CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs

P1. Leveraging Housing Resources

P1a-b. Development of new units and creation of housing opportunities

Community Shelter Board (CSB), the Unified Funding Agency, working on behalf of the CoC, solicits new projects annually by requesting Concept Papers – a high level overview of a proposed project. If the CoC approves a Concept Paper, the applicant prepares a comprehensive Project Plan for review, approval and prioritization by the CoC and the Citizens Advisory Council (CAC), a group comprised of people with lived experience of homelessness and expertise on this topic. The Project Plan must demonstrate mobilization of all resources, including state tax credits, Public Housing Authority vouchers, Medicare/Medicaid, healthcare plans, HOME funding, local city and county funding, and CoC funding. Proposing organizations work with Columbus Metropolitan Housing Authority (CMHA) to secure Housing Choice Vouchers.

P1c. Landlord Recruitment

Over the last three years, CSB developed and funded the Home4Good Landlord Initiative to improve our landlord recruitment work, which provides financial assistance to landlords to incentivize them to work with the vulnerable, second-chance renters our system serves. The program has two elements – recruitment and ongoing support – to increase access to market rate and affordable housing for people facing homelessness. The Community Housing Manager is a newly added position that has the exclusive role of recruiting and retaining landlords by visiting apartment complexes and covering both known and new housing complexes that we have not previously worked with, establishing relationships, following up on housing leads and continuously marketing our program to owners and property managers, accounting for geographic areas where people experiencing homelessness want to live but have not been able to find a unit. The Community Housing Manager also manages and updates the list of all available units and landlord contact information for the system.

CSB provides a financial incentive for any new unit that landlords add to our system. New landlords receive a onetime payment of $500 for one- or two-bedroom units and $750 for units with three or more bedrooms. The participating landlord agrees to dedicate the unit to people served by our programs for two years. CSB assists program participants with rent and security deposits, improving stability for both landlord and tenant. Landlords benefit from low vacancy rates, as our system always has tenants ready to move in quickly, and ongoing supportive services available to program participants to help them maintain stability.

CSB manages a Risk Mitigation fund for landlords. The fund reimburses a landlord for lost rent if a client abandons the unit or does not pay their rent and pays for documented unit damages the landlord incurs. The fund helps sustain the landlord relationship and avoid a potential eviction or refusal to rent to future tenants from our system. We have learned that landlords rarely need to access the Risk Mitigation fund, but it gives them peace of mind that encourages them to take on the perceived risk of partnering with homelessness programs. CSB works with Columbus Apartment Association to market Home4Good to landlords and property owners. CSB currently has 659 landlord partners. As a direct result of this strategy, in the past 12 months, we successfully added 48 new landlords in our programs. Without Home4Good we would not be able to reach as many new landlords in such a tight rental market.

As a more recent practice, CSB's Housing Department surveys landlords regularly to identify opportunities for further collaboration. CSB holds a quarterly landlord roundtable meeting based on the needs reflected in the surveys; recent speakers included a Columbus Mediation representative on landlord-conflict resolution resources, a City of Columbus Code Inspection officer and a City of Columbus City Attorney on how to maintain code compliant units. Every six months, CSB conducts face-to-face meetings with landlords with the highest number of units in our system to maintain relationships. We have learned that the roundtable and intensive recruitment and retention strategies helps landlords better understand our system and programs and engages both large and small landlords. These strategies have increased the number of Rapid Re-housing (RRH)

and scattered sites Permanent Supportive Housing (PSH) units that are available to people experiencing homelessness. To further increase the number of housing units, including units in areas where historically we have not been able to secure them, CSB works with Columbus Apartment Association to match our current landlord list with their member list and send out targeted marketing communication to landlords not participating. CSB will work with CMHA to get access to their list of landlords, and will use this list as another outreach mechanism to reach landlords that otherwise are not engaged. A performance measurement system is in place to consistently measure progress on the number of new landlords and units gained as a result of these efforts and the number of landlords retained. The units are mapped to show where we have concentrated units, areas of coverage and areas with lack of coverage for future landlord targeting and expansion. Padmission will be assessed for feasibility as a better real-time tool to connect individuals and families with landlords and as a landlord repository and recruitment tool.

P2. Leveraging Healthcare Resources

All PSH projects partner with community mental health, treatment, and recovery services for program participants who qualify for and choose such services. CSB's new Outreach provider is from Mount Carmel, one of our region's main hospital systems. Mount Carmel has provided street medicine services for many years. As they work to engage and house unsheltered people, they will help our system improve access to healthcare services, including during the transition from unsheltered homelessness to permanent housing.

CSB recently established new Crisis Response Specialist positions for PSH and shelter programs, using ARPA funding provided through the City of Columbus. These Specialists will be embedded in programs to develop supportive relationships with residents and provide immediate mental health crisis services when needed, helping to prevent violence, overdoses, suicides, and responses from emergency services that often are not the most appropriate intervention.

P3. Current Strategy to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness.

P3a. Current Street Outreach Strategy

Our system's core Outreach Team consists of six Outreach Specialists and one Outreach Coordinator, funded by local (public and private), and federal funding sources. Our system also has a YHDP-funded Coordinated Access and Rapid Resolution (CARR) Team for transition-age youth that conducts street outreach and outreach at youth drop-in centers. The CARR Team can access all system shelter and housing opportunities, including specialized PSH, RRH, and transitional housing for youth. These Outreach positions are augmented by other community-based outreach, all of which coordinate with each other to cover as much area as possible and prevent duplication of effort, through the Collaborative Outreach Team. This collaborative effort includes the PATH program, Primary One Health and Lutheran Social Services (Healthcare for the Homeless funded agencies), Volunteers of America (SSVF funded program with an Outreach component), Make-A-Day Foundation, warming/cooling centers, food sites, mental health providers, Columbus Coalition for the Homeless, Veterans Administration Outreach program, Franklin County Metro Parks, the local bus system, faith-based partners, Columbus Police Department, the City of Columbus, and Franklin County. Daily, a minimum of 18–20 people provide street outreach services community-wide. Monthly Collaborative Outreach Team meetings and daily informal coordination enable partners to leverage each other's expertise and divide the workload to best serve unsheltered people. Coordination with community partners help identify others who need assistance. Outreach Specialists visit different areas of town and encampments, to ensure maximum coverage of services. The Outreach Team operates Monday through Friday and staggers shifts to engage as many people as possible from 8 a.m. to 8 p.m. at known encampments, and at other places unsheltered people congregate.

