Tri-Cities Homeless Action Plan

Presented to the Tri-Cities Homelessness Policy Committee

Tri-Cities
HOMELESSNESS POLICY GROUP

Englewood • Littleton • Sheridan

Tri-Cities Homeless Action Plan

DRAFT

Presented to the Tri-Cities Homelessness Policy Committee

June 21, 2021

Table of Contents

Glossary/Terminology and Abbreviations[1]

Adults with a Serious Mental Illness (SMI) – This subpopulation category of the Point in Time (PIT) includes adults with a severe and persistent mental illness or emotional impairment that seriously limits a person's ability to live independently. Adults with SMI must also meet the qualifications identified in the term for "disability" (e.g., "is expected to be long-continuing or indefinite duration").

Adults with a Substance Use Disorder – This subpopulation category of the PIT includes adults with a substance abuse problem (alcohol abuse, drug abuse, or both). Adults with a substance use disorder must also meet the qualifications identified in the term for "disability" (e.g., "is expected to be long-continuing or indefinite duration").
At-Risk of Homelessness – people who are not experiencing homelessness, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards.

Case Conferencing – A region's formal, planned, and structured meeting in which providers coordinate staffing assignments, provide client level updates, and ensure coordination of services. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences should be used to identify or clarify issues regarding a participant's housing status and progress towards permanent housing; to review activities including progress and barriers towards housing; to strategize solutions; and to adjust current service plans, as necessary.

Case Management – Case management is defined by the Case Management Society of America as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services" to meet individual needs. Case Management should be voluntary, and client centered, with the goal of identifying strengths and client directed goals, while promoting "health, recognition, and well-being" (USICH, 2016). Case Managers should ultimately focus on linking the client to a permanent housing resource and providing the necessary services needed to promote housing stability.

Chronically Homeless –
1. An individual who:
   a. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND
   b. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least twelve months or on at least four separate occasions in the last three years where those occasions cumulatively total at least twelve months; AND
   c. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 [42 U.S.C. 15002]), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

---

[1] Modified from the Los Angeles Homeless Service Authority's HOMELESS SERVICES DELIVERY SYSTEM GLOSSARY OF TERMS/ACRONYMS document found here: https://homeless.lacounty.gov/wp-content/uploads/2017/12/25-Glossary-of-Terms-and-Acronyms.pdf.

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Chronically Homeless Family with Children – A family with children with an adult head of household (or if there is no adult in the family with children, a minor head of household) who meets all the criteria for a chronically homeless individual, including a family with children whose composition has fluctuated while the head of household has been homeless.

Continuum of Care (CoC) – A federal designation for local communities 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. It includes action steps to end homelessness and prevent a return to homelessness." Metro Denver Homeless Services (MDHI) is the sponsoring agency that manages the Metro Denver CoC of which the Tri-Cities is geographically located in.

Coordinated Assessment – a standardized approach to assessing a person's current situation, the acuity of their needs and the services they currently receive and may require in the future. It considers the background factors that contribute to risk and resilience, changes in acuity, and the role of friends, family, caregivers, community and environmental factors.

Coordinated Entry System (CES) – CES is a regionally based system that connects new and existing programs into a "no wrong-door network" by assessing the needs of individuals/ families/ youth experiencing homelessness and linking them with the most appropriate housing and services to end their homelessness. The goal of the CES is to streamline processes through which communities assess, house, and support housing retention for individuals/families who are homeless; to ensure all our homeless neighbors are known and supported; to target and maximize limited housing resources; and comply with the federal mandate to adopt a standardized intake and coordinated assessment process for housing.

Disability – An individual with one or more of the following conditions: A. A physical, mental, or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that: (1) Is expected to be long-continuing or of indefinite duration; (2) Substantially impedes the individual's ability to live independently; and (3) Could be improved by the provision of more suitable housing conditions. B. A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or C. The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

Emergency Shelter/Crisis Housing – An emergency shelter in the homeless coordinated entry system. Crisis Housing means any facility, the primary purpose of which is to provide temporary shelter for the homeless or to provide a bridge to permanent housing.

Extremely Low-Income Households (ELI) - Those with incomes below 30 percent of area median income.

Fair-Share – A good faith effort by local governments to create a collaborative response to homelessness so no one jurisdiction is overburdened with the provision of homelessness housing and services.

Homeless Management Information System (HMIS) - A computerized data collection system designed to capture client information over time on the characteristics, service needs and accomplishments of homeless persons. Implementation of an HMIS is required by the federal department Housing and Urban Development (HUD) for programs receiving federal funding through the Continuum of Care (CoC).

Housing Choice Vouchers (HCV) - Rental subsidy program (also known as Section 8). Under HCV programs, a tenant pays 30-40% of their monthly income for rent and the government pays the remainder, up to a set maximum Fair Market Rent. HCV subsidies can be tenant-based (awarded to a tenant household that can take them to any private landlord) or site-based/project-based (awarded to an owner who uses it on the same unit over time).

Housing First – Housing First is an approach that offers permanent housing as quickly as possible for people experiencing homelessness, particularly for people with long histories of homelessness and co-occurring health challenges, while providing the supportive services people need to keep their housing and avoid returning to homelessness. The provider ensures that the supportive services that program participants need or want to achieve permanent housing and to increase income are offered, but are not required as a condition of housing, including links to mainstream programs or partner agencies (i.e., mental health services, substance abuse treatment, medical services, childcare, etc.). Income, sobriety and/or participation in treatment or other services are voluntary and are not required as a condition for housing.

Housing and Urban Development (HUD) - U.S. Department of Housing and Urban Development HUD is a federal department created in 1965 to increase homeownership, support community development and housing free from discrimination. Since 1987, HUD has been responsible for funding homeless programs, which today comprise the CoC.

Metro Denver Homeless Initiative (MDHI) - MDHI is the Metro Denver Continuum of Care (CoC), which is a regional system that coordinates services and housing for people experiencing homelessness. MDHI works closely with each county in our continuum (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson).

Navigation Center – A centralized homeless access center that may provide temporary room and board with limited barriers to entry, showers, restroom, and laundry services, while case managers work to connect homeless individuals and families to income, public benefits, health services, permanent housing, or other shelter.

Permanent Housing (PH) – Community-based housing without a designated length of stay, which includes both Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH). Examples of permanent housing include, but are not limited to, a house or apartment with a month-to-month or annual lease term or home ownership.

Permanent Supportive Housing (PSH) – Long-term, community-based housing that has supportive services for homeless persons with disabilities. This type of supportive housing enables the special

needs of populations to live independently as possible in a permanent setting. Permanent housing can be provided in one structure or in several structures at one site or in multiple structures at scattered sites.

Point in Time (PIT) – A snapshot of the homeless population taken on a given day. Since 2005, HUD requires all CoC applicants to complete this count every other year in the last week of January. This count includes a street count in addition to a count of all clients in emergency and transitional beds.

Rapid Rehousing (RRH) – A support intervention that uses a combination of case management, Housing Navigation, and short to medium term financial assistance to assist mid-range acuity homeless households identify and stabilize in tenant-based, scattered site, permanent housing.

Regional Coordination – Oversight of partnerships across public and private entities within and adjoining the Tri-Cities region that ensure homeless persons are fully supported and connected to housing and services within their respective communities. Regional and coordinated access to housing and services ensures that a homeless person does not have to go to multiple agencies to obtain housing and services assistance.

Street Outreach – Programs that provide essential services to unsheltered persons residing in places not meant for human habitation. Outreach is defined as the activity of engaging unsheltered homeless individuals through the process of rapport building with the goal of linking that individual to a permanent housing resource. Outreach and engagement is an ongoing process that "involves creativity, flexibility, may take months or years, and involves establishing a relationship" to connect a client to services. Outreach can be viewed as a service and a process of building a personal connection that may play a role in helping a person improve his or her housing, health status, or social support network.

Supportive Services – Services that may assist homeless participants in the transition from the streets or shelters into permanent or permanent supportive housing, and that assist persons with living successfully in housing.

Transitional Housing – Transitional Housing assists homeless individuals who need more intensive services before moving into permanent housing. Transitional Housing offers housing and supportive

services for up to two years. It best serves young adults, people in recovery, and people fleeing domestic violence.

Veteran – This subpopulation category of the PIT includes adults who have served on active duty in the Armed Forces of the United States. This does not include inactive military reserves or the National Guard unless the person was called up to active duty.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) – A survey administered both to individuals and families to determine risk and level of need when assisting those experiencing homelessness and those at-risk of homelessness.

Additional definitions may be found here: https://www.homelesshub.ca/about-homelessness/homelessness-101/homelessness-glossary and https://ahomewithhope.org/education-2/glossary-of-terms#2774575318142-77ce84a7-18f2

Introduction

The Tri-Cities Homelessness Policy Committee is comprised of the cities of Englewood, Sheridan, and Littleton and was founded in 2018 out of a strong desire and commitment to address the growing incidence of homelessness through a comprehensive regional approach. Tri-Cities Homelessness Policy Committee Members include mayors and city council members, city managers, service providers, and representation from law enforcement.

In 2020, Tri-Cities initiated a series of steps to increase understanding of the local homeless population, its needs, and existing resources. This Homeless Action Plan is the cumulation of these efforts to produce an operational strategy that brings multiple community and public partners together under a coordinated effort to move the needle on the emerging homelessness crisis.

The recommendations and action steps comprising this Homeless Action Plan, seek to build a solid foundation for a unified and coordinated homelessness response system that leverages collaboration with the state, county, and local partners. Through regional collaboration, the plan seeks to leverage funding resources and expand capacity of local providers to offer comprehensive homeless services to individuals and families at-risk or experiencing homelessness in the region so that they may exit homeless and resume thriving lives.

