HUD Unsheltered NOFO

Comprehensive Community Plan

Overview:

- NV-500 = $14,981,348 for a 36-month project period
- Comprehensive CoC Plan to Serve Individuals and Families Experiencing Homelessness with Severe Service Needs
    - Severe Service Needs- physical, mental, developmental or behavioral health disabilities, high utilizers of other system, like jails, ER, psychiatric facilities etc., unsheltered and repeat homelessness, medically vulnerable, vulnerability of victimizations, like assault, trafficking or sex work
    - Conducting coordinated and comprehensive outreach
    - Providing access to low-barrier shelter and other temporary accommodations
    - Providing immediate access to low-barrier permanent housing
    - Leveraging of mainstream housing and healthcare resources to assist in their efforts to end unsheltered homelessness and stabilize individuals and families in housing
    - Increasing access to employment opportunities for those experiencing homelessness
    - Supporting underserved communities
    - Identifying barriers that led to any disparities in communities being served
    - Supporting equitable community development to address barriers
    - Involving individuals with lived experience in the decision-making process of the CoC
    - Ensuring resources funded under this Special NOFO will contribute to reducing unsheltered homelessness in their geographic area.
- This community plan will guide funding decisions under this local competition process.

Please keep answers succinct, use of incomplete sentences and bullets are okay. The final narrative will be limited to 15-pages.

Landlord Recruitment Listening Session Questions August 1, 2022; 1:30 PM – 3:00 PM Find meeting information here.	
How are units and or landlords identified?	Brenda -Clients and case managers travel around to different communities to recruit landlords by doing presentations with what is offered and how program works. Albert – Depends on programs and program services. We work closely with LEAPS team to identify landlords. In ES, looks into resources to help clients move from homelessness to housing. Depends on the clients and where they are at in their plan. Celeste – HELP Case managers help to establish connections to landlords, operates by word of mouth, uses social media, uses Southern Nevada Regional Housing – created relationships. Jim Dean – emails but nothing else being used currently to identify landlords MFH –OH! Initiative has been testing Padmission to see if we could centralize Padmission to whole community – this would be whole portal where everyone has access to see what's available. LEAPS was starting to work on this.

	Wanted to centralize a housing navigation hub for case managers. Does this make sense? Should it be a non-profit / for profit entity? Do we fund? Or go back to way we were doing it? Who has access to Padmission? Do all case managers? OH case managers? What does process look like right now? Maurice Page – likes Padmission for landlords. Landlords truly enjoy using it. Great feedback. Housing navigators have access, can create web pages for people who come on board. The Housing Locator Manager works with all non-admin used to create passwords, housing staff can activate/deactivate properties (LEAPS team, admins, CC staff)
What is the geographic region covered through landlord recruitment? (Urban vs. Rural)	-Most efforts are in the urban metropolitan areas of our CoC, but if client interested in living in rural area, we would take them to meet landlords in areas of their choice. - Brenda
How is data used to inform the recruitment plan? Give examples. o How will data be used to update the landlord recruitment plans?	Celeste – FMR drives landlord recruitment. FMR informs what areas and sides of town are affordable if they have successfully transitioned off subsidy. Different sides of town have different services. If a client would like to near a bus line ten we try to find a unit near a bus line. We try and follow client choice and provide options. Maurice – Goes by Costar website that provides update on going rates for vacancies and which part of town for affordable. Maurice can get July report for Henderson SW area, Spring Valley etc. will have rents for areas, will compile with FMR to check vacancies to bridge gaps to bring clients on to get them housed. **HUD: Look at your data/think outside the (red)lines: Use data to prioritize what landlords to target by unit type, location (transportation routes, near medical services, etc.), and site-specific needs (accessibility standards, on-site supportive services, etc.). Identify higher opportunity zones for targeted outreach and engagement.**
Are there any areas of our community that have been historically hard to find units? If so, how has landlord recruitment changed this? (Think Equity)	Celeste – unless using property manager – hard finding affordable housing / landlords in SW Las Vegas, past Decatur, parts of Henderson don't have housing available due to rates and/or qualifications. Maurice – NW, Summerlin, Spring Valley, highest vacancy rates, new construction and building out, but costs too high for us to partner with them. Average asking price is close to $1,700. Talking to property managers seeing rents coming more stagnant. Uptick in landlord recruitment and open to working with agencies and OH due to benefits we provide. Mostly focusing on getting investors, landlords near strip, LV Manor. As a community, focused on LV strip, NLV area. When initially came in, had 50 landlords active, now have 100 landlords to record in Padmission.

	Celeste – some agencies say they will work, but then will put extra qualifications so they won't work with agency. -The entire region of Las Vegas. - Brenda (Historic West Side (Mary) -The vacancy rate of less than 3%. (reference) -Less than 15 affordable homes available per 100 extremely low-income renter households. (reference) -3000 people per month moving to Las Vegas from California (reference) -Looking at landlords who are willing to do shared housing because people are able to pull funds together to be in economically stable or not historically disadvantaged area. (Mary C.) -FMR is a challenge, because not reflected on current market. ----Landlords know that they can get more than FMR for units if they rent to those outside of housing programs. (Brenda)
How does landlord recruitment build equity in our system of care?	**HUD: Lead with Equity: Address the disparities that people of color face in accessing and maintaining stable housing by utilizing translation services, solicit feedback from people with lived experience, and engage multi-cultural service providers.**
What types of incentives are being used? What funding streams support these incentives?	- $300,000 -ESG-CV landlord incentives. Signing bonus of $1000 to any landlord who adds units to permanent housing, this incorporates RRH/PSH/Vouchers -EHV also offers $1000 per unit (non CoC and ESG funds) - -Landlord mitigation fund -24/7 case manager response to emergency situations PDT What are the funding sources supporting these incentives? All $300,000 ESG or what are the non-CoC funds referenced above and how much? *Southern Nevada has elected to use $300,000 of its Emergency Solutions Grant-Coronavirus (ESG-CV) funds for landlord incentives. The community is instituting a signing bonus of* ***$1000*** *for any unit leased to an Operation HOME! Rapid Rehousing participant. The incentive is a reasonable amount for landlords in a tight housing market, as it is less than one month's Fair Market Rent for all bedroom sizes in the community. Operation HOME! case managers, housing navigators, the LEAPS team, or any person in the community trying to secure available units for Operation HOME! clients may offer the landlord incentive bonus to a landlord or property manager. The bonus will be paid after the Operation HOME! client signs a lease on the unit.* MFH - Sign on bonus has expanded past OH!. Now any program that client meets homeless definition. Doesn't include some of the vouchers from PHA because they have sign on bonus abilities. Most programs including veteran

	programs now eligible, under landlord partners there is a list of incentives of being landlord. Can submit damages once proven they've exhausted deposit. Or can do up to $3k per unit to bring up to HQS if the unit doesn't pass initially to bring it online to be used for renting to our clients. Currently ESG-CV for sign on bonus. Risk Mitigation is county general fund dollars. Going forward CLV has put forward 50k towards risk mitigation fun along with what county has set aside. CC set aside 150k for risk mitigation Brooke Page – NV Housing Coalition – communicate about wrap-around support, landlords shouldn't have to advertise units if working with PSH units, shouldn't have to market (non-fiscal incentive) Albert 1. When we are talking landlord engagement are we talking Operation Home! or Rapid Rehousing in general? 2. In my opinion there are big differences between the two (above) I stated before we rely heavily on Stage of Change This said Stage of Change wise: o Operation Home! clients initially can sometimes be found in precontemplation- this is big because it lends to so much regarding the entire experience for client and staff o Gen Rapid Rehousing= someone who is looking for housing assistance= preparation to action stage of change- here is a client motivated to find their own space, case management then does less footwork 3. How do we get the Operation Home! client I described in bullet 1 above to move toward housing= Housing Problem Solving conversation with specialists who have lived experience- this type of peer support gives the homeless client the ability to engage with someone who has been there done that and is thriving due to having their own place 4. In Operation Home! we have gone off the concept that we are building the plane while flying it. I believe we are in a good space now with some really good best practices put in place this said we should create: a. Written standards re: how the program works b. Meetings held with front line staff should involve: ▪ Agency leadership ▪ Leaps team member c. Each case is different, each individual is different but one consistent message needs to be created and followed
Identify any new practices it has implemented to recruit landlords in the past three years.	24-hour hotline and incentives 1,000 signing bonus Offer 2 months rent as a security deposit Risk Mitigation new as of this past fiscal year.
Is data available on the number of units secured through these recruitment efforts?	Agency request – LEAPS ESG has expended 150k of 300k allotment, ESG has leased up almost 300 units.