In early 2022, CSB issued a Request for Proposals for a new provider for outreach services, to improve our system's capacity to service people experiencing unsheltered homelessness. The CoC selected Mount Carmel,

one of our region's hospital systems, effective August 1, 2022. Since 2001, Mount Carmel's Street Medicine Team has provided direct physical, mental, spiritual, and social care to unsheltered people following evidence-based, housing and health focused best practices. As Mount Carmel adds outreach services to their street medicine services, our system will be able to provide both housing and healthcare resources to those most vulnerable in our community with the same team.

- Mount Carmel's new Housing Outreach Team collaborates with the existing Mount Carmel Street Medicine Team, which includes a Mobile Medical Coach and teams that make daily rounds in the community that are well-known to unsheltered people in the area. These Outreach Teams are multidisciplinary and include medical providers paired with a paramedic/nurse, psychiatric nurse practitioner paired with a paramedic/nurse, case managers paired with paramedic/nurse/peer supporters, and a community paramedic that pairs with community partners for specialty services. The Outreach Team will also collaborate with Mount Carmel's Healthy Living Center, Crime and Trauma Assistance Program, Social Care programs, and Welcome Home program, all of which help people transition from homelessness to stability. Each program supports specific needs of vulnerable populations and provides free services to the community member.
- Mount Carmel will lead the monthly Collaborative Outreach Team meetings and daily coordination and joint work with other community Outreach partners. Their full integration into the Homeless Management Information System (HMIS) and the Unified Supportive Housing System (USHS), the system's coordinated entry into PSH, improves the efficiency of the processes used to refer and house people experiencing unsheltered homelessness.
- Mount Carmel uses a Housing First approach to outreach engagement and prioritizes harm reduction approaches. Their street medicine capabilities mean that healthcare professionals can meet people anywhere in the community and provide direct care without barriers such as billing or insurance issues. Their ability to provide these services builds trust among unsheltered people and helps with housing engagement.
- Mount Carmel's team includes certified Community Health Workers, bilingual caseworkers and certified Peer Recovery Supporters who have lived experience with addiction, recovery, and homelessness. These Peer Supporters build relationships with unsheltered people and help them access addiction treatment and housing services. They maintain the relationship, continue to work on long-term treatment and housing. Once housed, the team continues to provide stability and recovery services to help maintain housing.

Outreach Specialists help connect people to the Homeless Hotline for access to emergency shelter, if desired, where they are screened and prioritized for RRH and PSH programs. The CoC especially targets vulnerable populations, like people experiencing unsheltered homelessness who are survivors of domestic violence, dating violence, stalking, or assault. They can be referred directly to our system's specialized CoC-funded RRH program for survivors without going through the normal shelter-based RRH screening and prioritization process. Unsheltered transition-age youth can be connected directly to specialized youth RRH, PSH, and transitional housing programs without entering shelter. Outreach Specialists can house unsheltered people directly into PSH via USHS, without entering shelter. When Outreach Specialists house people directly from an unsheltered situation, they maintain the relationship and help people transition to housing and access needed services, in collaboration with RRH and PSH program case managers.

Outreach partners also collaborate with the City of Columbus to address encampments of concern to neighborhoods and businesses. CSB is leading a stakeholder group that includes the City of Columbus to develop a shared community response to encampments based on USICH guidance. We encourage the City to only consider camp remediation when all members of an encampment have been engaged and offered re-housing support and there is a re-housing pathway for each individual who is interested. If the City decides to remove an encampment, we request advance notice for Outreach Specialists and community partners to have the opportunity to engage and assist camp residents with housing and other services prior to the camp's disruption. The Columbus Police Department participates in monthly outreach meetings and regular informal coordination, giving us the opportunity to educate law enforcement about constructive approaches to unsheltered homelessness and link people experiencing homelessness to our system's services. During the

COVID-19 pandemic, the community provided access to restrooms and handwashing facilities because the public spaces unsheltered people used were closed. This public health effort sets the stage for a more comprehensive community conversation about public space and access to facilities for people experiencing homelessness. The goal is to develop a consistent approach to encampments that centers the needs and preferences of the people experiencing unsheltered homelessness and provides the most effective and appropriate services focused on low-barrier access to shelter and housing.

CSB measures performance for the Outreach programs by analyzing the number of households served against goals put in place assessing caseload capacity, program occupancy/utilization rate based on capacity, average length of participation, usage and utilization of financial assistance for housing purposes, successful outcomes and successful housing outcomes, rate of exit to PSH, recidivism and cost per household and successful outcome achieved. The USICH Guidance on Core Elements of Effective Street Outreach are utilized to respond to unsheltered homelessness as Outreach employs emerging practices to coordinate for re-housing success. Our system's approach to outreach is effective and will continue to improve with Mount Carmel's leadership and collaboration with community partners, but we need additional resources to hire more Outreach Specialists, which is one of the most demanding jobs in any homelessness system. Larger, multi-disciplinary teams will be able to provide more services and better coverage. Hiring efforts will emphasize recruitment of people with lived experience of unsheltered homelessness. We know that we are missing some unsheltered people and additional Outreach Specialists, especially those with lived experience, would enable our system to engage more people over a larger geographic area and spend more time building the trusting relationships needed to engage and house people experiencing unsheltered homelessness. Our community is growing fast, and our Outreach effort must grow with it to serve everyone.

P3b. Current Strategy to Provide Immediate Access to Low-Barrier Shelter and Temporary Housing for Individuals and Families Experiencing Unsheltered Homelessness

Access to low-barrier shelter is centralized via the Homeless Hotline, part of the CoC's coordinated entry system. The Homeless Hotline is a local phone number that is staffed 24/7/365. It uses HMIS and direct contact with shelters to maintain a comprehensive picture of all available shelter beds and connects individuals and families to the most appropriate option. All families with children and pregnant women experiencing homelessness receive immediate access to shelter. If our system's two family shelters are full, CSB uses hotels to accommodate families and pregnant women. No family is left unsheltered at any point in time. During the past three years, additional resources enabled our system to shelter all single adults who wanted and needed shelter as well. We leased entire motels to provide non-congregate shelter to single adults and we were able to test this model of sheltering. People who were positive for or exposed to COVID-19 received shelter and medical care at a separate hotel site. When COVID-19 funds expire, it is expected that the COVID-19 hotel shelter and additional capacity will close and some single adults will be on a waitlist in the warmer months. If additional sustained funding becomes available, the shelter beds opened during the pandemic for single adults could become permanent, alleviating the warmer months' gap in shelter beds. Even with a gap in shelter beds during the summer, access to a bed occurs within two to three days of the person being placed on a shelter waitlist. Non-congregate sheltering is a viable model, but it is more expensive to implement and maintain. In the colder months, we operate additional overflow capacity by adding beds to existing shelters and use hotels, ensuring everyone who wants and needs shelter receives it, including sex offenders that otherwise are not able to be sheltered in regular shelters due to proximity issues. Outreach Specialists help people experiencing unsheltered homelessness access the Homeless Hotline as part of the engagement effort.

