STAFF REPORT

Date: April 1, 2019

To: Community Homelessness Advisory Board

Thru: Sabra Newby, City Manager

Subject: Staff Report (For Possible Action): Presentation, discussion, and possible action on OrgCode Consulting, Inc.'s report on the operational review of the housing and homelessness system in Washoe County.

From: Elaine Wiseman, Manager of Housing and Neighborhood Development

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Background

December 17-21, 2018- Orgcode team visited Reno/Sparks, conducted program monitoring visits with providers, as well as in person interviews with stakeholders (elected officials, key staff members, key service providers). Additionally, Orgcode met with two focus groups, including consumers, and Fourth St. business owners.

October 1, 2018 - Erin Wixsten, Project Lead – Orgcode, presented a detailed outline and timeline of the different phases of the study. Ms. Wixsten also stated she had already began collecting data and documents for analysis and review and had conducted a few face-to-face interviews during her time in the area. The Board provided direction on the stakeholders they wanted Ms. Wixsten to interview as part of the process.

August 8, 2018 - The Reno City Council approved an agreement with Orgcode Consulting, Inc. to analyze the region's housing and homelessness system and efforts. At the August 27, 2018 Community Homelessness Advisory Board Meeting (CHAB), staff presented Orgcode's Service Offer and Scope of Work to the Board for review and direction.

Discussion

Over the last eight months, Orgcode has been analyzing our community's homeless system. In order to gain insight into homeless issues and the services currently being provided, they have done extensive outreach and met with key stakeholders, business owners, and service providers.

Throughout the operational review, funded programs and services have been investigated to identify their demonstration of fidelity to practice a housing focused service orientation as well as its success and progress in getting the results needed to ensure that the Housing and Homelessness System is on track to reach a functional zero for chronic homelessness.

Orgcode Consulting will be in attendance to present the attached results of their Operational Review of the Housing and Homelessness System in our community.

Attachment:
Washoe County, City of Reno and City of Sparks Homeless Services Operational Review

Washoe County, City of Reno and City of Sparks Homeless Services Operational Review

Report prepared by OrgCode Consulting, Inc.

Introduction

In July 2018, OrgCode Consulting, Inc. was contracted by the City of Reno to complete a two phased project designed to assess and enhance the local housing and homelessness system of care. Phase 1 of the project was to complete a review of the performance, operations and fidelity to practice of the available homeless response and re-housing services, with emphasis on the Coordinated Entry System and available Permanent Supportive Housing resources. Using the system enhancement recommendations identified during the operational review, Phase 2 of this project includes the provision of the training and technical assistance to the agencies, partners and programs tasked with preventing and ending homelessness throughout Washoe County, the City of Reno and the City of Sparks. Phase 1 of this project occurred from July to December 2018 and the results and insights of this operational review are provided in this summary report. Although some community partners may view this report as the end product in this project, OrgCode identifies this report as the beginning of the more important work required in the months ahead to realign the coordination, investments and activities required to prevent and end chronic homelessness in the region.

As a starting point for the system enhancement phase of the project, the operational review included site visits, samples of policies and procedures, samples of case files, key informant interviews, engagement with community partners[1] and people with lived experience, a review of any available contracts and partnership agreements, a survey of service providers, and analysis of framework documents.

The review used three lenses of examination:

i) Service Orientation/Philosophy

- Alignment with Housing First core requirements
- Commitment to prioritizing those that are most vulnerable and require supports to prevent and end their homelessness;
- Demonstration of progressive engagement in the intensity, duration and frequency of supports provided, respecting people's

[1] Attachment A.1 and A.2

self determination to resolve their own homelessness whenever possible;
- Positive housing destinations as the goal of all programs with participants having independent and standard tenancy agreements.

ii) Service Delivery Excellence

- Consistent implementation of Policies and Procedures to govern local practices and operations;
- Demonstration of professional practices that are guided by evidence, including the use of reliable and valid tools and strategies;
- Demonstration of staff having the knowledge, skills and resources to complete their jobs in ending homelessness with a fidelity to practice;
- Clear safety procedures and protocols for in-community and in-home delivery of services;
- Coordination with the broader homelessness and housing system as well as mainstream ancillary services;
- Clearly defined relationships with such ancillary services as income benefits, employment, corrections, health and education;
- Clearly defined policies and standards when participants should continue or be discharged/exited from programming/service.

iii) Performance Benchmarks including Outputs, Outcomes and Impacts

- The number of households diverted from the homeless serving system;
- Reduction in the length of time that program participants remain homeless;
- Percentage of permanent housing success rate for exits/graduates;
- Reduction in the number of served households/individuals that return to homelessness;
- If relevant, the number of landlords and housing options recruited as well as the amount of time between program matching and housing move-in;
- Flexibility in rental and move-in assistance, reflecting progressive engagement to match the needs of the participants (providing only the assistance necessary to stabilize in housing);
- Housing-focused case management standards and practices are evident including ensuring that participants' basic needs are met at move-in and evidence that transitioning off financial

assistance, when possible, is coordinated with case management activities.

Current state of the efficacy of the Homelessness Response System in Reno/Sparks/Washoe County[2]

While the Annual Homeless Assessment Report (AHAR) submitted to HUD as part of Congress' understanding of the extent and nature of homelessness across the country represents limited information -- demographic data instead of outcomes, sheltered populations instead of unsheltered populations, most recent stay rather than longitudinal analysis -- until the more recent Longitudinal Systems Analysis process, AHAR represented one of the few federally required snapshots of one year's unduplicated count of people experiencing sheltered homelessness and whether it decreased across individuals, families, veterans and youth.

The Washoe/Reno/Sparks Continuum of Care's 2017 AHAR submission counted 3,864 total people in either emergency shelters or transitional housing (of the 4,429 people across all reporting categories, including those no longer experiencing homelessness in permanent supportive housing). This included:

- 406 people in families in emergency shelters
- 0 people in families in transitional housing
- 2,519 unaccompanied individuals in emergency shelter
- 939 unaccompanied individuals in transitional housing

The average utilization rate for each bed type estimated:

- 71% for families in emergency shelters
- 0% for people in families in transitional housing (not utilized)
- 83% for unaccompanied individuals in emergency shelter
- 80% unaccompanied individuals in transitional housing

Demonstrating these beds' potential as a pathway to permanent housing, these beds estimated the following turnover rates:

- More than 3 times per year for families in emergency shelters
- Zero times per year for people in families in transitional housing (not utilized)
- More than 6 times per year for unaccompanied individuals in emergency shelter

[2] HMIS data provided by BitFocus

- More than 2 times per year for unaccompanied individuals in transitional housing

With housing as the first foundation to end people's experiences of homelessness, 448 unaccompanied individuals and 117 people in families were housed in permanent supportive housing.

Importantly, valuable permanent supportive housing resources remain underutilized (94% for people in families and 93% for unaccompanied individuals).

This included 270 veterans in emergency shelters and 173 veterans in transitional housing in addition to 282 veterans residing in permanent supportive housing during the year. This represented a dramatic shift from the 0 veterans in emergency shelters, 240 veterans in transitional housing and 1 veteran in permanent supportive housing reported to HUD for the 2016 AHAR submission, with similar counts during the 2015 AHAR submission (0 veterans in emergency shelters, 79 veterans in transitional housing and 1 veteran in permanent supportive housing). In most communities with which OrgCode has worked, shifts from zero veterans in shelter to hundreds, and one veteran housed to 282, across one year's reporting period usually represent changes in reporting methodologies which required later justification to HUD, VA and other federal partners. For this reason, OrgCode focused primarily on the most recent 2017 AHAR submission in evaluating progress across time.

Since annual Point-in-Time counts represent single day snapshots during the last ten days of January, and AHAR represents twelve month data but with the specific limitations mentioned above (demographics not outcomes, sheltered not unsheltered populations, most recent stay not all stays), OrgCode also examined aggregate data from the last three years of federal System Performance Measures (SPM) submissions. These report Washoe County and the City of Sparks and City of Reno's role in national progress across the following seven metrics:

Measure 1: Length of Time Persons Remain Homeless

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

Measure 3: Number of Homeless Persons

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Measure 5: Number of Persons who Become Homeless for the First Time

Measure 6: Homeless Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

While the previous years' submissions were later revised, the most recent FY 2017 submission demonstrated the following progress and opportunities:

Measure 1: Length of Time Persons Remain Homeless

The 3,102 people experiencing homelessness in emergency shelter, safe havens and transitional housing represented a 5% increase from the 2,958 people in FY 2016, averaging 91 days with a median of 48 days of homelessness, and a 15% average and 17% median increase from the previous fiscal year's 79 day average and 41 days median.

People experience almost nine years of homelessness prior to housing move-in (3,196 days), which represents an increase from the revised FY 2016 counts, which reflected a 12% increase from the initial FY 2016 submission.

Measure 2: The Extent to which Persons who Exit Homelessness to

Permanent Housing Destinations Return to Homelessness

Of people who exited street outreach, emergency shelter, transitional housing, safe haven or permanent supportive housing, 16% returned to homelessness within 6 months, 7% from 6-12 months, 6% from 13-24 months, as part of 30% total returns to homelessness within two years from their initial exit.

Measure 3: Number of Homeless Persons

Homelessness is also rising as measured during recent Point-in-Time (PIT) counts: 12% more people resided in sheltered or unsheltered locations during the January 2017 PIT count than in 2016, with a corresponding 5% rise in annual counts of sheltered people in HMIS.

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Only 2% of adult system stayers increased earned income during the reporting period, which still represented an increase from the 0% of those in 2016. During FY 2017, 21% of adult system stayers increased their non-employment cash income (an increase from the 4% of those who did so in FY 2016).

Of adult system leavers during the same reporting period, 4% increased their earned income, even less than the 5% who did so in FY 2016. Those who left the system further struggled to increase access to benefits: the 18% who increased non-employment case income represented a reduction from the 23% who did so during FY 2016.

Measure 5: Number of Persons who Become Homeless for the First Time

People are increasingly likely to experience homelessness for the first time: 34% of people entering emergency shelter, safe haven and transitional housing projects were in similar locations during the reporting year, an increase from the 30% in FY 2016.

Measure 6: Homeless Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects

This measure is not applicable to CoC in FY2017 reporting period.

Measure 7: Successful Placement from Street Outreach and Successful

Placement in or Retention of Permanent Housing

During FY 2017, 6% of the 631 people who exited street outreach did so to permanent housing destinations (36 people), whereas 18% did so during FY 2016 (167 people). Of the 2,508 people who exited emergency shelter, safe haven, transitional housing, rapid re-housing (including other permanent housing projects who exited without moving into housing), 32% of them exited to permanent housing, reflecting a 9% decrease from the 41% of people who did so during FY 2016. People were less likely to retain their permanent housing recently as well: 87% of people in permanent housing other than rapid re-housing either remained or exited to other permanent housing destination during FY 2017, a 4% decrease from the 91% who did so in FY 2016.

OrgCode further requested person-level, de-identified information across the last three years across all people experiencing literal homelessness. These results did not reconcile with the information submitted to federal partners during AHAR, Point-in-Time or System Performance Measures submissions from corresponding time periods:

Of the 20,047 unique stays in emergency shelter, transitional housing or street outreach projects, 16,001 of households had exits to non-permanent destinations, with 3,578 self-reported "permanent" exits. This included 42 recorded exits to home ownership, 34 of which (81%) were reported as unsubsidized. This also included 159 self-reported permanent exits after only one-night stays, as part of the 3,459 households with one-night length of stays during the reporting period. In addition to the 9,385 unique individuals who exited to locations reported as "client doesn't know," "client refused," "data not collected" and "no exit interview completed," 245 people had their exit destinations left entirely blank, with another 610 people whose destination was recorded as "other." Perhaps most incongruent from the results reported to federal partners, zero people recorded as exiting to permanent destinations were later recorded as experiencing homelessness, as measured through a later start date at one of these providers.

Purpose of an Operational Review

Communities across the United States are working to implement effective and efficient programs and services to address housing and support needs for their residents who are at risk of or experiencing homelessness. Such efforts have intensified in recent years as the guidelines and expectations from Federal and local government have evolved and focused on preventing and ending homelessness – not simply managing it. The Federal Strategic Plan to Prevent and End Homelessness[3] calls on communities to transform their homelessness services into crisis response systems that prevent homelessness whenever possible and rapidly return people experiencing homelessness to stable housing.

Beyond increasing pressures from federal and state funders to prevent and end homelessness as a comprehensive system of care, much has been learned about communities that are achieving the results required to end chronic homelessness. In order to create a high functioning system of care, it must be realized that there are four sectors of service that must align with the community vision of preventing and ending homelessness: Coordinated Entry, including homelessness prevention and diversion; Connections to Permanent Solutions including shelters, day services and outreach; Housing Services, including permanent supportive housing; and Ancillary Services such as health and income benefits. With the acknowledgement that the only solution to homelessness is housing, OrgCode was honored to work with the City of Reno, City of Sparks, and Washoe County as they continue to identify gaps and opportunities for system and program enhancements to secure safe, affordable housing through a responsive system built upon evidence and best practices that ensures homelessness is rare, brief and non-recurring.

Investments and Services are most effectively utilized when:

- The local system of care demonstrates strong leadership and collective ownership over a coherent narrative as to *why* the community does what it does to prevent and end homelessness;

- Targeted outreach progressively engages people staying in places not meant for habitation through housing-focused conversations connected to system-wide housing resources, leading to people being housed directly from the street;

- Only those individuals and families with no other safe and appropriate alternatives in the community are admitted to shelters;

- Those being sheltered resemble the same characteristics of the households being prioritized for housing and support programs in the community;

- People with the greatest depth of need are prioritized for housing with supports programs;

[3] https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf

- Staff possess the training, skills and intentional housing focus to use shelter and day services as a process for obtaining housing, rather than a fixed destination.

To do this, the community must ensure that those being engaged by street outreach, shelter and day services should be the same population being prioritized for housing programs through a Coordinated Entry System. Currently, these ‘front door’ services and engagements are limited, if at all available. In most instances, this means trying to prioritize those with the deepest needs first through dynamic prioritization. This process and communication about how households are being identified, served, and housed occurs within a Homeless Management Information System[4] (HMIS). HMIS data is transparent, up to date, and accessible by all providers to ensure households are moving quickly into and out of the homelessness response system, and to reduce duplication of services.

Furthermore, when programs are viewed as having a direct role in the process of helping households access housing again, they become the programs of first choice for those that want assistance in moving out of homelessness, rather than seeing shelter and service providers as places of last resort or dumping grounds for other systems like health care or corrections across the community. Moreover, staff must be explicit that it is their intention to work *with* people to help them achieve housing again. The housing worker is not the sole answer to someone’s housing instability, and a shelter with a strong housing focus is never used as a free hostel by those that use it.

Without alignment of what the frontline staff aims to achieve and what the person they engage sees as the purpose of their interaction, progressive engagement is compromised. Washoe County, City of Reno and City of Sparks frontline service staff seem primarily focused on meeting the basic needs of safety, beds and meals of people seeking shelter, rather than working to end their homelessness. Opportunities for growth toward an increased housing focus can be implemented through the following recommendations.

A. Local Leadership and Continuum of Care Function

Deming famously is attributed with the following: *every system is perfectly designed to get the results it gets*. Within social movements it is commonly said that the system is not broken; it was built this way. Both sentiments are important for examining the system context within which the work is occurring in the City of Reno, City of Sparks and Washoe County. Examination of how the Continuum of Care is currently operating and the dynamics of local leadership provides an essential opportunity to enhance local efforts to prevent and end homelessness.