	Are new partnerships tracked? Are any equity outcomes tracked? Maurice- Incentives were used to entice new landlords to partner, found that additional funding helped to meet goals. Lease signing bonus started at 500 but increased as of March 2022. All created to help bring on landlords to bring on our clients that are in need of housing. Maurice - Equity – negotiating with landlords – having people obtain housing, go to work and a place to stay at night, increases buying power of community. PIT count shows how we can get them housed and move forward in lives. No matter client's background landlord is eligible for incentives
What suggestions do you have to improve landlord recruitment?	Maurice – Education, reach out more to property managers, developers, real estate agencies, explain efforts, need enough housing. If clients are making money, they can invest back into community. Need to treat clients as tenants and not homeless clients. Education is most important to explain how vital it is to the growth of our community and success. Financial incentives, LEAPS program, case managers continue to work with them. Kelly – Need to make sure every program has the ability to pay equally for these incentives. The whole community needs to be able to do this so landlords don't hold units as they wait for clients from other programs. Brenda B – Centralize the contact for landlords and programs to access housing. Otherwise, it's each program fighting for each landlord/unit (Padmission, etc.) Maurice - Need centralized message, training for case managers, currently mixed messaging going out to community. Different agencies saying different things. Need to have standardized message to landlords. Brooke – Consistency around funding sources, flexible funding pool – have separate entity to manage it. It would incentivize everyone working in that pool. If community had pool of resources to address need in community (flex funds) identify how many units need to be saved for clients.
How can landlord recruitment efforts continue to be expanded in Southern Nevada?	Jackie - Utilize more social media Kelly – We all have housing navigators of own and all competing for same exact units. Need to all have same message. Every agency needs to be in line with LEAPS to be consistent. Everyone needs to share message because everyone is working with same clients/ property message. Catrina – Need similar eligibility and payment standards across board. Have P&P that entire community follows. Maurice – would like to see an evaluation on community partners to see if beneficial to them and their staff. Sometimes navigating stretches their staff too thin – this could cause mixed messaging. Like's MFH's idea of one organization so everyone can be successful. Equity -

	Brooke – We need to build infrastructure in-house to see where unintended discrimination happens due to different sources of income. A tool (Padmission) to track why denied, FMR, if people are increasing rent, could they be creating unintentional disparities. If not tracked can't recognize that we have a problem. Jackie LSS – Client denied due to background, but won't be told what it was, could have to go private route Catrina – Legally, apartment complex has to provide reason client was denied because they paid for background. Celeste – Navigators work to see how to place clients, but don't have specific navigators to work with clients that are extremely hard to place. Josh – NHA – If we don't provide extra incentives to place clients that are extra hard to place, can help guide to employment services? Celeste – Incentive of case management, provide point of contact so landlord always has someone to reach out to. Extra community efforts Jackie – rallies, marketing, word of mouth, show landlord appreciation. Maurice had one landlord appreciation event already that was successful and another one this November. Brooke – Get a champion to get word out – sports partners etc.
Street Outreach Listening Session Questions August 2, 2022; 11:00 AM – 12:30 PM Find meeting information here.	
How does your team conduct outreach including number of people, geographic area(s) covered, services offered?	Laughlin to Mesquite 82,000 square miles. Rural areas are provided outreach by need. Laughlin has regular outreach but would like to see more frequency. Logandale (police) and Mesquite (police) call out. Sandy Valley – private parcels of land that have RVs with no hook ups so hard to provide services. 2 MCIT focus on areas where other teams aren't but will come as requested and coordinate or to cover boundary lines ROC coordinates across jurisdictions Henderson (HELP manages, covers jurisdiction of Henderson) NLV (3-person team) (HELP manages, covers NLV) MORE teams – CLV – cover LV – not managed by HELP (Salvation Army & WestCare run by CLV) - 5 teams each covers the city so there are 5 zones. Coord. Outreach Working Group CLV hosts monthly WestCare and Salvation Army Requests are sent to ROC for coordination of services.

	Level 1 outreach teams – borders – both teams come to the table Alyssa is going to send levels standards (still need to be approved by CoC) From Lou Lacey: Over the past 3 years (2019-2022), their (2 MCIT team of 6 people – week team (M-Th) and weekend team Th-Sun) team has made contact with **25,655** people during outreach. Currently no way to determine how many were repeat clients. In HMIS during past 3 years, **12,450** clients were enrolled/exited from HMIS from outreach. How were the 25,655 tracked if not HMIS? A: The teams use a tick sheet system and count everyone who is each encampment/streets/abandoned building. At encampments people may not want to be engaged but MCIT is still available for services. 12,450 engaged. Could be a housing assessment/referral/items/shelter placement. Multiple Assessment Paradigm Model. -Jurisdictions were expanded with Henderson and NLV also contract with HELP for homeless resource team (HRT) Reports show how many people are served each month. What year were these teams formed? How do they work with MCIT to cover all the geographic areas and ensure coordinated of services? A: Both teams formed in 2021 and work within their designated jurisdictions to provide outreach services to our homeless clients. We also conduct coordinated outreach activities when encampments cross jurisdictional boundaries. We also share information regarding clients which travel across jurisdictional boundaries. - Static outreach is conducted through NPHY's "Feel Good Friday" program where outreach workers and volunteers set up an anchored site in a targeted locale with a proven presence of homeless youth. Feel Good Friday sites are determined through a careful analysis of need, accessibility, logistics and safety. These anchored sites are not limited to neighborhoods, and may be found in transit centers, malls, community centers, recreation centers, libraries and other locations frequented by this population. Staff and volunteers engage with homeless and at risk youth, share information about services, provide referrals and distribute survival kits. Volunteers also canvas these neighborhoods to make additional youth aware of the site and the services available. - HELP's Crisis Teams have been conducting mobile street outreach for all populations since 2005. Their experience in serving the most service-resistant clients provides a strong foundation for the YO Team. As HELP's Crisis Teams conduct outreach in all areas of the County, including hard-to-reach tunnels, deserts and washes, they are able to

	connect youth and young adults with the YO Team with a warm hand-off, ensuring that youth receive the specialized service appropriate for their needs. The Regional Outreach Coordinator works with various jurisdictions to coordinate outreach efforts within the community. These are the HELP teams which Conduct Outreach 1. MCIT 12 People 2. Pro Active Team 3 People 3. Call Out Team 3 People 4. PATH Team SAMSHA Funded 3 People Henderson Team 4 People North Las Vegas 3 People We would need more access to placing clients into assisted living facilities We would like to see a truly multi-disciplinary team. SOAR Navigation team. 24-Hour Response Capability There are approximately 500 miles of tunnels in Clark County in which we have found that our clients occupy a small percentage of that total number. But they are spread out throughout the tunnel system. MCIT reported covering roughly 100 miles. 2021 CoC app: 1) Coordinated street outreach (SO) teams' activities targeting those least likely to request assistance include: 24-hour hotlines for Veterans; partner collaboration to locate clients; SO based on encampment movements, proactive and call out teams that target preidentified areas brought to the attention of the Regional Outreach Coordinator (ROC), and non-English speaking individuals. Coordinated entry assessments done in the field allow those with transportation or communication issues to receive immediate assistance and attention no matter where they are. SO teams employ persons with lived experience, including young people, as outreach workers and outreach leaders. SO teams put tremendous effort into building trusting relationships with those living on the streets. 2) SO covers 100% of the geographic area including hard-to-reach tunnels and frequently identified encampments; mountainous areas; the LV Strip; washes; and desert areas through tailored outreach activities. SO teams work with the Bureau of Land Management for safety when providing outreach in caves originally used for mining. Local jurisdictions have joined the county in providing funding for SO teams for their geographic areas to ensure a targeted approach that does not

