Closing the Gap - Homelessness to Housing

System Improvement: From Best Practices to Implementation

Michael Thomas: Welcome, everyone. Thank you for joining us for the fourth webinar in this five-part series, "Closing the Gap: Homelessness to Housing." My name's Michael Thomas. My pronouns are he/him. And I am a lead homeless services specialist with ICF. Would my co-presenter like to introduce himself as well?

Gordon Levine: Sure. Good afternoon, everyone. My name is Gordon Levine. My pronouns are he/him. I am white and Jewish. And I'm also a lead homeless services specialist with ICF. Thanks very much, Mike.

Michael Thomas: Thank you, Gordon. So during this series, we will provide guidance on best practices and strategies and stakeholder engagement for homeless services systems. We will cover topics designed to help communities establish equitable effective homelessness responses through meaningful collaboration, resource coordination, and efficient delivery.

Today's session, "System Improvement: From Best Practices to Implementation," we'll focus on how to implement system-level strategies that end homelessness. We'll cover topics including use of data to drive decisions, centering equity, considerations for rural areas, and considerations for tribal nations. And so here is our agenda. It will flow in the order I just went through.

First, we will talk about data-driven decisions, then centering equity in your decision-making, moving onto housing-focused practices, then considerations for rural areas, and then we will wrap up with considerations for tribal areas and some time for question and answer. So jumping right into our content, we'll start off with data-drive decisions.

To prevent and end homelessness, it's important for communities to be able to analyze data at both the system and project levels, evaluate their efforts by subpopulation and across project types, and in other ways based on local contact. This data analysis process puts -- excuse me, facilitates improvement by identifying how individual projects and other variables contribute to overall system performance and to equity.

So first, we'll talk about the Homeless Management Information System, or HMIS. This will likely be your first source of data for the local homelessness response system. HMIS is not all-encompassing. It does have limitations. We want to acknowledge that. For example, it will not contain any data related to victim service providers. They have to use a different venue. So that won't be in HMIS.

So although it does have limitations, HMIS is one piece of the overall data puzzle, and it is a large and very important piece. One of the most important things to understand about HMIS is that it is the primary vehicle for producing a number of reports required by HUD and by other federal partners for homeless service programs.

The data that's aggregated for these reports contain a wealth of information such as housing destinations, household income changes, and mainstream benefits access. HMIS data starts at the client level, and then that aggregate data flows up into project and system level performance

reports. And because of this, data quality is critical to ensure reliable data that informed performance accurately and facilitates furthering of equity.
So having that accurate data at the client level ultimately flows up into all of these other things we're talking about. At the system level, HMIS data helps understand pathways that household take from homelessness to housing so CoCs can identify what is working and what needs improvement in that process. Both system level and project level report elements can be used by the CoCs to craft a strategic performance plan with goals, milestones, and benchmarks.

Project level data can also be used to assess the overall impact of individual projects on your bigger system performance picture including aggregate the identified data from comparable databased used by victim service providers. Depending on what those relationships look like, your ability to get the identified aggregate data from those system, that can help inform your processes as well.

CoC is often used project-level Annual Performance Reports, or APRs to inform monitoring processes and local prioritization decisions. And we're going to talk a little more about APRs later on. Okay. So let's talk in a little more detail about the difference between project level versus system level data. Generally speaking, system-level data will be that which informs broader decisions about resource allocation and resource access.

Project-level data will inform decisions to improve performance by identifying how individual projects are impacting overall system performance. System-level data includes reports like the Longitudinal System Analysis, or LSA and System Performance Measures, or SPMs. Those reports asses the system's ability to successfully move people form homelessness to permanent housing. Analysis of system-level data should include reports like these.

It should include data from coordinated entry activities, and any other system-wide activities that you might have and be tracking locally. And it should also include a variety of non-homeless system data. And we'll talk a little more about the non-homeless system data in a few slides as well. Project-level data reports on and informs performance and outcomes for individual projects.

As I've mentioned a couple of times already, it's valuable for informing how those projects impact system-level outcomes. I mentioned it a few times because I think it's important to stress. That's a really critical way of looking-at how individual projects are affecting your overall system.

Analyzing individual project data allows the CoC to identify low-performing projects and then take whatever locally-appropriate action there might be to create a more efficient and effective system. So here, we're going to talk a little about the Special Needs Assistance Programs, office at HUD, SNAPS, the SNAPS data TA strategy to improve data and performance. This strategy was published by SNAP in 2018.

And it was one of several efforts to obtain an even more accurate picture of the scale and scope of homelessness nationally. SNAPS encourages communities to become familiar with this strategy since it is ultimately going to guide the SNAPS's approach to data-oriented efforts with

CoCs. So as SNAPS was thinking about how to approach data with the CoCs throughout the country, this is the strategy that is going to guide that.
The strategy indicates key markers and characteristics of a data-driven system. And CoCs can use that to set their own goals in alignment with this strategy. And the strategy contains ambitious and aspirational goals. I'm going to stress that out front, too. We're going to talk a little about some of these. They are very ambitious.

And they are very aspirational. CoCs are encouraged to integrate these goals into their local needs-driven performance metrics and then work towards collecting stronger, more useful data and make continuous progress towards their own goals. These are the overarching goals in the SNAPS strategy we just talked about. So there's three really big-picture goals.

The first is communities use their data to optimize systems of care through making ongoing system performance improvements and determining optimal resource allocation. The second overarching one is communities operate data systems that allow for accurate, comprehensive, and timely data collection, usage, and reporting.

And then the third is the federal government will coordinate to receive and use data to make informed decisions in coordination with other data sets and across and within agencies. So that's the big picture of the strategy. When you dig into it, it has different levels, and the third level, strategy three of this overall bigger strategy, defines specific characteristics of CoCs that effectively use data to improve their efforts.

So the first characteristic that we see define there is that the CoC uses data for system planning. This means that the CoC uses project-level performance data to make rating and ranking decisions and set local performance goals. It aligns homeless resources to meet the needs of people experiencing homelessness in the local context and uses all available sources to prevent and end homelessness.

The second characteristic that we see define there is the CoC uses data for coordination of care. This means that multiple homeless services providers coordinate to provide housing and services. All providers remove homeless services specific barriers to housing and services. And then providers and non-homeless system of care coordinate to further remove systemic barriers that might cross across different levels of the system.

The third characteristic we see is the CoC uses data to prioritize existing resources for the most vulnerable people. This means that the community uses all available resources for the most vulnerable. The homeless system uses rapid rehousing for progressive engagement, and 100 percent of permanent supportive housing is highly targeted. Data from non-homeless systems is used to prioritize highly-vulnerable persons.

And local evidence drives a highly-targeted homelessness prevention strategy. I want to note here that everything I just went through, it's a lot of information. This is a very brief, very high level overview of the strategy. There is a link to the strategy that will be in the materials at the end of this presentation. I would encourage you to look at the whole thing on your own.

In the document, all of the points that I just discussed are more detailed and laid out to show that they are progressive. And they build on one another. And again, they are ambitious and aspirational. I'm not aware of any community that currently hits every point that I just laid out. So it's just important to note that. This is a really big aspirational strategy. And it's meant to give you guidance.

