HOMELESSNESS RESPONSE SYSTEM REDESIGN

KING COUNTY

NIS National Innovation Service

The City of Seattle and King County are committed to ending homelessness. In August of 2018 they partnered with the National Innovation Service to launch a community-driven process of listening and, ultimately, designing a stronger regional response.

This document captures the results of this collaborative journey and lays out 10 Actions necessary to move forward. Associated media can be found at http://hrs.kc.future.com/. In 2019, dozens of partners across the region will come together to build a regional Homelessness Response System that can achieve greater levels of equity and impact.

Working together, we can end one of our country's most unacceptable realities.

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Website by the National Innovation Service

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Thank you.

We would like to thank the 207 customers and providers who took time out of their lives to contribute to this work.

Thank you.

A Note on Language

Throughout this website you will notice that our team uses the term "people experiencing homelessness" with the term "customer" interchangeably. Our goal is to appropriately position people experiencing homelessness as individuals with dignity and agency who are receiving a service that they have requested from paid staff.

The intent of this shift in language is not to encode that relationship within a traditional hierarchy of private sector structures, but rather to ensure that references to people experiencing homelessness are consistently being rooted in a way that conveys their status within the system that serves them. While the term "person experiencing homelessness" eschews more demeaning language like "the homeless" it doesn't accurately reflect their right to make requests of a system that serves them. In addition, it does not reflect their fundamental right to be satisfied with those services.

By choosing to use this language we hope to inaugurate a more robust conversation about how best to empower those we serve.

Theoretical Framework

The City of Seattle and King County are searching for ways to create faster and more robust pathways out of homelessness. To build on that momentum, Seattle, King County, and All Home (the county-wide HUD-funded Continuum of Care) partnered to contract with our team to assist them with a transformation of the system.

To create the transformational actions detailed in this release, we used elements of community-based participatory research. The inclusion of community members in both the research design process and data analysis ensured team members with different backgrounds did not misconstrue or render meaningless information collected due to their lack of lived experience or because they are not a member of that socio-cultural group.[1] A participatory process thus assumes the legitimacy of knowledge produced outside of professional research communities and looks to build on that expertise, thereby strengthening the value of findings.[2]

In designing a qualitative, community-driven design process we sought to:

1. Identify pathways into homelessness, service utilization patterns, and barriers to exiting homelessness among people in King County, WA.
2. Recognize qualitative data as a key first step in examining under-researched populations—to produce initial knowledge and inform future research questions.
3. Recognize the community affected as the experts.
4. Involve the community affected in system design, interpretation of existing information, and creating recommendations.

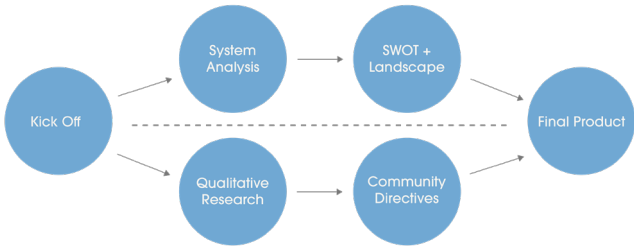
The goal of this design process was to inform the overall structure of homelessness response and prevention in Seattle and King County. As such, both the process and this final product are geared towards producing a holistic and integrated system as opposed to making recommendations for 'add-ons' that merely apply band-aids to structural failures.

This approach has three core understandings:

1. We must appropriately identify and listen to the end-user—in this case, people experiencing homelessness. While service systems are traditionally built with the input of 'experts' as the guiding voices (e.g. providers, policy makers, or community members at large) our practice understands delivering services that are effective means the input of people utilizing those services must be understood as the primary data source.
2. By designing with equity in mind we privilege the voices of those who are the most vulnerable to the experience of homelessness. By building a system that is responsive to the needs of those who are at the highest risk for prolonged or multiple episodes of homelessness, we build a system that has better capacity to respond to the needs of all.
3. Finally, we understand that a systems level approach requires we focus on transformation and redesign rather than modification. Our existing systems have not proven capable of providing us with the long-term outcomes we desire. By establishing a method that identifies the outcome objectives from the input of people experiencing homelessness as the primary data source, we recognize it is possible to engineer truly transformative solutions.

Process

To accomplish this, our team conducted two parallel tracks of work.



Systems and Policy Track

In order to develop real-time understanding of the current system architecture, we began by pulling in and analyzing data about the operating structure in place for the region right now. We collected organizational charts, job descriptions for staff who work on homelessness, policy positions, plans, reports and assessments, any identified theories of change, and meeting minutes. Following our analysis of current structure we identified preliminary areas where there was the potential for substantial growth. In order to validate the assumptions embedded in these growth areas we engaged system administrators, City of Seattle and King County staff, and national experts. This continued over the course of our engagement, as we continued to refine our diagnoses of the opportunity areas. Our team conducted informational meetings across formal and informal settings over 150 times during our engagement, gathering insights from over 100 people, not inclusive of frontline staff or customers.

Additionally, this work was reinforced by a team of analysts who conducted literature scans of national best practices, promising innovations (both domestic and international), and reached out to transformational leaders in communities across the country. The team focused their work on content areas identified through interviews with system administrators and people experiencing homelessness. These content areas were: re-entry/criminal justice; juvenile justice; economic mobility; behavioral health; technological innovation; healthcare; child welfare; and housing.

Findings from interviews and secondary research were then indexed against the results of the participatory design research for confirmation. This final step ensured the actions represented here, and the policy strategies that underpin their implementation, are supported by the customers we spoke with and reflect their explicit suggestions for how to improve the system.

Qualitative Research Track

Our ability to develop these actions required an understanding of the current state of services, which we uncovered by working with frontline staff and people experiencing varying degrees of housing instability. For participant recruitment, we reached out to twenty-five service organizations, thirteen of which were able to help us connect with customers and staff. We deliberately targeted populations disproportionately overrepresented in homeless populations (e.g. black, Native, transgender) and sampled across program subpopulation types (e.g. families, youth, chronic), to develop an understanding of their unique needs and perspectives.

123 CUSTOMERS

85 PROVIDERS

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207 PEOPLE

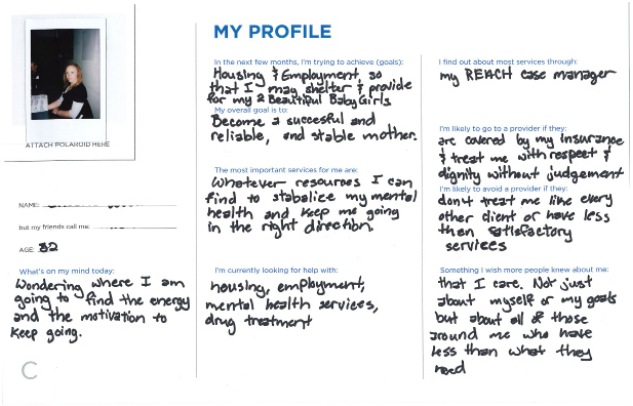
The approach leveraged a mix of design workshops, interviews, ride-alongs, and site visits across Seattle and King County. This enabled us to develop a rich body of data about the values, priorities, and interactions that play out in distinct social settings.

Our lines of inquiry helped us to identify the biggest challenges for both accessing and delivering services. In addition, we uncovered much about the complicated dynamics between service providers, customers, and

the system. For customers, we explored the ways in which they navigate the service ecosystem, the common unmet needs, the gaps they experience, and their strategies to overcome them. For staff, we inquired about their approaches to service delivery, common barriers that prevent them from providing value for their clients, and the touchpoints in need of improvement. These topics elicited diagnoses of the myriad challenges in the current system and illuminated opportunities for redesign.

Our primary source of data collection was through design workshops, which gave our team the opportunity to reach a significantly larger population in the limited time frame of this project. It also gave us a vehicle to develop solutions with both customers and staff. We iterated on the tools and activities used in the workshops throughout the course of our project. Below are a number of examples of the assets we used to solicit input from the community.

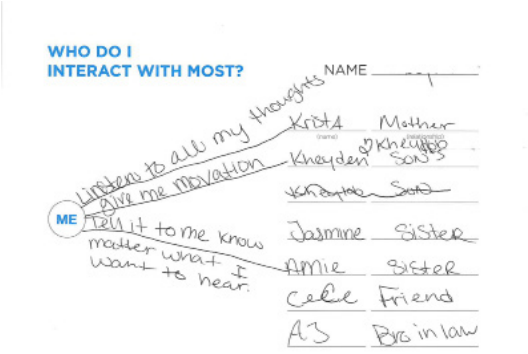
Profiles



This profile was framed as a part of a fictitious matchmaking service that would help customers and staff get to know one another before their first interaction. Customers were asked about their goals (near and long-term), service priorities, what they're currently seeking, and their ideal characteristics for a service provider. Providers were asked to articulate the services they provide, their expectations of customers, and their commitments to them.

This activity helped us to understand some of the nuanced dynamics that exist between service providers and staff, which we discuss in Action 3. It also confirmed an assumption we had around customer goals—they all want and need housing, over anything else—which we discuss in Action 9.

Networks



The network canvas asked customers to list the individuals they interact with the most, select the most helpful individuals, and describe how they're helpful. The majority of customers cited the most important assistance they receive is emotional support, speaking to the significant emotional strain the experience of homelessness brings.

Service Barriers and Delivery Challenges

All workshops had some version of this activity, which asked customers to articulate the biggest barriers to accessing services, and providers to name their top service delivery challenges. After discussing challenges as a group, we transitioned into the generation of solutions and ideas for improvement. Throughout this site, you'll frequently encounter images and audio content from this work. These informed the direction of our actions.

Data from workshops, interviews, site visits, and ride-alongs were subsequently synthesized by our team. We applied a common analytical process to this type of data, beginning by aggregating, cataloging, and tagging artifacts with codes; clustering into observational patterns; and then into broader themes that speak to the dynamics and interdependencies between the patterns. This resulted in a number of

distinct insights and opportunities that represent the myriad of changes the community needs and wants to see. As mentioned above, this stream of research was then indexed against the policy findings to either confirm identified strategies, or build support for new ones.

Given the scope of this work, we favored solutions at the systems level, despite unearthing a number of opportunities that exist at the service level. Additionally, the time constraints of this work necessitated two concurrent streams, which prevented us from deriving the actions solely from our primary research. Further limitations are discussed below.

Limitations

There are significant limitations to our work. The first, and most important, is that this process simply wasn't long enough. Engaging in authentic community processes takes time. It requires building trust, maintaining that trust, and entering into meaningful and mutually accountable relationships. Due to the nature of the contracting timeframe this was simply not possible. Many of the people who have been engaged over the course of our process, because they don't hold positions of status or power within the community, have not been part of any ongoing strategy to solicit feedback on the work presented here.

In order to build a methodology resistant to interpreter bias (i.e. the unconscious bias of our own team) our research structure involved asking questions as directly as possible, allowing people the opportunity to contextualize their answer or give it nuance in the moment, and giving people multiple opportunities to decline to engage if an activity or conversation did not seem to be structured in such a way that they could participate honestly. However, this does not guarantee that everyone felt comfortable or that everyone answered honestly. Our team heard multiple times over the course of this work that the timeframe didn't work for the community. Additionally, a number of people reached out to say that they were unable to provide complete answers. The most often cited reason for declining to participate was fear from an embedded power dynamic that could not be mitigated in time. People experiencing homelessness declined to participate when providers were present, providers were uncomfortable with system administrators, and agency staff were often suspicious of whether participating in candid conversation about their work would lead to reprisal. While all of these are manageable events, they are only manageable given the time to build trust.

Finally, it must be said that all of this reflects the current state of a lack of engagement with the communities most affected by homelessness and people who are currently experiencing homelessness. Had there been more robust frameworks in place with connectivity between decision points and the people most impacted by those decisions, it would not have been incumbent on this team to do such aggressive and methodical outreach.

If the region wishes to move forward authentically with the work that is summed here it must be done with ongoing accountability and feedback loops with the community at large. It is necessary to realize that to build with equity at the center requires time—and there is no substitute.

Why it Matters

Engaging in transformational work is difficult. It often feels daunting or impossible. Our team feels the seeds of transformation—of the pathways forward that will better life for all of us—are embedded in anti-oppression and anti-racist frameworks. We hope our work here, with this community, will be the beginning of a more robust conversation about the ways in which systemic inequities can be addressed.

1 AHRQ, (2004). Community-Based Participatory Research: Assessing the Evidence. Evidence Report/Technology Assessment No. 99 (Prepared by RTI University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication 04-E022-2. Rockville, MD: Agency for Healthcare Research and Quality.
2 Gaventa, J. (1993). The powerful, the powerless, and the experts: Knowledge struggles in an information age. In P. Park, M. Brydon-Miller, B. Hall. & T. Jackson (Eds.) Voices of Change: Participatory Research in the United States and Canada. Westport, CT: Bergin, Garvey.

A theory of change is essential to the effective performance of a system.

In our work with the region we found that there was no unifying theory of change that governed all of the resources being deployed to prevent an end homelessness. Theories of change, while they may feel arcane, are essential to the effective performance of a system. A theory of change gives system stakeholders a clear goalpost that everyone agrees they are moving toward and provides an axiomatic way of evaluating investments: "does this move us towards our long term goal or not?"

While, some programs (King County's Equity and Social Justice Initiative) or populations (for example work funded the Youth Homelessness Demonstration Project) have theories of change attached to them there was no evidence that the entirety of the system was governed by a uniform approach. This is in part due to severe system fragmentation (addressed in Action 2). However, a theory of change requires ratification beyond system administrators. The community must believe that the goal outlined is correct in order to appropriately allocate resources.

This action outlines a suggested theory of change based on work that was done with system administrators and people experiencing homelessness.

Background

In order to arrive at a shared theory of change, we convened a group of system administrators, philanthropic and business community representatives, and representatives from the broader region. Together they participated in a half-day workshop designed to identify what people felt like the most important outcomes of their work were.

Throughout the day, the following two repeatedly surfaced: Equity, which is explicitly about re-designing structures to enable those most affected to drive the design and delivery of the system. This should result in reduced disproportionality for historically marginalized communities (particularly people who identify as black, Native, LGBTQ, or living with a disability) and increased agency for customers, those with the most direct knowledge of what the needs and implications of the system are.

Ending homelessness, which means for all populations, an assurance of housing when they need it.

The group proposed that if they:

- enable choice for customers
- right-size resources
- embrace agile change responsive to customer need

Then they be able to:

- create customer-centered services
- create coordination that promotes public commitment across the region and is responsive in real time to the needs of its constituents
- restore public trust that the city and regional governments are in service to its constituents

The group also acknowledged some key weaknesses of the conversation:

- The room did not contain a diverse set of voices, particularly those who are most impacted by the crisis
- There needed to be greater attention on what it would take to "build the muscle" required to really engage in centering customer voice (e.g. what does a new continuous quality improvement framework look like?)
- We are in a crisis and are obligated to move as quickly as possible to design and implement something that works for the community

In response to those weaknesses our team engaged customers and lived experience advocates in helping to refine the theory of change. In some instances, this was done through interviews that simply asked people to identify what they felt was important about the work. In others, particularly with lived experience advocates, we asked them specifically to refine the theory of change possibilities that had emerged.

The final theory of change that emerged from the group was:

> **If we create a homelessness response system that centers customer voice, then we will be able to focus on responding to needs and eliminating inequities, in order to end homelessness for all.**

Our team suggests this theory of change be ratified.

Strategies

1. Ratify the Theory of Change

In order to move forward with the suggested theory of change, it will need to be adopted by the community. This will involve ensuring the there is alignment across the system which includes, people who are experiencing homelessness, providers, and administrators across King County.

2. Analysis

Policy, programs, and investments must be analyzed against a newly adopted theory of change to ensure alignment. Investments that are not inline with the community's theory of change should repurposed to support activities that are. The policy implications of this work are substantial. Investments can be quickly and axiomatically engaged against the criteria laid out in the theory of change. This theory of change also allows for alignment with federal policy around ending homelessness and functional zero and so a number of guidance documents that are federally ratified can be used to steer this analysis.

Related Actions

3. Become accountable to customers.

8. Create a defined public/private partnership utilizing a funders collaborative model.

10. Create long-term institutional alignment across systems to serve people experiencing homelessness.

Fragmentation is a critical weakness.

Fragmentation across programs and systems is a critical weakness of the homeless service systems in Seattle and King County. This is reinforced by providers, public officials, and previous work in the region.[1,2,3] Customers'[4] accounts of their experiences of homelessness reflected this fragmentation: stories of geographically—and administratively—disconnected services, duplicative data collection, and unnavigable systems produce dead ends rather than meaningful assistance.

Consolidating policy-making and funding activities into a new, joint regional authority is necessary to overcome this fragmentation and respond to the emergency at hand.

It is critical to note the actions outlined here are interdependent. Consolidation is vital to the transformational shift toward streamlined services and supports that center customers' needs and experiences and prioritize equity.