[4] https://www.hudexchange.info/programs/hmis/hmis-requirements/

While the City of Reno is in the CoC Lead Agency position, the functions and associated activities are currently outsourced to Social Entrepreneur's, Inc. Although other American communities rely on private companies to manage activities of the local Continuum of Care, within the Reno/Sparks/Washoe area, the lack of a shared ownership over the quest to prevent and end homelessness was evident. It is indeed possible that the extent of the outsourcing of responsibilities evident locally contributes to the lack of a consistent narrative throughout the region as to why community partners do what they do to address homelessness.

There were varied thoughts from community stakeholders on whether the City of Reno is the right entity for the Lead Agency role, and some feedback from local stakeholders reflected that Washoe County may be a better fit as they have a chartered responsibility to respond to issues like these through Social Services as well as have access to a tax base which produce necessary resources. Washoe County, whether in the role of CoC Lead Agency or not, has an obligation to have key leadership and participation involved in what it takes to end homelessness, both financially and aligning with best and promising practices, participation in HMIS, and standardization of care. Moving away from a siloed response to homelessness and identifying opportunities to work better, together, as a Continuum of Care will be essential starting now. Recognizing that the City of Reno regulates the majority of agencies and activities dedicated to homelessness and re-housing efforts for the region, OrgCode recommends that regardless of which entity is officially identified as the lead agency, a joint City-County leadership group be facilitated for strategic planning and investment decision making.

OrgCode feels strongly that it's less about *who* is in the Lead Agency role and more about *why* and *what* is being done, or adversely *not* done. There lie incredible opportunities for community coordination, collaboration and leadership within the CoC, the Cities and the County. Such opportunities allow communities to leverage the existing resources, investments, motivation and commitment to end homelessness through the Reno Area Alliance for the Homelessness (RAAH) and Reno Community Homelessness Advisory Board (CHAB). It is from this systems perspective unified with a shared vision that Reno/Sparks/Washoe can start to do what it takes to end homelessness, and not just manage it. Additionally, whichever entity is decided upon, there cannot be a conflict of interests with other sectors, especially tourism and business development. While these are important, the role of the CoC is to fundamentally respond to the needs of persons experiencing homelessness and to support a system and programmatic response that is evidence informed. It is our strong recommendation that the function of CoC Lead Agency comes in-house and is no longer contracted to a third party.

Beyond official Continuum of Care (CoC) leadership, the CoC membership must be inclusive of all relevant community partners – organizational and people with lived experience throughout the entire geographical area. A Continuum of Care (CoC) is the group organized to carry out the responsibilities under the CoC Program and that is composed of representatives of organizations including non-profit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and people who have formerly experienced homelessness including individuals, families and veterans. Continuums are expected to include representation to the extent that the type of organization exists within the geographic area that the Continuum represents and is available to participate[5].

An effective Continuum of Care ensures a well-coordinated planning process and allows the CoC to measure its effectiveness in reducing homelessness at both a system and project level rather than just at the level of individual projects funded by the CoC. Within communities getting the results needed to prevent and end homelessness, the CoC strengthens coordination between CoC-funded activities and other HUD funded activities directed at ending homelessness, such as activities funded through the Emergency Solutions Grant (ESG) program[6].

The need for a comprehensive and collaborative Leadership and CoC structure locally is further amplified in the McKenny-Vento Homeless Assistance Act. A critical aspect of the Act, as amended, is a focus on viewing the local homeless response as a coordinated system of homeless assistance options as opposed to homeless assistance programs and funding sources that operate independently in a community. To facilitate this perspective, the Act now requires communities to measure their performance as a coordinated system, in addition to analyzing performance by specific projects or project types.

The Act has established a set of selection criteria for HUD to use in awarding CoC funding in section 427 that require CoCs to report to HUD their system-level performance. The intent of these selection criteria is to encourage CoCs, in coordination with ESG Program recipients and all other homeless assistance stakeholders in the community, to regularly measure their progress in meeting the needs of people experiencing homelessness in their community and to report this progress to HUD.[7] The recommendation for reduced siloed approaches to strategic planning and investment decision making within the local leadership structure for Reno/Sparks/Washoe cannot be underestimated.

[5] https://www.govinfo.gov/content/pkg/CFR-2017-title24-vol3/xml/CFR-2017-title24-vol3-part578.xml#seqnum578.5
[6] https://www.hudexchange.info/resources/documents/EstablishingandOperatingaCoC_CoCProgram.pdf
[7] https://www.hudexchange.info/programs/coc/system-performance-measures/#guidance

To identify and align goals and create a unified vision, OrgCode recommends a Visioning Session to leverage local knowledge and expertise and create a forum that brings together a broad range of perspectives and promotes systems thinking about how to better respond to homelessness across the Reno/Sparks/Washoe Continuum of Care. OrgCode will facilitate this day-long session using a method called 'Breakthrough Thinking' which is an accelerated, public decision-making process designed to help organizations or working groups come to agreement on strategic priorities in a transparent, accountable manner. Through this visioning session, your community will develop a set of shared values and priorities that will lay the groundwork for how members of this group can continue to improve how they function as a system, and provide clarity to tasks and initiatives of which this entity is a part and can continue to support, and align with other work occurring within the community to avoid duplication and illuminate where each group can have the most impact.

OrgCode is also able to facilitate a training in How to be a Highly Effective CoC which would assist with the transition of moving the CoC Lead Agency functions in house. A CoC is not one person, although typically a CoC has staff assigned to the tasks and functions of the CoC responsibilities. The community must decide who has the staff and bandwidth to act as Lead Agency, although carrying out the necessary and required functions is a community-wide effort that is transparent and participatory.

Efficacy of Meetings in Achieving the Continuum of Care's Purpose

In communities of similar size as Washoe County, the City of Reno and the City of Sparks, organizations often find that a monthly meeting helps to inform each other of upcoming events, plan for and respond to changing resources, and build relationships among staff.

The meetings that OrgCode attended included helpful information sharing, but especially for staff who may have had to commute across the county or temporarily suspend their direct service work (as the only staff of a smaller organization), the updates shared during these face-to-face interactions may have been more efficiently communicated through an email or monthly newsletter.

During on-site conversations, staff described how the small nature of their organizations and staffing had strengthened relationships among providers and community-wide expertise on the processes to end homelessness -- often through word of mouth. While HMIS was still not fully utilized, significant community involvement and collaboration exists across Washoe County, the City of Reno and the City of Sparks. If the purpose of agency information sharing meetings is largely to communicate upcoming events and resources opportunities, staff may find that in-person time together achieves that purpose. If an email, newsletter or webinar would more efficiently distribute such information, additional time could be spent directly engaging (and housing) people experiencing homelessness.

B. Sector of Service: Coordinated Entry System, including Homelessness Prevention & Shelter Diversion

i. Coordinated Entry, Coordinated Passage Through and Coordinated Exit

Coordinated entry into system-wide resources dedicated to people experiencing literal homelessness and at imminent risk of losing their housing represents a critical first step in service delivery. A by-name list, readily accessible, HMIS-generated and reflective of real-time data ensures that a reliable count of people receiving services can be generated not only during the annual Point-in-Time count, but to measure progress and barriers on a daily, weekly and monthly basis.

As people enter shelter, engage service providers and/or connect with people who assist with the provision of their basic needs, sometimes people may have *entered* the system dedicated to serving them, even in a coordinated and intentional method, but then struggle to *pass through* the system as part of a *coordinated exit* process. The Cities of Reno and Sparks have joined Washoe County in establishing the first of these three components but have opportunities to ensure that people do not become "stuck" in a system that they have entered without a way to exit to housing or obtain what they need in order to become document-ready, identify units, and end their homelessness.

Coordinated passage through reflects the art and science of journeying with the individual or family to take care of all of the tasks that make housing possible, including landlords' required paperwork, government issued identification documents like birth certificates and social security cards, as well as income supports and benefits that make housing affordable. All of these require careful and skilled navigation from staff with expertise on how to move someone with few, if any, documents to their name and successfully complete the process to coordinate the passage through bureaucratic hurdles to obtain the paperwork required by housing providers. This involves an eye to administrative accountability and necessity that acknowledges that rarely are these linear, short in duration to attain, or easy. But if an individual or family is entering the system but is not navigated through it, they become increasingly unlikely to see their homelessness be brief. The by-name list becomes increasingly filled with the names of people that the community wishes were entering permanent housing but cannot because their administrative tasks are incomplete.

OrgCode recommends convening existing frontline service staff to identify the processes by which someone, across varying stages of document readiness, could (A) document their disabling condition and chronic homelessness (B) obtain government issued photo identification (C) secure both in-state and out-of-state birth certificates (D) receive a social security card and successful application for any eligible benefits (E) verification of income to determine thresholds of assistance (F) veterans affairs eligibility through DD-214 (G) criminal background checks and any additional frequently required documents required by landlords. This includes recognition of the financial assistance provided across the community to obtain any of these documents, with City and County-specific differences identified throughout. Collecting this information for a front end user manual, in some communities referred to as "The Frontline Service Professional's Guide to Getting Things Done" can become the most helpful dozen pages used by shelter and service staff on a daily basis, available on day one for new staff to read, learn and implement.

Coordinated exit is the goal at the end of the coordinated passage. It is the acquisition of a place to live. Once people have secured their required documents, there must be results in moving from homelessness to housing. The measure of success of coordinated entry is not how many people are on a list or assessed, it is how many people actually move into housing. Without outflow, the entire system jams, with people getting stuck having entered a system in however coordinated a fashion as passible, only to have no clear path to end their homelessness. This includes a community-wide recognition that frontline staff likely have not received real estate, and housing identification, training in social work school. The process for engaging landlords, completing applications, guiding a unit through the inspection process, and how to problem-solve as challenges arise within every step of that process may require additional specialization and training than the current skillset of frontline staff. This training becomes even more important in communities like Sparks, Reno and Washoe's expensive rental markets with low vacancy rates. Having the right staff with the right skills to find units to ensure coordinated exit builds upon the successes of coordinated entry and coordinated passage through the system currently focused more on quantifying people's demographics and meeting their needs than ending their current episode of homelessness.

ii. Re-examining the 'Descending Acuity' Approach to Coordinated Entry

Washoe County, the City of Sparks and City of Reno currently implement one of three best practice models for Coordinated Entry, also known as "descending acuity." This is the most frequently utilized model across North America, where the community possesses a list containing every person and family experiencing homelessness that has received the common assessment tool, as recorded within HMIS. In combination with other databases to include information from people served but by a not-yet-HMIS-participating provider, these people and families are ordered from the highest score to the lowest score. Different prioritization criteria, or rules to address tie-breaking scenarios have been established (priority #1 is chronic homelessness, then of two people both experiencing chronic homelessness, priority #2 is highest VI-SPDAT[8] score, then of two people with the same high VI-SPDAT score, priority #3 is unsheltered sleeping location, etc.) At least once per month, providers gather to discuss people on the list and to connect people to any new housing vacancies that have arisen since the last meeting.

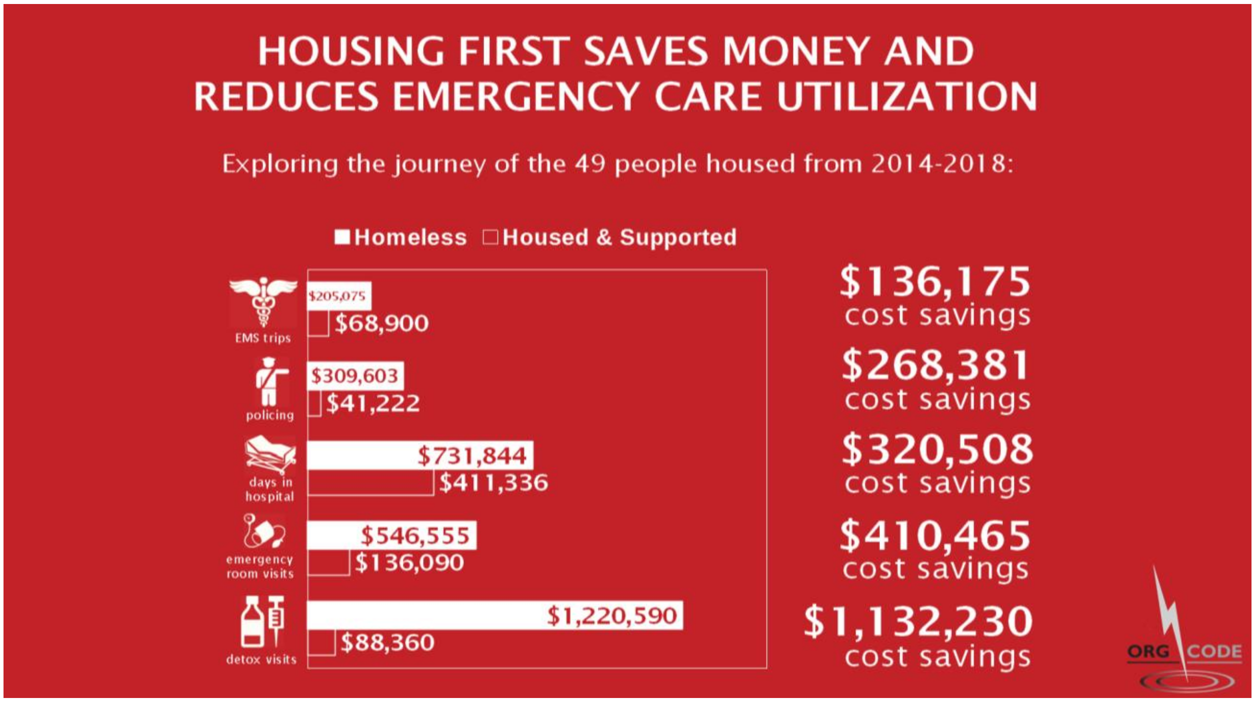
To reduce the potential for introducing subjectivity into the matching and housing referral process, many communities have ensured that the by-name list generates the community priorities automatically sorted, or manually rank their HMIS-generated by-name list when meeting publicly, to increase transparency on who is prioritized under which conditions. OrgCode further recommends convening at least annually to revisit whether the ranking of the current community priorities may benefit from refinement, as well as the categories included:

1. VI-SPDAT score
2. Number of days on the Community Housing List
3. Unsheltered current location (question 13 on the VI-SPDAT)
4. Youth ages 18-24
5. Length of time the client has been homeless (question 1 on the VI-SPDAT)
6. Health (questions 22-34 on the VI-SPDAT)
7. Wellness (questions 21-50 on the VI-SPDAT)

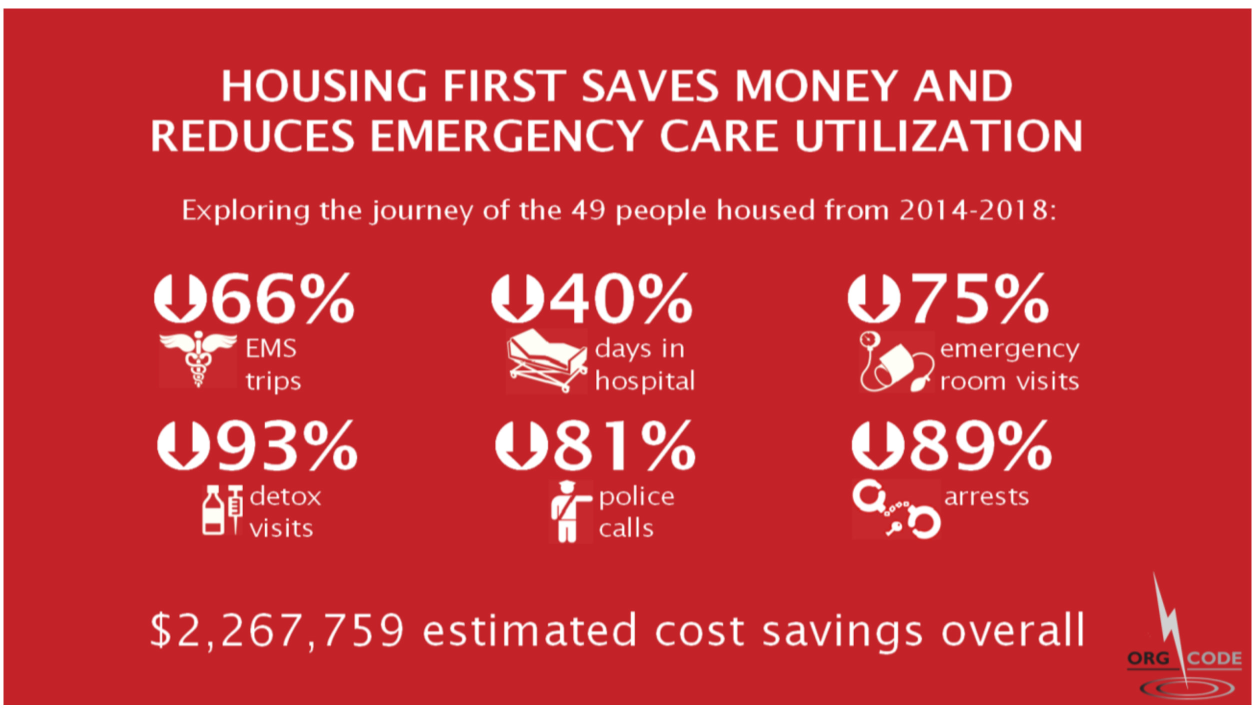
OrgCode also recommends adopting the VI-SPDAT version updated in 2015, which is quicker to administer, simpler to understand and builds upon the considerable testing and research that informs each update.

