

Historic Funding Opportunity to Address Unsheltered Homelessness as a Social Determinant of Health in Rural Communities – 06/30/22

Kristine Sande:

Good afternoon, everyone. I'm Kristine Sande, and I'm the program director for the Rural Health Information Hub. I'd like to welcome you to today's webinar. We'll be discussing housing and homelessness as a social determinant of health, hearing about one program that's been very successful in serving their rural areas, and learn more about a new Department of Housing and Urban Development funding opportunity that addresses unsheltered homelessness. We're really excited to see that that opportunity includes dedicated funds for rural projects and encourages the eligible applicants to partner, including with those, in the health sector.

I'd like to thank the Federal Office of Rural Health Policy for all the work they've done in helping us coordinate this webinar. And I have a few housekeeping items to run through before we begin. We have provided a PDF copy of the presentation on the RHHub website, and that's accessible through the URL on your screen. And now it is my pleasure to introduce our speakers. Jana Reese has been the funding resources specialist for the Rural Health Information Hub since 2016. In this role, Jana is responsible for identifying and selecting funding opportunities for inclusion on the RHHub website.

J Helms is director of training and advocacy at Pathways Vermont. They previously worked as a service coordinator on one of Pathways' Housing First act teams through Pathways Vermont Training Institute and Vermont's Pure Workforce Development Initiative. J facilitates various trainings in workshops.

Norman Suchar serves as director of HUD's office of special needs assistance programs, which supports the nationwide commitment to ending homelessness. He manages competitive and formula programs that provide needed shelter and housing assistance for hundreds of thousands of children, youth, and adults each year. He previously directed the National Alliance to end homelessness, center for capacity building, which helped communities implement system wide strategies that prevent and end homelessness. And with that, I'll turn it over to Jana.

Jana Reese:

Good afternoon. Like Kristine said, I'm Jana Reese. I'm the funding specialist for the Rural Health Information Hub. And I have been asked to talk just a little bit about why we're looking at this, why we're looking at talking about housing at the RHHub, and why it's an important... Why this particular project is important for the Federal Office of Rural Health Policy. When I was asked to talk about housing today, or talk about this program, I was really asked to think about why the Federal Office of Rural Health Policy is interested in this program and why we should be talking about housing as a part of health.

So I'm going to talk about this today. Alley, if you don't mind changing the slide. This is a graphic from the journal of preventive medicine from the county health rankings. And it shows that of the four modifiable factors impacting health, only 20% is clinical care, which is really eye-opening when you think about it. Because a lot of times when you're thinking about providing healthcare, you're thinking about clinical care. But if you look at this, 40% of modifiable factors impacting health are actually social and economic factors, which is where housing sits as well as health behaviors and the environment, which is also where at least the health of housing sits.

So we're going to talk a little bit about this today. If you can go to the next slide, Alley. What we're talking about here is the social determinants of health, and there are multiple definitions of the social determinants of health. You can see here on this slide, that there is a definition

from the Healthy People 2020 website, as well as the World Health Organization and the Robert Wood Johnson Foundation. And they give different examples of what the social determinants of health may mean. Next slide, please. Speaking of the healthy people program, one of the main reasons we're talking about this is that the US Department of Health and Human Services thinks of housing and health in terms of social determinants of health.

The Office of Disease Prevention and Health Promotion sets the national objectives every 10 years to monitor and improve the health of the United States. Excuse me, and this initiative aims to identify key areas important for improving health and to develop objectives that communities can use to measure progress towards achieving health goals. Nested within the neighborhood and built environment section, housing quality is there referring to the physical condition of a person's home, the space per individual, air and water quality, whether there's presence of mold, asbestos or lead, as well as the structures' age and design, along with any disrepair and safety issues.

Housing instability, which when we're talking about unsheltered or unhoused, people would be nested under the economic stability section. This agency suggests that there is no standard definition for stability or instability, but it includes things like forced evictions, financial difficulties meeting rent, spending too much of your income on housing, overcrowding or moving frequently between the homes of friends and relatives. Research indicates that not only do these challenges negatively impact physical and mental health, but they also lessen the ability to access healthcare and are especially traumatizing for children. Next slide, please.

According to a fact sheet published by the National Healthcare for The Homeless Council in 2019, people who are homeless have a higher rates of illness and die on average 12 years sooner than the general US population. And poor health, in addition to how homelessness and being unsheltered causing health problems, poor health is a major cause of homelessness. And then homelessness creates new health problems and exacerbates the existing ones, as well as recovering and healing being much more difficult without housing. Next slide, please. This came from the same fact sheet. The source is The Health Center Patient Survey.

It shows that the health conditions among homeless populations and comparing to the general population, and it looks at diabetes, hypertension, heart attack, all the way down to substance use disorders. And you can see there's a marked difference in unhoused, unsheltered people and housed people. Next slide, please. And then when we're talking about housing and homelessness, we're not just talking about what's happening right now. We're looking at the future as well. If we were talking about children who have unstable housing, they're more likely to experience emotional and behavioral problems, negative impacts on their physical, emotional, and cognitive development, hunger, missed educational opportunities and poor academic performance, as well as acute and chronic health problems and exposure to violence.