Background

The scope of homelessness in the King County region is a public emergency. Driven by the dramatic decrease in affordable housing, Seattle has the third highest number of people experiencing homelessness in any city in the country.[5] This growing crisis has had an outsized impact on marginalized communities.[6] Though people of color only make up 33% of the total population of King County, more than half of those counted as experiencing homelessness on a single night in January were people of color.[7]

Without substantial investments in affordable housing, the region will not end this crisis. However, these investments will be inadequately leveraged if programs and systems across the county maintain their current state of fragmentation. Auditors and technical experts have offered proposals and feedback to improve system performance to rise to the challenge of the region's crisis, but each assessment pointed to system-wide fragmentation as a barrier to progress.

Earlier this year, the King County Auditor's Office found that despite increased system performance, "diffuse authority still hinders regional homeless response."[8] This echoes the 2016 findings from Focus Strategies and Barbara Poppe and Associates that cited the

need to break down silos and reduce fragmentation.[9] In our own interviews with system administrators, six organizations and agencies asserted that they held major or even primary responsibility for ending homelessness in the region. Six agencies cannot hold primary responsibility for the same thing.

This fragmentation was clear in interviews and workshops with customers. Customers' perspectives on the disconnected nature of services illustrate the consequences of disparate structures governing disconnected systems. These dynamics led many to a dead end, the "not sweet spot,", where increases in income disqualified customers from certain services and supports, even though that income was already insufficient to maintain housing stability. This dead end directly drives bounceback into the homeless service system.

Aligning funders, providers, and public officials in a common vision, as outlined in the community-wide theory of change, would rectify some of these dynamics. The current state of distributed authority, however, leaves the region without an entity to implement that theory of change across the necessary systems and partners. None of the six agencies or offices noted above are jurisdictionally positioned to uphold a community-wide agreement.

Many agencies and offices play critical roles in the functions of the homeless service system: emergency response, service provision, housing, contracting, strategic planning, community engagement, and attempting to respond to racial and ethnic inequities.[10] The challenge is that each of these offices manage all of these functions. This lack of role clarity for an agency impacts staff morale, as they are unable to efficiently and simultaneously manage crisis response and strategic planning tasks. Beyond this, many of these functions also exist outside of those offices and in sub-regional agencies, furthering inefficiency. This functional confusion has minimized efficacy across systems and stunted progress toward ending homelessness in the region.

There are a number of solutions to these challenges modeled in other communities, but few would adequately meet the region's needs.

One model, often used in large cities, would be to appoint an individual lead for homelessness initiatives. While this would consolidate authority, it is impractical given the county's large population, which covers 39 cities and towns. The number of offices whose priorities, policies, and procedures would need to be managed by that lead would make the model untenable. In this region, such an office would likely only further duplicate functions and fragmentation.

Alternatively, simply aligning those offices and agencies could address concerns around functional confusion. However, in large regions this leads to partnerships that are personality-driven and fragile, with alignment relying on individual and political priorities. This is the current state of affairs, with collaboration functioning through ad hoc meetings and without formal arrangements or unified authority to meaningfully shift priorities or efficiently attend to pressing challenges.

In order to address the crisis at hand, Seattle and King County must consolidate the systems' command and control functions into a regional authority. The intensity of need in the region requires this crisis be managed as such. Universally-accepted frameworks for crisis response call for swift decision making that is informed by feedback from the front lines;[11] information symmetry that is isolated from threat rigidity;[12] and sharing situational awareness[13] through coherent messaging to the public.[14] A single authority avoids the need to coordinate across the current patchwork of regional authorities, thereby enabling faster coordination with front-line staff and more awareness among both responders and the public.

Without consolidated authority, the region will not be able to simultaneously manage emergency response functions, deploy the necessary services and supports for customers, and build a housing pipeline designed to meet the needs of those experiencing homelessness.

This dynamic is demonstrated by the status quo. These functions are necessary and critical; they cannot be prioritized against each other.

Similarly, public engagement and public/private partnerships are currently managed by a wide array of system administrators, public officials, and providers in a manner that leads to repeated miscommunication and poor messaging about the scope of the crisis and the work necessary and underway to address it. Consolidating these functions will allow for messaging and partnerships to be informed by real-time data, policy priorities, and direct access to system administrators.

Diffuse responsibility for data collection has constricted the region's ability to improve data quality and leverage data to inform priorities and policy-making. It is essential to consolidate all of the core functions of the homeless services system in order to appropriately identify and scale solutions, target resources based on emergent needs, and meaningfully leverage private funding against public investments.

Consolidation also allows the region to fully integrate equity as a core component of its goals and shape system-wide priorities that are tailored to those most often affected by homelessness. The regional homeless services system should perform in such a way that facilitates comprehensive care for anyone who comes into contact with it, rather than specialized or homogenized service options. An example of this is the lack of well-funded services that use traditional Native approaches to healing and care, which are among the most in-demand services for members of indigenous communities. Rather than piecemeal funding for such services, a transformed system could prioritize and scale culturally-specific services across the system. A joint entity would create the opportunity to institutionalize mechanisms for customer accountability and ensure the system is centering customers' needs and measuring performance accordingly.

A new regional authority established by King County and the City of Seattle would serve as the necessary and sufficient gate to all of the other opportunities identified here. Without consolidated authority, these interdependent actions will be impossible.

Strategies

Establish a regional authority that consolidates distributed functions of the homeless services system:

1. Consolidate all of the core functions of the homeless services system.

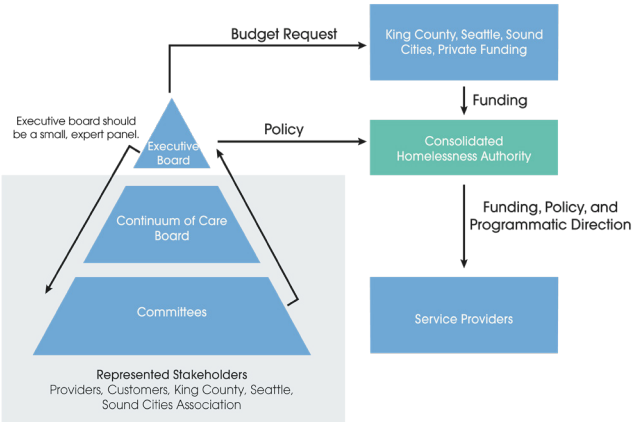
In order to effectively streamline policy-making, funding, and program management, the region must consolidate the core functions of the homeless services system into one joint, regional authority. To ensure customers have unfettered access to other services and supports, this regional authority must also oversee alignment with adjacent systems.

Looking across our data we have identified the core functions that should be consolidated:

EQUITY

The region must center equity as a core component of the principles governing homeless services by operationalizing it at the systems level. Under a

PROPOSED OPERATIONAL FLOW



Decision-making and funding flows informing the proposed consolidated authority.

CORE FUNCTIONS OF A REGIONAL AUTHORITY

new regional authority, this can be achieved by establishing a team to shape system- and agency-wide priorities and policies designed to target and improve access for marginalized groups; ensure fair treatment; eliminate barriers to services and supports; and create new services and supports tailored specifically to marginalized communities and those most affected by homelessness in the region. To be effective, oversight for equity functions must include responsibilities to inform and shape contracting processes, funding priorities, and program policies. It must also be closely linked to customer accountability.

EMERGENCY RESPONSE

Oversight of all emergency services for people experiencing homelessness—including shelter, permitted encampments, day centers, health services, diversion, and outreach—must be consolidated in order to ensure they are managed under the same data-driven principles and evidence-based best practices. This will also enable emergency services administrators to systematically identify resource gaps and thereby offer the spectrum of services and approaches customers need. Under a new regional authority, emergency services would inform system planning in real time and allow administrators to calibrate investments based on need and customers' outcomes.

CUSTOMER ACCOUNTABILITY

Responsibility for customer accountability must be consolidated in order to be operationalized. These responsibilities should include customer service, reporting and investigating violations, and managing the process to convey customer feedback to policy-making across the system. Certification, licensure, and continuous quality improvement should also be managed as functions of customer accountability. An Office of the Ombudsperson should be established to build customer decision-making power and to facilitate ongoing community engagement. This engagement should be leveraged to systematically integrate the daily lived experiences of customers and their perspectives into system policies and priorities.

SYSTEM PERFORMANCE

Consolidating system performance functions, including data collection and improvement, Homeless Management Information System management and cross-system data integration, performance and contract management, technical assistance, and research and planning, will allow the homeless services system to be truly data-driven, seamlessly integrating data collection and analysis, system improvement, and policy-making.

HOUSING

Oversight of permanent supportive housing, transitional housing, and rapid re-housing programs for people experiencing homelessness should also be consolidated. These oversight functions should include maintenance as well as efforts to improve and streamline access to those housing models. This degree of oversight would allow the regional authority to project and plan all housing development for people experiencing homelessness. This should be closely tied to collaboration with regional and state officials on related matters, particularly zoning, land use, and affordable housing development. This should include robust partnership with Public Housing Authorities through strong mechanisms of institutional alignment.

COMMUNITY IMPACT

In order to ensure key stakeholders, including the public, have consistent access to information about the scope of homelessness and efforts to address the crisis in the region, community and cross-system engagement functions should be centralized. These functions should include Continuum of Care (CoC) governance, reflecting the integral role of CoC stakeholders. Cross-system alignment, sub-regional coordination, and integration with economic mobility initiatives and prevention programs should also be tethered to this community impact work in order to solidify those partnerships and ensure that those programs are informed by homeless service system data and policy priorities. Community engagement should also encompass all functions related to public/private partnerships and communications.

Sub-regional coordination is a particularly critical function of a new regional authority. King County faces unique challenges in meeting the needs of people experiencing homelessness. As the 13th largest county in the country, there is often a substantial distance between service points and each municipality has a different level of resources to support customers. There are also demographic differences across sub-regions. The new regional authority should identify mechanisms, similar to the Los Angeles County Councils of Government model, that enable sub-regional areas to identify their own priorities and plans and funding streams around homelessness in alignment with system-wide policies and goals.

INNOVATION

Finally, to ensure the homeless service system is able to leverage the value that design and technology can bring to serving people experiencing homelessness, oversight for innovation should be centralized with access to each of the aforementioned functions. Innovation experts should be leveraged to apply human-centered design methods to evolve and iterate on core processes across the system. Innovation initiatives should be driven by public/private partnerships that would allow the system to leverage private investments to test promising practices and demonstrate the need for public funding to scale those innovations.

2. Establish a board that is representative of key stakeholders and has the technical expertise necessary to drive decision-making

As a regional authority that is responsible for a large geography and a full spectrum of consolidated functions, it is critical for the board of the entity to be representative of key local stakeholders who, together, have the technical expertise, decision-making authority, and resource control necessary to execute quickly. Expeditious decision-making requires the board to be as small as possible while maintaining fidelity to stakeholder representation.

In forming the Board, the community should consider representation from the following entities: the Office of the Mayor of Seattle, the Office of the King County Executive, the King County Council, the Seattle City Council, Sound Cities Association, the Continuum of Care, a health care provider, a representative of the Public Housing Authorities, the philanthropic community, and the business community.

Board composition should also include a meaningful number of customers of the homeless service system. In their role on the board, customers should not be tokenized. At a minimum, one-quarter of the board seats should be reserved for customers. The regional authority should engage technical assistance providers to support all members of the Board to ensure a shared understanding of roles, responsibilities, effective operating procedures, and to ensure that all members of the Board are well-positioned to participate as decision-makers. While the list above provides initial thoughts on who to include the most important question should be: who has the expertise necessary to accomplish the task at hand?

Additionally, it is critical the board be kept to a small number. In our work across the region, we found processes regarding homelessness consistently lacked agility and responsiveness to rapidly changing

conditions due to cumbersome multi-stakeholder approval processes. For a new regional authority to be effective, its Executive Director must be able to reach decisions, get approvals or necessary input, and move forward to implementation quickly.

3. Redesign Continuum of Care (CoC) governance bodies to align with the consolidated homeless services system.

The Continuum of Care (CoC) is a group of homeless assistance stakeholders, represented by a CoC Board, that is responsible for meeting the US Department of Housing and Urban Development's (HUD) program requirements and for ensuring that the funding it controls is allocated and used in the most effective way possible. The CoC controls approximately one quarter of the public homeless funding in the King County region, which it receives through an annual grant competition administered by HUD. Currently, All Home carries out most of the operating functions of the CoC.

By regulation, the CoC is responsible for specific local activities, including implementation and operation of HMIS and Coordinated Entry as well as developing written standards for the operation of programs that receive funding to serve people experiencing homelessness.

Through discussions with CoC Board members and stakeholders it is clear that the CoC—as it is currently operating—lacks substantive connection to the broader systems working to make homelessness rare, brief and one-time in King County. This isolation creates challenges in making adequately-informed decisions that are best for the community as a whole, and it perpetuates fragmentation. It also presents challenges for the implementation of system-wide practices to promote racial equity—one of the stated values of the CoC Board.

CoC leaders and homeless service system stakeholders have begun to redesign their governance processes in close collaboration with this initiative, in partnership with CSH. Overarching recommendations from that process include the following:

- The staff functions currently carried out by All Home should be absorbed into a new consolidated authority.
- The CoC Board should be re-formed and take on an additional advisory role to the board of the new consolidated authority, as detailed in the proposed operational flow. A new governance charter should be created to specify roles within the new structure and ensure compliance with federal requirements.
- The board of the new consolidated authority should include CoC leadership in order to represent and operationalize the integration of CoC resources and governance into the new structure.
- Current committees/workgroups should be evaluated and re-formed to address system-level -rather than CoC-specific - community priorities and needs while also meeting federal requirements.
- The desired end result would be a strong connection between the funding and policy priorities of the federally-required CoC and broader regional efforts on homelessness.

In order to complete the CoC governance redesign process, the CoC will review case studies on other city/county CoCs to identify promising practices, and will work to answer specific operational questions.

Related Actions

3. Become accountable to customers.

5. Improve customer outcomes through a comprehensive digital transformation.

6. Design intake processes that are connected, customer-centric, and radically accessible.

7. Expand physical and behavioral health options for people experiencing homelessness.

1 McKinsey. Booming cities' unintended consequences: Homelessness and congestion.
2 Anderson, J., Ko, M., Zadeh, K., & Thompson, B. (May 2018). Homeless crisis demands unified, accountable, dynamic regional response. King County Auditor's Office.
3 Barbara Poppe and Associates. (August 2016). Recommendations for the city of Seattle's homeless investment policy: the path forward – act now, act strategically, and act decisively.
4 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accrately reflect their status placement within the system.
5 McKinsey. Booming cities' unintended consequences: Homelessness and congestion.
6 Homelessness has been disproportionately prevalent among black and African American, Hispanic and Latino, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander communities, as well as among people who identify by multiple races. These local dynamics track against national trends. Olivet, J., Dones, M., Richard, M., Wilkey, C., Yampolskaya, S., Beit-Arie, M., & Joseph, L. (March 2018). Phase One Study Findings. Supporting Partnerships for Anti-Racist Communities (SPARC).
7 All Home King County. (2018). 2018 King County Point-In-Time Count Results.
8 Anderson, J., Ko, M., Zadeh, K., & Thompson, B. (May 2018). Homeless crisis demands unified, accountable, dynamic regional response. King County Auditor's Office.
9 Barbara Poppe and Associates. (August 2016). Recommendations for the city of Seattle's homeless investment policy: the path forward – act now, act strategically, and act decisively.
10 More than half of people identified as experiencing homelessness on a single in January indicated that they had a disability. One-third (33%) of unaccompanied youth and young adults under 25 years old identified as LGBTQ+, compared to 16% of all other survey respondents. AllHome (2018). Seattle/King County point-in-time count of people experiencing homelessness 2018 (Count Us In). King County, Washington. Nearly two thirds of people experiencing homelessness in the region are people of color: Native Americans and Alaskan Natives experience homelessness at seven times the rate of white people, while black people experience homelessness at five times the rate of white people, and Native Hawaiians and Pacific Islanders experience homelessness at three times the rate of white people. King County Department of Community and Human Sevices, Performance Measurement and Evaluation Unit, City of Seattle Human Services Department, Data, Performance, and Evaluation Unit (2018). CEA Interim Single Adult Prioritization Formula Proposal: Results from Workgroup. Seattle, WA: CEA Policy Advisory Committee.
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True accountability is rooted in customer power to ensure services, approaches, and outcomes meet their needs.

True accountability to customers[1] will be rooted in increasing customer power. Providers and customers alike recognize customers do not have agency in determining their own service paths or in shaping the system as a whole. System transformation requires that customers have power throughout the system to ensure the services, approaches, and outcomes that they seek and experience meet their stated needs.

To become accountable to customers, the new regional authority must establish system-wide structures and processes to prioritize customers' perspectives as key data points in the redesign process, as well as in all systems and program improvement initiatives.

