Washtenaw County CoC Comprehensive Plan to Serve Individuals and Families Experiencing Homelessness with Severe Service Needs

Washtenaw County CoC developed this plan collaboratively throughout July to October 2022. First, the CoC advertised two Community Dialogues about the Supplemental Notice of Funding Opportunity to Address Rural and Unsheltered Homelessness (SNOFO). Invitations were distributed through the CoC listserv and other community channels with the intention of casting a wide net. These sessions provided information about the opportunity and held space for community members to discuss what types of projects and populations should be prioritized. We also set the stage for a collaborative application process. Weekly working sessions ran from August – October, each focusing on a different component of the Comprehensive Plan, including Coordinating with Healthcare – Primary Care on 8/25, Landlord Engagement on 9/1, Discharge Coordination with Hospitals on 9/8, Immediate Access to Low-Barrier Emergency Shelter and Permanent Housing on 9/15, Intersections with the Criminal Legal System on 9/22, Street Outreach on 9/29, and Coordinated Entry for SNOFO Projects on 10/6. The Working Sessions were advertised publicly at the Community Dialogues, invitations were sent out to all CoC-listserv members and advertised through the CoC Newsletter, and individual participants were encouraged to reach out to their coworkers and cross-sector partners. As a result, a wide variety of people attended, representing outreach, shelter, and permanent housing staff; criminal justice stakeholders at the Sheriff's Office, Washtenaw County Jail, and probation and parole; disability advocates; health partners at major hospitals, local clinics, and mental health providers and advocates; realtors and housing advocates; and local government representatives and officials. Meetings were held online via Microsoft Teams, based on feedback from prior community meetings that this was more accessible than in-person meetings. Content experts in each area were invited to share a presentation at the beginning, but the bulk of the sessions were open for participants to ask questions of each other. The spaces were designed to be non-hierarchical and participatory, with no formal agenda or rules for engagement. We used less jargon and explained key terms, both verbally and through the chat functions. In one meeting, for example, we opened by walking through the HUD definitions of homelessness to ensure all participants were starting from the same foundational knowledge. CoC staff asked specific questions pertinent to the development of the Comprehensive Plan but came in with no prejudgments of the outcome and took care to open the space for everyone. Several conversations spun off as a direct result of engagement in the working sessions. For example, in one working session we discovered a need to tighten coordination between the Washtenaw County jail and other reentry providers and our Coordinated Entry system. We scheduled a subsequent meeting (open to all who were interested in attending) for that purpose, and a set of action steps resulted. The CoC received positive feedback on the working session series and saw new connections made in real-time.

This plan represents the culmination of these community conversations. It is intended to be a living document that should be evaluated and updated annually. We are still considering the best way to implement this—perhaps, through a new CoC committee that will take over from the working session meetings—but are committed to operationalizing this plan and continuing its commitment to being community-driven. Any future process will be accessible and encourage increased participation from people with lived experience.

1. Leveraging Housing Resources

Development of new units and creation of housing opportunities.

Washtenaw County CoC engages in partnerships and advocacy to expand affordable housing, supporting pro-tenant policy changes and engaging in cross-sector partnerships to leverage additional funds for housing. Landlord engagement is a key strategy in accessing more units within the existing housing stock.

Advocacy. The Washtenaw Housing Alliance (WHA) is a core member of the CoC, and one of the CoC's committees is WHA's Operations Committee. WHA has engaged in advocacy to promote policies that expand access to housing, for those with housing choice vouchers or other types of rental assistance, in Washtenaw County and across the state of Michigan. While Source of Income (SOI) protections cover the cities of Ann Arbor and Ypsilanti, areas outside these cities in the county are unprotected. Efforts are currently underway to establish SOI protections in the Townships of Ypsilanti and Pittsfield. WHA is involved in additional efforts to expand tenant rights and renter protections. The City of Ann Arbor recently adopted a Right to Renew Ordinance, which will now provide greater protections to tenants in Ann Arbor. Under the new ordinance, landlords will no longer be allowed to deny a tenant a lease renewal without cause. Last year, the City of Ann Arbor amended its Early Leasing Ordinance to prevent landlords from showing prospective tenants a property until 150 days before the end of the current lease term. These new protections are meant to help renters maintain stable housing.

Zoning Reform. In the past 12 months, the CoC advocated for significant changes to the City of Ann Arbor Zoning Ordinance and Land Use policies including the adoption of a new "T1 Transit Supported" zoning category which was approved by the Ann Arbor City Council in 2021 and expanded to additional locations in the City in 2022. The new T1 zoning district has the overarching goal to rezone areas along major bus routes to encourage higher-density housing where there are currently large parking lots and strictly commercial uses. Additionally, the CoC worked with the City of Ann Arbor to reduce or eliminate parking requirements throughout the city to reduce construction costs and make housing and office construction more affordable while also supporting the City's climate action goals. In August 2022, the City Council adopted changes to the city's Unified Development Code that eliminate off-street parking requirements for a variety of development types throughout the city. The CoC also engaged with the City of Ypsilanti government to reform their zoning ordinance to promote increased housing density, which was an identified goal of the City's master plan update process in 2021. One goal the CoC engaged in was to allow for density increases in residential zoning districts. Zoning changes were adopted in the fall of 2021 that included allowing accessory dwelling units permitted in all parts of the City of Ypsilanti zoned residential. This change was estimated to extend accessory dwelling units to roughly 3,000 more properties in the City of Ypsilanti. As part of the amendments adopted, City Council approved allowing higher-density development in residentially zoned corner lots, permitting townhouses and duplexes on these properties. Lastly, over the past 12 months, the CoC has also advocated to the Ann Arbor City Council to remove single-family zoning restrictions to increase affordable housing while reducing segregation in the City and sprawl in neighboring communities. A community conversation about single-family zoning and a new master planning process, which could result in changes to zoning, are forthcoming this year.