Okay. And I put this one in here because of what's been going on the last couple years. The CDC has a social vulnerability index, and housing is listed as one of the things that can weaken a community's ability to prevent suffering and financial loss in the case of a natural disaster or a hazardous event or a disease as outbreak, that sort of thing. So having a lot of unsheltered people in your community or overcrowded housing can increase the community's social vulnerability index overall in being able to respond to disasters. Next slide, please. So according to policy brief on homelessness in rural America by the National Advisory Committee on rural health and human services, rural homelessness looks, looks different.

People are more likely to live in substandard housing in their vehicles, or doubled up with families or friends rather than seeing a lot of homeless people on the street like you do in more urban areas. Next slide, please. And this creates barriers to addressing rural homelessness,

because it's hard for finding transportation to reach the services. Homeless individuals may have a sense of isolation because there are fewer people who are unsheltered. There are a lack of homeless specific services in the community, and there are a lack of flexibility in funding programs to meet the unique needs of rural areas. Next slide, please. Lack of employment opportunities, difficulty applying for services, either due to lack of permanent address or lack of internet access.

We know that's an issue in rural communities, as well as shortages of affordable housing. In addition to affordable housing, there are also, the age of housing is typically much older in rural areas. So you may have substandard housing due to age rather than just a shortage of housing stock. Next slide, please. There are some resources on the RHHub website that may help with looking into social determinants of health. We have an evidence based toolkit, as well as a topic guide on social determinants of health for rural people. And then we also have a topic in our database on housing and homelessness.

So if you follow that link, it will take you to the search on that particular topic on our site. Next slide, please. And we also have a free information resource and referral service. So as you are working on your projects or your proposals to this program, you can contact us and we can help you find resources. Might be data or models, that sort of thing that could help you apply and to prepare your proposal for this program. So you can give us a call there or send us an email to info@ruralhealthinfo.org. And then I will turn it over to J to talk about the program that he's doing in Vermont.

J Helms:

Thank you. All right. So my name is J. I'm with Pathways Vermont. I'm going to talk about our rural implementation of Housing First. I'm unable to control the slides, it seems. Okay. It's working now. So my name is J. I go by they/them pronouns, I'm director of training and advocacy at Pathways Vermont, and I lead our training Institute. So just quickly, I'm sure folks know where Vermont is, but sometimes I think this is useful. Vermont is in New England. It's the green state there that borders New York and Massachusetts and New Hampshire. Canada is above us. So Vermont's total area is about 25,000 square kilometers. The population is under 650,000.

So population of Vermont is smaller than many large cities in this country. Population density is 26 people per square kilometer. Just a quick sort of snapshot at homelessness in Vermont. These are from the point in time counts in 2020 and 2021. As you'll see here, the population of folks experiencing homelessness did increase greatly in 2021. And we think that that is partly, of course, due to the pandemic. So Pathways Vermont, our mission is to end homelessness and offer innovative mental health alternatives, and we do that in various ways. We have a Housing First program where we offer permanent supportive housing. We also operate a community center, a peer support harm line, a residential program for folks experiencing early episode psychosis.

So we do this in other ways as well, but I'm going to talk to you about our Housing First program. So in terms of ending homelessness in Vermont, our Housing First program has an 86% housing retention rate. Folks who are familiar with Housing First know that generally the housing retention rate for Housing First programs is around 85%. It's the most successful model for ending homelessness. We've housed nearly 1,300 Vermonters, and we offer permanent supportive housing as well as rapid rehousing. And so for Housing First, for folks who are unfamiliar, though maybe everyone is familiar. Housing First provides immediate access to permanent housing and support services for folks who are experiencing chronic homelessness and have serious mental health challenges.

Chronic homelessness, of course, as defined by HUD and that, chronic homelessness means one year of continued homelessness or of multiple episodes, I think up to three to four episodes of homelessness or more over a period of few years, and those individual episodes of homelessness total 12 months. So that's what defines chronic homelessness, as well as having serious mental health challenges or disability. So a bit about Housing First in Vermont. So for folks who are familiar with Housing First in general, the first Housing First program in this country began in the early '90s in New York city. Dr. Sam Tsemberis that program along with a team of folks. In 2009, Sam Tsemberis and the Vermont Department of Mental Health was awarded a grant from SAMHSA to start a Housing First program in Vermont, particularly to try to have the first rural Housing First program.

Pathways Vermont is the first rural implementation of Housing First. Our founding executive director and current executive director is Hilary Melton. And Hilary Melton was actually on the team that started the first Housing First program with Sam Tsemberis in the early nineties in New York city. Hilary happened to be living in Vermont. Sam and the Vermont Department of Mental Health were awarded this grants. Sam got in touch with Hilary and that's how Pathways Vermont began. Our first program participants were served in 2010 and we were designated as a specialized services' agency by the department of mental health in 2014. Our impact thus far, for permanent supportive housing, we've housed over 300 households who are experiencing chronic homelessness.