Background

This community-based participatory research process engaged customers who relayed a deep and nuanced understanding of the homeless service system. Collectively, customers uncovered a path toward a more robust, representative, and reliable system, underpinned by proposals for customer-driven continuous quality improvement. In workshops, one-on-one interviews, and during site visits, people shared their experiences with service access and delivery. Analysis of that research is reflected throughout this action and includes recurring troubling patterns and themes about the emotional and psychological impact of experiencing homelessness, homogenized treatment options, difficulties navigating systems of care, and struggles with establishing stability (as defined in their terms based on their personal needs). These insights framed the strategies here that are focused on systematically creating a holistic understanding of customer need that drives personalized care.

Customers also indicated that the region has not universally adopted best practices to center customers' needs. These practices are woven throughout these actions, namely, implementing trauma-informed care and Housing First approaches in programs across the

system, employing peer supports, and prioritizing community connections to combat isolation for people experiencing homelessness.

Trauma-informed services are necessary, cost-effective, and evidence-based.[2] After receiving training in trauma-informed care, service providers report more effective collaboration with customers, who then experience an increased sense of safety, better collaboration with staff, and a more significant "voice."[3] Initial studies also suggest that trauma-informed care has a direct positive effect on housing stability.[4]

Housing First is a widely accepted and evidence-based, systems-level orientation that operationalizes the principle that people experiencing homelessness—like all people—need the safety and stability of a home to pursue their own goals for their health, socio-emotional well-being, education, and employment.[5] Systems that are Housing First-oriented prioritize housing for individuals experiencing homelessness, without preconditions or service requirements. Access to programs should not be "contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, participation in services, or other unnecessary conditions."[6] Connections to sober living communities or other housing settings with similar policies are an important resource for many, but should not be the only option for any individual experiencing homelessness.

Effective Housing First approaches include: prioritizing people experiencing homelessness for new and existing affordable housing; providing rapid re-housing to families and individuals; and providing supportive housing opportunities to people with the most intense needs.[7]

Peer supports and co-planning give agency to people experiencing homelessness. In our research, customers frequently mentioned they felt it was easier to relate to people with lived experience, who they felt could better understand their own experiences in a non-judgmental way. This dynamic also enabled customers and providers to more easily co-plan the steps they need to take to access services and build stability, as defined by the customer. Peer supports who co-plan with customers are particularly effective in locating appropriate resources for that customer and in increasing opportunities for targeted care. Peer supports can supplement caseworkers by providing support in both daily activities and decision-making.

Peer supports have also been shown to reduce customers' own sense of isolation, ease integration their into permanent housing, and support them in improving their social skills.[8] Peer supports have been proven to be especially successful in improving outcomes for customers engaged in drug and alcohol treatment and supporting improvements in customers' mental and physical health, often acting as a social support through those experiences.[9] For all of these reasons, the region should increase opportunities to hire individuals with lived experience to bolster relationships and improve service offerings system-wide.

Community-oriented connections to combat isolation for people experiencing homelessness are a core element of supporting individuals in overcoming crisis and regaining stability in housing. As customers repeatedly expressed, social and physical isolation are key contributors to stress and declines in behavioral health. Customers described feeling happier when they were part of a community, when they had entertainment, and when they had companionship in pets, partners, and friends. Emotional support from close friends has also been found to reduce stress, health problems, and depression in people experiencing homelessness.[10] Other studies show that "perceived emotional support" is related to "better mental health status" for people experiencing homelessness.[11] However, shelters often turn away groups, couples, and pets due to limited space and inadequate resources. This forces people to make difficult choices between important relationships and necessary shelter. The region should incentivize social supports and community-focused care across services.

Each of these orientations and approaches are fundamental elements of a customer-oriented system. The region, however, will require additional work to create system-wide accountability to customers, and more specifically, build customer power into system-wide decision-making structures as well as improve staff conditions to help them be more accountable to customers.

Strategies

Build customer power into system-wide decision-making structures.

1. Implement an overall continuous quality improvement (CQI) framework driven by customer voice.

For customer experience and needs to be accurately represented, methods to collect customer data need to be improved significantly. A regional authority should redesign intake points to be customer-centered, connected to available and necessary resources, and radically accessible. That process should be facilitated by a digital transformation process that makes it easier to integrate customer data across services and systems to improve experience, coordination, and the ability of system administrators to identify and respond to strengths and weaknesses.

To build customer decision-making power, the Office of the Ombudsperson must facilitate ongoing community engagement through systematized feedback mechanisms that integrate the daily lived experiences of customers and their perspectives.

These mechanisms must be designed with equity in mind, to ensure all customers have the opportunity to participate in the ways that they find most useful. Options should include flexible operating hours, and multiple languages and locations throughout the county. Sampling should explicitly target customers who are black, Native, LGBTQI, and living with disabilities, as they are overrepresented. Additionally, customers must be paid for their time in formats that don't limit choice (e.g. not through store-specific gift cards). Customers should be compensated in sums that reflect the value of the expertise they offer, commensurate with rates paid for any staff that have specialized knowledge that cannot be gained without substantial investment of time and energy.

There are many mechanisms that this office could use to engage the community including, but not limited to, workshops, interviews, service reviews, and focus groups, as well as tools for customers to engage directly in system-wide planning. Customers had no shortage of ideas for how feedback could be collected, including in-shelter kiosks, online rating systems, and building feedback mechanisms into routine service interactions. Additionally, the Office should expand the use of follow-up assessments to understand how needs evolve over time and to flag and prevent potential bounceback into the system. At the most basic level, the Ombudsperson should respond to the immediate needs of individual customers in coordination with service providers. It should also develop a system dashboard that tracks specific customer input to be used in longer-term planning and provider performance management.

In workshops and interviews, many customers wanted to be notified if their expertise contributed to a particular outcome or decision. It is very important that this office ensure transparent and proactive communication with customers about the ways in which their voices are or are not being used. It's paramount that the region create environments that encourage authentic sharing so that customers will re-engage.

The new regional authority will have a flow of rich information to direct decision-making processes if these steps are taken to improve data quality by developing and strengthening mechanisms for customer input.

2. Create metrics for a holistic understanding of customer need that drives personalized care.

Customers frequently expressed feeling unseen by the service system. Many felt that services are not tailored to their unique needs or circumstances and that the system homogenizes them into a single representation of 'the homeless.' This plays out across many different types of services, where customers are assumed to need the same things, delivered in the same way. While some of this is due to bias and stigma, much of it is a result of the data used to inform the architecture of the system.

To truly ground planning and performance management in customer voice, the metrics used for evaluating services and providers must be reoriented around customers and how they experience the system. Currently, metrics often fail to reflect the reality of service delivery, as many of them focus on outcomes, such as exits to permanent housing, that assume the availability of those scarce resources. The most desired and consequential resources are typically unavailable for customers, which necessitates multi-year wait times and forces customers and staff into a dynamic where they tread water while waiting.

Given resource scarcity, metrics such as shelter referral or the completion of administrative tasks such as acquiring an ID are now outcomes that are consequential for organizations. The importance of these metrics is due to their attachment to funding sources, which drives a top-down prioritization of service delivery that is not connected to customer need. Staff frequently found the outcomes they track are disconnected from the outcomes their customers care about. They experience perverse incentive structures that drive behavior towards cherry-picking clients who are easiest to serve, increasing the odds that they'll renew their funds the following year. Many staff felt that these metrics prevented customer-centric case management and the ability to respond to an articulated need in an agile and flexible way.

Because providers have to support customers as they wait on long lists for housing, provider performance must be evaluated based on their ability to stabilize customers and keep them on the path to security, and eventual permanent housing. Frontline staff specified customer retention and appointment attendance rates as useful metrics that typically indicate progress toward stability among customers. The regional authority should also review with customers whether there are psychosocial and other quality-of-life metrics they see as reflective of their experiences. Many customers expressed a desire to be understood holistically, and for metrics to be aligned with their sense of self-worth, dignity, and agency. Particularly for Native and transgender customers and staff, the assessments, forms, and metrics they engage with fail to account for their identities, needs, and notions of healing.

This shift to customer-centric metrics would represent an important change in how quality and success are measured in this system, and bring it closer to representing the realities customers experience. However, capturing meaningful service metrics is only the first step to driving transformation in the system. Staff articulated the desire to leverage customer-centric metrics to drive service priorities, and eventually, shape the funding streams that are actually needed to deliver against service needs. This is a use-case meant to illustrate how a CQI framework could add value to all actors in a system by collecting and acting on customer voice.

Reshape staff conditions to help them be more accountable to customers.

We saw distinct patterns in our research where customers often attributed successful experiences with an organization or service to a dedicated, supportive relationship they formed with an individual staff member. This is particularly true of youth customers.[12] Those relationships can be transformative in providing emotional support and connections to the services that people need to stabilize their lives.

Because of the importance of staff and customer relationships, understanding this dynamic was a major line of inquiry in our work. In workshops with staff and customers, we used a profile-building activity to understand the most important criteria for building successful customer/staff relationships. This profile was framed as a part of a fictitious matchmaking service, that would help customers and staff get to know one another before their first interaction. Read more about our process in the methods section.

For customers, results showed that it is vital staff be non-judgmental, friendly, transparent, and committed to their wellbeing. They were likely to avoid staff or disengage from services if they experienced judgment, condescension, or sensed that staff weren't willing to invest in a relationship. These are elements needed to support any relationship outside of a service context, but they revealed some of the challenges that customers face in their interactions with staff. Customers are often met with inconsistent treatment across and within service organizations, citing inexperience, challenging power dynamics, and disrespect as commonplace. While some of these things can be attributed to personnel, both customers and staff spoke directly to the structural barriers that give rise to these dynamics. This is in part due to metrics that homogenize customer goals and prevent tailored services that are response to customers' unique strengths and needs.

1. Invest in support for staff to improve the customer experience and the health of the system.

Frontline staff frequently cited poor pay, long hours, and insufficient resources to serve customers well. Few staff are able to afford to live within Seattle city limits and some frontline staff even report being on the edge of homelessness themselves. Though they are the frontline for dealing with individuals in crisis, they receive little training in how to respond to crises, trauma, and co-occurring disorders, not to mention little to no regular support for their own emotional and psychological well-being. This is compounded by the fact that organizations tend to be resource constrained, which limits their ability to hire multidisciplinary teams that could meet the dynamic needs of clients with targeted services. Given these factors, staff turnover is incredibly high, resulting in abrupt relationship changes that disrupt the delivery of services and engender a sense of abandonment for customers.

Turnover has a significant impact on the ability of the system to deliver quality services. Institutional knowledge is difficult to develop without consistent staff, resulting in organizations that struggle to maintain consistent procedures, practices, and partnerships, let alone evolve and improve them. Many staff discussed the burdensome process of coordinating care with other service providers, often spending hours attempting to find someone they could trust to provide quality care to their customers. This challenge will continue to exist if there is not a focus on retaining talent across providers.

An investment in frontline staff is simultaneously an investment in customer experience and system performance. In addition to addressing inadequate compensation, service staff should be provided with the training they seek to better serve customers, as well as the flexibility to more easily route resources to customers at their time of need.

2. Increase opportunities to hire individuals with lived experience to bolster relationships and improve service offerings.

Low pay often means these critical roles are staffed as entry level positions, resulting in employees who lack the requisite experience to succeed in a role that requires them to understand nuanced needs. Customers frequently cited how much easier it was to build trust with staff who had direct experience with housing instability, substance use disorder, and the myriad challenges related to both. Many customers also preferred staff who share similar life experiences due to race, gender identity, or sexual orientation. This was particularly true for the Native and Transgender customers we spoke with, who struggle to engage with

staff who don't understand the unique communities of which they are a part. Overall, customers perceived staff with lived experience as more likely to be empathetic and possess strategies and guidance born from experiential knowledge. In general, frontline staff are often more representative of the communities they serve than managerial staff,[13] yet there are still barriers to demonstrating lived experience as a qualification on par with academic degrees. The system must recognize and resource this expertise in order to drive towards more equitable and successful outcomes.

Recognizing the essential role that frontline staff have in customers' lives, the King County homeless provider system must develop mechanisms for staff to be held accountable to customers and for better, more experienced staff to be hired and retained. In addition to developing customer-oriented program metrics, as described above, frontline staff salaries must be significantly increased to reflect their expertise and the value of their work, multi-disciplinary teams with mental health clinicians should be funded, and staff should receive robust emotional and psychological supports.

Related Actions

1. **Institute a system-wide theory of change.**
2. **Consolidate homeless response systems under one regional authority.**
5. **Improve customer outcomes through a comprehensive digital transformation.**
6. **Design intake processes that are connected, customer-centric, and radically accessible.**
7. **Expand physical and behavioral health options for people experiencing homelessness.**
8. **Create a defined public/private partnership utilizing a funders collaborative model.**
10. **Create long-term institutional alignment across systems to serve people experiencing homelessness.**

NIS

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 Hopper, E. K., Bassuk, E. L., & Olivet, J. (2009). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. The Open Health Services and Policy Journal, 3(2), 80-100.
3 Ibid.
4 Ibid. "A multi-site study of TIC for homeless families found that, at 18 months, 88% of participants had either remained in Section 8 housing or moved to permanent housing. An outreach and care coordination program that provided family-focused, integrated, trauma-informed care to homeless mothers in Massachusetts found that the program led to increased residential stability."
5 United States Interagency Council on Homelessness. (September 2016). Housing First Checklist.
6 Ibid.
7 United States Interagency Council on Homelessness. (December 2017). The Evidence Behind Approaches that Drive an End to Homelessness.
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9 Barker, S. L., & Maguire, N. (2017). Experts by Experience: Peer Support and its Use with the Homeless. Community mental health journal, 53(5), 598-612.
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11 Hwang, S. W., Kirst, M. J., Chiu, S., Tolomiczenko, G., Kiss, A., Cowan, L., & Levinson, W. (2009). Multidimensional social support and the health of homeless individuals. Journal of Urban Health, 86(5), 791-803.
12 From correspondence with Carrie Lippy, the research lead of the King County Youth of Color Needs Assessment Report. She emphasized the importance of programs like arts programs and drop-in centers that provide youth people of color with a space to go regularly. Those programs are especially useful because of the consistency of staff, who are there as needed. The young people only opened up to the staff after a long time of seeing the same people there every week.
13 Supporting Partnerships for Anti-Racist Communities (SPARC). (March 2018). Phase One Study Findings.

Economic stability lays the foundation for individuals to exit the system, secure permanent housing, and gain long-term stability.

Throughout our research, customers[1] illustrated the ways that economic instability drives housing instability. They often shared that when they were housed, they needed support to meet their basic financial needs and to gain stable employment. Those supports are essential for homelessness prevention and for eliminating bounceback, which is when individuals return to homelessness after "exiting" the system.

Therefore, the fourth action is to prioritize economic stability to reduce inflow.

This action is strongly aligned with our assessment that, while there are not enough resources in the community to end homelessness, resource deployment is suboptimal. Specifically, the region should shift towards prioritizing funding for services that have a clear pipeline to permanent housing and economic mobility supports. We found that supports that cannot facilitate these connections frustrate people experiencing homelessness and erode public trust by creating the impression that money is being spent on non-effective interventions.

Prioritizing the financial assistance and employment supports that customers have identified would transform the King County regional homelessness system into one that lays the foundation for individuals to exit the system, secure permanent housing, and gain long-term stability and control over their own lives.

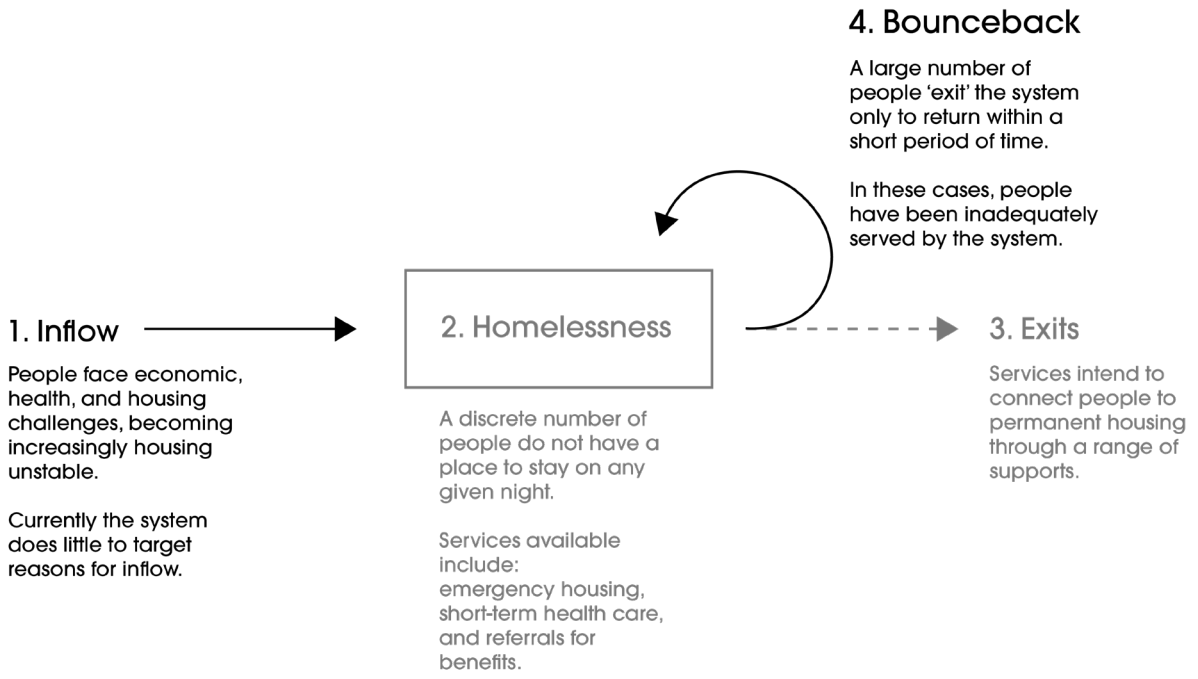
Background

In our workshops and interviews, customers spoke about wanting control over their own economic stability. They identified a range of basic economic supports that would enable them to achieve and maintain housing stability. In particular, they emphasized flexible financial assistance to cover living and emergency costs and employment pathways in stable, high-growth occupations.