	result in duplicated efforts. All SO teams enter data in HMIS to ensure a regional collaborative effort is made. 3) SO is conducted 24/7/365 including nights & holidays. 4) To target those least likely to request assistance, SO teams are equipped with food, drink, clothing, hygiene supplies and information cards about shelters and other community resources and services to build trusting relationships. To ensure individuals are safe, SO teams notify those living in tunnels and washes of anticipated storms and floods which have been deadly to individuals in the past. The HMIS Clarity App allows tracking of individuals and their locations via unique identifiers such as "dragon tattoo" to create a history of where individuals are and when they move to ensure ongoing communication and encouragement for them to engage in services. Surveys are conducted regularly to understand the needs of clients receiving outreach. The results are compiled monthly in reports to the CoC. NLV now has own outreach team; Henderson just implemented an outreach team; in conjunction with HELP and keeping most of same info as County's HMIS info; Working in collaboration w/ regional outreach teams and own PDs; not the same way as MORE, but more relational with officers (HPD knows to look out for outreach team and when they are out; NLV more like HRT and HOT)
How do you coordinate with other outreach teams?	-NPHY has feel good Fridays, go to apartments/motels/parks where at risk of homelessness and provide services and preventative measures. They include PLE as peers to help with events. 1) Coordinated street outreach (SO) teams' activities targeting those least likely to request assistance include: 24-hour hotlines for Veterans; partner collaboration to locate clients; SO based on encampment movements and non-English speaking individuals. Coordinated entry assessments done in the field allow those with transportation or communication issues to receive immediate assistance and attention no matter where they are. SO teams employ persons with lived experience, including young people, as outreach workers and outreach leaders. SO teams put tremendous effort into building trusting relationships with those living on the streets. 2) SO covers 100% of the geographic area including hard-to-reach tunnels and frequently identified encampments; mountainous areas; the LV Strip; washes; and desert areas through tailored outreach activities. SO teams work with Bureau of Land Management for safety purposes when providing outreach in caves originally used for mining. 3) SO is conducted 24/7/365 including nights & holidays. 4) To target those least likely to request assistance, SO teams are equipped with food, drink, clothing, hygiene supplies and information cards about shelters and other community resources and services to build

	trusting relationships. To ensure individuals are safe, SO teams notify those living in tunnels and washes of anticipated storms and floods which have been deadly to individuals in the past. The HMIS Clarity App allows tracking of individuals and their locations via unique identifiers such as "red shirt, dragon tattoo" to create a history of where individuals are and when they move to ensure ongoing communication and encouragement for them to engage in services.
How do you determine where to conduct outreach?	ROC receives Homeless Activity Reporter – Code Enforcement, Metro, public can submit a report and outreach will happen Public works will make direct requests ROC does data tracking – encampment report- outreach workers complete – services, size, vulnerability etc. Reported back to ROC. -Done on proactive basis including at community events such as concerts/festivals etc. -Also have reactive teams based on community notifications / Police/ commissioners notify and they respond
What are the days and times you conduct outreach?	7 days a week Monday – Sunday 7 AM – 5 PM 21 workers for HELP, NLV and Henderson make it 28 MORE teams 5 teams, 2 workers + 1 LE - Ideally we would like expanded hours and the ability to respond to emergency situations off hours. - Metro HOT – community orientated policing squad call MCIT and will drop clients to office or call for a dispatched team. Alyssa will send call outs for the last fiscal year. - HELP staff are on call after hours for severe issues or do troubleshooting to get through the night.
What are engagement strategies for individuals and families with the highest vulnerabilities?	Outreach workers are always looking for most vulnerable. The housing assessment assesses vulnerability. NCS Multi-engagement model, trauma-informed care, MI, harm reduction, ethic, and boundaries, MFHA are trained annually. Semi-annual outreach 101 & P&P - tunnel safety, building rapport with clients, crisis intervention. Lou – Has seen a spike in the last 1 –1.5 year of families living in car – park in the park at night. Hard to reach during normal outreach hours. Weekly event – Walk In Wednesday anybody can come and get seen. 7:30-4:30. Most of the time families come in. Families/ first time homeless seem to be

	proactive and approach providers through walk in Wednesday. Alyssa will get info for July. Vaccines/needle exchanges target vulnerability – try to bring medical services to level 1. Monthly multi-agency harm reduction event – SNHD, Trac B, Health Foundation, FFR, - go to locations as a multi-agencies and provide Hep C, Hep a/b, flu covid vaccines, needle exchange, Touro will come out sometimes. Last Thursday of each month. Technology allows housing assessments in the field and immediate connection to CES Arc GIS maps the encampments. Alyssa will send how many encampments were mapped in the last fiscal year. Melissa NPHY – Does youth outreach. Feel Good Friday every Friday in high-need neighborhoods – rec centers or zip codes targeting young people – staff and volunteers – anchored static – build rapport give items – engagement activities – rotate locations but stay for a couple of months to build rapport – canvas around the neighborhood to get people on site. Would like to see this expanded. Safe Place Program – 160 static locations – young people mobile crisis intervention – Terrible Herbst, NPHY, Las Vegas and Henderson libraries and CLV fire stations – RTC bus to get to nearest safe place, 24-hour access line – entry point to every corner Drop-in center – NPHY (St. Jude's) - draws in young people – basic needs, medical, harm reduction, trauma informed, Virtual outreach –NPHY for young people through phones. - web landing page for young people to access services – crisis hotline. Targeted paid social media- snapchat and Instagram – young people created PSA for peer-to-peer communication that focused on stigma and access issues. MCIT does virtual outreach – email in for assistance and get a housing assessment. This is very popular, and a housing assessment can be done. Can write in monthly to keep on the queue or communicate changes – ex. telephone number) families will use it. 100/ week – would like to see more resources to help manage this program. Has helped keep people safe during COVID, or fear/anxious / transportation issues. -Offer gateway services which are hygiene, food, water, weather appropriate needs, transportation, bus passes, etc. and offer as no obligation and no commitment. Understand they have to build relationships before people will be willing to come inside.

	-Pop up events provide one stop shop for all necessities (low barrier and removed stigma and barriers from going to place to place) -Clean the World - showers
How do you develop culturally appropriate strategies?	NPHY drop-in center – celebrate diverse cultures – different events/ holidays/ movies/ volunteers will decorate different months/ books represents diverse backgrounds, signage "No Hate Zone" to create a comfortable space that acknowledges diversity and participants help to design. Training – pronouns. Use of peers. Know population – you can't just walk into the tunnels you have to know the culture –own way of living – every encampment is its own society. Train team to be sensitive to adapting to the culture. Recruit diverse outreach workers – schedule diverse people together. Stigma and shame training. Hierarchy in every encampment - "Mayor" "Enforcer" "Mother" who you have identify roles. Talk to "Mayor" first. When dropping emergency items will hand to "Mayor" Workers will be aware of interactions and change it up as needed. - Tattoos etc. Difference physically Cantonese, 5 dialects of Arabic, several outreach workers Spanish, in the past sign language. Russian. Language line is used can be called if needed. Google translate can be used – tablets are in the field. TDD – hearing impaired – touch tone – call line and its translated. Relay Nevada. Project Star Fish on trafficking DV was last year **Trainings, specialized questions, tunnels, encampments?** -HELP employs PLE across all programs. In outreach, have PLE who coordinate and help to identify locations. It's peer navigation. They understand needs of population. Identify where hotspots are and barriers that people experiencing homelessness experience.
Do you have specific outreach strategies for encampments?	HOT team – twice a week with MCIT. Encampment "life sustaining items" food, water, hygiene kits. - break ice and open to engagement. Some camps all meth some camps all Heroin some camps more mixed drug use – workers are trying to understand the service needs that are unique to each encampment and provide tailored services. Different encampment sizes – large vs. small – smaller more isolated or rural tend to be more independent and operating on own and taking care of own needs.

