GAPS ANALYSIS

of the Homeless Crisis Response System

IN LAKE COUNTY

JUNE 2019

CSH

Contents

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CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided nearly $1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at www.csh.org.

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In addition, CSH would like to thank the all stakeholders who responded to the Lake County Survey of Homeless Needs and provided meaningful feedback.

EXECUTIVE SUMMARY

Every community across the country is grappling with the response to homelessness, which is widely acknowledged to require adequate and long-term housing, services, and income solutions in varying degrees to meet local needs. Lake County's response to homelessness, led by the Lake County Coalition for the Homeless (LCCH) and Lake County Community Development (LCCD), has followed national trends and expectations of the U.S. Department of Housing and Urban Development (HUD). Specifically, Lake County has an established governing body through the Coalition, a functioning Homelessness Management Information System (HMIS), a new Coordinated Entry system to assess and match households to appropriate and available housing in accordance with community priorities, and a range of temporary and long-term housing options.

Additionally, local leaders are exploring new investments into homeless outreach services, landlord engagement activities, and cross-system collaborations. These new investments focus on increasing engagement with services, promoting access to local rental markets, and addressing special subsets of households that touch multiple public systems, often due to their lack of stable affordable housing and services for physical and behavioral health. This level of local leadership and attention helps guide the community in asking and answering new questions on how to improve the current response system. As the findings will show, there is a need and an opportunity to generate new resources to address unmet needs of individuals, families, and youth, and to look deeper at the countywide accessibility issues that stem from the concentration of emergency response providers in one area of the county.

The following report and recommendations are based on community-wide data, written reports, surveys, individual interviews, and focus groups. Through these various media, CSH was able to draw connections between sources and posit observations and recommendations backed in part by the stated and observed needs of community members.

The recommendations by CSH are also rooted in extensive experience in similar communities who have made changes to yield improved outcomes, increased community vision, and partnerships on housing-based solutions to homelessness.

The continued focus on housing-based response systems requires communities to assess not only gaps in permanent solutions, but also the role of crisis response services like shelter, daytime supports, transportation, employment, health, and transitional housing. Specifically, the role of shelter is evolving beyond just providing safe spaces and basic services such as food and hygiene. In many communities, shelter services include providing crucial information on how to connect households to long-term housing options, assessing and problem solving, and connecting households to other housing and supportive services in the community.

Key Findings

There is an unmet need of supportive housing, rapid re-housing, and a new form of prevention supports that could divert households from shelter. These needs are informed by data that are consistently collected and analyzed by community providers and county staff. Lake County has a seasonal, rotating shelter for single individuals with limited daytime support and few places to secure belongings. This presents challenges to people who may work alternative schedules, need services or appointments during atypical hours, or travel with belongings. Lack of consistent services may negatively affect the county's effort to end chronic homelessness, as persons experiencing chronic homelessness typically spend long periods on the street and may cycle through emergency shelters or institutional settings. It is worth looking deeper into the impact of shelter access on the efforts to end chronic homelessness. There is no dedicated emergency housing for families with minor children. Congregate settings that mix families and single adults are not conducive to the feeling of safety for families and each group has its own unique set of needs and service interventions most appropriate to the population. The area's primary family emergency housing is for persons or families fleeing domestic violence (DV), which is a setting not suited to all families in a housing crisis.

Lake County has three housing authorities, which is a distinctive characteristic and affords opportunities to leverage a modest amount of existing housing to reduce the prevalence of homelessness in the region. HUD strongly encourages public housing agencies (PHAs) to build durable working relationships with Continua of Care (CoCs) to collaborate on strategies that reduce homelessness such as establishing waiting list preferences for persons experiencing homelessness and pursuing special funding opportunities.

Justice and health systems have similar goals to make discharges to stable settings, reduce recidivism, and align and use public resources more appropriately. The county's engagement to consider Pay for Success or Pay for Performance to target supportive housing resources to those who are cycling between streets, jails, and hospitals reflects the experience of people served through the CoC who report high rates of emergency department use, hospitalizations, and ambulance transport. As housing stability and access to services for these individuals increase through supportive housing, public costs decrease. The exploration of Pay for Success initiatives and the overall effort to address homelessness in Lake County dovetail and reinforce one another, increasing focus on long-term housing solutions that are developed via coordination and prioritize data-driven results

Overview of All Recommendations

The following list includes recommendations from multiple sections of the report. Recommendations that CSH believes are likely to have the highest impact to addressing homelessness in Lake County are towards the top of the list and recommendations likely to have lower impact are towards the bottom of the list. The higher impact recommendations address a large need in the community, would likely resolve homelessness for a high number of people, and are feasible to implement in the community with support from multiple stakeholders.

A. Create Permanent Housing Solutions Indicated by Data for Unmet Needs (Section 6)
B. Develop Year-Round Emergency Services and Day Center (Section 4)
C. Create Dedicated Services for Families with Minor Children (Section 4)

D. Create Dedicated Services for Youth (Section 4)
E. Align Funding (Section 4)
F. Evaluate Funding Prevention Program w/ ESG Funding (Section 4)
G. Increase Outreach and Mobile Crisis Team (Section 4)
H. Expand Access through Crisis Center (Section 4)
I. Create “Bridge” Housing for Persons Matched in Coordinated Entry (Section 4)
J. Convert Transitional Housing to Permanent Supportive Housing (Section 6)
K. Increase Access through Township Pilot (Section 4)
L. Conduct Summer Street Count (Section 4)
M. Engage PHAs and Create Set-Asides (Section 6)
N. Support Combined Transitional Housing-Rapid Rehousing Applications in CoC NOFA (Section 7)
O. Apply for UFA Status (Section 7)

Definitions

In order to make this report more accessible, terms that will be discussed throughout the report are defined below.

Homeless: The U.S. Department of Housing and Urban Development (HUD) defines the term "homeless" as "a person sleeping in a place not meant for human habitation (e.g. living on the streets, cars) OR living in a homeless emergency shelter."

Chronically Homeless: "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years."[1]

Prevention: an intervention that provides housing assistance to households that are at risk for becoming homeless, who would become homeless but for this assistance, which can include rental assistance and/or relocation and stabilization services such as utility payments, mediation and case management.

Diversion: an intervention that provides assistance or support to divert a household from the shelter system. This approach encourages households to find alternative and safe living situations, such as staying with friends and family.

Emergency Shelter: housing with minimal supportive services for homeless persons that is limited to occupancy of six months or less by a homeless person.

Transitional Housing: buildings configured as rental housing developments but operated under program requirements that call for the termination of assistance and recirculation of the assisted unit to another eligible program recipient at some predetermined future point in time, which shall be no less than six months.

Rapid Re-Housing (RRH): a support intervention that uses a combination of case management, housing navigation, and short to medium term financial assistance to assist mid-range acuity homeless households identify and stabilize in tenant-based scattered site, permanent housing.

[1] “Defining Chronically Homeless: A Technical Guide for HUD Programs”, U.S. Department of Housing and Urban Development, September 2007.

Permanent Supportive Housing (PSH): supportive housing is affordable rental housing which forms a platform of stability for vulnerable people who do not have a home or who are leaving institutions or hospitals. It is linked to intensive case management and voluntary life-improving services like health care, workforce development, and child welfare.

2. COMMUNITY BACKGROUND

This section provides context on the current numbers of people experiencing homelessness in Lake County as well as the current response. There has been significant effort by the Lake County community to address the challenges of people experiencing homelessness in the county. Multiple stakeholders have been involved in the effort including the Lake County Coalition for the Homeless (LCCH), social service providers, townships, county departments, and public housing authorities. Due to the local effort of the LCCH and stakeholders, there have been significant reductions in the number of people experiencing chronic homelessness and the number of Veterans experiencing homelessness in Lake County. Lake County has seen a 76 percent reduction in the number of people experiencing chronic homelessness and an 86 percent reduction in the number of homeless Veterans.[2] As of June 7, 2019, the Waukegan, North Chicago/Lake County Continuum of Care (IL-502) confirmed an end to homelessness among veterans, saying they "are confident that the infrastructure and systems [Lake County has] built will ensure that any Veteran experiencing homelessness in the region will get the support they need to quickly obtain a permanent home."

Annually, it is estimated that over 1,296 unduplicated persons experience homelessness across Lake County.[3] The annual Point-In-Time (PIT) count is conducted in January each year. The 2019 PIT count for Lake County found 252 people experiencing homelessness, which is a decrease from 2018. This number includes 136 people who were sheltered in emergency shelter at the time of the count, 84 people who were sheltered in transitional housing, and 32 people who were identified as unsheltered. In the PIT count, there were 28 people who were identified as chronically homeless: 21 people sheltered and seven unsheltered. As part of the count, there were 18 unaccompanied youth age 24 or younger.[4]

It may sound counterintuitive that homelessness among subpopulations is decreasing as total homelessness is increasing, yet by disaggregating the PIT data these trends come into sharper focus. Often the contributing factors that may affect subpopulations go beyond local policies and programs. In the case of Veteran and chronic homelessness, there have been specific housing and services resources granted for those populations at the federal level, as well as a shift in intentionally targeting resources to address these types of homelessness within communities across the country. Specifically, Congress has allocated steady increases in short and long-term rental assistance targeted to Veterans experiencing homelessness, creating more opportunities to exit homelessness altogether. HUD has directed local communities to prioritize ending chronic homelessness through offering permanent and rapid re-housing resources first to those experiencing long-term homelessness with disabling conditions.

[2] Lake County Coalition for the Homeless, Built for Zero, http://www.lakecountyhomeless.org/our-work
[3] Lake County Coalition for the Homeless, Homeless Information Management System (HMIS) count 2019.
[4] The 2019 Point-in-Time Count Lake County

At the same time, funding for homelessness prevention resources was impacted by the State budget stalemate, which reduced and withheld funding. Low-wage workers or people with a limited ability to work are often unable to manage the cost of rent with an hourly income or disability income only. According to the National Low-Income Housing Coalition's (NLIHC) report *Out of Reach 2018,*[5] it would require an hourly wage of $20.34 to afford a two-bedroom unit at Fair Market Rent (FMR). Considering units are rarely priced at FMR and additional factors that strain both budgets and housing stability of a household, such as an unexpected emergency expense, illness, domestic violence, the need for both crisis housing and permanent housing supports becomes apparent. Despite local efforts to reduce homelessness across the county, without an expanded and updated safety net and permanent solutions there will still be an inflow of people experiencing homelessness across the county. The stakeholder interviews revealed that there is a perception that the number of people experiencing homelessness has increased and the challenges are more visible than before due to the concertation of services in the eastern part of the county.

Institutional and systemic racial inequities in health, justice, economics, and education, have a disparate effect on homelessness and those experiencing homelessness. According to the HUD Racial Equity Analysis Tool, there is an overrepresentation of people who identify as African American or Black experiencing homelessness compared to white people in Lake County. People who identify as Black or African American account for approximately seven percent of the general population in Lake County, but they are overrepresented in people experiencing poverty and homelessness in Lake County, representing 19 percent of people living in poverty in the CoC for Waukegan/North Chicago/Lake County, and 44 percent of people experiencing homelessness in the CoC. The racial disparity is even greater looking at families with children. The tool shows that 75 percent of families with children experiencing homelessness identify as Black or African American compared to only 25 percent of homeless families who identify as White.[6] The overrepresentation of people of color and Black or African American people experiencing homelessness is a national challenge resulting, in large part, from structural racism. The Center for Social Innovation's Supporting Partners for Anti-Racist Communities (SPARC) Initiative studied oral histories of people who identify as Black or African American experiencing homelessness and found find key areas of racial inequity that increased vulnerability to homelessness. The five areas of racial inequity observed in the SPARC study were lack of access to economic mobility, lack of access to housing, lack of access to behavioral health, an overrepresentation in the justice system, and multigenerational involvement in the child welfare system.[7]

Lake County Coalition for the Homeless

The Lake County Coalition for the Homeless (LCCH) is the established Continuum of Care (CoC) for Lake County, representing and organizing government, service providers, businesses, and philanthropy. A key responsibility of the CoC is to manage the HUD Continuum of Care (CoC) Program. The CoC Program is one source of HUD funding that promotes communitywide commitment to the goal of ending homelessness. Broadly, CoC funding can provide permanent supportive housing, rapid re-housing, transitional housing, and supportive services. It can also fund certain administrative functions like maintaining a Homelessness Management Information System (HMIS) and CoC planning.[8] CoC funds are

[5] National Low Income Housing Coalition, *Out of Reach 2018.* https://reports.nlihc.org/oor/illinois
[6] HUD CoC Racial Equity Tool, https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/
[7] "Supporting Partnerships for Anti-Racist Communities: Phase 1 Study", Center for Social Innovation, March 2018.
[8] Continuum of Care Program Eligibility Requirements", HUD, https://www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/

competitive and must be applied for on an annual basis through the CoC Notice of Funding Availability (NOFA). Using the NOFA, HUD provides local communities wide latitude in making funding decisions and resource allocation. However, HUD has provided policy guidance around the NOFA that impacts scoring for competitive funding. In the last five years, HUD has promoted funding permanent housing solutions through the CoC program while strongly encouraging communities to focus transitional housing on special populations like survivors of domestic violence, youth, and people with substance use disorders.

LCCH is staffed by a Continuum of Care Coordinator and HMIS Administrator at Lake County Community Development Division. The LCCH has a General Board and five Steering Committees. The Steering Committees include:

- Community Engagement, Advocacy and Membership Committee
- Monitoring and Project Performance Committee
- ServicePoint (HMIS) Committee
- Strategic Planning and System Performance Committee
- System Coordination and Entry Committee

The LCCH CoC General Board currently has 27 members. Each member agency is one board member. The committees manage the work within their scope, sorting out details and making decision recommendations to the General Board, which will consider recommendations and make final decisions. A Steering Council, an executive committee of committee chairs and executive offices is also established and is empowered to make decisions under certain circumstances where time is of the essence.[9]

Coordinated Entry in Lake County

The LCCH System Coordination and Entry Committee oversees the operation of the Coordinated Entry system in Lake County. As part of the federal program *Opening Doors: Federal and Strategic Plan to Prevent and End Homelessness* that was launched in 2010 and updated in 2015, HUD created guidelines for communities to establish Coordinated Entry. Coordinated Entry is both an approach and a process to provide a centralized assessment and access points for people experiencing homelessness to connect to resources and housing. The Coordinated Entry system prioritizes individuals and households with the greatest need into the appropriate housing intervention.[10]

In 2015, in conjunction with the Zero: 2016 Campaign to End Homelessness, LCCH implemented the Vulnerability Index-Service Prioritization Decision Assessment Tool (VI-SPDAT) to assess people experiencing homelessness to connect with appropriate housing and resources. There are three versions of the VI-SPDAT used in Lake County: the VI-FSPDAT for families with minor children, the TAY-SPDAT for youth ages 18-24 (Transition-Aged Youth), and the VI-SPDAT for couples and single adults. The tool is used as a triage tool throughout the CoC and can usually be completed in 10 to 15 minutes with existing CoC providers as a part of their role in the network. The assessments cover history of housing and homelessness, risk factors around health and general wellness, interaction with the health system such as emergency services, and other factors that may increase vulnerability. Once an adult, youth, or

[9] Interview with Lake County Continuum of Care Coordinator, Brenda L. O'Connell, Lake County Community Development Division, April 17, 2019.
[10] Coordinated Entry Policy Brief, HUD Exchange, https://files.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

family is assessed, the information is entered into ServicePoint, Lake County's HMIS database, and given an assessment scored based on the household's vulnerability. A designated Coordinated Entry provider administers the VI-SPDAT; these providers must go through an approval process with LCCH and sign a Memorandum of Understanding (MOU), an agreement with LCCH to follow all procedures of the Coordinated Entry system. In addition to the providers, which generally operate at fixed locations, Lake County has the ability to administer VI-SPDAT assessments in the field through street outreach.[11]

The Coordinated Entry process established by the Lake County Coalition for the Homeless is the only referral source from which to consider filling vacancies in housing and/or services funded by CoC and ESG Programs. However, Coordinated Entry systems are not precluded from making referrals to other housing programs that have a homeless preference or priority. At this stage, households who are seeking assistance for housing through the CoC or area Public Housing Authorities still must apply to separate waitlists. Any person experiencing literal homelessness must connect to Coordinated Entry in Lake County and must be assessed using the VI-SPDAT. If a person experiencing homeless does not consent to the VI-SPDAT, there is a process to connect the person to the By-Name List of people experiencing homelessness without having to do the VI-SPDAT.

The LCCH Housing Placement Workgroup is the convening committee that maintains the centralized waiting list and makes a referral when housing resources become available. When a housing vacancy becomes available, the housing provider will notify the LCCH Housing Placement Committee that there is a vacancy and the HMIS Administrator will provide the contact information for three individuals or families who meet the criteria of that program. The housing provider will try to engage the candidates and start the intake process to move into housing. If an individual or family is accepted into housing, then the household is exited from Coordinated Entry as a positive exit into housing. An individual or family may also be exited from Coordinated Entry if they have not had contact with homeless agencies in the last 90 days or cannot be located by a housing provider, referral agency, or the Housing Placement Workgroup.

According to the Annual Assessment of Homeless Coordinated Entry for October 1, 2017 to September 30, 2018 416 assessments were completed in Lake County. From all 416 VI-SPDAT Assessments completed in Lake County during this timeframe,179 assessments or 44 percent of assessments scored highly vulnerable, an increase of 17 percent from the year prior. The assessments also show the vulnerability of people experiencing homelessness in Lake County: 38 percent of those assessed had taken an ambulance to the hospital in the last six months, 67 percent had received care in an emergency room setting, and 38 percent had been hospitalized. In addition, 19 percent of those assessed had been in jail in the last six months and 31 percent reported having been attacked or beaten up since becoming homeless.[12]

The LCCH also tracked housing placements and exits during the same timeframe. From October 1, 2017 to September 30, 2018, 32 percent of households in Coordinated Entry exited to a permanent destination and333 referrals resulted in 221 housing placements by the LCCH Housing Placement Workgroup. From the referrals, 86 homeless households were placed into housing, 52 into permanent supportive housing and 35 into rapid rehousing. These numbers represent a housing placement increase by 40 percent from the year prior. The average length of time to house a client was 71 days, a reduction of 15 days from the year prior.

[11] Lake County Coalition for the Homeless Policies and Procedures
[12] Lake County Annual Assessment of Homeless Coordinated Entry, October 1, 2017 to September 30, 2018.

Services and Housing Providers in Lake County

The 2018 Continuum of Care (CoC) Homeless Assistance Programs Housing Inventory Count (HIC) shows the inventory of housing and utilization of those beds and units during the last ten days in January.[13] Utilization of the beds is tracked in order to determine the demand for the resources and give the CoC the opportunity to examine other potential uses for resources that are more in-line with preferred HUD CoC program models. The report tallies the number of beds and units available on the night designated for the count by program type and includes beds dedicated to serve persons who are homeless as well as persons in permanent supportive housing. According to the HIC for LCCH in 2018, there were 186 emergency shelter beds available, 98 transitional housing beds available, 120 rapid re-housing units and 409 permanent supportive housing unit in Lake County. The 2018 HIC reported all emergency shelter as completely full and transitional housing beds at 80 percent or higher utilization. Likewise, supportive housing is being fully utilized according to the HIC.

Below is a chart of the service and housing providers in Lake County that were listed in the HIC and an explanation of the services each agency provides including outreach, emergency shelter, transitional housing, rapid re-housing (RRH), and permanent supportive housing (PSH).

Lake County Services and Housing Inventory Chart

Table 1. Services and housing available in Lake County

Provider	Outreach Services	Shelter Services	Transitional Housing	Rapid Rehousing	Supportive Housing	Funding Source
PADS	1 Outreach Navigator Countywide Fulltime	-Appx. 80 Emergency Shelter Beds October-April Appx. 30-40 Beds April-October Total annual capacity of 105 emergency shelter beds			23 units of PSH	Private grant funds the outreach position ESG funding for Shelter Services PSH-CoC Funded
Catholic Charities		24 Emergency Shelter Beds 14 Motel Vouchers provided in 2018 Operates a DV shelter program		40 households quarterly, appx. 120 households annually (Rapid Rehousing and SSVF)	26 units of PSH	Motel Vouchers-EFSP DV Shelter-Private Funding RRH- ESG, CoC and County's Affordable Housing Program

[13] "CoC Housing Inventory Count Reports", HUD Exchange, https://www.hudexchange.info/programs/coc/coc-housing-inventory-count-reports/

Provider	Outreach Services	Shelter Services	Transitional Housing	Rapid Rehousing	Supportive Housing	Funding Source
		for 6-7 families annually				PSH- CoC Funded
Thresholds					18 PSH	CoC, Medicaid
Alexian Brothers			6 Transitional Housing Beds- The Harbor		15 PSH Households - Community Housing Program 15 PSH Households- Housing Opportunities	TH- IL Recovery Home PSH-CoC, Medicaid PSH-HOPWA, Medicaid
Health Department					61 Units of Shelter Plus Care	CoC, Medicaid, Video Gaming Revenue
Independ-ence Center					8 PSH Units Site-Based, Shared Housing	CoC, Medicaid
Lake County Haven		10 Transitional Housing Beds	20 Transitional Housing Beds			CoC, IL ESG, Private Funding
Lovell Federal Health Center					244 HUD-VASH units	HUD, VA
TLS Veterans				Up to 11 RRH Units	SSVF	HUD, VA
COOL			38 Transitional Housing Beds			Private Funding
Waukegan Township			16 Transitional Housing Beds - Staben Center 14 Transitional Housing Units- Staben House			Township funds and private funds for both

Provider	Outreach Services	Shelter Services	Transitional Housing	Rapid Rehousing	Supportive Housing	Funding Source
A Safe Place		33 Emergency Shelter Beds for Victims of Domestic Violence	3 Transitional Site-based Housing Units		37 PSH Site-Based Units 30 PSH Scattered Site Units	Transitional and PSH-services funded by IDHS Scattered housing program is funded by IDHS. Emergency shelter is funded by multiple agencies, grants, and funders

Given that the HIC is taken during the last ten days in January, it does not fully represent the activity of homelessness from May to October, when many of the beds are off-line and unavailable for occupancy.

Public Housing Authorities in Lake County

Lake County Housing Authority (LCHA)

Lake County Housing Authority owns and operates 161 single-family homes and 332 units of housing for people ages 55 and over or who have a disability.. LCHA also provides rental assistance through Housing Choice Vouchers (HCV) to over 3,000 households each year. According to the 2017 annual report, approximately 360 vouchers – or nearly 10 percent of the rental assistance can accommodate new households each year. While the waiting list for HCV is closed, it is possible to investigate the number of current applicants experiencing homelessness and explore resources and other mechanisms that can be used to provide access to stable housing for people experiencing homelessness and those referred through LCCH.

Currently the Lake County Housing Authority has established a preference for people on the waiting list who are residing in nursing homes and referred through the Statewide Referral Network, which is managed by the State of Illinois. The purpose of this commitment was to support the State in its successful application to the Federal Government to secure HUD 811 project-based vouchers, which serve people with disabilities who are covered under the Olmstead Act of the Americans with Disabilities Act (ADA). The Act states that people with disabilities should receive services in the least restrictive setting in the

community, namely supportive housing. People experiencing chronic homelessness are included in the description of Olmstead-covered groups, in addition to people residing in nursing homes.[14]

In the same way that LCHA made a commitment to serve people exiting institutional care into services, a commitment could be made to address homelessness, specifically chronic homelessness, to maintain consistency with the Olmstead references in the current administrative plan.[15].

Housing authorities can apply to HUD for special resource allocations intended for specific subpopulations, including youth and families involved with child welfare, veterans experiencing homelessness, and people with disabilities at-risk for homelessness or institutional settings. LCHA has received non-elderly disabled (NED) vouchers, which could be paired with supportive services to help more people exit homelessness or address a potential Frequent Users of Systems Engagement (FUSE) population.

https://www.lakecountyha.org/plugins/show_image.php?id=288

Waukegan Housing Authority (WHA)

Waukegan Housing Authority owns and operates three multi-family apartment buildings with 325 units, as well as 448 public housing units in four developments. WHA manages a Housing Choice Voucher program, but the scale of that program, along with policies on waiting list preferences, was not accessible on the website.

https://waukeganhousing.com/about-waukegan-housing-authority/

North Chicago Housing Authority (NCHA)

The North Chicago Housing Authority supports 470 Housing Choice Vouchers and an additional 70 Veterans Affairs Supportive Housing (VASH) program vouchers in the community. NCHA also operates a 102-unit public housing site for seniors and people with disabilities.

