysis

This section outlines the key gaps that were identified in the overall functioning of the Southern Nevada / Clark County homeless housing and services system. Six key system level gaps were identified. Two are client focused, addressing people's ability to access the system of care and obtain coordinated assistance that results in ongoing stability. Three are focused on system level capacity, including for leadership, community engagement, planning and evaluation, and promoting ongoing quality improvement. The following section will look at gaps on the level of program component.

System Level Gap 1: Improve Access to the System and its Services

Clients spoke of not knowing where to turn for assistance when they became homeless, and of the frustration and time wasted when they were referred for services and then found ineligible. Providers spoke of the inadequacy of the current 211 system, and the need for an assessment process to guide referrals. Clients related experiences in which they felt that agencies were more focused on screening them out rather than finding a way to help them. Providers highlighted the importance of having a low threshold point of entry into the system and the importance a Housing First approach.

While there is some variation in percentages across programs, most people accessing shelter and housing assistance (emergency shelter, Homeless Prevention and Rapid Re-Housing (HPRP), transitional housing and permanent supportive housing) are coming from another homeless program, were staying with friends or family, or coming directly from unsubsidized housing. Overall, persons in families are more likely to come after staying with friends or family or directly from unsubsidized housing, and individuals in households without children are more likely to come from another homeless program or situation.[30] For supportive housing, a significant percentage (40%) also come from places unfit for human habitation (42% of individuals and 15% of persons in families).[31] Few people, particularly for those in families, come directly from an institutional setting (jail/prison, foster care, psychiatric facility, substance abuse treatment or detox, or a hospital), perhaps pointing to a need for institutions to improve their discharge planning and coordination with the homeless system of care.

Prior Residence: Institutional Setting*		
Program	**HH without Children**	**HH with Children**
HPRP	**2%**	**0%**
Emergency Shelter	**10%**	**2%**
Transitional Housing	**9%**	**2%**
Permanent Supportive Housing	**4%**	**0%**

*Emergency Shelter and HPRP data from HMIS for 2012 and transitional housing and permanent supportive housing data from 16 APRs from 2011-2012 (10 APRs for transitional housing and 6 for permanent supportive housing).

30 See System Entry/Prior Residence Analysis, page 14
31 Calculated from the 2011-2012 APRs for 6 permanent supportive housing programs.

What Is Needed

a. Establish centralized/coordinated intake and assessment

In addition to being a HEARTH requirement, centralized/coordinated intake and assessment was identified as a high priority need for the Southern Nevada / Clark County system of care. Such a system will enhance client access, reduce inappropriate referrals, and improve overall system efficiency by consolidating the intake function, reducing duplication and improving the targeting of assistance. It will also affirm a system-wide orientation and improve communication and collaboration between providers.

To meet the needs of the region, centralized/coordinated intake should:

- have multiple intake locations that are accessible to clients throughout the region (not requiring travel to downtown Las Vegas)
- incorporate a "no wrong door" philosophy
- involve mainstream agencies (including foster care, hospitals, jails/prisons, mental health facilities and substance abuse treatment programs)
- offer a comprehensive assessment of the client's full range of needs
- provide referrals linked with case management
- consider how to work with the existing 211 information and referral number

In addition, the Help Hope Home website should include information on all the housing and services available, including eligibility requirements and where to go, that clients or concerned citizens can easily access. Help Hope Home currently has a basic resources guide accessible through its website that provides agency names, addresses and phone numbers. Including additional information on populations served and eligibility requirements would make this information more helpful to users. A new website is currently being developed as a content management system for all housing and services available, with content generation and site design underway.

b. Provide low threshold access to the system

A drop-in program and additional outreach coverage were identified as being needed to engage people reluctant to interact with the service system, including the street homeless population, people who are chronically homeless, people with active substance abuse problems, people with mental illnesses, and others who are "hard-to-serve". Both the drop-in program and outreach teams should be able to link clients into coordinated intake and assessment, when they are ready. In addition, development of a Housing First approach was identified as important for certain sub-populations.

Drop-In Program: There was broad agreement on the need for a drop-in program providing low threshold access to services. While the Salvation Army currently fills some of this need, a program is needed with year-round 24-hour/day access. This would also provide police with a place to take people beside jail or detox.

Outreach Teams: While several outreach teams are in operation, there was strong consensus on the need for more. With 60% of the homeless population unsheltered, outreach services provide an important point of contact and engagement, especially with those who are chronically homeless and reluctant to interact with the service system.

An evaluation of existing outreach team coverage should be carried out, identifying team make-up, target population, hours of operation and geographic range to determine if gaps exist, how the teams can be coordinated to extend coverage, and if additional teams or staffing is needed. Additionally, the evaluation should consider how the outreach teams can function with a Housing First approach / link people directly to housing and how they can link people into case management (see next gap discussion). Systemwide outreach standards and tools should be established to ensure quality and consistency across teams.

Housing First: Housing First is a nationally recognized approach for addressing homelessness that evolved out of the recognition of the vital role of housing. Under "Housing First", people are helped to regain housing as quickly as possible, without requirements as to employment, sobriety or acceptance of services. "Housing First" helps people access permanent housing in conjunction with services to address the issues that have contributed to their homelessness, including health or behavioral health treatment and education or job training to enhance their employability and earning potential. It has been found to be effective with many populations, including individuals who have serious disabilities and have been homeless for extended periods of time as well as with families.

An evaluation should be carried out of how best to incorporate a housing first approach into efforts to house families and people who are chronically homeless and living on the streets.

See page page 39 for an overview of existing outreach and drop-in services.

BEST PRACTICE SPOTLIGHT: HOUSING FIRST WITH FREQUENT USERS

Project 25, FUSE, and the 10th Decile Project are three housing first best practice examples that subscribe to the same basic philosophy of care. Frequent and repetitive use of crisis services (emergency room, shelters, ambulances, jail medical centers, etc.) by a homeless individual often signals complex behavioral heath issues that cannot be adequately addressed within the existing system of services. Such patterns also represent a significant expense of public funds, in the form of emergency room visits, ambulance rides, and law enforcement. Research shows that moving the most frequent users of public emergency services into permanent supportive housing can significantly reduce public expense.[1]

PROJECT 25, SAN DIEGO

Project 25 works to connect the chronically homeless and most frequent users of crisis services in San Diego to permanent supportive housing. It uses a housing first model that provides comprehensive case management with a full range of supportive services. It operates with the cooperation of the City and County of San Diego.[2]

The program began in 2010 with a $1.5 million grant from United Way and a three-year commitment to a collaborative effort by United Way, the County of San Diego, the City of San Diego, and the lead agency,

1 CSH:http://www.csh.org/2013/04/10th-decile-project-focusing-on-high-utilizers-in-los-angeles-featured-in-scaling-what-works-initiative/; Project 25: http://www.uwsd.org/content/project-25-frequent-user-initiative-chronically-homeless.

2 St. Vincent de Paul Village project description. http://www.svdpv.org/permanenthousing.html.

the St. Vincent de Paul Village. The Project 25 staff at St. Vincent de Paul includes an Executive Director, two case managers, a nurse, a doctor, and a point person for data coordination, tracking and analysis. Partner organizations include Alpha Project, County of San Diego District Attorney, County of San Diego Health and Human Services Agency, Family Health Centers of San Diego, Father Joe's Villages, San Diego County Sheriff's Office, San Diego Medical Services Enterprise, San Diego Police Department, San Diego Rescue Mission and the UC San Diego Medical Center.[3]

Project 25 facilitates both housing and supportive services for clients. The San Diego Housing Commission has obtained permission from the Department of Housing and Urban Development (HUD) to target high-need homeless populations within the Section 8 voucher program. The Housing Commission gives priority to San Diego's most vulnerable homeless population by allocating housing choice vouchers specifically for programs like Project 25. Tapping into this opportunity allows Project 25 to fast-track its clients into permanent housing. Project 25 assists clients in applying for benefits, locating a primary health care provider, and connecting with local behavioral health services. Staff meets with clients in their homes, accompanies them to appointments, and helps clients set and meet goals. The Project also provides a 24-hour emergency hotline for clients and their landlords.[4]

Partner organizations, including the County's and the City's hospitals, ambulances, and jails, provide data for identification and monitoring of 35 high-need and chronically homeless individuals. Initial identification of the 35 participants was based on names provided by San Diego hospitals, law enforcement, and other partners, who identified their most frequent users experiencing homelessness. Partners then helped Project 25 staff locate each prospective client within the crisis services system of hospitals, jails, and clinics. Project partners provide ongoing data on clients' use of crisis services, allowing Project 25 to track the impact of the program both on client well-being and on cost to the public.

At the end of its second year, Project 25 reports that all clients have remained in the program, apart from one who is deceased. Several clients are now ready to "graduate" out of the program, able to hold jobs, pay rent, and care for themselves more independently.[5] A main focus of the program is to save public funds. In 2010, the 35 clients in Project 25 incurred a collective $4.3 million in public expenses through emergency rooms visits, ambulance rides, and other crisis services. In 2012, overall expense of public funds related to those 35 clients decreased by $1.4 million.[6] The future of the program is uncertain, as the end of the 3-year grant term approaches. Project 25 hopes to use the data it has collected on public savings to make their case to potential funding sources. The program plans to approach those who have benefitted from the cost savings, including hospitals, law enforcement, and the business community, in hopes that they will provide enough funds to maintain the program.

FREQUENT USERS SYSTEMS ENGAGEMENT (FUSE), LOS ANGELES

FUSE is a collaborative model developed by the Corporation for Supportive Housing (CSH) that targets frequent users of crisis services with the aim of connecting them to permanent supportive housing. The program seeks to increase quality of life for high-need populations while reducing their cost to the public.[7]

The FUSE program in Los Angeles currently comprises three "collaboratives". A collaborative is a partnership of service providers within a geographic area that includes a hospital, health care centers, and homeless services providers. The member organizations coordinate to provide comprehensive services including housing support, medical and behavioral health services, case management, monitoring, and status evaluation for participating individuals.[8]

The Los Angeles collaboratives identify their target populations using the Economic Roundtable's Triage Tool for Identifying Homeless Adults. The Triage Tool is a diagnostic interview performed in the partner hospital that collects data on medical diagnoses, substance abuse, inpatient hospital stays, ER visits, and use of jail medical facilities, among other indicators.

3 Home Again Website. http://homeagainsd.org/our-progress/project-25.

4 Voice of San Diego article. http://voiceofsandiego.org/2013/04/08/two-years-in-its-still-day-by-day-for-project-25-tenants/.

5 Interview with Brian Maienschein. http://www.youtube.com/watch?v=Ir26Tfl1i8Y.

6 Home Again Website. http://homeagainsd.org/our-progress/project-25.

7 CSH Website: Introduction to CSH's FUSE Model. http://www.csh.org/fuse.

8 CSH Website: Los Angeles Frequent Users Systems Engagement (FUSE) Program. http://www.csh.org/csh-solutions/community-work/systems-change/local-systems-change-work/los-angeles-fuse.

This data runs through a predictive algorithm that identifies likely members of the "10th Decile", the 10% of the homeless single adult population that incur the highest cost in public money.[9]

The collaboratives then locate and actively recruit identified individuals through in-reach in local jails and shelters. Once participants have been located and engaged in the program, the first step is to help clients find immediate housing and services, while beginning the application process for permanent supportive housing. A collaborative helps its clients enroll in benefits programs, connects them with medical centers and behavioral health services, and supports their continued use of those resources. The goal is to move clients into permanent supportive housing, in available permanent supportive housing units or through housing choice vouchers. When permanent supportive housing has been provided, collaborative member organizations continue to monitor clients' status and ensure access to housing and services.[10]

On average, the top 10% highest users of crisis services in Los Angeles cost $6,529 per month in public funds. Living in supportive housing, the average cost of those same individuals decreases by about $4,589 per month. The Los Angeles pilot program reports positive outcomes, both for public savings and for its participants. The program has seen a 30% decrease in emergency room visits and 25% reduction in inpatient hospital stays, with a public savings of $3.3 million a year. The program also reports high housing retention rates and health improvements in participants with stable housing. Current partners in the three Los Angeles FUSE collaboratives include: Housing Works, Ocean Park Community Center (OPCC), Homeless Healthcare LA, Venice Family Clinic, the John Wesley Community Health Institute, Clínica Monseñor A. Romero, St. John's Hospital and Health Center, Santa Monica-UCLA Medial Center, California Hospital Medical Center, and the Los Angeles County and University of Southern California Healthcare Network.

10TH DECILE PROJECT, LOS ANGELES

The 10th Decile Project in Los Angeles differs from FUSE and Project 25 in its size and scope. It is a citywide program that aims to place high-need, high-cost chronically homeless individuals into permanent supportive housing. The Project aims to serve 107 clients in Los Angeles and involves six lead agencies and 42 other partner organizations, including hospitals, Federally Qualified Health Centers, temporary and permanent housing providers, and various local governments and non-profit agencies. The Project is funded by a five-year grant through the Social Innovation Fund.[11]

The Economic Roundtable, one of the lead agencies, manages the Project's operations and contracts with a large web of hospitals, clinics, temporary and permanent housing providers, homeless services organizations, and housing navigators. It also provides training and technical assistance for partner organizations, particularly in the use of the Triage Tool for Identifying Homeless Adults.

The five other lead agencies are homeless service providers/housing navigators: Ascencia, Homeless Health Care Los Angeles, Housing Works California, Ocean Park Community Center, and People Assisting the Homeless (PATH). These organizations provide comprehensive, long-term case management for each client. Case managers offer continuing hands-on support in the client's daily life, from client intake to exit from the program. They coordinate all necessary services, in collaboration with a network of partner organizations.

13 hospitals and four clinic partners in the Los Angeles metropolitan area use the Economic Roundtable's Triage Tool to identify the highest-need homeless frequent users of crisis services. Hospital and clinic staff administer the Triage Tool diagnostic to potential participants who come to them for crisis services. If a potential client is interested in the program, the hospital or clinic staff contact one of the partner service providers/housing navigators, which immediately sends staff to pick up the client.

Housing navigators obtain and pay for temporary housing for clients, in collaboration with six temporary housing partner organizations. Case managers also assist clients with applying for benefits, filling prescriptions, obtaining clothing and other essentials, nutrition, education and job training, and connecting with health care. Lead agency staff work with the project's eight permanent supportive housing partners to help clients obtain housing vouchers and find available permanent supportive housing units that fit client needs. Clinic partners serve as primary health care providers and offer medical and behavioral health services.[12]

9 Economic Roundtable Website. http://www.economicrt.org/summaries/10th_Decile_Triage_Tool_v1.html.

10 Home For Good Funders Collaborative Spring 2012 Request for Proposals. http://www.unitedwayla.org/wp-content/uploads/2012/03/Spring-2012-RFP-3.14.128.pdf.

11 http://docs.geofunders.org/?filename=csh_final.pdf.

12 Economic Roundtable Team program description. http://

The Economic Roundtable and CSH predict that connecting the "10th decile", the highest-cost frequent users of crisis service, with permanent supporting housing will create significant savings of public funds. The Economic Roundtable predicts a 97% decrease in jail costs and an 86% decrease in health care costs of frequent users who live in supportive housing.[13] One program client reduced his yearly hospital visits from 52 to 3 after entering the program. CSH estimates that moving one homeless frequent user of public crisis services into permanent supportive housing can save the County over $30,000 a year.[14]

The 10th Decile Project in Los Angeles is funded by a five-year grant through the Social Innovation Fund and CSH. [15]

www.economicrt.org/innovation.

13 Ibid.

14 http://docs.geofunders.org/?filename=csh_final.pdf.

15 CSH: CARC. http://www.csh.org/csh-solutions/community-work/community-initiatives/social-innovation-fund-landing-page/connecticut-aids-resource-coalition-carc.

System Level Gap 2: Facilitate Coordinated Service Delivery and Follow-up after Housing Placement to Ensure Ongoing Stability

Most people who are homeless or at-risk of homelessness have multiple, inter-related needs for both housing and a variety of support services. Clients spoke of the need for an advocate to help them move through the system to secure the assistance they need. Providers spoke of the need for more case management capacity for people placed in housing, both those with disabilities who need ongoing wraparound services as well as those who need time-limited support to get back on their feet. Such case management capacity is seen as essential to facilitate ongoing housing stability.

