Gaps Analysis

Detroit Continuum of Care – MI 501

FINAL REPORT

October 30, 2020

This report has been prepared by OrgCode Consulting, Inc. for the Detroit Continuum of Care.
Conclusions and insights are based upon data compiled by OrgCode Consulting, Inc.

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I. Overview

The Detroit Continuum of Care and the Homeless Action Network of Detroit engaged OrgCode Consulting to conduct a gaps analysis of the homeless response system in order to determine resource and system needs. The completion of the gaps analysis fulfills the CoC's HUD requirement to conduct a gaps and needs analysis as part of CoC Planning activities in developing its strategic plan and inform setting priorities toward its efforts to effectively respond to homelessness within the community.

Methodology

The project was impacted by the COVID-19 pandemic preventing travel to the Detroit area. The review included both qualitative and quantitative analysis of unmet needs using several methods including:

- Comprehensive analysis of HMIS data from 2018, 2019, and first quarter of 2020
- Online survey of homeless service providers and leadership
- Online survey of persons with lived experience in homelessness
- Remote interviews and focus groups with homeless service providers and leadership
- Review of other CoC HUD documents such as CAPERS, HIC, PIT, GIW and other policy and procedure and committee reports

II. Perspectives of Persons with Lived Experience

Nineteen persons experiencing homelessness in Detroit volunteered to answer a few questions about their needs and experience in the homeless response system. The surveys were facilitated by street outreach and CAM staff.

In response to the question *Thinking about your experience with homeless services in Detroit, what services did you need but cannot find to help end your homelessness?* they responded:

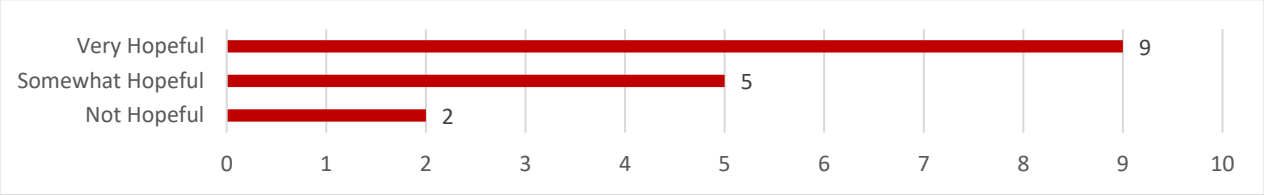
- Housing referral very slow. application is not being accepted
- Help with security deposit
- I did not know where to get help. My person sent me to Marygrove while I looked for an apartment
- Rides to my doctor appointments
- Help with rides to my doctor appointments. They called my doctor for me
- Everybody helped me at Marygrove
- Getting papers I needed to sign my lease
- Help with finding job/income
- Immediate housing
- Mental health therapy
- I could not meet with my navigator
- The slow process due to low income housing being scarce and unavailable

- Finding a steady job
- I needed someone to help me get an ID and I needed someone to help me get it

When asked *Thinking about a case manager, shelter worker or street outreach team member you have met with, what is the most helpful thing they are doing or have done to help you?* responses were:

- Nothing to say. "I've been in the shelter since January and I'm still homeless"
- Listen to my concerns
- You guys were great! I did not need anything you had everything
- They called me a LYFT. They helped me find my apartment and I love it!
- They helped me with everything
- [They] me in, shelter staff helped me get my apartment.
- Helping me find an apartment
- Housing referral
- All they did was sign me up and say I have to find it on my own
- Constant update on my situation and listens
- Listen to me try to understand where I am at
- My case manager at apartment complex helped me the most. She helped me getting my papers from social security and food stamps.
- Recorded my information and kept it protected and continued to keep me informed on my process.
- Help me get proper identification
- They help me get into shelter but she could not meet with me often enough

Finally, when asked *How hopeful do you feel today that you will return to safe stable housing in the next three months?* The responses were:



III. Perspectives of Service Providers and Leaders

Homeless service providers, members and leaders of the Detroit Continuum of Care were invited to participate in an online survey to gather their perspectives on the gaps and needs within the homeless response system. Thirty-eight persons responded.

When asked how available certain resources were for different populations, the services identified as not available or very limited availability were:

Top Three Needs	Low/Moderate Vulnerability Single Adults	High Vulnerability Single Adults	Low/Moderate Vulnerability Families	High Vulnerability Families
Priority 1	One-time Financial Assistance for Non-Rental / Housing Needs (Expenses other than housing)	Long-term Financial Assistance for Rental / Housing Needs with limited supports (Ex: HCV)	Child Care	Child Care
Priority 2	Long-term Financial Assistance for Rental / Housing Needs (Ex: HCV)	Short-term Financial Assistance for Rental / Housing Needs	One-time Financial Assistance for Non-Rental / Housing Needs	One-time Financial Assistance for Non-Rental / Housing Needs
Priority 3	One-time Financial Assistance for Rental / Housing Needs	One-time Financial Assistance for Non-Rental / Housing Needs	One-time Financial Assistance for Rental / Housing Needs Housing Navigation / Landlord Advocacy Employment Services Advocacy with Children's Protective Services	Advocacy with Children's Protective Services Short-term Financial Assistance for Rental / Housing Needs

Many communities across the United States are experiencing a bimodal presentation of populations based on age where the average age of homelessness is increasing and the number of persons aged 18-24 representing an increasing portion of all new homeless. For these populations, providers identified the following resources as unavailable or very limited availability:

Top Three Needs	Aging and Elderly Populations	Youth
Priority 1	Home Health Care Services Adult Daytime Care Services	Safety Planning (Sex Trafficking) and Youth Emergency Shelter
Priority 2	Assisted Living Units Memory Care	Transition from Foster Care

Priority 3	Nursing Care	LGBTQ2+ Services

In an effort to understand training and skill needs, providers were asked to rate their level of proficiency in several best practice approaches. Overall providers indicated strong skills. The two areas with the least knowledge and experience were diversion and progressive engagement.

When asked *Thinking about your work, what other training, tools, technology, or other resources would help you to achieve improved outcomes in your work to end homelessness?* they identified:

- Funding to support outreach and operations cost
- Improved coordination among agencies
- Systems training on HMIS and CAM
- Activities designed for the unique needs of LGBTQ+ and persons of color
- Improved HMIS reporting capacity at the agency and individual user level
- Reduce complexity and micro-management of CoC programs

When asked *What could your agency / Supervisor / Board of Directors do to support your work to end homelessness?* responses included:

- Continue to increase leadership awareness, understanding and program objectives
- Increase staff pay so that there is less turnover among staff thus less transition for our clients.
- Develop priorities and communicate those to the broader community, actively recruit and engage with other sectors (workforce, early education, health, etc.) to bring them to the table so that we can have a true systematic response to end homelessness.
- Increase funding for more staff

When asked *What tools and resources would improve your agency's current capacity?* they responded:

Tools and Resources	% of Respondents
Improved collaboration and cooperation with outside Community Partners (Ex: government, schools, hospitals)	76.92%
Professional Staff Training	69.23%
Improved collaboration and cooperation with homeless services providers	69.23%
Additional Funding	61.54%
Coordination with Property Managers	53.85%
Grant Writing / Development Training	23.08%

Tools and Resources	% of Respondents
Other capacity building strategies: Agency fund development focused on homeless programs Having multiple SOAR staff available to expedite applications. Detroit needs more than just one person doing this. Perhaps having multiple staff designated for Veterans and multiple staff for non-Veterans.	

When asked what *the most important supportive service or housing component need that would make the greatest improvement to rapidly rehousing persons experiencing homelessness* responses included:

- More focus on prevention of homelessness
- A true housing first program - where we take someone from the streets and get them into housing within a couple of days then work to do all the paperwork necessary once they are housed
- Better link with housing and the mental health system.
- Support the emergency shelters so that they can do more than just exist, but can help people move towards housing
- Expanding affordable housing, PSH, access to HCV, RRH/rental assistance
- Low barrier housing with services that are trauma informed that connects clients to mental health services; using best practices for working with people using substances
- Housing navigation and ongoing supportive services.
- Available affordable housing for individuals with barriers such as felonies and evictions.

When asked what *the most important system, policy, or funding change that would make the greatest improvement to rapidly rehousing persons experiencing homelessness* is:

- Addressing hunger issues for all.
- Holding organizations accountable to providing quality work and if that is not happening, take assertive action
- More effectively utilize the HMIS system to support people moving towards housing; sharing provider-specific data elements
- Invest in addressing and solving youth homelessness, which also helps disrupt cycles of homelessness and continued intervention throughout an individual's life.
- Expanding the HCV program, homeless preference
- Low-barrier flexible financial assistance for housing access, utilities, furniture, and household goods
- Reduce eligibility requirements
- Reducing GPD beds

IV. Impacts of COVID 19 on Service Delivery

During the entire duration of the gaps analysis work, COVID-19 response has been the most important, urgent, and prevailing impact on the entire homeless response system. Within the provider survey as well as the focus groups and interviews, providers and leaders were asked lessons learned during the unprecedented time and if there were changes in policies and practices during COVID that should be considered for continuance once the crisis is over. Observations and opportunities from those discussion are below.