Leveraging Funding for Affordable Housing. In November 2020, Ann Arbor voters passed an affordable housing millage that will add 1,500 new units within 20 years. Washtenaw County CoC worked with city and county officials in planning to allocate American Rescue Plan Act (ARPA) funding for affordable housing property acquisition. In summer 2021, the County developed an initial list of potential initiatives to help guide the use of these funds as part of a larger spending plan to appropriate leverage funds. After a two-month community engagement process, the County Board introduced and unanimously passed a resolution that represented the first expenditure of ARPA funding in September of 2021. In November and December of 2021, the Board introduced a second ARPA package and held several listening sessions in low and very low opportunity areas on the eastern side of the County. In March 2022, the Board officially approved a resolution to invest in the Health Department, create a community priority fund, and launch a mobile support services initiative. Among those investments is roughly $3.5 million of ARPA funding for affordable housing property acquisition, specifically to support new, sustainable, mixed-income housing development for zip code 48197.

Cross-Sector Partnerships. Washtenaw County CoC participates in cross-sector working groups to facilitate housing opportunities. In the COVID-19 pandemic, the CoC partnered with three Public Housing Authorities to distribute EHV vouchers to people experiencing homelessness. 47 vouchers made available by the Michigan State Housing Development Authority were leased up in 2021. Tenants were selected off a homeless preference waitlist maintained by Housing Access for Washtenaw County (HAWC), the CoC's lead coordinated entry entity and call center, with services provided by two CoC partner agencies. An additional 29 vouchers were leased up through the Ann Arbor Housing Commission and another 12 from the Plymouth Housing Commission. These 41 vouchers were allocated through the Community Housing Prioritization, which is the community process for prioritizing permanent housing resources such as permanent supportive housing (PSH) and rapid re-housing (RRH). Following community guidelines, the vouchers were divided for specific populations, including unsheltered persons, Veterans, transition aged youth, domestic violence survivors, and persons at high risk from COVID-19.

Some CoC Board Members and staff sit on the Housing Re-Entry Subcommittee, a Subcommittee of the Re-Entry Stakeholders Committee through the Washtenaw County Prosecutor's, and Public Defender's Offices. This Subcommittee compiled recommendations for housing-related programs and services for a Re-Entry Services RFP released by the County Prosecutor's Office. Awards will be made later this month and grants will begin January 2023. If a housing-related project is chosen, the CoC will reach out to the agency to discuss opportunities for coordination. If not, CoC stakeholders will continue using this collaboration with re-entry stakeholders to advocate for more housing solutions.

Leveraging Housing Sources for Projects Under the Supplemental NOFO. The Ann Arbor Housing Commission submitted a letter of intent to HUD for Stability Vouchers and committed 15 vouchers (covering 50% of the units) for Avalon Housing's proposed RRH Project. Avalon estimates that participant enrollment will begin 45 days after award, lease ups beginning 60 days and full enrollment attained within 120 days including in units covered by these vouchers.

Landlord Recruitment & Retention to Expand Access to Affordable Housing.
Collaborative Efforts to Engage Landlords. Washtenaw County's low vacancy rates (about 3% in 2020) and high average rents (over $1000 for studios/1-bedrooms) make it hard to find housing. Landlord engagement is therefore a key strategy to facilitating housing placement and retention in Washtenaw County. Most landlord engagement efforts in the CoC are led by the WHA. Since 2019, WHA has employed a Community Housing Locator, funded by CSBG, state ESG-CV funds, and private dollars. The Community Housing Locator leads landlord recruitment efforts, negotiates with landlords to keep units below Fair Market Rents, maintains positive experiences for landlords by acting as an intermediary when necessary, and creating and disseminating marketing materials to landlords.

WHA also operates the Housing Coordinators Network (HCN), a collaborative of staff at different agencies who all work with landlords in some capacity. HCN plans events for landlords to disseminate information (e.g., bed bug mitigation, eviction prevention resources) and promote landlord engagement through networking and recognition. These relationships are key to ensuring that voucher-eligible housing is identified, ready, and available for clients as soon as they obtain that assistance. HCN meets monthly.

Landlord Guarantee Fund. WHA's Landlord Guarantee Fund helps incentivize landlords to take on tenants they might not otherwise due to criminal background, eviction, or credit history, and help them maintain their tenancy. Eligible tenants are RRH or PSH participants. Formerly incarcerated people exiting Catholic Social Services Offender Success program are also eligible. If they house an eligible tenant, landlords could receive a monetary incentive ($400 at first lease signing and $200 for renewals) or holding fees. The fund can also pay for rental insurance (up to $200/year) if the landlord requires it for the unit. During a client's tenancy, landlords are eligible for money to cover damages made to the unit to help avoid eviction. The Landlord Guarantee Fund is designed to target specific pain points landlords have communicated about working with housing programs, such as the amount of time it takes to lease up a property and the potential for increased insurance liability. Ongoing conversations with landlords will continue to inform the design and targeting of the Fund. It is still operating as a pilot program while WHA works to obtain more funding to scale it up and make it more available.

