Nevada Department of
Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Strategic Plan

Nevada Interagency Council on Homelessness

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Name	Department/Agency
Betsy Aiello	Division of Healthcare Financing and Policy – Medicaid
James “Greg” Cox	Department of Corrections
Pat Cashell	Volunteers of America
Michele Fuller-Hallauer	Clark County Social Service
Steve H. Fisher	Division of Welfare and Supportive Services
CJ Manthe	Nevada Housing Division
Mike McMahon	Division of Public and Behavioral Health
Katherine Miller	Department of Veterans Services
Kevin Quint	Substance Abuse Prevention and Treatment Agency
Tony Ramirez	U.S. Department of Housing and Urban Development
Ellen Richardson-Adams	Division of Public and Behavioral Health
Kelly Robson	HELP of Southern Nevada
Kathleen Sandoval	Children’s Cabinet
Pastor John Schmidt	The Bridge Baptist Church
Stephen Shipman	Washoe County Social Services
Tyrone Thompson	State Assemblyman
Marka Turner	Nevada Rural Housing Authority

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Executive Summary

Nevada's Interagency Council on Homelessness was established via Executive Order 2013-20 to coordinate and focus the State's efforts to effectively address the challenge of homelessness in the State of Nevada. The Council provides the opportunity for Nevada to engage in an integrated approach regarding the issue of homelessness and promote interagency cooperation. The Council works to increase the awareness of homeless issues among state and local government agencies and local organizations that provide services to people who are homeless.

Mission

The mission of the Nevada's Governor's Interagency Council on Homelessness is to lead Nevada's efforts to prevent and end homelessness.

Values

Nevada has a common set of values it shares with federal, state and local jurisdictions:

- Every person matters and deserves to be treated with dignity and respect.
- Homelessness is unacceptable.
- Homelessness can be prevented.
- Homelessness is expensive; it is better to invest in solutions.
- Homelessness is solvable; we have learned a lot about what works.
- There is strength in collaboration.

Nevada uses guiding principles shared with the Dedicating Opportunities to End Homelessness (DOEH) initiative, a joint effort between the U.S. Department of Housing and Urban Development (HUD) and the United States Interagency Council on Homelessness (USICH). These guiding principles include:

- ✓ Coordinating Across Partners
- ✓ Community-led Action
- ✓ Data-driven Achievable Strategies and Goals
- ✓ Making Commitments and Measuring Results
- ✓ Leveraging Existing and Untapped Resources
- ✓ Removing Barriers
- ✓ Targeting Priority Populations

The Council created a strategic planning subcommittee during their first meeting in September 2014. The subcommittee was charged with establishing a strategic plan for the Council. The strategic plan subcommittee met bi-weekly to develop the strategic plan template, mission, vision, values, and needs assessment content. The plan was presented to the Council at the November 2014 and January 2015 meetings for approval and direction. A final version was presented and adopted during the June 2015 Council meeting.

The NVICH identified eight strategic issues facing the state through an analysis of statewide data. Strategic issues include both fundamental policy choices and critical challenges that must be addressed in order for the NVICH to achieve its vision. The NVICH reviewed the goals and strategies of the federal strategic plan to end homelessness, *Opening Doors*, and chose to integrate components into the statewide plan. The strategic issues to be addressed by this plan are as follows:

Strategic Issue #1 Housing

At its root, homelessness is the result of the inability to afford and maintain housing. Two trends are largely responsible for the rise in homelessness: a growing shortage of affordable housing and an increase in poverty. Proven housing-based policies include federal housing assistance which includes public housing and federal housing vouchers, permanent supportive housing which combines affordable housing assistance with supportive services, and housing first in which homeless individuals are placed in housing without any program sobriety prerequisite.[1]

Making housing stability the center of a homelessness system helps bring other mainstream resources to bear, including benefits and cash assistance, supportive services, housing assistance, health care, job training, and food and nutrition services. This emphasis helps spread the responsibility of preventing and ending homelessness across the community, and not just leaving it as the charge of homelessness assistance providers and shelters.

Strategic Issue #2 Homelessness Prevention and Intervention

Communities throughout Nevada work tirelessly to offer a range of activities to prevent homelessness. The most widespread activities provide assistance to avert housing loss for households facing eviction. Others focus on moments when people are particularly vulnerable or at-risk of homelessness, such as discharge from institutional settings. However, this isn't enough to prevent many Nevadans from becoming homeless each year.

One prevention and intervention model that allows homeless or at-risk of homelessness individuals to access the prevention, housing, and other services they need is centralized intake. Recent national research has highlighted centralized intake as a key factor in the success of homelessness prevention. Centralized intake can enhance the quality of client screening and assessment, and better target program assistance to where it can be most effective. When properly implemented, the system for preventing and ending homelessness is less fragmented and scare resources are used more efficiently.[2]

To ensure success of any prevention activities, it is imperative that they are a part of a multiyear approach supported by stakeholders, agencies and partners, and communities. In addition, sustainable resources are necessary to ensure that these prevention activities are supported so that they can significantly reduce homelessness in our communities.

[1] Retrieved on December 31, 2014. http://www.coalitionforthehomeless.org/ending-homelessness/proven-solutions/

[2] Retrieved on February 17, 2015. https://www.hudexchange.info/resources/documents/HPRP_CentralizedIntake.pdf

Strategic Issue #3 Wraparound Services

There is a significant need for the funding and provision of wraparound services for the homeless in Nevada. Wraparound services provide homeless individuals and families with a number of services they may need to stabilize their lives. Doing "whatever it takes" is considered a successful approach to ending homelessness. The most successful approach to ending homelessness is to combine wraparound services with permanent housing.[3]

Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. Since the term was first coined in the 1980s, "wraparound" has been defined in different ways. It has been described as a philosophy, an approach, and a service. In recent years, wraparound has been most commonly conceived of as an intensive, individualized care planning and management process. Wraparound is not a treatment per se. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.[4]

Strategic Issue #4 Education and Workforce Development

Life skills are the skills that many people take for granted, like managing money, shopping, cooking, running a home and maintaining social networks. They are essential for living independently. Some homeless people do not have all of these skills, either because they never acquired them or because they lost them through extended periods of homelessness. Helping homeless people acquire life skills can help them move on from homelessness and resettle into the community. Life skills training is different from support, help, or assistance in that the aim is to promote self-sufficiency.[5]

Studies estimate that 44% of homeless people have jobs and can't escape homelessness. Ending homelessness is virtually impossible for those without a job. For those with limited skills or experience, opportunities for jobs that pay a living wage are very limited. Additionally, many members of the homeless population have to combat barriers such as limited transportation and reduced access to educational and training programs (Long, Rio, & Rosen, 2007). In such a competitive environment, the difficulties of job seeking as a homeless person can be almost insurmountable barriers to employment.[6]

Success in school and being a part of the workforce begin early. Over 50 percent of children living in federally-funded homeless shelters are under the age of 5. Infants, toddlers and preschoolers who are homeless are at grave risk of developmental delays due to a variety of physical and mental health factors such as a lack of prenatal and early health care, crowded and unsanitary living conditions, environmental contaminants like lead, and the trauma caused by severe poverty and instability. Quality early education for children under the age of 5 who are homeless is essential.

[3] Retrieved on January 15, 2015. http://www.collabscc.org/blueribbonsite/Ch3Wrap.pdf
[4] Retrieved on January 20, 2015 http://www.nwi.pdx.edu/wraparoundbasics.shtml
[5] Retrieved January 20, 2015 http://homeless.samhsa.gov/channel/life-skills-training-226.aspx
[6] Retrieved January 20, 2015 http://www.nationalhomeless.org/factsheets/employment.html

Strategic Issue #5 Coordination of Primary and Behavioral Health

Higher incidence, prevalence, and acuity of medical and behavioral problems among people who are homeless requires the availability of comprehensive medical and behavioral health services. Limited access to mental health specialists, stigma associated with mental illness, and negative health outcomes related to undiagnosed or untreated behavioral disorders make it incumbent on primary care providers to address their patients' mental health needs.[7]

Medically fragile is defined as a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary. Many individuals who are medically fragile are accessing hospital services for primary care. Although their medical needs are not deemed acute enough to need more intensive care, they require long-term home care. The individual is dependent on medical technology such that without the technology, a reasonable level of health could not be maintained. Examples include but are not limited to intravenous therapy, wound care, enternal or parenteral nutrition support, feeding tube.[8]

Traditionally, primary care, mental health care, and addictions treatment have been provided by different programs in various agencies scattered throughout the community. People who are homeless—particularly those with mental illnesses and co-occurring substance use disorders—have difficulty navigating these multiple service systems. Lack of time, training, experience, and resources makes fully integrated primary and behavioral health care difficult to accomplish in primary care settings. Because of the number of barriers, the coordination of primary and behavioral health is an area of concern in Nevada.

Strategic Issue #6 Coordination of Data and Resources

A homeless management information system (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. HMIS can help provide a consistent and accurate snapshot of a region's homeless population, including a population count, information on service use, and a measurement of the effectiveness of homeless programs, as HMIS also helps track the number of chronically homeless clients and placements into permanent housing. This information can have important impacts on policy at the federal, state, and local levels.

Although HMIS is utilized by the three regional Continua of Care (CoCs) in Nevada, there is still a need for coordination of data and resources that are available to the homeless. Currently, most communities have fragmented systems for determining what kind of assistance people will receive when they become homeless. Much depends on where a person initially seeks help, which programs have open slots, and the specific eligibility criteria of different programs. In addition, there are a number of efforts underway across the country and the state that can impact how resources are deployed. Identifying and tracking new resources or changes to resources is essential to ensuring interagency collaboration and coordination. Fragmentation leads to inefficiency, because people with the highest level of need do not necessarily get directed to the most intensive programs, or those programs end up with longer waiting lists. Recent national research has highlighted centralized intake as a key factor in the success of homelessness prevention and rapid re-housing programs (and many other kinds of homeless programs).

[7] Retrieved on January 20, 2015 http://www.nhchc.org/wp-content/uploads/2011/10/May2006HealingHands.pdf
[8] Definitions for Healthy Living. Clark County Social Service.

Centralized intake can enhance the quality of client screening and assessment, and better target program assistance to where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.[9]

Coordinated Entry provides streamlined access to the homeless services system thereby allowing households facing housing loss to quickly access the services they need and for which they are eligible without having to call multiple social service programs. While coordinated assessment has been identified as a solution to the coordination of data and resources, these programs are still in their pilot phases in the three regions of Nevada.

Strategic Issue #7 Policies

Partnerships and collaboration in communities cannot go the whole distance to end homelessness. In an era of strained public budgets across all layers of government, effective interagency coordination is required to make progress on ending homelessness. Leadership and improved cooperation at the state level is needed to streamline and target resources to achieve a shared goal of re-housing people and offering the right amount of the right type of interventions to keep people housed.

Policies that can impact homelessness include addressing discharge planning and practices from state institutions or systems including prisons, hospitals and foster care, strategically allocating resources to prevent and end homelessness, promoting the sharing of data to quantify the issue and unmet need and measure progress over time, removing barriers to securing housing because of past substance use or criminal record, ensuring coordination of services and supports across state agencies, promotion of livable wage for the community in which people reside, streamlining application processes for mainstream resources, and promoting prevention activities based on risk. Because of the impact it has on homelessness, policies are a key factor in successfully implementing the strategic plan.

Strategic Issue #8 Long Term Planning

Sufficient funding for homeless programs continues to be an ongoing issue. In December 2014, HUD programs held on to the increases in funding they received in 2013.The approved spending bill provides $2.135 billion for the McKinney-Vento Homeless Assistance Grants program. However, this is $271 million less than what was requested. While the amount will be sufficient for maintaining the CoC and Emergency Solutions Grant (ESG), funding McKinney-Vento at the higher level would have helped secure 37,000 rent subsidies necessary to meet the goal of ending chronic homelessness by the end of 2016.[10]

Currently, funding for housing in Nevada comes from a limited number of sources and it is only sufficient to maintain current projects. Nevada lacks the resources to sufficiently fund housing, wraparound, and other services to effectively prevent and end homelessness. Long term planning would ensure that Nevada has sufficient resources and is able to sustain them. Long term and sustainability planning is an ongoing process that will be continually evaluated and updated by the ICH.

[9] Retrieved on December 31, 2014. https://www.hudexchange.info/resources/documents/hprp_centralizedintake.pdf

[10] Retrieved on December 31, 2014. http://www.endhomelessness.org/blog/entry/what-does-the-1.1-trillion-spending-bill-mean-for-homeless-assistance-in-20#.VKRfdivF_hA

Goals

The following goals when met, will address the strategic issues identified by the NVICH.

Strategic Issue #1 – Housing

Goal 1: Preserve the existing affordable housing stock.

Goal 2: Provide the resources necessary to further expand and develop the inventory by 2020.

Goal 3: Systemically as a state, identify, standardize and promote all types of housing interventions in Nevada for subpopulations by 2017.

Strategic Issue #2 – Homelessness Prevention and Intervention

Goal 1: Expand affordable housing opportunities (including Transitional Housing (TH)) through improved targeting of current housing programs that provide rental subsidies as well as an increase in construction of new or rehabilitated housing in all communities.

Goal 2: Coordinate housing programs and agencies to provide housing mediation opportunities for individuals and families who are at-risk of being evicted.

Goal 3: Rapidly rehouse people who fall out of housing.

Goal 4: Provide cash assistance to individuals and families who are at-risk of eviction to cover rent, mortgage, or utility arrears.

Strategic Issue #3 – Wraparound Services

Goal 1: Increase access to all funding (federal, foundations, grants, private) for which Nevada may be eligible.

Goal 2: Each homeless or at risk of homeless individual has a person-centered care plan, developed through appropriate credentialed personnel, that meets their medical and social needs.

Strategic Issue #4 – Education and Workforce Development

Goal 1: Expand economic opportunities (through initiatives such as workforce development, education opportunities, and job skills training) for those who are at-risk or are homeless to achieve self-sufficiency through a living wage.

Goal 2: Increase access to education for people experiencing or most at risk of homelessness.

Goal 3: Determine eligibility and apply for all mainstream programs and services to reduce people's financial vulnerability to homelessness.

Goal 4: Improve access to high quality financial information, education, and counseling.

Strategic Issue #5 – Coordination of Primary and Behavioral Health

Goal 1: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.

Goal 2: Increase health and housing stability for people experiencing homelessness who have frequent contact with hospitals and criminal justice.