All three public housing agencies have preferences for people with disabilities. As stated in data referenced above, 37 people with disabilities were found in the most recent PIT, a number which existing housing authority resources could potentially accommodate. A partnership with PHAs can be an invaluable tool to combat homelessness, but may require additional capacity, including administrative capacity to review and update administrative plans and services capacity to pair housing resources with services.

https://northchicagohousing.org/about/

Lake County Consolidated Plan

[14]"Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of Olmstead", HUD, 2016.

[15] https://www.lakecountyha.org/plugins/show_image.php?id=87

HUD requires every participating jurisdiction to submit a Consolidated Plan (Con Plan) on three to five-year cycles. Con Plans describe a community's needs, strategies, and actions for community and economic development, housing, and homelessness pertaining to a number of formula-driven HUD funding sources: Emergency Solutions Grants (ESG), Community Development Block Grants (CDBG), HOME Investment Partnerships (HOME), and Housing Opportunities for Persons living with HIV/AIDS (HOPWA). Each year of a Con Plan, communities submit Annual Action Plans and Consolidated Annual Performance and Evaluation Reports (CAPER) to measure progress against the Con Plan. The Con Plan process is often extensive and complex, requiring collaboration and consensus building across many governmental and community stakeholders.

The 2015-2019 Lake County Consolidated Plan, among other things, recognizes homelessness as a complex community issue that requires a multi-sector approach. The parts of the Con Plan that address homelessness specifically are the needs assessment (NA-50), housing market analysis (MA-30), strategic plan (SP-60), and annual goals and objectives (AP-65). The Con Plan thoroughly examines homelessness in Lake County, utilizing many of the same reports and resources that this report relies on; however, the strategic plan and annual goals and objectives are broad. The annual goals and objects set the ambitious goal of ending homelessness in Lake County without also establishing milestones and benchmarks to achieve that goal.

Nevertheless, Lake County government and civil society have been diligent in addressing homelessness by responding to both community needs and emerging federal requirements. Lake County restructured the CoC governance structure in 2009 just before the passing of the transformative federal HEARTH Act, which changed the requirements of federal homeless programs. LCCH updated the bylaws in 2016 to make every participating agency a board member. More recently in 2017, in response to a major policy guidance from HUD, Lake County reviewed and made changes to Coordinated Entry policies and procedures.

Over the last five years, from 2014 to 2018, homelessness in Lake County has been reduced by nearly a third; however, from 2017 to 2018 homelessness increased 21 percent to 277 people on any given night. Though unsheltered counts have been low, never exceeding 30 persons, the Point-in-Time (PIT) counts are conducted in late January, when persons experiencing homelessness often seek shelter due to inclement weather. In Lake County, a seasonal cold-weather shelter is in operation during the PIT count. In the spring and summer months, when less shelter beds are available, the unsheltered count may be higher.

LCCH and the City of Waukegan produced in partnership the *Report on the State of Homelessness in Waukegan,* published in 2018. The report's goals were to provide information and develop solutions to ending homelessness, gather and share accurate information about homelessness and homeless services in the community, and provide recommendations. The report made three important findings related to homelessness and homeless services in the community and developed several strategies and recommendations based on these findings. The three key findings of the report were:

- Finding 1: Misinformation contributes to tension among stakeholders in the community.
- Finding 2: Neighborhood safety and appearance are shared concerns.
- Finding 3: Lake County's homeless response system has gaps that leave residents experiencing homelessness without sufficient housing and services to address the overarching causes of homelessness.

3. OBJECTIVES FOR THE GAPS ANALYSIS REPORT

In partnership with Lake County Community Development (LCCD) Division, CSH conducted a gaps analysis to evaluate CoC accessibility, assess service and housing infrastructure to understand current availability and need of resources, and provide an overall assessment of system functionality and coordination. CSH worked with LCCD to understand how people experiencing homelessness in Lake County access services, shelter, and housing.

The research conducted by CSH including the following tools:

- **Stakeholder Interviews:** CSH interviewed a variety of stakeholders on the accessibility of resources and housing throughout the county. CSH spoke to government agencies, townships, services providers, law enforcement, healthcare providers, and housing providers to understand what supports and services are needed and/or provided to assist individuals and families in navigating the housing and homeless response systems.
- **Tenant Focus Group:** CSH conducted a focus group of those with lived experience of homelessness at the PADS Resource Center in Waukegan. The session included those who are currently accessing emergency shelter and residents in PADS' Permanent Supportive Housing program. The focus group provided feedback on ease of access across Lake County to housing and service resources and identification of missing services.
- **Review of System Performance Data:** CSH reviewed system performance data, including system performance measures (SPMs), CoC Annual Performance Reports (APRs), Longitudinal System Analysis (LSA) reports (formerly the Annual Homeless Assessment Report, AHAR), Point-in-Time (PIT) data, and the Housing Inventory Chart (HIC).
- **Survey of Homeless Needs:** CSH Reviewed the Lake County Survey of Homeless Needs conducted by the Lake County Coalition for the Homeless in spring of 2019 to understand the community's perception of needs and gaps in the homelessness response system in Lake County.
- **Stakeholder Survey:** CSH reviewed the Lake County Coordinated Entry Survey conducted by Lake County Coalition for the Homeless in fall of 2018 to understand the perceptions of stakeholder who were working as part of Coordinated Entry.
- **Mapping:** CSH requested LCCD and/or LCCH provide the addresses or any current mapping of providers of a variety of social services throughout the county in order to map the geographic location of programs within the region, including emergency shelters, assessment locations within Coordinated Entry, food banks and soup kitchens, and other community- based providers working to connect low-income populations to mainstream benefits and other supports. CSH also mapped affordable housing options, including Public Housing Authority housing and Low-Income Housing Tax Credit (LIHTC) properties, along with income and rent limits.
- **Modeling Tool:** CSH used a modeling tool that connects annual homelessness data with housing needs in alignment with patterns demonstrated through coordinated entry.
- **Review of Coordinated Entry Policies and Procedures:** Additionally, CSH reviewed Coordinated Entry policies and procedures, manuals, and materials. Related to CoC governance, CSH reviewed: meeting minutes and agendas, roles of officers, major policy and funding decisions in past years, and results of funding applications. This data provided insight into the governance of the network, and whether or not the leadership structure supports decision-making and goal-setting that improve availability of resources and provider accountability.

4. EVALUATION OF COC ACCESSIBILITY

In order to understand the quality of services and housing options for people experiencing homelessness in Lake County, CSH first sought to understand how someone accesses housing and services resources throughout the county. If an individual or family is homeless in any part of Lake County, there are multiple ways the individual or household can access services through the CoC. This section discusses what access looks like and the experience for someone who is seeking resources, services and housing in Lake County. The experience varies depending on where in the county households become homeless and the types of services households are seeking. CSH reviewed Coordinated Entry Policies and Procedures, FY 2018 System Performance Measure Report, the 2015-2019 Consolidated Plan, and spoke to stakeholder groups to understand how individuals and families access services, shelter and housing throughout the county.

Geography of Access Points and Services

To understand the geography of access, CSH mapped key service connections across the county. CSH obtained provider addresses of a variety of social services throughout the county in order to map the location of programs within the region, including emergency shelters, Coordinated Entry assessment locations, food banks and soup kitchens, and other community-based providers working to connect low-income populations to mainstream benefits and other supports.

As indicated by the maps in Appendix I, the majority of the key service sites and Coordinated Entry points are in the Waukegan and North Chicago area. This correlates with the daytime hotspots, which are near the PADS Resource Center and the primary Transitional Housing sites in Waukegan. Most of the county's soup kitchens and financial assistance resources are also located in Waukegan.

Outside of Waukegan and North Chicago, access to these services is limited, while health clinics remain geographically disbursed across the county. In addition, the 18 township offices provide an access point for resources, many of which offer financial assistance, warming and cooling centers, and referrals to PADS and other services. See Appendix I.

There are 18 townships in Lake County that have a walk-in opportunity for individuals seeking assistance. The Township Offices have assistance programs that someone experiencing homelessness can seek, but the services are limited to residents of the townships and vary depending on the townships. It should be noted that providing proof of residency can be challenging for households experiencing literal homelessness or living doubled up in a unit where they do not have a lease. If they cannot prove residency, they may not be eligible for the services offered by townships. Some services identified in conversations with townships include food pantry, utility assistance, senior services, and General Assistance. Townships are required by state law to provide General Assistance but establish their own rules and policies on distribution of aid.[16] Other services may be offered but vary from township to township. Three townships participated in stakeholder interviews and all indicated that for persons experiencing homelessness in their jurisdictions and seeking services, the next step would be a referral to PADS for assessment and

[16] "Understanding General Assistance", Illinois Legal Aid Online, visited June 2019, https://www.illinoislegalaid.org/legal-information/understanding-general-assistance

assistance. The townships do not provide Coordinated Entry VI-SPDAT Assessments at their offices, but often refer to agencies who can provide a Coordinated Entry Assessment. The townships that were interviewed for this report are located in the western part of the county and described challenges assisting with transportation for individuals and families who are seeking services that only exist in the eastern part of the county.

As described in the "Community Background" section above, from October 1, 2017 to September 30, 2018 there were 416 assessments completed in Lake County. The majority of assessments, over 64 percent, were completed by PADS, a decrease from 84 percent the year prior. PADS completed assessments at PADS' Day Center and via street outreach. Coordinate Entry access sites are concentrated in the eastern part of the county, specifically in the City of Waukegan where PADS is located. In addition to PADS, The Homeless Coalition has approved entry points at the following locations:

- A Safe Place (DV provider)
- Lovell Federal Healthcare Center (the VA)
- Lake County Haven Emergency Shelter
- Lake County Public Defender's Office

The Homeless Coalition also piloted using ServicePoint, the HMIS system, to send electronic referrals from the jail to PADS to conduct phone screenings for Coordinated Entry Assessment. The Homeless Coalition is also launching electronic referrals for Coordinated Entry for all providers in the referral network in summer 2019.

Access to Shelter Services

Lake County has four providers that operate overnight emergency shelter according to the Housing Inventory Count (HIC) in 2018. The largest emergency shelter provider is the PADS cold-weather shelter which offers emergency shelter to both individuals and families during the winter months. In addition to the cold-weather shelter, PADS operates a smaller year-round shelter. The PADS cold-weather shelter operates from October 1 to April 30 each year and has capacity for approximately 80-95 beds each night at a series of rotating locations throughout the county. The shelter services are provided in churches and each night of the week two churches host. Bus services are the most common way that people access the shelter services by arriving at the PADS Day Center at 1800 Grand Avenue in Waukegan and riding the bus to the rotating locations. The bus services return people to the PADS Day Center in the morning. If a person or family experiencing homelessness misses the bus service, they will need to find their own transportation to one of the shelter locations before 10:00 pm. After 10:00 pm, the person will need law enforcement to escort them to the shelter location in order to be able to stay at the shelter that night. The locations of the rotating site shelters are spread across much of Lake County as can be seen on the "Map of Shelters and Hot Spots," (See Appendix I). PADS' smaller year-round shelter is reserved in summer for clients who face the greatest health risks from being unsheltered and accommodates a limited number of families.

During the stakeholder interviews, some stakeholders identified challenges related to accessing shelter services. They reported that it can be a challenge to get to the PADS Day Center location due to a lack of public transportation in Lake County. Most trips across the county or even from Township to Township involve a series of Metra Trains and multiple buses. There are 32 Metra Train stops in Lake County across

four Metra rail lines, but the lines mostly run north and south to and from Chicago.[17] The Regional Transit Authority has 13 Pace Bus Lines that cover the county, but most lines only serve a few of the Townships, so a person must transfer if traveling between multiple Townships.[18] If a person is trying to travel east or west across the county, it can be challenging to navigate. The Lake County Division of Transportation does have additional paratransit options for seniors and persons with disabilities, but the person will need to be connected to services and apply to receive paratransit.[19]

Lake County has three additional overnight emergency shelters. A Safe Place, a shelter for survivors of domestic violence, has 33 beds. House of Peace, also a shelter for survivors of domestic violence, is currently operated by Catholic Charities and has 24 beds for families. Lake County Haven has 10 emergency beds.

In addition to the emergency beds, Lake County also has transitional housing beds operated by Lake County Haven, COOL, and Waukegan Township. Lake County Haven has 20 transitional housing beds, Cool has 38 transitional housing beds and Waukegan Township has 16 transitional housing beds at Eddie Washington Center and 14 transitional housing beds at Staben House.[20] The process to access each of the emergency shelter and transitional shelter beds varies by provider, and some have residency or other eligibility requirements.

Outreach

The U.S. Interagency Council on Homelessness (USICH) identifies street outreach and engagement as a key strategy to ending homelessness in communities. Street outreach brings access to services and housing resources directly to people who are experiencing unsheltered street homelessness, some of whom may not seek or access these services otherwise. People experiencing unsheltered homelessness may become disengaged with public resources and systems, therefore bringing services to people where they are is an effective practice to engage and provide access. Outreach may involve meeting people on the street or going to soup kitchens, shelters, and places where people may gather in the community to find and engage those who are homeless.[21]

During interviews with stakeholders, it was identified that there is only one outreach worker for the county. The PADS organization provides outreach services through one outreach worker who covers the entire area of the county. The outreach worker coordinates with service providers, law enforcement, and the townships to engage individuals who need assistance with access to services and housing. This outreach worker assists with intake into PADS' cold weather shelter, if appropriate, and administers the VI-SPDAT assessment to place literally homeless and unsheltered persons on the Coordinated Entry list. The stakeholders interviewed recognized the diligence of the outreach worker responding to calls, coordinating resources, and assisting people, but also indicated that the job is too large for one person and the geography is too vast and varied to cover and respond to all the needs of the community for outreach and engagement.

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[17] Metra Rail Lake County: https://www.lakecountyil.gov/616/Metra-Rail
[18] Regional Transit Authority, PACE Bus Line, https://www.lakecountyil.gov/627/Routes
[19] Lake County Division of Transportation, Paratransit Services, https://www.lakecountyil.gov/627/Routes
[20] Homeless Inventory County Report, CoC 502-Waukegan/North Chicago and Lake County 2018
[21] "The Role of Outreach in Ending Homelessness", USICH, 2015. https://www.usich.gov/resources/uploads/asset_library/Outreach_and_Engagement_Fact_Sheet_SAMHSA_USICH.pdf

Access and Law Enforcement

Law Enforcement plays a role in outreach and access to services and shelter in Lake County. In many communities, law enforcement interacts regularly with people experiencing homelessness. In Lake County, law enforcement plays a dual role, both interacting with people experiencing homelessness and serving as outreach and connection to services. Law enforcement can escort individuals or families experiencing homelessness in Lake County to PADS Emergency Shelter and allow access to the shelter after 10:00 pm.[22] Stakeholders also identified law enforcement, both municipal police departments and the Lake County Sheriff's office, as a transportation resource to services and shelter for people experiencing homelessness in Lake County.

Lake County Crisis Center

Lake County is considering creating a Crisis Center to provide an additional access point for jail diversion and mental health treatment. In partnership with the Lake County Health Department, Community Oriented Correctional Health Services created the *Lake County Jail Diversion and Health Engagement Project Implementation Guide* in 2016. The report includes potential goals for a Crisis Center:1) Increase the number of individuals with serious mental illness diverted from jail, 2) Reduce recidivism of individual with serious mental illness from the justice system, 3) Improve mental health services access and continuity of care for justice-involved individuals or likely to be justice-involved individuals with serious mental illness. The report recommends the development of a central drop-off center where law enforcement could bring individuals showing signs of serious mental illness in lieu of jail. Law enforcement officers across the county could transport individuals directly to the Crisis Center. The report offers several models for the Crisis Center including a geographically centralized drop off location, multiple drop off locations, and models that extend crisis services beyond the Crisis Center. The report provides benefits and challenges of five models for the Crisis Center, though there is no clear advantage of one model or another.[23]

In interviews with stakeholders, most notably law enforcement, there was a perceived need for a Crisis Center in Lake County. The Sheriff's Office described the challenges of responding to a mental health crisis in the county and not having sufficient interventions during and after a mental health crisis. Other stakeholders discussed the need for a centralized location for access to services and housing. The discussion focused less on the crisis services need, but more on a centralized location for access to services. The Veteran-dedicated drop-in center was noted as a model that worked well for Veterans, with one centralized location for triage and connections to services.

Specific Populations and Access

Access to the CoC and housing may vary depending on the specific population who is experiencing homelessness in Lake County. As stated previously, LCCH does have three versions of the VI-SPDAT

[22] PADS Emergency Shelter Site Locations, https://www.padslakecounty.org/shelter-site-locations

[23] "Lake County Jail Diversion and Health Engagement Project Implementation Guide", The Community Oriented Correctional Health Services2 December 31, 2016

used in Lake County: the VI-FSPDAT for families with children, the TAY-SPDAT for youth ages 18-24, and the VI-SPDAT for couples and single adults.

Youth and Families

While CoC housing and services are available to all homeless populations, there are additional dedicated funding sources for rental assistance coupled with state or local supportive services for families whose homelessness puts them at risk for child welfare involvement or whose homelessness is preventing family reunification. Young adults who are aging out of foster care at age 21 are also eligible for rental assistance. This dedicated rental assistance program, called the Family Unification Program (FUP), is federally funded and administered by local PHAs. The CoC is working with all three PHAs and the county's Department of Children and Family Services (DCFS) to connect youth and families to FUP vouchers by cross-matching data to screen for eligibility.[24]

Veterans

Veterans can access Coordinated Entry and a variety of services through the Veteran walk-in center located at the Captain James A. Lovell Federal Health Care Center. The walk-in center is a place for homeless Veterans to receive services and be assessed for Coordinated Entry. Veterans can receive immediate assistance with food, clothing, and connections to healthcare while also connecting to housing resources. Staff from Healthcare for Homeless Veterans, which operates at Lovell FHCC, said that the center has made a significant difference in access to services and housing for Veterans. Because of it, Veterans experiencing homelessness in Lake County have a place they know where they can go. Though there are no outreach services provided specifically to Veterans or by the center, law enforcement, and other community stakeholders know to assist or direct Veterans experiencing homelessness to the center to receive services.

Persons with Animals Seeking Shelter

Persons experiencing unsheltered homelessness who also have an animal companion often face a choice to abandon their animal and enter shelter or stay with them and remain on the streets. Many choose to stay with their animal, even if it means being unsheltered.

There are many considerations when allowing animals in a shelter setting. Under the Americans with Disabilities Act (ADA) and the Fair Housing Act (FHA) there are distinctions between service animals, who under most circumstances are allowed by law anywhere the owner can go in public, and emotional support animals or pets which may be prohibited. The rules and regulations are extensive on how a service animal is defined and what questions may be posed to the handler to verify an animal is a service animal. Generally, service animals must remain in the care and control of their handlers and reasonable accommodations provided to the handler to ensure equal access to shelter. It is recommended that communities consult with appropriate counsel to ensure requirements and obligations under the ADA and FHA are being met. It is also recommended to engage with people with animals to understand their perspective and experience to include in community policies and practices.[25][26]

Communities across the country are discussing this topic and developing strategies to accommodate persons with pets to gain access to shelter. A People Assisting the Homeless (PATH) shelter in Los Angeles, for example, created a separate kennel space where pets may be sheltered at the same location as their owner.

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[24] FY 2018 CoC HUD Application, CoC IL-502 Waukegan, North Chicago, Lake County
[25] "Service Animals", U.S. Department of Justice Revised Regulations Implementing Americans with Disabilities Act, September 15, 2010, https://www.ada.gov/service_animals_2010.htm
[26] "The Fair Housing Act and Assistance Animals", The Humane Society of United States, https://www.humanesociety.org/resources/fair-housing-act-and-assistance-animals

Stakeholder Perceptions

The perceptions highlighted during the stakeholder interviews reiterated what has been described in this section. The key themes in regard to the access of services and housing during the stakeholder interviews were 1) concentration of services in the eastern part of the county, 2) the challenges of transportation across the county (specifically in the western part of the county), and 3) the difficulty of having only one seasonal emergency shelter.

The concentration of services and housing in the eastern part of the county was a consistent theme for stakeholders. Almost all stakeholders discussed that if a person or family is homeless in Lake County, they will likely need to make their way to the eastern part of the county to access services. The stakeholders described the services that were centralized in the Waukegan area, including access to Coordinated Entry and emergency shelter and public services such as PHAs, the Lake County Health Department, and the Social Security Administration office. In addition to public services, stakeholders noted that the majority of justice system facilities were also concentrated in the eastern part of the county, so individuals who are homeless and involved in the justice system also tend to be concentrated in the eastern part of the County.

Stakeholders described that with the concentration of resources, the majority of people experiencing homelessness in Lake County access services in the eastern half of the County, specifically the City of Waukegan. In November 2018, the Lake County Coalition for the Homeless released *Report on the State of Homelessness in Waukegan*. To inform the report, the Lake County Coalition for the Homeless met with stakeholder groups including local businesses, residents, government representatives, and clients. There were three key findings of the report:

- Finding 1-Misinformation contributes to tension among stakeholders in the community.
- Finding 2-Neighborhood safety and appearance are shared concerns.
- Finding 3-Lake County's homeless response system has gaps that leave residents experiencing homelessness without sufficient housing and services to address the overarching causes of homelessness.

Stakeholders perceive that Coordinated Entry is working to connect individuals and families to housing opportunities once assessed. The challenges perceived by stakeholders appear to be more about being able to access the assessments. The *Lake County Coordinated Entry Survey 2018* was conducted by Lake County and asked service and housing providers a series of questions to understand their experience working with Coordinated Entry. The results of the survey showed that in general providers perceive that Coordinated Entry is working. On a scale of one to five, the providers rated the overall experience of Coordinated Entry as 3.8. Most providers believed that it was successful in housing clients with the greatest barriers and some provides also said that it housed clients faster. Most providers saw an increase in collaboration because of Coordinated Entry.

Transportation was a consistent theme and an identified challenge in the stakeholder interviews. All stakeholders described the challenges faced by a person or family who became homeless in other parts of the county that were not near the services in Waukegan or the eastern half of the county. Stakeholders described ways that they tried to connect people to services and shelter by providing bus token assistance at the townships or transport via law enforcement, but options were limited due to a lack of public transportation heading west and east across the county.

Regarding shelter services, stakeholders voiced a need for year-round shelter and shelter for families. A consistent observation from the group noted that once the PADS cold-weather shelter closes at the end of April, few other shelter services are available and people experiencing homelessness in Lake County are left without shelter. PADS staff noted that they have some emergency shelter beds available at PADS'

smaller shelter location from May to October, but the perception of most stakeholders was that there was no emergency shelter in the area over the summer months. Stakeholders described seeing an increase in unsheltered homelessness, especially in Waukegan and North Chicago, during the summer months. The stakeholder interviews also highlighted a need for increased access to shelter services. Some stakeholders described that it can be challenging for people experiencing homelessness to make the shelter bus from PADS or find their own way to the rotating shelter locations. The stakeholders described needing a year-round emergency shelter that was possibly in a fixed location for people to access.

Lake County Survey of Homeless Needs

The Lake County Survey of Homeless Needs was a comprehensive survey conducted by Lake County in spring 2019 that includes responses from over 40 participants. The participants included the nonprofit, public, and philanthropic sector in addition to concerned residents and advocates in Lake County. The majority of the survey participants work in all quadrants of Lake County, but participants from all four quadrants of the county were surveyed. Survey participants represented agencies or communities working with individuals who are homeless, low income households or both. The first part of survey asked respondents to self-report on how well the community is implementing 14 different strategies or programs to address homelessness.

The strategies that had been implemented most by communities or were planning to be implemented included the following:

- Coordinated interagency financing and production for supportive housing (i.e. "systems change"): *43% of survey respondents are implementing or planning to implement*
- A range of models of integrated supportive-affordable housing (i.e. some units in a building are for supportive housing populations and the rest are for people who need affordability but not intensive services): *40% of survey respondents are implementing or planning to implement*
- Supportive housing or services models for high utilizers of crisis health services: *40% of survey respondents are implementing or planning to implement*
- Supportive housing models for child welfare-involved families: *43% of survey respondents are implementing or planning to implement*
- Use of Vulnerability Indices or other tools to prioritize homeless individuals for supportive housing: *40% of survey respondents are implementing or planning to implement*
- Intensive case management/wrap-around services for vulnerable public housing residents: *40% of survey respondents are implementing or planning to implement*

The strategies that have not been implemented most by communities or are not currently planned to be implemented by communities included the following strategies:

- Supportive housing or services models for elderly: *Only 25 % of survey respondents are implementing or planning to implement*
- Leveraging Medicaid for supportive housing: *Only 25 % of survey respondents are implementing or planning to implement*
- Connecting Federally Qualified Health Centers within supportive housing: *Only 28 % of survey respondents are implementing or planning to implement*

Survey participants were asked which significant needs are not being met for the people that the communities/agencies or departments were working with. They were also asked which significant needs are not being met specifically for youth age 16-24 experiencing homelessness. The responses were similar

for both questions. The most common needs survey responders reported that were not being met were the following:

- Affordable housing and/or rental assistance,
- Housing-based services and case management
- Year-round emergency housing
- Transportation
- Mental health and psychiatric services
- Employment supports

The Lake County Survey of Homeless Needs highlighted similar themes regarding barriers to accessing services and housing as those discussed in the stakeholder interviews. The issues of transportation were noted by most of the survey respondents, as were issues caused by confusing systems that are difficult to navigate. Additional barriers noted by the survey respondents included criminal backgrounds and the eligibility criteria of service providers. The survey questions summaries of the responses to multiple choice questions are in Appendix II and Appendix III, respectively.