	Larger encampments where agencies bring food/items - less inclined to get services from MCIT – faith-based community will help to meet needs. Encampments – time AM vs. PM – will coordinate outreach once this is known. Outreach Workers will write up a report and submit to ROC. Level 1 at RIO needed clean needles so they would come in. entered a spreadsheet for tracking purposes. Responses to encampments are standardized by a rating system and given a corresponding response. The Regional Outreach Coordinator is responsible for gathering the results of encampment assessments and planning responses, including activation of necessary community partners and services. Each response is unique and can be scaled to fit the needs of individuals and safety at encampment sites. https://docs.google.com/document/d/1F-8hat5kvndn3lMRcF0C5wR9LTI0ZpAwoeBDDng2bmU/edit Homeless Encampment Written Standards The street outreach teams use Survey123 in ArcGIS to do encampment assessments and report back information on the state of the encampment.
Do you have specific outreach strategies for tunnels / washes?	-LV has extreme monsoon season (use article with person who just died in tunnel) -Agencies have access to GIS mapping system to know where rain will hit and what tunnels will flood and they will notify the people in those tunnels/washes. -LV has tunnels that people live in because they are under the strip. 1) Coordinated street outreach (SO) teams' activities targeting those least likely to request assistance include: 24 hour hotlines for Veterans; partner collaboration to locate clients; SO based on encampment movements and non-English speaking individuals. Coordinated entry assessments done in the field allow those with transportation or communication issues to receive immediate assistance and attention no matter where they are. SO teams employ persons with lived experience, including young people, as outreach workers and outreach leaders. SO teams put tremendous effort into building trusting relationships with those living on the streets. 2) SO covers 100% of the geographic area including hard-to-reach tunnels and frequently identified encampments; mountainous areas; the LV Strip; washes; and desert areas through tailored outreach activities. SO teams work with Bureau of Land Management for safety purposes when providing outreach in caves originally used for mining. 3) SO is conducted 24/7/365 including nights & holidays. 4) To target those least likely to request assistance, SO teams are equipped with food, drink, clothing, hygiene supplies and information cards about shelters and other community resources and services to build

	trusting relationships. To ensure individuals are safe, SO teams notify those living in tunnels and washes of anticipated storms and floods which have been deadly to individuals in the past. The HMIS Clarity App allows tracking of individuals and their locations via unique identifiers such as "red shirt, dragon tattoo" to create a history of where individuals are and when they move to ensure ongoing communication and encouragement for them to engage in services. However, when it does rain, a flash flood sweeps along the homeless people's camps, taking along all their belongings with it.
How do you coordinate pop-ups? o What considerations go into it (service type, frequency, location)?	Level 1: directly at an encampment with 20+ people. Last Thursday of each month but can activate emergency level 1. Outreach workers are reporting back to ROC for location identification and vary across jurisdictions. NLV tend to have small encampments of 1 or 2. Need to find a location that meets parking/set-up needs of providers. Lg. encampment by railroad tracks- hard to access by vehicle- some of the barriers. Or private property and owner refuses to host level 1. Provide all services at one site – One Stop Shop. NHA collaborates. Once a month. First Thursday of month. From Alyssa Johnson: Once a month we hold an outreach event called a Level One at encampments. When selecting a site I am looking for a location where 20+ people reside and that scores high on the encampment assessment tool. There are some limitations that can inhibit conducting a Level One at certain sites, like a lack of public land to set up on or no parking for providers. The aim of a Level One is to provide a plethora of same-day services onsite at the encampment. We try to get as many providers out as possible so that we are able to provide showers, food, housing assessments, medical services/vaccines, pet assistance, referrals to medical/mental health/substance abuse treatment/shelter, and assistance for clients to access various benefits through their health insurance or from welfare. Nevada Homeless Alliance helps us coordinate these events and get providers out. They also do their own Pop-Up PHCS at various community centers and other locations that assist unsheltered clients. We can also activate an emergency Level One response to an encampment if there are serious public health concerns about the amount of people or public health hazards there. From Catrina: The benefit of Level Ones is that they allow us to respond to encampments as a community and reduce operating in silos. In 2022, 5 events have been held. Data from those events:

	Cumulative Totals Number of clients served- 97 Bus Passes – 105 Gift Cards – 36 In-kind Donations – 169 COVID Vaccines – 36 Flu Vaccines – 17 Hepatitis A Vaccines – 14 Hepatitis B Vaccines – 17 Tetanus shots/Tdap Vaccines – 16 Pet Supplies – 19 Clothing – 67 Food – 80 Housing Assessments – 34 SNAP Assistance – 7 Medicaid Assistance – 6 Medical Care – 20 Showers – 60 Hygiene Kits – 71 Needle Exchange – 22 Housing Program Referrals – 4 Clients Housed - 1 Veterans Housing Referrals – 4 Cell Phones – 8 IDs/Birth Certificates – 8 From Catrina: There are a lot of factors that go into planning events, We strive to have at least two pop up events each month, generally covering both halves of the month. We also conduct standalone Covid Clinics for Persons Experiencing Homelessness. On average, we host 3-4 events per month in different parts of the valley. This allows us to have a consistent presence in the community as well as having information readily available for the next event if someone is unable to attend or needs additional assistance. Through outreach, community collaborations, and feedback from providers or business owners, we can determine which locations have larger levels of unhoused individuals and coordinate with community providers, religious organizations, and city/county resources to find accessible venues for events. In general, we have found success having events in the morning/early afternoon on workdays but will adjust to fit each location. When working with organizations with scheduled services (i.e., a weekly meal, walk-in hours) we will adjust the event to reach as many individuals as possible. When available, we prioritize having indoor events to give clients a reprieve from the potentially fatal elements of Las Vegas. We strive to have wraparound services available for all clients at each event. These services include food and water, housing assessments/opportunities, assessment/assistance to

	employment, social services, legal aid, mental health, and substance abuse resources, medical care/vaccinations/communicable disease testing, hygiene items/showers, health insurance, pet care/grooming, and affordable cell phones. Once a location is confirmed to be available for event use, we will invite providers to try to offer as many of these needed services as possible. Due to our frequent activity within the community, providers make an effort to make it to any NHA event they are able to, and we have received feedback that the direct service nature of these events keeps providers wanting to come back to give directly to the community. Since January 2022, we have hosted 23 events in the community (4 were co-hosted with HOSN). (July 1, 2021-Dec 31, 2022) we hosted 14 vaccine clinics. I am trying to find how many Pop ups were hosted. Once I get those numbers, I will send you the stats for the full FY21-22 FY 21-22 1813- Total served 201- Housing assistance 172 - SNAP Application/Redetermination 90 - Medicaid Application/Redetermination 45- NV ID/Birth Certificate Recovery 325- Assisted with Job Resources 54-Child Support Assistance 19- Disability Claims Assistance 13 Assisted/ Addressed Immigration Issue 10 - Referrals/ On-site Counseling for Recovery Support 60 - Clean Syringe Kits, 58 Naloxone Kits distributed 153- Immunizations/Vaccinations Administered 156-COVID19 vaccine 82-Mental Health Referrals/Appointments made 180- Vision Screenings, 206 Reading Glasses 68-Dental Kits 145-Received Follow-up Medical Case Management/ Made Appointments 158- Medical Screenings 1134 - Hygiene Kits 194- Haircuts 165 - Mobile Showers 300- Households Assisted by Food Pantry/ Market 1321-Guests obtained Clothing Items 1303-Guests received Hot/ Take-Away Meal 1658 -Guests received a 24hour Transportation Pass
When you do unsheltered outreach, how do you help people exit homelessness?	Workers – pre-engagement – assess situation and needs. Identify best route – housing problem solving (having these

	conversations with every person they come into contact with), family reunification (bus ticket – SW has provided airline tickets- verify first friends/family 1-year or longer and check addresses provided via google maps to make sure it exists.) – shared housing, sober, group home, is there income? Housing assessment can be done to PSH and CES. Community queue is backed up big gap in system. We don't have enough housing placement. -Case managers have access to enter into HMIS on streets. They have iPad and mobile devices to enter data in real time. - Can conduct housing assessments using assessment tools and enter it and help connect them to housing right away -have access to housing alerts in HMIS to provide the info directly to clients.
How do you adopt service delivery methods that respond to preferences and needs of the individual or family presenting for assistance?	Coordination with MCO and healthcare partners to ensure meeting medical needs and providing language and accessible tools that meet their needs (speak their language, etc.) outreach teams have a variety of exp, languages spoken and backgrounds, along with PLE
How do your outreach teams connect people experiencing unsheltered homelessness with services available?	-Meet them where they are at physically on the street (don't force them to go inside) to connect them to CE and to get connected to any resources.
What type of new partners would be helpful for street outreach?	Other communities have a multi-disciplinary team like – medical, BH, LE, outreach worker – sustain activity at encampment to hopefully resolve the encampments. We need multiple of these teams b/c they focus on an area Add SOAR members of the outreach teams – takes multiple touches to get through the lengthy process and access benefits. MH workers – working alongside who can do legal holds – we need an advocate to the hospital "treated and streeted" The interview passes and client is released instead of entering into the 72 hold. Advocates for stabilization. Best way to help SMI. Hard to get a client to accept services when they are in crisis. More successful with the call for the legal comes from licensed professional. - we need more continuity of care for SMI. - Having young team on team would be beneficial, isn't currently funded. -Would like to connect with faith based organizations and other non-profit organizations that aren't currently in the Coc to all work together
Describe specific strategies you'd like to see in Southern Nevada to rapidly (permanently) house individuals and families with unsheltered homelessness. -Housing / Other Resources / Supportive Services / Increase ID Access / Access to Healthcare / Housing Navigation Services	Could use more bridge housing. More programs that provide services to the low and middle vulnerability to clear out the middle of the queue. We need to look at the CES for equitability. This is supported – how can we better serve people "stuck" in the middle of the queue.

