DALLAS COMMISSION
ON HOMELESSNESS

FINAL REPORT

November, 2016

I. Introduction

On May 9, 2016, Dallas Mayor Mike Rawlings and other community leaders announced the formation of the Dallas Commission on Homelessness (the "Commission"), created in response to concerns about the current level of homelessness in Dallas. The Commission is not a public body, but rather an ad hoc group of community representatives studying homelessness. It was charged with the following: 1) analyzing the community's current system of addressing homelessness, 2) comparing it to best practices in similar communities, and 3) delivering a focused set of strategies and recommendations for the city and county to consider going forward. The Commission's charge did not include detailed operational planning, which is the responsibility of organizations that fund and implement strategies.

MEMBERSHIP AND SUPPORTING ORGANIZATIONS

The 40 Commission members represent a diverse cross-section of community members, including property owners, real estate developers, business leaders, managers and volunteers of local nonprofit organizations, and people who have experienced homelessness. Each city council district also appointed a representative on the Commission. The Commission met as a full group five times, and much of its work has been completed through six subcommittees: 1) community engagement; 2) homelessness prevention and discharge planning; 3) technology, data, and innovation; 4) street outreach, unsheltered homeless, and health and supportive services; 5) shelters and related services; and 6) housing and financing of supportive housing. The resulting recommendations and subcommittee objectives were validated by a majority vote of the Commission members.

The Commission's work has been generously supported by staff from the Office of the Mayor, United Way of Metropolitan Dallas, the Meadows Mental Health Policy Institute, the United States Interagency Council on Homelessness, Corporation for Supportive Housing, and many volunteers. No city or county funds were expended to support this work or produce this report.

Consistent with its charge, the Commission created this report to detail Dallas' current environment in relation to homelessness, best practices gleaned from similar cities, and the Commission's overarching recommendations, as well as to outline the subcommittees' specific recommended strategies for improvement.

II. Community Perspectives

The Commission actively engaged the community to better understand the opinions held by those affected by homelessness and to afford an opportunity for Dallas residents to offer solutions. The engagement strategies included a design-thinking-inspired series of structured charrettes, six topical forums held across the city, meetings with people experiencing homelessness, public surveys, and social media.

Dallas citizens and decision-makers have legitimate public health and safety concerns about homelessness and encampments; not surprisingly, many of these concerns align with those voiced by the city's homeless population.

CHARRETTES

During the week of July 18, 2016, four charrettes were held, all of which were open to the public. Participants were led through a series of exercises to offer qualitative feedback to the Commission. Several themes emerged from the exercises, and the following are some of the most telling findings:

- Participants tended to view homelessness as caused by a lack of a strong social fabric or community, versus financial instability.
- Participants most often viewed homelessness through their perspective, rather than trying to place themselves in the situation of people experiencing homelessness.
- Participants were clear that providing human support, rather than just money/funding, could be the best and most effective way to combat homelessness.
- Participants were largely pessimistic about the current state of homelessness in Dallas.

When asked what the city should start, stop, and continue to do about homelessness, the following themes were most common.

"Start" themes were 1) utilize better interagency communication, 2) address mental illnesses along with housing solutions, 3) implement prevention initiatives to keep people from losing their homes, and 4) diversify affordable housing.

The four major "Stop" themes that emerged were 1) stop wasteful spending on initiatives that are not effective, 2) stop the criminalization of homelessness, 3) stop a lack of accountability, and 4) stop closing encampments without having any alternatives ready.

The two things participants felt should be continued were efforts to create affordable housing options and raising awareness around issues related to homelessness. Two additional themes that arose were to continue creating awareness and utilizing effective best practices.
The other exercises demonstrated that community members desire innovative solutions. Some believe it is better to tackle the issue systemically with policy changes and large-scale solutions, whereas others want solutions tailored to the individual, such as addressing mental health issues or empowering and enabling people experiencing homelessness to help themselves.

PUBLIC FORUMS

To give citizens an opportunity to voice their thoughts, the Commission hosted multiple forums around the city to inform, educate, and garner more public feedback. The events were well attended, with more than 550 people present at the six public meetings. Common themes that emerged from the public meetings included the following:

- All North Texans—nonprofits, city and county government, businesses, and community members—must coordinate to address homelessness as a community.
- To effectively address homelessness, Dallas must make it a civic priority.
- Dallas must establish a centralized system of accountability to ensure that this work advances, organizations align, and resources are wisely spent.
- There is not just one solution to end homelessness, and the community must continually analyze an array of strategies as well as review and implement them based on the needs of the community and, most importantly, those experiencing homelessness.

More specific concerns of attendees included littering, harassment and obstruction, public intoxication, and not having a place for people experiencing homelessness to go during daytime hours.

Attendees ranked the top community challenges related to homelessness by order of importance. The results were as follows: lack of shelter, concentration of homeless services in one geographic area, lack of housing, lack of available mental health care, lack of substance use care, ex-offenders/sex offenders, and lack of a Dallas Police Department presence.

Attendees at Public Forums

MEETING WITH THOSE EXPERIENCING HOMELESSNESS

At least two meetings took place with those experiencing homelessness. Approximately 45 people who are currently homeless attended the meeting on August 22, 2016, along with five social services representatives. Most in attendance were currently on the waiting list for housing and were experiencing homelessness for the first time. When asked whether they had been denied housing, when the answer was yes, criminal history was identified as the top reason (60 percent) and no income as the second (47 percent)—participants could select more than one answer. When asked about the most important thing they would want to share with the Dallas mayor, two themes emerged:

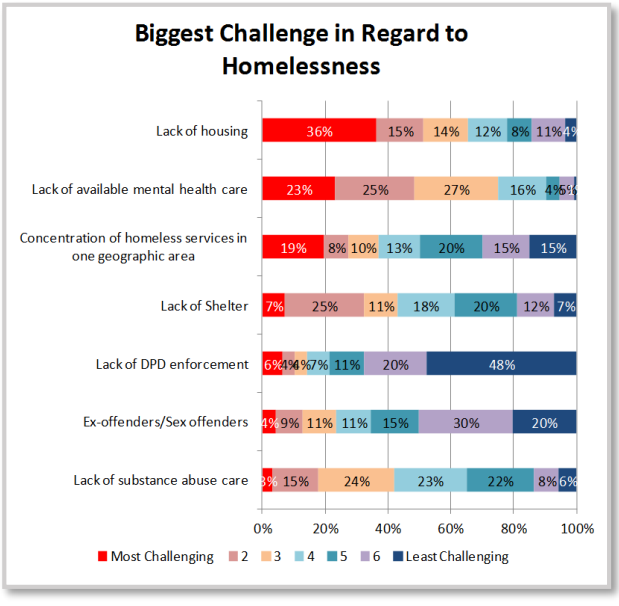
- **The need for help and more housing**, including comments such as "help us," "We need more housing for the homeless," "Help us, please," "Tent city should have been left open," and "I need housing, not more referrals."
- **Avoiding negative judgement of people experiencing homelessness**, including comments such as "Not all homeless people are chronically or mentally unstable," and ". . . not everyone is on drugs, alcohol, MHMR, etc. The new face of homelessness is women and children. People need a hand up, not a hand out."

By far the top *urgent need* expressed by people experiencing homelessness was to find **affordable housing**. Other urgent needs included income/employment, mental health services, clothes and a place to shower, identification, and transportation.

The need for housing is particularly pressing with the closing of encampments because many people in the encampments are on housing waiting lists and have nowhere else to go. As a woman in the encampment stated in a WFAA8/ABC broadcast about the encampment closure, "If they shut it down, do they realize we're going to pack up—those that don't have a place to go—and they are going to move to other places?" Clearly, the need for increased affordable housing is a pressing concern held by citizens and the homeless population alike.

SURVEY RESULTS

The Commission also developed and conducted a public survey over the course of several weeks, and those results are summarized here. The primary objectives of this study were to discover the biggest challenges Dallas communities face regarding homelessness and how the effects of homelessness affect these communities, as well as to identify solutions to these challenges. According to survey results, three challenges were ranked much higher than the others. By far the top challenge selected was the lack of housing, with lack of mental health care ranking second and homeless services being concentrated in one area ranking third.



SOLUTIONS

The most recommended solution was Housing First, spread throughout the City.

The most recommended solution was Housing First (spread throughout the city), cited by 36 percent with a plurality in each of the areas with a sufficient sample size to report. None of the other proposed solutions drew more than 13 percent of mentions. Housing First is an evidenced-based homeless assistance approach that prioritizes providing people experiencing homelessness with housing as quickly as possible and then afterward providing voluntary supportive services as needed. As a model, it has been adopted by numerous cities and is endorsed by all federal agencies involved in homelessness.

By far, the most impactful effect of homelessness selected was *quality of life issues*, with 62 percent ranking it number one and only 5 percent ranking it fourth of four issues. The next most impactful effect was *crime* (31 percent). In contrast, 60 percent ranked *public intoxication* third or fourth, and 59 percent ranked *encampments* third or fourth.

EFFECTS

The most impactful effect of homelessness reported by survey participants was *quality of life* issues.

SOCIAL MEDIA

Community members engaged online with the Solutions for Dallas Homeless Facebook page and following the Twitter account (@solutionsforDallasHomeless). In one week alone, there were more than 5,500 visits to the Facebook page.

III. Current Environment

THE CONTEXT

POVERTY AND ECONOMIC DISPARITY

Surprisingly, Dallas is among the most impoverished cities in the United States. A 2014 study conducted by Dr. Tim Bray showed that more than 300,000 citizens live in poverty and nearly 600,000 more live in housing-distressed households. Dallas also leads the nation in children living in poverty. The African American and Hispanic communities south of Interstate 30 suffer by far the worst effects of poverty. According to a 2015 study by the Urban Institute, Dallas also leads the nation in neighborhood inequality among major U.S. cities. The main reason cited was the extremely low average wages of those living in the poorest neighborhoods.

DISCRIMINATION AND FAIR HOUSING

The City of Dallas has a long and challenging history regarding the provision of affordable housing. Several court decisions provide evidence of decades-long housing discrimination against minorities and low-income individuals. In the *1987 Walker Consent Decree*, the U.S. Department of Housing and Urban Development (HUD) and Dallas Housing Authority (DHA) were found liable for knowingly and willingly perpetuating and maintaining racial segregation in DHA's low-income housing programs. In the *2013 HUD Letter of Findings of Noncompliance and Voluntary Compliance Agreement*, HUD accused Dallas of discriminatory affordable housing practices, citing the city's policies and procedures that have negatively affected low-income housing downtown. In June 2015, in *Texas Department of Housing and Community Affairs vs. The Inclusive Communities Project, Inc*., the U.S. Supreme Court ruled that Dallas policies that segregate minorities in poor neighborhoods, even if they do so unintentionally, violate the Fair Housing Act.