There are no minimum requirements for entering shelter. The Homeless Hotline confirms that callers do not already have a safe, viable alternative to shelter before connecting people to additional resources. If callers have no other safe options, the Hotline reserves a shelter bed for them and helps with transportation to the shelter. Shelter guests are only involuntarily exited from shelter if they present an immediate threat to staff and other guests. Shelter restrictions are analyzed quarterly to make sure restrictions are limited and unbiased. The

decision to restrict someone from shelter for lack of progress is based solely on that person's engagement, not on actual housing outcomes. No one is exited or restricted because they could not secure housing due to the affordable housing crisis in our community. Lack of engagement because of a severe behavioral health barrier is handled via system case conferencing and coordination with behavioral health providers, rather than shelter restrictions. Individuals who are restricted have an appeal process they can access.

The new USICH guidance on working with those experiencing unsheltered homelessness, and an increase in encampments around our community prompted considerations for a different approach for offering immediate accommodations for the unsheltered population. Some unsheltered individuals do not want to access emergency shelters because of the shelter's congregate nature. We are now piloting an approach that provides hotel rooms as non-congregate, temporary accommodations coupled with supportive services until the permanent housing process is completed.

Our system has two low-barrier transitional housing programs for transition-age youth, one of which is a YHDP funded program. Youth can access both programs via Outreach Specialists, the youth-specific coordinated entry, or shelter case managers; year over year we increased the number of transition-age youth we served by 20%. Once youth connect with the coordinated entry, a majority of them immediately begin receiving community referrals to address their mental and physical health, education, employment, mentorship, and life skills (M=0.4 days; n=128). Once exited from the coordinated system, only 2.57% of those who exited have an eviction on record within a year.

Our low-barrier shelters have been effective in quickly connecting people to housing opportunities and RRH programs, based on system-wide standardized screening and prioritization tools that identify the level of support each person needs and wants and the most appropriate program to facilitate quick re-housing. Shelter length of stay continues to rise, but this is a result of the affordable housing crisis, not issues with the shelter or re-housing system. We continue to improve processes and work with community partners and policy makers to address the lack of affordable housing for very low-income people.

P3c. Current Strategy to Provide Immediate Access to Low-Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

For the fiscal year ending on June 30, 2022, 423 unsheltered households were engaged and served by Street Outreach programs participating in HMIS; 93 households were successfully housed (30%) and 41 households opted to enter emergency shelter.

For RRH, over the past three years our CoC has expanded family RRH programs; added RRH, transitional housing, and PSH for transition-age youth via the YHDP; and added a CoC-funded RRH program for survivors of domestic violence, dating violence, sexual assault and stalking, to increase capacity to serve people experiencing both unsheltered and sheltered homelessness. This year CSB adjusted the referral system so that Outreach Specialists could refer unsheltered people directly to the RRH program for survivors without entering shelter. The Housing Assessment Screening Tool (HAST) prioritizes and expedites referrals of families and single adults to RRH programs based on vulnerability. Our new HMIS system, implemented in 2021, includes separate scored HAST "pools" for single adults and families that keeps track of each person's priority (score) – this implementation in HMIS significantly improved the efficiency of the referral process to RRH programs, moving to a seamless process that also incorporates our coordinated entry requirements. However, even with the added RRH capacity we are still unable to meet demand for single adults in need of RRH services based on vulnerability, which is why we are looking to further expand the CoC's RRH programming.

For PSH, our CoC manages vacancies and prioritizes program participants for PSH using the centralized Unified Supportive Housing System (USHS). USHS was established in 2008 by CSB, CMHA, and the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board, as the coordinated entry into PSH. USHS and PSH

programs are based on Housing First principles. Originally, Outreach Specialists and shelter case managers submitted applications to USHS on behalf of clients. Through analysis of HMIS data, CSB learned that the practice did not always result in the people with the most severe service needs accessing PSH. Instead, the system sometimes prioritized qualified clients who were best able to complete the needs assessment and obtain documentation, which could miss people experiencing unsheltered homelessness who could be more difficult to engage. Due to this, we moved to a process where USHS continuously screens active system Outreach and shelter clients for PSH using HMIS data. Monthly, CSB prepares a "hotlist" of prioritized clients based on their homeless status, history of homelessness, and self-declared disability. For the households prioritized by USHS as chronic or long-term homeless, the household's case manager is asked to submit a standardized service needs assessment. USHS uses this assessment to prioritize households for PSH based on vulnerability and match them to open units according to their needs and preferences. Case conferencing identifies those who need immediate assistance but may not rise to the top of the hotlist. USHS adheres to HUD CPD-16-11, prioritizing chronically homeless households first, then long-term homeless households with severe service needs. We found this process more effectively targets those with the longest homeless time and the most severe service needs, including more people experiencing unsheltered homelessness. With the addition of the Emergency Housing Vouchers in our community, with agreement from the PHA, we dedicated all the vouchers to the homeless and disabled population. Due to the immediate availability of this significant number of vouchers we were able to temporarily open up PSH applications to not only those that are on our hotlist but also to families and individuals with a disability that do not have the longest histories of homelessness, in an effort to prevent households from reaching a chronicity state. As the chart in section P4 shows, through this intervention we managed to keep the chronic homeless numbers stable throughout the COVID-19 pandemic, even though housing activities became extremely difficult during this timeframe. PSH is the most effective intervention for Outreach clients who have long histories of homelessness and disability. PSH programs are required to have processes that expedite the housing process so that vacancies are filled quickly, and people spend as little time as possible in an unsheltered situation or in an emergency shelter. Our system's PSH programs have an overall 99% success rate. People entering PSH from an unsheltered situation have an over 90% success rate. Continuously adding PSH units – including the PSH programs identified below – is a critical component of our CoC's strategy to reduce unsheltered homelessness. Our system has a good, coordinated effort to quickly house people who are in an unsheltered situation and additional PSH and Outreach capacity is essential to identify and house more.