We've supported over 200 individuals who were in institutional settings previous to being part of our program. As I said, we have an 86% housing retention rate. And a little bit about our population. 100% of the folks that we support through our permanent supportive housing do have a mental health diagnosis. 68% of those folks identify as having struggles or challenges with substance use, and 90% or more of those folks self-identify as having experienced trauma in some way before. Our impact. We have a community orientation to Housing First, I'll talk a bit more about that later, what that means. We practice progressive engagement and we have housed over 350 households through rapid rehousing with the supportive services for veterans and families, as well as HUD and care vouchers.

So we have the ability to bill Medicaid for services and provide long term support. I think just for folks thinking about, how does Housing First work in a rural setting? One of the ways that it works for us is that we're able to bill Medicaid, this allows folks to continue to receive services and allows us to keep providing services to folks. In Vermont, we are the largest Vermont housing authority sponsor. We're the first rural implementation of the evidence based practice of Housing First, we were the first Housing First program to partner with the department of corrections. So we provide support to folks who are leaving incarceration so that they are housed when they leave incarceration, that greatly reduces recidivism rates.

And also, we believe that every person deserves a home regardless of their history, even if that history includes incarceration. And as of July in 2021 Housing First services in 9 of the 14 counties of Vermont. So that's our impact thus far, we are always working to expand to the entirety of the state funding. Our funding partners include the Department of Mental Health, Department of Corrections, Agency of Human Services, Veterans Administration, HUD Continuum of Care Funds, as well as the United Way in Vermont, The University of Vermont Medical Center, and some private donors.

Mentioned this just because in order to sustain our program, we really have had to make sure that we're getting funding from various sources. For the housing in particular, we get funding from Hutch Shelter Plus Care, DMH Subsidies Plus Care, Local Choice Vouchers section eight. We have some DOC funded housing. As I mentioned, we collaborate with the Department of Corrections to support folks who are leaving in incarceration. And Pathways Vermont

administers the funds for that specific housing. Also, some folks self-pay, and we do sometimes have other resources or other sources of funding for housing. Outcomes. As I mentioned, 86% housing retention rate.

Once folks become a part of our Housing First program, 93% of their time is spent in the community versus institutions. So part of Housing First is to really disrupt the institutional circuit. When folks are not in a Housing First program and experiencing homelessness, they're often sort of bouncing around from emergency departments. Sometimes in jail, sometimes psychiatric hospitals, sometimes emergency shelters or transitional living situations. Housing First disrupts that. And again, 93% of the time of the folks in our program is just spent in the community, living in their homes rather than in institutions. 97% of our folks who we support through the department of corrections have not been charged for the new crime, and 75% of our current participants for Housing First have been housed for longer than a year.

This is just a quick nightly cost comparison for whom this is interesting, or if you feel motivated by cost or know that folks are motivated by cost. Housing First is a really effective way of ending homelessness. It's also incredibly inexpensive. As we can see here, a night in a psychiatric hospital, and these numbers are actually a bit outdated. It now costs more than \$1,500 a night in Vermont, in a psych hospital, and to stay in a Housing First program. I think it's now actually about \$45 a night. That includes everything though. That's rent as well as supportive services. And so you can see here all of the different costs, again, for a night and a motel a night in a correctional facility, in an emergency room department and in the psych hospital.

And so folks are able to live in their own homes and receive supportive services. It's much less expensive, and it's a much more effective way of ending homelessness, and it's much more human centered way person centered way to provide services to folks. So these numbers here, this follows 129 of our participants, and this is sort of conglomerate data around these specific 129 folks who receive Housing First services the six months prior to when they became a client of our Housing First program, and then the six months after. So in the six months prior, between the 129 folks, there was over a million dollars spent on psych hospitalization. Six months after, among that 129 folks, six months after they became Housing First clients, \$1,500.

So it was just one night in a psych hospital. Correctional facility costs, as you can see, decreased by \$500,000, motel cost by over \$100,000. Again, it is the most effective way to end homelessness. It is a person-centered way to provide services and it is cost effective. Some lessons that we've learned. And there's some funny stuff on this slide. Just to sort of emphasize how rural Vermont really is, there's one cow per every 3.8 Vermonters. As I said, the population of Vermont is less than 650,000 people, and there are a lot of cows in Vermont. We don't have billboards in our state. It takes as long to drive across the state, as it does to drive down the state.

Some things that we've learned, having local champions in our communities is really important. So coordinating with folks who are already doing that work in the community, or who are invested in that work. And that includes healthcare providers, of course. Also, when folks who have been homeless in their community for a long time, because our communities are so rural, people tend to know each other. Everyone tends to know everyone. And so once someone who's been experiencing homelessness for a long time is housed, we're able to also just get community members who feel really good about that, and are really grateful for that. And so those become local champions.

It helps in Vermont that we have an accessible legislature. I think our legislature's one of the most accessible in the United States. You can just walk into the state house in Mount Hill or Vermont and speak to a legislator if they're around. You can just go and knock on their door.

