Adapting the Durham Homeless Services Advisory Committee's Strategic Approach to Addressing Homelessness

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Executive Summary

The **Durham Homeless Services Advisory Committee (HSAC)** strives to support the City of Durham's homeless population through programming, advocacy, and policymaking. To best accomplish their mission, HSAC seeks to integrate public-private partnerships into its organization to strengthen the operations of the committee. In addition, HSAC aims to optimize its own organizational strategy and internal structure to best aid the homeless population of Durham.

The Sanford Consulting Team (referred to in this report as "the team") sought to address these goals by conducting expert interviews with prominent homelessness services advocates across the country. In consultation with HSAC the team selected three cities, each with varying approaches to homelessness services, to create a comparative analysis to Durham's Continuum-of-Care (CoC). Over several weeks, the Sanford Consulting Team spoke with CoC experts and homelessness advocates in Philadelphia, Pennsylvania; Boston, Massachusetts; Indianapolis, Indiana; and Durham, North Carolina to gain a clearer understanding of CoC organizational strategy, internal structure, and public-private partnerships. Interview subjects were selected based on their expertise in homelessness services.

In compiling the information from the experts, the team has crafted four recommendations for Durham's HSAC. The team recommends that HSAC should adapt its internal board structure, create a flexible and results-oriented strategic plan, improve data collection across CoC providers, and develop public-private partnerships with foundations, philanthropic organizations, and private sector entities throughout Durham.

Policy Question

HSAC has requested an analysis of how it can adapt its own organizational strategy and structure to better meet the needs of Durham's homeless population. Additionally, HSAC sought guidance on how **public-private partnerships** can be developed between the Durham CoC and other private entities to achieve their goals. To analyze both of these topics, HSAC directed the team to look at three other cities' CoC organizations. More specifically, HSAC asked for a comparative analysis of existing public-private partnerships in these communities. The data requested that will be compared between the cities and Durham includes health partners and regional corporations, and internal CoC structures that enable success.

The team has summarized the policy question as:

How can the Durham Homeless Services Advisory Committee adapt its organizational structure and strategy to best address the needs of the homeless populations in Durham? How do other Continuum-of-Care organizations develop public-private partnerships to best achieve the goal of aiding the homeless?

Policy Background

Efforts to Address Homelessness in American Communities

To better address **homelessness*** at the local level, the **Department of Housing and Urban Development (HUD)** implemented the **Continuum-of-Care (CoC)** Program. [1] The CoC Program is designed to promote community-wide commitments to the goal of ending homelessness. [2] The CoC program works by providing funding to nonprofit organizations and state and local governments for programming that caters to homeless individuals and families. [3] The goal of the program is to help individuals and families experiencing homelessness to move into transitional and permanent housing. [4] The distributed network of private and nonprofit social service providers came into existence as HUD required the institutional structure of homelessness services as a precursor for obtaining **Community Development and Block Grants (CDBG)** funds. [5] As a result, the CoC model encouraged decentralized, local approaches to tackle chronic homelessness via local coalitions of service providers. [6]

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, signed into law in 2009, sought to codify and formalize the CoC model. [7] The HEARTH Act established uniform performance measures for all CoCs to attain the national goal that homelessness be nonrecurring, rare, and brief. [8] Broadly, the HEARTH Act placed a greater share of responsibility for measuring program outcomes and performance oversight on the leaders of local CoCs. [9] The emphasis on performance measures is representative of the greater prioritization of data and outcomes in the annual planning processes of organizations dedicated to ending homelessness. The newfound focus on data aids the understanding of how various programs work together as a system rather than isolated entities.

*Please see Appendix D for the complete glossary of definitions.

Homelessness in Durham

Homelessness is an increasingly pressing social issue in cities across the United States, and Durham is no exception. The primary method for data collection regarding this increase in homelessness is the **Point-in-Time (PIT) Count**. The PIT Count is a community initiative to count and learn from people experiencing unsheltered homelessness. [10] Each year, more than 125 people including elected officials, leadership from community agencies and educational institutions, and committed volunteers, gather together at the Durham County Main Library downtown for the PIT Count. [11] Small teams of 4 to 5 people are led by an experienced counter and accompanied by a community safety team member or law enforcement officer as they spread out across the City and County of Durham. PIT Counters engage homeless individuals in unsheltered places or temporary spaces. [12]

Thes most recent Durham PIT Count in 2023 was performed by **Housing for New Hope.** The PIT Count found that Durham experienced an increase in unsheltered homelessness among families with children. The PIT Count also recorded that 375 people in Durham were experiencing homelessness and 158 people were unsheltered, a figure that has doubled since 2020. [13] Of the 375 individuals experiencing homelessness in Durham, only 34 were currently in transitional housing. [14] While the overall PIT Count has decreased by over 18%, the unsheltered count has grown by 105% since 2020. [15] These two metrics suggest that while the number of those homeless has decreased, the proportion of homeless persons being served has decreased. The total CoC Service population in Durham decreased by 13% due to a reduction in emergency shelter and **rapid rehousing** capacity. [16] These statistics underscore the challenges Durham's HSAC faces, and such challenges must be considered when looking at how other communities have helped to serve the homeless.*

*How homelessness was defined during the PIT count, and the people counting methods utilized could impact the analysis. PIT count inaccuracies are explained in latter sections.

Durham's Continuum-of-Care Organization

The Durham CoC works to prevent, reduce and end homelessness through effective and coordinated community-wide efforts and services. [17] The CoC coordinates the homeless housing system service provisions for the City and County. [18] Member organizations include service and health providers, nonprofit organizations, and local government representatives. Members of the CoC include:

- Alliance Health
- Durham Crisis Response Center
- Durham VA Medical Center
- Housing for New Hope
- Families Moving Forward
- Durham Social Services
- Healing of Care
- The ICNA
- Durham Housing Authority
- LIFE Skill Foundation
- North Carolina Coalition to End Homelessness
- Project Access of Durham
- Urban Ministries
- Open Table Ministries
- Volunteers of America
- LGBTQ Center of Durham. [19]