These past activities by the city and DHA, along with the Supreme Court's application of a "disparate-impact test" to the Fair Housing Act, have created challenges in efforts to increase affordable housing units in Dallas and develop supportive housing for those exiting homelessness. If not addressed going forward, these underlying issues related to fair and affordable housing will likely heighten the risk of a more extreme and challenging environment surrounding homelessness in the future.

HOMELESSNESS IN DALLAS

The impact of homelessness in Dallas is severe and pervasive. It wears on our neighborhoods, depresses our businesses, and shocks our visitors when they see such extreme deprivation alongside extreme prosperity. The human condition in our numerous tent encampments is deplorable, yet there is little excess shelter capacity, a lack of affordable housing, and no community-wide supportive housing plan to relieve the pressure on the system and move people experiencing homelessness into housing.

PERVASIVENESS OF HOMELESSNESS

There is no debating the fact that homelessness is pervasive in Dallas. On the day of the 2016 point-in-time (PIT) count, 3,810 individuals experiencing homelessness were identified. Of those, 739 were unsheltered. Among the 304 veterans identified, 54 were unsheltered. Other subpopulations include 1,177 individuals in families and 713 unaccompanied youth under the age of 18. African Americans made up 55 percent of those identified, and Whites accounted for 43 percent. In addition, males far outnumbered females, at 78 versus 21 percent; 1 percent were transgender. Annualized, the PIT numbers suggest that more than 10,000 individuals experience homelessness at some point throughout the year. Dallas' primary intake shelter, The Bridge, reported that 9,147 individuals were provided shelter services in 2015. Also, the number of people experiencing homelessness in Dallas County has increased 21 percent over the last year; in contrast, national data show an overall decline in homelessness of 6.5 percent. The issue of homelessness affects all council districts.

> In the 2016 point-in-time count, the number of people experiencing homelessness in Dallas County **increased 21 percent over the last year.**

As noted elsewhere, the number of affordable housing units in Dallas is inadequate for meeting the needs of households in poverty. Permanent supportive housing (PSH) is in even shorter supply. In 2015, combining all dedicated housing for people experiencing homelessness including SafeHaven, Transitional Housing, Rapid Rehousing, PSH, and project-based HCV homeless preference permanent housing, only 2,426 persons were housed. Of those, 72 returned to emergency shelter within a year, two people died, and 720 exited to other permanent housing situations. The outcome for the remainder is unknown.

PIT counts typically underestimate homelessness, and Dallas is no exception. Other data sources strongly suggest the number of people experiencing homelessness in Dallas may be even greater:

- Individuals experiencing homelessness in Dallas often reside in encampments—some as small as three people, some with more than 50 people. The largest encampment under I-45 had in excess of 200 people at one point prior to its closure. According to the Dallas Police Department Crisis Intervention unit, in August, there were more than 50 homeless encampments throughout the city.
- The Dallas Independent School District (ISD) reports that nearly 3,700 enrolled, homeless students, and youth-serving shelters turn away 20 to 25 youth per month, and children- and family-serving shelters turn away 30 to 40 families a month.
- The 2015 Domestic Violence Task Force Report revealed that, on average, 631 victims of domestic violence are turned away each month.
- The five largest shelters in the city indicate they are at or near maximum capacity.

Homelessness among veterans has been systematically reduced nationwide over the last half decade. Houston achieved "Functional Zero" for veteran homelessness in June 2015, and Austin achieved this goal in mid-August 2016. These massive reductions in homelessness among veterans were achieved by finding housing for veterans and making ending veteran homelessness an administrative priority. Dallas, unfortunately, has not seen declines in homelessness among veterans. In fact, in 2016 there was a 24 percent *increase* in the total number of veterans counted.

> Dallas has seen an increase in the number of veterans who are homeless. In fact, the 2016 data show a 24% increase in the number of veterans counted.

Among the homeless population in Dallas, there are approximately 600 people experiencing chronic homelessness, meaning they have a disability and have been homeless for a year or longer or that they have had frequent episodes of homelessness over time. Many people who experience chronic homelessness are super-utilizers of public systems, including health care, criminal justice, and emergency response services. Experts estimate that the costs to a community for providing reactive services for these super-utilizers is between $40,000 and $80,000 per year, per individual. Thus, *the total cost to Dallas for providing these services to the chronically homeless population is in the tens of millions of dollars a year and is significantly more expensive than the cost of creating and sustaining an adequate supply of supportive housing*.

EMERGENCY SHELTERS

The five largest shelters that provide services to people experiencing homelessness are: The Bridge, Austin Street Center, Dallas Life, Union Gospel Mission, and the Salvation Army. These shelters have various barriers to participation, including limits on pets, couples, and rules against alcohol use. Despite these restrictions, the shelters are utilized to near capacity on any given night—with four of the five reporting maximum capacity. The average stay in The Bridge is around four months; it also provides day shelter and a variety of homeless services. There is a system log jam in the shelters, given the lack of a successful housing placement strategy. This restricts shelter capacity and prevents much of the city's chronically homeless population and/or super-utilizers from being sheltered and then moving on to supportive housing.

CRIMINAL JUSTICE, BEHAVIORAL HEALTH DISORDERS, AND HOMELESSNESS

People in the Dallas criminal justice system are disproportionately likely to have received publicly funded mental health services; one in four people in jail are also clients of the public mental health system. In a survey of unsheltered individuals, the Metro Dallas Homeless Alliance (MDHA) received 358 responses to a query about previous contact with the criminal justice system. Of those responding, 267 (75 percent) had served time in jail or prison. It should be noted that responses were received from fewer than half of the 739 unsheltered individuals, meaning that it is quite possible that the overall percentage of unsheltered individuals with criminal justice involvement is even higher.

There is also a strong correlation between mental health and homelessness. Per the county sheriff, the Lew Sterrett Justice Center is home to the second largest mental health treatment facility in the state. In the Dallas/Irving continuum of care, 599 adults, or about 20 percent, reported having a serious mental illness during the 2016 PIT count. Statewide, about 3.3 percent of people receiving publicly funded mental health services are experiencing homelessness (including those staying in shelters), which is consistent with the national average. People experiencing homelessness who also experience mental illness and/or involvement with criminal justice are at a high need for services, and many are residents of encampments.

HEALTH

Chronic and acute health conditions are prevalent among people experiencing homelessness. Providers see acute infections such as viruses or scabies spreading rapidly in shelters and encampments. Contributing factors include crowded settings, sleep deprivation, and limited opportunity for common prevention measures such as hand washing. At the same time, flu vaccines are widely available and primary health care slots go unutilized. The treatment of chronic conditions such as diabetes or HIV is compromised by limited access to health care; the inability to store medications; complications in following a treatment regimen; and the lower priority that people might give health and wellness when compared to food, shelter, and safety.

AFFORDABLE HOUSING

The rental vacancy rate in Dallas is reported as very low, resulting in a market where landlords have little financial incentive to rent to individuals exiting homelessness and/or the criminal justice system. A report released in 2016 from the New York University Furman Center provides details:

- Between 2006 and 2014, the number of renter households in Dallas central city increased from 43 to 51 percent, and in Dallas suburbs the number increased from 29 to 34 percent.
- Overall, the number of renter households in the metro area increased by 35 percent; the number of rental units in the same area increased by 25 percent. Further, households with the lowest incomes cannot afford to rent most of the recently vacant housing units; in Dallas, 80 percent of the lowest income renter households face a severe cost burden.
- The Dallas vacancy rate fell from 13 percent in 2006 to 8 percent in 2014.
- The median gross rent is $950. This increased by less than 1 percent per year between 2006 and 2013. In the 12 months between 2013 and 2014, the median rent increased by nearly 4 percent.

There is also the issue of meeting the housing needs of people experiencing serious mental illness. Housing needs for this population are driven primarily by poverty; that is, the median gross rent of $950 exceeds the federal Supplemental Security Income (SSI) payment of $733.

In 2014, there were 65,546 people receiving SSI benefits in Dallas County; 57,490 were considered "blind or disabled." More specifically, the Caruth Smart Justice Planning Grant report estimated that there are 54,483 individuals experiencing serious mental illness who are at or below 200 percent of poverty. A review of supported housing providers revealed an inventory of 1,383 supported housing units. Even if only 20 percent of people with serious mental illness living in poverty have service needs that warrant PSH, Dallas needs more than 10,000 PSH units. The overall need for affordable housing is unmet, and the need for housing that is linked to supports and services is in even shorter supply.

Dallas simply does not have enough affordable housing to meet the needs of households in poverty, and this fact contributes to new households entering homelessness and complicates ending the homelessness of individuals on the streets and in shelters. Further, Dallas has had virtually *no net increase in its supply of PSH in two years*. PSH is an effective approach to the housing needs of people with significant disabilities, including mental illness and substance use disorders. To make matters worse, the tight housing market takes units formerly available for housing choice vouchers off the market every day. The DHA estimates that 1,100 housing vouchers available specifically for the homeless population (including veterans) went unused, primarily because of the generally high market demand and high occupancy rate that makes affordable housing difficult to find. This unused resource is worth $8 million per year.

> The Dallas Housing Authority made vouchers available for the homeless population, including veterans; **1,100 housing vouchers, worth $8M, went unused.**

CONTINUUM OF CARE

The MDHA is an association of organizations devoted to ending homelessness in Dallas and Collin Counties. It directly facilitates the distribution of funds and performance reporting for Dallas' annual federal HUD Continuum of Care (CoC) and Emergency Solutions Grant funding. Metro Dallas Homeless Alliance (MDHA) administers the core infrastructure of the homeless response system as the Continuum of Care Collaborative Applicant and manages both the Homeless Management Information System (HMIS) and the Coordinated Assessment System (CAS).

PROJECTS NOT FUNDED IN 2015	
NAME OF PROJECT	AMOUNT
22-bed	$201,811
8-bed	$43,246
APTS II	$361,854
Brighter Tomorrows	$180,304
Dallas/Collin HMIS	$180,687
Home and Hope	$355,530
Homeshare CARE	$95,172
Suburban Homeless Outreach	$196,712
SH for Victims of DV	$235,618
TH-20	$153,572
TX-600 Shelter Plus Care	$158,522
Total non-funded projects	$2,163,028
NEW IN 2015	
CoC HMIS	$409,588
Coordinated Access	$332,256
Rapid Rehousing	$363,236
TOTAL NEW IN 2015	$1,105,080

The CoC homeless agencies received $17 million in federal funding in 2014. This funding is contingent on meeting certain requirements. Communities that do not take systematic approaches to ending homelessness, with a focus on chronic homelessness, or that do not use evidenced-based practices to serve those most in need are at risk of losing this federal funding. Conversely, communities that align their priorities and perform well can and will increase their share of federal dollars. For example, Houston, as a high-performing CoC, realizes more than twice the funding that Dallas receives ($33 million).