- **Tele-health / Tele-help / Telephone Assessments Engagements** – Overall belief that use of telephone communication with clients has improved timeliness, improved engagements, removed travel time/waiting barriers, allowed street outreach to do more face to face triage and basic needs prior to waiting and paperwork. Majority want the best of this practice to continue post-COVID. Considerations moving forward as proposed by providers: *When will this be appropriate post COVID? What training, protocols, documentation, and case notes should be put in place?*
- **Waivers, Grace Periods** – Most are HUD authorized and limited. Efforts that housed/sheltered with no/less/limited documentations and reduced barriers follow a more housing first approach. Considerations moving forward: *What rules, barriers or document waivers can continue post COVID? AND oversight efforts to make sure all the documents are gathered*
- **Decentralization of CAM Intake** – "Can assess anywhere" Increased flexibility and less reliant on office hours received positively. Considerations moving forward: *How can access point flexibility be applied post-COVID?*
- **Sense of Urgency** – Response has established increased coordination, collaboration, responsive leadership, and strategic problem solving and housing focused community strategies. Considerations moving forward: *How can this sense of urgency and structured organizing around a problem continue in strategic planning and implementation for the CoC moving forward?*
- **De-congregating Shelter** – Provision of more space, individual space empowers the individual and provides more dignified sleep. Stay in place (24 hour) sheltering allowed deeper more productive housing, treatment and problem solving dialogues. Considerations moving forward: *How can we improve emergency housing facilities and engagements to achieve rapid resolution of homelessness?*
- **Increased Funding Welcome** – Providers interviewed were in agreement that new funds (CARES Act) will make a huge difference. Concerns were expressed to make sure that it can all be effectively spent and where possible build upon the system of care, and support RRH clients with the level of supports needed, especially for households that may have previously been guided toward PSH. Providers wish to see outcome and performance data gathered and reported transparently and frequently, including how funds are being spent over the course of the projects.

City/County/State recipients should support nonprofit agencies to have the administrative capacity to meet all documentation, financial, and other contract compliance requirements as they do not want to be worried about future monitoring.

V. HMIS Data Analysis

OrgCode worked with HAND to obtain de-identified, person-level reports from HMIS for further gaps analysis. This included 83,388 rows of data for calendar year 2018, 82,621 rows of data for calendar year 2019 and 40,282 rows of data for quarter 1 of 2020.

OrgCode analyzed information from enrollment -- including household demographics, age, gender, race, ethnicity, veteran status, income, non-cash benefits, domestic violence experience, prior living situation, and length of stay across 111,075 data elements.

As an indicator of vulnerability, disabling condition information was compiled to examine frequency, type, and quantity across 55,770 data elements.

To build upon the HUD-required data elements for disabling condition, OrgCode further examined VI-SPDAT records across 26,037 data elements and SPDAT records across 13,409 data elements.

	Enrollment Data	Disabling Condition	VI-SPDAT Information	SPDAT Information	Total
CY 2018	46,330	23,077	8,960	5,021	**83,388**
CY 2019	47,491	20,060	10,321	4,749	**82,621**
Q1 2020	17,254	12,633	6,756	3,639	**40,282**
Total	**111,075**	**55,770**	**26,037**	**13,409**	**206,291**

Data reflected robust information from multiple providers:

- 139 unique providers from quarter 1 2020,
- 132 unique providers from calendar year 2019, and
- 125 unique providers from calendar year 2018.

Since some of those providers overlap (in existence from calendar years 2018 - 2020) and some no longer exist (having closed prior to quarter 1 2020):

- 18 providers included data/were only in existence during one of the three reporting periods
- 3 providers were in two of the three reporting periods
- 118 providers were in all three data reporting periods/data sets

Wherever possible, data was compared across each of the three reporting periods to measure changes across time, and unduplicated to ensure each data element would be

counted once. Additional detail regarding shifts across time and deduplication accompanies each of the following reporting sections.
The comparative data is presented in the following format and represents the following data:

Demographics: Household Information

Almost two thirds of people served during each reporting period *(calendar year 2018, calendar year 2019 and quarter 1 2020)* ***were single adults, although 1 in 4 were children.***

	2018	2019	Q1 2020
Single individuals	62%	65%	63%
Family heads of household	11%	11%	11%
Children in families	24%	22%	23%
Other family members (spouse/partner/etc.)	2%	2%	2%

The percentage of family heads of household remained consistent throughout (11%), as did representation of other adult family members such as spouses or partners (2%).

The slight shift in percentages for single individuals (ranging from 62% to 65% moved in conjunction with a corresponding shift in percentages for children in families (ranging from 22% to 24%).

Again, the majority of people receiving services from HMIS-participating providers ranged from:

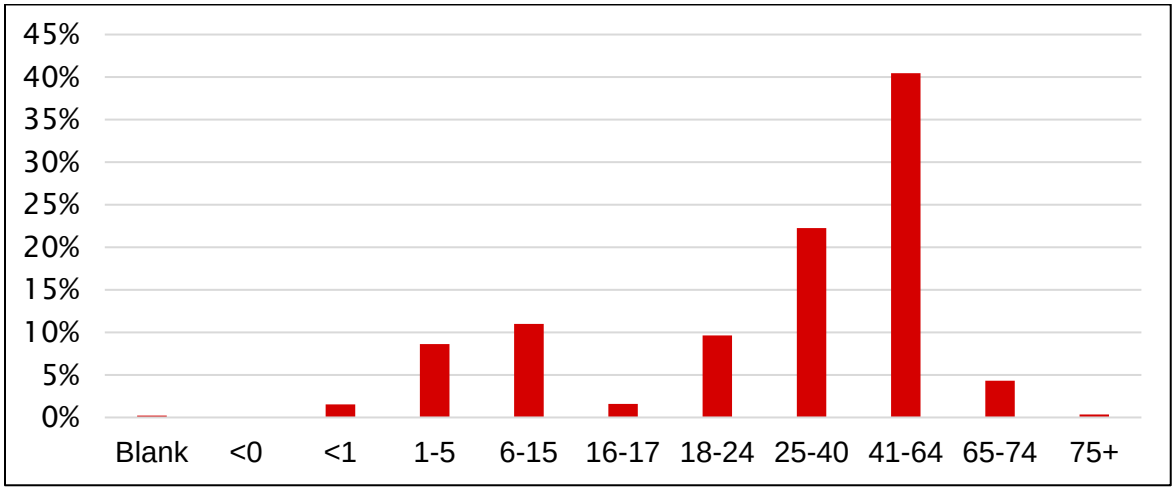
- homelessness prevention
- street outreach
- emergency shelters
- day services
- transitional housing
- permanent supportive housing
- rapid re-housing
- assertive community treatment
- non-market rate housing and rent-subsidy programs

Demographics: Age

People were most likely to be 41-64 years old.

	2018	2019	Q1 2020
<1 year	2%	2%	1%
1-5 years	9%	8%	8%
6-15 years	1%	2%	2%
16-17	2%	2%	2%
18-24	10%	11%	13%
25-40	22%	22%	20%
41-64	40%	42%	37%
65-74	4%	4%	5%
75+	<1%	<1%	<1%

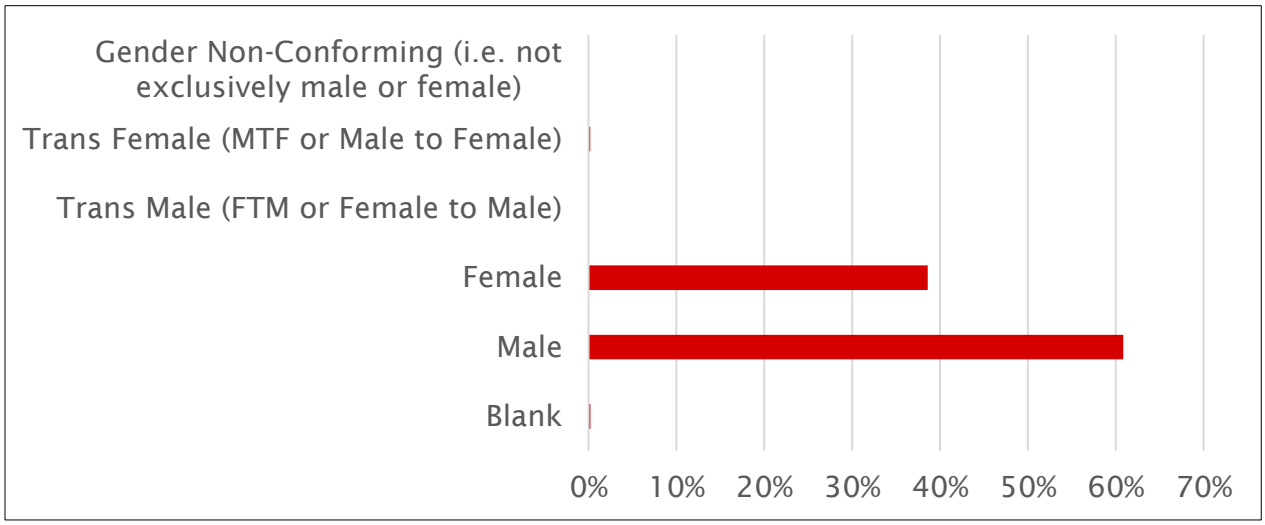
These percentages remained relatively consistent, ranging by 1-2% across the three reporting periods, with the exception of the most frequently occurring age range: people from 41-64 years old, which decreased by 5% during quarter 1 2020 after having risen by 2% during the previous calendar year. There is a slow rise in the number of persons 18-24 over the three year period moving from 10% to 13%.



Demographics: Gender

Most people served identified as male.

	2018	2019	Q1 2020
Male	61%	59%	58%
Female	39%	39%	41%
Transgender (female to male)	<1%	<1%	<1%
Transgender (male to female)	<1%	<1%	<1%
Gender non-conforming	<1%	<1%	<1%



Demographics: Race and Ethnicity

9 in 10 people identified as Black/African American.

	2018	2019	Q1 2020
American Indian or Alaska Native	<1%	<1%	<1%
Black or African American	90%	89%	89%
Asian	<1%	<1%	<1%
Native Hawaiian or Other Pacific Islander	<1%	<1%	<1%
White	8%	9%	8%
Other	<1%	<1%	<1%

Only 1 in 50 people identified as Hispanic or Latino.

