

“Missed Opportunities” in the Pathway from Referral to Housing

A Mixed-Methods Analysis of Success, Timeliness, and Disparities in Hennepin County’s Coordinated Entry System

Jordon Barthel, Adil Bashir, Erin Danielson, Taylor Diles, Lara Griffin, Cara Letofsky, Dana Mach
with the support of Dr. Maria Hanratty

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Executive Summary

Hennepin County began concentrated work to address homelessness in late 2006, and the resulting Ten-Year Plan to End Homelessness marked a greater level of attention to the growing population of individuals and families experiencing homelessness in the county. Since then, many revisions of this strategy have ultimately coalesced into the Hennepin County Coordinated Entry System. Under many of the guidelines set forth by the U.S. Department of Housing and Urban Development, this system attempts to properly assess, refer, and house individuals and families staying in homeless shelters throughout the county, with the explicit goal of providing equitable housing services to the most vulnerable clients.

In this report, Hennepin County's Coordinated Entry System is analyzed to determine its ability to successfully place clients, serve them in a timely fashion, and avoid disparities in service between various demographic groups. The rates and timeliness of successful and unsuccessful housing placements were compared for the 4,376 individuals and families in the sample who were referred to housing between 2017 and 2019. Differences between demographic group's likelihood of successful placement and average time between a referral and housing were then confirmed using regression and logit models. To support quantitative conclusions, the first-hand experiences of housing providers in the county, successes and shortcomings are presented and analyzed. In semi-structured video interviews, various employees at provider organizations expressed opinions and recommendations on issues of demographic disparities, perceived barriers for clients, and the improved utilization of HMIS within Coordinated Entry. These interviews were coded with NVivo software in order to track the most commonly addressed topics by providers, as well as to establish themes between interviews.

The report concludes that, while the majority of clients do progress through Coordinated Entry as intended by the county, there are significant barriers which directly contribute to clients being unable to capitalize on their referrals, and force them to either restart their process or leave Coordinated Entry altogether. Specifically, providers noted that the inability for many providers to contact their referrals within two weeks represents a major waste of time and resources for both the county and providers. Additionally, the need for many different documents to confirm income, disability status, or homelessness status can significantly delay access to housing, or prevent some clients from being housed at all. Contributing to these shortcomings is the significant need for greater data integrity and quality, a problem that providers believe is due to an underutilization of HMIS software, which could otherwise be providing more specific, up-to-date information on clients and referrals. As a result of these data inadequacies, a significant number of clients never connect with the provider to whom they are referred or are referred to organizations which either cannot serve them or are not specifically tailored to their needs. In particular, the single adult system is host to significant issues of timeliness, creating many barriers to placement and housing retention.

While this report does not find widespread demographic disparities by race, there are persistent disparities for Native American clients in comparison to their White peers. These clients are less likely to have their referrals accepted and have the worst outcomes of any racial group in the

sample as it relates to placement rates and time to placement. Similarly, clients with disabilities have concerning high rates of decline for ambiguous reasons.

This report recommends that Hennepin County:

- **Increase supportive services and the use of case management in each stage of CE as well as after a client accesses housing.**
- **Increase clarity and transparency about the level of documentation required to access housing and determine county-specific barriers in documentation that could be eliminated.**
- **Systematically assess HMIS data entry at each step of the CE process to identify how it could be better utilized to meet the needs of clients and providers.**
- **Utilize the expertise of existing culturally specific organizations to better understand and meet the needs of Black, Indigenous, and POC clients; with specific attention to the needs of Native American clients as they move through CES.**

Introduction

In 2018, Wilder Research counted 10,233 people experiencing homelessness in Minnesota, a 10 percent increase from 2015. Of those counted, Black or African Americans, Native Americans, and youth who identify as LGBTQ were overrepresented and more than half were 24 years old or younger. Additionally, many had chronic mental or physical health conditions.¹ Despite years of coordination and effort, homelessness continues to be a persistent problem facing the state of Minnesota.

Hennepin County's work to eliminate homelessness began in earnest in December of 2006 with the publication of *HeadingHome: Hennepin's Ten-Year Plan to End Homelessness in Minneapolis and Hennepin County*.² The plan outlined six goals: Prevent Homelessness; Provide Coordinated Outreach; Develop Housing Opportunities; Improve Service Delivery; Build Capacity for Self-Support; and Implement System Improvements. These goals were addressed in three phases:³

1. Collaboration and Connections (2007-2010)
2. Crisis Response and Targeted Services (2011-2013)
3. Systems Change (2014-2017)

The first phase was defined by newly created partnerships, such as the StreetWorks Collaborative (youth-serving agencies) and Project Homeless Connect, along with the City of Minneapolis and Hennepin County, which increased collaboration, funding, and housing opportunities amid the Great Recession of 2008. The second phase focused on targeting services for the homeless, specifically for those in the criminal justice system, those with medical conditions, sexually exploited youth, and the chronically homeless. Finally, the third phase introduced the Coordinated Entry System (CES), which launched in April of 2016. This helped streamline the process for getting services to those experiencing homelessness. In its first year, CES helped 963 single adults and 701 families find housing in Hennepin County.

Ultimately, the county did not meet their goal of ending homelessness by 2017. In fact, despite a reduction in homelessness in the last four years, the number of people experiencing homelessness was still higher in 2017 than it was before the Great Recession.

A partnership between the Hennepin County Office to End Homelessness and the Humphrey School of Public Affairs has sought to better understand the county's homelessness system. Since 2010, eleven prior projects have analyzed various aspects of homelessness, including assessments of Homelessness Prevention and Vulnerability Index - Service Prioritization Decision Tool (VI-SPDAT) Systems, and analyses of the county's Rapid Exit and Emergency Assistance programs. Most of these research projects have focused on the front end of the homeless-designated housing system, how shelter systems work, and how those experiencing homelessness are evaluated for services.

This project examines the process that individuals and families go through in CE in order to access housing. Utilizing a mixed-methods approach, we outline the multiple paths that

¹ Wilder Research. (2018) *2018 Minnesota Homeless Study*. St. Paul, MN. Amherst H. Wilder Foundation.

² Hennepin County Commission to End Homelessness. (December 2006). "The Ten-Year Plan to End Homelessness in Minneapolis and Hennepin County". *HeadingHome Hennepin*.

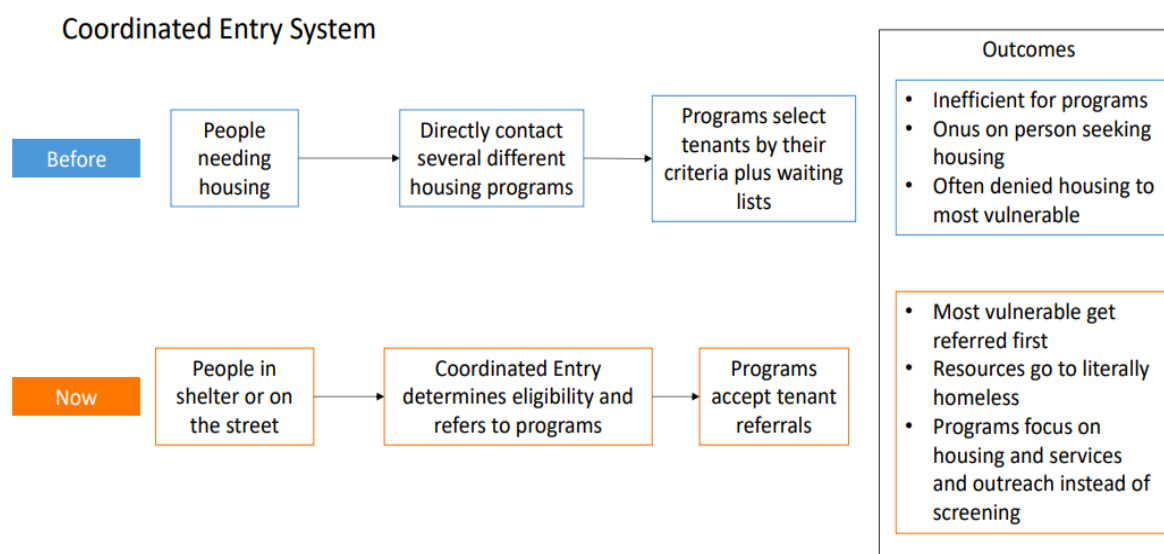
³ (2017). "Final Report". *HeadingHome Hennepin*. 1-17.

individuals and families take to access referrals to housing providers, and hopefully housing. The research team examines the extent to which individuals and families who encounter CES are successfully referred and housed, move through this step of the system in a timely manner, and whether there are demographic disparities in experience with the county system.

Overview of the Coordinated Entry System

Hennepin County adopted CES in order to streamline the process by which people experiencing homelessness can be connected to services and ultimately access housing. Whereas before CES, individuals experiencing homelessness would have to contact multiple housing agencies, now CES determines household eligibility and incorporates a referral to a housing provider (Figure 1). This change was intended to take the onus off the person searching for housing and to prioritize those deemed most vulnerable for faster access to housing services.

Figure 1



Coordinated Entry is designed to move people experiencing homelessness out of shelter and into housing, through a process of assessment and perceived need for services. Hennepin County seeks to assess individuals and families experiencing homelessness 14 days after entry into emergency shelter to begin the CE process. Clients within the data set for this research were assessed using the VI-SPDAT to determine the level of vulnerability of those in shelter, and to prioritize those deemed most vulnerable for the highest level of supportive services. This assessment tool utilized information about a client's history of housing and homelessness, risks, socialization and daily functioning and wellness to generate a numerical score representing vulnerability.⁴ Three different versions of the VI-SPDAT were used in Hennepin County prior to April of 2020; the Family F-VI-SPDAT, the Transition Age Youth TAY-VI-SPDAT, and the original VI-SPDAT which is used with single adults. Higher scores on the assessment contribute to a determination of more supportive services, while lower scores are intended to result in

⁴ <http://pehgc.org/wp-content/uploads/2016/09/VI-SPDAT-v2.01-Single-US-Fillable.pdf>

fewer services received. Past research has found mixed results on the tool being used as intended.⁵

Concerns about potential racial bias in the VI-SPDAT tool have been expressed by researchers in recent years; Olivet et al. (2018) found that use of the tool has led to White people receiving higher priority scores for housing resources, especially Permanent Supportive Housing (PSH).⁶ In addition, it seems racial bias may exist in the assignment of priority scores, as the tool fails to capture the vulnerabilities that Black, Indigenous, and People of Color (BIPOC) are more likely to endure compared to Whites.⁷ In recognition of the limitations of the tool, Hennepin County has decided to discontinue its use for prioritizing housing resources as of March, 2020.

After assessment, individuals and families are entered onto the county's 'priority list' to await a referral. The list is not a linear wait list, but rather prioritizes those with the highest need getting access to services the quickest. Because of this, clients' time on the priority list may be very brief or very long depending on their perceived level of vulnerability and the availability of housing units that fit the client's needs.

When a housing provider has an opening, the provider notifies the county, who then refers a client whose assessment appears to match the available unit. After receiving this referral, the housing provider must locate the client and begin an intake process. A housing provider may decline the referral due to an inability to locate the individual, a lack of verification of eligibility, a refusal on the part of the individual to accept the service, or a myriad of other reasons. If a referral is declined, the individual may resolve their housing situation without county intervention or may return to shelter to begin the CE process again. If a referral is accepted, the individual will ideally access housing facilitated by the provider.

This report investigates the extent to which the CE process has been successful in prioritizing housing resources to those deemed most vulnerable by the county. Additionally, this report examines the way that individuals and families move through the CE process and the factors that determine whether they are placed in housing successfully, in a timely manner, and whether clients experience disparities in outcome according to demographic identity.

Research Question

In Hennepin County, the introduction of CES was intended to allocate limited housing resources to the individuals and families determined to have the greatest need for services. Yet, not enough is known about the experience of individuals and families who encounter CES. This report seeks to investigate the process through which individuals and families are referred for services, interact with housing providers, access housing placements, and stay in housing permanently. The team examines the role that the county and housing providers play in matching housing resources to client needs. While this analysis will briefly examine the stages of shelter and assessment, the bulk of the analysis centers on the referral, intake, and housing placement process exploring the strengths and weaknesses of CES in addressing homelessness.

⁵ Rice, E., Holguin, M., Hsu, H. T., Morton, M., Vayanos, P., Tambe, M., & Chan, H. (2018). Linking Homelessness Vulnerability Assessments to Housing Placements and Outcomes for Youth. *Cityscape*, 20(3), 69-86.

⁶ Wilkey, C., Donegan, R., Yampolskaya, S., Cannon, R. (October 2019). "Coordinated Entry Systems Racial Equity Analysis of Assessment Data". Needham, MA: C4 Innovations

⁷ Wilkey, *ibid.*

Throughout the referral to placement process, we focus on three themes to evaluate how the system is allocating housing resources: the success of placements, the timeliness of movement through the system, and the presence of demographic disparities in services.

- **Success of Placements:**
 - At what rates are individuals and families housed? How do these rates differ across youth, families and single adults?
 - What provider-level factors contribute to successful placement in housing? What are the biggest barriers to someone being successfully housed?
 - Do individuals and families seem to be housed permanently? What are the rates of shelter re-entry after successful housing placement? How many clients have multiple referrals?
- **Timeliness of Movement through the System:**
 - How long does it take youth, families, and single adults to move through CES, with a specific focus on the time from referral to housing placement?
 - What are some of the barriers that prevent timely movement into housing?
- **Demographic Disparities:**
 - How do different demographic groups compare in how often they have referrals accepted and are placed in housing?
 - How do different demographic groups compare in how long they spend in CES?
 - What differences exist in barriers to successful referral and placement in housing for various demographic groups?

Literature Review

This analysis draws on previous research evaluating the implementation of CES in different jurisdictions around the country. Additionally, as Continuums of Care (CoCs) implement systems to respond to homelessness across the country, a wide range of performance metrics become available to compare performance of different systems. Research concerning successful housing placement, timeliness of CE systems, and demographic disproportionality have shaped our present findings.

Evaluating Successful Housing Placements

Studies have evaluated the extent to which the standardized nature of CE systems tends to result in successful outcomes for those experiencing homelessness. CE systems across the country strive to streamline the assessment and referral process using standardized protocols and assessment tools. However, several studies have documented that the service needs identified by standardized assessment tools (such as the VI-SPDAT) do not always align with individual and family self-understanding. Mismatches between homeless families and services fail to produce successful housing placements.⁸ These mismatches can be due to a lack of housing availability to meet client needs or requirements to accept a stigmatized label in order

⁸ Shinn, Marybeth, et al. "Mismatch between homeless families and the homelessness service system." *Cityscape* (Washington, DC) 19.3 (2017): 293.

to access supportive services.⁹ Such studies point to the potential limitations of standardized approaches to referral and housing placement.

Another area that research has evaluated is the relative success of different models of service provision at helping individuals and families access housing. Transitional Housing (TH), PSH, and rapid re-housing (RRH) represent different approaches to housing provision utilized within CoCs. TH is designed to assign provisional housing to families or individuals to provide stability for an eventual move to permanent residence. TH interventions often target subgroups of individuals experiencing homelessness who may utilize additional services to manage care for disability or treat substance abuse. RRH operates with a “Housing First” philosophy and allows families to exit shelter more rapidly than traditional interventions.¹⁰ RRH typically targets people who are not expected to need intensive or ongoing services after accessing housing.¹¹ In contrast, PSH is targeted to those experiencing homelessness who face multiple barriers to stable housing, and who require ongoing and intensive support services in order to remain housed permanently.¹²

The Family Options Study (2015) conducted by Gubits et al. for HUD’s Office of Policy Development and Research measured short-term outcomes of all three interventions on 2,300 participating families randomly assigned to twelve sites across the country.¹³ RRH was the most cost-effective intervention, and the fastest way to provide shelter for those who were given priority for entrance into the program. PSH reduced psychological distress, reduced reported alcohol and drug problems, and increased food security for participating families. TH reduced stays in emergency shelter and on the street but did not lead to measured success.¹⁴ Brown et al. (2017) used HMIS data from 2009 to 2015 to evaluate risk of return to homeless services among 370 single adults housed in PSH versus 71 housed using RRH. They found that PSH placements resulted in fewer returns to homelessness.¹⁵ They concluded that veteran status was the most consistently significant predictor of shelter re-entry among those permanently housed, followed closely by race; African American participants comprised over 50 percent of re-entries in the follow-up period.¹⁶ Overall, the scholarship provides mixed results with positive outcomes achieved in both RRH and PSH interventions. This research builds on these studies

⁹ Shinn, M., Brown, S. R., Spellman, B. E., Wood, M., Gubits, D., & Khadduri, J. (2017). Mismatch between homeless families and the homelessness service system. *Cityscape* (Washington, DC), 19(3), 293; Barile, J. P., Pruitt, A. S., & Parker, J. L. (2019). Identifying and understanding gaps in services for adults experiencing homelessness. *Journal of Community & Applied Social Psychology*.

¹⁰ Cunningham, M. & Batko, S. (2018). Rapid Re-housing’s role in responding to homelessness: What the evidence says. *Urban Institute*. https://www.urban.org/sites/default/files/publication/99153/rapid_re-housings_role_in_responding_to_homelessness_2.pdf

¹¹ <https://www.usich.gov/solutions/housing/rapid-re-housing/>

¹² <https://nhchc.org/clinical-practice/homeless-services/permanent-supportive-housing/>

¹³ Gubits, D., Shinn, M., Bell, S., Wood, M., Dastrup, S., Solari, C. D., Brown, S. R., Brown, S., Dunton, L., Lin, W., McInnis, D., Rodriguez, J., Savidge, G., Spellman, B. E., & Abt Associates, Inc. (2015). Family options study: Short-term impacts of housing and services interventions for homeless families. *U.S. Department of Housing and Urban Development Office of Policy Development and Research*.

file:///home/chronos/u-9617d5864273022b09eaa3ed48c1c73c4be18e58/MyFiles/Downloads/SSRN-id3055272.pdf

¹⁴ Ibid.

¹⁵ Brown, M., Vaclavik, D., Watson, D. P., & Wilka, E. (2017). Predictors of homeless services re-entry within a sample of adults receiving Homelessness Prevention and Rapid Re-Housing Program (HPRP) assistance. *Psychological Services*(14:2), 129-140. <http://dx.doi.org/10.1037/ser0000112>

¹⁶ Ibid.

as we examine how provider models and methods of intervention with individuals and families shape their successful placement into housing.

Timeliness of CES Service Provision

As jurisdictions nationwide adopt CE models in their CoCs, efforts have been made to determine shared standards around the time it should take for individuals and families to move through the system and access housing. HUD's Coordinated Entry Policy Brief (2015) directs CoCs to keep waiting times "short," recognizing that "a few days or weeks might be necessary to properly manage utilization," but does not specify guidelines or goals regarding efficiency in the system. HUD's release briefly states that "waiting times for homeless assistance of several months or years should be eliminated whenever possible."¹⁷

Research on the timeliness of three different CoC systems provides a mixed picture of waiting times. First, the City of Chicago has published CoC System Goals (2018), which include concise guidelines stating, "all individuals and families [will] resolve their homeless crisis in 90 days." Further, their guidelines articulate that "the amount of time from someone receiving a match to getting housing [should be] 30 days for all populations."¹⁸ Despite these goals, the city's HMIS Data Dashboard indicates the "average length of time in Chicago's homelessness system for persons currently experiencing homelessness" is 325 days.¹⁹

Second, the North Carolina Coalition to End Homelessness and the NC Balance of State CoC Coordinated Entry Council conducted surveys about timeliness in referral and placement to permanent housing. As of January 2019, 59 percent of currently-housed survey respondents reported waiting at least 3 months for housing, and 29 percent had waited 6 months or more.²⁰ Across the state, the assessment found that most permanent housing providers only wait 1 to 2 weeks to receive a referral from CE when a unit becomes available, but that 20 percent reported holding open units for a month or more before referral.²¹

Third, the Maricopa Regional Continuum of Care Board in Maricopa County, Arizona determined the average time between assessment and housing move-in for those placed through PSH interventions was 115 days, followed closely by 120 days for placement through RRH interventions.²² The report claims that these outcomes are 'efficient' as compared to other communities. Provider interviews also referenced in the findings make distinctions in outcomes for both single adults and families. Housing providers reported that families assessed and

¹⁷ U.S. Department of Housing and Urban Development. (2015). *Coordinated Entry Policy Brief*. Retrieved from <https://files.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>.

¹⁸ The Chicago CoC Action Agenda. (2018). Chicago CoC System Goals. Retrieved from https://allchicago.org/sites/allchicago.org/files/System_Goals_2018.pdf.

¹⁹ AllChicago. (2020). Chicago's Dashboard to End Homelessness. Retrieved from <https://allchicago.org/dashboard-to-end-homelessness>.

²⁰ North Carolina Balance of State Continuum of Care. 2018 Coordinated Entry System Evaluation. Retrieved from <https://www.ncceh.org/media/files/files/c4d3d177/nc-bos-coc-ce-evaluation-2018-2019-with-appendix.pdf>.