Many customers shared that economic support is often the primary intervention they are seeking, but service providers tend to direct them toward behavioral health and other intensive supports that are more widely available, even when they're not needed or requested.

They also described the challenges of the "not sweet spot," where increases in income disqualified them from certain services and supports, even though that income was not sufficient to maintain housing stability. The connection between economic stability and homelessness inextricable. Therefore it is critical that the region explicitly focus on reducing inflow and eliminating bounceback.

INFLOW AND BOUNCEBACK



To achieve this, the system must prioritize quality and flexible economic supports that directly meet the stated needs of people who are at risk of and experiencing homelessness. There is currently no coordinated effort to draw on performance data to identify what strategies are and aren't effective and scale resources accordingly. This, in turn, leads to a lack of regional coordination around the quality and long-term effectiveness of supports.[2]

Based on our work with customers and providers, and through national research, we know that many people experiencing homelessness are employed, though often working in multiple, low-wage jobs that are difficult to maintain without stable housing.[3] Customers' descriptions of living with this instability highlight the detrimental effects of toxic stress[4] on their quality of life, health, and abilities to make decisions.

Unaffordable housing, insufficient earned income, and unemployment are among the key causes of family homelessness.[5] Families have a high likelihood of exiting homelessness quickly if they receive sufficient

supports in these two areas. Increased income is a strong predictor of a person exiting homelessness[6] and also improves their access to food, clothing, healthcare, and housing. Increased income is also shown it improve individuals' wellbeing and supports recovery from serious mental illness and substance use disorders.[7]

Many people have immediate financial needs that could be the difference between maintaining stable housing and homelessness.[8] Customers talked about having medical care, childcare, and transportation costs that made it difficult for them to maintain employment. In these cases, a well-timed housing subsidy or cash transfer to cover those and other basic living costs, would help eliminate inflow into the system. This is especially relevant for black and Native populations who are at high risk for experiencing homelessness. These communities in particular experience a form of community-level poverty called "network impoverishment" that accelerates inflow from historically marginalized communities.[9]

Therefore, the first set of strategies here are designed to enable people experiencing homelessness or at risk of experiencing homelessness to meet their immediate financial needs.

There is also an overwhelming need to tailor employment supports to customers' stated needs and integrate those supports into the homeless service system. This should be done by focusing on employment navigation supports and targeting skills training and job placement for occupations with high-growth opportunities. To support this, we have included a set of strategies to prioritize employment supports for people experiencing homelessness.

For customers to benefit from these supports, providers will need to be responsive to their stated needs and adaptable enough to respond as needs change. We detail our recommendations in Action six for how the intake system should be transformed to better assess needs and connect customers to other supports available in the community.

Strategies

Focus on eliminating inflow and bounceback into the system.

1. Assess the prevalence of people returning to homelessness and implement strategies to measure and address the causes.

We currently do not have complete information on how many people return to the homeless service system. This is due to insufficient data collection and the systems' limited ability to track customers' service utilization across the system. The region should conduct an assessment to better understand the scope of returns to homelessness. The process should identify racial disparities and work with the affected populations to identify services and supports that would have bolstered their housing stability, and scale those resources accordingly. This can and should build on the foundation laid by the community engagement that has already taken place.

Meet the immediate financial needs of people experiencing homelessness or at risk of experiencing homelessness.

1. Use local funding to generate more flexible shallow rent subsidies that can be accessed before a person experiences homelessness.

Flexible, shallow rent subsidies should be available to customers to directly cover rental costs for individuals and families at risk of experiencing homelessness. Many people who experience homelessness, both for the first time and after having exited the shelter and service system, do so after experiencing housing foreclosure or leaving a living arrangement with friends, relatives, or acquaintances. Therefore, subsidies should also cover rental costs of hosts of those individuals and families.[10]

2. Utilize cash transfers to empower people experiencing homelessness or at risk of experiencing homelessness to meet their immediate financial needs.

A new regional authority should manage a cash transfer application process, drawing on resources from Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Emergency Food and Shelter Program (EFSP), Medicaid, and philanthropic partners to enable people to cover basic living and emergency costs that they identify. If people could cover their own basic costs, they could spend less or no time going to different service providers, freeing up time to spend on work, skills training, or other long-term planning.

There is currently a process underway to redesign the workforce system, which will offer several opportunities to strengthen cross-system collaboration. The most immediate opportunity is related to a pilot program, currently under consideration, that would offer a stipend to cover living expenses for low-income individuals engaged in longer-term skills training programs.[11] There are similar pilots underway in other cities[12] that provide direct cash transfers to low-income families. The Stanford Basic Income Lab recently released a guide[13] to support municipal innovations and pilot projects that should be useful in developing this program in King County.

Prioritize robust employment supports for people experiencing homelessness.

1. Co-locate workforce and homeless services supports.

A new regional authority will be well-positioned to establish strong connections between the Workforce Innovation Opportunity Act (WIOA) and Continuum of Care (CoC) systems, particularly in light of the King County workforce redesign process underway. This collaboration should include cross-system representation on key committees,[14] aligning system metrics, and cross-training and co-locating staff in integrated workforce and homeless service programs.

Collaboration should build on the groundwork laid by the Connections Project,[15] to develop a stronger employment needs triage process at the homeless service system's Referral Access Points. The region should look to Houston's Income Now program,[16] where coordinated entry intake processes include a short income assessment to determine whether customers should be referred to workforce services or disability benefits supports. That determination is made through an algorithm, but the staff conducting the assessment at provider discusses it with the customer and facilitates a warm hand-off, printing information on where customers should go, and arranging for an employment counselor to greet them.[17]

These strategies are particularly important to address racial inequity. The redesign of the workforce system is driven by a recognition that the system needs to strengthen services for marginalized communities and develop more targeted supports using a racial equity framework. Frameworks to drive toward equity should be aligned across the two systems to ensure both are deploying quality supports for people of color, particularly black and Native communities.

2. Align WIOA and CoC metrics on connections to employment.

The cross-system collaboration outlined above needs to be supported by alignment in metrics and priorities across systems. For example, WIOA discretionary funds and funding for hard-to-place jobseekers could be prioritized for jobseekers experiencing homelessness. CoC providers should be incentivized to streamline access to employment services.

The Department of Housing and Urban Development (HUD) requires that CoCs collect data on income and employment gains for people in CoC program-funded housing interventions. However, the data is focused on change in income (from employment and non-employment sources) rather than on employment needs or interests. Data collection, however, does not

equate to connections to income and employment services.[18] It will be important for the new regional authority to add questions to homeless service system intake assessment about interest in employment, based on the Chicago Connections Project[19] model. A memorandum of understanding between the WDC, CoC, and the new authority will be key to institutionalize this partnership. Such an agreement should also facilitate data sharing so partners can track customers through both systems and better understand the connection between housing instability and employment.

3. Align funding to invest in skills training and job placement in high-growth occupations and social enterprises.

Regional partners should identify funding streams that can be leveraged to improve employment and skills training programs. Investments should be focused on occupations that customers determine to be meaningful and appropriate, pay a living wage, offer both part-time and full-time options, and have future growth opportunities. This is essential for addressing racial disparities, given the widening wage gap between credentialed, high-skilled workers and low-skilled workers, who are disproportionately non-white and whose earned income has not kept up with the cost of living.[20] Those trends drive the need for programs that help low-wage workers gain in-demand skills and advance in their careers,[21] rather than just general job or soft skills training. Programs that provide skills training and job placement support coupled with case management and basic financial assistance have shown strong outcomes for low-income individuals.[22]

Funding should be enhanced to support training programs and employment case management, creating connections between homeless service providers and existing programs. Employment case managers should help customers access resources to meet job placement, training, childcare, transportation, clothing, and equipment needs. Those funding streams include:

- TANF
- SNAP Employment & Training
- WIOA Individual Training Accounts
- Medicaid Transformation Foundational Community Supports – Supported Employment Services

4. Leverage and integrate Moving to Work employment case management funding.

The Seattle Housing Authority (SHA) and King County Housing Authority (KCHA) should leverage Moving to Work (MTW) funding to develop stronger employment supports for residents in public housing or using vouchers, in alignment with the training and job strategy described above. Increased income should not affect an individual or family's rental subsidy for at least two years after securing employment.[23] This is especially important for ensuring housing access for people being released from prison, many of whom at risk of homelessness and have little immediate access to sufficient income to afford market-rate housing.[24]

5. Strengthen employment supports for customers accessing Rapid Re-Housing (RRH) and Permanent Supportive Housing (PSH) programs.

RRH programs are important paths out of shelters and into permanent housing. However, without immediate and direct employment supports, it is hard for people to increase their earned income and stabilize permanently in housing following the end of their subsidy period (typically six months). The region should build on the employment navigator model[25] from the King County Rapid Re-Housing for Families pilot[26] and leverage HUD funding and the funding streams referenced above to design and implement programs with longer housing subsidy periods. This will allow for completion of skills training in high-growth occupations.[27] Employment navigators in this model are focused on helping customers to identify the most appropriate training and job pathway, assist with connections to financial assistance to cover basic costs, and coordinate with health and housing supports. It is important to track employment stability and earned income as program

metrics and tie successful outcomes to funding. For strategies around employment and other supports in PSH programs, see Action 9.

Related Actions

6. Design intake processes that are connected, customer-centric, and radically accessible.

9. Increase access to 0-30% AMI housing.

NIS

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 According to the King County May 2018 audit report, and corroborated by our community engagement workshops, City and County funders of the homeless service system have not been sufficiently focused on system performance.
3 Olivet, J., Dones, M., Richard, M., Wilkey, C., Yampolskaya, S., Beit-Arie, M., & Joseph, L. (March 2018). Phase One Study Findings. Supporting Partnerships for Anti-Racist Communities (SPARC).
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11 From correspondence with Nancy Yamamoto in the Seattle Office of Economic Development.
12 Brinklow, Adam. Stockton rolls out universal basic income experiment. Curbed San Francisco. February 1, 2018.
13 Stanford Basic Income Lab, National League of Cities. (November 2018). Basic Income in Cities.
14 For more detail on governance and funding recommendations, see Heartland Alliance. (March 2018). Systems Work Better Together: Strengthening Public Workforce & Homeless Service Systems Collaboration.
15 Heartland Alliance Connections Project.
16 Houston Income Now.
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18 Heartland Alliance. (March 2018). Systems Work Better Together: Strengthening Public Workforce & Homeless Service Sytems Collaboration.
19 Heartland Alliance, Chicago Connections Project.
20 National Poverty Law Center. (April 2013). What We Know About Workforce Development for Low-Income Workers: Evidence, Background and Ideas for the Future.
21 Ibid.
22 Aspen Institute, Workforce Strategies Initiative. (2017). Investing in Workforce Program Innovation: A Formative Evaluation of Five Workforce Organizations' Experiences During the Human Capital Innovation Fund Initiative.
23 See New York City Housing Authority Family Rentry Pilot as a model.
24 Department of Housing and Urban Development. (June 2016). It Starts with Housing: Public Housing Agencies are Making Second Chances Real.
25 In addition to 1-1 services, employment navigators supported systems-level collaboration by assembling cross-sector teams to jointly address a family's barriers to both employment and housing. These teams included the family itself, the workforce system's navigator, the housing system's rapid re-housing case manager, and other service providers working closely with the family, such as emergency shelter providers. See Heartland Alliance Case Study: King County Rapid Re-Housing for Families Pilot.
26 The initial results from the pilot are promising. The average monthly income of families who worked with an employment navigator increased by $338 between program entry and exit, while the average monthly income for those who did not work with an employment navigator went up by only $56. Families who worked with an employment navigator were more likely to exit to permanent housing, and no family who exited to permanent housing and worked with an employment navigator returned to homelessness within 24 months. See Heartland Alliance Case Study: King County Rapid Re-Housing for Families Pilot.
27 See Pioneer Human Services as model.

A digital transformation will improve access to services and continuity of care.

We learned from both customers[1] and providers that data management is inconsistent. Most salient was that siloed data collection prevents the homeless service system from maintaining comprehensive information on individuals seeking services. This in turn makes it difficult for customers to get services that meet their needs, makes the process of accessing services inefficient and traumatic—as it requires customers to share personal information repeatedly—and limits the continuity and coordination of care across providers and systems.

There is a clear opportunity to use technology to collect and share data across service touchpoints. If data were shared across databases, it would allow for a real-time understanding of customers: which services they access, how they move among services, and within what timeframe. This understanding drives the fifth action: improve customer outcomes through a comprehensive digital transformation.

For this action, it is necessary to align and strengthen existing King County data sharing and integration initiatives, ensure they build towards a unique identifier that allows customers to be tracked through the system, and explore opportunities to create customer-driven services through digital identification.

Background

Across programs and systems that serve people experiencing homelessness, administrators struggle to access, understand, and make use of data. Service providers manage details about customer interactions with multiple databases and applications, preventing the possibility of a single record of the customer. The effects of siloed and inconsistent customer data are significant and impact every actor in the system.

For customers, this contributes to a feeling of being unknown to providers at the outset of a service engagement. As discussed in Action 6, this leads to

interactions in the system that are dehumanizing and impersonal, requiring an onslaught of intake forms and questions that customers may have answered elsewhere. This is compounded by the challenge of having to produce forms of identifying documentation, which are hard to maintain without stable housing. Without a recognized form of identity, service providers are often unable to engage customers and expend time helping customers obtain them.

Providers frequently lamented the inconsistent utilization of the Homeless Management Information System (HMIS) across the system, which contributes to the need for duplicative intake processes and inhibits collaboration and coordination among organizations. Without a shared understanding of a customer's history, staff spend a significant amount of time triangulating service history (even within the same agency) to make more informed decisions about their care.

Administrators spoke about how not being able to see comprehensive data about their customers makes the system inefficient and unresponsive to service failure. They also emphasized that data (and data collection) is not standardized across systems and providers, and that the current process for sharing select data through legal agreements is cumbersome and time-consuming.

Stakeholders in Seattle and King County have taken significant action to improve data sharing when regulatory frameworks do not allow for integration of datasets. They have also worked to integrate datasets where there is no regulatory barrier.

There is significant work ahead, however, to create a stable and useful data infrastructure that spans systems and programs serving people experiencing homelessness. In order to effectively operationalize the community's theory of change, the region must prioritize a digital transformation process to ensure that customers' needs are met, their experiences are understood, and their outcomes drive system improvement.

Digital transformation is the comprehensive change of system processes and assets to fully leverage the capabilities and opportunities of a mix of digital technologies. To transform the systems serving people experiencing homelessness in the King County region, the processes for collecting data, sharing data across service databases, identifying unique customers across systems, and enabling customers to maintain control of their personal information, must be fully digitized. As they are digitized, they must also be connected as part of a whole system. That transformation is essential to enabling structural accountability to customers and system-wide continuous quality improvement.

A digitally operational and connected system would enable robust continuous quality improvement, as outlined in Action 3. A cross-system data infrastructure means rapid identification of system failures, in particular, those related to customer requests. In addition, data sharing across homeless service providers; healthcare and behavioral health services; and employment and other economic supports would enable system administrators to leverage cross-system data to inform long-term planning and system improvement priorities. This would also mean having the ability to make short-term course corrections. For this to be possible, it is necessary to align existing King County data sharing and integration initiatives and ensure they build towards a unique identifier that allows customers to be tracked across systems. The strategies below lay out the steps necessary to improve administrators' ability to accurately understand and respond to current system strengths and failures.

Digital systems could also enable customers to control their own data, by digitally storing and securing personal records to create a digital identity that could only be accessed by service providers with customer permission. In this scenario, every time a customer interacts with a point of service they can choose what, if any, of their pre-established digital identity is shared with that provider. Once shared, that information also drives more targeted service delivery based on customers' recorded needs and previous service utilization. The region must commit

to exploring opportunities to create a customer-driven system through digital identification. That system could be built with blockchain technology, but it must be explored within an ethical framework developed by customers themselves. Therefore, the second set of strategies explore how best to enhance customer experience and preserve customer dignity.