I don't know any communities that are completely there on everything at the moment. On this slide, you see a list of some relevant HMIS reports that might be useful for your planning purposes. So I'm going to go through these and talk a little about each of them. The first is the Annual Performance Report, or APR. That shows performance for individual projects on items like housing destinations, income increases, and mainstream benefits excess.

They also contain client demographic information for the project, which can be useful as you're thinking about equity. APRs are also used for reporting related to coordinated entry, if you have a coordinated entry grant in your community. So an Annual Performance Report is prepared for that as well. So those can be really valuable for CoCs.

The Longitudinal System Analysis, or LSA, is the report that drives the Stella Analysis tool, which we're going to discuss in more detail momentarily. It is important to note that the LSA analyzes data for households not for individuals. So the reporting in the LSA is based on the household level and not for each individual in the system because you can, of course, have multiple individuals in one household.

System Performance Measures or SPM, those reports are used to analyze overall system performance for the CoC. If you're in a large Continuum of Care, it may be possible to work with your HMIS administrators to look at System Performance Measures data-regionally. But it's usually not useful to look at it for individual projects in my opinion.

The reason being, System Performance Measures look at things like returns to homelessness, for instance, that kind of span the entire system. And when you drill down to an individual agency level with System Performance Measures, I haven't seen that be particularly useful in my work. But looking at it regionally certainly can be helpful. Note here that System Performance Measures analyze data for individuals, not at the household level.

So it's the opposite of the LSA. The LSA looks at households. System Performance Measures look at individuals. The Coordinated Annual Performance and Evaluation Report, or CAPER, is required for all emergency solutions grants recipients. So the jurisdictions that receive that funding have to provide that report annually. And they were probably collecting information from their subgrantees for that as well.

This report can be useful specifically for looking at the performance of ESG-funded projects. Reports related to the Point-In-Time Counts, specifically, the shelter Point-In-Time Count might be available -- excuse me, available in your HMIS depending on how it's going to figure. Housing inventory count reports may also be available depending on how your system is configured and how you're tracking bed vacancies.

If they are available in your system, those can be useful. And then Federal Partner Reports at the project level may be helpful for planning. And that includes reports required for programs like Runaway and Homeless Youth, or RHY, and Supportive Services for Veteran Families, or SSVF. And you can see that, like my examples there, speaks specifically to really important subpopulations in the homeless system.

So that's why looking at those reports can be useful as well. On this slide, we're spotlighting the Stella P and Stella M tools. So Stella P is Stella Performance. And Stella M is Stella Modeling These are available from HUD and HDX 2.0. That's the website where the Longitudinal System Analysis data is submitted. Stella P is a ready-made tool that can help CoCs analyze the flow of households through various homeless services system pathways.

It uses LSA data to create dynamic visuals and illustrate how households move through the homeless system. And it visually highlights outcome disparities. It also visualizes performance in a variety of context including demographic breakdowns which are useful for equity analysis. Stella M is still very new. In fact, it's so new that I haven't had a chance to play around with it and use it.

So I can't speak to it in great detail other than to say that I'm really enthusiastic about it and the fact that it's finally rolling out. Stella M uses your community's data on homelessness project types and performance goals to calculate the inventory of housing, shelter, and services needed to fully meet your community's needs around homelessness. It can also be used to test variables related to these items so you can sort of change things around theoretically.

And that will predict the system impact of shifting those resources. So I can't go into much more detail on Stella M because I just don't know. But I know there will be more materials forthcoming on how you can use it. So keep an eye out for those. These tools are of great value to CoCs that are smaller and may not have the resources to create in-house data visualizations and other analysis tools.

We've seen a lot of CoCs out there developed by data dashboards and things like that. But not every CoC has the capacity to develop all that on their own. And that's where things like Stella P and Stella M, these ready-made tools, can be really helpful. They can be used for planning. And they can also be used in venues for a visual representation of your data as necessary. So an example from my background, I'm thinking of, is CoC board meetings.

If you want to visualize some of the elements of your system, Stella P can be a great tool for that. You can drop it right into those board reports and right into those slides. So far, we've talked a lot about HMIS which is a really fantastic source of quantitative data.

It's important that we don't overlook qualitative data in our system analysis efforts. Quantitative data represent measurable things that are expressed as numbers. And this type of data will inform what is happening in your system. So it's the what. It shows you, in a very measurable way, what is happening. Qualitative data are those which cannot be easily measured or expressed using numbers.

They represent things like consumer satisfaction, employee observations, those less-tangible things that can't be measured numerically. The qualitative data will add to the numerical side of things by informing why the numbers are what they are. So your quantitative data, your numbers, will give you the what. And then your qualitative data will give you a lot more context around why. Quantitative and qualitative data are both necessary to make truly informed decisions.

As you can probably imagine, the process for collecting qualitative data is less straightforward and more time-consuming than collecting quantitative data. So qualitative data usually comes from things like surveys, focus groups, interviews, round tables, public hearings, listening sessions, CoC membership meetings. And it could be a variety of other venues.

I will note here that Coordinated Entry Evaluation can be a really important source of qualitative data because during that process, there is usually going to be some sort of focus group or some sort of consumer surveying process. So that's a really important source, too. It's important to consider a wide range of stakeholders to ensure the most comprehensive set of qualitative data possible.

Some of those to keep in mind are people with lived experience, people experiencing poverty, people from historically marginalized populations, case managers, street outreach workers, culturally-specific organizations, and other service providers. So importantly here, remember the consumers of the services in the homeless service system. Their experiences in that system will provide invaluable information for your planning efforts.
Throughout this section, we've mentioned non-homeless system data a few times. The data that you use in this category will probably be very localized. And it'll be dependent upon the relationships that you have in your community. And it'll be dependent upon what actually exist in your community that you can draw this data from. But in any case, here are some data sources to consider.

Think about things like census data, poverty data, evictions data, child welfare data, data from hospitals and the public health system, Medicaid, law enforcement, education system, behavioral health, mainstream benefits, and public housing. Those can all be really insightful data sources.

I will note here that when we say law enforcement, we are referring to the broader system of law enforcement that would also include any relevant data you might have for jails and prisons and things like that. So once you've collected all of your data, how do you proceed? Here, we're going to outline the process for performance improvement that is presented in HUD's Performance Analysis and Improvement Toolkit.

One of the main themes here is that the process is ongoing and interactive. And it will change over time as you improve some things and then move onto other things. Step one in the process is analyze system performance that the overall system, household, pathway, and subpopulation levels, then prioritize areas for improvement with intentional consideration for equity.

You also want to have intentional consideration for the CoC's established performance targets and the CoC's priorities. Step two, identify factors contributing to current performance. And that can be things like individual projects, data quality, and resource capacity. And then when you

identify these things, gather evidence to support your result. So I'm giving a shoutout there for qualitative data. That's stuff that tells you why the results are what they are.

Step three, design improvement strategies that are prioritize for impact and consider using a logic model designed for this. We didn't include a lot on that because you could do entire presentations. But if you're not familiar with the logic model design, it is suggested here. You can certainly find plenty of examples of logic models out there.

And then step four, create a performance-improvement plan, conduct at least quarterly progress monitoring and implement a formal evaluation strategy to make sure that you're keeping track of how your strategies are playing out. Another quick spotlight here, this spotlight is on Targeted Universalism.