²¹ *Ibid*, 22.

²² Maricopa Regional Continuum of Care Board. (2019). Annual Coordinated Entry System Evaluation. Retrieved from <https://www.azmag.gov/Portals/0/Documents/MagContent/Annual-Coordinated-Entry-System-Evaluation.pdf?ver=2019-05-15-110913-787>.

placed through CES had an average wait time of four and a half months—slightly longer than single adults.²³

These three evaluations provide little consensus on a benchmark for the time people should spend going through CES. Rather, time spent interacting with the system seems to vary by location, and potentially based on demographic identity. This report seeks to better understand the amount of time that individuals and families spend moving through Hennepin County's CES and identify key steps in the system that prevent more efficient movement.

Demographic Disparities in Housing Outcomes

HUD guidance around the implementation of CES emphasizes that the system should result in, “communities prioritiz[ing] people who are most in need of assistance” and “strategically allocat[ing] their current resources.” This focus on those most in need of assistance is intended to be implemented through all stages of housing services.²⁴ As jurisdictions across the country have implemented CES, some have explicitly included goals around the elimination of racial disparities as a part of their efforts to address homelessness.²⁵ Proponents of CES models argue that coordinated efforts can enhance equity in allocation of resources by creating a “no wrong door” model in which those facing the highest barriers to housing can access services from streamlined points of entry.²⁶ However, there is little explanation about how CoC policies and protocols will function in practice to address disparities in those experiencing homelessness.

Concerns about demographic disparities in CES implementation have been supported by research. There are well documented racial disparities in individuals and families who become homeless nationwide.²⁷ There is also a growing literature examining the ways that individual and family demographic characteristics are associated with outcomes across the whole spectrum of service delivery. Literature suggests that larger families, those with an older head of household, and in some cases Black or African American families take longer than others to exit shelter.²⁸ Additionally, there is evidence that race and ethnicity, gender identity, sexual orientation, and age may be associated with individuals' duration in housing, returns to homelessness, and other indicators of housing stability.²⁹ Olivet et al. (2018) examined shelter data from Hennepin County between 2011 and 2016 and found that race was a significant predictor of returning to homelessness after entry into shelter. Their study found that individuals who identified as Black or African American, Native American, or Native Hawaiian/Other Pacific Islander were

²³ Ibid, 16.

²⁴ HUD Exchange. *Coordinated Entry Core Elements*. (2017). Retrieved from <https://files.hudexchange.info/resources/documents/Coordinated-Entry-Core-Elements.pdf>

²⁵ Special Focus Areas: Homelessness and Heroin & Prescription Opioids. (2017-2018.). Retrieved, from https://bellevuewa.gov/sites/default/files/media/pdf_document/hs-needs-2017-18-Homelessness.pdf

²⁶ Eubanks, V. (2018). *Automating inequality: How high-tech tools profile, police, and punish the poor*. St. Martin's Press.

²⁷ Olivet, J., & Wilkey, C. (2018). SPARC Phase One Study Findings. *Cent Soc Innov*.

²⁸ Culhane, D. P., Metraux, S., Park, J. M., Schretzman, M., & Valente, J. (2007). Testing a typology of family homelessness based on patterns of public shelter utilization in four US jurisdictions: Implications for policy and program planning. *Housing Policy Debate*, 18(1), 1-28.

²⁹ Hsu, H. T., Rice, E., Wilson, J., Semborski, S., Vayanos, P., & Morton, M. (2019). Understanding Wait Times in Rapid Re-Housing Among Homeless Youth: A Competing Risk Survival Analysis. *The journal of primary prevention*, 40(5), 529-544.

significantly more likely to return to homelessness after accessing the shelter system.³⁰ The mixed results of studies examining disparities in outcomes point to the need for further research on the ways that demographic factors shape individual and family movement through homelessness systems.

A substantive research base exists indicating concerns about the ability of CES to create equitable outcomes for all people experiencing homelessness. As CoCs across the country continue to implement this model, it is vital to better understand the mechanisms through which CES policies and protocols achieve such equitable outcomes. This research examines both participant outcomes and housing provider processes as a means for understanding how demographic identity influences individual and family experience in CES.

Methodology

Mixed Methods Approach

This project uses a mixed methods approach to address questions regarding successful access to housing, timeliness of movement through CES, and demographic disparities in access to housing resources. Mixed methods analysis can both determine key indicators of successful housing referrals and placements and pinpoint sources of delay in the system. Combining administrative data with provider interviews uncovers how demographic groups move through CES, highlighting both the strengths in the system as well as areas for improvement.

The quantitative research uses select administrative data from Hennepin County's Homeless Management Information System (HMIS) database regarding shelter stays and housing referrals between 2017 and 2019. This information is enhanced with qualitative data collected through ten interviews with housing providers who are part of Hennepin County's Continuum of Care (CoC) program.

Qualitative

Qualitative Design

Qualitative research allows researchers to hear directly from housing providers who work with individuals and families that are referred to them through the County's CES. The qualitative research for this project was derived from interviews with Hennepin County's CoC housing provider partners. The interviewees represented the different housing programs and the populations that they serve, including RRH, PSH with and without disability requirements, and those that focus on single adults, families, and youth. Providers helped answer questions related to the timelines of the placement process, how it works for clients, and their recommendations for improvements to the system. Direct interviews enhanced the research gleaned from administrative data and allowed researchers to better identify common issues for providers, issues with CES, and how providers think about their position and purpose within the process.

In determining the sample of providers to interview, the research team sought representation from four main program types (RRH, TH, PSH, and PSH-Disability required for entry), and populations served (single adults, youth, and families). Hennepin County provided the research team with a list of providers, and the sample was selected for its broad representation of

³⁰ Olivet, J., Dones, M., & Richar, M. (2018). Supporting Partnerships for Anti-Racist Communities. Needham, MA: Center for Social Innovation.

services, size, and longevity. While the team was eventually unable to conduct planned interviews with TH providers, it should be noted that a TH provider was ultimately not interviewed due to availability limitations of providers. The inclusion of PSH, PSH-D, and RRH programs helped identify trends unique to the program type and target population served, as well as issues that run through the homeless-designated housing system. The sample included a balance of small and large agencies, as well as new and old.

Qualitative Data Collection and Analysis

Interviews with housing providers were scheduled between March 16 and March 26. Two team members participated in each interview. The lead interviewer followed a prepared interview guide, and the second member took notes. The interviews were audio recorded, but the recordings were destroyed at the conclusion of the report for both security and anonymity of participants.

The data collected from interviews was processed using an iterative coding process, which identified the subjects, themes, or trends that emerged from provider interviews. Codes and queries identified consistent subjects, themes, or trends among the various housing providers.

Direct (but unattributed) quotes from the interviews are used to support and enhance key takeaways from the research.

Sample Results and Limitations

The research team was able to interview ten representatives from housing providers. Of the ten Hennepin County housing providers that the research team interviewed, three provided RRH services, five provided PSH, and two provided permanent housing only. Five of the programs served single adults only, three served families, one served both single adults and families, and one served youth clients.

The rise of the COVID-19 pandemic had a tremendous impact on the team's ability to complete more interviews. While it was possible to shift many of the interviews from in person to virtual methods, the impact of the pandemic on the population experiencing homelessness required immediate attention by Hennepin County's housing providers. While securing the additional interviews that were originally planned would have provided greater fidelity of data, interviews were still conducted with providers of every major type, serving adult, youth, and family clients.

Quantitative

This study employed quantitative methods in order to better understand the way individuals and families move through CES from referral to housing. A sample of shelter stay and housing referral data from 2017 to 2019 was pulled from HMIS, representing 4,376 individual and family clients. Both referral acceptance and housing rates were compared across demographic groups as was the timeliness at which these clients moved through CES. Additionally, researchers examined the extent to which demographic factors are predictive of successful and timely referral acceptance and housing placements through logit and OLS regression models. All rate and time analysis was split and run separately for youth, families, and single adults to account for the drastic differences in both the shelter systems and the number of providers and units designated for these population types.

Rates and Timeliness of Successful CES movement

Examining the period of time after a referral is made through CES, several measures across demographic factors were compared to better understand the success rates of clients moving through the system as well as the timeliness of their housing placement. We compare the rates of referral acceptance by housing provider type as well as rates of housing placement across demographic groups to explore any differences in these two steps of successful placement into housing. Further, we compare the median time it took clients to move from the point of referral to being successfully housed to explore differences in the timeliness of movement through the system. We utilized the median as a method of comparison instead of the mean due to a skewed distribution that included a small share of very long wait times during this period.

OLS Regressions on time from referral to housing

Logistic regressions were utilized prominently in previous research to explore the risk or likelihood of individuals and families moving through stages of CES. In our analysis we employ Ordinary Least Squares (OLS) models to regress the average time from referral to housing on race, gender, disability status, veteran status³¹ and chronicity status in order to better understand the factors that predict timely movement through the system. Additional models were run including VI-SPDAT score buckets³² as controls to check the robustness of results. Minimal changes occurred between the models, with slight decreases in significance for clients with disabilities and chronicity when adding the VI-SPDAT score control. Due to high correlations between VI-SPDAT scores and disability and chronicity status, we elected to exclude VI-SPDAT scores from our final models to avoid multicollinearity. In order to address significant outliers in the time analysis, those with extremely long wait times—the top 1 percent—were excluded from the sample, as it appeared unlikely that clients were spending more than 250 days in the intake process.³³

Logit Models on the likelihood of referral acceptance and placement into housing

Our analysis estimates the probability of referral acceptance and placement into housing separately for youth, families, and single adults, controlling for race, gender, disability status, veteran status³⁴ and chronicity status in a series of logit models. Similar models are run to predict the likelihood of unsuccessful movement through CES, with dummy dependent variables for returning to shelter post housing and for having multiple referrals during the two-year time period (2017-2019). All logit coefficients were converted to odds ratios for ease of interpretation within this report. To address potential censoring bias, logit models on likelihood of being housed were run with a time restriction, to show clients likelihood of being housed within two months, as this was the time frame providers strive to meet according to qualitative interview findings. Few changes occurred between the original and time constrained model.

Creation of Shelter Spells

In order to determine if any clients returned to shelter post housing, 'shelter spells' were created using three years of shelter data (2017-2019). The shelter system often checks-in individuals and families on a daily or weekly basis creating multiple entries for the same client IDs which often overlap. To understand the cyclical nature of shelter exit and entry, back to back dates

³¹ As noted in findings, veteran status was not a statistically significant predictor in quantitative analyses.

³² VI-SPDAT scores were broken into three categories, with low scores [0-4] as the reference group, middle scores [5-8], and high scores [9+] to analyze whether or not county guidelines for referral and housing were in line with VI-SPDAT assessments.

³³ 64 households were dropped, due to their time from referral to housing placement being over 250 days.

³⁴ As noted in findings, veteran status was not a statistically significant predictor in quantitative analyses.

were grouped into one 'spell.' Any spells that occurred after a housing placement indicate a lack of permanence for that client.

Limitations

The data analyzed for the purposes of this report included entry onto the priority list and referral dates for nearly all client IDs. This is not the experience of all individuals and families within CES, some clients are never assessed, while others will enter the priority list but never receive a housing referral due to a low assessment score or the lack of housing units that become available each year. The limitation within this data informed the scope of research, which begins at the point of referral in this report.

Additionally, the HMIS data sample only included the most recent housing date for each client ID within the sample period. This does not allow for the analysis of any previous referral outcomes. For this report, the housing placement date connected to the referral immediately preceding was used for analysis if a client ID had multiple referrals. This limited our ability to analyze housing outcomes for clients with multiple referrals and explains why most of the analysis was limited to one referral or pathway through CES.

Data

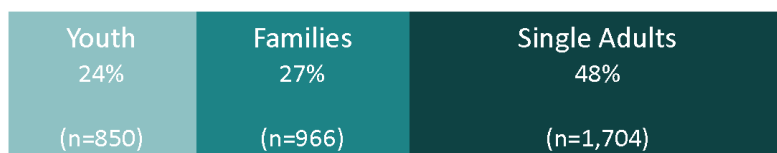
Who is in the Sample?

Quantitative research for this report relied on a select data set derived from Homeless Management Information System (HMIS) administrative data; information therein was submitted by assessors, Hennepin County CoC, and housing providers to report client movement through CES. The sample consisted of 4,376 individuals and families, nearly all of which included dates of assessment and referral in the CE process between 2017 and 2019. The data provided detailed demographic information about each household as well as referral and housing dates, and which housing provider was associated with the clients' referral. Unfortunately, missing fields and incomplete entries were common in the data. Though we did not have complete information on all 4,376 clients, we preserved entries and analyzed the demographic and referral information that was available for each individual or family. This method allowed us to analyze the largest possible sample for each category, however it resulted in varying sample sizes for each category of analysis. Throughout this report, sample sizes are clearly noted to provide clarity regarding analytical changes.

Population Type

The data sample consists of three 'population types' (*Figure 2*). Youth (defined as age 24 or younger), families (listed by head of household), and single adults. Youth were separated and designated as a different category because they were most frequently served by youth-specific housing providers, but those in this population type may be classified as individuals or as family head-of-households in the county's data. Single adults comprised much of the sample (48 percent), followed by families (27 percent) and youth (24 percent).

Figure 2: Share of the Sample by Population Type

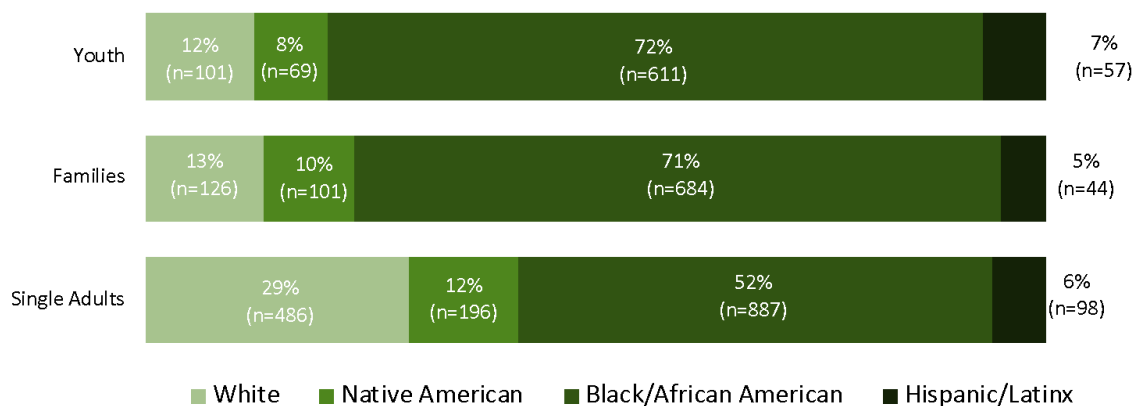


Throughout this report, analyses are performed according to these three population types to highlight differences in experiences through CES. Additionally, race, gender, disability status, and whether a household met Hennepin County’s criteria for being considered chronically homeless, were analyzed.

Race/Ethnicity

HMIS data separated racial demographics from Hispanic ethnicity. For the purpose of this analysis, we merged race and ethnicity in order to examine the experiences of Hispanic/Latinx individuals and families as a distinct group. Anyone who identified as Hispanic/Latinx was put into one category making the remaining racial groups non-Hispanic (*Figure 3*). Across all population types, Black or African American clients were by far the most widely represented in the sample, followed by White, Native American, and Hispanic/Latinx individuals and families. There were very few clients who identified as Asian or Native Hawaiian/Pacific Islander; results for this subgroup are not reported for the purposes of robust analysis in this report.

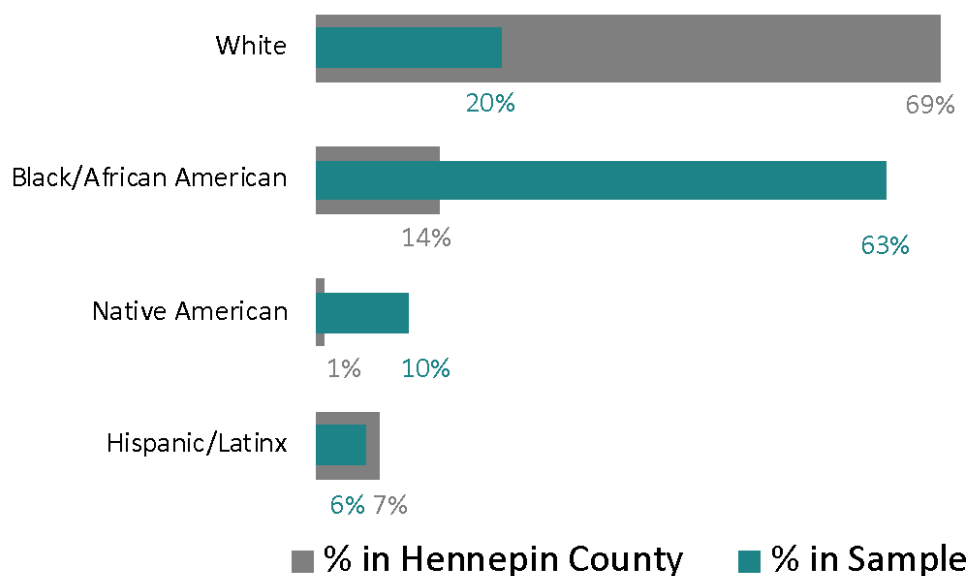
Figure 3: Racial Demographics of each Population Type



There is a disproportionate representation of people of color in the HMIS data set compared to the overall demographics of Hennepin County—notably Black or African American and Native American clients (*Figure 4*). Research, including C4’s Supporting Partnerships for Anti-Racist Communities (SPARC) Report (2018), confirm that these racial groups are vastly over-

represented in the population experiencing homelessness in the county. This disproportionality is an important grounding for the findings discussed in this report. While aspects of CES may appear to be performing in a racially equitable manner, it must be kept in mind that the system itself is entrenched in larger systemic inequalities.

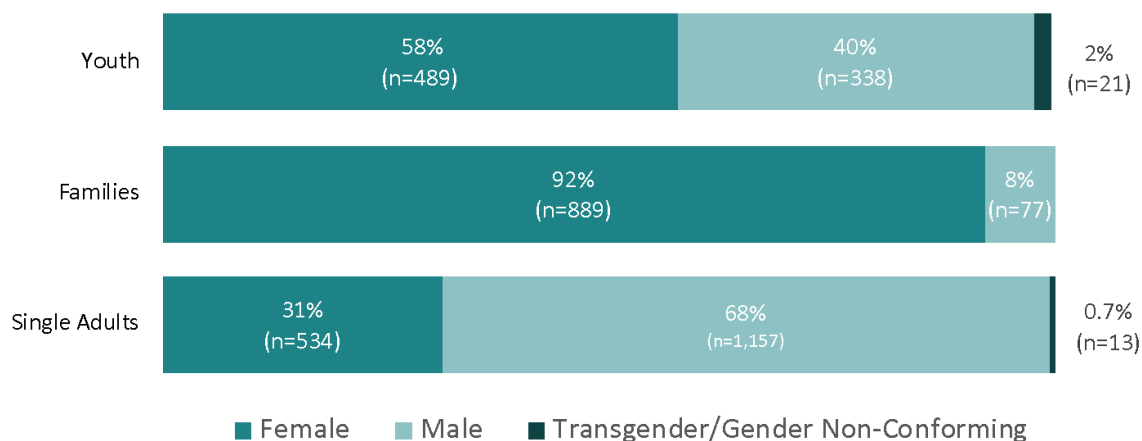
Figure 4: Racial Disproportionality in the Population Experiencing Homelessness



Gender

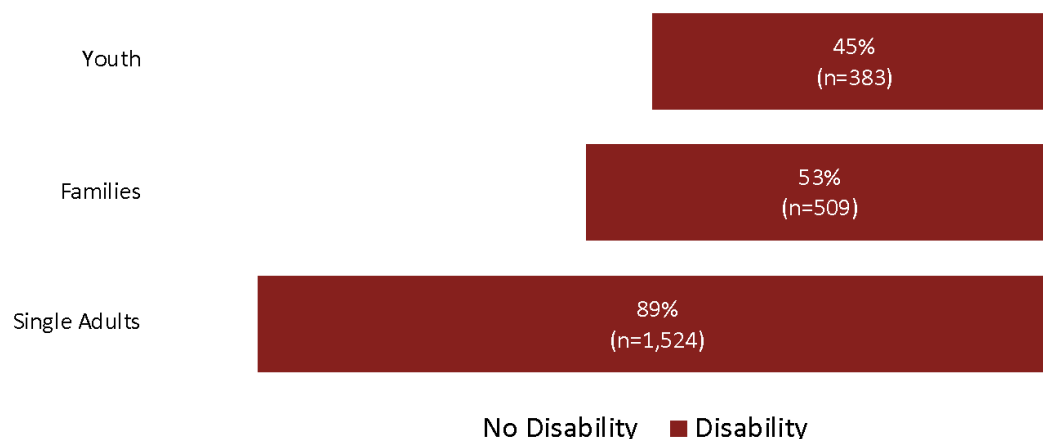
Gender identification varied across the different population groups in our sample (*Figure 5*). For youth, female-identifying individuals made up the majority (58 percent). For families, female-headed households were disproportionately common in the sample (92 percent), while male-identified heads-of-household made up a small minority (8 percent). Conversely, for single adults, male-identified individuals made up the bulk of the sample (68 percent).