Information from the “frequent service user” approach to Coordinated Entry may also be further integrated within current procedures. The scope of emergency service utilization analysis may be limited by the accessibility of system data (across hospitals and other health providers, justice and corrections engagement, and homeless services across the community, among others). Communities who struggle to obtain or connect with these service sectors sometimes rely on the self-reported emergency services provided through the VI-SPDAT process, rather than externally verified sources. Regardless of the methodology, that information can be quantified pre and post-housing in order to quantify cost savings like the following:

[8] The VI-SPDAT is the result of a combination of two tools – the Vulnerability Index (VI) survey created by Community Solutions for use in street outreach, which helps to determine the chronicity and medical vulnerability of homeless persons, and the Service Prioritization Decision Assistance Tool (SPDAT) created by OrgCode as an intake and case management tool. The VI-SPDAT is a triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.



Even without precise cost savings, the overall emergency service utilization can also be quantified as it reduces post-housing, visually demonstrated as below:



Another potential improvement to Washoe County, the City of Sparks and City of Reno Coordinated Entry processes would continue to build upon the current "descending acuity" model, incorporating additional cost savings through the "frequent service user" model, while simultaneously exploring more dynamic prioritization through the "universal system management" model.

This approach addresses multiple priorities at once, making the housing process more efficient, and taking as much subjectivity out of the process as possible while leveraging HMIS. Washoe County, the City of Sparks and City of Reno would need to address community priorities for each type of housing interventions, asking "who do we want to offer permanent supportive housing/rapid re-housing/prevention/others to first?" Using the Grant Inventory submitted to HUD each year, each community would inventory each of the eligibility requirements for housing program.

Nevada providers may determine, for example, that their top priority for offering a PSH unit is a person who meets the definition of chronic homelessness, who is tri-morbid[9], who has been homeless for three or more years, and who has a VI-SPDAT score of 13 or higher. The HMIS-generated by-name list can be filtered to display just those people that meet that group for the top priority. Assuming all of the documentation is in order for each of those people, the list can be provided to PSH providers (or run by the PSH providers themselves) that have a vacancy, and they can pick anyone from meeting the community's first priority group. In this approach, the emergency side of the system (shelter, outreach, drop-ins) are responsible for getting people document ready and HMIS automatically adds them to the by-name list, and housing providers are responsible for taking people off the list to fill their vacancies. Safety measures to ensure that providers are not repeatedly overlooking specific people can be incorporated, so that equally eligible "priority one" persons who have never been assigned for a community-determined length of time (i.e. three months) may be automatically matched or reviewed through case conferencing.

Staff who regularly participate in case conferencing meetings that accompany housing match identified challenges with seeing infrequent movement from the community's by-name list into permanent housing. OrgCode strongly recommends imminently revisiting everyone on the current by-name list who is recorded as "matched," "assigned" or "referred" to housing resources to verify whether (1) the vacancy to which each person was initially referred still exists (2) whether the count of matched people (sometimes vastly) exceeds the actual available system resources (3) complete an "unassignment" process for people who have not been successfully located, engaged or currently possess the required documentation for housing, all prior to making any additional new matches.

This process may be required at least quarterly, in order to more clearly demonstrate to staff participating in the Coordinated Entry housing referrals

[9] Chronic homelessness is characterized by tri-morbidity, meaning those that are impacted by mental health, physical health and substance use issues, and at the same time less likely to access the health services they need.

process that the goal of the community's matching process isn't simply to make new matches, but rather to match people so that they are imminently housed following that referral. Without that regularly established process, the by-name list will not reflect the actual count of people matched to actual current housing vacancies, as well as the length of time it has been since that initial match, in order to inform community case conferencing to resolve identified issues.

Almost every interviewee could identify opportunities to increase clarity and consistency of expectations. While community providers could point to VI-SPDAT scores and length of time homeless as community priorities, staff still struggled to articulate who is getting prioritized and housed, with when and how that occurred across the community as a whole. VI-SPDATs continue to be completed at or near first contact, even for people newly experiencing literal homelessness.

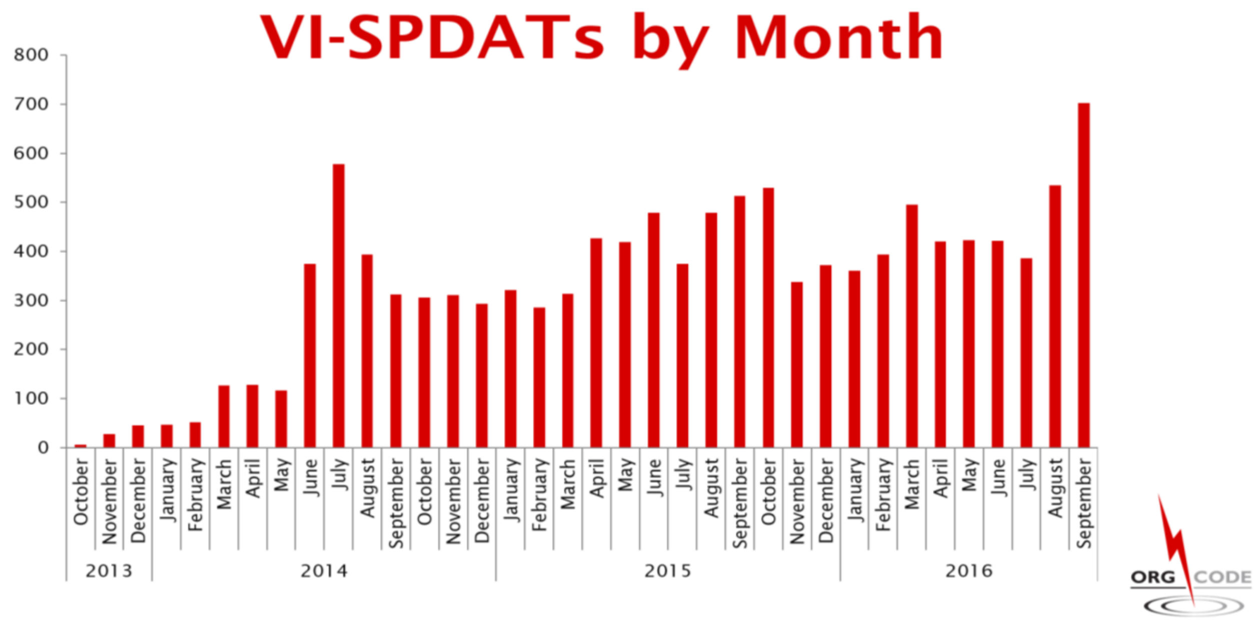
iii. Local Prevention and Diversion Efforts

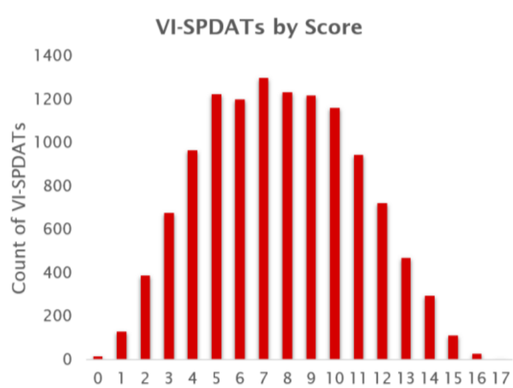
You only want to shelter people that have no safe and appropriate alternatives to being sheltered. Diversion is often misunderstood as turning people away or saying "no". That is the wrong mindset. Diversion is about saying "yes" to helping neighbors navigate to a safe alternative to shelter that is appropriate to their specific circumstances through an investment in staff time that have specific problem-solving skills and access to flexible resources to put the solution into action.

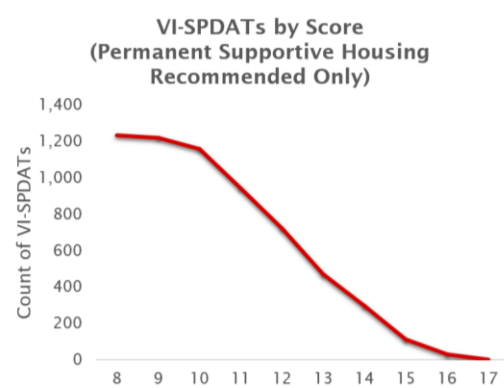
Multiple staff described how they daily engage individuals and families, including youth and survivors of domestic violence, to prevent their literal homelessness and rapidly re-house them. While some staff identified diversion as part of their daily tasks, many also frequently identified wanting to know how to more effectively and consistently provide diversion strategies, with multiple requests for both additional and ongoing technical assistance. Where diversion is happening, staff stated that it was not tracked consistently within the Homeless Management Information System (HMIS).

All shelter access points within the Coordinated Entry System in the Reno/Sparks/Washoe Coordinated Entry System should provide the Nine Steps to an Effective Diversion Practice before admitting a household for shelter. When Diversion is unsuccessful, and a household is admitted into shelter, housing-focused shelters also work on rapid exits out of shelter within the first 24-48 hours after admission and up to two weeks before any formal intake occurs. These discussions should also replicate the 9 steps conversation. The support that OrgCode can offer for enhancing the Coordinated Entry System in Reno/Sparks/Washoe will provide clarity on the role of access points and identify opportunities to create or reallocate and train existing staff for the role of Diversion Specialist.

At the front door, a robust By-Name List of everyone experiencing both literal homelessness and housing insecurity at-risk of homelessness should be available to each organization's staff, and its results should be simple to understand in both aggregate (how many people are at each location, what is their average length of stay, how many people are exiting homelessness to housing each month) as well as person-level (the names, entry and exit dates, lengths of stay, VI-SPDAT scores and permanent housing move-in dates) for both direct service staff and executive directors. This currently represents a missed opportunity, although the results could look similar to the following monthly reports:







These reports can be created within HMIS or Microsoft Excel (using HMIS results).

Name of Your Community Here By Name List of People Experiencing Homelessness

With VI-SPDAT Completion Status, Current Location and Housing Referral Information

Date Range: 3/10/2017 - 3/17/2017

Personally Identifiable Information					Experience of Homelessness Information				Assessment Status				Housing Referral (If Applicable)				Contact Information		Housing Unassignment (If Applicable)		
HMIS ID	First Name	Last Name	SSN	DOB	Current Provider	Entry Date	Exit Date (If Applicable)	Length of Stay	VI-SPDAT Complete?	Individual VI-SPDAT	Family VI-SPDAT	Youth VI-SPDAT	Provider Assigned	Date Assigned	Move-In Date	Days Since Match	Time / Place to Locate	Phone / Email	Provider Unassigned	Date Unassigned	Unassignment Reason
98192	Han	Solo	123-45-6789	7/13/1942	Outer Rim	3/16/2017		2	Yes	16			Housing NO'	3/9/2017	3/15/2017	6	Millennium Falc	me@OrgC			
24274	Leia	Organa	444-44-4444	10/21/1956	Alderaan	3/9/2017	3/14/2017	5	Yes	15			Skilled Hous	2/28/2017	3/2/2017	2	Yavin IV base fro	202-123-45			
13855	Luke	Skywalker	321-54-9876	9/25/1951	Dagobah	3/6/2017		11	Yes	14			We Can Hou	2/1/2017		45	Evenings betwee	313-313-131			
16587	Lando	Calrissian	111-11-1111	4/6/1937	Cloud City	8/17/2016		212	Yes	8							7-9pm at shelter	123-11-1212	Housing NOW -	1/1/2017	Unable to locate
40059	Boba	Fett	222-22-2222	Unknown	Nar Shaddaa	3/16/2017		2	Yes	12							Mos Eisley canti	101-11-1001	Skilled Housing	2/15/2017	Moved out of area
184503	Bib	Fortuna	121-21-2121	6/29/1947	Tatooine	1/27/2017		49	Yes	7	7		Housing NO'	3/2/2017	3/3/2017	1	Jabba's Palace (	717-111-1111			
81817	Poe	Dameron	313-33-1313	3/9/1979	X-Wing	12/13/2016		95	Yes			13	Skilled Hous	2/27/2017	3/1/2017	2	Yavin IV mess ha	321-11-1234			
116772	Mon	Mothma	987-11-7891	2/13/1933	Yavin IV	8/12/2016		217	Not Yet												
22831	Kylo	Ren	717-71-7171	11/19/1983	Coruscant	3/13/2017	3/15/2017	2	Yes		10						Starkiller Base la	123-11-2121			
126930	Cassian	Andor	272-22-2772	12/29/1979	Scarif Beach	3/6/2017		11	Yes			7	Skilled Hous	3/11/2017		7	Contact K-2SO a	333-11-3131	Housing NOW -	3/7/2017	Declined opportunity
126614	Jyn	Erso	456-11-4567	10/17/1983	Scarif Beach	12/10/2014		829	Not Yet												
23782	K-2	SO	987-65-4321	3/16/1971	Death Star	3/10/2017		7	Yes	9	10						24 hours a day vi	Info@OrgC			
24169	Obi-Wan	Kenobi	414-14-1414	4/2/1914	Tatooine	2/21/2017		24	Yes	9	12		Housing NO'	3/14/2017		4	Tatooine desert	191-91-1919			
114512	Chirrut	Îmwe	531-53-5315	7/27/1963	Jedha	7/20/2016		240	Yes	13			We Can Hou	2/8/2017	2/21/2017	13	Jedha commerc	101-00-1111			
31060	Mara	Jade	777-77-7777	Unknown	Myrkr	3/14/2017		4	Not Yet												

Name of Your Communitiy Here By Name List of People Experiencing Homelessness
With VI-SPDAT Completion Status, Current Location and Housing Referral Information
Date Range: 3/10/2017 - 3/17/2017

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System-Level Dashboards

People On Our By Name List

830

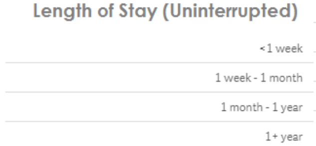
PEOPLE HOUSED

13

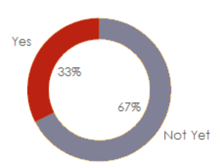
People Re-Experiencing Homelessness Previously Housed Through Coordinated Entry

3

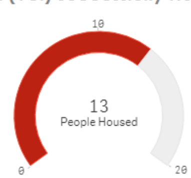
Length of Stay (Uninterrupted)



VI-SPDAT Complete?



