STATEWIDE PROGRESS IN ENDING HOMELESSNESS

Phase I and Phase II observations and findings

August 2, 2017
What we have learned

Inputs:
- Phase 1 findings: Reviewed in orientation
- Phase 2: CoC-level data analysis, stakeholder survey, emerging themes and gaps from CoC site visits, service provider and lived experience input sessions

Collective conclusions: 5 cross-cutting priorities, 5 population goals

Task ahead: build out/revise “strawman”
What causes homelessness?

- **Housing**
  - More than at any other time, there is a lack of housing that low income people can afford. Without housing options, people face eviction, instability and homelessness.

- **Income**
  - Low income households often do not earn enough to pay for food, clothing, transportation and a place they can call home.

- **Health**
  - Health problems can cause a person’s homelessness as well as be exacerbated by the experience. Housing is key to addressing the health needs of people experiencing homelessness.

- **Racial inequality**
  - While homelessness affects all races and ethnic groups, it impacts some minorities at higher rate.

- **Domestic violence**
  - Many survivors of domestic violence become homeless when leaving an abusive relationship.

While virtually all homeless people are poor, only a very small fraction of people who live in poverty ever experience homelessness.
Actionable Strategies

5 Cross-Cutting Priorities
- Housing that’s affordable
- Employment and earnings
- Streamlined and accessible systems and services
- Supporting effective local crisis response systems
- Using data and analysis to inform planning, tracking and resource allocation

5 Population Goals
- Resolve and prevent homelessness among veterans by 2018
- Resolve and prevent chronic homelessness by 2018
- Prevent and end family homelessness by 2020
- Prevent and end youth homelessness by 2020
- Reduce homelessness among single adults by 25% by 2020
3 of 4 renter households at lowest incomes (<30% of Area Median Income) are severely cost burdened, paying 50%+ of their income for housing.

### Exhibit 6-7. Renter Housing Cost Burden by Income

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Severe Cost Burden (Rent ≥50% of income)</th>
<th>Moderate Cost Burden (Rent 30-49% of income)</th>
<th>Not Cost Burdened (Rent 0-29% of income)</th>
<th>Total Renter Households</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Households</td>
<td>Percent</td>
<td>Households</td>
<td>Percent</td>
</tr>
<tr>
<td>30% AMI or less</td>
<td>302,090</td>
<td>73.5</td>
<td>45,880</td>
<td>11.2</td>
</tr>
<tr>
<td>31% to 50% AMI</td>
<td>74,975</td>
<td>27.1</td>
<td>133,880</td>
<td>48.3</td>
</tr>
<tr>
<td>51% to 80% AMI</td>
<td>12,940</td>
<td>4.2</td>
<td>106,780</td>
<td>34.5</td>
</tr>
<tr>
<td>81% to 100% AMI</td>
<td>1,515</td>
<td>1.1</td>
<td>13,545</td>
<td>9.4</td>
</tr>
<tr>
<td>101% AMI or more</td>
<td>1,950</td>
<td>0.6</td>
<td>7,435</td>
<td>2.2</td>
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<tr>
<td>All households</td>
<td>393,470</td>
<td>26.5</td>
<td>307,520</td>
<td>20.7</td>
</tr>
</tbody>
</table>

Note: Percent totals add up to 100% horizontally to show cost burden within income brackets.

### Housing Affordability/Homelessness

<table>
<thead>
<tr>
<th>Continuum of Care</th>
<th>PSH Units (2015)</th>
<th>Affordable Units</th>
<th>Households in poverty</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youngstown/Mahoning County</td>
<td>166</td>
<td>5,156</td>
<td>22,800</td>
<td>17,478</td>
</tr>
<tr>
<td>Canton/Massillon/Alliance/Stark County</td>
<td>485</td>
<td>6,082</td>
<td>29,282</td>
<td>22,715</td>
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<tr>
<td>Akron/Barberton/Summit County</td>
<td>419</td>
<td>12,433</td>
<td>40,560</td>
<td>27,708</td>
</tr>
<tr>
<td>Dayton/Kettering/Montgomery County</td>
<td>873</td>
<td>23,093</td>
<td>52,588</td>
<td>28,622</td>
</tr>
<tr>
<td>Toledo/Lucas County</td>
<td>864</td>
<td>10,934</td>
<td>48,633</td>
<td>36,835</td>
</tr>
<tr>
<td>Cincinnati/Hamilton County</td>
<td>1,699</td>
<td>21,206</td>
<td>75,109</td>
<td>52,204</td>
</tr>
<tr>
<td>Columbus/Franklin County</td>
<td>2,051</td>
<td>26,320</td>
<td>99,842</td>
<td>71,471</td>
</tr>
<tr>
<td>Cleveland/Cuyahoga County</td>
<td>3,183</td>
<td>35,261</td>
<td>123,870</td>
<td>85,426</td>
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<tr>
<td>Balance of State</td>
<td>2,126</td>
<td>79,604</td>
<td>437,698</td>
<td>355,968</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,866</strong></td>
<td><strong>220,089</strong></td>
<td><strong>930,382</strong></td>
<td><strong>698,427</strong></td>
</tr>
</tbody>
</table>