Non-Hispanic/Non-Latino	98%	95%	95%
Hispanic/Latino	2%	2%	2%

Multi-Racial Identification:

- 51-54% of people did not identify a "Secondary Race"
- 41% identified being Black or African American as a "Secondary Race"
- 4% identified as being White as a "Secondary Race"

This means that for Detroit area providers, the face of homelessness is overwhelmingly more likely to be Black or African-American and non-Hispanic than any other race or ethnicity.

Demographics: Veteran Status

1 in 12 people identified as veterans.

Over time the number of veterans has remained consistently 8% of the homeless population.

	2018	**2019**	**Q1 2020**
Veteran	8%	9%	8%
Not a veteran	87%	85%	86%
Blank/refused/don't know	4%	6%	6%

Income at Entry and Exit

1 in 3 people report entering with income, and only 1 in 20 gain income prior to exit.

Across 2018, 2019 and Q1 2020, 5% of people consistently report gaining income from entry to exit, for example in 2018 36% of persons had income upon entering a program and when persons exited programs, 41% had income, an increase of 5%.

	2018	**2019**	**Q1 2020**
Income at entry	36%	33%	33%
No income at entry	59%	61%	59%
Blank/refused/don't know	5%	6%	8%

	2018	2019	Q1 2020
Income at exit	41%	38%	38%
No income at exit	54%	57%	55%
Blank/refused/don't know	4%	5%	7%

Non-cash Benefits at Entry and Exit

2 in 5 people enter with non-cash benefits, and only 2% gain benefits upon exit.

Across 2018, 2019 and Q1 2020, only 2% of people consistently report gaining non-cash benefits from entry to exit. For example, 44% of persons entering programs in 2018 had non-cash benefits and 46% of persons had non-cash benefits when exiting programs in 2018.

	2018	2019	Q1 2020
Non-cash benefits at entry	44%	36%	39%
No non-cash benefits at exit	50%	57%	52%
Blank/refused/don't know	4%	5%	7%

There was no improved access overall among persons to non-cash benefits from entry to exit

Domestic Violence Experience

In addition to experiencing homelessness, 1 in 7 people have survived domestic violence.

	2018	2019	Q1 2020
Domestic violence experience	14%	16%	16%
No domestic violence experience	81%	79%	79%
Blank/refused/doesn't know	5%	5%	5%

Disability Status

A substantial and increasing amount of people live with a disabling condition.

Most recently, the count rose to 1 in 2.

	2018	2019	Q1 2020
Living with a disabling condition	44%	46%	50%
Not living with a disabling condition	53%	51%	46%
Blank/refused/doesn't know	3%	3%	4%

This may reflect multiple phenomena, whereby as people continue to grow in age, they also age into chronic homelessness and long-term homelessness where it is not yet chronic. The longer that people experience homelessness, the more likely that additional health concerns like disabling conditions increase in frequency (more commonly), quantity (more than one) and intensity (more than a minor obstacle).

For people with disabling conditions, most were mental health-related.

	2018	2019	Q1 2020
Mental health	71%	72%	75%
Physical	39%	41%	40%
Drugs	21%	19%	17%
Chronic health	20%	18%	17%
Alcohol	15%	14%	13%
Both alcohol and drugs	13%	12%	12%
Physical/medical	10%	8%	9%
Developmental	8%	8%	8%
HIV/AIDS	3%	3%	3%
Others	<1%	<1%	<1%

For people with disabling conditions, they frequently co-occur with another disabling condition. Overtime, the rates of the presence of disability is unchanged.

	2018	2019	Q1 2020
1 disability	45%	47%	47%
2 disabilities	28%	28%	28%
3 disabilities	14%	14%	14%
4 disabilities	8%	7%	7%
5 disabilities	3%	3%	3%
6 disabilities	1%	1%	1%
7 disabilities	<1%	<1%	<1%
8 disabilities	<1%	<1%	<1%
9+ disabilities	none	<1%	none

1 in 7 people have 3 disabling conditions, and the same amount live with between 4 and 9 disabilities.

Disabilities of Stayers

An examination of 2018, 2019 and 2020 HMIS generated CAPER reports, identified characteristics of those persons that were stayers in street outreach and emergency shelter programs. The two most prevalent disabilities of persons remaining in homelessness were mental health conditions and physical disabilities.

Stayers in Street Outreach	2018 Number of Stayers	2018 Rate of Stayers	2019 Number of Stayers	2019 Rate of stayers	2020 Number of Stayers	2020 Rate of Stayers
Total Stayers	474		1046		1524	
Mental Health Condition	**190**	**40%**	**405**	**39%**	**444**	**29%**
Alcohol Abuse	20	4%	24	2%	25	2%
Drug Abuse	22	5%	36	3%	44	3%
Both Alcohol and Drug Abuse	35	7%	59	6%	67	4%
Chronic Health Condition	52	11%	83	8%	93	6%
HIV/AIDS	31	7%	54	5%	58	4%
Development Disability	18	4%	48	5%	52	3%
Physical Disability	**121**	**26%**	**186**	**18%**	**218**	**14%**

Stayers in Emergency Shelters	2018 Number of Stayers	2018 Rate of all Stayers	2019 Number of Stayers	2019 Rate of stayers	2020 Number of Stayers	2020 Rate of Stayers
Total Stayers	846		868		692	
Mental Health Condition	**208**	**25%**	**210**	**24%**	**203**	**29%**
Alcohol Abuse	22	3%	11	1%	11	2%
Drug Abuse	24	3%	22	3%	20	3%
Both Alcohol and Drug Abuse	31	4%	26	3%	33	5%
Chronic Health Condition	42	5%	30	3%	28	4%
HIV/AIDS	4	0%	4	0%	3	0%
Development Disability	28	3%	32	4%	29	4%
Physical Disability	**159**	**19%**	**176**	**20%**	**161**	**23%**

The data examined in 2020 represents January through May. The increased number of street outreach stayers is likely due to restrictions and limitations in service delivery due to COVID-19 and outreach workers not exiting persons from programs. The decreased number of emergency shelter stayers also is likely impacted due to COVID-19 and reductions in shelter capacity in compliance with social distancing.

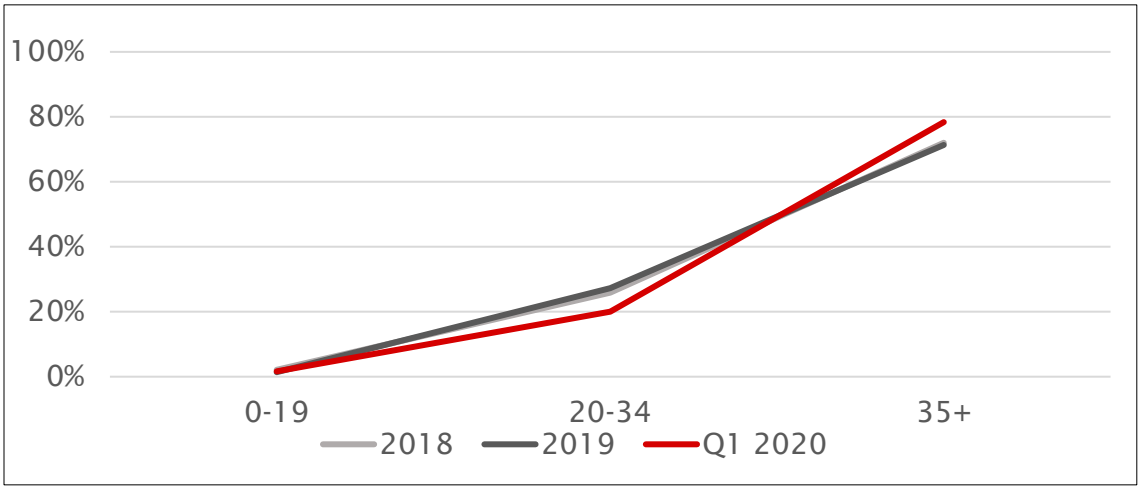
Chronic Homelessness

CAPER reports for 2018, 2019 and 2020 for emergency shelter programs consistently reported 19% of persons served were persons experiencing chronic homelessness. Among persons served in street outreach programs over the same period, an average of 23% were experiencing chronic homelessness (2018 23%, 2019 34%, 2020 22%).

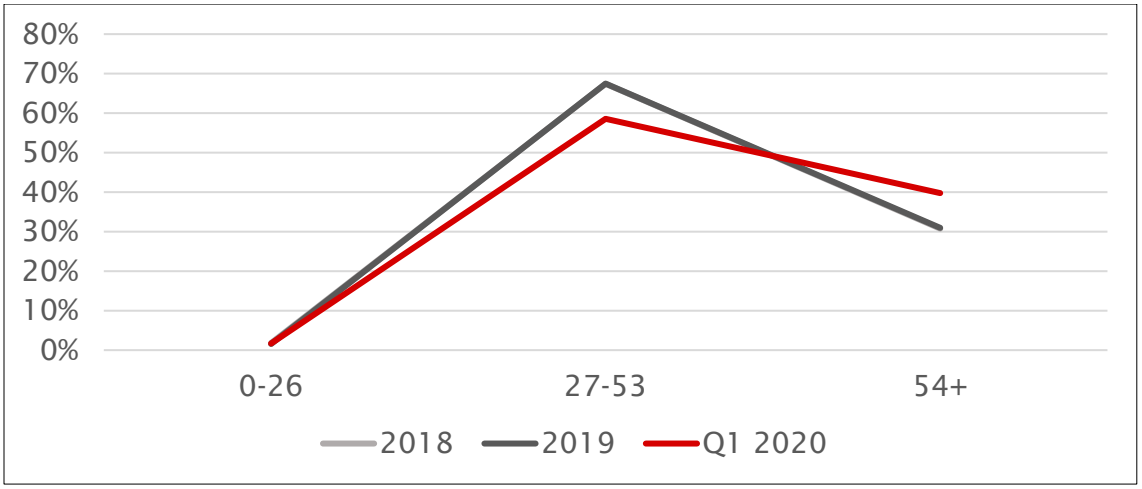
SPDATs at Intake

The rate of SPDAT scores at intake for both single adults and family households have a significant increase from 2019 to 2020.