Using Data and Community Input to Improve Work with Landlords. The CoC also consults Comprehensive Housing Affordability Strategy (CHAS) data to understand the County's unit inventory, challenges, and opportunities. The 2014-2018 data found 2,085 vacant rental units across the County. Most vacant units were in buildings with 5+ units, although buildings with 5+ units were also less likely to be affordable for people below 50% HUD Area Median Family Income (HAMFI). Only 6% of vacant units are affordable for households <30% HAMFI. Two-bedroom units are essentially out of reach for these households – only 4 such vacant units existed. A larger share of units with 3+ bedrooms were affordable for people <30% HAMFI. This suggests that strategies such as shared housing could be pursued to maximize the housing available for single adult households (the largest population experiencing homelessness in the CoC). The CoC is committed to reviving conversations about expanding shared housing in 2023. The CoC will also continue to review CHAS data to illuminate trends and opportunities, and share this information with the HCN and the public, through the CoC's newsletter and other channels.

In 2021, a Community Housing Prioritization retreat focused on strategies and ideas for improving landlord engagement. On September 1, 2022, the CoC hosted a public meeting about Landlord Engagement. The WHA presented information about these programs and all participants engaged in a discussion about where future efforts could go. A local property manager presents at the meeting suggested ways to better market the Landlord Guarantee Fund and dispel myths about leasing to tenants with HCVs or enrolled in permanent housing programs, for example by presenting at the Ann Arbor Board of Realtors. WHA is already maintaining a database of landlords. An affordable housing resource list is jointly maintained by WHA and our Coordinated Entry lead entity, HAWC. This list is available on the HAWC website and updated for the public quarterly. At the meeting, we discussed data points to start tracking, such as landlord retention and exit surveys for landlords who are not retained. Efforts to tighten collaboration between entities doing landlord engagement, and to broaden outreach to landlords, are ongoing, and a priority of the CoC moving into 2023. A landlord survey, fielded fall 2022 by WHA, will provide qualitative data about unit inventory and affordability, as well as landlord feedback on their concerns with working with people who formerly experienced homelessness, and which strategies would be most helpful to incentivize landlords to take on tenants they might not otherwise.

Geographic Trends in Strategies. These strategies cover the entirety of Washtenaw County, although specific areas are more difficult for different reasons. Housing is often available and covered by Source of Income (SOI) protections but is very expensive within the City of Ann Arbor. The housing stock is lower in rural areas and access to transportation is difficult if someone does not have access to a car. Keeping track of landlord relationships through the landlord database will help illuminate geographic trends to better target proactive landlord outreach in the future.

2. <u>Leveraging Healthcare Resources</u>

Washtenaw CoC is committed to partnering with local healthcare organizations to improve outcomes for all residents who may touch both systems.

Partnerships for Primary Care and basic healthcare supports. Corner Health, a community clinic for young people, has a partnership with Ozone House, the only service provider in the County for youth experiencing homelessness. The Clinical Director of Corner Health goes on-site to Ozone House 1 day a week to see individuals for their healthcare concerns. A goal for the future is to expand the accessibility of this program to reach people who may not be at the drop-in center that day. Corner Health also operates several programs that may serve people experiencing or at risk of experiencing homelessness, including a Maternal Infant Health Program that does house calls, runs support groups for SUDs and for transgender youth and teens. Collaboration and communication between entities like Corner Health and the CoC is key to ensuring people are connected with both housing and healthcare supports.

Supporting Linkages between Housing Providers and Healthcare. Individual housing providers have their own strong partnerships. For example, Avalon Housing, one of the main PSH providers in the County, partners with Packard Health. Two clinics are co-located in PSH developments. Case managers make linkages to primary, specialty, and behavioral healthcare. Avalon also partners with Community Mental Health and Substance Use Disorder providers. The

Shelter Association of Washtenaw County (SAWC) operates a Recuperative Care program for people who are discharged from the hospital without a place to go, for example, cancer patients, people post-surgery, or with diabetes. This program has been highly utilized since inception and demonstrates the need to expand it past its current 8-bed capacity. A Community Health Worker at SAWC assists shelter guests with setting up medical appointments while they work towards a permanent housing placement. Packard Health Clinic workers visit the Delonis Center (the county's primary emergency shelter) twice a day to see anyone with a healthcare need. One of the projects under this NOFO (SAWC SSO) has a strong healthcare component, including a subcontract with Packard Health to provide nursing care. Over the three-year grant period, this partnership will serve 150 people in the Recuperative Care program with outpatient health services and housing case management. People in the program will also receive referrals to other providers including Primary and Specialty care, treatment providers for mental health and substance use, and assistance with accessing health insurance and other benefits.

System Planning to Improve Coordination Between Housing and Health. CoC governing committees also review strategies to improve coordination between systems. For example, the Built for Zero Leadership Team focused on ending chronic homelessness brought in substance use disorder providers in August to discuss improving voluntary connections to SUD services for people who are contemplative and newly housed through HCVs. Healthcare partners like Michigan Medicine and St. Joe's Complex Care are represented on these leadership teams so they can proactively suggest ways to improve healthcare connections from their perspective. The CoC has identified areas to improve future work, including to strengthen healthcare partnerships to serve children and families.