In the youth and single adult population categories, a very small minority of households identified as a gender other than male or female. For families, only male and female genders were self-reported. Due to the extremely small sample size of those identifying as another gender, this group was included in regression models, but findings are not explored in this report. However, we recognize that further research should be done to understand the experiences of non-binary and transgender individuals as they interact with CES, and whether their needs are being met by the current system.

Figure 5: Population Type by Gender**Disability**

Clients with self-reported disabilities comprised a significant portion of the sample. Disabilities seem to include both physical disabilities as well as mental illness; the conflation of multiple types of disabilities into one self-reported category makes it difficult to understand the effects of specific types of disabilities on clients' ability to successfully navigate CES and access housing.

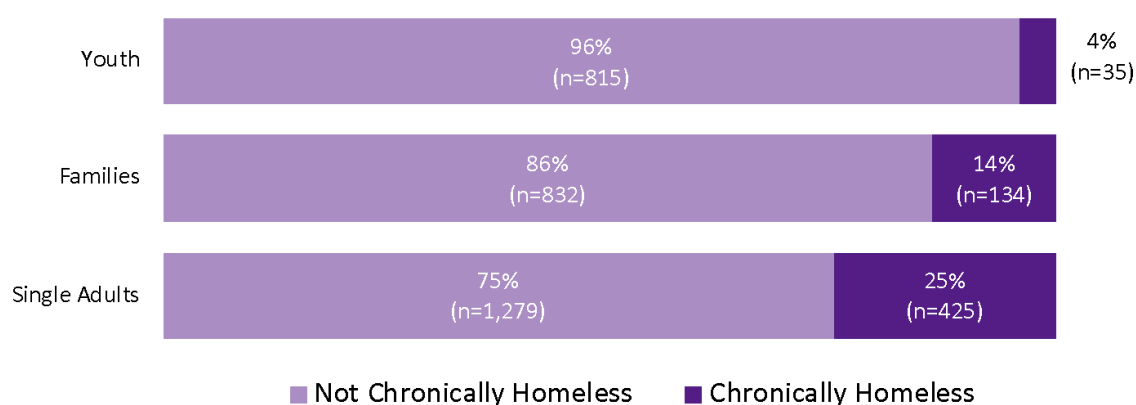
Most youth did not identify as having a disability (55 percent), however the remaining 45 percent are a significant minority of the sample (*Figure 6*). For family data, the head-of-household reported whether any member of the family had a disability. A majority (53 percent) of this population group reported that someone within the household did have a disability. Disabilities were found most often in the single adult population sample, with 89 percent self-reporting a disability. Based on comments from providers, this figure could suggest significant challenges those with disabilities face in traditional housing markets or may signal a unique incentive for those experiencing homelessness to claim a disability in order to secure access to the priority list in CES. Findings suggest that the presence of self-reported disabilities have important implications for a client's likelihood of successfully accessing housing through CES, as well as the length of time they spend in the system.

Figure 6: Self-Reported Disability in each Population Type

Chronicity

An individual is defined as 'chronically homeless' by Hennepin County if they have a self-reported disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (totaling 12 months).³⁵ Meeting the needs of individuals experiencing chronic homelessness has been identified as a priority for Hennepin County and as such, is an important factor to analyze in this sample. Rates of chronicity were low across all three population groups, with the majority of those identified as chronically homeless identified as single adults, 25 percent (*Figure 7*).

Figure 7: Those Who Meet HC Definition of Chronically Homeless in each Population Type



Veterans

Military veterans represented a very small minority in all population groups (n=108). Of these clients, 90 were single adults, 84 of whom self-reported a disability. After preliminary analysis of this demographic category, it was determined that the sample size was too small to produce any conclusive findings concerning this group. Evidence from the qualitative interviews suggests that veterans often utilize the many VA-specific services available to them, and that those who end up in the traditional CE system tend to have higher needs and additional barriers to accessing housing. An analysis of veterans in the sample revealed that their experience often parallels that of single adults with disabilities. Further research could focus on the experience of veterans in CE, and the extent to which their experience differs from other single adults with disabilities.

³⁵ HC CES Operating Manual <https://www.hennepin.us/-/media/hennepinus/residents/human-services/docs/family-policy-procedure-manual-2019.pdf?la=en&hash=C3F33E218E4DCCEA3D5A6E5347665D26F6A54A6C>

Findings

Both quantitative and qualitative findings provide insight into the extent to which CES is working as intended by Hennepin County and its shelter and housing provider partners. Throughout our analysis, we draw conclusions about 1) the success of the system in placing people into housing, 2) the timeliness with which clients move from referral to housing, and 3) the extent to which demographic disparities exist in outcomes. Findings within these conclusions are organized into the following:

1. *Pathways through CES:* Varying pathways that clients take while navigating the CE process were examined through analysis of the HMIS data sample. Results suggest that CES does not always function linearly as intended for individuals and families in the system.
2. *Client Intake and Housing Outcomes:* The intake process following a referral to a housing provider, reasons for referral decline, and rates and factors influencing successful outcomes from the point of referral to placement into housing are explored to understand whether this step of the CE process is functioning as intended.
3. *Unsuccessful Housing: Shelter Re-Entry and Multiple Referrals:* HMIS data sample analysis examines what happens to these clients after an unsuccessful path through CES. Outcomes of unsuccessful housing placements are explored by analyzing returns to shelter and the effect of multiple referrals.
4. *Timeliness of CES:* Utilizing data points for samples with dates for each step of the CE process, a time analysis was conducted to better understand where clients are experiencing major delays in the system. While broad findings are included about each time period in CES, the bulk of this report focuses on the time between when a client is referred to a housing provider, and when they access (or fail to access) housing. This period is further explored across population types and key demographics to uncover any disparities that may exist in timeliness of housing placement after referral acceptance.
5. *Comparisons by Provider Type:* Comparison of rates and timeliness across provider types explore how the referral and housing steps of CES may yield differing results. Comparison of unsuccessful housing outcomes between provider types is also performed.

Pathways Through CES

To better understand the context of the process of moving from a referral to accessing housing, it is imperative to gain a broader sense of how individuals and families move through each stage of the CE process. While the data does not provide a comprehensive understanding of peoples' experiences moving through CE, there are several pathways through the system that are instructive for understanding the challenges that clients and providers face as they attempt to move through intake to placement into housing.

Clients with a linear pathway through CES

Of the 4,376 individuals and families in the HMIS sample, approximately one quarter had one complete entry for every stage of the CE process. In these cases, CE functions largely as it was designed. Clients enter shelter, go through an assessment process and are entered onto the priority list. These individuals then go on to receive a referral, are accepted by the provider, and ideally access housing. For this group of 1,688 clients, CE seems to function in a linear way (See *Figure 8* below).

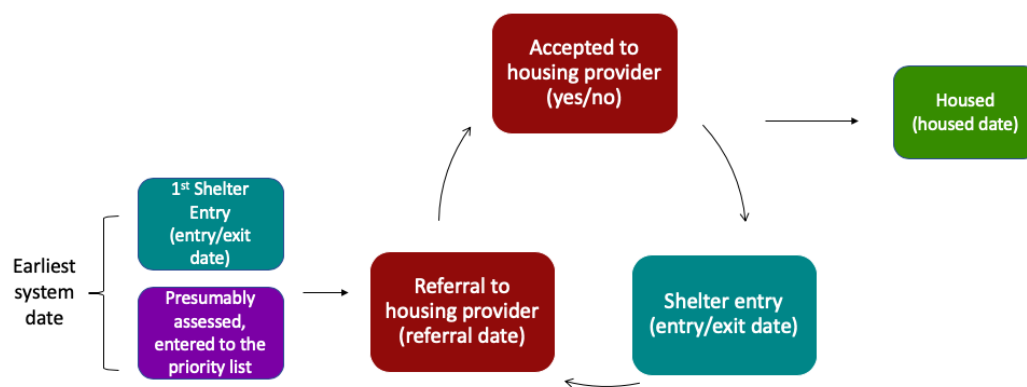
Figure 8



Clients with multiple/incomplete entries: Cycling through CES

For the remaining three quarters of the sample, movement through the stages of CE happens in a variety of different ways. Missing or inconsistent data on these individuals and families makes it difficult to understand how they experience the system, and which aspects present the largest barriers to accessing housing. From what is known in the data about these client experiences, it appears some clients cycle through the stages of referral and shelter entry, sometimes resulting in access to housing, other times with housing left unresolved (See *Figure 9* below). An individual may go through assessment and enter the priority list before the two-year period showcased in the data or be living unsheltered when they enter the priority list. They may then go on to utilize shelter and access referrals multiple times throughout the two-year period. For many clients, the outcome of their referral is missing from the data. Because of the cut-off date present in the data, some of these clients were likely waiting to be accepted by housing providers and have since gone on to be accepted and housed after the period of analysis. On the other hand, some clients in this group may be caught in the cycle of referrals and shelter stays described below, with missing data obscuring their current needs and experiences.

Figure 9



The non-linear pathway of many clients in the system illustrates the need for further inquiry on the part of the county to better understand the experiences of these clients. It is unclear based on the current HMIS methods of data collection included in the sample whether clients who are not successfully housed are finding solutions to their housing crises outside of the county system, or if they are intending to return to the priority list and be referred again.

Summary

Success of Placements

As *Figure 8* and *Figure 9* demonstrate above, clients in the data set moved through the system in both linear and cyclical ways—not always as the county intends. Unfortunately, not enough is known about the clients who cycle through the system multiple times, or who have missing or incomplete data. Methods of tracking client movement through CES included in this sample do not appear sufficient to understand the exact points in the process where clients face barriers to accessing housing or where they terminate contact with CES, however HMIS capability to track client paths may be more robust than that of the data sample provided.

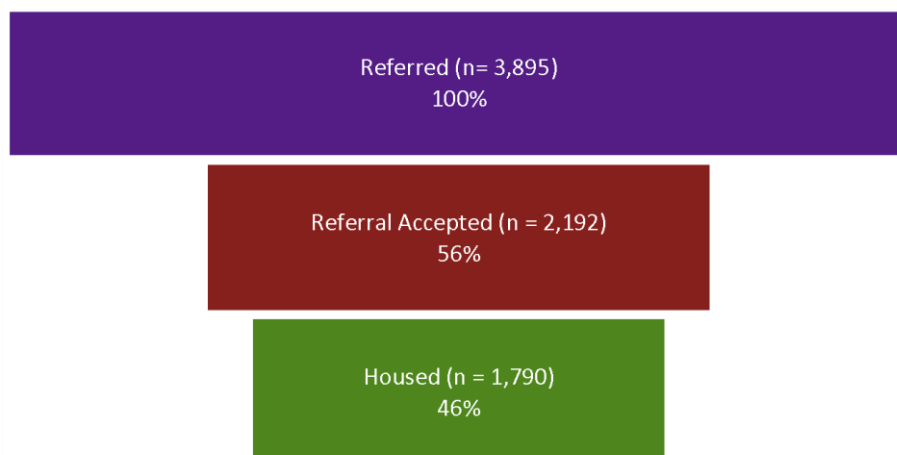
Client Intake and Housing Outcomes

Rates of Success

A sample was constructed to explore the outcomes of those in the HMIS data set who went through the CE referral process. Client IDs utilized for this analysis consists almost entirely of clients who remained in shelter long enough to be assessed and entered onto the priority list, and who received a referral through CES. The numbers within this sample should not be considered representative of the entire population experiencing homelessness in Hennepin County.

Approximately 3,900 clients were referred to a housing provider through CES in the sample. Of those, only 56 percent, or slightly more than 2,000 had their referral accepted (*Figure 10*). Forty-six percent, or about 1,800 clients were successfully housed through CES between 2017 and 2019. The focus of this report is to explore the dynamics of the period after a client is referred to a housing provider and the factors affecting subsequent success or failure in placing clients into housing. There are many reasons that a referral might be rejected, and this section will cover time analysis of the intake process by population and provider type, the reasons that clients are declined, and the rates of referral acceptance and decline.

Figure 10: Overall Rate of Success in Each Period



After a referral is received and client contact is made, a provider begins the intake step in the process. Intake typically consists of any number of meetings between the client and the provider to confirm program eligibility, explain the type of housing and services that will be provided, and establish long-term goals for the client while in housing. Intake ends when a client is placed in housing. The HMIS data sample analyzed for this report tells us how long it takes between when the referral is made, and the client gets placed into housing. Many people moving through CES fail to successfully access housing after their referral, and the reasons vary widely.

Reasons for Referral Decline

Overall, 43 percent of those who were referred were declined. To better understand referral decline, reasons listed by providers in HMIS data were analyzed by population types and key demographics, and provider perspectives on common barriers to referral acceptance were explored. Ten categories for referral decline were created from the original 21 entries listed in HMIS: found housing/self-resolved, out of shelter or CoC, unable to locate housing, placed in institution, refused service, unreachable, deceased, eligible--but provider unable to accept, ineligible, and other.

Providers often took the perspective that instances of decline were exceedingly rare. In every interview with single adult or family providers, interviewees estimated that ten percent or fewer of their total referrals would be declined, one remarking “[I] have only rejected one or maybe two people ever since Coordinated Entry started.” Provider perspective of the dynamics of this stage seemed to contrast with the way that data is recorded and measured in HMIS.

Table 1 below includes a full breakdown of reasons for decline within this study. To identify whether any of the demographic groups were more likely to be declined for particular reasons, we performed logit analysis on the five most common reasons for decline (*Table 1*).³⁶ The point at which a referral may be declined by a provider differs across these reasons.

³⁶ Five most common reasons for decline were run as dummy dependent variables, controlling for race, ethnicity, gender, disability, military, and chronicity status.

	%	N
Client Unreachable	36%	486
Client Refused Service	19%	251
Ineligible	18%	242
Other	9%	119
Found Housing/Self-Resolved	7%	94
Client out of Shelter/CoC	4%	56
Is Eligible, but Provider Unable to Accept	3%	34
Client Placed in an Institution	2%	28
Client Unable to Locate Housing	1%	18
Client is Deceased	1%	7
Total	100%	1,335

Understanding the reasons for the high level of referral declines can help identify areas in need of improvement, which when addressed can create successful and timely placements of clients into housing. HMIS data cannot capture the apparent, substantive differences in types of decline. In this section, findings on each reason for decline will be separated into “Before Intake Begins” and “After Intake Begins.” While these reasons are grouped together in HMIS, they appear to represent distinct stages of barriers to housing. Barriers that exist before a provider contacts a client may require substantively different solutions to address than ones that happen once the intake process has begun.

Logit analysis was conducted on the reasons for referral decline in order to better understand the extent to which demographic categories were predictive of clients being declined for particular reasons. The results are summarized in *Table 2* below and key disparities are described in more detail for each top reason for decline.

Table 2: Likelihood of being Declined from a Referral by Demographic groups: Odds Ratios [2017-2019]

VARIABLES	(1) Client Unreachable	(2) Client Refused Services	(3) Ineligible	(4) Other	(5) Found Housing Self-Resolved
Native American	1.220 (0.248)	0.583** (0.147)	0.983 (0.295)	0.935 (0.333)	1.085 (0.394)
Asian	0.489 (0.570)		2.422 (2.844)		4.288 (5.079)
Black or African American	0.844 (0.127)	0.706** (0.124)	1.870*** (0.381)	1.024 (0.263)	0.790 (0.223)
Native Hawaiian/ Pacific Islander	1.808 (1.507)	0.596 (0.666)	4.174 (3.716)		
Hispanic/Latinx	0.577* (0.162)	0.764 (0.246)	2.136** (0.686)	1.603 (0.632)	0.983 (0.477)
Female	0.693*** (0.095)	1.593*** (0.254)	0.850 (0.149)	1.153 (0.258)	1.255 (0.320)
Disability	0.916 (0.151)	1.288 (0.271)	0.565*** (0.110)	2.345*** (0.716)	1.192 (0.382)
Military or Veteran	0.507** (0.163)	0.899 (0.330)	1.827* (0.586)	0.686 (0.422)	1.486 (0.742)
Chronically Homeless	0.819 (0.130)	1.202 (0.221)	0.690* (0.142)	1.842** (0.446)	1.343 (0.371)
Youth	0.978 (0.157)	1.024 (0.197)	0.558*** (0.117)	2.316*** (0.586)	1.223 (0.372)
Families	0.733 (0.194)	0.273*** (0.108)	0.887 (0.270)	1.233 (0.505)	1.195 (0.521)
Constant	0.820 (0.170)	0.224*** (0.058)	0.291*** (0.076)	0.030*** (0.012)	0.056*** (0.023)
Observations	1,213	1,209	1,213	1,203	1,207

Referral Decline: Before Intake Begins

Client is unreachable

The most common reason for referral decline was that a CES client was unreachable, representing 36 percent of all declines. Overall, men were more likely than women to be declined because they were reported to be unreachable. This finding is reinforced by the fact that in the overall sample, women are overrepresented as heads-of-household of families, and

the family shelter system more effectively supports connecting providers to clients after referral. Logit analysis of the entire sample predicts that 69 women will be declined for every 100 men (0.69*** odds ratio) for this reason.

Providers expressed concerns about the difficulty in contacting clients after referral, especially single adult populations that are not often remaining in shelter. Most providers agree that their goal is to intake clients into their program a week after making first contact. However, the sample of HMIS data analyzed for this report clearly shows this does not always happen. When a client doesn't have consistent access to a mobile phone or email service, it is a significant challenge for providers to reach them. Providers often rely on data in HMIS which indicates the shelter(s) the client has stayed in, so that they might be able to contact the client through staff. However, because single adults are not likely to stay in a single shelter long-term, some providers described this strategy as "hit and miss."

Conversely, providers noted that clients in the family system were much easier to contact, and therefore easier to house. Providers attributed this to the shelter requirements for families, which in some cases require them to be "in shelter" up to the day they are referred. This guarantees clients have up to date contact information and staff who can ascertain their whereabouts. While providers suggested this contact leads to better outcomes, some were concerned about families' ability to maintain their placement in shelter. If families are diverted from shelter for any reason, their housing opportunity through CES vanishes. One provider said this winnowing of clients in the family system may exclude those with the highest need from CES, going directly against its stated purpose.

Throughout interviews, providers were reluctant to consider "Client Unreachable" as an indication of decline. Because the provider is not at fault and the decline is not in defiance of CES guidelines, a provider is more likely to consider a lack of communication as a "no-fault" resolution than a decline. In rare instances, some providers suggested that a client being unreachable was an indication of a missed opportunity by assessors or the county, who may have been able to help connect a client after a referral. If a client is referred to an organization and contact can't be established within two weeks, most will, in one provider's words, "...just turn it back around to the county and tell them we couldn't get into contact. Then they send us someone else." When asked what percent of clients a provider thinks might be declined in a given month, many providers would suggest that they simply "do not reject referrals." Ultimately, providers were much more likely to see declined referrals as neither the fault of clients nor providers, and instead perhaps an inadequacy of the referral process.

Client found housing, self-resolved homelessness

Of the 1,335 referral declines analyzed, 7 percent were due to clients self-resolving. Providers did report that on occasion clients were able to find housing on their own, though it was often precarious, such as "doubling up" with family or friends. These sentiments are echoed throughout provider interviews on the issue of clients self-resolving their homelessness. One provider shared a positive sentiment about self-resolutions, saying "...and I mean that's great, right? That's ultimately better that they found some housing and didn't need our services." Some providers suggested that encouraging clients to be on the lookout for opportunities to self-resolve, especially during potentially lengthy housing searches, was not uncommon. There were no statistically significant findings along key demographics or population types regarding client referral outcomes in this category.

Referral Decline: After Intake Begins

After contact is made with a client, they are brought in for a meeting with the provider to confirm eligibility and discuss the specifics of the housing services being offered. Clients can still be declined at this stage or refuse services once they learn more about the service they are being offered.

Refusal of service

The second most common reason for reported referral declines was because the client refused service (19 percent). Across all demographics, families were less likely to refuse service than single adults on average (0.27^{***} odds ratio). At the same time women were 1.5 times more likely to refuse service compared to men (1.6^{***} odds ratio). These findings are somewhat contradictory, and it is unclear what is driving the distinction between the behavior of female and family clients who so often are one and the same. Along racial lines, Native Americans and Black or African American clients were less likely to refuse service than White clients (0.58^{**} and 0.71^{**} odds ratios respectively), indicating that these groups seem more likely to take whatever housing they are offered through CES.