Single Adult Intake SPDATs	2018	2019	Q1 2020
0-19 (lower acuity)	2%	1%	2%
20-34 (moderate acuity)	26%	27%	20%
35-60 (higher acuity)	72%	71%	78%
Average score	39	38	40



Family Adult Intake SPDATs	2018	2019	Q1 2020
0-65 (lower acuity)	2%	2%	2%
27-53 (moderate acuity)	67%	67%	59%
54-80 (higher acuity)	31%	31%	40%
Average score	47	47	48



OrgCode noted in the analysis that the distribution of SPDAT scores were higher than other communities. Specifically, that nearly a third or more were falling into a high acuity bracket where we would expect no more than 20%. Over the past two years, the Detroit CoC CAM has modified the procedures for intake and SPDAT implementation. First, in 2018, CAM shifted away from doing the full SPDAT on both people who scored for Rapid Rehousing and Permanent Supportive Housing on the VI-SPDAT and began only administering the full SPDAT on people who scored for PSH on the VI-SPDAT. In 2020, "Acuity Groups" were introduced, which organizes multiple housing priority lists based on levels of acuity as determined by the score a person received on the VI-SPDAT or full SPDAT.

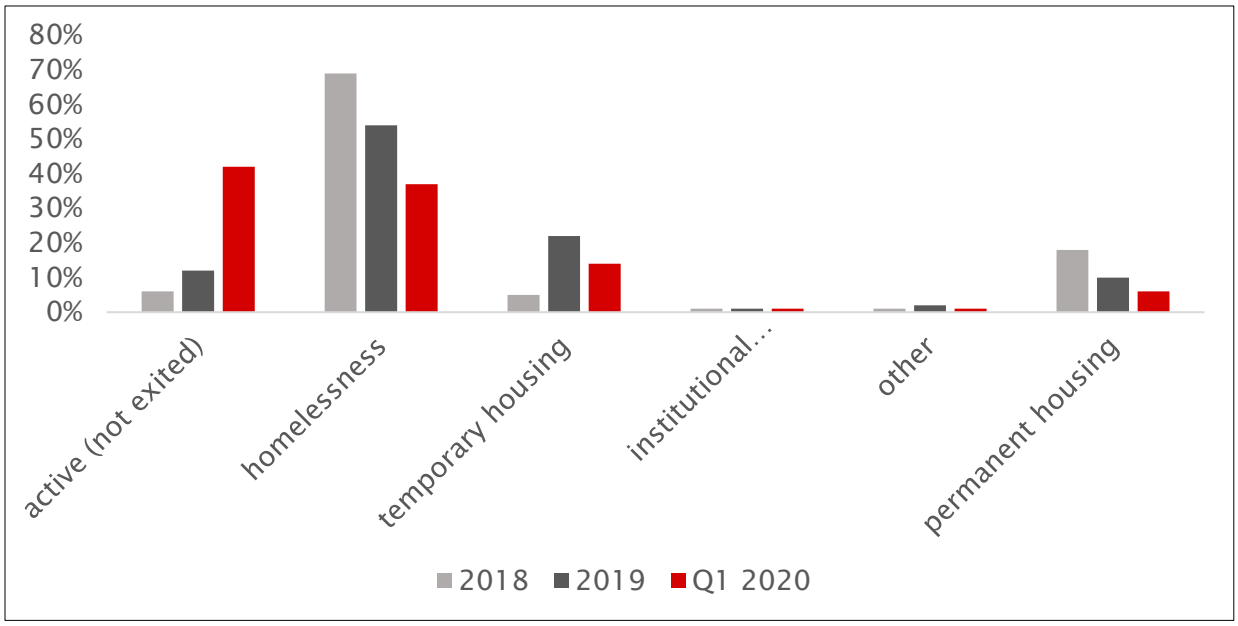
The practice of only administering the SPDAT assessment tool for only a preselected group (those with a higher VI-SPDAT score) has contributed to the increase in the portion of persons taking the SPDAT resulting in a higher score than anticipated.

Exits

Across time, exits to homelessness are decreasing, although concerningly, so are exits to permanent housing.

	2018	2019	Q1 2020
active (not exited)	6%	12%	42%
homelessness	69%	44%	27%
temporary housing	5%	22%	14%
institutional settings	1%	1%	1%
other	1%	2%	1%
permanent housing	18%	10%	6%

While almost 1 in 5 people exited to permanent housing in 2018, that count decreased by 8% during 2019, and dropped an additional 4% in quarter 1 2020 to its current (and record low) rate of 6%.



Utilization of Existing Housing Resources

One factor that may be contributing to this decrease in exits to permanent housing is the increased utilization and efficient use of all existing housing resources. In identifying gaps, it is important to understand the extent to which the community is using its current resources effectively. This is primarily measured in spend down rates, occupancy rates, and successful exits from programs.

A review of CoC Program Grant funded projects spending trends showed a steadily improved expenditure rate, which means less funds returning to HUD upon completion of a project year.

FY2016 CoC Complete Projects	FY2017 CoC Completed Projects	FY2018 CoC Completed Projects * to date
92% Spend Down Rate	**95%** Spend Down Rate	**96%** Spend Down Rate

As is commonly the case, the majority of expenditures left are from the rental assistance budget line item. Total rental assistance drawn down can be complex to project because of the multiple variables in amount of rental assistance subsidy per household, tenant contributions, family size, early exits or changes to household incomes.

Examining housing inventory chart (HIC) data from the past three years provides a one-night snapshot of utilization shows a similar gradual increase in utilization. HIC information is less useful for rapid rehousing (RRH) utilization measurement as the HUD methodology measures RRH inventory to be reported as equal to the point in time count of persons in RRH.

FY2018 HIC	FY2019 HIC	FY2020 HIC
87% Total Utilization of all Housing and Shelter Resources **94%** PSH Utilization	**92%** Total Utilization of all Housing and Shelter Resources **98%** PSH Utilization	**93%** Total Utilization of all Housing and Shelter Resources **107%** PSH Utilization

The HIC reports demonstrate that Detroit has experienced improved utilization of available resources overall (ES, SH, TH, RRH, and PSH) and specifically an increased maximization of PSH resources. CoC accountability, performance monitoring, and coordinated match, referral, and assignment of resources through coordinated entry all contribute to these improvements.

As existing resources are maximized, this puts increased pressure to identify new PSH opportunities to meet the demand for supportive housing as evidenced by stayers and persons remaining on the housing priority list. Housing opportunities are created through increased PSH units from new CoC funded projects, increased dedicated HCV homeless preference units, and careful exit planning for stabilized PSH households.

Housing need projections for supportive housing for chronic and highly vulnerable persons has been researched by the Chronic Homeless Leadership Committee in spring of 2020 and calculates a matrix of PSH rental subsidies and levels of supportive services that informs gaps in permanent supportive housing.

VI. Deeper Dive into HMIS Race Data

As demonstrated in the HMIS demographic data, Blacks/African Americans make up 90% of all the persons that have been served in the Detroit homeless system. In general, at this level, homelessness in Detroit is primarily a Black experience. With only 10% of persons within the data set non-Black, diving into the data with a racial equity lens is more difficult because of this disproportionality that results in an implicit bias.

Therefore, the data extractions below provide some insight into information that is gathered from basic HMIS universal data elements and HMIS entry assessment information. The table below examines the annual data set from 2018 examining three groups: Primary Race: 1) Black or African American (90%), 2) White (8%) and 3) Other which includes American Indian or Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander (2%). Note that these proportions of all homeless persons in HMIS held steady throughout 2019 and first quarter 2020 data. Note that some totals do not equal 100% because of missing data within the HMIS. For example, the total % of gender for "Other" totals only 80% because 20% of those records did not have a gender identified within the data set.

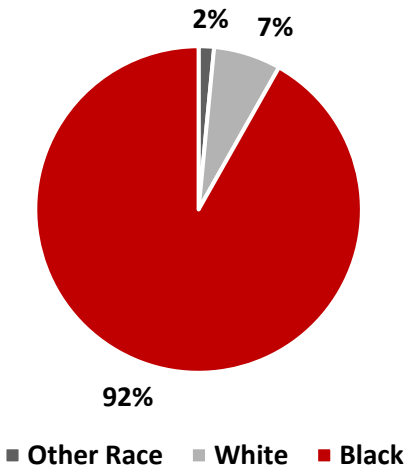
Within each race classification:

	Black/African American	**White**	**Other: Am. Ind/Asian/PI**
Total % Single	71%	93%	89%
Total % Families w/Child	26%	5%	9%
Total % Female	40%	24%	21%
Total % Male	60%	75%	59%
Total % Children 0-17	25%	4%	8%
Total % Youth 18-24	10%	8%	10%
Total % 65 and older	4%	6%	4%
Total % Veteran	7% (1,046 persons)	19% (231 persons)	11% (21 persons)
Total % Disabling Condition	43%	62%	39%
Total % Income at Entry	37%	34%	20%
Total % Income at Exit	41%	42%	26%
Prior Living w/Friends/ Family	21%	16%	14%
Homeless Four or More Times	15%	15%	12%
Homeless One time	34%	38%	24%
Exited to Permanent Housing	37%	21%	16%
Exited to Temporary Housing	4%	8%	5%
Exited to Institutional Situations	1%	3%	3%
Exited to Homelessness	36%	45%	48%
Exited Due to Death	1% - 77 persons	1% - 12 persons	0% - No persons

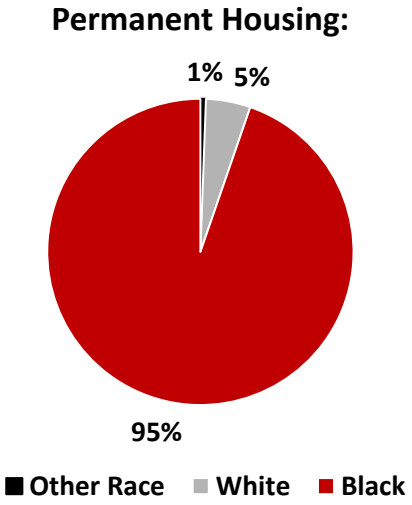
One of the most profound observations in the basic racial data is the prevalence of Black families and Black females that fall into homelessness in comparison to other races.

