Phoenix CoC Check-up Debrief Meeting Notes

Areas of Strength	
Governance and Structure	
1. Seated as a committee of the Maricopa Association of Governments, the CoC primary decision-making group has its administrative roles and responsibilities clearly written out, as well as working committees, sub-committees and groups that work towards effectively accomplishing CoC goals and management.	• Agreed
2. The CoC has an established process in place to evaluate programs on a regular basis. It has a written and transparent process for evaluating and selecting projects for the annual CoC funding competition, a neutral ranking process, and a clear procedure for communicating decisions.	• Agreed
3. The CoC uses APR, HMIS and other performance data in the annual CoC application review process to inform its decision making to evaluate projects and allocate resources more effectively.	• Agreed
CoC Plan and Planning Process	
4. The CoC has a written strategic plan to prevent and end homelessness that is consistent with the Ten Year Regional Plan, recognized by CoC stakeholders, and is overseen by a specific body tasked with implementation and regular review and update of the Plan. The Strategic Plan has over 30 specific action steps and entities that are responsible for carrying out parts of the plan.	• Agreed
5. The CoC has been engaged in the development of the Arizona Plan to Prevent and End Homelessness for Veterans. The plan localizes the Federal Strategic Plan to End Homelessness and leverages the goals and action steps in the Regional Plan with a specific focus on homeless veterans.	• Agreed
CoC Infrastructure and Administrative Capacity	
6. The CoC has an HMIS that has been consistently administered by the same lead agency and has high utilization across HUD-funded programs. For example, the HMIS bed coverage in all areas (emergency shelter, safe haven, transitional housing, and permanent supportive housing beds) is at least 73% and over 86% in most areas.	• Agreed
7. The CoC has sufficient capacity to administer HMIS and has policies and procedures in place. The HMIS is able to produce project level APRs, produces system level data for the Homeless Pulse Report, and can generate reports that meaningfully support CoC planning and project development. The number and percent of AHAR Categories with Usable Data is at 100% in 2010 with the inclusion of PSH.	• Agreed
CoC Housing and Services	
8. The CoC includes a range of prevention, outreach, housing (shelter, transitional housing, and permanent supportive housing), and service elements (including rapid re-housing and stabilization), with linkages to mainstream benefits, treatment, and employment assistance systems, whose providers are knowledgeable, and whose programs routinely meet or exceed HUD performance standards	• Agreed

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Areas of Challenge	
Governance and Structure	
9. Although functionally, the CoC is strengthened by the participation of a broad range of stakeholders, participation in decision-making was described as largely restricted to representatives from key government agencies and large providers. Largely seen as missing from or under-represented in goal-setting, decision-making, and evaluation processes were consumers, landlords including public housing authorities, mental health service providers, legal services providers, and representatives from justice/corrections, the academic/research community, and the philanthropic community.	• The CoC has a membership committee that will be working to reach out to segments of the community whose participation is needed.
10. Because of the formal nature of the CoC structure within MAG, stakeholders seemed to see issues with transparency, ability of stakeholders to make their opinions heard, and ability of the CoC to make significant changes. Comments included that the structure was cumbersome and complex and needed more inclusion of service providers and other stakeholders.	• There was a discussion comparing the more highly structured meetings of the Phoenix CoC (in which only appointed decision-makers get to speak, and in which other participants must pass notes to the appointed decision-makers) to the more freewheeling meetings of another Arizona CoC that some participants had attended as providers in that other community. On the one hand, there is concern that erring on the side of too much structure can short-circuit or preclude some important discussions. On the other hand, erring on the side of too little structure could reduce the efficiency and accountability of the CoC at a time when HUD is looking to solidify the locus of accountability. • There was agreement that the solution was not in scrapping the existing structure, but rather in amending it to broaden and deepen participation by stakeholders, while understanding that there are some decisions that a government entity can only entrust to designated persons. This is an area in which TA could be helpful.

CoC Plan and Planning Process	
11. Stakeholders indicated that discharge policies in place by foster care, corrections and health care are not consistent with the CoC plan. There was general agreement that discharge policies from all institutions could be improved to be more consistent with CoC policies.	• The problem isn't with the policies, but instead with the "practice." This is an ongoing issue, but one that is difficult to address. A State-level working group is addressing some of the legal challenges (information sharing, zoning, etc.). As it is not "low-hanging fruit," the recommendation for the Phoenix CoC is to defer addressing it. The one thing that the CoC could do on an interim basis -- as part of the process of creating a more coordinated intake/assessment process -- is to augment the HMIS/intake process to track the frequency with which persons seeking emergency housing have "recently" been discharged from systems of care.

