# Strategic Plan

## for Preventing and Ending Homelessness in Summit County

**August 2025**

Summit County Continuum of Care

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## Summit County Continuum of Care

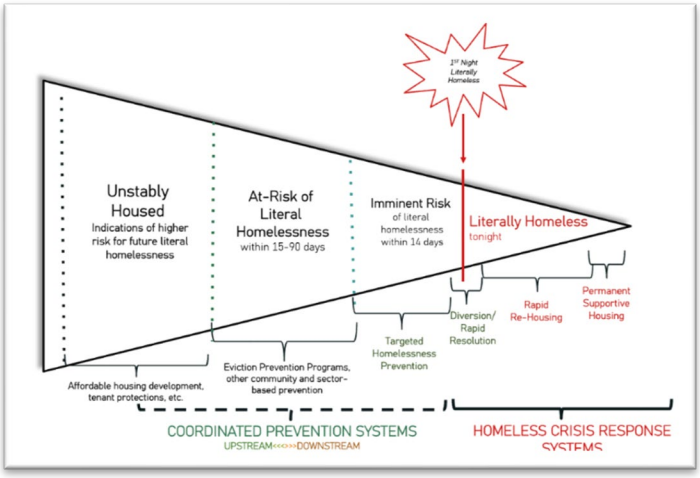
The Summit County Continuum of Care (SCCoC) is a group made up of people who have experienced homelessness, community advocates, government agencies, and organizations that help people without homes. This group works together to support people facing housing crises.

A Board of Directors leads the SCCoC. The board includes people who were chosen or elected to serve. Their job is to make sure the SCCoC follows its mission and all important rules and laws. The board can also create special teams or committees to work on different projects and tasks.

# Introduction

Summit County is facing serious housing problems. More than one out of three households spend too much of their income on housing, and 16% spend more than half just to keep a roof over their heads. During the COVID-19 pandemic, the community worked hard to help, giving out $63 million in emergency rent and utility support. But now that the help has ended, evictions are rising. More people are turning to local programs for help than our system can handle.

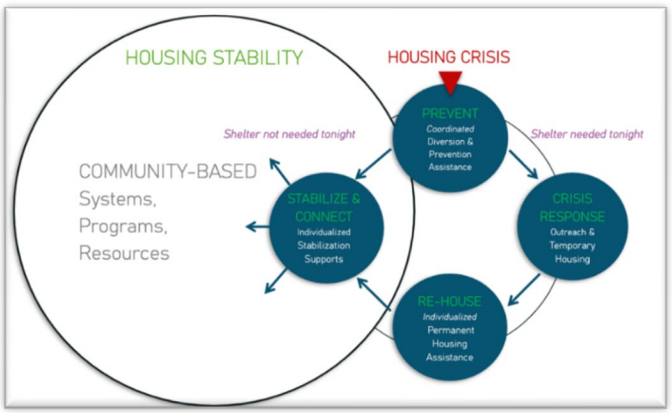
To respond, Summit County has created a new strategic plan to prevent and end homelessness. This plan outlines clear strategies to help people before they lose housing, and to support them if they do. The plan recognizes that people face different levels of housing trouble—from being at risk of losing housing to living on the streets—and we need different kinds of help for each situation, as shown below.




### *What the Homelessness Response System Includes*

The system starts with targeted **Prevention,** including shelter "diversion". This means helping people stay housed and avoiding shelters altogether. If prevention doesn't work, people can then access **Crisis Response**—like emergency shelter, outreach teams, or short-term housing. Finally, the system provides **Rehousing** support to help people move into permanent housing and stay there.

The goal is to make sure that every part of this system—**Prevention**, **Crisis Response**, and **Rehousing**—is fully built, funded, and available to everyone who needs it, when they need it.



### *What This Plan Focuses On*

This plan reflects the shared goal of ending homelessness. It centers on fairness and collaboration in developing and further improving community services in three main areas -call ***service system elements***:

- **Prevention and Stabilization** – Bringing together community partners to expand help that keeps people from losing housing.
- **Crisis Response** – Adding more shelter space, lowering barriers to access, and expanding outreach to people living outside.
- **Rehousing** – Creating more permanent housing options and offering strong support to help people stay housed.

The plan also includes important system-wide supports—called ***backbone elements***—like good coordination, strong leadership, and partnerships with landlords to find more available housing.

### *What We Hope to Achieve*

By working together, we aim to:

- Prevent more people from becoming homeless
- Help people find and keep housing faster
- Make sure services are fair and work well for everyone
- Build a stronger system that meets the needs of our whole community

### *A Call to Action*

Putting this plan into action will take hard work, new funding, and support from the entire community—including local leaders, service providers, landlords, healthcare workers, and residents with lived experience. Housing market changes and funding cuts are outside our control, but we can still move forward by working together.

This plan is our roadmap for change. With collective effort, we can prevent and reduce homelessness in Summit County and make sure everyone has a safe, stable place to live.

# Current Conditions

## Housing and Homelessness in Summit County

This section gives a summary of the current housing situation in Summit County and how the community is helping people facing a housing crisis. For more details, including a closer look at fairness and feedback from local residents, see the companion report ***Summit County Landscape & Equity Analysis***, located at https://summitcoc.org/strategic-planning/.

### *Housing Problems and Trends*

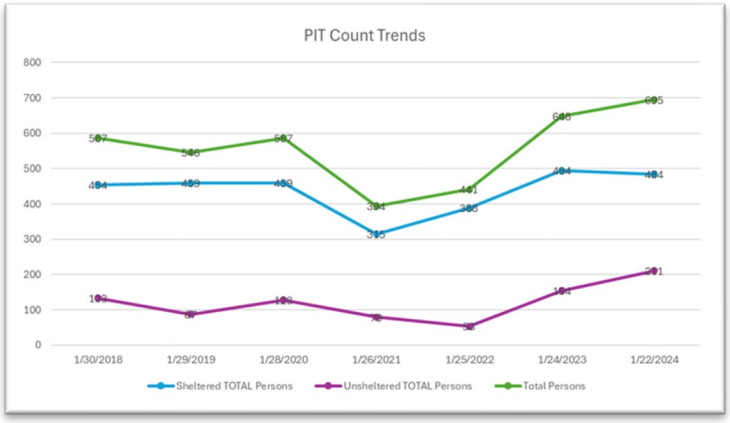
Summit County, Ohio has a population of about 535,733 people as of 2023. The number of people living in the county has gone down slightly since 2008. Housing has become more expensive and harder to afford. Since 2018, rent for a two-bedroom apartment has gone up by 26%. About 1 in 3 households now spend more than 30% of their income on housing, which is considered too much. Renters have it even harder—

while the average renter makes about $17 per hour, they would need to make nearly $20 an hour to afford a typical two-bedroom apartment.

Even worse, 16% of households are paying more than half of their income just to keep a roof over their heads. During the COVID-19 pandemic, the county gave out $63 million in emergency rental help to keep people housed. But those funds are now gone, and evictions have been rising. More people are now at risk of losing their housing.

### *Trends in Homelessness*

In 2023, more than 3,500 people—including adults and children—used homeless services in Summit County. This includes help from street outreach teams, emergency shelters, and housing programs. That's about 0.66% of the county's population. A count in January 2024 found 695 people experiencing homelessness—an increase of 56% since 2022 and 18% since 2018.



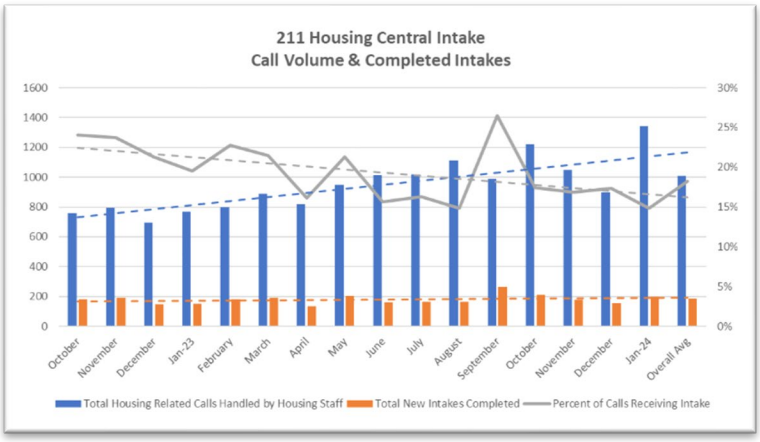

More people are living outside or in places not meant for living. The number of unsheltered people went up 59%, and the number of people who are chronically homeless—meaning they've been homeless a long time or have serious health needs—rose by 196%. About 62% of these chronically homeless people are living without shelter.

Black residents are hit especially hard. Though they make up only 14% of the county's population, they make up 49% of people experiencing homelessness. The number of older adults and people with disabilities who are homeless is also going up.

## The Homeless Response System

Summit County has a system to help people who are homeless or at risk of becoming homeless. This system is designed to act fast and help people find safe housing. The "front door" to the system is run by United Way through the 211 Housing Assistance Crisis Line. People who call 211 can talk to trained staff who figure out what kind of help they need and connect them to services like rental assistance, shelters, and housing programs.