In addition, there was concern about a lack of standards and quality control in the case management that is currently provided. The need for case management training in best practices as well as system-wide standards and common case management tools were identified. This would facilitate inter-agency collaboration in case management for common clients, something that was identified as a key system level gap by providers.

See page 39 for an overview of existing case management services.

What Is Needed

a. Expand case management capacity

Identify funding for additional case management to help clients access services after coordinated intake and assessment and to assist clients placed in housing to achieve ongoing stability. Peer-mentors can work in tandem with case managers, providing day-to-day support from an understanding perspective. This addresses the need expressed by many clients to have people helping them that have had similar experiences and are sympathetic to their problems.

BEST PRACTICE SPOTLIGHT: CASE MANAGEMENT

KEY PRACTICES FOR EFFECTIVE CASE MANAGEMENT

- Keep case loads low, ranging from 10:1 for high-need clients to 25:1 for clients with the lowest need1
- Provide case management services in the client's community
- Cultivate peers as advocates and case management staff[2]
- Help clients build strong connections within their community
- Involve clinical case managers who can participate in delivering services
- Encourage collaboration between service providers[3]

1 Calgary Homeless Foundation. Standards of Practice: Case Management for Ending Homelessness, p 87. 2001. Available at: http://calgaryhomeless.com/assets/agencies/Accreditation/CHF-Case-Management-Accreditation-Manual.pdf.

2 Morse, Gary. A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research, p 17. http://bbi.syr.edu/nvtac/training/training_mats/051911/4_tucker_crone/review_case_management_homeless.pdf.

3 Strengthening At Risk and Homeless Mothers and Children. Step-by-Step: A Comprehensive Guide to Case Management. http://www.familyhomelessness.org/media/237.pdf.

SELECT CASE MANAGEMENT MODELS[4]

Clinical Case Management Model

- Utilizes clinicians (e.g. nurses, psychiatrists, etc.) as case managers
- Case managers provide services to clients, while still coordinating holistic service plans and connecting clients to other providers
- Smaller case loads (10:1-25:1)
- Helps case managers build a strong therapeutic relationship with the client

Assertive Community Treatment (ACT) Model

- Especially effective for high-need clients
- Small case loads per individual case manager (10:1)
- Multi-disciplinary teams of case managers, mental health professionals, and peer advocates
- Shared case loads increase effectiveness and reduce burnout

4 Id. edia/237.pdf http://bbi.syr.edu/nvtac/training/training_mats/051911/4_tucker_crone/review_case_management_homeless.pdf.

b. Establish system-wide case management standards and tools and provide best practices training

Development of case management standards and a common tool will help improve the quality of case management and facilitate joint case management between agencies. Training in best practices will also enhance quality of care.

Case Management Standards

Performance standards for case management generally cover some combination of the following process components and competency areas:[32]

- Intake and Assessment
- Planning of Services
- Monitoring, Documentation, and Evaluation

32 See: Case Management Society of America. Standards of Practice for Case Management. http://www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf; National Association of Social Workers. Standards for Social Work Case Management. http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp.

- Data Sharing, Referrals, and Coordination of Services
- Exit Planning and Discharge
- Cultural Competency/Knowledge of Relevant Services
- Data Management and Privacy

The following examples of case management standards can be adapted to fit program needs or used as models for the development of new standards:

- **Case Management Standards Toolkit – New York City Department of Youth and Community Development (DYCD)**[33]
  This model consists of eight standards embedded in a step-by-step process for case management, from intake to closure. Each standard outlines a case manager's core responsibilities, as well as expectations regarding timeliness, client-participation, and coordinated service provision. [34]

- **Standards of Practice – Calgary Homeless Foundation (CHF)**
  The CHF Standards of Practice outline an extensive set of expectations for program structure, training, and data systems, as well as for the case management process. This model provides detailed guidance for case managers, with 11 broad standards broken down into as many as ten sub-standards each.[35]

c. Use Peer-Mentoring to Supplement Case Management Support

Peer-mentors can work in tandem with case managers, providing day-to-day support from an understanding perspective. This addresses the need expressed by many clients to have people helping them that have had similar experiences and are sympathetic to their problems.

BEST PRACTICE SPOTLIGHT: PEER-MENTORING

COMMUNITY ADVOCATES, PROJECT BRIDGE PROGRAM — MILWAUKEE, WI

Project Bridge is a permanent supportive housing program that provides full case management services for residents in 80 units. In 2011, they initiated a Peer Specialist program.[1] Peer Support Specialists are part-time paid employees who are in recovery for mental or behavioral health. They assist clients with admission, development of recovery plans, and accessing services. They assist case managers and housing specialists by participating in outreach, maintaining logs and HUD-mandated record-keeping, and helping to assess client needs. A central function of Peer Support Specialists is to model recovery and independent living skills.

HOUSING TO HOMES, HEARTLAND HOUSING MODEL

The Heartland Housing Model serves individuals with disabilities, particularly severe mental illness, who have experienced homelessness.[2] The program's peer

1 Community Advocates website. Project Bridge. http://communityadvocates.net/who/people_living_with_mental_illness.

2 Housing to Homes. Our Housing Model: How It Works. http://www.homelessnomore.org/h-to-h-solution/heartland-housing-model.

33 The Case Management Standards Toolkit was developed for use by all DYCD programs, which include but are not limited to programs serving homeless populations.

34 New York City Department of Youth and Community Development. Case Management Standards Toolkit, pp 7-14. Available at: http://www.nyc.gov/html/dycd/downloads/pdf/NYC_DYCD_Case_Management_Toolkit-2011.pdf.

35 Calgary Homeless Foundation. Standards of Practice: Case Management for Ending Homelessness. 2001. Available at: http://calgaryhomeless.com/assets/agencies/Accreditation/CHF-Case-Management-Accreditation-Manual.pdf.

support workers serve as role models, mentors, and advocates for residents to service providers. Peers are able to provide "real world" coping strategies and more easily develop relationships of trust and support with residents. [3]

LEICESTER CITY COUNCIL, SUPPORTING TENANTS AND RESIDENTS (STAR) — LEICESTER, ENGLAND

STAR provides housing-related services to individuals and families who have experienced homelessness, including training and resources around living skills, money management, health, safety, education and employment, substance abuse, and parenting. Through the Rise and Shine program, former STAR clients serve as peer mentors to formerly homeless or precariously housed community members. Participants act as a support network for people using STAR's services. They develop and enhance trainings offered to clients, drawing on their own experiences to anticipate issues clients might face and to identify useful resources. Rise and Shine participants also produce a newsletter, which addresses common obstacles to maintaining housing and directs clients to resources in the community.[4]

3 Housing to Homes. Peer Support: Utilizing Unique Knowledge. http://www.homelessnomore.org/h-to-h-solution/heartland-housing-model/peer-support.

4 Homeless Link. Peer Mentoring in Resettlement and Tenancy Sustainment Services. http://homeless.org.uk/Leicester-peer-mentoring-case-study#.UcOa8esh2eu.

System Level Gap 3: Enhance System Level Capacity for Leadership, Planning, Oversight and Program Support

A problem as big and complicated as homelessness, with its numerous causes and need for solutions coordinated across agencies and service systems, requires concerted and coordinated action by multiple parties. Isolated action by individual agencies, no matter how effective their programming, will not rise above individual success stories to achieve a real and lasting impact on homelessness. True progress in ending homelessness requires a common agenda agreed upon by all parties, mutually reinforcing activities toward shared goals, ongoing communication among stakeholders, and shared performance measurement to document collective impact. Action of this size and complexity can only be realized through a centralized/regional infrastructure and dedicated staff focused on promoting the shared vision and coordinating collective action.

Existing Regional Infrastructure

The Southern Nevada Regional Planning Coalition Committee on Homelessness (CoH) functions as the region's policy and planning body on homelessness. With a cross-jurisdictional and cross-sector membership that includes all key stakeholders, it is staffed by the Clark County Social Service Department's Regional Initiatives Office. The CoH coordinates the Continuum of Care and its annual HUD application for homeless assistance funds, oversees a variety of regional efforts, such as the annual census and the inclement weather shelter program, and will be leading CoC efforts to comply with HEARTH regulations. While numerous individuals interviewed commented that the CoH has made significant progress in building collaboration and cross-participation, most felt that additional levels of regional planning and collaboration are needed to truly have an impact on homelessness.

What Is Needed

a. Enhance staffing for the CoH

Additional staff capacity is needed in order for the CoH to provide regional / system level leadership and coordination of the effort to address homelessness.

Key system level roles that were identified as important include the following:

- Organizing CoC compliance with HEARTH requirements
- Source for information on complying with HUD grant management requirements
- Fostering interagency collaboration and partnership within the system of care in order to facilitate a "no wrong door" approach to service provision, involve mainstream providers, develop and operate housing, and promote coordinated project development and fundraising
- System level planning and evaluation, based on system level data analysis and performance, including setting policy direction, identifying programmatic needs, and determining resource allocation based on overall system needs and outcomes
- Facilitating communication among stakeholders and public relations to promote community engagement
- Promoting use of best practices and quality improvement by providers

b. Enhance the effectiveness of the CoH membership

Evaluate current CoH membership to ensure that all appropriate stakeholders are at the table and that its makeup is compliant with HEARTH requirements. In addition, in order for the CoH to be effective, the stakeholder representatives must be individuals in positions where they have decision-making power and access to resources.

In addition, CoH staff should organize orientation for new members as they join the CoH, on their roles and authority, homelessness and HUD. Additional training should be organized on selected topics as needed.

System Level Gap 4: Increase Community Engagement and Support for Preventing and Ending Homelessness

Against the fiscal reality that government can't do it all and that need is growing, there is a need for innovative ideas and collaborative action by the full community. Joint funding commitments by local jurisdictions as well as investment by business and community interests are needed, all aligned toward a common vision and goals. Ending homelessness requires cross-sector action targeted for collective impact.

Existing Collaboration

Through the Southern Nevada Regional Planning Coalition Committee on Homelessness (CoH), a public/private partnership is in in place and great strides have been made in inter-jurisdictional and inter-sector collaboration in addressing homelessness. In 2007, "Help Hope Home: Southern Nevada's Regional Plan to End Homelessness" laid out a shared vision and strategies that have provided a blueprint for regional efforts. The 2010 Plan Implementation Update provided further detail to guide continued implementation efforts. Currently, Plan Implementation is again being updated and this gaps analysis will provide information to guide the development of consensus on priorities for regional action.

What Is Needed

a. Initiate a regional campaign to build public awareness and support for efforts to address homelessness

Based on the region's plan and identification of priorities for action, carry out a campaign to engage all sectors, local governments, non-profit sector, business community, and citizen leaders to come together with targeted action in support of concrete common goals.

Develop materials that outline the vision, document the need with data, and identify and quantify the solution, including quantity and cost. Use these materials to promote a coordinated public engagement and fundraising campaign to collect and align funding to address the targeted priorities and to encourage volunteerism.

BEST PRACTICE SPOTLIGHT: THE HOME FOR GOOD INITIATIVE

In 2010, the Hilton Foundation provided $13 million in grants to the United Way of Greater Los Angeles to fund key components for the launch of Home For Good.[1] Home For Good is an Action Plan, overseen by the Business Leader's Task Force on Homelessness, to end chronic and veteran homelessness in L.A. County by 2016. It was created after the Task Force conducted research and elicited extensive community input. The Action Plan establishes clear goals and concrete steps that all stakeholders and community members can take to end homelessness.[2] To read the Action Plan, visit: http://uwglacdn.s3.amazonaws.com/wp-content/uploads/2012/02/HomeForGood_Action_Plan.pdf

With over 100 signatories, the plan has received broad support from a unique cross-section of public, private, philanthropic, and community stakeholders. In 2011, the Hilton Foundation provided a $1 million challenge grant to seed the Home For Good Funders Collaborative, a group of 24 public and private funders, created to align public and private sector funds for permanent supportive housing. The Collaborative will create a single application process, align priorities, and make funding decisions together, aiding donors to leverage funds for maximum impact.[3] This $1 million was matched with $4 million in philanthropic funds and aligned with $100 million in public resources awarded to 30 nonprofit service providers in July 2012.[4]

1 http://www.hiltonfoundation.org/quarterly-connection-december-2011/289-hilton-foundation-seeds-home-for-good-funders-collaborative.
2 http://www.unitedwayla.org/home-for-good/about/.
3 http://www.unitedwayla.org/home-for-good/about/.
4 http://www.hiltonfoundation.org/home-for-good-grant-2012.

System Level Gap 5: Support Provider Capacity-Building and Quality Improvement

The CoH has an important role to play in building provider capacity, promoting use of best practices within the system of care, and encouraging ongoing quality improvement.

What Is Needed

a. Commit resources to provider training and capacity building

Areas identified by providers as top priorities for training and support include:

- Building collaboration and partnership with other providers, including referrals, joint program development, and case management/information sharing
- Data collection and HMIS participation
- Evaluation capacity and use of system-wide performance measures for agency planning

and quality improvement
- Best practices in case management
- "Homeless Cultural Competency" training for all staff that work with clients

Other topics mentioned include: agency and program management, financial management and accounting and fundraising support.

BEST PRACTICE SPOTLIGHT: CONTINUUM OF CARE STAFFING

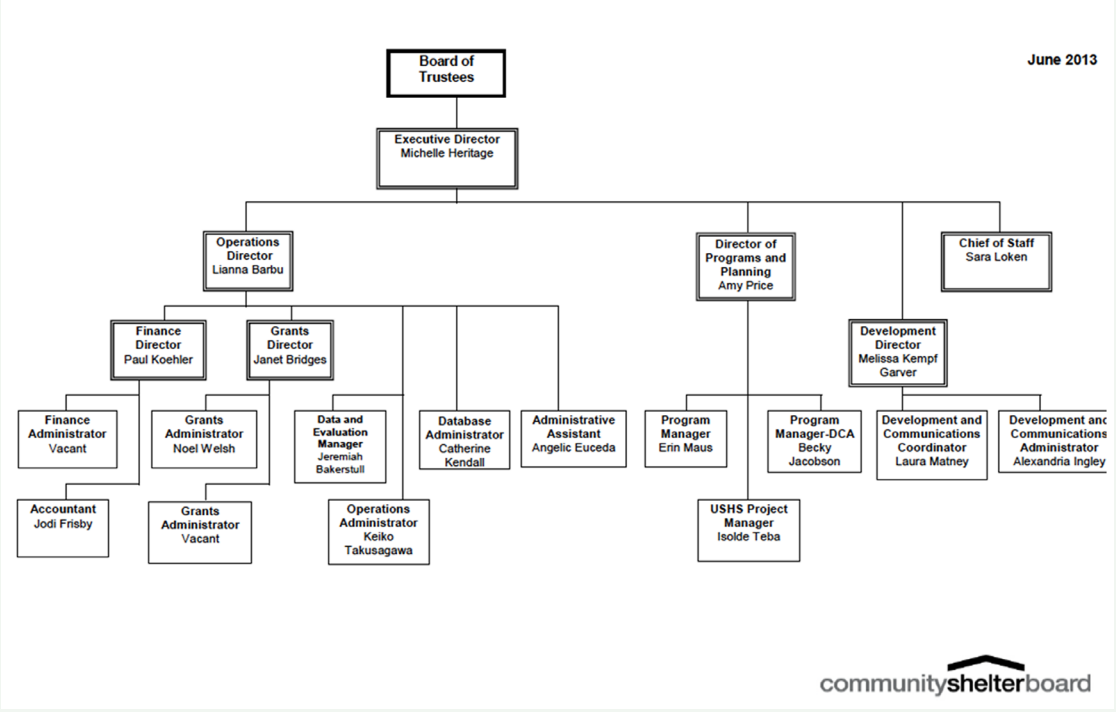
COLUMBUS, OHIO

In Columbus/Franklin County, Rebuilding Lives Funder Collaborative (RLFC) acts as an advisory committee to the CoC. A team of 20 staff from the Community Shelter Board (CSB), a public-private partnership, provide support for CoC administration.