To examine housing outcomes through a racial equity lens, the analysis included looking at proportions of persons exiting into different destinations. The data suggests that within the homeless response system, the distribution of exits by race is consistent with the overall race distribution across persons being served.

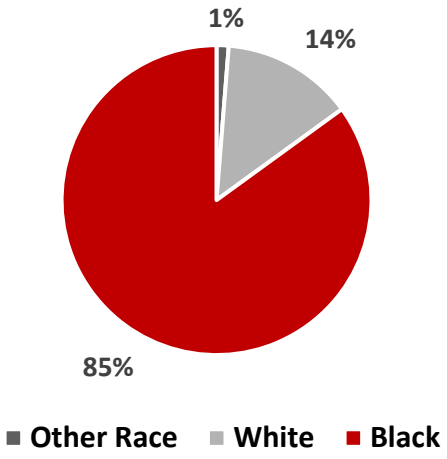
Active Client (Not Exited):



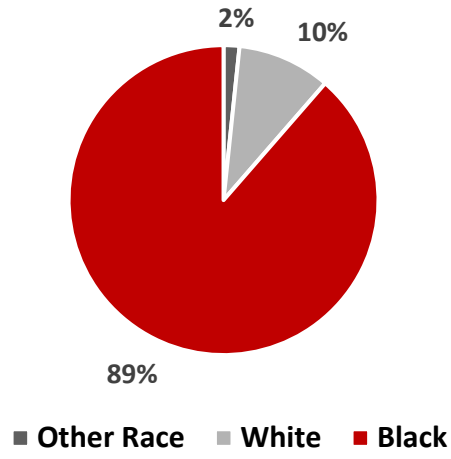
Permanent Housing:

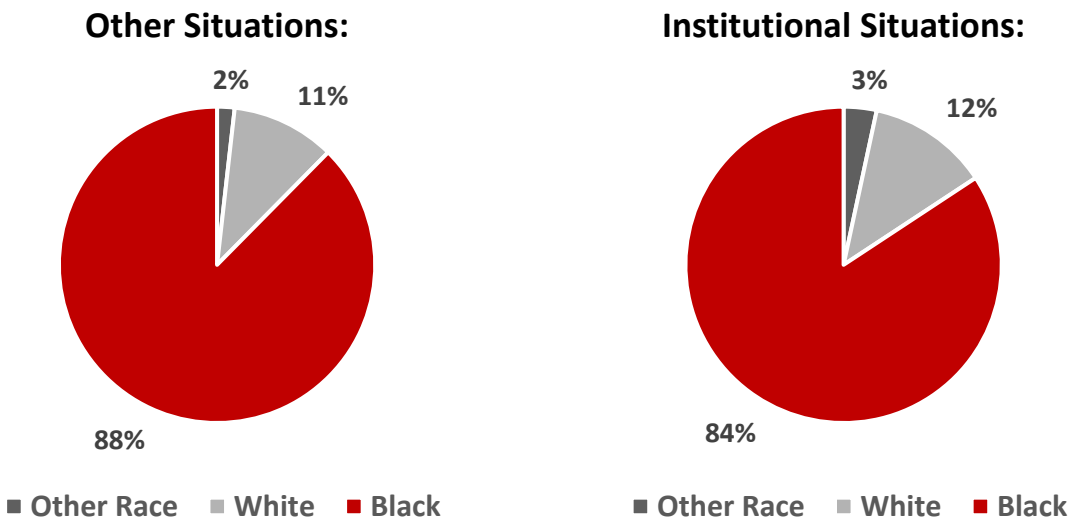


Temporary Housing:



Homelessness:

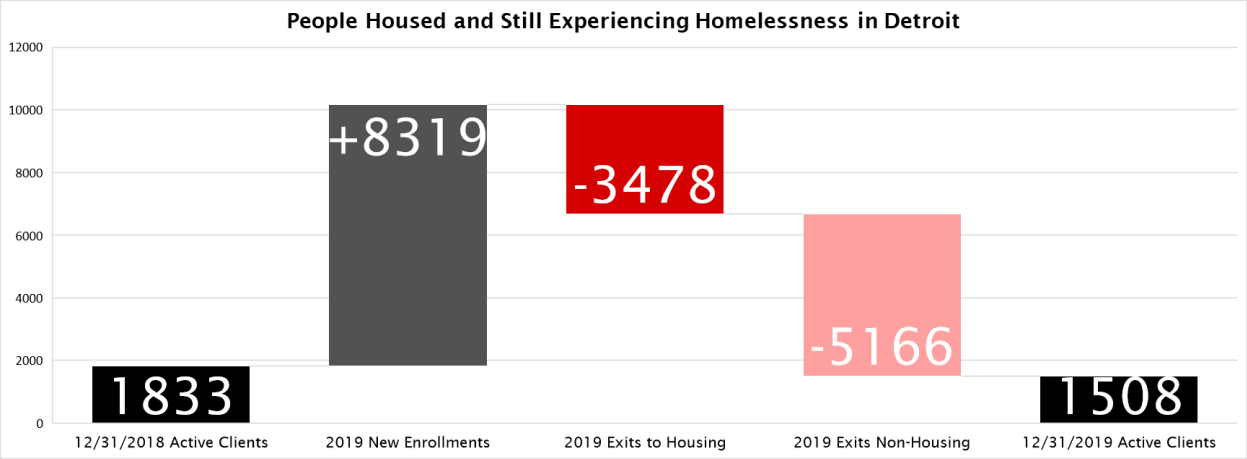




These diagrams demonstrate that most categories of pathways through the homeless response system generally follow the same proportionality by race as represent the whole homeless population.

In order to answer the question of what specifically Black households need to exit homelessness, further analysis is recommended to examine person-level data including not just the VI-SPDAT or SPDAT aggregate scores but to examine the individual responses that can provide insights to barriers to housing and formulate strategies to rehousing planning.

VII. Mapping System Inflows and Outflows



The waterfall chart above examines HMIS data from 2019. To appear in the HMIS, clients have an active enrollment in a CoC program (example: street outreach, CAM, emergency shelter, transitional housing). Over the course of the 2019, 10,152 unique persons engaged the Detroit emergency response system. Of those, 3,478 exited to a housing destination. At the end of the year, on December 31, 2019 there were 1,508 actively enrolled persons experiencing homelessness as recorded in the HMIS.

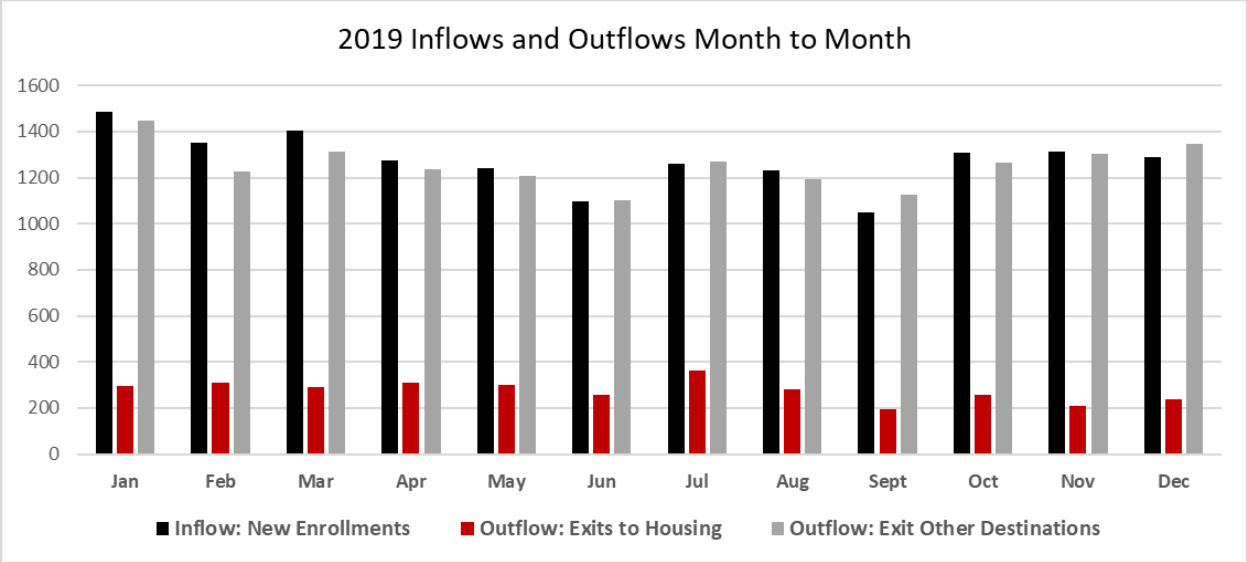
The annualized inflow and outflow chart major takeaways are:

- Over one-third (34.35%) of persons experiencing homelessness and engaging in the homelessness serving system exited to a housing destination.
- In 2019, more persons exited homeless services programming than entered into the system.