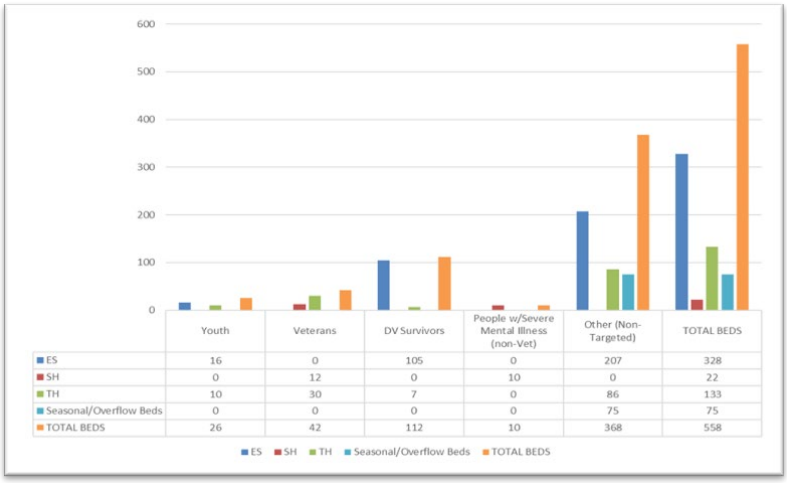
In 2023, the 211 line helped 3,525 people. Calls to the hotline increased by 50% compared to the year before. That's a big sign that more people are struggling to find or keep housing.

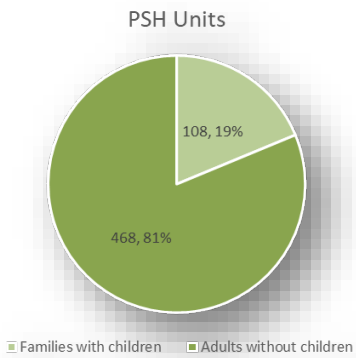



At the same time, there hasn't been much growth in shelter or temporary housing options. Most of the available shelters are in the city of Akron. Since 2018, shelter space has only grown by 3%, mostly due to extra

beds added in the winter months. There hasn't been much growth in rapid rehousing services either—this is help that quickly moves people from homelessness into stable housing.

Supportive housing for people with disabilities who have experienced long-term homelessness has increased by 27% since 2018. But with only 576 units as of early 2024, it's still not enough to meet the growing need, especially for single adults.




## Homeless System Performance

From 2018 to 2023, Summit County's homeless system has faced some serious challenges. Here are a few key signs of concern:

### *People Are Staying in Shelter Longer*

The average time people spend in emergency shelters, safe havens, or transitional housing has gone up a lot. This means beds aren't turning over as quickly, so fewer people can get help, and more are left without shelter.

- In 2018, the average stay was 58 days. In 2023, it was 78 days—a 34% increase.
- The median stay (the middle number) went from 18 to 29 days—a 61% increase.

### *Fewer People Are Moving Into Permanent Housing*

Fewer people are successfully leaving the homeless system and moving into stable homes:

- In 2023, only 26% of people in shelters or housing programs moved into permanent housing, compared to 31% in 2018.
- For people helped by street outreach, the number who got into housing or shelter dropped from 41% in 2018 to just 22% in 2023.

### *Fewer People Are Coming Back After Being Housed*

The good news is that fewer people are returning to homelessness after being housed:

- In 2023, 20% of people returned to homelessness within 2 years, down from 27% in 2018.
- Return rates were even lower for those helped by street outreach (13%) and those in rapid rehousing or permanent supportive housing (14%).

# Community Experiences

About 250 people from the Summit County community took part in interviews and group discussions between June and September 2024 to help shape this plan. Participants included many people who have experienced homelessness and housing insecurity who shared their stories and ideas about how to better help people who are struggling with housing. Some of their main points are shared below. For more details, see the companion report, ***Summit County Landscape & Equity Analysis*** located at https://summitcoc.org/strategic-planning/.

## Challenges People Are Facing

### *Housing Costs and Affordability*

- Rent keeps going up, and there aren't enough affordable places to live.
- Low wages and not enough job training make it harder for people to stay housed.

### *Gaps in Services and Poor Coordination*

- Some groups—like people with criminal records, mental health needs, single moms, and young people on their own—face extra challenges getting help.
- Services like housing, healthcare, and mental health aren't well connected. This makes it hard and confusing for people to get the help they need.
- Inadequate public transportation makes it harder for people to get to shelters or other services.

### *Not Enough Resources or Staff*

- More people are becoming homeless, but there isn't enough shelters or affordable housing.
- Experts said about 300 more housing units are needed for people who have been homeless for a long time. These people also need extra support like help with jobs and mental health.
- Workers in this field are often stressed, overworked, and not given enough training, which makes it harder to help everyone well.

### *Groups That Need Special Support*

- **Families**: Single parents need more help with childcare and finding work.
- **LGBTQ+ Youth**: There aren't enough safe places or mental health services for these young people.
- **Seniors**: Older adults are increasingly at risk, but there aren't enough programs focused on them.
- **People with Mental Health or Substance Use Issues**: There aren't enough trained workers or specialized places to meet their needs.

### *System Problems*

- **Police and Housing Help**: Some people don't trust the police, which can keep them from getting the help they need. Unpaid legal issues, like warrants, also block access to housing.
- **After Housing Help Ends**: People often don't get enough follow-up support—like mental health services or help with finding work—which puts them at risk of becoming homeless again.

### *What the Community Says We Need*

Participants shared clear ideas for improving the system, such as:

- Grow prevention programs so people don't become homeless in the first place
- Make services easier to access and better connected
- Train workers in trauma-informed care to better help people with past trauma
- Focus on helping those most at risk, like people with disabilities, youth, and families

# Strategic Framework

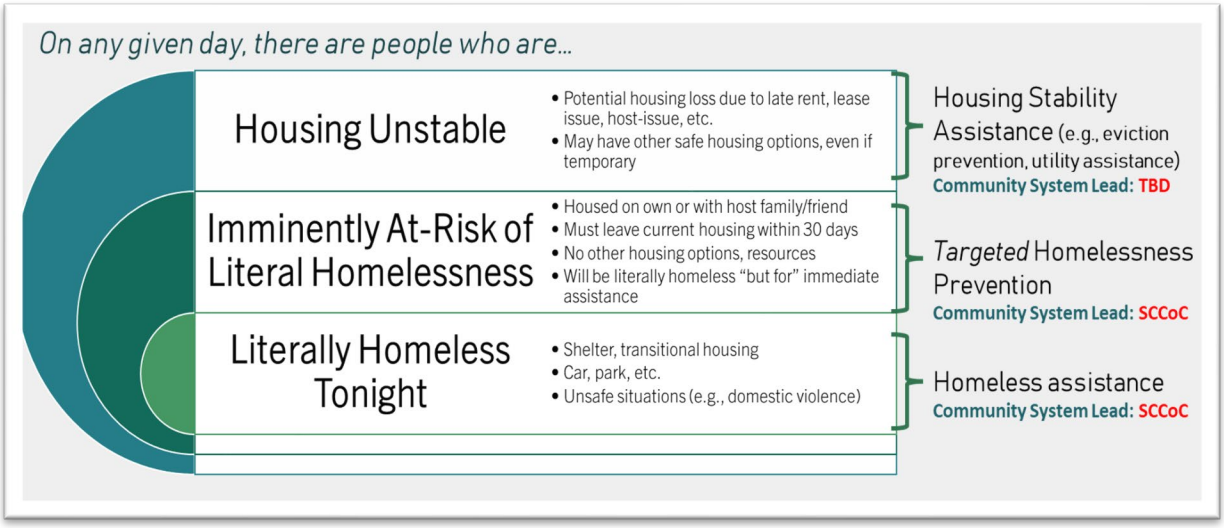
The plan was created through a series of planning meetings with local partners. It's meant to guide how Summit County helps people who are homeless or at risk of becoming homeless. This plan includes our shared **Vision**, **Guiding Principles**, and **Mission**—plus big-picture goals for the three main parts of the system: **Prevention & Stabilization**, **Crisis Response**, and **Rehousing**. These goals help point the way for what we want to achieve over the next year. You can find more about who helped create the plan in Appendix B.

The main goal of this framework is to give the community a clear plan and specific steps to stop homelessness or solve it quickly when it happens. The framework will stay the same over time, but the action plan will be flexible and updated as things change—like new challenges, more resources, or different needs. Recent federal actions are a particular concern and the community continues to monitor what changes or challenges those may present.

### *What We're Responsible For*

Before creating the full plan, the planning team first figured out what parts of the work the Summit County Continuum of Care (SCCoC) would lead and what parts would need help from other groups and the broader community.

The team decided that the SCCoC is responsible for helping people who are already homeless or are just about to lose their housing. But for people who are struggling earlier on—before they are in a true housing crisis—other community partners will need to take the lead. The SCCoC doesn't have the staff or resources to manage those "upstream" efforts alone. These early prevention efforts need to be led by a broader group yet to be determined (TBD) that includes a broad cross-section of community partners, which is further explained in the action plan below.



## Vision

We developed our vision together during community planning sessions to ensure it reflected everyone's hopes and dreams for Summit County. Our **vision** is a statement about our big goal—what we hope to achieve for the people of Summit County, even if it takes time. This vision guides everything we do, including our mission, plans, and actions.

### VISION

*Summit County is a community committed to seeking an end to homelessness and to ensuring that everyone has safe, stable, affordable housing that enhances their quality of life, and the resources needed to maintain it.*

## Guiding Principles

**Guiding Principles** are the core values and beliefs that help shape our plans, decisions, and actions. They serve as the foundation for how we work together. The following Guiding Principles were created and agreed upon by community partners.