3. Current Strategy to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness

Current Street Outreach Strategy

Street Outreach in Washtenaw County is led by the Project Outreach Team (PORT), mostly funded by a Substance Abuse and Mental Health Services Administration grant. As part of Community Mental Health, PORT is trained to work with people who may have barriers to engagement, including serious mental illness. One of the four PORT staff is a peer support specialist with lived experience of unsheltered homelessness. When needed, services are contracted for language translations (e.g. signing) to ensure effective communication during outreach efforts. Outreach staff make every effort to connect with households, particularly those without phone/internet access or transportation. Outreach staff employ a variety of methods to ensure they are providing outreach to those least likely to request assistance. They make multiple repeated attempts to reach people, using spreadsheets to organize reports of unsheltered homelessness to follow up on as well as early engagements, when they might only have a description of the person and location and no name yet. These spreadsheets keep track of outreach attempts by time of day and suggest next steps for building the relationship. Outreach staff focus on housing from the beginning of their interactions but take care to follow client-directed goals. PORT staff build rapport through repeated and thoughtful interactions, getting to know people overtime. PORT staff are trained in evidence-based practices and routinely use Motivational Interviewing, Mental Health First Aid, Harm Reduction, Trauma Informed Care, Housing First, and Person-Centered Care. When they are ready to engage, PORT will assist unsheltered households to either access a phone or walk-in hours to complete initial

intake and assessment with coordinated entry, or PORT administers the common assessment tool to further increase likelihood of engagement and quick connection to services. Bus tokens or rides are given to connect clients to necessary services. In addition to canvassing the area and providing necessities for health and safety (e.g., tends, sleeping bags, and water), PORT conducts case management with people who are interested in engaging in services. PORT team members provide an extensive range of services with the goal of removing any imaginable stressor or barrier to housing. This can look like helping people sign up for subsidized housing waitlists or driving them to resolve outstanding criminal charges. Once a person is enrolled in case management, PORT uses HMIS and the CMH database to record case notes and interactions.

In addition to PORT, the VA conducts quarterly PIT counts of unsheltered vets, Ozone House conducts outreach for youth and young adults, and Avalon Housing (PH provider) conducts regular street outreach. Street outreach by PORT, the VA, Ozone House and Avalon Housing covers all of Washtenaw County, which is 100% of our CoC's geographic area, through regular canvassing and through response to reports of unsheltered homelessness. Street outreach is conducted daily by PORT, and weekly by Avalon and Ozone. Outreach teams are organized in pairs. PORT operates at off-schedule hours, including early mornings and on the weekends (two days per week from 7am-3pm, two days 8-5pm, and a Saturday 7-3pm shift once per month). Routes and locations are scheduled ahead of time for safety purposes, and hours vary to reach different groups of people, and to contact those who are elusive. Timing is discussed at community meetings.

PORT routinely canvasses the urban core of Washtenaw County, which is where most unsheltered homelessness is known to occur. PORT also responds to reports of homelessness anywhere in the county, for example in Chelsea, Dexter Township, and Ypsilanti Township. PORT keeps track of outreach attempts by zip code. Outreach staff partner with local law enforcement, hospitals, agencies in rural areas, and others to identify and connect with homeless households quickly and effectively. If someone calls HAWC (the primary way to engage with coordinated entry in the CoC) and informs them they are sleeping in a place not fit for human habitation, PORT will go out to visit the household. If law enforcement receives a complaint from a citizen or business owner about someone sleeping outside, they will contact PORT to help relocate the person. PORT also works with grassroots organizations working to address homelessness in the County, including Washtenaw Camp Outreach which is run by people with lived experience. PORT staff are in ongoing communication with these entities to strategically allocate resources to best meet people's needs. For example, if someone is unwilling to engage with County staff, they might be willing to talk to someone from Washtenaw Camp Outreach.

Outreach staff do everything in their power to support people who are forced to live outside due to the lack of sufficient emergency and permanent housing in the County. One barrier to helping people stay service connected is that there is nowhere in the County where people are legally allowed to camp. This means that people are forced to go into hiding in often remote areas, far from services. Most services are located downtown Ann Arbor, but the closest location someone can sleep without detection is 2-3 miles away. In recognition of the undue burden this places on people—and the unnecessary barrier it imposes to someone seeking services—the CoC commits to reaching out to city officials in 2023 to open talks about options like safe parking or sanctioned encampments near services.

4. Current Strategy to Provide Immediate Access to Low-Barrier Shelter and Temporary Housing for Individuals and Families Experiencing Unsheltered Homelessness

Shelter referrals are made through HAWC. There is one primary adult shelter in the CoC operated by SAWC. People who present at SAWC asking for services are directed to a HAWC intake to go through the referral process, since the amount of shelter is insufficient to the need. Additional winter capacity helps ensure that people are not left out in the cold during November – April. People may present to a winter warming shelter and be immediately served, unlike during the other months when they must be referred through HAWC first. During the COVID-19 pandemic, in addition to spacing out beds within their residential program, SAWC operated non-congregate shelter options through hotels. Someone was on-site at the hotel daily, making sure people and rooms were being taken care of. This program successfully supported clients and kept them safe during the pandemic. Having an address and phone number supported clients' efforts to obtain benefits, jobs, housing, and medication.