In considering cases where clients refused service, providers shared similar sentiments to being unable to contact a client; because the provider wasn't necessarily at fault and CES guidelines were still being followed, providers would not describe these occurrences as declined referrals. Instead, many providers responded to questions about client preference with the opinion that most clients who refuse services do so only because they did not adequately understand the program to which they were referred. For example, multiple RRH providers noted that many clients will come to intake meetings with an understanding that they're getting into a "30-percenter," meaning a program that requires clients to pay 30 percent of their income towards rent. While some programs in CES do operate this way, others may require 50 to 75 percent of a client's income for housing. In those cases, clients may refuse service simply because they don't believe they can afford a program which might entail them spending more money: "It's not that they don't want housing, it's that they don't want the housing we can offer them." Other providers suggested the type of housing can influence client decisions. One PSH provider told us their units are Single Room Occupancy (SRO), which are dormitory-style units with communal bath and kitchen facilities. That provider told us multiple clients were hoping to have a one-bedroom apartment and decided to decline the SRO housing offer. In another case, a client refused housing because of the neighborhood the unit was in, due to previously having difficulty avoiding criminal activity in that area.

Ineligibility

Ineligibility for services comprised 18 percent of the reasons for decline, the third most common reason. Among population types and demographics, notable disparities were found in the likelihood of referral decline for this reason. Single adult, Hispanic/Latinx, and Black or African American clients were more than twice as likely to be deemed *ineligible* (1.87^{***} and 2.1^{**} odds ratios) compared to youth or White clients, while those with disabilities were more likely to be *eligible* compared to those without. It is important to note that eligibility can change mid-process in CE for many clients. For example, disability status can change as a client is awaiting a referral, and single adult clients who become a family client under county definitions may be declined by a provider who exclusively serves single adult clients. Ineligibility due to income restrictions is another common reason for decline, in the instance when someone's employment status changes.

In interviews, providers across all types consistently spoke to issues surrounding client eligibility verification. Most providers require two types of documents to grant eligibility for their programs: homelessness history and income verification, such as pay stubs or bank statements. Some require further information, such as a doctor's signature confirming disability status, state identification, or social security cards. No matter the type of documentation required, providers suggest that securing these required documents and scheduling multiple meetings could add up to a month or more in the intake process. Clients typically come to an intake meeting with a provider with no clear expectations of what is required for eligibility or what kind of services they are being offered. A month-long wait to secure documents is rare, but the more documents that are required, the longer the process can take. If the data in the client's file doesn't match with what the client brings to the first intake meeting, time can be wasted trying to find documentation the provider didn't know was needed or sending staff after unnecessary verifications. This can also lead to clients being ineligible for the program they have been referred to, through no fault of their own. One provider described securing disability confirmation from a client. The client could either get the doctor's signature themselves, or they could grant the provider third-party authorization to contact the doctor on behalf of the client. The provider suggested this process was more reliable in securing the signature, but it may add up to a week or more to the intake process. In these cases, disability documentation, long-term homelessness verification, or income verification can present delays to accessing housing.

"The fundamental issue is that people can tell assessors whatever they want and there is no verification or documentation at that level. The verification and documentation generally don't happen until they have already been referred to a housing program. It can take a month to six weeks to get all their ducks in a row if they don't have a state ID or social security card, which are both required. But, they have been waiting on that coordinated entry system list for weeks or more than two months... why isn't somebody working with them in that interim period to obtain all their vital documents, do the long term homeless verification and make sure that when they get referred, they are ready to move in."

Consistently, providers identified the time that a client waits on the priority list before referral as a "missed opportunity" to maximize efficiency, and an area where the process could be accelerated. If a client could be in contact with a caseworker, county representative, or shelter staff, the odds of that client staying in contact and being prepared to collect appropriate documentation would improve.

Another eligibility challenge is a lack of compatibility between the client and the provider's organization. For example, some programs are specifically tailored for clients experiencing long-term homelessness, but clients who don't fit into that categorization are referred anyway. These incompatibilities waste a significant amount of time for both clients and providers as they try to rectify discrepancies between HMIS data available to providers and the client's true background. Perhaps the most striking example came from a provider that does not have accessible units for clients with physical disabilities; clients referred to this program must be able to climb stairs. On multiple occasions, clients with physical disabilities or mobility challenges have been referred, only to be declined at the first intake meeting. In situations where a client either doesn't claim to have a disability or an assessment doesn't adequately describe the extent of their mobility issues, clients and providers could waste a significant amount of time only to decline a client and create another unsuccessful referral.

“Other” reason for decline

Nine percent of the sample analyzed were declined for a reason listed as “other.” Though much about this category of referral decline is unknown, and therefore cannot be thoroughly analyzed, clients who self-report disabilities (2.3*** odds ratio), and those who were deemed chronically homeless were nearly twice as likely to be declined for “other” reasons (1.8** odds ratio). Ultimately, it is unclear what justification providers have for marking a decline as “other.” This creates serious concerns for both the client and the county. First, clients are not served by vague, ambiguous reasons for decline if they are referred again and the original problem isn’t easily understood by those who might work with them in the future. Second, this creates concerns for the county (and future researchers) when attempting to understand whether clients are being declined for legitimate reasons. It is possible that providers may feel that HMIS does not have the ability to specifically describe each of the various scenarios that might lead to decline.

Providers’ Recommendations for Referral Stage

Providers shared some recommendations for improving the process and accuracy of referrals to successfully housing the referrals. Many suggest that quality and consistency of assessment should be ensured by document verification prior to making a referral. If documents could be collected and verified during the waiting period while on the priority list, a client could move in much sooner once they receive a referral. It is important that clear expectations are communicated to the people on the priority list regarding the type of housing to which they will be referred. Including contact information for a shelter worker or caseworker who has worked with a client already could improve the time to contact a client significantly. Per county guidelines, providers must wait for two-weeks before declining a referral due to lack of communication. However, in certain cases this two-week time frame can be excessive if a client is known to be no longer eligible or available for services. The providers also suggested that as soon as referrals are made, families or individuals should also be notified that they have a referral, perhaps by the shelter employee who may have contact with them, even if they are not staying in shelter now.

Providers also reported that the intake process would be made more efficient if additional information about the client could be made available to them in HMIS before they received the referral. This stage requires assessment and document verification related to income verification, housing history, and rental history, to ensure that referrals meet the eligibility requirement for the housing type. However, clients are usually not well-aware of these requirements before meeting with a provider. If someone in contact with the client, such as the assessor, shelter staff, or county case manager, could help prepare them in advance for these requirements, it could greatly reduce the time it takes to complete the intake process. Success rates and the speed at which clients move through CES could be improved through small changes in how individuals and families are tracked through HMIS, and in ensuring this data is available to those working at each step of the CE process. Centralizing information and uploading all the required documentation into HMIS would lower the work burden for providers and streamline the process.

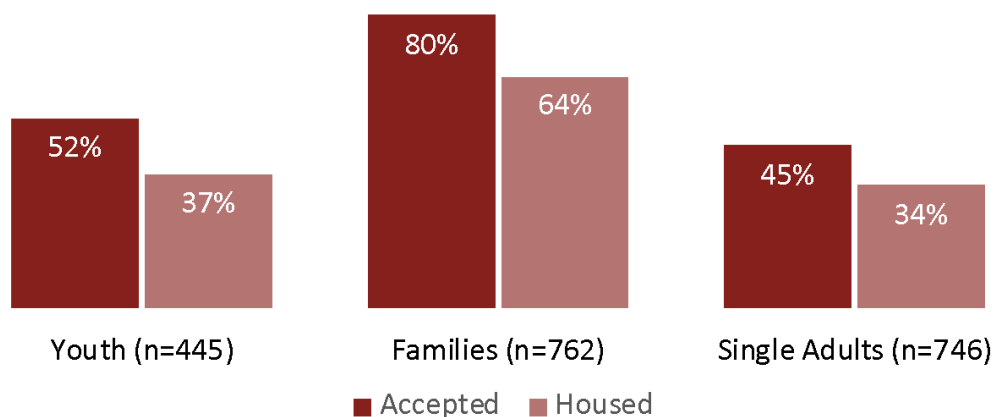
“The intake process is some-what efficient, but if there were some ways to get documentation before the intake meeting for the first time, like something that’s in HMIS, that would speed up the process. Perhaps assessors could get this documentation and upload them on HMIS.”

Referral Acceptance and Housing

The reasons for referral decline shed important light on some of the dynamics between clients and housing providers during the intake period that might lead to a lack of successful placement in housing. In order to examine the statistically significant differences in referral acceptance and housing placement rates between different demographic groups, the rates and regression-adjusted likelihood of success are examined together. In doing so, we gain a better understanding of the extent to which demographic disparities shape the success of individuals and families as they move through intake and into housing.

Referrals tend to end in an acceptance most frequently for families; 80 percent of families who were referred were accepted by a housing provider. In stark contrast, youth are accepted only 52 percent of the time and single adults, only 45 percent of the time (see *Figure 11* below). As discussed above, there are many reasons why a referral might be declined and the perceptions of decline from the perspective of providers, the county, and clients themselves might be quite different.

Figure 11: Percent of Referrals Accepted and Housed by Providers



Of those referred, 64 percent of families are ultimately placed into housing, followed by 37 percent of youth, and only 34 percent of single adults (see *Figure 11* above). Put differently, approximately 15 percent of families, 21 percent of single adults and 29 percent of youth whose referral was accepted, fail to successfully access housing. Numerous factors might shape why a client would not be placed into housing successfully at this stage.

Clients with past felonies or evictions on their record, especially if they occurred within the last two or three years, find more barriers to housing, as do clients with poor credit histories. These barriers are particularly impactful in RRH programs, as they work with market-rate units that typically have much stricter screening procedures. Multiple providers stressed how important strong relationships with landlords are to securing housing. Strong relationships can lead to better housing outcomes, as those landlords tend to be understanding and flexible with clients and housing providers, which can lead to waived requirements and streamlined processes.

Financial assurances that clients receive by being in a program have also proven to be helpful with securing an agreement with a landlord. If the security deposit, and/or first and last month's rent are provided, landlords are more likely to house the client. Similarly, one provider described an arrangement with a landlord in which if the organization provided the client's housing history, the landlord would waive their application fee. This process also saved a bit of time, as the landlord did not have to track down that report. Some of the providers suggested that the county should generate a landlord risk mitigation fund to provide insurance for any losses/damages associated with homeless-designated housing. If landlords could have some insurance against housing what they perceive to be riskier clients, it could end some of the concerns of the landlords and create more spaces for housing options.

While factors such as landlord relationships impact many clients seeking to access housing, these effects differ across demographic groups. To understand the extent to which demographic disparities exist in referral outcomes and housing placements, we examined rates of acceptance and housing across the key demographic factors of race, gender, disability status, and chronicity. Additionally, logit analysis was used to uncover statistically significant differences between having a referral accepted and going on to access housing within two months for each group. One housing provider interviewed for this report expressed that two months is a typical amount of time for a client to be placed into housing after they receive the referral. Based on this benchmark, HMIS housing data was utilized to uncover the likelihood that key demographic groups will be housed within a two-month time period, using odds ratios to explore potential disparities. Key results are examined for youth, families and single adults below.

Youth

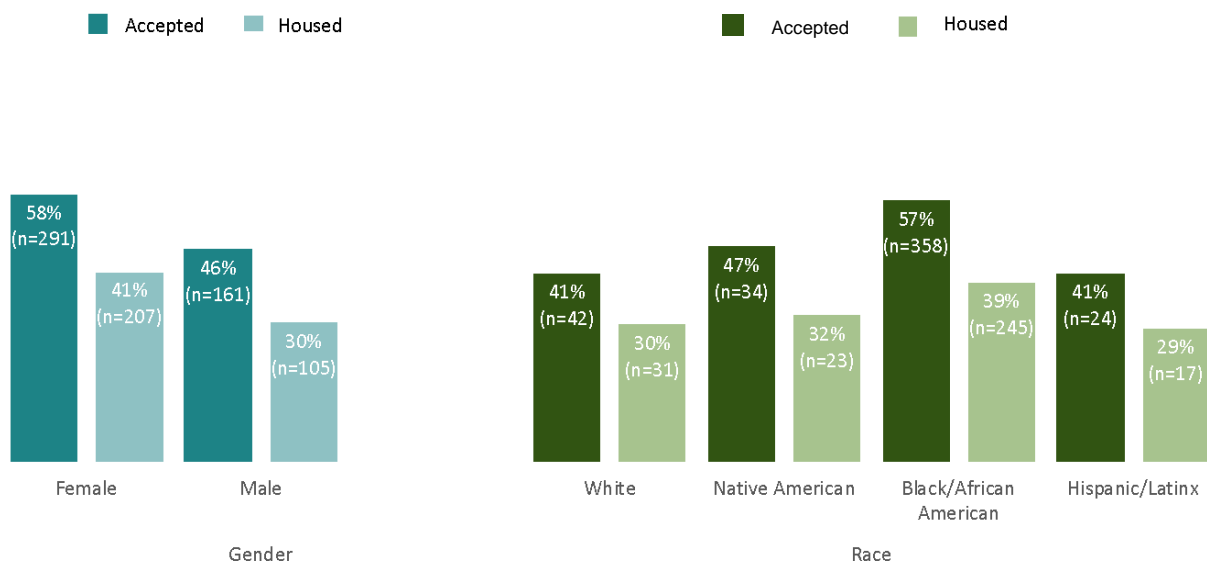
Acceptance Rates

When examining differences in referral acceptance rate by race, Black or African American youth were disproportionately more likely to be accepted by providers than their White counterparts (see *Figure 12* below). Logit analysis controlling for all demographic factors confirms that Black or African American youth had a referral acceptance rate of nearly twice their White counterparts, with an odds ratio of 1.89 (Appendix B: Table 2).³⁷ CES seems to be performing well in its ability to move Black youth from referrals into acceptances.

When looking at gender, female youth had higher referral acceptance rates than male youth, at 58 percent compared to 46 percent (see *Figure 12* below). Logit results indicate that females in this population were accepted 1.5 times more often than males (Appendix B: Table 2). CES seems to be serving young women more effectively than young men. No other demographic differences in the rate of acceptance were found to be statistically significant.

³⁷ All Logit Analysis regarding likelihood of referral acceptance, housing placement, return to shelter, and having multiple referrals can be found in Appendix B: Tables 1-4

Figure 12: Youth--Percent of Referrals Accepted and Housed by Gender and Race



* Figure displays demographic categories found to be statistically significant in logit model

Housing Rates

In examining differential rates of housing placement, Black and African American youth no longer have a statistically significant advantage compared to their peers of other races, although rates of housing continue to be slightly higher for this group (see *Figure 12* above).

In terms of gender, the comparatively positive outcomes that young women experience extend into their rates of housing. While only 41 percent of young women's referrals result in a housing placement, this is significantly better than the 30 percent of young men who end up being housed (see *Figure 12* above). Logit analysis confirmed that female youth were more likely to be housed within a two-month period (1.79 odds ratio) compared to male youth (*Appendix B: Table 4*).

Overall youth referral acceptance and housing rate were significantly lower than those of families, yet higher than for single adults. Within the youth population, it seems that young women tend to have more positive outcomes than young men. Black or African American youth seem to do better in referral acceptance, but their gains do not ultimately result in statistically significantly greater likelihood of housing placement.

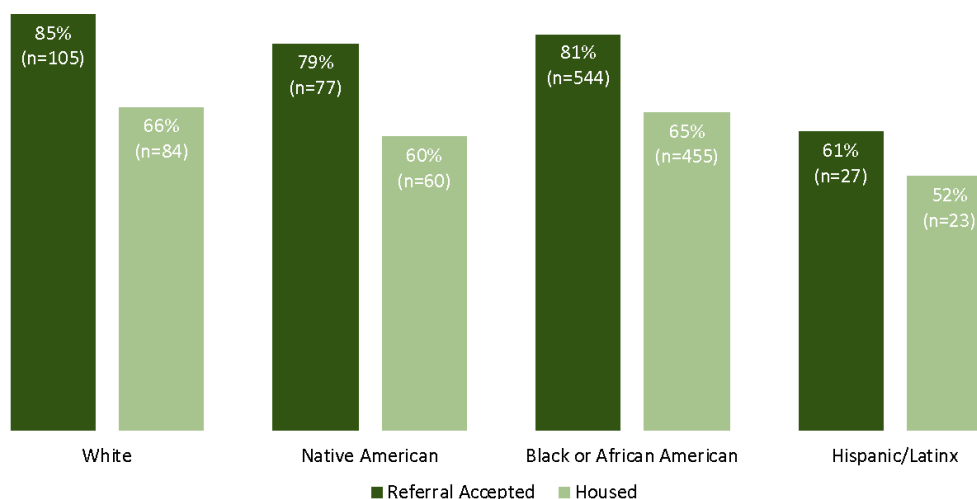
Families

Acceptance Rates

Across demographic factors, the likelihood of referral acceptance for families was four times greater than that of single adults, at a near 4:1 odds ratio. Though outcomes for families overall were promising, Hispanic/Latinx families had referrals accepted 61% of the time compared to White families, whose referrals were accepted 85% of the time (see *Figure 13* below). Logit analysis confirmed a significant disparity when controlling for other variables; only 33 Hispanic/Latinx families on average were accepted after referral in CES for every 100 White

families (0.33*** odds ratio) (Appendix C: Table 3). While the sample size of Hispanic or Latinx families is relatively small, it indicates possible dynamics of the intake process that lead to a lower acceptance rate for this population. There were no other significant findings across demographic groups. It appears that rates of acceptance are generally high for all family groups, however Hispanic/Latinx families do not tend to be accepted as often as demographic groups.

Figure 13: Families--Percent of Referrals Accepted and Housed by Race



* Figure displays demographic categories found to be statistically significant in logit model

Housing Rates

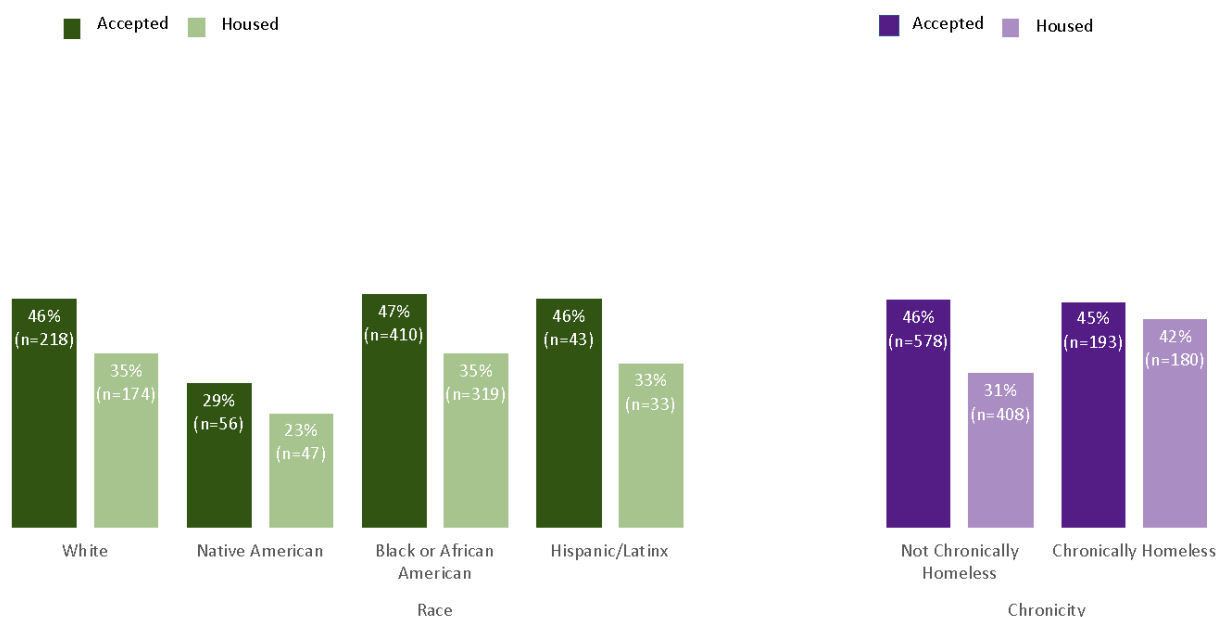
Similarly, when it comes to rates of housing, families are disproportionately successful compared to other groups. Families are more likely to be housed within a two-month time period compared to single adults with a 4:1 odds ratio. However, one notable exception exists for Native American families who were housed only 52% of the time in comparison to White families who were housed 66% of the time (see *Figure 13 above*). Logit analysis confirmed that Native families were less than half as likely to be housed in a two-month time period (0.475*** odds ratio) (Appendix C: Table 5). Interestingly, the statistical significance of the disparity for Hispanic/Latinx families does not persist into rates of housing. In the intake stage, Native American families seem to be accepted at comparable rates while Hispanic/Latinx families struggle. However, in housing their outcomes are switched with Native American families struggling to receive successful placements after acceptance. Overall the family system seems to be the most successful at moving clients from homelessness to housing. Native American and Hispanic or Latinx families are the only groups who seem to experience disproportionately negative outcomes in the family system.