***We believe that…***

- *Equity is at the heart of all our efforts: we prioritize the voices and needs of marginalized and historically underserved communities, recognizing that neighbors with lived experience have important insights and expertise that are essential to lift up*
- *People experiencing a housing crisis have a right to assistance that is person-centered, rights-based, and honors the dignity and unique experiences of individuals and families. It must follow trauma-informed approaches and be provided equitability to reduce disparities and assure equitable access, services, and outcomes*
- *People experiencing homelessness have a right to low-barrier shelter and easy access to housing crisis assistance where they are living; communities within Summit County must collaborate to efficiently and effectively address critical housing needs*
- *Solving homelessness is the responsibility of every community in Summit County: collaboration is essential to bringing together community partners to prevent and end homelessness*
- *Housing is an essential foundation for personal, family, and community well-being, and everyone deserves decent, safe, and stable housing as a basic human right*
- *Homelessness is a public health crisis and housing insecurity is a community problem*
- *We must work concurrently on resolving homelessness and preventing homelessness, including addressing the root causes of homelessness*
- *Improvement and equity work must be driven by data, evidence-based practices, and ongoing feedback and direction from people using assistance*

## Mission

The **mission statement** for the SCCoC was updated during the planning process to better explain how we work together to reach our shared goals. The new mission reflects what we stand for as a group and matches the larger community vision. Community members helped shape the mission during in-person meetings, and the SCCoC Board reviewed, revised, and approved the final version.

### MISSION

*The mission of the Summit County Continuum of Care is to engage local organizations in a collaborative response to prevent and end homelessness for all individuals and families in Summit County.*

## System Performance Goals

The goals below show what the homeless help system is working toward. These goals match national efforts to make sure homelessness is prevented when possible—and when it does happen, it should be rare, short, and not happen again. The purpose of this plan is to improve how well the system works and how people feel when they ask for or get help. As we carry out the plan, the Summit County CoC will keep track of progress and report on how we're doing on the following goals:

- *Reduce the length of time people remain homeless*
- *Reduce the number of returns to homelessness within 6 to 12 months and within 2 years*
- *Reduce the number of people who become homeless for the first time*
- *Reduce the total number of people experiencing homelessness*
- *Increase successful placements in and retention of housing from street outreach*
- *Reduce racial and other inequities in homelessness, including inflow, length of time homeless, and housing placements*.

This plan will guide our efforts to further develop and improve our responses for people experiencing a housing emergency in a manner that will reduce the need for ***crisis*** responses.

# Year One Action Plan

Using the strategic framework, local data, and input from community experts, Summit County CoC partners created this **Year One Action Plan**. The plan includes strategies for three main service areas or elements — **Prevention & Stabilization**, **Crisis Response**, and **Rehousing**—along with important support areas called **System Backbone Elements**, which include **Governance & Management**, **Coordinated Entry**, and **Landlord Engagement**.

These parts work together to build a strong and organized system that follows clear standards and makes the best use of limited resources. Many of the strategies in this plan will need new partnerships and funding, and the SCCoC will keep pushing to get the support needed.

The Action Plan includes specific goals and steps for both services and backbone elements. Service strategies will be led by the SCCoC Steering Committee and workgroups. Backbone strategies will be carried out by SCCoC staff and board members as part of their role in managing and improving the system.

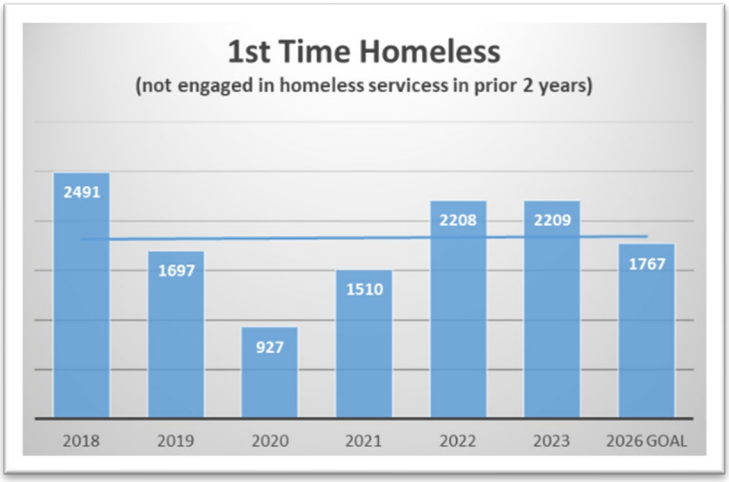
For a shorter version of this plan, see Appendix D: Year One Action Plan Summary.

# System Service Elements

## PREVENTION & STABILIZATION

**Goal: Prevent housing loss and homelessness and promote housing stability for Summit County residents.**

**Key Success Measure & Target: Reduce the number of people becoming literally homeless and needing homeless system assistance by 20% over 3 years (from 2,209 in FY2023 to 1,767 in FY2026).**



Summit County uses different strategies to help stop people from becoming homeless. One main way is by helping people solve housing problems early. These steps try to keep people out of shelters. Right now, there's not enough money or programs to meet the need because special COVID-19 funds have run out.

Currently, the main help for families with children comes from TANF/PRC funding, which is managed by United Way and Family & Community Services. These programs are only available for a short time (up to 3 months) and have strict rules. There isn't much tracking of who gets turned away.

School homeless liaisons and other school staff play an important role in spotting and helping students and families who may be losing their housing. Looking at education data alongside HMIS and other local data can give a fuller picture of housing instability and homelessness, helping the community act earlier to keep families housed.

Help for adults without children is very limited. Most of the funding goes to Veterans or others in special groups. Local funding from programs like the Emergency Food & Shelter Program are small and don't serve many people.

Summit County is working with healthcare groups (called MCOs) to find new ways to support housing help. These new partnerships are just starting, but more help is needed, especially for people who don't qualify for current programs.

### *Key Opportunities*

**Get Involved Earlier**

Summit County can do more to stop housing problems before they get worse. This includes pushing for more affordable housing and better renter protections.

**Work Together as a Community**

We need a shared plan where lots of local groups (like schools, courts, health clinics, and churches) work together to stop homelessness. Other cities like Columbus, Cincinnati, and Hartford, CT have shown this works.

**Make Help Easier to Get**

Some people don't qualify for help because of strict rules. If we offer case managers and flexible rental help, more people could stay housed. These services should work like rapid rehousing programs.

**Train Staff to Help Sooner**

We need to teach more staff across the community how to help people solve housing problems early. This includes using flexible emergency money, expanding programs that already work like the 211 line, and build more partnerships and coordination between sectors – like education staff and emergency financial assistance programs.

***Hamilton Co, Ohio – Coordinated Prevention & Predictive Targeting***

*In Hamilton Co, Ohio, the CoC is actively developing a coordinated approach to prevention to better target and assist residents who are at risk of housing loss and homelessness.The CoC is currently developing a "predictive" approach to identifying and assisting people who are at-risk before they require shelter diversion – similar to efforts already underway in Los Angeles and elsewhere. Shelter Diversion – Strategies to End Homelessness, Hamilton Co, Ohio*

**Help Available More Often**

Housing help should be available on evenings and weekends too, and in more places like schools, churches, or courts. We could also use technology—like apps or websites—to help people get services faster.

**Secure More Local Funding**

To do all this, Summit County needs more local money and partnerships. These will help us build a system that solves housing problems before they become crises.

## *Year 1 Priority Strategies & Implementation Steps*

### Strategy 1: Build a Community Prevention Team

1. Identify, engage and bring together partners by Fall 2025 to assume responsibility for 'upstream' coordination and development of prevention resources.

2. Create a shared understanding of what local residents need and how to help. Map out current prevention resources, including eligibility criteria, access/location information, etc.

### Strategy 2: Set Up Prevention Access Points Around the County**

1. Look at who is newly homeless and where they lived before to identify where to focus access and new partnerships.

2. Set up basic prevention screening, referral, and coordination protocols between programs, based on what they offer and with priority for households who with the most urgent housing crises and needs.

3. Use tools like Unite Us to connect people to services.[1]

4. Make sure staff have the right skills and competencies for emergency and urgency-care like housing assistance. Train staff to help with housing problems using field-tested approaches.[2]

5. Offer court-based help like legal aid and mediation, along with immediate connection to emergency assistance that can be quickly issued.

6. Share simple info with renters and landlords at all locations. Encourage landlords to refer tenants who are at-risk for assistance.

### Strategy 3: Make It Easier to Get Benefits and Income

1. Help people apply for disability benefits through SOAR.[3]

2. Teach staff how to help people get public benefits like SNAP and ensure all households are screened and connected to benefits they quality for.

3. Partner with healthcare providers to connect housing and health support, track benefits, and share updates with clients.

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[1] See: Home - Unite Summit County

[2] See: Housing Problem-Solving - HUD Exchange and Problem-Solving: An Innovative Approach to Addressing Homelessness | United States Interagency Council on Homelessness

[3] See: Home | SOAR Works!

## CRISIS RESPONSE

**Goal 1: Provide same-day access to shelter or temporary housing for people who need and want it that is comfortable (e.g., allows them to stay with their family/partner/pets, does not depend on participation in religious services), safe, and appropriate.**

**Goal 2: Provide comprehensive street outreach that ensures anyone who is unsheltered has to access shelter and housing assistance immediately where they are.**

**Key Success Measure/Target: Reduce the number of people experiencing unsheltered homelessness by 20% by January 2027 (compared with January 2025 PIT count).**

Crisis response services are a big part of solving homelessness. They help people get the support they need to feel safe and find stable housing. Right now, more people are living outside, and not everyone can get into a shelter. The 211 phone line is also overwhelmed, with many people calling repeatedly to check their status.