[20] Durham, NC Continuum-of-Care Organizational Chart

The CoC Board has multiple Standing Committees, each with specific roles in the governance of the CoC. Leadership, specifically, falls under the Executive Committee. [21] The Executive Committee is comprised of the HSAC Chairperson, Vice Chairperson, Secretary, and Standing Committee Chairpersons. [22] These Committees appoint Subcommittees or workgroups to advise on specific issues within the scope of the appointing committee and its responsibilities. [23] The appointing committee may allow each Subcommittee Chair define and oversee its membership, or it may appoint all subcommittee members. [24] Each subcommittee reports back to the Committee by which it was appointed. [25]

Durham's HSAC sits within the broader city government. HSAC is under the guidance of Mr. Keith Chadwell, the Deputy City Manager for Community Building. [26] HSAC is housed within the Office of Community Development. [27]

The Homeless Services Advisory Committee Addresses Homelessness in Durham

Multiple organizations in the City of Durham are working towards ending homelessness in the city, with many of their leaders serving on the City of Durham Homeless Services and Advisory Committee (HSAC). HSAC is the official body that advises the City Council and Board of County Commissioners on all matters related to homelessness. [28] HSAC serves as the board of Durham's Continuum-of-Care, leading all decision-making related to the City of Durham CoC. [29] Additionally, HSAC leads city- and county-wide efforts to address homelessness. [30]

The HSAC board is composed of 23 members. Each board member is a local representative. The board's composition reflects the various stakeholders that interact with and serve Durham's homeless population. The vision of HSAC is to have a dynamic, thoughtful, inclusive, and progressive leadership style that encourages community engagement on multiple levels. [31] The board also aims to strengthen community relations with private funders, local nonprofits, and religious-based organizations. [32]

Landscape of Public–Private Partnerships in Durham

The primary support that Durham's HSAC and its broader community has received from private organizations has been from Duke Health. Duke Health contributes to its communities in numerous ways, totaling $823M in "community benefits," primarily through financial aid support, neighborhood low-income health access support, and affordable housing support. [33] In the Durham community, its notable programs include the Walltown Neighborhood Clinic and Local Access to Coordinated Healthcare (LATCH). [34] Both primarily aim to help local low-income and uninsured residents gain access to primary care and health education. [35]

The Durham County Public Health Department collaborates with Duke University Hospitals to complete the Durham County Community Health Assessment. [36] The report lists that all homelessness efforts were managed by the Durham CoC. [37] Moreover, it highlighted $1.52M in funding from HUD and an additional $1M in grants from the Emergency Solutions Grant, CDBG, and the City of Durham's Dedicated Housing Fund. [38]

Since 2018, Duke Health has listed 5 health priorities, including [39]:

1. **Affordable Housing**
2. **Access to Healthcare and Health Insurance**
3. **Poverty**
4. **Mental Health**
5. **Obesity, Diabetes, and Food Access**

In its FY23 Progress report, Duke Health partnered with Habitat for Humanity of Durham on home builds. Other directed funds include $3M towards the City of Durham's Affordable Housing Loan Fund. [40] In FY22, it directed Affordable Housing efforts to be led by Duke University's Office of Durham and Community Affairs. [41]

Duke Health Provides Opportunities for More Public–Private Partnership and Financial Support

While Duke Health contributes to helping build affordable housing in Durham, a local homelessness healthcare expert emphasized that more can be done. [42] The expert notes that, when looking at other communities, Duke Health's support for Durham's homeless population is not comparable. [43] Specifically, when pointing to the amount of support the hospital system gave to the homeless population during the pandemic, the expert says that Duke Health has done more to help. [44]

The local healthcare expert also detailed the impact of Duke Health's funding of medical services provided to Durham's homeless population. LATCH, the local medical respite programs funded by Duke, helps connect the homeless population with critical care and provide recovery for the unique challenges homeless populations face. [45] In a study measuring 29 individuals in the Duke-Durham CoC collaboration, hospital admissions decreased and resulted in fewer stays. Healthcare charges for the patients decreased by almost 50%. [46]

Duke has historically spent much of its community benefits through charity care. Typically, charges by patients that lack insurance will be absorbed by the hospital and are a part of the $159 million in tax-deductible charity care that Duke Health spends this year. [47] However, with the roll-out of Medicaid Expansion in the fall of 2023 in North Carolina, the increase in coverage is likely to reduce the amount contributed by the hospital system. [48]The reduction in charity care presents an opportunity for Duke Health to look to new charitable causes, which aligns with Duke University's Office of Durham and Community Affairs' current funding efforts directed to homeownership and housing affordability. [49]

However, as the local health expert noted, seeking funding from Duke Health requires detailed metrics on how funds would be spent and their expected impact. [50] Measuring such an impact requires detailed data on the homeless populations served by Durham's CoC organizations. One barrier to such data collection is the lack of reporting and proper data collection of those served in routine care throughout the year. [51] Increased data collection by Duke Health would require expanded efforts beyond the annual PIT count. [52] For example, the expert pointed to collecting Z-codes when receiving medical care. Z-codes would allow for the CoC to better understand the healthcare needs of its population. Such data collection would require a persistent effort by the CoC to ensure its member organizations collect and maintain data points on the needs of Durham's homeless population. [53]

Moreover, the expert pointed to the lack of health-specific data as a hindrance to receiving competitive funding from HUD's CoC funding application. [54] While this is one instance of how data can be further collected to help the homeless population regarding health, other non-health related charitable organizations and corporations will turn to data in considering if and how much to contribute [55].

Beyond Duke Health, the Durham CoC has helped to serve its population through its member, Alliance Behavioral Health. Alliance Health's Restoring Hope Initiative has helped to provide those served by Durham HSAC with rental, utility, and security deposit assistance [56]. The local health expert emphasized the contributions of this program in helping those in critical need of housing support. [57]

Challenges in Durham HSAC

Key Findings

- Addressing Issues of Internal Coordination Will Lead to a Better Strategic Vision
- Inconsistent Knowledge of Board Members Dampens Policy Efficacy
- Developing an Accurate Data Collection Mechanism Will Allow for Better Solutions