Other shelter options exist for families and survivors of domestic violence, and the capacity of these beds is generally sufficient to the need. Family shelters can accommodate larger families through low-barrier housing options, for example through a private home where 4-6 people can comfortably live temporarily. These private homes used as shelter capacity allow family members to have their own room and cook food, unlike in a congregate shelter or hotel. All shelter options are low barrier. Someone who is under the influence would not be turned away, nor would a person with an acute mental health condition (so long as it was appropriate to manage on-site). Shelter staff are trained in de-escalation and interpersonal problem solving to help people stay on site when possible. Case managers use assertive engagement to work with clients towards their goals and quickly connect them with housing and other supports.

HAWC has a well-known presence in the community. Partners in other sectors, like hospitals and healthcare providers, know to connect people with HAWC if they are experiencing or imminently facing homelessness. Hospitals in particular attempt to provide a warm handoff during their discharge process. At current system capacity, this is not always possible – sometimes clients are discharged with nowhere to go. A project proposed under this NOFO (described in section 7) would strengthen these ties, integrating that referral through CES and providing staffing support. In community conversations, hospital staff noted that their documentation of housing status was currently shaky, which made proving homeless program eligibility tricky. The CoC commits to working with the local hospitals to support building out this infrastructure and more direct referral pathway through CES.

Criminal justice system stakeholders regularly communicate with PORT and SAWC. SAWC has 5 designated shelter beds available for people who do not have a safe place to go after being discharged from the jail and meet Category 1 eligibility. A SAWC case manager goes to the jail to help assess what people might be eligible for and sign them up for services prior to exit. The CoC restarted conversations with criminal justice stakeholders this fall, and recently stood up a Coordinated Entry Working Group focused specifically on this collaboration to tighten referral pathways and better ensure immediate access to temporary and permanent housing. The CoC is also collaborating with a new program in the community, Supportive Connections, which aims to help people at risk of becoming re-involved in the criminal justice system through service connections and financial assistance, including up to $500/person for housing.

Anyone who is referred to a shelter comes through coordinated entry, which means they are also immediately placed on the Community Housing Prioritization (CHP) list to work

towards a permanent housing placement. If shelter space is not available, individuals are instead connected with PORT. Because PORT is not a crisis team, this referral can take longer than 24 hours, which is a barrier. When people are connected to PORT, staff will help them connect with Community Mental Health and other services. They will also be placed on the CHP list to work towards permanent housing.

The CoC is committed to strengthening our Coordinated Entry System and streamlining processes in between intake, assessment, and referral. The CoC released an RFP this fall for new providers to take over the call center and operate satellite access sites for HAWC. Providing clear information, expediting referrals, and tightening collaboration across sectors, are all priorities for the CoC as we engage in this redesign. The CoC is also committed to reaching out to providers that currently operate outside of the formal CoC structure, including a peer-led street outreach team and grassroots-supported emergency shelters. These organizations often fill vital gaps in our system, serving people with dignity through a mutual aid model. Individual providers like PORT already collaborate with these organizations regularly, but the CoC would benefit from a more formalized collaboration including mapping out where each might strategically fit into our system and how we can learn from their models to improve our service delivery.

5. Current Strategy to Provide Immediate Access to Low-Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

Commitment to Housing First. All CoC permanent housing projects use a Housing First Approach. It is embedded into the work each partner does. Agencies, including Avalon Housing, PORT, and others, require Housing First trainings for new staff. All providers use evidence-based techniques like progressive engagement and motivational interviewing. The CoC regularly shares out resources related to Housing First (such as the Housing First webinar series hosted by the National Low Income Housing Coalition, National Alliance to End Homelessness, and Center on Budget and Policy Priorities). The CoC periodically conducts Housing First trainings as part of its All-Staff training. The CoC reviews provider commitments to Housing First during the auditing process, and the CoC's Funding Review Team (FRT) reviews provider outcomes (like housing retention) during annual funding processes. Of the 14 PSH projects ranked in the FY22-23 CoC Program competition, 7 met or exceeded the standard of 95% permanent housing retention, and 6 others were above 90%. The FRT discusses retention strategies with providers as part of their review. Similar outcomes are attained through RRH, for example 94% Avalon Housing RRH clients exit to permanent housing.

At a community meeting, providers walked through the United States Interagency Council on Homelessness Housing First Checklist and affirmed their commitment to these components. Screening-in is commonly practiced. Providers noted that any pain points that exist in terms of implementing the Housing First approach are often with private landlords they work with. The CoC noted this as an important component of future landlord engagement efforts. Still, housing providers endeavor to provide options so that clients can choose the housing that works for them. Different types of PSH units (e.g., site-based, scattered-site) are available within the CoC and used strategically to meet specific clients' needs and hopes. Formal and intensive programmatic CoC monitoring of programs paused during the COVID-19 pandemic, but when it restarts, the CoC plans to use tools such as SAMHSA's Fidelity Scale and General Organization Index to quantitatively measure providers' implementation of Housing First.