Some people face legal problems like open warrants, which make it harder to find housing. Outreach teams need training and support to help people with these challenges. When outreach teams are well-prepared and have the right tools, they can help people go straight from the streets to stable housing.

The main goal of crisis response is to get people into housing quickly while also giving them the services they need—like help with mental health or nursing care in shelters. This not only solves the short-term crisis but helps people stay housed in the long run.

There is a strong need for health care—both mental and physical—within shelters and short-term housing programs. This includes special services like medical care for people who are sick while homeless. Many people who are unsheltered have serious needs. In 2024, 62% of people who had been homeless for a long time were living in unsafe places like tents or cars.

To fix this, Summit County needs a ***stronger crisis response system that helps people get permanent housing faster***. While building this system, we also need safe shelter options and help with finding housing. More places should be available to help people get started on their housing journey.

***Dallas, Texas – Street to Housing***

*Dallas has made significant strides in reducing street homelessness through its **All Neighbors Coalition**. Collaborative efforts between the city, nonprofits, and private partners to help people move directly from the street to permanent housing has led to 24% reduction in unsheltered homelessness. Street to Home initiative successfully rehoused over 100 individuals experiencing chronic homelessness in downtown Dallas within 100 days, contributing to the Coalition's goal of reducing street homelessness by 50% by 2026*

We also need to more deeply examine barriers to shelter access and, overall, ensure faster access to services, ***so everyone has a fair chance to get help***. This work will need strong teamwork between Summit County, local cities, and community organizations.

### *Key Opportunities*

**Help More People Know About Services**

Many people still don't know they can call 211 to get help. We need outreach campaigns, clear messaging, and partnerships with local groups to spread the word. Helping people connect faster to services also means fewer repeat calls and less pressure on 211.

**Reach People Where They Are**
More staff and better coverage are needed for street outreach teams. These teams need to meet people in all areas of the county, like Barberton. Outreach should help people find housing fast, conduct regular "street-to-housing" surges, and offer shelter and individualized support while waiting.

**Link Health Services to Housing Help**
We should offer health services directly through street outreach, shelters, and housing programs. Using peer mentors and trained guides also helps people trust the system and get better care.

**Improve and Expand Shelter Options**
Shelters need to focus on moving people into housing quickly. Keeping a complete, updated list of people experiencing homelessness helps us do this. We also need more shelter options, especially for single men and couples, and in areas outside Akron, such as Barberton and Cuyahoga Falls. Shelter space should be available year-round, especially during colder months.

## *Year 1 Priority Strategies & Implementation Steps*

**Strategy 1: Make Sure Everyone Can Get Help, No Matter Where They Are**

1. Create a comprehensive coverage and coordination plan. Bring together local street outreach teams to create a map and schedule that covers the whole county.
2. Work with the community to create clear goals and messages that explain what street outreach is and how it helps people find housing.
3. Make sure outreach teams have enough trained staff, the right tools, and time to give each person the help they need.
4. Build new partners and increase access. Reach out to local community groups—like churches and other small organizations—especially in areas with fewer services.

**Strategy 2: Keep Track of Everyone Who Needs Help and What They Need**

1. Make sure the "by-name list" (a list of everyone experiencing homelessness) includes all people and families. Each person should have a clear plan and someone responsible for helping them find housing if they don't find it on their own.
2. Create rules and routines to keep this list updated with fresh information so that it stays accurate.

**Strategy 3: Add More Shelter and Transitional Housing for People Who Are Being Left Out**

1. Start a group to explore (dependent on funding) current and new shelter and housing options for people who don't fit well into the current system, such as:
    - People who need medical help
    - Youth and young adults
    - People leaving jail or prison
    - Women who don't qualify for domestic violence shelters
    - People who don't want to or are unable to stay in group shelters, particularly people who are disabled and need more "reasonable accommodation"

- People who aren't comfortable in shelters requiring participation in faith-based services, particularly for those with a different faith

2. Look closely at why people are leaving shelters without finding housing, especially based on race and other factors. Use that information to change shelter rules and improve support.
3. Give regular training to shelter staff so they are ready to help in the best ways. This includes training in trauma-informed care, housing problem-solving, and housing-focused support.
4. Make sure there are ways for people to get help with housing even if they don't want to stay in a shelter or transitional housing.

## REHOUSING

### Goal: Provide individualized, high-quality, holistic, and person-centered rehousing services to any individual or family experiencing homelessness who cannot otherwise regain housing on their own.

### Key Success Measure & Target: Increase system exits to permanent housing to at least 40% by FY2027 (ending 9/30/2027).

Both data and interviews with people experiencing homelessness in Summit County show one clear message: the most important way to reduce homelessness is to create more permanent housing for people who need it.

**Rapid Rehousing (RRH)** is one way Summit County helps people move quickly from homelessness into housing. There are 13 RRH programs that work together with the Akron Metropolitan Housing Authority (AMHA). These programs help different groups of people who are homeless. Since 2018, RRH for adults without children has grown, but help for families with kids has gone down. We still need to better understand the full capacity of these programs, but local providers say rising housing costs have eaten up most of the recent funding. That means even with more money, we haven't been able to help more people.

**Permanent Supportive Housing (PSH)** is housing for people who have disabilities and need long-term support. Right now, there are 24 PSH programs in Summit County with 784 beds. As of January 2024, 92% of these beds were in use. Since 2018, PSH has grown by 27%, adding 167 new beds—75 of those since 2023. But the number of people who need this kind of housing has gone up quickly—especially people who are aging or have disabilities. Since 2018, the number of people who are chronically homeless has gone up by 196% (+90 people). That means we need even more PSH to meet the growing need.

To make our system work at the scale needed, we also need more landlords to rent to people exiting homelessness. Building stronger relationships with landlords and making more rental units available is a key part of the solution. This work is also part of the system's support efforts and requires more investment and capacity.

In addition to more housing, we also need other services to help people move in and stay housed. This includes one-time financial help, legal aid, and other supports to remove the barriers that make it hard for people to find or keep housing.

### *Key Opportunities*

**Use Rapid Resolution and Flexible Funds**

Rapid resolution, also called housing problem-solving or diversion, helps people find quick solutions to their housing problems. It's used in prevention, but is also useful for people who are newly homeless or don't have major barriers. With a little support and flexible money for things like deposits or short-term stays, many people can avoid shelters and get back into housing quickly. Reducing the amount time people are in shelter helps open up beds for other people and reduces pressure on the homeless system.

**Expand Rapid Rehousing**

More people—including individuals and families who have been homeless for at least one week or have higher needs—should be able to access ***Rapid Rehousing (RRH)***. RRH offers short-term financial help and case managers who help people find and keep housing. It is a flexible intervention that can work well for many different people when run the right way.

**Improve Supportive Housing Transitions**

Some people in ***Permanent Supportive Housing (PSH)*** no longer need as much help. They should get "move-up" assistance to help them live more independently. This opens up space for others who need more support. There are also a growing number of people entering or continuing to reside in PSH who are older and need more care than PSH can offer, including higher levels of medical or mental health support.

**Create More Permanent Housing Options**

We need more types of housing for people moving out of homelessness. Strategies should be diverse, including building ***tiny homes***, expanding ***shared housing***, repurposing/reusing ***vacant and abandoned housing***, and ***setting aside units*** in HUD-funded housing for people experiencing homelessness. These options should be affordable and include support services.

***Tiny Homes – Austin, TX***

*Mobile Loaves & Fishes, a nonprofit in Austin, Texas, operates 550 "tiny homes" for people who were homeless with another ~1,300 planned for development. Most of the village's funding comes from private donations, though the government of Travis County, in which part of Austin lies, provided funds to help with the group's planned expansion.* *Tiny houses offer a healthy dose of community - Homes.com*

**Work More Closely with Healthcare and Senior Service Providers**

Healthcare and housing should work better together. When PSH and RRH programs partner with healthcare providers and senior services, residents get the care they need and are more likely to stay housed. Expanding these partnerships is essential to meeting the needs of residents.

**Improve Data for Veterans**

We need to make sure that Veteran housing programs like HUD-VASH are included in the system's main data tool (HMIS). This will help track and serve Veterans more effectively and ensure they're included in the real-time list of people who need help.

Together, these improvements will help close gaps in housing programs, serve more people, and lead to better outcomes for those who are most at risk.

## *Year 1 Priority Strategies & Implementation Steps*

**Strategy 1: Make Sure Everyone Has a Clear Path to Housing**

1. Create a rehousing working group that includes service providers, housing developers, people with lived experience, and advocates. This team will help build up housing options with an emphasis on filling critical gaps (e.g., additional PSH).

**Strategy 2: Build More Permanent Housing That Works for Everyone**

1. Keep adding more permanent supportive housing (PSH), especially for single adults and couples, based on the needs we learn from more data.
2. Create new types of permanent housing like Tiny Homes and make sure people experiencing homelessness are given priority in HUD-funded housing.
3. Secure funding to restart the successful Landlord Mitigation Program, which helps landlords by covering things like damages, missed rent, or holding fees. This makes landlords more willing to rent to people exiting homelessness.