CoCs are scored and ranked annually by HUD, and Dallas is among the lower performing COCs in the United States. The most critical performance metrics in this national competition involve demonstrating progress in reducing chronic homelessness, improving coordination, increasing housing stability, fully embracing best practices of Housing First to remove barriers to housing, and building a data-driven performance-based system of care including both HUD-funded and mainstream service and housing systems. Weaknesses in our system's performance included incomplete implementation of a community-wide client data system, lack of priorities aligned with national objectives, and lack of system-wide accountability. In 2015, the Dallas community had $2.1 million in programs that were not re-funded by HUD. To avoid future funding cuts, the efficiency and performance of the current CoC system must be improved.

LACK OF LOCAL GOVERNMENT OVERSIGHT

The homeless response system in Dallas is aligned primarily through HUD funding and historically has not been a model of collaboration. Neither the city nor the county has taken meaningful steps to provide local governmental oversight of the system, such as creating a department dedicated to managing this work. There are numerous examples of cities and counties that have dedicated functionality, including New York, San Francisco, and Los Angeles, and that achieve government oversight through a function in the mayor's office. Without a structure that fosters alignment, including a specific and prioritized plan backed by the authority of the city and county, the Dallas response to homelessness has been consistently insufficient.

HUD requires communities to develop a governance structure to guide the planning, development, and implementation of a CoC system. MDHA is the lead agency and collaborative applicant for HUD CoC funding and is, from HUD's perspective, functioning as the governance structure for the community. Examples of governance structures are found in Appendix D.

COMMUNITY INVESTMENT IN HOMELESSNESS

Currently, substantial investment is being made into the community's homeless response system, however, it is a relatively small investment compared to other communities. Investments in Dallas are primarily being made with federal funds and federal housing subsidies, with relatively small local investments. There are significant local philanthropic resources, as well as federal, state, and local mainstream funding.

According to the 2015-16 budget, excluding pass-through funding from others, the City of Dallas dedicated approximately $7 million from the General Fund to address homelessness. The total budget for the City exceeded $3 billion dollars. Thus, the local investment represents substantially less than 1 percent of the budget. By contrast, communities throughout the United States are dramatically increasing their levels of community investment in homelessness.

For example, San Francisco's current budget allocated $241 million from general operating to fund a variety of homeless programs, most which involve provision of supportive housing and eviction prevention.

Since 1993, the Miami-Dade County Homeless Trust has developed or facilitated development of more than 8,000 emergency, transitional, and permanent housing beds. Among its other responsibilities, the Trust administers proceeds of a food and beverage tax made possible by the Florida legislature with the support of Governor Lawton Chiles and the Miami-Dade County Commission. Establishments in Miami-Dade County licensed by the State of Florida (excluding hotels and motels) that generate more than $400,000 in gross receipts annually are required to collect a 1 percent Homeless and Domestic Violence Tax. All but 15 percent of these tax receipts are dedicated to addressing homelessness. For fiscal year 2015-16, this source of revenue is expected to exceed $22 million.

Just this month, voters in Los Angeles approved a measure to raise property taxes to pay for homeless housing. The measure received the support of the LA City Council and 70% of the voters, and will raise $1.2 billion to pay for PSH and shelters for the homeless population.

LOCAL INVESTMENT

Strategic investment in a set of aligned priorities is essential to a successful homeless response system.

STRENGTHS IN THE DALLAS COMMUNITY

Dallas has recently become more engaged in addressing the problem of homelessness and has many strengths that can contribute to the solutions, including the following.

- Elected leaders of the city and county have voiced a strong interest in making measurable progress toward ending homelessness. Mayor Mike Rawlings was proactive and purposeful in creating the Commission and has set a high bar for the community to craft workable solutions with measurable results. County Judge Clay Jenkins is an active partner, engaged in the search for meaningful action and committed to the overall goal of addressing the issue. Dr. Theresa Daniel (Commissioner, District 1) chairs the Dallas County Behavioral Health Housing Work Group, providing leadership regarding the intersection of homelessness, behavioral health, and criminal justice.
- MDHA has developed a strong provider network and has been successful in meeting significant challenges, such as closing encampments. Also, MDHA has recently taken steps to address system issues. For example, the implementation of a coordinated entry system that includes a standardized assessment is underway. MDHA instituted a performance review system that is part of the process for ranking and rating proposed CoC projects. An increasing level of collaboration is evident in provider support for these system improvements.
- Dallas has a strong private philanthropic community that has made significant commitments designed to address the subset of individuals who experience behavioral health disorders and who cycle in and out of jail, hospital emergency departments, crisis services, homeless

shelters, and homeless encampments. For example, the W.W. Caruth Jr. Foundation has made a significant investment through the Smart Justice Initiative, which includes a county-wide planning project to identify strategies to improve outcomes for people with mental illnesses within the Dallas County justice system.

- The Dallas community has a strong network of providers, many of whom deliver exemplary and evidence-based services. For example, The Bridge provides comprehensive services to thousands of individuals experiencing homelessness every year and has been a powerful voice for people experiencing homelessness.
- The Dallas Regional Chamber reports strong growth in key economic indicators for the Dallas-Fort Worth metro region. A growing population, increasing employment, increasing personal income, and steady growth in the housing market all indicate that Dallas has a strong economy and a growing tax base.

IV. Effective Practices in Other Communities

Several communities have distinguished themselves in addressing homelessness. The Commission reviewed many outstanding accomplishments across the nation, and in Appendix B specifically summarizes the key elements and notable practices of the solution to homelessness in Houston, Salt Lake City, Austin, Orlando, and Denver. Each of these communities has seen substantive improvement, and all them invested in a system to address homelessness that included financing strategies, significant investments in housing, and evidence-based practices. Perhaps the best example is Houston, which in the past 5 years has accomplished a significant transformation. We hope to adapt these best practices to our strategies going forward. Highlights are offered here.

OUTCOMES — HOUSTON

From January 2011 to January 2016, Houston has achieved the following reductions in homeless populations:

- **Veterans – down 99%, at functional zero**
- **Chronically homeless – down 76%**
- **Families – down 61%**
- **Unsheltered – down 76%**
- **Overall – down 57%**

LEADERSHIP, ACCOUNTABILITY, AND SYSTEM IMPROVEMENTS

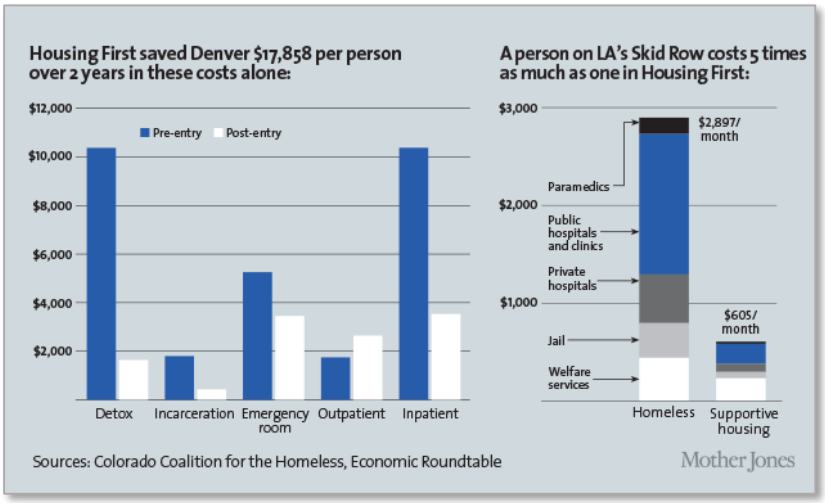
Each of the highlighted communities has a clear leadership structure. In Houston, as part of a full-system transformation, the redesigned leadership structure is led by a Steering Committee comprising stakeholders who are the decision-making authority for the system. The Steering Committee designates a CoC lead agency that operates the system. In Austin, the Ending Community Homeless Coalition (ECHO) Board is comprised of community leaders—business owners, public relations and media representatives, attorneys, and experts on housing and homelessness. The Board works with city and county leaders to coordinate and bring resources to bear beyond HUD funding, such as two rounds of General Obligation (GO) bonds and a Pay-for-Success initiative. The ECHO Membership Council functions as the decision-making body for CoC purposes, but decisions must be reviewed and ratified by the Board. Orlando's system structure is supported by a full-time senior advisor to the mayor.

HOUSING

Utah adopted a statewide policy of Housing First, and since 2005, the number of chronically homeless people has dropped by an estimated 91 percent. Utah invested in permanent supportive housing (2,281 beds), transitional housing (1,174 beds), and rapid re-housing (646 beds). There are also 2,268 beds in shelters. Austin has used GO bonds to fund affordable housing development, with a subset of PSH. In Orlando, the Orange County government and Florida Hospital led the way with investments in PSH.

EVIDENCE-BASED PRACTICES

Denver used a Pay-for-Success social impact bond to move from short-term strategies to a long-term sustainable solution based on supportive housing, the implementation of Housing First, and a modified Assertive Community Treatment team (intensive case management). Several communities have reported cost savings associated with the implementation of PSH approaches. The illustration below provides data on Denver and Los Angeles.



NOTABLE PRACTICES

In addition to the featured communities that have made broad and measurable improvements, the Commission also identified specific practices that might be adapted for use in Dallas.

- San Francisco:
  - **Navigation centers:** This pilot project brings together service providers in a central location and allows people experiencing homelessness to access a wide variety of services in one place.
  - **Master leasing:** The city master leases single-room occupancy units using a network of providers and more than 30 different properties. The agreement specifies provider obligations, including supportive services and property management. Property management includes signing rental agreements, screening and placing tenants, HQS inspections, and rent certification. Prospective tenants are referred through the coordinated entry system.
- Columbus, OH: The Community Shelter Board oversees a navigator program. Case managers called "navigators" provide intensive services to single men and women, which are focused on ending the homelessness crisis quickly and stabilizing people in housing. Navigators link people to services such as employment and job training, medical care, and mental health and housing resources.
- Miami-Dade County Homeless Trust: Funded by a 1 percent food and beverage tax, the Homeless Trust is responsible for the implementation of policy initiatives developed by the Miami-Dade County Homeless Trust Board and the performance monitoring of agencies funded by the county to deliver housing and services to people experiencing homelessness.

V. Taking Action - Recommended Strategies

The Commission expressed support for all recommendations developed through the diligence and hard work of its subcommittees. A detailed description of those recommendations and, when available, funding projections, can be found in Appendix C. The following are recommended strategies that incorporate their work.

Get organized and aligned

Develop a Community-Wide System of Leadership, Accountability, and Sustainable Funding.

This strategy is immediate**.** The City of Dallas and Dallas County should develop a formal and ongoing collaborative structure that provides overarching leadership and sustainable funding, coordinates community investments, develops and oversees the implementation of a comprehensive plan, and guides and directs improvements in the homelessness service system. This system of leadership accountability should hold all organizations responsible for performance against agreed-upon plan metrics.