Strategic Issue #6 – Coordination of Data and Resources

Goal 1: The system is integrated, streamlined, promotes data sharing and is captured consistently in HMIS.

Goal 2: Implement centralized/coordinated intake assessment and access for all housing programs throughout the state for the homeless or those at risk of homelessness.

Goal 3. Regularly identify options to coordinate resources.

Strategic Issue #7 – Policies

Goal 1: Public and private partners who provide services to prevent and end homelessness will coordinate policy to ensure that barriers are eliminated and goals of the strategic plan are achieved.

Goal 2: Close the gap between available and needed appropriate credentialed health professionals statewide.

Goal 3: Break the cycle of incarceration that leads to disrupted families, limited economic prospects and poverty, increased homelessness or at risk of homelessness, and more criminal activity.

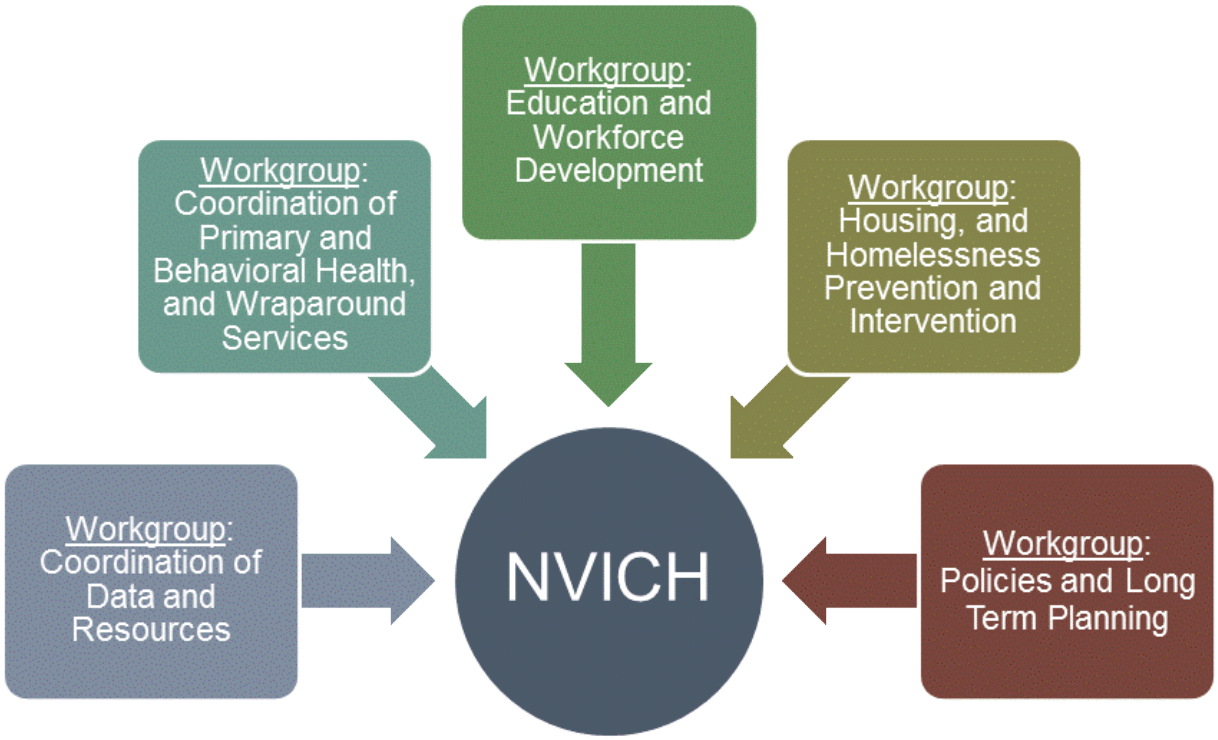
Strategic Issue #8 – Long Term Planning

Goal 1: The strategic plan document is re-assessed and updated at least every five years to prevent and end homelessness.

Goal 2: Public outreach and education is conducted to create awareness to remove the stigma around homelessness.

Evaluating and Updating the Plan

The strategic plan is intended to be used as both a management and communication tool for action. It is intended to be a living document that guides the work of the NVICH. To implement the plan, the NVICH will establish Committees to complete the strategies within each goal area. Each Committee will include a Chair and Vice-Chair made up of members of the NVICH. Each of the Committees will be responsible for tracking and reporting progress. Five workgroups will be established and report back to the NVICH. They include:



Per the Executive Order, the strategic plan will be reviewed in its entirety annually to remove strategies that have been accomplished or that no longer apply and to update the plan, revising timing and adding strategies that are identified as necessary to achieve the mission of the ICH ("lead Nevada's efforts to prevent and end homelessness").

The human costs of homelessness are incalculable – trauma, despair, loss of family, job and community, illness and injury. Homelessness is also costly for the state and local governing bodies and taking steps to address the problem is fiscally wise. In communities that have engaged actively in ending homelessness, public costs have been reduced – often substantially – in the areas of crisis response, public safety, and emergency services.

Introduction

Nevada's Interagency Council on Homelessness was established via Executive Order 2013-20 to coordinate and focus the State's efforts to effectively address the challenge of homelessness in the State of Nevada. The Council provides the opportunity for Nevada to engage in an integrated approach regarding the issue of homelessness and promote interagency cooperation. The Council works to increase the awareness of homeless issues among state and local government agencies and local organizations that provide services to people who are homeless.

Methods

The Council created a strategic planning subcommittee during their first meeting in September 2014. The subcommittee was charged with establishing a strategic plan for the Council. The strategic plan subcommittee met bi-weekly to develop the strategic plan template, mission, vision, values, and needs assessment content. The plan was presented to the Council at the November 2014 and January 2015 meetings for approval and direction. A final version was presented and adopted during the June 2015 Council meeting.

Engaging Stakeholders

Council members applied through an open application process and were appointed to the Council by the Governor. The Governor's Executive Order details that the Council shall consist of no more than twenty members and members should represent private businesses, state agencies, nonprofit organizations that provide services to homeless people, public housing, local governments, federal agencies, at least one person who is or has been homeless, and any others with an interest in addressing homelessness. The strategic planning subcommittee includes council members and members not on the council that represent other groups working on homeless issues throughout Nevada. These include the faith based organizations, the Continua of Care, and members from homeless initiatives.

There are a number of planning projects recently completed or underway in Nevada that address aspects of homelessness. The Council utilized a number of these plans from stakeholders to inform the strategic plan. The Council's guiding principles are shared with the Dedicating Opportunities to End Homelessness (DOEH) initiative, a joint effort between the U.S. Department of Housing and Urban Development (HUD) and the United States Interagency Council on Homelessness (USICH). Data from the three regional continua of care in Nevada was utilized to inform the needs assessment section of the plan regarding the number of homeless and bed availability, and the plans from northern and southern Nevada as well as the Nevada Housing-Healthcare (H2) initiative were used to identify critical issues. Recommendations from the Governor's Council on Behavioral Health and Wellness, and white papers recently completed by the Division of Public and Behavioral Health were also utilized. Data from the USICH/HUD Dedicating Opportunities to End Homelessness Initiative's Strategic Planning Guide was also used to demonstrate homeless population projections.

Vision for the Future

Mission

Nevada's Governor's Interagency Council on Homelessness will lead Nevada's efforts to prevent and end homelessness.

Values

Nevada has a common set of values it shares with federal, state and local jurisdictions:

- Every person matters and deserves to be treated with dignity and respect.
- Homelessness is unacceptable.
- Homelessness can be prevented.
- Homelessness is expensive; it is better to invest in solutions.
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- ✓ **Coordinating Across Partners**
- ✓ **Community-led Action**
- ✓ **Data-driven Achievable Strategies and Goals**
- ✓ **Making Commitments and Measuring Results**
- ✓ **Leveraging Existing and Untapped Resources**
- ✓ **Removing Barriers**
- ✓ **Targeting Priority Populations**

Needs of the Community

While circumstances can vary, the main reason people experience homelessness is because they cannot find housing they can afford. It is the scarcity of affordable housing in the United States, particularly in more urban areas where homelessness is more prevalent, that is behind their inability to acquire or maintain housing.[11] According to U.S. Department of Housing and Urban Development (HUD), an estimated 12 million renter and homeowner households now pay more than 50 percent of their annual incomes for housing, and a family with one full-time worker earning the minimum wage cannot afford the local Fair Market Rent (FMR) for a two-bedroom apartment anywhere in the United States.[12]

Two trends are largely responsible for the rise in homelessness: a growing shortage of affordable housing and an increase in poverty. Proven housing-based policies to address homelessness include federal housing assistance which includes public housing and federal housing vouchers, permanent supportive housing which combines affordable housing assistance with supportive services, and housing first in which homeless individuals are placed in housing without any program sobriety prerequisite.[13]

Individuals and families become homeless due to a variety of factors aside from the inability to afford and maintain housing. As mentioned previously, poverty is one contributing factor that is linked to homelessness. Those living in poverty are frequently unable to pay for housing, food, childcare, health care, and education. Difficult choices must be made when limited resources cover only some of these necessities. Often it is housing, which absorbs a high proportion of income that is impacted. If you are poor, you are essentially an illness, an accident, or a paycheck away from living on the streets. Declining wages have put housing out of reach for many workers. In every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at FMR. Declines in value and availability of public assistance is another contributing factor. Those with a loss of benefits, low wages, and unstable employment struggle to get medical care, food and housing. Additional contributing factors include a lack of affordable housing, health care, domestic violence, mental illness, and addiction disorders.[14]

Sufficient funding for homeless programs continues to be an ongoing issue. The President's Budget Proposal for fiscal year (FY) 2015 recommended providing level funding to the Runaway and Homeless Youth Act (RHYA) and Education for Homeless Children and Youth (EHCY) programs through an allocation of $114 million for RHYA and $65 million for EHCY. The budget also proposed an additional $2 million for an incidence and prevalence study of unaccompanied youth homelessness. The FY2015 amount proposed for RHYA is insufficient to ensure existing programs are supported and communities are able to meet the needs of homelessness and runaway youth. According to the National Alliance to End Homelessness, Congress should provide at least $140 million in funding for RHYA programs in FY 2015 to support existing programs and help communities better meet the needs of homeless and

[11] Retrieved on January 2, 2015. http://www.endhomelessness.org/pages/snapshot_of_homelessness
[12] Retrieved on January 2, 2015. http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/
[13] Retrieved on December 31, 2014. http://www.coalitionforthehomeless.org/ending-homelessness/proven-solutions/
[14] Retrieved on January 15, 2015. http://www.nationalhomeless.org/factsheets/why.html

runaway youth, for instance through helping to close the gap between the number of homeless youth and number of available RHYA beds for them.[15]

In December 2014, HUD programs held on to the increases in funding they received in 2013.The approved spending bill provides $2.135 billion for the McKinney-Vento Homeless Assistance Grants program. However, this is $271 million less than what was requested. While the amount will be sufficient for maintaining the CoC and Emergency Solutions Grant (ESG), funding McKinney-Vento at the higher level would have helped secure 37,000 rent subsidies necessary to meet the goal of ending chronic homelessness by the end of 2016.[16]

The following section further details the specific homeless and housing needs in Nevada.

State Assets/Demographics

- The State of Nevada's population has changed dramatically in recent years. Between 1990 and 2000, Nevada was ranked the fastest growing state in the nation with total population jumping 66 percent during that decade (Social Science Data Analysis Network (SSDAN), 2000). The State of Nevada continues to grow, though at slower rate than the previous decade. According to United States Census Bureau (2012) and Nevada State Demographer's Office (2012) the rate of population growth from 2000 to 2012 was 27.3 percent. Between 2012 and 2017 the population is projected to grow by 8.5 percent, and by 2032, Nevada's population is expected to reach 3.2 million people (The Nevada State Demographer's Office, 2015). In 2014, Nevada's population was estimated at 2,843,301 (The Nevada State Demographer's Office, 2015).
- Nevada has 17 counties with two metropolitan areas. Clark and Washoe Counties contain most (88%) of the state's population. The remaining 12 percent of Nevada's population resides in the remaining 15 rural counties (The Nevada State Demographer's Office, 2015). The population per square mile, a measure of density, varies dramatically by county.
- In 2013, Nevada's male population (1,402,163; 50.52%) was slightly greater than the female population (1,373,053; 49.48%) (The Nevada State Demographer's Office, 2015).
- In 1991, persons of Hispanic Origin constituted 12 percent of the population. In 2007, persons of Hispanic Origin made up nearly 25 percent of the total population, and in 2013 constituted 26.5 percent of the Nevada population (The Nevada State Demographer's Office, 2015). Growth of the Hispanic population is projected to continue, reaching an estimated 33.9 percent of the total population by 2032 (The Nevada State Demographer's Office, 2015).
- Persons that are Black (not of Hispanic Origin) make up a small proportion of Nevada's population (9%). The proportion of people that are Black is projected to remain relatively constant as a component of total population (The Nevada State Demographer's Office, 2015).
- Asians/Pacific Islanders have increased as a percentage of Nevada's total population. In 1991, this group made up just over 3 percent of the population. In 2007, persons who were Asian or Pacific Islander made up 6.5 percent of the total population, and in 2013 constituted 6.7 percent

[15] Retrieved on December 31, 2014. http://www.endhomelessness.org/library/entry/fy-2014-appropriations-rhya-programs

[16] Retrieved on December 31, 2014. http://www.endhomelessness.org/blog/entry/what-does-the-1.1-trillion-spending-bill-mean-for-homeless-assistance-in-20#.VKRfdivF_hA

of Nevada's population (The Nevada State Demographer's Office, 2015). This trend, observed nationwide, is attributed to recent immigration. This group is also expected to grow slightly in coming years, reaching 7 percent by 2032 (The Nevada State Demographer's Office, 2015).

- The federal poverty level as defined by the U.S. Census Bureau is one indicator used to understand need. In 2012, updated estimates developed by the Census Bureau indicated that 16.2 percent of Nevadans were below the poverty level during the past 12 months. Furthermore, those estimates show that 24.8 percent of the population under the age of 18, and 26.6 percent of the population under the age of 5 live in poverty in Nevada (United States Census Bureau, n.d.).
- Nevada's current unemployment rate stands at 7.1 percent as of February 2015 (United States Department of Labor, 2015), the second highest in the nation. Unemployment in many of Nevada's rural counties exceeds the overall state rate.