The Homeless Action Plan is proposed as a three-year plan. The implementation of the recommendations and action steps are estimated at a total of $705,000. The combination of a clear

plan forward including the identification of potential strategic partnerships, will make the Tri-Cities efforts competitive for private, state, federal, and continuum of care funding resources to actualize these efforts.

Background

In July 2020, the Tri Cities Homelessness Policy Committee conducted a PESTEL Analysis of the region's homelessness services to identify assets, opportunities, and gaps in six domains: Political, Economic, Social, Technology, Environmental, and Legal. PESTEL analyses are used to evaluate outside factors that affect or have the potential to affect an organization or initiative. This assessment identified key issue areas in each domain. Key findings include strong commitment by local leaders to address homelessness, dedicated homeless service organizations, regional public and private investments in homelessness, and consistency in local ordinances regarding occupancy of public spaces. Areas of opportunity include increasing affordable permanent housing options for persons exiting homelessness such as rapid rehousing, permanent supportive housing, and allocation of housing authority vouchers; increased participation in the local data collection platforms managed by Metro Denver Homeless Initiative including the Homeless Management Information System (HMIS) and OneHome, Coordinated Entry System; and additional safe alternatives to unsheltered dwelling.

In October 2020, the Center for Housing and Homelessness at the University of Denver released two commissioned reports: The Tri-Cities Family Homelessness Assessment and the Tri-Cities Chronic Homeless Assessment Results Report. The reports applied qualitative methods of semi-structure interviews to capture the essence of homelessness for both the families and single-adult populations. The research sought understanding of key drivers into homelessness and barriers to exiting those prolonged episodes and undermined stable reintegration back into society. While it is important to acknowledge the unique characteristics and essence of homelessness that form chronic and family homelessness, similar themes emerged for both populations that led to their pathway into homelessness and that prevented exiting with ease. These included lack of access to affordable housing, changes to or inability to secure employment, physical and behavioral health challenges, and fragile or troubled social relationships. The report recommended a prevention approach to retain precariously housed families in housing through the provision of comprehensive financial and service interventions; and holistic and flexible programs to stably rehouse chronic homeless adults.

On January 28, 2021, the city councils of Englewood, Littleton, and Sheridan hosted a joint Council study session to update decisionmakers and the public on the findings of the above reports. During this session, Metro Denver Homeless Initiative (MDHI), the continuum of care for the Denver Metro Region, identified potential priority areas for the Tri-Cities Homelessness Policy Committee to focus on in the creation of its homelessness strategy.

- Create a single Access Point for housing services.
- Increase usage of the statewide Homeless Management Information System (HMIS) by all homeless services organizations.
- Participate in OneHome, the region's Coordinated Entry System (CES)
- Develop eviction prevention strategies (more cost effective and trauma-informed to keep people housed).
- Develop diversion resources and strategies to keep people from entering the homeless service system.

- Develop a workforce strategy by partnering with an employment program.
- Find or create more affordable housing in the community for people exiting homelessness.
- Include financial education in service offerings.
- Acknowledge traumatic Stress found in people experiencing homelessness and create trauma-informed programs and services.
- Develop a whole person/family approach that embeds wrap around services (domestic violence, child welfare, mental health, physical health, and addictions) with homeless services.

Finally, the Tri-Cities Homelessness Policy Committee engaged Florence Aliese Advancement Network (FAAN) to develop an incremental operational action plan organized into four to five priority areas (i.e., street engagement, healthcare, affordable housing, and employment) with recommendations for action-steps based on national and regional best-practices. This action plan will also identify stakeholder roles and responsibilities, and daylight current and/or potential future funding opportunities.

Methodology

FAAN conducted 55 semi-structured interviews with diverse regional stakeholders involved in supporting the local response to homelessness. This process hoped to uncover local nuances, attitudes, and beliefs toward homelessness; discover acceptance level of potential solutions; and identify potential actors who may have been impacted by homelessness but did not envision a role in assisting with the creation and implementation of solutions.

The interviews ranged from a half hour to an hour and were all conducted via teleconferencing. Approximately 20% were group interviews and 80% one-on-one interviews. Participation was voluntary. Stakeholders were asked three open-ended questions to open the dialogue. These were: what is working, what can be improved, and what priority do you want to see addressed in the final Homeless Action Plan. Responses were transcribed and arranged through a method of data-analysis called *thematic coding*[2] that organizes responses according to repetitive themes.

FAAN also conducted a pre and post document review of the two key reports prepared by Denver University's Center for Housing and Homelessness and the PESTEL Analysis to ground findings from the stakeholder interviews and inform recommendations found in this Homeless Action Plan.

The composition of the stakeholders interviewed included local mayors and councilmembers, city staff, county staff, law enforcement, housing authorities, school districts, South Suburban Parks; and community and government partners including leadership from Change the Trend, All Health Behavioral Health Services, Tri-County Health, Family Tree, Sheridan Rising Together for Equity, Communities That Care, A Bridge Home, Colorado Department of Local Affairs (DOLA), Denver Mayor's Office, Denver Foundation, Metro Denver Homeless Initiative (MDHI), CSH, and Community Solutions – Built For Zero initiative.

---

2 The Coding Manual for Qualitative Researchers, Johnny Saldaña. Sage Publishing. 2013

Stakeholder Interview General Themes

Emergent general themes from the stakeholder interviews were grouped into Hopes, Fears, and Desires to identify the current homelessness response system's strengths, weaknesses and challenges, and opportunities.

Hope: What is working well

Stakeholders were invited to share what was working well to identify areas of pride and successful implementation of homelessness services.

Phrases repeated by more than one stakeholder and are listed here for consideration as an emerging values framework:

- *Equity.* Wanting to ensure a fair distribution of federal, state, county, and continuum of care homeless resources across the region.

- *Humanization of homelessness.* A recognition that "it could happen to any of us one day."

- Personal responsibility and empowerment. A desire to provide the right level of services in the spirit of "Neighbor helping Neighbor" or offering a "hand up."

- *Stewardship.* Ensuring thoughtful use of public funds.

- *Fair-share regional approach.* Encouraging each jurisdiction and surrounding communities to do their part to address homelessness.

Stakeholders also identified several local assets that they would like to see leveraged in the final recommendations of the homeless action plan.

- *Confidence in the Co-Responder Program:* Stakeholders appreciate a mechanism to respond to constituent concerns/complaints on behalf of people experiencing homelessness.

- *Food Distribution:* There is pride in the innovation and coordination of local meal and food distribution programs for individuals and households facing food insecurity.

- *Inter-jurisdictional Coordination:* Recently, multiple agencies convened to plan and coordinate large encampment clean-ups, setting up precedence for ongoing inter-agency cooperation, data-sharing, and formalization of frequent communication.

- *Change the Trend is a trusted convener:* A cross-disciplinary number of organizations and advocates attend the Change the Trend meetings and have confidence the organization can formalize as a lead homeless services provider with additional investments to hire a dedicated staff.

- *Libraries, recreation centers, and parks are mutual-aid partners:* These city assets are valuable field-based access points for information sharing to people in need and provision of basic services such as food and showers.

- *School Districts strongly support families at-risk or experiencing homelessness:* The McKenny Vento student resource staff are extremely knowledgeable of local resources and are a consistent/trusted point-of-contact to connect family to services.

Fears: Areas of Concern and Opportunity

In discussing areas of opportunity, stakeholders were invited to share their angst, frustrations, fears, and concerns. This process was important to surface opportunities for additional dialogue and education, and to ensure that recommendations addressed potential community concerns and barriers to implementation.

- *Lack of funding:* Decreased tax review impacted by the COVID-19 pandemic and limited federal aid for local governments and providers within the Tri-Cities region raised concerns about funding for new or expanded homelessness services. Stakeholders would like to leverage regional partner resources (e.g., County, State, Federal, Veteran Affairs, MDHI) before increasing general fund dollars.

- *Tri-Cities region may become a homeless magnet:* There is a general assumption that the increase in single adult homelessness within the Tri-Cities region is a spill-over effect from Denver. For example, several stakeholders cited displacement by Denver police after a series of encampment clean-ups as a cause of an increased presence of single adults in the region. Stakeholders also expressed concerns about attracting people from outside of the Tri-Cities region if the local cities increase homeless services.

- *Homeless services are underutilized:* Several stakeholders shared that while there were many homeless services in the Tri-Cities region, people in need and community members do not know how to access them. Additionally, there was also a perception that people in need were not accessing available public benefits due to complicated enrollment processes that many vulnerable adults cannot navigate on their own. As a result, resources that could support pathways to self-sufficiency are being underutilized.

- *Vulnerable People are falling through the cracks:* There were general concerns about the capacity of local service providers to address the needs of chronically homeless persons living with severe mental health and substance use challenges. Without a seamless, low-barrier, transparent process, stakeholders expressed concerns that this population is ending up in the criminal justice system instead of being connected to appropriate services.

- *Homelessness housing is complex and expensive:* In theory many persons understood that access to affordable housing is a necessary component of the homeless response system, however there were many questions around the development of affordable housing including: options of housing typology for very low income persons, how many units would be needed, how do you subsidize rent for the units, where would the housing be located, who would provide services to occupants and how would those services be funded, and how could they ensure local people experiencing homelessness would be able to access new housing opportunities.

Desires: Expressed Priorities

After reflections on the current system, stakeholders were invited to dream and reimagine how the homeless response system could better meet the needs of people experiencing homelessness, while co-existing with the needs of residents and business owners. Responses included:

- *Increase interjurisdictional coordination:* City staff expressed a desire to increase inter-jurisdictional cooperation among colleagues within the same city organization and with peers in other jurisdictions to share data, staff training, service coordination, and open communication on emerging encampments and frequent users of city services to better direct limited city resources.

- *Identify a regional coordinating body:* There was a strong desire to identify a centralized regional leadership body to guide homelessness policy, set and monitor system outcomes, advocate for state and federal funding, streamline   implementation of the Homeless Action Plan, and communicate progress with the public.