An effective structure is one that addresses ending homelessness from the broader community perspective, identifying priorities, establishing alignment, and bringing resources to bear from many sources: federal, state, local, and private sectors. Fully utilizing existing resources, maximizing new opportunities, and identifying sustainable funding streams is essential.

The new organizational structure should complement the existing work of MDHA and the CoC. It would also benefit from the advice of our citizens. See Appendix D for a description of the structures in place in other communities.

Act now

Increase Targeted Street Outreach, Housing Placement, and Supportive Services to Manage Encampments and Unsheltered Individuals. This strategy is immediate and should continue until the Dallas street population is under better control. The city and other community stakeholders should develop a formal protocol for encampment closures with expectations that there are housing options available to those being displaced. It also expects an immediate, aggressive, and persistent street outreach, with apartment unit acquisition for PSH through an existing inventory scattered-site model. This will require financial incentives for apartment managers and expanded case management support to place the maximum number of clients in housing with supportive services.

The immediate short term goal is to house 600 homeless individuals, including all veterans. State funding has been awarded to four organizations to implement this strategy. Since the work under this program began, approximately 75 homeless individuals have been housed.

Use technology

Convert to Community-Wide Coordinated Entry and Single System HMIS. This is a critical immediate strategy to achieve alignment among organizations around priorities and will result in an automated homeless response system. Once built and fully deployed, all clients will be matched with housing and related services based on an established priority system. A key first step is to set up a single-system HMIS platform, with maximum community participation, to meet client and agency needs. The HMIS platform should include dashboard support for performance analysis. In addition to participation from all homeless housing and service providers, platform participants should include major health providers and criminal justice facilities.

The efficiency of the current CoC system will be increased by:

- A single data platform: All agencies responsible for homeless services must use a common data platform; agencies with shared responsibility for the high-need, high-utilizer group (hospitals, criminal justice, behavioral health) must have access to common data platform.
- A full commitment to ending chronic homelessness, evidenced by prioritization of resources.
- The implementation of a comprehensive performance-based evaluation system focused on HUD and Dallas' priorities. Funding must be linked to performance, including rating and ranking within the CoC.
- Full implementation of a coordinated entry system across the CoC and linking to efforts within the criminal justice system, hospitals, and behavioral health communities.
- Reducing the number of people discharged into homelessness from the criminal justice system, hospitals, health care facilities, and behavioral health treatment through screening for housing stability before discharge and making a definite and measurable connection to post-discharge housing and services.

Address Capacity

Facility Development and Shelter Capacity. This strategy is both immediate and intermediate and subject to feasibility analysis for each potential project. Expanding shelter capacity, create respite facilities for those discharged from hospitals, increase transitions from shelter to housing, and explore temporary housing options. Increase the number of people making a transition from shelter to housing by 300.

Increase shelter capacity/utilization by 150 slots. Develop temporary housing options. This action expects the full utilization of available shelter capacity and expanding shelter capacity as needed. It also considers expanded day and inclement weather shelter.

Add housing

Increase Supportive Housing to Correspond to the Demand. This strategy requires immediate action to begin a 5-year effort that includes intermediate and long-term actions. The end goal is to add at least 1,000 new PSH units to existing inventory by 2021. These units will be added through five approaches: 1) scattered-site apartment location through housing navigation; 2) single-manager, multi-unit leasing of apartment blocks through a master leasing program; 3) aligned city development and zoning policies; 4) acquisition and conversion of existing complexes throughout the city and county; and 5) new PSH development.

Homelessness cannot be addressed without an adequate supply of affordable housing. A subset of people experiencing chronic homelessness, including many living in encampments, may require the additional supports and services offered by the evidence-based practice of PSH. Some may be better served through the practice of Rapid Re-Housing (RRH). The Housing and Financing of Supportive Housing subcommittee, working with Corporation for Supportive Housing, has identified a need for 995 PSH units, with 950 for individuals and 45 for families. The subcommittee report includes an analysis of the funding necessary to support the development or leasing of these units. Also, using the RRH tactic allows the system to offer shorter-term housing and service assistance to an estimated 4,000 individuals and families.

Prevent homelessness

Create System Navigator Program within Criminal Justice and Treatment Facilities. This strategy is immediate. Add system navigator staff to correctional facilities and treatment settings to assist in preventing homelessness and streamlining access to medical, mental health, substance abuse, and respite care services.

Develop and implement system-wide protocols to ensure that all persons entering treatment and correctional facilities are screened for housing stability upon intake and at release. Also, staff these facilities with dedicated homeless system navigators who link those identified as experiencing homelessness with housing (temporary or permanent) and supportive services.

The expected time horizon for full implementation of these strategies is five years, however, annual review is essential to understand the need for course corrections.

The Commission respectfully encourages the community to take action.

II. AFFORDABLE HOUSING

Efforts to increase access to existing housing units may include the following:

- Landlord outreach/incentive program
- Master leasing
- Eviction prevention
- Increased availability of tenant-based rental assistance

Efforts to increase the development of affordable supportive housing units may include the following:

- Targeting and coordinating a portion of city, county, and DHA funds to new development
- Project-based rental assistance
- Aligning development and zoning policies
- Acquiring and converting existing complexes
- Developing new PSH units

VI. Conclusions

The many months of work were truly enlightening, and the Commission respectfully submits this Final Report in furtherance of its charge.

Through this process and after engaging the community through several methods, we learned that with our diversity comes different perspectives about homelessness. Many people view the situation from a humanitarian perspective and others have a more pragmatic perspective. Both are valid. Most people can see both perspectives and appreciate the tremendous value our community would realize from the creation of meaningful short term solutions as well as sustainable longer term strategies. Virtually everyone sees this as an important issue for Dallas and wants it to be solved.

Our sincere efforts notwithstanding, we have not been well aligned and the problem has worsened over the years. This past year we saw a significant spike in the overall number of homeless in our community. We believe the actual number of homeless to be over ten thousand. It is pervasive but concentrated and hits those hardest who are in extreme poverty and most vulnerable. Families, youth, veterans and the many considered chronically homeless are in our shelters and in encampments. The public service costs we all share to support our neighbors living on the streets is remarkable, and likely exceeds what it would cost to simply house them. Unfortunately, we have a severe shortage of affordable and supportive housing, which restricts access to those in our shelters and the many living unsheltered. Over a thousand of our homeless have qualified for rent subsidies, that couldn't be used due to the affordable housing shortage.

While our situation has gotten worse, many communities across the nation and in Texas have made progress. Over the last five years Houston has seen dramatic reductions in their homeless population. There is much to learn from others, including the way cities and counties have formally organized and aligned to drive agreed upon outcomes. It is also apparent that no city can make great progress without an aggressive supportive housing plan.

We have offered many strategic recommendations in various areas including prevention, health, technology, shelters and housing. However, at the core of our work we see a need for an ongoing and formal organizational structure that fosters collaboration and leadership in our community and at the highest levels. While progress in the short term is clearly expected, without an ongoing organizational leadership strategy we should not expect meaningful or sustainable progress over time.

We recognize Dallas is faced with many challenges, and homelessness is one of our greatest. We also know that if other cities can do it, so can we, provided we have the will to make solving homelessness one of our highest priorities.

APPENDIX A: Community Engagement

The Commission used two targeted methods, charrettes and a survey, to elicit community members' opinions and garner information about homelessness in Dallas.

Charrettes. During the week of July 18, 2016, four charrettes were held, all of which were open to the public. Participants were led through a series of exercises to offer qualitative feedback to the Commission. Several themes emerged from the exercises. Following are some of the most telling findings:

- Participants tended to view homelessness as a result of a lack of a strong social fabric or community, versus financial instability.
- Participants most often viewed homelessness through their perspective, rather than trying to place themselves in the situation of people experiencing homelessness.
- Participants were clear that providing human support, rather than just money/funding, could be the best and most effective way to combat homelessness.
- Participants were largely pessimistic about the current state of homelessness in Dallas.

When asked what the city should start, stop, and continue to do about homelessness, the following themes were most common:

"Start" themes were 1) utilizing better interagency communication, 2) addressing mental illnesses along with housing solutions, 3) implementing prevention initiatives to keep people from losing their homes is critical for social safety, and 4) diversifying affordable housing.

The four major "Stop" themes that emerged were 1) stop wasteful spending on initiatives that are not effective, 2) stop the criminalization of homelessness, 3) stop a lack of accountability, and 4) stop closing encampments without having any alternatives ready.

The two things participants felt should be continued were efforts to create affordable housing options and raising awareness around issues related to homelessness. Two additional themes that arose were creating awareness and utilizing effective best practices.

The other exercises demonstrated that community members desire innovative solutions, though some believe it is better to tackle the issue systemically with policy changes and large-scale solutions, whereas others want solutions tailored to the individual, such as addressing mental health issues. About 15 percent of participants felt homelessness was resolved by empowering and enabling people experiencing homelessness to help themselves.

Results of the public survey yielded similar sentiments. Among respondents, the two biggest challenges to combating homelessness were cited as lack of housing and lack of available mental health care. Similarly, the most recommended solution was *Housing First (spread throughout the city),* and the second choice was *Mental Health Treatment*. These results indicate public awareness that affordable housing is a major issue in combating homelessness and tie back to the charrette participants' feelings about needing to address affordable housing and mental illnesses. As for the most impactful effect of homelessness in Dallas, more than half of survey respondents selected quality of life issues as the top impact; crime was ranked second. Public intoxication and encampments were ranked third or fourth by most participants.

In addition to these two specific means of information gathering, the Commission hosted multiple events around the city to inform, educate, and garner more public feedback as follows:

FORUM TOPIC	DATE	LOCATION
"Sheltering the Homeless"	June 20	Dallas City Hall
"Homeless in Dallas"	June 21	Harry Stone Recreation Center
"Homelessness and Mental Health"	July 5	Dallas Public Library
"The Alliance Homeless Forum"	July 8	Dallas Public Library
"Homeless Youth"	July 19	North Dallas High School
"Affordable Housing"	July 20	Fair Park

APPENDIX B: Practices of Other Communities

I. Houston

Lead Agency: Coalition for the Homeless, Harris County, Texas

Goal: To end chronic and veteran homelessness by 2016 and create a path to end all homelessness by 2020

Background: Like other large Southern cities, Houston's homeless population was visible and growing. HUD identified Houston as a "priority community," based on its increasing homeless population, most of whom were not sheltered. Studies showed homelessness cost the community $100 million annually.