Current Coordinated Entry Processes. Washtenaw County CoC relies on a centralized intake and assessment process managed through HAWC for all CoC services, including permanent housing. HAWC operates a call center and has some capacity for walk-in or mobile intakes. After a VI-SPDAT is completed, a person is put on an appropriate Community Housing Prioritization (CHP) list (organized separately for veterans, families, chronic individuals, and non-chronic individuals). Referrals to permanent housing (PSH & RRH) are made from these CHP lists on a rolling basis and discussed at bi-weekly meetings of the CHP Committee (comprised of outreach, shelter, and permanent housing providers). All community PSH is primarily prioritized for people experiencing chronic homelessness. VI-SPDAT score, physical/mental health vulnerability, and length of time homeless are used to further prioritize in the case of ties. Transfers from RRH to PSH are available when necessary for the client. Most community RRH is for families; only with additional federal COVID-19 resources was the community able to operate significant RRH for individuals. In addition to the previously mentioned factors, unsheltered status is considered for RRH family prioritization. Once made, housing providers always accept referrals through CHP, making every effort to engage the household and follow their lead on goals and next steps. The CoC periodically conducts trainings such as on Basic Documentation (to assist people in obtaining birth certificates, Social Security Cards, or income verification) to help speed up administrative barriers to housing.

Additional Housing Opportunities. Community need extends beyond current PSH and RRH capacity. CoC providers work with outside partners to stand up programs that help fill some of the gaps. Over $1 million in funds from Washtenaw County's Public Safety and Mental Health Preservation Millage was awarded to organizations to support health and housing needs of people experiencing homelessness. For example, SAWC began a Housing Crisis Stabilization program that sets aside residential beds for people with a mental health diagnosis who need stabilization after crisis. Referrals come from Community Mental Health. Avalon has also utilized local millage resources through Washtenaw County and the City of Ann Arbor to support services. In 2022, Avalon Housing opened a partnership with the Washtenaw County Sheriff's Office to support housing needs for individuals being released from the Washtenaw County jail. The program works with people who experienced homelessness prior to incarceration. Case managers assist with finding housing on the private market and through CHP as appropriate, for example helping people to bridge into PSH. These efforts will be expanded if they win the County Prosecutor Office's RFP for reentry housing services.

6. Updating the CoC's Strategy to Identify, Shelter, and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

Using Data to Develop the CoC's Comprehensive Plan & Solicit SNOFO Project Applications. According to 2020 Longitudinal Systems Analysis data, adult only households spend the longest time homeless before permanent housing placement: 117 days, compared to 90 days for adult and child households. Adult only households are also less likely to exit to permanent destinations (37%) compared to adult and child households (82%). Adult-only households are much more likely to exit to temporary destinations (31%) compared to family households (15%). Because of the backlog in the system and the limited capacity of the Delonis Center as the primary shelter, many adult-only households are forced to endure unsheltered homelessness while they wait to be served. 66 percent of single adults served in CoC projects in 2020 came from a place not fit for human habitation. Even other populations report high levels of unsheltered histories – 61% of

seniors over 55, for example. Overwhelmingly, based on this quantitative data and qualitative community feedback at these meetings, the community decided that Washtenaw's CoC needs to invest more in non-chronic adults experiencing homelessness, with histories of unsheltered homelessness. Stakeholders observed that adults with high-health needs are lacking resources in our system, for example people being discharged from the hospital. One PSH provider noted an increasingly higher incidence of medical acuity among participants. Adding capacity for non-chronic adults is key to reducing the length of time it takes for people to be served by our CoC after they become homeless.

Using Data to Understand System Performance of SNOFO Projects & Street Outreach.
All SNOFO projects will participate in CES and HMIS. Our CoC's HMIS data standards will be followed, including real-time data entry. Project-level outcomes will be monitored alongside regular system tracking, including program referrals, admissions, and exits. Primary outcomes of interest are related to client self-sufficiency, health outcomes, and housing outcomes. SAWC's Recuperative Care program, for example, aims to reach 80% client self-sufficiency upon discharge. Avalon Housing's RRH aims to see 83% participants exit to permanent, affordable housing; 83% maintain housing for one year; and 90% increase income. Regular case noting is expected as part of record keeping.

The PORT Street Outreach team tracks data regularly, including the number of engagements and non-duplicated enrolled individuals. PORT uses a spreadsheet system to track reports of people experiencing unsheltered homelessness and progress towards engagement. This is where PORT staff document referrals they receive from businesses, law enforcement, and other community organizations. Once receiving and documenting a report, they will make multiple attempts to engage the individual or family (all of which is recorded). This spreadsheet monitors outreach by zip code. No matter where in the county a request comes in from, PORT will outreach to it – full geographic coverage. The spreadsheet also enables PORT staff to look out for any trends in stakeholder outreach to PORT, informing their planning on how to engage geographically and collaboratively through partners.

HMIS profiles are created for clients who chose to complete a Coordinated Entry intake and assessment. This dual system enables the PORT team to have a holistic view of current need regardless of someone's willingness to engage in services or data collection, while rigorously keeping track of outcomes for people who do. PORT reviews outcome metrics quarterly, including the number of individuals connected to SOAR and permanent housing. PORT also tracks the length of time of engagement, as well as the length of time to housing. This also helps build documentation towards chronicity.

Using Data to Update CoC Strategies. In addition to monitoring project-level outcomes under the SNOFO, the CoC will analyze system level trends on key metrics: length of time homeless, exits from the homeless system to permanent destinations, and returns to the system after exits to permanent destinations. After these new projects are operational, we expect to see the number of people experiencing unsheltered homelessness with high health needs to decrease. We expect to see a decrease in single adult homelessness. We will use HUD's reporting tools including Stella P and Stella M to guide this analysis. The CoC's Data and Performance Measurement Subcommittee and Built for Zero Leadership Team will be responsible for implementing this analysis. If appropriate, an additional subcommittee may be formed to focus specifically on data and strategies to end unsheltered homelessness. This subcommittee would use HUD's Group Agreement Template as a guide to its operation.