	More drop-in centers, mobile case management, other ways for housing assessments, creative ways to enter into system to increase access. Employment program – highest need given by clients for resolving homelessness. Medicaid expansion (training on how to use services) – clients have coverage but don't know how to navigate so outreach workers are trained on it. - Dr. Don't take clarity card. The longer they are on the street the more trauma.
Rapid Rehousing & Permanent Supportive Housing Listening Session Questions August 2, 2022; 3:00 PM – 4:00 PM Find meeting information here.	
Please describe how your project type is low-barrier.	Dani – HopeLink –RRH Learn. Collab. Follows housing first – minors in home for eligibility but all barriers have been removed. Don't require identification but help get documents. Celeste- HELP- similar to HopeLink – youth RRH and family RRH and RRH low-barrier – don't require IDs but help to obtain while locating housing. Emergency housing and Bridge don't require ID but property managers require gov. Issued IDs. Clarity cards can be made on-site. Some landlords will accept a clarity card for ID. Track who will accept what and align based on needs. HELP has done landlord education to reduce the ID barrier and accept clarity cards. Andrea- HELP – similar. PSH – single, couples, families – will help get doc ready, wrap arounds and housing connections to get into PH at the end. ID, BC, SS – temp. Bridge for some clients to help in the meanwhile. It's required in our CoC – Housing First – low barriers to entry are a threshold criterion for initial funding as well as identified through program monitoring. Ally – Just one project (RRH) OH! Receive referrals for individuals and families- connected with NV homeless alliance, have been able to get ID's, birth certs, etc. This has helped reduce barriers.
How do you ensure your services are culturally appropriate to people who have histories of unsheltered homelessness?	Celeste- HELP- Immediate engagement for walk-ins – diversion, HPS, housing assessment (CES), pre-engagement (before doing housing assessment, asking background questions to understand experiences/life/reunification options) this will guide the client's plan forward. Referrals can come from other projects that have more restrictions. Support individuals struggling with immigration status – culturally background comes into consideration.

	Pre-engagement team was developed by outreach. -- aligns with HMIS, projects etc. - Human trafficking SME? Housing assessment allows to determine if someone is fleeing DV then a CoC wide procedure is followed-Safety Plan. - safe places are available. (CES P&P). Have educational materials on hand. Shared housing – Celeste (HELP) does in 2 forms – maternal group home for young families 16-22 and youth 18-24 both do shared housing. Places that are mastered leased. 2-bedroom units. Questionnaire that aligns with dorm - understand preferences of client – case manager introduces clients - "warm intro" client choice to say no. No major cultural or demographic differences, roommate pairing has been successful sometimes it has been personality conflict. - do ask about smoking (landlords have went non-smoking) HELP tries to make sure there is outdoor space. Shared housing – Andrea (HELP) has a Shared Housing Program for adults. Similar to Celeste with roommate questionnaire and master leasing two-bedroom units. Roommate agreement once housed to discuss the common areas, chores, house rules, etc. Aaron- HopeLink- quarterly staff training – cultural competence, de-escalation, recognize child abuse and neglect, DV specific. Andrea- trauma-informed care, ethic/boundary/confidentiality/MI/ Nicole –CC – extensive training – trauma informed, MI, stages of change, MH 101, de-escalation, MHFA, Alzheimer's/dementia. Require case managers receive education onboarding and then annual trainings as well. Also, MH / addiction – look at self for employee care-compassion fatigue – personal bias/belief system. Employees experience trauma, check-in with staff. Kelly- Crisis Prevention Intervention stress first aid. PYD, LGBTQ+ training and DV specific training. Onboarded and annual. HELP University – first two weeks will be strictly training before being deployed to the department- on-site trainer. compassion, care staff –4/15 going to the 4-day work week to allow for self-care. Kristin HopeLink- ask what areas of town and not comfortable for housing placement and what they want in a unit before the house search.

	Celeste- Fair Housing Training – make sure the client is treated fairly that the landlord are not discriminated – annual training. Dani (HopeLink) -sometimes kids are enrolled in school so try to find housing to allow that. Ally Just one Project – translator – staff bi-lingual English/Spanish and a couple who know other languages. Try to accommodate everyone. Kelly if they are already connected to the community – churches, doctor etc. It is important to house where support is. In order to access these services, they have to do assessment, and assessments can be done in the field. Offering housing services regardless of substance abuse issues. -Shared housing allows clients to stay with their family from their community
How do you adopt service delivery methods that respond to preferences and needs of the individual or family presenting for assistance?	Celeste – HELP- forms in languages – deaf client or one who can't read /illiterate, case managers will read forms, sign language, can slow down the process if the client needs to go through forms longer, understand signing, services, programs. Connect to wrap around services – Blind Center. Youth managers meet on a weekly basis with clients, go over person centered treatment plan and reviewed monthly and updated quarterly. Dani HopeLink – case manager meets families once a month in home to check on kids and condition on home and additional meetings as requested/needed - adjusted based client. Victoria Just one Project – similar. Tier 1, 1x per month tier 2 – twice tier 3 – weekly – collaboration between staff and client to determine how frequent. Tier 1 first time with homelessness. - Coordination with programs that will best fit the needs of the client and family and can include medical care -meeting them where they are at, providing services that fit each person -Important to include PLE because when doing service delivery, able to do 1:1 relationship building, can relate more to clients -Have accessible forms and language in of client's preference.
Please specifically identify any new practices that you have implemented in the past 3 years.	Clarity cards for landlords has been post pandemic. Housing navigators have been instituted in the process. ID has been major barrier – researching landlords, minimum standards – low-barrier landlords. ** Housing Navigator – 2021

	Celeste is seeing more families –needs assessment asks more open-ended questions – pinpoint root cause – 12 months vs. 24 months RRH – case managers can engage and get more info. 2022 these changes were made. Kristin – navigation efforts-built relationships with landlords – easier to find housing for clients.
What lessons have been learned by implementing those practices?	
Please describe strategies you'd like to see in Southern Nevada to rapidly (permanently) house individuals and families with unsheltered homelessness that will help build equity across our system of care.	Kristin – streamline – shelter to housing. We need more housing and low-income housing available. Victoria – Just one project – lacking MH assisted living we have RRH and placing SMI in this. Lacking low-barrier MH services. Ridge- legislation – high rent, how can we avoid "gouging" Celeste- consistent Bridge/TH etc. Not all grants have this. Some funding only has rental dollars. Sometimes you need bridge or emergency shelter to get acclimated to being back inside. The newer programs have ES or Bridge – very important for someone's transition. **Case managing from the street** – real struggle to transition street to apartment. Kelly – system modeling – we need to go back and look at the gaps identified through data – well-being respite and the respite model and the MH assisted living. All things identified in system modeling and close. Albert – yes, we spent so much time on that. Andrea- More Assisted living facilities for clients Nicole – dementia is a different kind of placement and in early stages are falling into a gap and intellectual or learning disabilities. Leases can be comprehensive – this can be hard to understand. Evictions or owe money here or there – can be difficult to house, especially if funding won't cover prior money owed. (This is where flex funds would be helpful.) Ally Just one Project – more bridge housing more opportunities with grants that would cover that. It takes longer for the application to be processed –can wait 3 to 4 weeks and living on the streets/tunnels. - that transition phase. Distributed low barrier navigation centers similar to facilities we've built in CA, Reno & WA using prefab. Buildings. Renovating homes into group homes; also shipping container and prefab micro housing villages that are self-governed work very well for transitional housing (Rick Van Diepen, AIA).