From January 2011–January 2016, Houston has achieved the following reductions in homeless populations:

- **Veterans—down 99%, at functional zero**
- **Chronically homeless—down 76%**
- **Families—down 61%**
- **Unsheltered—down 76%**
- **Overall—down 57%**

What Did They Do? In January 2012, HUD identified Houston as a priority community based on the high level of individuals experiencing homelessness who were on the street coupled with the opportunity for strategic improvement. With this designation, the Houston/Harris County Continuum of Care received support and technical assistance to redesign the homeless response system from one of crisis management to one centered on long-term housing placement. With support from HUD's technical assistance program, the Coalition completely redesigned its system to create a transparent, connected, and integrated system that is led by a CoC steering committee. The steering committee comprises stakeholders across the system (city, county, housing authorities, mental health authorities, workforce, philanthropy, consumers, providers, etc.) who are the decision-making body for the community; they rely on the recommendations and expertise of the CoC lead agency to support the work.

The Steering Committee adopted a community plan born out of a week-long community planning process and a Corporation for Supportive Housing (CSH) charrette, which identified the key strategies for ending homelessness in Houston. Change agents within organizations led project and implementation workgroups and used data to drive decision making around community-wide policies and priorities.

By creating a transparent process, the Coalition began functioning as a network of connected providers with a collective goal rather than a collection of providers with a variety of goals. Central to this change was implementing coordinated access and placement in housing, which prioritizes units based on vulnerability and need (rather than program design, preference, or controls from shelters, hospitals, the criminal justice system, and street outreach teams). Orderly inflow to a central point allowed the Coalition to thoughtfully develop an assessment process for each person experiencing homelessness, and housing navigators allowed coordinated placement into respite or medical beds, rapid rehousing, or permanent supportive housing.

III. Austin

Lead Agency: The Ending Community Homelessness Coalition (ECHO)

Goal: End homelessness in Austin through housing

Background: With an incredibly tight housing market and high rates of street homelessness, Austin committed to shifting its response to homelessness to permanent housing solutions.

What Did They Do? Austin committed to developing housing and using a Housing First model. In 2006, voters overwhelmingly approved $55 million in general obligation (GO) bonds for affordable housing. Those funds have provided a critical local resource and helped to meet the community's growing housing needs. By 2013, those funds were 100 percent obligated and had resulted in the creation or preservation of 3,417 affordable units. The CSH's 2010 report clearly identified a need for 1,891 PSH units in Austin. In September 2010, City Council adopted a PSH strategy that commits to developing 350 PSH units within the next four years. In 2013, voters approved $65 million in GO bonds for affordable housing. Based on previous leverage and per-unit costs, it is anticipated that the bonds will result in more than 4,000 deeply affordable housing units.

In addition, Austin was recently awarded two Pay-for-Success investments centered on developing Housing First permanent supportive housing in the city. In total, these awards and their match will dedicate $1.3 million to develop a Pay-for-Success initiative, which will bring investors, philanthropists, property owners, health care and social services providers, and government partners to the same table to increase the capacity to end homelessness.

IV. Orlando

Lead Agency: Homeless Services Network with assistance from the Central Florida Commission on Homelessness

Goal: Rethink homelessness

Background: In 2011, Florida had the second-largest population of veterans experiencing homelessness in the nation, second only to California. In fact, HUD and the United States Interagency Council on Homelessness issued a report in May 2013 that ranked Central Florida number one in chronic homelessness for like-sized cities and in the top four in every category of homelessness measured.

Just days before Christmas in 2015, the Central Florida Commission on Homelessness announced that virtually all the region's once chronically homeless veterans were in housing. In all, nearly 1,000 veterans have been housed over the past three years. The annual point-in-time count showed a 23 percent drop in homelessness in just one year.

What Did They Do? Florida Hospital announced in 2014 that it was committing $6 million over three years to address homelessness in the region. The city of Orlando dedicated a position to the issue with a senior advisor to the mayor on homelessness, Orlando Housing Authority and Homeless Services Network pledged subsidies and other resources, and Orange County allocated an additional 40 units for the chronically homeless in 2015. Orange County became the largest source of funds for homeless programs in Central Florida. In addition to this fiscal year's $7.7 million, the county government recently announced $4 million for new affordable housing projects that will set aside units for individuals experiencing homelessness as well as homeless families with children.

V. Denver

Lead Agency: Metro Denver Homeless Initiatives (MDHI)

Goal: Reduce chronic and episodic homelessness

Background: The City of Denver, like many other communities around the country, faces limited resources to invest in existing preventive programs for people experiencing chronic homelessness and individuals who struggle from mental health and substance use challenges. The Denver Crime Prevention and Control Commission (DCPCC) has tracked these interactions across systems for the last four years and has calculated that a group of 250 heavy utilizers cost taxpayers upward of $7.3 million per year on average.

What Did They Do? Denver has developed a social impact bond initiative to ensure the city is paying for the most effective services— "Paying for Success"—and shifting its spending from short-term band-aids to long-term, sustainable solutions. The supportive housing initiative targets individuals experiencing chronic homelessness who also struggle with mental health and substance use challenges.

Through local and national partner organizations, the initiative will serve at least 250 chronically homeless individuals over the next five years using social impact bond financing in combination with existing housing and Medicaid resources. The program will be based on a proven model that combines the approaches of Housing First with a modified assertive community treatment (ACT) model of intensive case management.

Appendix C: Subcommittee Reports and Recommendations

DATA, TECHNOLOGY, AND INNOVATION SUBCOMMITTEE

OBJECTIVE 1 –

a. Identify ways to use data and technology to improve the overall community response system.

b. Understand the current environment in our community, review best practices, and prepare strategies and recommendations to position us among the most progressive.

Recommendation # 1: Implement a comprehensive and coordinated Homeless Management Information System (HMIS) to capture demographic and performance data across the spectrum of homelessness. Consistent data capture and analysis will enable a more complete assessment of how well the community is preventing and ending homelessness. System-wide adoption of coordinated entry and assessment practices is essential to the timely, effective provision of services most closely aligned with client needs. MDHA will serve as the lead agency responsible for implementation and coordination of the HMIS platforms, including PCCI's IRIS and OrgCode's VI-SPDAT tools across the network of agencies and providers.

Recommendation # 2: Establish system-level performance measures to (a) enable the community to evaluate and improve its performance in preventing and ending homelessness and (b) maximize the community's access to HUD funding Continuum of Care (CoC) programs. HUD has expressly stated its priorities regarding HMIS and system-level performance measures and charged CoC's (defined as a community plan to organize and deliver housing and services to meet the specific needs of people experiencing homelessness as they move to stable housing and maximize self-sufficiency) to organize and operate as an integrated system of homeless assistance, and its selection criteria for awarding funding is in large part a function of a CoC's alignment with these priorities. In addition, routine, coordinated system-level performance measurement will enable timely, credible, and transparent public reporting of the results of the community's progress.

Recommendation # 3: Design, fund, and implement incentives and mandates to encourage coordinated, comprehensive, and transparent data sharing in one single open source. Systemic change is dependent on system-wide adoption of HMIS. As resources are increasingly targeted to achieve specific goals, access to these resources will require compliance with policies, procedures, reporting, and performance expectations.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority / Integration with Other Recommendations
All	**Lead Agency:** Metro Dallas Homeless Alliance will establish the formal governance and infrastructure necessary to lead the system and has put into place a strategic work plan that it is following to build an effective homeless response system. **Collaborating Departments/ Agencies:** PCCI Iris, city government, county government, private funders, nonprofit agencies serving the target population, hospital systems	• Change in the number of agencies participating in HMIS system for all clients • Change in the number of chronically homeless or those identified as most at risk receiving services • Increase in HUD and other funding brought into the community • Track housing placements/attrition • Track hospital and jail entry and discharge • Track job placements • Track seasonal day and night shelter bed usage	• PCCI Iris has been selected by the MDHA board of directors to serve as the HMIS system for the Continuum of Care. • Agencies funded by HUD will use this system to catalog their homelessness-related activities. HUD funding available for these agencies is $400,000 annually. • This is an excellent step in the right direction. Many community organizations serving the homeless population have maintained multiple information systems for years, or none. • Data sharing and coordination across organizations is required to fully address homelessness. Doing so will allow unprecedented alignment, focused community-wide strategies, and provide overarching analytics across organizations. • Funding beyond HUD is necessary to achieve full implementation.	This is one comprehensive recommendation and is our first and only priority.

Table 1: Current Investments Made in Community Platform (Pieces Iris)

	Funding Secured	Funding Organizations
Development of Community Platform (Pieces Iris)	Over $13 Million	Communities Foundation of Texas, W. W. Caruth Jr. Foundation, United Way of Metropolitan Dallas, Commonwealth Foundation, RWJF
HMIS System and MDHA Staff to Support HMIS	$400,000 Annually	HUD

Table 2. High-Level Budget Proposal to Expand HMIS System (Pieces Iris)

Objective	Estimated Funding Requested
One-time data migration from legacy systems to community platform	$800,000
Centralized community-wide reporting and effectiveness dashboard	$250,000

HOMELESS PREVENTION AND DISCHARGE PLANNING SUBCOMMITTEE

OBJECTIVE 1

Reduce the number of people discharged into homelessness from legal, social services, and health care delivery systems, including custodial care facilities such as correctional facilities, hospitals, and residential behavioral health treatment facilities.

Recommendation # 1: Develop and implement system-wide protocols to ensure that all persons entering treatment and correctional facilities are screened for housing stability upon intake and at release and staff these facilities with dedicated homeless system navigators who link those identified as experiencing homelessness with housing (temporary or permanent) and supportive services.

Population Impact	Best Practices and Existing Models	Potential Performance Metrics	Funding	Long- and Short-Term Goals
Although potentially any population can be found in custodial care treatment programs, the primary needs are with single adults, veterans, and chronically homeless adults.	• Frequent Users Systems Engagement (FUSE) framework developed by the Corporation for Supportive Housing (CSH) • Harris County and other jurisdictions that have engaged CSH for systems development around frequent utilizers	• Number of consumers screened for housing stability at treatment facility • Number referred for housing (temporary or permanent) and supportive services • Outcomes of the referrals-number housed through rapid re-housing, number of placements in PSH, respite care, temporary supportive shelter, etc.	Estimated annual cost is $400K, which includes salary and benefits cost for 5 homeless system navigators at the Dallas County Jail, Parkland, and Green Oaks. • Local government funding from Dallas County, the City of Dallas, and other municipalities in Dallas County • Hospitals and Medicaid managed care organizations that are financially incentivized to reduce readmissions • Philanthropy	**Immediate:** After funding is secured to support these staff positions, the largest facilities and organizations that are discharging homeless individuals can hire for these positions and implement the services.

Recommendation # 2: Develop medical respite care options for persons needing short-term medical or behavioral health support upon release from treatment.