So Targeted Universalism is an excellent framework to drive your efforts to address equity. It's a framework within which you can analyze your data to ensure racial equity is prioritized. Using a Targeted Universalism approach is simple, outcome-oriented. It rejects a blanket universal strategy and builds from a shared goal or universal aspiration.

The approach looks to meet the specific needs of each member in the community, identifying the specific barriers to attaining the universal goal for them and for each group within your community that you're looking at. So the steps are as follows, establish a universal goal, assess performance relative to that universal goal for the populations in your community, then identify different performance between the goal and the overall population.

And then you want to assess and understand structures so that you can fully understand why there is a difference between a subpopulation and your overall population, and then, finally, develop and implement targeted strategy. This is just a brief spotlight. We do have a link to a document that will be at the end of this presentation that you'll be able to access and the materials to another document that -- it goes through Targeted Universalism in detail.

So I would encourage you to check that out as well. And we will wrap up this section with some final thoughts on data-drive decisions. The first one here is really important. Don't let perfection get in the way of progress. If you -- a lot of times, you'll hear this referred to as analysis paralysis. If you get lost in the data and lost in the analysis and are constantly waiting for things to be perfect before implementing a strategy, you might never get there.

So my thing here is basically be willing to innovate, be willing to set bold goals. And then when there are shortcomings, use those as learning tools rather than waiting for everything to fall into place perfectly. It's hard for any decision to ever be absolutely perfect. But in many instances, action may be preferable to inaction. Don't forget the qualitative data. It is curtail to understanding context around the numerical data that you have in your system.

Remember, use both project-level and system-level data in your analyses. They are both incredibly important. They complement one another. And that project-level data will really help you figure out what's driving your system performance in a lot of ways. And then finally, always

center equity and data in your decision-making process. And on that note, I will turn you over to Gordon to talk more about centering equity.

Gordon Levine: All right. Thanks very much, Mike, looking forward to it. We're going to talk a little bit now about centering equity in decision-making. I'll adjust my WebEx client [first hand??] for a moment. So the structure for advancing equity is the same for all populations. But the process of advancing equity is different for every population. You've heard us say that before in the series. We're going to say it again. The structure is roughly the same.

The process differs based on population. And in the context of talking about advancing equity, there's a significant overlap between the drive to advance equity and the drive to create equity and decision-making. They have the same underlying structure. They often have the same approach. And each approach feeds into the other. You can't advance equity without creating equity decision-making.

And you can't create decision -- you can't create equity and decision-making without also taking steps toward advancing equity system [pipe??]. So some essential principles for creating equity and decision-making, one is meaningful participation.

Creating opportunities for meaningful participation requires that current stakeholders relinquish some level of control ensuring that marginalized people are empowered to identify where and how they want to participate and ensuring that the systems provide new decisionmakers with the training, support, and space to grow.

And that's really the underpinning of everything we're going to say over the next few slides, that ultimately, when you bring in new stakeholders and new decisionmakers who are not, for example, CoC programmers [at bans??] or folks who work in homeless services, there is going to be an onboarding period whereby you are building on the skills and knowledge to put people to participate in the way that it's most appropriate to them.

There's an education piece where you enable people to understand where they want to plug in. And there's an accommodation piece where you must necessarily adjust your regular way of doing business to equitably accommodate people who are not necessarily the stakeholders that you've always incorporated. More on that in [moment??]. Another element is equity and expertise.

What that means ultimately is that the system and your current stakeholders have to recognize that marginalized people, including people with lived experience of homelessness, are experts which means prioritizing the knowledge, skills, and expert -- and experience, rather, or marginalized people within their areas of expertise.

And in general, what we're talking about is recognizing that people with lived experience of homelessness are experts on their experience of homelessness and will have insights into that that people who do not have similar experiences have and that those experiences are exactly the qualitative data that Mike was talking about just a moment ago.

Beyond that, when we talk about subpopulations, and we've touched on several of them in past presentations, including people who are black, people who are LGBTQ+, people who are living with disabilities, youth who are age 24 and under, veterans and so on, we're really talking about ensuring that we're not just saying people with lived experience all had the same experience but recognizing that people with specific apertures on marginalization have something to contribute that goes beyond simply knowledge of homelessness, but knowledge of homelessness from that specific lens.

Incidentally, that was not intended to be an all-inclusive list of marginalized identities. Those are simply the ones that we're throwing out as examples. Finally, as I mentioned before, there needs to be a level of adaptation and accommodation, that systems have to adapt to the needs of their new stakeholders, creating flexibility in dates, times, formats, letting go of professional norms, such as communication styles and dress expectations, are two critically important steps for almost any population you are newly incorporating. Again, that's not all-inclusive.

Those are sort of the lowest hanging fruit of things that are unspoken and often unconsidered norms that present significant barriers to many marginalized people including people experiencing homelessness or with lived experience of homelessness who are becoming their new stakeholders. And so dismantling some of those norms [at least??] critically examining how to accommodate around them is critical to promote engagement.

You know, ultimately, creating equity in decision-making is, as I said, a key part of advancing equity in homeless services systems that requires putting into practice some of the principles discussed in the first webinar of the series, which was about advancing equity. It does require sustained effort to both identifying and overcoming associated challenges.

And that's everything from resistance to change from current stakeholders to reimage the decision-making process to creating meaningful opportunities for participation, which are tailored to the individual stakeholders you're trying to bring in.

It also requires dedication and commitment to identifying who is not at the table and incorporating them into the decision-making process in a way that is respectful and mutually beneficial and that is not tokenism. Equitable decision-making process must be as accessible, inviting, and interesting in marginalized people as it is in its traditional stakeholders.

And what we mean by that is the current decision-making process in most systems is designed to be accessible, inviting, and interested in the perspectives, opinions, and voices of traditional stakeholders, [susee??] program recipients and homeless services system participants and so on. And fundamentally, those accommodations, accessibilities, and invitations are tailored to that audience but not to the audience of marginalized people.

And so systems really have to reformat those accessibility points, invitation points. And it's curiosity, fundamentally, to become a space in which marginalized people will feel invited but also will prosper and succeed. So creating equity in decision-making, these are a few of the things that you want to hit on. You have to consult with numbers of the marginalized populations that you're trying to represent. Fundamentally, you can't create equity without input.

You need to create change in partnership with the people that we'll impact. Again, you can't just say, "Okay. We're going to be inclusive today" without talking to the folks that you're going to try to include. You need to apply changes gradually and with intentionality. There is a sense, again, as Mike was saying earlier, that you got to it right. You got to do it perfect. And it's just never going to be right and perfect from jump.

The best way to, sort of, negotiate with that tendency toward perfection or nothing is to implement changes gradually, be willing to make additional changes and to adapt as time goes on and act intentionally rather than waking up one morning and deciding, "All right. We're going to be inclusive this week." It just doesn't work that way.

And so taking it slow and deliberate steps will huge hoard that vision of right action while also giving you space to adjust as necessarily. You make missteps, which is okay. Missteps are an understandable part of the process. And how you react to them is really much more important than whether or not you make them.

You have to assess your outcomes and for several reasons. One of them is if you don't access your -- assess your outcomes, you can't identify what isn't working. And so outcomes around inclusivity are really about whether you are effectively including marginalized people. But that, again, is qualitative data. But it's also about celebrating successes.
You have to be able to -- you can't be in this permanent cycle of castigating yourself of saying it's never good enough and nothing we do is sufficient to remedy marginalization. You have to be able to celebrate progress and success even if it isn't perfect. Again, this is about not letting the perfect become the enemy of the good. And finally, you have to continue to consult and reiterate as your old barriers persists but also as new barriers are encouraged.