Strategies

Improve administrators' ability to accurately understand and respond to current system strengths and failures.

1. Align and strengthen existing King County data sharing and integration initiatives.

There are a number of ongoing initiatives in Seattle and King County working toward back-end data sharing and integration across systems. However, these initiatives need to be better aligned and expanded. In order to build a complete picture of customers moving within the system, data silos must be eliminated.

Through the Data Integration Project, the Departments of Public Health (PHSKC) and Community and Human Services (DCHS) are connecting DCHS's Homeless Information Management System (HMIS) data and Behavioral Health and Recovery Data (BHRD) with PHSKC's Medicaid claims and enrollments data. Drawing from those separate datasets, all data on particular individuals can be viewed and analyzed together through a dashboard, which allows for sharing without complete integration.[2] The project is driven by the state Medicaid Transformation mandate[3] to integrate physical and behavioral health services.

To build an understanding of health outcomes across housing program types, the King County Data Across Sectors for Housing and Health (DASH) project has integrated the Seattle Housing Authority (SHA), King County Housing Authority (KCHA), and PHSKC Medicaid data.[4] The University of Washington School of Public Health has also undertaken a project to link HMIS and PHA data within a time-limited period to understand movement between homeless services and public housing.[5] The University of Washington hospital system also plans to consolidate all medical records into a single Electronic Health Records (EHR) system, which would facilitate healthcare data sharing.[6]

To ensure these initiatives are working in alignment towards a comprehensive, rather than piecemeal, digital transformation, the region should leverage philanthropic investments against Medicaid Transformation funding designated for enhanced data utilization to connect these projects and expand the scope to incorporate other datasets.

2. Ensure existing data sharing and integration initiatives build toward a unique identifier.

In order to have a clear understanding of service utilization patterns to inform investments and planning, the region must be able to identify customers while protecting their privacy. Currently, where dissimilar identification systems are used, they inhibit administrators' ability to analyze patterns across programs and systems.

The master person index developed through the Data Integration Project algorithmically deduplicates across datasets and provides a unique identifier for each customer as well as a lookup function for care coordinators.[7] This is the ideal foundation for a system-wide digital transformation process.

A unique identifier is the first step towards a seamless customer-facing data collection infrastructure, as it gives all new datasets an anchoring unit to organize around. The open source code for the master person index was developed by the University of Washington School of Public Health team.[8] The master index should be seen as the first step in the development of a digital identity system.

3. Establish processes that allow the new regional authority to govern and improve data collection practices and evaluation system-wide.

The new regional authority should be responsible for managing the digital transformation process and system-wide data analysis as it is collected, shared, and integrated, as well as for setting standards for data, metadata, and program metrics and outcomes. This process should be deeply connected to customer service functions within the new authority to ensure that customers' concerns and insights are readily integrated into planning and improvement processes.

Enhance customer experience and preserve customer dignity.

1. Explore opportunities to create radically accessible, customer-driven services through digital identification.

The master person index requires individuals to be able to offer some form of issued identification in order to connect that individual with their unique identifier. As customers expressed in interviews and in workshops, it is very difficult for them to hold on to identity cards or documents, which are easily damaged by weather, stolen, or misplaced when people do not have stable housing. As a result, customers reported spending a considerable amount of time reverifying their identity and reapplying for benefits and services.

Customers also expressed tremendous frustration with repetitive and de-humanizing data collection processes that weaken their relationships with service providers. Digital identification could enable customers to store their documents and other personal information digitally and therefore control their own data and choose when and what to share with providers. This would eliminate all repetitive data submission processes and allow customers to record and have verified service needs, attendance at appointments, development of specific skills, and other activities. This strategy would transform customer experience and pave the path for radically accessible services.

However, these opportunities need to be explored further by system administrators to better understand how customers who are living in unstable situations and with limited technology access could hold and share their data. This could be mitigated by leveraging private investments to expand access to technology at key touch points throughout the systems.

System administrators must also identify a third party entity to back-up data as well as a strategy for backing up and validating digital identity. System administrators should analyze strengths and weaknesses implicit in this opportunity and strive to pre-empt any challenges or inefficiencies it could create.

2. Determine whether blockchain is the right technology for building a connected digital identity and data sharing infrastructure.

Digital identity does not have to be built on a blockchain. However, blockchain—a technology that provides an encrypted time-specific record of information and activities—might offer benefits in terms of trust (and the immutability of a record), as well as the ability to track the different steps an individual takes through a service system over time.

Blockchain and distributed ledger technologies, broadly defined, have emerged as a promising solution to challenges facing multi-stakeholder systems. We recommend a rigorous exploration of this technology beginning with the Blockchain Primer, developed by the Blockchain Working Group, American Council for Technology-Industry Advisory Council Emerging Technology Community of Interest. As the Primer puts it, blockchain solutions must be carefully designed, as they are "not a single solution and it is not a technology that can be integrated in a plug-and-play manner."

Homeless service system leaders in the region should explore partnerships with groups already working in this space, particularly the Austin MyPass Initiative,[9] as a core component of exploration. The feasibility and desirability of a blockchain-based digital identity for customers experiencing homelessness has been

proven in Austin. King County could learn a lot from Austin's process and what they are currently proposing as a minimum viable ID product. The Blockchain Playbook outlines a process for the development of a blockchain solution, which also could be helpful to that exploration.

In consultation with a range of experts, it became clear that the region's best option would be to build on a public blockchain, in order to ensure sustainability and lay the groundwork for future integration with other digital ID systems. The region could also build that blockchain as a coordinating layer between an integrated data warehouse and individual data that is owned and shared by customers. This is a model that is currently being developed by lifeID in Seattle,[10] which looks different from storing customer data directly on a blockchain. That coordinating layer would map onto existing and proposed data sharing agreements across systems.

The region should explore the efficacy of blockchain-enabled solutions, with particular attention to the following use cases:

- Providing a resilient digital identification;
- Serving as a connecting layer between sets of data as an immutable ledger of interactions across the system;
- Using smart contracts aligned with eligibility criteria to automate benefits enrollment and service deployment; and
- Providing attestation for services received.

3. Develop and institutionalize an ethical framework to guide all data collection and data sharing processes across systems serving people experiencing homelessness.

Data sharing agreements across systems will continue to exist within regulatory frameworks surrounding data privacy. However, there is no ethical framework guiding how data is collected from customers: who is collecting the data, when and how often it is collected, which data is being collected under which circumstances, and what role customers have in those processes. An ethical framework for data would simplify and ensure continuity in contracting processes and data sharing agreements. It would also provide continuity for consent forms across customer groups, establishing a uniform understanding of legal responsibility.

Customers should be key participants in the creation of an ethical framework, in addition to processes, related to:

- **Access:** Ensuring everyone has access to the proper technology to participate in the digital ecosystem.
- **Literacy:** Shaping training opportunities so customers can fully participate in the digital ecosystem.
- **Transparency:** Building a shared understanding between administrators, providers, and customers of why and how data is being used and tracked within the digital ecosystem.
- **Ownership:** Prioritizing the rights of customers in the decision to grant access to specific pieces of data and to determine the circumstances of that access.
- **Privacy:** Prioritizing individuals' rights to not share data and still have their needs met in an efficient manner.

4. Plan around the ideal future state of the system.

With a high-quality data infrastructure, a variety of innovations and solutions become possible. As seen in the private sector, digital transformation and data collection unlock new insights about customers. Quality data can also train machine learning algorithms to predict when customers' needs will not be met. Through data science, the system could prescribe highly-specific solutions on an individual level based on a robust understanding of customers' strengths, needs, and service histories.

Greater system-wide efficiency could be achieved by using technology to anticipate the most efficient paths to supporting individuals' stability. With integration

across systems and a unique identifier that allows insight at a customer level, the following would be possible:

- When utilities are about to be cut off or an eviction notice is about to be served, benefits could be automatically mobilized for an at-risk individual.
- Case managers could focus on customers rather than paperwork.
- Greater transparency around housing availability and customers' status on waitlists.
- Attestation of meetings attended, skills developed, and goals achieved to more granularly measure system performance and to track service utilization patterns and outcomes.
- Implement automated warnings for when a person is nearing the "not sweet spot" and automatic deployment of benefits to fill gaps in service needs.

A fully-connected digital system could provide de-identified information on thousands of individuals and aggregate information on the most successful paths to customer stability and permanent housing.[11] The system could also determine where there are available resources to deliver exactly what is needed for each customer at any given point in time. That would unlock unprecedented opportunities for system performance improvements and would transform the experience of homelessness in the region.

Related Actions

2. Consolidate homeless response systems under one regional authority.

3. Become accountable to customers.

6. Design intake processes that are connected, customer-centric, and radically accessible.

7. Expand physical and behavioral health options for people experiencing homelessness.

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 From correspondence with Josephine Wong at the King County Department of Community and Human Services.
3 The Washington State Medicaid Transformation Waiver Application from August 2015 stipulates this Integrated Managed Care approach: "The State is reforming its purchasing for physical and behavioral health care services through a new regional approach to Medicaid managed care contracting." It later explains: "In a transformed system, the Medicaid program, MCOs [Managed Care Organizations], BHOs [Behavioral Health Organizations], LTSS [Long-Term Services & Supports], health care and community service providers, and beneficiaries will have incentives to work together, leveraging the resources of the larger community to address clinical and social determinants of health...The Healthier Washington initiative, with the support of the Medicaid Transformation Demonstration, will reduce fragmentation in administration while improving care coordination, service delivery, and financing of services for Medicaid beneficiaries."
4 From correspondence with Danille Bezemer at the Seattle Housing Authority and Amy Laurent at the Department of Public Health-Seattle & King County.
5 From correspondence with Danille Bezemer at the Seattle Housing Authority.
6 Monica, Kate. (July 2018). $180M EHR Implementation Project Approved at UW Medicine. EHR Intelligence.
7 From correspondence with Josephine Wong at the King County Department of Community and Human Services.
8 From correspondence with Alastair Matheson at the Department of Public Health-Seattle & King County and University of Washington School of Public Health.
9 From correspondence with Kerry O'Connor at the City of Austin Innovation Office.
10 From correspondence with Chris Boscolo at lifeID.
11 To gain a comprehensive understanding of how customers are moving in their system, New York City undertook a robust mapping of how several clients successfully navigated the system, going from being street homeless to moving into permanent housing. They outline all of the touchpoints of the journey here: New York City Stakeholder Research Insights Report. In a mature digital system, all of that research and mapping would be automated.

Intake processes should be connected, customer-centric and radically accessible.

Customers[1] consistently characterized intake procedures as a deeply negative experiences, describing them as dehumanizing. In workshops and interviews, customers communicated significant dissatisfaction with invasive, superfluous assessment processes; endless waitlists and mismanaged expectations;[2] complex, unnavigable systems; and geographically disconnected service points.

Not only are intake processes frustrating, they can also be re-traumatizing for customers. Assessments often include questions about deeply personal information that are functionally unnecessary for the services available. This generates inefficiency in programs and systems, as well as amplifies the customers' negative experience. In addition, it can worsen their living situation by increasing levels of toxic stress, clouding normal decision-making processes[3] and destabilizing their physiological well-being.

Therefore, the sixth action is to **design and implement intake processes that are connected, customer-centric, and radically accessible.**

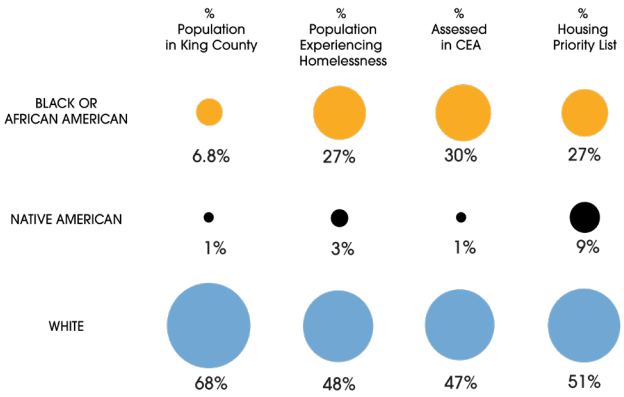
Background

In a comprehensive evaluation of national standards of best practice, we identified three key opportunities to strengthen coordinated entry in the region. The first is to structure outreach efforts as a bridge to housing and supportive services through coordinated entry. The second is to structure coordinated entry as a touchpoint from which customers are offered hand-offs and referrals to all relevant resources available both within and outside of the homeless service system.[4] The third opportunity is to design and implement phased assessments[5] that only collect data relevant to the resources accessible from any given support point. Below, there are several strategies that accelerate the development of intake processes that connect to all

available supports in the community for permanent housing and economic mobility.

An analysis of the local coordinated entry system and system-wide referral processes found limited connections to and from other resources available in the community, indicating weak inter-system collaboration that would, in part, be addressed by consolidating authority. This, in turn, would relieve customers of the burden to develop expertise in navigating a fragmented system. In interviews and workshops, customers shared that current intake processes inhibit trust-building and create uncomfortable dynamics between providers and customers. Similarly, providers recognized the tension between their organizational values and available resources, which often leads to false promises and a lack of transparency.

RACIAL DISCREPANCIES IN HOUSING PRIORITY



King County Department of Community and Human Services, Performance Measurement and Evaluation Unit, City of Seattle Human Services Department, Data, Performance, and Evaluation Unit (2018). CEA Interim Single Adult Prioritization Formula Proposal: Results from Workgroup. Seattle, WA: CEA Policy Advisory Committee.

The review of recent Coordinated Entry for All reports delineates significant racial disparities produced by the assessment and prioritization process. Though black single adults make up 30% of those assessed within the coordinated entry system, they only make up 21% of those prioritized for housing. In contrast, single adults who identify as white makeup 51% of those prioritized for housing, despite only accounting for 47% of those assessed.[6] Nearly two thirds of people experiencing homelessness in the region are people of color: Native Americans and Alaskan Natives experience homelessness at seven times the rate of white people, while black people experience homelessness at five times the rate of white people, and Native Hawaiians and Pacific Islanders experience homelessness at three times the rate of white people.[7]

This degree of disproportionality requires that the system reorient itself based explicitly on the needs of customers, particularly historically marginalized populations, in order to be effective. Redesigning intake processes, implementing comprehensive coordinated entry structures, and consolidating oversight would allow for those needs to be understood at the systems level and for solutions to be scaled accordingly.

Programs often use battery-style assessment tools that map every potential aspect of customers' needs. However, customers expressed that most of the time these assessments don't lead to any new material support, behavioral health care connections, or resources to support economic mobility, and are therefore simply invasive. In response, a set of strategies below assure that customer experience is the primary driver for process design.

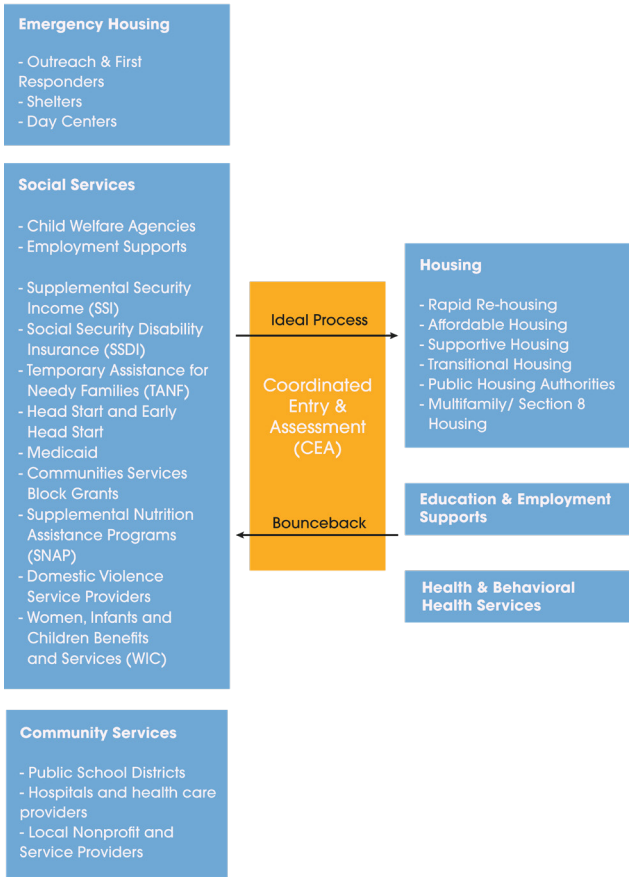
Strategies

Develop intake processes that connect to all available supports in the community for permanent housing and economic mobility

1. **Design and implement a low-barrier, comprehensive coordinated entry process that connects to all services and supports available in the region.**

Homeless service system intake processes should be widely accessible and designed to connect customers to resources both within and outside the system, representing the community-wide effort required to end homelessness.[8] Coordinated entry processes and procedures should be established at every entry point into the system and should prioritize timeliness,

PROPOSED OPERATIONAL FLOW



accessibility, and customer experience.