Population Impact	Best Practices and Existing Models	Potential Performance Metrics	Funding	Long-and Short-Term Goals
While potentially any population can be found in custodial care treatment programs, the primary needs are with single adults, veterans, and chronically homeless adults.	• Austin Recuperative Care Program (RCP): Leases beds from a nursing and rehabilitation facility. RCP reports significant (>70%) reduction in ER visits following respite care, with 62% discharging directly into permanent housing. Average length of stay is 50 days. • The Homeless and Community-Based Services model is currently used by the Department of State Health Services to provide intensive wraparound services in community settings for the intellectual and developmentally delayed population. Many consumers reside in group home type facilities. This model is being expanded to persons with frequent use of the state hospital systems and for jail diversion.	• Number of consumers placed in respite care • Length of stay in respite care • Permanent housing placement upon discharge from respite care • Reduced recidivism rates	Establish medical respite beds. The Bridge has space for 14 beds; more beds are needed. **Additional Note:** Many individuals need assistance with activities of daily living (ambulating, hygiene, toileting). Some people cannot stand for long periods of time in lines or cannot tolerate extremes in their environment (heat, cold, dampness). These numbers are increasing every year. These individuals do not have funding for nursing homes, refuse nursing home care, or do not qualify for skilled nursing facilities. Yet, they cannot care for themselves or conform to typical shelter rules. Shelters have neither the funds nor the appropriate staffing to fill this gap. Well-run group homes could be part of the answer. Hospitals would be required to provide transportation to the facility. Medical personnel associated with the respite facility would need to monitor the appropriateness of the referrals.	**Short-Term:** With the allocation of nursing staff and wraparound services, the community can immediately begin providing respite care for 14 homeless adults. Assuming an average length of stay of 30 days, an estimated 170 persons can be served annually with these 14 beds. **Long-Term:** Develop additional respite care options and funding.

OBJECTIVE 2

Strengthen community efforts to prevent homelessness with a focus on eviction prevention and increasing workforce development skills and financial literacy skills for individuals at risk of homelessness.

Recommendation # 1: Increase investment in eviction prevention and rapid rehousing funding and improve coordination of financial resources with organizations providing the case management support.

Population Impact	Best Practices and Existing Models	Potential Performance Metrics	Funding	Long-and Short-Term Goals
This recommendation will impact all populations.	• Hennepin County's Homeless Prevention Program helped nearly 1,700 families, single adults, and youth in 2014 and 2015. A total of 95% of families and single adults were stable six months after receiving assistance. The average prevention cost was $1,104 per family or $714 per adults.	• Number of households referred for short-term to medium assistance and the number receiving assistance. • Number of households that avoided eviction. • Number of people receiving assistance who remained housing six months' post assistance.	Estimated financial investment needed = $31.2 M. This is a conservative estimate that will provide 3,100 households living in poverty with financial assistance to avoid eviction and will utilize $1,000 as the average prevention cost. • Emergency Solutions Grant provides eviction prevention and rapid rehousing funding and is distributed among city and county governments. • Supportive Services for Veteran Families provides eviction prevention and rapid rehousing funding for veteran families. • Local government funding from Dallas County, the City of Dallas, and other municipalities in Dallas the County, faith, and philanthropy communities.	**Intermediate:** After funding is secured to support these staff positions, the largest facilities and organizations that are discharging homeless individuals can hire for these positions and implement the services.

Recommendation # 2: Increase DISD resources to allow earlier identification and intervention of people experiencing homelessness or at risk of homelessness resulting in an improved connection to nonprofits in the community that can assist the families with housing, workforce development, financial literacy, and basic needs.

Population Impact	Best Practices and Existing Models	Potential Performance Metrics	Funding	Long-and Short-Term Goals
Families and Youth	Lincoln County School District in Oregon created the Homeless Education and Literacy Project (HELP). They have four HELP Centers located within schools in their district as well as have five staff dedicated to helping the 717 students identified as homeless and at-risk families in their district.	• "High risk factors" identified • Number of families at risk of homelessness identified • Number of families at risk of homelessness who avoid eviction • Number of families at risk of homelessness engaged with nonprofits within the community	Estimated financial investment of $1.5 M to: DISD staff Homeless Identification and Assistance Training = $22,800 Increase number of drop-in centers for homeless youth and families = $950,000 Hire 9 additional homeless liaisons = $450,000 • Dallas Independent School District (McKinney-Vento federal funding) • State of Texas	**Immediate:** With limited financial investment, DISD can train staff in all 228 on Homeless Identification and Assistance. **Long-Term:** The creation of additional drop-in centers and hiring additional homeless liaisons requires significant financial investment and the coordination of multiple systems.

HOUSING AND FINANCING OF SUPPORTIVE HOUSING SUBCOMMITTEE

Dallas continues to experience a significant "housing gap" among its poorest residents—those who experience homelessness. Based on available data about the current inventory and the need, the subcommittee identifies immediate, short-term, and long-term recommendations.

OBJECTIVE 1

Some individuals experiencing homelessness need housing with supports and services to successfully end their homelessness. The evidence-based practice of permanent supportive housing (PSH) successfully helps people with significant service needs retain housing. To close this gap, 995 additional PSH units must be provided, with 300 new units in 2017.

Recommendation #1: Implement PSH as the evidence-based practice to end chronic homelessness in Dallas. Use the PSH strategy as the city-wide approach to serving people with significant service needs who experience homelessness.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
All citizens will be affected one way or another by this proven approach to ending homelessness in our community.	**Lead Agency:** Commission on Homelessness immediately and Metro Dallas Homeless Alliance going forward **Collaborating Departments/Agencies:** Every governmental, public, private, nonprofit organization, and advocacy group working to eliminate homelessness in Dallas will need to "buy in" to this approach.	Track development and deployment of PSH units that come online in Dallas Track housing retention rates annually among the housed population in all PSH units (new and existing) Assess fidelity of PSH operations using objective criteria Comparative analysis of the use of public benefits and resources before being housed and in the subsequent years after being housed Tracking funding success will be necessary	Research, training, and public education costs TBD	Embracing PSH as the Dallas approach for people with significant needs is foundational and essential. This is our first, most important step.

Recommendation #2: Fund a robust team of housing navigators and case managers that will coordinate and execute housing placements. The team will deliver supportive services using an accepted vulnerability index to determine housing priority on a case-by-case basis. These services are to be provided to all people experiencing homelessness and formerly experiencing homelessness with whom we work from initial street engagement to integration in an acceptable housing community.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
In view of our need to prioritize housing placements based on an agreed-upon national best practice vulnerability index, this category applied to Recommendations 2 and 3 is superfluous.	**Lead Agency (ies):** To be determined/selected by RFP and administered by MDHA **Collaborating Departments/Agencies:** • Dallas County • Dallas-area foundations and organizations driving innovative strategies (such as utilizing Medicaid funds for services to disabled homeless persons being placed in housing) • City of Dallas	Number of persons placed in housing units added to PSH housing stock against annual goal: • Measure success in maintaining housing across all units available • Metrics provided/ required by MDHA that increase community score for Continuum of Care increased funding, and move Dallas/Collin counties to the rank of "high performing Continuum of Care" by the standards of the U.S. Department of Housing and Urban Development • Comparative analysis of client cost savings/ shifting year-to-year as the result of placement in PSH	$1,179,550 (annualized budget) To be funded by the City of Dallas, surrounding cities, Dallas County, and surrounding counties, as well as other public sources, Dallas area foundations, private philanthropy, and faith communities organized and trained to engage, as well as others.	Immediate action required

Recommendation #3: Establish a fund dedicated to developing new housing for people experiencing homelessness. Roughly $75 million in new and existing funding will be needed over the next five years to provide 995 additional PSH units. This recommendation includes a portion of new funding from a proposed general obligation bond of up to $25 million.

A Request for Proposals (RFP) could be issued, and proposed projects will be graded on whether they pass three required tests and then on four criteria. The tests will be as follows:

- **Is the proposal in compliance with city (and any other relevant) housing policies?**
- **Is the proposal financially feasible?**
- **Does the developer or development group have the proven ability to complete the development and to provide adequate support services to maintain housing for people formerly experiencing homelessness?**

The criteria (100-point scale, 25 points for each) will be:

- **How efficiently does the proposal use the dedicated funding? How much per unit and how much of it comes from other sources?**
- **How long will the proposal take to be complete?**
- **What is the quality of the housing?**
- **What is the quality of the location? Is it in a bad neighborhood? Is it located near public transportation?**

Proposals will be funded in the order they are ranked, and once per year new proposals will be accepted and ranked against existing proposals, which will remain in the queue until funded or withdrawn.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
All homeless persons, including people experiencing chronic homelessness	Lead Agency: MDHA and/or the Mayor's office will assist with forming the "panel" of donors that will decide the use of the new fund. Collaborating Departments/Agencies: City, Counties, Dallas Housing Authority, private developers, nonprofit organizations working among people experiencing homelessness, and academics who will evaluate the work.	Track the production and deployment of housing units using development strategies; track access to housing through vouchers and other approaches Track housing retention rates annually among the housed population Conduct comparative cost analysis of the use of public benefits and resources before and after housing Track performance of funded projects	Will require 75,000,000 over 5 years; includes targeted use of existing funding streams, DHA resources, as well as new funding (such as GO bond)	Immediate action required

OBJECTIVE 2

Some individuals experiencing homelessness need shorter-term assistance, including rapid access to housing with short-term services. The Rapid Re-Housing (RRH) approach is recommended for this group of people experiencing homelessness. To close the gap for this group, 4,200 units of RRH must be made available.

Recommendation #1: Expand and implement a coordinated system-level RRH program that supports community priorities to end homelessness and community goals to end family homelessness.				
Population Impact	**Who Will Execute?**	**Potential Performance Metrics**	**Funding**	**Priority/Integration with Other Recommendations**
All	**Lead Agency:** Commission on Homelessness immediately and Metro Dallas Homeless Alliance going forward Collaborating Departments/Agencies: Every governmental, public, private nonprofit organization and advocacy group working to eliminate homelessness in Dallas will need to "buy in" to this approach.	Track provision of new and existing RRH units Track housing retention rates and recidivism Comparative analysis of the use of public benefits and resources before being housed and in the subsequent years after being housed	Estimated allocation of $30M to support 4,206 RRH units over five years. RRH costs are based on: • RRH rental assistance (1BR $4438; 2BR $7046) • RRH services cost per household (1BR $2640; 2BR $3323)	Immediate action required

INCREASED PERMANENT SUPPORTIVE HOUSING—IMPLEMENTATION ANALYSIS

The subcommittee recommends increasing PSH by 995 units by using two strategies—development and increased access to existing housing. Development includes new construction, the acquisition/conversion/rehabilitation of existing properties, and the development of alternative strategies such as container homes. Increasing access to existing units is accomplished through leasing. Leasing strategies include maximizing housing authority resources, an aggressive landlord outreach and support program, and master leasing. The subcommittee offers this analysis as an illustration of one way the goal can be accomplished. Of the needed 995 units, this example proposes to develop 320 units and lease 675 units between 2017 and 2021, with 950 units intended for single adults and 45 units intended for families. The model proposes an aggressive start in 2017, assisting 300 high-need individuals. The annual target numbers then decline each year.