- *Establish a central point of entry to access local homeless services:* Stakeholders would like to see the designation of a central provider responsible for coordinating local homeless services, communicating those services out to the public so that people know how to access them, provide staffing to assist vulnerable populations navigate services, and enter data into the HMIS OneHome databases to increase access and placement of clients into available housing and services.

- *Proactively address behavioral health needs of unsheltered residents:* There was a desire to increase local capacity to proactively outreach and engage unsheltered persons with behavioral health conditions as an alternative to police, and provide street-based mental health and substance use interventions while seeking to build rapport and connect such persons to longer term behavioral health care services.

- *Prevent families and seniors from becoming homeless:* Increase capacity to identify seniors and families at-risk of losing housing and provide wrap-around services and financial assistance such as rental protections and legal services for eviction prevention.

- *Strengthen workforce development opportunities:* Employment and skills training, especially the building trades, was identified as an important pathway to re-engage people experiencing homelessness with a sense of purpose and dignity. Employment was also seen as a viable option to build financial stability to access housing opportunities.

- *Identify diverse housing typologies:* Several stakeholders wanted to increase their understanding of permanent housing options for persons exiting homelessness including exploration of shared housing, accessory dwelling units (ADUs), use of landlord incentives to encourage landlords to lease to people experiencing homelessness, and public-private partnerships to create permanent supportive housing.

Cumulative Findings

The following findings emerged through a synthesis of the stakeholder general themes and key observations generated in the recent reports. These findings informed the recommendations presented in the next section.

- *Acknowledge the unique needs of families and individuals experiencing homelessness in the Tri-Cities region:* While many people associate homelessness with unsheltered single adults visible on the street, job loss during the COVID-19 pandemic against a backdrop of rising rents that are out of reach for many households, has increased housing instability among low-income families placing them into homelessness or at severe risk. While families may be able to hide their homeless status by temporarily staying at the home of a friend or family, these arrangements are not permanent, can be stressful, can fracture relationships, and in some cases, place children at-risk in unsafe environments. It is therefore important to reimagine a local homeless response that addresses the needs of unsheltered homeless adults and the needs of families experiencing or at imminent risk of homelessness.

- Dedicate a fulltime, proactive homeless outreach team to respond to constituent concerns and connect unhoused people to local services. In all three cities, law enforcement is assigned to respond to calls for service for people experiencing homelessness. The service call volume is significant, as according to one law enforcement department approximately fifty percent of service calls involve substance use, mental health and homeless.

keeping themselves safe. Staff also would like to increase communication with fellow department heads within their jurisdictions and across jurisdictions to share concerns, best practices, and leverage resources such as staff training, data collection, and dedicated homeless navigators.

• *Create an easier system for people to access and navigate homeless services:* Homeless services should be streamlined through the creation of a central access point. Residents, public servants, and people in need do not know how to access various homeless services, although there is strong recognition that many exists. Local homeless service providers participate in the Change the Trend meetings to exchange information on services, client needs, and pooling together funding for resources such as emergency motel vouchers. However, there is a need to formalize these efforts and increase the capacity of Change the Trend or incubate a new organization that can hire staff and become designated as the single point of contact for local homeless services.

• *Increase data collection and tracking practices:* While each jurisdiction participates in the national Annual Point in Time Homeless Count, it is now commonly understood that this single-night snapshot is not an accurate assessment of who is homeless within each community, nor is it able to inform understanding of needs to exit homelessness. Data systems that offer a more near-real-time understanding including the Homeless Management Information System (HMIS), a HUD mandated regional database that stores individual demographic data and captures entrance and exits of persons in and out of HUD funded programs; and Metro Denver Homeless Initiative's OneHome Coordinated Entry Database. OneHome is a database that collects assessment data on individuals along with various housing opportunities to create a match between the needs of a person and the funding source to best meet those needs. Both databases are currently underutilized by local providers due to limited staff and technology capacities.

` At the same time, city staff and contracted providers, are also storehouses of data for people experiencing homelessness that could be leveraged to inform the deployment of city resources to proactively address emerging concerns such as a growing encampment. However, data collection among city staff is currently informal and mechanisms to collect and share data would have to be put in place.

• *Enhance local and regional coordination:* Homeless services in the Tri-Cities region need a central champion to continue to drive its homelessness agenda forward. Homelessness is a complex human crisis that requires dedicated attention to guide and prioritize policies, coordinate public services and nonprofit service providers, liaison with other jurisdictions, and advocate for funding. A high-level, influential body representing local political will, is needed to oversee the implementation of this Homeless Action Plan and keep the community and other stakeholders abreast of progress to sustain public support and trust of this initiative. The Tri-Cities Homelessness Policy Committee partially fulfills this role, however, is all volunteer body with no full-time staff to execute these duties daily.

• *Dedicate a fulltime, proactive homeless outreach team to respond to constituent concerns and connect unhoused people to local services:* In all three cities, law enforcement is assigned to respond to calls for service for people experiencing homelessness. The service call volume is significant, as according to one law enforcement department approximately fifty percent of service calls involve substance use, mental health and homeless.

To meet constituent demand, the cities have each partnered with All Health to create a Co-Responder Program. However, while the Co-Responder Program is a partnership between a clinician and law enforcement officer that responds to mental health, domestic violence, and behavioral health crisis among the general population that may include people experiencing homelessness, it is not a dedicated homeless outreach team as found as a best-practice in cities across the country.

However, the City of Englewood recently launch a pilot to create a case management model that pairs a case manager with law enforcement, to meet with chronically homeless people. This case manager conducts the Vulnerability Index – Service Prioritization Decision Assistance Tool (Vi-SPDAT) assessment with clients and enters their information into the OneHome Coordinated Entry System to position persons for housing opportunities. The program is demonstrating promising results. The expansion and sustainability of this model will require additional funding.

- *Leverage partnerships to proactively address the health and behavioral health of single adults experiencing unsheltered homelessness:* Evidence[3] shows that providing housing is one of the most cost-effective health interventions for people who experience chronic homelessness. Experiencing homelessness on the street exacerbates chronic medical and behavioral health conditions, that are costly to local governments and create life-threatening results. According to the County Coroner's Office, during the period of January 2020 to January 2021, 17 people experiencing homelessness in Arapahoe County died of natural causes on the street, 22 died by drug overdose, and 4 by hypothermia, possibly exacerbated by substance use. Therefore, strategies that keep people safer on our streets are essential components of an adequate response to homelessness.

  Nationally, cities and counties have partnered with healthcare partners to create non-emergency interventions that have reduced the use of emergency services, adverted public spending on such services, and improved lives. Health networks have invested internally through the creation of "patient navigators" who help homeless patients connect to interim housing or other programs before discharge, and as external funders to support multidisciplinary homeless outreach teams, street medicine teams, and mini-health clinics located inside of homeless navigation centers.

  The Tri-Cities region is rich with healthcare partners including Tri-County Health and Sheridan Health Services, who have expressed interest or are operating street-based programs that engage people experiencing homelessness. It is recommended that the cities, county, homeless service providers, and the healthcare entities come together to explore ways to increase street-based physical and behavioral health interventions to save lives, improve neighborhood conditions, and build rapport to guide people into housing and supportive services.

- *Expand housing opportunities to increase successful exits from homelessness:* Placement in permanent affordable housing is an evidence-based practice to end one's homeless episode.[4] Cities and counties across the country have developed innovative ways to create housing opportunities for individuals and families exiting homelessness. Some cities allocate a percent of their housing authorities housing choice vouchers by preferencing homelessness in their application process. Others provide rapid rehousing through federal, state, or local funding sources. Still others incentivize landlords to accept housing subsidies from people exiting homeless and some modify local zoning codes to allow for shared housing to increase affordability.

---

3 http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf; https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue

4 https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/; https://endhomelessness.org/study-data-show-that-housing-chronically-homeless-people-saves-money-lives/; https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf

Permanent supportive housing (PSH) is an evidence-based housing model that provides housing retention success for persons living with chronic physical and mental health conditions. PSH includes a rental subsidy, wrap around supportive services (i.e., case management, substance use counseling, mental health services, financial management). Research shows that this form of housing decreases emergency room visits, length of hospital days, psych admissions, Medicaid costs, justice involvement while increasing retention in stable housing into the range of 79% to 93%.[5] Although a best practice to intervene in chronic homelessness, there are currently no PSH units within the Tri-Cities region.

[5] Tenancy Supports for Coloradans Experiencing Long-Term Homelessness, CoDOLA, updated 3/1/2019. A copy is in Appendix 2.

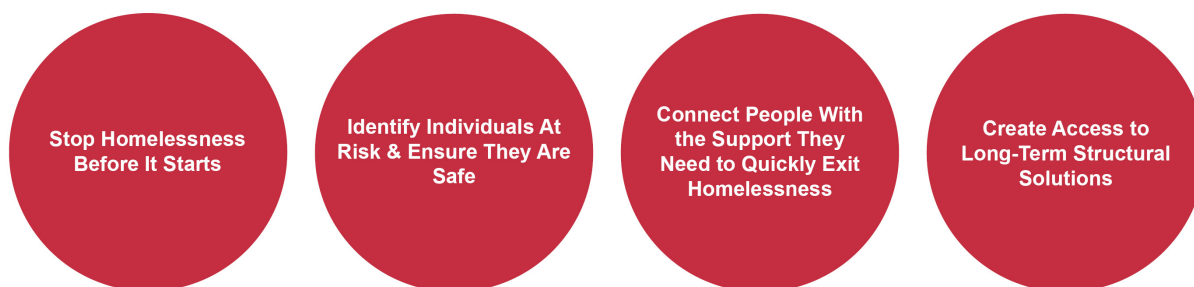# Recommendations and Action Steps

The following recommendations and action steps are offered to Tri-Cities city and county policymakers, and wider public for consideration. The recommendations were informed by the cumulative findings presented in the last chapter and seek to address the needs of individuals and families experiencing homelessness in balance with the needs, cares, and concerns of the entire community. The recommendations are in alignment with national, state, and regional best practices and evidenced-based solutions to address homelessness at the local level.