The reality is both current system participants and marginalized people will not have a perfect vision of all of the barriers that they will face in the process of moving toward increased participation and dismantling marginalization. And so those new barriers will emerge overtime as you succeed.

And be willing to engage with those new barriers in partnership with people who are marginalized, especially people with lived experience, is a critical part of being successful overtime. Compensating people with lived experience. This is a personal passion of mine. I think it's incredibly important. I'm glad that we're highlighting it here. Fundamentally -- and this isn't on the slide in front of you.

Fundamentally, what we're looking at here -- what we're really saying is that people with lived experience who are lending their expertise to your system need to be paid for the same reason that the experts that you already employ are paid for their time because people who are participating toward the uplift of the system deserve compensation for their actions.

So marginalized people, which includes people with lived experience, ought to be paid as experts participating in the decision-making process. If you bring in an HMIS expert, you're going to pay them as an HMIS expert. If you bring in a consultant to assist you with an application or with

your coordinated entry system revisions or assessments, you will pay them as expert consultants. The same must be true with people with lived experience. They are experts.

They are acting as consultants. They should be paid as such. Asking your experts how they want to be compensated is also critically important. And if you're going to ask, you have to be flexible about the answer. Many consultants will want to be paid in cash or in check or via payment app or in gift cards. Those are reasonable requests.

And they are exactly as reasonable for people with lived experience or people who are not working in our field as they are when they come from people who work in our field. You would not look at a consultant who is working on your coordinated entry system who is asking to be paid for their work in the form of an electronic fund deposit or a check and say, "You know, we don't really do that."

You wouldn't do that. And so the same must apply when you're dealing with people with lived experience who are providing expert knowledge. You simply can't turn around when they express a preference for the way in which they're compensated and say, "Well, we don't really want to do that." You have to ask. And then you have to act on that ask.

Finally, you have to recognize that there are associated costs for many of the marginalized people that we're talking about, especially people who are actively experiencing homelessness, to contribute their expert knowledge to your system that simply are not the case where -- that are differently the case with other consultants. So transportation, meals, childcare. Those are all frequent costs. They're also reasonable costs.

If we're going to keep using this consultant analogy, all of those costs are built into this sort of flat consulting fee whether you're paying by the hour or whether you're paying as a lump sum. But for people with lived experience you presumably not entering into a large contract with, those are going to be itemized costs. And as they are requested, it's completely reasonable to honor those requests and to compensate people appropriately.

There are lots of ways to pay for those costs. We've listed some of them on the screen. These are not intended to be -- this isn't an all-encompassing list of every way that you can pay for the time and costs associated with people with lived experience and other marginalized people providing their insight into your system. But it is a pretty good list I would say. And I would note that not all of this is -- you have to go find a local source of private funds.

I would highlight, specifically, many of you out there are probably CoC program recipients. Some of you are probably collaborative applicants. Some of you are ESG recipients. And some of you are probably ESG subrecipients.

CoC planning grant funds and, to some extent, ESG funds depending on how it's earmarked, those can be used to pay for the time and expertise of people with lived experience and other marginalized people contributing to your system improvement. And so you don't need to necessarily look at -- or you don't have to start necessarily your most unrestricted funds. You may have grant funds available that can pay for this.

That's all I'll say about that. So housing-focused practices. So the goal of homeless services -- and really, if you take nothing else away from today, this is kind of the piece that I, in my heart, wish you would take away. The goal of homeless services, the underlying purpose, the thing that we're doing is achieving or helping to achieve safe, stable, permanent housing for people experiencing homelessness.

It is the underlying goal of everything that we do from high-acuity interventions like PSH and rapid rehousing and long-term housing options to first-touch options like street outreach and emergency shelter. The goal is safe, stable, permanent housing. That's what we're aiming at. And everything that we do has to focus, center around, and aim toward achieving that goal.

And so centering permanent housing in your homelessness response means that all of these things that are on the screen -- and again this is just a sort of sampling of the things that we do in our many different project types and activities types.

All of these are important. But they're important because they exist in service of the primary goal, which is getting people back to safe, stable housing or maintaining them in safe, stable housing if you're working on the prevention side. And so just picking on for example, behavioral healthcare, critically important.

It's critically important for a number of reasons, both because it's important to individual people but also because we know behavioral healthcare is needed by so many people who are experiencing or at risk of homelessness. But from our perspective as homeless services providers, behavioral healthcare needs to exist in relation to permanent housing. And so the question is not, "What can I do to improve your life," which is ultimately what many of us want.

And we [will??] touch on that a little bit. The question is is there a housing barrier that we can resolve using a behavioral-healthcare approach. So this is my favorite slide in this entire presentation.

This is, as far as I can tell, what goes on inside the mind of many, if not most, homeless services providers at every level of the business from your frontline staff up through your directorial staff, your executive directors, your c-suite staff, and your TA providers. At the end of the day, most of us are thinking we work in homeless services because we want to help people. That's why we're here. That's what drives up.

Most people become homeless service providers to help people. And the way that we help people is by helping them return to safe, stable permanent housing. And it's important to maintain that focus, that we help people. And the way that we help people is housing because an undirected desire to help people can be not just spinning our wheels. But it can actually be counterproductive because it draws focus away from housing more on than just [money??].

So housing-focused practices are Housing First practices. And Housing First is a service approach that treats housing needs as foundational and urgent which, incidentally, it is. So what is Housing First?

According to HUD, Housing First, and this is one of several definitions, is an approach to quickly and successfully connecting people experiencing homelessness to permanent housing without preconditions and barriers to entry such as sobriety treatment or service participation requirements. Other definitions of Housing First also include a prohibition against service participation requirements once a person is housed.

In recent years, the prohibition against participation requirements has been incorporated into the Housing First definition used by many HUD programs that serve people experiencing homelessness. So principles of Housing First. So there's six principles here. We're going to break these down a little bit. Homeless is first and foremost a housing crisis. It's really the essence of homelessness.

Homelessness can be addressed by providing safe, stable, secure, affordable, permanent housing. Note that this is not about ensuring that every person experiencing homelessness receives a voucher through the CoC program or any other source or that every person experiencing homelessness receives any housing subsidy at all.

One of the most powerful emergency -- emerging practices in homeless services is housing problem-solving which seeks to return people to housing without an ongoing subsidy via their existing strength and support efforts. More on that later. But the key takeaway is that while the resolution to homelessness is housing, the approach to housing is always specific to the participant and doesn't need to be a subsidy or a big subsidy or an ongoing subsidy.

Next, all people experiencing homelessness can achieve safe, stable housing. For many people, this can happen very quickly, especially if there's solved -- especially, rather, if they're served using a housing problem-solving approach. For some people, it can take much longer, not just to achieve housing, but even to be getting aging services. And relate -- and this is one of my favorite stories.

In one of the CoCs that I worked with a while ago, there was a participant who was well known in a small rural community. If I recall correctly, the participant in question was the only person experience literal unsheltered homelessness in this entire community, wasn't a small -- it wasn't a big community. It's a small rural town, 30,000, 40,000 people with a sort of large rural area out there.