***Risk Mitigation Funds for Landlords***

*Landlord guarantee or risk reduction funds are an added protection for landlords willing to rent to someone with limited income, a poor rental history, or a criminal history. Across the country, such funds help reduce real and perceived risks by covering excessive damages to the rental unit, lost rent, or legal fees beyond the security deposit. Reimbursement limits are typically set in advance.*
*Risk Mitigation Funds for Landlords - USICH*

4. Set up more master leasing programs, where an organization rents apartments and then helps people with leasing barriers live in them.
5. Offer local training and tools to support Shared Housing, where two or more people live together to make housing more affordable.

**Strategy 3: Provide Quality, Person-Centered Support for People Finding or Keeping Housing**

1. Improve services in PSH by using Peer Support—people with lived experience who can support others—during move-in and after.
2. Make sure all staff who work with clients are trained in Housing Problem-Solving and Housing-Focused Case Management. Offer regular training to keep skills strong and services focused on people's full needs.
3. Create a system to check the quality of services, including secret shoppers and feedback surveys from people using the programs. Use this input to make improvements.
4. Look at cases where people returned to homelessness—especially broken down by race or other groups—to understand what went wrong. Use this information to adjust support and services to prevent it from happening again.
5. Speed up help for people who don't want or can't stay in shelters, Safe Havens, or transitional housing. Make sure they still get support and help finding permanent housing.

# System Backbone Elements

## SYSTEM GOVERNANCE & MANAGEMENT

To solve housing problems, including homelessness, Summit County needs strong, fair, and effective services. The U.S. Department of Housing and Urban Development (HUD) requires local communities (called Continuums of Care or CoCs) to follow certain rules—like who can get services, how data is tracked, and how programs are run. But communities like Summit County can also go further by setting even better standards for all programs. These extra steps can make sure that the help people get is based on the best methods that really work.

It's also important to check how well programs and the whole system are working. This can be done by using dashboards to track key numbers (called Key Performance Indicators or KPIs) and by reviewing programs at least once a year. These reviews help make sure people are getting consistent care, no matter which organization is helping them.

To keep the system strong, staff need regular training. Key skills like helping people solve housing problems, finding housing quickly, and understanding how to guide people through the system must be taught and refreshed often. This kind of training costs money, so we'll need to look for extra funding, including from HUD or private donors.

As more people who are older or have health problems experience homelessness, we also need to work more closely with healthcare systems. This includes partnering with groups like Managed Care Organizations (MCOs) and creating plans to connect health and housing services. People should also be connected to other community supports they need to stay stable.

To make all this work, the CoC Board needs to be strong and active, with leadership from people who have lived through homelessness and with enough staff to manage training, planning, and funding decisions. When everyone—especially funders and service providers—works together, the whole system becomes easier to use, more focused on people's needs, and more cost-effective.

### *Year 1 Priority Strategies*

**Strategy 1: Update the CoC Governance Charter to make sure the leadership group includes:**

- People with lived experience of homelessness
- Funders and partners from different sectors
- Workgroups that focus on putting the Strategic Plan into action

**Strategy 2: Create clear service and performance standards for every type of program, including:**

- Prevention and diversion
- Street outreach
- Emergency shelter

***Sacramento CoC: Community Standards***

*Sacramento CoC created comprehensive Community Standards with providers and people with lived experience for all homelessness prevention and homeless assistance programs, assuring all programs operate according to evidence-based practices and shared standards. Community Standards - Sacramento CoC*

- Transitional housing
- Rapid rehousing
- Permanent supportive housing

***Additional Priority Strategies***

**Strategy 3: Set up a process to regularly check how programs and the system are performing**.

**Strategy 4: Figure out how many more staff and how much more money the CoC needs to keep training, improving services, and helping programs follow the rules.**

**Strategy 5: Find ways to attract and keep good workers. This might include better pay, benefits, and training.**

**Strategy 6: Bring together healthcare and other partners—like hospitals, the aging network, and behavioral health providers—to review data on older adults and people with disabilities who are homeless and determine next steps.**

## COORDINATED ENTRY

A strong **Coordinated Entry System (CES)** helps people who are homeless or about to lose their housing get connected to the right help—whether it's prevention, shelter, or long-term housing. When CES follows national rules and best practices from HUD, it makes the system work better for everyone. It helps people get the help they need faster and more fairly.

Across the country, communities are showing that using data and teamwork helps find and fix gaps in housing services. These systems work best when all local housing and homelessness programs take part in CES and use a shared data system called HMIS (Homeless Management Information System). This system keeps a real-time list (called a by-name list) of everyone who is homeless or at high risk. That list helps programs adjust and improve services quickly through regular check-ins and planning meetings.

***Grand Rapids, MI: Advancing Housing Solutions Through Coordinated Entry***

*Grand Rapids, Michigan used a human-centered design process to reimagine their coordinated entry system to ensure their system works for the users, resulting in a web-based application local residents can use to immediately access housing assistance. Advancing Housing Solutions Through CE - HUD Exchange Toolkit for Supporting Self-Service Data Entry within a CES – HUD Exchange*

A strong CES also uses a phased assessment approach. This means asking just enough questions at each step to figure out what someone needs—without making the process too long or uncomfortable. This makes sure people with the greatest needs get help first. It also includes survivors of domestic and intimate partner violence, who may need shelter or housing right away to stay safe. Because Summit County recently received new HUD funding to help people fleeing violence, there also is now more support to improve how survivors access housing and shelter quickly.

Summit County is also building stronger partnerships with healthcare providers and insurance plans (like Managed Care Organizations). These relationships are important because more people who are homeless

now have serious health needs. Connecting housing and healthcare services will make sure people get the care they need to stay safe and stable.

### *Year 1 Priority Strategies:*

**Strategy 1: Evaluate how the Coordinated Entry System (CES) works and compare it to HUD rules and national best practices; identify areas for improvement.**

**Strategy 2: Review the Homeless Management Information System (HMIS) to make sure it meets HUD rules and best practices; identify what parts of the system need to be improved.**

**Strategy 3: Improve the CES assessment process and build on recent updates to make sure the system collects only the information needed and at the right time to connect people to assistance.**

#### *Additional Priority Strategies*

**Strategy 4: Look closely at how CES works for different groups of people to make sure their unique needs are met, such as:**

- Survivors of domestic or intimate partner violence
- Youth
- Veterans
- Families with children
- People with disabilities
- Seniors

## LANDLORD ENGAGEMENT

Programs that help people connect with landlords and find rental units are very important in the fight against homelessness. These programs make it easier and faster for people in crisis to find housing. Staff work directly with landlords and property managers to find available homes and negotiate rental agreements. They often use special tools like holding fees (to reserve units) and risk funds (to cover things like damage or missed rent) to make landlords feel more comfortable renting to people who may have struggled in the past.

These efforts build trust with landlords and lead to more housing choices. Online tools like Padmission and Zillow's Housing Connector also help by showing available rental listings in real time. This helps case managers, housing staff, and clients find housing more quickly and prevents different programs from all contacting the same landlords.

Housing navigators are specially trained workers who help people find and move into housing. They work with clients, case managers, and health providers to figure out the best housing options. These navigators help guide people through the often confusing and expensive process of finding a home. Having more of these staff makes the system work better and faster for everyone. Housing navigators are also very helpful during large housing efforts, like moving people from a big camp into permanent homes. They can also support shared housing, where people live together to save on costs.

To make this system work well, Summit County needs a shared pool of flexible funds that staff can use to help people stay in or quickly get back into housing. This money can cover urgent needs like rent, utility payments, or deposits. This is especially important for people who are just days away from needing shelter and people who recently became homeless and just need some financial help to get back on their feet. Research shows that flexible funding is a proven, cost-effective way to stop or quickly end homelessness.

***Washington, DC: Flexible Funding to Obtain and Maintain Housing***

*In Washington, DC, flexible funding is used to help expedite housing placement and increase stabilization for single adults experiencing homelessness by providing funds that could cover small but critical expenses that are essential to obtain and maintain housing. Community Foundation Flex Fund Learnings*

Creating a successful landlord engagement and housing navigation program will take more resources. Other cities, like Austin, Texas and Columbus, Ohio, have used a mix of public and private funding to build strong systems. Summit County will likely need to do the same to fully support this important work.