Coordination Within HSAC Could Be Better Developed

Experts and other stakeholders who work or have worked with HSAC repeatedly emphasize that current dynamics of the board pose challenges to HSAC effectively achieving its strategic vision. [58] One large issue that HSAC faces internally is a lack of coordination. [59] One expert, who has worked extensively with both Housing for New Hope and HSAC, noted that the lack of coordination between the differing members of the board leads to a distinct lack of vision for homelessness services in Durham. [60] Without coordination and collaboration between the myriad of representatives on the board, there cannot be a strategic operation. The homelessness expert described that the issues with the vision of HSAC creates a lack of results-oriented solutions to addressing homelessness in Durham. [61] The expert described that conversations in HSAC get "too mired into the details and minutiae" of HUD-funding and requirements, and fail to take a step back to focus on the larger issues of homelessness at hand in Durham. [62] The expert recommended that HSAC refocus its vision to tackling the root problems of homelessness, including the lack of affordable housing. [63]

Ms. Rikki Gardner, a member of Housing for New Hope, described a similar problem with HSAC's operations. The lack of coordination on the board, in her view, trickles down into lack of effective collaboration between differing providers of the CoC. In one particular example, Ms. Gardner noted that some organizations will receive grants, but will not be able to utilize all the funds. [64] Ideally, she would like to see more flexibility in moving funds within the CoC, in order to help CoC providers achieve their respective missions. [65] For collaboration like this to happen effectively, Ms. Gardner emphasized that the CoC needs to be more coordinated and involved in its individual providers' projects. The CoC, in her view, only really "comes around" during funding cycles. [66] Providing avenues for increased coordination could lead to a more strategic vision overall, which would allow HSAC to better serve the homeless population of Durham.

Lack of Homelessness Services Knowledge Amongst Board Members Inhibits HSAC Efficacy

The experts interviewed emphasized that current operations within HSAC are inhibited by the discrepancy in knowledge amongst board members. Ms. Gardner described a disconnect between the members of the board and the vision it sets out to achieve. [67] She highlighted that everyone on the board has good intentions for participating in HSAC, but the compulsory service requirement of certain representatives hinders board operations. [68] Ms. Gardner noted that it "does no good for the board to have members who lack the requisite knowledge to understand the inner-workings of homeless services agencies or funding streams." [69] While she noted that HSAC should not be limited in its membership, it was imperative in her view that members of HSAC have an acute understanding of how homelessness services work, and what funding can be utilized to address homelessness in Durham. [70]

Streamlining Data Collection and Interpretation Will Allow for a More Accurate Understanding of Homelessness in Durham

HSAC also has an issue with data collection and interpretation. A local healthcare expert from Durham noted that the change in how PIT counts are conducted lead to inaccurate numbers of homeless individuals in Durham. [71] The local health expert emphasized the difficulties of the PIT Count accurately representing Durham's homeless population. [72] For example, people served by Durham Rescue Mission were excluded from the count. [73] Moreover, people may continue to access services from service organizations but not be considered a part of the homeless population for the purposes of the count. [74] The expert flagged that this has downstream negative consequences on HUD funding. Without accurate data, HSAC cannot properly conduct homelessness services. One homelessness expert advocated for an HSAC that is data-driven. Accurate collection of data is pivotal to developing homelessness services strategies that are solutions-oriented. [75]

Research Methods

The research conducted to compile this report relied on two primary methods of data: publicly available CoC documents and expert interviews. Through the analysis of this data, the team developed four recommendations for HSAC.

Analysis of Public Information

To understand the background of each city highlighted by HSAC, the team first began by researching publicly available information on CoC websites. The team sought to understand how the CoCs across the cities were structured, what their organizational strategies were, and if there were any key public-private partnerships within the CoC that HSAC could draw inspiration from. Without conducting background research on the three cities' CoCs, the team would not have been able to point out key differences within Durham's CoC.

Additionally, the analysis of public information served to prepare the team for the expert interviews that were conducted. By gaining a foundational understanding of how each city functioned in its homelessness services, the team was best able to tailor interview questions to each expert interviewed. The information analyzed created the framework through which the team was able to emphasize which data was most important to verify with the experts selected to interview.

The information provided in the publicly available documents on the CoC websites did not provide the team with the full breadth of data across the three CoC cases selected. As such, expert interviews for each city were required for the team to gain the best understanding of CoC structure and strategy. The expert interviews served as the critical data collection process for the team. The interviews served to further develop the team's understanding of day-to-day CoC function, and how strategy and structure allowed the CoCs selected to most effectively serve the homeless populations within their cities. From the interviews, the team was able to understand the landscape of homelessness in each city, CoC structure, strategy, and internal dynamics, and how public-private partnerships developed between the CoC and varying entities.

Expert Interviews

The cities utilized for the case studies were selected by HSAC. Interview subjects were selected from publicly available data on CoC leadership. Additional experts for Durham were recommended by HSAC to interview. All of the team's interview subjects gave consent to be recorded and have their responses quoted in this report. Two interview subjects asked for anonymity. The anonymous interview subjects are referred to in this report as "a local healthcare expert," and "a local homelessness expert."

*Interview questions and interviewee profiles can be found in Appendices B and C, respectively.

Case Study 1: Philadelphia, Pennsylvania

Key Findings

- CoC Board Structure Enhances the Active Participation of Stakeholders
- Nonprofits, Private Sector Entities, and Philanthropic Foundations Play an Important Role in Addressing Homelessness
- Developing a Strategic Plan Includes a Self-Assessment of Performance and Discussions with Stakeholders to Adopt a Better Approach to Homelessness Services, and Define Programs
- Data Collection and Management Helps to Evaluate the Current State of Operations and Program Performance, and Improve Housing Assessments

Background

Philadelphia, located in the Southeast of Pennsylvania, is one of the most populous cities in the nation, with an estimated population of 1,567,258. [76] The CoC in Philadelphia is staffed by the Office of Homeless Services (OHS). [77] It is governed by an 18-member board, and includes representatives from homeless, housing, and health providers, community institutions, governmental entities, and groups or advocates working to end homelessness. [78]