The inflow and outflow analysis included de-duplicating the data set across several factors within both non-housing enrollments, non-housing exits, housing enrollments and housing exits. Overall, the duplication rate of all persons presenting over the year was 1.7%. The analysis also adjusted for persons that both enrolled and exited multiple times over the course of the year (2,267 persons).

The beginning and ending counts of "Active Clients" does not represent a point – in – time count because it includes only persons currently enrolled (active) in the system of care as documented in the HMIS. The actual number of *all* persons experiencing homelessness would be higher as all persons experiencing homelessness are not all actively represented in the HMIS. For example, the January 2019 point-in-time count identified 1,965 persons. Comparing the 2019 beginning count, 1,833, to the PIT Count, 1,965 does inform that the Detroit homeless response system was engaging approximately 93% of those persons known to be experiencing homelessness.

The diagram below provides insight into how these annual inflows and outflows played out month – to – month in 2019.



The monthly inflow and outflow analysis major takeaways are:

- In no month did new enrollments exceed all outflows.
- Average number of new enrollments per month was1,275 with a peak in January, 1,485, and lowest in September 1,048.
- Average number of persons exiting to housing per month was 276 with a peak in July, 364, and lowest in September 195.
- The lowest level of activity overall was in September and the highest rate of activity in January.

Service utilization patterns among persons served also provide an understanding of the throughflows in the system. A basic analysis of client to number of enrollments showed that half (49%) of persons served only had one service as recorded in the HMIS. The highest users having 10-124 enrollments most represent those persons moving in and out of emergency shelters over the course of the year.

Frequency of Occurrence	Count	Percentage
1	6644	49%
2	2558	19%
3	1350	10%
4	782	6%
5	463	3%
6	294	2%
7	195	1%
8	168	1%
9	153	1%
10-124 Times	1054	8%

VIII. System Models to Meet Housing Needs

The objective of this analysis is to examine the characteristics of those persons that are not succeeding in the current system, not able to find a pathway out of homelessness or continue to return to homelessness and what it would take to resolve those experiences in homelessness.

From the inflow and outflow estimates, aggregate stayer information from CAPER reports, and personal-level household and acuity level data of stayers and long term homeless, the following analysis assists in building system models of housing strategies and resources and levels of impact.

1. *Making incremental improvements* – Addressing identified priorities with resource shifting, funding reallocation, and/or system redesign. Impact results in more effective pathways through the system, slight improvements in improvement measures.
2. *Making significant improvements* – Addressing multiple priorities with both CoC and non-CoC resources including resource and funding reallocations, system redesign and new community resource commitments. Measurable improvements in performance.
3. *Meeting all housing needs* – Envisioning what it would take to achieve an end to homelessness through a systematic response that ensures homelessness is prevented whenever possible or if it can't be prevented is a rare, brief, and one-time experience.

Housing Needs of Families with Children

Approximately 1,460 family households were served in 2019.

445, 30%, had experienced 3 or more episodes of homelessness

113 family households did not exit the system. Attributes of these households remaining, *stayers,* in the homeless response system were:

- 15 Family stayers had 5-7 household members
- 25 Family stayers had been homeless a year or more
- 8 Family stayers presented with high acuity as assessed with the SPDAT
- 94 Family stayers entered the system of care with no income
- 84 Family stayers entered with no income and have no recorded income since entering
- 41 Family stayers had experienced domestic violence
- 37 Family stayers had a head of household with a disabling condition. Of those families:
    - 17 had no income at entry
    - 15 had no income at entry and had no income since entry
    - 16 had income at entry and were homeless for the first time
    - 9 had been homelessness six months or longer
    - 8 had experienced homelessness three times
    - 10 had experienced homelessness four or more times

Rapid Rehousing Interventions for Families

With the infusion of new ESG-CV funding, rapid rehousing represents the most accessible and likely opportunity to impact exits to housing in 2021 and 2022. Examining the experiences of Detroit families in rapid rehousing programs helps inform strategies moving forward.

In 2019 395 families were served in rapid rehousing programs. A review provides insight to the successes of RRH in resolving family homelessness. The experiences of these families in rapid rehousing include:

144 families exited from emergency shelter and entered Rapid Rehousing

192 families exited from Rapid Rehousing in 2019, of these families

- 8 Families exited to a temporary situation

- 184 Families exited to a permanent situation

Of the exits to permanent situation:

- The average length of stay in RRH was 308 days/10 months, with a range of 1- 26 months
- 37 Families exited to Public Housing, HCV or VASH
- 95 Families exited into another rental subsidy program

System Model Strategies for Families

In modeling strategies to significantly address the housing barriers faced by Detroit families, objectives include:

- Families experiencing repeated episodes of homelessness need long term rental assistance subsidies to reduce trauma, end education interruptions, and provide household stabilization capacity needed for employment, transportation, and childcare.
- Families that present with existing income and experiencing first-time homelessness need a rapid resolution to housing with one time or short-term and moderate term rental assistance.
- Families presenting with long term or frequent episodic homelessness, disabling conditions, or high acuity needs require long term housing with supports.
- All families need access to household income supports both benefits and employment, and childcare.

Making Incremental Improvements	Making Significant Improvements	Meeting All Housing Needs
• CoC RRH Rental Assistance Policy should be flexible and allow up	• Increase HCV Vouchers with a Homeless Preference for Families	• Provide HCV Vouchers with a Homeless Preference as a formal

Making Incremental Improvements	Making Significant Improvements	Meeting All Housing Needs
to **24 months** of assistance to accommodate higher needs families • CES matching decisions for ESG-CV RRH (limited to 12 months assistance) should be strategic in assigning families with lower acuity, less episodic homelessness • Household income supports should be implemented immediately upon entry into the system of care for zero income households and continue engagement throughout the housing process • Continue to monitor utilization of all housing to assure maximum use of available resources	by at least **48 units** to reduce the length of stay in RRH and open up more RRH for families that remain in ES and providing a permanent exit destination • Formalize the transition strategies between RRH to HCV/Public Housing, targeted large, moderate acuity families, and families with disabling conditions, especially those with repeated experiences of homelessness • Increase HCV Vouchers for families transitioning out of PSH after stabilization and in continued need of long-term rental assistance subsidy by at least **15 units** • Develop **5 PSH units** for families[1] • Develop formal partnerships with employment, workforce and education and training programs coupled with childcare and transportation targeting RRH, HCV and PSH families • Assign early intervention specialists to family shelters to work more intensely on housing options outside of Coordinated Entry (e.g., self-resolution; family reunification when safe and appropriate)	systemic method of housing stabilization for families that cannot exit rapid rehousing without long term rental assistance • Provide HCV Vouchers for families transitioning out of PSH after stabilization and in continued need of long-term rental assistance • Package all rental assistance (one time, short term, or long term) with education, training, employment, and childcare programming • Develop **11 PSH units**[1] for families • Expand one-time financial assistance (arrears, deposits, and first/last month's rent) for first time homeless through rapid resolution and diversion programs packaged with short-term supports to effectively connect to needed medical and mental health services • Expand flexible funding resources to the diversion process to keep at least 20% of families out of homelessness

[1] Chronic Homelessness – Filling the Supportive Housing Unit Gap, Detroit CoC Chronic Leadership Committee Report. See Appendix for Details.

Housing Needs of Single Individuals

Approximately 8,939 single individuals were served in 2019.

3,054, 34%, had experienced 3 or more episodes of homelessness

1,138 single individual households did not exit the system. Attributes of these individuals remaining, *stayers,* in the homeless response system were:

- 579 Individual stayers were homeless only one time
- 272 Individual stayers were homeless only one time and had income
- 411 (42%) Individual stayers had no disabling conditions
- 164 Individual stayers had income and report no disabling condition

- 647 Individual stayers entered the system of care with no income
- 609 (54%) Individual stayers had no recorded income *since* entering
- 463 (41%) Individual stayers had been homeless a year or more, of which 92 (20%) were between the ages of 18-24
- 373 Individual stayers experienced homelessness four or more times
- 418 (37%) Individual stayers presented with high acuity as assessed with the SPDAT
- 716 (63%) Individual stayers reported a disabling condition, of those persons:
    - 413 had no income at entry
    - 376 had no income at entry *and* had no income since entry
    - 439 had experienced homelessness six months or longer

Rapid Rehousing Interventions for Single Individuals

363 Individuals Exited RRH in 2019

- 287 (80%) exited to permanent destinations
- 73 (20%) exited to temporary destinations

266 Individuals Entered into RRH in 2019, of those:

- 62(23%) have remained in housing
- 159 (60%) exited to permanent destinations

Of those that exited to permanent destinations in 2019, the average length of the rental assistance was 6 months. Detroit rapid rehousing interventions for individual households has a recent history demonstrating 80% success rate in exited to permanent destinations and maintaining housing.