And the participant in question had been experience literal unsheltered homelessness for years. The best of my recall, it took nearly 80, 80 outreach attempted, recorded in HMIS, over several years before the person in question began engaging services. And the outreach attempts were like -- there was a lot, kind of upfront.

And then there was an ongoing -- every three months, you check in with the participant and say, "Hey, how are you doing? What do you need? Are you interested in engaging services at this point?" He said, "No, not -- I'm good. I'm where I'm at." And over a period of years, eventually, the participant in question did say yes. But it took consistent outreach over a period of years.

And the reason that I highlight this participant is because -- and some of the communities that I work with, this participant would have been dismissed early in the process or in the middle of this processes, like "This is foregone. We're not going to do outreach with this person. Why would we possibly waste the time?" And the answer is it's not a waste of time.

It is absolutely a valuable use of time to recognize that everyone can achieve stability and permanent housing and to take the time to continue doing even minimal outreach to the people that you know about because eventually everyone will resolve their experience of homelessness one way or the other. And if you continue to make options available to people, you are likely to get a response. It might not be today or this year. But you will get a response.

Another principle is that everyone is housing ready. What we mean by that is that people experiencing homelessness frequently have challenges navigating the transition back to housing. But that shouldn't delay their return. So instead, what it should do is prompt housing and homeless services providers to assist participants in addressing the needs and barriers that occur during that transition period.

In other words, you want to flip it around. It's not about getting participants housing ready. It's about having service providers ready to house. And that's everything from getting people the documents they need to move into housing, to prepping them on the life skills that they need to maintain housing once they're into it.
It's about making sure that you provide the support the participants need rather than worrying about whether the participant is really ready for housing because ultimately, the question, "Is the participant ready for housing?" can often come down to is "Does a participant deserve housing." And that's simply not an effective approach. Sort of ethics to the side, the reality is that housing often leads to the resolution of many of those challenges.

And so resolving them before housing is counterproductive. Achieving housing often results in quality-of-life improvements, which goes back to the core service provider drive to help people. No matter who you are, self-sufficiency or, what a friend of mine calls, deeply flourishing, requires recognizing and addressing challenges that arise in many areas of our lives including our physical and mental health, our relationship with substances that are employed, and income.

Experiencing homelessness is a significant barrier to achieving stability in all of those areas. And on the flipside, achieving housing frequently empowers people to begin addressing those quality-of-life issues, rapidly in many case, that they were unable to address while they were experiencing homelessness. Again, housing is the foundational element. And when you address housing, lots of the rest of it starts falling in place.

Next, people experiencing homelessness have the right to dignity, respect, and self-determination. This is fundamentally about how we treat people experiencing homelessness. The two most frequent errors in thinking and acting on these issues are treating people experiencing homelessness like, one, elements of the system that need to be acted upon or, two, problems or situations that need to be solved or fixed or diagnosed or made whole.

These errors in thinking can be rooted in everything from an overwhelming desire to help people, I said this desire to help people can be counterproductive, to secondary trauma from working in homeless services, which is not just real but very prevalent, especially for people who are directly with people experiencing homelessness.

The solution is -- solution to these problems is, ultimately, remembering believing and acting on the truth that all people, including people experiencing homelessness, must be recognized as complex, fully formed, and in possession of needs, desires, and preference that should and must be honored by their communities including their service communities. Finally, participant needs dictate the exact configuration of their housing and services. So why?

In addition to what I just said about dignity, respect, and self-determination which is important, homeless services are simply more effective when they're responsive to each participant's needs. One of the homeless service providers' primary duties is to work with each participant to understand those needs which always begins with asking and then acting. Case management techniques are outside the scope of this presentation.

But this is where approaches like trauma-informed care and motivational-interviewing care would look like. Let's talk about implementation layers. Housing First requires commitment and implementation of many different levels of service. And each layer of commitment depends on each other layer to function well. Any of the layers of commitment that are absent the benefits of Housing First will ultimately not reach participants.
That said, the most frequent problems are, one, that Housing First commitments exist only at the CoC or the community or the organizational level and because they don't exist at the project or service levels, the benefits of Housing First never trickle down to participants. And, two, Housing First commitments exist only at the project and direct service staff levels.

And without organizations, CoC, or community buy-in and support, the benefits of Housing First are really never fully realized and reach only a limited number of participants. And when they do, they're pretty uneven. Each stakeholder needs to work together to ensure both their commitment and the operationalization, excuse me, of Housing First works well and supports each other stakeholder's commitments and implementations.

So CoC and community-level implementations in Housing First. These are -- and this is really not, as I said before, inclusive. This is really about underlying steps that you can take at the broader level. Implementing project-level low-barriered entry requirements in the CoC DST written standards is kind of the first step. But it creates a policy grounding for their actions. Streamlining acts as to housing subsidies through coordinated entry is critical.

And that's about everything from like a streamline triage [compartmentalization??] approach to strong integration with your public housing authority resources. That's really outside the scope of this presentation. But really, it's about making sure coordinated entry is any quick shot to routes out of housing. Creating system-level partnerships with non-coordinated entry housing subsidy providers. Again, that's your public housing authority. That's other entities as well.

But those are really the large untapped resource in many communities. We talked a lot about it in our previous webinar in this series, the third webinar in the series. We encourage to go back and look at that. Developing system-level partnerships with landlords that include eviction prevention education.

Fundamentally, if you don't have landlords who are willing to accept affordable housing subsidies, you're doing to be missing a significant portion of what you can do with the funding and activities available to you. Often, landlords just need a little bit of handholding and just need a little bit of education. And building that into your approach at the system level can have significant impacts at the project level.

Investing time and money and creating a range of returned-housing models. Again, this is about fitting that the return the housing to the participants. Housing problem-solving is the obvious, "Okay. We're going to do something other than just housing people."

But this is also about recognizing that there is a really significant difference between PSH and rapid and transitional housing and public housing and Section 8 and path permanent housing and permanent housing through VA resources and the [conses VF??] and so on and so on and so on and making sure that participants are correct -- connected to the right resource and the right route. Building system-level bridges to mainstream benefits providers.

This is really about addressing common housing barriers that can lead to resolutions to housing. We've highlighted this in previous presentations. I'm going to say it again. SSI and SSDI is a critical resource for many participants. It is a primary source of income for many people experiencing homelessness, especially people who are experiencing high-acuity homelessness.

And so connecting with your SOAR providers, SOAR being a model for quickly and successfully getting people to apply to receive SSI and SSDI. It's a really important system-level activity that can have huge benefits at project level.

Working with other funders to align resources other than CoC and ESG with Housing First, very important, and finally, and I want to highlight this one as this -- not the foundation, but the capstone piece, monitoring the fidelity of Housing First implementation at the provider and staff levels. Fundamentally, systems are positioned to make sure that everybody is doing the thing. And you can develop the best policies in the world.

And that's true for Housing First as everything else. You can have the best policy body in the world. If you're not going to monitor and ensure that it's actually being implemented, then fundamentally, it's not going to be implemented well. On the other side of that, organization and project-level implementations. Again, this is not all-inclusive. This is first steps and foundations. Eliminating prerequisites to project intake. This is a requirement for many of your projects.