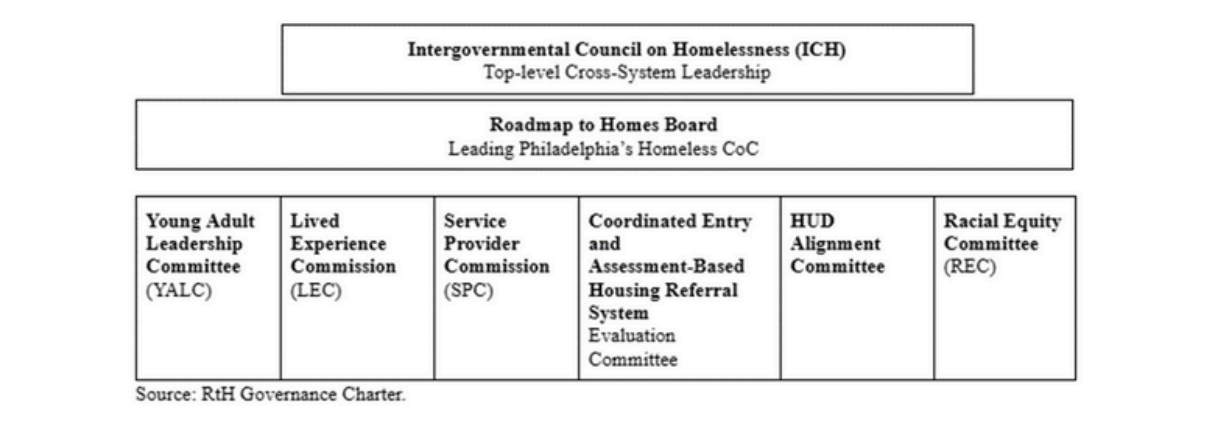
In 2023, the CoC received $40,128,936, representing the largest competitive grants award the city has received. [79] The CoC utilizes these funds in a variety of ways. They identify and address needs for housing and related homelessness services. CoC responsibilities include conducting street outreach, assessing homelessness resources, and creating homelessness prevention strategies for the city of Philadelphia. [80]

According to the 2023 PIT Count, the city experienced a 5.2% increase in homelessness from 2022. [81] There were 4,725 unhoused individuals, of which more than 17% were under 18 years old. [82] Nearly 8% were between 18 to 24 years old. [83]

The CoC is currently working through challenges regarding the homeless population in Philadelphia. One particular issue the CoC is working to address is the different types of vulnerable populations facing homelessness. [84] In particular, the CoC is concerned with elderly individuals and those experiencing opioid addiction. [85]

Structure

Philadelphia's CoC is known as the Roadmap to Homes Community (RtH Community). [86] The RtH Community includes an Intergovernmental Council on Homelessness (ICH), a Roadmap to Homes Board, Standing Committees, and Ad Hoc subcommittees and work groups. [87]



[88] Philadelphia's CoC Structure

The ICH consists of 13 City Commissioners or Directors, representing the highest leadership of the City's Offices. [89] The RtH Board consists of 22 members, with representatives from the Philadelphia City Government, homeless services providers, people with lived experience of homelessness, business, civil, government, hospitality and philanthropy leaders, stakeholders, and representatives from historically marginalized communities. [90] The RtH Board is the CoC Board and decision-making body, led by the RtH Executive Committee. [91] There are 8 Standing Committees that are part of the RtH Community's structure. [92] The Ad Hoc subcommittees and work groups oversee specific goals or focus on specific community needs. [93] These may include Philly Homes 4 Youth, Point-in-Time Count planning subcommittees, nominating subcommittees, and board development subcommittees. [94]

Public-Private Partnerships

The OHS works collaboratively with more than 70 housing service providers. They collaborate with the city, state, and federal governments to provide prevention, diversion, emergency, temporary, and long-term housing to homeless individuals, or those at risk of becoming homeless. [95] The city plan considers a multi-level, collaborative and cross-system leadership structure to ensure partnerships and community engagement in implementing strategies. [96]

Mr. David Weathington, Director of Philadelphia's CoC Planning and Funding, highlighted the importance of permanent interaction with partners, business leaders, hospitals, services and healthcare providers. [97] He described stakeholder meetings where each representative discusses how they can best address homelessness. [98]

The collaboration between multiple different sectors, who are united in their strategic vision, creates highly involved public-private partnerships between the CoC and the varying representatives. Throughout the year, stakeholders are given the opportunity to join committees at the CoC and interact with the RtH Board to define CoC priorities and policies. [99] Representatives from the varying sectors are encouraged to use their own experience and expertise to help direct CoC operations.

Additionally, Mr. Weathington emphasized the importance of the interaction between the CoC and private sector entities, specifically. He described the utilization of active communication and marketing campaigns towards the private sector to obtain greater funding for the CoC. [100] In one particular example, Mr. Weathington described a homelessness demonstration program, that successfully raised philanthropic funds for the CoC. [101] The event had participants across sectors, including private partners, providers, and the general public, and it served to raise awareness of homelessness in Philadelphia. [102] He noted that the event was a productive space for the CoC and stakeholders across sectors to discuss private and public funds available for CoC programming. [103]

Mr. Weathington also highlighted the role of nonprofit organizations in addressing homelessness in Philadelphia. Some nonprofits in the city, he noted, hone in on specific vulnerable populations, leading to a tailored approach to homelessness services. [104] One such nonprofit, Project HOME, works intensively to address homelessness and poverty through its focus on ending chronic street homelessness. Having tailored nonprofits creates the space for specific homelessness services across the city.

Other Operational Successes

Mr. Weathington highlighted that one of the key factors for the Philadelphia CoC's performance, was its comprehensive strategic plan, along with the management and use of data. [105] Philadelphia's 5-year strategic plan, "Roadmap to Homes (RtH)" included 5 priority areas that the CoC, successfully focused on, following the plan's conclusion in 2021. These priority areas were [106]:

1. **Expand Homeless Housing Resources:** Finding new resources to expand housing inventory
2. **Coordinate Across and Integrate Systems:** Improving coordination and access across government services and systems
3. **Implement Transparent and Inclusive Quality Improvement Process**: Providing a high-quality person-centered experience with homelessness services
4. **Communicate More Effectively:** Supporting a system transformation, communicating with stakeholders and the public to educate on the homelessness response
5. **Connect People to Employment and Workforce Development:** Increasing long-term housing stability, and connect people with jobs through strategic partnerships within the City

Philadelphia's CoC is currently working on a new strategic plan. They are conducting a retrospective evaluation on the last 5-year plan, to evaluate what was effective in their homelessness services. [107] Not all aspects of the previous 5-year plan were met, so Mr. Weathington emphasized that the creation of a new strategic plan was an opportunity to look at the varying CoC committees to evaluate and organize them. [108] In the creation of the new plan, the CoC will incorporate information collected from listening sessions between stakeholders and the board. [109]