Our CoC has the following site-based PSH projects in the development pipeline: (1) National Church Residences Permanent Supportive Housing, Berwyn East Place: 36 units designated for seniors (aged 55 and older) with advanced geriatric conditions who are experiencing chronic homelessness. Tailoring PSH to this older population is important in our community, where 54% of people experiencing unsheltered homelessness are aged 40–64 and 4% are over age 65. CMHA committed to providing HCVs. The project is projected to open in spring 2024. (2) Community Housing Network, Poplar Fen Place: 35 units dedicated to chronically homeless individuals aged 55 and older. CMHA committed to providing HCVs. The project is projected to open in fall 2024. (3) Beacon Communities, PSH: 70 units, all dedicated to people experiencing chronic homelessness. CMHA committed to providing HCVs. The project is projected to open fall/winter 2024. (4) National Church Residences Permanent Supportive Housing, Expansion: Adds 35 units in exiting supportive housing projects that are currently not dedicated as PSH units. The units will be occupied by chronic homeless individuals through unit turnovers. CMHA is already providing HCVs.

P4. Updating the CoCs Strategy to Identify, Shelter, and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

1. Our system's Street Outreach program participates in the CoC's HMIS, collecting data on services and referrals for people experiencing unsheltered homelessness. Inclusion in HMIS gives our CoC the ability to use data to analyze the needs of the unsheltered population and identify those who meet chronic and long-term homelessness criteria to prioritize for housing. CSB analyzes demographics and trends over time and focuses on

continuous performance improvement. Street Outreach programs adhere to performance metrics that set standards for successful outcomes (75%), successful housing outcomes (55%), six months recidivism (< 10%) and average length of participation (90 days), among other output-based metrics that set goals for number served, exits to permanent supportive housing, full utilization of program capacity and efficient utilization of funds available per person served and per successful outcome achieved. A renewed focus will be to track time to housing for the unsheltered population with the goal of reducing the overall time by reducing the time for the components of the housing process – time to housing referral, time for eligibility determination and submission of housing documentation, and time to lease signing.

CSB tracks time to housing via USHS, as shown in the table below. This work will be refined going forward to assess metrics by subpopulations (e.g., unsheltered population vs. severe service needs sheltered population). Continuous data-informed system and process improvements enabled us to prioritize people with the longest homeless time and most severe service needs for PSH. The difficult affordable housing market is a serious problem, as evidenced by the current time to housing. Our system strives to optimize the elements of the housing system we can control, to speed the process. The numbers below reflect time to housing in 2022, an average of 160 days. In contrast, in 2020 the time to housing ranged between 74 and 181 days, and we had an average of 122 days to housing. The deepening affordable housing crisis impacted our ability to house by a 31% increase in our time to housing.

Average Days for USHS Processes								
	January	February	March	April	May	June	July	August
Invite to Assessment Submission	14	1	22	-3	-2	-1	4	2
Invite to File Submission	18	7	19	3	10	6	8	13
File Submission to Pool Entry	6	1	2	0	2	1	2	1
Pool Entry to Housing Referrals	64	70	46	36	45	46	27	76
Referral to Housed	71	83	92	93	104	98	125	80
ID Date to Housed Date	148	157	159	155	186	146	183	143

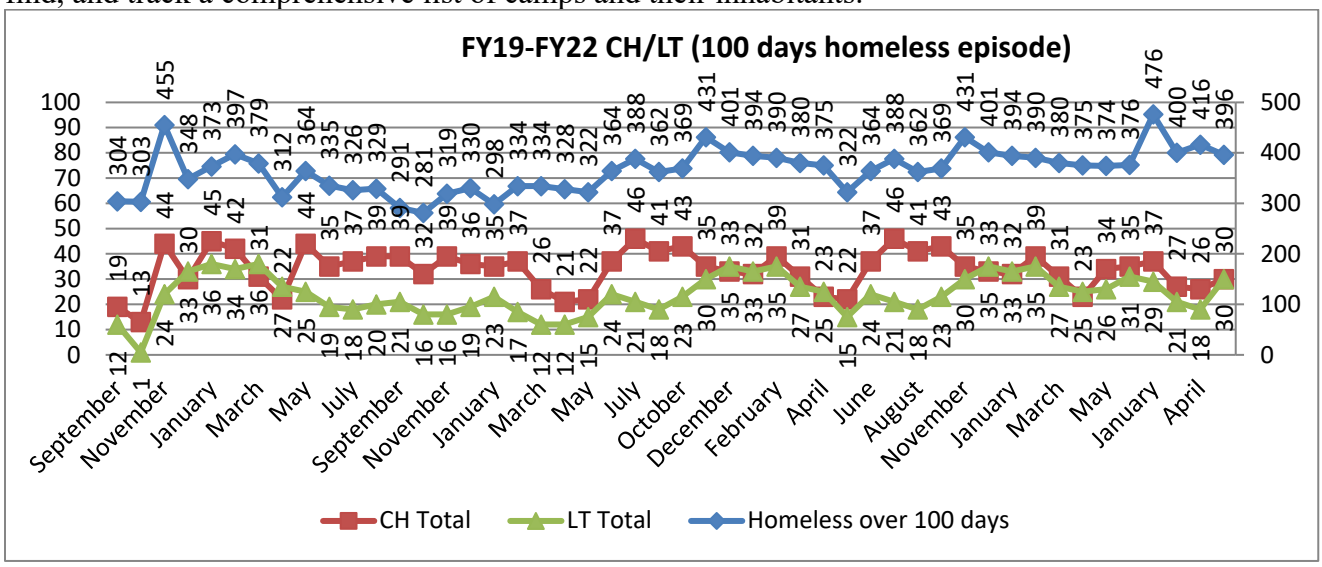
Adding capacity to our Street Outreach program will allow us to broaden the team's reach and collaborations by working with mainstream healthcare providers, social service, and employment agencies to bring more services to those unsheltered. They will help with a housing focused engagement, while sharing information about the other needs people have and improving our ability to identify and address trends and best practices.

CSB's data indicates the demographics of people experiencing unsheltered homelessness differ from the general homeless population in our community. Understanding these demographics ensure our Outreach efforts and teams are inclusive and representative of the people we serve and services are culturally appropriate. Better understanding the unsheltered population will also help us improve access to low-barrier shelter.

- Men are overrepresented among people experiencing unsheltered homelessness; 63% are male and 36% are female, while the sheltered homeless population is 55% male and 44% female.
- Unsheltered people tend to be older than the sheltered population, with 54% aged 40–64 years and 4% over 65 years.
- 36% of people experiencing unsheltered homelessness are African American, 55% are White, and 9% are Multiracial or Other. The sheltered homeless population in our community is 61% African American, 32% White, and 7% Multiracial or Other.
- Almost everyone experiencing unsheltered homelessness self-reports a disability (96%), while only 59% of the sheltered population do so. 84% report a mental health disorder, 61% a substance use disorder and 62% a chronic health condition.