Source: OHFA administrative data retrieved from the DevCo system, national affordable housing database, and data de-duplication by CSH/BPA. PSH units are those listed in the 2015 HUD Housing Inventory Chart plus the state’s Returning Home Ohio units. Poverty data retrieved from the American Community Survey for 2014.
Local perspectives

- Lack of quality affordable housing in safe neighborhoods near jobs
- Preserve and expand supply of affordable housing
- Needed:
  - Rental assistance – short-term and ongoing
  - More landlords willing to rent to people with prior evictions, credit problems and/or criminal histories
  - More partnerships with landlords, particularly nonprofit housing providers
- Lack of PSH to prevent vulnerable households from becoming homeless
Preliminary CoC Data Analysis

- Rates of exit to permanent housing from local homeless crisis response systems are variable but could be improved in all CoC’s.
- PSH inventory increased by one-half between 2013 and 2016 - limited gap between need for PSH and available units.
- Greatest gap is RRH for single adults.
Best/Promising Practices

- **Connecticut** multi-prong strategy to address affordability – state rental subsidy programs, aggressive capital strategy for PSH, RRH, and affordable

- **Minnesota** state funded rental subsidies: Housing Trust Fund rental assistance, Bridges Rental Assistance, and Family Homeless Prevention & Assistance Program (FHPAP)
“No single social activity conveys more of a sense of self-worth than work. To be excluded from the workforce… creates a sense of isolation and marginalization that is a key risk factor for mental disability.” Heather Stuart, “Mental Illness and Employment Discrimination” Current Opinions in Psychiatry 19 (5) 2006

Source: *NLIHC “Out of Reach: 2017”
Homeless Systems and Earned Income

% Exiting with Earned Income: all Ohio CoCs (2016)

- Transitional Housing: 43%
- Rapid Rehousing: 53%
- Supportive Housing: 26%
Local perspectives

• Obtaining good employment is very difficult
  • Better paying fulltime 40 hours/week jobs
  • More permanent (not temporary) employers willing to hire people with criminal background
  • More jobs for people with disabilities, mental illness, etc.
• Partnerships with Ohio Means Job centers and WIOA (federal Workforce Innovations Opportunity Act) funded employment/training programs are generally lacking and/or programs have barriers that prevent people experiencing homelessness from participating
• Lack of childcare and transportation make finding and keeping job harder
• Need to increase minimum wage
Promising Practices

- **Houston**: integration of WIOA into CES
- **Virginia**: Capitalizing on SNAP E&T, Vets employment
- **Ohio**: Investments in supported employment
- **Heartland Alliance**: promising practices for integrating employment into RRH
Streamlined and accessible systems and services: health care and behavioral health

- Poor health puts one at risk for homelessness
- Homelessness puts one at risk for poor health
- Homelessness complicates efforts to treat illnesses and injuries  
  Source: National Healthcare for the Homeless Council, “Housing is Health Care”, 2011

- Average life expectancy for homeless adults: 42-52  
  Source: Jim O’Connell, Premature Mortality in Homeless Populations, 2006
Impact of Medicaid Expansion

- Medicaid expansion has been vital to people experiencing homelessness.
- 71% of shelter residents in Hamilton County ES programs reported having health insurance.
- Prior to ACA, 73% of homeless adults seeking services at Healthcare for the Homeless clinic cited at least one unmet health need, including:
  - an inability to obtain needed medical or surgical care (32%),
  - prescription medications (36%),
  - mental health care (21%), eyeglasses (41%), and dental care (41%).