The Philadelphia CoC's utilization of data was another aspect of its operational success, according to Mr. Weathington. [110] The CoC uses data to evaluate situations, challenges, and programming surrounding homelessness. Additionally, data is analyzed to understand CoC performance and cost. [111] While the Philadelphia CoC has no formal data committee, data teams work throughout the CoC to collect and interpret data. [112]

For example, data teams on the Street Outreach team within the CoC conduct a quarterly PIT Count, in addition to the mandated annual PIT Count. [113] The information gathered in the quarterly PIT Counts, in conjunction with other data collected in the Coordinated Entry and Assessment-Based Housing Referral System, helps the CoC place individuals in temporary shelters. [114]

Mr. Weathington noted that the data collection system within the CoC is still being updated. The CoC is looking to pull data directly from **HMIS**, which will enhance housing assessments and track records form the most vulnerable populations. [115]

Lessons for Durham

The performance of the Philadelphia CoC is intrinsically linked to its structure, strategic plan, stakeholder relationships, and data collection. Both its structure and plan promote the active participation of providers, the private sector, and the community. Stakeholders share their ideas and perspectives and discuss with the board, which helps the CoC to create a comprehensive vision of homelessness services and make decisions about necessary CoC programming. A permanent relationship with the private sector that raises awareness about homelessness helps in raising funds for programming. Data management and collection are important to monitor programs' capabilities, improve housing assessments, and aid in placement of homeless people in shelters.

Mirroring Philadelphia, an evaluation and restructuring of HSAC could enhance efforts to achieve its goals. The active partnership and interaction with the private sector, business leaders and philanthropic organizations has shown to be beneficial to raise financial resources for activities in Philadelphia. Durham HSAC could also derive success through the creation of partnerships. The participation of data teams in the different committees is key to understanding homelessness and allows the CoC to make data-driven decisions. Active use of data, with innovative tools could help HSAC evaluate the performance of their programs and services and improve the direction of homelessness services.

Case Study 2: Boston, Massachusetts

Key Findings

- Outsourcing Knowledge and Services that Exceed the Capabilities of the CoC Board
- Partnership with a Strong, Regional Health System is a Powerful Tool
- Strong Support from the Local Government is Crucial to Creating a Strong CoC
- CoC Governance Benefits from Sustainably Formed Private-Sector Partnerships of Provider Organizations

Background

Located on the eastern coast of Massachusetts, Boston is the largest city in the state with an estimated population of 650,706. [116]The Boston Continuum-of-Care is one of 12 CoCs within the Commonwealth. [117] Massachusetts is the only state in the United States with a "right-to-shelter" law, guaranteeing homeless families and pregnant women temporary housing and emergency services across the state. [118]

According to the city's 43rd annual homeless PIT count conducted in 2023, homelessness among single adults in Boston increased by 16.7% between 2022 and 2023. [119] The percentage increase was larger among families at 18.4%, leading to an average increase in homelessness of 17.2% overall and a total number of 5,202 individuals facing homelessness. [120]

In February 2024, the city received a grant of $47 million, the largest grant the city has received, from the U.S. Department of Housing and Urban Development's Continuum-of-Care Program. [121]

Structure

The Continuum-of-Care for the City of Boston is coordinated through the Mayor's Office of Housing, Supportive Housing Division.The Continuum-of-Care is primarily directed and managed by the CoC Board, the Boston Continuum-of-Care Housing and Stabilization Committee, with input from the Boston Advisory Council on Ending Homelessness (BACHome Council) and the Boston CoC Youth Council. [122] While there are no publicly available documents that provide deeper information regarding Boston's CoC management structure, the team was able to glean useful information from an interview with members of the Department of Housing that work closely with the city's CoC.

Through an interview with Ms. Katie Cahill-Holloway, Senior Development Officer for Supportive Housing, the team learned that the Boston Continuum-of-Care Housing and Stabilization Committee is currently undergoing a restructuring process. [123] They recognized that their CoC governance consists of two tiers: an executive tier that concerns itself with the strategic focus of the CoC and a tactician tier that consists of individuals that concern themselves with on-the-groundwork of the CoC. [124] While interviewees did not provide explicit detail of the intricacies of the restructuring process or the specific outcomes that they desired to see, they alluded to a hope that the restructuring would break down the siloes between the two tiers of government. [125]

Interviewees also noted the importance of having individuals with lived experience at all levels of CoC governance. [126] This is reflected in the Committee's collaboration with the BACHome Council, which is a consumer group that consists of seven council members who have or are currently experiencing homelessness.

Public-Private Partnerships

According to both Ms. Cahill-Holloway and Mr. Jim Greene, the City's Assistant Director for Street Homelessness Initiatives, the CoC management board does not engage in formal public-private partnerships. [127] However, they noted that the overall performance and effectiveness of the CoC is enhanced by the private-sector partnerships formed by participating providers. [128] These partnerships span across large-scale, national corporations such as Amazon, and smaller, regional entities such as the Boston Foundation. [129] These partnerships are especially beneficial when engaging in practices such as funding matching, where private partners will match the funding that a provider receives through the CoC. [130] However, these private-sector relationships are peripheral to the primary operations and structure of CoC management in Boston. [131]

Interviewees noted that the CoC Board works closely with the regional health system, specifically MassHealth. MassHealth provides health benefits for individuals across Massachusetts. [132] MassHealth both offers direct benefits to consumers, as well as offering financial assistance with health insurance premiums. [133] The Committee's partnership with MassHealth is an asset to the efficiency of the Committee, as it gives the Committee the ability to outsource expert knowledge. [134] CoC management organizations and homeless service providers are often burdened by navigating an area that exceeds their expertise, as explained by Ms. Cahill-Holloway, so the ability to receive assistance in areas where the committee does not hold expertise frees the committee and providers to focus on other important operations. [135]

Other Operational Successes

The Boston CoC Board places a great importance on data collection practices. Ms. Cahill-Holloway noted that their providers provide a wide range of services, which leads to a wide range of individual data collection processes. [136] Thus, the Boston CoC Board has a strong HMIS team that effectively trains providers to streamline their federal reporting and individual data collection processes. [137] In fact, data collection training is a part of the onboarding process for new CoC provider organizations. The effective data collection training and practices directly corresponds to enhanced system performance. [138]

Lessons for Durham

The Boston CoC Board's success is primarily rooted in its sustainable relationship-building and the support that the Board has given to its providers in their independent relationships with private entities. The CoC Board strategically focuses on collaborations that can symbiotically aid in the Board's operations and the success of its providers, such as its relationship with MassHealth and the division's HMIS team. The decision of Boston CoC leadership to have a provider-first focus to their partnerships strongly contributed to the Board's success and its strong relationships with providers.