Single Adults

Acceptance Rates

Single adults had the overall lowest rates of acceptance by housing providers. Additionally, within the single adult population, disparities existed across several demographic groups, shaping the likelihood of positive outcomes for these clients. When looking at race, 46 percent of White single adults had their referral accepted, while only 29 percent of Native American clients were accepted (see *Figure 14* below). Native American single adults were significantly less likely to receive an accepted referral than their White counterparts, at nearly half the rate with an odds ratio of 0.521*** (Appendix C: Table 4). No significance was found for other key demographic groups, however these disparate outcomes for Native Americans may be cause for some concern.

Figure 14: Single Adults--Percent of Referrals Accepted and Housed by Race and Chronicity



* *Figure displays demographic categories found to be statistically significant in logit model*

Housing Rates

When it came to rates of housing, the disparity experienced by Native American single adults persisted, with only 23 percent of Native American clients accessing housing compared to 35 percent of White clients (*Figure 14* above). Logit analysis found Native Americans were a little more than a third as likely to end up being housed in a two-month period compared to White single adults (0.38*** odds ratio) (Appendix C: Table 5). Through both the stages of intake and placement into housing, Native American single adults seem to have worse outcomes.

One additional finding of significance was the increased rate of access to housing for single adults experiencing chronic homelessness. Logit results showed that single adults who were chronically homeless end up being statistically significantly more likely to end up housed within two months than their single adult peers who were not chronically homeless (1.4*** odds ratio) (Appendix C: Table 5). No other differences in housing rates by race were shown to be statistically significant after controlling for other demographic characteristics. Overall, the single adult system seems to produce the worst outcomes for clients. Of concern is the persistent disparity in the acceptance and housing placement of Native American single adults who experience the lowest rates of success of any demographic group.

Summary

Success of Placements

Among clients who were referred to a housing provider in the HMIS data provided for analysis, only 56 percent had their referral accepted, and only 46 percent were ultimately placed into housing. Of the total sample, approximately 1,800 clients accessed housing in the 2017-2019 period.

While providers attempt to make contact and intake all clients referred to their organizations, there are several reasons why clients do not successfully continue in CES through the intake period. Clients being unreachable, self-resolving, refusing services, or being ineligible were some of the major reasons why a client may not persist in CES through the intake stage. There is a disconnect at this stage between the way the county collects data on these reasons in HMIS and provider perceptions. While the county sees all reasons as a “decline” of services, providers expressed only having control over certain reasons that get listed as a decline.

It seems that at this stage, there are a variety of barriers to successful outcomes for clients that are not sufficiently addressed by the county or providers to move people into housing. Providers indicated a need for increased support to contact clients and verify their eligibility for services. They indicated that this kind of support might come before a client is referred to their organization.

The success that youth, families, and single adults experience in referral acceptance and access to housing varies widely across population type. For both acceptance and housing, families are much more likely to achieve positive outcomes than youth or single adults; youth perform slightly better than single adults who have the lowest rates of positive outcomes at both stages.

These dynamics may be in part due to the ease with which housing providers are able to contact families during the intake process. Whereas families are required to remain in county shelters while on the priority list, single adults can be much harder to contact, possibly resulting in lower rates of success in acceptance and housing placement. At the same time, the requirements that families stay in shelter while waiting for a referral may create additional barriers to accessing CES in the first place and may not be replicable for the single adult system.

Demographic Disparities

For some demographic groups, CES seems to be performing equitably, with no disparities noted in most demographic categories related to success of referral acceptance or housing placement. However, some key demographic groups seem to struggle disproportionately to achieve successful outcomes at certain points in the system.

During intake, Hispanic/Latinx and Black or African American clients were less likely to be eligible for the services they were referred for. At the same time, Native American and Black or African American clients were less likely to refuse any service offered. This seems to indicate that people of color and indigenous communities may be experiencing more severe misalignment between their needs and the housing options available to them. At the same time, these groups seem more likely to take any housing offered. The county might target efforts at better understanding the housing needs of BIPOC communities entering CES and meeting

those needs with appropriate referrals to eliminate the increased incidence of decline for these groups during intake.

During intake, clients with disabilities were more likely to be eligible for services they received but were highly more likely to be declined for “other” unspecified reasons. More needs to be understood about why those with disabilities tend to be disproportionately declined for unspecified reasons on the provider’s part.

For youth, young men are disproportionately likely to have negative outcomes for both referral acceptance and subsequent placement into housing. More must be understood about the reasons why young men are less successful as they move through CES. While families have significantly more successful outcomes than other groups, Hispanic/Latinx families are disproportionately less likely to have their referrals accepted and Native American families are disproportionately less likely to be placed in housing after being accepted. Racial disparities exist at distinct periods of CES for these two groups likely representing unique challenges for these communities. Despite the overall low rates of success for single adults, those who are chronically homeless seem more likely to access successful housing placements after referral. On the other hand, Native American single adults are less likely to find success in either referral acceptance or housing representing the worst outcomes of any demographic group in CES.

Unsuccessful Housing: Shelter Re-entry & Multiple Referrals

Once individuals and families access housing through CES, little is known about the stability or permanence of the housing placement. The HMIS data set provided for this report did not track specific reasons a client may not remain stably housed. Providers noted that individuals and families face difficulties keeping up with housing payments or abiding by tenant rules, sometimes facing eviction as a result. HMIS data available to providers does not always track these reasons and is often missing a date of exit. Even in cases where a client may exit a housing placement for “positive reasons” (no longer needing assistance, finding more affordable housing, moving in with family members/partners), data available in HMIS is not particularly sophisticated or robust.

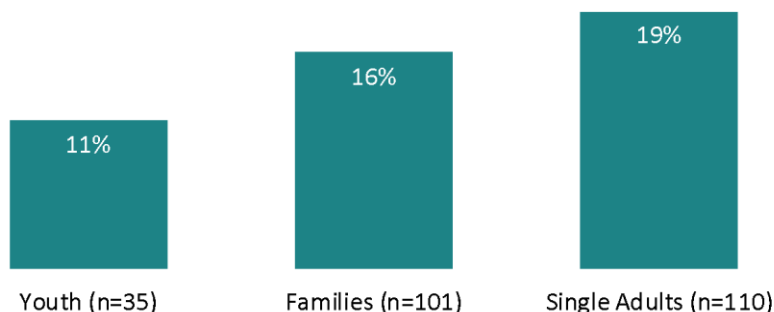
Shelter Re-Entry After Housing

One measure of outcomes that we were able to assess is whether a client returned to shelter after being housed through CES. While not much is known about how or why individuals and families experience a return to shelter after being housed, our research was able to analyze how often this happens for households in the sample.

Overall, 11 percent of youth, 16 percent of families, and 19 percent of single adults in the sample who successfully accessed housing went on to re-enter shelter (*Figure 15*).³⁸ A logit model confirmed that youth were significantly less likely to return to shelter (0.62** odds ratio) (Appendix C: Table 1) than single adults, who were of greatest concern across population types. Additional support may be needed for these individuals to remain permanently housed after accessing CES.

³⁸ All those who re-entered shelter after a housing date (n=277)

Figure 15: Percent of Population Group who Were Housed Then Subsequently Returned to Shelter



Research also examined the extent to which differences existed in the rate of return to shelter after housing for different demographic groups in the sample. Primarily, it found that rates were comparable across race, gender, disability and chronicity with the exception of some differences for those with very small sample sizes. Further logit analysis did not reveal any significant findings in the differences in rate of return to shelter. It should be noted that the lack of disparity for any group may be due in part to the fact that this measure examines those who returned to shelter after a *successful* housing placement. As explored above, the likelihood of placement in housing is in fact related to client demographics.

Providers had limited insight into the circumstances surrounding clients exiting housing, whether back to homelessness or to alternative housing. Interviews revealed consistent stories from providers about their experiences with clients leaving housing; one common reason for exiting housing was to live with either family or a domestic partner. In these instances, clients were typically communicative with providers, with some providers continuing to support the clients with programming in their new living arrangements. One provider suggested that when clients leave for reasons like moving in with family or finding affordable market housing, they are much more likely to stay in touch so they can receive their security deposit. How often these clients return to shelter after a later housing situation proves unsuccessful, is unknown.

Providers suggested that clients with many barriers (disability, criminal history, etc.) are much more likely to return to the shelter system, as well as those who struggled to adhere to the terms of their lease. Providers noted that the most common reasons for a client to leave housing with little to no notice were a failure to pay, lack of adherence to the terms of the lease regarding visitors, or they had some sort of altercation with their landlord. Providers believe that clients who either leave housing through a mutual agreement with a landlord to terminate the lease or are evicted for failure to pay rent make up the majority of those who return to shelter. Typically, providers described mutual agreements to terminate the lease as a way for clients to avoid an eviction on their record while still allowing a landlord to remove a client who has either broken the terms of their lease or cannot pay their portion of rent. Under circumstances where there was some form of conflict between a client and a landlord, providers are likely to lose contact with clients, which makes understanding where clients go more difficult. As housing prices increase, any loss of income can quickly escalate into more evictions like these.

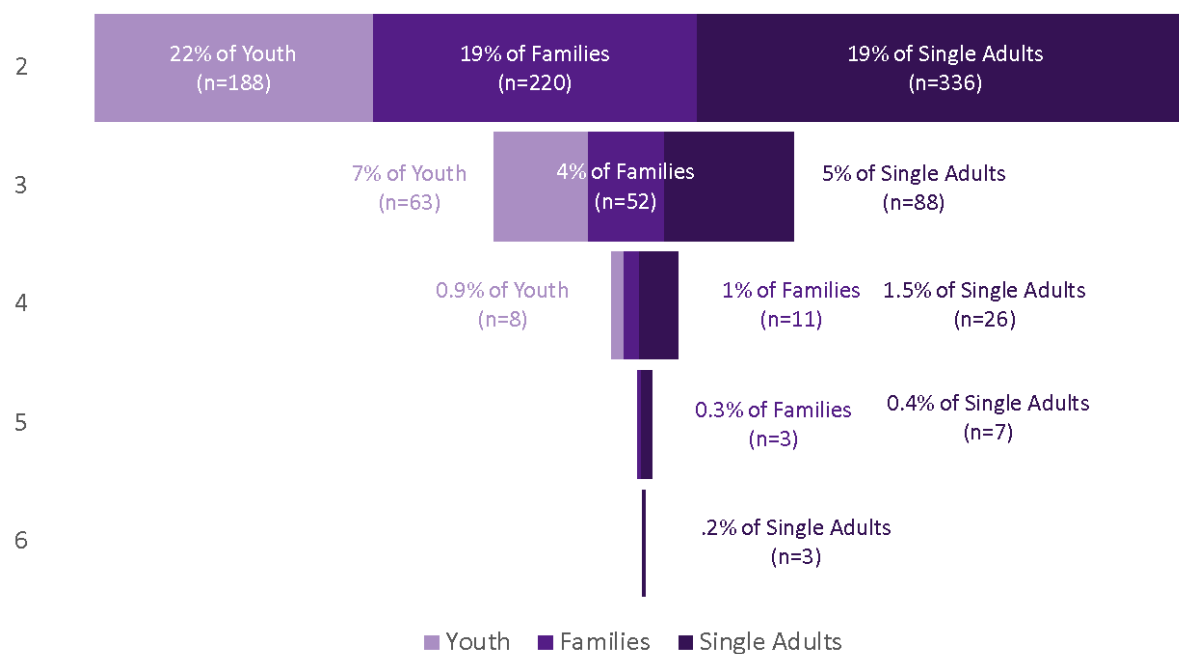
In interviews with providers, it also became apparent how important mental health is in long term housing outcomes. Clients suffering from mental illnesses face significant barriers across sectors, making stability in housing and employment much more challenging. According to

providers, these are the clients that are likely to return to shelter if housing is lost but are less likely to be communicative about their challenges while still in housing.

Multiple Referrals: Rates

As outlined in earlier findings, not all client referrals resulted in successful housing placements. Another way to explore the cyclical nature of CES is analyzing clients who have multiple referrals in the data set. These individuals might not show up in the returned to shelter post housing analysis above if they were not successfully housed. We analyzed the number of referrals for individuals and families across population types and key demographic variables for the two-year period. Although the majority of the 3,775 entries that included referral dates and outcomes in this sample had only one referral on record, many clients were referred to CE multiple times. Exploring the demographic differences in these groups is important to better understand why some clients are cycling through CES multiple times, while others are successfully housed after one referral as is intended (see *Figure 16*).

Figure 16: Percent of Population Group with Multiple Referrals



Youth

Thirty percent of youth had more than one referral on record, with a maximum referral count of 4.³⁹ Although no significant racial or gender disparities were readily apparent in logit analysis, youth with self-identified disabilities were found to be 1.5** times more likely to have multiple referrals compared to youths without on average (Appendix C: Table 2). While youth were more likely than single adults to have a referral accepted and to be placed in housing, they were the most likely of any population type to have multiple referrals. This finding suggests a higher incidence of failed attempts at accessing housing for this group.

³⁹ Total population of youth in this sample n=871

Families

In this sample, 25 percent of families had more than one referral on record, fewer overall than either comparative population group.⁴⁰ At most, families were referred 5 times in the two-year period analyzed. Families across racial and gender lines were equally likely to receive multiple referrals, however families with a reported disability in the household and those who are deemed chronically homeless were 1.5*** to 2.0*** times more likely to have multiple referrals than their peers without disability or chronicity of homelessness. While having a family member with a disability did not significantly affect the rates of successful referral acceptance or housing placement, it does seem to suggest a higher likelihood of failed attempts at housing through CES for families.

Single Adults

For single adults, 26 percent received more than one referral, with the highest number of maximum referrals at 6.⁴¹ Though less than one percent of single adults received six referrals in the two-year period reported, the number of times this population cycles through CES is cause for concern. Disparate outcomes in referral counts along racial lines were uncovered in logit analysis, where Native American single adults are found to be 1.7*** times more likely to have multiple referrals than White single adults on average. Further analysis also shows that single adults with disabilities were 1.7*** times more likely to have multiple referrals than those without disabilities, and those who were chronically homeless were 1.9*** times more likely to have multiple referrals compared to their non-chronically homeless peers. It seems that the racial disparities that Native Americans face in accessing successful referrals and housing placements persist when we examine unsuccessful housing attempts and multiple referrals through CES.

Multiple Referrals: Outcomes

Multiple referrals after unsuccessful housing placement for clients in the data set led to increasingly poor outcomes and reduced likelihood of future housing security. Utilizing the data set, we were able to uncover some of the outcomes for clients who received multiple referrals within the two-year time period.⁴² While we cannot assume client experiences as they cycled through CE multiple times, we were able to analyze some information concerning the likelihood that an individual or family would ultimately access housing as the number of referrals increased. Findings suggest that as clients cycle through CE multiple times, their likelihood of successfully accessing housing tends to decrease.

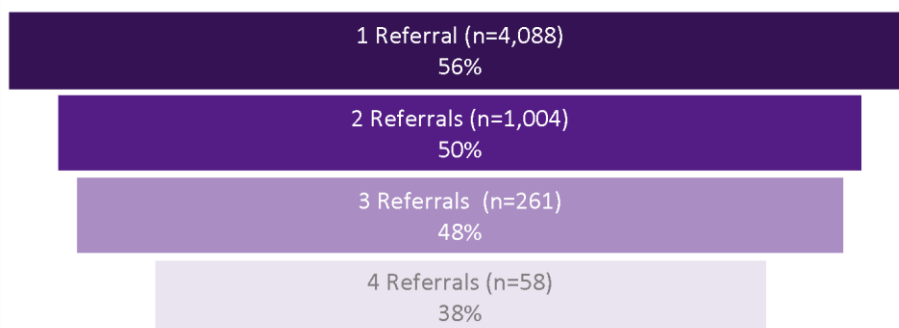
About 1,000 clients received more than one referral to a housing provider during this two-year time period. Clients with multiple referrals were less likely to have each subsequent referral accepted by a provider. For these 1,000 individuals and families, their first referral was accepted by a provider 56 percent of the time (see *Figure 17* below). A client's second referral is only accepted 50 percent of the time, the third referral 48 percent of the time, and the fourth referral only 38 percent of the time. This is concerning given the county's emphasis on ending chronic homelessness, and points to the need to better understand the reasons why individuals and families cycle through CE without successfully accessing housing.

⁴⁰ Total population of families in this sample n=1,748

⁴¹ Total population of single adults in this sample n=1,156

⁴² While our sample includes demographic information for only 4,376 individuals, we had access to additional referrals not tied to demographics in the two-year time period.

Figure 17: Acceptance Rates Decline with Multiple Referrals



Summary

Success of Placements

Single adults were significantly more likely to return to shelter after being placed in housing through CES, but not enough is known about the specific challenges that single adults face in housing that result in its lack of permanence. Youth fall in between families and single adults in their chances for referral acceptance but were found to be the most likely to have multiple referrals, which suggests that their accepted referrals may fail to meet longer term needs, especially for youth with disabilities.

Demographic Disparities

While there were no significant differences in return to shelter based on race, gender, disability, or chronicity, these factors have been shown to affect a household's likelihood of accessing housing in the first place and their chances of having multiple referrals.

Not only were Native American single adults less likely to be successfully housed than their White peers, this group was twice as likely to have multiple referrals in CES. This finding indicates that CES is struggling to house and refer this subgroup appropriately to providers. The county should focus on improving the longevity of housing solutions by reducing the count of multiple referrals for Native American single adults, as well as single adults with disabilities and those deemed chronically homeless. These clients appeared to have disparate outcomes in many steps of the CE process, including rates of referral acceptance and housing placement. When housing placement occurs, data suggests placement is unsuccessful in the long run. These subgroups are deserving of additional attention to understand why these disparities persist throughout CES.

Providers did remark that increased barriers during intake were likely to correlate with increased barriers to remaining in housing long-term. Providers suggested that there are two main factors leading to leaving housing and returning to shelter: mental health and loss of income. These two factors may work in tandem to destabilize individuals and families in housing, forcing them back into the shelter system.

Timeliness of CES

To better understand the timeliness of clients' movements from shelter entry through to successful placement into housing, we calculated median times for each stage of CES across different demographic groups.⁴³ HMIS data provided for this report tracked three distinct time periods in a client's journey through CES: the time from their entry to shelter until they are put on the priority list, entry to the priority list to when they are referred to a housing provider, and from referral to successful housing. Because the sample was constructed for the purpose of analyzing the stage of CES between when a client receives a referral to when they were housed, the bulk of our analysis focuses on this period of time. However, additional analysis was conducted on earlier time periods and some broad findings are included here.

The median and quartiles for each time period (as opposed to the mean) were utilized to account for extreme outliers in the data (see *Table 3* below). These outliers may be explained by HMIS inaccuracies, or could accurately capture some client experiences with CE, however for the sake of robust analysis the median experience is reported using the largest sample possible. Each measure used client IDs in the HMIS data provided with entries for each time period in the analysis.

Table 3: The length of time in each period can vary widely

# of Days	Shelter Entry to Priority List (n=1,423)	Priority List to Referral (n=3,631)	Referral to Housed Date (n=1,492)
Minimum	0	0	0
25th Percentile	7	10	8
Median	16	37	34
75th Percentile	34	158	65
Maximum	638	929	826

Shelter Entry to Priority List

Overall, clients in the sample had a median stay in shelter of 16 days before being entered to the priority list, though there was wide variation among demographic groups (see *Table 3* above). Although this measure is outside of the scope of this report, it is worth noting that for those who were entered into the CES priority list in this sample, the county's goal of assessment within two weeks from shelter entry is nearly being met (Appendix B: *Table 1*). This may be an incomplete picture of the first stage of CES, as the majority of the sample accessed the priority

⁴³ In order to preserve the largest possible sample size in each period, we calculated time for all households that had a date entered in the beginning and ending respective date of the period (e.g. shelter entry and entry to the priority list). Because not all households have a date entered for each time period, the sample size differs in each period presented.

list and received a referral. More research could seek to understand the demographic disparities that exist for groups before they are entered onto the priority list.

Priority List to Referral

After clients in this sample were entered into the CES priority list, they spent a median time of 37 days waiting for a referral to a housing provider (see *Table 3* above). Again, the amount of time spent waiting for a referral varied greatly between demographic groups in the sample (Appendix B: *Table 2*). Because the data appears to include only those who were referred in the two-year time period analyzed, this measure can only be used to express timeliness of this step for those that were successfully referred. The long wait times experienced by clients pending a referral may point to a lack of frequent vacancies in housing that meets the needs of those on the priority list. This suggests confirmation of the well-known lack of affordable housing in the Twin Cities region. Lack of housing may factor significantly into client wait times in CES but is not the focus of this report.