Recommendations

Develop Year-Round Emergency Services and Day Center: Lake County's current shelter system is seasonal, based on a rotating-site model, and has limited space to secure belongings. This model creates barriers and does not promote consistent engagement with clients, limiting the ability of staff to connect clients to housing solutions and supportive services. The development of a year-round shelter, in conjunction with 24-hour services, would allow for consistent engagement. Ideally, the shelter and day center would be a single 24-hour site that provided emergency shelter services at night and day center services during the day; however, alternate models may be able to meet these needs as well.

Example: District of Columbia Interagency Council of Homelessness Strategic Plan for Year Round Access to Shelter created a shelter and access point for DC in 2017. The year-round access to shelter and access point for Coordinated Entry has led to a decrease in homelessness in the District of Columbia.[27]

- https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.11%20web.pdf
- https://dhs.dc.gov/page/shelter

Create Dedicated Services for Families with Minor Children: Lake County currently has no emergency shelter, day center, or crisis response location dedicated to families with minor children, yet there is an identified need for these resources. Committing a location to families would improve the ability of providers to address the distinct needs of this special population.

[27] "Homelessness in DC region drops for 3rd consecutive year", Nick Ianneli, WTOP, May 2, 2019. https://wtop.com/local/2019/05/homelessness-drops-dc/

Example: YWCA of Columbus Ohio provides emergency shelter and is a Coordinated Entry Access Point for families experiencing homelessness.

- http://www.ywcacolumbus.org/site/PageServer?pagename=services_familycenter

Resource: "Closing the Front Door: Creating a Successful Diversion Program for Homeless Families", National Alliance to End Homelessness

- http://endhomelessness.org/wp-content/uploads/2011/08/creating-a-successul-diversion-program.pdf

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Create Dedicated Services for Youth: Lake County currently has no service or housing resources dedicated to unaccompanied youth. This special population is recognized as having unique needs and is not well served under models traditionally used for adults. Expanding the capacity of service providers to create programs and projects dedicated to youth would improve Lake County's ability to respond to youth homelessness.

Expand Access through Crisis Center: crisis center could also offer an additional point to access for assessment to services and housing. The community has identified a lack of locations and services that can assist those with serious mental illness or those under the influence of drugs or alcohol, which results in unnecessary jail or hospital stays. The development of a Crisis Center could address these issues by potentially providing a jail alternative to those with serious mental illness and providing medically assisted treatment for safe detox and sobering. Additionally, a crisis center could serve as a Coordinated Entry access point, increasing engagement and access to services.

Example: San Francisco operates six Navigation Centers that serve as short-term stays and an access point for Coordinated Entry.

- http://hsh.sfgov.org/services/emergencyshelter/navigation-centers/

Increase Outreach and Mobile Crisis Team: Given the geographic spread of the county and the transportation challenges that have been identified by stakeholders, having a comprehensive, multidisciplinary mobile outreach team would increase access to services, shelter, and housing throughout the county. The outreach team could include case managers/housing navigators, a behavioral health specialist, and peer support workers. While the specific team composition is flexible and may be shaped by funding availability, it is critical that the team is able to cover the whole county and coordinate with multiple systems including law enforcement, health care providers, and service agencies.. The outreach team would be able to provide mobile VI-SPDAT assessments and connect with clients that are not actively engaged with Coordinated Entry. Ideally, the outreach team would also be able to provide transportation to shelter or the Crisis Center.

Resource: CSH, "Tools, Policies & Templates for Address Unsheltered Homelessness"

- https://www.csh.org/communityresponse/

Resource: U.S. Interagency Council of Homelessness, "Core Elements of Effective Street Outreach to People Experiencing Homelessness"

- https://www.usich.gov/resources/uploads/asset_library/Core-Components-of-Outreach-2019.pdf

***Example*:** Southern Nevada's MCIT (Mobile Crisis Intervention Team) operated by HELP of Southern Nevada provides outreach and engagement to all Clark County, NV.

- https://helpsonv.org/programs-mcit.php

Example: C3 (County + City + Community) Outreach Teams in Los Angeles are an example of a public/private multi-disciplinary outreach team.

- http://file.lacounty.gov/SDSInter/dmh/246486_C3PresentationforHousingInstitute.pdf

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Increase Access through Township Pilot: Lake County's township offices are often geographically accessible to those experiencing homelessness in less dense areas of the county; however, the townships' varying policies and procedures may serve as a barrier to those seeking services. Some townships recognize that homelessness is an issue in their community and have expressed interest in further engagement with the homeless response system. The township offices are well positioned to serve as an access point to Coordinated Entry and could facilitate VI-SPDAT assessments and warm hand-offs to additional services. A township pilot program could be used to explore expanding the relationship between townships and the CoC, including standardizing processes across townships to facilitate access to emergency shelter, housing, and services.

Conduct Summer Street Count: The regular PIT count takes place in late January when inclement weather forces those experiencing homelessness indoors. Lake County's residents experiencing unsheltered homelessness may be in local shelters, but they may also seek shelter in other communities or be in other areas where they will not be counted, such as with friends or in hotels. This may result in an unsheltered PIT count which does not capture the true depth of unsheltered homelessness in Lake County. A summer street count could more accurately measure unsheltered homelessness in Lake County, which could help size any newly developed emergency shelter services.

Example: Richmond, VA

- http://homewardva.org/data/point-in-time-count

Create "Bridge" Housing for Persons Matched in Coordinated Entry: Data indicate that clients could be moved into housing more quickly if agency staff were able to reliably contact them. Clients who are waiting for a housing unit to become available must utilize the rotating-site shelter model, a model that is not conducive to stability and which reduces the ability of agency staff to quickly locate clients once they are matched to housing. This issue could be ameliorated with "bridge" housing, interim housing that is available to clients that are matched to a housing resource. Bridge housing could reduce the time from voucher to move-in, increase landlord and participant confidence, and increase the success of each match. Bridge housing can be modeled in several ways to account for the funding resources and unique needs of community; several of these models may be feasible in Lake County.

Example: Southern Nevada/Las Vegas runs a program called 'Link' that has an outreach team that finds individuals once they come up on the prioritization list, gets the individuals into bridge housing, then into permanent housing. The outreach team is operated by HELP of Southern Nevada and paid through CoC and county funds.

Example: Chicago Coordinated Entry System provides bridge housing for individuals matched through Coordinated Entry who are waiting to lease up in Permanent Supportive Housing.

- https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2019/03/Bridge-Info-Doc.pdf

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Evaluate Prevention Program w/ ESG funding: ESG resources are durable sources of funding which can pay for Emergency Shelter (ES), Street Outreach (SO), Rapid Rehousing (RRH), Homeless Management Information System (HMIS), and Homelessness Prevention (HP). CSH recommends that Lake County reevaluate the use of ESG resources for RRH and HP by exploring eligibility criteria, success rates, and spend down of funding. Outcomes may be improved by shifting resources to street outreach or emergency shelter or increasing RRH funding for those experiencing literal homelessness. Additionally, shifting the funding source of RRH and HP to local flexible funding rather than ESG funding may help.

Align Funding: Public funding sources typically carry strict restrictions but are reliable sources of long-term funding. Private funding sources are typically more flexible but may be for shorter terms. Using public dollars for long-term durable housing and using private dollars to fund innovation or fill gaps in program budget improve a communities' dexterity and ability to respond to change. CSH recommends establishing a "funders' collaborative" which brings public, private, and philanthropic funders together to better align resources across homeless services.

Example: Los Angeles Funders Collaborative

- http://homeforgoodla.org/our-work/funders-collaborative/

5. SERVICES AND HOUSING INFRASTRUCTURE ASSESSMENT

Residential Programs – Crisis Housing

According to the 2018 Housing Inventory Count (HIC) there are a total of 165 year-round beds for emergency shelter and transitional housing, augmented by an additional 65 seasonal beds. Of the 165, 98 beds are Transitional Housing and 67 are Emergency Shelter. Of the 67 Emergency Shelter beds, only 10 are not set aside for survivors of domestic violence. During the fall and winter, PADS makes an additional 65 seasonal beds available to shelter people experiencing homelessness. For families who are not survivors of domestic violence, motel/hotel vouchers are available. There are no emergency resources dedicated specifically to youth ages 18-24. Crisis housing resources dedicated to Veterans are available through a local VA Domiciliary "Dom" Care for Homeless Veterans (DCHV) program.

Residential Programs – Permanent Housing

In Lake County, there are 392 permanent supportive housing (PSH) beds, which is inclusive of the HUD-VA Supportive Housing (HUD-VASH) program dedicated to Veterans. Seventy-six additional beds for other permanent housing (OPH) are for survivors of domestic violence. In addition to PSH and OPH resources, Lake County has both rapid re-housing (RRH) and homelessness prevention (HP) programs that serve families with minor children. The HIC indicated there are 120 RRH slots available per year, though due to the nature of RRH being based on need there may be resources to assist additional households.

Non-Residential Programs

Stakeholders interviewed discussed Lake County's emphasis on diversion, an emphasis that aligns with national best practice. Diversion, which can be used to resolve a family's housing instability with limited financial assistance, involves problem solving with persons who are at risk of homelessness and connecting them to support. Diversion is a best practice and can be a powerful component of a progressive engagement model.

6. SUPPORTIVE HOUSING AND AFFORDABLE HOUSING ANALYSIS

Breakdown of Permanent Housing Inventory from the Lake County 2018 Housing Inventory Count

Table 2. Inventory of permanent housing beds by population

Housing Intervention	Total Beds All Populations	No Special Population: Families and Adults Only	Special Populations					
			Families w/ Adults and Children		Adults Only		Survivors of Domestic Violence: Families and Adults Only	Persons Living with HIV/AIDS
			Veteran	*Chronic Homelessness*	*Veteran*	*Chronic Homelessness*		
Other Permanent Housing	**76**	0	0	0	0	0	76	0
Permanent Supportive Housing	**409**	19	59	29	185	102	0	15
Rapid Re-Housing	**83**	67	3	0	13	0	49*	0
Total	**568**	**86**	**62**	**29**	**198**	**102**	**76**	**15**

Current Resources and Observations

Table 2 shows the current resources in Lake County according to the 2018 Housing Inventory Count (HIC). Like many communities, the main drivers of permanent supportive housing (PSH) in Lake County are HUD-Veteran Affairs Supportive Housing (HUD-VASH) and HUD Continuum of Care (CoC) PSH. Many individuals and families experiencing homelessness do not have access to these resources; HUD-VASH units are dedicated to veterans and CoC PSH units are dedicated to persons experiencing chronic homelessness.

Families who do not qualify for VASH or CoC set-aside units may be eligible for rapid re-housing (RRH). Through the FY 2018 CoC Notice of Funding Availability (NOFA), Lake County was able to secure an additional RRH grant for survivors of domestic violence. RRH and homelessness prevention (HP) services are centralized in one agency, Catholic Charities. As federally funded RRH and HP activities have

restrictions and extensive documentation and monitoring obligations, there are advantages to consolidating these programs under one experienced agency.

Gaps Analysis Results and Discussion

As part of this report, CSH conducted a gaps analysis of the homeless system's crisis and permanent resources using data from the 2018 Housing Inventory Count, 2018 Point in Time Count, and Annual Performance Reports (APRs). Additionally, the analysis covered outcomes for emergency shelter, transitional housing, permanent supportive housing, and rapid re-housing projects from Homeless Management Information System (HMIS) data.

The analysis estimates the amount of housing resources needed per population by considering the annualized number of persons experiencing homelessness, exits from housing programs, and turnover rate. When calculating annual need, the tool assumes 15 percent of persons experiencing homelessness will be able to "self-resolve," or resolve their homelessness without deep subsidies or service.

Permanent housing need is separated into permanent supportive housing (PSH) , rapid re-housing (RRH), and diversion (DIV). Temporary housing need combines emergency shelter and transitional housing. The gap for both permanent and temporary housing resources is calculated separately for individuals and families. The final column in the table presents the "gap." If the supply does not meet demand, the number of additional units which must be added in order to meet the community's need is in parentheses. If supply exceeds demand, the number of excess units is not in parentheses.

Table 3. Existing stock and annualized need for permanent and temporary housing interventions by population

Need for Permanent Housing					
Housing Intervention	**Existing Stock**	**Annual Turnover Rate**	**# Available Annually**	**Annual Need (based on assumptions)**	**Annualized U/B/S Over/(Under)**
PSH - Fam.	88	0.03	3	21	(18)
PSH - Ind	321	0.07	24	132	(108)
RRH - Fam.	107	0.23	25	30	(5)
RRH - Ind.	25	1.73	43	263	(219)
DIV - Fam.	0	1.00	0	16	(16)
DIV - Ind.	76	1.00	76	139	(63)
Need for Temporary Stay					
Population	**Existing Stock**	**Average Turnover Rate**	**# Available Annually**	**Annual Need (based on assumptions)**	**Annualized U/B/S Over/(Under)**
Families	64	1.13	66	51	15
Individuals	220	1.67	528	395	134

The shortfall for permanent housing annual need is 126 units of PSH and 224 units of RRH. It is further estimated that an additional 139 individuals and 16 families could be diverted from entering literal homelessness through a combination of services and financial assistance.

This tool provides a cursory analysis; in order to have community discussions regarding resource allocation and deployment, a deeper analysis of service use among multiple sectors may be required. The model displays unmet housing needs to present an aggregate picture but does not delineate unmet needs by subpopulations such as domestic violence. Deeper studies can be made on housing needs and turnover for this group, using data that is captured outside of the Homelessness Management Information System. It is assumed that households will be offered housing in accordance with community priorities for any new housing resources.

Based on community resources, households fleeing domestic violence could be diverted to an affordable housing program for this subpopulation. The community's 76-unit affordable housing program does not have the same disability or homeless requirements as other permanent supportive housing programs, making it feasible to refer households who have not yet touched literal homelessness.

For permanent housing resources, the gaps analysis indicated a shortfall; however, the tool indicates a modest surplus of temporary housing resources. This is due to the tool's inclusion of all temporary housing listed in the HIC, including seasonal beds, overflow beds, and beds reserved for survivors of domestic violence. The turnover rate for emergency shelter, particularly for individuals, is high—this is most likely a result of the seasonal program exiting all participants when it closes in the spring. If the seasonal resources were available year-round, the needs for crisis resources for singles would be met.

Other Considerations

Emerging Efforts: Pay for Success (PFS) and Frequent Users Systems Engagement (FUSE)
In addition to the work on the gap analysis, CSH is also engaged with Lake County on a Pay for Success project and exploring options for a potential cross-sector data match project using the Frequent Users Systems Engagement (FUSE) model developed by CSH and used in almost 40 communities across the country. The FUSE model draws data from multiple sectors such as jails, healthcare, and homelessness. Data matching can be used to identify persons who are high utilizers of services in multiple sectors and prioritize them for supportive housing.

Recommendations

Create Permanent Housing Solutions Indicated by Data for Unmet Needs: Data indicate an unmet need for supportive housing. Single-site supportive housing developments that incorporate daily supportive services for both tenants and people in the community can be effective for clients with intensive service needs. Small and medium-size developments of 25-30 units often provide services that are more intensive and have leasing accommodations and property management strategies for people with higher needs. The Illinois Housing Development Authority has funded several small single-site projects that could be used as models for Lake County to explore. Examples of supportive housing site-based projects that CSH has worked with in other communities in Illinois include:

Example: Ogden Ave Supportive Housing operated by BEDS Plus in LaGrange, IL is a 20 unit single site building to house highly vulnerable people with a history of chronic homelessness, physical and mental disabilities, and serious health conditions.

- http://beds-plus.org/how-we-help/housing-services/#oash

Example: Lincoln Park Community Shelter is expanding their operations through a capital campaign fundraiser. As part of the expansion, Lincoln Park Community Shelter is developing 20 units of supportive housing in a single-site model.

- https://lpcsonline.org/wp-content/uploads/2018/03/LPCS_5.5Xx8.5-2-1.pdf

Resource: CSH Dimensions of Quality Supportive Housing Guidebook

- https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2013/07/CSH_Dimensions_of_Quality_Supportive_Housing_guidebook.pdf

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Engage PHAs and Create Set-Asides: Lake County's Public Housing Agencies (PHAs) report a low rate of homeless participants enrolling in the Housing Choice Voucher (HVC) program; one PHA reported 25% in the previous the fiscal year, and the other two reported 0%. To increase PHA engagement the CoC and Lake County could:

- Work with the PHAs to develop a more comprehensive policy preference for those experiencing homelessness
- Continue to apply for federal funding opportunities where new resources can target specific sub-populations that are identified through LCCH priorities and services pathways
- Work with the PHAs to provide "Moving On" opportunities for people in supportive housing who are able to live more independently, opening up a space for more vulnerable individuals who need the services
- Identify opportunities to set aside HCV allocations for persons experiencing homelessness
- Provide pre-inspections to increase the likelihood of a unit being approved
- Assist in document collection, application submission
- Assist in managing relationships with landlords
- Help establish a Handyman fund
- Help establish a damage mitigation fund
- Apply for more CoC Rental Subsidy units in the HUD CoC NOFA

Resource: "PHA Guidebook to Ending Homelessness" by USICH.

- https://www.usich.gov/resources/uploads/asset_library/PHA_Guidebook_Final.pdf

Resource: "Moving On" by CSH.

- https://www.csh.org/moving-on/

Convert Transitional Housing to Supportive Housing When transitional housing or shelter beds become default long-term housing, it may be time to consider converting to permanent housing. An assessment of local transitional housing programs' funding source, agency capacity, and other issues can be done to evaluate whether resources should be converted to permanent housing, adding supportive housing stock to the community.

Resource: "Transitional Housing Conversion: A Building Owner's Toolkit" by National Alliance to End Homelessness.

- https://endhomelessness.org/resource/transitional-housing-conversion-a-building-owners-toolkit/

7. SYSTEM FUNCTIONALITY AND COORDINATION ASSESSMENT

HUD CoC System Performance Measures (SPMs) Analysis

Increasingly, HUD has relied on objective data to evaluate and fund local communities through the Continuum of Care Notice of Funding Availability (CoC NOFA). System performance data, along with data from the PIT count and HIC are becoming integral to the Con Plan and CAPER processes. The System Performance Measures (SPMs) are seven priority measures identified by HUD to evaluate a community's homeless response system. The measures touch on three core themes of an ideal homeless response system: to make homelessness rare, brief, and non-recurring. SPMs are submitted yearly, along with PIT, HIC, APRs, and LSA (formerly AHAR) as part of a large and comprehensive data-reporting package required of communities.

The SPMs in brief:[28]

1. Length of time persons remain homeless
2. Extent to which persons who exit homelessness (are housed) do not return to homelessness
3. Number of homeless persons (participating in HMIS)
4. Employment and income growth for homeless persons in CoC Program-funded projects
5. Number of persons who become homeless for the first time
6. Homelessness prevention and housing placement of persons defined by category 3 of HUD's homeless definition in CoC Program-funded projects
7. Successful permanent housing placement

The following analysis will focus mainly on measures 1, 2, 5 (including 3), and 7. Measure 4 is a subset of programs in the community and may not provide a large enough picture of income and benefits in the community for this context. Measure 6 focuses on homelessness prevention and housing placement of persons who are homeless as defined by category 3.

Category 3 homelessness has a rather complex definition[25] and includes those who do not meet category 1 (literal homelessness) or category 2 (imminent risk of homelessness), but are an unaccompanied youth or a family with minor children who are homeless by another federal statute or have a distinctive history of housing instability. Under HUD rules, CoC funding cannot be used to serve this population without written approval as provided in 24 CFR 578.89.

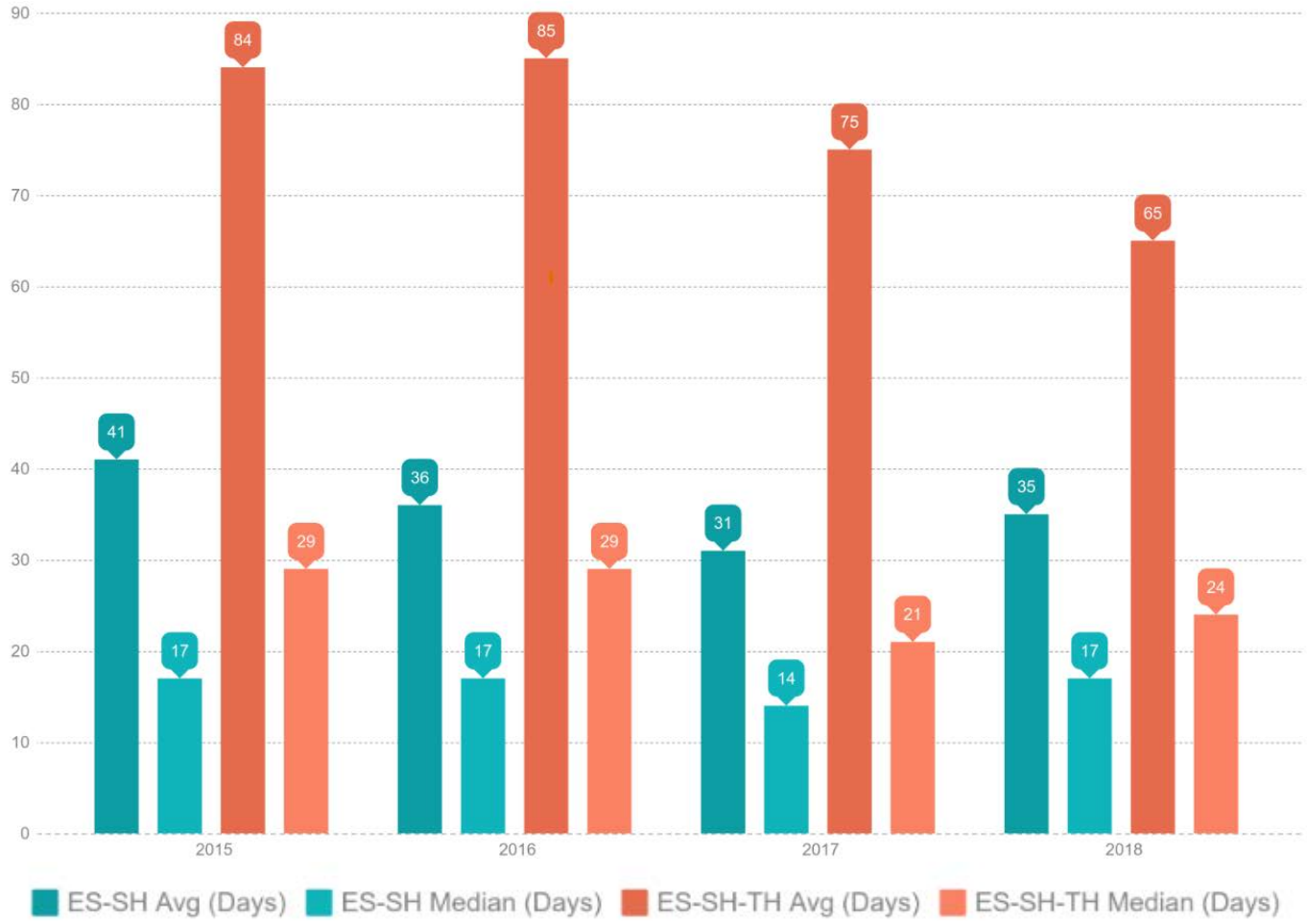
It should be noted that these numbers are heavily affected by HMIS data quality and the quality of the HIC, PIT, SPM, and the other HUD reports, which are complex and consequential prerequisites to many funding sources. Lake County has demonstrably improved its data quality over the last few years to make these analyses possible. Lake County also has complete HMIS shelter bed coverage and an HMIS staff dedicated to quality reporting, training, and capacity building, qualities that few communities share.