CSB operates an outcomes-based funding model, establishing measurable performance standards to monitor agencies' progress. By setting performance outcome standards that measure length of stay, housing outcomes, shelter/program occupancy, recidivism, and other outcomes, CSB's performance outcomes monitor the success of each provider. CSB also includes in its evaluation compliance with administrative and program standards, as well as cost-efficiency measures. The system's effectiveness as a whole is monitored by quarterly and annual reviews of aggregated data from providers. The program evaluation includes all programs in HMIS including CoC funded programs, programs that receive Veterans Administration funding, and additional programs that voluntarily participate.

CSB leads a strategic community plan called Rebuilding Lives. It's a comprehensive and interrelated set of strategies to decrease the number of people who experience homelessness. The focus is on improving effectiveness and efficiency of the system, including assuring no duplication of services. Strategies are organized into four broad goals: Access, Crisis Response, Transition, and Advocacy.

During the past year, CSB has been working to develop a crisis response system that meets the needs of single adults who are homeless or at imminent risk of homelessness and can be sustained by the resources that are available. The core team represents a cross-section of funders, providers, advocates, CSB staff and board members that are committed to various workgroups. Focus areas include diversion, best practices, centralized case management, system criteria and faith-based. The redesigned crisis response model includes a centralized case management role called a "navigator".



CHICAGO, ILLINOIS

In 2011, the Chicago Alliance to End Homelessness merged with Emergency Fund to create a single, seamless system for delivering housing assistance and services to the city of Chicago. The merger brought together the Alliance's strengths in policy analysis with the Emergency Fund's fundraising. The consolidated entity represents 84 providers and plays an integral role in implementing Chicago's Plan to End Homelessness. During the past year, the CoC has focused on service integration, improving HMIS, fundraising, advocacy, and collaborating with the health care system. Their staff includes:

Development Department
Senior Director of Development
Director of Individual Giving
Director of Strategy and Impact
Development & Communications Assistant

Program Department
Senior Director of Systems Change
Senior Director of Program Development
Director of Planning & Policy
Director of Emergency Assistance
Director of Program Development
Program Associate
Director of Information Services
Lead Data Analyst & Trainer
Data Analyst
System Administrator

Finance Department
Senior Director of Finance and Administration
Staff Accountant

Emergency Fund administers a Flexible Financial Fund to provide immediate financial help to low-income families in crisis through two grant programs. Crisis Solution grants provide funding for transportation passes, food vouchers, eyeglasses, prescription medicine, and clothing. Self-Sufficiency Grants assist families with rent, utilities, and basic necessities while the head of household completes an employment program. In addition, Emergency Fund administers the State Homeless Prevention program that provides funding for security deposits, rent, mortgages, and utilities for families in crisis.

2011 At a Glance

	Emergency Fund	Chicago Alliance to End Homelessness	Total
Total Number of Staff	9	5	14
Total Investment in Staff and Employee Benefits	$913,379	$404,447	$1,317,826
CEO Salary	(Info not available)	$113,333	
COO Salary	(Info not available)	$83,960	
Major Sources of Revenue	Grants	HUD (CoC Program, HPRP), Illinois Department of Human Services	
Major Expenses	Grants to other agencies, Administration	Emergency Fund, Administration	
Total Organization Budget	$15,287,351	$570,371	$15,857,722
Total CoC Program Grants			$53,546,555

WASHINGTON, D.C.

The Community Partnership (TCP) is Washington DC's Collaborative Applicant. TCP is responsible for CoC and HMIS administration, in addition to providing prevention services, street outreach, emergency shelter, transitional housing, permanent supportive housing, and supportive services. Their staff includes:

Executive Director
Deputy Director for Operations

Senior Accountant
Chief of Staff
Accountant
Receptionist
Senior Policy Analyst
Program Coordinator
Housing Subsidy Coordinator
Program Analyst
Accounts Payable Manager
Program Officer
Housing Subsidy Administrator
Property Administrator
Chief of Housing
HMIS Coordinator
Junior Accountant
Chief Finance Officer
Chief of Systems Integration
Family Housing Coordinator
Systems Coordinator
Program Liaison
Program Manager
Prevention Specialist
Administrative Assistant
Prevention Specialist
Shelter Director
Deputy Shelter Director

2011 At a Glance The Community Partnership	
Total Number of Staff	28
Total Investment in Staff and Employee Benefits	$1,614,969
	$160,524
Executive Director Salary	$163,685
Major Sources of Revenue	Government grants: HUD CoC Program, Shelter Plus Care, Department of Mental Health, Child Family Services Agency, Emergency Rental Assistance Program, HPRP. Freddie Mac Foundation.
Major Expenses	Administration, Subcontractor Expenses, Shelter Operations,
Total Organization Budget	$90,055,786
Total CoC Program Grants	$20,539,506

System Level Gap 6: Engage in System Level Data Analysis and Performance Evaluation to Drive Resource Allocation

In order to maximize effectiveness of resources invested in ending homelessness, the CoH needs to engage in more system level analysis to determine how best to allocate resources across emergency shelter, rapid re-housing programs, transitional housing and permanent supportive housing, and to determine what additional policy or program interventions are needed to enhance effectiveness in each of these modalities.

See section II. Overview of the Current Southern Nevada / Clark County Homeless Housing and Services System on page 10 for an overview of shelter and housing inventory, as well as the appendices for more detailed inventory information.

What Is Needed

a. Conduct a system-wide evaluation of emergency shelter, rapid re-housing, and transitional housing to inform resource allocation and policy and program development.

Consider the following factors:

- Length of Stay: Average length of stay for individuals in emergency shelter is 35 days and for families with children, it is 43 days. Average length of stay for individuals in emergency shelters transitional housing is 175 days and for families with children it is 182 days.

  How would a reduction in length of stay reduce costs/permanent housing exit and increase the number of people who could be served? What interventions would reduce length of stay?

- Rate of Exit to Permanent Housing: 18% of individuals exit emergency shelter to permanent supportive housing and 34% of families with children. 52% of individuals exit transitional housing for permanent housing and 58% of families.

  How would an increase in the rate of permanent housing exits increase efficiency – increasing the number of exits to PH and reducing the cost per PH exit? What interventions would increase this rate?

- Rate of Recidivism/Return to Homelessness: How will reducing the rate of return increase the efficiency of the system and help keep homelessness numbers down? What interventions would reduce recidivism?

- Cost Data: Current rough cost data shows:

Average Cost of a Permanent Housing Exit (based on average length of stay)*		
Program	**Individuals / HH without Children**	**Families / HH with Children**
Emergency Shelter	$1,110	$1,613
HPRP	$1,200	$3,240
Transitional Housing	$7,711	$8,100

* See System Costs, page 17 for data sources.

What sub-populations should be targeted for more expensive transitional housing? What capacity is needed and how does this compare with existing capacity? What sub-populations should be assisted through shelter and rapid re-housing? What capacity is needed and how does this compare with existing capacity?

IV. Program Level Gaps Analysis

This section outlines the key gaps that were identified in seven different program components within the system of care. Evaluation of gaps within each component considered what else is needed, including both new services as well as expansion of existing services, changes that would make these services more effective and accessible, and identification of underserved and high priority sub-populations.

Homeless Prevention and Rapid Re-Housing Services

- *Short term rental assistance*
- *Rental arrears payments*
- *Rental security deposits*
- *Utility payments*
- *Utility deposits*
- *Emergency/short term motel/hotel vouchers*
- *Moving cost assistance*
- *Early identification and referral from mainstream providers*
- *Outreach and engagement*
- *Housing search and placement*
- *Legal services (mediation)*
- *Credit repair*

Homelessness prevention and rapid re-housing services are a high priority given Nevada's difficult economic backdrop. Falling household incomes, high unemployment rates, and low wages for many of the jobs that do exist, combined with a lack of affordable housing, undermine the housing stability of many households. Key indicators of homeless risk are on the rise, including increases in the number of poor renter households with severe housing costs burdens, a rise in the number of poor people living doubled up, growth in the number of poor adults accessing safety benefits and an increase in the number of poor single person households. (See PIT count highlights, page 6.)

Existing Services

The federally-funded HPRP program was in operation from 2010-2012 and was successful, with four out of five households assisted able to achieve a stable housing situation. Despite the program's success with those it served, the evaluation of the program pointed out possible weakness, including: the low percentage of homeless households assisted with rapid re-housing (only 2%); that most of the funds (85%) were spent on financial assistance with only 15% going for housing relocation and stabilization services, including assessment and case management; and the need for better recruitment/outreach for certain sub-populations, including veterans, foster children, victims of domestic violence, and Hispanic and Latino households.[36]

Of the programs that completed the Homeless Housing and Services Survey, three programs indicated rapid re-housing as their program type. 93% of programs provide housing search assistance as a part of the case management and advocacy services offered. With regard to financial services provided, 16 programs offer prevention services and 8 offer rapid re-housing services. 11 programs provide permanent rent subsidies, and 14 provide temporary rent subsidies. 12 programs provide one-time financial assistance other than rent, including deposits, utilities, rental applications, and other financial assistance.

36 Clark County Department of Social Service. Homeless Prevention and Rapid Re-Housing Program Evaluation. 2012.

Priority Gaps Identified

a. Expand prevention and rapid re-housing services

In particular, need was identified for the following:

- Eviction prevention support
- Rental assistance, including extended support (more than 2-3 months) for certain households
- Targeted support for people who are newly homeless
- Credit repair assistance

b. Facilitate access to services through improved outreach and collaboration with other agencies, particularly mainstream agencies

85% of those interviewed for the HPRP evaluation found out about the assistance from someone other than an agency. Better referral relationships, in particular with mainstream agencies and agencies in contact with under-served sub-populations, would assist in early intervention.

c. Improve linkage of clients with additional support to foster ongoing stability

Only 30% of HPRP-approved clients recalled being evaluated for other programs and services. In order to better ensure ongoing housing stability, it is important to provide more comprehensive evaluation of needs and effective referrals. In particular, need was identified for case management follow-up and furniture for homeless households being rapidly re-housed.

Basic Needs Services

- *Day services / hospitality program*
- *Showers*
- *Restrooms*
- *Laundry facilities*
- *Personal hygiene products*
- *Food assistance*
- *Water*
- *Safe/secure storage*
- *Transportation*

Existing Services

A total of 9 programs offer day services and hospitality programs. There is wide availability of a number of basic needs services offered by homeless service providers: food (including pantries, soup kitchens, etc.) (29 programs), clothing (38 programs), toiletries (40 programs), showers (27 programs), restrooms (29 programs), laundry facilities (28 programs), storage facilities (14 programs), and voice mail services (15 programs).

For adults, Salvation Army offers a Day Resource Center that is open from 7 am to 6 pm daily. Catholic Charities offers a Summer Weather Day Shelter that can accommodate 130 men at a time. Men come and go throughout the day, and Catholic Charities estimates that they serve 250-300 clients per day. The day shelter

provides showers, toiletries, restroom facilities, and cold drinking water, and is open from 9 am to 5 pm seven days per week. In addition, a free Community Meal is provided at the shelter at 10 am.

For youth under the age of 19, the William Fry Drop-In Center is open Monday – Friday, 9 am to 6 pm. The Drop-In Center offers onsite counseling, a kitchen, shower, food pantry, clothing closet, laundry room, meditation room, garden, television, hygiene kit pantry, school supply closet, computers, library, life skills and board training room, and persona business station. Parental consent is not required.

Priority Gaps Identified

a. Expand availability of transportation assistance.

Through bus passes or van service, people need transportation assistance to help them look for employment, attend interviews and access services.

b. Establish a year-round 24-hour drop-in program

There was broad agreement on the need for a drop-in program providing low threshold access to services. While the Salvation Army currently fills some of this need, a program is needed with year-round 24-hour/day access. This would also provide police with a place to take people beside jail or detox. In particular, people expressed a need for storage facilities. Opportunities to access emergency shelter and additional services should be readily available and encouraged, but not required.

Health and Behavioral Health Services

- *Primary health care*
- *Vision*
- *Dental services*
- *HIV/AIDs services*
- *Mental health services (crisis intervention, clinical therapy, counseling, support groups, medication management)*
- *Drug and alcohol treatment (detox, day treatment, counseling, residential treatment, support groups)*
- *Gambling treatment*
- *Co-occurring disorder treatment*

Many homeless people are unable to access needed health care, mental health services and substance abuse treatment. The 2011 Southern Nevada Homeless Census and Survey found that:

- 24% of homeless survey respondents reported that they were experiencing chronic health problems.
- Over 29% of homeless survey respondents reported they needed medical care but were unable to receive it.
- 50% reported that they had used the ER for treatment at least once in the previous 12 months.
- 27% of respondents said they were currently experiencing a mental illness.
- 21% of respondents experienced alcohol/drug abuse.

Existing Services

While many homeless service providers provide education, access, and referrals to appropriate health and behavioral health services as needed, fewer providers offer those services directly. Of those surveyed, 5 providers offer primary health services, 14 provide health education, and 10 provide HIV/AIDS education and services. Only 4 providers offer allied or supporting health services such as dentistry, optometry, and nutrition, and zero providers surveyed offer medical respite care.

Eighteen providers offer mental health services. Mental health services include crisis intervention (9 programs), clinical therapy and outpatient treatment (9 programs), medication management (5 programs), care coordination (8 programs), support groups (16 programs), and co-occurring mental and substance abuse disorder services (6 programs). Other services offered include sobriety support, crisis intervention, respite care for families, change motivation, and wraparound services.

Eight providers offer residential addition treatment, with 6 providing detox services, both medical and social models. Sixteen providers offer substance abuse outpatient treatment, including individual counseling, peer counseling, and support groups. Ten providers offer harm reduction services, and 7 offer gambling treatment.

Accessing these services is extremely difficult, involving complicated applications and long wait times. Eligibility criteria for mental health services in particular often requires a referral from an emergency shelter, enrollment in the program, an assessment, a diagnosis, or the ability for self-care. In addition, service sites are limited so transportation is often a problem. While 38 programs offer bus passes, only 19 offer van service or other agency transportation.

Priority Gaps Identified

a. Provide dental and vision services for people with low or no income

The Clark County Medical Card does not cover these services. They are the first to be filled at Project Homeless Connect events.

b. Enhance access to health care services and provide appropriate follow-up

Affordable health care needs to be available at more locations, perhaps through a mobile clinic that has sites throughout the region. Other problems/needs identified include:

- better follow-up from health care workers
- assistance with medication and refills
- assistance with paperwork, including insurance paperwork

c. Provide more mental health services

Needs identified include:

- medication management
- full range of mental health treatment
- access to assistance for those with milder disorders that fall short of a diagnosis but

interfere with their ability to exit homelessness and achieve stability
- co-occurring disorder services

d. Offer additional substance abuse treatment.

Key treatment gaps include:
- treatment facilities for families, where parents are not separated from their children
- relapse prevention support
- treatment focused on alcohol abuse

Shelter and Housing

- *Emergency shelter*
- *Transitional housing*
- *Permanent supportive housing*
- *Affordable housing (subsidized)*
- *Sober living housing*
- *Wet housing/harm reduction*
- *Safe haven*
- *Housing search assistance*

Existing Services

There are a total of 2,207 emergency shelter beds according to the 2013 Housing Inventory County (HIC), 35% are vouchers and the rest are facility-based beds. Based on the 2012 bed turnover rate of 5.2, this is 11,476 bed nights available over the course of a year. There are a total of 1,074 transitional housing beds. Based on the 2012 bed turnover rate of 2.2, this is 2,363 bed nights available. In addition there are 25 safe haven bends, and 2,032 permanent supportive housing beds.

For the current inventory, the distribution of beds across sub-populations does not mirror the respective size of those sub-populations.

Sub-Population	% or Number of Beds for the Sub-Population	Sub-Population % of Overall Homeless Population (number of persons)
Households with Children	25% – 1218 beds (including 383 emergency shelter, 278 transitional housing and 557 permanent supportive housing beds)	8% (610 adults and children)
Survivors of Domestic Violence	128 emergency shelter beds	11% (777 adults – doesn't include # of children with them)
Persons Living with HIV/AIDS	8 permanent supportive housing beds	1% (71 people)
Veterans	26% – 1271 beds (including 57 emergency shelter, 328 transitional housing and 886 permanent supportive housing)	12% (866 veterans)
Chronic Homeless	749 permanent supportive housing beds	9% (695 individuals)

Sub-Population	% or Number of Beds for the Sub-Population	Sub-Population % of Overall Homeless Population (number of persons)
Unaccompanied Youth under 18 years of age	1% – 70 beds (including 24 emergency shelter and 46 transitional housing beds)	7.3%

See page 52 for an overview chart of 2012 housing and shelter inventory and the appendices for detailed inventories.