7. Identify and Prioritize Households Experiencing or with Histories of Unsheltered Homelessness

Amended Coordinated Entry (CES) Processes for Projects Under this NOFO. The CoC solicited projects under this NOFO to serve primarily non-chronic literally homeless adults with histories of enduring unsheltered homelessness. The overreaching goal of all SNOFO projects is to increase immediate access to housing resources so people are not forced to endure homelessness long enough to age into chronicity to be served. CES processes will be amended to increase direct pathways into SNOFO projects.

Recuperative Care Program. This program supports people with high medical acuity who are literally homeless and need healthcare support while a more permanent housing plan is developed. Referrals will come through CES. The Community Health Outreach Worker will serve as a direct access point to CES, performing HAWC Intake and Assessments at hospitals, health clinics, and alongside PORT staff through street outreach. This streamlined process will enable hospitals and other health providers (such as community clinics and sub-acute rehab facilities) to make same-day referrals to avoid discharging anyone into homelessness. Threading it through CES will ensure that people these health entities refer meet Category 1 and have histories of unsheltered homelessness – and, that people who might not be connected to medical services can still access the program through PORT or other CES access points as appropriate. It also connects the client to HMIS and ensures required assessments and documentation are completed. Eligibility for this program targets people with high health needs but who are independent in Activities of Daily Living and do not have an active communicable disease. They must have a medical issue that would benefit from a stay in the program. Common client conditions include post-surgical procedures, cancer, wound care, diabetes management, uncontrolled hypertension, or amputations. This program provides crucial healthcare management while working towards permanent housing, through a CHP referral to a CoC resource, or to HCV, or a unit on the private market, as available and appropriate.

Rapid Re-Housing. Access and assessment for SNOFO RRH will occur through the regular processes: people are connected through HAWC, and an intake and assessment including the VI-SPDAT are administered. Eligibility will be standard for RRH (moderate score on the VI-SPDAT) plus unsheltered history. A new process for referrals will be instituted. A CHP list for non-chronic individuals will be maintained on a regular basis (currently, since no resources are available for this population, it is used to track general trends and not as much for case conferencing or referrals). This list will be used to generate the first tranche of referrals based on length of time spent unsheltered (longer time meaning higher prioritization). PORT staff will be an important partner in building this list, as they can directly connect people who are unsheltered but may not yet be connected to the system. Referrals will be taken on a rolling basis from this list until program spots are filled. Then, any turnover spots that become available will be prioritized on a first-come first-served basis. Meaning, people with shorter stays of unsheltered homelessness will be prioritized when the spot becomes available. This is the first and only way our community would be able to provide immediate access to housing resources for people who are unsheltered. Additional prioritization will be given to people who may not qualify for the full recuperative care program but have medical vulnerability, as indicated by a hospital referral, prescription requirements, mental or physical health diagnosis, or the “Risk” subsection of the VI-SPDAT. Avalon Housing, the provider of this RRH, is prepared to work with people with

medical needs, incorporating trauma-informed care, behavioral and physical healthcare, substance abuse treatment, extensive programming built on community and peer-support, and 24/7 on-call crisis response into their program. After the CHP committee makes the decision to refer someone to this RRH, the referral will be processed in HMIS.

Ensuring People with Histories of Unsheltered Homelessness Can Access Community Resources. These SNOFO projects open direct access to permanent housing resources for people experiencing unsheltered homelessness. Key to their success will be tight ongoing coordination with street outreach through the CHP committee and the additional Community Health Outreach Worker who will work directly with PORT staff. These policies will be formally written up and put up for discussion and approval by the Coordinated Entry Evaluation & Oversight Committee. Once enacted, the new CES policies will be published on the CoC's website and disseminated publicly through the CoC's Newsletter and social media. The CoC's annual Staff Training will include a module on these new projects under the SNOFO, their eligibility criteria, and referral pathways, to ensure all CoC stakeholders are aware of them. The Community Health Outreach Worker will also provide additional capacity to the street outreach team, enabling them to increase their reach and connections to health care and other supportive services.

8. Involving Individuals with Lived Experience of Homelessness in Decision Making

Informed by known racial disparities in homelessness and with momentum for change, the Washtenaw County CoC sought to better understand the ways people of color, specifically those who identify as Black or African American, experience homelessness and the local homelessness response system. Through a series of focus groups held in the Fall of 2019, the Office of Community and Economic Development (OCED) gathered firsthand stories and feedback from clients served by the CoC. Analysis of focus group discussions and participant responses yielded key themes and insights for consideration. Based on OCED's analysis of the focus group discussions, a series of recommendations were identified to address inequities. These recommendations continue to inform a systems-level Racial Equity Action Plan.

In the Spring of 2020, OCED and the Ann Area Community Foundation (AACF) partnered with the Corporation for Supportive Housing (CSH) to support local efforts and open pathways for long-term, cross-sector, systems transformation towards more equitable outcomes for Washtenaw residents. Early assessments of disaggregated Washtenaw County data in the homeless response system and Public Health datasets demonstrate the deepened disproportionate impact that the Coronavirus continues to have on communities of color as a result of this public health and economic crisis.