People Permanently Housed Compared to People Matched to Housing But Not (Yet) Successfully Housed



Average Length of Time From Housing Match to Housing Move-In by Provider

Provider Assigned	Average Days From Match to Move-In
Housing NOW - PSH	81
Skilled Housing Securers - We Love Veterans	2
We Can House Anyone - ACT Model	58

9 Steps to an Effective Diversion Practice

It must be recognized that the sheltering system is NOT the sole answer to someone's housing instability. A shelter with a strong housing focus is never used as a free hostel by shelter users, never accessed by anyone who has another safe place to stay in the community and never pathologizes the experience of housing crisis/homelessness.

There are nine steps to an effective diversion practice, with each step progressing more deeply into resolving the current housing crisis while concurrently determining if shelter access will be required. For obvious operational reasons, it may not be practical to work through all the steps if your shelter accepts admissions in the middle of the night. But by and large this should be the approach applied to most households presenting for shelter in most instances. Diversion, when done well, is staffed by a person with specialized skills and resources to engage with any household seeking shelter at the 'front door' of the Coordinated Entry System.

OrgCode offers training on homelessness and shelter diversion through each of those nine steps, as well as sample scripts, processes and evaluation tools to assist. When dedicated prevention and diversion resources are available, they should be prioritized -- some communities choose to exclusively prioritize people whose characteristics prior to housing loss look most similar to those currently experiencing homelessness; others dedicate their resources to people who have been served by their system and previously exited to the permanent housing now in jeopardy of being lost; still others use a standardized vulnerability tool to quantify acuity and determine service prioritization. Communities across the country that have seen the largest reductions in homelessness (measured across Point-in-Time counts, AHAR and Longitudinal Systems Analysis submissions) have invested heavily in diversion, and moved away from a "first come, first served" model for both homelessness resources and homelessness prevention.

C. Sector of Service: Connection to Permanent Solutions – Day Services, Outreach and Emergency Shelters

i. Outreach and Day Services

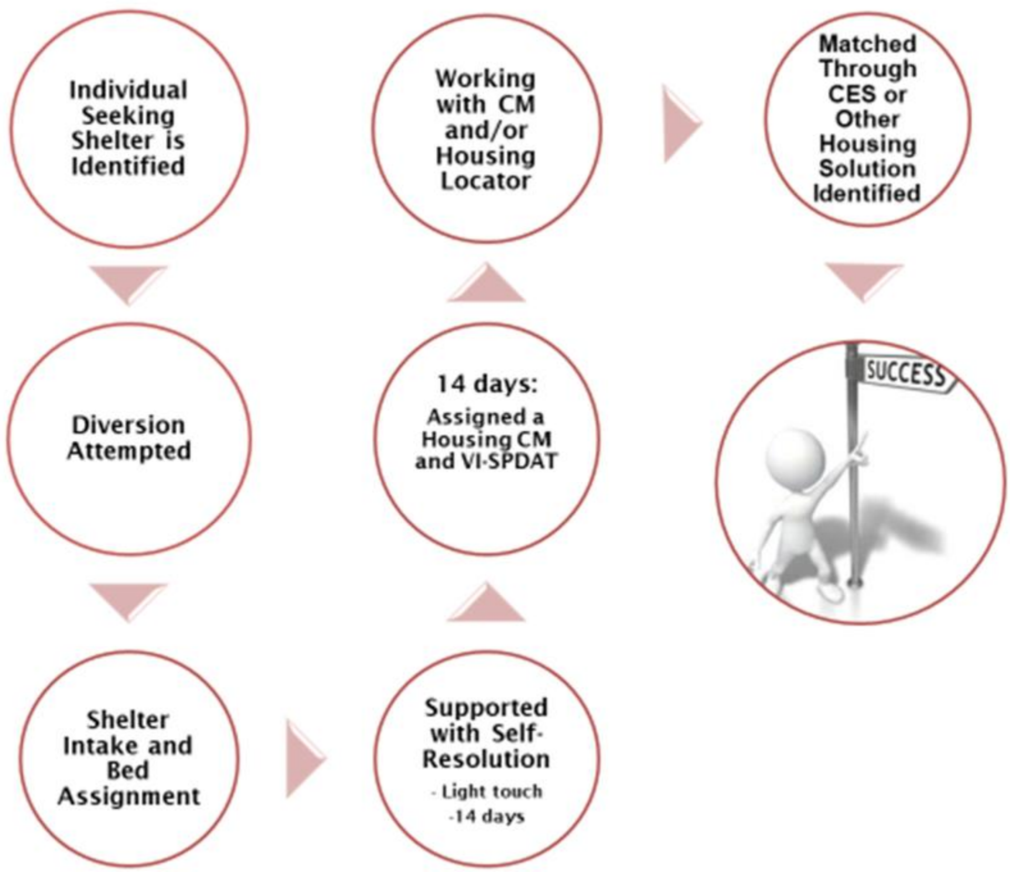
There is currently a lack of targeted street outreach across Reno/Sparks/Washoe. It is recommended that the community works to identify funding for new or reallocated positions dedicated to street-based outreach throughout the region. These positions would be actively seeking to engage unsheltered households to provide them with basic needs, connect them to day services and sheltering, and to have housing-focused conversations to identify a solution to their housing crisis as well as partner with law enforcement to provide a human-centered, social service response to issues and community concerns as they arise, currently being dealt with as 'nuisances' and resulting in an often punitive response.

Similarly, there is a significant gap in day center or drop-in services available within Reno/Sparks/Washoe, especially for Chronically Homeless men. While other sub-populations, such as youth and families, have dedicated resources and services, there is a lack of services for this group. The Record Street campus means to function as a location for persons experiencing homelessness to go or be brought, however this proves unsuccessful due to a lack of clarity of roles, services, and funded activities. The VOA staff who do provide sound sheltering services are not funded to handle the volume of need that presents itself on campus grounds every day. OrgCode staff observed large volumes of very vulnerable persons just hanging out, with no staff actively engaging them or providing any direct services. Other community stakeholders report that unsheltered homeless individuals are swept by a 'benevolent broom' to the campus every day, although there aren't any real services being offered once they arrive. Finally, while moving women, youth, maternity and families to another location may reduce some of the mixed population issues, the open campus, lack of security, services and clarity about what is the purpose of that space creates a high-risk environment for anyone sheltering, working, or volunteering at the Record Street campus. Moving day services to another location within the community is recommended. Providing robust, housing focused services for every person seeking day services is also recommended. The Record Street campus should not be publicly accessed, which would reduce the targeting of vulnerable persons by those not being sheltered at Record Street, as well as provide an increased opportunity for engagement and direct services for sheltered persons, enhanced safety controls, and management of activities provided on campus (i.e. the 'feedings' for persons within the community). Staff who progressively engage people residing in places not meant for habitation as they engage with services located on the shelter campus will allow for increased exits to permanent housing through the following recommendations.

ii. Stronger Emphasis on Housing-Focused Conversations and Progressive Engagement is Required

From street outreach to day services to emergency shelter, progressive engagement is possible with a hyper-focus on housing. Currently, there is a lack of strong engagements at the 'front door' in your community. To investigate the road ahead for Reno/Sparks/Washoe, it is important to explore the role of progressive engagement and the opportunity to act as a deliberate connection to a permanent housing solution for people experiencing a housing crisis or homelessness.

Progressive engagement is an essential approach for these services to ensure that the lightest touch possible is used with individuals and families in their return to housing stability. Assistance is then intensified when, and if, households need greater intervention to increase a successful return to housing. Related to shelter diversion, progressive engagement demands that all shelter staff acknowledge and capitalize on household's self determination to avoid the trauma of homelessness and to rely on service providers to assist them in addressing the immediate issue impacting their ability to maintain or find a safe place to be tonight. Focus on calmly and objectively assisting the household in resolving its immediate crisis impacting the neighbour today is essential during this crisis response.



Street-based outreach teams go into your communities, seeking out unsheltered persons to offer them basic needs, health care, and to offer housing-focused engagements. They are typically easily identifiable for consumers. Offering targeted street-based outreach and day services can increase engagements for those who are unsheltered or otherwise service disengaged, as well as provide a mechanism for identifying persons experiencing homelessness to your community and providing services such as Prevention and Diversion to reduce the volume of households having to go deeper into the homelessness response system to get their needs met.

Furthermore, street-outreach can offer 24 – 7 opportunities for supports and can partner with law enforcement, ambassadors, residents, and business owners to provide a social service response to issues impacting persons experiencing a housing crisis. Targeted outreach and robust day-services can offer an alternative to the current challenges of unsheltered or at-risk persons and families congregating in areas throughout the region or being shuffled from here to there without any actual interventions being provided.

Revisions to the current approach begin with redirecting (or refining) the orientation of staff. No longer should we think of outreach and shelter staff referring the people they serve *to* housing workers. Instead, every frontline staff should see themselves as being some form of housing worker in County and Cities' efforts to end homelessness. This doesn't mean that all staff should do assessments or engage with landlords or prepare materials for housing access. But in what can feel like complicated or overwhelming work, we distill our many activities into the guiding principle that if staff engaging people experiencing homelessness are not talking about housing with everyone they encounter, they are having the wrong conversation. (OrgCode has seen that message so strongly communicated in other communities that shelter staff wear it on their uniforms).

The second important change relates to expectations. We need to continually reframe the experience of being sheltered from one of rules (which lead to social control and policing of shelter users) to one of expectations (which is aligned to social service and supporting shelter users). One of the clearest expectations to be shared with shelter users is the expectation of getting housed quickly and not returning to homelessness. This expectation is independent of any program offerings like permanent supportive housing. Regardless of what resources are available, the expectations are the same.

The third important change is messaging. Active dialogue between staff and the people they serve is the most obvious way to change messaging. However, shelter and service providers need to also look at passive communication that occurs within their locations. Is every message on bulletin boards and message boards related to housing? Or is the core purpose of the services provided being confused by messaging things like free food, access to employment, health services or other basic needs? When the message of the importance of housing is diluted, people will struggle to progress towards housing. One important message for people receiving services to hear that appeared absent is how many people have self-resolved their homelessness without needing to wait for any type of program assistance.

Service providers need to remove any programming or messaging that interferes with the ability of people to focus exclusively on getting off the streets and out of shelter as quickly as possible. Unless frontline service staff struggle with having too much free time, there is no reason why any person during the first two weeks of their engagement should be enrolled in any programming or assigned to a case manager to navigate a broad range of life issues. Instead, to best engage, there should be intentional housing conversations with each person in their first two weeks of engagement that is driven by tasks, not goals. Staff should also make available passive resources to assist in this endeavor. For example, overnight staff at a shelter can research and print off every online listing of an apartment for rent within the County and Cities every single night so that people searching for housing do not have to do their own online research.

Homelessness prevention and shelter diversion during the first two weeks of engagement form an important foundation for people newly experiencing both literal homelessness and housing insecurity. If the individual or family continues to experience homelessness 15 days later, then the conversation and approach needs to shift, going deeper into engagement. This would be the most appropriate time to complete an assessment like the VI-SPDAT as a way of understanding which strengths the household has, and to create an individualized housing plan for each person. Every individualized housing plan must have two or more approaches to helping the household achieve housing, one of which will always continue to be self-resolution, and the other one(s) would include opportunities like Rapid Re-Housing. Any provider that puts all of the proverbial eggs into the basket of one housing program while giving up on self-resolution is not practising an appropriate response to helping the person get housed.

For those individuals and families whose homelessness continues for 15 or more days, the level of engagement changes. Whereas those staying two weeks or less had daily, quicker meetings with staff about housing tasks, those households with identified higher acuity should now be having more intensive, likely longer discussions about activating their housing plan and the tasks associated with it, about two times per week.

There will undoubtedly be some people experiencing homelessness with a plethora of co-occurring complex needs, long histories of trauma, and both personal and institutional realities that interfere with quick passage into housing. It is easiest, in these instances, to focus on those with fewer issues or to resign oneself that people with such circumstances will have to remain outdoors or in shelter until a permanent supportive housing opportunity becomes available. A better alternative is to examine what non-homeless individuals and families with the same needs, histories and realities across Washoe County, the City of Reno and City of Sparks do to find and stay housed and replicate those strategies ("reverse engineering"). That requires boots on the ground intelligence, including going to lower-income neighborhoods and speaking with tenants about how they figured out their housing needs without becoming homeless. That means seeing the strengths of the dozens, hundreds or even thousands of people in the community itself as local community experts that can teach how to overcome the obstacles seen in the people currently being engaged by frontline services.

iii. Emergency Sheltering in Reno/Sparks/Washoe

OrgCode Associates spent three days at the Record Street campus, meeting with Leadership and key staff, observing day to day operations, and interviewing service recipients. Overall, we were satisfied with the shelter operations and services being provided. Staff seem committed to ensuring a low-barrier access, however there are some barrier to having a truly successful, housing focused model.

It's important that all providers of homeless services, especially those funded through CoC, State, County, and/or City funds have clear goals established for their program, and with those set target performance measures. Programs should know exactly what they are funded to do, and outcomes should be reflective of those goals and objectives. Programs need training and technical assistance to ensure that they have the funding and staffing capacity to be able to meet target measures, and then be allowed to do so without other activities or priorities getting in the way.

First, only individuals or families (this would also be true for any new shelter locations) who are being sheltered or who have an appointment with a health care or other provider should be allowed onto campus. It is important for the community to be clear about what the VOA's role and purpose is and what responsibilities come with that role regarding homelessness in Reno. With a goal of ending homelessness for the participants staying at the VOA shelter, the VOA is responsible for what directly impacts its participants as well as the outcomes of its service delivery model and operations. The VOA is not currently contracted for and is *not* responsible for all street homelessness. Such a broad responsibility rests with the entire community including several city agencies and entities besides the City of Reno and the Volunteers of America. Your community must look at what is happening immediately outside and around that campus as not being solely because of the VOA's service delivery model and respond accordingly.

While OrgCode strongly recommends not implementing any policies that criminalize behaviors associated with homelessness (such as sleeping or sitting on the sidewalk), there are ways that partnerships with law enforcement, outreach staff, emergency medical staff, and neighborhood agencies can work to change this perception that currently exists and reduce the concentration of activities that are occurring outside the building.

Removing all non-sheltering activities from the Record Street campus can also support a safer and more housing-focused shelter model. Day services, including health care can be moved to another part of the City as these typically have little to do with sheltering activities or shelter guests and will also support a concentration of people and non-sheltering activities. Finally, the “feedings” should stop immediately or be moved to another part of the community.

iv. Enhancing Housing Focused Sheltering

For an emergency shelter to be effective, it must:

- Be a process, not a destination.
- Have trauma-informed services that promote collaboration, empowerment, and self-determination for every household seeking or needing shelter.
- Provide robust Diversion efforts to divert people from the homelessness service system when possible.
- Ensure low-barrier access to incentivize ease and access.
- Adopt a rigorous Housing First approach to support shelter guests moving into a permanent housing solution as quickly as possible, as they are.