Continuum of Care Listening Session Questions August 1, 2022; 12:00 PM – 1:00 PM Find meeting information here.	
How will the CoC work to ensure that resources (including match cash and in-kind) will reduce unsheltered homelessness in Southern Nevada?	Emily- Anthem, interested in partnering and providing match for unsheltered individuals with Anthem Medicaid. Priority projects would provide housing. Aaron - United Way – state grant matching program – timeline may not align, allows up to 50% federal grant match. - 25% match ($4m) RFP processes in spring and future years for United Way specific resources and volunteer time as in-kind? United Way can help with volunteer recruitment. Our community has been involved in system modeling exercises since at least 2019. We have assessed data to determine the strongest strategy for reducing homelessness. This grant will provide the funding needed to fully implement the data driven plan. The collaborative applicant actively supports the development of new projects by providing technical assistance as well as funding from a variety of local and state funds and initiatives. (HPS, Shared Housing, etc.) The collaborative applicant fully supports CoC initiatives.
How will the CoC adopt program eligibility and coordinated entry processes to reduce unsheltered homelessness?	Kelly R - Depends on the project types, CES is constantly adapting to meet the needs of the program. Albert – what comes from the funding, can adjust as we go – housing problem solving. Training is always important – Albert Michele- NHA Conf. SNAPS Q&A - CE system should not interfere with housing unsheltered. Need to make sure there are no barriers built in system that precludes us from moving clients from unhoused to housed situations. Kelly R – Need to relook at racial disparity tool Many communities are using 1 tool across sub pops. Analysis of racial disparities –F-CHATT and youth. - EBP process – how do serve most vulnerable? - a number is assigned. Is a deeper dive needed? - look at other tools that are out there & how this can be leveraged to support our CoC. - How many projects will this create? We may need additional support int the matcher team. Emily P – How do you prevent inflow from jails and detention center? Anthem members cycle in/out of hospitals. Outreach teams who can help prevent this inflow and get housing assessments. Catrina- as people “cycle” out of institutions – how can an assessment happen before discharge? Or do they need to go

	to a specific site or work directly with an outreach worker. Can virtual platforms be leveraged? Albert – We have done better collaborating and not being in silos. Are we able to track success at an individual level as they move through systems? How is data shared? All systems to avoid fragmented data. How a person flows through the different pathways. Kelly – How would CES assessment for 2-1-1 work? If we just need the assessment to get initiated – HELP has HA line (call for housing assessment) Does this line need to be expanded too? Right now, 1 staff. Or should it be in 2-1-1? Promote within jails and hospitals. We need more creative entry points. All proposed projects for local, state and federal funds are required to utilize the coordinated entry process. Organizations are supported through HMIS training, office hours, and ongoing support to ensure the coordinated entry system continues to be efficient and up to date. While each program sets program criteria, the coordinated entry process looks at those on the community queue daily to match the most vulnerable clients with program vacancies. The CoC also assesses the community queue data to help inform project development and to meet the needs of those most vulnerable.
Please describe the additional steps the CoC is taking to ensure unsheltered persons, or with a history of unsheltered homelessness, are able to access housing and other resources in the community, including system-level efforts.	Our coordinated entry sites are open to all individuals and follow the "No Wrong Door" guidelines for ensuring that anyone seeking help is connected to care. This ensures that anyone can access a full system of care and supportive services no matter their location or circumstance. Coordinated entry is available 24/7 to meet the needs of people experiencing homelessness in Southern Nevada. Placement into some emergency services is available 24/7 and outreach efforts are scaled to meet the schedule and events and help identify individuals who may be living unsheltered. Aaron- challenge in 2022 was how to onboard new EFSP agencies into HMIS – expand the number of agencies linked into HMIS and look to HMIS as where housing assessments can be placed – Who is the responsible agency who can do the "remote" assessments? Onboarding costs can be prohibitive – how can new agencies be supported with $? Albert – Enroll clients at ES – housing assessment/HMIS - training and certification process to have the know how to do HMIS and assessments – weekly/monthly trainings – ongoing support and reminders as system changes. How can we build capacity for staff? - staff feel time pressures for data entry and struggle to meet benchmarks (like SSI). Kelly – Bridge housing and NCS our CoC has done. Placeholder while finding RRH or PSH – give clients a place to go while the permanent placement is being secured. NCS

	for COVID and has been continued, serves about 600 people, over 65 (underlying medical conditions specific to covid risk)
What steps are being done to increase access to IDs? Any system-level efforts?	With outreach – they assist clients with obtaining birth certificates, Clarity cards (HMIS identification cards), identification card, membership cards that include photo id to access housing. Kelly - HELPs MCIT provides assistance with BC and ID with clients they encounter in the field and all clients in the NCSP Emily - New State Law passed in 2019 and was improved in 2021 to provide free vital records to homeless youth. NV DMV also provides waiver for 1x time replacement. Emily - Anthem members receive ID recovery support in WellCare Emergency Behavioral Health Housing. Catrina – NHA has barrier busing with ID restoration services. Catrina will send outcomes around this. - ARPA funding leveraged to support this activity. Community-wide Jackie – LSS – Increase access to IDs, support birth certificates by paying fees. Courtyard – Catrina – order BC but can't pay for ID so refer to NHA. Aaron - CCSN immigration program – work authorization – Albert will reach out to Theresa to confirm these efforts. Legal Aid Center helps with ID – may want to reach out. Renew Hope – target clients who are work ready to move towards employment and housing. Track where clients can get support ID and BC. EFSP – most of the services don't require ID for all services – alternative ways to verify identity NHA – when someone doesn't have ID check HMIS, clarity card – verify that way. - and answer to questions will help with IDs. Allow office to be mailed documents. Safe storage. Covid created barriers for out of state IDs. Can modify individual plans – work closely with client.
What steps are being done to provide housing navigation services?	Most agencies offer housing navigation services with an assigned specialist whose role is to build relationships with landlords and increase level of affordable housing units in community. The Landlord Engagement and Property Services (LEAPS) team and contracted partners main function is to identify available units and help connect program clients with prospective landlords. Jackie – LSS – case managers work with LEAPS. Other case managers go directly to apartment complexes for recruitment and advocate on behalf of the client. Nicole - CCSN– LEAPS and some landlords directly as relationships are built and advocate on behalf of client.

	Education – client will have a case manager for self-sufficiency – avoid certain words – unemployed/no income/ don't provide too much information on background. Landlord has a resource to go to if there are any concerns that arise. Kelly – talk about accountability – 24-hour number. These clients have a case manager and a person to call unlike other tenants. HELP is working to imbed with LEAPS – consistent messaging. Padmission - How are landlords identified for recruitment? - Case management up front has to be thorough – different action steps for change.
Does Southern Nevada need more housing navigation services? If so, what would that look like?	YES – SNV needs more affordable housing and we need better marketing strategies to engage landlords in unique ways through incentives, funds to improve units, solar units to help reduce cost of utilities, multiple levels of support, and other ways to encourage more participation.
What steps are being done to provide other supportive services?	-Partnerships with healthcare organizations (MCO's) to provide the necessary services to clients.
Does Southern Nevada need more supportive services? If so, what would that look like?	-Several Low Barrier Navigation centers/ One stop shops (combine with Project Homeless Connect) and could be pop up shops and will travel around together to different areas to meet the clients where they are at. -Furniture Warehouse – with employment training -Employment services and SOAR
What current strategy is there to identify homeless populations that have not been served by the homeless system of care? o Outreach? o Engagement? o Housing Interventions?	Outreach – going to new places as it's being identified by local partners and through current outreach communication, it may identify. - Providers all have social media accounts – reach out to community through public announcements (inclement weather notifications for cooling/heating locations) Through pop up and other events in the community, providers are able to identify new homeless populations that need to be served. PLE being in all levels of programming can also help to identify homeless populations that have not been served or those that could be served in a better way. They can help inform on service gaps and needs.
How many underserved groups interact with the homeless system? Who are these groups in Southern Nevada?	All subpopulations are served but not proportionate to the demographics of our community. We are continuing to assess our continuum of care to implement and amend policies and procedures that ensure equity among all subpopulations.
Are there any other continuum of care gaps or system-level gaps that need to be addressed?	A system level gap is that we don't know what we don't know. When there are new emerging non-profits, we may not be made aware of them to invite them to be part of the CoC process and to enter into HMIS. There are also some faith-based organizations where HMIS entry is a financial barrier so while they continue to do good work, it isn't being captured in HMIS. There CoC needs to focus on more