But really identifying whether you got allowable but sort of sideways prerequisites like complicated intake forms, requiring identification if you're allowed to but you don't really need to. These are things that are functional prerequisites even if they're not de facto prerequisites that projects are empowered to remove and thereby improve access.

When appropriate, you want to try housing problem-solving, rapid exist case management before housing search and subsidy. This is kind of an advanced practice. But what it means at the bottom of it is that if a participant is referred to, for example, a [free??] housing project, your first action shouldn't be, "Okay. Let's get you into housing with a subsidy."

Take some time, dig in with the participant, and identify whether there are supports in their lives that have not been explored upstream. In systems with high-performing housing problem-solving structures that exist, embedded in a coordinated entry system., this might be a moot point. This could be well-explored territory in systems where housing problem-solving is still taking root.

Projects implementing this can see a significant return on getting people back to housing quickly without using a subsidy or without using much of the subsidy. Creating a communications template, sell landlords on saying yes to participants. This, again, is about equipping landlords to say yes and, conversely, to not be afraid, ultimately, of getting participants to buy in. We've touched on this in previous webinars in this presentation.

But fundamentally, CoC program, ESG, and other public housing resources have two advantages that they can use to sell landlords. One of them is that even though fair market rents in many jurisdictions will require landlords to accept a lower rent than they might get from private clients, for example, CoC and ESG and our other resources pay on time. And they're always good for it.

And so that consistency can really be balanced against a potentially and higher rent [out??] from a different renter, number one. And number two, your service providers can sell themselves as being always available. One of the primary concerns we hear from landlords is, "Well, oh, gosh, person experiencing homelessness. What if they trash the place. What if they do X," what if something goes wrong that is specific and unique to people experiencing homelessness.

First of all, those of us who work in homeless services know that that's not unique to people experiencing homelessness. People experiencing homelessness are people. Things go wrong with renters. This is a thing that happens with renters. It's not specific to homelessness. There are not specific problems with renters experiencing homelessness or who formerly experienced homelessness. But to allay that fear, you can say, "Okay.

You rent to our folks, you will always have somebody to call if there's a problem." And just having that safety net there could often make it easy to get a landlord to say yes. Protect the legal tendency rights and responsibilities of participants. That's pretty straightforward. Soliciting feedback from past and existing participants of housing barriers. That's really about continuous quality improvement, making sure that you ask folks.

Reviewing and rereviewing your project policies and procedures for unintentional barriers. As we discussed, this is about identifying those barriers that are explicit but are implicit. Providing staff training on person-centered practices such as trauma-informed care. This is about ensuring that your staff are able to deliver the highest quality service as possible to your participants. And finally, again, ensuring staff are correctly and consistently implementing housing first.

This is about ensuring, again, fidelity to the model. If you don't do that, if you don't monitor for it, it won't happen. So the Housing First model was pioneered first in the early 1990s. Since then, it's been incorporated and studied by many different funders serving a range of participant populations and geographies to learn more about in, including best practices for implementation at every level.

We have a couple of resources on the screen from HUD and the United States Interagency Council of Homelessness. There are lots of other resources out there. We encourage you to dig. But these are great starting places. These resources will be available.

They will be clickable and available when this PowerPoint becomes available after this presentation, in addition to which, my co-presenter will -- I hope you're dropping in the chat as we have historically done with other webinars. Housing-focused practices are also about identifying and providing access to every possible route back to housing. And what we're saying this that there are routes other than a whole housing subsidy.

So this is the most familiar path back to housing from an unsheltered location. You're going to recognize this slide from the last webinar in the series. It's the most familiar or the most conventional path back to housing. And it really envisions a participant contacting the homeless services system, moving through coordinated entry, and eventually being referred to subsidized housing through the CoC program or a similar resource.
And so you can see, you get street outreach content -- contact, rather. You do coordinated entry activities. Eventually, they refer to PSH and rapid. And then they're housed with PSH or rapid. So let's talk about more complex route to housing. You'll recognize this slide from the last webinar, too. It shows a more complex route to housing.

But more importantly, it shows a route that features diversion and rapid exit, two of the core techniques in housing problem-solving. The critical difference is that this route, housing does not include a housing subsidy, just case managing, mediation, and critically, time for that case management and mediation to take effect. Housing problem-solving. So what is housing problem-solving.

It is a person-centered housing-focused approach to explore creative, safe, and cost-effective solutions to quickly resolve a housing crisis. Let's talk a little bit more about that. So housing problem-solving is the set of approaches and techniques. They're most commonly called homeless prevention diversion and rapid exit. There are other names. For example, SSVF has an approach called rapid resolution, which overlaps the diversion and rapid exit to buy.

But these are techniques not interventions because each of them really share the same common tools, all of which are rooted in the following. Servicing each participant's strength and support networks, then helping the participant use those strengths and support networks to return to housing without an ongoing subsidy.

The real difference between each of those techniques, which again prevention diversion rapid exit, are when they occur, where the conversation starts, and what happens next if the technique

does not provide a quick route back to safe and stable housing. Housing problem-solving offers two great advantages.

One, it is not rooted in historically marginalizing practices, meaning that it is an especially powerful approach to housing when you are working with people from marginalized populations. And two, it is cost-effective. It is incredibly cost-effective. It requires no additional housing subsidies or affordable housing [inaudible].

And if housing problem-solving is successful with an average of even 5 percent of the clients that you try it on, it is still roughly as cost-effective as providing a year of rapid rehousing. And while housing problem-solving is still an emergence -- an emerging practice, and communities are still producing data on it effectiveness, early-adopter communities are reporting success rates at and above 50 percent using diversion and rapid exit with people experiencing first-time homelessness or at-first system contact.

50 percent of people return to housing without a subsidy using only case management, mediation, landlord negotiation, and other techniques that are fundamentally about talking rather than providing money to resolving a barrier. Core tools, as I said -- really one-time payment mediation case management. And there's a reason one-time payments are kind of the smallest piece of this slide.

There is a sense, I think, and this was incidentally me several years ago, that if you are requesting homeless services, you've already done absolutely every possible thing you can to not be experiencing homelessness. And that sense that that's true simply isn't, that many people do actually have options for returning to housing that they're not taking advantage of. And there are barriers to them, which is why they're not taking advantage of them.

But those barriers do not necessarily, in fact, in many cases -- in the majority of cases, rather, they seem not to require an ongoing housing subsidy but instead, some level of case management and mediation to help person either recognize those barriers, resolve those barriers, or engage with the folks that are presenting those barriers.

And that can be everything from landlord negotiation to mediation with a participant in their family to just helping a person deal with their own sort of personal emotional barriers to accessing a route to barrier that may impact their sense of self or their sense of pride or their sense of self-esteem. And helping a person work through those issues can often help a person resolve their experience of homelessness.

Sometimes, you will bump into a barrier that is a one-time payment barrier, for example. The barrier may simply be rental arrears. That's a homeless prevention or a diversion [hellbet??]. And that's a one-time payment that makes sense that says, "All right. Well, we can resolve your experience of homelessness for a few hundred or a few thousand dollars rather than a full year of rapid rehousing assistance which can run $15,000, much more cost-effective.

So I'll move on from that. Housing problem-solving furthering. It is, as I said, an emerging practice which means resources about best practices in project design are still being developed.

To learn more about housing problem-solving including how to fund common housing problem-solving activities with CoC program and ESG funds, they're a couple of resources on the screen. Again, this will be clickable when this material becomes available widely.