The Unmet Health Care Needs of Homeless Adults: A National Study [Travis P. Baggett, MD, MPH, James J. O'Connell, MD, Daniel E. Singer, MD, and Nancy A. Rigotti, MD](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882397/)
Streamlined and accessible systems and services: access to benefits

- Generally partnerships with local state-funded mainstream systems was weak
- Inadequate capacity especially for childcare, health care and behavioral health
- Inadequate response to prevent homelessness
Local perspectives

• Keep Medicaid expansion
• Access to childcare is greatest unmet need for families with children (need both subsidy and providers)
• Recertification for all benefits is difficult, especially for employed households and people with disabilities
• SOAR helpful but not at scale of need
• Lack of transportation makes accessing services and benefits more difficult
• Long wait times for mental health and addiction services
• Alignment needed between health/behavioral health services and housing
• Staff in homeless crisis response system need more training on available services and benefits
Better partnerships needed

- ADAMH
- JFS
- Health
- Transportation
- OMJ
- Legal

- Hospitals
- Medicaid/Insurers
- Primary and Specialty Care
- Child Welfare Benefits
- Medicaid
- Housing Courts
- Legal Services
Preliminary CoC Data Analysis

% of adults who increased non-employment cash income

- A: 10%
- B: 5%
- C: 20%
- D: 36%
- E: 25%
- F: 25%
- G: 20%
- H: 15%
You don't need key at right of the graph
Barbara Poppe, 7/31/2017
Streamlined and accessible systems and services: prevention and diversion

Managing the Front Door – Engaging “Upstream” Partners – Problem Solving Conversations
Supporting effective local crisis response systems

- Crisis Response System = diversion, shelters, street outreach, and other crisis services that provide access to housing stabilization
- Effective coordinated entry process includes prioritization, Housing First orientation, emergency services, standardized assessment, referral to housing, outreach, and use of HMIS.
- Big lift in implementing CES – ramped up significantly between 2016-2017
Integration of CES and Housing Interventions

% of Ohio CoC’s that include CoC-funded Housing Interventions in CES

<table>
<thead>
<tr>
<th>RRH</th>
<th>PSH</th>
<th>TH</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>88%</td>
<td>100%</td>
<td>44%</td>
</tr>
</tbody>
</table>

CoC’s must meet new HUD CES requirements by Jan. 2018
Preliminary CoC Data Analysis

- PSH was high performing and targeted to literally homeless in most CoC’s.
- RRH was generally high performing and targeted to literally homeless in most CoC’s.
- TH was high performing in some but not all CoC’s. Not consistently targeted to literally homeless population.
- ES performance was uneven.
Local perspectives

• High alignment with Housing First but not universal. Program staff are trained in and practice Housing First. CoC’s are not routinely assessing alignment with Housing First practices.

• Diversion is being practiced by most CoCs but more training, best practices, and resources needed to increase success. More and better organized upstream homelessness prevention needed.

• Street outreach was not consistently available in all CoC’s, especially concern in BoS. Highly effective at connections to permanent housing in some CoC’s.
Local perspectives

- **Emergency shelter** is available and exit to housing is the primary objective, however, entry requirements and/or lack of capacity meant some people are unsheltered. More effective 24/7 programs with better trained & more respectful staff needed per people with lived experience.

- **Transitional housing** operates less well-aligned with focus on exit to permanent housing than other interventions. Shift from TH to RRH occurred and is generally viewed as positive for people/families experiencing homelessness. Targeting to high need households is variable.

- **Rapid Rehousing** is a resource in all CoCs, but additional capacity was needed, especially for single adults. Need to assess and align all RRH programs with National Alliance to End Homelessness (NAEH) standards. More on how to integrate employment with RRH is needed since many households have no or limited income.
Local perspectives

- **PSH** is prioritized for the highest need populations and operates consistent with a voluntary services best practices model. Concern about the need for access within reasonable time frames and ongoing financial stability due to funding needs. Many noted need for more intensive services to match resident needs.

- **Flexible funding** was cited as need to help all programs be more successful and efficient at meeting client needs.

- Increased use of **peer support** and leadership from people with lived experience in planning and allocation processes was highly recommend by people with lived experience.
Local perspectives – training and technical assistance

• Training
  • Housing First practices in all settings (e.g. ES, TH, RRH, PSH, outreach, diversion)
  • Relevant best practices (e.g. CTI/motivational interviewing, SOAR, progressive engagement, person-centered and trauma-informed services, by-name/master lists, shared housing, coordinated entry and prioritization, harm reduction, etc.)