The team believes that forming a focused, sustainable relationship with Duke Health, reminiscent of the relationship that the Boston CoC Board has formed with MassHealth, could greatly benefit the operations of HSAC. Not only could HSAC benefit from the knowledge and resources that a relationship with Duke Health could bring, but a partnership with Duke Health could also benefit the operations of provider organizations through fund matching. Beyond Duke Health, HSAC should work together with providers to develop ways that private-sector collaborations can benefit all parties, as the success of providers contributes to the success of the CoC. Partnering with private organizations that could provide onboarding training in areas such as leadership or data management for both board members and providers would ensure that all parties are working on the same knowledge and common ground. The team believes that this would greatly contribute to the efficiency of HSAC.

Case Study 3: Indianapolis, Indiana

Key Findings

- CoC Board structure that balances interests across the city can help with operational success, strategic planning, and financial prosperity
- Looking to partnerships with foundations and other grant-making institutions can help provide new opportunities, such as flexible funding, to help CoC reach its strategic goals
- Emphasizing and clearly stating strategic goals can help to improve board cohesiveness
- Data collection can help to improve service to homeless populations and foster future grant opportunities

Background

Indianapolis is located in central Indiana with a population of approximately 880 million residents. [139] Its Continuum-of-Care is led by its "Blueprint Council", the organization's governing board which oversees the body's day-to-day implementation and overall strategy. The CoC's Community Plan to End Homelessness is primarily directed towards a "coordinated entry" approach. [140]

In 2023, Indianapolis witnessed an 8% drop in homelessness, per its annual PIT Count. [141] However, the number of its 1,619 homeless who were unsheltered increased by 77%, coinciding with the sharp increase in chronic homelessness. [142] The PIT Count is also accompanied by a housing inventory count, which saw a sharp decrease in bed utilization by its homeless population and a decrease in Rapid Rehousing beds as a result of lapsed COVID funding. [143]

Structure

The Blueprint Council represents leadership from its constituent organizations, a city official, a university official, the CEO of the local housing authority, a faith-based representative, persons with lived experience, and local business representatives and private funders. [144] The primary distinction, compared with Durham's CoC governing body, is the presence of business representatives and private funders. [145]

In speaking with Mr. Jeff Bennett, who serves on the Blueprint Council and worked on housing policy for years in the Indianapolis Mayor's Office, he cites the Council's 2016 restructuring as a major conduit for success. [146] Prior to 2016, he noted that the Council was disproportionately composed of service providers and the number of individuals on the Council hindered its success. [147] Rebalancing the board brought in funders, advocates, city officials, business representatives, and outside funders. [148]

He cited the composition as a major reason for the Council's inability to make "tough decisions." [149] In 2016, Bennett noted a drastic difference in the Council's success since the restructuring. The CoC witnessed increased funding from HUD, the ability to focus on long-term strategic planning, and bold policy proposals such as acknowledging housing as a human right. [150] Most importantly, he noted the ripple effect on relations within the CoC that came with increased HUD funding, stemming from the ability to increase service capacity and better coordinate housing for its homeless population. [151]

Public-Private Partnerships

Mr. Bennett also described how the Indianapolis CoC's success can also be largely attributed to its public and private benefactors. Indianapolis relies on its "anchor institutions" for consistent funding, such as IU Health. [152] However, private philanthropy, which includes the city's community foundation, has helped CoC to significantly expand its capacity. [153] For example, a major challenge that the CoC ran into, especially during COVID, was that the different constituent organizations would run out of use cases for HUD funding and risked a funding lapse. [154] However, with the help of its private philanthropy, the CoC was able to launch a flexible fund that provided a continual source that could be used as the CoC saw fit to meet its strategic vision. [155]

Other Operational Sucesses

One success that stemmed from the Blueprint Council restructuring was its newfound focus on data collection and use. Prior to 2016, not everyone was using HMIS and data collection was limited at best. [156] Today, Bennett describes how their data practices allows them to know how many beds are vacant and accessing a "by-name" list of who is currently being served, which has enabled them to have more adaptable services. [157] According to the CoC's website, the organization tracks different types of data, such as entry and exit points, that enable the CoC to better serve its homeless population. [158]

Lastly, the development of a strategic plan that was continuously updated helped keep all members of the CoC board focused on the same high-level vision. [159] Mr. Bennett further emphasized that not having timeline-bound goals, but rather a goal that is flexible and can be shifted has helped the CoC have continuous success. [160]

Lessons for Durham

A critical component of the Indianapolis CoC has largely been linked to the improvement that happened on the CoC board. The board changes have allowed the board to better tackle its strategic vision, with downstream impacts on funding and effectiveness of service member operations. Moreover, the increased funding was a result of relationship-building between anchor institutions, such as its local hospital system, and philanthropic organizations such as Indianapolis' community foundations.

Durham could take lessons from Indiana by focusing on how a potential board restructuring could best facilitate a focus on HSAC's strategic goals. Better data collection and data-driven insights can help identify chokepoints and needs for better CoC performance. Moreover, identifying potential philanthropic groups, such as the Fred Fletcher Foundation that can help to boost financial support, and setting goals to seek more support from Duke Health can foster more organizational flexibility could have significant downstream impacts on how Durham HSAC's homeless population.

Recommendations

Recommendation 1: Adapt the HSAC's Board Structure

Adapting the organizational structure of the HSAC board may be necessary to meet the needs of CoC providers and effectively work together towards a common goal. Interview participants from the city of Durham cited a lack of understanding of the purpose for some members of the Board as a source of inefficiency. Through the interviews with contacts in both Boston and Philadelphia CoC leadership, the team learned that consistent reassessment of board structure and performance was an important practice to progress the organization. While having board members of various professional backgrounds and lived experiences is important to creating a well-rounded board, every member of the board must serve a specific purpose. Clearly redefining the role and purpose of each board member could address the matter of purpose.