Aligning shelter operations with these best practices will advance your community’s goals to prevent and to end homelessness. Shelters have radically changed over the past decade. While historically a charitable response to homelessness, they are now a professional, housing-focused operation that aims to get people out of homelessness rapidly. Furthermore, there has been a movement in sheltering to decrease service requirements and make shelters as low-barrier as possible. What this means is that people seeking shelter are screened in for services when they have higher depth of need attributable to things like mental illness and substance use disorders as opposed to being screened out. Shelters that operate as a connection to permanent housing solutions must also recognize their responsibility to serve those individuals and families with the homeless histories and vulnerabilities that are also prioritized for re-housing programs in the Continuum of Care communities.

For shelters within any community to effectively address the needs of people experiencing homelessness, it is helpful to understand how shelters are utilized. A typology of shelter utilizers developed by the researcher Dennis Culhane[10] provides detailed information on who uses shelter and for how long. From this research we know that there are three types of groups who experience homelessness. In Culhane's study among individuals:

- The largest group of shelter users (80%), called the *transitional* group, stayed in shelter once, for a short period of time. National data is currently reflecting that most persons in this group are typically homeless only once

[10] Kuhn, R., and Dennis, C. "Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data." American Journal of Community Psychology 26.2 (1998): 207-32.

in their lives, usually for about 7 – 14 days, and often resolve their homelessness on their own. Results show that the transitionally homeless, who constitute approximately 80% of shelter users in both cities, are younger, less likely to have mental health, substance abuse, or medical problems, and tend to over-represent Whites relative to the other clusters. The Housing Urban Development (HUD) Annual Homeless Assessment Report[11] which in recent years has shown about 30% of people stay a week or less, 25% stay 8-30 days, and about 35% stay 31 to 180 days.

- The remaining 20% of individuals were divided into two groups. The *episodic* group comprised 10% of the population and was characterized by cyclical homelessness, often moving in and out of homelessness as well as between other system institutions such as jails and hospitals.

- Finally, the *chronic* group comprised only 10% of the population, but are heavy system utilizers and tend to stay in shelter much longer than the other two groups, consuming half of the total shelter days.

Continuing with Culhane's research findings, among families, the largest group (70 to 80%) was also homeless for a short period of time. The episodic group among families is very small (5 to 8%) as compared to individuals. The long-term group (20% of families) differed significantly from the chronic group of individuals. Members of this group were the costliest to the homelessness system because of their long lengths of stay, but they did not have the highest service needs.

What this tells us is that the majority of service seekers have relatively brief episodes of homelessness: they exit homelessness within three to six months and do not return. This research also indicates that people with short- and long-term stays in homeless service programs face myriad challenges, but these are like the challenges faced by many other low-income families who never become homeless. It is only a small subset of people who experience multiple episodes of homelessness.

Of those that do stay longer in shelter, there is a natural tendency to think that they must be higher acuity with more pronounced needs and profound barriers to housing. While there are absolutely going to be some people in that position in shelter, it would be erroneous to think that everyone is, or that people with higher acuity cannot have short shelter stays. There is no way to predict who will stay in shelter longer and who will not. You can have two individuals or families with seemingly identical characteristics and one will be homeless a short period

[11] https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

and the other a longer period. Mary Beth Shinn's[12] research has demonstrated the only predictive variable we know to be true is that if a household has been homeless once they are more likely to be homeless again. Therefore, longer shelter stays may have more to do with the programs and services and policies within a shelter or community, and less to do with the characteristics or acuity of the household itself.

This can assist Reno/Sparks/Washoe with shelter design by indicating that shelter should provide Diversion before shelter intake to seek a safe, alternative to shelter if possible. If admitted, services are provided and facilitate conversations and resources for people who need a light touch of services to be re-housed. Shelter guests receive support through progressive engagement to ensure a rapid exit from shelter to housing for everyone who enters shelter, provide more intensive services to the small number of people experiencing multiple episodes of homelessness, and create low-barrier entry and programming so more people who are unsheltered can access shelter to shorten the length of time people experience homelessness.

In addition to ensuring that only those who have no safe alternative place to be enter shelter, the goal of the emergency shelter in the City of Reno should be to end homelessness. It must be a primary objective that through built form and services offered you are not simply managing people's homelessness but resolving homelessness for every person or family staying at the shelter. Shelter staff should be provided the adequate resources, training, and support to build operational and staff capacity to provide low-barrier and housing-focused services and shelter while serving the people with the highest needs. A shelter that is focused on ending homelessness and operates a low-barrier, housing-focused model must use data to measure both shelter and overall system performance.

As the shelters in the Reno/Sparks/Washoe County continue to explore options for sheltering sub-populations, including Youth[13] (18 – 24) and Families[14]. It's important that staff are trained in effective models of services and interventions that support the unique needs of these populations. Ending homelessness is not a one-size-fits-all solution and takes creative, highly responsible service delivery and we encourage you to have ongoing training and supervision of shelter staff to ensure they are utilizing the current trends in best and promising practices for each person/household served.

[12] Shinn, Marybeth, Andrew L. Greer, Jay Bainbridge, Jonathan Kwon, and Sara Zuiderveen. "Efficient Targeting of Homelessness Prevention Services for Families." American Journal of Public Health. 2013; 103(S2): S324-S330.
[13] https://www.hudexchange.info/resource/5138/ending-youth-homelessness-a-guidebook-series/
[14] https://www.usich.gov/resources/uploads/asset_library/family-criteria-benchmarks-july-2017-revision.pdf

Key Performance Measures

Key performance measures to evaluate the effectiveness of shelter and the shelter system include:

- Increased exits to permanent housing
- Decreased length of stay in shelter
- Reduction in returns to homelessness

In addition to the above key performance measures, all shelters within the system should track monthly performance measures including:

- Total number of beds (i.e. unaccompanied individuals and/or families)
- Total unique households served
- Total households entering shelter
- Total households exiting
- Total households exiting to permanent housing
- Average length of shelter stays in days for all households exiting the shelter to any destination
- Average length of shelter stays in days for all households exiting to a permanent housing destination
- Total household stayers (those households who entered in previous months and did not exit this month)

To ensure attainment of key performance measures, careful consideration of an experienced shelter operator should be top priority. Performance should be monitored regularly because shelter performance impacts the entire crisis response system in the City of Reno/City of Sparks/Washoe County Continuum of Care. As the sold shelter provider within the CoC, it is important that the data and narrative of operations and service delivery match as data illustrates need, capacity, local coordination, and the strategies taken to end homelessness. Ensuring performance data is used for strategic decision making ensures improved system performance and more participants served with best practices.

Key Performance Outcomes

All shelters within any system should be aligned to track their performance by analyzing, for example:

- The number of long shelter stayers being housed quickly, compared to the number of households that are staying in shelter for over a year.
- How shelter is prioritizing people who are unsheltered and the most vulnerable versus taking households on a first-come, first served basis.
- Number of persons housed returning to shelter/homelessness = recidivism.
- Shelter utilization is at 90-100% capacity.

D. Sector of Service: Housing Programs & Related Services

i. Exploring Local Housing Options

There is a tendency to look at independent living in the private market as the dominant housing solution. Depending on local conditions within Washoe County, the City of Reno and the City of Sparks, this may not be practical when examining the amount of income people have relative to the cost of housing. It is also one of the reasons why diversion, self-resolution and light touch interventions may not yet be thriving. When these options are cut off, a system of care quickly bottlenecks with long waiting lists (even with more restrictive local priorities) and impossibly unwieldy by-name lists. To increase flow-through into housing, individuals and families experiencing homelessness should be coached to progress through a range of housing options, not just focusing on independent living in the private market. In addition, service providers that are trying to help individuals and families realize housing solutions need to examine a range of residential solutions across different systems, not just within the homeless service delivery system:

Housing Option	Commentary
Family	While often considered for youth and to some extent families (especially single parent families) there is an advantage to supporting single adults to consider reuniting with their aging parents, siblings or adult children.
Hospice Care	Helping people die with dignity in secure housing is important, independent from the homelessness and housing services sector.
Adult Development Services/Mental Health Supportive Housing	These are often group home situations or smaller congregate opportunities where adults with developmental delays (and in some instances, pronounced cognitive deficits) live with others with comparable circumstances with supports catered to their specific needs.
Roommates	Matching for roommates can happen by encouraging people currently experiencing homelessness to find one or more person that they feel they could be compatible with in housing, or through more intentional matching approaches.
Shared Housing	Like the roommate approach, but with separate agreements (leases) between each of the inhabitants and the landlord.
Room-letting	Some communities have taken intentional approaches to match people that are homeless and in need of housing with people that are "over-housed" (usually seniors, especially widow(er)s that have more bedrooms than required for the housing occupants).

Independent Living	It is possible to think of independent living as the housing opportunity that a person or family progresses to only after all other less costly permanent options have been considered (or even attempted), rather than as the starting point for considering housing options.

ii. Continuity of Services in Housing

When highly vulnerable and chronically homeless or instable people finally enter permanent housing, providers mentioned their concern that services and supports can be lost as people move-in. With Housing First as a foundation, determining what comes second, third, thirteenth and thirtieth will help ensure that each household will have the necessary supports to maintain their housing. Having a regular organization-wide, and system-wide feedback opportunity at least once a month to determine system gaps and specific people who need additional support may be helpful. Additional data sharing or authorizations to disclose information may be required, but repeatedly asking "*who* has to do *what* by *when*?" increases accountability for everyone involved.

Providing Housing First, but not Housing Only requires dedicated resources to work with individuals and families who have been housed to ensure they have the holistic, evidence informed services they need to make sure they do not re-enter homelessness. These services are critical for the success for both the participant and your homelessness response system. It is a recommendation that resources or partnerships are secured to ensure cohesive, longitudinal supports are in place for households housed through eh Continuum of Care.

An important consideration when evaluating available housing stock is the amount of occupied PSH units that either do not have any turnover or can't be accounted for at all. On paper[15], your community has over 400 units of Permanent Supportive Housing for single adults, and 125 for families (403 total prioritized for Chronic Homeless), yet not a single person we spoke to could name where those units were, who was residing in them, or if there was turnover or availability to these upon vacancy, if any. It was suggested that these were previous Shelter + Care units which have remained filled for years with no turnover. The lack of awareness about these critical resources is alarming. At a system level, there needs to be a stronghold on what are the funded housing resources in the community, with whom they are occupied, who is the service provider, and how vacancies are communicated with they occur. Again, this is likely due to the CoC Lead Agency functions being outsourced as there is a lack of ownership over this data.

[15] HUD 2017 Continuum of Care Homeless Assistance Programs Housing Inventory Count Report

iii. Enhancing Available Housing Solutions

525 units of Permanent Supportive Housing cannot be discounted. These units must be made transparent to the broader community, vacancies need to be communicated and the next, most vulnerable Chronically Homeless household much be quickly matched, and services must be available for households to ensure they don't re-enter homelessness. If there are households occupying PSH units who no longer need the supportive services component, a strong partnership with the Public Housing Authority is an opportunity to connect those households to voucher-based programs, thereby opening up the supportive units to persons or families who need those permanent supports to maintain their housing.

Finally, where there is an increase and growth of developers coming into the City to rehabilitate blighted motels into high-end housing for population growth, the State, County, and/or City should identify incentives to bring in developers, or to incentivize building PSH for the developers in Reno. An example of this in other communities is to require developers to display a commitment to building more affordable housing by reserving 5 – 10% of all new developments to be affordable.

E. Best and Promising Practices – Improving Service Orientation & Service Delivery Excellence in Every Sector of Service

i. Housing First

Housing First[16] is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. Housing First is based on the theory that client choice in housing selection and supportive service participation, will likely make a person or household more successful in remaining housed and improving their life[17].

Housing First emerged as an alternative to the linear approach in which people experiencing homelessness were required to first participate in and graduate from short-term residential and treatment programs before obtaining permanent housing. In the linear approach, permanent housing was offered only after a

[16] https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf

[17] Tsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000

person experiencing homelessness could demonstrate that they were “ready” for housing. To be clear, Housing First is not “housing only”. Housing stability supports are often the critical tool that is needed to ensure households don’t return to homelessness in the future.

To have the philosophical and service orientation for delivering Housing First Aligned Homeless and Re-Housing Services, there are primarily 5 principles to be remembered:

- Homelessness is primarily a housing problem and all people are ready to be housed/re-housed now, if they choose. No housing readiness requirements are established - people can move into housing without preconditions such as sobriety, employment, being attached to mental health care, or graduating through a transitional programming.

- Self-determination and client choice: people who are experiencing homelessness voluntarily choose to participate in support services and re-housing programs rather than accessing housing and supports because of court order, house arrest, or any other coercive or restrictive means. People experiencing homelessness have the right to self-determination and should be treated with dignity and respect.

- Recovery orientation: Everyone is housing ready provided they receive client-centered support, which is tailored to their individual needs versus generic programming which is for everyone. Sobriety, trauma, criminal histories, etc. should not pose a barrier when a shelter provides programming and services that meet the needs of the recipient and the tools needed to reintegrate into society, versus a shelter which focuses on shelter rules and a preconceived agenda.

- Individualized and client-centered supports: every approach to supporting people is customized to their specific needs rather than generic programming that everyone accesses in the same manner. Emergency shelters must be recipient ready and must develop and provide programming and services that meet the needs of the person, rather than expect them to conform to the rules or agenda of the program.

- People should be returned to or stabilized in permanent housing as quickly as possible and connected to resources to assist them in maintaining their housing, as required. To maintain housing, it is essential that the importance of social and community integration is understood. The deliberate activities of helping people reintegrate back into society demands that people that we support are connected to a broad range of supports and receive the coaching required to increase their independence in the community.

Housing First, as a philosophy, tries to avoid homelessness whenever possible. When responding to homelessness, Housing First tries to keep the experience brief and tries to ensure it is non-recurring. In serving people who are homeless, Housing First uses various types of case management models from those that are very clinical and intensive in a permanent fashion to those that are time-limited and customized without clinical assistance.

Currently, not all programs are operating with a Housing First orientation. It is a recommendation that programs align with a Housing First service orientation to ensure a low-barrier, housing-focused approach to ending homelessness. A result of this will be intentional prioritization of, and an increase in supports provided to, the most vulnerable in your community resulting in a decrease in street-based and chronic homelessness. Shelters and housing programs should be as low barrier as possible, allowing for partners, pets, and possessions.

While not all programs operating within the Reno/Sparks/Washoe are housing first, it's imperative that all CoC funded programs align with a low-barrier, housing first model. It's also critical that there is an understanding and buy in to this model, and that the accolades for what defines "success" focuses on programs that have an abstinence-based model or require sobriety or employment. While this model may work for a certain household, it is a policy priority to prioritize the most acute within our HUD funded units, this includes persons who present with co-occuring disorders, substance use issues, and who have experienced significant trauma and unsheltered homelessness. It is unacceptable for the programs providing direct services to ignore or play 'hot potato' with this incredibly vulnerable population, especially considering they are the most frequently reported as creating a nuisance either in their presence or behavior. You must target these acute needs through assessment and housing first, then provide the wraparound services that are critically needed to ensure these households do not become homeless ever again.

ii. Trauma Informed Care

Trauma Informed Care is an intentional process that emphasizes understanding the symptoms, prevalence, and impact of trauma and looks at physical, psychological, and emotional safety for both clients and providers. The five tenets of TIC: Safety, Trustworthiness, Choice, Collaboration, and Empowerment ensure programs recognize that people have had different and complex traumatic experiences and ensure systems and programs do not unintentionally re-traumatize service seekers through any process, policy, or procedure and instead create environments where recovery from trauma is possible.

iii. Harm Reduction[18]

At its core, harm reduction is a pragmatic approach that aims to reduce the adverse consequences of drug abuse and psychiatric symptoms. It recognizes that people can be at different stages of recovery and that effective interventions should be individually tailored to each person's stage. People are allowed to make choices for themselves regarding substances or other 'high-risk' behaviors and regardless of their choices they are not treated adversely, their housing status is not threatened, and help continues to be available to them.