The National Alliance to End Homelessness defines an effective homeless response system as one that identifies those experiencing homelessness, prevents homelessness, when possible, connects people with housing quickly and provides services when needed. Common programs of crisis response systems include:
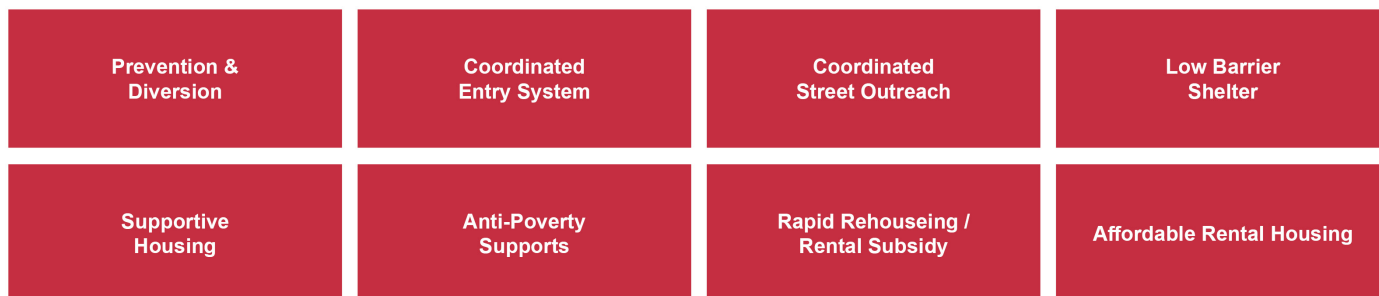
- Outreach
- Coordinated Entry System
- Diversion and prevention
- Emergency shelters and interim housing
- Permanent Housing

The State of Colorado[6] and Metro Denver Homeless Initiative (local Continuum of Care) have adopted these practices in the shaping of their homeless plans at the state and Metro Denver region.

Proposed Key Goals in Alignment with the State

| Stop Homelessness Before It Starts | Identify Individuals At Risk & Ensure They Are Safe | Connect People With the Support They Need to Quickly Exit Homelessness | Create Access to Long-Term Structural Solutions |

Proven Solutions Recommended by Metro Denver Homeless Initiative (MDHI)

| Prevention & Diversion | Coordinated Entry System | Coordinated Street Outreach | Low Barrier Shelter |
| Supportive Housing | Anti-Poverty Supports | Rapid Rehouseing / Rental Subsidy | Affordable Rental Housing |

---

6 Making Homelessness History in Colorado, Colorado Department of Local Affairs https://drive.google.com/file/d/1dQ-FbbNyCW9ecpqBJcCkxrOad_5X7IsH/view
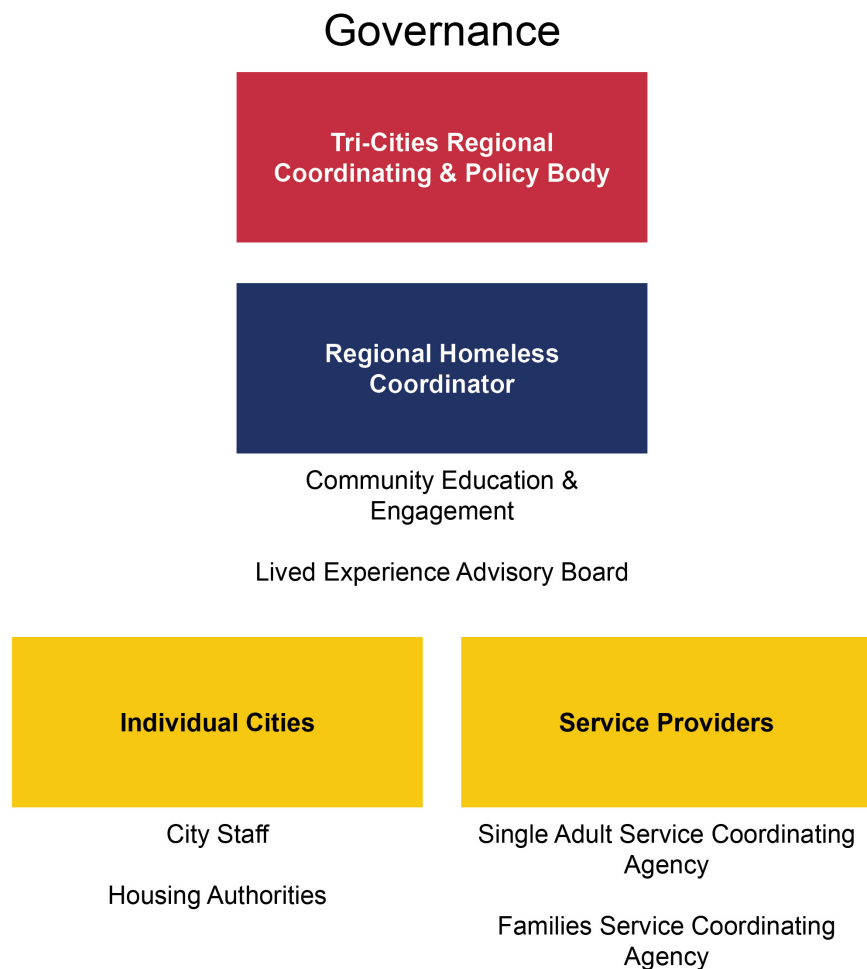
The recommendations are clustered into four key thematic areas, listed below, and are prioritized according to project readiness, available funding or eligibility for new funding, staff capacity, and time. The recommendations are also presented in narrative format to include a more detailed description and community examples, and a matrix on page 32 that outlines funding sources and proposed assignments of activities.

The four key thematic areas:

1. Building a Strong Foundation
2. Single Adult System
3. Workforce Development
4. Family System

1. Building the Foundation

The first series of recommendations focus on building a solid foundation with an eye towards strengthening local governance of homeless programs, data collection, cross-jurisdictional partnerships, and community engagement. While the Tri-Cities region is a part of the Metro Denver Homeless Initiative Continuum of Care, it is still important that local jurisdictions collaborate together to create additional resources for homelessness housing and services. A strong governance structure builds local capacity, supports coordination across governmental entities and nonprofit partners, and attracts additional public and private funding for homelessness programs.

Governance

Tri-Cities Regional Coordinating & Policy Body

Regional Homeless Coordinator

Community Education & Engagement

Lived Experience Advisory Board

Individual Cities

City Staff

Housing Authorities

Service Providers

Single Adult Service Coordinating Agency

Families Service Coordinating Agency

Recommendation #1.1 Build a Strong Governance Structure

Action Step 1. Formalize a regional leadership body.

Formalize the Tri-Cities Homelessness Policy Committee as the regional leadership body for the cities of Englewood, Sheridan, and Littleton. Adopt a strategic vision to set-forth the direction of homelessness policy, an annual legislative agenda, transparent provision of benchmark achievements, and liaison with external regional coordinating bodies and policymakers.

Action Step 2. Create a regional Homelessness Coordinator.

Pool city, county, private foundation resources to hire a full-time limited term (possibly 3 years) Homelessness Coordinator (The Coordinator) to staff the Tri-Cities Homeless Policy Committee and be a single-point-of-contact on homelessness for the region. This would be a senior leadership position with authority to convene stakeholders across the Tri-Cities region. The Coordinator will develop strategic partnerships with key organizations such as the local School Districts, Tri-County Health, and the Denver Foundation to leverage programs and resources. The coordinator could liaison with homelessness-related staff in surrounding communities to engage in joint advocacy for policies and funding at local, regional, and statewide levels; encourage participation of service providers, first responders, business and faith-based groups, and residents in community roundtable discussions to increase education on homeless solutions. The coordinator could also be a single point of contact for service providers and community members, including those experiencing or at risk of homelessness.

Action Step 3. Increase Local Government Staff Capacity to Address Homelessness

Local leadership may want to work with staff to help clarify roles and expectations on addressing homelessness within their organizations. Staff engaged in providing city services to unhoused constituents should receive training to increase their safety and cultural humility skills to serve this vulnerable population. Examples of standard trainings include Mental Health First Aid, Trauma-Informed Care, De-escalation Training, and safe handling and disposal of biohazards and sharps. Several trade organizations such as the American Library Association and the National Recreation and Park Association, offer rich resources on homelessness for training, issue briefs, and peer support. The Homeless Training Institute also provides training for local government staff.

Local government staff should also be encouraged to collect and track data on services provided to people experiencing homelessness to help leadership understand the expenditure of resources, identify service gaps, and monitor emerging concerns such as new encampment. There are a wide variety of data collection tools used by cities including Survey123 and Akdio Lab's Project Connect for more sophisticated data collection efforts to meet the needs of highly vulnerable clients.

Action Step 4. Create a Lived Experience Advisory Board

The National Alliance on Homelessness and national philanthropic funding partners strongly advocate for the inclusion of persons with lived experience as a formal part of unified homeless response systems. It is recommended that Tri-Cities or the County's emerging regional coordinators, create a Lived Experience Advisory Board (LEAB) to help guide and develop programs and policies that address homelessness within the region. It is further recommended that the LEAB be composed of five to seven members who are currently housed but have experienced homelessness within the region. Participants should receive a stipend or honorarium for their contributions.