[28] "System Performance Measures", HUD Exchange, https://www.hudexchange.info/programs/coc/system-performance-measures/#guidance

Measure 1: Length of Time Persons Remain Homeless

Measure 1 has two parts, both calculating the average and median length of time persons are homeless. The first part is for those in emergency shelter (ES) and safe haven[26] (SH) programs, the other part includes persons in transitional housing (TH) programs.

Chart 1. Average and median time (in days) persons remain homeless, by program type combination



This measure provides the average and median of the total number of days people spend in ES, SH, or TH, regardless of the number of program enrollments, within the year.

The averages are higher than the medians in the above graph. The difference is especially pronounced once transitional housing is added. This may be caused by data quality, service population and project type, or a mixture of the two.

From a data quality perspective, there are several data errors that could impact this measure but there are appropriate protocols in place to identify and correct errors in a timely manner. From a program perspective, TH programs may serve participants up to 24 months, so a longer length of stay compared to shorter-term ES programs is not unusual. Another factor that would cause the average to be greater than

the median is the presence of long-term stayers in emergency shelter. Strategies that target households with long-term stays will drive down the average length of time.

This metric has an important, but narrow view of length of time homeless. Communities may adopt other metrics to gain a more comprehensive view, which would require project or client level data. Additional metrics may include HMIS data or PHA data and cover process steps, which may be reduced by adopting or changing policies, barrier busting, and communication among stakeholders. Below are some examples of these process metrics:

Questions for HMIS:

- How many assessments are conducted? How many unduplicated persons were assessed?
- How many days from RRH program entry to RRH move-in?
- How long do persons remain on an RRH subsidy?
- How many days from PSH program entry to PSH move-in?

Questions for PHAs

- How many vouchers applied for/issued to persons experiencing homelessness?
- How many days from voucher application to issuance?
- How many days from voucher issuance to move-in?

Measure 2: Extent to Which Persons who Exit Homelessness Do Not Return to Homelessness

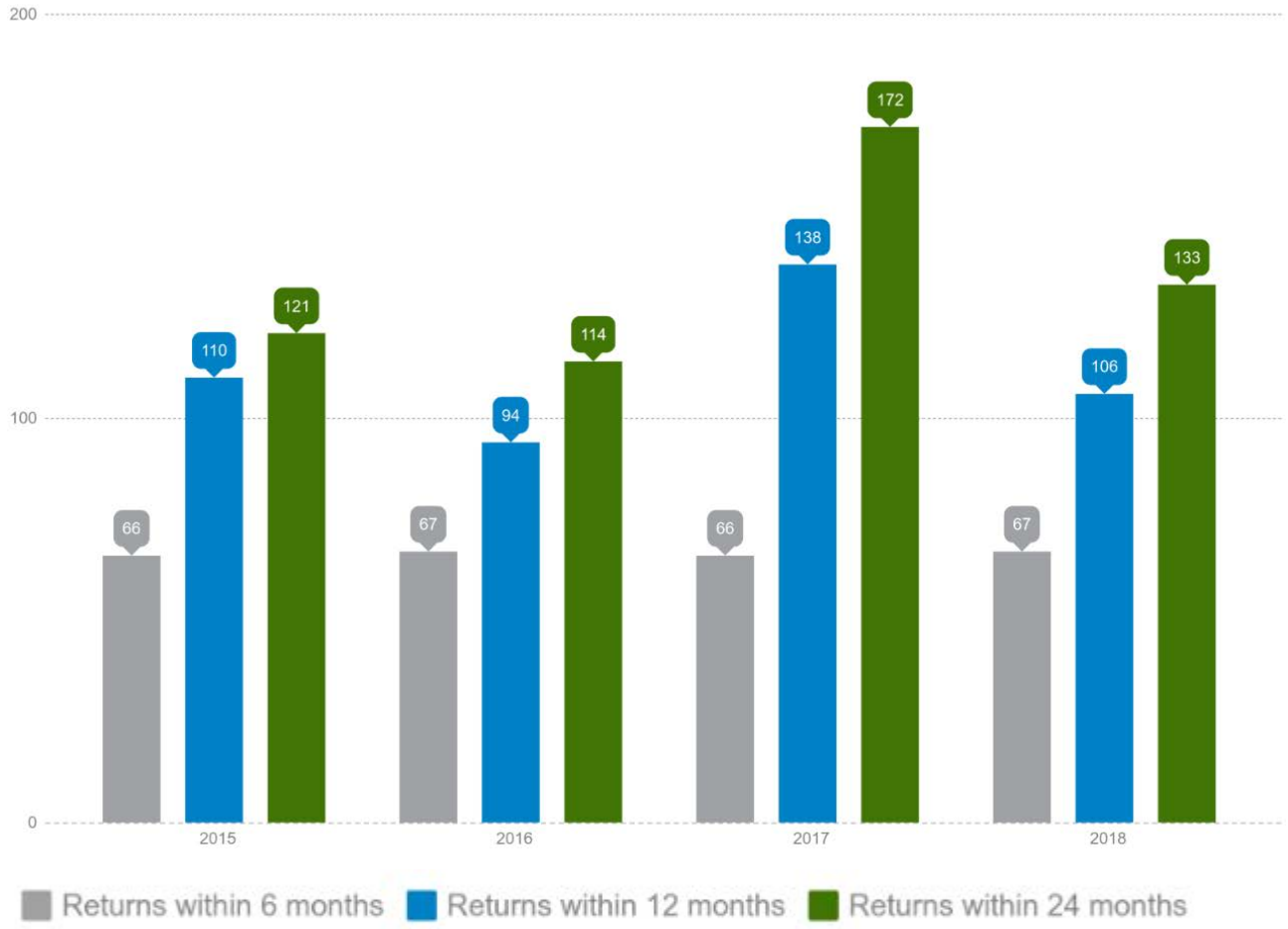
The client universe that makes up this measure is all those who participated in an HMIS program *and* exited to a permanent housing destination (*e.g.,* rental situation, permanent supportive housing, family and friends) in the two years *prior* to the SPM report period. For example, for the FY 2018 report period, the look back would start FY 2016. After the universe is calculated, the measure looks for a subsequent record in HMIS to see if that person or family "returned" to the system. Dividing the returned group by the universe produces the return rate percent.

Table 4. Returns to homelessness within 6, 12, and 24 Months (2015-2018)

Year	2015		2016		2017		2018	
	Nat'l Avg.	Lake County	Nat'l Avg.	Lake County	Nat'l Avg.	Lake County	Nat'l Avg.*	Lake County
Returns within 6 months	10%	14%	10%	12%	9%	11%	N/A	11%
Returns within 12 months	14%	24%	14%	17%	14%	23%	N/A	17%
Returns within 24 months	20%	26%	20%	21%	20%	28%	N/A	21%

*National Averages for 2018 are not yet published by HUD

Chart 2. Returns to homelessness within 6, 12, and 24 Months (2015-2018)



It is important to note when reviewing this metric that there is a “lag” as the above chart and table show the results of placements from up to two years ago. The national trend shows an increase in rates of return as time advances, consistent with the trend in Lake County, though the rates in Lake County are higher than the national average.

As with all these metrics, a two-pronged analysis of data quality and program performance should be conducted. Timeliness and accuracy of data entry are especially critical to this metric because of the two-year look back. If a record is left open or entered after the event occurred and not properly backdated, it may lead to errors. At a system-level, it is difficult to observe these issues and identify them for correction. Often, continued training and support along with provider engagement are the most effective tools in improving data quality.

Deeper analysis of client data on a population-level and a project-level will help identify potential program or policy gaps. For example, looking at the adults only households to households with minor children. How do the rates of return for these populations compare? How do they compare from 6 months to 24 months? What are the range of services offered to each population? Which cohorts of programs have higher rates of return? Particularly among Homelessness Prevention (HP), Rapid Re-Housing (RRH) and Permanent Supportive Housing (PSH), which provide direct financial assistance to participants. How long are

participants receiving RRH or HP rental subsidies? How is level of need determined for financial assistance?

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

First time homeless looks at all persons who *entered* an HMIS program during the report year and looks back two years to determine if the same persons had prior engagements with an HMIS program. If no record is found, they would be considered homeless for the first time. Dividing first time homeless records (Measure 5) by the total HMIS count of persons homeless (Measure 3), a rate is determined.

The two parts of this measure observe crisis interventions (ES, Safe Haven (SH), and TH) and crisis interventions, plus permanent housing interventions (ES, SH, TH, RRH, and PSH).

Chart 3. Number of persons experiencing homelessness for the first time by program combination (2015-2018)

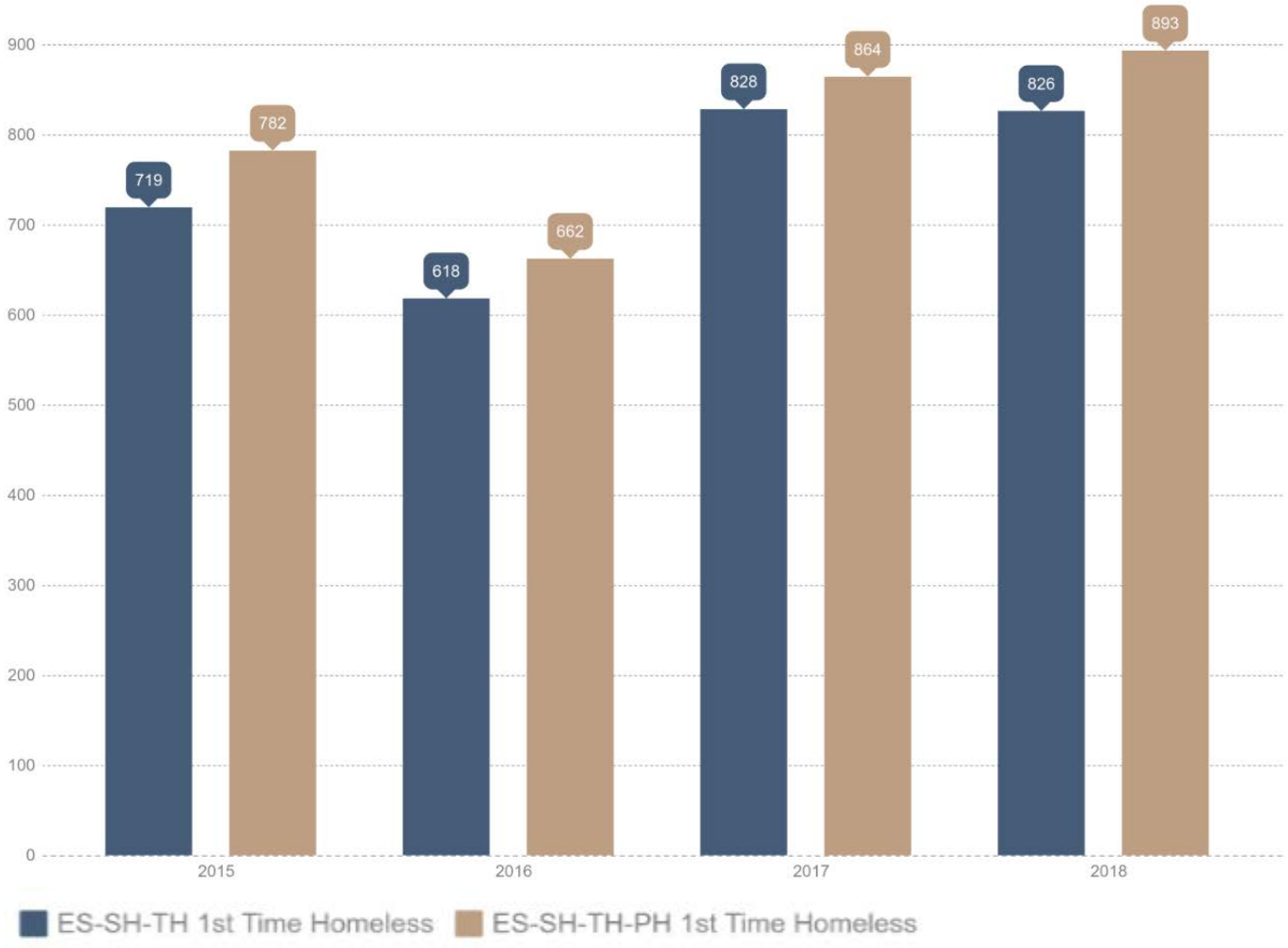


Table 5. Number of persons experiencing homelessness for the first time by program combination (2015-2018)

	2015		2016		2017		2018	
	#	%	#	%	#	%	#	%
ES-SH-TH 1st Time Homeless	719	58%	618	58%	828	69%	826	67%
ES-SH-TH-PH 1st Time Homeless	782	63%	662	63%	864	72%	893	73%
Total HMIS Count (SPM 3)	**1232**		**1059**		**1199**		**1227**	

This measure is to assess the homeless response system's ability to ensure persons experience homelessness that is non-recurring. The vision of "functional zero" put forward by HUD in creating a system to end homelessness is not necessarily that no one will ever experience homelessness ever again. "Functional zero" is about creating a system that rapidly responds to a person's housing instability, preventing homelessness, providing tailored and appropriate crisis services, and quickly returning someone to housing. A higher rate of persons experiencing homelessness for the first time, coupled with a relatively static number of total persons experiencing homelessness, is not necessarily negative in building toward functional zero and an ideal system where homelessness is a one-time experience or prevented altogether.

Measure 7: Successful Permanent Housing Placement

Measure 7 is broken into two parts, the first (7a) measures successful permanent housing placement from Street Outreach (SO) projects and the second (7b) measures successful placement from ES, Safe Haven (SH), TH, and RRH (7b1) or retention of permanent housing from RRH or PSH projects (7b2).

Measure 7a: Successful Permanent Housing Placement from Street Outreach

Table 6. Total persons exiting street outreach to temporary and permanent destinations (2015-2018)

Year	*2015*	*2016*	*2017*	*2018*
Total Persons Exiting Street Outreach (SO)	0	0	62	104
Total Persons Exited SO to Temporary Destinations	0	0	11	38
Total Persons Exited SO to Permanent Destinations	0	0	35	39
Percent with Successful SO Outcome	NA	NA	74%	74%

Measure 7b: Successful Permanent Housing Placement in or Retention of Permanent Housing

Table 7. Total persons exiting housing interventions to permanent Housing (2015-2018)

Year	*2015*	*2016*	*2017*	*2018*
Total Persons Exiting ES, TH, SH, PH-RRH	*1,031*	*1,000*	*1,023*	*1,123*
Total Persons Exiting ES, TH, SH, PH-RRH to Permanent Housing	542	577	419	520
Percent with Successful ES, TH, SH, PH-RRH Exit	*53%*	*58%*	*41%*	*46%*
Total Persons Exiting PH or Remaining in PH at end of reporting period (measure excludes PH-RRH)	128	134	144	161
Total Persons Exited PH to permanent destinations or Remained in PH for 6+ months (measure excludes PH-RRH)	*119*	*128*	*137*	*157*
Percent with Successful PH Retention or Exit	93%	96%	95%	98%

The first Street Outreach (SO) project started in FY 2017, which is why there is no information for FY 2015 or FY 2016. A successful outcome for a SO project includes a placement directly into permanent housing or a placement into a temporary situation, like an emergency shelter bed or transitional housing, as most persons encountered in the project will be unsheltered.

The rate of permanent placement in both reporting years is impressive, especially considering the very small scale of the one operating SO project; literally a one-person operation. The SO project achieved a 56 percent PH placement rate in 2017 and a 38 percent PH placement rate in 2018. While these are indeed very positive outcomes, it should be noted that the successful SO depends on positive relationships and trust between the SO program and crisis service providers, permanent housing providers, and above all, persons experiencing homelessness who are served by the SO project. It also relies on an adequate infrastructure of crisis and permanent services in a community in a system where all interventions coordinate, combine, and enhance each other.

HUD Continuum of Care (CoC) Notice of Funding Availability (NOFA)

The HUD CoC NOFA is an intensely competitive application process where communities across the country make difficult evaluation, funding, and strategic decisions.

Communities must evaluate each CoC-funded project against established and community-approved metrics. Projects falling below a predetermined and approved threshold are reallocated. Reallocation is a process by which communities may use funding from low performing projects and apply for new projects. It allows for greater community control to respond to local needs and priorities. Lake County has developed a comprehensive evaluation and reallocation process. Additionally, the community approval process is in line with HUD standards.

CoC Joint Component: Transitional Housing – Rapid Re-Housing (TH-RRH)

Introduced in the FY 2017 NOFA, the TH-RRH joint component offers an opportunity for communities to provide crisis housing services and financial assistance, expanding both shelter and RRH capacity.

Reallocation and HUD's emphasis on both performance and CoC funding going toward permanent housing solutions has deemphasized transitional housing in recent years. The last NOFA cycles awarded fewer points to TH and SSO projects than to permanent projects, like PSH or RRH. HUD has also more explicitly stated that TH is appropriate for three subpopulations or people experiencing homelessness: transition-age youth, persons with substance use disorders, and survivors and survivor families of domestic violence.

These strong signals from HUD led many communities to reallocate portions of their TH projects and put the CoC funding into PSH and RRH. Some of these communities had the capacity through private, local or other federal dollars to backfill or convert the reallocated TH to lower-barrier and less service intensive emergency shelters. The joint component is a way for HUD to assist communities to increase shelter capacity through the CoC program and maintain its commitment to permanent solutions through CoC funding.

Administratively, TH-RRH operates as two programs, with a transitional housing (shelter) component and a rapid re-housing (financial assistance) component. The participant has the option to enter either the TH component, the RRH component, or both, working with the program to determine the best service and housing plan for their needs. The program is obligated to provide both components to eligible participants. HUD recommends TH-RRH programs budget *at least* double the amount of RRH than TH to ensure there is enough funding to assist persons.

Depending on the needs of the community, the target population could be specified. Some communities have left it open because of the dearth of crisis housing in their area, particularly in rural communities. Others have limited it to survivors of domestic violence, which allows DV service providers the continuity of service with a survivor from TH through to independent housing and support in RRH, all in-house which appeals to many DV providers as safety is a critical concern.

Since its introduction, the joint component has been pioneered by communities and far more information and guidance is available from HUD to explain its administration and purpose. It is a viable strategy to

consider in the next NOFA, particularly where Lake County is looking to expand shelter opportunities for families with minor children in an environment not shared with other adults-only programs. Because of the distinctive nature of RRH and homelessness prevention in Lake County, the RRH component could be subcontracted out to that provider to maintain all the RRH/HP services under one provider. Particularly if this provider has strong financial capacity to handle the additional funding, it may further strengthen the application in the NOFA.

Unified Funding Agency (UFA)

Under 24 CFR 578.11, collaborative applicants have the option "to become designated as the Unified Funding Agency (UFA) for [the] Continuum." The UFA designation as defined in section 402(g) of the 2009 HEARTH Act, which grants CoCs more autonomy in decision-making, particularly on funding and budgets, sub-recipient selection, and reallocation. Once the UFA status is conferred on a CoC, all HUD CoC funding goes to the UFA as the recipient, CoC funds are then passed down to sub-recipients. The designation also comes with more responsibility and oversight requirements, specifically accountability for beds, units, and persons served in each year's CoC NOFA application. UFAs are eligible for additional funding from HUD to fulfill these administrative responsibilities.

To be eligible for UFA status, in addition to the basic requirements related to legal status of an organization (must be a nonprofit organization or state or local government organization, including PHAs), the Collaborative Applicant must be selected and approved by the CoC and demonstrate existing capacity to carry out all the requirements. Additionally, the Collaborative Applicant must have written standards and demonstrate capacity for the responsibilities that come with the UFA designation.

There are several benefits of UFA status as administrative contracting and budgets can be streamlined. The CoC generally receives two grant agreements, one for renewal projects, CoC planning funds, and UFA costs and one for any new grants awarded. By consolidating individual projects under the UFA structure, there is a single start and end date for all CoC-funded projects adding predictability and consistency to a community's contracting cycle.

Programmatically, there is more autonomy granted to communities and Collaborative Applicants in sub-recipient selection, funds reallocation, and monitoring. Performance reporting is also reduced; instead of submitting APRs for each project, a UFA must report by program component, reducing the reporting burden to just the components funded in the community. These increased responsibilities and options are why HUD requires written standards as part of the UFA application. Additionally, HUD recommends the CoC and broader community to weigh in on establishing local policies related to UFA status to draw the right contours for them.

HUD has produced tools to assist communities in navigating the pros and cons of becoming a UFA.[27] The tools assist communities to ensure CoC responsibilities are being met and that capacity exists to take on the additional UFA tasks.

Recommendations

Support Combined Transitional Housing-Rapid Rehousing Applications in CoC NOFA: CoC funding does not fund emergency shelter, however does offer a "joint component" Transitional Housing/Rapid Re-Housing model, which may be a creative way to modestly expand crisis resources, particularly for families with minor children and survivors and survivor families of domestic violence.

Resource: "SNAPS In Focus: The New Joint Transitional Housing and Rapid Re-Housing Component" by HUD.

- https://www.hudexchange.info/news/snaps-in-focus-the-new-joint-transitional-housing-and-rapid-re-housing-component/

Apply for UFA Status: Available in the CoC NOFA is the ability for collaborative applicant to apply to become a Unified Funding Agency (UFA). UFAs have more financial and monitoring responsibility but allow for more flexibility in reprogramming funding responding to local conditions outside of the NOFA process and risk of reallocation.