Coordinated entry staff at each access point should be able to facilitate direct access or referrals to the partners and supportive services outlined in the illustration, including services provided by faith-based organizations as well as those not specifically targeted to people experiencing homelessness. Coordinated entry staff should be co-located within the child welfare and juvenile justice systems (a process called 'in-reach' where people are identified and offered supports while either already service-connected in another context or while being detained by another system) in order to ensure that young people exiting those systems are assessed for housing stability and immediately connected to available resources whenever needed.

The coordinated entry framework should reflect the systems' customer-centered, Housing First orientation and the diversity of partners engaged should reflect the opportunity for customers to have a meaningful choice in the service and housing approaches that are accessible through coordinated entry.[9]

Cross-system collaboration should be built on a shared understanding of the drivers of homelessness and the community-wide responsibility to support customers. This collaboration should be mandated where possible and otherwise incentivized through collaborative applicant funding pools and other opportunities to ensure comprehensive connections and efficiency in meeting customers' needs.

Effective coordinated entry will leverage on the digital transformation strategies outlined to facilitate data sharing across programs and systems as well as the use of a de-duplicated master index to improve connections and customer experience.

In order to be meaningfully customer-oriented, the coordinated entry system should be transparent: expectations and level-setting should be openly discussed with customers.

To ensure that customer experience is the primary factor around which the process is designed and questions are connected to imminently available services and the housing waitlist:

2. Design and implement a phased assessment process.

Phased assessment would enable providers to screen only for the services, supports, and resources available directly at or from the access point in question.[10] This is supported by the digital transformation process outlined to facilitate data sharing across providers.[11] This type of process would create significant efficiencies for system administrators and providers and directly addresses customers' frustration with duplicative and impersonal assessment processes. This type of functional transformation will also play a part in mitigating the tremendous burden of homeless system navigation on customers.[12]

Phasing assessment relies on dynamic tools that axiomatically unlock or move past questions based

on a customer's responses in real time, rather than the current intake instruments (which are primarily battery-style evaluation tools which ask every question regardless of response). Phased assessment allows providers to identify customers' immediate service needs as well as necessary referrals and connections. These referrals and hand-offs to other providers and partners in the community should be backed by well-established processes and procedures as outlined above. Peer supports should be employed in these outreach, intake, and in-reach roles and receive specialized training to do so.[13]

3. Connect all in-reach and outreach to coordinated entry.

All outreach to people experiencing homelessness should be positioned as the first step in phased assessment, data collection, and relationship building. Outreach providers should be positioned to facilitate warm handoffs to coordinated entry providers and other service providers in the community. Discharge planning processes and procedures also should be modified to identify people at risk of experiencing homelessness[14] who are currently residing in jails, prisons, hospitals, and behavioral health treatment programs in order to begin the process of identifying resources available to prevent that experience.[15] These in-reach efforts should be led by the system that currently has the primary point of contact with the person (e.g. criminal justice), but well-informed by and structurally connected to the homelessness authority through data sharing agreements and programmatic memoranda of understanding. Outreach and in-reach providers should be trained in trauma-informed care,[16] motivational interviewing,[17] and critical time intervention[18] strategies to improve and streamline approaches to engagement with customers. To the maximum extent possible, people with lived experience of homelessness and existing peer support staff should always be considered for roles like these which require a deep understanding of a person's current circumstances and what will seem reasonable to them in that situation.

4. Streamline 2-1-1 information to align with coordinated entry and available resources.

The 2-1-1 information hotline should be leveraged as a key point for disseminating information about service availability within the system. Operators should be given regularly-updated information on prevention and diversion resources, shelter availability, locations for basic needs and services, human trafficking and emergency response protocols, domestic and sexual violence providers, and coordinated entry access points. When a data sharing infrastructure is established, operators should have a dynamic screening tool that offers a preliminary eligibility assessment for available prevention and diversion resources and the ability to connect people directly to them.

Related Actions

3. Become accountable to customers.

4. Prioritize economic stability to reduce inflow.

5. Improve customer outcomes through a comprehensive digital transformation.

7. Expand physical and behavioral health options for people experiencing homelessness.

9. Increase access to 0-30% AMI housing.

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013, August 30). Poverty Impedes Cognitive Function. Science, 341 (6149), 976-980.
3 Seeman, T., Epel, E., Gruenewald, T., Karlamangla, A., & Mcewen, B. S. (2010). Socio-economic differentials in peripheral biology: Cumulative

allostatic load. Annals of the New York Academy of Sciences, 1186 (1), 223-239.

4 U.S. Interagency Council on Homelessness (February 2017). Enhancing Coordinated Entry through Partnerships with Mainstream Resources and Programs.

5 United States Department of Housing and Urban Development. (2017). Coordinated Entry Core Elements.

6 System administrators are aware of these failures, as well as the fact that the current assessment process produces racial disparities in housing placements. System administrators are aware of these dynamics and have adjusted the prioritization formula until a new prioritization tool is developed or identified. King County Department of Community and Human Services, Performance Measurement and Evaluation Unit, City of Seattle Human Services Department, Data, Performance, and Evaluation Unit (2018). CEA Interim Single Adult Prioritization Formula Proposal: Results from Workgroup. Seattle, WA: CEA Policy Advisory Committee.

7 Ibid.

8 Coordinated Entry. (June 2018).

9 Deploy Housing First Systemwide. (August 2018).

10 United States Department of Housing and Urban Development. (2018). Coordinated Entry Process Self-Assessment.

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Access and improvements to health services are needed to support safe and stable exits from living outside.

There are not adequate health services to support safe and stable exits from living outside for people experiencing chronic unsheltered homelessness. There have been many behavioral health improvements and innovations in King County, however, the lack of targeted care for people experiencing homelessness is a significant barrier.

While the majority of people experiencing homelessness do not suffer from substance use disorder or psychotic spectrum illnesses, they make up a disproportionate number of people currently living outside. Due to the nature of the crisis they are facing, the needs of this population are often acute and debilitating. Any attempt to directly incorporate them into existing behavioral health services would likely tax providers and destabilize the system.

Because of this, Action 7 is to expand physical and behavioral health options for people experiencing homelessness.

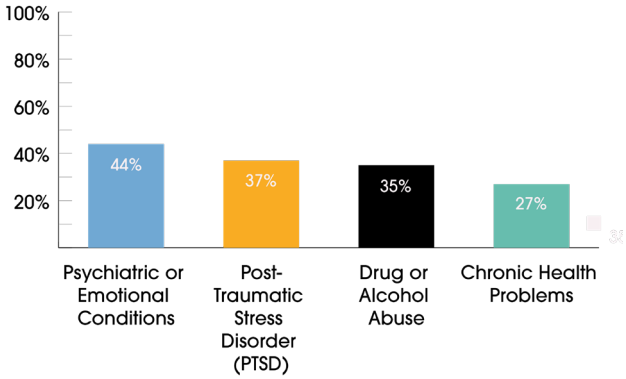
To appropriately respond, it is necessary to develop resources tailored to the needs of this population. These will require the deployment of new service models and the activation of different funding models from both the federal and state levels, as opposed to the repurposing of existing system components, which are already performing vital functions for other vulnerable populations.

Background

Our research with customers[1] and providers identified two main areas of health-related need among those experiencing homelessness. First, health needs (both physical and behavioral) are difficult to prioritize for customers who find themselves in 'crisis mode.' Their ability to sort out their degree of need is compromised by the complexity of their situation, the stress associated with finding ways to navigate unfamiliar service systems, feelings of isolation, and (often) the need to care for the basic needs of others (children or family). Second, continuity of care is particularly challenging within service systems that typically don't address co-occurrence of health needs (e.g., substance use and mental health), or basic access challenges (such as transportation and coordination among providers). In addition, lack of familiarity with health services and care coordination among staff providers creates a piecemeal and reactive approach to addressing the health needs of customers. Finally, many health services are staffed by inexperienced providers whose tenure is frequently very brief, which results in inconsistent quality of care.

Based on the 2018 King County point-in-time (PIT) count, 27.3% of respondents identified themselves as having a chronic health problem or medical condition, 34.6% as living with "drug or alcohol abuse", 43.9% as living with a psychiatric or emotional condition, and 36.5% identified as living with PTSD. 8.8% of survey respondents (approximately 1,000 people) believed that "mental health issues" were the primary event or condition that lead to their homelessness.[2]

SELF-REPORTED HEALTH CONDITIONS



n = 1,036 - 1,040 Note: Multiple response question. Percentages may not add to 100.
Source: AllHome Count Us In 2018 Report

Given the reality that many people are not captured by even the most well executed PIT count, it is reasonable to operate under the assumption that the need for behavioral health supports is greater than what is reported here. This represents a large population in need of services, particularly services that are capable of responding to high levels of acuity. People living with serious mental health conditions who are also forced to reside outside often have complicated physical health needs in addition to their behavioral health needs. Managing these simultaneously is often too difficult for standard health providers, and is attempted only to the detriment of the patient. Creating programs that have the capacity to meet customers needs will require a focus on the development of innovative models of clinical support, some strategies for which can be found below.

However, those models will only function if they are embedded with providers who have the capacity to manage them. While some providers may be able to scale quickly into providing robust physical and behavioral health services to people experiencing homelessness, others will need assistance. Overall, there is a need to have a secure pipeline of clinicians skilled at providing the kind of support necessary. Therefore, several strategies below **focus on increasing the capacity of providers.**

Strategies

Focus on the development of innovative models of clinical support.

1. Invest in holistic care communities.

Holistic care communities are housing models that incorporate Assertive Community Treatment

(ACT), a customer-involved and multidisciplinary team casework model, to provide comprehensive community-based psychiatric treatment. The model focuses on rehabilitation and support for people living with serious mental health conditions, substance use disorders, and histories of incarceration. Holistic care communities provide patients with community support, medication, education, empowerment, and complementary treatment to meet each person's medical, social, psychological and spiritual needs.[3] Holistic care communities are made up of employed caseworkers and patients who live together and build support networks that can address each individual's personal, social, and environmental needs.[4] The goal is to equip customers to transition into the community-at-large should they express the desire to do so.

Holistic care communities and the broad practice of ACT are effective in addressing behavioral health needs for people experiencing homelessness.[5] A comprehensive review of ACT models showed a 37%[6] greater reduction in homelessness and a 26% greater improvement in psychiatric symptom severity than traditional casework.[7] Further studies showed that ACT significantly reduces hospitalization[8] and improved treatment outcomes for both housed patients and those who are experiencing homelessness. While not a substitute for appropriate medical intervention, ACT significantly decreases the necessity for psychiatric or medical evaluation as well as expensive medicines for patients.[9] Instead of managing behavioral health through emergency rooms and clinics at heavy cost, ACT is a community-centered, lower-cost alternative that can be tailored to people experiencing homelessness.

2. Implement shared decision making.

In order for medical and non-medical services to both meet the clinical needs and preserve the dignity and independence of people experiencing homelessness, Shared Decision Making (SDM) should be implemented across service streams. SDM is a clinical model where providers and patients work to reach decisions around care plans together.[10] SDM training is not exclusive to clinical decisions; it should also be integrated into the training frameworks of caseworkers and other staff who will engage in decision making roles with customers.

SDM improves the quality of medical consultation, treatment decisions, patient-physician communication, and satisfaction of both patients and physicians in clinical practice.[11] SDM improves patient health outcomes by removing anxiety in interactions and increasing compliance with treatment regimens. These approaches are especially good at increasing successful outcomes for vulnerable populations. Decision aids, or peer support, improved SDM consultation outcomes even more by increasing patient knowledge, reducing decisional conflict, and increasing patient involvement.[12] SDM as an interdisciplinary casework and medical tool increases equity and impact disparities in housing, medicine, and behavioral health. Clinical research found that with SDM, homeless women felt "empowered" and their input increased intervention success.[13]

3. Expand employment of peer supports in behavioral health care programs.

In workshops and interviews, customers shared the positive role of lived experience peer supports. Peer support workers are "experientially credentialed" by their own recovery journey, and as such are not trained as clinicians or more technically credentialed.[14] However, the Washington State Health Care Authority does train and qualify mental health consumers as certified peer counselors,[15] which allows peer workers to provide Medicaid prevention services at behavioral health agencies, which is billable under Medicaid.[16]

Peer support workers have been shown to be especially helpful in supporting people with mental health conditions, substance use disorders, and those with co-occurring disorders. Peer support workers who have been successful in their own recovery process are in an ideal position to share practical guidance, help people develop their own goals, and take concrete steps towards building stable lives for themselves.

Many of the struggles customers shared with regards to experiencing homelessness are well-addressed by peer supports: reducing isolation, easing integration into permanent housing, and improving social skills. Peer supports are also especially successful in improving outcomes for drug and alcohol treatment, mental and physical health, and social support.[17] Structured relationships with peer supports have been shown to reduce hospital admissions rates, decrease psychotic symptoms, and decrease substance use and depression.[18] As an empowering, strengths-based approach, drawing on peer support is also effective in increasing people's sense that their treatment is responsive and inclusive of their needs,[19] increasing engagement in self-care and wellness,[20] and increasing social support and functioning.[21]

The Substance Abuse and Mental Health Services Administration (SAMSHA) has outlined core competencies for peer supports. These core competencies require that services are recovery-oriented, centered on the person participating in services, voluntary, and trauma-informed.[22]

In order to better meet customers' socio-emotional needs, which are inextricably connected to their physical and mental health, the city and county should leverage Medicaid reimbursability to embed peer supports in all mental health and substance use disorder recovery services for people experiencing homelessness, scaling the number of peers based on the number of individuals enrolled in the program. Following recruitment, peers should be engaged in ongoing training in the core competencies listed above. These identified competencies should inform salary structures, certification standards and job descriptions. Supervisors and workers themselves should also use these competencies to assess job performance.

This opportunity to provide effective, culturally-competent care to behavioral health customers is also an opportunity to develop a robust employment pipeline for people experiencing homelessness who have been successful in their own recovery.

4. Establish access to harm reduction approaches system-wide.

Harm reduction policies consist of a wide range of ways to limit the negative social and/or physical consequences related to human behaviors within and outside the law. Harm reduction should be targeted specifically to prevent permanent consequences from behaviors related to substance use disorder or other behavioral health conditions. Relevant examples of effective harm reduction services include: needle distribution and recovery programs; substitution therapies for heroin with legally prescribed opioids; take-home naloxone programs to reverse overdoses; supervised consumption facilities in encampments not designated as sober; education on lower levels of consumption; and peer support programs. Increasing the availability of needle exchange programs and broader harm reduction initiatives incentivizes safer substance use, which reduces lethality and infection.[23]

In un-housed communities, harm reduction strategies have the ability to reduce hepatitis,[24] HIV,[25] overdose deaths, early deaths among those who use substances,[26] IV drug use in public places, the number of used needles in public, the sharing of needles,[27] emergency department visits,[28] substance use frequency, and crime. Harm reduction strategies increase employment among those who use substances, education, and successful referrals to treatment programs and health and social services. Additionally, harm reduction can be enhanced with peer supports, trauma-informed care,[29] and co-planning to give agency to people experiencing homeless.

Research on needle exchange programs in the United States verifies that they are cost efficient inhibitors of HIV transmission[30] and increase substance user access to social, medical, and behavioral support services.[31] A mobile needle exchange contributes to decreases in emergency room visits; in the case of Yale New Haven Hospital it helped lower ER visits 20% in a year.[32] Safe injection spaces increase enrollment in detoxification treatment and are not correlated with social disruption to their communities.[33] Housing first

programs which provide services regardless of an individual's substance use[34] habits reduce medical costs, social care costs, housing costs and alcohol use while improving clinical outcomes for those living with HIV/AIDS.[35]

5. Expand access to medication-assisted treatment (MAT) for people experiencing homelessness who are struggling with opioid use.

Though most people experiencing homelessness do not have opioid use disorders, there is an overrepresentation of people struggling with opioid misuse among those experiencing homelessness. Overdoses in King County disproportionately affect people experiencing homelessness: 1% of the population in King County is experiencing homelessness, but 14% of all drug and alcohol deaths were people presumed to be experiencing homelessness.[36] The region must expand access to medication-assisted treatment and make treatment accessible for those living outside, in shelter, and in housing programs in order to reduce the rate of fatalities and the prevalence of opioid use disorders among those experiencing homelessness—and in order to prevent people from returning to homelessness due to opioid misuse.[37] MAT treatment has been identified by SAMHSA to:

- Improve patient survival.
- Increase retention in treatment.
- Decrease illicit opioid use and other criminal activity among people with substance use disorders.
- Increase patients' ability to gain and maintain employment.
- Improve birth outcomes among women who have substance use disorders and are pregnant.
- Increase housing stability for people experiencing homelessness.[38]

Medication-assisted treatment (MAT) is defined as the use of FDA-approved medications, paired with behavioral therapies and counseling, to treat substance use disorders and prevent overdoses. The National Institutes of Health asserts that MAT decreases behavioral inpatient readmission[39] and increases rates of survival among patients with substance use disorders,[40] retention in treatment,[41] and housing stability for people experiencing homelessness.[42]

In the Seattle and King County region, MAT clinics specifically tailored to the needs of people experiencing homelessness are limited. The region can work with state and federal partners to leverage public funding to expand access to treatment for people who are struggling with opioid misuse and experiencing homelessness in the region. This work can be undertaken by:

- Assessing the prevalence of opioid use disorders and opioid misuse among individuals experiencing homelessness.
- Developing and implementing overdose prevention and response strategies system-wide, including in encampments, shelters, and in permanent and transitional housing programs.
- Strengthening partnerships between housing and health care providers to provide assistance in facilitating connections between services and housing when applicable.
- Expanding access to medication-assisted treatment by scaling the services already available in the region, increasing the number of providers who are able to prescribe these medications, and pairing these services with behavioral therapies and counseling.
- Removing barriers to housing for those in treatment by ensuring that landlords and providers do not misunderstand these medications to indicate ongoing drug use.