For best and emerging practices to be operationalized, all funded programs within the CoC should be trained on basic principles to increase staff competencies. All current contracts and any new funding should require alignment with best and promising practices for compliance and evidence-informed programming. This can be supported through ongoing training, technical assistance, program monitoring, and HMIS reports.

iv. HMIS and Technological Improvements

HMIS contains considerable potential not currently utilized across Washoe County, the City of Reno and the City of Sparks. Agency representatives described keeping paper records and separate electronic databases in order to evaluate who they engaged, housed and supported. At each shelter and day service location, staff would greatly benefit from both reminders of existing HMIS reports as well as ongoing technical assistance to ensure comprehensive use of these HUD-required tools. Generally, organizations relied on one specific staff at each agency to generate reports, rather than possessing the ability or knowledge on how to run reports themselves. Multiple organizations expressed frustration at the limited HMIS utilization and coverage across various providers, in addition to concerns with data quality and how the information they recorded could inform their understanding of system strengths and gaps.

v. Increased Data Tracking on Outcomes

HMIS should be implemented not primarily as a data quality exercise (no matter how rigorous or comprehensive) but as a performance measurement tool to better end and prevent homelessness. Most database users are not inspired by the latest round of reports documenting fields with missing, incongruent or partially completed responses. Everyone from the case manager to the executive director (and the public) should be able to see in real-time, how many people have left homelessness to permanent housing, how long that took, and who was responsible for that achievement.

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[18] Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American journal of public health, 94(4), 651-6.

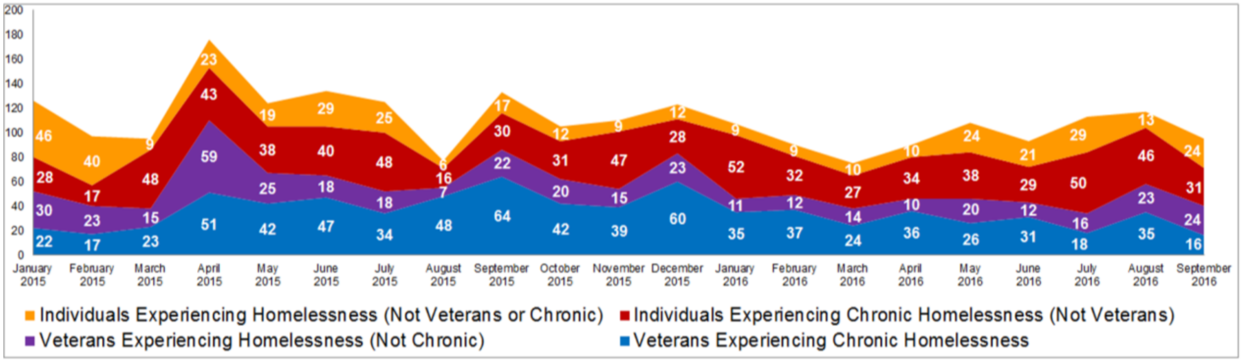
We know that HMIS can seem like a "black box" where staff input data, without being able to extract that information into meaningful reports. HMIS should help staff understand how each organization's current data demonstrates (or does not yet fully demonstrate) their excellence in ending homelessness, from the first engagement of someone sleeping in shelter or outside, to when they enter permanent housing and receive the supports to ensure they never experience homelessness again. The following represents another data visualization either directly from HMIS or from Microsoft Excel using HMIS results:

HOUSING PROGRESS

January People Housed	**107 housed** (including 46 veterans)	35 chronically homeless and veterans 52 chronically homeless only 11 veterans only 9 homeless but not chronic or veterans
February People Housed	**90 housed** (including 49 veterans)	37 chronically homeless and veterans 32 chronically homeless only 12 veterans only 9 homeless but not chronic or veterans
March People Housed	**75 housed** (including 38 veterans)	24 chronically homeless and veterans 27 chronically homeless only 14 veterans only 10 homeless but not chronic or veterans
April People Housed	**90 housed** (including 46 veterans)	36 chronically homeless and veterans 34 chronically homeless only 10 veterans only 10 homeless but not chronic or veterans
May People Housed	**108 housed** (including 46 veterans)	26 chronically homeless and veterans 38 chronically homeless only 20 veterans only 24 homeless but not chronic or veterans
June People Housed	**93 housed** (including 43 veterans)	31 chronically homeless and veterans 29 chronically homeless only 12 veterans only 21 homeless but not chronic or veterans
July People Housed	**113 housed** (including 34 veterans)	18 chronically homeless and veterans 50 chronically homeless only 16 veterans only 29 homeless but not chronic or veterans
August People Housed	**117 housed** (including 58 veterans)	35 chronically homeless and veterans 46 chronically homeless only 23 veterans only 13 homeless but not chronic or veterans
September People Housed	**95 housed** (including 40 veterans)	16 chronically homeless and veterans 31 chronically homeless only 24 veterans only 24 homeless but not chronic or veterans

These housing outcomes -- the answer to the question "are we ending homelessness?" that drives our work -- should be examined across various demographic groups (people experiencing chronic homelessness, veterans, families, unaccompanied adults, youth) and across time. The following data visualization could be presented on a weekly, monthly, quarterly and yearly basis:

PEOPLE HOUSED BY MONTH



	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016
Unduplicated Total	**126**	**97**	**95**	**176**	**124**	**134**	**125**	**77**	**133**	**105**	**110**	**123**	**107**	**90**	**75**	**90**	**108**	**93**	**113**	**117**	**95**
Chronically Homeless (Veteran and Non-Veteran)	50	34	71	94	80	87	82	64	94	73	86	88	87	69	51	70	64	60	68	81	47
Veterans (Chronically Homeless and Non-Chronically Homeless)	52	40	38	110	67	65	52	55	86	62	54	83	46	49	38	46	46	43	34	58	40

vi. Increased Community Partnerships

On any given night, nearly 85,000 Americans with disabling health conditions who have been homeless for long periods of time—some for years or decades—can be found sleeping on our streets, in shelters, or other places not meant for human habitation. These men and women experiencing chronic homelessness commonly have a combination of mental health problems, substance use disorders, and medical conditions that worsen over time and too often lead to an early death. Without connections to the right types of care, they cycle in and out of hospital emergency departments and inpatient beds, detox programs, jails, prisons, and psychiatric institutions—all at high public expense. Some studies have found that leaving one person to remain chronically homeless costs taxpayers as much as \$30,000 to \$50,000 per year[19]. Your community can use these investments in a way that not only reduces costs to taxpayers but ends homelessness and housing instability for your most vulnerable neighbors.

vii. Supporting People Through Partnerships with Benefits and Healthcare

Especially in a community where high client to staffing ratios, reliance on volunteers and engagement once people enter shelter represent the overwhelming majority of street outreach assistance, the successful navigation of the SOAR process in order to gain access to SSI/SSDI benefits provides an important income generator to assist with affording housing. Communities of similar size and fair market rent to Washoe County, the City of Reno and the City of Sparks often find that various combinations of the housing options above (especially roommates and shared housing) among two people with SSI/SSDI

[19] https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

benefits can make a unit or shared home increasingly affordable. Additional SOAR training for frontline service employees would be invaluable for shelter and day services staff.

Similarly, our conversation with a Health and Social Service Coordinator with United Health Care was illuminating. While they are currently doing outreach, providing housing and robust, holistic services to their clients (persons eligible for Health Plan of Nevada), there is a lack of partnership with the homelessness response system in Reno/Sparks/Washoe. Though they are serving many of the same households, they are not formally at the table. This is a significant gap in service collaboration. Not only do they already have a strong housing first orientation, they are able to provide intensive case management.

A partnership between the CoC and these types of heath care providers would increase the availability of in-home supports to people who are housed through the Coordinated Entry System and respond to concerns that there isn't enough case management available for high risk families. Health Partners of Nevada has taken a huge lead on using data to inform decisions around increasing housing and homeless services in Nevada, specifically for persons experiencing homelessness to decrease utilization and cost to community. Their absence at the homelessness response system table is a gap in expertise and knowledge. This is an example of how programs and services must move away from siloed responses to homelessness and build partnerships for a collective impact approach.

viii. Partnering with Law Enforcement

Homelessness is a social issue, not a law enforcement issue. Ending homelessness requires strong relationships with law enforcement as part of the solution, but criminalization of homelessness is not the solution. Currently in Reno/Sparks/Washoe law enforcement is being used as a replacement for the absence of day services, street-based outreach, and a 24-7 response to crisis. Respondents told us that 911 is used as a way to respond to 'nuisances' or people sleeping in a place not meant for human habitation by both residents and business owners. Feedback from law enforcement was clear that while there is obligation and commitment to enforce the law, many of these calls require a social service, not law enforcement, intervention. There needs to be an increase in not only a human and social service intervention to these issues in your community which will have a greater human impact and less over utilization of law enforcement.

ix. Specialized Interventions for Youth Experiencing Homelessness

On a single night in 2018, 36,361 unaccompanied youth were counted as homeless. Of those, 89 percent were between the ages of 18 to 24. The remaining

11 percent (or 4,093 unaccompanied children) were under the age of 18[20]. According to a December 2017 report from the U.S. Department of Housing and Urban Development, Nevada is home to one of the nation's fastest growing homeless populations (5th highest at 12.4% growth 2007-2017) and the highest rate of kids living alone on the streets[21].

Programs, such as Eddy House and the Nevada Partnership for Homeless Youth are responding to the issue of youth homelessness in a proactive, trauma-informed way. Initiatives include program expansion and the development of a Youth Homelessness Roadmap. Services for youth need to be grounded in Trauma Informed Care and Positive Youth Development with an emphasis on Youth Engagement. Ending youth homelessness is achievable, and to meet all the physical, developmental, and social needs of youth experiencing homelessness, a unified, collaborative response in every community must be part of the system design.

Building on local, state, and federal efforts to support healthy families, this response must:

- Prevent youth from becoming homeless by identifying and working with families who are at risk of fracturing.
- Effectively identify and engage youth at risk for, or actually experiencing, homelessness and connect them with trauma-informed, culturally appropriate, and developmentally and age-appropriate interventions.
- Intervene early when youth do become homeless and work toward family reunification, when safe and appropriate.
- Develop coordinated entry systems to identify youth for appropriate types of assistance and to prioritize resources for the most vulnerable youth.
- Ensure access to safe shelter and emergency services when needed.
- Ensure that assessments respond to the unique needs and circumstances of youth and emphasize strong connections to and supported exits from mainstream systems when needed.
- Create individualized services and housing options tailored to the needs of each youth, and include measurable outcomes across key indicators of performance, including education and employment[22].

The recommendentations contained within this report for elements of program design – specifically outreach, Coordinated Entry Systems, staff development, etc. – will be inclusive of youth-specialized considerations throughout implementation and will include parterships with local experts in Reno/Sparks/Washoe, including youth with lived experience.

[20] https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2018.pdf

[21]https://www.unlv.edu/sites/default/files/story_attachments/167/The%20State%20of%20Homeless%20Youth%20in%20Southern%20Nevada.pdf

[22] https://www.usich.gov/resources/uploads/asset_library/Youth_Homelessness_Coordinated_Response.pdf

In Conclusion

Ending homelessness requires both leadership and management. On the leadership front it is about bringing people on a journey to realize a vision where homelessness is rare, brief and non-recurring. On the management front it is about aligning resources, investing in training staff and partners in evidence informed practices and measured execution of the tactical aspects of the vision. The City of Reno, the City of Sparks and Washoe County, together with the CoC partners, have much work to do to demonstrate their dedication to preventing and ending homelessness. Through the proposed Visioning Session, enhancements to the Coordinated Entry System, training and technical assistance, OrgCode is confident that working with the local partnerships and funded services a re-alignment of values, priorities, and vision is possible. It is though the participation of Phase 2 of this Project that the City of Reno, City of Sparks, and Washoe County will be able to make better use of investments, track and measure outcomes, and support providers with their work on the ground toward ending homelessness. There are incredible opportunities for a community of this size to truly make an impact, however collectively the hard work must be done to shift to a collaborative, participatory approach to working together. From this new foundation, success is possible.

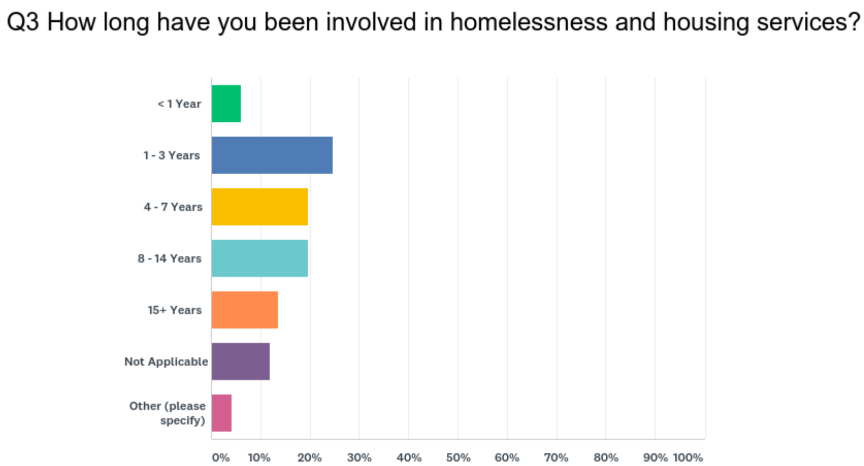
Attachment A.1 Summary of Service Excellence Self-Assessment

Service Excellence Self-Assessment for the City of Reno/Sparks/Washoe County Homeless and Housing Services

The Service Excellence Self-Assessment was generated and distributed to providers of homeless and housing services. The following is a summary and analysis of the results:

Page 1: Preventing and Ending Homelessness in Reno/Sparks/Washoe County | Service Provider Self-Assessment

There were 120 respondents to this survey in total, the majority of which (48%) of were Case Managers and approximately 100 respondents answered all the questions. 15 (15%) were Agency Leadership (Executive Director, COO, CEO, etc.), 15 (15%) were Program Directors or Managers, and 13 (13%) were Administration (Finance, IT, etc.). 8 (8%) were Outreach Workers and 5 (5%) were Finance staff. 3 (3%) Housing Support Workers, 2 (2%) Board Members, and 1 (1%) Shelter staff. While some respondents identified a specific agency with which they were working, most respondents, 17 of the 36 respondents (47%) reported not working directly with any program. Respondents represented a diverse range of time working with persons experiencing homelessness:



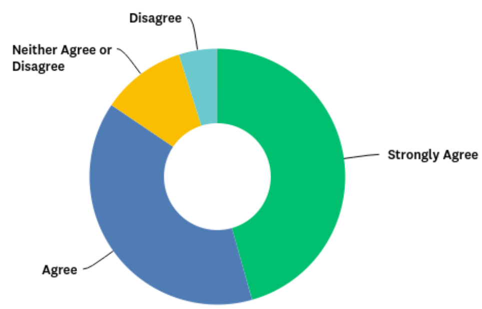
68 (57%) of respondents feel every member of staff, from the Executive Director/CEO to the administrative staff, feel that they fully believe everyone who is currently homeless should return to permanent housing as quickly as possible if they choose to do so. 34 (29%) Agree, 7 (6%) Neither Agree or Disagree, and 5 (5%) either Disagree or Strongly Disagree. 5 (5%) report that they didn't know.