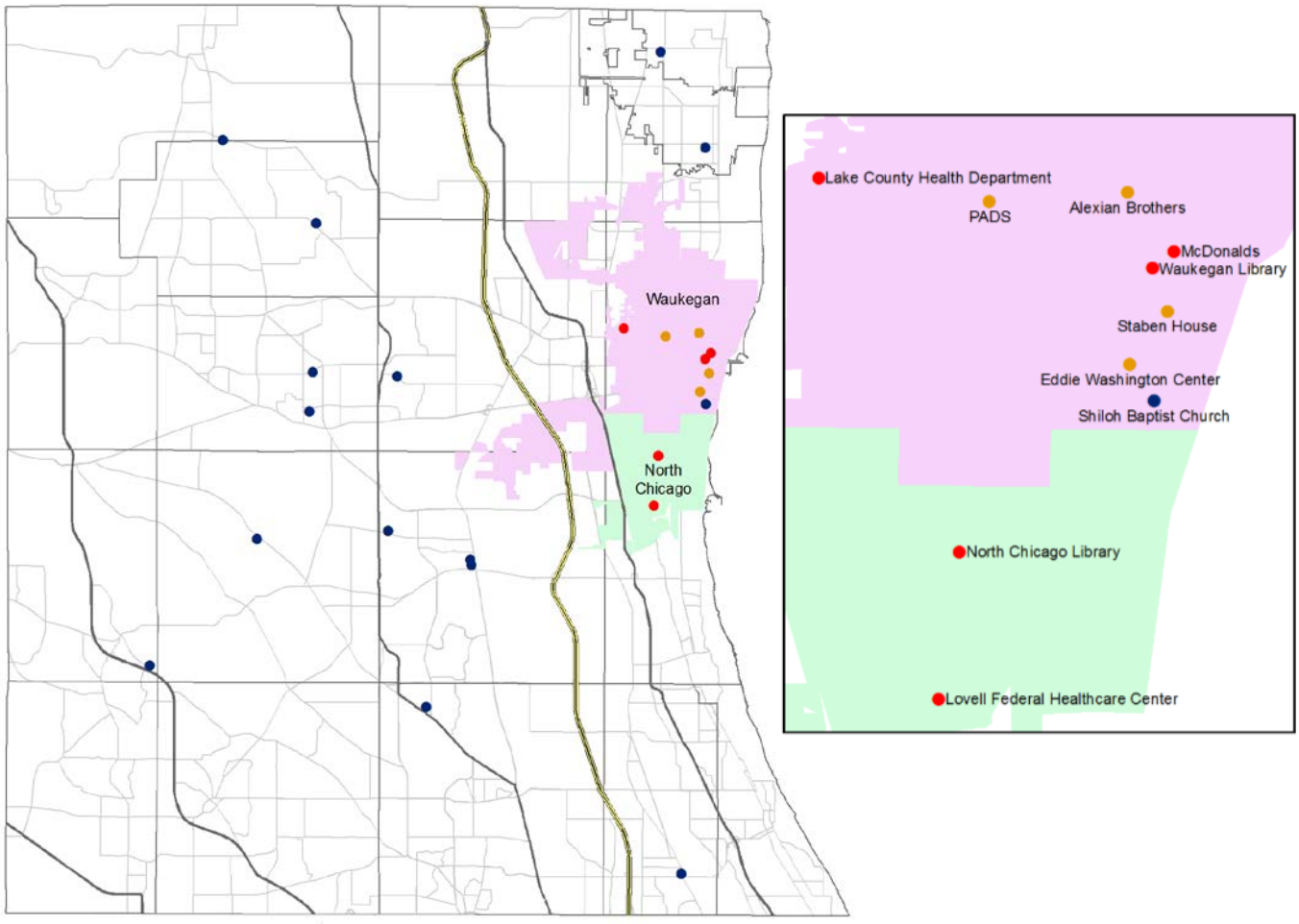
Example: UFA Application for CoC Program NOFA, Long Beach, CA

- http://www.longbeach.gov/globalassets/health/homeless-services-divsion/coc-project-applications/lb-coc-ufa

Appendix

Appendix I: Maps

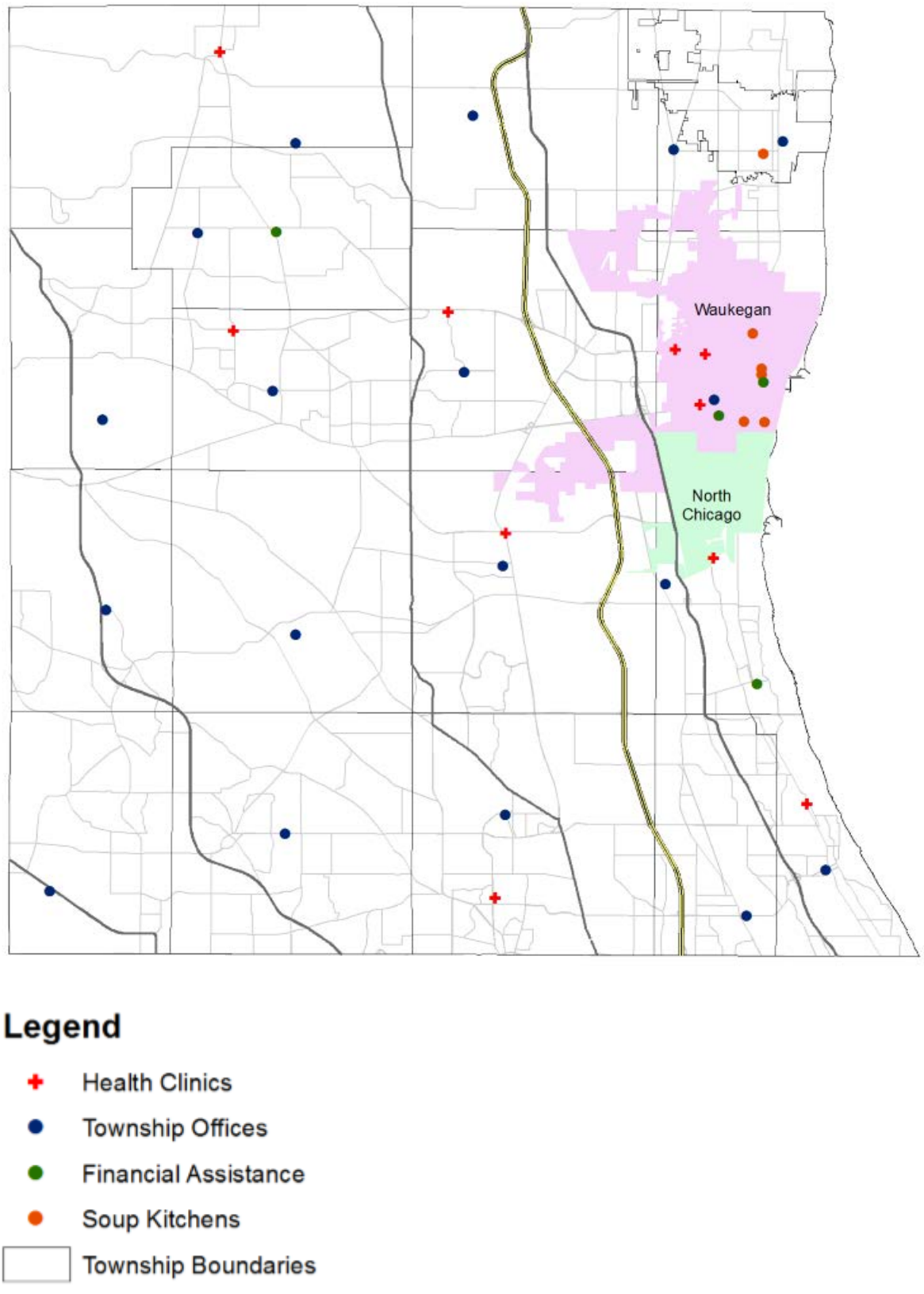
Appendix I: Lake County Homeless System Entry Points and Hot Spots



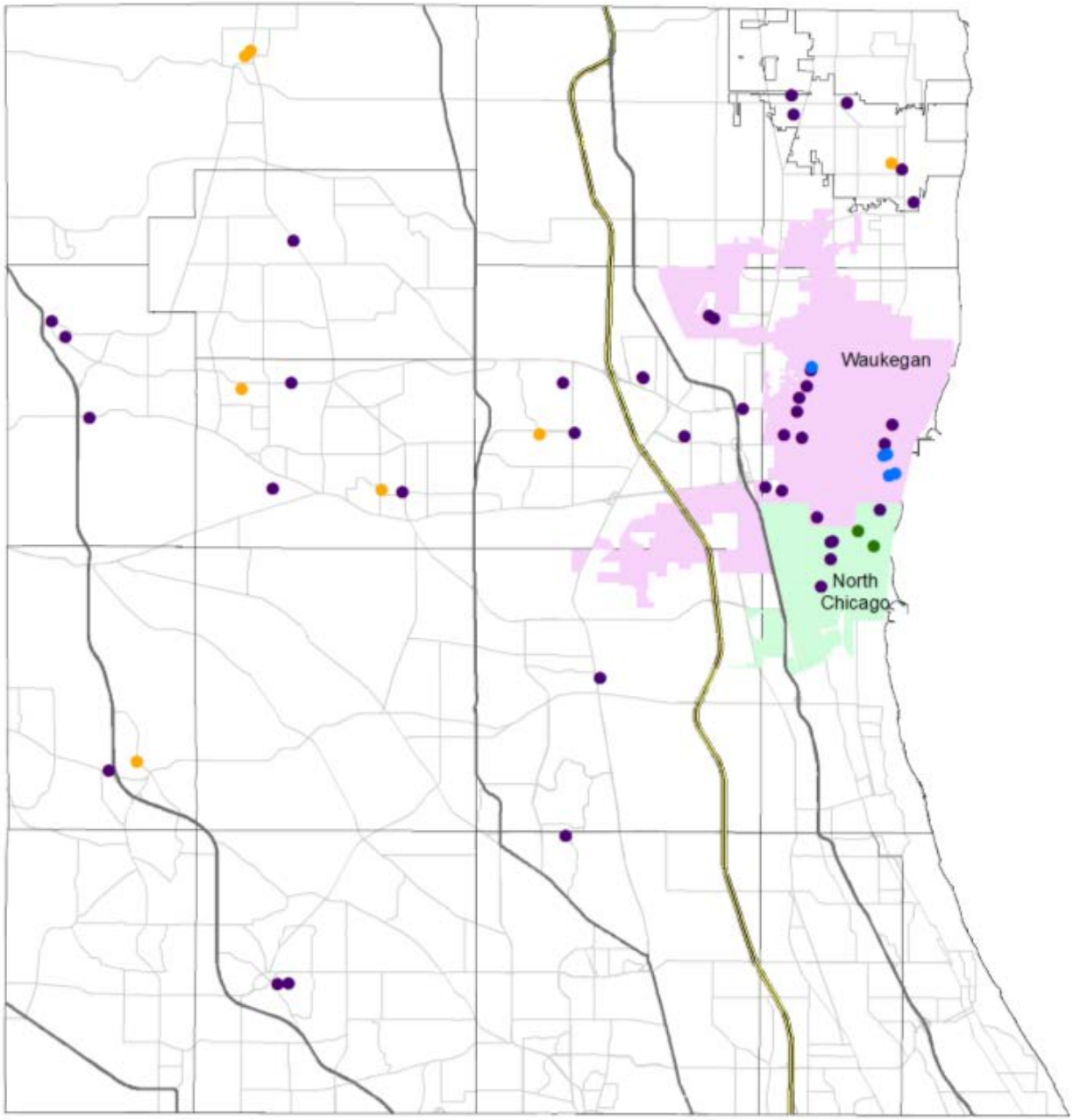
Legend

- Night by Night Shelter Sites
- Key Hot Spots
- Key Service Sites
- Township Boundaries

Appendix I: Lake County Homeless System Key Service Connections



Appendix I: Lake County Housing Resources



Legend

- North Chicago Housing Authority
- Lake County Housing Authority
- Waukegan Housing Authority
- Low Income Housing Tax Credit Properties

Appendix II: Lake County Survey of Homeless Needs Questions

1. Which of the following best describes your primary role in your community?
    a. Non-Profit Organization
    b. Concerned Resident/Advocate*
    c. Local/Government or Authority
    d. For-Profit Business
    e. Foundation/Philanthropic/Charitable
    f. Other (please specify)

*Note: Respondents that answer 'Concerned Resident/Advocate' skip to 22

All other answers are directed to questions 2-21.

2. Which area of the county does your agency primarily serve?
    a. Northeast quadrant of Lake County
    b. Northwest quadrant of Lake County
    c. Southeast quadrant of Lake County
    d. Southwest quadrant of Lake County
    e. All quadrants of Lake County equally
3. Which choice(s) best define your primary field of work? (Up to three)
    a. Service Provider: Housing/Homeless Service Provider
    b. Service Provider: Mental Health
    c. Service Provider: Youth Services
    d. Service Provider: Community Action Agency
    e. Service Provider: Employment/Workforce Development
    f. Service Provider: Substance Use
    g. Service Provider: Criminal Justice/ Corrections/Public Safety
    h. Service Provider: Faith Based Organization
    i. Service Provider: Public Health/Medical Provider
    j. Emergency Shelter provider
    k. Housing Provider: Landlord/Property Owner
    l. Housing Provider: Property Manager
    m. Housing Provider: Developer
    n. Housing Provider: Public Housing Authority
    o. Funder: Housing and Community Development Funder
    p. Funder: Social Service Funder
    q. Other (please specify)
4. Which population does your current work focus on? (choose multiple)
    a. Direct services for people experiencing homelessness
        i. Homeless individuals
        ii. Homeless families
        iii. Chronically homeless individuals
        iv. Chronically homeless families
    b. At-risk populations in the community
        i. Low-income households at-risk of homelessness
        ii. Unemployed/Underemployed
    c. Subpopulations/Specialized Services
        i. Persons experiencing mental illness
        ii. Persons experiencing acute/chronic health conditions
        iii. Persons experiencing addiction and substance use issues

d. Child welfare involved families
    i. Aging/seniors
    ii. Formerly incarcerated/criminal justice-involved/reentry
    iii. Veterans
    iv. Young adults/youth aging out of foster care
    v. Persons living with HIV/AIDS
e. Other (please specify)

5. Please indicate how your community is currently implementing each of the following strategies or programs to address homelessness.

(Add as a "multiple choice grid" with options of Currently implementing successfully, currently implementing with moderate success, currently implementing unsuccessfully, planning/working on implementing, unknown)

a. Housing solutions
    i. Coordinated interagency financing and production for supportive housing (i.e. "systems change")
    ii. A range of models of integrated supportive-affordable housing (i.e. some units in a building are for supportive housing populations and the rest are for people who need affordability but not intensive services)
    iii. Supportive housing or services models for high utilizers of crisis health services
    iv. Supportive Housing or services models for elderly
    v. Supportive housing models for child welfare-involved families
    vi. Reentry supportive housing for people leaving or diverted from prisons/jails
    vii. Veterans supportive housing (including VASH)
    viii. Use of Vulnerability Indices or other tools to prioritize homeless individuals for supportive housing
b. Service Strategies and Funding Sources for Supportive Housing
    i. Leveraging Medicaid for supportive housing
    ii. Integration of community health clinics
    iii. Connecting Federally Qualified Health Centers within supportive housing
    iv. Housing First, harm reduction, and low demand models of supportive housing
    v. Critical time intervention/time limited supportive services
    vi. Intensive case management/wrap-around services for vulnerable public housing residents
c. Homeless System Interventions
    i. Rapid rehousing
    ii. Rapid resolution/Diversion from Shelter to Housing
d. **(offered space for additional comments, which respondents had answers such as inadequate access to information on housing and services, noted issues with coordination among agencies in their communities and programs across the state, implementation of Housing First varies among agencies, issues with time limited services, that institutions (including state mental health facilities, medical facilities, and DOC) discharge to homelessness, need for housing and services for aging populations, the capacity of housing and service providers, high turnover, lack of participation in HMIS, Support And Services at Home (SASH))

6. What strategies have been most effective for addressing homelessness in your community and why? What is the best innovation in practice or policy that exists in your community and what is the impact?

a. (Open-ended)

7. What partnerships (between organizations or across systems) have been the most effective at addressing homelessness in your community? (check and describe)
    a. Coordinated Entry
    b. Public Housing Authority
    c. Public Schools
    d. Child Welfare
    e. Healthcare
    f. Justice
    g. Employment
    h. Mental Health
    i. Substance Use
    j. Targeting Housing for Most Vulnerable
    k. Other (Open-ended)
8. What partnerships (between organizations or across systems) are needed?
    a. (Open-ended) give same options to guide responses to narrow in and then get narrative?
9. What are the most significant unmet needs for the people you work with? (Please select up to 5)?
    a. Affordable housing and/or rental assistance
    b. Housing-based services and case management
    c. Year-round emergency housing
        i. Low-barrier emergency housing for adults
        ii. Emergency Housing for Families
        iii. Domestic Violence emergency housing and services
        iv. Street outreach
    d. Coordination with Other Systems of Care
        i. Enrollment in healthcare
        ii. Medical and primary care
        iii. Mental health and psychiatric services
        iv. Substance abuse treatment, counseling and supports
        v. Basic needs/quality of life resources (food pantries, clothing, furniture, etc.)
        vi. Access to benefits, income supports
        vii. Employment supports, job training, and workforce development
        viii. Family services, parenting, child welfare services
        ix. Education
        x. Transportation
        xi. Criminal justice supervision
        xii. Criminal justice services
    e. Other (please specify)
10. What are the most significant unmet needs for unstably housed or homeless youth (ages 16-24) you work with? (Please select up to 5)?
    a. Affordable housing and/or rental assistance
    b. Housing-based services and case management
    c. Year-round emergency housing
        i. Low-barrier emergency housing for adults
        ii. Emergency Housing for Families
        iii. Domestic Violence emergency housing and services
        iv. Street outreach
    d. Coordination with Other Systems of Care
        i. Enrollment in healthcare
        ii. Medical and primary care
        iii. Mental health and psychiatric services

iv. Substance abuse treatment, counseling and supports
v. Basic needs/quality of life resources (food pantries, clothing, furniture, etc.)
vi. Access to benefits, income supports
vii. Employment supports, job training, and workforce development
viii. Family services, parenting, child welfare services
ix. Education
x. Transportation
xi. Criminal justice supervision
xii. Criminal justice services

e. Other (please specify)

11. Next, think about system-level barriers to addressing homelessness, several are suggested below. Indicate which barriers your community is facing, and which you think are barriers across the state. Please use the other option to list additional barriers.
    a. Community support for more affordable or supportive housing
    b. Housing options have high housing barriers and programmatic requirements
    c. Housing discrimination based on source of income (i.e. disability) and lack of support from landlords to lease to people with rental assistance
    d. Tenant screening barriers for credit and justice involvement are too restrictive
    e. Denial of shelter access due to behavior
    f. Lack of physical rental units to meet demand in community
    g. Lack of availability or access to mental health services for those who need/want
    h. Coordination between housing and service systems
    i. Data collection and utilization
    j. Insufficient resources
    k. Other (please specify)
12. Indicate which barriers your clients are facing to access homeless services, including emergency shelter. Please use the other option to list additional barriers.
    a. Transportation
    b. Pets
    c. Criminal Background
    d. Physical Health
    e. Mental Health
    f. Confusing Systems
    g. Language barriers
    h. Shelter/service capacity
    i. Eligibility Criteria of Service Providers
    j. Other (please specify)
13. Indicate which barriers your clients are facing to housing. Please use the other option to list additional barriers.
    a. Transportation
    b. Pets
    c. Criminal Background
    d. Past evictions
    e. Utility Debt/Bad Credit
    f. Housing Affordability/Income
    g. Upfront costs such as security deposit
    h. Physical Health
    i. Mental Health
    j. Language barriers
    k. Housing Discrimination (for race, familial status, etc.)
    l. Source of Income Discrimination (i.e. Landlords refusing vouchers)

m. Eligibility Criteria of Housing Providers
n. Other (please specify)

14. Please indicate the degree to which each of the following data collection and utilization issues are a problem in your community. (1= “not a problem” and 5 = “major problem”)
    a. Not enough homeless programs use the Homeless Management Information System
    b. The data needed do not exist (we don’t track the right info)
    c. The data exist but are not high quality enough to be trusted
    d. The data exist but there is not enough capacity to spend on analysis to know what the data show
    e. Data from different populations, regions or systems aren’t merged to answer key questions
15. Of the barriers you identified, which are the greatest? How do these barriers affect your work?
    a. (Open-ended)
16. Are there any other gaps or bottlenecks in the homeless services system that should be addressed?
    a. Too many people falling into homelessness without prevention
    b. CoC communication across agencies
    c. Timeliness of housing assessment to referral
    d. Timeliness of housing referral to connecting with the housing program
    e. Too many denials of housing
    f. Insufficient service partnerships to offer support to people who don’t qualify for or aren’t enough housing resources
    g. (Open-ended)
17. Think about what areas you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply) *Housing Development*
    a. Supportive Housing Development and Finance
    b. Integrating Financial Capability and Asset-Building Services
    c. Using the National Housing Trust Fund for Supportive Housing
    d. Development
    e. Property Management in Supportive Housing
    f. Tenant Screening, Selection, and Fair Housing
    g. Reasonable Accommodations in Supportive Housing
    h. Other (please specify)
18. Think about what areas you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply) *Housing Strategies and Services*
    a. Housing Based Case Management
    b. Housing First/ Providing Voluntary Services
    c. Service Planning
    d. Motivational Interviewing
    e. Progressive Engagement
    f. Coordinating Property Management and Supportive Services
    g. Harm Reduction
    h. Accessing Substance Abuse Screening, Treatment and Recovery Resources
    i. Trauma Sensitive Services/Trauma Informed Care
    j. Healthy Aging in Supportive Housing
    k. Veterans in Supportive Housing
    l. Other (please specify)
19. Think about what areas you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply) *Housing Placement and Stability*

a. Conflict Coaching and Mediation
b. Creating Tenant Groups
c. Fostering Tenant Leadership
d. Eviction Prevention
e. Housing Appeals and Reasonable Accommodations
f. Property Management and Service Coordination
g. Managing Tenant and Landlord Relationships
h. Enhancing Landlord Networks/Landlord Recruitment
i. Housing Search and Placement
j. Master Leasing
k. Other (please specify)

20. Think about what areas you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply) *Systems Coordination*
    a. Coordinated Entry and Assessment
    b. Cross-system Care Coordination
    c. Health and Housing Partnerships
    d. Accessing Employment and Training Resources
    e. Mapping Community Resources
    f. Data Matching 101: A Primer for Using Data to Target Supportive Housing
    g. Using Data to Identify Gaps in Resources and Plan Strategically
    h. Other (please specify)
21. Think about what areas you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply) *Human Resources*
    a. Self-Care
    b. Boundaries
    c. Preventing Employee Burnout
    d. Culturally Sensitive & Informed Approaches
    e. Client Privacy and Confidentiality
    f. Other (please specify)
22. Which area of the county do you currently reside?
    a. Northeast quadrant of Lake County
    b. Northwest quadrant of Lake County
    c. Southeast quadrant of Lake County
    d. Southwest quadrant of Lake County
23. The following services are available and accessible/affordable in my community:

(Rate on a scale from 1 to 5. 1= Strongly agree 2=Agree 3=Neutral/Undecided/Unsure 4=Disagree 5=Strongly Disagree)

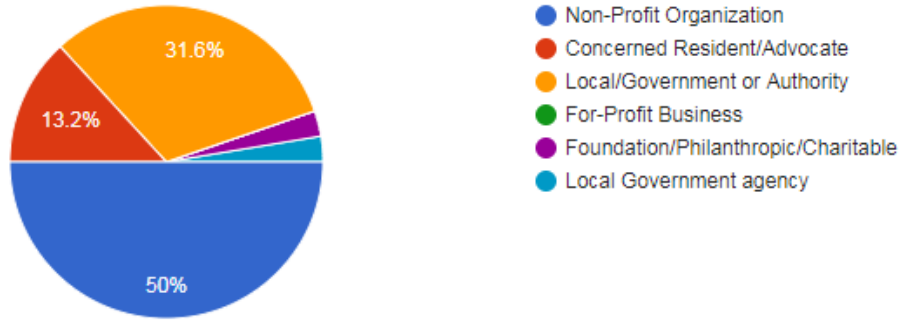
a. Affordable housing and/or rental assistance
b. Street outreach
c. Transportation
d. Employment supports and job training
e. Homeless shelters
f. Rapid resolution/Diversion from Shelter to Housing
g. Education
h. Housing-based services and case management
i. Access to benefits, income supports
j. Mental health and psychiatric services

    k. Senior/elderly services
    l. Youth Services
    m. Medical and primary care
    n. Health insurance/coverage
    o. Basic needs/quality of life resources (food pantries, clothing, furniture, etc.)
    p. Family services, parenting, child welfare services
    q. Criminal justice services
24. Please rate the quality of services available locally. (Rate on a 5-point scale. 1=excellent 2=good 3= Neutral/Undecided/Unsure 2=fair 1=poor)
    a. (Same list of services as above)
25. Are there any other gaps in housing or services in your community that should be addressed?
    a. (Open-ended)
26. Would you be interested in participating in an in-person discussion about your experience and responses?
    a. Yes
    b. No
27. If yes, Name and email address.

Appendix III: Lake County Survey of Homeless Needs Responses

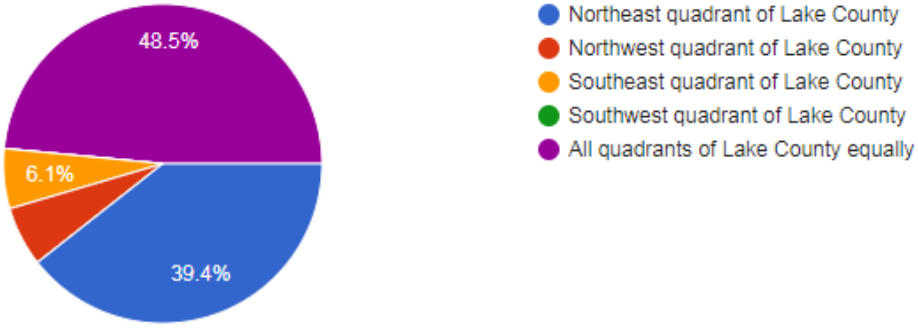
Which of the following best describes your primary role in your community?