## *Year 1 Priority Strategies:*

**Strategy 1: Create a job description and find funding to hire a system-level housing manager**.

**Strategy 2: Look into funding, adopt and expand use of housing software (like Padmission) to keep track of available rental units.**

**Strategy 3: Explore starting central housing navigation services or creating a standard training and certification program for housing navigators who help people find and keep housing.**

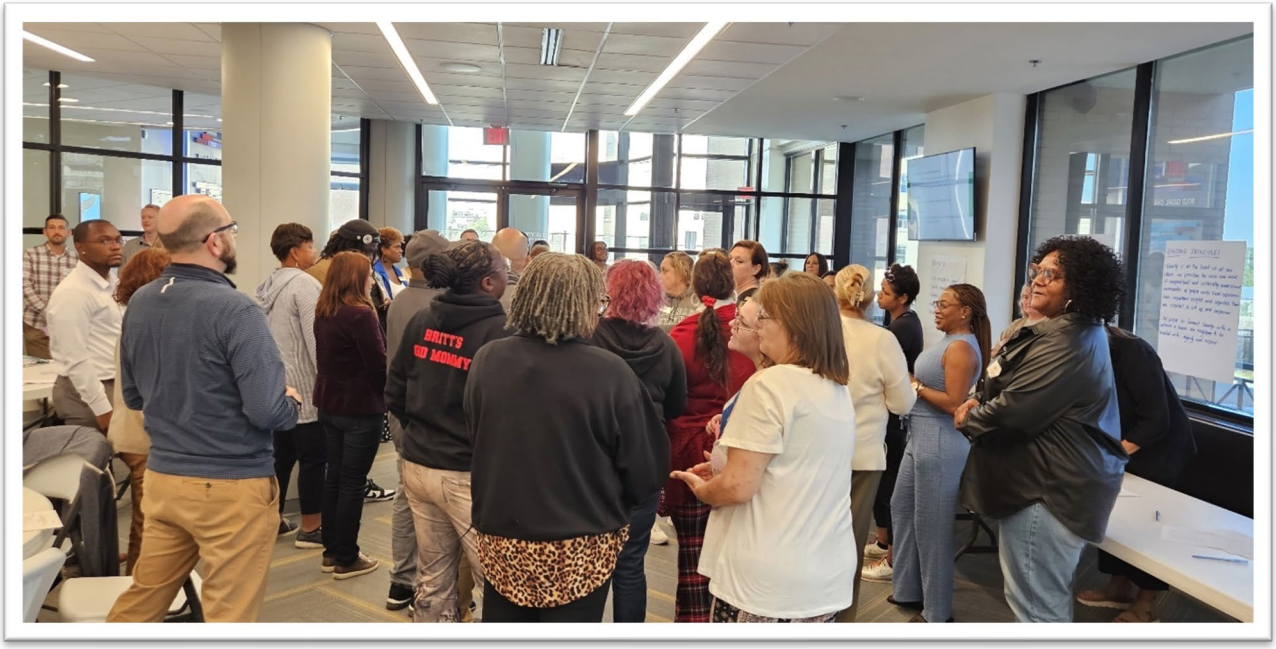
### *Additional Priority Strategy*

**Strategy 4: Find funding and build a system to manage flexible financial help for people who are at risk of becoming homeless or are already homeless.**

# Conclusion

This Framework and Strategic Plan for Summit County's Continuum of Care (CoC) shows our shared promise to end homelessness using proven strategies, strong teamwork, and a focus on fairness for everyone. By focusing on prevention, improving crisis response, and speeding up rehousing, while also strengthening the system that supports all of this work, our plan aims to build a system where homelessness is ***rare, short, and doesn't happen again***.

We know there will be challenges, but we also believe there are big opportunities to change lives and improve our community. By working together, using our resources wisely, and holding ourselves accountable, Summit County will continue to lead the way in finding real solutions to end homelessness.



## Acknowledgements

This plan was created through a detailed and inclusive process to better understand the needs of people in Summit County and to make sure everyone had a voice—especially people who have experienced homelessness. The goal was to create a strong foundation for working together to prevent, reduce, and eventually end homelessness.

Planning began in early 2024 with a Core Team made up of SCCoC board members and staff. Later in the year, a new committee was formed to include people with lived experience of homelessness, ensuring that those most affected were fully involved. With support from the City of Akron, Tom Albanese Consulting LLC was brought on to help guide the community engagement process, review local needs, and develop a strategy for both short- and long-term change.

We started with a Community Kickoff Meeting in August 2024 to share the goals and timeline of the project with SCCoC board members. After that, a Landscape Assessment was completed. This looked at local data and included interviews and listening sessions with people who were currently or recently homeless.

In October 2024, we held a large Community Planning Session. This in-person event brought together people from all parts of the community—people with lived experience, government officials, nonprofit providers, healthcare partners, and others. They reviewed the findings and helped shape the plan's core framework.

To help design real, useful solutions, three Work Groups were created during this session. Each focused on a key part of the system:

- **Prevention and Stabilization**
- **Crisis Response**
- **Rehousing**

These groups continued to meet through October and November to develop strategies and actions for the plan. Their work led to the comprehensive, community-based strategy outlined in this document.

### *Our Thanks*

This plan would not have been possible without the time, effort, and ideas shared by many individuals and organizations. We give special thanks to people with lived experience of homelessness, whose voices were central to shaping this plan.

We extend our deepest gratitude to the following individuals for generously sharing their time, insights, and expertise to inform the landscape analysis: Steve Arrington, Cindy Bach, Debbie Barry, Vanessa Beane, Fred Berry, Chris Brewer, Lerryn Campbell, Julie Carneal, Colleen Cicero, Jim Cole, Becky Cool, Deniese Cutting, Holly Cundiff, Tim Edgar, Anne Face, Erin Franz, Cassie Harhager, Michael Harhager, Jackie Hemsworth, Greta Johnson, Mayor William Judge, Amanda Kostura, Kyle Kutuchief, Annie McFadden, Melissa Massey-Flinn, Chris Miller, Abby Morgan, Georgann Mirgliotta, Jennifer Montisanto, Imokhai Okolo, Marie Payden, Tia Payne, Jesse Reed, Brian Rink, Annaliese Russell, Shannon Shippe, Keith Snodgrass, Margo Sommerville, Keith Stahl, Teresa Stafford, Cheryl Stephens, Toree Stokes, Peggy Szalay, Aimee Wade, and Susan Wong. Your valuable contributions have been instrumental in shaping this work, and we appreciate your dedication to strengthening our collective understanding and impact.

We also want to thank the Core Team for leading this work: Mar-quetta Boddie, Latoya Harris, Jackie Hemsworth, Joe Scalise, Tamala Skipper, and Helen Tomic

Thank you to the SCCoC staff for your support: Ron Hart, Shana Miller, Tae Miller, Jada Moore, and Mar-quetta Boddie

We also thank everyone who joined the planning process—members of the Summit County CoC, Summit County officials, the City of Akron, nonprofit partners, healthcare providers, and community advocates. Your dedication and hard work are what made this plan possible.

Special thanks to our consultant team who supported this process: Tom Albanese, LSW; K.O. Campbell; and Anna Bialik

Finally, we want to recognize the many people who shared their knowledge and experience to help create this plan. You can find the full list of contributors and more details about the planning process in **Appendix C**.

# Appendices

## Appendix A: Common Terms & Acronyms

**Chronically Homeless Individual** refers to an individual with a federally qualified disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless on those occasions is at least 12 months.

**Chronically Homeless People in Families** refers to people in families in which the head of household has a disability and has either been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless on those occasions is at least 12 months.

**Coordinated Entry (CE):** As defined by HUD, CE means a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. CE must include means to match people to shelter and housing resources for which they are eligible, as well as prioritize people based on an assessment of their needs and vulnerabilities when shelter, housing, or other needed assistance is limited and unable to assist everyone who is eligible and seeking assistance. HUD requires every CoC operate a Coordinated Entry process which must at minimum allocate all CoC Program funded housing resources.

**Continuum of Care (CoC)** is the local planning body responsible for coordinating the full range of homelessness services in the Sacramento region inclusive of the cities and unincorporated areas within Sacramento County.

**Continuum of Care Program** is the largest federal funding source for homeless assistance in communities, providing annual funding for permanent supportive housing, rapid rehousing, transitional housing, street outreach, and supportive services.

**Diversion Services** is the most targeted form of homelessness prevention and involves strategies and practices seeking to assist people to resolve their immediate housing crisis by accessing a safe and appropriate housing alternative versus entering emergency shelter or otherwise staying in a place not meant for human habitation that night.

**Emergency Shelter** provides safe, temporary housing for individuals and/or families who have no alternative safe housing options while they are supported in obtaining permanent housing or access to other appropriate assistance, such as treatment. Shelters serve people who have neither a safe home nor the means to obtain other safe permanent or temporary housing. Emergency shelters may serve specific populations (e.g., families with children, single adults, transition age youth), in congregate or non-congregate facilities, and do not require occupants to sign leases or occupancy agreements.

**Congregate Shelter** is an emergency shelter where the residents share a common sleeping area.

**Non-congregate Shelter** is an emergency shelter that provides private sleeping space, such as a hotel or motel room.

**Emergency Solutions Grants (ESG) Program** is an annual federal block grant provided to federally designated "entitlement communities" to fund homelessness prevention, street outreach, emergency shelter, and rapid rehousing.

**Fair Market Rent (FMR)** provides a standard for rent based on unit size for different geographic areas. These standards are often used as a limit for how much rent can be charged or supported in certain programs. FMRs are published in the Federal Register annually by HUD.

**"Harm Reduction"** means a set of strategies, policies, and practices aimed at mitigating the negative social and physical consequences associated with various human behaviors, including, but not limited to, substance use, and that do not rely on punitive measures to gain program compliance.

Homeless (HUD Definition):

Category 1: Literally Homeless. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Has a primary nighttime residence that is a public or private place not meant for human habitation;
- Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, TH, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
- Is exiting an institution where he/she has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2: Imminent Risk of Homelessness. An individual or family who will imminently lose their primary nighttime residence, if:

- Residence will be lost within 14 days of the date of application for homeless assistance;
- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Category 3: Homeless Under Other Federal Statutes. An unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who:

- Are defined as homeless under the other listed federal statutes;
- Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
- Have experienced persistent instability as measured by two moves or more in the preceding 60 days; and
- Can be expected to continue in such status for an extended period due to special needs or barriers.

Category 4: Fleeing/Attempting to Flee Domestic Violence. Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; and
- Lacks the resources or support networks to obtain other permanent housing.