9. Supporting Underserved Communities and Supporting Equitable Community Development

Strategy to identify underserved communities. Individuals and families identifying as Black or African American continue to be overrepresented in homelessness compared to the general Washtenaw County population, as demonstrated by an analysis of HMIS records compared to Census data. While 12 percent of the County population identifies as Black, a staggering 58 percent of people experiencing homelessness identify as Black. This represents a slight decrease from 61% in 2019, but the disproportionate impact is still severe. People of all other races received homelessness services at rates equal to or lower than their share of the county population. Racial disparities are seen in both single adults and families seeking services: 46% of

single adults and 69% of families identify as Black. Examining system performance metrics, we find that Black households exit to positive destinations at higher rates (53%) than white households (41%) in 2020, although the overall share of positive exits has decreased (from 60% in 2017). Black and white households show relatively similar lengths of stay in the system, with Black households staying longer than white households in permanent housing programs. Black households do have longer stays in emergency shelter.

The CoC has not rigorously tracked the true length of time it takes for a household to be served by the system from when they first present; it is likely much longer than what we see through these measures. Further investigation is needed here. The CoC will also incorporate information on additional points such as: analysis of street outreach engagement, progress to permanent housing from street outreach, assessment scores, and whether people receive the appropriate intervention, all with a breakdown by race and ethnicity. Qualitative data could supplement these points, such as understanding the differences in length of stay in permanent housing programs and what that means for client experiences and outcomes. The CoC conducted focus groups of Black households in 2019 to learn about their experiences, and their policy recommendations were written and publicized. Future efforts should start by going back to these recommendations and tracking CoC progress towards them. The CoC's Subcommittee on Data Measurement and Performance will be tasked with this in 2023.

The CoC recognizes that people with high health needs and past utilization of crisis services are not adequately served by our system. We are seeing increasingly older adults and people with higher medical acuity than we have in years past. SNOFO Projects are designed to begin to address these important gaps. The CoC has not studied disparities by gender identity or sexual preference. This is due to the small sample size and also sensitivities around disclosing this data. We do know that people who identify as nonbinary are more likely to be young adults. The CoC commits to scoping out a plan to better understand and address any disparities experienced by LGBTQ+ population in 2023.

Geographic Disparities. Most services are based out of Ann Arbor, the largest city in the county, including the single-adult shelter and primary hospitals. Many health and homelessness service providers operate out of offices in Ann Arbor as well. Services, like a youth drop-in center, are available in other areas of the county like Ypsilanti, but there is a clear disparity in available resources. Ann Arbor is the most affluent part of the county and also the whitest. People may have to travel in order to receive services. While providers make every effort to remove geographic barriers to services – by bringing services to people or providing them with bus tokens – it still makes a difference. Efforts to open a shelter in Ypsilanti have not progressed in years. In community meetings about CES, some people voiced that people living in zip codes 48197 and 48198 do not trust HAWC. The population in these zip codes is 24% and 35% Black, respectively. This might contribute to fewer calls for services and more hardship in Black communities. The racial disparity we see in our system is likely understanding underlying racial disparities in need. HAWC does not currently track call outcomes, but the CoC will prioritize this as the new system is operationalized in 2023. Call outcomes will be tracked by caller's race and geographic origin, to help illuminate any trends in system access. These disparities also illustrate that grassroots, community-based nonprofits are not currently receiving CoC funding. In advertising the opportunity under this NOFO, the CoC made it clear that we were interested in funding organizations that have not previously received CoC funding. We did not receive any

applications from non-CoC providers, demonstrating the need for more proactive outreach and relationship building in the future.

Current Strategy to Provide Outreach, Engagement, and Housing Interventions to Underserved Populations. The CoC will continue to work in partnership with non-CoC partners and allies to educate a broad range of entities- from local and state government, law enforcement, mental health, health care, and other partners/stakeholders- about the intersection of racism and homelessness in Washtenaw County, and to work in collaboration to identify and respond to opportunities to reduce racial disparities. In rebuilding our CES, we will place intentional focus on increasing outreach to households identifying as Black or African American by ensuring that it is marketed to and accessible by Black or African American household. We will encourage service providers to expand outreach and services in neighborhoods and geographic areas with higher concentrations of Black or African American residents. Washtenaw County will leverage AFFH results and its Washtenaw Opportunity Index to identify and target those neighborhoods that are almost exclusively comprised of individuals and families identifying as Black or African American, where deep disparities exist around various domains, such as health, housing, income, and education. In our yearly strategic planning for the CoC NOFO and other funding, we will disaggregate systems data by race to ensure that the strategies we are choosing, and implementing are making a difference in serving underserved communities in our county.

In 2021, Washtenaw County entered into a formal partnership with Buenos Vecinos to support the COVID Emergency Rental Assistance (CERA) program. Buenos Vecinos serves Latinx/Hispanic-identified households most directly within the Ypsilanti Community Schools district (zip codes 48198 and 48197) because of the organization's diligent work to build trust with students and their families in this geographical area. Many people who participate in Buenos Vecinos programming are limited-English proficient, Spanish speaking immigrants. Through this partnership, between June 1, 2021 and July 14, 2022, 91 CERA Latinx/Hispanic households were supported through the cumbersome application and recertification process.