Priority Gaps Identified

a. Evaluate and expand shelter capacity

Based on meetings and interviews held, there was consensus that more emergency shelter is needed, in particular for selected sub-populations. Many people spoke of the need for additional shelter for families; however, this is at odds with the housing inventory numbers which show that 25% of all beds (emergency shelter, safe haven, transitional housing and permanent supportive housing) are for persons in families who make up 8% of the overall homeless population. An evaluation should be carried out that considers existing shelter capacity, average length of stay and bed turnover rates, and sub-population needs, and based on this, determines how many beds are needed and for which sub-populations. Additionally, shelter programs should be evaluated to determine what programmatic capacity, such as additional case management, is needed to lower length of stay. Lower length of stay allows for greater efficiency as the same number of beds can serve more people in need.

Specific shelter needs that have been identified that are not being adequately served include:

- Wet shelter / harm reduction facility
- Beds for medically fragile
- People with pets
- Couples and families so don't have to be broken up
- Youth
- People with mental health disorders and those with co-occurring mental and substance abuse disorders

b. Provide centralized housing search assistance and explore master-leasing of units

People need assistance in locating housing and in addressing barriers to housing, including eviction history, criminal record and other issues. Explore the master-leasing of units to facilitate access to housing by the hardest to serve, people with chronic substance abuse problems, ex-offenders, sex offenders, and other groups.

BEST PRACTICE SPOTLIGHT: MASTER LEASING

Master leasing, a legal arrangement in which a master tenant subleases units to subtenants, is a strategy that can expand homeless people's access to affordable housing. With many programs seeking to implement a "Housing First" approach with their homeless clients, master leasing provides a means for accessing housing units that can then be used for clients who are often unattractive to landlords, such as those who have bad credit histories or problems with addiction or mental illness. In addition, by developing collaborative arrangements with providers of services needed by the clients, master leasing becomes a quick way to bring vitally needed supportive housing units on line.

The San Francisco Department of Public Health operates Direct Access to Housing which provides permanent housing with on-site supportive services to approximately 400 homeless adults who have concurrent mental health, addiction and chronic health problems. The housing is provided through master leasing agreements with five single room occupancy (SRO) hotels and a residential care facility. In order to keep the rents affordable and cover service costs, the units are subsidized at an average $900/month from government sources.

c. Develop more permanent supportive housing and affordable housing, and including Housing First capacity.

The average annual bed cost for permanent supportive housing in Southern Nevada / Clark County is $11,277 or $940/month.[37]

See also: Best Practice Spotlight: Housing First with Frequent Users, page 20.

Outreach, Case Management, Referral, Advocacy and Legal Services

- *Individualized goal setting and plan development*
- *Intensive case management*
- *Mobile outreach services*
- *Help in obtaining ID and other documents*
- *Legal advocacy*
- *Benefits advocacy*
- *Information and referral to housing and services*
- *Peer mentoring and support*

Existing Services

Case management and advocacy services offered by providers include individualized goal setting and achievement planning (40 programs), benefits advocacy (31 programs), intensive / wraparound case management (36 programs), housing search assistance (40 programs), civil legal advocacy (18 programs), and help in obtaining ID cards and other documents (10 programs). Other case management and advocacy services include transportation assistance, financial literacy, education advocacy, entrepreneurship education, networking education, life skills classes, bus passes, food assistance, wellness checks (weekly or daily), referrals to Veterans Administration services, housing counseling, and safety planning for victims of domestic violence, sexual assault, and human trafficking.

Eighteen providers conduct mobile outreach to clients as a part of their outreach, engagement, and referral

37 Calculated from the 2011-2012 APRs for 6 permanent supportive housing programs. Total SHP and cash match or S+C and supportive services match expenditures for the 6 programs divided by the total number of beds.

process. 100% of programs surveyed offer information and referral to community resources, including housing and services. Staff on outreach teams include intensive case managers, program managers, licensed clinical social workers, RN nurses, substance abuse counselors and coordinators, mental health counselors, outreach coordinators, AmeriCorps VISTA volunteers, trained outreach volunteers, entrepreneur re-educators, charity coordinators, Veteran volunteers, consumers, client advocates, bilingual caseworkers, and housing counselors.

O.U.T.R.E.A.C.H. (Organizations United To Reach, Educate, & Assist Chronic Homeless) includes the following participating agencies: HELP of Southern Nevada, Straight From The Street, Community Counseling Center, Clark County Social Services, Nevada Health Centers, Southern Nevada Adult Mental Health Bridge Team, METRO HELP Team, Regional Office of the Homeless Coordinator, Westcare of Nevada, and Mobile Crisis Intervention Teams (MCIT).

MCIT conducts interventions and abatements and Health and Safety checks from all jurisdictions, and offers supportive services and access to housing. Straight from the Streets Homeless Outreach provides intensive case management through a team of case managers, substance abuse counselors, licensed clinical social workers, and mental health counselors. Through the United States Veterans Initiative, U.S. VETS – Las Vegas has a team of staff and interns that conduct outreach for its Veterans in Progress Program.

Nevada Partnership for Homeless Youth (NPHY) conducts preventative and education outreach in schools and at community events, street outreach, and operates Safe Place, an outreach program and mobile crisis intervention program available to youth in crisis at virtually every street corner in Clark County. NPHY's outreach teams regularly include an Outreach Coordinator, AmeriCorps VISTA, and trained outreach volunteers. Eligible clients are then referred to their staff of four licensed social workers for assessment and intake.

Priority Gaps Identified

a. Expand case management capacity & quality

Identify funding for additional case management to help clients access services after coordinated intake and assessment and to assist clients placed in housing to achieve ongoing stability. Key needs identified that case managers can assist with include:

- providing individualized care
- coordinating a package of services
- help in obtaining ID and other documents
- benefits advocacy
- money management and budgeting
- Intensive/wraparound case management

Development of case management standards and a common tool will help improve the quality of case management and facilitate joint case management between agencies. In addition, training in best practices will also enhance quality of care.

See also: Best Practice Spotlight: Case Management, page 26.

b. Use peer-mentoring to supplement case management support

Peer-mentors can work in tandem with case managers, providing day-to-day support from an understanding perspective. This addresses the need expressed by many clients to have people helping them that have had similar experiences and are sympathetic to their problems.

See also: Best Practice Spotlight: Peer-Mentoring, page 25.

c. Provide more outreach and engagement and establish system-wide standards

While several outreach teams are in operation, there was strong consensus on the need for more. With 60% of the homeless population unsheltered, outreach services provide an important point of contact and engagement, especially with those who are chronically homeless and reluctant to interact with the service system.

An evaluation of existing outreach team coverage should be carried out, identifying team make-up, target population, hours of operation and geographic range to determine if gaps exist, how the teams can be coordinated to extend coverage, and if additional teams or staffing is needed. Additionally, the evaluation should consider how the outreach teams can function with a Housing First approach / link people directly to housing and how they can link people into case management. Systemwide outreach standards and tools should be established to ensure quality and consistency across teams.

BEST PRACTICE SPOTLIGHT: HOMELESS COURT

The San Diego, California Homeless Court Program (HCP), operating since 1989, was the first of its kind in the country. Homeless court sessions take place at participating homeless shelters around the County. The HCP builds on partnerships between the court, the prosecutor, the public defender, local shelters, service agencies, and homeless participants. It is designed for homeless citizens to resolve outstanding misdemeanor warrants and offenses (principally "quality-of-life" infractions such as unauthorized removal of a shopping cart, disorderly conduct, public drunkenness, and sleeping on a sidewalk or on the beach). Participants voluntarily sign up for the HCP through a participating homeless service provider and participate in approved program activities before appearing in court. Participants get credit for "time served" in program activities that address the underlying causes of their homelessness, like life-skills, substance abuse or AA/NA meetings, computer and literacy classes, training or searching for employment, medical care (physical and mental), and counseling.

d. Establish a Homeless Court

Homeless courts are special court sessions held in a local shelter or other community site designed for homeless citizens to resolve outstanding misdemeanor criminal warrants (principally "quality-of-life" infractions such as unauthorized removal of a shopping cart, disorderly conduct, public drunkenness, and sleeping on a sidewalk or on the beach). Resolution of outstanding warrants not only meets a fundamental need of homeless people but also eases court case-processing backlogs and reduces vagrancy. Homeless people tend to be fearful of attending court, yet their outstanding warrants limit their reintegration into society, deterring them from using social services and impeding their access to employment. They are effectively blocked from obtaining driver's licenses, job applications, and rental agreements. Homeless

courts provide a more accessible and less intimidating way for homeless people to resolve outstanding non-felony legal issues.

Children, Youth and Family services

Unaccompanied youth under 18 years of age are an under-served population. While they make-up 6% of the overall homeless population, only 1% of the beds listed in the 2013 Homeless Inventory Count (HIC) are targeted for them. 92% of homeless youth are unsheltered.

Existing Services

Of the programs surveyed, 24 identified families as one of the primary populations they serve. Fifteen providers serve children as a primary population, and 19 serve Transition Age Youth (age 18-24) as a primary population. Children, youth, and family services offered by providers include childcare (8 programs), parenting classes (15 programs), child placement services and custody services (4 programs), education and schooling (11 programs), mental health services (8 programs), substance abuse treatment (7 programs), and youth housing (7 programs). Other services include domestic violence support groups, homelessness prevention, and family reunification.

Priority Gaps Identified

a. Develop shelter and housing for youth, linked with intensive case management

b. Provide youth-targeted education and employment services

This includes assistance in getting a high school diploma, support for college, job training and employment assistance.

c. Expand affordable housing for families

Housing placement should be linked with case management, at least during the transition and until stability is achieved. Units should be targeted for families who are victims of domestic violence.

d. Improve collaboration and communication between homeless services providers and Child Protective Services

e. Facilitate affordable child care options for working families

Education, Skill Building and Employment Services

- *GED and academic tutoring*
- *Money management and budgeting*
- *Life skills*
- *Computer literacy*
- *Tenant and homeownership education*
- *Conflict resolution*
- *Work readiness*
- *Career coaching and job placement*
- *Vocational rehab/job skills training*
- *Transitional and subsidized employment*
- *Job retention and followup*
- *Employer engagement*

Nevada's unemployment rate is the highest in the country. Almost one out of five jobs are in occupations paying below the poverty level, and almost a third of workers age 18 and over are in low wage jobs. For people who are homeless trying to re-enter the job market, the situation is even more bleak. The 2011 Southern Nevada Homeless Census and Survey found that 82% of survey respondents indicated that they were not employed. In addition, job and income growth for people who are homeless is one of the HEARTH Act Continuum of Care performance indicators.

Existing Services

Providers offer a number of skill building and education services: academic tutoring and GED (22 programs), budgeting and credit-repair classes (28 programs), homeownership skills (8 programs), life skills (e.g., cooking, cleaning, laundry, time management) (36 programs), money management services (e.g., trusteeship, budgeting) (35 programs), conflict resolution and communication skills (30 programs), computer literacy services (18 programs), and tenant education (14 programs). Other services provided include education and employment libraries, budgeting assistance through case management, entrepreneurship classes, personal responsibility classes, online vocational skills classes, and wraparound services.

Providers also offer a range of employment and vocational services: work readiness (e.g., resume development, interview skills) (30 programs), career coaching and job placement services (22 programs), vocational rehabilitation and job skills training (14 programs), transitional and subsidized employment (3 programs), job retention and follow-up services (12 programs), employer engagement (17 programs), and assistance with employment-related needs (e.g., interview clothing, uniforms, work cards, tools, transportation) (36 programs). Other employment services include vocational case management, individual case plans to meet employment goals, childcare, and referrals to employment agencies and Nevada JobConnect.

Priority Gaps Identified

a. Facilitate homeless access and success in mainstream employment and training services

Build better collaboration with mainstream providers of employment services and identify how to support homeless people in being successful, including with clothes, interview skills, basic skills, employment history gaps etc. Provide targeted support to assist people with criminal backgrounds. Provide access to working computers for online applications. Assist with life skills as needing, including money management and budgeting.

b. Identify employers who will hire homeless people, and provide follow-up and support to facilitate job retention

Establish a CoH committee or working group to facilitate employer outreach and engagement.

Appendices

Shelter and Housing Inventory — Emergency Shelter

Organization Name	Program Name	Inventory Type	Bed Type	Target Pop. A	Target Pop. B	Beds HH w/ Children
Catholic Charities	Night Shelter	C	Facility-based beds	SM	NA	0
Catholic Charities	Residential Work Program	C	Facility-based beds	SM	NA	0
Clark County Social Service	Financial Assistance Service (FAS)	C	Voucher beds	SMF+HC	NA	152
Emergency Aid of Boulder City	ES	C	Voucher beds	SMF+HC	NA	0
Family Promise	Sheltering	C	Other beds	HC	NA	14
HELP of Southern Nevada	O.U.T.R.E.A.C.H.	C	Voucher beds	SFHC	NA	0
HELP of Southern Nevada	Shannon West Homeless Youth Center ES	C	Facility-based beds	SMF	NA	0
HELP of Southern Nevada	SWHYC-Outreach	N	Facility-based beds	SMF		0
HopeLink/HACA	Inclement Weather	C	Voucher beds	SMF+HC	NA	0
Las Vegas Rescue Mission	Emergency Shelter	C	Facility-based beds	SMF+HC	NA	36
Living Grace Homes	Transitional Housing	C	Facility-based beds	SFHC	NA	6
Nevada Partnership for Homeless Youth	Emergency Shelter	N	Facility-based beds	YMF	NA	0
Red Rock Assisted Living Facility	Contracted ES beds (medical or MH)	N	Facility-based beds	SMF	VET	0
Safe House	Victims of domestic Violence Shelter	C	Facility-based beds	SMF+HC	DV	36
Safe Nest	Emergency Shelter	C	Facility-based beds	SMF+HC	DV	53
Salvation Army	Men and Women's Dorms	C	Facility-based beds	SMF	NA	0
Salvation Army	Personal Safety Shelter	U	Facility-based beds	SMF	NA	
Salvation Army	VA contract beds	N	Facility-based beds	SMF	VET	0
Southern Nevada Adult Mental Health Services	Utopia	N	Facility-based beds	SMF	NA	0
The Shade Tree	Emergency Shelter	C	Facility-based beds	SFHC	NA	84
Westcare	CC Family Services Shelter	U	Facility-based beds	HC	NA	5
Westcare	Crisis Triage Center	C	Facility-based beds	SMF	NA	0
Westcare	HCHV/EH Empowering Women Warriors	N	Facility-based beds	SFHC	VET	2
Westcare	Youth Emergency Shelter	C	Facility-based beds	YMF	NA	0

Sum : 388

Shelter and Housing Inventory — Safe Haven

Organization Name	Program Name	Inventory Type		Target Pop. A	Target Pop. B	Beds HH w/ Children
Salvation Army	Safe Haven	C		SMF	NA	0

Beds HH w/o Children	Year-Round Beds	Total Seasonal Beds	Availability Start Date	Availability End Date	Overflow Beds	PIT Count	Utilization Rate
160	160	155	19/11/2012	31/03/2013	60	359	96%
150	150					122	81%
591	743	0			0	743	100%
0	0	2	18/11/2012	31/03/2013	0	2	100%
0	14	0			0	12	86%
5	5					2	40%
12	16	0			0	6	38%
4	5					5	100%
0	0	26	19/11/2012	31/03/2013	0	20	77%
128	164	0			0	156	95%
2	10	0			0	5	50%
0	2	0			0	4	200%
15	15	0			0	10	67%
6	42	0			0	27	64%
33	86	0			0	46	53%
110	110	104	19/11/2012	31/03/2013	0	292	136%
10	10						
39	39	0			0	7	18%
21	21	0			0	10	48%
80	164	60	19/11/2012	31/03/2013		170	76%
0	5						
36	36	0			0	37	103%
1	3	0			0	1	33%
0	15	0			0	10	67%
Sum : 1403	Sum : 1815	Sum : 347			Sum : 60	Sum : 2046	78.5454545%