And that's one of the ways that we make sure that we sustain these programs. We do a lot of advocacy at the state level. Technology has been really important. I'll talk about that in a little bit. Understanding that we can have a really big impact in small towns. Car time is something to think about for those of you who are living in rural places. You maybe spend a lot of time in your cars if you're providing services.

I think it's important to think about how to use that car time. Things have gotten a little tricky with their being a pandemic, of course, and we have used car time... When taking someone to an appointment that's an hour away because that's the closest hospital, for example, we use that time to really focus on building relationships with folks. And so I think it is both a challenge and something that we can utilize in a rural Housing First program is that, there isn't a lot of car time. It takes a lot of time to get between places, and we can use that time when participants are with staff to build relationships.

It's important to really think about the folks who are local to the community, different advocates, getting to know people. Really important to be flexible. All of our folks who work for Pathways Vermont are very creative and trying to figure out how to get the needs met of the folks that we're supporting. We've also really learned that lived experiences an asset, and I'll talk a bit about that as well. So this is a bit about our service array. I'm just going to drink a little water. So we have multidisciplinary community based support. So we have a lot of different experiences reflected in our staff. Some folks who maybe have been certified and providing counseling or support to folks struggling with substance use issues. Some folks who provide peer support, some folks who have a background in working with folks with disabilities.

We have some folks who are artists, who provide services. And so people are just bringing a lot of different perspectives. We also do have a psychiatrist. We have multiple psychiatrists. We have nursing staff available to folks who would like that support. We take a team approach to services. So within our Housing First teams, and those are called ACT teams. And that stands for assertive community treatment. The ACT team has a caseload. Individual staff do not have caseloads, typically. And we take a team approach to services. Each person receiving services knows everyone on the team and has opportunity to build relationships with everyone. It is also important to really think about local connections.

In our different communities, across the state of Vermont, where we provide Housing First services, we do have connections with different pharmacies, with different primary care providers, different therapists, with the VOC rehabs there, with the COSA groups that circles of support and accountability groups, with faith-based groups with emergency services. So again, we really... Part of, I think one of the benefits of being so rural is again that a lot of people know a lot of other people in our small communities. We can really work together and figure out ways to connect the folks that we're supporting with different services in the area. I do want to just touch briefly on technology, and I'm going to wrap up shortly.

So, because we are so spread across the state, as I said, we provide Housing First services in 9 of the 14 counties in Vermont. We very much utilize virtual meetings. We were doing that pre pandemic for years. We have a lot of shared resources. We use the Google suite of apps, share our contacts, calendars, do all sorts of things that way, organize a lot of content via Google drive. We have paperless ACT meetings and we utilize statewide online communications. This has just really helped because again, we are spread out throughout pretty much the entire state. And so it's really useful to have utilized technology in this way, and we continue to explore new ways to do that.

I quickly just want to note that we hire folks who have lived experience, including folks with lived experience mental health challenges, which is about 78% of our staff. Folks with lived

experience of substance use challenges. Folks with lived experiences of trauma. We have about 43% of our staff have a lived experience of homelessness. 17 of our staff have heard voices before or currently hear voices. And 21 of our staff have actually attempted to take their own life before. And many more of our staff have experienced suicidality, including myself. And we're really straightforward and open about this because we think that lived experience is an asset.

And this greatly improves our relationships with the folks that we provide support to, because we're in rural communities. Again, it's a small community. We're all about building community, and feeling integrated within the community. And so I think just normalizing that, people who are receiving housing for services, for example, they aren't the only ones who've ever experienced a mental health challenge or a struggle with a substance use challenge or have considered suicide, right? That other folks have those experiences as, as well. And that many of our staff actually have had similar experiences. I'm going to quickly wrap up just by talking about our values-based service philosophy.

So we have these five values, individual choice, and self-determination. We provide trauma informed services spaces and try to build trauma informed relationships. We practice harm reduction, and we practice harm reduction beyond just things related to drug use or related to sex. We practice harm reduction in all of our interactions with everyone, and a variety of experiences and circumstances. We practice peer support. And as I've been talking about, community integration is a really important value for us. Just for example, when I worked on one of our Housing First teams, about 10 of our participants who were receiving Housing First services lived within about a half a mile of where I lived, right.

So, I think just part of community integration is that the folks who are receiving services in our Housing First program in Vermont, they are literally our neighbors. And so it's important to think of them as such. That yes, they are people receiving services. They're also community members. They are also neighbors. They also have value and worth. I'm just going to quickly say what I mean by peer support, and then that will wrap me up. So we practice peer support or peer approach at Pathways Vermont. And what that means is that we take an approach to relationships, that recognizes each person is the expert of their own experience. That fosters connection through shared and similar experiences. As I mentioned, many of our staff have lived experience.

We approach relationships in a way that centers mutuality and mutual support, preserves autonomy choice and self-determination, and creates opportunities for making meaning and exploring possibilities. And again, I think this makes sense, honestly, for any sort of housing services program. I think it particularly makes sense for us in a rural setting, because again, we live in small communities. We know each other. The people that I provided support to, I would see them at the grocery store. I'd see them out for my walks around my neighborhood, right? So these folks are our community members, and it's important to treat them as such. And that is it. These slides will be included in the PDFs. You can feel free to reach out to me at j@pathwaysvermont.org. You can also contact training@pathwaysvermont.org, and that email will also go to me. Thank you for your time.