• Training with technical assistance
  • best practices in diversion and RRH, including practice, partnerships, and resources
  • landlord engagement and partnerships, including mitigation funds
  • addressing opioid use
  • how to increase employment for program participants in all types of housing interventions
  • how to house populations with special needs (e.g. sex offenders, DV survivors and perpetrators, people with DD, young people with autism, pregnant/post-partum women and infants)

• Guidance
  • CoC management, including strategies to increase transparency and collaboration with providers
  • Using data for program and system improvement
Emerging & best practices

- Best practices in **rapid rehousing**
  - progressive engagement
  - integrate with employment
  - right-size capacity
- Effective **emergency shelter**
  - use a Housing First approach,
  - safe and appropriate diversion,
  - immediate and low-barrier access to shelter,
  - housing-focused services, and
  - using data to measure performance
- **Scaling diversion**
  - creative staff trained in mediation
  - problem-solving conversation
  - access to flexible

Ohio is pioneer in urban, suburban, and rural RRH

Cleveland Mediation Services is pioneer and national best practice
Using data and analysis to inform planning, tracking, and resource allocation

Inform Policy
- Identify gaps
- Learn what works

Reduce Homelessness
- Set benchmarks
- Refine strategies
- Publish results

Accountability
- PIT and AHAR – required reports
- Program and system performance reports (APRs)

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CSH
Local perspectives

• Variable data quality across state

• Most stakeholders reported need for more publicly-available data on performance and investments

• Technical assistance on using data and metrics for planning, monitoring, and quality improvement at system and program level (e.g. data transparency by CoC and analytics), including staff who use HMIS data/analysis but don’t administer it

• Use data warehouse project to integrate data across state agencies and understand how to more effectively leverage/use mainstream resources to prevent/end homelessness
Best practices

• Set measurable goals with interim targets
• Measure and report on program and system level results
  • By sub-population
  • By intervention type
  • By race, gender and age
• Assess all programs for:
  • exits to permanent housing,
  • length of stay/time homelessness,
  • utilization rate,
  • return to homelessness,
  • cost per successful outcome
• Use data for quality improvement and resource allocation decisions
• Publish reports

“We’ve been reducing homelessness in the US. And it’s because we’ve learned what does-- and what doesn’t work -- and changed how we do things. We’ve learned it’s important to have good data, to know what the size of the problem is, what interventions are effective and cost-effective, and to measure progress.”
Nan Roman, NAEH 2017
Resolve and prevent future homelessness among Veterans by 2018

- Federal benchmarks on targeting, resources, and strategies
- TA provided by Abt Assoc. across state in 2016
- Investments in VASH and SSVF in Ohio
- 50 communities (3 states) achieved functional end
Status of Ohio CoCs – Vet Designation

- Akron: 2
- Dayton: 2

- CoCs Approved: 2
- CoCs Submitted: 2
- To Submit in 2017: 3
- TBD: 2
Progress as of 2016 PIT

Homeless Veterans in Ohio

Source: HUD 2007-2016 PIT Counts by CoC
A Model for other Populations?

- Mutual Accountability
- Strategic Resource Alignment
- By Name List
- Data Quality
Best Practice Examples

• Virginia and Connecticut were first two states to receive USICH designation.

• Connecticut: Key state partners:
  • VA Connecticut Healthcare System, VA SSVF managers, the state Departments of Housing and Veterans Affairs, CT Heroes Project, nonprofit providers of homeless services across the state, the co-leads of Zero: 2016, and the Reaching Home Campaign

• Virginia: multi-pronged approach
  • Emphasis on coordinated entry and by-name list (VetLNK)
  • Enhanced and trauma-informed services
  • Focus on benefits and employment
Prevent/end chronic homelessness by 2018

- 7 of 9 CoCs appear to have capacity to end CH in 2017
- None have submitted to USICH
- Strong progress growing PSH
- Not always direct match
  - BoS geography, low shelter
  - Entry requirements/criminal backgrounds
  - Timing of vacancy and identification of chronic status may not line up
### Inputs