	recruitment of organizations and PLE to collaborate more efficiently across the board. While we are still getting better at it, it's not where we desire to be at.
Emergency Shelter, NCS, Bridge and Transitional August 2, 2022; 1:00 PM – 2:30 PM Find meeting information here.	
What low barrier strategies are in place? ES/NCS/TH/Bridge	Albert – Housing first model, 400 beds, provide intensive trauma informed case mgt, if intoxicated – allow to enter, get plugged into resources. Sunnie Mcconnel - HELP Rita Suites NCS – no curfew, allows clients to obtain employment during night hours Don-HopeLink – Helps people with past utility bills Nicole CC – Designated beds program, no curfew, can sleep during day as long as working as long as within 30 days of housing, don't have to worry about where they are going sleep Lou – With properties will work with individuals that have pets to get both client and pet housed depends on which properties. May accept service animals or of certain size, some properties will allow animals, have grant to pay for pet deposits. James – Crossroads – Crisis stabilization unit, clients come to detox, will bring to TH if qualified, no insurance requirements, but will bill insurance, if available. Eligibility ins on site that gets clients signed up for insurance. Stephen – CC – clients will come in with walkers, canes, etc. have space available Alyssa J - LINK – designed for high scorers who need low barrier access to housing – housing first model HopeLink – House intact families and those that are medically fragile instead of traditional shelter. Hotel placement. Melissa – Also provides low barrier ES for youth. Drop-in center for day service and ES for night and work in tandem. Access the shelter through the drop-in center and safe place program. The only entrance requirements are age and homelessness. Offers robust supportive services, wrap around services, works with NV Health Centers once a week, case mgt internally, individualized based on client's needs.
How is client feedback gathered? 1. How have PLE informed any policies or operations? 2. What are some other strategies to engage PLE?	Kristin – HopeLink – Print out surveys given at end of services. Amy SNCHIP – pre (needs- goal setting) and post surveys when transitioning or leaving voluntarily by paper. - Look for trend data and then discuss feasibility of change. Surveys can remain anonymous-placed in drop box. Stephen CC – drop box for anonymous feedback. Used to help write P&P Nicole – CC – Renewing Hope manager meets with client on reg basis, survey to get clients feedback on how program is going

	James – Crossroads – No special internal surveys but if detox program, primarily do discharge plan with them, give referrals, all TH clients are admitted into clinical program, Case managers do work based on what their needs are, then discharge summary is done at end. Melissa – NPHY – Suggestion box is anonymous. After care program – Monthly for 3 months and at 6 months satisfaction survey done through virtual engagement or phone (optional) Youth council meets monthly – feedback on program, engagement activities. Always open and encouraging. Amy - SNCHIPS – Listens to clients, uses their voice when creating P&P when tangible to them. A lot of TH there are champions, they are leads to designing P&P especially in areas that are challenging. Team does round tables and best practices – will tour other orgs to see successes. - Visitor Policy for TH – at first no one was allowed, champions put together safety plans and visitors were allowed on site. Kim – Help – meets regularly with youth, does town hall each week with youth, what works well, what should be changed, and what they would like to see. Starting this month, youth will be involved with planning activities, do a monthly focus group so they can pick food on menu – also have a suggestion box in case they aren't comfortable speaking up Albert – CC – Case mgt in ES 24/7, able to build great rapport with clients, team gets feedback/suggestions from clients, IE: charging stations for motorized wheelchairs/phones (have charges lockers,) has lowered theft due to this, renovations just came from many suggestions from clients. Open door policy. Clients go to his team to provide feedback and additional information that they may need to know about. ES staff is accessible. Make changes based on suggested if able to. Amy – when clients involved, they are less likely to violate the P&P. To get buy in off bat, have low rate of clients violating them because of buy in. James Crossroads- treatment first model, was able to put gym into building because clients asked, workforce worker onsite. Job fair/training comes to CrossRoads. All from feedback from clients and implemented to be easily accessible to them. Feedback comes to case managers directly from clients. Albert - CC – Many Staff members have come from programs. Clients on staff that were in designated bed program / or in ES – culture has allowed clients to succeed. Provide them education/training. Resource boards posted all over campus. Shows employment opportunities.

	Jackie – Lutheran – Has many employees with Lived Exp, recruit from AARP, diverse recruitment, hire from within to grow within agency. James- CrossRoads – Clients can become employable such as a mental health tech, front desk, etc. Because treatment first, there is a timeframe that they must be out of treatment before they can work in some positions. Some become PRSS through FRR For if 12-step programs can Clients can mentor and become speakers, attend graduation and to support those in program. Nicole – CC – Many staff, front line to middle mgt have lived exp, diff experiences from dv exp, lived exp, SUD exp, allows to better build rapport with clients. Shows can move forward and understand situation clients are going through. James – CrossRoads – 9 out of 10 staff have been homeless and have been homeless, lived in tunnel, SUD are able to relate Kim – HELP – within Shannon West – hire PLE – want to hire people that can relate to clients, several peer positions within agencies – equal to employees, Sunnie with NCS Rita program – outreach team while waiting for NCS still does outreach. HEART team – offers case mgt until clients ready for housing, feedback from exit surveys shows how much they appreciate that someone was with them through entire process from tunnels all through housing. Clients come back and visit – have relationships with staff. Melissa – Several people in staff PLE Lou- Outreach specific people on team PLE. PATH SAMHSA - MH outreach team.
What new practices have been put into place over the past 3 years?	Steve – CC – Moved ES from security-based shelter into a client based shelter, implemented case management program into shelter – allows them to touch each client – allows them to feel empowered and more say-so in their program. Case managers available from 8am-4pm then night team until 11pm allows for better client interactions and better outcomes. Night case management came at 2020. Nicole CC – October 2020 also added housing nav center onsite. Swing shift for case managers allows for dayshift to do warm handoff to night shift. Nav center allows for diversion services. If div not possible, they provide referrals, designated beds for individuals who are working and are 30 days or less from moving into housing. ES case mgt – used to be a gap now able to support clients – use housing first – allow to for intoxicated individuals. - Housing First Learning Collaborative through the CoC led to this decision – didn't use breathalyzer anymore. Case managers at apartments too Sunnie – HELP – started offering extended case mgt 7am-8pm to accommodate those with varying work shifts, allows case managers to make more individual case plan – Rita

	Suites – upon entering, don't discuss cap on when they have to leave, create plan and discuss barriers as long as actively working towards plan able to stay as long as they need. ARPA funding Kristin – Hope link- able to early 2019 eliminate drug testing, intensive case management. extended shelter time from 30 to now 90 days. Extensions allow clients to successfully get into PH. Now able to help take anyone into shelter. Prioritize families with children and medically fragile. Gets everyone rental assistance, Kim – HELP –confirm date ES learning collab – made a lot of progress working together between agencies within last 3 years, brought on ES queue. This allows client or outreach worker/other shelter to see what location has a bed available, and will do referral. Leadership meetings have brought agencies together, Shannon West used to have a big rule book and now cut down into minimal rules. Wants to be a safe place to stay and not be too overwhelming, has been low barrier and still removing barriers as rules as they come across them. For youth, doesn't deny based on sub use/ mental health disabilities.
What lessons have been learned by implementing these practices?	Kristin – HopeLink- clients not having clear exit plan in past / not passing drug test, etc. now able to work on barriers when couldn't before. More successful outcomes. Albert cc- over years have been able to grow case mgt team. And coordinators Many programmatic changes changed title of staff to be more involved in case mgt has allowed to work more closely with clients. With radios can hear clients asking security to talk to case mgt. Feel is more welcoming due to changes, does have es enrollment First time shelter are required to work with a case manager in an effort for diversion or rapid exit. Clients approach staff for additional needs – items etc. The culture has shifted in recent years. Programs and services but case managers deserves the credit and the position changes from ES monitors to ES coordinators (safety minded to housing first minded/case management)
Do you have any performance data?	Sunnie HELP – with case managers – they submit monthly reports to see what's happening – admin discharges if wasn't how many went to shelter and how many went back to street. Data specialist tracks discharges to see whether positive or not. Due to this able to meet with team to review causes to make changes to be proactive going forward to increase positive exits compared to negative ones. Address root causes – mental health – team thinks about delivery of resource to empower/encourage client – vulnerable to open up - "we would like to do a MH referral" - reframed "losing housing is traumatic, everyone deserves an outlet and give you an outlet to express it to someone" this has improved referrals and make it more of a conversation. Normalized services. Last month 38 discharged only 13 admin