Norman Suchar:

I think I'm up next. J, I just want to start, before I go into my presentation, and say that was a fantastic presentation. Congratulations on your implementation of the Pathways model. It's a fantastic model. I knew you guys are doing a fantastic job. So well done and also want to encourage everyone else who's listening to really look into that kind of a model. It's a really great approach. So I'm here. I want to talk about a new funding opportunity that we just released last week. And it's a special, as you can see from this title slide, a special notice of funding opportunity, that's what NOFO stands for, to address unsheltered and rural homelessness. So let's go to the next slide. So here are some of the major details.

We are making available \$322 million. And there are two components to the funding opportunity. One is there are about \$55 million set aside for rural areas specifically. And then there are about \$268 million that are available to address unsheltered homelessness in the whole country, which also includes rural areas. If you're in a rural area, you're not limited to the rural portion of this, but we recognize that it can be a challenge to compete in rural areas. And so there's funding set aside specifically for rural areas there. So to apply for funding, those of you who are familiar with the Continuum of Care Program that HUD operates will sort of understand this, but I want to talk about it for those of you who are less familiar.

The Continuum of Care Program is an annual competition for HUD funding, for HUD homelessness funding. And it involves the providers and other stakeholders in the community working together as part of a Continuum of Care and submitting a combined application to HUD. If you are familiar with how the Continuum of Care program works on a regular basis, this application will work very much the same way. You will submit applications to your Continuum of Care, they will rank them, and submit them to us for funding. If you are not sort of regularly part of the Continuum of Care funding process, the first step here is going to be to reach out to your Continuum of Care and to talk to them about how you can submit an application for funding here.

There are approximately 400 Continuums of Care across the country. They come in all shapes and sizes. In some cases, a Continuum of Care isn't one state is a Continuum of Care. In some cases, all of the Continuum of Care can be a county or one city or a collection of cities. So the geographies of Continuums of Care vary dramatically, but we do have all a list of all the points of contact on our website. The last slide here will have a resource page that you should go to. If you want to connect with any of the resources that I'll be talking about. Projects have to be submitted to the Continuum of Care, and the Continuum of Care has to include it on their priority listing. The Continuum of Care will rank and rate all of those projects.

Again, if you're not familiar with that process, you should definitely reach out to your Continuum of Care contact. The grant terms here will be for three years, and the funding deadline is October 20th. Although I should note that typically what happens in this competition is that applications will be due to the Continuum of Care at least 30 days before that deadline, so that would be about September 20th. So let's go to the next slide, please. So I want to talk a little bit about the rural set aside within this competition. Specifically, Continuums of Care are going to be eligible to apply for up to 150% of the PPRN of the rural areas in their geographic area. If you don't know what that means, don't worry about it.

We have an appendix to the notice that lists all of the rural counties or list all of the counties that are considered rural, so you'll know which counties count as rural. We also have a list of how much funding every Continuum of Care is eligible for both under the unsheltered portion and the rural portion of this NOFA. NOFO, sorry. So you can go to those to get all the information about how much your community is eligible for and which areas count as rural. If you are getting funding under the rural set aside, you can only serve rural areas. This is a restriction that is in our statute, so we really can't change this. So if you're a project that's going to serve a lot of different areas, some rural, some non-rural, then you'll want to apply for those projects under the regular unsheltered competition.

But if you are only going to serve rural areas, and we'd encourage you to try to develop some projects that are only serving rural areas, you can do that, but the rural competition. We have a very complicated way of determining which applications we're going to select. They're based on three different factors. One is a Continuum of Care score. There's a whole section of the notice that describes all the rating factors. I'll talk about it in a second though. Another is how the COC ranks your project. I mentioned that Continuums of Care have to rank every project when they

submit it to us. The number one project they submit to us is much more likely to get funded than the number 10 or 20 project that gets submitted to us.

And then we have special points for project that serves structurally disadvantaged areas. The notice describes what that means specifically, but to give you a very brief version, it's an area that currently does not have any Continuum of Care grant serving it, and that has some high need as indicated by high rates of poverty, housing distress, or high rates of homelessness. Again, the notice spells that out in a little more detail. Let's go to the next slide, please. There are four major sections to the application, and they're listed here, and their point values are listed here. There is the capacity. There is performance, there is coordination and engagement, and there is having a comprehensive plan to serve individuals and families with severe service needs, especially those who are unsheltered.

The funding is not restricted only to people who are unsheltered, but we are evaluating the degree to which the application will help reduce unsheltered homelessness. So for example, we didn't want a situation where an outreach worker is able to get someone who has been outside for three years, get them into a motel for a few days. We know they're going to end up, there's a good chance they'll end up back on the street again. We didn't want to sort of create a weird incentive for them to have to go back out onto the street to get served. So you can definitely serve that individual, and that's clearly part of a good strategy to reduce unsheltered homelessness in the community. But I do want to be clear the expectation here is that this is addressing unsheltered homelessness.