Beds HH w/o Children	Year-Round Beds	Total Seasonal Beds					Utilization Rate
25	25	20					80%

Shelter and Housing Inventory — Transitional Housing

Organization Name	Program Name	Inventory Type	Target Pop. A	Target Pop. B
HELP Las Vegas Corp.	HELP @ Bonanza	C	SMF	VET
HELP of Southern Nevada	Shannon West Homeless Youth Center-SA	C	SMF	NA
HELP of Southern Nevada	SWHYC HUD TH	C	SMF	NA
HELP of Southern Nevada	SWHYC TH Non HUD Funded	C	SMF	NA
HELP of Southern Nevada	TBRA-A New Path	C	SMF+HC	NA
HELP USA	HELP Genesis	C	SMF	VET
HopeLink/HACA	COH-Henderson	C	SMF	NA
HopeLink/HACA	Special Supportive Housing	U	SMF+HC	NA
HopeLink/HACA	TH-HUD I	C	HC	NA
HopeLink/HACA	TH-HUD II	C	HC	NA
Lutheran Social Services	Aaron David	C	HC	NA
Lutheran Social Services	Supportive Housing	C	HC	NA
Nevada Community Associates	E.I.G.H.T.-TH	N	SMF	NA
Nevada Partnership for Homeless Youth	Independent Living	C	YM	NA
Nevada Partnership for Homeless Youth	TLP ILP	U	SMF	NA
New Genesis	Transitional Housing	N	SMF+HC	NA
salvation Army	Lied Vocational Training Center-2nd floor	C	SMF	NA
salvation Army	Private and Jewish War Veterans Funded	C	SMF	VET
salvation Army	Rental beds (triple rooms)	C	SMF	NA
salvation Army	Single room rental units	C	SMF	NA
Southern Nevada Adult Mental Health Services	Pathways	U	SMF	NA
Southern Nevada Adult Mental Health Services	Total Recovery Program	C	SMF	NA
Southern Nevada Children First	Living Beyond	U	SMF+HC	NA
Southern Nevada Children First	Moving Forward, Dare to Dream--Phase 2	C	SFHC	NA
St. Jude's Ranch	Crossings	N	SMF	NA
St. Vincent	St Vincent HELP Apartments	C	SMF	NA
The Key Foundation	The Key Foundation	C	SM	VET
The Shade Tree	GPD-TH	C	SF	VET
The Shade Tree	Homeless to Home (HtH)	C	SFHC	NA
The Shade Tree	Housing in Place (HiP)	C	YMF	NA
The Shade Tree	Transitional Housing non HUD	C	SFHC	NA
US Vets	CHAMPS TH	C	SMF	VET
US Vets	Veterans in Progress	C	SMF	VET
Westcare	Voyages Apts	C	SFHC	NA
Women's Development Center	Transitional Housing	C	HC	NA
Women's Development Center	Transitional Housing Private Funded	C	HC	NA

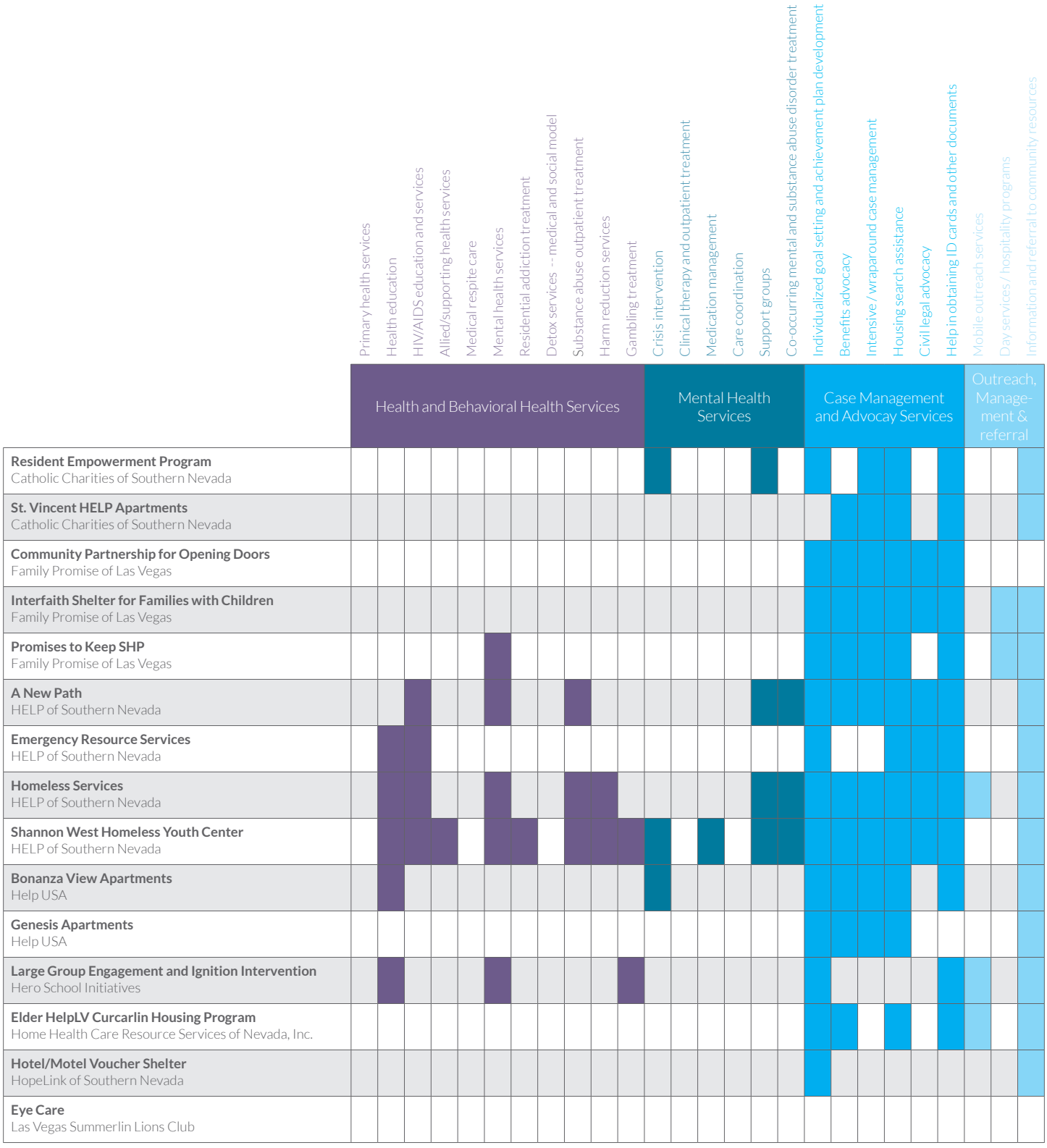
Beds HH w/ Children	Beds HH w/o Children	Year-Round Beds	PIT Count	Utilization Rate
0	75	75	73	97%
0	6	8	7	88%
0	24	28	28	100%
0	4	8	7	88%
45	0	45	46	102%
0	85	85	79	93%
0	12	12	5	42%
8	15	23		
39	0	39	11	28%
30	0	30	16	53%
12	0	12	12	100%
18	0	18	20	111%
0	8	8	10	125%
0	12	16	14	88%
0	4	4		
6	22	28	12	43%
0	67	67	34	51%
0	9	9	2	22%
0	6	6	3	50%
0	6	6	3	50%
0	42	42		
0	27	27	26	96%
4	4	8		
20	2	26	28	108%
0	15	15	15	100%
0	120	120	86	72%
0	24	24	17	71%
0	7	7	4	57%
14	23	37	28	76%
0	0	16	10	62%
18	65	83	78	94%
0	10	10	8	80%
0	118	118	102	86%
9	3	24	23	96%
43	0	43	28	65%
24	0	24	19	79%
Sum : 290	Sum : 815	Sum : 1151	Sum : 854	77.28125%

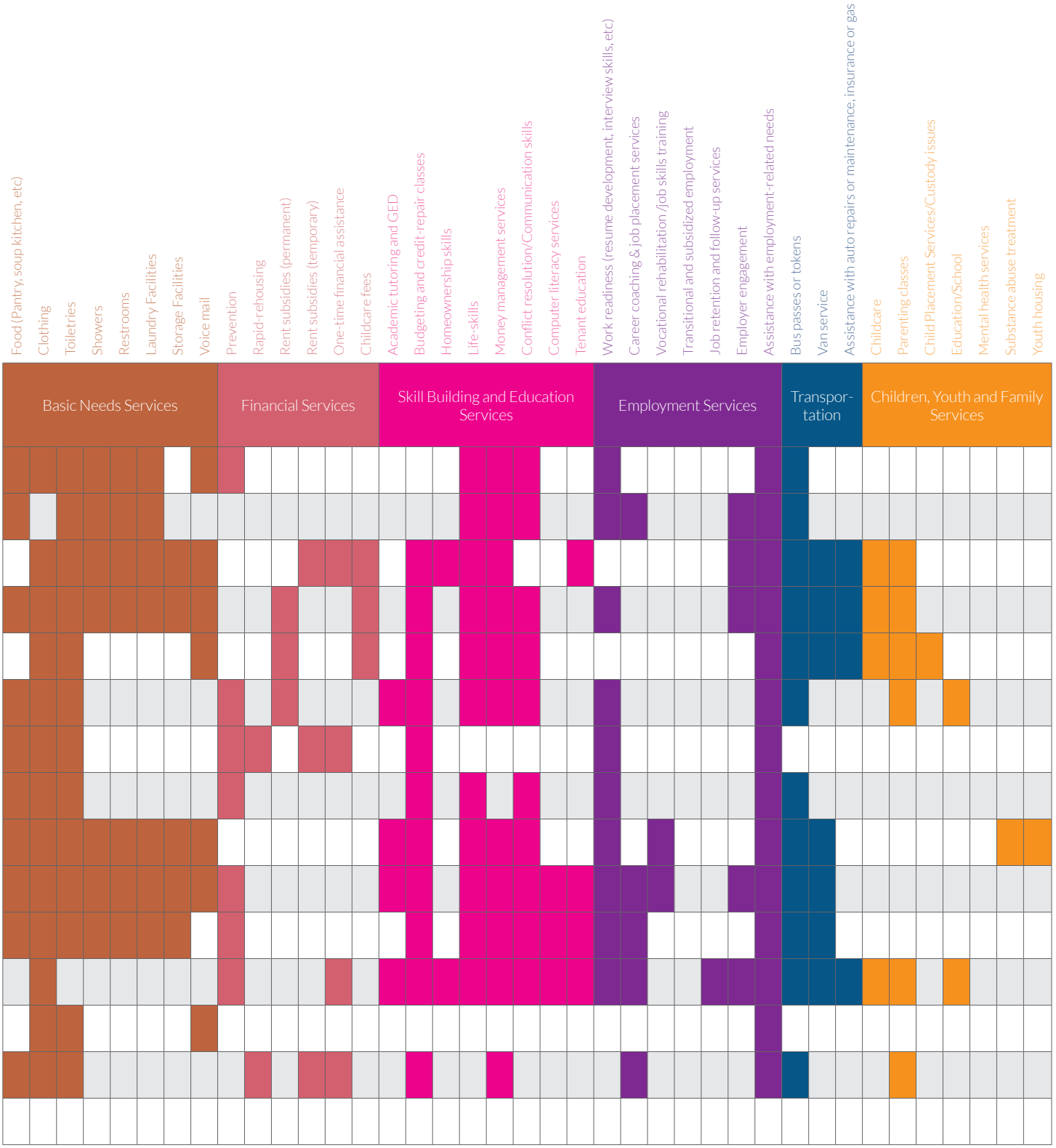
Shelter and Housing Inventory — Permanent Supportive Housing

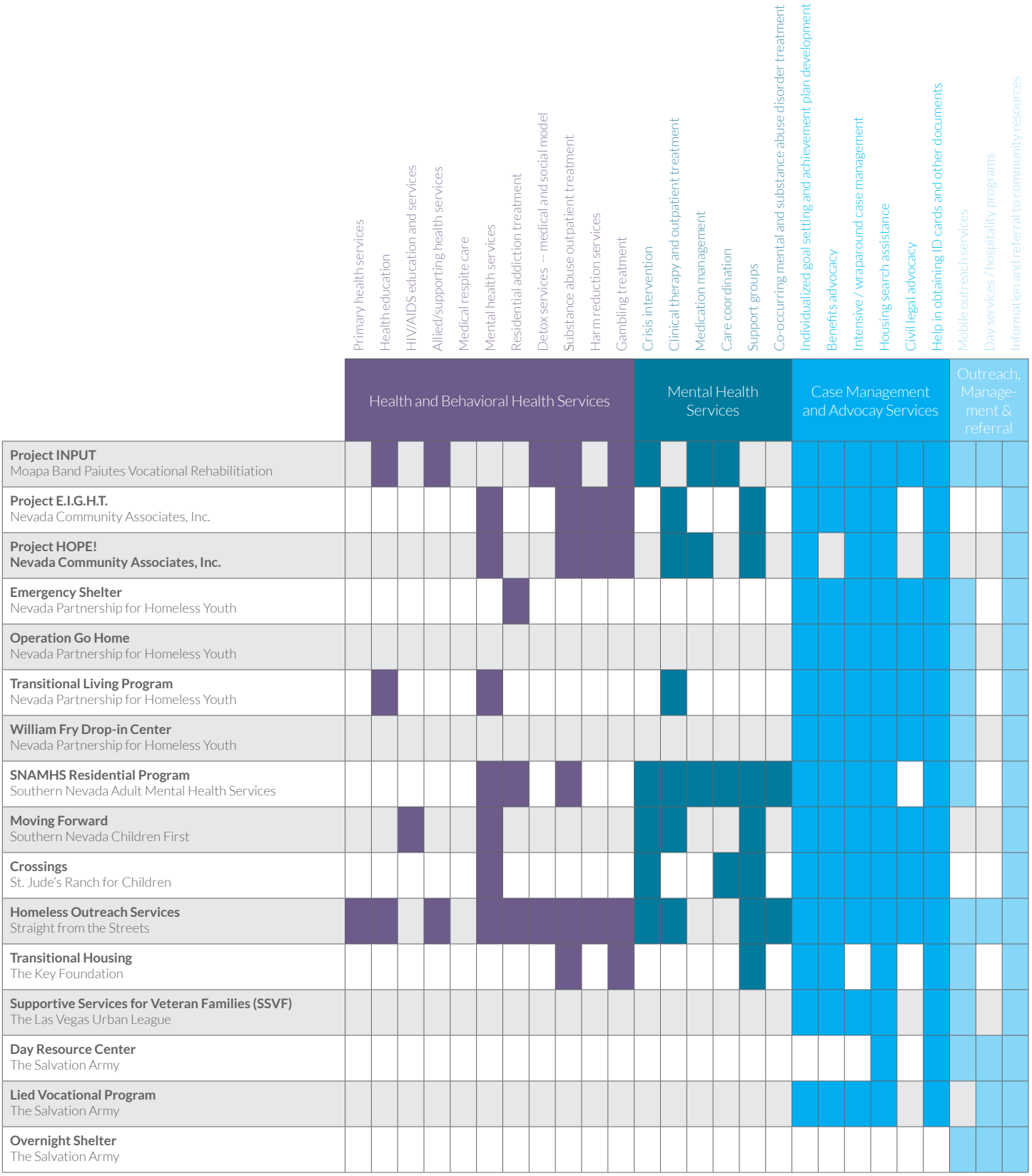
Organization Name	Program Name	Inventory Type	Target Pop. A	Target Pop. B
Aid for AIDS Nevada (AFAN)	Casa Esparanza	C	SMF	HIV
Catholic Charities	Homeless to Homes	C	SFHC	NA
Clark County Social Service	Permanent Housing Project	C	SMF	NA
Family Promise	Community Partnership fo Opening Doors	C	HC	NA
Family Promise	Promises to Keep Housing	C	HC	NA
Freedom House Sober Living	Freedom House	C	SMF	NA
HELP of Southern Nevada	A New Start	N	HC	NA
HELP of Southern Nevada	HELP them HOME	C	SMF	NA
Salvation Army/ Nevada Hand	Horizon Crest Apts	C	SMF	NA
Southern Nevada Adult Mental Health Services	Dual Success	U	SMF	NA
Southern Nevada Adult Mental Health Services	Group Homes	C	SMF	NA
Southern Nevada Adult Mental Health Services	HUD I, II, III & IV	C	SMF+HC	NA
Southern Nevada Children First	Paradise	U	HC	NA
Southern Nevada Regional Housing Authority	Housing Choice Vouchers	C	SMF+HC	VET
US Vets	CHAMPS PH	C	SMF	NA
US Vets	Disabled Vets 2	U	SMF	VET
US Vets	SHP-Disabled Vets	C	SMF	VET
US Vets	Transition in Place (TIP)	U	SMF	VET
Women's Development Center	Housing Stability for Families	N	HC	NA
Women's Development Center	Re-entry Housing Services	N	HC	NA