Table 1 Unemployment rate by county[17]

County	Unemployment Rate
Carson City	8.1
Churchill County	7.3
Clark County	7.2
Douglas County	7.5
Elko County	5.5
Esmeralda County	3.9
Eureka County	5.9
Humboldt County	6.0
Lander County	7.3
Lincoln county	6.8
Lyon County	10.1
Mineral County	11.2
Nye County	9.0
Pershing County	7.1
Storey County	8.0
Washoe County	7.0
White Pine County	6.2

- As is the case with unemployment, Nevada also leads the nation in rates of foreclosures. The Nevada foreclosure rate of 0.12 percent as of June 2014 is higher than the national average of 0.08 percent (Realty Trac LLC, n.d.).
- High unemployment, poverty, foreclosure rates and a continuing budget crisis in the state all lead to greater risk of homelessness. U.S. Department of Housing and Urban Development (HUD) has four federally defined categories under which individuals and families may qualify as homeless:
    - Literally homeless

[17] Retrieved January 2, 2015. http://www.nevadaworkforce.com/

  - Imminent risk of homelessness
  - Homeless under other Federal statutes
  - Fleeing/attempting to flee domestic violence
- Nevada has three Continua of Care (CoCs) in the state that cover distinct regions: northern, southern and rural Nevada. CoCs are most commonly organized around two main goals – planning for a homeless housing and service system in the community and applying for funding from HUD's competitive McKinney-Vento Act programs that were amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.
  - CoCs primarily receive funding for supportive housing programs for the homeless.
  - The three CoCs work to end homelessness in their respective regions and collaborate to address statewide issues, such as:
    - **SOAR** (SSI/SSDI, Outreach, Access, and Recovery) — a process to expedite access to Social Security disability benefits for the homeless; The State SOAR Coordinator aligns statewide efforts to ensure clients are efficiently being assisted for approval of SSI/SSDI benefits.
    - **Homeless Management Information System (HMIS)** — a statewide data collection system required by HUD and widely used by homeless service providers to track client data and outcomes;
    - **Homeless Census (Point in Time)** – conducted annually on the same date;
    - **Quarterly Statewide CoC Meetings** —discuss progress and develop unified plans to address issues; and
    - **Housing** – partnering with public housing authorities and jurisdictions to ensure resources are prioritized for re-housing the homeless.
- Each year, HUD requests CoCs to update a Housing Inventory Chart (HIC) which lists the number of emergency shelter, transitional housing, permanent supportive housing, and safe haven bed and unit numbers for homeless individuals and families on a specific date in January. The HIC provides a snapshot of the utilization of those beds at that specific point in time. In 2015, the northern, southern and rural continua reported there were a total of 8,832[18] beds in Nevada for the homeless:

Table 2 2015 Housing Inventory

Bed Type	N. Nevada	S. Nevada	R. Nevada	State (total)
Emergency Shelter	523	2,874	134	3,531
Transitional Housing	401	1,034	92	1,527
Safe Haven	0	25	0	25
Permanent Supportive Housing	471	2,093	222	2,786
Rapid Re-Housing	0	963	0	963
Total	1,395	6,989	448	8,832

[18] 2015 Housing Inventory Charts for northern, southern and rural Nevada.

- On the same date as the HIC information is collected, CoCs are required to conduct a Point in Time (PIT) count of the homeless. Emergency shelter and transitional housing providers are asked to provide the number of homeless individuals served on that specific date. Additionally, an unsheltered or street count is conducted to count the number of individuals living in areas not meant for human habitation (such as on the street, in parks, etc.) Results of the 2015 Point in Time count showed that a total of 12,336 individuals are homeless in Nevada[19].

Table 3 2015 Point in Time results

Bed Type	N. Nevada	S. Nevada	R. Nevada	State (total)
Emergency Shelter	454	2,719	78	3,251
Transitional Housing	340	859	63	1,262
Safe Haven	N/A	15	N/A	15
Unsheltered	113	7,509	186	7,808
Total	**907**	**11,102**	**327**	**12,336**

- In addition to the HIC and PIT, CoCs report the unmet need for their region. The unmet need is a calculation that utilizes both HIC and PIT data to determine the number of beds needed, by type, in order to meet homeless needs. Based on 2015 PIT and HIC data, the following table shows the unmet need for southern, northern and rural Nevada. By far, the biggest unmet need in Nevada is permanent supportive housing.

Table 4 2015 Unmet Need

Type of Beds	N. Nevada	S. Nevada	R. Nevada	State (total)
Emergency Shelter (includes seasonal and overflow beds)	470	264	40	774
Transitional Housing	150	3,611	90	3,851
Permanent Supportive Housing	1,000	3,496	150	4,646
Safe Haven	30	0	0	30

- There are three public housing authorities (PHA) in Nevada: the Southern Nevada Regional Housing Authority, the Reno Housing Authority, and the Nevada Rural Housing Authority. Each PHA provides public housing units, HUD-Veterans Affairs Supportive Housing (VASH) vouchers, and Housing Choice vouchers (a program for assisting very low-income families, the elderly, and

[19] Point in time count numbers are compiled from the results reported to HUD by the three CoCs.

the disabled to afford decent, safe, and sanitary housing in the private market[20]). As of January 9, 2015, there were a total of 19,485 PHA units in Nevada (table 5).

Table 5 Public Housing Authority Units as of January 2015

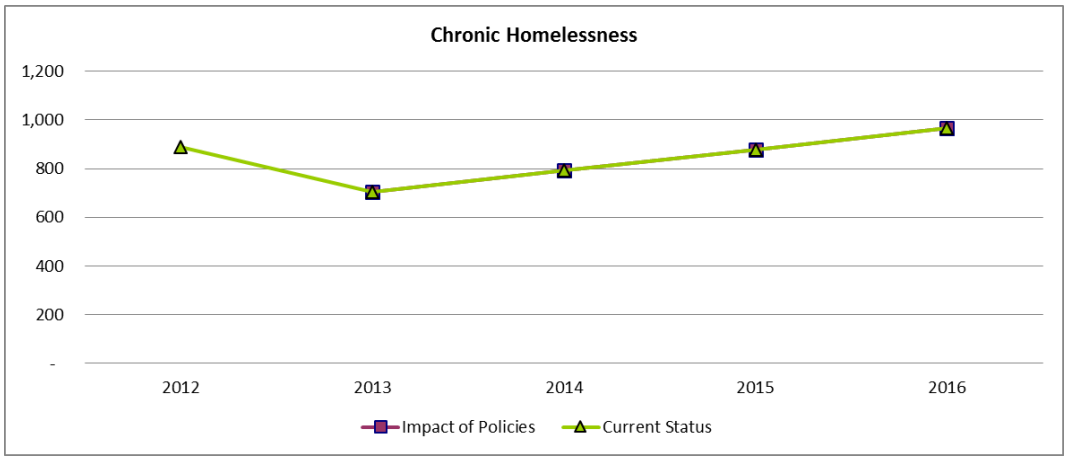
Agency	Number of Public Housing Units	Number of HUD-VASH Vouchers	Number of Housing Choice Vouchers	Total PHA Units
Southern Nevada Regional Housing Authority	2,882	880	10,319	14,081
Reno Housing Authority	764	205	2,752	3,721
Nevada Rural Housing Authority	0	70	1,613	1,683
Nevada Totals	**3,646**	**1,155**	**14,684**	**19,485**

- Utilizing USICH/HUD Dedicating Opportunities to End Homelessness Initiative's Strategic Planning Guide, projections for chronic, family, and veteran homelessness were developed utilizing 2014 PIT data from southern, northern and rural Nevada. The tool is intended to help communities think strategically about resources that are available within the community, from HUD and other sources, to end homelessness. The tool projects how many people (chronically homeless, veterans, and families) are likely to experience homelessness from now until 2020 based on current policies and investments. The tool is intended to be used to estimate the potential impact of increasing investments or making other changes that improve access to housing opportunities, and to determine what additional resources or program improvements are needed to end homelessness.
    - Projections are calculated by entering the number of homeless individuals and families from the most recent PIT count and the number of units available based on HMIS and the HIC. The projections also take into account other factors, such as known or estimated percentages of length of stay, those who receive housing due to rapid re-housing interventions, etc. Once all known and estimated data is entered, the projections auto-generate each graphic for the specific subpopulation.
    - The graphics show the current status that Nevada is on to currently end homelessness. The "Impact of Policies" reflects the trajectory that Nevada could be on by increasing the availability of housing units by creating new permanent supportive housing units and affordable housing units. For the purposes of this strategic plan, only the graph for veteran homelessness actually utilizes the line. This is because it includes the number of Veteran Affairs Supportive Housing (VASH) vouchers allocated. Because local planning data is not readily accessible for providing additional PSH units to address the needs for chronic and family homelessness, the "Impact of Policies" line is omitted in those graphs.

[20] Retrieved on January 15, 2015. http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/about/fact_sheet

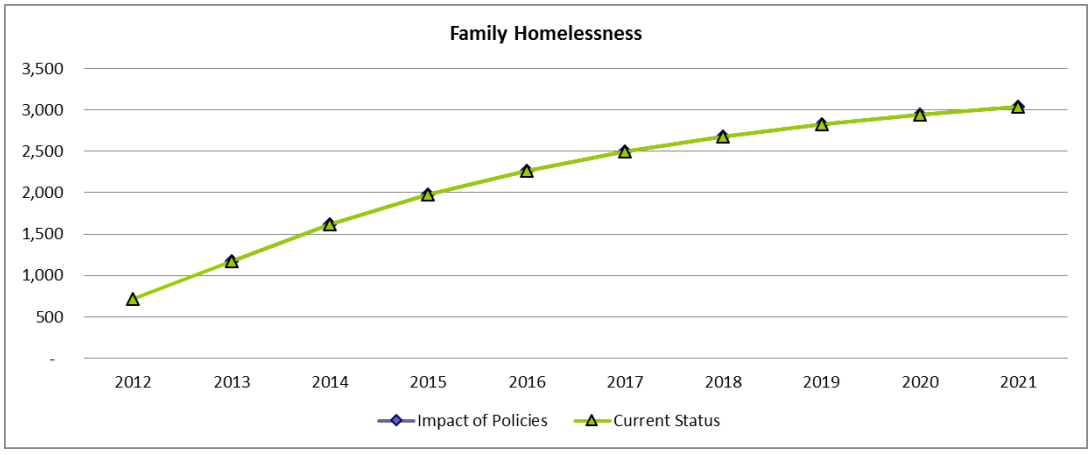
- When reviewing HUD homeless projections for the state of Nevada[21], it is anticipated that:
  - The number of chronically homeless individuals will increase by over 40 percent from 2013 to 2016.

Figure 1 Chronic Homelessness Projection - State of Nevada



- The number of homeless families will increase by 50 percent from 2,000 in 2015 to 3,000 in 2021:

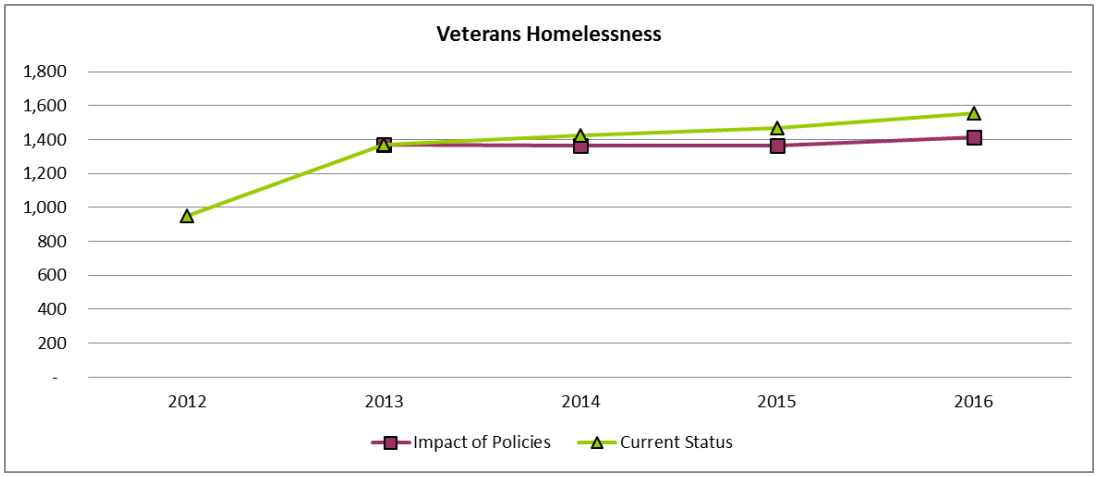
Figure 2 Family Homelessness Projection - State of Nevada



[21] Projections provided by the Reno HUD field office.

- And the number of homeless veterans will increase by over 60 percent from 2012 to 2016:

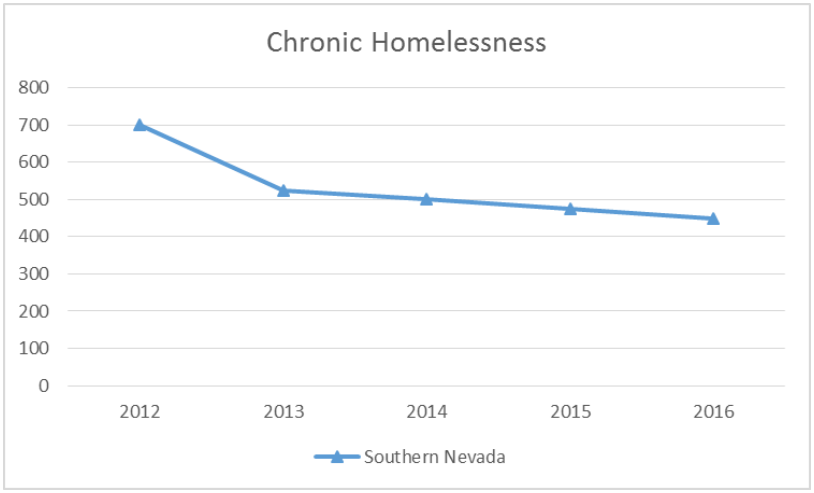
Figure 3 Veteran Homelessness Projection - State of Nevada



Projections were also calculated for northern, southern and rural Nevada for chronic, veteran and family homelessness. Because southern Nevada has a larger proportion of homeless when compared to northern and rural Nevada, their projections are shown as separate from northern and rural Nevada.

- Chronic homelessness in southern Nevada is projected to decrease in 2016 to nearly half (50 percent) of its 2012 numbers. This decrease is due to increased permanent housing resources for those chronically homeless individuals in southern Nevada.