And as you can see, that's the major chunk of the points available here. Let's go to the next slide, please. I want to talk about the types of projects that are eligible for funding. For those of you who are familiar with the Continuum of Care program, this should look familiar. But for those of you who aren't, let me walk through these individually. There are two types of permanent housing projects that are eligible. One is called permanent supportive housing. The project that J was talking about is a permanent supportive housing project. It includes long term rental assistance and supportive services that meet the needs of the individual that's being served. Another type of project is called Rapid Rehousing. That's similar to permanent supportive housing, except it is not long term.

It is shorter term. It can last up to 24 months. We have the joint TH and PH RRRH. Let me walk through that acronym really quick. So that's a project that combines transitional housing and rapid rehousing in the same project. So you can fund a location where a person can stay temporarily while you help them with rapid rehousing assistance. People can stay in that combination of assistance for up to 24 months. So maybe three months in the transitional housing and 21 months in the rapid rehousing, for example. So anyway, that's one of the options. There are three different types of supportive service only projects that are eligible. I want to be clear here, we call this project type supportive services only.

All of our projects have supportive services in them. It's just that this is the only type of project that has only supportive services and not a housing component. There are three types of projects you can apply for. One is coordinated entry. That's something typically the Continuum of Care will apply for. Another one is street outreach, and another one is essentially other kinds of supportive services only projects, which typically has been things like training programs or employment programs or something like that. HMIS stands for homeless management information systems. Again, that is something that would typically be applied for by the agency that is responsible for data collection for the Continuum of Care.

And then only for the unsheltered portion, not for the rural portion. There are two other kinds of projects, Continuum of Care planning and UFA costs, which again would really only apply to

those Continuums of Care. So those are the types of projects that are eligible to be funded. Let's go to the next slide, please. I did want to talk about some of the resources that are available here. First of all, if you have a question about this funding opportunity, that question mailbox, specialcocnofo@hud.gov is where you should go. And we have a resource page here, which has a ton of resources, both about the funding opportunity and a whole bunch of other resources about best practices, and other information that will be helpful for you. There's one other issue I want to address here.

I don't have a slide for it, but there is a very strong incentive in the funding opportunity for leveraging mainstream housing and healthcare resources. So the way this works is that projects and applications that leverage, for example, housing vouchers or leverage Medicaid assistance, or leverage funding from hospitals or other healthcare partners or mental health agencies, those applications get a huge boost in the scoring and determining whether which projects get funded. So if you are thinking about applying, one thing I would recommend is to go to those leveraging sections and see what the expectation is. Developing those partnerships often takes a long time, and so it's worth starting on those as quickly as possible.

So that's a very quick rundown of the notice. If you're wondering the technical details of how to apply, we have a system called ESNAPs for applying for HUD funding. We have not opened the system to take in applications yet, but what I'd recommend is looking at the notice and looking at the section on the strategic plan that you'll be expected to submit. That strategic plan is going to be submitted as an attachment. So it's going to be a 15 page plus tables and charts document that you'll just type into word and turn into a PDF. So you can start working on those immediately.

And we'll have the system open in the next couple weeks with some instructions about how to use the system. But if you're wondering about all that, and how to access that, again, the special NOFO webpage that we have listed here is the first place you'd go. In any case, you will definitely have to work with your Continuum of Care to submit an application. So if you're thinking about, "I'm interested, what's the first step here?" The first step is definitely to reach out to your Continuum of Care and start a conversation about this. So thank you. And I think we're ready to take some questions. I see there are a whole bunch of questions already.

Kristine Sande: All right. So are healthcare services covered under supportive services, such as basic health screenings?

Norman Suchar: So, there are some healthcare services that are covered under supportive services. So, I could possibly talk about maybe they provide some healthcare services with our Continuum of Care funds, but you can absolutely provide some healthcare services. You cannot provide healthcare services in an inpatient setting, which is probably a good idea, but outpatient health services, you can provide those.

Kristine Sande: All right, thank you. Can a shelter be funded without a definite time limit on transition to permanent housing?

Norman Suchar: None of the funds can be used for emergency shelter. So you can definitely use these funds coordinated with an emergency shelter. For example, a lot of emergency shelters operate rapid rehousing programs, and you could apply for a rapid rehousing program, but you cannot pay for the costs of operating or providing services in an emergency shelter.

Kristine Sande: So, they're wondering about property management companies that have rules about not renting to people with poor credit scores or criminal histories, and whether they could use the

grant funding to contract with those local property management companies to make those apartments available to people who wouldn't qualify.

J Helms:

Sure. Okay. So at Pathways Vermont, we work primarily with local landlords and we do a scattered site housing. So there are some apartment buildings, but these are apartments that are like, there's four apartments in what used to be one really big home, for example. And so that is pretty much how we provide housing to folks. There's also smaller apartments than that or individual units sometimes. And the thing with a Housing First program is that the rent is going to be paid. If there's a housing voucher, it's going to be paid. And so we really do emphasize that when building relationships with landlords is that this is a sure thing, right? This is a guarantee that rent is going to be paid.