**Homeless-Dedicated Housing** refers to any form of permanent housing or permanent housing subsidy that is formally designated to serve individuals or families experiencing homelessness.

**Homeless Management Information System (HMIS)** A computerized data collection system designed to capture client information over time on the characteristics, service needs, and accomplishments of homeless people. Implementation of an HMIS is required by the U.S. Department Housing and Urban Development (HUD) for programs receiving federal funding through the Continuum of Care (CoC) Program.

**Homeless Response System** refers to the various organizations and entities within an area that serve homeless individuals and families and their respective programs, services, and supports designed to respond to and resolve housing crises.

**Homelessness Prevention** programs assist people who are imminently at-risk of literal homelessness with housing problem solving, temporary financial assistance, information and referral to other resources, and time-limited housing stabilization assistance.

**Housing Choice Voucher Program (HCV)** is a federal rent subsidy program under section 8 of the US Housing Act, which issues vouchers to eligible households.

**Housing First** is an evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and that do not make housing contingent on participation in services.

**Housing Problem Solving** is a person-centered, housing-focused approach to explore creative, safe, and cost-effective solutions to quickly resolve a housing crisis — even if just temporarily — with limited or no financial support. Housing problem solving is not a one-time event and instead, problem-solving techniques can be used in many circumstances to support a more effective implementation of homelessness prevention, diversion, and rapid exit strategies.

**Programs** are services provided by a local social service, housing, healthcare, or other entity to meet the homelessness prevention or assistance needs of people in Summit County.

**Individual** refers to a person who is not part of a family with children during an episode of homelessness. Individuals may be homeless as single adults, unaccompanied youth, or in multiple-adult or multiple-child households.

**Other Permanent Housing** is housing with or without services that are specifically for people who formerly experienced homelessness but that do not require people to have a disability.

**People in Families with Children** are people who are experiencing homelessness as part of a household that has at least one adult (age 18 and older) and one child (under age 18).

**Permanent Supportive Housing (PSH)** include single site and scattered site rental housing with a permanent subsidy and supportive services for individuals and families who are homeless and have at least one household member with a federally qualified disabling condition. PSH programs include supportive services that are designed to meet the needs of the program participants.

**Point in Time (PIT) Count** is an annual count of people experiencing homelessness on a single night. Data are required to be reported to the U.S. Department of Housing and Urban Development. Summit County reports an annual shelter count and an every other year unsheltered count.

**Rapid Rehousing (RRH)** provides (directly and/or via service partnership) housing search and placement, time-limited financial assistance, and housing-focused case management for individuals and families who are literally homeless. RRH programs help households secure private rental market housing, where the lease is initially or eventually between the landlord and the program participant following conclusion of housing stabilization services. RRH assistance may be used as a bridge to or as a means to help people access other ongoing subsidized housing and services (e.g., permanent supportive housing). RRH assistance for eligible participants is typically limited to a specific number of months based on program funding sources.

**Street Outreach** programs offer mobile services to engage and assist unsheltered individuals and families experiencing homelessness within the CoC's geographic area, including those least likely to request assistance. Services typically include engagement, connection to emergency shelter, housing, critical/crisis services, basic needs support, and urgent, non-facility-based care.

**Sheltered Homelessness** refers to people who are staying in emergency shelters, transitional housing programs, or safe havens.

**Trauma-Informed Care** means a set of practices that promote safety, empowerment, and healing in recognition that program participants may have experienced trauma that informs their experiences and responses.

**Victim Service Providers (VSP)** are private nonprofit organizations whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. Providers include rape crisis centers, domestic violence shelters and transitional housing programs, and other programs.

**Transitional Housing Programs** provide temporary housing with supportive services to individuals and families experiencing homelessness with the goal of interim stability and support to successfully move to and maintain permanent housing. TH programs can cover housing costs and accompanying supportive services for program participants for up to 24 months.

**Unaccompanied Homeless Youth (under 18)** are people in households with only children who are not part of a family with children or accompanied by their parent or guardian during their episode of homelessness, and who are under the age of 18.

**Unaccompanied Homeless Youth (18-24)** are people in households without children who are not part of a family with children or accompanied by their parent or guardian during their episode of homelessness and who are between the ages of 18 and 24.

**Unsheltered Homelessness** refers to people whose primary nighttime location is a public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for people (for example, the streets, vehicles, or parks).

**Veteran** refers to any person who served on active duty in the armed forces of the United States. This includes Reserves and National Guard members who were called up to active duty.

## Common Acronyms

The following is a list of common acronyms used in this document. For definitions of specific terms used in this document, see Appendix A.

- AMI: Area Median Income
- CH: Chronically Homeless
- CoC: Continuum of Care

- CE: Coordinated Entry; CES: Coordinated Entry System
- DV: Domestic Violence
- ES: Emergency Shelter
- ESG: Emergency Solutions Grants Program (federal funding source)
- FMR: Fair Market Rent
- HP: Homelessness Prevention
- HMIS: Homeless Management Information System
- HQS: Housing Quality Inspection
- HUD: U.S. Department of Housing & Urban Development
- IPV: Intimate Partner Violence
- LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Ally, and Other Non-Heterosexual People
- PIT Count: Point-in-time count
- PSH: Permanent Supportive Housing
- RRH: Rapid Rehousing
- SOAR: SSI/SSDI Outreach, Access, and Recovery (SSI/SSDI application assistance program)
- SSDI: Social Security Disability Income
- SSI: Supplemental Security Income
- SSO: Supportive Services Only
- TAY: Transition Age Youth (18-24 years old)
- TH: Transitional Housing
- SCCoC: Summit County Continuum of Care
- VA: U.S. Department of Veterans Affairs
- VAWA: Federal Violence Against Women Act

## Appendix B: Participants in Interviews and Focus Groups

Steve Arrington

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Holly Cundiff

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Anne Face

Erin Franz

Cassie Harhager

Michael Harhager

Jackie Hemsworth

Greta Johnson

Mayor William Judge

Amanda Kostura

Kyle Kutuchief

Annie McFadden

Melissa Massey-Flinn

Chris Miller

Abby Morgan

Georgann Mirgliotta

Jennifer Montisanto

Imokhai Okolo

Marie Payden

Tia Payne

Jesse Reed

Brian Rink

Annaliese Russell

Shannon Shippe

Keith Snodgrass

Margo Sommerville

Keith Stahl

Teresa Stafford

Cheryl Stephens

Toree Stokes

Peggy Szalay

Aimee Wade

Susan Wong

# Appendix C: Planning Background and Process

The methodology for developing this plan involved several key steps to ensure alignment with local needs and to engage community members effectively.

**Establishment of a Core Team:** A Core Team of representatives was established to guide the planning process and ensure its rhythms and goals were responsive to local priorities. Although representatives with lived experience were requested for inclusion on the Core Team, this goal was not achieved.

**Community Kick-off:** To launch the work, a kick-off meeting was held for all community members to explain the purpose of the project and provide an overview of the proposed timeline. X number of members were involved, and we did X.

**Landscape Analysis:** The project incorporated a data-driven approach, starting with a review of various quantitative data sources. This was complemented by interviews and listening sessions with key groups and individuals to gather qualitative insights. As the work progressed, additional listening sessions were added to ensure comprehensive coverage of community perspectives.

**Community Planning Sessions:** Initially, the plan included two in-person meetings: one to establish the framework and another to finalize the strategic plan. However, due to timing constraints on the part of Summit County, these meetings were condensed into a single in-person planning session. To prepare for this consolidated meeting, a preparatory session was held in August. This involved the Core Team and CoC Board members, who participated in a planning meeting to review learnings from the landscape analysis and develop draft materials for community discussion.

The in-person planning meeting itself was designed to focus on building a strong base of local implementers by actively involving them in the decision-making process. This collaborative approach ensured that the resulting strategies were informed by those most directly involved in and affected by the work.

**Community-Driven Work Groups:** To further enhance the community's engagement and ownership of the project, three community-driven work groups were established, each focused on a critical aspect of the housing and homelessness response system: Prevention and Stabilization, Crisis Response, and Re-Housing. These work groups were composed of a diverse mix of stakeholders, including service providers, local government representatives, and community members with lived experience. Their purpose was to develop actionable strategies aligned with the broader goals of the initiative, ensuring that the resulting plans were both locally informed and actionable.

The **Prevention and Stabilization** work group concentrated on identifying upstream solutions to prevent individuals and families from experiencing homelessness. Their efforts included assessing the adequacy of existing prevention programs, identifying gaps, and recommending scalable interventions to promote housing stability.

The **Crisis Response** work group focused on improving immediate support systems for individuals and families facing housing emergencies. This group analyzed crisis response protocols, shelter utilization rates, and service accessibility to design a more responsive and coordinated crisis intervention network.

The **Re-Housing** work group centered their efforts on reducing the time households spent experiencing homelessness by streamlining pathways to permanent housing. They evaluated existing re-housing programs, proposed innovative solutions, and prioritized efforts to remove barriers to housing access.

Three regular meetings of these work groups were facilitated to encourage cross-sector collaboration and ensure alignment with the project's overarching goals. There was also a Work Group Round-up meeting, during which each work group team presented their draft plan to the larger community and received feedback to strengthen it. Each work group then revised and presented its findings and recommendations for goals, key milestones, and strategies. contributing to a comprehensive, community-driven strategic plan. This approach ensured that solutions reflect the unique needs and perspectives of the community while leveraging the collective expertise of those involved and preparing the larger community to drive implementation of the plan.