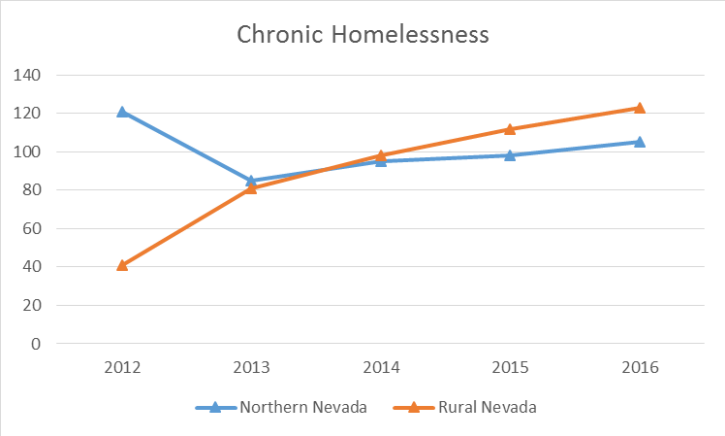
Figure 4 Chronic Homelessness Projection - Southern Nevada



- Chronically homeless projections for northern and rural Nevada show an increase in the number of chronically homeless individuals. Chronic homelessness in rural Nevada dipped in 2013 from the 2012 baseline but is anticipated to increase over 20 percent

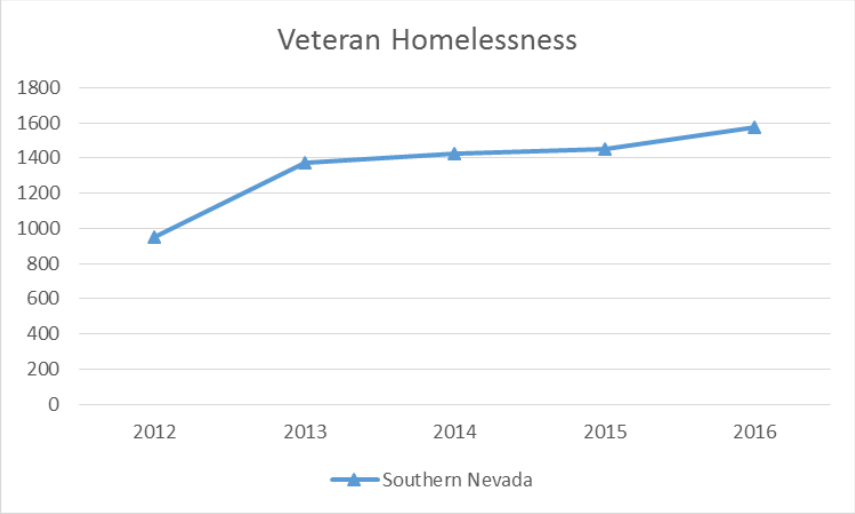
from 2013 to 2016. It is also estimated that the number of chronically homeless individuals in rural Nevada will triple the 2012 baseline by 2016. Northern and rural Nevada have a limited number of permanent housing resources for chronically homeless individuals, including a lack of permanent housing stock which contributes to the growing number of chronically homeless.

Figure 5 Chronic Homelessness Projections - Northern and Rural Nevada



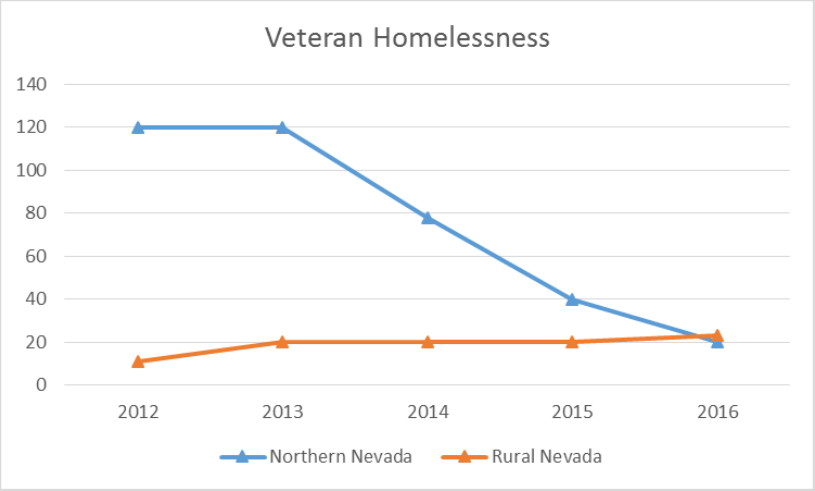
- Veteran homelessness in southern Nevada is anticipated to increase by over 60 percent from the 2012 baseline. Veteran specific resources in southern Nevada are limited, especially when considering the high number of homeless veterans counted in the 2014 PIT.

Figure 6 Veteran Homelessness Projection - Southern Nevada



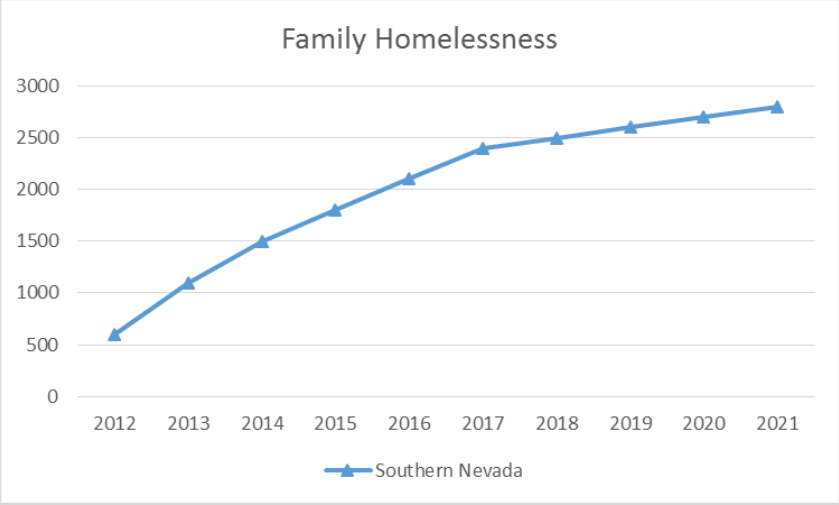
- Conversely, veteran homelessness is projected to decrease by nearly 80 percent in Northern Nevada. Rural Nevada shows some stabilization in the number of homeless veterans. Veterans Affairs Supportive Housing (VASH) vouchers and the availability of other veteran specific resources have impacted the number of homeless veterans in northern and rural Nevada.

Figure 7 Veteran Homelessness Projections - Northern and Rural Nevada



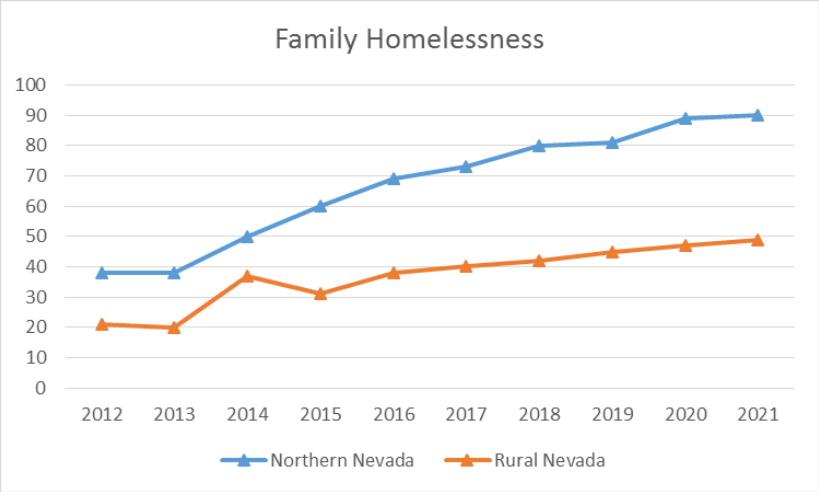
- Family homelessness in southern Nevada is projected to increase over 350 percent from 2012 to 2021. Family and youth homelessness continues to be an issue statewide with a lack of housing, prevention, wraparound services and other resources.

Figure 8 Family Homelessness Projection - Southern Nevada



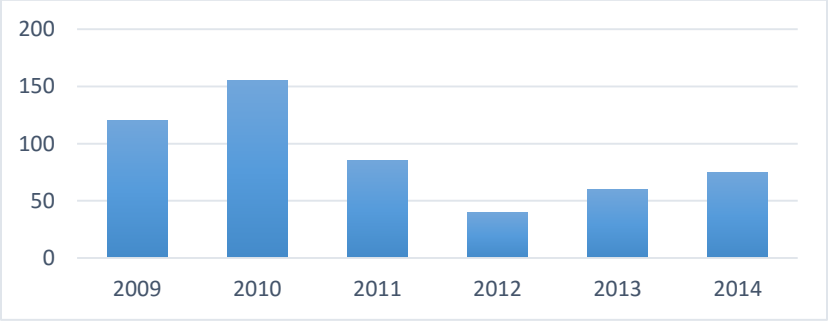
- Similarly, family homelessness in northern and rural Nevada is projected to increase over 130 percent by 2021. Both regions experience similar shortages in family and youth resources as southern Nevada.

Figure 9 Family Homelessness Projections - Northern and Rural Nevada



- Youth at Risk of Homelessness (YAHR) is a planning project in southern Nevada intended to build intervention strategies for youth and young people who are most likely of experiencing challenges in transition to adulthood, to include homelessness and unstable housing experiences. They target youth entering foster care between the ages of 14-17, youth aging out of foster care, young adults (under 21) accessing homeless support services with former child welfare history, and youth in multiple systems and victims of human trafficking. Core activities developed during the planning project are expected to produce positive outcomes, including stable housing, permanent connections, education/employment, and enhanced well-being.
  - YAHR has identified the total number of youth who aged out of the system in 2009-2013. These are youth who are at heightened risk for negative outcomes, including homelessness. Based on data for January 2014, they estimate a total of 72 youth will age out by the end of the year.[22]

Table 6 Youth at Risk of Homelessness - Total Youth Who Aged Out or Emancipated



[22] Youth At Risk of Homelessness Planning Project (YARH) Presentation. Christina Vela. Clark County Department of Family Services.

- The Nevada Behavioral Health System Gaps Analysis report details that lack of housing is one of the biggest gaps for behavioral health system users. In Fiscal Year (FY) 2011-2012, the state provided services to 35,894 children and 47,589 adults.
- There are a variety of types of affordable housing, Housing Choice Vouchers (Section 8 which is currently unavailable for new enrollees), public housing, tenant based rental assistance (TBRA) as well as others. TBRA works well with housing first because the program places homeless persons into permanent housing quickly and is usually set up to include case management. Historically, Nevada has always provided more transitional housing than permanent.
- A consolidated plan is a planning document required by HUD. It is designed to help states and local jurisdictions to access their affordable housing and community development needs and market conditions so that they are able to make data-driven, place-based investment decisions. Consolidated plans have been developed for Clark County and Washoe County, as well as Carson City, Henderson, Las Vegas, and Reno. Their goals are presented below:
    - City of Reno FY2014-2015 Draft Action Plan Goals:
        - Goal 1: Expand affordable rental housing opportunities for extremely and very low income households, including those with special needs.
        - Goal 2: Stabilize neighborhoods and increase appropriate housing opportunities for low and moderate income households, including those with special needs.
        - Goal 3: Support organizations that provide supportive services to the region's lowest income residents and residents with special needs.
        - Goal 4: Increase economic opportunities for the region's residents and businesses.
        - Goal 5: Support quality living environments of low- and moderate-income households through infrastructure improvements and blight reduction.
    - Carson City FY2014-2018 Draft Consolidated Plan Goals:
        - Goal 1: Expand transitional housing opportunities for families and individuals.
        - Goal 2: Maintain access to availability of health and dental services.
        - Goal 3: Maintain suitable living environments for those in imminent danger of homelessness.
        - Goal 4: Expand transitional housing for young adults-Ventana Sierra Project.
        - Goal 5: Sustain independent living opportunities for owners through rehabilitation and modification of existing structures.
        - Goal 6: Encourage universal design in new construction of multifamily housing supported by Carson City.
        - Goal 7: Expand mental health counseling services.
        - Goal 8: Maintain access to housing for person with disabilities through shelter plus care grant and COC.
    - Clark County FY2014 Action Plan Goals:
        - Goal 1: Provide Decent Housing. This includes affordable housing for homeless persons, preserving the affordable housing stock, increasing the availability of permanent housing that is affordable to low-income Americans without

discrimination, and increasing supportive housing that has special structural features and services to enable persons with special needs to live in dignity.

- Goal 2: Provide a Suitable Living Environment. This includes improving the safety and livability of neighborhoods, increasing access to quality facilities and services, reducing the isolation of income groups within target areas by increasing housing opportunities and revitalizing deteriorating neighborhoods, restoring and preserving natural and physical features of special value for historical, architectural, or aesthetic reasons, and conserving energy resources.
- Goal 3: Expand Economic Opportunities. This includes creating employment opportunities and job training accessible to low- and extremely low-income persons, providing access to credit for community development that promotes long-term economic and social viability and empowering low-and extremely low-income persons residing in Federally assisted and public housing to achieve self- sufficiency

- City of Las Vegas Consolidated Plan Goals:
  - Goal 1: Create more affordable rental and owner-occupied housing opportunities for its citizens
  - Goal 2: Support diverse, safe, sustainable and livable neighborhoods through the improvements to housing, facilities, infrastructure, and services
  - Goal 3: Provide public facilities and services that promote healthy lifestyles for all segments of the community, including the disabled, homeless, low-income residents, seniors, and youth
  - Goal 4: Promote open government by providing its citizens with public input and comment opportunities regarding the Consolidated Plan and Action Plan
  - Goal 5: Improve housing stock, public facilities and infrastructure to provide a safe environment for City residents, businesses, and visitors
  - Goal 6: Provide affordable housing, improve streets and sidewalks, parks and recreation facilities that help revitalize and invigorate the City's urban core and surrounding neighborhoods.
- City of Henderson Draft Annual Action Plan Goals FY2014-2015:
  - Goal 1: Decent housing
  - Goals 2: Suitable living environment
  - Goal 3: Economic opportunity

Identifying Strategic Issues

The human costs of homelessness are incalculable – trauma, despair, loss of family, job and community, illness and injury. Homelessness is also costly for the state and local governing bodies and taking steps to address the problem is fiscally wise. In communities that have engaged actively in ending homelessness, public costs have been reduced – often substantially – in the areas of crisis response, public safety, and emergency services. The NVICH identified eight strategic issues facing the state through an analysis of the data in the previous section. Strategic issues include both fundamental policy choices and critical challenges that must be addressed in order for the NVICH to achieve its vision.