Norman Suchar:

So, the thing I would add to that is that, there are actually a lot of different tools in the Continuum of Care program to address this very issue. One is that you can just bulk lease apartments from a property management company. And again, like J's saying, the rent gets paid, and there are supportive services available to handle conflicts or drama or concerns about keeping the place up. And then you can sublease to individual tenants. There's also an approach called sponsor based rental assistance, which is sort of similar in that there's an organization that will pay the rent and sort of lease the unit, and then there's a tenant...

They do it on behalf of the tenant. So again, that helps with issues like credit scores and things like that. A lot of the challenges that the property management companies don't actually sort of have, they don't operate like a human being, they just plug numbers into the computer and whatever it spits out, that's their determination. So sometimes things like sponsor based rental assistance can help sort of get around those kinds of things, but using leasing approaches and sub-leasing and sponsor based rental assistance, all good approaches to sort of overcoming some of the property management practices.

Kristine Sande:

All right. I see a few questions related to FQHCs. And the screen shifted on me. Excuse me. So one was whether FQHCs or health centers are eligible applicants. Another is, can health centers use these funds to provide onsite healthcare at shelters? And are there recommended actions to connect COCs with FQHCs in their service areas for comprehensive primary care service referrals?

Norman Suchar:

So great set of questions. Let me walk through a couple of these scenarios here. This funding cannot be used to provide healthcare in a shelter setting, so that would not be allowed. However, an FQHC would be eligible to apply for funding under this program, and I expect we will fund some FQHCs. In addition to that, we have strong. This is why we have a section on healthcare leveraging is because we know the way a lot of nonprofit providers do that is in partnership with their FQHC, which for those of you who don't know, stands for federally qualified health center. So we definitely encourage those partnerships, very strongly encourage those partnerships. And yeah, sorry. I was going to say something else, but I was just repeating myself.

Kristine Sande:

All right. So there are a few questions about the designation of rural and how... So one was, is the NOFO funding also for areas that aren't designated rural, but smaller urban?

Norman Suchar:

So the NOFO has funding for every part of the country, and it just has a special set aside for rural areas, but rural areas can actually get funded under both parts, both the sort of non-rural part and the rural part. It's just that if you're applying under the rural section of this, you can only serve rural counties, but if you have a small town that doesn't quite meet the rural definition, you can definitely still apply for funding under the NOFA.

Kristine Sande: Okay. Then there's one about, if the county served falls outside of a COC and into the BOS, can they apply?

Norman Suchar: BOS stands for balance of state; a balance of state is actually a Continuum of Care. So the balance of state can... Continuum of Care can definitely apply for funding. And we do expect a lot of applications from balance of state Continuums of Care, yes.

Kristine Sande: Okay. I have a couple of questions about using the funds for people with substance use disorders. So one is, can the funds be used to help keep folks experiencing SUD or in treatment in housing and shelters? Such as technical assistance training, fostering partnerships between housing and healthcare. Do you have examples or specific gaps that you were looking to see addressed in this area? And then there was another question related to recovery housing, and whether that's an acceptable use.

Norman Suchar: Okay. So let me walk through both of these separately. So A, you can use funding for recoveries oriented services. So, that is one of the eligible types of funding you can use. You cannot use this funding to provide recovery or treatment assistance in an emergency shelter. You can use it to provide recovery support in a permanent supportive housing, rapid rehousing, or one of those joint transitional housing, and rapid rehousing projects that I talked about. In addition, there is a heavy emphasis, as I mentioned, on leveraging healthcare resources. We specifically call out substance abuse treatment beds as one of the eligible leveraged sources provided that the individual can choose whether to go into the treatment bed or not.

I should have mentioned this more clearly, but this is a Housing First NOFA, NOFO sorry. We used to call these NOFAs notice of funding availability, and then we had to change it. So I keep reverting back, but this is a Housing First NOFA, all the projects have to use a Housing First approach. So we can't require treatment for any of the people we're serving with these funds. But certainly, a lot of people in Housing First programs want treatment and would like to participate in a substance abuse treatment program or a recovery support program, and you can definitely count that as leverage. The notice actually describes sort of how you count that and what the calculation is and all that stuff. Oh, the other question was about?

Kristine Sande: Recovery housing.

Norman Suchar: Oh, recovery housing. So as I mentioned, you have to use a Housing First approach. There are definitely Housing First projects that provide recovery assistance, but you cannot require the person to be clean and sober or test negative, or you can't do or participate in treatment. You can't do any of that, but the Housing First recovery programs, you can do those. Great example, I can't remember the name of the project now, so this is not going to be super helpful, but I know a project in Philadelphia, the Housing First project that really focuses on people with opioid disorders, great program model. And I wish I could remember it, or remember how to look it up very easily, but maybe that's something we can follow up with at some point, but there are definitely examples around.

Kristine Sande: All right. Could this funding be used to focus on homeless youth and youth transitioning out of foster care or children homes?