Data over the past three years indicates that the number of people with over 100 days of continued homelessness is increasing. A more robust Outreach Team will help to understand this trend, more comprehensively identifying where unsheltered people are living and what engagement strategies are most effective to help them access low-barrier shelter and permanent housing. Our current outreach effort is strengthened by leveraging community partners. A larger structured team is needed to fully engage unsheltered

people over time, better identify encampments, especially camp locations in wooded areas that are difficult to find, and track a comprehensive list of camps and their inhabitants.



Under this plan, CSB will lead the creation of an "active list" to help identify people on the street regardless of the unsheltered individual's use of services. This active list of everyone who is unsheltered will be updated regularly by all Street Outreach providers in the community. Outreach Specialists will be provided with mobile technology that will expedite the housing process and provision of services by working with unsheltered individuals where they are located. CSB will improve the collaboration between the Outreach Team and RRH services to help facilitate the housing process of unsheltered and severe service needs individuals.

There is community consensus that a combined system of data and information for Street Outreach and medical teams is needed, one that can potentially track individuals before their information is available for HMIS purposes and/or a system where the healthcare and homelessness systems can safely collaborate and share information about people that need assistance. For example, emergency rooms often serve unsheltered and severe service needs individuals who are unknown to the Outreach Teams and who are not appropriately engaged for housing purposes. The ability to share information will not only improve the service provision to this population but will also increase the healthcare participation in the care of vulnerable individuals. Access of the Outreach Team to a system used by hospitals, like EPIC, will significantly increase the quick identification and appropriate service provision for individuals that otherwise may not be identified as needing services or whose identification would be delayed. This is a long-term strategy that will be developed by a multi-stakeholder workgroup.

Considering the challenges inherent to the online environment, CSB will assess its current system to find opportunities to reduce duplicative data collection and entry processes, so an individual does not have to provide the same data multiple times.

2. For low-barrier shelter and temporary accommodations during the COVID-19 pandemic, additional resources enabled our system to shelter all single adults who wanted and needed shelter. CSB leased entire motels to provide non-congregate shelter to single adults which allowed us to test this model of sheltering. If additional sustained funds become available the shelter beds opened during the pandemic for single adults could become permanent, alleviating the warmer months' gap in shelter beds. Non-congregate sheltering is a viable model, but it is more expensive to maintain and implement.

The Homeless Hotline, which is our first step in accessing emergency shelter, is monitored continuously by CSB staff with "mock calls" that follow prescribed scenarios to test and ensure that no person is denied shelter unless they have other safe accommodations in place. The scenarios tested cover a wide range of callers,

including but not limited to people who are inebriated, sex offenders, non-English language speakers, and people with various criminal backgrounds. Results of the calls are shared with the Homeless Hotline leadership as part of our continuous training and improvement efforts. We also monitor the Hotline for their phone wait time, and call reports are analyzed monthly and quarterly.

We already operate low-barrier shelters, and as a best practice, shelter guests are only involuntarily exited from shelter if they present an immediate threat to staff and other guests – individuals who are restricted can appeal the decision. CSB will continue to review and analyze quarterly the list of those individuals who are service restricted from shelters to ensure that the restrictions are not excessive, are valid and not biased, and to address inadequate restrictions. CSB will continue to refine use of data and examine how many clients are restricted from each shelter for use of drugs/alcohol inside the shelter and initiate community conversations around advancing harm reduction options by involving the local Alcohol, Drug and Mental Health Board. With greater emphasis on harm reduction, we will expand harm reduction coordination and training for Outreach and system partners.

CSB continuously works with emergency shelters and transitional housing programs to address the average length of stay and participant success rate. By decreasing the average length of shelter/transitional housing stays and increasing success rates, the positive bed turnover creates more availability for beds and low-barrier shelter and temporary accommodations expand without increasing the bed capacity of these programs.

3. For permanent housing, CSB's Housing Department, established in 2020, serves as a central point of contact for landlords and program participants to help resolve any challenges early, preventing evictions and returns to homelessness. The Housing Department focuses on expediting the housing process for both RRH and PSH programs. For RRH, CSB issues the first iteration of financial assistance on behalf of the client, usually the first month's rent, security deposit, and/or utility assistance. By handling these initial payments, CSB ensures quick payment and compliance with all funder requirements. For PSH, CSB operates the USHS, a centralized system for managing PSH vacancies and prioritizing program participants for PSH, depending on their needs and preferences. USHS continuously screens active system clients for PSH using HMIS data and case conferencing, including people experiencing unsheltered homelessness. Monthly, a hotlist is prepared with prioritized clients based on their homeless status, history of homelessness, and self-declared disability. For the households prioritized by USHS as chronic or long-term homeless, the household's case manager submits a standardized service needs assessment. USHS uses this assessment to prioritize households for PSH based on vulnerability and matches them to open units according to their needs and preferences. USHS adheres to HUD CPD-16-11, prioritizing chronically homeless households first, then long-term homeless households with severe service needs. All system PSH programs are contractually required to participate in USHS. USHS housing activities are tracked rigorously, with time to housing being the most important metric utilized. By reducing the time it takes to complete each of the housing components we will also improve the overall time to housing and the performance of the housing system (please see the table under section P4.1).

The Housing Department also manages our system's Rental Assistance programs. A dedicated Housing Inspector conducts inspections quickly, reducing the time to housing for program participants and vacancy time for landlords. In the past two years, 1,400+ inspections were completed and the average time to complete a new unit inspection is four days. A Community Housing Manager focuses on recruiting and retaining landlords in our very tight affordable housing market, aided by the Home4Good program. A Housing Administrator works with system programs to administer the technical aspects and requirements for rental assistance programs. CSB's problem-solving interventions and timely responses to landlords' needs have improved and expanded our housing abilities. A newly hired Client Housing Manager helps program participants gather necessary documentation for housing, a task that has become increasingly difficult during the COVID-19 pandemic. Identification documents, social security benefits, and certificates of disability are extremely difficult to obtain. The Client Housing Manager works with public entities to improve access for our system's clients and acquire

the needed documentation more quickly. Recently, CSB contracted with a LISW to conduct disability assessments for people who are otherwise eligible for PSH but who are unable to get a disability assessment due to long wait times or because the individual needs a specialized person to conduct the assessment. The LISW has extensive experience working with the homeless and disabled population with severe mental illness, addiction, or HIV/AIDS. This contract greatly expedites the eligibility determination process for severe service needs individuals. These new initiatives that address basic eligibility determination for PSH will also expand our ability to house those most vulnerable, unsheltered individuals who are unable to gather the necessary housing paperwork because of their vulnerabilities. The goal of the Housing Department is to expedite the housing process for individuals and families experiencing homelessness. The activities of the Housing Department are performance-focused on rapidly housing unsheltered and severe service needs individuals and families.