	discharged. The rest of the clients placed in PH or reunified with family. James Crossroads – sub abuse facility as well – at beginning of care do a MH assessment for how mental health is working, case mgt – does bi-weekly meeting, tracks in own spreadsheet to see how each client exits safe disposition. Uses electronic medical records. Tracks if connected to any other services and if they utilized them.
If so, how is it used?	
How do you adopt service delivery methods that respond to preferences and needs of the individual or family presenting for assistance?	Alyssa – link bridge housing – takes clients shopping to get start up items for housing. They get to make their own purchases. Shannon west places clients based on gender identity they are currently identifying as Kristin – shelter is not gender specific has been able to place anyone. Services offered based on gender identify NPHY does this as well.
What type of new practices or activities would you like to see provided in Southern Nevada?	Melissa – NPHY – Significant increase in mental health and SUD concerns. Needs more support. Immediate ES with high level medical care to work with them on treatment/stabilization right when they enter shelter. Meet those needs while working on long term housing Alyssa – crisis services there with hospitals, but not strong with follow-up when discharged they fall back into homelessness. Need aftercare / follow-up strategy.to stop the loop Kim Help – mental health issues have dramatically increased – right now 65% of pop at Shannon West have severe mental health issues, that impacts ability to self-resolve. Community lacking ability to get people with mental disability to get housing. Currently 18 months wait. Hard to get these individuals into proper places because there aren't a lot of options. Group homes for mental health / developmental health disabilities. James- CrossRoads – they get clients in crisis stabilization have 7-10 days max, when they go to find safe dispositions can create problem setting clients up for success and long term programs, tries to bring as many clients to TH program 90 days to work with them longer, get them more stabilized. At end of 90 days hard to find long term supportive help, many can't keep jobs. Navigating SSI/SSDI can take 6 months –2 plus years. Alyssa – barrier – clients say they want detox but can't follow through while on streets Kristin -HopeLink- streamlined services, use additional rental assistance for those that aren't as high need or more self-sufficient to have services available for those with higher needs Amy – need to focus on older pop 65+, have been homeless for so long, many have given up,

	Barrier to access, not sure how to navigate – MH and SUD services – need to go through loop holes – need wrap around service center for a client to enter for 1 roof of services.
Describe strategies you'd like to see in Southern Nevada to rapidly (permanently) house individuals and families with unsheltered homelessness?	Kristin- highest needs need PSH – we've placed in short-term housing and then loop back into homelessness as there tends not to be support systems Amy – removing the requirements of how long a program is –time frames have been barriers – setting up a system that targets progress vs. Time. Hit outcomes not time. Other states have higher success of ending repeat homelessness Veronica CC- at shelter some adult clients have autism, partially verbal, think about programming, currently no agency available to help them work with basic life skills. Need training/ programming / group homes for these clients, Kim – HELP – need additional housing nowhere to house clients., FMR is issue. Need to build capacity. more units 30% AMI. Youth $1600 rent for 1-bedroom, this can't be paid, creating a back flow in the ES system. James – Amy's comment about performance rather than time. CrossRoads is limited to 90 days. Focus on treatment, barriers to living wage jobs – 2 or 3 months more would really be helpful to allow vocational training / job readiness to happen as the start is focused on treatment. SUD/SMI - if they stop medication – may lose housing – supportive services need to be wrapped up into the housing to help maintain and stay connected to progress. Albert- Many root causes to homelessness – understand trauma-informed care – medical, mental, dental are some issues – homelessness is a systemic, cycle, generation to generation – we need to understand. Survival mode. We need to have conversations to be client-centered and housing problem solving – more PSH, more supportive housing. The ability to follow a client and assist a client. Some secure own space and then end back in ES. Support system lacking. CC has apartments – wait list long- but if placement from ES they end up staying a long-time b/c of the support system established. Dementia is increasing as population ages – Alzheimer's too. We need these services. Step down services. Client had open heart surgery – how can we create a system where hospitals can appropriate refer and discharge that can provide the level of care that is needed for these medically vulnerable. Amy – sometimes individuals aren't ready to be housed, what may seem normal to us won't be normal to them. No income and no resources. Need services in place to help James- after 90 days sends to programs and clients aren't ready. Send from TH to their TH but still not enough.
What additional steps can be taken to help individuals currently unsheltered access:	

Housing/ other resources/support services/Increase ID access /access to healthcare/housing navigation	
Additional Questions about Housing Resources	
What are the new permanent housing units that have been created? (PSH / RRH)	Housing Choice Vouchers, HOME-ARP, HOPWA and other funding beyond CoC and ESG.
What are the dates the units have been or will be available for program participants to use?	
How many new permanent housing units will be available for individuals and families experiencing homelessness?	
Additional Questions about Healthcare Resources	
What are the programs in the CoC that integrate behavioral health?	Behavioral Health Coordinator- Michelle Bennet Senior Management Analyst - emailed
What are the crisis stabilization programs?	Emailed Alexandria – SNVCHIPS for this info
What are the current health care related programs?	Healthy Living Consolidated Project, Healthy Living Rapid rehousing (Mary C. / Brenda)
What housing projects serve individuals with HIV/AIDS?	The only one I know of is HOPWA, which is limited in its capacity. (Emailed Heather Shoop)
How could we better serve individuals with HIV/AIDS this population?	These clients need to be prioritized for housing placements within the CoC. Living on the streets, they are often unable to maintain their medication regimen and medical care leading to high viral loads and increased medical care costs, including emergency department visits and hospitalization. We need to support these clients with housing to reach and maintain viral suppression. When a person is virally suppressed, also referred to as undetectable, they are unable to pass the virus on to sexual partners. (Undetectable = not transmitted). Failure to do so has a negative impact on public health, HIV and AIDS incidence and prevalence, leading to more cases of HIV across the community and high costs of healthcare. Heather Shoop, Ryan White Project Director HOPWA is only available to people with a steady income. This leaves out a substantial percentage of homeless and unstably housed people living with HIV. There is a two-path solution to this problem, and they both start with dedicated temporary housing for people living with HIV who do not have income. This dedicated temporary program is necessary to foster safety, trust, and engagement because this population faces significant barriers of mistrust and a history of abuse which makes it very difficult to engage with the current offerings of general population shelters. From there, the people who are unable to work due to disability need increased access to SSDI through a robust public SOAR program. The people who can and want to work can better engage with work-training programs when they are safe and

	not dealing with threat of assault and/or their belongings and medications being stolen or destroyed by heat, wind, and floods. By denying assistance to the most vulnerable, we are missing out on an opportunity to provide essential comprehensive public health to this population and our community at large. -Danielle Haldeman, RN, BSN, Ryan White Case Manager SNHD
Describe any unmet needs in Southern Nevada around healthcare.	
Describe any unmet needs in Southern Nevada around behavioral health.	From Maurice Cloutier: one of the biggest areas of concern is the revolving door issues with the IMDs (IP Psych Hospitals). Generally, individuals experiencing homelessness who have been deemed appropriate for placement in an IMD are held for anywhere from 3 to 7 days; this is not nearly long enough for medication stabilization – then these individuals are released back into homelessness where they are either unable to fill prescriptions/unwilling to fill them/unable or unwilling to take medication/self-medicate, et al. – then circle back into the IMDs and so the cycle goes. Having an appropriate facility that is a lower LOC for individuals to transition to, that is stable and supportive and still requires these individuals to engage in the community is the only way I see us breaking the current cycle. I had been discussing with Jocelyn at the City of Las Vegas, when I was employed there, about a RCC model approach to mental health stabilization – a LOC below an IMD/ER/ED but greater than an group home setting, where individuals with BH concerns would be able to stay and become stable through medication management and talk therapy. The RCC fills (albeit we need to ramp up beds by 200% minimum) a gap of care in our system for physical health and now we desperately need to shore up something similar to tackle some of the BH issues that plague the unsheltered community. Additionally, incorporating onsite BH services into the shelter continuum is crucial – at a minimum, at least offering BH services, I don't mean PT 14 either, I'm talking PT 17. This way there is an option for those who want it and feel they need it – right now, anyone who wants BH services is required to travel for them and I think our community is well aware that most individuals won't travel for just about any service. Bringing services to where these folks are will help the sheltered community engage in these services and remain sheltered until housing can be appropriate/adequately addressed and potentially entice the unsheltered community into sheltered services. This is ideal thinking and there are myriad of barriers that impact unsheltered individuals, but

	these two ideas would be a start in the right direction, from my perspective.
Describe any unmet needs in Southern Nevada around developmental issues.	