Norman Suchar: So the goal of this NOFA is to reduce unsheltered homelessness. We know a lot of young people are unsheltered, so we expect that any good plan to address unsheltered homelessness would look at the young people who are unsheltered in the community, and make sure they are incorporated into the plan. So we definitely expect that. I think transitioning from foster care, that kind of program is a little more challenging. I would strongly encourage you to apply for our

youth homelessness demonstration program, which sort of more specifically suited to, I think, the kind of program model you're talking about.

We will have sometime later this calendar year, probably early next calendar year, have another funding opportunity for YHDP. And you may also want to look at that. But we do absolutely expect people... What we wanted to see is we want people to look at their unsheltered population, to understand it, and to create a strategy that reduces unsheltered homelessness that meets the needs of their unsheltered population. So to the degree that's youth, definitely.

Kristine Sande: All right. There are a couple of questions about allowable uses. One, is it allowable to use it for construction of housing units for chronic homeless or people at risk of homelessness? And the second is, in some of our remote, rural communities, we lack any housing stock that's affordable or not, which affects things like healthcare workforce recruitment. Would that be within the scope of the grant?

Norman Suchar: So, construction, acquisition and rehabilitation is ineligible use only for the rural portion of this. So yes, that is an eligible activity. You can't develop workforce housing with this funding. You can't serve people who are not experiencing homelessness. That's not allowed. So it really does have to be directly serving people who are experiencing homelessness or, and consistent with a plan to reduce unsheltered homelessness.

Kristine Sande: All right. Another question about FQHCs. What if the FQHC is also the housing provider, can the funding be used to fund housing in that instance?

Norman Suchar: So, anybody can do housing with this funding. I am aware of many FQHCs that are also housing developers. It's great. So you absolutely can do that, yes.

Kristine Sande: All right. The next question is, the HUD exchange grantee contacts listed in Wisconsin don't include any of the 11 federally recognized native American tribes. Are tribes eligible?

Norman Suchar: Tribes aren't eligible. So that's a bit of a complicated question because we have a registration process for Continuums of Care to be registered, and to describe the geographic area, including all the counties and tribal areas that are included in the Continuum of Care geography. If a Continuum of Care did not register or did not register a particular geographic area, then those geographic areas are not eligible to be assisted with this funding. But if they are registered, then they are eligible to be funded. Any tribal or tribally designated housing entity is eligible to be an applicant and to provide, and to receive funding to provide assistance.

Kristine Sande: All right. A couple of questions. Is there a projected timeline of knowing when an application is approved or denied after the October application deadline? And is there a certain number of awards that are planned to be given?

Norman Suchar: We expect to make awards in January. We'll make a lot of awards. \$54 million or \$55 million is a lot of rural funding and \$268 million, it's a lot of funding. For the unsheltered portion we expect... We're targeting the assistance. We expect to award about 20 to 40 Continuums of Care. And each of those continuums will receive many, many projects. On the rural side, we expect to fund more different communities, but probably fewer projects per community. I don't have any way of estimating how many though, but we do anticipate a funding announcement in January.

Kristine Sande: Okay. Then there's another person who's asking about the maximum for a rural county, confused about what that maximum is. Can you explain that again?

Norman Suchar: The maximum would be the... So the way to look at this is there's one appendix that lists the counties that count as rural. There's a separate appendix that lists the Continuums of Care and how much they are eligible to apply for, or how much they're eligible to receive. So if you want to know how much rural funding your Continuum of Care could get, you would want to look at appendix A, and find your Continuum of Care and then see how much they're eligible for under the rural section. And then if you wanted to know, well, which parts of this Continuum of Care are actually eligible for the rural funding? You'd want to go to appendix B and look at the list of counties that are listed under the rural section.

Kristine Sande: Can you use the funding for a staffing, the case management component of a Housing First program?

Norman Suchar: Absolutely, yes.

Kristine Sande: All right.

Norman Suchar: It's a very common thing that we fund, to be honest about it.

Kristine Sande: Okay. And then what types of housing are eligible, SROs or congregate housing, multi-family housing?

Norman Suchar: If the housing meets housing quality standards, then it's eligible. We don't fund shelters. Some many SROs do qualify and we fund many SROs types of... Also people use SRO in a lot of different ways so it's hard to answer. We also get a lot of questions about tiny homes. And the issue isn't whether it's a tiny home or not, or whether it's an SRO or not. It's whether the unit meets housing quality standards. You can just sort of Google housing quality standards and get a ton of information about that. But that's the ultimate determinant of what kinds of housing are eligible? We definitely have people who use group homes. We definitely have people who... I think J talked about subdividing, larger houses. We definitely have people who have sort of SRO or converted hotel kinds of approaches. We definitely have people who use single family homes in some areas, and definitely, a lot of multi-family housing.

Kristine Sande: I really appreciate all the great information that our speakers gave us today. Some really great, great information. On behalf of RHHub, I'd like to thank all of our participants for being with us as well. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available on the RHHub website. Thank you so much for joining us, and have a great day.