Page 2: Beliefs & Values

Overall, it appears that respondents feel aligned with best and promising practices including a Housing First orientation and ensuring that housing is not a reward for 'good behavior'. 87 (85%) of respondents either Strongly Agree or Agree that housing is a right for every person, 11 (11%) Neither Agree or Disagree, and 5 (5%) Disagree. 54 (53%)

Agree that staff effectively implement housing-focused services and supports to clients/participants and 21 (21%) Strongly Agree that they do. While 16 (16%) Neither Agree or Disagree, or Don't Know, 7 (7%) Disagree and 4 (4%) Strongly Disagree that staff effectively implement housing-focused services.

Q5 Housing is a right for every person.

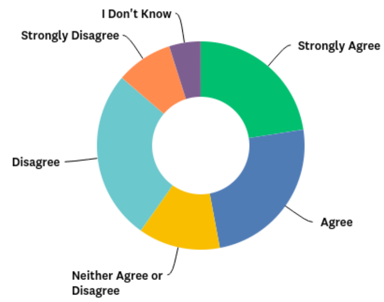


56 (56%) Strongly Agree or Agree that access to housing is not used as a reward for clinical or programmatic success by community partners. 19 (19%) Neither Agree or Disagree, and 8 (8%) Don't Know. 15 (15%) Disagree and 4 (4%) Strongly Disagree that housing is not used as a reward for programmatic success.

41 (40%) Agree that clients with mental illness do not need to demonstrate compliance with their medication before being housed and 24 (24%) Strongly Agree that they do not. 13 (13%) Disagree with this statement, and 5 (5%) Strongly Disagree. 14 (14%) Neither Agree or Disagree and 4 (4%) Don't Know.

Answers reflected a more punitive response to consumers and substance use as it relates to program participation or 'compliance'. 27 (26%) of respondents Disagree and 9 (8%) Strongly Disagree that consumers/clients do NOT have to be compliant/sober/have income/etc. to receive housing and supportive services. This doesn't align with a housing first approach which would ensure that there is a low-barrier, non-punitive response to substance use as it relates to housing access and stability. However, 48 (48%) either Strongly Agree or Agree that consumers do not have to be sober to receive housing or services. This may be based on which programs the respondents were representing as not all programs within the CoC are aligned with a housing first orientation regarding sobriety and substance use issues.

Q9 Consumers/clients do NOT have to be compliant/sober/have income/etc. to receive housing and supportive services.

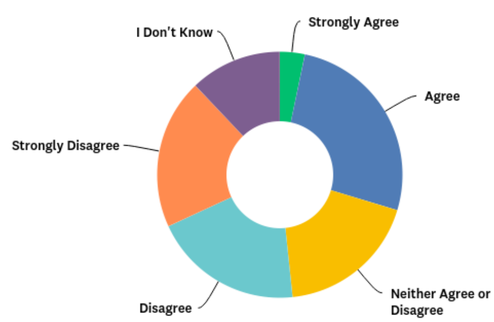


While 12 (12%) Disagree, the clear majority either Strongly Agree or Agree that Clients are assisted, and services delivered in a way that will help them achieve greater independence with less reliance on them or their agency as 68 (68%) of 102 respondents answered as such. 21 (21%) Strongly Agree and 51 (50%) Agree that consumers/clients are presented with choices for the types of services they receive. 15 (15%) Neither Agree or Disagree, and 8 (8%) Don't Know. 6 (6%) Disagree and 1 (1%) Strongly Disagrees.

Page 3: System and Community Activities

Unsurprising, there was inconsistency from respondents on whether they knew about the community's plan to end homelessness and while 24 (26%) Agreed they knew the community's plan to end homelessness, 36 (40%) either Disagreed or Strongly Disagreed.

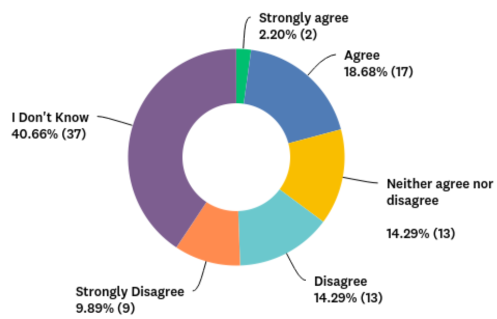
Q13 I know what our community's plan is to end homelessness.



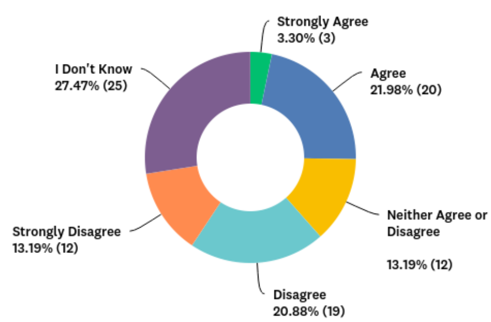
From there, 18 (20%) Disagreed and 12 (13%) Strongly Disagreed that they fully understand their organization's role and responsibility in/with the Coordinated Entry System. However, similar percentages either Strongly Agreed or Agreed that they did. This lends itself to an opportunity for clarification through messaging and training about what the Coordinated Entry System is, roles, and policies and procedures as 44 (48%) of respondents Don't Know if the written policies, procedures, and protocols that govern the Coordinated Entry System are readily available if they have questions. At this point, anyone working within the homelessness and/or housing sector should understand what a Coordinated Entry System is and the policies and procedures that impact day to day operation, especially with 48% of respondents being in a Case Manager role.

Similar themes of 'not knowing' were reflected within the rest of the System and Community Activities section among the remainder of the questions around prioritization, the identification and role of access points specifically around Diversion, and the process for triage, prioritizing, housing matching, and referral to housing.

Q16 The Coordinated Entry System prioritizes the needs of the most vulnerable, while ensuring all individuals, families, and youth who come into contact with the homeless system are quickly identified, assessed, and provided with appropriate supports to exit homelessness as quickly as possible.

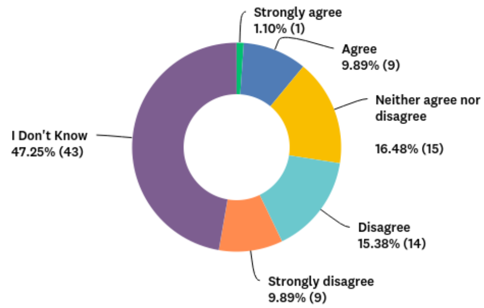


Q17 Access points in your community are effectively diverting clients from shelter when they have a safe and appropriate place to stay in the community and preventing literal homelessness, when possible.



While some respondents did Strongly Agree or Agree that these mechanisms were understood and transparent, the inconsistency of respondents reveal a need to revisit existing policies and procedures to ensure they meet your communities needs for prioritization and matching, and that messaging and training is happening on the ground so that those providing services as well as those receiving services understand the Coordinated Entry System and how it works to assist in ending homelessness in Reno/Sparks/Washoe County.

Q18 The Coordinated Access Process for triage, prioritizing, housing matching, and referral to housing is administered consistently, transparently and is defensible.



Page 4: Prioritizing Services

Aligning with best and emerging practices requires that communities prioritize the most vulnerable first, for the limited amount of resources that are available. The unfortunate truth is that there are not enough resources to meet the need and because of this, we must choose our investments wisely, focusing on the hardest to house with the most acute needs to both move the needle on ending chronic and unsheltered homelessness, but also to have a greater cost benefit to the resources your community is using and allocating. Providing an equitable distribution of resources based on acuity of needs ensures we do not overserve or underserve, households experiencing a housing crisis.

Approximately 86 people answered the following questions about prioritizing services. Unsurprising, because of the underutilization and inconsistency with the current Coordinated Entry System both in design and function, 24 (29%) Don't Know if the only people that gain access to our homeless and re-housing programs are those that are referred through the Coordinated Entry System. 19 (22%) Disagreed and 17 (20%) Strongly Disagreed that they do, 11 (13%) were neutral, and 8 (9%) Agreed so. It's important from a systems-lens that providers of services trust that they system within which they are working, works. This is lived out through programming, outcomes, and messaging to consumers. Also, in our key informant interviews, similar feedback was given about not only the access to the Coordinated Entry System, but the process by which people were prioritized and matched, and lack of clarity of roles and functionality. OrgCode' s recommendations around the enhancements of the Coordinated Entry System in Reno/Sparks/Washoe are reflective of this analysis and stakeholder feedback.

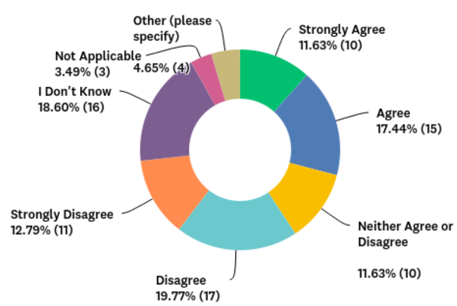
Although there seems to lack clarity on what the CES is and who does what, there were greater consistencies among respondents when it came to access to the system or programs, however with programs operating still somewhat siloed this is less reflective of a system design than programmatic. While 14 (16%) Don't Know and 12 (14%) are Neutral, 26 (30%) Disagree and 8 (9%) Strongly Disagree that those who are eligible for services are served on a "first come, first served" basis, which reflects an intention to serve based on need or acuity and not luck. Although, while 39% Disagree or Strongly Disagree that households are served on a first come, first served basis, 24 (28%) either Strongly Agree or Agree that they are. If a Housing First service orientation and

Coordinated Entry System were effectively implemented, you would likely see a more consistent alignment among respondents about access being less about first come, first served, and more about acuity of needs.

Question 21, an objective and evidence informed assessment of needs is used to identify what program/service is most needed by consumers/clients, reflects a stronger alignment and consistency among respondents. While 16 (19%) Don't Know and 14 (16%) were neutral, 45 (53%) either Strongly Agreed or Agreed that an objective based approach to assessing for needs is used. This was reflected in-person interviews as well that front line workers know there is an assessment used, but what happens with that information after the assessment is where there are opportunities to increase education and training around the process of triage, assessment and matching to housing resources.

Respondents were consistent in their understanding of client choice as it relates to a housing first service orientation and low barrier access. Through the analysis of this data, when respondents are so inconsistent with answers across the board (i.e. almost equal number of respondents Agree and Disagree), we look at this as an opportunity to revisit best practices, ensure policies and procedures align with a housing first service orientation including a low barrier access, and recommendations around training and technical assistance to support continuity of programming across your system of care.

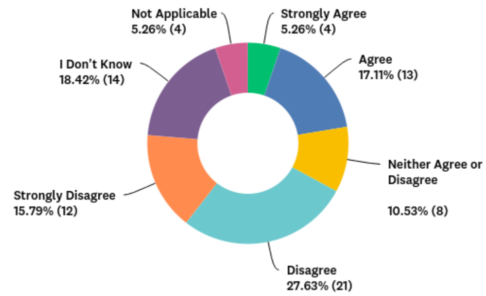
Q22 Our eligibility criteria to enroll in our program does not restrict access to shelter or re-housing because of the use of alcohol, drugs, lack of income, criminal history background, or because the person has a partner with whom they want to shelter, or a pet.



Page 5: Housing

A housing first orientation supports housing without pre-conditions, as well as prioritizing the most vulnerable household(s) first, understanding that housing persons who have long histories of housing instability, while at the same time facing barriers and challenges related to acute, co-occurring disorders, we would be remiss if we did not anticipate the efforts needed to assist those households to stabilize. A system that is housing focused would prioritize households who struggle to maintain housing with prevention resources, and rather than having households who lose their housing be penalized by going to the 'bottom of the list', prioritize them for the next available housing opportunity. This benefits both the community's system data with reduced recidivism and supports a trauma-informed system approach avoiding re-traumatization of returning to homelessness if possible.

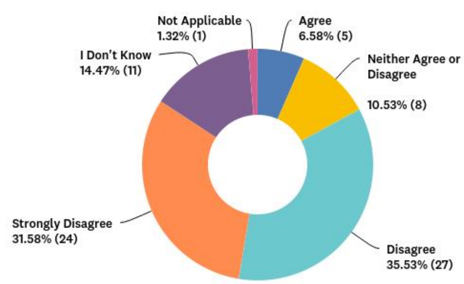
Q23 Policies and procedures support participants in moving into permanent housing in the most rapid and streamlined way possible, without unnecessary service pre-requisites, rules, or program requirements.



It is also reflective of values and when there is work still to be done to enhance how communities view a homelessness response system as a crisis response system, and that housing is not a reward for good behavior. In addition to the 19 (25%) who Don't Know, the largest group of respondents, 22 (29%), Disagreed that if a client loses their housing, for whatever reason, they are prioritized for the next available housing resource. This could be attributed to a lack of understanding of how prioritization works, however there were accompanying comments that reinforced the values behind this critical policy decision, such as 'it depends on why they lost it'.

Many respondents both electronically and in person blame the 'lack of affordable housing' as a reason for homelessness, however it is also true that respondents disagree that the community has been successful in engaging landlords that are amenable to housing formerly homeless individuals or families. Only 5 (7%) Agree that landlords have been engaged in a way that would support access to affordable units.

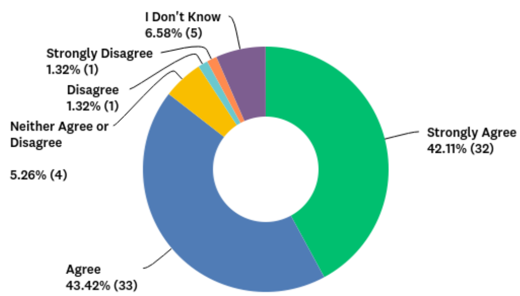
Q26 The community has been successful in engaging landlords that are amenable to housing formerly homeless individuals or families.



Page 6: Case Planning & Teams

In this section we explore how services are provided through case planning and team structure and supervision at a program level. Overwhelmingly, 65 (85%) of the 76 respondents feel that clients are empowered to collaborate with case plans. As two of the five tenets of trauma recovery, empowerment and collaboration are critical for a strong service milieu when working with trauma survivors.

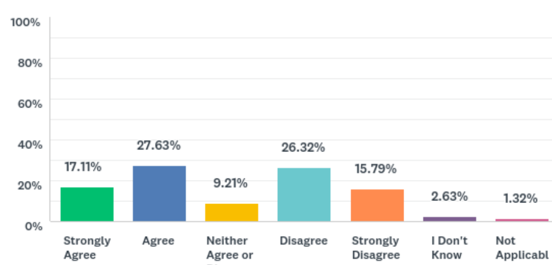
Q28 Clients are empowered to collaborate with case plans.



Not inconsistent with the rest of the analysis within this Service Excellence Self-Assessment survey is the nearly equal split of responses of those that either Strongly Agree/Agree or Strongly Disagree/Disagree that there is an adequate amount of case management services within the agency relative to the presenting needs and level of support necessary to support our clients.

When communities are working as a system, and not siloed programs, there is a stronger commitment to the standardization of services provided, including staff to client ratio, how services are delivered, and target performance measures. the variance in responses supports the opinion that there are opportunities for system-level performance, including reviewing at how many resources or case management services the *system* has available, not just program to program and then decisions around sustaining or identifying new funding to fill gaps is objective-based and evidence informed and not status quo renewal of funding.