Examples: CSH Speak-Up, San Jose, CA, Baltimore Lived Experience Advisory Committee

Recommendation #1.2. Formalize a Data-Driven Approach to Guide Allocation of Homeless Resources

The Tri-Cities region is a part of the Metro Denver Homeless Initiative (MDHI) Continuum of Care (CoC), an entity that receives federal and other funding to address homelessness. As the CoC, MDHI oversees the implementation of two important databases to collect homelessness data. The first is the Homeless Management Information System (HMIS) and the second is OneHome, the database for the local coordinated entry system. Access to both programs is free to homeless service providers.

Action Step 1. Increase participation in the Homeless Management Information System (HMIS).

Increased utilization of data-entry into the Homeless Management Information System (HMIS) is a critical step to increasing understanding of who is experiencing homelessness in the region, what are their needs, and if they already connected to services. Using data collected in an HMIS enables communities to better understand the local needs and dynamics among specific subpopulations of people experiencing homelessness, as well as measure the performance of their approaches to preventing and ending homelessness.

The database also enables providers to provide consistent care by reviewing notes on previous homeless interventions to prevent the client from having to retell their story. Local governments can support this action step by encouraging their homeless service agencies to participate in data-entry into the HMIS system. Local governments and private foundations can also support by removing participation barriers to using the HMIS system by providing computer equipment (i.e., laptops, tablets) and access to high-speed and consistent wi-fi or other form of internet access. MDHI will assist organizations download the software and issue software licensing as well as provide training and ongoing technical assistance, for free.

*While law enforcement has a role in the provision of homeless services, federal policy forbids the use of HMIS by any law enforcement agency.

HMIS Factsheet

Action Step 2. Increase referrals to MDHI's OneHome[7] Coordinated Entry System (CES).

Coordinated Entry Systems (CES) are local processes applied to prioritize homeless populations for limited supply of housing resources. The use of coordinated entry systems is also to ensure that access to resources is equitable. In response, most communities use their CES to help identify and prioritize people based on various forms of vulnerabilities defined by the local communities. For instance, some communities prioritize people actively fleeing from domestic violence, persons with severe mental health or physical health conditions, and others unsheltered persons over the age of 65. To help assess a person's eligibility based on local priorities, communities utilize a HUD approved assessment tool. The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) is one of the most popular assessment tools and is the current tool used by the Metro Denver Homeless Initiative (MDHI) Continuum of Care (CoC). Assessment scores are then entered into a customized database that may be separate from the HMIS platform. MDHI utilizes a CES database called OneHome.

OneHome is a database that creates a technical platform to manage a list of clients awaiting housing, their housing needs and eligibility criteria (e.g., veteran status, mental health disability), and new housing opportunities that come online and shared with MDHI. The OneHome system then prompts case managers with possible matching opportunities for clients who meet the eligibility requirements for a specific housing opportunity. For example, an elderly Veteran is assessed by a case manager and his information is entered into the OneHome database. The local housing authority receives 10 new housing vouchers for Veterans. The case manager searches his client list in the OneHome database for potential matches. Based on the client's age, disabilities, and Veteran status, his name may populate a list of eligible clients able to take advantage of one of the new housing vouchers for Veterans.

Unlike the HMIS system, not all providers will assess people and enter data into the local CES due to the very sensitive information that is collected as part of the VI-SPDAT assessment questionnaire. Instead, usage is often limited to case managers who have a direct involvement on a person's care team and is responsible for matching clients with housing resources.

Currently, the City of Englewood's homeless case management program embedded within Englewood Police Department is one of the few providers conducting the Vi-SPDAT assessment and entering eligible clients into the OneHome system. As more providers build capacity, especially if a lead provider emerges and operates the proposed navigation center, it is encouraged to expand Vi-SDAT assessments among the single adult population and enter their information into OneHome to place them in line for housing. Housing placement wait times vary depending on available housing resources, however OneHome participation significantly increases a person's ability to be housed.

---

1 https://www.mdhi.org/onehome_community_training

Action Step 3. Partner with Community Solutions Built for Zero initiative to build capacity by addressing the needs of specific subpopulations.

Built for Zero is a national campaign to end chronic and Veteran homelessness in the U.S. by applying a data-driven approach to help people experiencing homelessness, service providers and local leaders see reductions in homelessness in 2021 and beyond.

A key component of the Built for Zero framework is to work with local communities such as Tri-Cities to select a specific sub-population and allocate homeless housing resources towards that population. Examples of subpopulations selected by communities across the country participating in the Built for Zero initiative include Veterans, chronically homeless persons (those who are homeless for over a year with a chronic health of mental health condition), or frequent users of local police and fire services. Once a subpopulation is identified, local homeless service providers then create a confidential "By-Name List" of persons engaged in homeless services who meet the subpopulation criteria. Through a mechanism called case-conferencing, the providers meet weekly to discuss the status of housing and service connection for each client on the list. All client updates are entered into the HMIS system. The goal is to leverage resources and knowledge on the clients to help streamline their placement into housing.

Through MDHI, Tri-Cities is working with the Colorado Built for Zero team. To date, a Built-for-Zero Homeless Coordination Team with a focus on Tri-Cities has been established and this team is participating in the Metro Denver Regional Design Team. MDHI has also assigned an Improvement Advisor and staff to support Tri-Cities entrance into this work.

Recommendation #1.3. Create a Community Education and Engagement Strategy

Action Step 1. Create a centralized Tri-Cities webpage outlining the unified homeless response.

Increased transparency of the region's plan to address homelessness and updated progress reports may increase community ownership and support of the overall effort. While each city currently lists its homeless services, a central webpage may be easier to navigate. The webpage could host the following content:

- Portal to request homelessness services for self or on behalf of a homeless neighbor (see Recommendation # Action Step)
- Downloadable educational materials on homelessness
- Success stories to highlight people who exited from homelessness through employment or placement into housing.
- Volunteer opportunities with local homeless service providers
- Progress updates on the implementation of these recommendations

Englewood and Littleton currently host a landing page for local homeless services. A partnership with Denver University students was initiated before the pandemic to consolidate these efforts into a single page. As operations resume, it may be possible to reengage this resource to implement this action step.

Examples: Westside Cities Council of Governments, San Gabriel Valley Council of Governments

Action Step 2. Streamline volunteer and giving opportunities to help neighbors in need.

Engage the local community in opportunities to learn more about homeless solutions and participate as a "neighbor helping a neighbor" through streamlining local volunteer opportunities, engagement events, and ways to give. Local organizations across the country have created centralized webpages for volunteer opportunities with online applications and sign-up ability. They have also created dedicated community funds to support homelessness programs. Community giving opportunities create the ability to leverage private contributions to make a significant collective impact. These funds are usually managed by a local community foundation with oversite and guidance on grantmaking provided by an appointed community advisory board. The South Metro Community Foundation is a new philanthropic organization in the region that has expressed some initial interest in becoming involved in local homeless solutions. As the foundation grows, it may be a potential partner to manage a community fund dedicated to local homeless programs and this possibility should be explored.

Examples: We Are Santa Monica; We Are Santa Monica Fund

Action Step 3. Create a Welcome Home Community Engagement Program

Engage community members in conversations about the myths and facts about homelessness while assembling "welcome home" baskets for people who successfully move into housing. Welcome Home Assembly events could be sponsored by a local church, civic organization like the Rotary Club, and even in a private home for a coffee chat. Nonprofit or city staff could participate by providing the educational content, while neighbors join neighbors to assemble laundry baskets with many small household items such as cleaning supplies, bath towels, bedsheets, coffee pot, dishes, and utensils, etc.
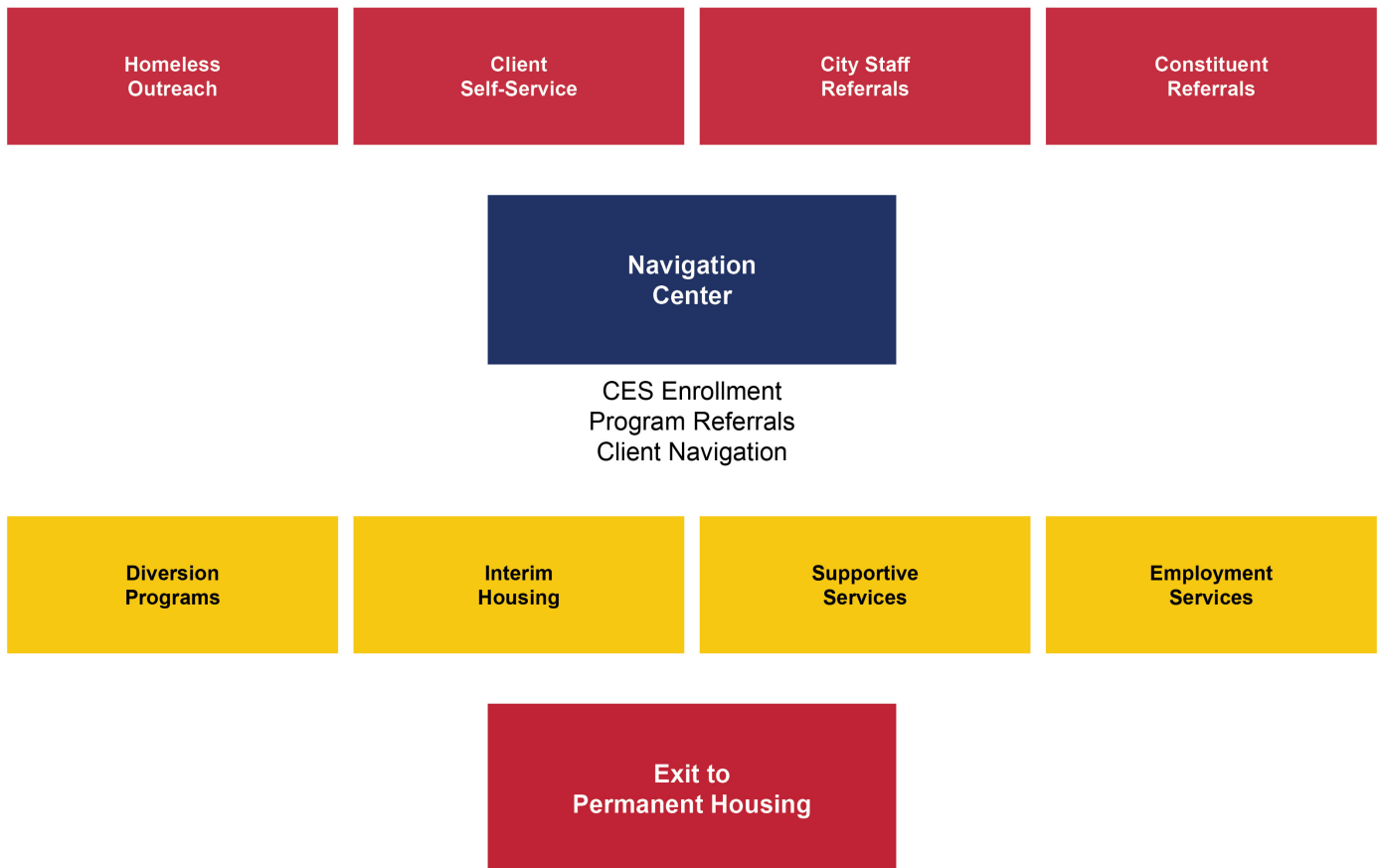
Examples: Welcome Home Project, SFAR Foundation