38 responses



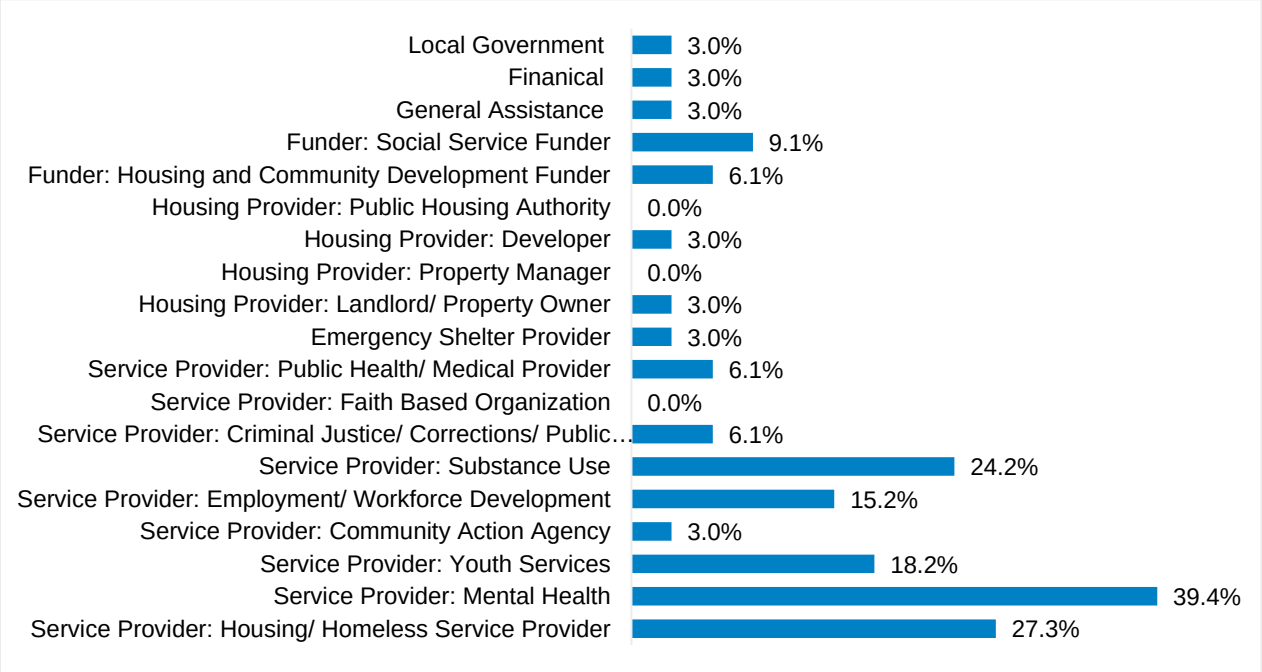
1. Which area of the county does your agency primarily serve?

33 responses



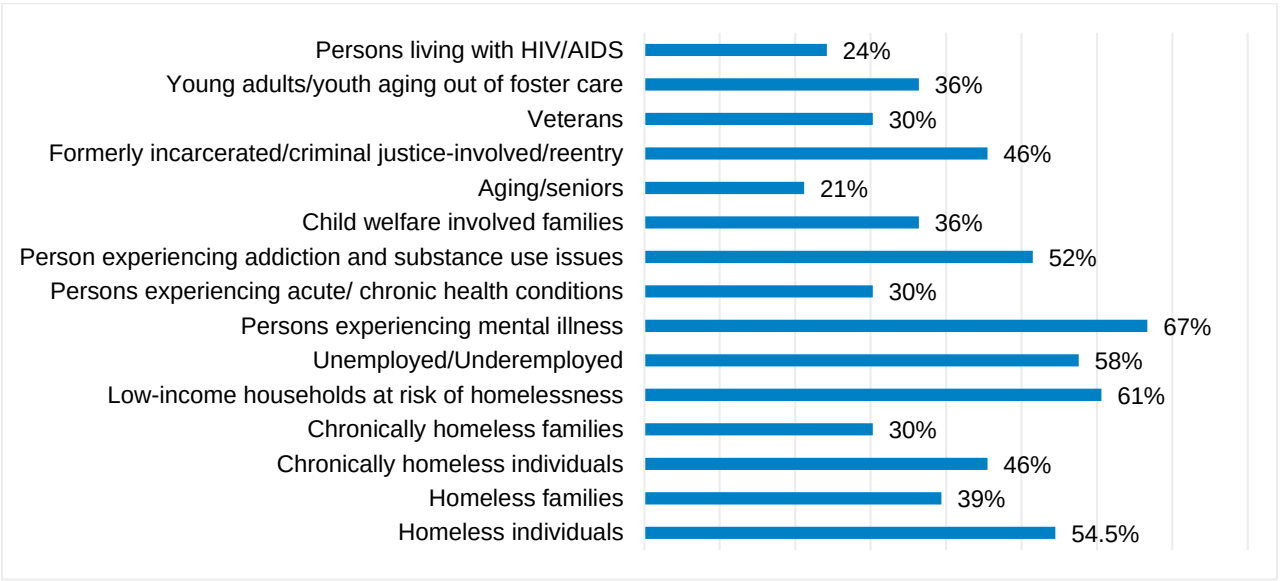
2. Which choice(s) best define your primary field of work? (choose up to 3)

33 responses

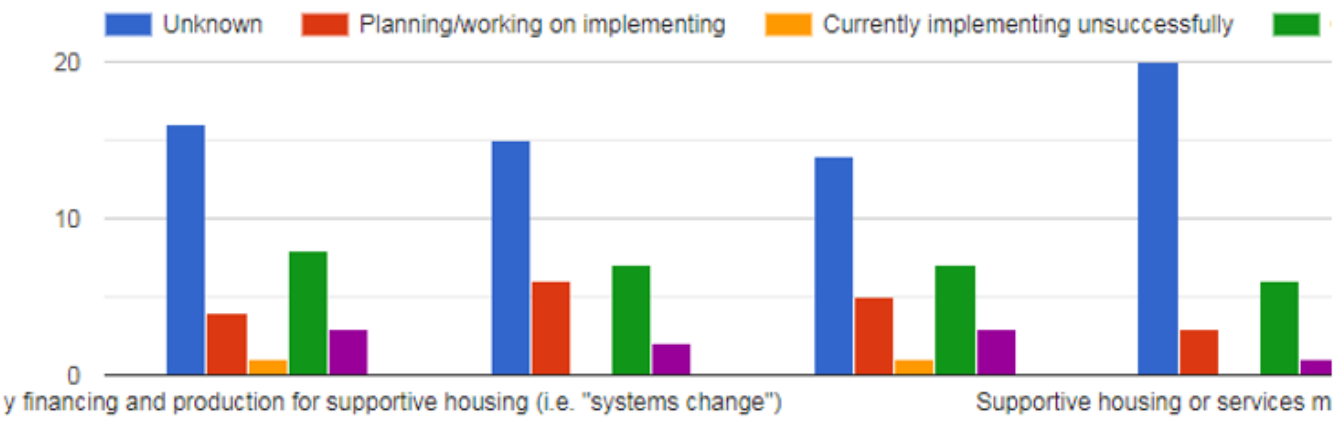


3. Which population does your current work focus on? (choose multiple)

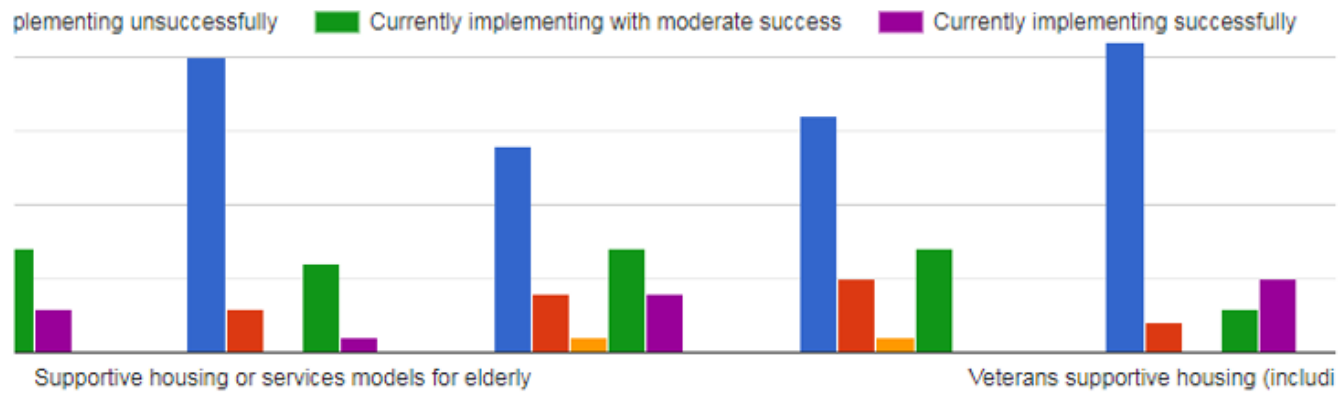
33 responses



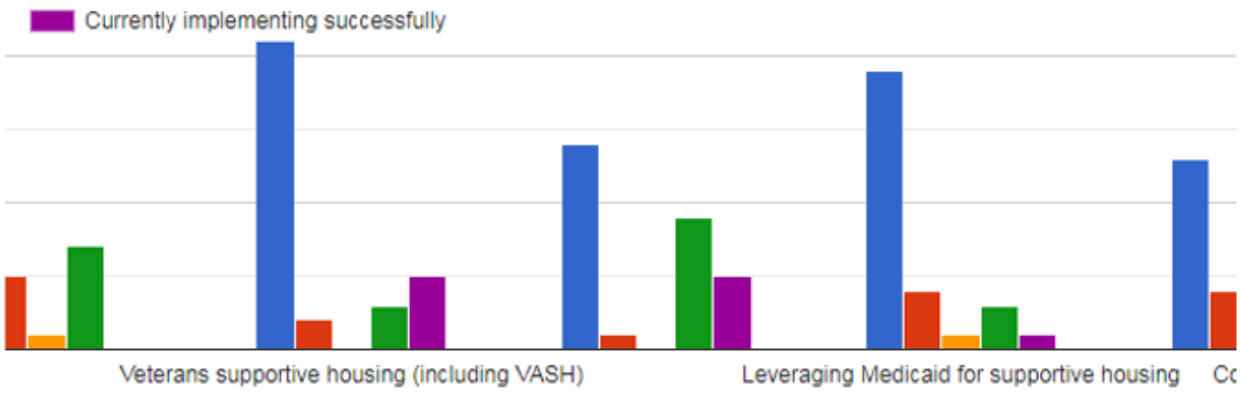
4. Please indicate how your community is currently implementing each of the following strategies or programs to address homelessness.



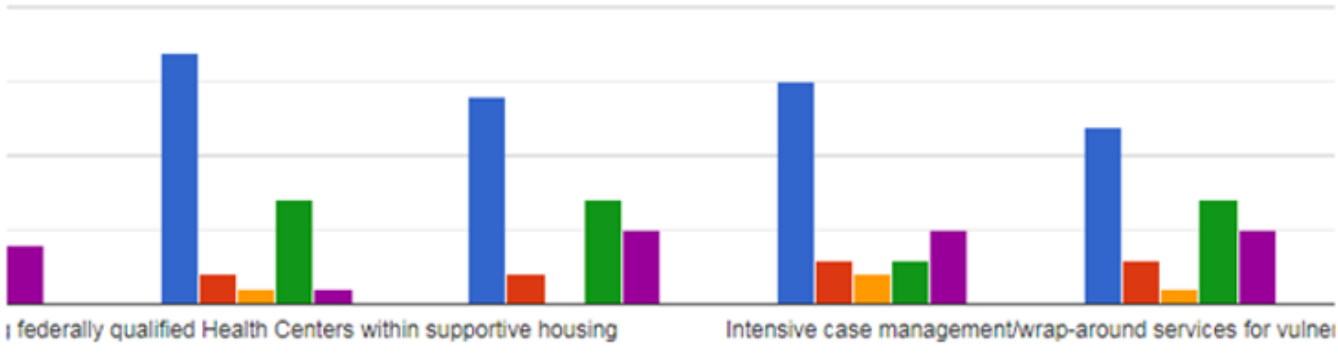
4. Please indicate how your community is currently implementing each of the following strategies or programs to address homelessness.



4. Please indicate how your community is currently implementing each of the following strategies or programs to address homelessness.

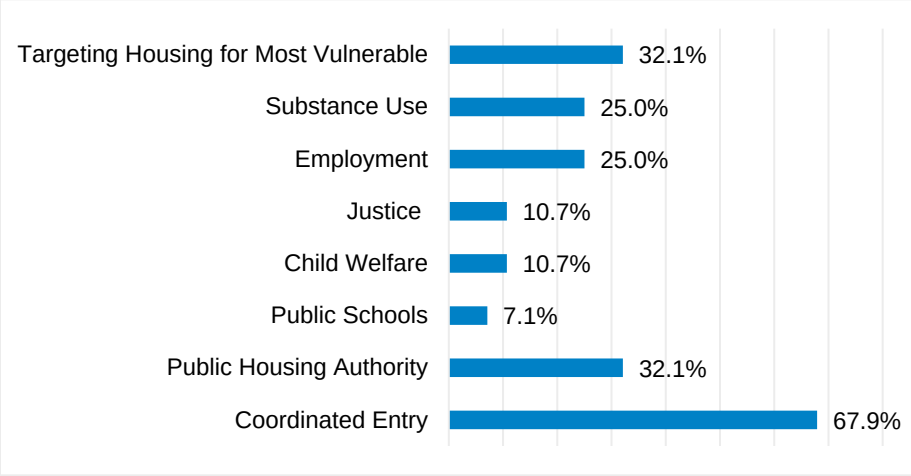


4. Please indicate how your community is currently implementing each of the following strategies or programs to address homelessness.



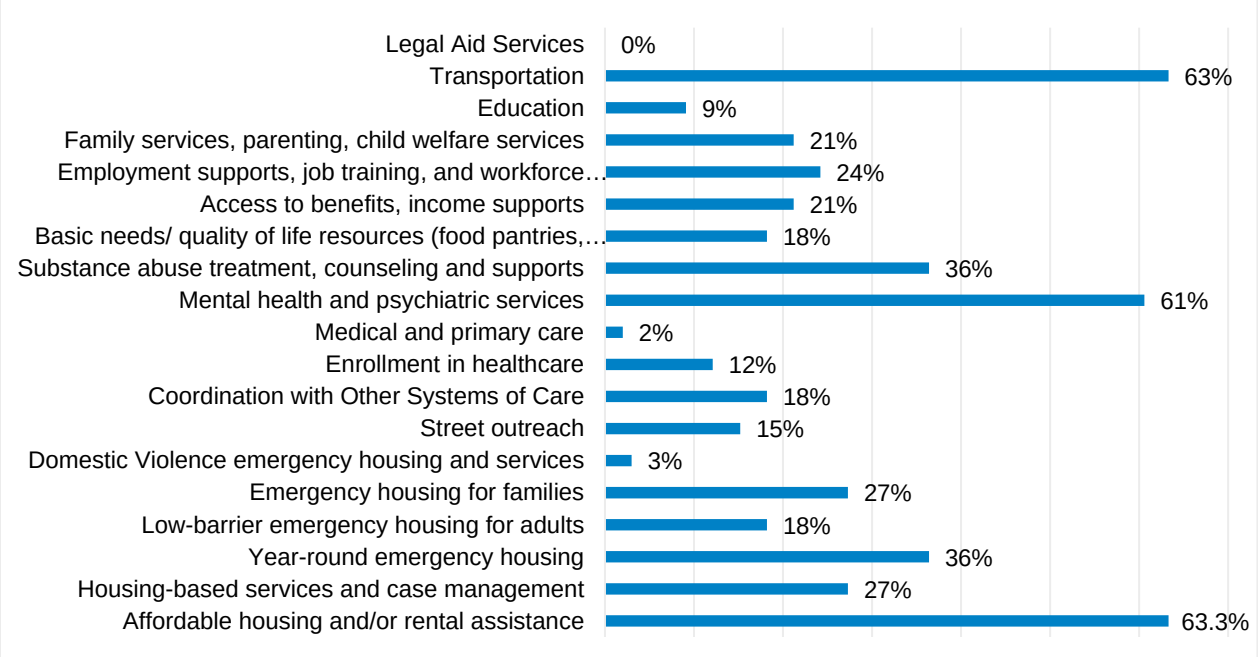
6. What partnerships (between organizations or across systems) have been the most effective at addressing homelessness in your community? (check all that apply and describe your selections in "Other")

28 responses



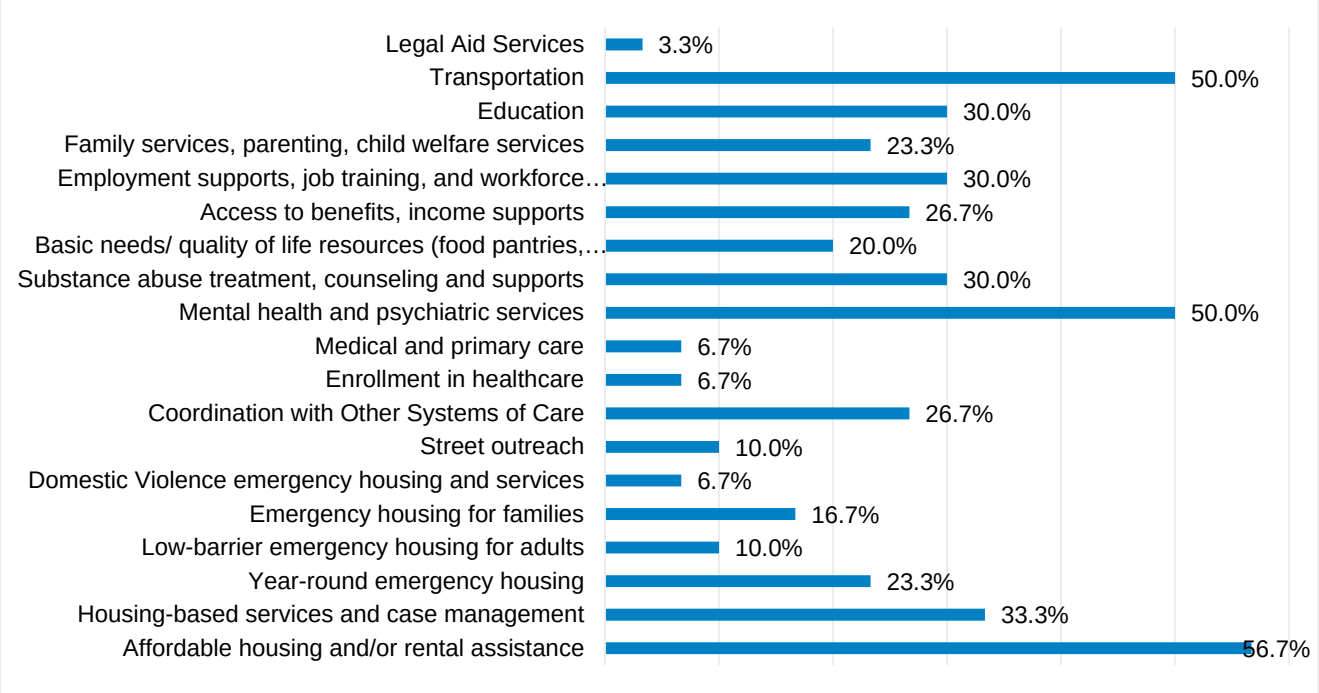
8. What are the most significant unmet needs for the people you work with? (Please select up to 5)

33 responses



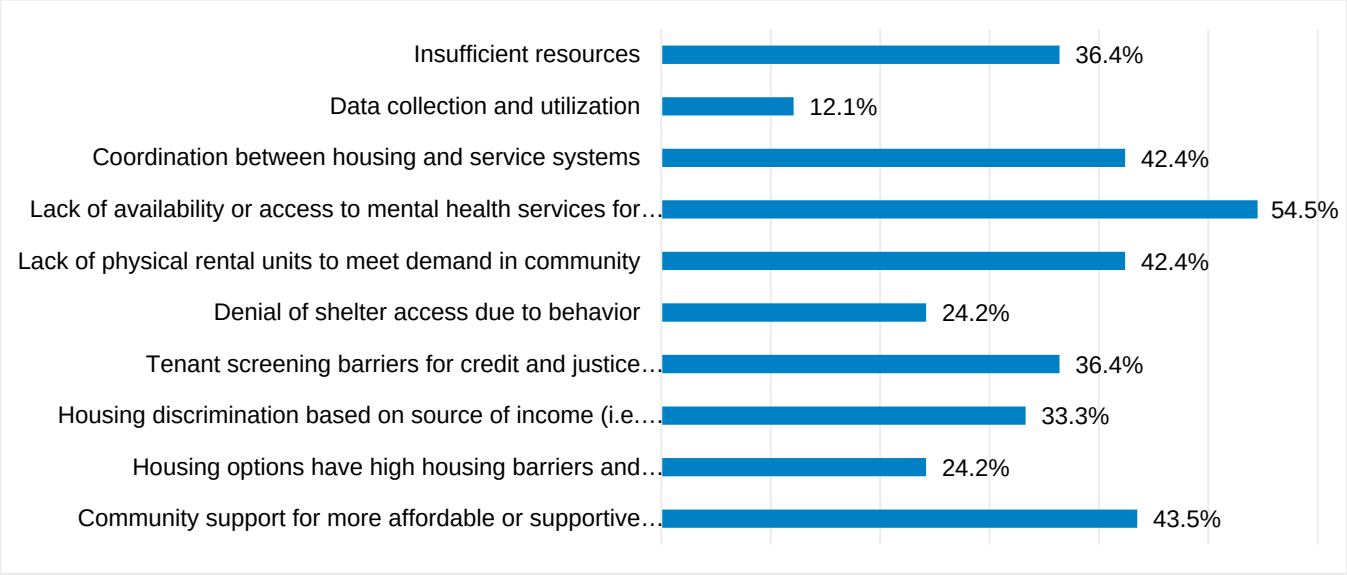
9. What are the most significant unmet needs for unstably housed or homeless youth (ages 16-24) you work with? (Please select up to 5)

30 responses



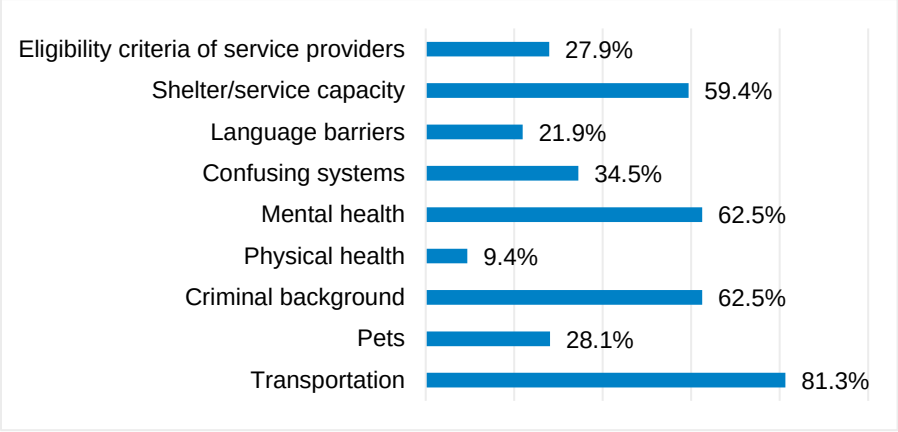
10. Next, think about system-level barriers to addressing homelessness. Several are suggested below. Indicate which barriers your community is facing. Please use the other option to list additional barriers.

33 responses



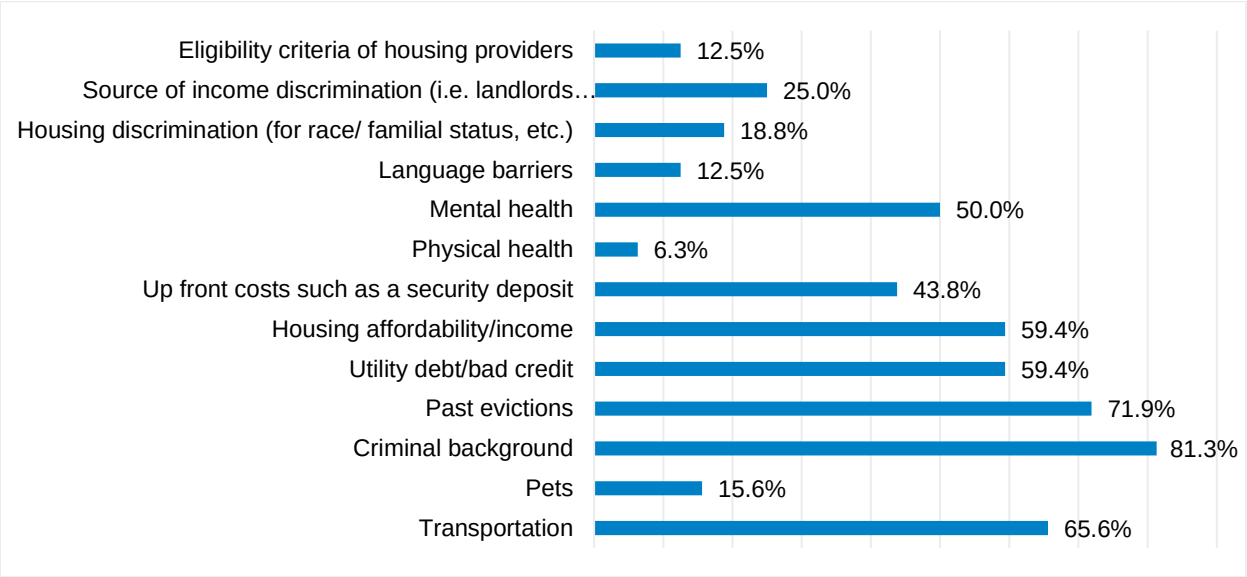
11. Indicate which barriers your clients are facing to access homeless services, including emergency shelter. Please use the other option to list additional barriers.