Strategic Issue #1 Housing

At its root, homelessness is the result of the inability to afford and maintain housing. Two trends are largely responsible for the rise in homelessness: a growing shortage of affordable housing and an increase in poverty. Proven housing-based policies include federal housing assistance which includes public housing and federal housing vouchers, permanent supportive housing which combines affordable housing assistance with supportive services, and housing first in which homeless individuals are placed in housing without any program sobriety prerequisite.[23]

Homelessness is expensive. Hospitalization, medical treatment, incarceration, police intervention, and emergency shelter expenses can add up quickly, making homelessness surprisingly expensive for municipalities and taxpayers. People experiencing homelessness are more likely to access the most costly health care services. Homelessness both causes and results from serious health care issues, including addiction, psychological disorders, HIV/AIDS, and a host of order ailments that require long-term, consistent care. Homelessness inhibits this care, as housing instability often detracts from regular medical attention, access to treatment, and recuperation. This inability to treat medical problems can aggravate these problems, making them both more dangerous and more costly. Studies have shown that providing people experiencing chronic homelessness with permanent supportive housing saves money.[24]

The transformation to a housing stability approach builds on research and successful community practices, which demonstrate that focusing resources on quickly stabilizing people in housing diminishes the chaos in their lives and enables programs to address their clients' longer-term service needs. While shelter is a critical form of emergency assistance, it should only be used for crisis. Focusing on housing stability affords greater opportunity for the homelessness assistance and mainstream systems to succeed.[25]

Making housing stability the center of a homelessness system helps bring other mainstream resources to bear, including benefits and cash assistance, supportive services, housing assistance, health care, job training, and food and nutrition services. This emphasis helps spread the responsibility of preventing and

[23] Retrieved on December 31, 2014. http://www.coalitionforthehomeless.org/ending-homelessness/proven-solutions/

[24] Retrieved January 15, 2015. http://www.endhomelessness.org/pages/cost_of_homelessness

[25] Retrieved January 20, 2015 http://www.endhomelessness.org/library/entry/hprp-opportunities-for-systems-transformation-and-sustainability

ending homelessness across the community, and not just leaving it as the charge of homelessness assistance providers and shelters.

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – and then providing services as needed. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve.

Housing First programs share critical elements:

- A focus on helping individuals and families access and sustain permanent rental housing as quickly as possible without time limits;
- A variety of services delivered to promote housing stability and individual well-being on an as-needed basis; and
- A standard lease agreement to housing – as opposed to mandated therapy or services compliance.

While all Housing First programs share these critical elements, program models vary significantly depending upon the population served. For people who have experienced chronic homelessness, there is an expectation that intensive (and often specialized) services will be needed indefinitely. For most people experiencing homelessness, however, such intensive services are not necessary. The vast majority of homeless individuals and families fall into homelessness after a housing or personal crisis that led them to seek help from the homeless assistance system. For these families and individuals, the Housing First approach is ideal, as it provides them with assistance to find permanent housing quickly and without conditions. In turn, such clients of the homeless assistance networks need surprisingly little support or assistance to achieve independence, saving the system considerable costs.[26]

Strategic Issue #2 Homelessness Prevention and Intervention

Communities throughout Nevada work tirelessly to offer a range of activities to prevent homelessness. The most widespread activities provide assistance to avert housing loss for households facing eviction. Others focus on moments when people are particular vulnerable or at-risk of homelessness, such as discharge from institutional settings. However, this isn't enough to prevent many Nevadans from becoming homeless each year.

Homelessness prevention can also take place earlier in an individual's life, such as targeting at-risk youth and families with children. Additionally, there are other subpopulations that can be included in prevention, such as those who are chronically homeless (those individuals who have been homeless for a year or more, or have experienced four episodes of homelessness within the last 3 years), those with mental health disorders or are dually diagnosed, or are veterans.

The human and fiscal costs of homelessness cut across all major systems of care, and an effective response to homeless requires the coordinated effort of partners across healthcare, behavioral health, criminal justice, and other fields.

[26] Retrieved on January 15, 2015. http://www.endhomelessness.org/pages/housing_first

One prevention and intervention model that allows homeless or at-risk of homelessness individuals to access the prevention, housing, and other services they need is centralized intake. Recent national research has highlighted centralized intake as a key factor in the success of homelessness prevention. Centralized intake can enhance the quality of client screening and assessment, and better target program assistance to where it can be most effective. When properly implemented, the system for preventing and ending homelessness is less fragmented and scare resources are used more efficiently.[27]

Other promising homeless prevention activities were identified by HUD's Office of Policy Development and Research[28]:

- Housing subsidies – research shows that subsidizing housing costs for extremely low-income people has the strongest effect on lowering homelessness rates compared to other interventions.
- Supportive services coupled with permanent housing – permanent supportive housing works to prevent initial homelessness of those individuals with a serious mental illness, with or without co-occurring substance use.
- Mediation in housing court – mediation under the auspices of housing courts show the ability to preserve tenancy, even after the landlord has filed for eviction.
- Cash assistance for rent or mortgage arrears – a commonly used primary prevention activity for households still in housing but threatened with housing loss that has shown to be effective in the prevention of homelessness.
- Rapid exit from shelter – this activity, while aimed at individuals and families just entering shelter, ensure that they quick leave shelter and stay permanently housed afterwards.

To ensure success of any prevention activities, it is imperative that they are a part of a multiyear approach supported by stakeholders, agencies and partners, and communities. In addition, sustainable resources are necessary to ensure that these prevention activities are supported so that they can significantly reduce homelessness in our communities.

Strategic Issue #3 Wraparound Services

There is a significant need for the funding and provision of wraparound services for the homeless in Nevada. Wraparound services provide homeless individuals and families with a number of services they may need to stabilize their lives. Doing "whatever it takes" is considered a successful approach to ending homelessness. The most successful approach to ending homelessness is to combine wraparound services with permanent housing.[29]

Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. Since the term was first coined in the 1980s, "wraparound" has been defined in different ways. It has been described as a philosophy, an approach, and a service. In recent years, wraparound has been most commonly conceived of as an intensive, individualized care planning

[27] Retrieved on February 17, 2015. https://www.hudexchange.info/resources/documents/HPRP_CentralizedIntake.pdf
[28] Retrieved on February 17, 2015. http://www.urban.org/UploadedPDF/1000874_preventing_homelessness.pdf
[29] Retrieved on January 15, 2015. http://www.collabscc.org/blueribbonsite/Ch3Wrap.pdf

and management process. Wraparound is not a treatment per se. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.[30]

For example, experiencing homelessness exacerbates health problems and the ability to access appropriate care. Residential instability and insecurity, including doubling up and overcrowding, creates substantial risks to child health, development, and educational outcomes. Housing instability and living in lower socioeconomic neighborhoods can lead to significant stress, mental health problems, obesity, and diabetes. Patients with multiple and chronic health needs often find navigating a complex and fragmented healthcare system overwhelming, making wraparound supportive services an essential component of linking health care, human services, and housing.[31]

Wraparound is a key component to the Housing First model. Without providing all necessary resources and supports, permanent housing and Housing First are not nearly as effective. One key to ensuring that wraparound is provided is to ensure there is sufficient case management staff. One known issue in Nevada is the lack of service providers and case managers to support the homeless population. In addition, there is a lack of services for special populations such as single men who have custody of their children, Lesbian, Gay, Bi-sexual, Transgender, and Questioning (LGBTQ) individuals, transition age youth, unaccompanied minors, individuals with co-occurring disorders and individuals who are medically fragile.

Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) is one wraparound strategy to help states increase access to mainstream benefits. The SSI/SSDI application process is complicated especially for those who are homeless, with a mental illness, substance use issues or co-occurring disorders. For those individuals, accessing income and health care benefits is often the critical first step on the road to stability. SOAR trained case managers are better able to assist clients in completing application processes and paperwork to enable them to access mainstream resources for which they are eligible. Implementing SOAR and wraparound is necessary to prevent and end homelessness.

Strategic Issue #4 Education and Workforce Development

Life skills are the skills that many people take for granted, like managing money, shopping, cooking, running a home and maintaining social networks. They are essential for living independently. Some homeless people do not have all of these skills, either because they never acquired them or because they lost them through extended periods of homelessness. Helping homeless people acquire life skills can help them move on from homelessness and resettle into the community. Life skills training is different from support, help or assistance in that the aim is to promote self-sufficiency.[32]

Life skills can be thought of in terms of three broad categories: 1) core or basic skills (e.g. numeracy, literacy and information technology); 2) independent living skills (e.g. managing a household, budgeting, appointment keeping and contacting services, dealing with bills and correspondence); and, 3) social skills (e.g. interpersonal skills, avoiding or dealing with neighbor disputes, developing self-confidence

[30] Retrieved on January 20, 2015 http://www.nwi.pdx.edu/wraparoundbasics.shtml
[31] Retrieved on December 31, 2014. http://www.huduser.org/portal/periodicals/em/summer12/highlight3.html
[32] Retrieved January 20, 2015 http://homeless.samhsa.gov/channel/life-skills-training-226.aspx

and social networks). There is limited knowledge on the life skills needs of many groups of homeless people including: families, people from ethnic minorities, and women.

Many factors combine to force so many to subsist without permanent housing, and too often without even basic shelter. Not only is there a shortage of affordable housing, but also wage and public benefits often yield incomes insufficient to obtain and maintain housing while simultaneously meeting the high costs of health care, child care and other support services. Although some people who experience homelessness are employed, they have jobs that pay wages too low to afford permanent housing. Others are not working due to job loss, child-caring responsibilities, age, disability, trauma, incomplete education or insufficient occupational skills.[33]

Studies estimate that 44% of homeless people have jobs and can't escape homelessness. Ending homelessness is virtually impossible for those without a job. For those with limited skills or experience, opportunities for jobs that pay a living wage are very limited. Additionally, many members of the homeless population have to combat barriers such as limited transportation and reduced access to educational and training programs (Long, Rio, & Rosen, 2007). In such a competitive environment, the difficulties of job seeking as a homeless person can be almost insurmountable barriers to employment.[34]

Many families who are homeless have difficulty accessing education and training programs. Lack of transportation and access to phones, email, and a reliable mailing address are among the challenges. Additionally, some homeless shelters require residents to be on the premises during certain hours which may not coincide with the requirements of a training program or job. Lack of child care is another large barrier to entering a job training program; parents who are homeless often do not have a reliable place to leave their children during the day. Families experiencing homelessness often have limited access to technology which impedes searching for, applying for, and maintaining employment. Additionally, the Workforce Investment Act (WIA) holds states, communities, and service providers accountable for performance measures, such as success rates in placing people in jobs and improving earnings. This may discourage them from reaching out to hard to serve populations who may need more supports to find employment.[35]

Success in school and being a part of the workforce begin early. Early education for children under the age of 5 who are homeless is essential. Over 50 percent of children living in federally-funded homeless shelters are under the age of 5. Infants, toddlers and preschoolers who are homeless are at grave risk of developmental delays due to a variety of physical and mental health factors such as a lack of prenatal and early health care, crowded and unsanitary living conditions, environmental contaminants like lead, and the trauma caused by severe poverty and instability. Tragically, these children also face unique barriers to enrolling and participating in early childhood programs. Common barriers include the following:

- Lack of Documents: Families experiencing homelessness often lack documents normally required for enrollment, such as health records and birth certificates, which may result in enrollment being delayed or denied.

[33] Retrieved January 15, 2015. http://nationalhomeless.org/advocacy/WIA_ReAuth-0709.pdf
[34] Retrieved January 20, 2015 http://www.nationalhomeless.org/factsheets/employment.html
[35] Retrieved January 15, 2015. http://www.familyhomelessness.org/media/367.pdf

- High Mobility: Families in homeless situations often are forced to move among temporary living situations. Shelters often limit a family's stay; parents move in search of employment; acquaintances may only be able to provide temporary shelter for a short period of time. Due to the instability of homelessness, families often leave the service area of early childhood programs before their children rise to the top of enrollment waiting lists.
- Transportation: Homeless families often do not have vehicles or funds to pay for transportation for their young children to attend preschool programs.
- Lack of Awareness: Early childhood programs often are not aware of the extent of family homelessness in their communities. Most homeless families stay in a variety of unstable situations, including staying temporarily with other people, or in a motel room. These largely hidden living arrangements make outreach and identification a challenge. In addition, homeless service providers often lack awareness of the unique needs of young children, and may not know how best to serve them.[36]

The cradle to career model focuses on improving outcomes through the continua of a child's academic life. It focuses on improving outcomes such as kindergarten readiness, early grade reading, middle grade math, high school graduation, post-secondary enrollment, and post-secondary degree completion.[37] Children under the age of 5 who are homeless are less likely to have preschool opportunities and because of this, their cradle to career outcomes are already impacted as they are less likely to be ready for kindergarten.[38] Intervening with families with young children could help prevent homelessness in the next generation.

Strategic Issue #5 Coordination of Primary and Behavioral Health

Higher incidence, prevalence, and acuity of medical and behavioral problems among people who are homeless requires the availability of comprehensive medical and behavioral health services. Limited access to mental health specialists, stigma associated with mental illness, and negative health outcomes related to undiagnosed or untreated behavioral disorders make it incumbent on primary care providers to address their patients' mental health needs.[39]

Medically fragile is defined as a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary. Many individuals who are medically fragile are accessing hospital services for primary care. Although their medical needs are not deemed acute enough to need more intensive care, they require long-term home care. An individual can be considered medically fragile if:

1. A physician specified that the patient is not suitable for a shelter based on medical condition.
2. There is a life threatening condition characterized by a reasonably frequent period of acute exacerbation, which requires frequent medical supervision, and/or physician consultation, and which in the absence of such supervision or consultation, would require hospitalization.