Table 1: Example—possible use of development and leasing strategies for singles and families, 2017–2021

Type	2017 All singles	2018 All singles	2019 Includes 20 families	2020 Includes 25 families	2021 All singles	Total by type
Development	50 units	50 units	70 units	75 units	75 units	320 units
Leasing category	250 units	125 units	100 units	100 units	100 units	675 units
Target total by year	**300 units**	**175 units**	**175 units**	**175 units**	**170 units**	**995 units**

In the financial modeling *for development* presented below, estimates include housing costs, ongoing operating and supportive services costs. Costs for leasing, with service dollars included, are presented as well.

In reviewing the examples of possible activity in 2017 and 2021, please note that 2017 proposes to expand 250 units through leasing and 50 units through development, all for singles (Table 2). In the 2021 example, the new leasing target number is set at 100, and 75 units are proposed for development, again, all for singles (Table 3).

Table 2: Example—PSH Units for 2017

Development = 50 units; Leasing = 250 units

NEW COMMITMENTS—2017				
DEVELOPMENT—50 UNITS	**CAPITAL**	**OPERATING**	**SERVICES**	**TOTAL**
Source	**2017**	**2017**	**2017**	
City of Dallas Community Development	$1,000,000			**$1,000,000**
Dallas County Community Development	$153,050			**$153,050**
LIHTC				**$0**
City of Dallas Obligation Bonds	$4,000,000			**$4,000,000**
NHTF	$100,000			**$100,000**
FHLB	$100,000			**$100,000**
In-Kind/Land	$200,000			**$200,000**
Developer Equity	$100,000			**$100,000**
Philanthropic	$700,000		$500,000	**$1,200,000**
DHA		$500,000		**$500,000**
DCHA		$250,000		**$250,000**
CoC		$550,000	$500,000	**$1,050,000**
HHSP		$246,050	$274,800	**$520,850**
Medicaid			$50,000	**$50,000**
TOTAL	**$6,353,050**	**$1,546,050**	**$1,324,800**	**$9,223,900**

Leasing: 250 units, including service costs = $3,173,500

Development = 75 **units**; Leasing = 100 units

New Commitments—2021				
	CAPITAL	**OPERATING (INCLUDING LEASING STRATEGY)**	**SERVICES**	**TOTAL**
Source	2021	2021	2021	
City of Dallas Community Development	$2,000,000			$2,000,000
Dallas County Community Development	$320,000			$320,000
LIHTC	$1,500,000			$1,500,000
City of Dallas Obligation Bonds	$4,000,000			$4,000,000
NHTF	$200,000			$200,000
FHLB	$150,575			$150,575
In-Kind/Land	$200,000			$200,000
Developer Equity	$100,000			$100,000
Philanthropic	$1,059,000		$100,000	$1,159,000
DHA		$750,000		$750,000
DCHA		$50,000		$50,000
CoC		$550,000	$150,000	$700,000
HHSP		$130,125	$67,950	$198,075
Medicaid			$50,000	$50,000
TOTAL	**$9,529,575**	**$1,480,125**	**$367,950**	**$11,377,650**

Leasing: 100 units, including services costs = $**95**s**2**,050

SHELTER AND CRISIS SERVICES SUBCOMMITTEE

OBJECTIVE 1 –

Provide immediate access to shelter and crisis services without significant barriers to entry, while permanent stable housing and appropriate supports are being secured.

Recommendation #1: Increase placements from shelter system to housing system by 300 per year by investing in a collaboration modeled on Franklin County, Ohio; Houston; and other major metropolitan areas recognized for innovative housing placement collaborations; coordination of key activities modeled on community shelter board, Columbus shelter/housing, and Bridge/DHA processes (documented in their MOAs).

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
All	Shelter providers; housing providers	Metrics (from community shelter board, Columbus): • Individuals/ households served • Successful housing outcomes • % of successful housing outcomes • Average engagement time • Average length of stay • Movement % • Recidivism % • Pass/fail program review	**Cost:** $3M additional per year (homeless recovery costs from VA's health care for homeless veterans' program, to be distributed for both housing placement services from shelter system and administrative services from housing systems)	Number one

Recommendation #2: Increase utilization of shelter system by 150 per night/day, including utilization of respite care bed				
Population Impact	**Who Will Execute?**	**Potential Performance Metrics**	**Funding**	**Priority/Integration with Other Recommendations**
Single adults Veterans Adults experiencing chronic homelessness	Shelter providers	Metrics (from community shelter board, Columbus): • Individuals/ households served • Successful housing outcomes • % of successful housing outcomes • Average engagement time • Average length of stay • Movement % • Recidivism % • Pass/fail program review	Cost: $3M additional per year (shelter and homeless recovery costs from VA's health care for homeless veterans' program, per diem--$55)	Second priority

OBJECTIVE 2 –

Create new options for temporary housing. The Shelter and Crisis Services Subcommittee recommends increasing the system capacity to respond to needs for temporary, safe housing. Through years of observation, we have noted that many individuals benefit from longer, while still temporary, stays in emergency shelters. Shelter is not the ideal environment for these longer stays, even though they seem to benefit a subset of our homeless population. We recommend a new alternative, a temporary housing choice modeled after single room occupancy residences. This new alternative will offer an extended, but still temporary, stay in a safe space.

Recommendation #1: **Develop temporary housing options.**				
Population Impact	**Who Will Execute?**	**Potential Performance Metrics**	**Funding**	**Priority/Integration with Other Recommendations**
All	Shelter providers; funding sources	Metrics • Individuals/households served • Length of stay in temporary housing • % of successful transfers to permanent housing • Average length of stay • Recidivism %	Develop cost modeling to support temporary housing options. Include: • RRH resources • SRO capital and operating funding • Project-based vouchers	Needs immediate action to begin

STREET OUTREACH, UNSHELTERED HOMELESS, HEALTH, AND SUPPORTIVE SERVICES SUBCOMMITTEE

OBJECTIVE 1 –

Identify, engage, and assist unsheltered homeless populations.

Recommendation #1: A crisis response team, composed of members from multiple agencies but functioning as one agency, should be created. Ideally, the team would work full time and collaborate closely with an assertive community treatment (ACT) team. The team must conform to the Coordinated Assessment Priority Status Guidelines for Continuum of Care Housing Resources to guide the outreach efforts. The United States Interagency Council on Homelessness states the crisis response team should a) identify individuals experiencing homelessness, b) provide immediate access through coordinated entry to shelter and crisis services without barriers to entry, and c) quickly connect individuals to housing assistance.

The outreach team should draw from multiple agencies with skills in outreach to offer a variety of engagement expertise, such as substance use counseling (e.g., peers, LCDC), Veterans Affairs entitlements, faith-based approaches, and housing availability. One team member would have case management duties, including a formal handoff to the "best fit" agency for further coordinated care when appropriate and agreeable to the client.

Information should be recorded in HMIS with photo identification and real-time documentation. Storage of important, costly documents would be accomplished via scanning or photography. Team members need access to a detailed and comprehensive resource database for referrals and assistance with medical, mental health, and substance use issues. All outreach team members would participate in an alert system to allow immediate notification of potentially dangerous and evolving situations.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Single adults Veterans Adults experiencing chronic homelessness	**Lead Agency:** Metro Dallas Homeless Alliance would request proposals and award the grant. **Collaborating Departments/Agencies:** Essentially all agencies that assist individuals experiencing homelessness: City of Dallas Crisis Intervention, City of Dallas Housing, shelters (Bridge/Dallas Life Foundation/Union Gospel Mission/Center of Hope/Austin Street/Salvation Army/Promise House), City Square, Metrocare/ABC/Phoenix House, Veterans Affairs, Our Calling (peer, volunteer, spiritual), Homeward Bound/Turtle Creek/Nexus, Parkland/Baylor/EMS	Team formed Team operates X hours per week Team has X number of contacts X number of people make it into a shelter/housing X number of other referrals completed	Cost can be tiered from one half-day a week to all day 5 days a week. The ACT team would be responsible for the mental health care. A substantial though poorly coordinated outreach effort already exists. Funding would be used to provide structure and additional outreach individuals to achieve full time status.	This is the number 1 recommendation to engage and assist the unsheltered homeless population.

OBJECTIVE 2

Develop a protocol with procedures for addressing homeless encampments.

Recommendation #1: An encampment would be closed for a specific reason not based on complaints (unsafe for the inhabitants, health risk); the initial step should be to help those in the encampment not focused on closing; agencies should be present to offer beds; closure should still follow the Coordinated Assessment Priority Status Guidelines for Continuum of Care Housing Resources and not be a way to jump to be the top priority; data for all encampment individuals will reside in the Metro Dallas Homeless Alliance's Homeless Management Information System (HMIS); 45 days minimum to plan for closure; the crisis response team would devote up to 50% time to an encampment that was deemed by the city to be closed.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Single adults Veterans Adults experiencing chronic homelessness	**Lead Agency:** City of Dallas **Collaborating Departments/Agencies:** Crisis response team, assertive community treatment (ACT) team, all housing providers in the coordinated assessment system	Percentage of encampment persons placed in shelter or housing; avoidance of any lawsuit	$1,179,550 (annualized budget The City of Dallas would fund the actual closure activities. The crisis response team and ACT team would divert some existing resources	This is a lower-priority recommendation than creating strong ACT and crisis response teams. This priority will only be successful with a successful housing plan.

OBJECTIVE 3

Improve the quality, scope, and delivery of medical services.