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Individuals experiencing chronic homelessness (2017)</td>
<td>960</td>
</tr>
<tr>
<td>B</td>
<td>Annualization factor (based upon projections for inflow and undercount)</td>
<td>30%</td>
</tr>
<tr>
<td>C</td>
<td>Total inventory of supportive housing units for households without children (2017)</td>
<td>10,821</td>
</tr>
<tr>
<td>D</td>
<td>% of supportive housing units that turnover annually</td>
<td>18%</td>
</tr>
<tr>
<td>E</td>
<td>% of supportive housing dedicated to chronic homelessness (2017)</td>
<td>38%</td>
</tr>
<tr>
<td>F</td>
<td>% of non-dedicated supportive housing prioritizing people experiencing chronic homelessness</td>
<td>96%</td>
</tr>
<tr>
<td>G</td>
<td>Newly created supportive housing units to become available in 2017</td>
<td>224</td>
</tr>
<tr>
<td>H</td>
<td>Newly created supportive housing units to become available in 2018</td>
<td>177</td>
</tr>
<tr>
<td>I</td>
<td>Newly created supportive housing units to become available in 2019</td>
<td>169</td>
</tr>
</tbody>
</table>

### Impacts

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of individuals experiencing chronic homelessness at beginning of year</td>
<td>960</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Number newly entering or not counted in Point-In-Time count or other data used</td>
<td>284</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>3</td>
<td>Projected annual need</td>
<td>1244</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>4</td>
<td>Total available supportive housing inventory for households without children</td>
<td>10821</td>
<td>11045</td>
<td>11222</td>
</tr>
<tr>
<td>5</td>
<td>Supportive housing units dedicated to chronic homelessness</td>
<td>4891</td>
<td>5115</td>
<td>5292</td>
</tr>
<tr>
<td>6</td>
<td>Annual turnover of dedicated supportive housing units</td>
<td>859</td>
<td>898</td>
<td>929</td>
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<tr>
<td>7</td>
<td>Total non-dedicated supportive housing for households without children</td>
<td>5930</td>
<td>5930</td>
<td>5930</td>
</tr>
<tr>
<td>8</td>
<td>Annual number of non-dedicated supportive housing units that will turnover</td>
<td>1041</td>
<td>1041</td>
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</tr>
<tr>
<td>9</td>
<td>Non-dedicated supportive housing turnover units prioritized for chronic homelessness</td>
<td>1002</td>
<td>1002</td>
<td>1002</td>
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<tr>
<td>10</td>
<td>Chronically homeless individuals housed through dedicated supportive housing</td>
<td>859</td>
<td>898</td>
<td>929</td>
</tr>
<tr>
<td>11</td>
<td>Chronically homeless individuals housed through prioritized supportive housing</td>
<td>1002</td>
<td>1002</td>
<td>1002</td>
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<tr>
<td>12</td>
<td>Chronically homeless individuals housed through newly created supportive housing</td>
<td>224</td>
<td>177</td>
<td>169</td>
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<tr>
<td>13</td>
<td>Total number of individuals experiencing chronic homelessness housed</td>
<td>2084</td>
<td>2077</td>
<td>2100</td>
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<tr>
<td>14</td>
<td>Number of individuals experiencing chronic homelessness at year end</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>Percent change since end of 2017</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Best Practice Examples

- **Utah** reduced CHI more than 90% (1,932 in 2005 to 168 in 2016)
- **CT** places all CHI in permanent housing in 90 days or less
Prevent and end homelessness among families with children by 2020

• Poignant input from families with lived experience, emphasizing trauma to children of becoming homeless

• Primary intervention in Ohio for family homelessness = Shelter + RRH (79% of estimated 4,628 homeless families received RRH)

• Local CoCs leading with housing first orientation, focus on permanent placements
Family Homelessness Down 30%

OH: People in Families Experiencing Homelessness

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>2010</td>
<td>4,850</td>
</tr>
<tr>
<td>2011</td>
<td>5,218</td>
</tr>
<tr>
<td>2012</td>
<td>6,122</td>
</tr>
<tr>
<td>2013</td>
<td>4,714</td>
</tr>
<tr>
<td>2014</td>
<td>4,119</td>
</tr>
<tr>
<td>2015</td>
<td>3,617</td>
</tr>
<tr>
<td>2016</td>
<td>3,458</td>
</tr>
<tr>
<td>2017</td>
<td>3,386</td>
</tr>
</tbody>
</table>
Best Practice Example: Virginia