Shelter-Based MAT with Buprenorphine exhibits the benefits of Office-Based Opioid Treatment while limiting systemic barriers of child care needs, stigma, and travel distance.[43] Shelter-Based MAT is flexible, portable, can be instituted long-term, and is effective for treating people experiencing homelessness comparable to housed patients.[44] If properly controlled for shelter stay lengths that facilitate phased treatment

timelines, Shelter-Based Suboxone MAT can be instituted to effectively deliver MAT and combat alcohol and drug addiction. According to DEA regulations, the process to initiate Shelter-Based Suboxone MAT requires a Federally Qualified Health Center (FQHC) to obtain a waiver from the county Department of Public Health. DEA regulations require referrals to happen only within the qualified shelter organization, thus incentivizing a centralized FQHC body across the county to be embedded into shelters.[45]

There is opportunity to expand MAT in King County. In a 2015 Washington State Medication Assisted Treatment report, areas served by MAT clinics in King County saw positive 80.7% change in publicly funded opioid treatment admissions between 2003 and 2015, and 21.1% change in deaths attributed to opioids.[46] Still, access is limited. Substance Abuse Prevention and Treatment Block Grants as well as SAMHSA funding for free treatment referral services and new certified MAT treatments can improve regional capacity to rehabilitate people who experience homelessness and addiction co-occurrence.

For refutation of myths that surround MAT please refer to The National Council Challenging the Myths pamphlet.[47] The National Institute on Drug Abuse also offers a general model[48] and tools[49] for implementing MAT.

Focus on increasing the capacity of providers.

1. Launch a homelessness specific residency program with a longitudinal integrated clerkship model.

Given the density of hospitals and medical providers in King County, and particularly Seattle, a new regional authority on homelessness could work to foster relationships with residency programs to a launch homelessness specific residency program via a longitudinal integrated clerkship (LIC). LICs are a model of clinical education where medical and psychiatric school residents follow a set of homelessness patients across the homelessness system, build relationships in the community, and administer care.[50] A homelessness specific LIC would open new pathways to quality, targeted care for people experiencing homelessness and monitoring and evaluation of the homelessness system.[51] In this framework, residents, working as both a health system navigator and an arm of primary care, would be assigned specific patients experiencing homelessness. Partnerships with local universities would mobilize available resources and integrate residents to better understand lived-experiences of homelessness.

Homelessness specific residency programs leverage medical residents to facilitate comprehensive care for patients experiencing homelessness over time. Learning relationships between residents and patients are effective in producing successful primary care outcomes at lower resource cost. While typical medical services are often short-term and overly focused on inpatient clinical experiences, such clerkships incentivize a holistic patient-centered focus on outpatient and inpatient needs.[52] For example, the Tufts Maine Track model for rural health, pairs residents with a rural community in the state of Maine and is tightly interwoven in community health efforts. Retention of graduating physicians was high. 64% of the graduating class of this LIC program stayed in Maine after completion, many even returning to the same rural community. Patients treated by Maine Track graduates note that graduates understand their cultural context, liveliness concerns, and are more likely to be effective in shared decision making (as described above).[53,54]

Designating certain residents to directly address the needs of people experiencing homelessness builds critical capacity and increases the overall skill level available within healthcare systems to manage the high levels of acuity that many people experiencing chronic homelessness present within medical settings. Increased community clinic abilities lower emergency room admittance and saves significant tax-payer dollars.[55] More importantly, LIC students show

heightened understandings of social determinants of illness and recovery and exhibit increased commitment to patients.[56]

Instead of only treating symptoms that result from homelessness, LIC students are longitudinally trained to uncover much deeper and complex understandings of homelessness lived experience in order to wholly address its complications. LIC students follow patients over time through different care venues, shelter-based health clinics, ER visits, psychiatric hospitalization, surgical treatments for medical complications, detoxification, and addiction treatment. In the event that a customer obtains permanent supportive housing or some other permanent housing option, clinicians learn to adapt to new patient realities and reorient care to the new customer goals, such as the stabilization of chronic conditions like substance use, HIV, or depression.[57]

2. Colocate services and braid funding streams.

Creating innovative programs at scale to serve the needs of customers will require fostering and investing in partnerships across provider networks rather than funding individual providers. In order to effectively address co-occurrence of serious mental health conditions, substance use disorders, and serious physical health needs, fully integrated clinics should be prioritized for funding. This should include incentives for mental health, substance use, and medical clinics to be colocated using a collaborative applicant model (as exemplified by the HUD CoC application process). As evidenced by customer voice in workshops and interviews, people experiencing homelessness with significant health needs find themselves juggling time between noncontinuous health offerings. Individuals experiencing homelessness see non-specific and scattered healthcare as a barrier to accessing effective care.

It is also possible, through innovative partnerships between shelters and HRSA Federally Qualified Health Centers (FQHCs) to leverage reimbursement frameworks that allow for customers to engage in meaningful psychiatric, behavioral, and medical treatment while they are temporarily housed in a shelter context. Additionally, FQHC frameworks allow for the treatment delivered to be culturally relevant to the customer. This makes possible the development of reimbursable programs that are specific to historically marginalized populations, which are overrepresented in the population experiencing homelessness (e.g. Native, black, or LGBTQI people).

This model, which has proven extremely effective at Central City Concern (CCC) in Portland, Oregon, incorporates ACT with housing and other services as an FQHC. By leveraging their status as an FQHC, all health services that CCC provides, including culturally holistic non-medical treatments, are billable to Medicaid. A recent study done by Portland State University found a 95% reduction in the use of illegal drugs among participants and a 93% reduction in criminal activities among program participants. Central City Concern also contributed significant financial returns to the city. Before treatment, the 87 people cost the city roughly $2 million dollars in policing and processing their criminal activity, and $6.5 million dollars in emergency room visits, policing, and substance use treatment in one year. In the year after the Central City Concern intervention, the city saved a collective $5,729,750 on those 87 individuals alone. All services were billable to Medicaid or directly subsidized.[58]

3. Leverage the Medicaid Transformation initiatives and reimbursement processes to expand access to long-term services and supports

The Medicaid Transformation transition to Integrated Managed Care (integrated physical and behavioral health services), away from just acute care, begins under the Managed Care Organizations in January 2019.

In order to facilitate sustainable long-term services, King County should capitalize on 1) the mandate under the Accountable Communities of Health initiative of the Medicaid Transformation waiver (detailed below) to design and scale

integrated care delivery models, including bi-directional integration of behavioral health and community health clinics; 2) the March 2018 amendment to the waiver that covers expanded access to inpatient and residential services for individuals with substance use disorders; and 3) the mandate under the Foundational Community Supports initiative to cover more behavioral health, long-term care, and employment support services.

It is especially important to leverage the reimbursement framework for Foundational Community Supports, as it specifically enables supports for accessing and maintaining housing and obtaining and keeping a job under the same framework. The connection between housing and economic instability is described in Action 4, as is the importance of providing integrated quality supports that simultaneously address a person's stated health, housing, and healthcare needs. The scope of this mandate is expected to expand with the transition to more integrated care systems overall. This must be capitalized on for people experiencing homelessness.

Related Actions

2. Consolidate homelessness response system under one regional authority.

3. Become accountable to customers.

5. Improve customer outcomes through a comprehensive digital transformation.

6. Design intake processes that are connected, customer-centric, and radically accessible.

NIS

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A defined public/private partnership will enable funders to contribute meaningfully.

In King County has well-resourced business and philanthropic communities that have made significant investments in initiatives to end homelessness in the region. However, these investments have not been aligned with each other or with public priorities. This has resulted in competing—rather than complementary—efforts and a public perception that investments are mismanaged. The region's inability to leverage private investments against public priorities is rooted in the absence of a shared theory of change, which has hindered the progress both sectors have sought in King County.

Creating a defined public/private partnership will enable funders across the region to organize around the community's theory of change in a meaningful way. Specifically, it will allow them to develop a shared understanding of community-wide priorities, shape investments that are mutually-reinforcing, and offer smaller donors and the public an ongoing opportunity to contribute to those investments.

Background

Over the course of the last 15 years, public and private partners in Seattle and King County have invested significant resources in preventing and ending homelessness. These investments helped connect more than 30,000 households to permanent housing in the last six years alone.

However, the lack of a common vision has undercut these initiatives. Providers compete against each other for resources while the system continues to fall short in meeting the needs of people experiencing homelessness. Fragmentation between publicly and privately funded initiatives contributes to the disjointed nature of the homeless service system, directly impacting customers' experiences.[1]

The funders collaborative model allows for a transformational, authentic whole-of-community approach to the work to end homelessness in the region. Under this model, partners from the private and public sectors work in tandem under a shared theory of change to strategically match gaps in public resources to private funding opportunities. This ensures that investments will be meaningfully complementary rather than unintentionally misaligned. It will allow the region to drive toward specific goals at the campaign level and overall improvement at the systems level.[2,3]

There are successful models for this type of collaboration at the national level and in several communities. Partners in King County should engage technical experts to support the design and establishment of a funders collaborative.

By consolidating private funding with a single representative of the philanthropic community, the sector will streamline and align investments and create meaningful space for private sector input on public priorities.[4] This partner should be positioned to align procurement processes and priorities with the new regional authority. The collaborative could grant to the public entity, but could also grant to community-based organizations to support innovations and campaigns toward specific goals. This public/private partnership should be institutionalized by establishing a designated team within the new agency to partner with the funders collaborative.

Strategies

To create a defined public/private partnership, business and philanthropic sector partners should:

1. **Engage national experts and partners from other communities.**

Homeless service systems in seven other states have partnered with funders collaboratives to institutionalize alignment across the public and private sectors.[5] In addition to offering peer expertise, national experts are well-positioned to support the business and philanthropic communities in establishing a shared understanding of their roles and responsibilities to customers, grantees, and the public.[6]

2. **Adopt the community's theory of change as the governing principle over local investments.**

The theory of change should provide the framework for aligned investments towards a common vision of making homelessness rare, brief, and one-time.

3. **Develop two-way information sharing processes that inform and shape shared policies and priorities across sectors.**

In order for collaboration across sectors to be meaningful, insights should flow with ease between the consolidated entity and the funders collaborative. A liaison between the new entity and the funders collaborative should be designated. This liaison should be responsible for ensuring that private sector partners are connected to opportunities to inform policy and support resource gaps identified through the system.

4. **Establish shared performance metrics across systems, which are centered on customers' experience, outcomes, and cross-system policy priorities.**

Cross-sector alignment based on the community's theory of change will only be effective if performance metrics are established across funders to demonstrate a shared commitment to the same housing-focused outcomes for customers. These core metrics should be developed by the new entity in collaboration with partners.

5. Align procurement priorities, goals, deliverables, and timelines according to the community's theory of change and cross-system policy priorities.

Initiatives funded through the funders collaborative should be operationally aligned with those funded through the public sector, both those directly funded by the joint agency and those funded through adjacent systems. With an aligned procurement process, public and private partners alike would have an opportunity to streamline grantees' and providers' processes and support more fluid processes for customers.[7]

Related Actions

1. Institute a system-wide theory of change.
3. Become accountable to customers.
10. Create long-term institutional alignment across systems to serve people experiencing homelessness.

NIS

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 In San Diego, a funders collaborative was able to leverage $240,000 into $10 million of public funding to support the operational expense of creating permanent supportive housing, and converting existing transitional housing. Funders Together San Diego.
3 The Funders Together to End Homelessness Los Angeles chapter has more than thirty funder members who meet quarterly to learn about and discuss new solutions to homelessness in LA County. Many of these members are also part of Los Angeles County's Home For Good Funders Collaborative, led by the local United Way. Between 2012 and 2015 the Funders Collaborative aligned over $650 million in public and philanthropic resources toward permanent solutions to homelessness in Los Angeles County.
4 This single entity model was maximized in Los Angeles through Funders Together Los Angeles and streamlined investments in permanent supportive housing to drive progress toward ending chronic homelessness. (Abt Associates. (May 2013). Home for Good Funders Collaborative: Lessons Learned from Implementation and Year One Funding. Conrad H. Hilton Foundation).
5 Funder Collaboratives.
6 Funders Together to End Homelessness is the leading organization in the work to expand philanthropy's impact and influence in advancing the movement to prevent and end homelessness. Funders Together to End Homelessness provides critical resources, learning and networking opportunities to its members to increase their knowledge, capacity, and effectiveness in their individual and collective work to prevent and end homelessness.
7 Learnings published by Los Angeles' funding collaborative highlight the benefit of including stakeholders' preferences in the application review process, either through "impartial" or "expert" reviewers. (Abt. Associates. (May 2013). Home for Good Funders Collaborative: Lessons Learned from Implementation and Year One Funding. Conrad H. Hilton Foundation).

There is a need to build and make accessible truly affordable housing.

In workshops and interviews, customers[1] often emphasized that their primary goal is to secure stable housing. However, because of the shortage of housing, customers can spend years on waitlists. They described how the act of waiting can further erode their social and economic stability, cause toxic stress,[2] and exacerbate physical and behavioral health conditions. Customers' instability increases as they wait for housing, as does their use of emergency services. These long wait times also correspond to declines in customers' overall wellbeing.

In response, the Action 9 is to **increase access to 0–30% AMI housing.**

Communities across King County must significantly and strategically increase the rate of affordable housing acquisition and development for people experiencing homelessness. Based on the shortage of housing for those with the deepest levels of need, the strategies outlined below hinge on the principle that all capital investments should be prioritized for permanent housing across the county.

This action supports the forthcoming housing development recommendations from the Affordable Housing Task Force. There is also a significant need and opportunity to prioritize access to existing affordable housing for people experiencing homelessness, as well as invest in services that help people access and maintain that housing.

Background

It goes without saying the shortage of affordable housing is a core driver of our nation's homelessness crisis. We see the impact of this shortage in the lives of frontline staff and people experiencing homelessness. In workshops and interviews, customers emphasized again and again that their primary goal is to secure stable housing. However, because of the shortage of housing, customers spend months and years on waitlists. They described how much that waiting period can exacerbate their social and economic instability, toxic stress,[3] and physical and behavioral health conditions. The increased instability that people experience while waiting for housing directly undermines their ability to achieve long-term stabilization and leads to an increased utilization of services.

Frontline staff also expressed the shortage of affordable housing makes it hard for them to do their jobs well, strains their relationships with customers, and increases staff burnout. Many staff stated they were 'betraying' customers, given their inability to deliver on their customers' desired housing.

According to estimates by the Regional Affordable Housing Task Force: Five-Year Action Plan, 156,000 households in King County are currently cost-burdened, including 73,000 at 0-30% AMI. Given that extreme shortage, capital investments in the work to end homelessness should be prioritized for permanent housing across the county. In support of this we have included a set of strategies to increase the rate of 0-30% AMI housing acquisition and development across the region.[4]

The Task Force, which is made up of King County mayors and city and county council members, developed its draft recommendations with involvement from a group of advisors from community organizations, nonprofit and for-profit housing developers, housing authorities, and tenant advocacy groups. People experiencing homelessness or at risk of experiencing homelessness were not engaged in the development of the initial recommendations. However, the Task Force has committed to authentically engage communities of color and low-income communities in affordable housing development and policy decisions as part of its action plan.

That engagement should be closely coordinated with a consolidated authority's development of structures to center customer voice. Planning for 0-30% AMI housing development should be done in alignment with the priorities of the new entity (as described in Action 2) and in collaboration with its administrators (as described in Action 10). That will help ensure the pipeline of permanent housing opportunities for people experiencing homelessness is strategically sited, sized, and paired with services to meet stated need.

For customers on waitlists, their qualifications for specific types of housing shift as they pursue employment or experience other life events. This shift requires them to re-engage the service system for (re)qualification, which in turn extends their waiting period, leading to further destabilization. Customers also shared a lot about the mismatch between their qualifications for housing and the housing types available. This reflects a systematic lack of attention to customers' stated needs in defining housing qualification criteria, deciding placement, determining affordability, and understanding what's required to maintain housing. To respond to this, the second set of strategies expand access to existing affordable housing for people experiencing homelessness and extremely low-income households.