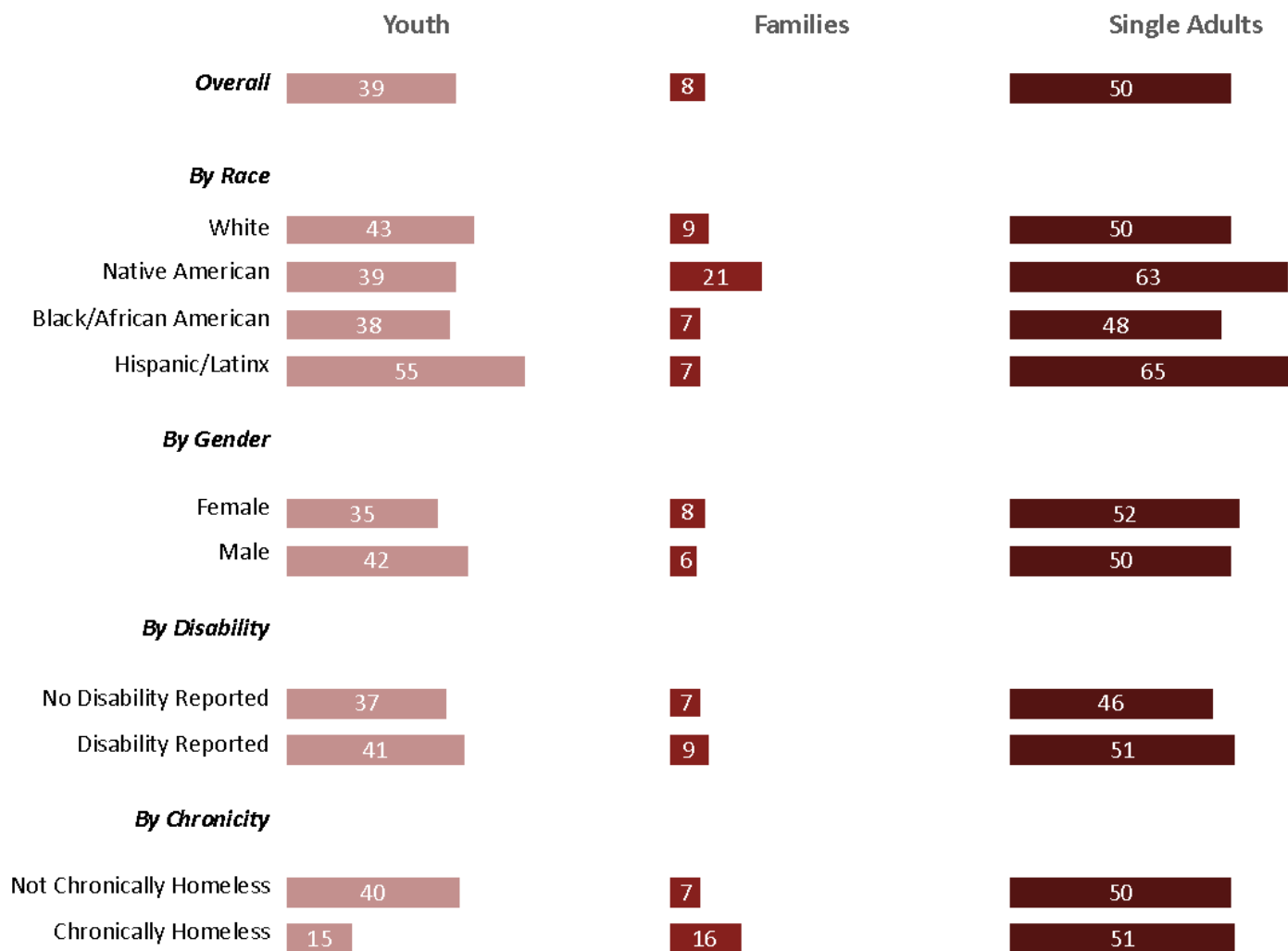
Referral to Housed Date

The time clients spent in the intake and placement process (between a referral and housing) was a median time of 34 days (see *Table 3* above). The sample examined in this period only captures those who were accepted by a housing provider, and who subsequently accessed housing through CES.

Interviews with providers suggested various reasons why the time a client waits for a housing placement after a referral may vary, including findings on the difficulty of the intake process for some population types and demographic groups. Providers emphasized that delays in securing eligibility documentation was one of the most significant barriers of the intake process and lengthened the time it took to house a client. Verifying homelessness histories, income, disability status, and other program-specific requirements can delay placement into housing by multiple weeks.

To measure whether disparities are apparent in the data, median times for youth, families, and single adults in this step are shown in *Figure 18*, below, broken out by demographic groups. Along with summary statistics of the median time from referral to housing, OLS regressions explore the average time controlling for race and ethnicity, gender, disability status, veteran status, and chronicity status. Three separate models were run for each population type. Results from the OLS regression analysis are captured in Appendix B: *Table 3*.

Figure 23: Median Days from Referral to Housed



Youth

Overall, for the 297 youth entered in the sample the median time from a referral to a housed date was 39 days. Above, *Figure 18* shows that the median time for most of the demographic groups is relatively close to the overall median, and comparable between other demographic subgroups. Once again there were no racial disparities present for the youth population in timeliness of movement.

Families

The median time for families to move from referral to housing is only eight days, which was much faster than youth or single adults in the sample. OLS results confirm that families were housed faster after a referral than single adults, 41 days*** sooner on average after controlling for other demographic differences (Appendix B: Table 3).

When breaking down the median time by race and ethnicity, *Figure 18* shows that White families had a median time between housing and referral of ten days, compared to Native American families who took 22 days. OLS results confirm that Native American families took longer to be housed after a referral than White families, an extra 16.1 days** on average, all else constant.

Median time analysis also showed a disparity between families deemed chronically homeless and those without a chronic designation. Families who are deemed chronically homeless had a median time of 17 days compared to the not chronically homeless who took 7 days. OLS modeling confirmed that chronically homeless families take longer to get housed compared to the not chronically homeless, an extra 13 days** on average after controlling for additional factors.

Single Adults

Single adults in the sample took the longest, overall, to be housed after an accepted referral. Though median time comparisons and OLS results did not show stark contrasts between the times it took demographic groups to be housed, this population took 50 days in this step of the CE process.

Summary

Timely Movement through the System

Clients in the HMIS sample used for this analysis had near-universal rates of assessment, and rates of referral to a housing provider. The amount of time it took different clients to move through the stages of CE varied greatly. Some individuals and families appeared to move promptly step by step, while extreme outliers in the data suggested that some clients took as long as several years to access referral or housing placement. Though the time periods of CES before referral are not the focus of this report, for clients in our sample the county was close to meeting its goal of assessment at two weeks from shelter entry (16 days median time). This finding is not likely representative of all clients who entered shelter over this time period. Consistently, the length of time a client spent awaiting a referral after entry to the CES priority list appeared to take the longest across all population types and demographic groups.

Providers consistently identified the work with the client to secure all the required documents as one of the main reasons why intake took as long as it did. They suggested that one way to streamline the process and shorten the time would be for standard documentation

(homelessness history, some income verifications such as SSI or SNAP enrollment), be uploaded into HMIS and made available to providers while clients wait on the priority list.

Outcome Comparisons by Provider Type

Prior analysis explored acceptance and housed rates by demographic groups, and the timeliness of movement from referral to housing placement. Here we compare how provider types perform by analyzing rate comparison and logit analysis. We then analyze the likelihood that clients referred to each provider type had unsuccessful movement through CES by comparing multiple referral rates and clients' likelihood of returning to shelter following a successful housing placement.

Provider Types

Clients in the sample were referred to ten different types of housing organizations (as defined by HMIS categories) ranging from those facilitating access to scattered-site housing to facilities with intensive supportive services for people with disabilities. For the purpose of this analysis we grouped housing providers into four broad categories: permanent supportive housing that required a member of the household to have a disability (PSH-D), permanent supportive housing that did not require a member of the household to have a disability (PSH), rapid re-housing (RRH), and transitional housing (TH).⁴⁴

Clients are referred to a housing provider when the provider has an open unit and notifies the county of that opening. Qualitative analysis of unit availability shows that, for most providers, one or two referrals are requested by providers in a given month. Unit availability can vary between providers of all types, and across population types. For example, PSH providers who operate their own units don't need to search for market housing but can have internal processes to evaluate how a client might need to be supported in order to be successfully housed. For RRH providers, placement consists almost entirely of the search for market units, as well as helping clients navigate communication and negotiations with landlords. Placement into housing was consistently identified as the longest part of the housing process for providers who do not operate their own housing. Simply finding a landlord that will accept the referred client is a significant challenge. Anecdotally, providers said the placement process could take anywhere from two weeks to five months, with most providers saying it typically takes about two months to get a client into housing.

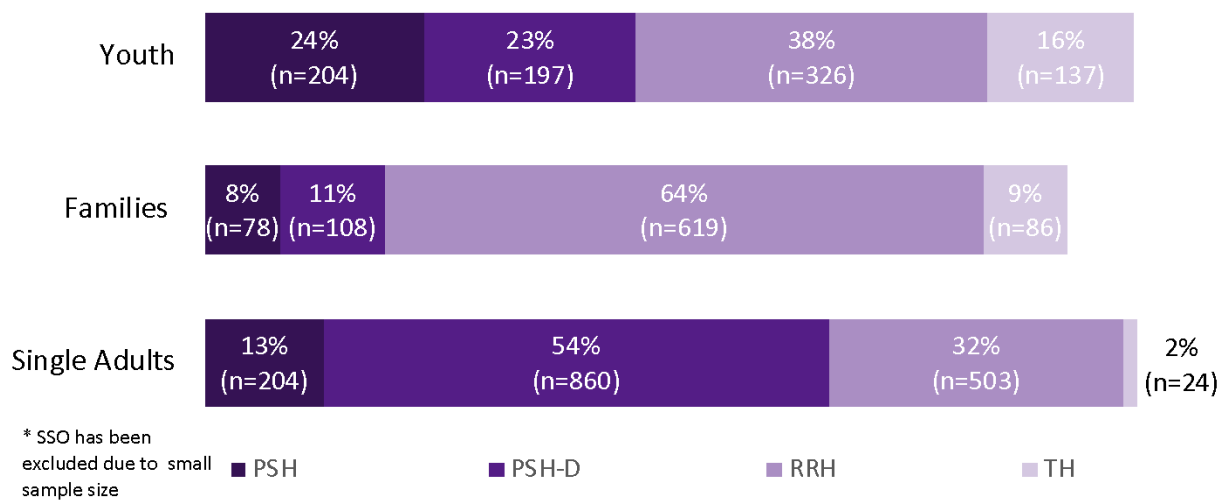
Rates of Referral, Acceptance, and Housing

Overall Referral Rates

Many clients in our sample regardless of population type were referred to RRH providers, representing 43.3 percent of all referrals. The second most frequently referred to service was PSH-D, receiving 24.8 percent. PSH and TH providers had the fewest referrals. The type of housing provider that individuals were referred to varied significantly based on population type. The distribution is shown in *Figure 19* and analyzed below.

⁴⁴ Analysis originally included a category of providers that only provide supportive services, but because this category represented an extremely small portion of our sample and lack of qualitative data to triangulate findings, we decided to drop the analysis of this group from the report.

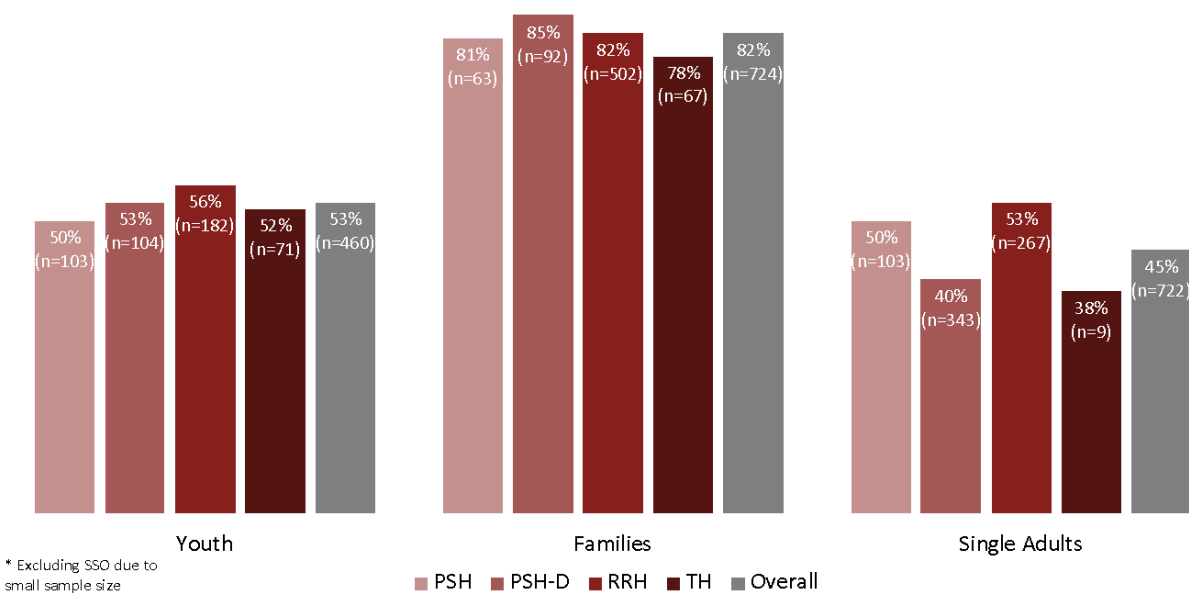
Figure 19: Percent of Referrals to Each Category of Provider*



Overall Referral Acceptance Rates

In general, RRH providers had the highest overall acceptance rate at 66 percent. Across provider types, families were accepted at the highest rates, while single adults experienced the most variation in success rates, with PSH-D accepting far fewer single adults when compared to PSH and RRH providers. *Figure 20* below represents rates of acceptance for each group.

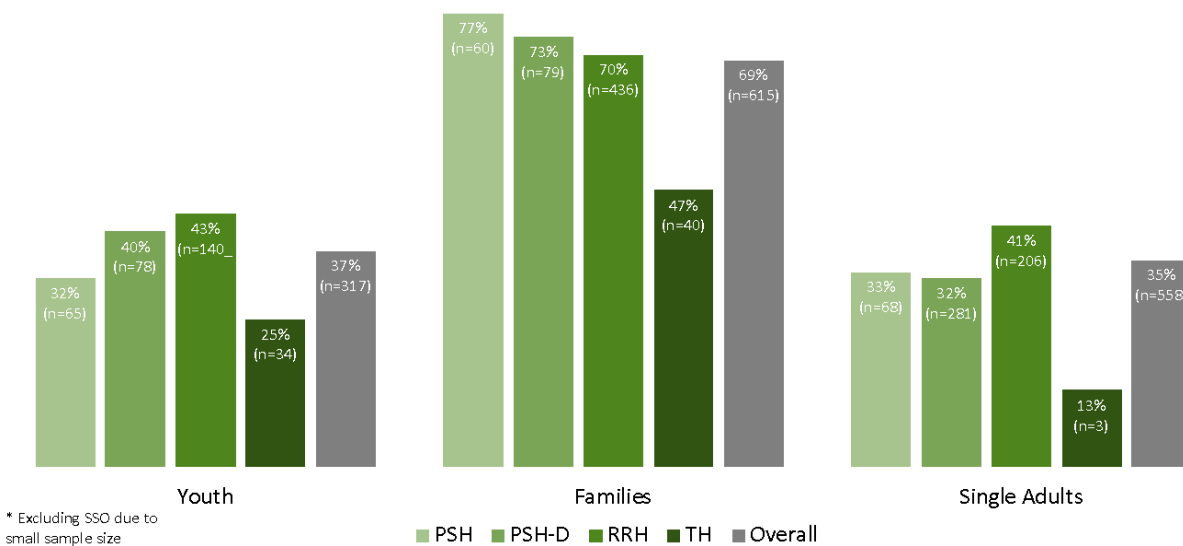
Figure 20: Percent of Referrals Accepted by Provider Type*



Overall Housing Rates

Across population types, RRH providers had the highest housing rate at 54 percent, followed by PSH with 40 percent, and PSH-D providers with 38 percent. This differed slightly when separating out the experiences of youth, families, and single adults. The breakdown of housing rates by provider type and population type are shown in *Figure 21* and explored further below.

Figure 21: Percent of Referrals Housed by Provider Type*



Youth

Of the 844 youth who were referred, 38 percent of them went to RRH, followed by PSH, PSH-D, and finally TH programs. Of all the youth referred, 53 percent end up getting accepted. This acceptance rate was constant across providers, with RRH slightly above others with a 56 percent acceptance rate. Logit analysis confirmed the success of RRH providers, finding youth were almost half as likely to be housed by PSH compared to RRH (Appendix C: Table 2).

So not only are the largest percent of youth referred to RRH, but they then have the highest acceptance rates, suggesting a slight advantage for youth referred to these providers. This advantage is bolstered by relatively high housing rates for RRH, with 43 percent of youth referred subsequently being housed (see *Figure 21* above). While PSH and PSH-D providers receive and accept youth referrals at equal rates, PSH-D have better housing outcomes, housing 40 percent of their referrals compared to PSH who only housed 32 percent.

Although TH providers received the smallest percent of youth referrals, youth make up the largest portion of clients referred to TH, which can be attributed to the fact that many providers labeled “transitional” provide youth-specific housing programs. While TH providers accept over half of youth referrals, they only end up housing 24 percent of them, demonstrating a flaw in the final stages of the intake process.

Families

Of the 947 families who were referred, a large majority went to RRH (64 percent) with much smaller numbers referred to the other providers. Overall, 83 percent of all family referrals get accepted, a rate nearly double that of youth and single adults. The high acceptance rate holds true across the four provider types, all of which are over 80 percent. The disparities arise in housing rates, with TH providers only accepting 40 percent of those referred, while the other providers' house 70 percent or more of their referrals. Logit results supported these findings; families were nearly four times as likely to be housed by PSH providers after a referral, over three times as likely to be housed after a referral to PSH-Disability providers, and almost three times as likely to be housed after a referral to RRH when compared to families referred to TH providers (Appendix D: Table 2). These results demonstrate that providers serving families are accepting and housing their clients at significantly higher rates than providers serving youth and single adults.

Single Adults

For the 1,674 single adults, PSH-D represented the largest portion of referrals at 54 percent, as expected given the large rates of reported disabilities in the single adult population. A significant share of single adults was also referred to RRH (32 percent). Acceptance rates differed the most for single adults between provider types. Although the low acceptance rate for TH was likely due to a small sample, PSH-D providers only accept 40 percent of referrals, well below the rates of PSH (50 percent) and RRH (53 percent). This is problematic given that nearly half of all single adults get referred to PSH-D. Housing rates for both PSH and PSH-D providers are only 30 percent, with RRH having the highest housing rate at 40 percent. Despite 89 percent of all single adults reporting a disability, they were less likely to be accepted or housed by PSH-D providers compared to RRH providers as shown in the logit results above. If only a quarter of single adults with disabilities end up referred to and accepted by PSH and PSH-D providers, this means a large portion are not reaching the permanent services built to serve their unique needs.

Demographic Disparities Across Provider Types

In order to assess if any demographic disparities exist in outcomes for different provider types, we analyzed acceptance and housing rates to the four provider types by gender, race, veteran status, disability status, and chronicity status. Logit models were run to analyze likelihood of referral and placement to each provider type. Results are shown in *Tables 4-6*.

Table 4: Youth Likelihood of being Referred to each Provider Type [2017-2019]				
VARIABLES	(Odds Ratio) PSH	(Odds Ratio) PSH-Disability	(Odds Ratio) RRH	(Odds Ratio) TH
Native American	0.937 (0.344)	1.011 (0.406)	0.938 (0.341)	1.535 (0.903)
Asian	0.880 (1.058)	1.852 (2.164)		5.619 (7.013)
Black or African American	0.634* (0.165)	0.929 (0.261)	1.021 (0.264)	2.542** (1.127)
Hispanic/Latinx	0.558 (0.239)	1.276 (0.536)	0.990 (0.393)	2.166 (1.286)
Female	0.639** (0.113)	0.709* (0.134)	2.358*** (0.386)	0.657** (0.136)
Disability	1.454** (0.259)	5.563*** (1.133)	0.344*** (0.055)	0.455*** (0.101)
Chronically Homeless	0.317* (0.197)	3.275*** (1.285)	0.556 (0.242)	0.776 (0.491)
Constant	0.456*** (0.125)	0.127*** (0.040)	0.622* (0.168)	0.138*** (0.061)
Observations	778	778	774	778

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran.

Youth

As shown above, there were very few racial differences in which providers' clients get referred to in the youth system, with only Black or African Americans having higher odds of going to TH than their White youth peers. PSH and PSH-D providers were more likely to receive referrals for male youth and for those with disabilities, which could be an indicator of the successful prioritization of permanent housing for those with disabilities in the youth system, and is the only indicator in which male youth are better off than their female peers.