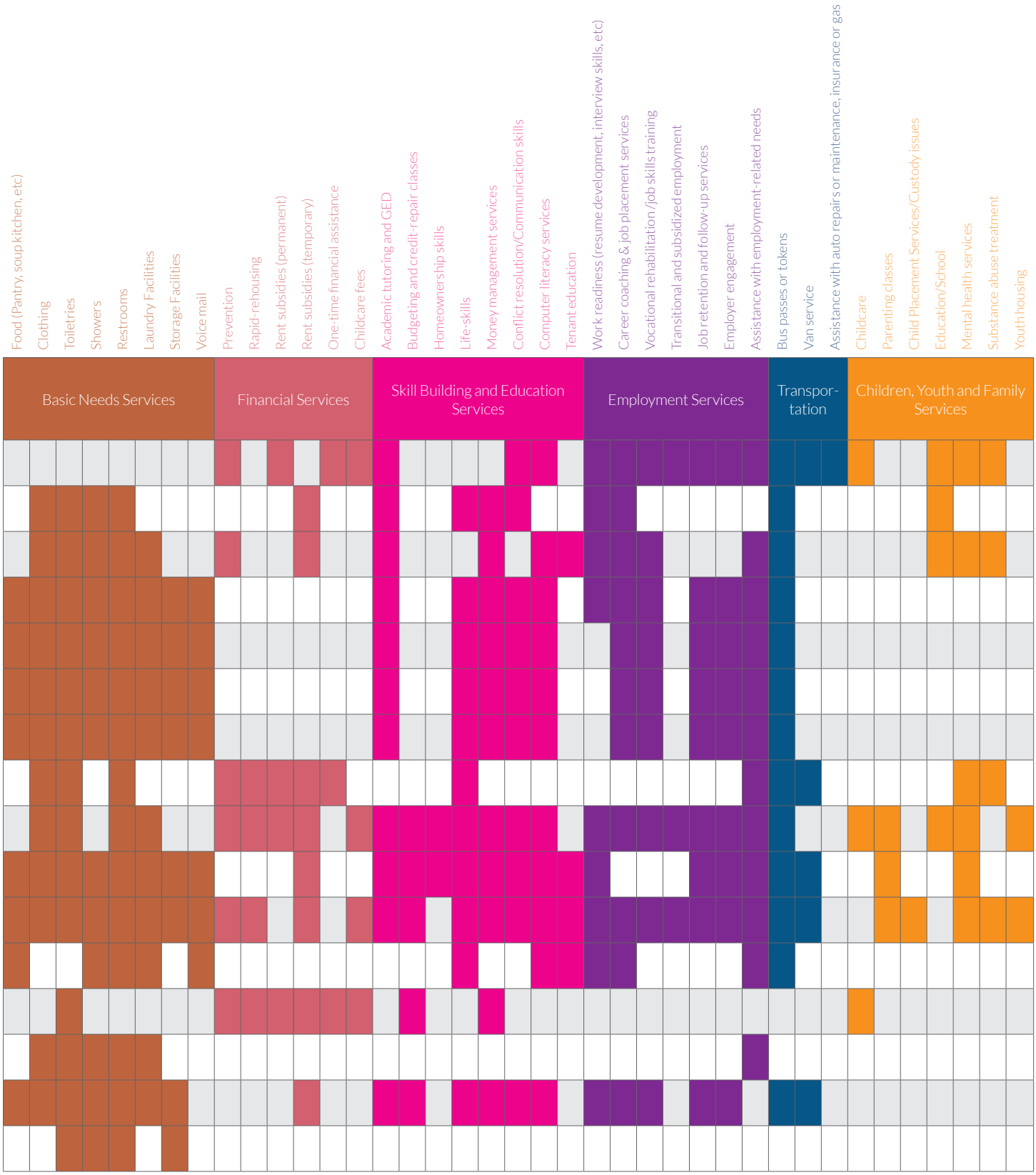
Beds HH w/ Children	Beds HH w/o Children	CH Beds	Year-Round Beds	PIT Count	Utilization Rate
0	8	0	8	8	100%
35	10	15	45	79	176%
0	130	130	130	140	108%
21	0	12	21	20	95%
45	0	4	45	60	133%
0	106	10	106	69	65%
74	0	5	74	69	93%
0	30	30	30	31	103%
0	12	12	12	12	100%
0	38	4	38		
0	361	0	361	309	86%
50	187	59	237	204	86%
8		1	8		
268	609	442	877	782	89%
0	13	13	13	13	100%
0	44	4	44		
0	9	0	9	8	89%
0	25	0	25		
48	0	6	48	4	8%
16	0	2	16	1	6%
Sum : 565	Sum : 1582	Sum : 749	Sum : 2147	Sum : 1809	

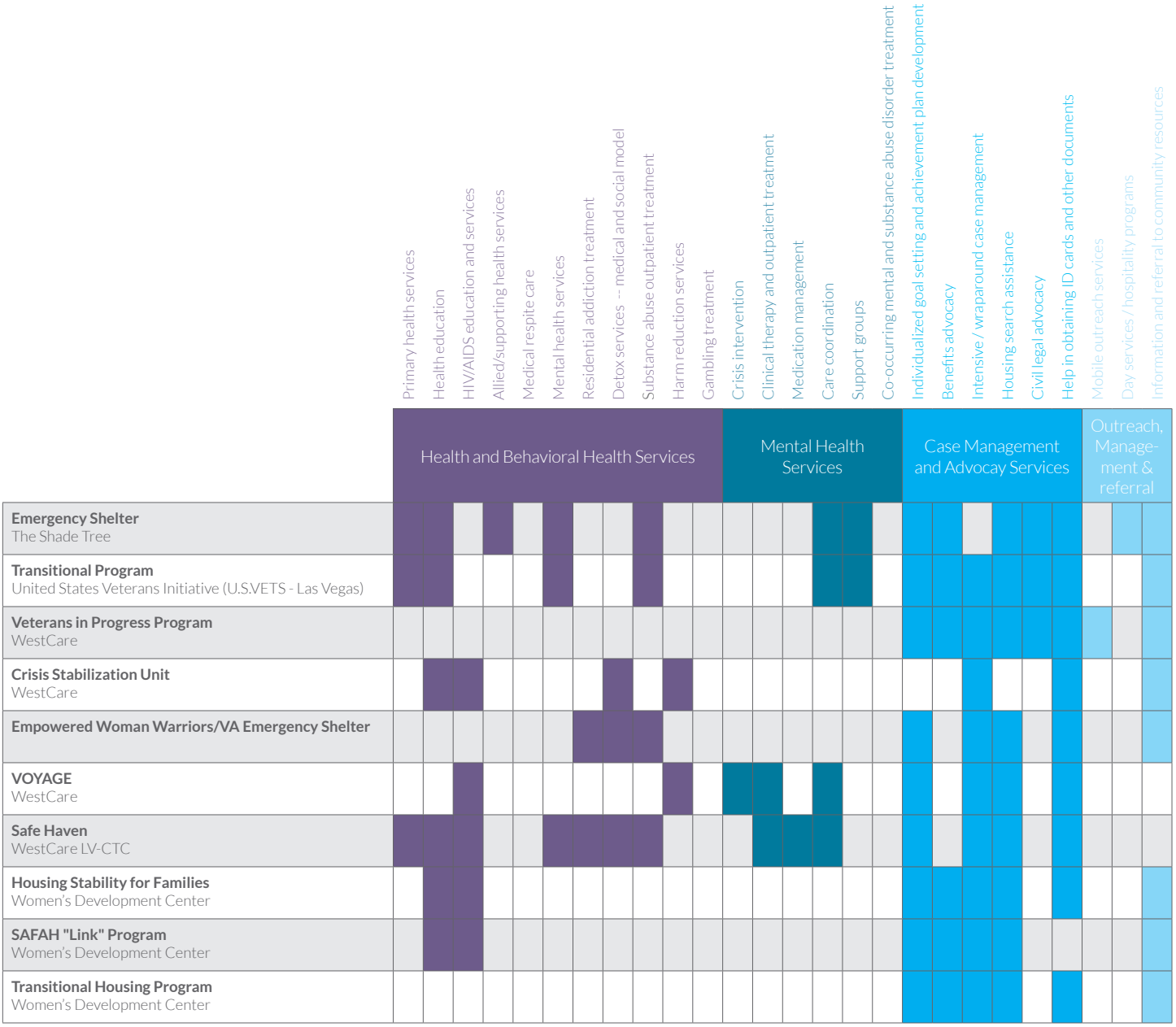
2013 Services Inventory Analysis

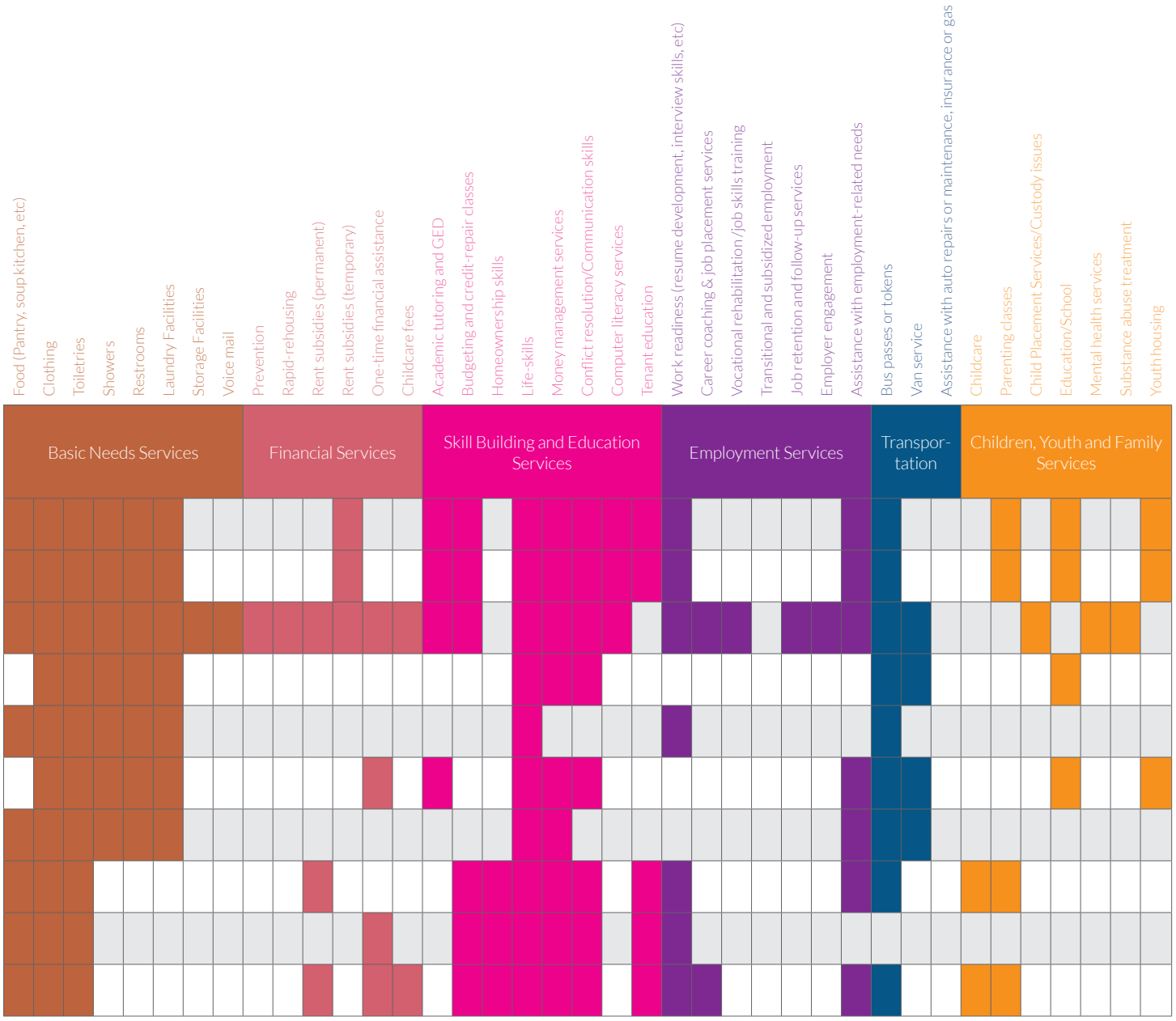



Food (Pantry, soup kitchen, etc)
Clothing
Toiletries
Showers
Restrooms
Laundry Facilities
Storage Facilities
Voice mail
Prevention
Rapid-rehousing
Rent subsidies (permanent)
Rent subsidies (temporary)
One-time financial assistance
Childcare fees
Academic tutoring and GED
Budgeting and credit-repair classes
Homeownership skills
Life-skills
Money management services
Conflict resolution/Communication skills
Computer literacy services
Tenant education
Work readiness (resume development, interview skills, etc)
Career coaching & job placement services
Vocational rehabilitation /job skills training
Transitional and subsidized employment
Job retention and follow-up services
Employer engagement
Assistance with employment-related needs
Bus passes or tokens
Van service
Assistance with auto repairs or maintenance, insurance or gas
Childcare
Parenting classes
Child Placement Services/Custody issues
Education/School
Mental health services
Substance abuse treatment
Youth housing
Basic Needs Services
Financial Services
Skill Building and Education Services
Employment Services
Transpor-tation
Children, Youth and Family Services


Primary health services
Health education
HIV/AIDS education and services
Allied/supporting health services
Medical respite care
Mental health services
Residential addiction treatment
Detox services -- medical and social model
Substance abuse outpatient treatment
Harm reduction services
Gambling treatment
Crisis intervention
Clinical therapy and outpatient treatment
Medication management
Care coordination
Support groups
Co-occurring mental and substance abuse disorder treatment
Individualized goal setting and achievement plan development
Benefits advocacy
Intensive / wraparound case management
Housing search assistance
Civil legal advocacy
Help in obtaining ID cards and other documents
Mobile outreach services
Day services / hospitality programs
Information and referral to community resources
Health and Behavioral Health Services
Mental Health Services
Case Management and Advocay Services
Outreach, Manage-ment & referral
Project INPUT
Moapa Band Paiutes Vocational Rehabilitiation
Project E.I.G.H.T.
Nevada Community Associates, Inc.
Project HOPE!
Nevada Community Associates, Inc.
Emergency Shelter
Nevada Partnership for Homeless Youth
Operation Go Home
Nevada Partnership for Homeless Youth
Transitional Living Program
Nevada Partnership for Homeless Youth
William Fry Drop-in Center
Nevada Partnership for Homeless Youth
SNAMHS Residential Program
Southern Nevada Adult Mental Health Services
Moving Forward
Southern Nevada Children First
Crossings
St. Jude's Ranch for Children
Homeless Outreach Services
Straight from the Streets
Transitional Housing
The Key Foundation
Supportive Services for Veteran Families (SSVF)
The Las Vegas Urban League
Day Resource Center
The Salvation Army
Lied Vocational Program
The Salvation Army
Overnight Shelter
The Salvation Army


Food (Pantry, soup kitchen, etc)
Clothing
Toiletries
Showers
Restrooms
Laundry Facilities
Storage Facilities
Voice mail
Prevention
Rapid-rehousing
Rent subsidies (permanent)
Rent subsidies (temporary)
One-time financial assistance
Childcare fees
Academic tutoring and GED
Budgeting and credit-repair classes
Homeownership skills
Life-skills
Money management services
Conflict resolution/Communication skills
Computer literacy services
Tenant education
Work readiness (resume development, interview skills, etc)
Career coaching & job placement services
Vocational rehabilitation/job skills training
Transitional and subsidized employment
Job retention and follow-up services
Employer engagement
Assistance with employment-related needs
Bus passes or tokens
Van service
Assistance with auto repairs or maintenance, insurance or gas
Childcare
Parenting classes
Child Placement Services/Custody issues
Education/School
Mental health services
Substance abuse treatment
Youth housing
Basic Needs Services
Financial Services
Skill Building and Education Services
Employment Services
Transportation
Children, Youth and Family Services