Establishment of CSB's Housing Department in 2020 allowed us to expedite inspections, vacancy processing, and landlord recruitment for scattered sites units. For PSH units that have HCVs, EHVs and other subsidies, the Housing Department meets weekly with CMHA to help move application packets and inspections forward quickly and address any barriers, including missing documentation. We continue to evaluate strategies to improve housing outcomes for people experiencing unsheltered homelessness, using robust data analysis. This coordination is just the start of our work to expand the CoC's ability to rapidly house individual and families with histories of unsheltered homelessness and severe service needs. As this coordinated system reaches its optimal operations it will expand to service more households. CSB measures performance for the permanent housing programs quarterly by looking at performance metrics that set standards for the volume of households served against the goals established based on their capacity (capacity multiplied by expected turnover rate), program utilization rate (95%), successful housing outcomes (90%), recidivism (<10%), rate of involuntary exits (<20%), housing stability (24 months), increases in income from employment (15%) and other sources (30%) and positive unit turnovers (20%). Programs that fail to meet goals are provided technical assistance and are required to establish quality improvement plans.

P5. Identify and Prioritize Households Experiencing or with Histories of Unsheltered Homelessness

The Columbus and Franklin County CoC, in contrast with other larger communities with a significant number of unsheltered individuals, has less than 1,000 unsheltered people at any point in time. However, this number continues to grow despite our efforts to implement a systemic response to unsheltered homelessness. This plan addresses improvements to our systemic approach that we believe, if implemented, can provide a model of how to implement a community-wide strategy to decrease the number of unsheltered individuals and house the most vulnerable, despite the affordable housing pressures felt nationwide.

Coordinated Entry Improvements

To make sure that people who are unsheltered are able to access housing or resources in the community, the coordinated entry process will include Outreach Teams with a presence at Drop-in Centers as another means of engaging unsheltered individuals. The consistent practice for the intake and re-housing process will happen at the location where the unsheltered person is at or is currently residing. This includes assisting someone with paperwork for services and housing. Drop-in and Warming Centers will be utilized for appointments and meetings, particularly in the colder months. This will allow for people, who otherwise would not engage, to access housing and services in an alternative way. The Housing Assessment Screening Tool (HAST) will be administered at intake but also after the person has been more deeply engaged. Often, once a relationship has been established, the HAST is able to provide a better reflection of the needs of an individual. Identification is a significant problem for housing purposes as individuals are missing basic documentation needed for housing. Acquiring this documentation can sometimes take a significant amount of time due to delays in processing by federal agencies or cross-state bureaucracies. Use of the CSB contracted LISW to expedite documentation and the Franklin County Recorder's Office to store birth certificates and use of the HMIS as a repository for identification documents is essential to move the housing process further.

Street Outreach Expansion and Coordination Improvements
Additional Outreach will improve consistent engagement with unsheltered people and allow us to cover a wider geographic area. We will also be able to link and coordinate more effectively with unsheltered individuals being discharged from hospitals and jail and help us better integrate community services and partners into outreach efforts. It will also improve staff recruitment and retention for these challenging roles.

The CoC will support projects that connect unsheltered people with housing resources. Additional Outreach Specialists are needed in the community, especially considering that the average current caseload per caseworker is 40 individuals. We will support projects that include cross-disciplinary team members to address various needs. We will adopt a zonal approach where each organization's members cover a specific sector of the community. This zonal approach allows Outreach Teams to become familiar with neighborhoods and develop trust with unsheltered individuals who are hesitant to utilize services. Agencies providing street outreach services will be expected to work together and standardize their teams following a set of best practices. The Collaborative Outreach Team will implement this coordinated approach. Outreach Specialists will be trained on a culturally sensitive response approach that is mindful of race and ethnicity, LGBTQ+ issues and trauma and additional complexities that individuals present. Establishing a coordinated approach between partners will be key to providing services. The CoC will support projects that provide survival services to unsheltered individuals including providing lanterns, blankets, insulin, or other resources that assist unsheltered persons at the time of engagement. The goal of these efforts is to promote familiarity and trust with Outreach Specialists and build a bridge to connect with housing services.

Street Outreach programs will target individuals who are often hard to reach, such as unsheltered individuals living in cars or families who fear separation. To further ensure unsheltered individuals' access to resources, the CoC will support partners that provide street outreach services during non-business hours. The CoC strategy will include reaching out to faith-based providers who have effective Outreach Teams and drop-in centers to establish collaborative partnerships that will aid in the identification of those who do not currently engage but need housing and services.

To further engage unsheltered individuals with severe service needs who are reluctant to use services, support will be given to programs designed to address fear of using the services – empowering people to embrace healthy change. To minimize fear associated with accessing services, programs that promote the concept of 'communities who are already together stay together' will be supported, such that they allow unmarried couples or groups of campers to stay together during the transition into housing. Projects are encouraged to incorporate the care of pets, whether a provider proposes to add to their outreach partnerships a veterinarian that visits encampments (this service currently exists but needs formalizing) or facilitation of a pet foster care program.

The City of Columbus commits to increasing the number of 24/7 drop-in centers and safe centers of support to be outreach hubs to accommodate the increase in Outreach Specialists and engagement goals outlined in this Plan. The outreach 'hubs' provide access for immediate/urgent needs and will be open during non-traditional hours. The Citizens Advisory Council will expand its presence to more sites frequented by unsheltered or previously unsheltered individuals, like the drop-in centers, for better engagement and peer support. The Columbus Coalition for the Homeless will continue to operate a warming/cooling center with the goal of adding more warming centers/drop-in centers that provide healthcare and behavioral healthcare services.

As part of leveraging behavioral health resources, we will explore a peer-supported warmline that focuses on severe mental health and addiction services. Additionally, we will consider funding peer-support centers that are open throughout the day, across the city. The programs that will be developed will increase access to housing navigation services, health care, and other supportive services. We will support a coordinated care plan, in which behavioral health, physical health, street outreach case management, and housing providers work

together in a coordinated manner to meet the needs of the person. The coordinated care will be managed by the Outreach Specialist to ensure the care pathways are meeting the person's needs through one consistent contact. The CoC will continue to leverage healthcare services by increasing awareness of the services that Managed Care Organizations provide. Our revamped Street Outreach program embeds a healthcare partner in the provision of their services, who can work alongside the team and follow unsheltered individuals into housing – maintaining the individual's trust along the way. Another goal will be to expand the use of healthcare navigators to provide services and help unsheltered individuals navigate health insurance options.