2. Meeting the Needs of Single Adults

The next series of recommendations focus on addressing the needs of single adults experiencing homelessness by streamlining pathways to access services.

Homeless Outreach	Client Self-Service	City Staff Referrals	Constituent Referrals

Navigation Center

CES Enrollment
Program Referrals
Client Navigation

Diversion Programs	Interim Housing	Supportive Services	Employment Services

Exit to Permanent Housing

Recommendation #2.1. Streamline access to homeless services for single-adults within the Tri-Cities Region.

Action Step 1. Designate a lead service provider to coordinate services for single adults.

Invest in Change the Trend, or an incubated nonprofit guided by the organization, to build local capacity to coordinate homeless services for single adults among public, nonprofit, and faith-based providers. As the service provider lead, this entity will set the pace, standards, and expectations for participating homeless services providers to ensure seamless access to service provision. The lead service provider will also be responsible for problem-solving emerging challenges in communication with the regional homeless coordinator; interface regularly with local providers and volunteer organizations through continuing monthly convenings; and host weekly case conferencing on people experiencing homelessness and actively receiving homelessness services, to monitor and advance their movement into housing.

Action Step 2. Create a Central Navigation Center.

A dedicated space for walk-ins and client referrals is needed to help transient populations build trust, learn about services, and receive navigation support to apply for benefits and programs. Navigation centers across the country vary in size, scope, and service provision based on the needs and resources of the hosting community. The key function of navigation centers is to create a central access point to connect people to available housing and services. The lead homeless service provider may co-locate within the navigation center and be responsible for daily operations.

Initial space may co-locate in an existing homeless service agency, however long-term the provider may want a stand-alone location that has capacity to support the co-location of additional county and nonprofit services, and provision of client basic needs such as day-storage, showers, mailboxes, laundry, and pop-up shelter for inclement weather or other emergencies.

In addition to a central site, the central navigation center may want to leverage the existing relationships between current informal access points such as local libraries and recreation centers or the number of social cafes, and people experiencing homelessness to create satellite access points. The sites can build rapport by meeting basic service needs and refer clients to the navigation center for more comprehensive services.

Examples: Project HOME Hub of Hope, Center at Blessed Sacrament, Saint Francis Center, and City of Freemont

Action Step 3. Create an online platform to request homeless services.

To reduce police responses to non-emergency homeless calls, an online service platform could be created to educate the public and persons seeking homeless services on available programs, eligibility, and how to access the programs. Management of the site would have to be determined; however, it should be in close communication with the lead service provider. The platform should offer an online service request option so that an individual or concerned neighbor could set up an appointment with staff at the central navigation center or request a visit by the outreach team to engage people experiencing homeless in local services. The site could also have links to cities and county resources too, such as city service request portals and the County's ArapaSource site. The public should also be reminded that all requests are for non-emergency services only and expectations set on approximated response times.

This online system could be a part of the regional webpage on homelessness described in Recommendation 1.3, Action Step #1.

Examples: City of Santa Monica's online 311 system, Los Angeles Homeless Service Authority's LA HOP Portal, and Tri-Cities Homelessness & Housing Task Force (British Columbia, Canada).

Recommendation #2.2. Provide Street-Based Services to Increase the Health and Wellbeing of Unsheltered Residents

Action Step 1. Launch a Coordinated Outreach Team.

Multidisciplinary street teams are a best practice deployed by many communities to proactively engage persons experiencing unsheltered homelessness. These programs include cross-functional

teams that often include case managers, peer support specialists, substance use counselors, and social workers. The City of Englewood Homeless Case Management program embedded within the local police department is a preliminary model that can be scaled and expanded, and even placed within a nonprofit organization to increase eligibility for various forms of homelessness funding.

Ideally a coordinated outreach team for the Tri-Cities region would consist of two roving 2-to-3-person outreach teams that for at-least 5 days a week are engaging the street population and helping them navigate enrollment into the various homeless programs. Often it takes time for outreach workers to build rapport with people experiencing homelessness, so it is not out the norm for a case manager to make and accommodate someone to a doctor's appointment, help them apply for public benefits online or in-person, or even help the person reconnect back with family. Consistency is the key to trust and that is way a 5-day a week team dedicated to outreach is necessary. Other activities that the street outreach team can provide include securing certified copies of birth certificates or state identification cards so that people can apply to programs and entering client information into the HMIS and OneHome systems.

Examples: [Santa Monica C3 Team](#), [City of Austin Homeless Outreach Street Team](#)

Action Step 2. Continue to Support Local Meal and Food Distribution Programs.

Throughout the COVID Pandemic, many of these programs found creative ways to continue to provide meals to people experiencing homelessness, including the creation of a Community Fridge. These touchpoints may have been the only point of human contact for some within this community. As these programs reopen, it is hoped that they will have the financial capacity to continue to serve unhoused neighbors. An enhanced service once reopened, would be for meal programs to leverage their trusted relationships with unhoused residents and connect them to HMIS and/or food stamps through ArapaSource to support their pathways toward housing and self-sufficiency.

Examples: [Graceful Cafe](#), [Cafe 180](#)

Action Step 3. Pilot a Safe Parking Program.

According to the Center for Housing and Homelessness Reports on Homeless Families and People Experiencing Chronic Homelessness, 35 people reported sleeping in a car, van, or RV the night before the interview, and 142 people had at least one night over the past two years. Persons who are newly homeless tend to sleep in their car while trying to maintain other supports such as employment, proximity to family members, and to stabilize school access for children.

In the era with limited options for interim and permanent housing, Safe Parking programs have emerged over the past few years to use public and private parking lots after-hours to offer a safe place to sleep. Participants must pre-register to access the parking lots and have an operable vehicle. Some programs require participation in employment, school, or social services, while others allow people to stay if they are taking steps to move into permanent housing. Safe parking programs also offer basic need services such as access to restrooms, mobile showers, overnight security, and to-go dinner and breakfast meals. Local zoning laws may create barriers to safe parking on private lots such as church lots or shopping malls and should be reviewed to assess feasibility.

Examples: [Safe Parking LA](#), [Overlake Christian Church](#)

Action Step 4. Convene local mental, physical, and behavioral healthcare providers to explore the creation of a medical street team.

The Tri-Cities region is rich with many healthcare providers that engage people experiencing homelessness but may be slightly disconnected to the network of local homeless services. Street-based medical teams dedicated to serving this population have had a significant impact on increasing the health and wellbeing of street populations through the provision of wound care, vital health screenings, renewing prescriptions for physical and mental health care, and most recently providing COVID testing and vaccines. They differ from the homeless outreach teams because their primary focus is to provide medical and behavioral health care to help stabilize someone to increase their likelihood to then want to take advantage of housing and supportive services.

Medical street teams reduce expensive emergency services such as ambulance transports, emergency room visits, and sever deteriorating health conditions. Ideally, a medical street team is multidisciplinary and includes a license social worker, public health nurse, and substance abuse counselor, and visiting physician or nurse LPN or emergency medical tech (EMT). Strong possible partners to engage include Tri-County Health, Sheridan Health Services, All Health, the local Veteran Affairs hospital, local medical and social work schools.

Examples: [Santa Monica Homeless Multidisciplinary Street Team](), [Street Medical Institute]()

Recommendation #2.3. Expand Housing Opportunities for Single-Adults Exiting Homelessness

The action steps listed below represent low-barrier housing options applied in other communities to create housing opportunities for people existing homelessness utilizing existing housing stock and housing subsidies. It should be noted, that while they are low barrier compared to developing a new housing site, further analysis of local code, zoning, and licensing must be conducted to determine feasibility as viable options.

Action Step 1. Promote shared housing as a viable option to increase housing affordability.

Shared housing is the ability to rent rooms in a single-family dwelling to unrelated persons to make the housing affordable to all. Occupants each have their own lease that provides access to a private bedroom and shared common spaces such as the bathroom, living room, and kitchen. Shared housing works best when it is facilitated by a service organization who can help match tenants based on personalities, interests, and needs, and help mitigate roommate conflicts.

Example: [Share, Inc]().

Action Step 2. Strengthen outreach to private landlords to increase participation in housing rental subsidies.