Table 5: Families Likelihood of being Referred to each Provider Type [2017-2019]				
VARIABLES	(Odds Ratio) PSH	(Odds Ratio) PSH-Disability	(Odds Ratio) RRH	(Odds Ratio) TH
Native American	2.273 (1.136)	1.475 (0.570)	0.899 (0.283)	0.623 (0.276)
Asian	-	-	0.802 (0.919)	1.974 (2.298)
Black or African American	1.536 (0.630)	0.548** (0.167)	1.548* (0.358)	0.517** (0.159)
Native Hawaiian/ Pacific Islander	18.36** (24.31)	-	0.158 (0.209)	3.110 (3.953)
Hispanic/Latinx	1.633 (1.091)	0.742 (0.416)	1.116 (0.467)	0.622 (0.369)
Female	0.726 (0.310)	5.460** (4.147)	0.776 (0.237)	0.984 (0.443)
Disability	2.681*** (0.853)	38.98*** (28.16)	0.168*** (0.029)	1.954*** (0.486)
Military or Veteran	4.193 (3.866)	1.283 (1.587)	0.430 (0.376)	-
Chronicity	4.719*** (1.292)	4.535*** (1.112)	0.186*** (0.045)	0.282*** (0.135)
Constant	0.026*** (0.016)	0.001*** (0.001)	6.424*** (2.426)	0.129*** (0.069)
Observations	922	919	927	920

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran.

Families

Families with a self-identified disability or deemed chronically homeless were significantly more likely to be referred to PSH and PSH-D providers compared to those without disabilities or chronicity status and less than half as likely to be referred to RRH providers on average. Regression analysis confirmed higher total referrals going to PSH-D providers for families with disabilities and for those who were deemed chronically homeless. All these findings point to the success of the family system in prioritizing referral to permanent housing providers for Hennepin County priority groups; those with disability or chronicity status.

While these results are promising for the family system overall, Black or African American and male headed-households were not as likely to be referred to PSH-D providers as their White and female peers (*Table 5* above). While more analysis is needed to understand why these disparities exist, the overrepresentation of Black or African Americans in the homeless

population draws into question why they are not also reaping the benefits of the family system in the same way as their White family peers.

<i>Table 6: Single Adults Likelihood of being Referred to each Provider Type [2017-2019]</i>				
VARIABLES	(Odds Ratio) PSH	(Odds Ratio) PSH-Disability	(Odds Ratio) RRH	(Odds Ratio) TH
Native American	1.140 (0.311)	1.784*** (0.365)	0.393*** (0.107)	0.311 (0.250)
Asian	-	1.694 (1.151)	1.195 (0.828)	-
Black or African American	1.044 (0.192)	0.571*** (0.0722)	1.922*** (0.268)	0.797 (0.383)
Native Hawaiian/ Pacific Islander	-	4.658 (5.508)	-	-
Hispanic/Latinx	1.546 (0.486)	0.871 (0.213)	0.956 (0.274)	-
Female	0.591*** (0.113)	1.297** (0.161)	0.779* (0.108)	14.02*** (8.850)
Disability	3.371*** (1.342)	7.464*** (1.837)	0.108*** (0.024)	0.931 (0.720)
Military or Veteran	0.802 (0.281)	1.409 (0.345)	0.769 (0.211)	-
Chronically Homeless	1.015 (0.178)	1.449*** (0.182)	0.649*** (0.092)	0.563 (0.358)
Constant	0.051*** (0.021)	0.191*** (0.0497)	3.173*** (0.756)	0.005*** (0.005)
Observations	1,487	1,505	1,499	1,319

Single Adults

For single adults, more males and clients with disabilities were referred to PSH providers, which is expected given their overrepresentation within the sample. Perhaps unexpected, however, is that males are not being accepted as rapidly as other clients for PSH-D providers. Instead females, Native Americans, clients with disabilities and those who are chronically homeless were more likely to be referred to PSH-D providers. While it is positive that those with additional barriers were more likely to go to PSH-D providers, it is problematic that men and Black or African American single adults were less likely to go to PSH-D compared to females and Whites, even after controlling for disability and chronicity status. This disparity between men and women as well as Black or African American and White single adults could point to a flaw or bias in the VI-SPDAT scoring system as was uncovered in past research.

Providers working in RRH, PSH, and PSH-D indicated that a challenge of their work stemmed from receiving referrals in which assessment data did not match a client's presentation. While

providers believe that most components of the assessment were valid and carried out appropriately, they perceived discrepancies between what assessors input into HMIS and how clients' backgrounds were presented during intake. Multiple providers remarked that, upon reading referrals which categorized someone as experiencing long-term homelessness, a meeting with the client revealed that they did not actually fit the county's categorical definition of "long-term homelessness." As a result, there may be concerns about the accuracy of HMIS data as it is presented in this sample, and referrals of clients to different provider types could be impacted as a result.

VI-SPDAT Logit Analysis by Provider Types

Although the Hennepin County Continuum of Care decided to end the use of VI-SPDAT assessments as part of CES, these scores were being used for the two-years of data we analyzed. Quantitative analysis of reported scores was conducted to uncover how often those with medium or higher scores were being referred to the provider types associated with those scores in accordance with Hennepin County guidelines.⁴⁵ Using logit models, we captured the odd ratios of placement into the four main provider types for the highest VI-SPDAT scores [9+], and the middle VI-SPDAT scores [5-8] compared to the lowest VI-SPDAT scores [0-4].

Table 7: Likelihood of being Referred to Provider Types by VI-SPDAT Score				
VARIABLES	(1) PSH	(2) PSH-Disability	(3) RRH	(4) TH
Middle VI-SPDAT Score [5-8]	0.740 (0.221)	0.667* (0.143)	1.437** (0.232)	0.779 (0.185)
High VI-SPDAT Score [9+]	3.928*** (1.116)	7.738*** (1.592)	0.056*** (0.010)	0.319*** (0.082)
Constant	0.080*** (0.022)	0.189*** (0.038)	1.779*** (0.270)	0.139*** (0.031)
Observations	3,335	3,335	3,335	3,335

Standard Errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: Low VI-SPDAT Score [0-4]

Those with the highest scores [9+] were nearly four times more likely to be placed into PSH and over seven times more likely to be placed into PSH-D than those who scored in the lowest bracket [0-4]. High scores were also less likely to be referred to RRH and TH than those who scored in the lowest bracket [0-4]. Clients who received a middle score range [5-8] were 1.4** times more likely to be referred to RRH than those who scored in the lowest bracket [0-4] on average.

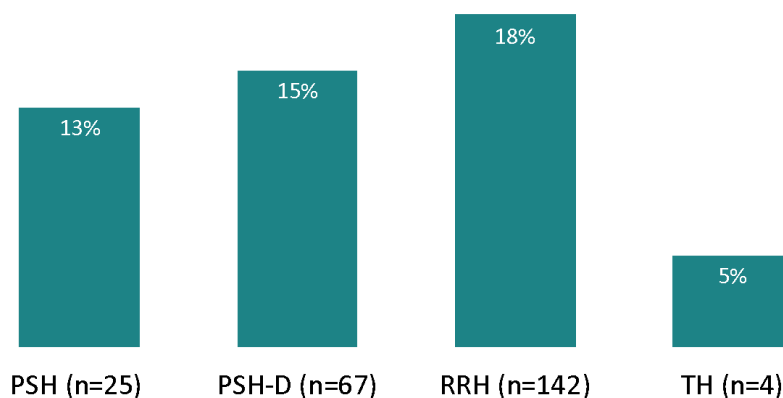
⁴⁵ HC Procedure Manual. <https://www.hennepin.us/-/media/hennepinus/residents/human-services/docs/family-policy-procedure-manual-2019.pdf?la=en&hash=C3F33E218E4DCCEA3D5A6E5347665D26F6A54A6C>

These results show that clients who were deemed the highest priority or most in need from this assessment tool were in fact more likely to be referred to permanent housing providers compared to the lower scored clients, while those in the middle range were more often referred to RRH providers. Although these results show the county was prioritizing referrals according to VI-SPDAT scores, the underlying problem with this assessment was not regarding what type of housing provider clients were referred to, but about the ability of the VI-SPDAT to accurately and equitably measure vulnerability in the first place.

Unsuccessful Housing by Provider Type: Return to Shelter & Multiple Referrals

Different types of housing vary in the extent to which they provided permanent housing for those placed through CES (see *Figure 22*, below). Thirteen percent of those placed in PSH and 15 percent in PSH-D returned to shelter. Of those placed in RRH, 18 percent returned to shelter. Furthermore, though the sample size was small, of the 77 people placed in TH, only four returned to shelter—or five percent. There were no findings concerning the significance of these differences when using a logit model. While not conclusive, the higher rates of return for those placed in RRH may suggest that the temporary nature of services could create a barrier to individuals and families staying in housing permanently. While this report found higher rates of acceptance and placement into RRH, those gains may not be sustained as demonstrated by the nearly 1-in-5 chance of re-entering CES post a successful housing placement.

Figure 22 Percent of those who were Housed that Returned to Shelter by Provider Type



* Excluding SSO due to small sample size

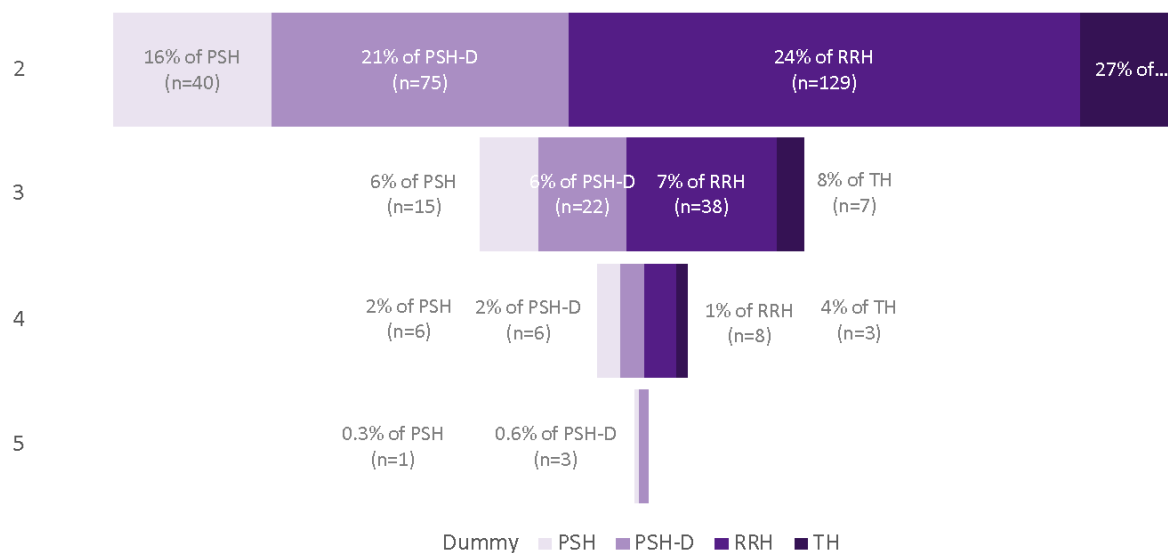
Multiple Referrals by Provider Type

Analysis of multiple referrals is another way of exploring unsuccessful housing outcomes. The sample for this analysis includes those who had at least one referral date in the time period, and information about the provider to which they were referred.⁴⁶ Results of this analysis can be seen in *Figure 23* below. Over 20 percent of clients referred to PSH-D, RRH, and TH providers had two referrals during the time period, and six percent or more of clients referred to all four provider types had three referrals, demonstrating the cyclical nature of CES and the lack of

⁴⁶ n=1,444

permanence for nearly a fourth of all clients. While the number of clients with multiple referrals is concerning, there do not appear to be any major discrepancies between provider types.

Figure 23: Percent of Housing Providers with Multiple Referrals



Provider Type Comparison of Intake Time

Along with exploring rates of referral acceptance and housing, we compared the amount of time the intake process (from referral to housed) was taking for the four provider types. Those who were referred to PSH-D and TH providers took the longest to be housed after a referral, while those referred to RRH took the shortest amount of time. Those referred to PSH-D providers took a median of 50 days, followed by TH providers with 43 days, PSH providers with 38 days, and finally RRH providers with 13 days. Further analysis and more sophisticated data is needed to perform robustness checks on these differences.

Summary

Success of Placements

Provider comparison found that RRH providers accepted the highest percent of their referrals, while PSH-D accepted the least. At the same time, PSH and PSH-D providers had the lowest rates of clients referred to them who went on to have multiple referrals. This implies that despite lower acceptance rates, PSH-D tends to have more successful long-term housing solutions for clients who make it through the referral and intake process. While not statistically significant, a slightly higher rate of those placed in RRH tended to return to shelter, suggesting that a portion of these clients are unable to maintain housing permanently.

RRH appears to be the most efficient housing provider type, likely due to higher turn-over, flexible subsidies, and higher exit rates leading to more open units than PSH providers, which is to be expected due to PSH's intentional permanence. Although RRH providers had the highest acceptance and housing rates, and moved clients through intake quickest, they also had the highest return to shelter rate and largest percent of clients with multiple referrals. This demonstrates that while RRH might succeed in moving clients through the steps of CES, and doing this quickly, they struggle to provide long term or permanent solutions for their residents.

Youth specifically have greater success in the RRH system with higher referral, acceptance, and housing rates compared to other provider types. Families do better than both youth and single adults with higher referral acceptance and housing rates across the board, especially for PSH, PSH-D, and TH providers. For single adults, only 30 percent of those referred to PSH and PSH-D providers end up getting housed, demonstrating the significant barriers still facing those with self-identified disabilities or deemed chronically homeless in accessing permanent housing options in the single adult system.

Demographic Disparities

Those with disabilities or who were deemed chronically homeless were significantly more likely to be referred to PSH or PSH-D providers and were significantly less likely to be referred to RRH providers. Clients with disabilities or who were deemed chronically homeless did appear to be prioritized for PSH and PSH-D referrals after assessment.

In both the family and single adults system, Black or African Americans are less likely to get referred to PSH-D providers. While also being overrepresented in the single adult population, Native Americans were more likely to be referred to PSH-D providers than their White peers. While it may be true that the county's efforts to prioritize clients with disabilities is beginning to bear fruit in referral results, the effects do not appear to be impacting all subgroups equally. Further research and efforts should be focused on the male and Black or African American single adults and families who were not as likely to be referred to PSH-D providers to understand why they were less likely than their female and White peers to reap the benefits of the county's targeted efforts.

Timeliness of Movement through the system

RRH is the timeliest housing provider type, likely due to the flexibility of subsidies and access to private housing markets, but it also has higher return to shelter rates and multiple referrals, indicating a lack of permanence. Based on provider interviews, while it still takes clients in RRH time to ultimately find suitable market housing, openings are much more common due to the frequency with which clients drop out of housing or move to market housing without the use of RRH services. Alternatively, referral openings for PSH services are less common, and providers believe anecdotally that those who are successfully placed tend to stay in housing longer than their RRH counterparts.

Conclusions

Success of Placements

A large share of clients appear to cycle through CES rather than progress into housing in a linear way as is intended by the county. Missing data makes it difficult to understand where clients' contact with CES begins and ends. More needs to be understood about how and why individuals and families cycle through CES, utilizing shelter and referrals multiple times.

The intake process after a client is referred to a housing provider presents a significant barrier to successful housing outcomes. There are a variety of reasons why a client might not successfully move through the intake process. One major barrier to starting the intake process is the inability of providers to quickly reach clients after a referral. Because many clients don't have adequate contact information in HMIS, providers often rely on relationships they have with shelter staff or Street Outreach in order to track down clients who are otherwise unreachable. In the family system, this strategy is much more effective because many family programs require that the

client be in shelter up to the day they're referred, meaning shelter staff are much more likely to be able to connect clients and providers if contact information isn't available.

Often, unsuccessful referrals are due to a mismatch at the assessment stage between client needs and provider services. Clients who are referred to a specific provider which doesn't offer their ideal type of housing may respond by refusing services, and providers who receive clients they cannot serve due to disability, criminal history, or homelessness status are forced to decline them for ineligibility.

Families had the highest successful referral and housing rates. Youth and single adults had drastically lower referral acceptance and housing rates than this group. Though variation and disparity existed between demographics at this stage of CES (notably for Native American families in the sample), the family system seems to be functioning best for clients seeking housing.

There seemed to be more difficulties getting clients into PSH placements, but once clients accessed housing through these providers data suggested that these become more permanent and stable placements with clients reentering the CE process less often after being housed. Conversely, RRH providers had high referral acceptance and housing rates, but appear to be less permanent; clients referred to RRH in the data set had higher rates of return to shelter after housing and higher incidence of multiple referrals.

Evaluating outcomes for clients housed through CES poses a challenge for analysis because once individuals and families access housing, the HMIS data provided did not track housing permanence or stability. Providers noted that increased barriers at the point of intake correlated with the likelihood of housing instability, often resulting in shelter re-entry or additional CE referrals. Analysis of available HMIS data provided for this report found that single adults were more likely to access shelter after housing placement than any other population type. Youth, overall, were most likely to have multiple referrals in the two-year period. Rates of housing placement for those with multiple referrals in the data set uncovered a strong trend in which each subsequent referral a client receives in CES led to increasingly poor outcomes.

Clients who are successfully placed but prematurely leave housing are a major source of uncertainty for providers. While providers may not know why every client leaves housing, many suggest that those with high barriers to housing, such as mental health problems or an extensive criminal history, are more likely to leave housing unexpectedly.

Timeliness of Movement through the System

Though nearly all clients in the sample were entered into the priority list and received a referral to a housing provider in the two-year period, significant differences were found in the amount of time it took each population type to move through steps of the CE process.

Though variation existed in the data, findings suggest that the county appears to be close to meeting its goal of assessing clients two weeks after shelter entry for those in the HMIS sample analyzed—though this is not necessarily representative of assessment overall. The most significant source of delay for all clients identified in the data was the time between entry to the priority list and referral. As is well known to the county, referrals are only available to individuals and families when housing becomes available—a driving factor behind the long wait clients face for a referral to a housing provider is the lack of available units and affordable housing in Hennepin County. Multiple providers stressed how important strong relationships with landlords are to securing housing.

After a referral to a housing provider is made, clients must undergo a process of intake before housing placement. One housing provider interviewed for this report expressed that two months is a typical amount of time for a client to be placed into housing after they receive the referral. Analysis was done on clients housed in the data set to interrogate this goal. Across demographics, Native American single adults are least likely to be housed within two months of a referral to a provider. Families moved through this step fastest by far, followed by youth, then single adults. This may be due to the dynamics of the family shelter system and ability to contact these clients quickly once a referral is made.

The most time-consuming part of the intake process is collecting the level of documentation required to verify income, homelessness history, and at times disability status. This creates a barrier to housing individuals and families in a timely manner. Working with clients prior to referral, keeping complete records in HMIS, and requiring only the most critical documentation decreases the time this step takes.

Demographic Disparities

Overall, CES appears to be operating without significant demographic disparities for most groups. However, disparities do exist at key points in the process for some clients.

Race

Racial disproportionality is apparent both in the overrepresentation of people of color and Native American people experiencing homelessness in Hennepin County overall, and in the prevalence of these groups in the rates of those who are never referred or housed through CES.

Black or African American clients

Although rates of referral acceptance and housing were comparable to White clients, at the point of referral, and acceptance rates were significantly better for youth, Black or African American clients were less likely to be eligible for the services they received from providers and less likely to refuse any service offered. In addition, Black or African American single adults were less likely to be referred to PSH-D providers—which is problematic when considering how overrepresented Blacks are within the sample, and how nearly 90 percent of all single adults have disabilities. These two disparities point to a possible misalignment between the needs of this population and the housing options available to them through CES.

Hispanic/Latinx

Hispanic/Latinx clients were also less likely to be eligible for services they were referred to. In addition, Hispanic/Latinx families were disproportionately less likely overall to have their referrals accepted. This again points to services that may not meet the needs of this population, as well as a possible barrier in the intake stage preventing providers from successfully helping families navigate CES.

Native American

Native American clients experienced the most persistent and widespread disparities across CES. Despite being more likely to accept any housing options available to them, this population still had disproportionately lower rates of success moving through CES. Native American families were significantly less likely to be placed in housing within a two-month period after their referral is accepted. For families who were housed, the process tends to take significantly longer. Native American single adults are less likely to find success in either referral acceptance

or housing representing the worst outcomes of any demographic group in CES. On top of this, Native American single adults are twice as likely to have multiple referrals indicating that CES is struggling to house and refer this subgroup appropriately to providers. For both Native American families and single adults, CES is not sufficiently meeting their needs to move them from homelessness to permanent housing.

Gender

The youth system seems to be working much better for young women than for young men. Young women in the sample had higher rates of success for referral acceptance and housing. Determining how young women experience this system differently could be a key next step for improving the housing outcomes for young men.

Disability

During intake, clients with disabilities were more likely to be eligible for services they received but were much more likely to be declined for “other” unspecified reasons. More needs to be understood about why those with disabilities tend to be disproportionately declined for unspecified reasons on the provider’s part, and what these reasons entail.

People with disabilities were more likely to be referred to PSH or PSH-D providers, in line with expected needs for supportive services. However only about a quarter of all single adults with disabilities end up getting referred to, accepted, and housed by PSH and PSH-D providers, meaning a large portion are not reaching the permanent services built to serve their unique needs. This part of the system does not appear to function as intended for this vulnerable population.