System Model Strategies for Individuals

In modeling strategies to significantly address the housing barriers faced by Detroit individuals that are not successfully exiting the system, objectives include:

- Transitional aged youth individuals (aged 18-24) need access to supports for education, training and employment combined with rental assistance to establish a stable housing destination.
- Individuals that present with no disabling conditions and first time or short-term homelessness need rapid access to income supports such as education, training, and employment to reestablish steady household income and possible one-time or short-term rental assistance.
- Individuals that present with disabling conditions, high acuity, and long-term and multiple episodic homelessness need income and benefits long-term housing with supports

Making Incremental Improvements	Making Significant Improvements	Meeting All Housing Needs
• Improve occupancy rates of transitional housing especially for programs appropriate for transitional aged youth aged 18-24 • CES matching decisions for ESG-CV RRH (limited to 12 months assistance) should be strategic in assigning to single individuals • Household income supports should be implemented immediately upon entry into the system of care for zero income households and continued employment engagement throughout the housing process • Develop working unit inventory and expertise of senior housing such as assisted living, retirement, long term care targeting those individuals 55 and older with multiple disabling conditions	• Development of CoC TH/RRH program of at least **36 units** program targeting transitional aged youth • Develop program transfer / bridge strategies between RRH to PSH units for chronic homeless individuals not able to successfully exit RRH and presenting with continued supportive services needs – **at least 24 units** • Development of **115 PSH units** for chronic individuals[2] • Add at least 40 units of Bridge Housing for individuals of moderate acuity with two or fewer barriers to housing (e.g., awaiting results of Social Security Application; awaiting identification; etc.) • Add a minimum of 5 rapid resolution specialists to shelter to work intensely with individuals less than six months with lower to moderate acuity, to	• Provide HCV Vouchers with a Homeless Preference as a formal systemic method of housing stabilization for disabled and older individuals who cannot exit rapid rehousing without long term rental assistance • Development of **311 PSH units** for chronic individuals[2] • Provide HCV Vouchers for individuals transitioning out of PSH after stabilization and in continued need of long-term rental assistance • Package all rental assistance (one time, short term, or long term) with education, training, employment, • Expand one-time financial assistance (arrears, deposits, and first/last months' rent) for first time homeless through rapid resolution and diversion programs packaged with short-term supports to effectively connect to

[2] Chronic Homelessness – Filling the Supportive Housing Unit Gap, Detroit CoC Chronic Leadership Committee Report. See Appendix for Details.

Making Incremental Improvements	Making Significant Improvements	Meeting All Housing Needs
	explore housing options outside Coordinated Entry (e.g., family reunification when safe and appropriate) • Add roommate/shared housing matching specialist • Add or train up a minimum of 4 SOAR specialists to assist shelter guests with access benefits	needed medical and mental health services • Add flexible funding for diversion activities and rapid resolution activities

IX. Service-Level Gaps Recommendations

Street Outreach Services

- **Treatment Programs** – To prevent a gap in services and treatment from in patient to outpatient or when a client transfers from one agency care to another, it is important to have a more integrated service delivery structure with street outreach and housing through *formal partnerships* – packaged with housing and coordinated discharge to housing transitioning care. These integrated processes should be a specially designed client-centered program/procedure that can be influential and essential in the CAM match and housing prioritization process.

Emergency Shelter Services

- **Treatment Programs** – Behavioral health and treatment programs are needed to be more integrated with the shelter and CAM process through *formal partnerships* to provide a more seamless process of housing stability when moving from in-patient to outpatient services.
- **Essential Housing-Focused Services in Shelter** – Shelter providers, upon accepting guest referrals from CAM, need the capacity to provide shelter-based housing planning, staff, resources, rapid resolution, housing search, navigation, placement. Several shelters strongly expressed that they want to be housing focused but too often lack the resources or capacity to take it successfully to scale for the households they serve.

  Each stage of engagement in shelter require shelter-based tools and training in order to engage all clients in productive housing solution conversation. Rapid exit from shelter strategies (housing planning, search) and housing readiness services (documentation, addressing housing barriers) in shelter should complement CAM

activities for high acuity and chronic guests, and provide workable pathways out of shelter for moderate and lower acuity guests.

Reinforcing housing based emergency shelter will support performance metrics to reduce the length of stay in homelessness and improve shelter exits to housing.

Other housing focused services either provided by shelter staff or provided in shelter through partnerships may also include: guest instruction on housing process/tenancy supports (e.g. ReadytoRent.org), continuous searches for vacant unit listings in both primary and secondary rental markets shared in shelter community areas, landlord engagement and advocacy, especially for first time renters such as youth, young families.

- **Expand Access to Flexible Funds** – The need for one-time rent and non-rent related financial assistance that is low-barrier, quickly administered, and accessible to front-line staff can support both diversion and rapid resolution efforts. These funds can be targeted to low and moderate acuity shelter stayers to resolve barriers to housing applications, employment, or other similar needs.
- **Formalize Employment Services Accessible in Shelter** – Employment coaching, search, recruitment services, especially through a formal collaboration with programs supported by the Workforce Development Commissions, are essential especially for low and moderate acuity households. Overall, there must be structured efforts on household income development (both employment or other income sources) prioritized as part of shelter essential services (or partnerships).

Rapid Rehousing

- **Seamless connections to RRH** – RRH that works more seamlessly with shelter will support reducing the length of stay in shelter. The urgency in which the pandemic encouraged multiple providers to coordinate both shelter, CAM, and housing resources for exiting to PSH (e.g. Marygrove) should be applied also to RRH resources. Targeting guests at the emergency shelter matched to RRH, coordinated through CAM, and supported with onsite intensive wrap around services resulting in successful rapid exits to housing.
- **Flexibility in RRH Centered on Client** – With the infusion of CARES Act ESG-CV funds that will provide additional RRH funding, this will become one of the most accessible rental assistance programs. Analysis identified that 80% of households had successful exits from rapid rehousing. Of those households an average of 6 months of assistance was provided to individual households and 10 months for families. ESG RRH will have more limitations than CoC funded RRH and should be strategically matched to client needs. CoC RRH rental assistance policies should incorporate flexibility in lengths and amounts of assistance to assist more vulnerable households.

- **Create TH/RRH for special populations** - This relatively new HUD CoC Program is a new component type in Detroit targeting households fleeing domestic violence. These flexible housing program designs have been proven effective in providing the needed longer term housing stabilization for Youth.

Permanent Supportive Housing

- **Seamless connections to PSH** – This strategy was implemented at the COVID emergency shelter at Marygrove where persons at risk for COVID 19 and matched and enrolled in PSH. The urgency of the pandemic created the urgency for multiple providers to coordinate resources between shelter and CAM and supported with onsite intensive wrap around services resulting in successful rapid exits to housing.
- **Mental Health / Behavioral Health Services** – As with shelter, mental health and behavioral health services are not required but there should be enhanced efforts to encourage use and access - trauma informed, stigma-free, private as well as supporting seamless transition in care – no break in care, no break in sheltering and no break upon entry to housing or while housed. With care accessible and oriented to the client's location or transportation restrictions, and offered in easily understood, barrier-free approach, the voluntary acceptance of services that will support stability may become more appealing. Negotiating with clinical providers to consider changes may be necessary to develop creative delivery strategies.
- **HCV Vouchers** – HCV vouchers within a structured homeless preference commitment are one of many essential tools to see a dynamic positive exit (moving on) from CoC PSH programs. HCV with homeless preference are also important to moving disabled and elderly households with moderate and somewhat high acuity clients demonstrating housing stabilization characteristics into needed long-term housing subsidies. However, when the release of HCV homeless preference vouchers is erratic or conducted en masse, it makes it difficult to plan and be a part of structured options to housing assignment process. Where possible leadership should examine opportunities to have a more consistent number of vouchers committed to the CAM housing prioritization process that is more certain and manageable.
- **Development of Permanent Supportive Housing** – Detroit has completed substantial work on projecting PSH needs through its Detroit Chronic Leadership Committee's 2020 analysis "*Chronic Homelessness – Filling the Supportive Housing Unit Gap.*"

Youth Services

- **Structured Discharge Care** – Youth providers understand some of the challenges to intercept and provide supportive care when young persons are discharged without any planning from justice, health, or treatment entities. Not only are discharges often conducted without a warm handoff, there were noticeable differences in follow-up instructions based on the race of the patient. Black youth were observed as being less able to navigate institutional systems, nor having informed supportive networks in which to understand how to access follow-up

care, legal assistance, or connections to supportive care. Structured supports following discharge from institutional settings should be pursued with formal partnerships and relationships for youth.

- **Moderate Term RRH** – Utilizing CoC funded RRH programs would allow more moderate term housing supports (up to 24 months) for households transitional aged youth 18 – 24. Development of a TH/RRH CoC funded program would improve housing transition options for households presenting on housing priority lists. (https://endhomelessness.org/the-joint-component-is-for-homeless-youth-too/).

  The TH/RRH model follows a housing first approach with emphasis on Youth choice and can provide a step of transitional housing (often facility-based) for stabilization and further housing planning and resolution. In examining the snapshot prioritization lists, on average at any point in time there are 3 youth actively awaiting a match/referral to housing. An example of a housing model for a TH/RRH Project:

TH/RRH	12/18 TH/RRH units Avg. LOS in TH 3-6 months Avg. LOS in RRH 12 months Target Number Served Annually: TH – 36 Target Number Served Annually: RRH - 20

- **Long Term Employment/Career Support** – Youth are particularly in need of being connected to pathways to long-term earned income career opportunities. The CoC is better equipped to provide housing interventions and stabilizations but must have strong and expansive community partners whose missions align with training, education, and employment such as Workforce Development Commission.
- **Youth Homelessness Demonstration Program** – With the delay of the next round of the HUD YHDP funding opportunity due to COVID, there is more time to improve Detroit's application and planning in drafting a map, coordination, and identification of new partners for the development of a Youth Coordinated Community Plan.

X. System-Level Gaps Recommendations

- **Clarifying roles and responsibilities in the Housing Planning, Navigation, Placement Process** – There is balance between housing first and housing eligibility that involve many administrative tasks. The tensions from street outreach, shelter and coordinated entry to quickly house the most vulnerable is matched by the requirements and concerns of housing providers to assure their program participants meet eligibility and they have the documentation to prove it, else be at risk for paying back funds for what may later be determined by a monitor as ineligible activities.