Currently, the local housing authorities outreach to landlords with limited capacity funded through an external grant. More robust landlord engagement programs provide dedicated funding for signing bonuses, additional security deposits, minor repairs so that units pass the housing authorities' inspections, and vacancy loss and damage payments. Funding is also provided for an ongoing case manager to help mitigate conflicts to prevent evictions and help clients stay housed as good neighbors. Landlord services also keep landlords active in the program to continue their acceptance

of housing choice vouchers without stigma. Local governments in communities with low vacancy rates have provided incentives to landlords to participate in housing authority housing choice voucher programs such as waiving business license fees for landlords who rent to tenants exiting homelessness within the city. Local Veteran Affairs have also sponsored landlord incentives to increase rentals to homeless Veterans.

Example: [Lease-up](#)

Action Step 3. Sponsor a feasibility analysis to determine the approximate number of Permanent Supportive Housing (PSH) units required to end chronic homelessness in the Tri-Cities Region.

PSH is an evidence-based housing model that provides congregate or scattered site housing units to vulnerable persons who have experienced long-term homelessness and have a disabling mental and/or physical disability. The housing unit is subsidized and supportive services such as mental health, substance use, financial management, are provided at appropriate levels for as long as the person needs it. Retention rates for vulnerable persons placed into PSH averages at 79% to 93% after one year, higher than many non-PSH program models. PSH tenants are identified through the local community's coordinated entry system. For Tri-Cities, this would be the OneHome system.

Permanent supportive housing development projects are not easy to create due to their complex finance structure. The PSH funding model is often referred to as the "three-stool" model as it requires 1) capital dollars for construction, 2) ongoing rental subsidies to cover operating costs of the property, and 3) long-term supportive services funding to provide intensive case management and mental health and substance use interventions. Since there is a need to provide deep subsidies to make PSH units affordable, most PSH sites are developed by nonprofit housing developers who utilize low-income tax credits, project-based housing choice vouchers, in-kind land donated by local municipalities, county mental health or public health funding for services, and private funding to close any financial gaps.

It is recommended that a feasibility study is conducted to assess the need for PSH in the region. The Housing Division of the Colorado Department of Local Initiatives or the Arapahoe County Department of Housing and Community Development Services may be great partners to conduct or hire a consultant to perform this study.

3. Workforce Opportunities

Pathways to workforce opportunities is a viable strategy for some persons experiencing homelessness achieve financial self-sufficiency. There are many workforce models that help transition dislocated workers back into the workforce including transitional work and social enterprises. Some workforce programs are supported with transitional housing. Most programs also offer case management or job coaching support to help participants reacclimate to the job site. The following workforce strategies are offered to encourage the continued development of programs currently in negotiation and to expand the offering of existing programs to people experiencing homelessness.

Recommendation #3.1. Create partnerships with existing workforce programs.

Action Step 1. Continue to pursue partnership with Bridge Home.

Bridge Home is a comprehensive transitional work program that provides paid work opportunities through contract with local municipalities while offering interim housing and supportive services to prepare disenfranchised populations reintegrate into society as taxpayers. Currently the organization is conducting a feasibility study to see if it would be possible to open a residential site and office and is working with the cities to potentially provide temporary or seasonal work opportunities.

Action Step 2. Promote Local Library Online Skills Training Programs.

The local libraries provide access to many online programs for free for all patrons. The Bemis Library in Littleton for example, offers a Career Online High School residents aged 19 and over who have completed the 8th grade. Online/self-directed programs should be promoted by homeless service agencies, case managers, and librarians to people experiencing homelessness with low barriers to self-sufficiency and simply need support to increase skills, prepare resumes, and apply for employment.

Action Step 3. Support the launch of Cross Purpose at Wellspring Church.

Cross Purpose is a Denver based workforce development program that offers a six-month job training program for free to participants facing barriers such as homelessness, re-entry, and other circumstances where one needs a hand up. In the Fall, Cross Purpose will launch a satellite program at Wellspring to offer opportunities for people experiencing homelessness and others in the Tri-Cities region.
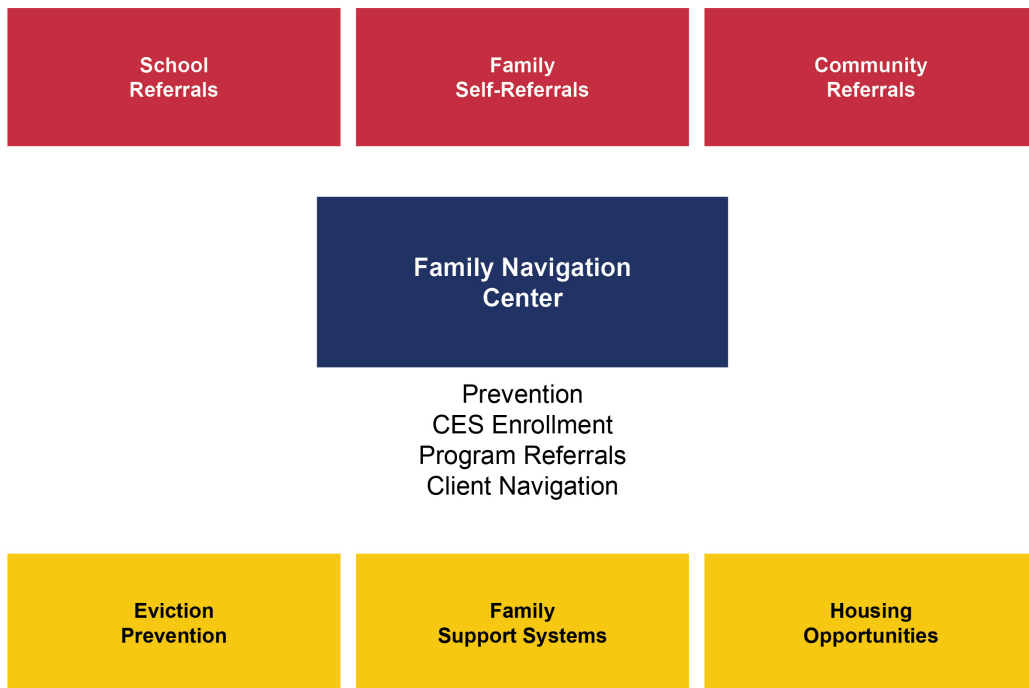
Recommendation #3.2. Create employment opportunities for persons exiting homelessness.

Action Step 1. Engage the local Chamber of Commerce.

Engage local businesses and business groups in community roundtable discussions about hiring homeless and formerly homeless individuals, providing job training, or becoming an employment site for Arapahoe/Douglas Works! Program graduates.

4. Develop a streamline system to address the needs of families at imminent risk and experiencing homelessness.

School Referrals	Family Self-Referrals	Community Referrals

Family Navigation Center

Prevention
CES Enrollment
Program Referrals
Client Navigation

Eviction Prevention	Family Support Systems	Housing Opportunities

Recommendation #4.1. Streamline access to homeless services and prevention for families experiencing or at imminent risk of homelessness within the Tri-Cities Region.

Action Step 1. Engage the local school districts as a partner to help lead prevention and homeless services for families.

All three school districts expressed active engagement in identifying and working with families experiencing or at imminent risk of homelessness through their Student Services staff. Through federal McKinney Vento funding for students, staff provide case management services, school supports and supplies, and make referrals to local resources for interim housing options at local motels and the Family Tree Shelter. The staff expressed a desire to be more formally involved with the local response system to advocate for more resources for families and stay up to date on housing and behavioral health resources designated for families.

Action Step 2. Designate a lead service provider to coordinate services for families.

Similarly, as recommended for single-adult services, it is advised to designate a lead organization to be the central coordinator for resources dedicated to family homelessness in the region. Family Tree may be a natural partner as the organization currently operates an interim housing facility in Sheridan and works closely with the local school districts. A next step could be engaging their leadership to gauge interest in taking on this leadership role and identify additional resources needed, if any.

Recommendation #4.2. Prevent Families from Becoming Homeless

Action Step 1. Collaborate with the school districts to ensure that school families-at-risk of homelessness are aware of new eviction prevention programs.

Arapahoe County recently received nearly $10 million dollars in CARES Act funding to protect families at-risk of eviction from inability to pay rent due to COVID-19 related job loss. Due to disparities in technology access, not every family will be able to navigate online applications to apply for the funding/and or have been notified that funding is available. As additional funding is allocated to help families recover, the regional family coordinator could bridge support by working with the school districts to identify families and help them apply for relief.

Action Step 2. Pilot a peer-support specialist program to extend outreach to immigrant families at-risk of homelessness.

Immigrant families may be silently falling into or at great risk of homelessness due to COVID-19 job layoffs and evictions, however, are not seeking assistance. There are many fears and sometimes cultural shame in accessing public and private resources for assistance.

Peer based support models may be an appropriate intervention to outreach to these families. Promotoras are one peer-based model that utilizes community health workers in a variety of roles to educate marginalized households on local resources and encourage utilization to increase social and health outcomes. Locally, Sisters of Color United For Education hosts a promotoras program. Outreach to this organization to explore possibilities of expanding or replicating services to liaison with immigrant families with children enrolled in the local school districts may increase economic, health, and social outcomes for all and prevent these families from falling into homelessness.

Example: [Sisters of Color United For Education](#), [Rural Community Health Workers](#)

Recommendation #4.3. Increase Housing Opportunities to Families

Action Step 1. Work with local housing authorities to explore possible ways of expanding Housing Choice Vouchers (HCH) to families exiting homelessness.

For the first time in decades, housing authorities across the country are expected to receive an increase in housing choice vouchers under the [American Rescue Plan](#). If the local housing authorities are awarded extra vouchers, it is recommended that they assess the reasonableness of allocating[8] a number or percentage to families exiting homelessness. Rigorous studies[9] demonstrate that housing choice vouchers create a pathway out of poverty for families by allowing them to secure stable housing, increased access to opportunity neighborhoods where parents may find higher wage jobs and children may benefit from increased quality education.