Even longstanding, historically successful CoC Boards like the Boston CoC board have undergone restructuring to address shortcomings. While the team does not endorse a board restructuring as a panacea for the organizational obstacles that HSAC experiences, the team believes that adapting the board to reflect a prioritization of purpose and efficiency would help address the current difficulties that HSAC faces. Adaptation of the Board is not a one-time solution, but rather something that should be continually considered as both the Board and the City of Durham change over time.

Prior to any restructuring or adaptation, however, HSAC must diagnose existing problems with the current structure. For example, the leadership of Indianapolis' CoC recognized that the board's efficiency and work was hindered by the large number of members on the board. Thus, it determined that paring down the board to a core group of members would be in the best interest of the city. Considerations such as downsizing the board, adjusting board assignments, changing committee assignments, and redefining Board roles are changes that HSAC should consider.

Recommendation 2: Create a Results-Oriented Strategic Plan

All individuals that the team interviewed from cities outside of Durham emphasized the importance of strategic planning in creating an effective CoC board that works with purpose and direction. Devoting time to developing a strategic plan would give the board a vision for the future . By determining the organizational interests of the board and board priorities, the development of a strategic plan would also inform which private-sector organizations would advance the goals of HSAC through public-private partnerships.

Having a strategic plan assures external entities interested in a partnership that they are devoting their time and resources to a goal-oriented, well-organized committee.

Strategic planning provides both a guide for the work of the CoC and a tool for reflection and improvement once the strategic plan cycle has concluded. The interview with the Director of Planning for Philadelphia's CoC showed the benefit of having a baseline body of goals for improving future operations, as their team is currently performing a retrospective analysis of its previous five-year strategic plan that concluded in 2021. Lessons of success or failures, whether about funding determinations or programmatic priorities, can help inform Board decisions of the future.

A results-focused strategic plan would be beneficial to HSAC. Expectations for both Board and provider can be established during this process. The importance of having a results-driven strategic plan is that it would give the Board clear goals to guide its work. When asked about how disagreements regarding strategic planning are managed on the Board, the Boston interview participants noted that disagreements are managed by turning back to the strategic plan that the group developed as a reminder that all members are working towards a common goal. Striving for results rather than ambiguous aims will ground the board in its decisions and provide clear metrics for success.

Recommendation 3: Improvement of Data Management Practices

The need for more data collection throughout all aspects of CoC operations was consistent in interviews with local Durham housing experts. Often, the lack of data was pointed to as a reason that coherent policy was not agreed upon uniformly with a large majority of the board. With the right data points collected, board members and those involved in daily operations can point to critical chokepoints in addressing the systemic factors contributing to chronic homelessness in Durham. In addition to promoting more cooperation on the board, increased data-driven findings can help to discover needs that have not been historically recognized by the board or even those who manage daily operations underpinning the CoC.

Outside of CoC management, robust data collection and reporting is critical to any new partnerships, particularly in support from foundations and other financial supporters. Many organizations with trusts and grants of all sizes rely on the data of their recipients to measure the impact of their funding.

Pointing to clear data points, grant-making institutions can point to their contributions and justify further financial support. Before developing a robust outreach plan to boost public-private partnerships with Durham's HSAC, the board should consider how it can improve data-driven decision-making and what types of data need to be collected to make such decisions.

Without any clear repository of metrics that HSAC and its member organizations collect, the consulting team cannot recommend specific types of data that should be collected. Interviews pointed to a lack of data and information sharing among CoC member organizations. Promoting consistent information and data-sharing in any data collection strategy is critical. While the example in one of the interviews pointed to the helpfulness of aggregated Z-code data, the consulting team recognizes that this is only one example and that a more robust inventory must be taken to understand the governing body's data needs.

Recommendation 4: Development of Public-Private Partnerships with Foundations, Philanthropic Organizations, and Private Sector Entities

Further development of partnerships should be prioritized to allow the Durham HSAC expand its operational capacity. Indianapolis' transformation of its CoC was largely enabled by the increased financial support from its local hospital system and especially its community foundation. Increased capacity reduced the number of challenges the HSAC faced and inter-CoC conflict because of the flexible funding made possible that allows the board to shift funds as needs of the organization fluctuated. Particularly as an organization that is reliant on annual funds from HUD that are required to be directed towards specific purposes, Durham HSAC would benefit from additional funds to pursue strategic goals in a manner that is best positioned for its success, not necessarily what's required in HUD funding.

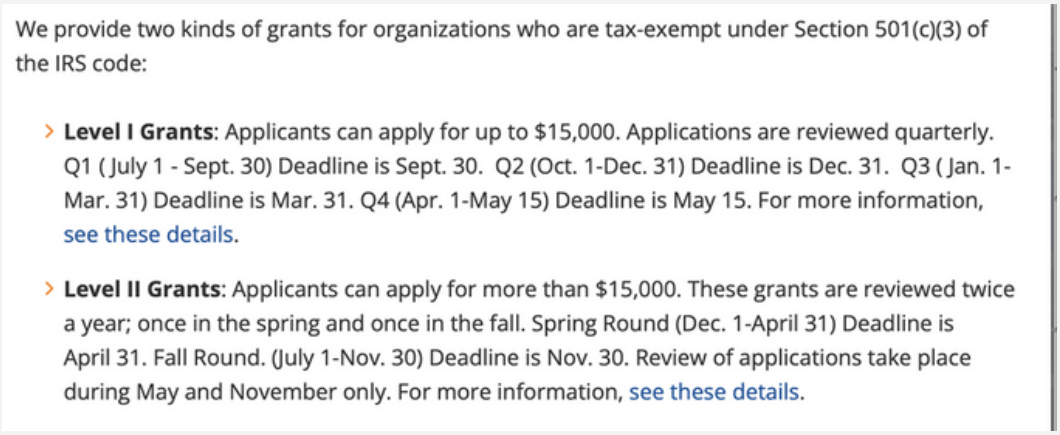
As Indianapolis has benefited significantly from IU Health and Boston from MassHealth, Durham could also benefit from further developing its collaboration with Duke Health. The recent Medicaid expansion in North Carolina can provide new opportunities for Duke Health to expand its outreach portfolio and extend resources towards a partnership with HSAC. The interview with a healthcare expert in Durham shed light on the possibility of extending cooperation, but the struggles of getting increased funding. The expert mentioned the struggle in making such an ask without clear metrics to demonstrate the needs that more funding could help support. As mentioned in the previous recommendation, improving data-driven capacity and a renewed strategic vision could assist in better communicating that need with partners like Duke Health.