Prioritizing the Needs of Unsheltered Individuals and Needed Improvements: Local Voices

Stemming from the working groups and focus groups with unsheltered individuals (further described in section P6), *empowerment* was commonly cited as a necessity within the community for unsheltered individuals. To facilitate empowerment, partners will provide learning opportunities for unsheltered individuals and for those with a history of homelessness. The CoC funded projects will embed in their supportive services provision employment and job training services that will also help unsheltered individuals learn how to use computers and navigate websites. This is an essential skill as most applications to access benefits, housing, employment and other supportive services are online, and in general, unsheltered individuals and people with severe service needs are unskilled with this technology. Focus group respondents report that they would feel more comfortable completing the application processes alone because it would eliminate the discomfort of sharing personal identifiers with strangers. Teaching computer and navigation skills empowers people to be self-sufficient and independent in navigating services, including permanent housing.

Economic barriers hinder individuals from obtaining and retaining permanent housing. Because individuals with criminal backgrounds remain unhired despite an abundance of available jobs, support will be given to partners that work with companies to hire an unsheltered individual with skills, despite their criminal record. To prevent discouragement resulting from possible multiple unsuccessful interviews, support will be given to programs that help to line up jobs for unsheltered individuals. Peer support interventions are also encouraged. Hiring individuals who have themselves experienced homelessness as service providers offers jobs that help them maintain permanent housing and encourages those who are distrustful of accessing resources to engage and participate in services.

Another common theme that emerged from the focus groups is protection of self/personal belongings. Focus group informants made it clear that storage space is needed to protect their personal belongings, and this will be incorporated in the 24/7 drop-in centers. Partnerships with organizations that provide legal aid to protect individuals' employment status and housing/eviction status are encouraged, along with support to expunge criminal records. With respect to protection of self, programs and organizations that extend their assistance beyond typical business hours will be supported, along with shelters/soup kitchens that offer high-nutrition and a variety of foods, along with safe spaces.

The CoC will support Outreach programs that expand their information dissemination processes. Based on recommendations from the focus groups, further advertising via fliers and marketing materials will be incorporated, and the distributed information will include additional information such as upcoming weather reports. Use of social media to get information about housing, shelter availability and access to essential services is encouraged. Much information is spread via word-of-mouth between unsheltered individuals, and thus Street Outreach programs should take advantage of that knowledge to spread information in a way that is easy to pass along. To support existing social networks of care, the CoC plans to expand existing transportation programs to include transportation services that connect individuals to their families.

Permanent Housing Approach and Prioritization

For PSH programs, participants are prioritized via the USHS. Using HMIS data, all clients with long periods of continuous or episodic homelessness are identified and compiled into a monthly hotlist. Regular system case

conferencing and recommendations from Outreach Specialists help identify and add people who need PSH, including those who do not appear on the HMIS hotlist due to incomplete data. For the identified people, shelter or RRH case managers, or Outreach Specialists are invited to submit a Severity of Service Needs Assessment that covers physical, mental, behavioral, and developmental health, substance use, utilization of crisis or emergency services to meet basic needs (e.g., emergency rooms, jails), vulnerability to victimization, vulnerability to illness or death, and barriers to housing/risk of continued homelessness. Clients are prioritized for open PSH vacancies based on their Assessment scores. The Assessment automatically prioritizes people experiencing unsheltered homelessness – often extremely vulnerable with serious health challenges. Specifically, people experiencing chronic homelessness receive the highest priority; those with the highest scores, and therefore the highest need, are offered PSH first.

The case manager or Outreach Specialist for a prioritized client is notified when an appropriate PSH vacancy opens, so they can discuss the opportunity with the client. Prioritized clients can view the unit and learn about the PSH programs and can decline up to two PSH offers if they do not think it is a good fit for them. When a client accepts entry into a PSH program, CSB's Housing Department works with the organization operating the PSH program and CMHA (if applicable) to house the person as quickly as possible. If a client declines the PSH unit, the opportunity moves to the next highest prioritized household that fits the vacant unit configuration. When unsheltered clients decline housing, they stay on the hotlist and Outreach Specialists continue to engage with them, provide services, and help them access housing opportunities.

For RRH programs, our system uses the Housing Assistance Screening Tool (HAST), an assessment administered by shelter staff when people enter shelter or are engaged in Outreach programs. HMIS data and the results of the HAST are used to prioritize people for RRH. The HAST assesses homeless time, healthcare and other service needs, and housing barriers. The HAST also collects information needed to identify people who would benefit from specialized RRH programs for transition-age youth and survivors of domestic violence, dating violence, sexual assault, and stalking. People in an unsheltered situation often score higher on the HAST because of longer homeless time, higher service needs, and higher vulnerability. Unsheltered people who are survivors of domestic violence can enter the specialized DV RRH program without entering shelter, via referral from their Outreach Specialist.

CSB's prioritization system prioritizes people with the longest homeless time and most severe service needs which often are those who are unsheltered. Additional resources for Outreach and PSH will allow us to engage and house more unsheltered people, reducing unsheltered homelessness in our community. With additional Outreach funding, Outreach Specialists can reduce caseloads – the average is currently 40 – to better engage and gain trust with unsheltered individuals to more quickly establish a housing path. Additional funding for 176 homeless units in the four PSH programs in development would help provide supportive services and health care needed by people with severe service needs who have experienced long-term homelessness and disability.

Our CoC aggressively pursues development of new PSH programs, building partnerships and leveraging all available resources to develop new units. We have expanded existing RRH programs and created new programs tailored to specialized vulnerable populations, and implemented creative strategies for landlord engagement, building a community of partners willing to give people a second chance. Using data and analysis, CSB continually adjusts system procedures to help people move more efficiently and effectively from homelessness to housing, despite the severe challenges imposed by the deepening affordable housing crisis. With additional resources for Outreach and PSH programs, we will be able to do more.

The CoC will encourage and support housing projects to take advantage of their communities and create centers of support for the severe service needs population. For example, site-based PSH should incorporate the recommendations from the Plan related to engaging severe service needs individuals by routinely inviting healthcare providers to their sites. This will allow healthcare providers to more easily connect with individuals

who need services because they can serve one locale rather than track down individuals living in different areas. This strategy will increase recruitment of healthcare providers and help ensure that high service needs are met.