12. Comments indicated that progress implementing the CoC plan may be hindered by 1) the existence of a second, agency-driven community initiative that does not coordinate effectively with the CoC and 2) the CoC's lack of power over individual agencies to implement the necessary changes required in the plan.	• There was some lack of clarity about what was meant by the comment about a "second, agency-driven community initiative that does not coordinate effectively with the CoC." The local United Way (Valley of the Sun UW) has made addressing homelessness one of its top priorities and is part of the Continuum. There is, perhaps, an opportunity to strengthen the connection between the United Way and the CoC, but there is no obvious problem or weakness. • In the discussion about "the CoC's lack of power over individual agencies to implement the necessary changes," there was some agreement about the inherent awkwardness of a group of peers pushing one of its members to do something differently. There was a sense that if program access were more centralized and governed by more uniform standards, and if performance standards could be more clearly delineated, then it would be easier to hold member providers to those standards. Thinking through this process is an area where TA might be helpful.
CoC Infrastructure and Administrative Capacity	
13. Though the CoC monitors all grants by examining program and APR data, the CoC has difficulty monitoring and evaluating the 50+ HUD grants as effectively or thoroughly as it would like because of a lack of administrative staff.	• Agreed
14. Questions related to fair housing advancement generally scored weaker, which may be an area where training is needed.	• Participants were unsure about this element. Perhaps, if there isn't clarity about how the CoC is advancing fair housing practices, it isn't happening to the extent that HUD would like to see. This could be an area where TA might be helpful.

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CoC Housing and Services	
15. Stakeholders indicated a concern that transitional housing providers may not be serving individuals and families who cannot otherwise be more appropriately served in other programs, and that screening is not done upon intake to determine the most effective type of intervention needed. In fact, one comment stated that transitional housing is reserved for the highest functioning people, who may better be served in other, less resource-intensive programs.	• There was agreement that (a) the CoC needs help in resolving questions about the role and performance of transitional housing; (b) moving to a centralized intake -- which makes referral decisions based on explicit admission criteria -- will force an open discussion and resolution of some of these difficult questions; and (c) that information about how transitional housing is used/implemented in other CoCs can help inform the Phoenix CoC's decision-making about TH. This is an area where TA would be helpful. • Some of the ideas that were discussed: ➢ If the goal is helping homeless households gain stability, perhaps persons who have rejected rules/structure in other settings are better served by permanent supportive housing (PSH). To the extent that the CoC seeks to target that population, perhaps it makes sense to convert some TH programs to PSH. Perhaps, in the case of clients with lesser needs, the CoC could substitute "transitional services" for "transitional housing." ➢ If HUD expects TH programs to achieve 65% placement rates in permanent housing, does that discourage enrollment of "risky" clients? Or can the TH model used by some providers be modified to provide structure without some of the sanctions that result in client turnover (e.g., a more relapse tolerant program vs. relapse = discharge) ➢ If "difficult" clients are targeted for PSH, what is the role of TH? If TH programs primarily enroll persons who are not actively involved in substance abuse, or who are well along in their recovery, and persons with potential to work, they become vulnerable to the charge of "creaming" ... and if that is the population currently being served by a significant number of TH programs, why is the CoC's overall placement rate into permanent housing below the HUD target of 65%? ➢ If some TH programs are able to effectively serve households with multiple barriers, and help them gain permanent housing, what does that say about other TH programs that appear to be selecting an "easier" caseload but exhibiting a higher "failure" rate? Perhaps a uniform assessment tool could help clarify whether, indeed, there are such disparities within the CoC, and help inform a collegial process of learning and program strengthening. ➢ To the extent that some programs have "worse outcomes" because they are serving a more difficult clientele, how does that information get communicated to funders, so that they are willing to invest in programs that don't "look as good" on paper? ➢ If there are poorly performing TH programs, what is the best way for a CoC of peer organizations to navigate the awkward process of identifying the need for improved performance, and then providing support for that improvement? This is an area where TA focused on improving mutual accountability among the component programs of the CoC could help.

16. There was general concern over the availability of emergency shelter and transitional housing, as well as street outreach; the ease of navigating the shelter, prevention, and re-housing systems; and the effectiveness of those systems in linking participants to permanent housing.	● Discussion indicated that there is more demand than there are beds. Both individuals and families are calling for shelter. When they cannot find a bed, they may temporarily stay with friends of family, but they are still "homeless". ● There was concern that people who end up on the street are those with fewer resources; they are the "discouraged" homeless, who need someone to reach out and bring help to them; they aren't able to seek out the help. ● There is specific concern about the lack of youth/young adult-specific resources, that is, for persons up to age 25. Youth/young adults (including families headed by a young adult) are one of the fastest growing subpopulations in this CoC. Although there are drop-in and case management resources for homeless and runaway youth/young adults, as well as shelter/TH/permanent housing programs sponsored by UMOM, the CoC could benefit from TA assistance in learning about best practices across the country for preventing and addressing youth/young adult homelessness.