32 responses



12. Indicate which barriers your clients are facing to housing. Please use the other option to list additional barriers.

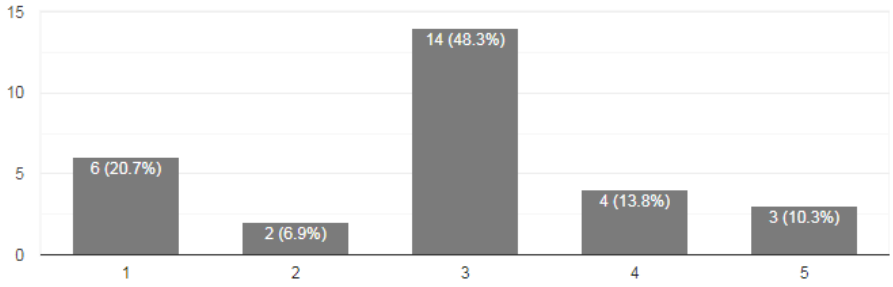
32 responses



14. Please indicate the degree to which each of the following data collection and utilization issues are a problem in your community. (1= "not a problem" and 5 = "major problem")

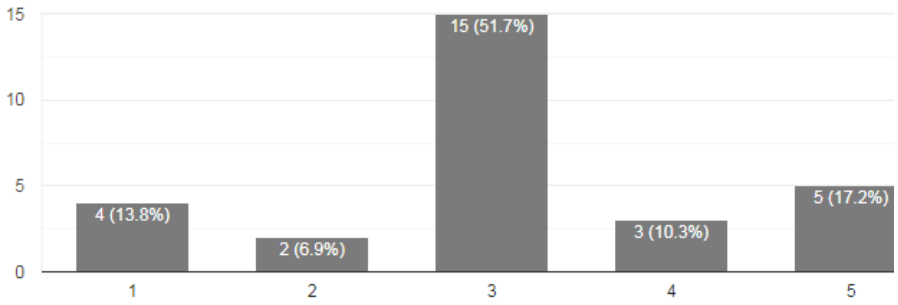
Not enough homeless programs use the Homeless Management Information System

29 responses



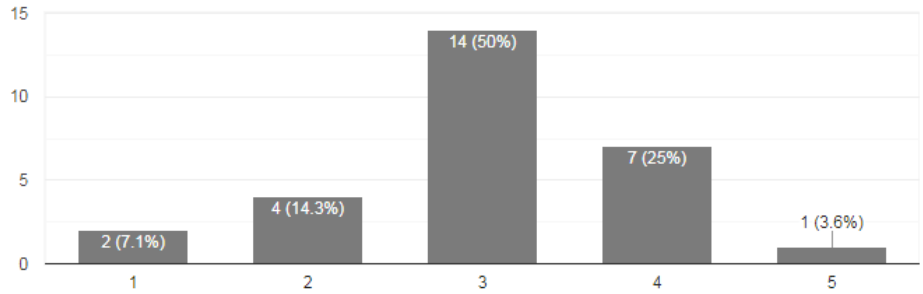
The data needed does not exist (we don't track the right info)

29 responses



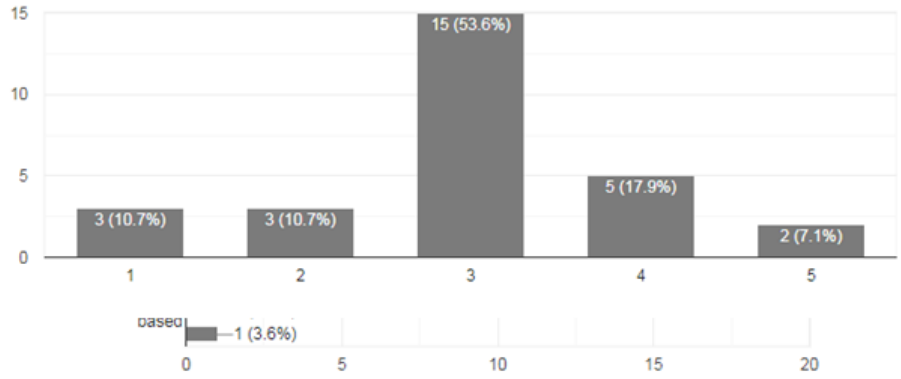
The data exists but it is not high quality enough to be trusted

28 responses



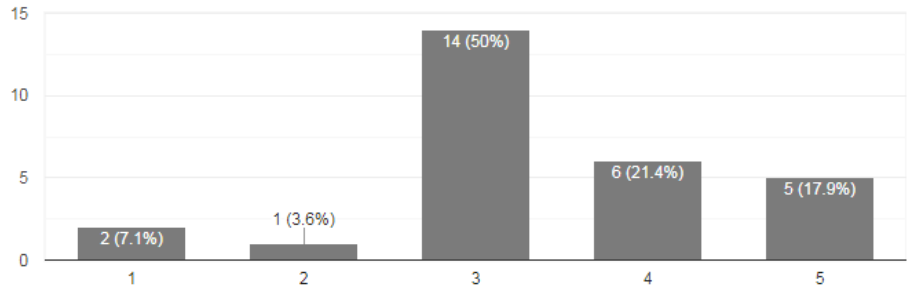
The data exists but there is not enough capacity to spend on analysis to know what the data shows

28 responses



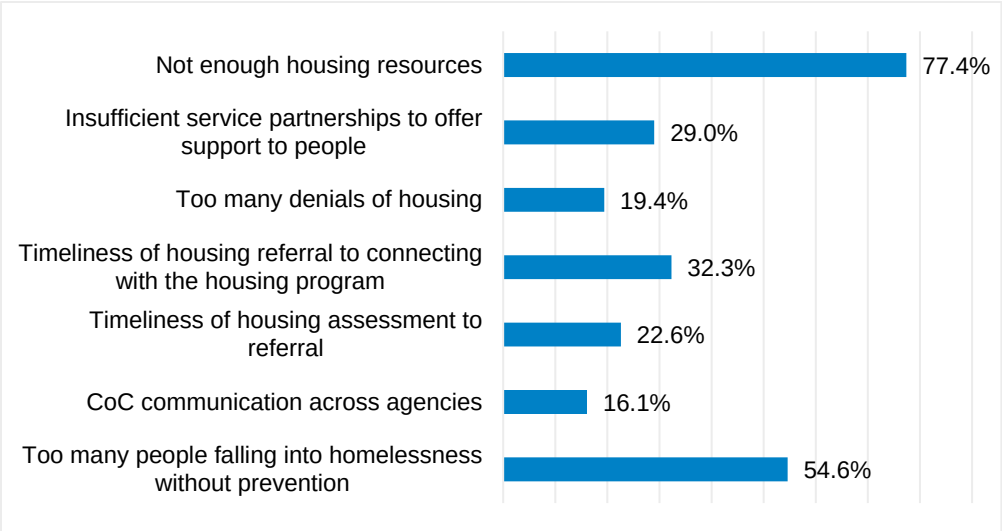
Data from different populations, regions or systems aren't merged to answer key questions

28 responses



15. Are there any other gaps or bottlenecks in the homeless services system that should be addressed?

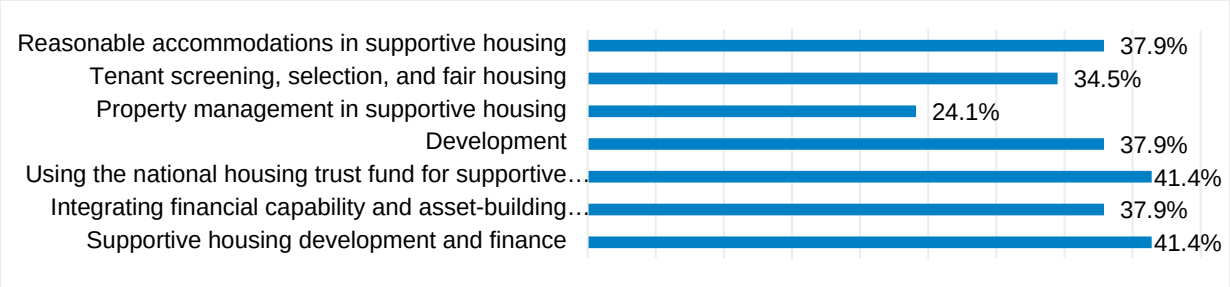
31 responses



Housing Development

16. Think about what areas where you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply)

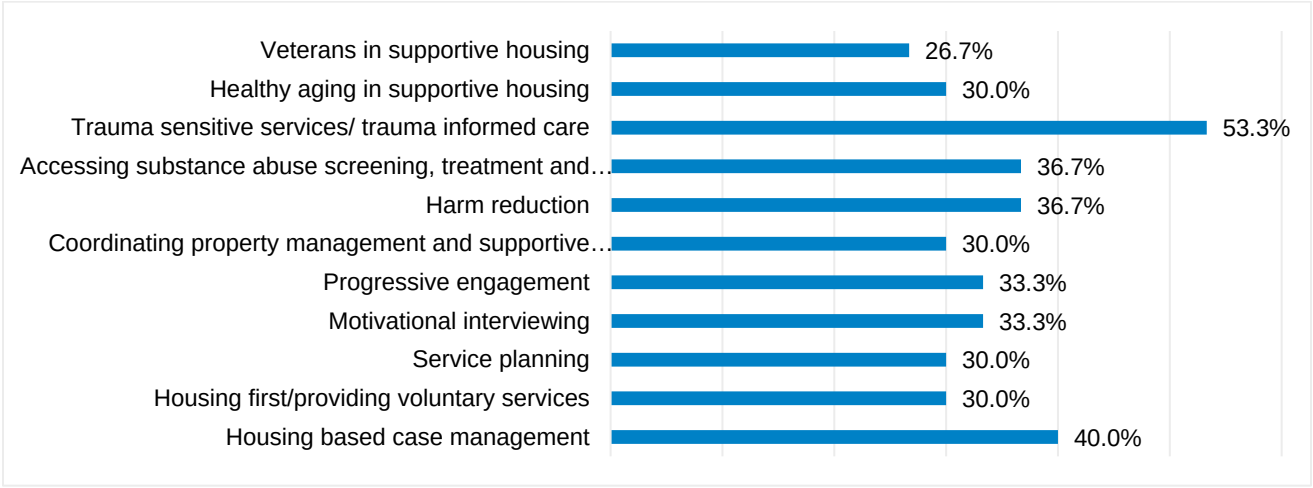
29 responses



Housing Strategies and Services

17. Think about what areas where you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply)

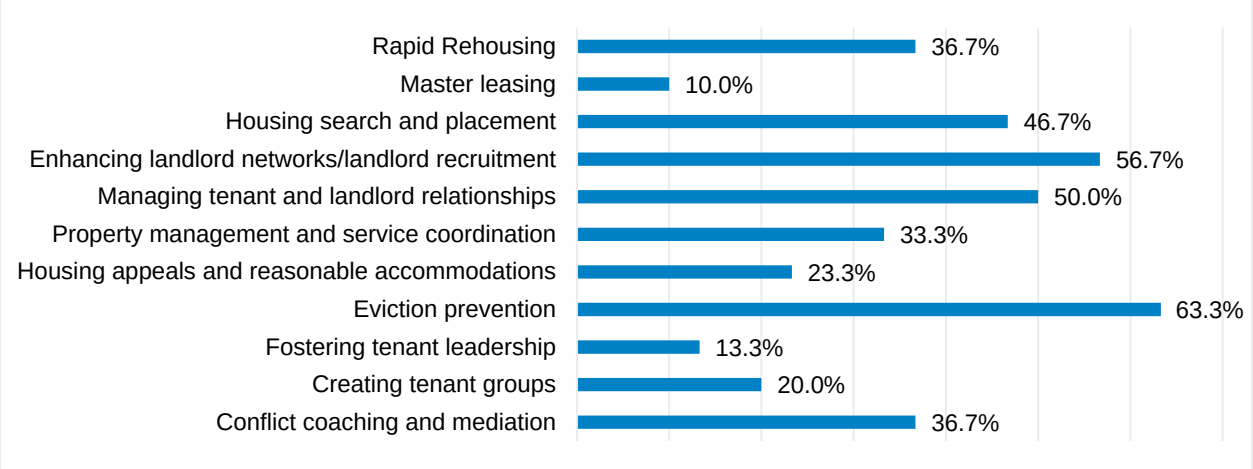
30 responses



Housing Placement and Stability

18. Think about what areas where you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply)

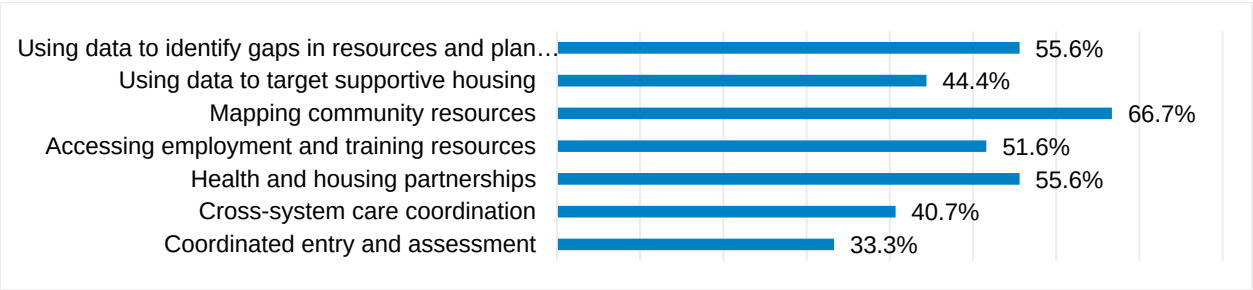
30 responses



Systems Coordination

19. Think about what areas where you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply)

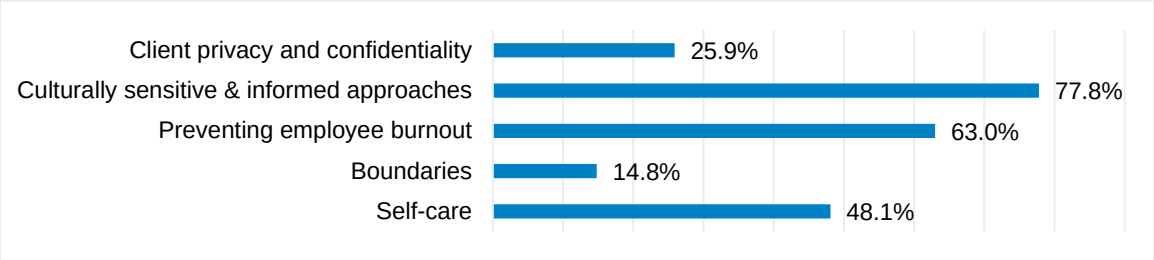
27 responses



Human Resources

20. Think about what areas where you, your organization, or your community could use additional training or technical assistance in order to effectively address homelessness? (select all that apply)

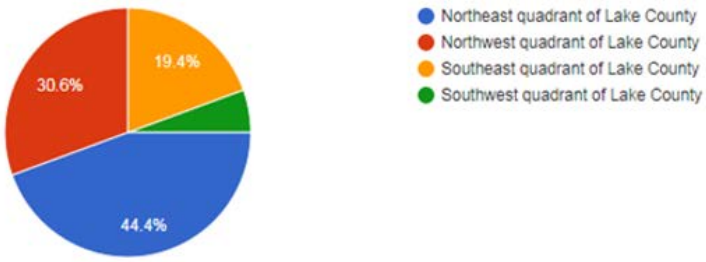
27 responses



Services in your community

1. In which area of the county do you currently reside?

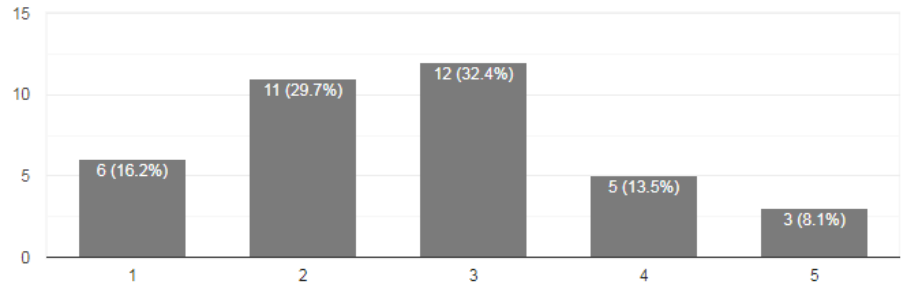
36 responses



2. The following services are available and accessible/affordable in my community:

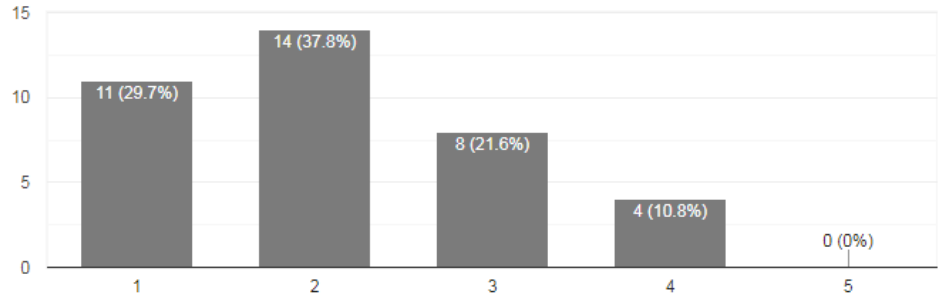
Affordable housing and/or rental assistance

37 responses



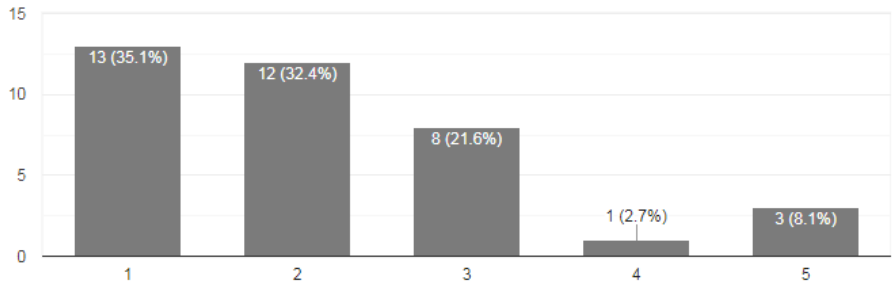
Street outreach

37 responses



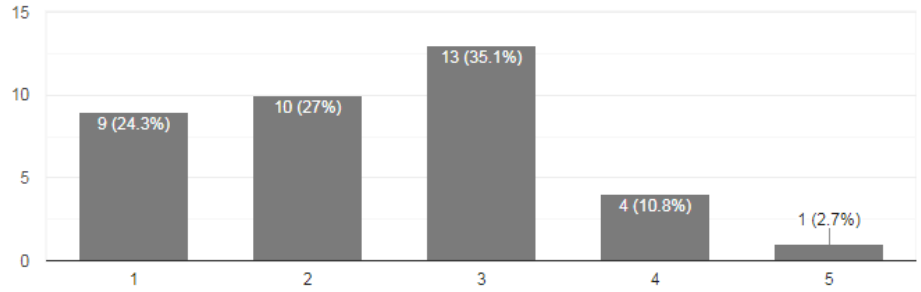
Transportation

37 responses



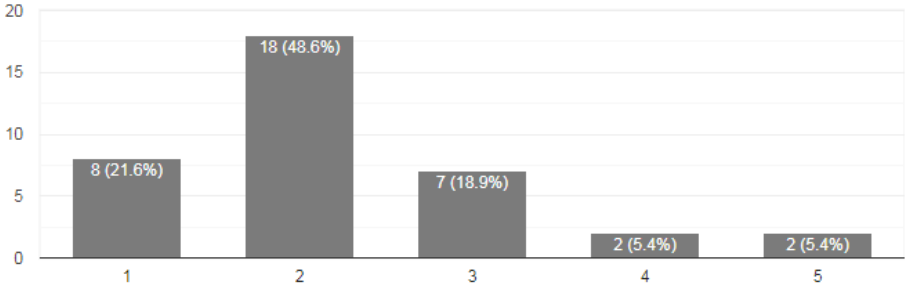
Employment supports and job training

37 responses



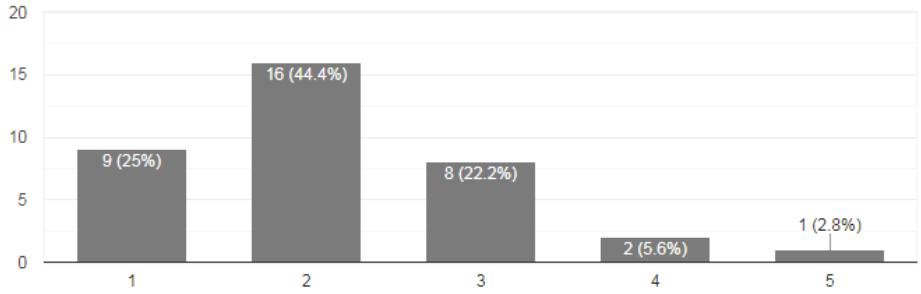
Homeless shelters

37 responses



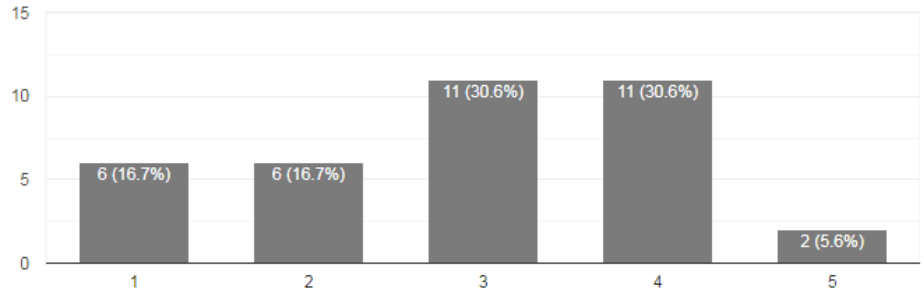
Rapid resolution/diversion from shelter to housing

36 responses



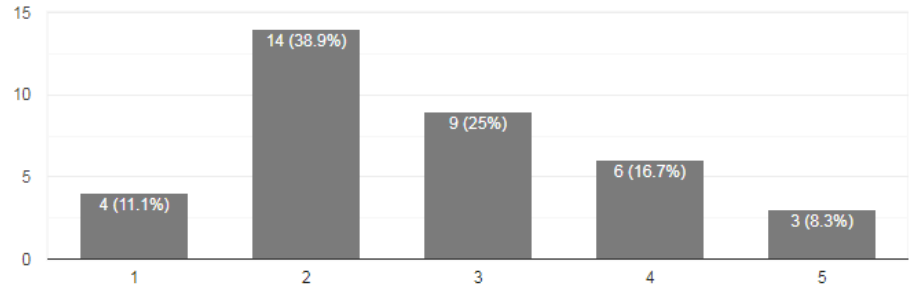
Education

36 responses



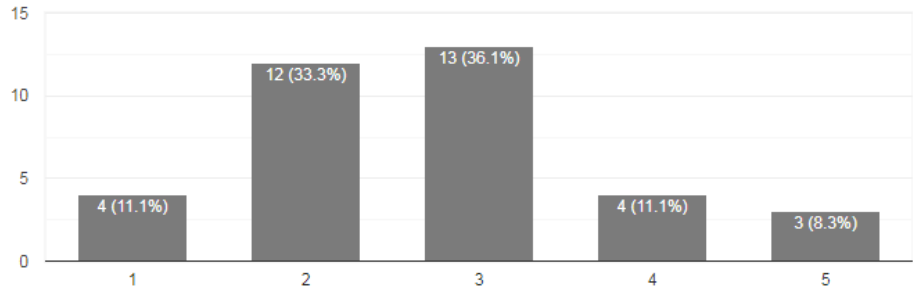
Housing-based services and case management