[36] Retrieved January 15, 2015. http://www.naehcy.org/educational-resources/early-childhood
[37] Retrieved January 15, 2015. http://www.strivetogether.org/cradle-career-network
[38] Retrieved January 15, 2015. http://www.icphusa.org/index.asp?page=16&report=117&pg=123
[39] Retrieved on January 20, 2015 http://www.nhchc.org/wp-content/uploads/2011/10/May2006HealingHands.pdf

3. The individual requires frequent time-consuming administration of specialized treatments, which are medically necessary.
4. The individual is dependent on medical technology such that without the technology, a reasonable level of health could not be maintained. Examples include but are not limited to intravenous therapy, wound care, enternal or parenteral nutrition support, feeding tube.[40]

In Integrating Primary and Behavioral Health Care for Homeless People, the following statistics were cited:

- Nearly 70 percent of all health care visits have primarily a psychosocial basis, and about 25 percent of all primary care recipients have a diagnosable mental disorder, most commonly anxiety and depression.
- Two thirds of homeless service users report an alcohol, drug, or mental health problem. These behavioral health disorders account for 69 percent of hospitalizations among homeless adults, compared with 10 percent of non-homeless adults.
- One-third of all patients with chronic illnesses, homeless or housed, have co-occurring depression. Major depression in patients with chronic medical illnesses amplifies physical symptoms, increases functional impairment, and interferes with self-care and adherence to medical treatment.
- Half of all care for common mental disorders is delivered in general medical settings. Many patients, particularly ethnic minorities, perceive primary care as less stigmatizing than the specialized mental health care.
- Half of mental disorders go undiagnosed in primary care. Primary care physicians vary in their ability to recognize, diagnose, and treat mental disorders.[41]

Traditionally, primary care, mental health care, and addictions treatment have been provided by different programs in various agencies scattered throughout the community. People who are homeless—particularly those with mental illnesses and co-occurring substance use disorders—have difficulty navigating these multiple service systems. Lack of time, training, experience, and resources makes fully integrated primary and behavioral health care difficult to accomplish in primary care settings. Referrals can also be problematic for indigent patients. There are a number of barriers to integrated care:

- Clinical barriers - There are different and often conflicting paradigms in “physical” versus “behavioral” health care and treatment of mental illness versus substance use disorders.
- Programmatic barriers - The pressures of a busy primary care practice leave clinicians little time to attend to each patient’s needs. Visits typically last 13 to 16 minutes and patients have an average of six problems to address with their provider. Lack of training for interdisciplinary care is also a significant barrier.
- Financial barriers - Funding interdisciplinary care is a significant hurdle to providing integrated services. There are few, if any, economic incentives for primary care and behavioral health care

[40] Definitions for Healthy Living. Clark County Social Service.
[41] Retrieved on January 20, 2015 http://www.nhchc.org/wp-content/uploads/2011/10/May2006HealingHands.pdf

providers to collaborate. Funding for mental health services is more restrictive than for general health care.[42]

Because of the number of barriers, the coordination of primary and behavioral health is an area of concern in Nevada.

Strategic Issue #6 Coordination of Data and Resources

A homeless management information system (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. HMIS can help provide a consistent and accurate snapshot of a region's homeless population, including a population count, information on service use, and a measurement of the effectiveness of homeless programs, as HMIS also helps track the number of chronically homeless clients and placements into permanent housing. This information can have important impacts on policy at the federal, state, and local levels.

Although HMIS is utilized by the three regional CoCs in Nevada, there is still a need for coordination of data and resources that are available to the homeless. In the Nevada Behavioral Health Gaps Analysis report, information gathered from key informant interviews and surveys indicated that data collection has not been uniform throughout or between complimentary systems, making data analysis challenging. In addition, insufficient service options was also identified as a gap. This includes lack of housing, care management, and wraparound services. State and local level programs provide services and resources to the same populations in silos, which proves the need for coordination. These data management programs do not communicate with HMIS nor with one another. While the possibility of migrating service providers to a common database system exists, there is little to no funding to provide incentives to providers. Additionally, the authority to require service providers to participate in a common system is another issue.

Currently, most communities have fragmented systems for determining what kind of assistance people will receive when they become homeless. Much depends on where a person initially seeks help, which programs have open slots, and the specific eligibility criteria of different programs. In addition, there are a number of efforts underway across the country and the state that can impact how resources are deployed. Identifying and tracking new resources or changes to resources is essential to ensuring interagency collaboration and coordination. Fragmentation leads to inefficiency, because people with the highest level of need do not necessarily get directed to the most intensive programs, or those programs end up with longer waiting lists. Recent national research has highlighted centralized intake as a key factor in the success of homelessness prevention and rapid re-housing programs (and many other kinds of homeless programs). Centralized intake can enhance the quality of client screening and assessment, and better target program assistance to where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.[43]

[42] Retrieved on January 15, 2015. http://www.nhchc.org/wp-content/uploads/2011/10/May2006HealingHands.pdf
[43] Retrieved on December 31, 2014.
https://www.hudexchange.info/resources/documents/hprp_centralizedintake.pdf

By improving data sharing and coordinating intervention efforts, mainstream systems are able to simultaneously reduce costs while improving client outcomes. The Nevada Governor's Interagency Council on Homelessness (NVICH) supports efforts to leverage data from multiple systems to develop effective interventions that prevent and end the cycle of homelessness and minimize the use of public services for the highest need, highest cost persons in Nevada.

Significant investments in HMIS, the Homeless Census, and other data gathering and reporting efforts provide an incredible resource for providers, policymakers, and planners in their efforts to draw from in their response to homelessness in Nevada. Data collected, however, is only valuable to the extent it is used to inform service delivery, policy making and strategic planning. Developing tools and strategies to better utilize data to drive decision-making helps ensure choices are made with the benefit of the best knowledge available.

Careful tracking of system performance and client outcomes enables more robust and effective planning and optimizes the use of limited public resources. Measuring progress is also crucial to making the case for future investment. Robust outcome tracking and performance measurement helps secure the financing and support necessary to expand the inventory of evidence-based interventions.

Coordinated Entry provides streamlined access to the homeless services system thereby allowing households facing housing loss to quickly access the services they need and for which they are eligible without having to call multiple social service programs. The process centers on streamlining access to homeless assistance services (such as prevention, rapid re-housing, shelter, and permanent supportive housing), screening applicants for eligibility for these and other programs using a consistent and well-coordinated approach, and assessing their needs to determine which interventions are the best fit.[44] While coordinated assessment has been identified as a solution to the coordination of data and resources, these programs are still in their pilot phases in the three regions of Nevada.

Strategic Issue #7 Policies

Partnerships and collaboration in communities cannot go the whole distance to end homelessness. In an era of strained public budgets across all layers of government, effective interagency coordination is required to make progress on ending homelessness. Leadership and improved cooperation at the state level is needed to streamline and target resources to achieve a shared goal of re-housing people and offering the right amount of the right type of interventions to keep people housed.

Increasingly, our state's capacity to access scarce federal dollars for housing assistance depends on its interagency strategies. An example is HUD's Section 811 disability housing demonstration. This program awarded new federal rental assistance to states that agreed to set up memoranda of understanding (MOUs) between their housing officials and Medicaid programs. Other initiatives provide opportunities to leverage federal and state programs, depending on states to drive policy priorities and coordination efforts. Examples are:

- Using Temporary Assistance for Needy Families (TANF) money to help poor homeless families find and keep permanent housing.[45]

[44] Retrieved January 15, 2015. http://usich.gov/usich_resources/solutions/explore/coordinated_entry
[45] "Making Effective Use of TANF," National Alliance to End Homelessness, 2013.

- Implementing Medicaid program changes to improve behavioral and physical health care delivery in supportive housing.[46]
- Training state personnel dedicated to Social Security determinations that benefit the most vulnerable homeless people. [47]

Policies that can impact homelessness include addressing discharge planning and practices from state institutions or systems including prisons, hospitals and foster care, strategically allocating resources to prevent and end homelessness, promoting the sharing of data to quantify the issue and unmet need and measure progress over time, removing barriers to securing housing because of past substance use or criminal record, ensuring coordination of services and supports across state agencies, promotion of livable wage for the community in which people reside, streamlining application processes for mainstream resources, and promoting prevention activities based on risk. Because of the impact it has on homelessness, policies are a key factor in successfully implementing the strategic plan.

Strategic Issue #8 Long Term Planning

Long Term Planning was identified as a strategic issue by the ICH. This issue area includes linking with the strategies of other regional strategic plans as well as sustainability planning for homeless programs.

Sufficient funding for homeless programs continues to be an ongoing issue. In December 2014, HUD programs held on to the increases in funding they received in 2013.The approved spending bill provides $2.135 billion for the McKinney-Vento Homeless Assistance Grants program. However, this is $271 million less than what was requested. While the amount will be sufficient for maintaining the CoC and Emergency Solutions Grant (ESG), funding McKinney-Vento at the higher level would have helped secure 37,000 rent subsidies necessary to meet the goal of ending chronic homelessness by the end of 2016.[48]

Nevada's homeless assistance resources are largely grant funded through the federal government. Changes in administrators and budget impact state resources. In Nevada, there are a number of grants that support housing, behavioral health and wraparound services that must be sustained in order for the system to remain intact. Understanding the costs and savings of different programs within the homelessness assistance system can be extremely illuminating and help drive change. Two key data points would be to:

- Know the per-person cost of every intervention and who bears the cost;
- Know how much every intervention saves and to whom the savings go.

Having this information can help the system utilize the most cost-effective interventions. It can also strengthen long-term planning to end homelessness by quantifying the needed resources. [49]

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[46] "Can Medicaid Reform Make a Difference for Homeless Individuals," National Alliance to End Homelessness, 2011.

[47] "SSI/SSDI Outreach, Access and Recovery (SOAR): An Overview," Substance Abuse and Mental Health Services Administration," accessed with additional resources at http://www.prainc.com/soar/.

[48] Retrieved on December 31, 2014. http://www.endhomelessness.org/blog/entry/what-does-the-1.1-trillion-spending-bill-mean-for-homeless-assistance-in-20#.VKRfdivF_hA

[49] Retrieved on January 20, 2015 http://www.endhomelessness.org/library/entry/hprp-opportunities-for-systems-transformation-and-sustainability

In terms of sustainability, Housing First is one strategy that is has been proven to yield a higher cost benefit than other program The Denver Housing First Collaborative is designed to provide comprehensive housing and supportive services to chronically homeless individuals with disabilities. Initial federal funding created the capacity to house and serve 100 chronically homeless individuals. The program uses a Housing First strategy combined with assertive community treatment (ACT) services, providing integrated health, mental health, substance treatment, and support services. Their cost benefit analysis demonstrated an average cost savings of $31,545 per person. If that were projected for the 150 chronically homeless individuals participating in their two programs, the total savings would amount to $4.7 million in addition to the improved quality of life as demonstrated by their participants.[50]

Currently, funding for housing in Nevada comes from a limited number of sources and it is only sufficient to maintain current projects. Nevada lacks the resources to sufficiently fund housing, wraparound, and other services to effectively prevent and end homelessness. Long term planning would ensure that Nevada has sufficient resources and is able to sustain them. Long term and sustainability planning is an ongoing process that will be continually evaluated and updated by the ICH.

[50] Retrieved January 15, 2015. http://www.denversroadhome.org/files/FinalDHFCCostStudy_1.pdf

Goals, Strategies and Objectives

This section lists all of the long-term goals (3 to 5 year statements of desired change) established by the ICH for the state. It will also identify specific strategies that will be pursued to achieve the goals and objectives and specific course of action.

State Councils are critical in aligning State and Local Plans with the four principal national goals as set forth in Opening Doors, the Federal Strategic Plan to End Homelessness. The national goals include:

1. Finish the job of ending chronic homelessness by 2016;
2. Prevent and end homelessness among Veterans by 2015;
3. Prevent and end homelessness for families, youth, and children by 2020;
4. Set a path to ending all types of homelessness.

The USICH recommends that state plans include:

- Develop measurable goals to end homelessness
- Set targets and measure results.
- Set numeric goals for permanent housing units made available for target homeless populations.
- Measure progress using the annual point-in-time data for the four population goals.
- Measure housing retention and how well homeless programs help their clients become employed and access mainstream programs.
- Create and coordinate statewide data collection and reporting system
- Assemble accurate fiscal and demographic information and research/data to support policy development and track outcomes
- Map out a state-wide production plan for permanent, supportive housing
- Coordinate goals and tasks of Balance of State Continuum of Care with local continuums
- Promote systems integration (e.g. health services and housing supports) to increase effectiveness and efficiency

The ICH has proposed the following goals and strategies by strategic issue area:

Strategic Issue #1 – Housing

Goal 1: Preserve the existing affordable housing stock.

Goal 1 Strategies	Lead	Resources	**Resources Needed**	Timing
1.1.1 Utilize the Housing Inventory Chart (HIC) data from the three CoCs to establish a housing stock baseline.		Nevada Housing Search and three CoCs Section 42 properties		

	Goal 1 Strategies	Lead	Resources	**Resources Needed**	Timing
1.1.2	Evaluate and identify a system-wide analytic and projections tool for the state.	Nevada Housing Division – lead entity while also engaging the three CoCs and local housing authorities	Southern Nevada CoC Monitoring working group	Data personnel Contract or cooperative agreement through the CoCs for data analysis	
1.1.3	Conduct a capacity analysis assessment and compare results to the baseline to identify gaps.		CoC Coordinated Entry Data	Housing Authority project based vouchers	

Goal 2: Provide the resources necessary to further expand and develop the inventory by 2020.

	Goal 2 Strategies	Lead	Resources	Resources Needed	Timing
1.2.1	Based on the results of the capacity analysis assessment, identify the need for specific housing types and sources of funding to develop the inventory.				
1.2.2	Improve access to federally-funded housing assistance, including rental subsidies, by eliminating administrative barriers and encouraging prioritization of people experiencing or most at risk of homelessness.	Department of Business and Industry	Housing Authorities, CDBG, and HOME	Additional project-based vouchers, CDBG, HOME	
1.2.3	Identify resources to develop a coordinated entry report in HMIS to be	HMIS Lead			

Goal 2 Strategies	Lead	Resources	Resources Needed	Timing
submitted annually to the Council.				

Strategic Issue #2 – Homelessness Prevention and Intervention

Goal 1: Increase construction of new or rehabilitated housing in all communities.

Goal 1 Strategies	Lead	Resources	Resources Needed	Timing
2.1.1 Advocate for the construction of new or rehabilitated housing in all communities.	CoCs, Housing Authorities, State, Housing Division, and Jurisdictions that receive CDBG and HOME funding	Senate Bill 340	Funding Developers Local Planning Offices	Ongoing

Goal 2: Coordinate housing programs and agencies to provide housing prevention and diversion services, including mediation opportunities, for individuals and families who are at-risk of being evicted.