17. One stakeholder noted that the CoC is creating a centralized intake/assessment system and would like help in this, which may address some of the issues noted above. In this new system, the CoC may want to consider including a mechanism for assessing households, and then targeting effective resources to appropriate households.	● See also items #15 and #16. ● Two agencies in the CoC are already using a common assessment tool. However, not all agencies may have sufficient staffing to allow universal assessment, and there isn't necessarily consensus that the existing assessment tool is right for all households. ● There was discussion about the need to strengthen data sharing across CoC providers as part of the process of coordinating intake/assessment/referral. There was interest in learning from examples from other CoCs of successful data sharing. This is an area in which TA could be useful. ● Apropos the transitional housing question (see #15), there was reference made to an ongoing study involving Abt Associates looking at outcomes vis-à-vis household vulnerability. To the extent that the HUD data set is not rich enough to measure vulnerability -- that is, to distinguish potential client households in terms of their needs, housing barriers, challenges faced, etc. -- the CoC would have to agree upon some additional (assessment) fields to collect as part of an augmented HMIS data standard. To the extent that providers "manage what they measure," these fields would have to include indicators that predict client stability (to track progress) as well as variables that might be used to determine which program is best for each client. TA could be useful in supporting the process of reaching consensus on how to expand the HMIS data set. (Mention was made of the dwindling use of the Self-Sufficienty matrix, and that at this point, it is primarily used as a case management tool, rather than for outcomes tracking.) ● With a more refined set of measures of client vulnerability and predictors of stability, the CoC could hold providers accountable for helping clients make progress based on their starting point; that is, in addition to HUD's one-size-fits-all metrics tracking progress to housing and income, regardless of a given household's unique set of vulnerabilities, circumstances, and challenges, a more refined HMIS could provide a basis for more fine-grained tracking of impact, and would provide insights into how their different caseloads affected the "HUD-level performance" of different programs.
18. There was fairly broad concern that local discharge planning practices by foster care, corrections, health care, and mental health care systems is contributing to homelessness	● Yes; as noted above, discussants agreed that the problem is in how discharges are implemented, and not in whether the discharge protocols are adequate. See item #11.

19. There was concern that domestic violence providers were not coordinating effectively with other providers in the Continuum. One of the goals of the updated Regional Plan is to bring together CoC providers and Domestic Violence providers to coordinate and partner on various service provision issues.	• There was agreement that better coordination would be helpful, both in terms of more fully utilizing emergency resources managed by DV providers, as well as in building the capacity of other CoC providers in delivering trauma-informed care, and, in particular, in delivering services to the large numbers of families and women who have experienced domestic violence, but are being served in the "mainstream" homeless system. This might be an area in which limited TA could be of assistance in catalyzing change.
20. There was concern that although many organizations are doing good work, they sometimes operate in silos, and without adequate attention to collaboration. There was suggestion to use the update of the Ten Year Regional Plan as a way to encourage a more comprehensive and cohesive structure amongst providers that strengthens coordination.	• Agreed
CoC HDX Dashboard	
21. Despite a large number of individuals and families on the street, data from the Annual Homeless Assessment Report (AHAR) shows that a large percentage of both individuals and families entering emergency shelter, transitional housing, and even permanent supportive housing are coming from housed situations, either family/friends or rental housing situations. This seems to raise resource allocation questions, with such a large number of families and individuals on the street. Alternatively, the problem could be a data quality issue, or a misunderstanding by some staff of the intent of the “prior living situation” intake question, or that the data used to answer these questions is coming from inadequately updated old assessments dating from the clients' entry into homelessness, rather than from assessments capturing their immediately prior living situation.	• It will take "data mining" to get to the bottom of this issue. However, one very possible reason for the large number of people labeled as coming from housing is that -- as noted above in the response to item #16 -- people who are homeless and are closed out of shelter find friends or family to stay with until they can get into a shelter or other emergency housing. • Although there are certain circumstances in which coming from housing still qualifies a person as "homeless" under HUD's existing regulations, the high percentage of TH and PSH clients who are labeled as coming from a housed situation raises some questions. The revised (broader) definition of homelessness may reconcile some of the problem, with respect to TH (which is accessible to anyone who is homeless), but not necessarily with respect to PSH (which -- at least under the existing regulations -- is available only to persons coming from the street, shelter, or transitional housing after having stayed on the street or in shelter). • This is an area in which TA could be of assistance.
Other Information	
22. The CoC’s outcome for moving households from transitional housing to permanent housing is 57%, which is below the HUD national goal of 65%.	• Addressed in the response to item #15

23. Since the Veterans Administration and veteran service organizations did not weigh in on the self-assessment process, what is the CoC's relationship with the VA and veterans service organizations?	• There is veteran representation in the CoC, and this is not seen as a deficiency.
24. There has been a decrease in the number of sheltered homeless counted in the Point in Time counts, but not a corresponding decrease in emergency shelter and transitional housing capacity. Does this indicate that ES and TH are not running at capacity?	• This very well may be a result of reclassification of beds that were previously treated as ES or TH, but that did not meet the HUD definitions.... So, the drop in inventory is not a concern in that it is a definitional issue; the real concern is the inadequate supply of emergency beds.
25. What can be done about the comment made: "There are a few PSH providers that won't update their missing data; the HMIS coordinator indicated that they won't do so until HUD requires them to"?	• Once the new regulations come out defining the CoC's leverage in obtaining high quality HMIS data, this will be less of a problem.