To ensure individuals retain access to housing and healthcare services, the CoC will continue to work with partners to have low-entry barriers to housing with high tolerance for behavioral non-compliance. In addition, programs that teach housekeeping/lifestyle skills will facilitate individuals' ability to maintain permanent housing. Efforts to improve the quality of housing and safety of the neighborhoods where PSH units are located is recommended by unsheltered individuals. Moreover, quick time to housing into deeply affordable, high-quality housing will prevent individuals from losing hope in the system.

P6. Involving Individuals with Lived Experience of Homelessness in Decision-Making

In preparation of this plan, 10 unsheltered individuals were interviewed in two focus groups at The Open Shelter drop-in center. The 10 individuals were recruited working with center staff and the Outreach Team. A third focus group of eight members of the Citizens Advisory Council (CAC) was held at a public library. The groups were asked about the types of resources/services they have used, what would make those services better, what barriers they faced accessing those services, and recommendations for how the CoC should spend these funds. Their input was notated, and thematic analysis was used to identify common ideas/recommendations. The results were used to inform the programs and services proposed in this plan and described in section P5 above. While not all recommendations from the focus groups can be directly funded through CoC funding or relate to this plan, partners will consider the input as they move forward with their projects. Four common themes emerged from participants' reported barriers and recommendations: (1) empowerment; (2) economic assistance/employment; (3) protection of self and personal belongings; and (4) Outreach programs. These themes were translated into the strategies in section P5.

The CAC is comprised of people with lived experience and expertise of homelessness. The Youth Action Board (YAB) is comprised of youth with lived experience and expertise. The CAC has two representatives with voting rights on the CoC governing body, one of whom also serves on the CoC Board. The YAB has one representative with voting rights on the CoC governing body. These representatives attend meetings and actively participate in CoC decision-making. The CAC and YAB meet monthly to discuss system programs, identify challenges, and propose solutions. The CAC and YAB consistently provide unique value to our system, alerting us to emerging issues and barriers and helping the system develop more effective strategies and procedures. In addition, persons with lived experience are providing feedback and are involved in decision-making at all levels of an organization serving them:

- Every organization that operates homelessness programs in our system is required to have at least one person with lived experience of homelessness on their governing board. The CAC helps identify candidates for board positions. This is not a check-the-box exercise. Agencies are required to ensure board members attend meetings, including adjusting dates and times when needed and helping with transportation. Agencies also ensure board members are empowered to fully participate and provide meaningful feedback on agency programs by providing board orientation and mentorship. CSB monitors agencies annually to ensure compliance with this requirement, including reviewing board meeting notes to confirm participation.
- All homelessness programs in our system are required to survey their program participants regularly and incorporate feedback to improve services. Programs are also required to involve program participants in program operations when possible and most programs employ peer support specialists with lived experience. CSB monitors agencies annually to ensure requirement compliance.
- Organizations proposing new PSH projects must present the Project Plan to the CAC in writing and via a prerecorded video. CAC members provide feedback on PSH Project Plans, ensuring that the proposing organization has the physical space and service plans that will best stabilize people with disabilities exiting homelessness to housing. CSB staff capture this feedback in writing for the CoC, so they can take it into account and require any needed adjustments prior to approving a PSH project. The CAC and YAB

representatives on the CoC also provide input during the CoC's discussion of each project. Feedback from people with lived experience improves our system's PSH programming.

- People with lived experience and expertise from the CAC reviewed the responses to the results of the Request for Proposals for Outreach Services that CSB issued earlier this year. They discussed each proposal and provided feedback that informed CSB's decision-making and helped make the best possible choice for people experiencing unsheltered homelessness.
- The voting representatives from the CAC on the CoC governing body participated in the Workgroup to develop this CoC Plan and contributed to the CoC's review and approval process for this Plan and the accompanying project applications for funding.

P7. Supporting Underserved Communities and Supporting Equitable Community Development

Throughout the past three years the CoC expanded its work with Outreach partners that serve individuals experiencing unsheltered homelessness who do not traditionally access programs. The goal is to expand services to locations unsheltered individuals frequent. The Collaborative Outreach Team (COT) is the group that incorporates all the entities included below, in addition to traditional Street Outreach providers like the Mount Carmel Street Medicine, Southeast PATH, Veterans Affairs, and Volunteers of America. The COT coordinates the community work, collaboration and improvements.

- Homes for Families targets unsheltered pregnant women including pregnant women who have been victims and survivors of domestic violence and/or of human trafficking.
- Out of Darkness serves the population traumatized by human trafficking and are working on referral opportunities for clients to be linked with street outreach and re-housing support.
- Sanctuary Night hires staff who have histories of homelessness to serve as outreach peer-supporters to help unsheltered individuals access substance abuse treatment facilities. In addition, they reach the community of female sex workers, providing them with resources and referrals.
- For transition age youth, Huckleberry House CARR Team and the Star House drop-in center for youth are working together to engage with unsheltered youth that otherwise are not participating in the system.
- Equitas Safe Point program, an agency serving the HIV/AIDS and LGBTQ+ population, engage individuals currently using substances and not currently linked with either street outreach or re-housing support. The Southeast PATH team has collaborated with this program to provide motivational interviewing with these individuals through a harm reduction lens to build rapport.
- Southeast and Primary One, Healthcare for the Homeless funded agencies, provide health care in the jail systems, maintaining contact with people released from jail along their pathway to stable housing.
- There are 18 drop-in centers or meal locations that provide support to people experiencing homelessness in the community that are key to engaging those that are reluctant to participate: The Open Shelter, Stowe Mission, Church for all People, Reeb Avenue Center, The Dream Center, Saint Sophia's, Star House, Clintonville Community Resource Center, Jordan's Crossing, PEER Center West, PEER Center East, Columbus Coalition for the Homeless Drop-in Centers, Community Kitchen, Sanctuary Night, Como Recovery, Out of Darkness, 1DivineLine2Health, and The Hope House. Mount Carmel focuses on empowering partners to help clients engage with the system and start the sheltering or housing path.
- We recognize that although unsheltered individuals may not engage with the homeless system, they might interact with other systems (e.g., mental health) which can be used as a collaboration to leverage all resources that may benefit the client. The RREACT (Rapid Response Emergency Addiction Crisis Team) is a partnership with the Columbus Police Division, Columbus Fire, ADAMH, Southeast Healthcare, Central Ohio Area Agency on Aging, and the Central Ohio Hospital Association. The team consists of paramedics and social workers who respond to overdoses in attempts to engage and link clients to treatment. This team consistently serves unsheltered homeless individuals who are difficult to engage due to addiction.