Recommendation #1: Establish medical respite care. The United States Interagency Council on Homelessness supports the creation of a medical respite program to allow hospitals to discharge homeless, medically complex patients to respite care to help stabilize the medical condition and assist them to return to or obtain stable and safe housing. Medical respite care for people experiencing homelessness is defined as acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be in a hospital. Nationwide, the average hospital stay for most patients is 4.6 days, but those facing homelessness average a stay nearly twice as long. The costs associated with these increased lengths of inpatient stays can be substantive for both hospitals and the larger health care system—medical respite care can offset the impact of these expenditures. Homeless patients discharged to a medical respite program experience 50% fewer hospital readmissions within 90 days and 12 months of discharge compared to patients discharged to their own care.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Families (adult members only) TAY (transition age youth) Single adults Adults experiencing chronic homelessness (superfluous)	**Lead Agency:** Area hospitals **Collaborating Departments/Agencies:** Housing agencies must be a crucial part of the program to ensure there is an appropriate place to discharge the individuals after their recuperative time has ended.	Number of respite beds; duration of respite care; percentage of respite patients discharged to housing	Establish medical respite beds. The Bridge has space for 14 beds; more beds are needed. Additional note: Many individuals need assistance with daily living activities (ambulating, hygiene, toileting). Some people cannot stand for long periods of time in lines or cannot tolerate extremes in their environment (heat, cold, dampness). These numbers are increasing every year. These individuals do not have funding for nursing homes, refuse nursing home care, or do not qualify for skilled nursing facilities. Yet, they cannot care for themselves or conform to typical shelter rules. Shelters have neither the funds nor the appropriate staffing to fill this gap. Well-run group homes could be part of the answer. Hospitals would be required to provide transportation to the facility. Medical personnel associated with the respite facility would need to monitor the appropriateness of the referrals.	**Number one** medical priority

Recommendation #2: Provide medical services to residents of permanent supportive housing while reducing duplication of services. Wraparound services for those in permanent supportive housing must include both behavioral and physical health services. Relying on an already saturated and difficult to navigate community health care system far too often results in the inappropriate use of the emergency departments for such things as prescription refills and management of chronic conditions.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
All	**Lead Agency:** Community health care providers **Collaborating Departments/Agencies:** Providers of permanent supportive housing	Number of permanent supportive housing residents with an identified primary care provider; perhaps emergency room use and hospitalization	No additional funding, just better coordination and avoidance of duplication	High priority because it speaks to a more efficient use of existing resources

Recommendation #3: Identify resources to conduct physical disability examinations. Currently insurance or fees are required to specify any limitations in function that result from the condition or disorder, including lifting/carrying/pushing/pulling; sitting/standing/walking; posture (for example, climbing/stooping/bending/balancing/crawling/kneeling/crouching); fine motor skills (that is, handling/fingering/gripping/feeling); overhead and forward reaching; environmental exposures (for example, heat/cold/humidity/noise/vibration).

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Single adults Adults experiencing chronic homelessness	**Lead Agency:** Metro Dallas Homeless Alliance (MDHA) **Collaborating Departments/Agencies:** Medical providers would make the referrals for financial assistance	Number of examinations funded; of those funded, the number of individuals who obtained Social Security Disability (SSD) benefits	MDHA flex fund; referrals from hospitals might require a fee	This is important to establish financing for a person with disabilities

Recommendation #4: In 2014, about 4.3 million Americans reported nonmedical use of prescription opioids. Chronic pain, as well as pain medication addiction, is a frequent issue for adults experiencing homelessness. These problems greatly contribute to frequent visits to the area emergency rooms and high, redundant utilization of medical services. The American Society of Addiction Medicine (ASAM) created a National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Nationally, 30% of drug treatment programs offer medication treatment for opioids. Buprenorphine represents the latest advance in medication-assisted treatment of heroin and opioid dependency. In Dallas, patients who are experiencing homelessness do not have access to buprenorphine treatment.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Adults	**Lead Agency:** Either a medical or drug treatment provider **Collaborating Departments/ Agencies:** Area hospitals, substance use treatment programs, and primary care providers	Number of patients screened for the program, number of patients who enter the program, and number of patients who complete the program	HRSA or SAMHSA grant	High, with recommendation # 1 on page 50

OBJECTIVE 4

Improve the quality, scope, and delivery of behavioral health services.

Recommendation #1: People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. These co-occurring disorders are common among people experiencing homelessness. Integrated screening of individuals experiencing homelessness is an important first step to identify who would benefit from specialized housing with treatment programs that integrate mental health, physical health, and recovery elements to address the variety of services required.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Adults	**Lead Agency:** North Texas Behavioral Health Leadership Team **Collaborating Departments/ Agencies:** Medical, behavioral health, and recovery providers	Number of individuals needing services for co-occurring disorders, number of individuals placed in a treatment program, number of individuals who successfully complete the program	SAMHSA State Behavioral Health Funds Residential treatment for co-occurring disorders is a minimum of $90 per day.	High

Recommendation #2: Group homes should be licensed by the city and routinely inspected. Educational meetings for group home operators could provide overviews of licensing requirements, provide resources in the community, establish uniformity in referrals, and offer support. Group home operators may need to have access to additional operating resources above disability checks to meet minimum standards.

Population Impact	Who Will Execute?	Potential Performance Metrics	Funding	Priority/Integration with Other Recommendations
Single adults Veterans Adults experiencing chronic homelessness	**Lead Agency:** City of Dallas **Collaborating Departments/Agencies:** Mental health programs that refer individuals to group homes; group homes	Frequent and regular inspection of all group homes, licensing of group homes, and outcomes of inspections	Inspectors trained and paid by the City of Dallas	This priority needs to be inserted into the housing priority planning for those individuals who are not ready to live in permanent supportive housing.

OBJECTIVE 5

Improve the quality, scope, and delivery of substance use services.

Recommendation #1: **Increase residential services; buprenorphine/naloxone treatment for opioid addiction; naltrexone; help address chronic pain.**				
Population Impact	**Who Will Execute?**	**Potential Performance Metrics**	**Funding**	**Priority/Integration with Other Recommendations**
All	**Lead Agency:** Who oversees executing this recommendation? **Collaborating Departments/Agencies:** Homeward Bound, Nexus, Salvation Army, Turtle Creek, Veterans Affairs, housing agencies, hospitals	Quantitatively and qualitatively, how will we know whether we are successful with this recommendation?	TBD	TBD

Appendix D: Sample Leadership and Accountability Structures

SAMPLE LEADERSHIP AND ACCOUNTABILITY STRUCTURES

Los Angeles, California: The city of Los Angeles is in Los Angeles County. The Los Angeles CoC includes much of Los Angeles County, including the city of Los Angeles and 84 other cities but excluding three medium-sized cities (Glendale, Long Beach, and Pasadena).

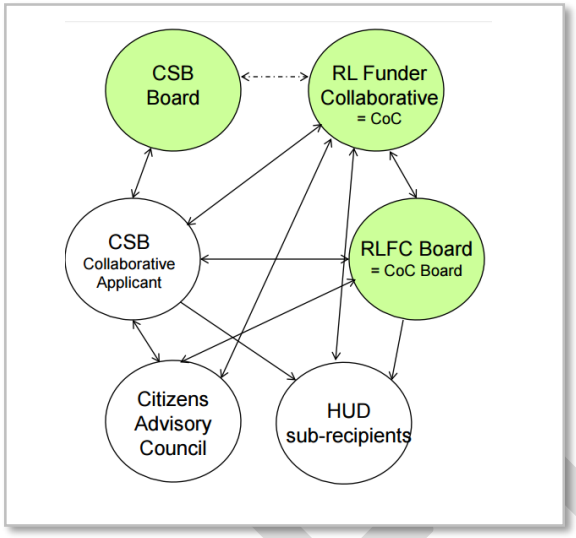
The CoC is governed by a politically appointed Los Angeles Homeless Services Authority (LAHSA) that includes five representatives appointed by the city mayor and another five county representatives, each appointed by a county commissioner (https://www.lahsa.org/commission). LAHSA has an executive director and a management team of seven additional people, but it is not clear how many staff it has. https://www.lahsa.org/leadership

In 2009, LAHSA established the LA CoC Coordinating Council, which is designed to expand community input into the CoC process. Currently, the Coordinating Council votes on policies before they are voted on by LAHSA. These minutes contain the Coordinating Council's charter: https://documents.lahsa.org/planning/2016/Coordinating-Council-Meeting-Agenda-and-Supporting-Documents-April-2016.pdf. In 2016, LHASA's Ad Hoc Governance Committee met to respond to the city's and county's request that it form a Regional Homelessness Advisory Council that will serve as the CoC Board, as defined by the HEARTH Act. https://documents.lahsa.org/Administrative/Supporting-Documents/2016/06.23.16SpecialCommissionAgenda&SupportingDocuments.pdf

Columbus, Ohio: Columbus is recognized by HUD as an effective model. There are two community structures: The Community Shelter Board (CSB) and the Rebuilding Lives Funder Collaborative (RLFC). The CSB oversees community efforts to address homelessness, including the work of the RLFC, and has more than $30 million in funding from diverse sources. The RLFC provides "stewardship and oversight" for implementation of the community plan and serves as the CoC lead agency for HUD purposes. Provider agencies operate within the plan and are working within an outcome-oriented performance measurement system.

The CSB Board has representatives from the following: City of Columbus (four members); Franklin County Board of Commissioners (four members); Columbus Chamber of Commerce (two members); United Way of Central Ohio (two members); The Columbus Foundation (one member); Metropolitan Area Church Council (one member); At-large (six members). The RLFC Board has one representative each from the following: City of Columbus; Franklin County; Citizens Advisory Council; Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH); Columbus Metropolitan Housing Authority; United Way of Central Ohio; The Columbus Foundation; Columbus Coalition for the Homeless; Affordable Housing Trust Corporation; Ohio Capital Corporation for Housing; Community Shelter Board.

Snapshot of Columbus, Ohio, Leadership Structure (2013 NAEH presentation):



Houston, Texas: Houston's homelessness initiative, The Way Home, is a significant system change that was introduced in 2012. The system is governed by a 17-member steering committee, with representatives as follows:

City of Houston	City of Pasadena	Funders Together Coalition
Harris County	Provider representatives (2)	Interfaith community
City of Houston PHA	Consumer representatives (2)	At-large agency representatives (3)
Harris County PHA	Business Community	Fort Bend County
Montgomery County	Gulf Coast Workforce Board	VA Medical Center

The Steering Committee is the primary decision-making body for the system to address homelessness and is described as the "single table for all systems and funders to align investments, standardize performance expectations, and operating policies" (http://www.endhomelessness.org/page/-/files/Houston%20Governance_NAEH_072213.pdf). The Coalition for the Homeless operates the CoC system. Related network and task groups work on planning and make policy recommendations to the steering committee. The city employs a full-time special assistant to the mayor for homeless initiatives.

Richmond, Virginia: Richmond is using the collective impact model of social change (http://www.collaborationforimpact.com/collective-impact/) to develop, organize, and implement a community-wide solution to homelessness. The community's process included a conceptual shift among key players to the collective impact approach, including developing a common agenda, consistent outcome measurement, "mutually reinforcing activities," and a structure that supports communication and transparency. This model includes a backbone organization—in Richmond, this is Homeward. Homeward operates the CoC and serves as the collaborative applicant. The CoC board of directors is a mix of business community representatives, foundations, providers, and government agencies (www.homewardva.org).

SAMPLE CHARTERS/BY-LAWS

- Columbus, OH: http://docs.csb.org/file-Continuum-of-Care-Structure-FY-2017.pdf
- Houston, TX: http://www.homelesshouston.org/wp-content/uploads/2013/12/December-2013-Meeting-Packet.pdf
- Chicago, IL: http://www.allchicago.org/sites/default/files/Chicago%20CoC%20Charter%20Package%20Final_Proposed2.pdf
- Orange County, CA: http://www.ocpartnership.net/images/website/1236/files/final_coc_governance_charter_2113.pdf