Looking towards different community foundations could also help. The flexible funding in Indianapolis was specifically attributed to the support of its own foundation. It could also lend support outside of strategic goals not as deeply linked to health, as would likely be required for Duke Health. The AJ Fletcher Foundation serves as a model organization that Durham HSAC could look to, and expand the search from there, given its commitment to indigent persons. [161] As previously mentioned, a clearly spelled out strategic vision and data-supported metrics would help to further building out such a relationship. With Durham becoming a home for large tech companies, there are opportunities for HSAC to partner with potential collaborators such as Google and Qualtrics to improve data management capacity.

Appendices

Appendix A: Grant Information

Duke Health has existing grants that could be leverage by Durham HSAC. The "Building Healthy Communities" grants can be used for affordable housing and homelessness. [162]



We provide two kinds of grants for organizations who are tax-exempt under Section 501(c)(3) of the IRS code:

- **Level I Grants**: Applicants can apply for up to $15,000. Applications are reviewed quarterly. Q1 (July 1 - Sept. 30) Deadline is Sept. 30. Q2 (Oct. 1-Dec. 31) Deadline is Dec. 31. Q3 (Jan. 1-Mar. 31) Deadline is Mar. 31. Q4 (Apr. 1-May 15) Deadline is May 15. For more information, see these details.
- **Level II Grants**: Applicants can apply for more than $15,000. These grants are reviewed twice a year; once in the spring and once in the fall. Spring Round (Dec. 1-April 31) Deadline is April 31. Fall Round. (July 1-Nov. 30) Deadline is Nov. 30. Review of applications take place during May and November only. For more information, see these details.

Directions to apply for Level II Grants can be found on Duke Health's website. [163] Grants are administered and reviewed by Duke University's Office of Durham and Community Affairs.

Appendix B: Interview Questions

Below are the questions that were asked during the expert interviews. While not every question was asked in every interview, these questions provide an outline of how the team collected data for the case studies.

Section 1: Landscape of Homelessness in Respective City

Interviewer script: I'd like to start by asking you about yourself and the overall landscape of homelessness in your city.

1. Describe the work that you do with the unhoused population of [city]?
2. How has the landscape of homelessness changed in [city] during your time working in homelessness services?
3. What do you perceive as the greatest challenges that organizations addressing homelessness in your city face?

Appendices

Appendix B: Interview Questions

Section 2: CoC Performance

I**nterviewer script:** Now we want to hear about how your experience and expertise in CoC performance.

1. Historically, how would you describe [city's] CoC performance?
2. How was the CoC performance changed since you have been a part of [organization]? How has this impacted your work?
3. What is the greatest challenge that your CoC is currently working through?

Section 3: Private-Sector Partnerships

Interviewer script: We want to better understand key collaborators who help maximize the operations of your organization.

1. Does your CoC partner or collaborate with any private-sector organizations? When did these partnerships begin?
2. What role does these organization(s) play in the operations and/or strategic planning activities of your CoC?
3. Can you describe the impacts that these public-private partnerships have had on your homelessness services?

Closing

Interviewer script: We are approaching the end of the interview. Thank you again for your time.

1. Is there any other information you'd like to share about engaging in strategic partnerships and collaboration to improve CoC performance that you think might be helpful for us?

Appendices

Appendix C: Interviewee Profiles

Below are the profiles of the interviewees who agreed to be cited in this report. The team had two anonymous interviews, that will not be included in this profile section.

Rikki Gardner
Rikki Gardner is the current Director of Operations for Housing for New Hope. Ms. Gardner has been apart of Housing for New Hope for over seven years, and provided critical information to the team's analysis of the Durham CoC. [164]

Jeff Bennett
Jeff Bennett was the Deputy Mayor for Community Development in the City of Indianapolis. Currently, he works as the Chief Innovation Officer for the Central Indiana Community Foundation. Mr. Benett is also a member of Indianapolis's CoC Board. He provided the data for the internal operations of Indianapolis's CoC, that was critical to the team's analysis. [165]

Katie Cahill-Holloway
Katie-Cahill Holloway is the Senior Development Officer for Supportive Housing at the City of Boston. With nearly 3 decades of experience within the City of Boston, Ms. Cahill-Holloway was able to describe the City's changing strategies in addressing homelessness. [166]

Jim Greene
Jim Greene has worked nearly 21 years within the City of Boston on a variety of homelessness services endeavors. He was the Director of the Emergency Shelter Division prior to moving to the Mayor's Office of Housing where he currently works on public health. Mr. Greene's extensive knowledge on the variety of homelessness issues within Boston provided the team with important data on how Boston develops its homelessness responses. [167]

David Weathington
David Weathington is the current Director for Planning and Grants in Philadelphia's CoC. With over 14 years of experience in grant management, Mr. Weathington gave the team important data on HUD funding, CoC management, and the development of public-private partnerships between the CoC and private sector entities. [168]

Appendices

Appendix D: Definitions

Bolded words throughout the report are defined below.

Homelessness	HUD defines homelessness using the following four categories: • People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. • People who are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing. • Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. • People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing. [169]
Continuum-of-Care (CoC)	A community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. [170]
Housing and Urban Development (HUD)	The United States Department of Housing and Urban Development. HUD is responsible for housing on the national level. This includes providing shelter for vulnerable populations and homeless individuals and offering rental assistance. HUD also ensures that housing discrimination does not occur. [171]
Public-Private Partnerships	A long-term contract between a private party and a government agency for providing a public asset or service. [172]

Appendices

Appendix D: Definitions

Rapid Rehousing	Rapid re-housing rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services. [173]
Point-In-Time (PIT) Count:	An unduplicated count on a single night of the people in a community who are experiencing homelessness that includes both sheltered and unsheltered populations. [174]
Community Development Block Grants (CDBG)	Funds that support community development activities to build stronger and more resilient communities. [175]
Homelessness Services Advisory Committee	The Continuum of Care (CoC) decision-making body for the Durham Continuum of Care. [176]
Housing for New Hope	The primary organization providing housing services for the unhoused in Durham. [177]
Homeless Managment Information System (HMIS)	A local information technology system used to collect client-level data on the provision of housing and services to individuals and families at risk of and experiencing homelessness. [178]

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