Primary health services
Health education
HIV/AIDS education and services
Allied/supporting health services
Medical respite care
Mental health services
Residential addiction treatment
Detox services -- medical and social model
Substance abuse outpatient treatment
Harm reduction services
Gambling treatment
Crisis intervention
Clinical therapy and outpatient treatment
Medication management
Care coordination
Support groups
Co-occurring mental and substance abuse disorder treatment
Individualized goal setting and achievement plan development
Benefits advocacy
Intensive / wraparound case management
Housing search assistance
Civil legal advocacy
Help in obtaining ID cards and other documents
Mobile outreach services
Day services / hospitality programs
Information and referral to community resources
Health and Behavioral Health Services
Mental Health Services
Case Management and Advocay Services
Outreach, Manage-ment & referral
Emergency Shelter
The Shade Tree
Transitional Program
United States Veterans Initiative (U.S.VETS - Las Vegas)
Veterans in Progress Program
WestCare
Crisis Stabilization Unit
WestCare
Empowered Woman Warriors/VA Emergency Shelter
VOYAGE
WestCare
Safe Haven
WestCare LV-CTC
Housing Stability for Families
Women's Development Center
SAFAH "Link" Program
Women's Development Center
Transitional Housing Program
Women's Development Center


Food (Pantry, soup kitchen, etc)
Clothing
Toiletries
Showers
Restrooms
Laundry Facilities
Storage Facilities
Voice mail
Prevention
Rapid-rehousing
Rent subsidies (permanent)
Rent subsidies (temporary)
One-time financial assistance
Childcare fees
Academic tutoring and GED
Budgeting and credit-repair classes
Homeownership skills
Life-skills
Money management services
Conflict resolution/Communication skills
Computer literacy services
Tenant education
Work readiness (resume development, interview skills, etc)
Career coaching & job placement services
Vocational rehabilitation/job skills training
Transitional and subsidized employment
Job retention and follow-up services
Employer engagement
Assistance with employment-related needs
Bus passes or tokens
Van service
Assistance with auto repairs or maintenance, insurance or gas
Childcare
Parenting classes
Child Placement Services/Custody issues
Education/School
Mental health services
Substance abuse treatment
Youth housing
Basic Needs Services
Financial Services
Skill Building and Education Services
Employment Services
Transpor-tation
Children, Youth and Family Services

Funding Matrix

Program	Agency	Program Type (ES, TH, PH, SSO)	Funding Amount	Funding Type	Cash Match (If HUD)	Total Cost per Client	Total Funding
HIP for Youth	The Shade Tree	TH	$164,327	HUD	$77,311	$70,830	$2,054,087
Homeless to Home	The Shade Tree	TH		HUD		-	
Transitional Housing Program	Women's Development Center	TH	$126,073	HUD	$9,186	$4,548	$300,173
St. Vincent HELP Apartment	Catholic Charities	TH					
Youth Services	Help of Southern Nevada	TH	$618,478	HUD	$87,593	$29,877	$3,435,877
Moving Forward	Southern Nevada Children First	TH	$740,022	HUD	$147,775	$22,627	$1,088,267
Independent Living Program	Nevada Partnership for Homeless Youth	TH	$221,854	HUD	$143,038	$12,989	$363,695
HUD 1	Southern Nevada Mental Health Services	TRA	1,613,256	HUD	$1,930,722	$14,119	$3,543,978
Safe Haven	The Salvation Army Safe Haven	TH	$368,425	HUD	$107,281	$9,543	$657,901
Pathways	The Salvation Army	TH	$429,929	HUD	$272,229	$8,520	$741,256
Adams Washington Program	Luthern Social Services	TH					
HELP Las Vegas Apts	HELP Las Vegas Housing Corporation	TH	$195,230	HUD			
CHAMPS #2	United States Veterans Initiative	PH	$639,047	HUD	$32,905	$26,850	$751,820
TH2	HopeLink	TH	$105,000	HUD	$8,423		?*
Help them Home	Help of Southern Nevada	PH	$385,075	HUD	$86,839	$70,526	$2,962,115
Promises to Keep	Family Promises of Las Vegas	PH	$848,967	HUD	$56,889	$10,856	$922,790
TH1	HopeLink	TH	$162,056	HUD	$46,099		?*
S+C	Clark County Social Service	TRA	$3,153,480	HUD	$1,282,799	$22,971	$4,778,000
PH for Veterans with Disabilities	United States Veterans Initiative	PH	$116,015	HUD	$19,321	$4,265	$136,488
SAFAH	Women's Development Center	SSO	$147,153	HUD	$27,868	$1,323	$183,941
VIP Program	United States Veterans Initiative	TH		HUD			
CHAMPS	United States Veterans Initiative	TH		HUD			
Total			$10,034,387		$4,336,278	$309,844	$21,920,388
Average			$590,258		$217,017	$15,502	$1,565,742
N=			17		16	14	14

Total Beds	Clients Served	Housing Stability	Increase Total Income	Increase Earned Income	Notes
22	29	45%	38%	19%	
	128	60%	47.80%	17.80%	
56	66	75%	91%	0%	
	186	58%	81.70%	44.40%	
28	115	42%	33%	18%	
26	48	64%	46%	8%	
16	28	100%	80%	80%	
237	251	98%	65%	4%	APR reports HUD funding 50% of total program, but match exceeds total HUD funds.
25	69	no outcomes - special designation			
42	87	13%	13%	0%	
	49	73.90%	40.90%	27.30%	
75					
14	28	96%	82%	0%	
65	73	14%	14%	14%	APR reports HUD funding 0% of total budget. Also, all outcomes reported as 14%.
42	42	86%	17%	2%	
85	85				
33	80	90%	95%	95%	APR says HUD funding 100% of total budget, but there is match $.
208	208	79%	18%	1%	
9	32	72%	88%	0%	Total funding seems low. Also, if the program served 32 people in PH, and 9 are currently housed, how has the program achieved 72% housing stability?
	139	98%	2%	0%	
	347	61.60%	41.70%	25%	APR reports 0 beds, but that it is a TH program
	35	53.80%	68.60%	0%	APR reports 0 beds, but that it is a TH program
983	2125	1279%	963%	356%	
61	101	67%	51%	18%	
16	21	19	19	19	

Focus Group Meetings Questions and Locations of Focus Groups

CLIENT FOCUS GROUP DISCUSSION QUESTIONS

2013 Southern Nevada/Clark County Gaps Analysis

[Staff: Please make note of the focus group location and type of service provided there, number of attendees, and rough observations about demographics of the attendees (gender, age, ethnicity, etc).

The following questions are a guide to conducting a conversation that will elicit information on the most important gaps in services and the barriers to accessing services. We are interested in why people were or weren't able to get the help they needed to prevent or end homelessness. Specifically, we are interested in identifying any lack of capacity or gaps in services and any process barriers that inhibit people from getting the full range of assistance they need.

To this end, use the following questions as a base for drawing people out on these issues. Some questions include "Possible Responses" that you can use if the initial question is not yielding a response. When appropriate, use follow-up questions to get people to expand on their point ("Can you say more about that?") and encourage alternative points of view ("Does anyone feel differently?")]

Introduction: We would like to ask you some questions about your experience in accessing assistance to prevent or end homelessness. We are interested in what you think about all of the homeless housing or services programs that you have used here in Clark County, including prevention, outreach, shelters, health care, transitional or permanent housing, employment programs, or any other housing or service programs. And we are interested in your opinions on how we can improve the process of receiving assistance and the effectiveness of the assistance provided.

1a. What kind of help do you most need to move back into permanent housing? Are there support services you need that you haven't been able to get? Are there types of housing that you need that you haven't been able to access?

1b. What kind of help might have prevented you from becoming homeless in the first place? Possible Responses: discharge planning, rental assistance, relocation assistance landlord mediation or legal assistance

2a. Why do people live unsheltered (on the streets, in parks, in vehicles, in abandoned buildings, etc)? Possible Responses: not enough shelter and housing, not eligible, don't like the rules, don't know how to access shelter/housing

2b. What would help or encourage people to move off the streets into temporary or permanent housing?

3a. When you go to an agency for help, do they consider all your needs or just one? Possible Responses: assessed for all their needs, just given the one service they came for

3b. If you are referred elsewhere for services, what help do you receive to access those services? Possible Responses: I was given a phone number and an address; someone made an appointment for me at the other agency; the referring agency called someone they knew at the other agency before they sent me over there

4. How can programs be more sensitive to people's culture, background and experience? Possible Responses: bilingual staff and materials, awareness of different experiences – vets, mental illness, substance abuse

5a. What has stopped you from getting the help you need to move back into permanent housing? Possible Responses: lack of information, process too confusing, transportation problems, shame, lack of services, unhelpful staff, not eligible

5b. When people get help (such as shelter or case management), why isn't it enough for them to regain permanent housing? Possible Responses: effectiveness of services, coordination of services

5c. How can we make it easier for people to get the help they need to end their homelessness? Possible Responses: more outreach services, being able to go to one place for all the help that is needed, more sensitive, trained staff, more information about what assistance is available, more housing and/or specific service availability

Focus Group Locations

Catholic Charities
HELP of Southern Nevada
Nevada Partnership for Homeless Youth
Salvation Army

Homeless Housing and Services Survey Tool

2013 Las Vegas - Clark County Homeless Services and Housing Survey

Dear Provider,

In order to plan for how to best address the needs of people who are homeless or at-risk in the Clark County / Las Vegas region, HomeBase, a nationally-known consultant agency that specializes in homelessness issues, is conducting a homeless gaps analysis to identify unmet needs in the system of care. To this end, information is being gathered through a number of forums, including this housing and services survey, client focus groups, a provider meeting and community meetings.

This housing and services survey will collect important information on the housing and services available within the Las Vegas – Clark County system of care, providing a basis for better understanding what gaps exist. It also includes a few questions on system level functioning, in particular regarding interagency collaboration, coordinated intake and assessment and shared case management.

Please complete the following survey, giving us information about the housing and services you provide and the population you serve. If your agency operates more than one housing or service program for people who are homeless or at-risk, please complete a survey for each program. If any question is not applicable to your program, please respond with “Not Applicable” or “N/A”.

We ask that you return this survey by May 31st, to give us plenty of time to analyze and synthesize the information.

Thank you. We greatly appreciate your participation. If you have any questions or concerns, please contact Amanda Stempson at amanda@homebaseccc.org.

BASIC PROGRAM INFORMATION

***Q1. Name**

- Agency Name:
- Program Name:

(Note: If your agency operates more than one housing or service program for people who are homeless or at-risk, please complete a separate survey for each program.)

***Q2. Contact Person:**

- Name:
- Email:

***Q3. Address(es) Where Services are Provided:**

Q4. Type of Program (Check all that apply):

- Emergency Shelter
- Safe Haven
- Transitional Housing (Scattered-site)
- Transitional Housing (Facility-based)
- Permanent Supportive Housing (Scattered-site)
- Permanent Supportive Housing (Facility-based)
- Subsidized Permanent Affordable Housing
- Rapid Re-housing
- Supportive Services
- Other (please specify)

Q5. What is the average length of client engagement/stay in your program?

- 1-7 days
- 8-30 days
- 1-3 months
- 3-6 months
- 6-12 months
- 12-18 months
- 18-24 months
- 24+ months

Q7. If you are a shelter or transitional housing program: how long can clients access services after they exit?

- 0-30 days
- 30-60 days
- 60-90 days
- 90-120 days

- 120+ days
- N/A

***Q8. How do clients first access services?**

- Drop-in/Walk-in
- Referral from another agency
- Referral from another program within your agency
- Shelter Hotline/Phone/211 referral
- Other (please specify): _____

Q12. What is your housing or service program's annual budget?

Annual Budget: _____

SERVICES

Q13. Health and Behavioral Health Services Offered (Check all that apply.):

- Primary health services
- Health education
- HIV/AIDS education and services
- Allied/supporting health services, e.g., dentistry, optometry, nutritionist, etc.
- Medical respite care
- Mental health services
- Residential addiction treatment
- Detox services -- medical and social model
- Substance abuse outpatient treatment (Individual counseling, peer counseling, support groups)
- Harm reduction services
- Gambling treatment
- Other (please specify) _____

Q14. If you provide mental health services, please indicate which services you provide?

- Crisis intervention
- Clinical therapy and outpatient treatment
- Medication management
- Care coordination
- Support groups
- Co-occurring mental and substance abuse disorder treatment
- Other (please specify) _____

Q15. If you provide mental health services, what are your eligibility criteria?
Eligibility criteria: _____

Q16. Case Management and Advocacy Services Offered (Check all that apply.):

- Individualized goal setting and achievement plan development
- Benefits advocacy
- Intensive / wraparound case management
- Housing search assistance
- Civil legal advocacy
- Help in obtaining ID cards and other documents
- Other (please specify) _____

Q17. Outreach, Engagement & Referral (Check all that apply.):

- Mobile outreach services
- Day services / hospitality programs
- Information and referral to community resources (housing and services)
- Other (please specify) _____

Q18. If you provide outreach services, what is the staffing makeup of your teams (e.g. nurse practitioner, social worker, etc.)?
Staffing: _____

Q19. Basic Needs Services Provided (Check all that apply.):

- Food (Pantry, soup kitchen, etc)
- Clothing
- Toiletries
- Showers
- Restrooms
- Laundry Facilities
- Storage Facilities
- Voice mail
- Other (please specify) _____

Q20. Financial Services Provided (Check all that apply.):

- Prevention
- Rapid-rehousing
- Rent subsidies (permanent)
- Rent subsidies (temporary)

- One-time financial assistance (deposits, utilities, rental applications or other financial assistance—not including rent)
- Childcare fees
- Other (please specify) _____

Q21. Skill Building and Education Services Provided (Check all that apply.):

- Academic tutoring and GED
- Budgeting and credit-repair classes
- Homeownership skills
- Life-skills (e.g. cooking, cleaning, laundry, time management, etc.)
- Money management services (e.g. trusteeship, budgeting)
- Conflict resolution/Communication skills
- Computer literacy services
- Tenant education
- Other (please specify) _____

Q22. Employment Services (Check all that apply.):

- Work readiness (resume development, interview skills, etc)
- Career coaching & job placement services
- Vocational rehabilitation /job skills training
- Transitional and subsidized employment
- Job retention and follow-up services
- Employer engagement
- Assistance with employment-related needs (interview clothing, uniforms, work cards, tools, transportation, etc)
- Other (please specify) _____

Q23. Transportation (Check all that apply.):

- Bus passes or tokens
- Van service
- Assistance with auto repairs or maintenance, insurance or gas
- Other (please specify) _____

Q24. Children, Youth and Family Services (Check all that apply.):

- Childcare
- Parenting classes
- Child Placement Services/Custody issues
- Education/School
- Mental health services
- Substance abuse treatment

- Youth housing
- Other (please specify) _____

Q25. Other Services (Please specify.): _____

CAPACITY

Q26. Is there unmet demand for the housing or services you provide?

- Yes
- No

Q27. If there is unmet demand, can you quantify it – put it in numerical terms? (number of turnaways/month, size of the waitlist, etc.)

Unmet demand: _____

Q28. If you have a waitlist, please describe the average length of time someone stays on the waitlist, the average # of people/families on the waitlist, and the process that an individual should follow to move up the waitlist:

_____

Q29. Primary Population(s) Served:

- Individuals
- Families
- Children
- Seniors
- Transition Age Youth (Age 18-24)
- Survivors of Domestic Violence
- Veterans
- Persons with mental illness
- Persons with substance abuse issues
- Persons with co-occurring disorders
- Ex-offenders
- Persons who are chronically homeless
- Persons with HIV/AIDs
- Persons without citizenship or legal residency
- Other (please specify)

Q30. What are your hours of service provision? _____

ELIGIBILITY, INTAKE & COLLABORATION

***Q31. What is the basic eligibility criteria required to enter your program?**

_____

Q32. What are potential "screen-out" factors for your program (i.e., eligibility criterial that might prevent clients from entering your program)?