Q29 There is an adequate amount of case management services within our agency relative to the presenting needs and level of support necessary to support our clients.

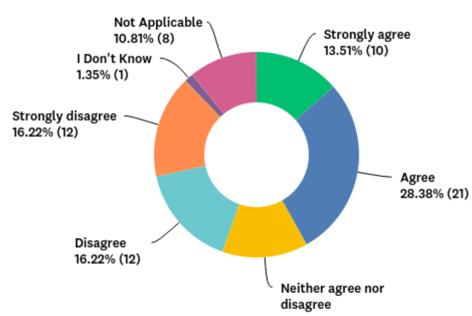


22 (29%) Strongly Agree and 30 (39%) Agree that clients identify their own vision and goals for the future, although 9 (12%) either Strongly Disagree/Disagree with this. And while a close 45 (59%) either Strongly Agree or Agree that there is a process within the agency for reviewing every client's goal progress and housing stability on a regular basis, 10 (13%) do not. This is reflective of a desire to have consumers involved in the decision making about their goals and case plans, but not having the full capacity to do so. Greater discrepancy was among responses about whether their agency uses an assessment tool to determine areas of risk to housing stability. 9 (12%) Strongly Agreed and 12 (27%) Agreed that their agency does, while 15 (20%) Strongly Disagreed and 11

(15%) Disagreed with this. Again, this is very likely program specific and is reflective of a non-standardized system of care. Recommendations in the report include using a standardized assessment tool to ensure services are objective informed and reflective of consumer needs and risks to housing stability.

5 (7%) Strongly Disagree that they receive ongoing supervision to support me in my role, 57 (74%) of respondents feel that they do and while analysis does reflect a general understanding of best and emerging practices such as Trauma Informed Care, Housing First, and Harm Reduction, there was significant variance in respondents feeling as though they received the necessary, ongoing staff development which would support programmatic implementation and accountability.

Q34 My team receives regular training on Housing First and other best and promising practices (Assertive Engagement, Motivational Interviewing, Trauma Informed Care, Harm Reduction, Positive Youth Development, etc.)



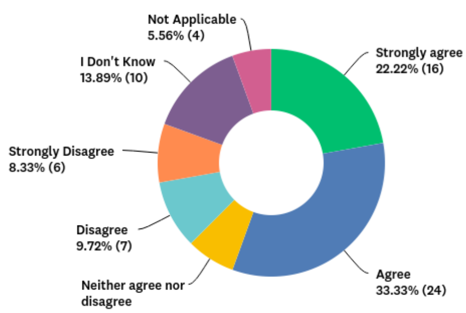
Page 7: Community Resources, Service Planning & Delivery

We know that ending homelessness is possible. To do so, it's critical that community resources, service planning and delivery are consistent in a way that is evidence based and ends homelessness. To end homelessness, we know that emergency shelters must function as a process, and not a destination. Furthermore, a housing-first orientation promotes housing *first*, and then providing households with the necessary, wrap-around services they need to maintain their housing. Of the 72 responses, 44 (61%) said emergency shelter should create programs and services that prepare people to be successfully housed. This reflects a false understanding about the role of emergency shelter and that there must be program-heavy sheltering to promote 'housing readiness', the opposite of a housing first approach.

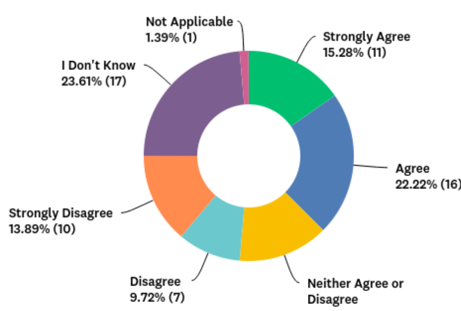
This shift of perspective is an important consideration for several reasons, the least of which is the limited amount of sheltering options in the Reno/Sparks/Washoe Continuum of Care. Sheltering people who are experiencing a housing crisis is a critical role and the VOA should be supported to ensure that households are provided with their basic needs while they are supported in resolving their housing crisis, identifying the households with the most acute needs, first.

Most respondents either Strongly Agree or Agree that staff are knowledgeable and comfortable in supporting people who actively use substances and are knowledgeable and comfortable supporting clients/consumers that demonstrate the signs and symptoms of mental illness. They treat their clients/participants with respect and dignity, regardless of substance use. Analysis of responses shows that while there is confidence in staff's ability to work with persons who have substance use or mental health barriers, it is unclear what competencies are being utilized, as lesser consistency was among respondents answers about Trauma Informed Care and Motivational Interviewing. It's important to be able to both allow access for persons who are struggling with the impacts of mental health or substance use, but even more critical is a trauma-informed lens though which not only policies and procedures are created and implemented, but in how we view consumers. Trauma informed care allows for safe environments for both staff and program participants, as well as reduce re-traumatization, and shifts the framework of how we view certain activities or high-risk behaviors as strengths, not deficits. Training and staff development for staff can promote a trauma-informed, housing first orientation across your community's homelessness response system.

Q37 Staff are knowledgeable and comfortable in supporting people who actively use substances. They treat their clients/participants with respect and dignity, regardless of substance use.



Q36 Trauma Informed Care is effectively implemented.



Page 8: Evaluation

Evaluation of program performance is important both through a system-lens as well as in day to day operations. Programs providing homeless and/or housing services must know what they are working toward through established target performance measures, and then track, measure, and evaluation progress toward those measures on a very regular basis. Moving from 'managing homelessness' to ending homelessness requires program and system performance oversight and accountability to ensure an evidence based programmatic and systemic impact.

Of the 70 respondents, 16 (23%) Strongly Agree and 23 (33%) Agree that outcomes and impacts of service delivery to clients is monitored and reported regularly. This is strong evidence to support that there is already commitment and understanding about evidence-based practice and accountability. 9 (13%) were neutral and 11 (16%) Don't Know. 3 (4%) Strongly Disagree and 7 (10%) Disagree that outcomes are measured and reported regularly.

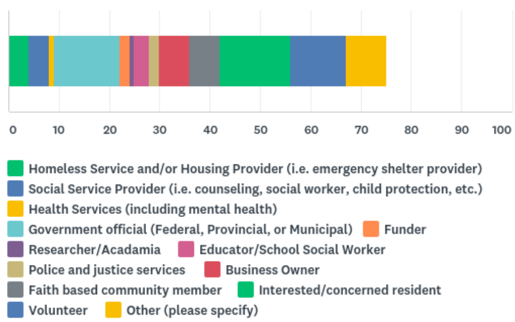
Along with this, high numbers reported a strong sense of accountability to outcome measures with 67% either Strongly Agreeing or Agreeing that they believe they are held accountable for helping consumers/clients and/or my funded program achieve predetermined outcomes. Unfortunately, this doesn't align with success as reflected in outcomes, while 22 (31%) Strongly Agree they are held accountable to outcomes, only 5 (7%) Strongly Agree that most clients (>80%) are successful in their housing because of our supports and services provided and in fact 20 (29%) Disagree that housing success is due to programs and supports provided. Strengthening program design to align with best and promising practices, establishing standard performance measures, and requiring full utilization of HMIS will allow your community and programs to see the overall impact of their work, evaluate data, and make changes as necessary for constant system enhancement.

Attachment A.2

Community Partner Surveys for the City of Reno/Sparks/Washoe County Homeless and Housing Services

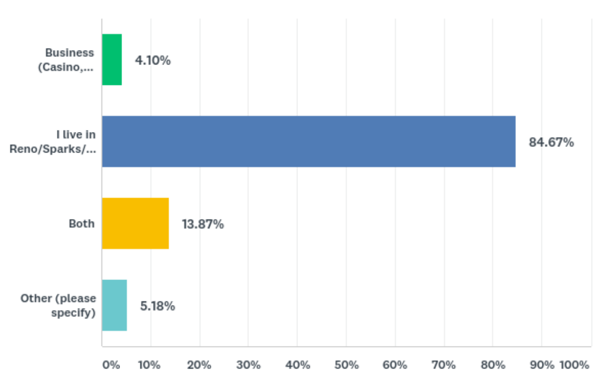
There were two surveys that went out to community stakeholders, the first of which was the *Community Partner Survey for the City of Reno/Sparks/Washoe County* Homeless and Housing Services. The 48 respondents to this survey were comprised of residents, Government officials, and other community stakeholders.

Q1 Which of the following best describes you? Please select all that apply.



The second, which cast a much wider net, was titled *Homelessness System of Care: Survey for Businesses and Residents in Reno/Sparks/Washoe County* generated over 1000 responses, primarily of business owners, residents, or a combination of both within the City of Reno, City of Sparks, and/or Washoe County. Approximately 60% of both survey respondents said they were Somewhat Familiar with the programs and services that work with individuals, families, and/or youth experiencing homelessness in Reno/Sparks/Washoe County. This is an analysis of combined survey responses.

Q1 Which of the following best describes you? Please select all that apply.



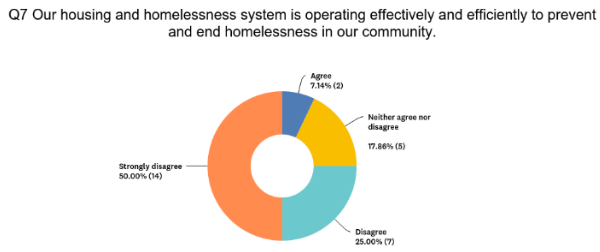
Overwhelmingly, community stakeholders with were either Extremely Dissatisfied or Dissatisfied with the effectiveness of the homelessness service response system in Reno/Sparks/Washoe. While it is evident that many of the respondents would have no idea about the nuts and bolts or day to day operations of either the system as currently designed, or specific programs and their impact, respondents were responding to the public, social issue of homelessness in their community. Peppered throughout the thousands of comments within the narrative sections of the surveys were concerns about the human impact and social justice issues of homelessness, but in general the public opinion of homelessness in Reno/Sparks/Washoe is very negative and tied to a misunderstanding of what are the root causes of homelessness and a deep absence of knowledge and understanding about effective solutions to homelessness. A key part of moving forward with any recommendations will be to have key messaging for all three entities, and rather than using homelessness as a political tool or hot potato of conversation, rather reflecting that the City of Reno, City of Sparks, and Washoe County are working together to do what works, through evidence based, human-centered practices and system re-design, to end homelessness in these communities.

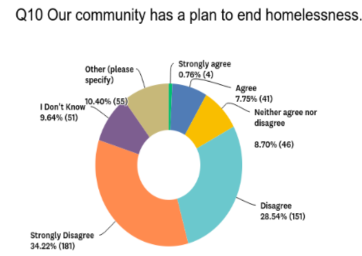
Much of the community stakeholder feedback aligned with what OrgCode Associates identified through all the operational and system evaluation, which is that the three communities aren't working together, there lack strategic planning and leadership, and that solutions that come offline are short-term, 'band-aids', that don't have longitudinal impact but rather shuffle homelessness from one site to another. Community stakeholders seem disenchanted with the idea that there is any real solution and recommendations were very punitive in nature, focusing on substance use, downtown 'nuisances', and 'out of sight out of mind' solutions to the publicness of unsheltered homelessness in downtown Reno in particular.

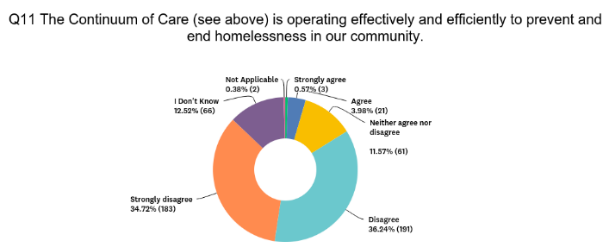
Q8 Satisfaction with the effectiveness of the programs

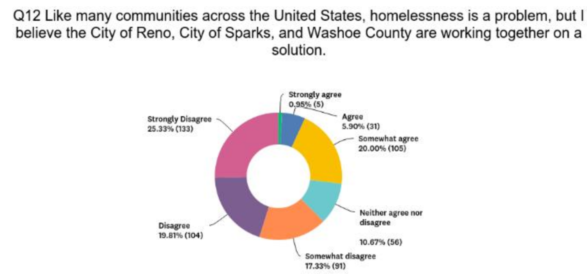
In both community stakeholders' surveys, it is apparent that there is a lack of awareness of a community's plan to end homelessness which is not unsurprising as this reflects a shared truth. Again, an alignment of vision and messaging will be key for community stakeholder buy-in moving forward as you decide upon and implement system enhancements. It is also reflective in respondents answers about the ability and effectiveness of collaboration across the three communities. Community stakeholders, in majority, Disagree or Strongly Disagree that the City of Reno, City of Sparks, and Washoe County have aligned goals and objectives for how they respond to the issue of homelessness and are working together collaboratively as a Continuum of Care on a solution.

While this may be difficult to hear, the positive side is that once collaboration and an aligned vision is in place, along with consistent messaging, the opportunity to have significant impact and community stakeholder support is evident.









There was also consistency in community stakeholder feedback about whether the system is evidence based. Over 50% of respondents either Strongly Disagree or Disagree that the community is provided with observable and measurable evidence (data) to assure accountability in providing a more efficient and effective homeless services system. And while 29% Don't Know, 11% are Neutral, and 14% Agree, 47% of respondents either Strongly Disagree or Disagree that your community uses data to make decisions based on allocation or reallocation of funding to ensure you are meeting the greatest need across the Continuum of Care. Again, the establishment of transparent target performance measures, and ongoing evaluation and transparency of outcomes will be incredibly important in implementation of system re-design methods to ensure accountability and community stakeholder trust and buy-in.

The remaining content of both surveys focused around solicitation of narrative feedback. Over 400 responses were given for each question, and some important themes emerged. In terms of what did community stakeholders consider to be the most important accomplishment that has been made so far for ending homelessness for individuals, families, and youth in Reno/Sparks/Washoe County, key among them was an acknowledgement that there are emerging efforts to collaborate, acknowledge the problem, and organize efforts – the CHAB and RAAH were mentioned multiple times, as was the development of the NAAHMS campus and the benefits of expanding sheltering to serve women and children through specialized services.

Lack of leadership and direction were frequently mentioned when respondents were asked what the biggest struggles were with the Homelessness Response System in

Reno/Sparks/Washoe County. Also mentioned frequently was the lack of collaboration and communication from Government and lead agency, and noticeably there is a 'blame game' and lack of ownership and accountability around the issue of homelessness as well as a deep lack of understanding and clarity about 'who does what'. From providers, key points about certain programs not utilizing Coordinated Entry for months and that going completely unnoticed is important feedback. Systems should work for both providers and consumers if they are to have impact, and there is a strong sense of desire for these systems and accountability to them.

As expected, much of the community stakeholder feedback was about homelessness in general, or rather misconceptions about it – 'drug use', 'mental illness', and 'bums/panhandling' were mentioned multiple times about the problem of homelessness. The Record Street campus was highlighted as an area where there is a high concentration of negative activities which impact community stakeholders' sense of safety and understanding that homelessness is being addressed. Many suggestions were punitive in recommendation and suggest policing, forced treatment programming, and/or removing persons experiencing homelessness from the community altogether. Asset based solutions include many respondents recommending creative solutions to increase affordable and deeply subsidized housing – from old hotels, to increased incentives for developers. There seems to be an extreme community opinion pendulum with 'just get rid of all of the bums' on one end, and 'more compassion and housing' on the other. Key messaging going forward will help to reduce the disparities in opinion about homelessness in Reno/Sparks/Washoe and the collaborative, shared vision and initiatives being implemented for a quick solution to immediate issues as well as a long-term plan to end homelessness.