Goal 2 Strategies	Lead	Resources	Resources Needed	Timing
2.3.1 Develop coordinated access to prevention and diversion housing services.	Local CoCs and ESG recipients	Coordinated Intake Leadership Teams	Identified local point person and identified state point person	
2.3.2 Increase funding opportunities to support access to prevention and diversion housing services.	Local CoCs and ESG recipients			
2.3.3 Increase the number of homeless providers who are able to act as intermediaries between the landlord and tenant	Local CoCs and ESG recipients	Nevada Housing Division Training CoC Teams		

Goal 2 Strategies	Lead	Resources	Resources Needed	Timing
through training by 25 percent annually.				
2.3.4 Provide cash assistance to individuals and families who are at-risk of eviction to cover rent, mortgage, or utility arrears.	Nevada Housing Division and county social service administrator agencies	LIHTF program (utilize as a model)	Funding pool from State, set aside, or other allocations Expansion of TANF Public/private involvement	July 1, 2016 - June 30, 2019

Goal 3: Public and private partners who provide services to prevent and end homelessness will coordinate policy to ensure that barriers are eliminated and goals of the strategic plan are achieved.

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
2.3.1 Identify and contact all agencies who provide services to prevent and end homelessness to coordinate policy priorities.	ICH	ICH Leadership SNV CoC	Lead staff person	
2.3.2 Provide training and technical assistance on homeless policy to public and private partners to ensure barriers are eliminated.	ICH		Training by a subject matter expert. Technical assistance to be provided by a Statewide Homeless Coordinator or equivalent.	July 1, 2016 - June 30, 2018
2.3.3 Research and implement initiatives such as using Temporary Assistance for	ICH, Leadership from three CoC's, DWSS		Ad-hoc working group	

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
Needy Families (TANF) money to help prevent or end homelessness by 2018.				
2.3.4 Implement Medicaid program changes by 2017 to improve behavioral and physical health care delivery in supportive housing.	ICH		Secure legislative approval and Medicaid authority Working group to oversee all Medicaid program changes	
2.3.5 Provide four (4) training(s) annually to state personnel dedicated to Social Security determinations that benefit the most vulnerable people.	ICH Statewide SOAR Coordinator	Covered by CABHI grant (exception of travel costs for extra trainings)	Training resources, staff time, etc. Increase travel budget for travel to conduct the extra trainings	

Goal 3: Rapidly rehouse people who fall out of housing.

Goal 3 Strategies	Lead	Resources	Resources Needed	Timing
2.3.1 Expand funding statewide to support community-specific rapid rehousing program.	ICH	LIHTF program		
2.3.2 Standardize a prioritization and referral process for rapid rehousing by 2017.	Three CoCs			

Goal 3 Strategies	Lead	Resources	Resources Needed	Timing
2.3.3 Integrate rapid rehousing into centralized/coordinated intake.	Three CoCs			

Goal 4: Break the cycle of incarceration that leads to disrupted families, limited economic prospects and poverty, increased homelessness or at risk of homelessness, and more criminal activity.

Goal 3 Strategies	Lead	Resources	Needed Resources	Timing
2.4.1 Collaborate with the AG's Office to identify alternatives to prison sentences for low-risk offenders, inconsistent or unfair sentencing policies that may unduly burden certain target populations and advocate policy changes.	Attorney General's Office	Statewide Re-entry Task Force	Identification of Best Practices	July 1, 2015 - June 30, 2018
2.4.2 Identify and assess the effectiveness of different community reentry programs and expand programs at the community level, including streamlining of employment barriers and expansion of opportunities for those who have been discharged.	Department of Corrections	Statewide Re-entry Task Force	Lead staff person to compile information	July 1, 2015 - June 30, 2018

Goal 5: The strategic plan document is re-assessed and updated at least every five years to prevent and end homelessness.

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
2.5.1 Develop an annual work plan that identifies strategies and goals to be achieved during that one year timeframe.	ICH	USICH Regional Coordinator	ICH Staff time to help coordinate	

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
2.5.2 At the end of four years, reconvene the Strategic Planning Subcommittee to re-assess and update the strategic plan document.	ICH		ICH Staff time to help coordinate	July 1, 2015 - June 30, 2019

Goal 6: Public outreach and education is conducted to create awareness to remove the stigma around homelessness.

Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
2.6.1 Develop information materials by the end of 2017 and conduct training quarterly on community resources for those who are at-risk or are homeless.	ICH	Expand on MPBT that the SNV CoC hold monthly SNV CoC is developing public awareness campaign, utilize to expand efforts statewide	Lead staff person to compile information and facilitate trainings	
2.6.2 Develop a public awareness campaign about homelessness to implement statewide by 2018. a. Engage business and community leaders in public awareness campaign.	ICH	SNV CoC is developing public awareness campaign, expand efforts statewide	Coordination of PA message and resources to market the issue	

Strategic Issue #3 – Wraparound Services

Goal 1: Increase access to all funding (federal, foundations, grants, private) for which Nevada may be eligible.

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
3.1.1 Advocate to Medicaid to	DHHS with program deputy/DHCFP/DWWS	Habilitative services under	Secure legislative funding and	July 1, 2015 -

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
expand habilitative services through 1915(i) funds.		waiver authorities in Medicaid; existing knowledge of programs; 1915(c) in state budget; 1915(i) written into state plan	approval, Medicaid authority including federal approval, and new service system development (MMIS provider enrollment, billing codes and claims payment system) including provider training	June 30, 2018
3.1.2 Research expanding Targeted Case Management (TCM) billing to benefit all PSH Medicaid providers.	DHHS with program deputy/DHCFP/DWWS		Secure legislative funding and approval, Medicaid authority including federal approval, and new service system development (MMIS provider enrollment, billing codes and claims payment system) including provider training	
3.1.3 Secure funding for 75 additional case managers statewide to provide wraparound services according to need and provide training to community-based providers to implement ICM and obtain reimbursement for provided habilitative services.	DHHS with program deputy/DHCFP/DWWS DPBH/Medicaid		Secure legislative funding and approval, Medicaid authority including federal approval, and new service system development (MMIS provider enrollment, billing codes and claims payment system) including provider training	July 1, 2016 - June 30, 2018

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
3.1.4 Develop sustainability plans for all sources of new funding.	DHHS with program deputy/DHCFP/DWWS		Secure continued Legislative budget authority for state funded programs. Identify other sources/processes for continued funding if State funding not an option.	July 1, 2017 - June 30, 2019

Goal 2: Each homeless or at risk of homeless individual has a person-centered care plan, developed through appropriate credentialed personnel, that meets their medical and social needs.

Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
3.2.1 Coordinate and provide two (2) training opportunities quarterly (eight annually) for personnel in southern, northern, and rural Nevada who are not appropriately credentialed.	DHCFP, ADSD	Statewide SOAR Coordinator, Licensing Boards		
3.2.2 Upon intake, personnel develop a person-centered care plan for each homeless or at risk of homeless individual.	DHCFP, ADSD	Statewide SOAR Coordinator, Licensing Boards		

Goal 2: Close the gap between available and needed appropriate credentialed health professionals statewide.

Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
7.2.1 Work with universities in the state to recruit and train licensed professionals.	DHHS/ICH	UNLV/UNR School of Social Work (Michele Fuller-Hallauer is a	Lead staff person who understands the needs and act as	

Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
		part-time instructor for UNLV)	educator and liaison to the universities	
7.2.2 Remove licensure barriers so that out of state licensed professionals are offered reciprocity when moving to Nevada.	DHHS/ICH	Work with licensing agencies to review and revise policies regarding reciprocity	Secure legislative approval Lead staff person to facilitate discussions and track outcomes	
7.2.3 Increase the number of appropriate credentialed health personnel statewide by 10 percent annually by providing training opportunities and incentives annually/quarterly.	DHHS/ICH, Licensing entities		Lead staff person to facilitate discussions and track outcomes	July 1, 2017 - June 30, 2019
7.2.4 Conduct outreach to all agencies to ensure health professionals are aware of training opportunities and incentives to become credentialed by 2017.	DHHS/ICH	Nevada Homeless Alliance distribution list, Mainstream Programs Basic Training (MPBT) distribution lists for SNV	Centralized data base to post all training opportunities, Public awareness	

Strategic Issue #4 – Education and Workforce Development

Goal 1: Expand economic opportunities (through initiatives such as workforce development, education opportunities, and job skills training) for those who are at-risk or are homeless to achieve self-sufficiency through a living wage.

Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
4.1.1 Collaborate with economic recovery and jobs programs to enroll 500 at-risk or homeless adults in workforce or technical	DETR (working with DWSS and veterans services)/ Workforce	Case managers (homeless providers) partnering with WIOA Implementation	Reporting mechanism to the ICH Point person to follow	July 1, 2015 - June 30, 2017

STRATEGIC PLAN					
	Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
	training programs annually statewide.	Investment Board	Planning team and local Job Connect	progress and convene meetings if necessary	
4.1.2	Work with the Department of Veterans Affairs and Veterans Resource Centers to provide opportunities for work and support recovery for veterans with barriers to employment, especially veterans returning from active duty, veterans with disabilities, and veterans in permanent supportive housing.	DETR (working with DWSS and veterans services)/ Workforce Investment Board	WIOA Implementation Planning team	Identified local person to convene an ad-hoc working group to develop collaborative protocols	July 1, 2015 - June 30, 2017
4.1.3	Improve coordination and integration of employment programs with homelessness assistance programs, victim assistance programs, and housing and permanent supportive housing programs.	DETR (working with DWSS and veterans services)/ Workforce Investment Board	Case management at provider level, WIOA Implementation Planning team	Point person to convene meetings, track progress and act as liaison if necessary.	July 1, 2016 - June 30, 2019
4.1.4	Collaborate with the Nevada Workforce Investment Board (WIB) to support and ensure coordination of goals and strategies of their strategic plan and the NVICH strategic plan.	DETR (working with DWSS and veterans services)/ Workforce Investment Board	WIOA Implementation Planning team		July 1, 2016 - June 30, 2018

Goal 2: Increase access to education for people experiencing or most at risk of homelessness.

	Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
4.2.1	Identify at-risk or homeless children and coordinate with the local school district to enroll 100 percent of those children in school annually.	Department of Education, statewide management team, and local school superintendents CoC providers, CoC leads	Title One HOPE Youth meetings (SNV), Washoe County School District Children in Transition (CIT) Office, other school district CIT programs, Southern Nevada Regional Planning Commission (Youth Planning Group), the Nevada Partnership for Homeless Youth, UNR Head Start Office and regional Head Start Offices		July 1, 2015 - June 30, 2016
4.2.2	Identify at-risk or homeless children ages 0-5 and coordinate with early childhood programs and child service providers to enroll 100 percent of those children in early childhood programs annually.	Department of Education, statewide management team, and local school superintendents CoC providers, CoC leads	Nevada Early Childhood Advisory Council		July 1, 2015 - June 30, 2016
4.2.3	Identify at-risk or homeless individuals and coordinate with providers to provide opportunities for enrollment in classes or obtaining a General Educational Development (GED) degree for 100 percent of those individuals annually.	Department of Education, statewide management team, and local school superintendents CoC providers, CoC leads	Title I HOPE staff, Washoe County School District Children in Transition (CIT) Office, other school district CIT programs, Southern Nevada Regional Planning Commission		July 1, 2015 - June 30, 2017

Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
		(Youth Planning Group), the Nevada Partnership for Homeless Youth, UNR Head Start Office and regional Head Start Offices		

Goal 3: Determine eligibility and apply for all mainstream programs and services to reduce people's financial vulnerability to homelessness.

Goal 3 Strategies		Lead	Resources	Needed Resources	Timing
4.3.1	Identify gaps in wraparound services e.g., behavioral health, life skills, education, financial literacy, basic needs, transportation.	DHHS with program coordinator/DPBH		Ad-hoc working group	July 1, 2015 - June 30, 2016
4.3.2	Provide comprehensive case management training for all case managers statewide to include SOAR/SSI/SSDI/TANF/SNAP annually.	DHHS with program coordinator/DPBH State SOAR Coordinator	Standardized Case management training in development through SNV CoC	Lead to coordinate and lead ad-hoc groups	July 1, 2016 - June 30, 2019
4.3.3	Link to state workforce development efforts to create financial stability opportunities for at risk and homeless individuals.	DHHS with program coordinator/DPBH	SNV COC working with jurisdictions to provide supportive work opportunities; Opportunity Alliance of Nevada; WIOA Implementation Planning team		July 1, 2015 - June 30, 2017

Goal 4: Improve access to high quality financial information, education, and counseling.

	Goal 4 Strategies	Lead	Resources	Needed Resources	Timing
4.4.1	Identify ten (10) community or statewide organizations annually and assist them with implementing evidence-based programs to increase individual's financial capabilities.	Opportunity Alliance Nevada Local United Way	WIOA Implementation Planning team	Creation of Evidence Based Practices Capacity Building Academy	July 1, 2015 - June 30, 2017
4.4.2	Evaluate and research existing programs quarterly for emerging or evidence-based practices to implement statewide.	Opportunity Alliance Nevada	Lincy Institute		July 1, 2015 - June 30, 2020
4.5.1	Create menu of safe, affordable product and services for employers, service providers and employees.	Opportunity Alliance Nevada	WIOA Implementation Planning team	Coordination between ICH and Opportunity Alliance	July 1, 2015 - June 30, 2017

Strategic Issue #5 – Coordination of Primary and Behavioral Health

Goal 1: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.

	Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
5.1.1	Link housing providers with health and behavioral health care providers to co-locate and/or coordinate health, behavioral health, safety, and wellness services to create better resources for providers connecting patients to housing resources by 2018.	DPBH and Medicaid working with the CoCs	Governor's Council on Behavioral Health and Wellness	Federally approvable Medicaid model for existing programs or new programs developed under Strategy 5.1.3	July 1, 2015 - June 30, 2017

	Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
5.1.2	Provide services in the homes of people who have experienced homelessness including using Medicaid-funded Assertive Community Treatment Teams for those with behavioral health needs by 2018.	DPBH and Medicaid working with the CoCs	Training as to services currently available and any gaps that need improvement	Legislative approval for identified gaps	July 1, 2015 - June 30, 2017
5.1.3	Support and evaluate the effectiveness of a "medical home" model to provide integrated care for medical and behavioral health, and to improve health and reduce health care costs in communities with the largest number of people experiencing homelessness by 2019.	DPBH and Medicaid working with the CoCs		Comprehension of current case management systems, and the medical home model to determine what systems provide and which are best to utilize. Secure budget authority and federal approval for new system development.	July 1, 2015 - June 30, 2018
5.1.4	Support medical respite programs in southern and northern Nevada to allow hospitals to discharge people experiencing homelessness with complex health needs to medical respite programs that will help them transition to supportive housing by 2019.	DPBH and Medicaid working with the CoCs		Secure federal and legislative approval	July 1, 2015 - June 30, 2018
5.1.5	Increase availability of behavioral health services by 15% in southern,	DPBH and Medicaid		Qualified providers and	July 1, 2015 - June 30, 2017

	Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
	northern and rural Nevada, including community mental health centers, to people experiencing or at risk of homelessness.	working with the CoCs		provision of education Changes to Medicaid plan, and legislative approval	
5.1.6	Engage 100 formerly homeless individuals statewide to provide peer navigator support in their local communities to at-risk or homeless individuals.	ICH		Coordination of and funding to provide "Navigator" services.	July 1, 2016 - June 30, 2018

Goal 2: Increase health and housing stability for people experiencing homelessness who have frequent contact with hospitals and criminal justice.

	Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
5.2.1	Improve discharge planning from hospitals, VA medical centers, psychiatric facilities, jails, and prisons to connect people to housing, health and behavioral health support, income and work supports, and health coverage prior to discharge so that no one is discharged to the streets.	ICH (DBPH, DOC, and VA), Affordable Housing providers	Frequent Users of Public Programs (FUSE) Project through CCSS grant (if awarded)	Identification of housing resources to house individuals being discharged	July 1, 2015 - June 30, 2017
5.2.2	Ensure systems are in place to identify people experiencing homelessness who are most likely to end up in an emergency room, hospital, jail, or prison, and connect them to the housing and support they	ICH (DBPH, DOC, and VA)	Frequent Users of Public Programs (FUSE) Project through CCSS grant (if awarded)	Identification of housing resources to house individuals	July 1, 2015 - June 30, 2017

	Goal 2 Strategies	Lead	Resources	Needed Resources	Timing
	need to reduce admission to the above institutions.				
5.2.3	Collaborate with the Governor's Council on Behavioral Health and Wellness to implement the Super User Project by 2017.	ICH (DBPH, DOC, and VA)	Frequent Users of Public Programs (FUSE) Project through CCSS grant (if awarded)		July 1, 2015 - June 30, 2016

Strategic Issue #6 – Coordination of Data and Resources

Goal 1: The system is integrated, streamlined, promotes data sharing and is captured consistently in HMIS.

	Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
6.1.1	Work with Bitfocus to develop standards that permit data inter-operability between data systems while protecting the confidentiality of all individuals by 2019.	DHHS coordinating with program coordinators of DPBH, Medicaid, DWSS, DCFS	Data Integration work through Homebase and SNV CoC		July 1, 2016 - June 30, 2018
6.1.2	Create a common data standard and uniform performance measures across all targeted and mainstream federal programs by 2019.	DHHS coordinating with program coordinators of DPBH, Medicaid, DWSS, DCFS	Data Integration work through Homebase and SNV CoC		July 1, 2016 - June 30, 2018
6.1.3	Establish an oversight subcommittee that meets quarterly to review data and report to the NVICH.	DHHS coordinating with program coordinators of DPBH, Medicaid, DWSS, DCFS		NVICH Staff time to coordinate quarterly meetings	July 1, 2016 - June 30, 2017
6.1.4	Revise NVICH policies based on results of oversight subcommittee.	DHHS coordinating with program coordinators of			July 1, 2017 - June 30, 2020

STRATEGIC PLAN				
Goal 1 Strategies	Lead	Resources	Needed Resources	Timing
	DPBH, Medicaid, DWSS, DCFS			

Goal 2: Implement centralized/coordinated intake assessment and access for all housing programs throughout the state for the homeless or those at risk of homelessness.

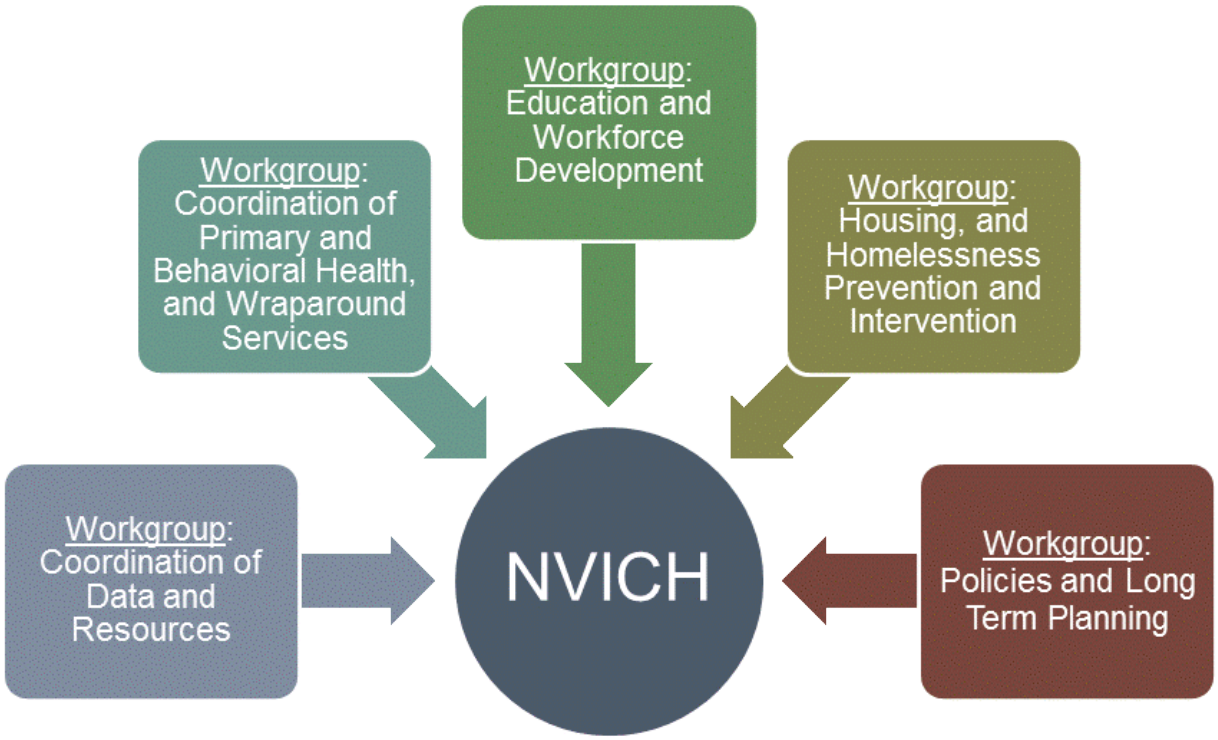
Goal 2 Strategies		Lead	Resources	Needed Resources	Timing
6.2.1	Implement a statewide housing and vulnerability assessment tool by 2016 and provide training quarterly on its utilization.	Three CoCs working with Mike McMahon at DPBH and BitFocus	SNV Coordinated Intake Change Advisory Team for lessons learned	NVICH Staff time to coordinate quarterly meetings	July 1, 2015 - June 30, 2016
6.2.2	Utilize the results of the statewide housing and vulnerability assessment tool to create a prioritized list.	Three CoCs working with Mike McMahon at DPBH and BitFocus	SNV Coordinated Intake Change Advisory Team for lessons learned		July 1, 2016 - June 30, 2017
6.2.3	The statewide HMIS working group evaluates the prioritization process by providing real-time reporting on housing utilization, retention rates, placements, and performance measures, and reports to state oversight, HMIS Steering Committee, and CoCs	HMIS Steering Committee	Performance measures as developed by CoC's measuring through HMIS HMIS Housing and vulnerability assessment tool		July 1, 2016 - June 30, 2017
6.2.4	Secure MOAs to participate in centralized/coordinated intake and establish policies for all community providers to utilize centralized/coordinated intake by 2018.	Three CoCs working with Mike McMahon at DPBH and BitFocus			July 1, 2015 - June 30, 2017

Goal 3: Regularly identify options to coordinate resources.

	Goal 3 Strategies	Lead	Resources	Needed Resources	Timing
6.3.1	Identify other parts of the service delivery system at the local, state, and federal level that could impact the plan.	NVICH	NVICH	NVICH staff time	Annually
6.3.2	Regularly identify and communicate emerging issues, trends and resources related to preventing and ending homelessness or that address strategic issues of the plan to the full NVICH	NVICH	NVICH	NVICH staff time	Annually

Evaluating and Updating the Plan

The strategic plan is intended to be used as both a management and communication tool for action. It is intended to be a living document that guides the work of the NVICH. To implement the plan, the NVICH will establish Committees to complete the strategies within each goal area. Each Committee will include a Chair and Vice-Chair made up of members of the NVICH. Each of the Committees will be responsible for tracking and reporting progress. Five workgroups will be established and report back to the NVICH. They include:



Per the Executive Order, the strategic plan will be reviewed in its entirety at annually to remove strategies that have been accomplished or that no longer apply and to update the plan, revising timing and adding strategies that are identified as necessary to achieve the mission of the ICH, "lead Nevada's efforts to prevent and end homelessness."

Glossary

Behavioral Health: as a discipline refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrists, psychologists, neurologists and physicians. A behavioral health disorder is a condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that is mediated by the brain and associated with distress and/or impaired functioning.[51]

Chronic Homelessness: a chronically homeless individual is someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.

Cooperative Agreements to Benefit Homeless Individuals-States (CABHI-States): the Substance Abuse and Mental Health Services Administration program to enhance or develop the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services; permanent housing; peer supports; and other critical services for the following: veterans who experience homelessness or chronic homelessness, and other individuals (non-veterans) who experience chronic homelessness

Department of Health and Human Services: The Nevada Department of Health and Human Services (DHHS) promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. The Department is the largest in state government comprised of five Divisions along with additional programs and offices overseen by the DHHS's Director's Office. The Department's Interim Director, Richard Whitley, was appointed by Governor Brian Sandoval and manages nearly one-third of the state's budget.

Department of Employment, Training and Rehabilitation: The Nevada Department of Employment, Training & Rehabilitation (DETR) consists of divisions that offer assistance in job training and placement, vocational rehabilitation, workplace discrimination and in collecting and analyzing workforce and economic data. Many of these services are provided through DETR's partnership with the Nevada JobConnect system.

Department of Education: The Nevada Department of Education (NDE)'s mission is to improve student achievement and educator effectiveness by ensuring opportunities, facilitating learning, and promoting excellence. The NDE oversees three divisions: the Business and Support Services Division, the Educator Effectiveness and Family Engagement Division, and the Student Achievement Division.

Division of Public and Behavioral Health: Formerly the Nevada State Health Division, the Nevada Division of Public and Behavioral Health (DPBH) was created due to the passage of Assembly Bill 488, which merged mental health and public health. Developmental Services was consolidated into the Division of Aging and Disability Services. Division operations consist of community health services, administrative services, clinical services, and regulatory and planning services.

[51] Retrieved on March 9, 2015 at http://www.businessgrouphealth.org/pub/f3139c4c-2354-d714-512d-355c09ddcbc4.

Homeless: as defined by HUD in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (P.L. 111-22, Section 1003) includes:

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- An individual or family who will imminently lose their housing [as evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days, having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause]; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing; and
- Unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who have experienced a long-term period without living independently in permanent housing, have experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

Mainstream resources: Mainstream resources are federal and state benefit service programs that offer a wide range of supports to meet basic needs, such as housing, employment, income, child care, food, health, and mental health. To use these programs, people must qualify based on criteria, such as income, disability, and family composition. Medicaid and Temporary Assistance for Needy Families (TANF) are the two largest mainstream programs that can help homeless individuals. Other examples of mainstream programs important to homeless individuals and families include nutrition programs like the Supplemental Nutrition Assistance Program (SNAP), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), health and mental health programs (Community Health Centers and Medicare), Supplemental Security Income (SSI), employment supports from Workforce Investment Act programs, and housing subsidy programs (public housing and Housing Choice Vouchers).[52]

[52] Retrieved February 17, 2015 at http://www.familyhomelessness.org/media/363.pdf.

Nevada's Interagency Council on Homelessness: established via Executive Order 2013-20 to coordinate and focus the State's efforts to effectively address the challenge of homelessness in the State of Nevada. The Council provides the opportunity for Nevada to engage in an integrated approach regarding the issue of homelessness and promote interagency cooperation. The Council works to increase the awareness of homeless issues among state and local government agencies and local organizations that provide services to people who are homeless.

Social Security Disability Insurance (SSDI): SSDI pays benefits to individuals and certain members of the individual's family if they are insured (meaning they have worked long enough and paid Social Security taxes).

Supplemental Security Income (SSI): the SSI program pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. People who have worked long enough may also be able to receive Social Security disability or retirement benefits as well as SSI.

Temporary Assistance for Needy Families (TANF): the TANF program is designed to help needy families achieve self-sufficiency. States receive block grants to design and operate programs that accomplish one of the purposes of the TANF program.

Transition Age Youth: transition age youth are those individuals between the ages of 18 to 24. They are also referred to as "youth in transition."

Unaccompanied Youth: HUD defines unaccompanied youth as any person under the age of 18 who receives homeless services or are counted as unsheltered who are not with their legal guardian(s).

References

Realty Trac LLC. (n.d.). *Nevada Foreclosures*. Retrieved July 23, 2014, from Realty Trac: http://www.realtytrac.com/mapsearch/nevada-foreclosures.html

Social Science Data Analysis Network (SSDAN). (2000). *CensusScope.* Retrieved April 11, 2014, from States Ranked by Rate of Poulation Growth, 1990 to 2000: http://www.censusscope.org/us/rank_popl_growth.html

The Nevada State Demographer's Office. (2013, October 1). *Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections: 2000 to 2032.* Retrieved April 15, 2014, from http://nvdemography.org/wp-content/uploads/2013/10/Nevada-Summary-Workbook-ASRHO-Estimates-and-Projections-2000-to-2032.pdf

United States Census Bureau. (n.d.). *Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States*. Retrieved April 16, 2014, from U.S. Census Bureau: http://www.census.gov/did/www/saipe/index.html

United States Department of Labor. (2014, June). *Local Area Unemployment Statistics Map.* Retrieved July 23, 2014, from Bureau of Labor Statistics: http://data.bls.gov/