- Must be clean and sober
- Must have income (either employment or benefits or both)
- Must have a job
- Must have health insurance
- Must have legal residency status
- No criminal history convictions (please specify the rules below)
- Other (please specify)

***Q33.How does a person/family get referred to your program?**

_____

***Q34. Please describe your intake/assessment process. Consider the following questions:**

- What is the intake/entry point for a client?
- Is there staff dedicated to performing intake?
- What information/documentation do you need from a referring agency?
- Can a client come to you without a referral?
- Is your assessment designed specifically for your program or is it a comprehensive assessment considering the client's full range of needs?
- What happens if a need is identified that your agency cannot address?
- Other comments on your intake procedures?

_____

Q35. Please describe your referral process. Consider the following questions:

- Do you have formal agreements (MOUs) with the agencies that you typically refer clients to?
- Do you refer to agencies for which you do not have referral agreements in place?
- How do you support the client in completing the referral?
- How is client information shared with the agency the client is referred to?

_____

Q36. What potential benefits do you see for your agency in having a regional coordinated assessment system with multiple access points and a dedicated assessment team at each point?

_____

Q37. What challenges do you see for your agency in implementing a regional coordinated assessment system with multiple access points and a dedicated assessment team at each point?

_____

Q38. Do you collaborate / have partnerships with other agencies in providing services to the homeless and at-risk population?

- Yes
- No

Q39. Who do you partner /collaborate with?

_____

Q40. Does your partnership involve shared intake/assessment or case management for common clients? How does this work?

_____

Q41. What would help improve the degree of interagency coordination/collaboration within the CoC?

_____

Q42. What do you do to make your services sensitive to people's culture, background and experience?

_____

Provider Meeting Questions

2013 Southern Nevada/Clark County Gaps Analysis

Provider Meeting Question Guide

This meeting has been organized to help identify unmet needs and program and system level gaps that should be addressed in order to more effectively prevent and end homelessness in our community. In particular we are interested in identifying:

- housing and services where existing capacity is insufficient to meet the demand/need
- sub-population specific needs that are not currently being addressed
- program policies and procedures that create barriers to access
- system level changes/improvements that would enhance access, effectiveness and/or quality of care
- provider training and capacity needs that would enhance access, effectiveness and quality of care.

I. Prevention & Rapid Rehousing Services

- *Short term rental assistance*
- *Rental arrears payments*
- *Rental security deposits*
- *Utility payments*
- *Utility deposits*
- *Emergency/short term motel/hotel vouchers*
- *Moving cost assistance*
- *Early identification and referral from mainstream providers*
- *Outreach and engagement*
- *Housing search and placement*
- *Legal services (mediation)*
- *Credit repair*

1. What more do we need to be able to prevent people from becoming homeless and/or to rapidly rehouse them once they lose their housing?

- More of existing services – specify which ones are highest priority

- An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

- Improved assessment and referral mechanisms?
- Reinforce existing/create new partnerships/collaboration?
- Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
- Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

II. Basic Needs Services

- *Showers*
- *Restrooms*
- *Laundry facilities*
- *Personal hygiene products*
- *Food assistance*
- *Water*
- *Safe/secure storage*
- *Transportation*

1. What more do we need to be able to meet people's basic needs?

   - More of existing services – specify which ones are highest priority

   - An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

   - Improved assessment and referral mechanisms?
   - Reinforce existing/create new partnerships/collaboration?
   - Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
   - Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

III. Shelter and Housing

- *Emergency shelter*
- *Transitional housing*
- *Permanent supportive housing*
- *Affordable housing (subsidized)*
- *Sober living housing*
- *Wet housing/harm reduction*
- *Safe haven*
- *Housing search assistance*

1. What more do we need to be able to meet the need for housing in this community?

   - More of existing housing types – specify which ones are highest priority

   - An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

   - Improved assessment and referral mechanisms?
   - Reinforce existing/create new partnerships/collaboration?
   - Changes in how shelter/housing is currently provided
   - Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

IV. Health and Behavioral Health Services

- *Primary health care*
- *Vision*
- *Dental services*
- *HIV/AIDs services*
- *Mental health services (crisis intervention, clinical therapy, counseling, support groups, medication management)*
- *Drug and alcohol treatment (detox, day treatment, counseling, residential treatment, support groups)*
- *Gambling treatment*
- *Co-occurring disorder treatment*

1. What more do we need to be able to meet the need for health and behavioral health services?

- More of existing services – specify which ones are highest priority

- An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

- Improved assessment and referral mechanisms?
- Reinforce existing/create new partnerships/collaboration?
- Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
- Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

V. Outreach, Engagement, Case Management, Referral and Advocacy Services

- *Individualized goal setting and plan development*
- *Intensive case management*
- *Mobile outreach services*
- *Help in obtaining ID and other documents*
- *Legal advocacy*
- *Benefits advocacy*
- *Day services/hospitality program*
- *Information and referral to housing and services*

1. What more do we need to be able to coordinate and support people's efforts to exit homelessness and achieve ongoing stability?

- More of existing services – specify which ones are highest priority

- An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

- Improved assessment and referral mechanisms?
- Reinforce existing/create new partnerships/collaboration?
- Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
- Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

VI. Education, Skill Building and Employment Services

- *GED and academic tutoring*
- *Money management and budgeting*
- *Life skills*
- *Computer literacy*
- *Tenant and homeownership education*
- *Conflict resolution*
- *Work readiness*
- *Career coaching and job placement*
- *Vocational rehab/job skills training*
- *Transitional and subsidized employment*
- *Job retention and followup*
- *Employer engagement*

1. What more do we need to support people in achieving financial independence and self-sufficiency?

- More of existing services – specify which ones are highest priority

- An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

- Improved assessment and referral mechanisms?
- Reinforce existing/create new partnerships/collaboration?
- Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
- Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

VII. Children, Youth and Family Services

- *Child care*
- *Parenting skills*
- *Education/school issues*
- *CPS / Custody issues*
- *Mental health / trauma services*
- *Substance abuse*
- *Housing for youth*
- *Other*

1. What more do we need to be able to meet support families and youth in exiting homelessness and achieving ongoing stability?

- More of existing services – specify which ones are highest priority

- An additional service, approach or capacity that does not currently exist

2. What can we do to make these services more accessible and effective for those who need them?

- Improved assessment and referral mechanisms?
- Reinforce existing/create new partnerships/collaboration?
- Changes in how these services are currently provided – policy, operations, hours, cultural competence, etc.?
- Other changes?

3. Are there specific sub-populations who need additional outreach or targeting for these services?

Overall Top Programmatic Priorities

Please rate each of the preceding seven program areas as High (H), Medium (M) or Low (L) for additional investment.

____ Prevention and rapid rehousing services

____ Basic needs services

____ Shelter and housing

____ Health and behavioral health services

____ Outreach, engagement, case management, referral and advocacy services

____ Education, skill building and employment services

____ Children, youth and family services

For each that you identified as a high priority, identify specifically where resources should be invested.

System Level Issues

1. What are the key system level gaps that need to be addressed in order for the Continuum of Care to function more effectively? Please rate the following as High (H), Medium (M) or Low (L) priorities:

   - _____ Increased collaboration with mainstream agencies
   - _____ Increased interagency collaboration in development and operation of housing
   - _____ Increased partnership and collaboration among local governments in addressing homelessness
   - _____ Capacity for interagency data sharing and joint case management
   - _____ Improving the cultural competency of the system and its programs
   - _____ Provider training and capacity building
   - _____ Other (Please specify) _____

2. Which of the following CoC/system level functions would most support your agency's effectiveness and quality of service provision? Check all that apply.

   - _____ Source for information on complying with HUD grant management requirements
   - _____ Leadership to facilitate CoC compliance with HEARTH requirements, ie coordinated assessment system, transitional housing conversions, monitoring and oversight, etc.
   - _____ Facilitating interagency collaboration, including no wrong door approach, creation of shared staffing positions, etc.
   - _____ Promoting coordinated project development and fundraising
   - _____ Data analysis and evaluation
   - _____ System level planning
   - _____ Building collaboration and partnerships with other stakeholders, such as PHA and housing developers
   - _____ Financial and accounting capacity in order to function as a UFA

3. What are providers' key training and capacity building needs? Please check all that apply.

    - _____ Agency and program management
    - _____ Board development
    - _____ Financial management and accounting
    - _____ Building collaboration and partnership with other providers, including referrals, joint program development, information sharing, etc
    - _____ Data collection and HMIS participation
    - _____ Evaluation capacity and use of systemwide performance measures for agency planning and quality improvement
    - _____ Best practices in case management
    - _____ Other best practices in program operation (Please specify)

      _____
    - _____ Improving cultural competence of service provision
    - _____ Other (Please specify) _____

Key Informant Interview Participants

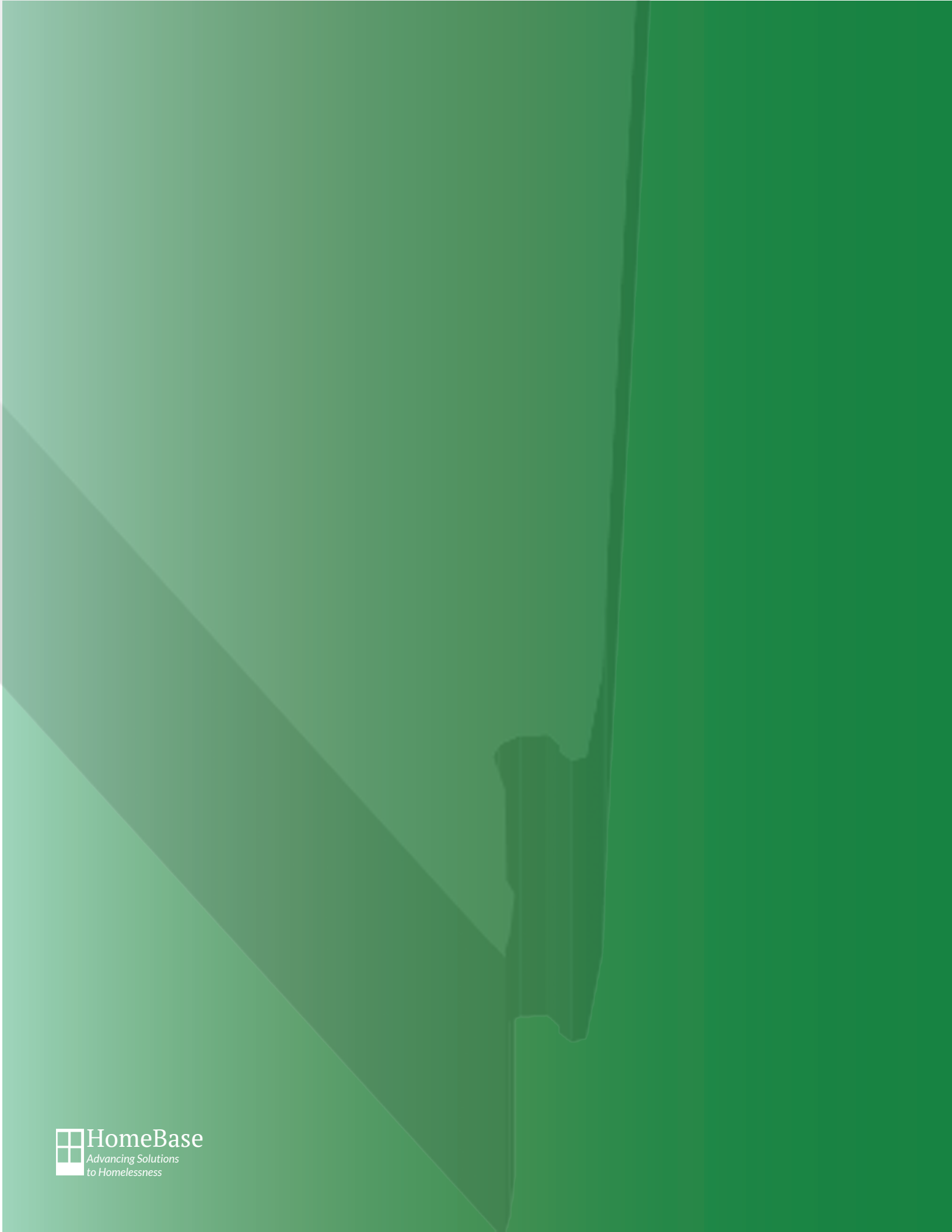
- Shawn Anderson
- Gorden Ashber
- Soni Bigler
- Tim Burch
- Dr. Cynthia Dodge
- Michele Fuller-Hallauer
- Barbara Geach
- Jodie Gerson
- Steve Harsin
- Lisa Morris Hibler
- Mike Husted
- Scott Kerestesi
- Leone Lettsome
- Ken LoBene
- Rose Ann Miele
- Julie Murray
- Kathy Somers
- Stacy Sutton Pollard
- Tyrone Thompson
- Annie Wilson
- Paula Zier

Recommendations & Action Steps Table

System Level Gaps	Recommendations	Action Steps	Who	When
Improve Access to the System and its Services	Establish centralized / coordinated intake and assessment	*A CoH committee has been formed*		
	Provide low threshold access to the system			
Facilitate Coordinated Service Delivery and Follow-up after Housing Placement to Ensure Ongoing Stability	Expand case management capacity			
	Establish system-wide case management standards and tools and provide best practices training	*Form a small working group to look at possible best practices to adopt?*		
Enhance System Level Capacity for Leadership, Planning, Oversight and Program Support	**Enhance staffing for the CoH**			
	Enhance the effectiveness of the CoH membership	*Provide training and orientation to CoH members?*		
Increase Community Engagement and Support for Preventing and Ending Homelessness	**Initiate a regional campaign to build public awareness and support for efforts to address homelessness**	*This work has started*		
Support Provider Capacity-Building and Quality Improvement	**Commit resources to provider training and capacity building**			
Engage in System Level Data Analysis and Performance Evaluation to Drive Resource Allocation	Conduct a system-wide evaluation of emergency shelter, rapid re-housing, and transitional housing to inform resource allocation and policy and program development			

Program Level Gaps	Recommendations	Action Steps	Who	When
Homeless Prevention and Rapid Re-Housing Services	Expand prevention and rapid re-housing services			
	Facilitate access to services through improved outreach and collaboration with other agencies, particularly mainstream agencies	*Include this as an action step in Coordinated Assessment planning?*		
	Improve linkage of clients with additional support such as after-care services to foster ongoing stability			
Basic Needs Services	**Expand availability of transportation assistance**	*Include this as an action step in Coordinated Assessment planning?*		
	Establish a year-round low-barrier 24-hour drop-in program			
	Increase services for persons who are LGBTQ			
Health and Behavioral Health Services	Provide dental and vision services for people with low or no income			
	Enhance access to health care services and provide appropriate follow-up			
	Provide more mental health services			
	Offer additional substance abuse treatment services			
Shelter and Housing	Evaluate and expand shelter capacity			
	Provide centralized housing search assistance and explore master-leasing of units	*Include this as an action step in Coordinated Assessment planning?*		
	Develop more permanent supportive housing and affordable housing, including Housing First capacity with matching support services	*Include this as a priority for CoC funds?*		

Program Level Gaps	Recommendations	Action Steps	Who	When
Outreach, Case Management, Referral, Advocacy and Legal Services	Expand case management capacity and quality			
	Use peer-mentoring to supplement case management support	*Set up a CoH Consumer Advisory Committee to focus on this idea?*		
	Provide more outreach and engagement and establish system-wide standards	*Form a small working group to look at possible best practices to adopt?*		
	Establish a Homeless Court	*Discuss models with local judges?*		
Children, Youth and Family Services	Develop shelter and housing for youth, linked with intensive case management			
	Provide youth-targeted education and employment services			
	Expand affordable housing for families			
	Improve collaboration with CPS			
	Facilitate affordable childcare options for working families			
Education, Skill Building and Employment Services	**Facilitate homeless access and success in mainstream employment and training service**s	*Form an ad-hoc CoH committee to focus on employment?*		
	Engage business community and identify employers who will hire homeless people, and provide follow-up and support to facilitate job retention	*Form an ad-hoc CoH committee to focus on employment?*		


HomeBase
Advancing Solutions
to Homelessness