The local housing authorities should work closely with MDHI, the local continuum of care, to explore the feasibility of increasing housing choice vouchers through application to special programs including President Biden's Emergency Housing Vouchers allocated under the American Rescue Plan, and vouchers designated for youth aging out of foster care or for parents seeking to reunite with children in the child welfare system.

---

8 http://www.evidenceonhomelessness.com/topic/rental-housing-subsidies
9 http://www.evidenceonhomelessness.com/wp-content/uploads/2019/07/evidence-page-children-and-families-updated-2019.pdf; https://www.cbpp.org/research/housing/research-shows-rental-assistance-reduces-hardship-and-provides-platform-to-expand

Appendix 1: Matrix of Recommendations and Action Steps

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
1.1 Build a Strong Governance Structure	1. Formalize a regional leadership body	County and Tri-Cities Policy Council	1	In-Kind	County, Cities	**In-Progress** The Arapahoe County is convening partners to create a countywide regional coordinating body.
	2. Create a regional Homelessness Coordinator Position	Tri-Cities Homeless Policy Council, County	1	$50,000 to $80,000 a year for 3 years.	Private philanthropy, Cities, County	**New Concept**
	3. Increase local government staff capacity	Cities	1	In-Kind to $5,000 per city	County, Cities, free trade training.	**In-Progress** Several departments have begun providing homeless related training.
	4. Create a Lived Experience Advisory Board	County, Homeless Coordinator Homeless Providers[10]	2	$10,000	Private philanthropy, Cities, County	**New Concept**

---

10 Homeless Providers refer to organizations currently providing homeless services and future lead organizations of the single adult and family pathways.

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
1.2 Formalize a Data-Driven Approach to Allocated Resources	1. Increase participation in HMIS	Homeless Providers	1	In-Kind	MDHI	**In-Progress** The Severe Weather Shelter Network organizations are increasing utilization of data input into the HMIS system.
	2. Increase referrals to MDHI's OneHome System	Homeless Providers	1	In-Kind	MDHI	**In Progress** Case Manager assigned to Englewood Police Department is entering eligible clients into the OneHome System.
	3. Partner with Built for Zero	Tri-Cities Policy Council, Homeless Coordinator, Homeless Providers	1	In-Kind	Community Solutions, Tri-Cities, Homeless Providers, Veterans Affairs, Housing Authorities	**In Progress** Currently participating in Built-for-Zero's Metro Denver Regional Design Team and are establishing a Homeless Coordination Team focused on Tri-Cities.

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
1.3 Create a Community Education & Engagement Strategy	1. Create a centralized Tri-Cities webpage	Tri-Cities Policy Council, County, Homeless Coordinator, & Homeless Providers	1	In-Kind to $5,000	Cities, County, Healthcare Partners, Business Community	**In Progress** The cities of Englewood & Littleton host a landing page for homeless resources and will engage D.U. students to assist in creating a single page.
	2. Streamline volunteer and giving opportunities	Tri-Cities Policy Council, Homeless Coordinator & Homeless Providers	2	$5,000 to $10,000 for software license	Philanthropy, Business Community, Tri-Cities	**In Progress** South Metro Community Foundation has expressed interest in engaging in local homeless solutions and local stakeholders have identified it as a potential partner in the future.
	3. Create a Welcome Home community engagement program	Homeless Providers & Chamber of Commerce	1	In-Kind	Business Community, Community-at-Large	**New Concept**

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
2.1 Streamline Access to Homeless Services for Single-Adults	1. Designate a lead service provider	MDHI, County, Tri-Cities, Homeless Providers	1	$150,000	MDHI, County, Tri-Cities, Private Philanthropy	**In Progress** Change the Trend members are exploring the feasibility of incubating a dedicated organization out of one of their existing committees.
	2. Create a central navigation center	Tri-Cities Policy Council, County, and Homeless Providers	2	$25,000 pre-development feasibility study	City and County CDBG, American Rescue Plan, Private Philanthropy	**In Progress** Englewood is reviewing city-owned inventory for possible sites. Change the Trend created a proposal to manage the site through creation of a dedicated organization with staff.
	3. Create an online platform to request homeless services	County, Cities, Homeless Providers	3	In-Kind to $10,000 for software.	County, Cities, Private Philanthropy	**New Concept**

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
2.2 Provide Street-Based Services in Increase Health & Wellbeing	1. Launch a coordinated outreach team	County & Homeless Providers	2	$125,000 to $150,000 for staff	County, Cities, Healthcare Partners, Business Community, Private Philanthropy	**New Concept**
	2. Continue to support local meal programs	Community at large	1	In-Kind	Community at large.	**In Progress** Local meal programs are supported by a wide range of patrons and community members.
	3. Pilot a safe parking program	Homeless Coordinator, Homeless Providers	2	$10,000 to $25,000 for insurance, security, porta-potties	Faith-based community, Private Philanthropy	**New Concept**
	4. Convene local healthcare providers to discuss feasibility of a street medicine team	Tri-Cities Policy Council, Homeless Coordinator, Tri-County Health, Sheridan Health Services	3	In-Kind		**New Concept**

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
2.3 Expand Housing Opportunities for Single-Adults	1. Promote shared housing	Cities, Housing Authority, Homeless Coordinator, Homeless Providers	2	In-Kind for city staff to review zoning and building code changes.	Cities	**In Progress** Cities are reviewing local codes and zoning to accommodate potential shared-housing site for the Bridge Home workforce program.
	2. Strengthen outreach to landlords	Housing Authorities, Chamber of Commerce, Veteran Affairs	2	In-Kind to $25,000 for "Move-In Incentives"	State, Housing Authorities, Private Philanthropy, American Rescue Plan, Veteran Affairs	**In Progress** Innovative Housing received a small private grant to launch a pilot. Renewed or new funding will need to be allocated to continue.
	3. Sponsor a feasibility analysis for PSH	State, County, Tri-Cities, Housing Authorities	3	$50,000	State, County, Private Philanthropy	**New Concept**

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
3.1 Create Partnerships with Workforce Programs	1. Continue to pursue Bridge Home's Ready-to-Work partnership	Cities	1	?	Cities, County, American Rescue Plan	**In Progress** Bridge Home is conducting a feasibility study and will present findings to the cities in the coming weeks.
	2. Promote local online skills training programs	Cities, County, Homeless Coordinator, Homeless Providers	1	In-Kind	Cities, County, Homeless Providers	**In Progress** All three libraries offer formal or informal online skills training programs. They now need to be marketed to providers and unhoused residents.
	3. Launch Cross Purpose (6-week career prep program)	Change the Trend	1			**In Progress** Contracts are signed and prepared for a Fall 21' launch.
3.2 Create Employment Opportunities	1. Engage the local Chamber of Commerce	Homeless Providers	2	In-Kind	Homeless Service Providers and Chamber of Commerce	**In Progress** Change the Trend is partnering with the Englewood Chamber of Commerce to bridge relationships between the business and homeless provider communities.

Recommendation	Action Step	Recommended Project Sponsor(s)	Project Year	Estimated Cost	Potential Funding Source	Current Status
4.1 Streamline Services for Homeless Families	1. Engage the local School Districts as a resource partner	Tri-Cities Policy Council, Homeless Coordinator, MDHI, School Districts	1	In-Kind	Tri-Cities Policy Council, MDHI, School Districts	**In Progress** The McKinney Vento liaisons are active members of Change the Trend meetings.
	2. Designate a lead service provider	MDHI, County, Tri-Cities, School District, Homeless Providers	1	$50,000	MDHI, School Districts, Private Philanthropy	**In Progress** Family Tree is active in the region and could be a potential partner to lead the family strategy.
4.2 Prevent Families from Becoming Homeless	1. Promote new resources for homeless prevention	County, School Districts, Homeless Providers.	1	In-Kind	County, School Districts	**In Progress** Promotional efforts are being made.
	2. Pilot a peer-support specialist program to outreach to homeless families	MDHI, School Districts, Homeless Providers	2	$25,000 for peer support specialist stipends	School Districts, Healthcare Providers, Private Philanthropy	**New Concept**
4.3 Increase Housing Opportunities for Families	1. Explore expanding HCV to families.	MDHI, State and Housing Authorities	1-2	In-Kind	Housing Authorities, MDHI, American Rescue Plan	**New Concept**

Appendix 2: Report Limitations

The following topics reflect national conversations on homelessness that did not emerge as themes to address during the research process, however, are listed with resources for future consideration.

- Addressing the disproportionate rate of Black, Indigenous, and People of Color experiencing homelessness. National Alliance to End Homelessness; Strategic Partnerships for Anti-Racist Communities; Just Strategies
- Safe spaces and culturally sensitive programs for LGBQT community members experiencing homelessness. True Colors United; National Coalition for the Homeless; The Trevor Project
- Language access to ensure all critical documents are available in multiple languages. Language Justice Initiative; Los Angeles Homeless Services Authority
- Adoption of the national Housing-First philosophical approach to address homelessness. National Alliance to End Homelessness; Utah's Housing First Program
- Reframing homelessness as a public health crisis and housing as a prescriptive intervention to save lives. Housing Matters; Health Affairs

Acknowledgements

Englewood City Council

Linda Olson, Mayor

Cheryl Wink

Dave Cuesta

Joe Anderson

Othoniel Sierra

Rita Russell

Steven Ward

Shawn Lewis, City Manager

Tim Dodd, Assistant to the City Manager

Littleton City Council

Jerry Valdes, Mayor

Carol Fey

Karina Elrod

Kelly Milliman

Pamela Grove

Patrick Driscoll

Scott Melin

Mark Relph, City Manager

Samma Fox, Assistant to the City Manager

Sheridan City Council

Tara Beiter-Fluhr, Mayor

Dallas Hall

Don Smith

Sally Daigle

Shevieve (Shevy) Gallegos

Devin Granbery, City Manager

Acknowledgements

Prepared by,

Alisa Orduña

Florence Aliese Advancement Network, LLC