On which note, I'm going to turn it back over to my co-presenter, Mike, for considerations for rural areas.

Michael Thomas: Thank you, Gordon. Okay. So we will talk about considerations for rural areas. I might move a little quickly because I want to try and make sure we reserve a little time for Q&A at the end. So let's get into it. I want to start off here acknowledging that rural communities often face unique challenges when establishing a coordinated community response to homelessness. And that's for a variety of reasons. So there are unique challenges there.

And they also possess unique strengths and resiliencies that make them well-positioned to prevent and end homelessness. So some system-wide considerations for rural areas. One of those is creatively engaged non-targeted systems and programs, faith communities, that's a really big one in a lot of rural areas, and other informal partners to address resource gaps. We've talked a little about most of the things on this slide and other presentations.

We'll be providing links to those a little later. So the second one here, design leadership and governance structures in a way that creates efficiency and thus increases capacity. I want to touch on that a little more in another couple of slides, too. Develop outreach and engagement practices that reach people experiencing homelessness where they are, which is often different in rural areas than urban and suburban areas.

Implement coordinated entry processes that promote access across large geographies. And then think outside the box to expand the availability of crisis bed and permanent housing opportunities. I want to note here that data is critical when building strategies around all of these considerations. So for example, promoting access to coordinated entry requires knowledge of the local population and its specific needs. And that can be drawn from the available data sources.

And when I say "local population" there, the definition of that is going to depend on the Continuum of Care that you're working with and the area that you're in. So local could be the entire Continuum of Care. If you're a smaller CoC of if you're a balance of state, the local context might be a region of the Continuum of Care or a specific county depending on how you set your system up. So just want to note that. But data is incredibly important.

Data is also important when considering the strategic expansion of crisis beds especially if you're doing so with limited resources and you really need to target where those are. So data is really important. I would just say when thinking about these considerations, also think back to the discussion from earlier in this presentation around data and how it can be applied to your geography.

It's important to recognize that when we talk about rural areas, that is often incredibly relevant to balance of state CoCs. They often contain large geographies and may include hundreds of

counties. It may include a mix of rural and suburban communities. There can be numerous cities. I mean, balance of state geography is usually large and more complicated.

So while the total number of people experiencing homelessness in these areas, the rural areas, in a balance of state may be relatively small, the percentage of people experiencing homelessness and particularly unsheltered homelessness is often disproportionately high. It's also hard to accurately quantify homelessness in these rural areas of big CoCs because data collection and statistical challenges play into the mix.

So specifically, when we think about the Point-In-Time Count. The magnitude of homelessness in rural areas is something that we do think we have good ideas about. But we want to acknowledge that the data may not be perfect. And it's always going to be an improvement process. So we just want to note that sometimes, it's unclear. But we do know that it does appear to disproportionately affect people in rural areas.

So one highly effective way to make a large rural Continuum of Care more manageable is to establish regional governance. I'm a really big fan of this idea. To do this, first, you would divide the CoC into subregions, which may be defined by a leadership body or by the CoC membership body. It may be based on equitable distribution of coverage areas. But each region should be a manageable size. And it should be conducive to local collaboration.

Defining regions is highly subjective. And it should be driven by what works best for your CoC. Next, you would establish local structure to implement governance in those regions. These should reflect the community in the region and may take the form of local boards or coalitions or something along those lines. Representation of local structure should be included purposefully in the overall CoC governance.

So just one example of what that could look like is that a representative from each region structure could be included in the overall CoC board via a mandate in the governance charter. Finally, local governance structures should be given defined roles for various staff and participants. This can include things like a local chairperson, a local Point-In-Time Count Coordinator, an coordinated entry coordinator, or a performance coordinator.

These will be the people who would take point locally on CoC priorities that are established by membership and/or the overall governance structure. For example, regional governance structures can drive the implementation of coordinated entry and street outreach, among other things, across your whole Continuum of Care. Regional structures can also have important implications for how data are collected.

More local implementation of data collection efforts like the Point-In-Time Count and the housing inventory count can lead to higher-quality results which will then better inform decisions for the CoC as a whole. So purposeful focus on data quality and HMIS at the local level will also produce more accurate system performance measure and thus drive more informed decision-making.

Note the details of implementing this may look different from CoC to CoC. I mean, I say "may look different." It will look different. The way that things are prioritized and the roles that are assigned locally will vary. So you do what works best for your CoC. Benefits of this regionalized model include more local buy-in due to the local focus. You know, when it's focused on people in that region, you're naturally going to get more buy-in.

Better tailored local responses in each region, a decreased burden on CoC staff. So your overall Continuum of Care staff will have a decreased burden when things are delegated out locally in this way. And it better ensures coverage and coordination across the entire CoC. When you focus these regional efforts on data, local structures can drive higher-quality data.

And as we mentioned, that ultimately increases the accuracy of system performance, monitoring efforts. And it leads to more informed decisions as a whole. When we think about coordinated entry in rural areas, I'm going to point out three main considerations. The first here involve key stakeholders from across the area in planning and design, identify leads for each region or community, and solicit feedback and be inclusive throughout the process.

Next, tailor the process to the community or region, consider finding the coordinated entry method that works best in each region, which may be a combination of approaches. There are different approaches to coordinated entry. I won't detail all of them. But it's things like a multi-site centralized access approach, a no-wrong-door approach. Some CoCs use an assessment hotline.
You want to consider things like that when you're implementing coordinated entry across a large or a rural CoC. And then finally, establish a network of referral sources including entities such as police firefighters, EMTs, park ranger, if you have them, mainstream benefits offices and school liaisons among others that you might identify locally. And then establish partnership with large organizational partners like the United Way if you have one active in your area.

And I'm thinking here about things like 2-on-1 hotline, which some CoCs have used pretty effectively as part of their coordinated entry process. Another challenge for rural areas is increasing the number of crisis beds and housing opportunities. Here are some things to consider, engage developers and consider using the USDA's housing services and programs. They can be found through the HUD's Rural Gateway which is linked at the end of this presentation.

We also understand that a crosswalk of USDA programs relevant to CoCs is coming soon to the HUD Exchange. It has not bee posted at this time or, at least, not the last time I checked yesterday. But when it is completed, it will be posted there. So be sure to keep an eye out for that. That'll be a good resource. Develop relationships with landlords. This is especially important.

More details on strategy for that can be found in the materials for our previous webinar, stakeholder engagement and advancing equity. We'll provide a link for that, too. Educate the community on landlord-tenant issues. This can lead to broader understanding of rental market operations and may open up opportunities with new landlords or other relevant partners. Conduct housing-focused outreach.

As we've said in our previous webinar, specifically on street outreach, which we will link, all outreach should be housing-focused. Consider shared housing opportunities. There are resources out there on the HUD Exchange around this. There are other organizations that have put out resources about shared housing. But that can be a powerful tool in rural areas as well. What you see here on this slide is just the additional information that I mentioned.

So those are links to the two previous presentations we did that I referenced here, the "Stakeholder Engagement and Advancing Equity" and "Street Outreach," would encourage you to take a look at those. I don't think the materials are posted yet. But they will be posted in the coming weeks. And then finally, we'll talk about considerations for tribal nations. A lot of these slides are repeats from previous presentation. But they're still important.