36 responses



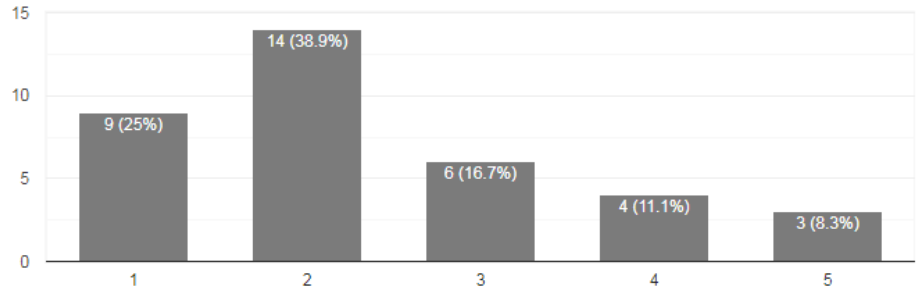
Access to benefits, income supports

36 responses



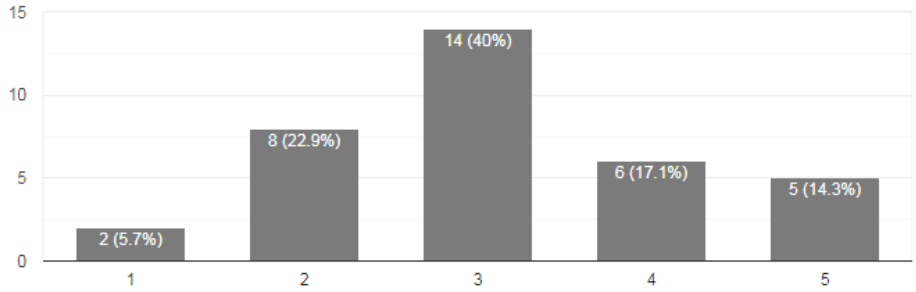
Mental health and psychiatric services

36 responses



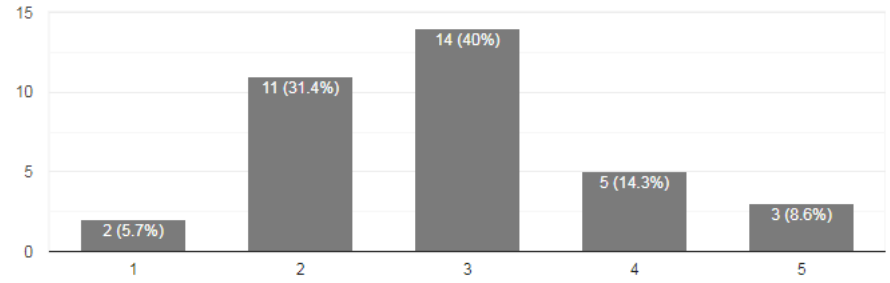
Senior/elderly services

35 responses



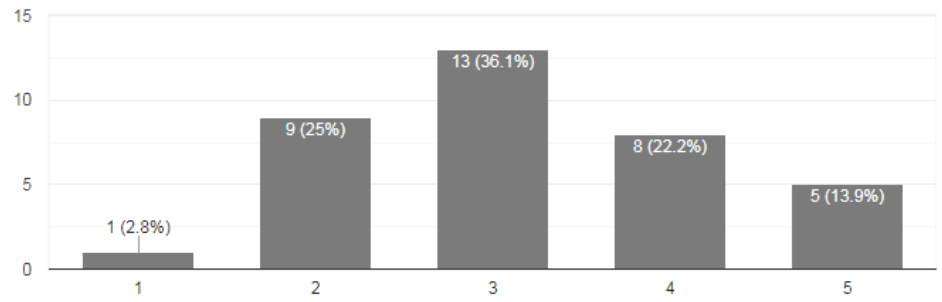
Youth services

35 responses



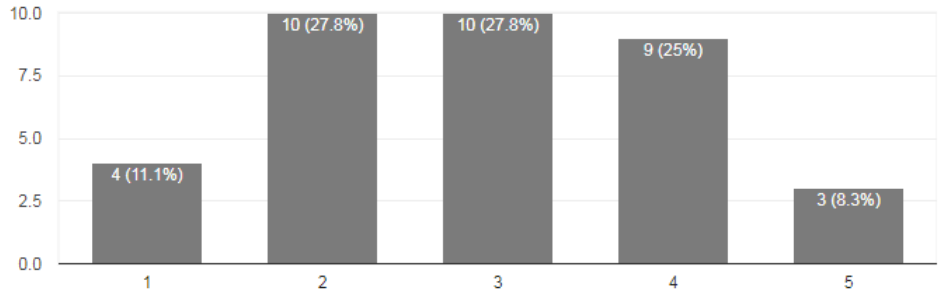
Medical and primary care

36 responses



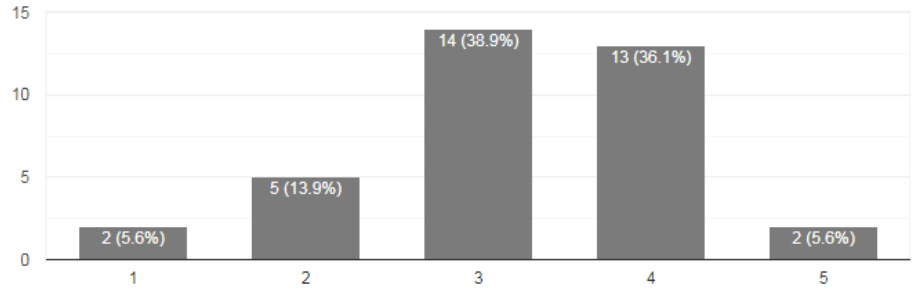
Health insurance/coverage

36 responses



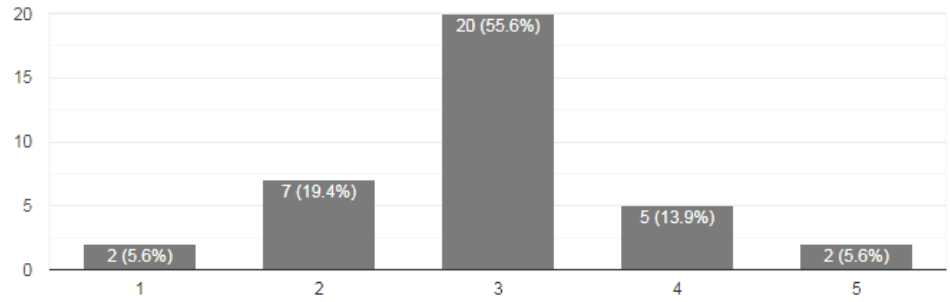
Basic needs/quality of life resources (food pantries, clothing, furniture, etc.)

36 responses



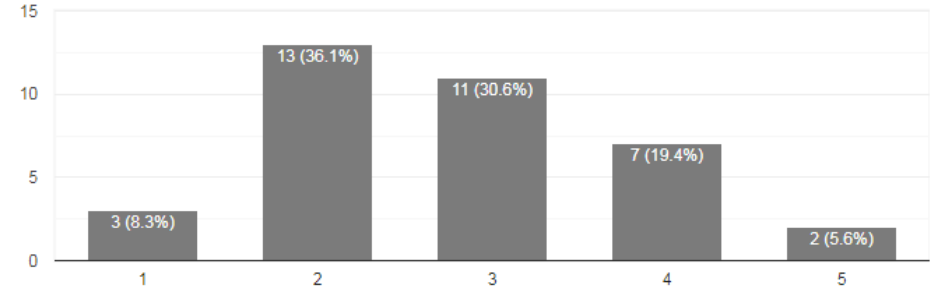
Family services, parenting, child welfare services

36 responses



Criminal justice services

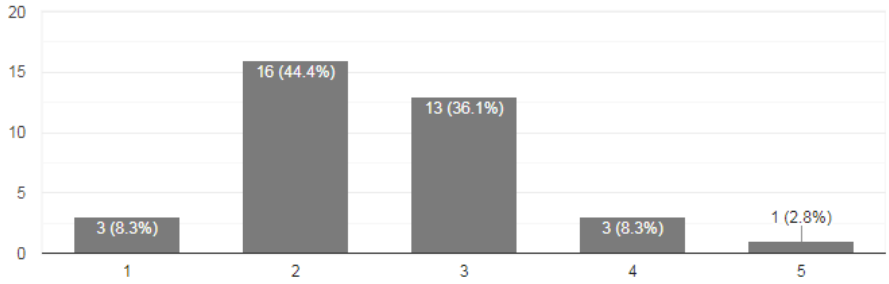
36 responses



3. Please rate the quality of services available locally:

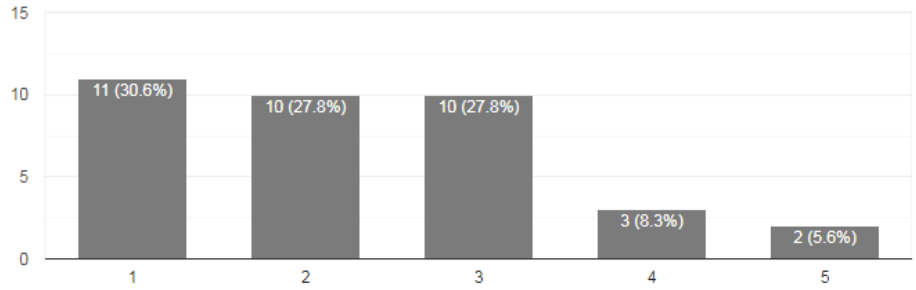
Affordable housing and/or rental assistance

36 responses



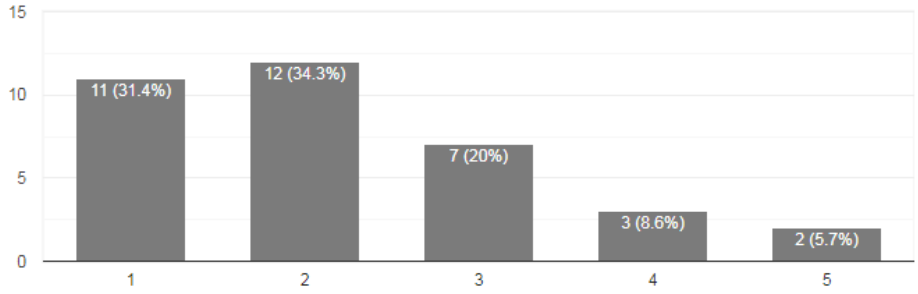
Street outreach

36 responses



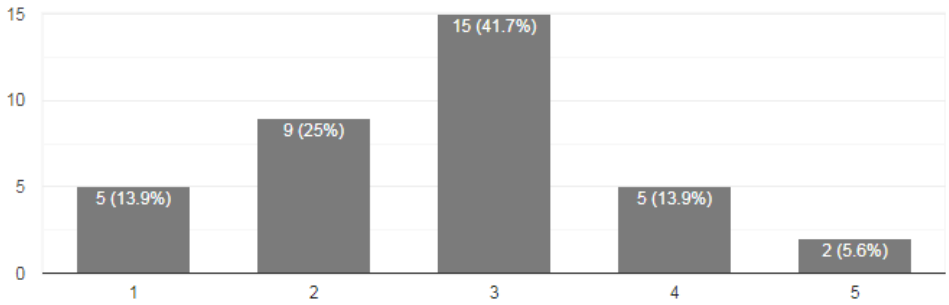
Transportation

35 responses



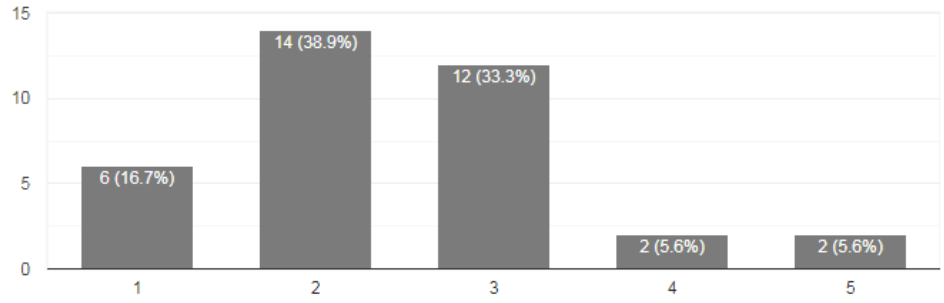
Employment supports and job training

36 responses



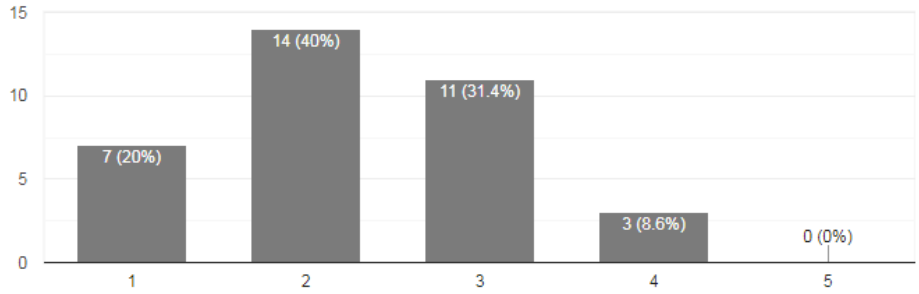
Homeless shelters

36 responses



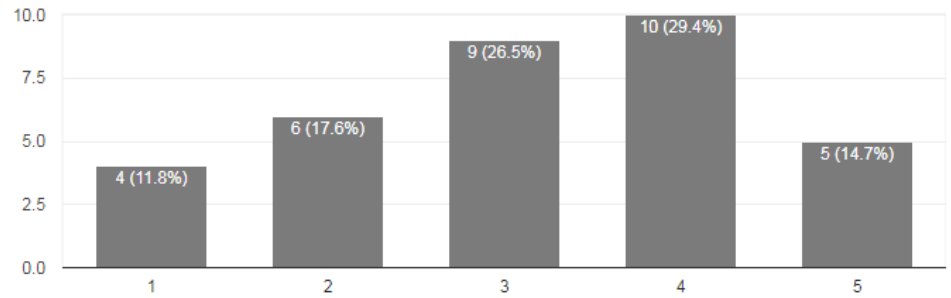
Rapid resolution/diversion from shelter to housing

35 responses



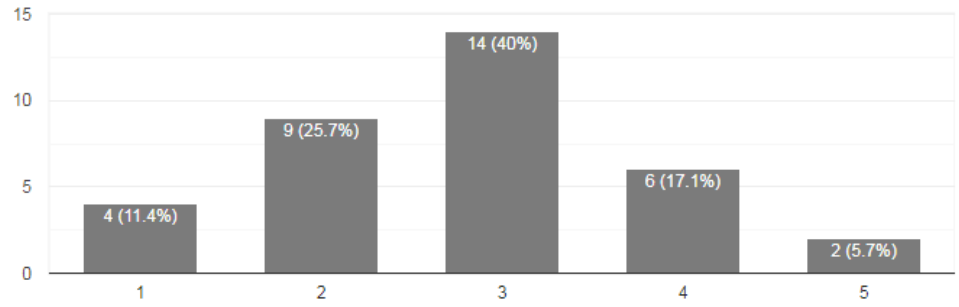
Education

34 responses



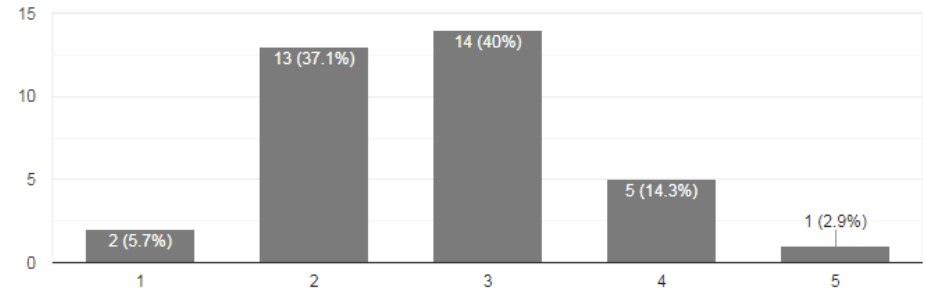
Housing-based services and case management

35 responses



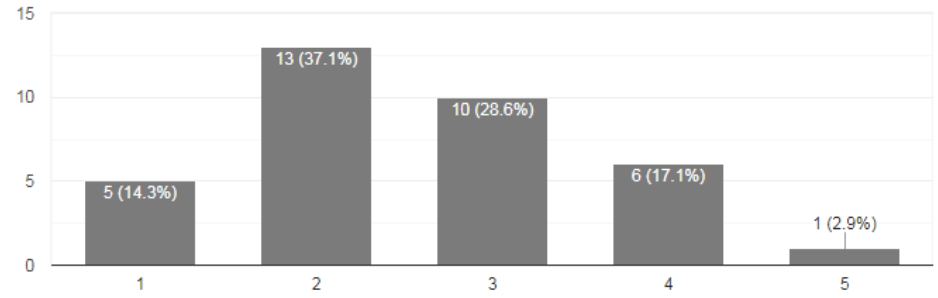
Access to benefits, income supports

35 responses



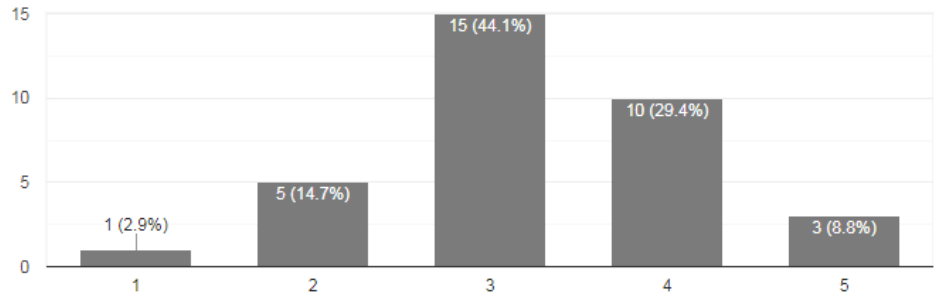
Mental health and psychiatric services

35 responses



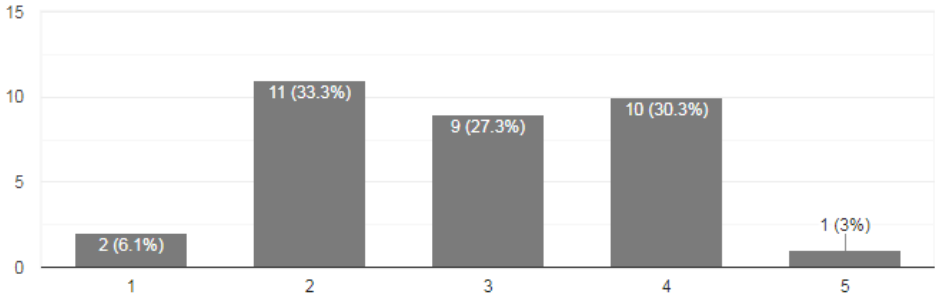
Senior/elderly services

34 responses



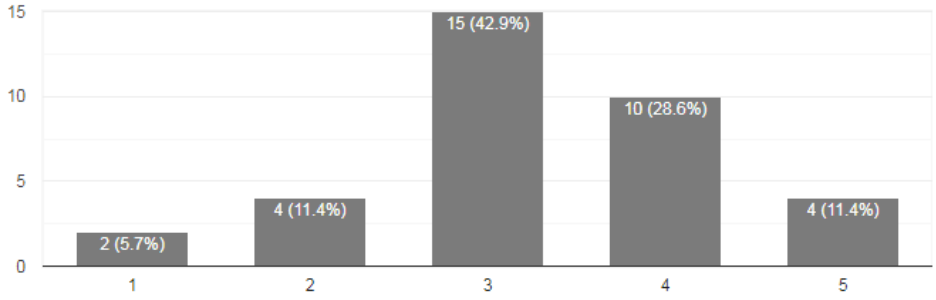
Youth services

33 responses



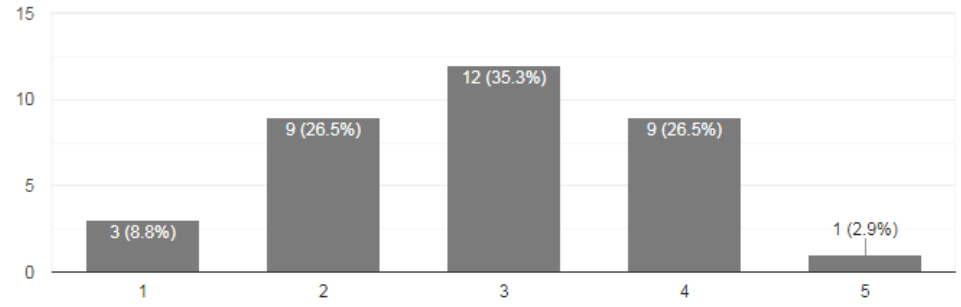
Medical and primary care

35 responses



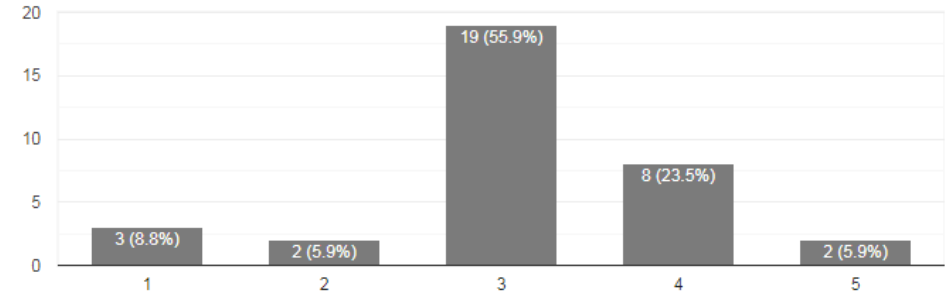
Health insurance/coverage

34 responses



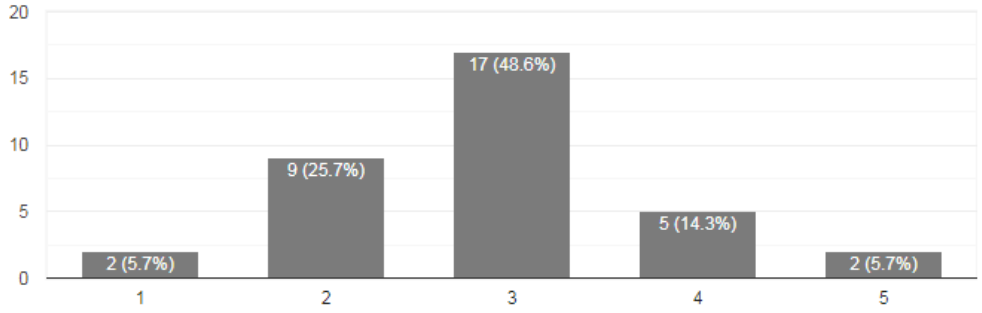
Basic needs/quality of life resources (food pantries, clothing, furniture, etc.)

34 responses



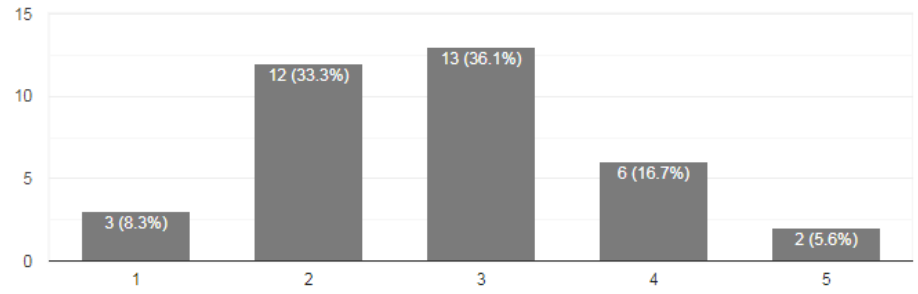
Family services, parenting, child welfare

35 responses



Criminal justice services

36 responses



Appendix IV: USICH Veteran Homelessness Letter

June 7, 2019

The Honorable Sandy Hart
Lake County Board Chair
18 North County Street, 10th Floor
Waukegan, IL 60085

The Honorable Leon Rockingham, Jr.
Mayor, City of North Chicago
1850 Lewis Avenue
North Chicago, IL 60064

Dear County Board Chair Hart and Mayor Rockingham:

Thank you for your commitment to ending Veteran homelessness. Your leadership—and that of your colleagues throughout Lake County—has been instrumental as we work together to ensure that every Veteran in our country has a home.

The United States Interagency Council on Homelessness, Department of Housing and Urban Development, and Department of Veterans Affairs are pleased to confirm that the Waukegan, North Chicago/Lake County Continuum of Care (IL-502) has ended homelessness among Veterans. We are confident that the infrastructure and systems you have built will ensure that any Veteran experiencing homelessness in the region will get the support they need to quickly obtain a permanent home.

On behalf of USICH and our federal partners, thank you for answering the call to action through the Mayors Challenge to End Veteran Homelessness. We recognize and appreciate your extraordinary team, and look forward to continuing our collaboration as we work to end homelessness for all Americans.

Sincerely,

Matthew Doherty
Executive Director

Cc: Jemine Bryon, Deputy Assistant Secretary for Special Needs, HUD
Monica Diaz, Executive Director, VHA Homeless Programs, VA