# Appendix D: Year One Action Plan Summary

## System Service Element: PREVENTION & STABILIZATION

**Goal:** Prevent housing loss and homelessness and promote housing stability for Summit County residents.

***System Performance Measures Impacted***

· *Reduce the number of people experiencing homelessness*
· *Reduce the number of people experience unsheltered homelessness*
· *Reduce the number of people who become homeless for the first time*
· *Reduce the number of persons who return to homelessness after housing placement*

**Key Measure/Target:** Reduce the number of people becoming literally homeless and needing homeless system assistance by 20% over 3 years (from 2,209 in FY2023 to 1,767 in FY2026).

| Priority Straegies & Implementation Steps | Lead | Timeframe | Est Cost Range |
|---|---|---|---|
| **Strategy 1: Establish county-wide homelessness prevention and stabilization coalition** | | | |
| 1. Convene community partners | SCCoC Board | Q1 Year 1 | $ |
| 2. Develop and document a shared understanding of the range of housing insecurity needs | Prevention WG | Q2 Year 1 | NA |
| **Strategy 2: Establish a coordinated, community-wide network of prevention access points with trained staff** | | | |
| 1. Examine characteristics of people who are "newly homeless" | Prevention WG | Q1 Year 1 | NA |
| 2. Inventory and assess existing prevention-related needs and resources | Prevention WG | Q1 Year 1 | $ |
| 3. Explore Unite Us as a platform for coordinated prevention service | United Way of Summit/ Medina | Q3 Year 1 | NA |
| 4. Develop and institutionalize Housing Problem Solving (housing crisis intervention) training | Prevention WG | Q2 Year 1 | $ |
| 5. Expand coordination among and services available at Summit County municipal courts | TBD | Q3 Year 1 | $$$ |
| 6. Develop and ensure broad access to educational materials for residents and property owners/managers | TBD | Q2 Year 1 | $ |
| **Strategy 3: Ensure universal, expedited access to assistance with obtaining income and benefits for people at-risk** | | | |
| 1. Expand access to disability benefits through expansion of SSI/SSDI Outreach, Access, and Recovery (SOAR) services | TBD | Q3 Year 1 | $$ |
| 2.Ensure prevention and homeless assistance staff are aware of and can help clients navigate public assistance benefits | SCCoC Staff | Ongoing | $ |
| 3. Continue to develop integrated approaches with Medicaid managed care organizations (MCOs), health systems, and other health care partners | SCCoC Staff | Ongoing | $ |

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| $ = Less than $10,000 |
| $$ = $10,000-100,000 |
| $$$ = 101,000-1,00,000 |
| $$$$ = >$1,000,000 |

## System Service Element: CRISIS RESPONSE

**Goal 1:** Provide same-day access to shelter or temporary housing for people who need and want it that is comfortable (e.g., allows them to stay with their family/partner/pets, does not depend on participation in religious services), safe, and appropriate.

**Goal 2:** Provide comprehensive street outreach that ensures anyone who is unsheltered has to access shelter and housing assistance immediately where they are.

***System Performance Measures Impacted***

*· Increase the number of people exiting homelessness into permanent housing*
*· Reduce the length of time people remain homeless*
*· Increase successful placements from street outreach*

**Key Measure/Target:** Reduce the number of people experiencing unsheltered homelessness by 20% by January 2027 (compared with January 2025 PIT count).

| Priority Straegies & Implementation Steps | Lead | Timeframe | Est Cost Range |
|---|---|---|---|
| **Strategy 1: Ensure that the homeless response system can be accessed by everyone experiencing literal homelessness** | | | |
| 1.Develop a map and schedule for street outreach coverage | Crisis Response WG | Q1 Year 1 | NA |
| 2. Co-create goals and messaging | Crisis Response WG | Q1 Year 1 | NA |
| 3. Ensure outreach has the staff capacity, training, tools, and resources to provide comprehensive and individualized (i.e., via low caseloads) system navigation | TBD | Ongoing | $$ |
| **Strategy 2: Ensure a comprehensive and coordinated understanding of all individuals experiencing homelessness** | | | |
| 1. Ensure existing by-name lists include everyone currently experiencing literal homelessness | SCCoC Board | Q2 Year 1 | NA |
| 2. Develop policies and protocols to ensure that HMIS data and corresponding by-name list stays up to date | SCCoC Board | Q2 Year 1 | NA |
| **Strategy 3: Increase emergency shelter and transitional housing options** | | | |
| 1. Establish a working group to develop a plan to create emergency shelter and transitional housing capacity | SCCoC Board | Q1 Year 1 | NA |
| 2. Review recent negative exits, disaggregated by race and other characteristics, from shelters | Crisis Response WG | Q2 Year 1 | NA |
| 3. Provide regular training for all shelter employees to ensure they can stay up-to-date on best practices | SCCoC Staff | Ongoing | $ |
| 4. Ensure there is swift connection directly to housing | TBD | Q2 Year 1 | $$ |

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| $$$ = 101,000-1,00,000 |
| $$$$ = >$1,000,000 |

## System Service Element: REHOUSING

**Goal:** Provide individualized, high-quality, holistic, and person-centered rehousing services to any individual or family experiencing homelessness who cannot otherwise regain housing on their own.

***System Performance Measures Impacted***

*· Reduce the number of people experiencing homelessness*
*· Reduce the number of people experiencing unsheltered homelessness*
*· Increase successful placements in and retention of housing from street outreach*
*· Reduce the length of time people remain homeless*

**Key Measure/Target:** Increase system exits to permanent housing to at least 40% by FY2027 (ending 9/30/20207).

| Priority Straegies & Implementation Steps | Lead | Timeframe | Est Cost Range |
|---|---|---|---|
| **Strategy 1: Examine and develop rehousing system and program elements to ensure all populations have a clearly defined rehousing pathway** | | | |
| 1. Convene multi-disciplinary rehousing workgroup | SCCoC Board | Q1 Year 1 | NA |
| **Strategy 2: Expand permanent housing options** | | | |
| 1. Continue to expand PSH capacity | SCCoC Board | Ongoing | $$$$ |
| 2. Develop additional dedicated permanent housing options, including Tiny Homes and other dedicated options | Rehousing WG, local CDCs and developers | Q1 Year 1 | $$ |
| 3. Fund and promote the existing Landlord Mitigation Program | XXXX | Q3 Year 1 | $$ |
| 4. Develop additional third-party (master) leasing to expand housing options | Rehousing WG | Q2 Year 1 | $$ |
| 5. Develop local guidance and training around Shared Housing options | Rehousing WG | Q3 Year 1 | NA |
| **Strategy 3: Provide quality, holistic, person-centered services to residents experiencing homelessness** | | | |
| 1. Strengthen services coordination in PSH | Rehousing WG | Q1 Year 1 | NA |
| 2. Establish standardized training on Housing Problem-Solving | Rehousing WG | Q2 Year 1 | $ |
| 3. Build a continuous improvement learning loop | Rehousing WG | Q2 Year 1 | NA |
| 4. Review recent recidivism cases to understand the circumstances that lead to returns to homelessness | Rehousing WG | Q1 Year 1 | NA |
| 5. Strengthen and expedite connections to permanent housing and services | Rehousing WG | Q3 Year 1 | NA |

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| $ = Less than $10,000 |
| $$ = $10,000-100,000 |
| $$$ = 101,000-1,00,000 |
| $$$$ = >$1,000,000 |

| System Backbone Element: SYSTEM GOVERNANCE & MANAGEMENT | | |
|---|---|---|
| **Year 1 Priority Strategies** | | |
| **Strategy 1:** Update CoC Governance Charter to ensure appropriate and comprehensive representation | | |
| **Strategy 2:** Develop comprehensive service and performance standards, including performance targets, for all project types | | |
| **Year 2+ Priority Strategies** | | |
| **Strategy 3:** Establish program and system monitoring and evaluation process | | |
| **Strategy 4:** Identify additional CoC staffing and funding necessary to coordinate ongoing system training, monitoring, quality improvement | | |
| **Strategy 5:** Identify opportunities to attract, retain, and improve system staffing | | |
| **Strategy 6:** Convene key healthcare and cross-sector partners (e.g., health systems, MCOs, ADM Board, Area Agency on Aging) to examine data on aging and disabled populations | | |

| System Backbone Element: COORDINATED ENTRY | | |
|---|---|---|
| **Year 1 Priority Strategies** | | |
| **Strategy 1:** Evaluate the coordinated entry system (CES) against HUD requirements and national best practices to identify priority areas for further CES development. | | |
| **Strategy 2:** Evaluate HMIS against HUD requirements and national best practices | | |
| **Strategy 3:** Refine CES assessment building on recent improvements made through HUD CES equity initiative | | |
| **Year 2+ Priority Strategies** | | |
| **Strategy 4:** Examine the pathways for specific subpopulations to ensure CES processes account for unique subpopulation needs and available resources | | |

| System Backbone Element: LANDLORD ENGAGMENT | | |
|---|---|---|
| **Year 1 Priority Strategies** | | |
| **Strategy 1:** Establish job description and secure funding for a system-level housing manager | | |
| **Strategy 2:** Expand use of existing Padmission software | | |
| **Strategy 3:** Strategy 3: Explore development of centralized housing navigation services | | |
| **Year 2+ Priority Strategies** | | |
| **Strategy 4:** Secure funding and develop capacity to administer flexible funding | | |