- Family homelessness in Virginia down 46.5% in 7 years (2010-2017)
- Statewide orientation toward Housing First
- Retooled crisis response system – funding shifted to Rapid Rehousing
Prevent and end homelessness among youth and young adults by 2020

YOUTH HOMELESSNESS IN THE UNITED STATES

ANNUALLY:
- 550,000 youth & young adults

ANY ONE NIGHT:
- 46,808 youth & young adults experience homelessness without a parent/guardian

IMPACT OF FOSTER CARE
- 36% who age out of foster care experience homelessness

LGBTQ
- Up to 40% of youth experiencing homelessness are LGBTQ

YOUTH OF COLOR
- Over half of youth experiencing homelessness are youth of color

DEFINITIONS

“youth homelessness” encompasses homelessness among all unaccompanied youth and young adults 12 – 24

“youth” refers to under 18-year-olds

“young adult” refers to 18 – 24-year-olds

“unaccompanied” refers to a youth not under the care of a parent or legal guardian

“parenting youth” are people under age 25 with children of their own

We can end youth homelessness in the United States by the end of 2020

Here’s how

Barbara Poppe and associates
The collective for impact
WHAT WILL IT LOOK LIKE WHEN WE’VE ENDED YOUTH HOMELESSNESS?

PREVENTION
Early warning signs are seen & homelessness is prevented in schools, child welfare & juvenile justice.

YOUTH OF COLOR & LGBTQ YOUTH FOCUS
Youth of color & LGBTQ youth are safe & welcomed in every program. Young people's personal agency is valued.

EMERGENCY RESPONSE
In every community, shelter & family re-connection supports respond immediately to end the emergency of homelessness.

CARE FOR FAMILIES
Support for families is prioritized whenever this connection is safe & appropriate for the young person.

SAFE & STABLE HOUSING
Young adults who become homeless are supported to secure safe and stable housing quickly and transition to independence.

Source: A Way Home America
Local perspectives

• Generally CoCs and providers did not raise topic of homeless youth and young adults
• CoC’s have not yet begun to develop plans to serve youth and young adults aligned with federal benchmarks and criteria
• Trying to serve young adults within adult shelters was raised noting that services were not developmentally appropriate
• Just beginning to collaborate with mainstream youth systems (i.e. child welfare, youth employment programs, etc.)
• Communities participating in national demonstration projects noted these as ways their community was beginning to tackle youth and young adults homelessness
Ohio Emerging as National Youth Leader
BP3  the legend is not readable  
Barbara Poppe, 7/31/2017

BP4  can you make it larger print?  
Barbara Poppe, 7/31/2017

BP5  Voices with "s"  
Barbara Poppe, 7/31/2017
Promising Practices

- Commit to prevent and end youth homelessness and **mobilize cross-sector partners**, especially public systems that serve youth.

- **Include youth** with lived experience in planning and program delivery.

- **Scale up resources** to help youth and young adults **find safe and stable housing quickly**.

- **Support the transition to independence** through connections to family, wellbeing, education and employment.

- **Ensure youth of color** and LGBTQ youth have access and equitable outcomes.
Reduce homelessness among single adults by one-quarter by 2020

• Largest proportion of people experiencing homelessness (66% in 2017)

• Non-chronic, non-Veteran singles have highest unmet need:
  • Diversion
  • Shelter best practices
  • Rapid rehousing (only 29% of annualized single individuals received RRH)
  • PSH turnover
Disparities: Disproportionate Rates of African-Americans in Homeless Population

In Ohio, percent of population that is Black in a county is significant indicator of homelessness at the community level

Ives, 2017
Wrap Up

• Strong foundation of investments and local partnerships
• Broad recognition of effective and evidence-based practices
• Opportunity for alignment of investments and actionable strategies
• Peer to peer sharing opportunities
• Improving data
• Engagement in the process to develop statewide plan
Additional Information

• Connecticut’s Statewide work: Opening Doors – CT
  http://pschousing.org/reachinghome

• Virginia’s Statewide work:
  https://www.va.gov/homeless/about_the_initiative.asp

• Minnesota’s Statewide work:
  http://www.headinghomememnnesota.org/

• Utah’s State Performance Info:

• Houston’s progress:
  http://www.homelesshouston.org/local-data-and-research/