I do like to note at the beginning of these that I am not a member of a tribal nation. I do not have that lived experience. And I do not intend to speak from that type of position of authority on this by any means. [You??] just want to present some information that we have from reputable sources and that we have had that advice subject matter experts.

So first, HUD encourages CoCs to reach out to neighboring tribes and tribally-designated housing entities, to reach out to CoCs so they can identify opportunities for meaningful partnership. In 2021, there were 691 tribal organizations whose land may overlap with 132 different CoCs. So there is a lot of opportunity for partnership there.

Subject to all applicable HUD requirements, CoCs with explicit tribal approval, I want to stress that part, with explicit tribal approval, are expected to serve tribal lands as part of the Coca geography including creating ways for tribal entities to achieve equitable access to CoC program funds.

According to the First Nations Development Institute, outdated definitions and poor data quality in the U.S. Census have led to misunderstanding about the size and significance of the rural Native American population. Due to challenges with data collection, data-drive decision-making often leads to rural Native communities being left behind regarding provision of public assistance and private philanthropic funding.

Citing a 2012 report from the Housing Assistance Council, 54 percent of the national American Indian and Alaskan Native population lives in rural and small town areas with large fluctuations in this percentage at the state level. So it varies a lot from state to state. Members of tribal nations and indigenous populations experiencing homelessness in rural areas will likely experience similar issues as other populations.

And these issues will likely be more acute and severe for them. It is critical for response systems in rural areas to intentionally and meaningfully include tribal nations and indigenous populations. So what we see here, these are ways that CoCs can work with tribal nations. Engage with tribal entities while recognizing tribal sovereignty. I'm going to stress that part again, while recognizing tribal sovereignty. That's incredibly important.

Rely on and grow existing relationships between tribal entities and existing CoC stakeholders. So if those relationships are already there, recognize them and grow them. Create a NOFO process that facilitates equitable access by tribal entities, offer tribal-focused training on essential CoC functions. So we're thinking about things like HMIS, coordinated entry, those things that the CoC has to do that tribal nations can be included in.

Create opportunities for meaningful representation of tribal entities such as in governance and recognize tribal entities as experts on their own experiences, accept and adjust to the feedback that they provide. And with that, I am going to take us into the Q&A time.

Gordon Levine: All right. Mike, you got anything in the Q&A you want to hit on? I think I tried to provide written answers to lots of things. Is there anything you saw that you wanted to lift on up and handle verbally?

Michael Thomas: I am just having a second to scroll back through. I do want to note. We had an early-on question. We are unable to answer questions related to open NOFOs. And that is not because of relevance to the subject matter here. It's because we are formally prohibited from doing that. So any questions about NOFOs must go directly to HUD.

Gordon Levine: Absolutely true. And I think you dropped the relevant email link in the Q&A. So folks can look at that. There was a question that I wanted to uplift for you while you're looking, Mike. Someone asked whether Stella P and Stella M are available only for the CoCs or whether you can access them as other entities. And I'll note that I actually got two separate texts from other people during this webinar asking that same question. So it's a hot-button. What say you?

Michael Thomas: It's a good question. And access to that is largely determined by the CoC because they are designed to be tools for the Continuum of Care. So they are available to the CoC staff typically. And then the CoC decides if access is given to other entities, what that looks like. It is not uncommon for access to HDX 2.0 to be fairly restricted because of the fact that it's where official reports to HUD are submitted by the CoC. I think there might be an option for read-only access. But I don't really want to speak to who should or shouldn't have it because that's a CoC-level decision. So the short answer is yes. Those are CoC-level planning tools. That's where the primary access is. And then anything beyond that is determined by the Continuum of Care.

Gordon Levine: Sounds great. Any questions you wanted to send my way?

Michael Thomas: There was actually one about housing problem-solving I am trying to find. "Are you aware of any examples of successful housing problem-solving models with transition-age youth?"

Gordon Levine: So it's a great question. I am not a transition-aged youth specialist. I work with several folks who are incredible with that population. I simply don't have that experience. My understanding is that housing problem-solving is comparably effective for transition-age youth to the general population. I don't have more specific data than that. What I would suggest if you're

interested in data that is specific to a subpopulation about housing problem-solving, that you connect with the folks in your state who are working with that population who might have deployed housing problem-solving strategies or with national organizations that provide technical assistance on that subject.

And for transition-age youth, you're actually really asking a great question because of your YHDP communities are likely -- so Youth Homeless Demonstration Program communities are likely to have some experience using housing problem-solving serving youth and can provide you with information about that. And if your state doesn't have a YHDP community, it's very likely that one of your neighboring state does. I would just reach out to them.

It's been my experience that they're very open and friendly about their information and like to share. At the same time, there are other national organizations that have information about transition-age youth and techniques for serving them such as True Colors United. And I would encourage you to reach out to them as well.

Michael Thomas: All right. Thank you, Gordon.

Gordon Levine: I want to fire this one over to you if you don't mind. "So with our clients offering mental health as an option but not mandatory" -- I assume what they mean is behavioral healthcare. "are some," I would assume behavioral health programs, "mandatory from HUD?" So I think what they're asking is can you require participants to receive behavioral healthcare under a HUD-funded program?

Michael Thomas: So I feel like there are so many variables as to how a project could be set up, that it's hard to give a blanket answer. The fact is you might have different funding sources with different requirements and if one program has a requirement for a service and it is paired with a HUD program and HUD does not prohibit that requirement, then maybe that's how it should be set up.

So what I'm saying is I don't think there is a blanket prohibition from HUD. I think you do have to abide by all of your funding sources. I think we want to create as few barriers as possible. That's kind of the goal. So that's my answer. You want to minimize barriers, minimize requirements. But you also have to meet the obligations that your funders put upon you.

Gordon Levine: I think that's perfect. That's exactly what I would have said. I want to take one. We had several different versions of -- "Can you elaborate on how CoCs use ESG and CoC funds for housing problem-solving." I cannot, is the answer. We do not have time for me to elaborate on that. I really encourage you all to review the resources that we dropped in this and the slideshow. These materials will be available later.

But what I will say, and you're going to have to forgive me for a little bit of a pitch, our final webinar in this series is coming up next week at this time. It's structured a little differently than the past four have been. We're leaving a lot more time for Q&A. And that's going to be a great place for you to ask questions like that, as we will have time to get into it a little bit more. So save your housing problem-solving questions.

We'd love to answer them. Mike, anything else you wanted to pick up in our last minute or so?

Michael Thomas: I don't think there's anything we can answer in a few seconds. I would certainly encourage people to attend the next one like you did, though. We should have much more time for Q&A in that one. Think I'm going to go ahead and move us over into the Resources slide so we can just show you what will be available when we post these materials.

So everything that we talked about, everything we referenced, these are the places where we drew that information from. You know, just a few to point out, the SNAPS data strategy, Target Universalism there. I had directed people to that. Paying People with Lived Experience. That's a wonderful piece of guidance from HUD. All of this is good stuff. So we've got this slide. And then we will also have a second slide of resources here.

Also would point you, if you're in a roll -- excuse me. If you are in a rural areas to the Rural Gateway and Rural Homelessness resources. And with that, I think we can wrap it up.

Gordon Levine: Think so. Thanks you all. Hopefully, we will see all of you back next week.

Michael Thomas: Thank you for attending, everyone.

(END)