Understanding who is responsible for assisting and securing basic documents and services can be essential to successfully housing clients. Examples include:

- Verification of Homelessness and/or chronicity
- Disability Status
- Birth Certificate
- State ID
- Social Security Card
- Probation/Parole/Registration
- Transportation
- Mail/Email/Phone
- Document Storage
- SSI/SSDI/SOAR
- VOH Updates
- Medicaid/Medicare/ACA
- Housing Search
- Housing Applications
- Landlord Advocacy/Negotiations
- Transportation
- Start-up/Move-In Kits

With the sophisticated design of CAM into two distinct agencies and responsibilities, their coordination with street outreach, shelter, and housing solution providers is essential to ensure the administrative and bureaucratic realities of the housing process demanded of funding entities does not itself become a housing barrier. To combat this, it is important to clearly define who is responsible for what tasks and to also clarify *where* best to coordinate and distribute activities to assure agencies are '*meeting clients where they are*'.

The majority of persons prioritized for housing should be document ready upon referral to assure eligibility and focus housing transition efforts on client housing supports. For those persons that are highly vulnerable, presenting with high acuity and where housing is essential for safety and health, these persons may be targeted for waivers to documentation or pre-housing application requirements in an assertive housing first model.

- **Housing Search/Navigation** – All persons, regardless of acuity and vulnerability need assistance in pathways to returns to housing. The process for the decision making and distribution of housing subsidy programs is very distinct and well managed in Detroit. Persons that are not likely to rise to the top tier of acuity group lists will need the same broad support in housing planning, search, and placement, including interagency coordination.

  Not all shelters and providers have the same capacity or access to resources. Providers expressed that improving centralization of access to information, housing planning skills, and one time financial assistance for housing related needs would boost their success in rapidly housing clients. This could take the form of formalized partnerships and in-reach by CAM or street outreach staff, or other agencies that are funded through state or federal funds.

- **Aging & Elder Care** – Persons presenting into homelessness that are 64 and older make up approximately 6% of persons served. To address the often specialized health and housing needs of the elderly, establishing more expertise as well as formal relationships with elder care, health care, senior and assisted living housing can expand housing options where such care may be a better intervention than CoC PSH options.

- **Childcare / Education Services** - Families experiencing homelessness are not just without housing. Many are affected by trauma, including domestic violence, physical, emotional, and sexual abuse. Homelessness itself can also be a traumatic experience. For young children, research has shown that toxic stress affects brain development, particularly in the earliest years from birth to age three when rapid brain development and wiring lays the foundation for future social, emotional, physical, and cognitive development.

  As more families are steered to Rapid Rehousing programs, especially with the new ESG-CV funding, it is essential that households are directed to both childcare resources and assisted in reestablishing a home school as part of ongoing supports. Formal partnerships are critical to provide stable care and education services to go beyond housing case management and support families into long term sustainability after the housing subsidies end.

- **Coordination and Collaboration** – Providers expressed the need to broaden community coordination and collaboration in the development, design, and implementation of homeless response initiatives in the community. In order to improve housing outcomes, CoC leadership must further leverage other systems such as childcare, education and training, workforce development, mental health services and public housing authorities. This may take dedicated staff who can coordinate cross-sector service provision, knowledge, and skill to develop formal agreements and partnerships that will make more efficient use and alignment of the resources and services available to address barriers to housing for families, individuals, and youth.

- **Diversity of Staffing** – As identified and evident from demographic data, the overwhelming majority of persons experiencing homelessness are Black/African American. As part of effective service delivery strategies, the CoC should not only consider representations of persons of color in positions of leadership and upper management, but also among direct service staffing.

- **HMIS Enhancements** – Changes to the HMIS beginning on October 1, 2020 in response to new HUD Coordinated Entry Data Element requirements will improve shared information to provide a more coordinated rehousing process. In order to improve increased transparency, accountability, data quality, and improved useful reporting, some recommendations to the ServicePoint HMIS implementation include:

  - Increased ART Viewing licensure for staff responsible for daily HMIS input, to ensure accurate data reporting can be monitored by the same staff responsible for its initial completion, with the ability to run their own reports and make corrections in real-time

  - Provision of new resource(s) -- or reminder of existing resources -- that outline daily, weekly, and monthly HMIS reports to monitor program performance, outcomes, data accuracy, completeness, and congruence (no 17 year-old veterans, chronically homeless people without disabling conditions, etc.)

- For HMIS data quality purposes, for people in programs at least one year, a particular emphasis on pending interim reviews to be completed in the 30 days surrounding their program anniversary date, with a corresponding "how to properly record updates at interim review" for staff with questions regarding the process/workflow.

- Regularly updated (at least weekly), easily accessible (ideally online) aggregate data dashboarding to measure (1) the count of people experiencing homelessness at the beginning of the reporting period (2) new inflow into homelessness, (3) new outflow into permanent housing (4) new outflow to other non-permanent locations and (5) the count of people experiencing homelessness at the end of the reporting period; essentially a way for community members to see if this week/month/quarter's homelessness is less than previously, and whether that's due to inflow outpacing outflow, outflow outpacing inflow, or the amount of time between inflow and outflow (to highlight the need for enhanced prevention/diversion, housing navigation/securing or outreach/documentation expertise).

Summary of Recommendations

System and Services Areas	Next Steps
Treatment, Mental and Behavioral Health Programs - Formal Partnerships between CoC and providers - Coordination with Street Outreach - Coordination with Emergency Shelter - Seamless transition from care and treatment to housing	- CoC and Provider leadership meet and plan development and components of MOU/MOA including access points, in/outreach, care coordination navigation, funding sources - Create community care navigators among care provider organizations
Housing-Focused Services in Emergency Shelter - Shelter-based housing navigators, housing case management, housing search, housing placement - Flexible Funding for one-time financial assistance - Employment and Workforce Services through formal partnerships shelter and transition to housing - Elder & Aging Care and senior housing specialization	- Conduct comprehensive Housing – Focused Shelter Transformation process and Detroit-wide learning collaborative - Create or expand Flex Funding program centralized for access by multiple ES, TH, and RRH providers - CoC and Employment/Workforce leadership meet and plan development and components of MOU/MOA including access points, in/outreach, workforce training navigation, and funding sources - CoC and Elder, Aging Care, and Senior Services leadership meet and plan system resource assessment and referral protocols, and care coordination navigation. Establish senior housing inventory as other permanent housing for vulnerable aged clients
Seamless Coordination between CAM, Street Outreach, Emergency Shelter & Housing Providers - Clear roles and responsibilities for documents, search, transition - RRH & PSH - Consistent HCV inventory commitment	- CoC Committee(s) review and refine coordination and communication roles and responsibilities between CAM, SO, ES and housing navigation steps with RRH and PSH providers - CoC and PHA leadership meet to expand HCV homeless preference and 'moving on' partnership
Flexible Household-Centered Rapid Rehousing Programs - Flexible terms of assistance - Flexible subsidy amounts	- CoC and ESG program review of RRH programming - Engage landlord input on RRH program implementation improvements

System and Services Areas	Next Steps
Youth Service Enhancements - Coordinated discharge from institutional care - Youth TH/RRH Project - YHDP planning	- Develop capacity to provide care coordination navigation for youth being discharged from health care, mental health, and criminal justice organizations - Seek new TH/RRH project for youth in FY20 or FY21 CoC competition - Research successfully YHDP projects, plans and applications from other communities. Continue planning in anticipation of 2021 YHDP NOFA
Family Service Enhancements - Education relocation assistance - Childcare	- CoC and Childcare Advocate leadership
HMIS - Expand standardized reporting - Expand user licensing	- Utilize increased HMIS resources (e.g. ESG-CV) to increase service levels - Increase HMIS Administration Technical Assistance, training and require additional WellSky ServicePoint support - Develop CoC Program Analyst position or responsibilities to regularly review, analyze and interpret HMIS data

Appendix:
Chronic Homelessness – Filling the Supportive Housing Unit Gap

Revised February 13, 2020

Chronic Homelessness – Filling the Supportive Housing Unit Gap

Detroit CoC Chronic Leadership Committee

Purpose

The CoC Chronic Leadership Committee wanted to understand:

1. how many chronically homeless households are accessing supportive housing (SH), through the turnover of existing units and newly funded units coming online.
2. The number of new SH units needed to house those currently experiencing chronically homelessness by utilizing 2019 Chronic By Name List (BNL) data.
3. Identify the financial costs to create and sustain annually for both the housing and services.

There are two important caveats:

1. This does not include households that may age into chronicity in the future. To calculate households aging into chronicity would require additional data.
2. Creating new units of SH alone will not end chronic homelessness. This requires work upstream to engage, support and connect with housing before someone ages into chronicity.

Step 1: Calculating the number of chronically homelessness holds in need of SH

	Chronic Households
Total Households Jan-Dec 2019	642
% Scoring for SH*	95%
SH Unit Demand	**610**
Single Adults**	592
Families	18
**95% of CH households need SH based on chronic BNL completely Full SPDAT*	
***97% of CH households are single adults*	

Data Source - Chronic by Name List (BNL) report from HMIS and review of each client HMIS record

The chronic numbers utilized in this document may not match other numbers used throughout the CoC. Here's why the Chronic Committee decided this approach – The committee is aware of data accuracy concerns related to the HMIS chronicity questions and have a plan to improve accuracy. However, until that plan is fully implemented, the committee is taking an extra step of reviewing each client pulled on the BNL report to determine chronicity. While this is a time intensive process the committee wants to ensure the accuracy of the baseline data.

Step 2: Calculating the SH need after turnover and new units

Housing Intervention	Existing Stock	Available Jan-Dec 2019	Demand (Step 1)	Over/ (Under)
PSH Total	3016*	289 (165** + 124^)	610	**(321)**
** 2019 HIC PSH Total Beds* *** Number of new and existing SH unit availability from Jan 1–June 30, 2019* *^ estimated number of new and existing SH availability from July 1-December 31, 2019 (75% of first 6-month total)*				
SH Units Needed to Meet 2019, by Sub-population				
Single Adults				311
Families				10
Total Number of SH units to fill 2019 need				**321**