This includes developing and expanding access to supportive housing and housing with economic supports. As part of that, there is a significant need and opportunity to align Public Housing Authority (PHA) priorities with efforts to end homelessness across the county. PHA and Continuum of Care (CoC) partnerships in other regions have shown significant success in decreasing the number of people experiencing homelessness, even when the

PHA contribution of housing units is incremental.[5] With effective coordination of existing resources, PHAs and homeless service providers have been able to streamline connections to permanent housing and ensure that customers receive the services that they need.[6] Therefore, the last set of strategies we have gathered here are designed to prioritize services that enable people to access and maintain permanent housing.

Strategies

Increase the rate of 0–30% AMI housing acquisition and development across the region.

1. **Prioritize capital for permanent housing, including leveraging emergency shelter funding for temporary shelters rather than capital funding for permanent shelters.**

In order to rapidly scale both shelter capacity and permanent housing capacity, it is necessary to disaggregate capital investments (those investments that are targeted towards the creation of new physical infrastructure e.g. 'bricks and mortar' dollars) from any shelter investments. However, this does not mean the rate of shelter openings should be slowed down, rather, it must be accelerated in order to meet the needs of those experiencing unsheltered homelessness.

This means shifting the strategy for opening shelters towards one of working with service providers to identify vacant buildings or high capacity spaces across the county that are being underutilized and resourcing them with operations and service provision dollars to rapidly transition them into operating shelters. These spaces must be identified as fit for human habitation, with appropriate insulation, water and sewage hookups, and the ability for people living there to maintain privacy and dignity. This strategy is crucial to deploy during wet and cold winter months to ensure people survive.

Focusing on opening shelters under this strategy accelerates shelter openings by eliminating the need for lengthy permitting processes. It also allows for the shift of development dollars towards permanent housing solutions.

2. **Work with the Affordable Housing Task Force to ensure the housing needs of people experiencing homelessness or at risk of experiencing homelessness are a focus of the policy planning process.**

The Task Force Action Plan calls for public resources to be prioritized for serving households 50% AMI and below. The consolidated agency should work closely with the to-be-established Affordable Housing Committee of the King County Growth Management Planning Council to ensure the committee's representation of communities impacted by displacement includes communities with experience of homelessness. As the agency develops structures around its customer orientation, it should ensure robust capacity-building with and engagement of those communities in the Committee's policy work. That engagement should be especially focused on the expansion of legislation and statewide policies related to tenant protection, the expansion of supports for low-income renters and people with disabilities, and the updating of zoning and land use regulations to increase and diversify housing choices.

3. **Advocate for broader rezoning efforts than those outlined in the Seattle Planning Commission's Neighborhoods for All report.**

The December 2018 report recommends developing more residential areas across the city and rezoning areas currently zoned for single-family homes to allow for a greater variety of housing types. The report does not make clear how many additional 0-30% AMI units would result from the plan. To meet the need for affordable housing of people experiencing homelessness or at risk of homelessness, King County must undertake a more comprehensive rezoning of neighborhoods for multi-unit residential housing.

Expand access to existing affordable housing for people experiencing homelessness and extremely low-income households.

1. Redesign the housing waitlist process to improve customer experience and enhance customer dignity.

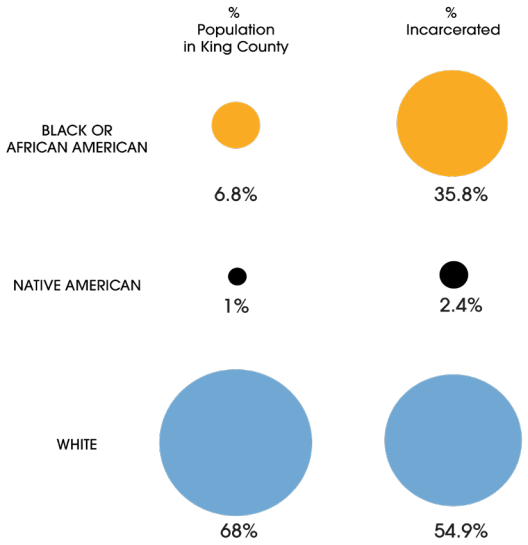
Customers shared that the process for getting and staying on housing waitlists is complicated and often requires the support of case managers with inside knowledge of how to qualify for different lists. Once they're on housing lists, they can wait for months and years without knowing if or when housing will become available and be disqualified by life events and have to start the process over again. Customers describe emotional and psychological destabilization from the waiting and lack of control.

To improve this process for customers, it should be redesigned to consolidate housing lists, and make qualifying information transparent and accessible to first-time users. This would build on the success of a fully implemented coordinated entry system that drew on the data integration described in the digital transformation action. Given customers frequently cited their confusion about how they moved (or didn't) we suggest that any list optimization involves creating a portal through which people could both see a clear explanation of the standards that govern the waitlist as well as their current place in line. A robust system with customer control of data as a central tenant also has the ability to allow people to upload documentation reflecting changes in circumstance so that eligibility determinations remain up to date.

2. Align Public Housing Authority priorities with community-wide efforts to end homelessness.

Aligning the Seattle Housing Authority (SHA) and King County Housing Authority (KCHA) priorities with the regional homelessness system's prioritization of permanent housing is especially important for ensuring housing access for people being released from prison. Many returning citizens have little immediate access to sufficient income to afford market-rate housing and are at risk of homelessness.[7] This is doubly important from a racial equity perspective, as black people are 6.8% of the overall population in King County, but represent 35.8% of the incarcerated population, and Native people are 1%, but represent 2.4% of the incarcerated population.[8]

RACIAL DISCREPANCIES IN INCARCERATION



King County Department of Adult and Juvenile Detention. (September 2018). Detention and Alternatives Report.

SHA and KCHA strategies for aligning priorities with the new entity should include:

- **Expanding on local preferences for Housing Choice Vouchers (HCV)/Section 8 for people experiencing homelessness or at immediate risk of homelessness.** Work with the PHAs to focus the HCV program on people at risk of homelessness should align with the King County Department of Corrections (DOC) around a commitment to permanent housing. The DOC currently runs an Earned Release Date Housing Voucher Program, but this only offers rental subsidies for three months and these subsidies are not sufficient in the high-rent market.[9]

- **Establishing a clear policy under their Admissions and Continued Occupancy Policies (ACOP) that lifts most permanent exclusion**

from public housing of people with criminal backgrounds. SHA and KCHA should follow the lead of the Housing Authority of New Orleans and establish a clear policy in which no applicant will be denied housing because of their criminal record without consideration of individual and present circumstances.[10] HUD restricts people convicted of manufacturing methamphetamine or subject to lifetime sex offender registration in federally subsidized housing. But beyond those restrictions, PHAs have discretion when determining who to accept to or reject from their programs. Establishing a clear policy will also lay the groundwork for being able to address admissions/exclusion policies for affordable housing developers, which often have similar admissions policies to PHAs.[11]

- **Employing Family Unification Program (FUP) Vouchers or Project-Based Vouchers (PBV) to assist people to live with family and friends already in public housing.[12]** Using FUP and PBV to enable people to live with family and friends is hugely important for connecting people both with permanent housing and with the emotional support many customers say is essential to their stability. The NYC Housing Authority has a successful family reentry program, which SHA and KCHA should look to as a model.[13] The program allows individuals to contribute to the household income for the first two years without it affecting the household's rent, which helps host families maintain sufficient income to support the addition of people to the household. It also provides case management services that are referenced below. SHA and KCHA should also expand the PHA definition of family to allow people to live with those with whom they have mutually supportive relationships.[14]

3. Leverage Seattle's Fair Chance Housing policy and push for its expansion to King County.

Seattle's Fair Chance Housing ordinance went into effect in February 2018. It prevents landlords from unfairly denying applicants housing based on criminal history[15] and prohibits the use of advertising language that automatically or categorically excludes people with arrest records, conviction records, or criminal history. The new agency should align with the Seattle Office of Civil Rights to support enforcement of this law and help connect landlords and tenants to training. It should also recommend the adoption of a law with the same provisions for King County. Given the disproportionate number of black and Native individuals incarcerated in King County, this is an essential component of any racial equity approach to housing.[16]

Prioritize services that enable people to access and maintain permanent housing.

1. Invest in educational and skills training programs connected to housing.

As described at length in Action 4, customers have repeatedly stressed that access to economic mobility supports is essential to long-term stability in housing.

In alignment with the commitment to skills training and job placement in high-growth occupations (described in Action 4), SHA and KCHA should leverage Moving to Work (MTW) flexibilities to develop strong employment supports for residents in public housing programs. In addition, the new agency should build on the employment navigator model from the King County Rapid Re-Housing for Families pilot to design and implement Rapid Re-Housing programs with longer housing subsidy periods, allowing for completion of skills training in high-growth occupations. Housing programs should partner with service providers that can provide case management for basic well-being, economic, and health supports along the lines of the NYCHA Family Reentry Program. The most successful housing programs with supports allow PHAs to provide housing and rely on other partners to provide services beyond the scope of the PHAs.[17]

SHA and KCHA should also look to develop an educational partnership along the lines of the Tacoma Housing Authority (THA) partnership with Tacoma

Community College, which provides rentalassistance to students enrolled in the college who are experiencing homelessness.[18] Existing funding may not support a strategy this robust and it is important to look at ways to raise the amount of revenue necessary to make the investment in this critical connection. THA is also now pursuing a property-based subsidy strategy where they offer a rental subsidy for whole buildings owned by private landlords,[19] to address the increased difficulty of finding housing that can be covered by vouchers.

2. Scale successful Permanent Supportive Housing (PSH) models in Seattle and King County.

The Seattle-King County CoC has successful PSH models, including through DESC and Plymouth Housing, which should be expanded to reach more people. In addition, King County should build on KCHA's Passage Point partnership with the YWCA. That program leverages PBVs and MTW flexibilities[20] to reunite recently released single parents[21] at risk of homelessness with their children and provides skills training and employment supports over an extended period. Although they don't participate in the CoC, Pioneer Human Services[22] provides comprehensive supportive housing with long-term case management that has demonstrated the effectiveness of flexible supports. Their model should be considered as PSH is scaled in King County, as well as the model of holistic healing communities described in Action 7.

Related Actions

4. **Prioritize economic stability to reduce inflow.**
6. **Design intake processes that are connected, customer-centric, and radically accessible.**

NIS

1 Please note this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.
2 Also called allostatic load or cognitive load.
3 Also called allostatic load or cognitive load.
4 King County Regional Affordable Housing Task Force. (August 2018). Draft Regional Affordable Housing Task Force Five-Year Action Plan.
5 United States Interagency Council on Homelessness. (May 2015). Public Housing Authorities and Continuums of Care: Establishing and Maintaining Powerful Teams.
6 Ibid.
7 United States Department of Housing and Urban Development. (June 2016). It Starts with Housing: Public Housing Agencies are Making Second Chances Real.
8 King County Department of Adult and Juvenile Detention. (September 2018). Detention and Alternatives Report.
9 From correspondence with Angie Gogerty at the King County Department of Corrections. Also from Transitional Housing Provider Orientation Packet, Earned Release Date Housing Voucher Program.
10 This follows best practices recommended by the Sargent Shriver National Center on Poverty Law and the United States Department of Housing and Urban Development. The Housing Authority of New Orleans was the first PHA to institute this policy in 2016, but several others have followed.
11 From correspondence with Margaret di Zerega at The Vera Institute of Justice.
12 Best practices around these housing programs and reentry are laid out in the Vera Institute of Justice's September 2017 report Opening Doors: How to develop reentry programs using examples from public housing authorities.
13 Ibid.
14 From correspondence with Margaret di Zerega at The Vera Institute of Justice.
15 Seattle Office for Civil Rights. (2018). Fair Chance Housing.
16 Pablo, E. (April 2018). Seattle: A Fair Chance Housing Ordinance Centering Racial Equity.
17 Bae, J., Finley, K., di Zerega, M., Kim, S. Vera Institute of Justice. (September 2017). Opening Doors: How to develop reentry programs using examples from public housing authorities.
18 This started at 25 rental subsidies, and they are now at 150.
19 THA put out an RFP for this program and currently have two market-rate landlords.
20 The Gates Foundation and United Way have also provided some funding.
21 The program serves 46 families annually.
22 From correspondence with Kevin Osborne at Pioneer Human Services.

Institutional alignment formalizes relationships across mission-critical partners regionally.

Homelessness represents multi-sector, multi-system failures that require whole-of-community solutions. Many of the strategies, connections, and services needed to support individuals experiencing homelessness are managed outside of the homeless service system or in geographically separated systems.

Consolidation captures critical functions of the homeless service system in a new, centralized authority. Institutional alignment creates the mechanisms necessary to formalize relationships between that entity and other mission-critical partners across the region.

Background

In workshops and interviews, customers'[1] experiences reflected cross-system fragmentation and illustrated how unclear program pathways, dispersed service locations, and complex eligibility policies slow progress toward stability. Customers need access to a wide array of resources and supports outside of the homeless service system[2] in order to achieve their personal goals, but those supports are not well-aligned with the homeless service system. Regional transformation is dependent on cross-system collaboration to address the crisis at hand.

To address fragmentation, leaders in partner systems should adopt the uniform theory of change as the governing principle across programs and providers that serve people experiencing homelessness. Some programs (identified below) are not structurally suited for consolidation, though they offer integral services for people experiencing homelessness. Consolidation would also not be functionally viable because it would destabilize services for customers not experiencing homelessness. However, aligning these programs with homeless service system policy priorities, performance metrics, and customer referral processes established by a regional authority would ensure effective cross-system collaboration and streamline services.

Robust institutional partnership, using contractual mechanisms to inform and shape cross-system policies and priorities, is key to ensuring customers'

access to resources. Affordable housing development, human services, public health services, and public housing are just four examples of the systems to which the homeless service system must be closely tethered. The role of partners in informing joint policy-making, advisory, oversight, and input roles will vary. However, the core functions of procurement priorities, program goals, deliverables, and timelines should be aligned according to the community's theory of change and cross-system policy priorities.

Alignment between other agencies and the new entity would produce the change needed to support a consolidated, customer-oriented regional approach. Representatives of the following agencies have been engaged throughout this design process:

- The Seattle Office of Housing
- The Seattle Human Services Department
- The Seattle and King County Department of Public Health
- The King County Department of Community and Human Services
- The Seattle/King County Continuum of Care
- The King County and Seattle Public Housing Authorities

Strategies

Create long-term institutional alignment across systems serving people experiencing homelessness.

1. Adopt a uniform theory of change across programs serving people experiencing homelessness that are not consolidated under the new regional authority.

To be operationalized, the community's theory of change should guide all programs reaching people experiencing homelessness. Administrators across these programs should index internal policies and priorities against the theory of change. Programs should also develop performance metrics in alignment with the homelessness response system. This would translate the customer orientation of the homeless service system to these adjacent systems, and set the stage for meaningful systems collaboration.

2. Develop and institutionalize mechanisms to inform and shape cross-system policies and priorities.

Data-driven insights on customers' challenges and opportunities must flow fluidly between the new entity and partner programs within other systems. Partnerships should be underpinned by memoranda of understanding that outline partner roles and responsibilities, including oversight over system-wide priorities; robust data sharing agreements; and mechanisms for sharing program data to inform policy priorities and help partners identify scalable practices.

Partner systems should identify staff who are responsible for system coordination, as well as staff who are responsible for navigating cross-system connections for customers. Mechanisms for systems to be held accountable to robust coordination should also be established.

3. Leverage shared frameworks and data sharing agreements to align metrics that are centered on customers' experience, outcomes, and cross-system policy priorities.

Alignment around the community's theory of change will only be effective if cross-system performance metrics are established that reflect common goals, a shared understanding of best practices, and community-wide, customer-centered services. These metrics should be developed by the regional entity in collaboration with partners and should prioritize customer-driven, housing-focused outcomes. A metrics dashboard should be developed to give administrators a real-time view of system performance and drive continuous quality improvement across systems.

4. Align procurement priorities, goals, deliverables, and timelines according to the community's theory of change and cross-system policy priorities.

Best practices (e.g. harm reduction, Housing First approaches, shared decision making, and peer supports) should be implemented across systems.

Procurement processes are a core element of cross-system collaboration, particularly when providers receive funding from multiple sources and devote significant staff time to navigating duplicative reporting processes and competing priorities. The new entity should consolidate contracting into an omnibus procurement process for homeless service providers that streamlines funding and reporting into the minimum number of contracts possible. Those contracts should reflect uniform, system-wide priorities and preferred practices. They should also be structured to incentivize collaboration among providers, leveraging both public and private funding streams.

For systems serving a broader population, partners should identify their distinct connections to the work to prevent and end homelessness and delineate priorities, goals, deliverables, and timelines in alignment with established performance metrics and community-wide goals.

Related Actions

1. Institute a system-wide theory of change.

3. Become accountable to customers.

8. Create a defined public/private partnership utilizing a funders collaborative model.

NIS

1 Please note that this team refers to "people with lived experience" or "people experiencing homelessness" as "customers" to accurately reflect their status placement within the system.

2 United States Interagency Council on Homelessness. (February 2017). Enhancing Coordinated Entry through Partnerships with Mainstream Resources and Programs.