Across all population types, clients with a self-reported disability were more likely to have multiple referrals in the two-year period than those without. Though these disparities are not universally apparent in rates of referral acceptance and housing placement, this finding suggests a higher incidence of failed housing attempts for these groups—especially in the case of youth and families, who may appear to access housing more often than single adult clients, but were not finding housing permanence through CES.

Chronicity

Despite the overall low rates of success for single adults, those who are chronically homeless seem more likely to access successful housing placements after referral. The county’s efforts to prioritize housing the chronically homeless seems to be evident in these higher rates of success for single adults, however this success is less apparent for chronically homeless families. Though families moved from the point of referral to housing placement more quickly than other population types overall, families who were deemed chronically homeless took significantly longer, despite similar rates of referral acceptance and housing. Housing for this population overall was less successful or permanent. Chronically homeless clients across the board were nearly twice as likely as those who were not to have multiple referrals in the two-year period. This finding suggests that housing outcomes for this group are cause for concern, and for further analysis.

Recommendations

- 1. Increase supportive services and the use of case management in each stage of CE as well as after a client accesses housing.**
 - a. Findings pointed to the need to have a consistent and reliable point of contact with each client. The use of case management services throughout the entire CE process could help to facilitate the hand-off from the county to housing providers while keeping the client informed and connected to needed services.
 - b. In order to improve the ability to contact clients, Hennepin County should provide all clients with low-cost cell phone service after assessment until they are placed in housing. Cell phone service could also be included in the bundle of services provided to clients after placement, particularly for RRH and Youth clients.
 - c. Case management services can be utilized to ensure that clients are informed of intake requirements before being connected to housing providers and any eligibility verification procedures could begin ahead of the formal referral. This could help to reduce the confusion and misunderstanding between providers and clients in the intake period.
 - d. Providers do not always have capacity to support or even track client permanence in housing. Increased use of case management could support housing permanence goals for clients and ensure more accurate data when clients leave housing.
 - e. Hire enough case managers so that every client in the single adult and youth systems who enters the priority list could receive case management services.

- 2. Increase clarity and transparency about the level of documentation required to access housing and determine county-specific barriers in documentation that could be eliminated.**
 - a. Clients should be better prepared about what documents they will need to have to be successfully housed. The county can work with providers to understand the documentation requirements for each specific provider, then communicate clearly to clients as they approach referral. This would help expand awareness and improve client preparation for housing intake.
 - b. The county could conduct a review of existing documentation requirements, and where not required by other funders or landlords, consider limiting or reducing the level of documentation required to confirm eligibility of clients before they access housing.

Appendix A: Summary Statistics of the HMIS Sample

	Total		Youth		Families		Single Adults	
	%	n	%	n	%	n	%	n
Youth	24%	850						
Families	27%	966						
Single Adults	48%	1,704						
White	20%	777	12%	101	13%	126	29%	486
Native American	10%	391	8%	69	10%	101	12%	196
Black/African American	63%	2,386	72%	611	71%	684	52%	887
Hispanic/Latinx	6%	219	7%	57	5%	44	6%	98
Female	55%	2,121	58%	489	92%	889	31%	534
Male	44%	1,676	40%	338	8%	77	68%	1,157
No Disability Reported	32%	1,215	55%	461	47%	457	11%	179
Disability Reported	68%	2,613	45%	383	53%	509	89%	1,524
Not Chronically Homeless	82%	3,150	96%	815	86%	832	75%	1,279
Chronically Homeless	18%	692	4%	35	14%	134	25%	425

Appendix B: Time Analysis – OLS Regression

Table 1: Average Number of Days from Shelter Entry to Priority List Entry [2017-2019]				
VARIABLES	(1) All	(2) Youth	(3) Families	(4) Single Adults
Native American	-12.54* (6.540)	35.24*** (8.593)	-1.153 (4.419)	-28.79** (12.29)
Asian	-15.51 (24.72)	-4.329 (19.97)		-16.44 (39.23)
Black or African American	-18.76*** (4.164)	7.140 (5.884)	-5.769* (3.337)	-27.98*** (6.759)
Native Hawaiian/Pacific Islander	-23.71 (22.87)	38.17 (27.08)	2.959 (17.38)	-56.50 (39.26)
Hispanic/Latinx	-9.960 (8.271)	11.79 (12.01)	-7.503 (6.088)	-9.973 (13.91)
Female	-12.38*** (4.124)	-10.60** (4.650)	0.639 (3.913)	-11.75* (6.802)
Disability	-12.40*** (3.961)	-0.0365 (4.693)	0.899 (2.385)	-28.32*** (8.551)
Military or Veteran	-10.64 (9.446)		36.13*** (12.44)	-16.16 (12.92)
Chronically Homeless	30.24*** (4.217)	0.991 (8.610)	-0.344 (3.570)	42.53*** (6.467)
Youth	-18.28*** (5.589)			
Families	-22.60*** (4.635)			
Constant	69.21*** (5.397)	21.87*** (7.119)	20.95*** (4.995)	85.86*** (9.538)
Observations	1,318	166	456	696
R-squared	0.120	0.145	0.030	0.095

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran, Single Adults (Model 1).

Table 2: Average Number of Days Between Entry of Priority List and Referral [2017-2019]				
VARIABLES	(1) All	(2) Youth	(3) Families	(4) Single Adults
Native American	-13.63 (9.73)	-5.585 (16.69)	7.996 (18.41)	-27.40* (14.71)
Asian	11.96 (31.28)	16.30 (50.68)	-24.46 (61.37)	22.58 (46.59)
Black or African American	27.14*** (6.71)	13.85 (11.71)	16.58 (13.47)	36.13*** (9.79)
Native Hawaiian/ Pacific Islander	79.46* (45.94)	86.02 (99.43)	232.2*** (78.27)	1.08 (68.02)
Hispanic	24.95** (12.15)	24.76 (18.12)	-6.31 (24.03)	34.93* (18.85)
Female	-9.01 (6.05)	9.93 (7.45)	8.34 (16.27)	-18.04* (9.41)
Disability	14.11** (6.22)	6.87 (7.40)	21.05** (9.39)	29.31** (14.00)
Military or Veteran	-21.58 (15.06)	-39.95 (69.97)	-4.54 (51.47)	-25.49 (18.24)
Chronically Homeless	75.36*** (6.91)	27.34 (17.98)	29.70** (13.41)	93.54*** (9.53)
Youth	-75.03*** (7.32)			
Families	-69.92*** (7.46)			
Constant	108.5*** (8.70)	36.77*** (12.28)	31.63 (20.41)	89.56*** (15.60)
Observations	3,239	756	909	1,574
R-squared	0.128	0.014	0.026	0.083

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran, Single Adults (Model 1).

Table 3: Average Number of Days ⁴⁷ between a Referral and Housed Date [2017-2019]				
VARIABLES	(1) All	(2) Youth	(3) Families	(4) Single Adults
Native American	10.52** (4.704)	-6.536 (12.18)	16.09*** (5.922)	12.06 (8.95)
Asian	14.41 (12.80)	1.790 (28.70)	23.74 (17.69)	13.50 (22.42)
Black or African American	-2.386 (3.048)	-0.750 (8.453)	1.028 (4.217)	-6.124 (5.08)
Native Hawaiian/Pacific Islander	-3.289 (20.92)		-10.83 (34.59)	-3.13 (28.83)
Hispanic/Latinx	3.097 (5.874)	21.91 (13.82)	-9.729 (8.257)	5.77 (10.14)
Female	2.175 (2.887)	-5.110 (5.185)	0.926 (5.393)	6.42 (4.82)
Disability	4.109 (2.634)	2.124 (4.949)	4.110 (3.014)	1.39 (7.19)
Military or Veteran	-4.949 (8.093)		-21.50 (20.17)	-2.57 (10.27)
Chronically Homeless	1.838 (3.041)	-8.064 (10.68)	12.90*** (4.324)	-3.123 (4.75)
Youth	-18.40*** (3.582)			
Families	-40.96*** (3.250)			
Constant	60.12*** (3.966)	47.22*** (9.395)	16.30** (6.599)	64.48*** (8.14)
Observations	1,371	273	589	509
R-squared	0.178	0.026	0.050	0.019

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran, Single Adults (Model 1).

⁴⁷ The Top 1% of times between referral and housed were excluded. It is likely those spending more than 250 days in this stage of CES are data errors.

	Table 4: Median Days from Referral to Housed					
	Youth		Families		Single Adults	
	# of Days	n	# of Days	n	# of Days	n
Overall	39	281	8	595	50	526
White	43	27	9	82	50	159
Native American	39	18	21	58	63	40
Black/African American	38	220	7	426	48	285
Hispanic/Latinx	55	14	7	22	65	29
Female	35	189	8	549	52	167
Male	42	86	6	46	50	356
No Disability Reported	37	159	7	293	46	57
Disability Reported	41	120	9	302	51	469
Not Chronically Homeless	40	266	7	513	50	360
Chronically Homeless	15	15	16	82	51	166

Appendix C: Moving Through CES – Logit Models

Table 1: Likelihood of Moving Through the Coordinated Entry System
[2017-2019]

VARIABLES	Odds Ratio ReferralAccepted	Odds Ratio WasHoused	Odds Ratio Returnedtoshelter	Odds Ratio MultipleReferrals
Native American	0.634*** (0.0883)	0.652*** (0.0926)	1.946* (0.772)	1.505*** (0.215)
Asian	1.965 (0.933)	1.190 (0.524)	2.108 (2.303)	0.388 (0.246)
Black or African American	1.092 (0.105)	1.053 (0.101)	1.260 (0.374)	0.945 (0.0979)
Native Hawaiian/Pacific Islander	0.515 (0.321)	0.873 (0.535)	19.307*** (19.085)	2.153 (1.298)
Hispanic/Latinx	0.746* (0.130)	0.768 (0.136)	1.388 (0.699)	0.956 (0.179)
Female	1.251*** (0.106)	1.270*** (0.109)	0.617* (0.153)	0.962 (0.0896)
Disability	0.868 (0.0799)	0.876 (0.0772)	2.131*** (0.543)	1.580*** (0.156)
Military or Veteran	0.646** (0.143)	0.851 (0.192)	0.373 (0.384)	1.302 (0.295)
Chronic Homeless	0.980 (0.0975)	1.422*** (0.141)	1.066 (0.283)	1.910*** (0.192)
Youth	1.302*** (0.132)	1.131 (0.117)	2.176*** (0.629)	1.759*** (0.196)
Families	3.921*** (0.443)	3.055*** (0.324)	1.400 (0.417)	1.290** (0.148)
Constant	0.905 (0.113)	0.531*** (0.0659)	0.340*** (0.013)	0.200*** (0.0275)
Observations	3,358	3,358	3,358	1,501

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran, Single Adults.

ReferralAccepted is conditional on someone being referred. WasHoused is conditional on being referred. Returned to Shelter (post housed date) is conditional on being Housed. Multiple Referrals is not conditional.

**Table 2: Youth: Likelihood of Moving through the Coordinated Entry System
[2017-2019]**

VARIABLES	Odds Ratio ReferralAccepted	Odds Ratio WasHoused	Odds Ratio Returnedtoshelter	Odds Ratio MultipleReferrals
Native American	1.225 (0.408)	1.054 (0.368)	2.078 (1.758)	1.63 (0.58)
Asian	4.310 (5.113)	2.003 (2.070)	9.521 (15.200)	1.89 (1.97)
Black or African American	1.891*** (0.450)	1.416 (0.352)	0.858 (0.573)	0.99 (0.26)
Hispanic/Latinx	1.036 (0.378)	0.919 (0.357)	1.067 (1.056)	1.19 (0.47)
Female	1.517*** (0.229)	1.541*** (0.238)	0.882 (0.363)	1.13 (0.19)
Disability	0.807 (0.121)	1.003 (0.152)	2.819** (1.182)	1.54*** (0.25)
Military or Veteran	0.714 (1.012)			- -
Chronic Homeless	1.034 (0.386)	1.160 (0.426)		1.72 (0.63)
Constant	0.670 (0.168)	0.387*** (0.102)	0.071*** (0.054)	0.313*** (0.086)
Observations	782	780	295	759

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran.

Table 3: Families: Likelihood of Moving through the Coordinated Entry System [2017-2019]

VARIABLES	(Odds Ratio) ReferralAccepted	(Odds Ratio) WasHoused	(Odds Ratio) Returnedtoshelter	(Odds Ratio) MultipleReferrals
Native American	0.594 (0.205)	0.738 (0.210)	0.359 (0.407)	1.34 (0.41)
Asian		1.678 (1.912)		- -
Black or African American	0.741 (0.200)	0.923 (0.196)	1.683 (0.932)	1.20 (0.28)
Native Hawaiian/ Pacific Islander	0.343 (0.429)	0.224 (0.278)		2.05 (2.57)
Hispanic/Latinx	0.327*** (0.134)	0.564 (0.207)	0.870 (0.904)	1.25 (0.51)
Female	1.129 (0.332)	1.072 (0.274)	0.490 (0.254)	1.07 (0.30)
Disability	0.965 (0.167)	0.824 (0.120)	1.922* (0.750)	1.60*** (0.26)
Military or Veteran	0.617 (0.529)	0.718 (0.560)		3.79 (3.04)
Chronic Homeless	0.814 (0.192)	1.151 (0.239)	2.019* (0.848)	2.03*** (0.42)
Constant	5.229*** (2.022)	2.222** (0.714)	0.051*** (0.038)	0.193*** (0.069)
Observations	941	946	614	923

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran.

Table 4: Single Adults: Likelihood of Moving Through the Coordinated Entry System [2017-2019]

VARIABLES	Odds Ratio ReferralAccepted	Odds Ratio WasHoused	Odds Ratio Returnedtoshelter	Odds Ratio MultipleReferrals
Native American	0.521*** (0.0956)	0.523*** (0.104)	4.462*** (2.384)	1.80*** (0.34)
Asian	1.511 (0.830)	0.936 (0.533)		0.18 (0.19)
Black or African American	1.028 (0.120)	1.029 (0.125)	1.032 (0.441)	0.83 (0.11)
Native Hawaiian/ Pacific Island	0.645 (0.476)	1.636 (1.176)	27.103*** (30.933)	3.80 (2.99)
Hispanic/Latinx	0.947 (0.214)	0.867 (0.207)	1.833 (1.285)	0.83 (0.22)
Female	1.125 (0.127)	1.206 (0.141)	0.464* (0.193)	0.82 (0.11)
Disability	0.942 (0.156)	0.906 (0.155)	1.268 (0.762)	1.75** (0.39)
Military or Veteran	0.608** (0.142)	0.866 (0.206)	0.396 (0.415)	1.17 (0.28)
Chronic Homeless	0.979 (0.113)	1.529*** (0.180)	0.841 (0.314)	1.90*** (0.24)
Constant	0.909 (0.168)	0.527*** (0.101)	0.063*** (0.042)	0.205*** (0.049)
Observations	1,629	1,629	563	

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran.

<i>Table 5: Likelihood of being Housed within two months after a Referral</i>				
VARIABLES	(1) All	(2) Youth	(3) Families	(4) Single Adults
American Indian/Alaska Native	0.545*** (0.0905)	1.364 (0.544)	0.475*** (0.132)	0.387*** (0.109)
Asian	0.971 (0.480)	3.785 (3.967)	0.734 (0.688)	0.609 (0.472)
Black or African American	1.030 (0.111)	1.541 (0.450)	0.793 (0.164)	1.057 (0.153)
Native Hawaiian/Pacific Islander	0.759 (0.555)	-	0.264 (0.328)	1.498 (1.270)
Hispanic	0.651** (0.135)	0.686 (0.339)	0.636 (0.231)	0.670 (0.210)
Female	1.238** (0.121)	1.789*** (0.315)	1.046 (0.259)	1.046 (0.150)
Disability	0.807** (0.0758)	0.926 (0.157)	0.792* (0.112)	0.826 (0.165)
Military or Veteran	0.869 (0.235)	-	0.570 (0.448)	0.893 (0.257)
Chronically Homeless	1.244** (0.138)	1.305 (0.501)	0.898 (0.179)	1.393** (0.196)
Youth	1.407*** (0.166)			
Families	4.655*** (0.533)			
Constant	0.276*** (0.0380)	0.196*** (0.0606)	1.952** (0.609)	0.278*** (0.0625)
Observations	3,288	759	928	1,598

Standard Errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1

Table 6: Percent of referrals accepted and housed by demographic category

	Youth				Families				Single Adults			
	Referral Accepted		Housed		Referral Accepted		Housed		Referral Accepted		Housed	
	N	%	N	%	N	%	N	%	N	%	N	%
Overall	445	52%	318	37%	762	80%	629	64%	746	45%	588	34%
<i>Race</i>												
White	42	41%	31	30%	105	85%	84	66%	218	46%	174	35%
Native American	34	47%	23	32%	77	79%	60	60%	56	29%	47	23%
Black/African American	358	57%	245	39%	544	81%	455	65%	410	47%	319	35%
Hispanic/Latinx	24	41%	17	29%	27	61%	23	52%	43	46%	33	33%
<i>Gender</i>												
Female	291	58%	207	41%	716	81%	580	64%	241	47%	186	34%
Male	161	46%	105	30%	60	78%	49	64%	522	45%	397	34%
<i>Disability Reported</i>												
No Disability Reported	263	56%	174	37%	369	81%	306	66%	86	50%	65	36%
Disability Reported	198	50%	142	36%	407	81%	323	62%	684	45%	522	34%
<i>Chronically Homeless</i>												
Not Chronically Homeless	444	53%	444	53%	671	81%	671	81%	578	46%	578	46%
Chronically Homeless	19	54%	19	54%	105	81%	105	81%	193	45%	193	45%

Appendix D: Provider Comparisons

Table 1: Likelihood of Referral by Provider Types and Demographic Groups [2017-2019]				
VARIABLES	(1) PSH	(2) PSH-Disability	(3) RRH	(4) TH
Native American	1.228 (0.238)	1.516*** (0.237)	0.648*** (0.106)	0.783 (0.246)
Asian	0.280 (0.294)	1.513 (0.848)	0.900 (0.496)	1.651 (1.327)
Black or African American	0.952 (0.132)	0.611*** (0.0653)	1.632*** (0.174)	0.911 (0.194)
Native Hawaiian/ Pacific Islander	1.854 (1.549)	1.680 (1.314)	0.101** (0.114)	1.924 (2.154)
Hispanic/Latinx	1.110 (0.263)	0.897 (0.175)	1.074 (0.211)	0.812 (0.303)
Female	0.614*** (0.075)	1.217* (0.122)	1.074 (0.103)	1.149 (0.200)
Disability	2.013*** (0.272)	8.020*** (1.178)	0.188*** (0.019)	0.884 (0.134)
Military or Veteran	1.095 (0.331)	1.317 (0.310)	0.764 (0.194)	
Chronically Homeless	1.376** (0.190)	1.911*** (0.207)	0.480*** (0.055)	0.448** (0.146)
Youth	3.421*** (0.474)	0.578*** (0.069)	0.456*** (0.055)	9.653*** (2.492)
Families	1.101 (0.187)	0.163*** (0.0225)	1.942*** (0.224)	5.432*** (1.495)
Constant	0.078*** (0.015)	0.167*** (0.029)	1.980*** (0.275)	0.020*** (0.006)
Observations	3,213	3,213	3,213	3,120

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: White non-Hispanic, Males, No self-identified Disability, not Chronically Homeless, not Veteran, Single Adults.

Table 2: Likelihood of being Housed at each Provider Type: Odds Ratios [2017-2019]			
VARIABLES	(Youth) WasHoused	(Families) WasHoused	(Single Adults) WasHoused
PSH	1.417 (0.352)	3.833*** (1.322)	3.500** (2.222)
PSH-Disability	1.986*** (0.488)	3.133*** (0.960)	3.397** (2.111)
RRH	2.280*** (0.518)	2.740*** (0.640)	4.855** (3.029)
SSO	1.010 (1.183)	0.245*** (0.092)	7.000 (10.80)
Constant	0.330*** (0.065)	0.870 (0.188)	0.143*** (0.088)
Observations	868	965	1,593

Standard Errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Group: Transitional Housing [TH]

Appendix E: Total Number of Referrals – OLS Model

Total Number of Referrals on average by Demographic Group [2017-2019]	
VARIABLES	Number of Referrals
Native American	0.115** (0.045)
Asian	-0.148 (0.145)
Black or African American	-0.017 (0.031)
Native Hawaiian/Pacific Islander	0.409** (0.199)
Hispanic/Latinx	-0.013 (0.057)
Female	-0.007 (0.028)
Disability	0.135*** (0.029)
Military or Veteran	0.031 (0.071)
Chronically Homeless	0.221*** (0.032)
Youth	0.139*** (0.034)
Families	0.057* (0.035)
Constant	1.192*** (0.040)
Observations	3,358
R-squared	0.030

Standard Errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Reference Groups: Whites, Males, No Disability,
Non-veterans, Not Chronically Homeless, Single Adults