System Performance Committee Agenda
Thursday, September 24th, 2020 from 9-11 AM
Zoom Link: https://homebaseccc.zoom.us/j/91674911453

I. Welcome & Introductions: Noel Kammermann, Chair		
II. New Business:		
A. CESH Work Products for Feedback/Discussion: 1. Final Presentation & Analysis: Sacramento County Department of Behavioral Health Services, Mental Health Division, Housing Resources Visual Map 2. Key Takeaways from Systems Mapping Work Products to Date	**Presenter(s):** Homebase	**Time:** 25 minutes
B. Gaps Analysis Framework a. Overview of Proposed Gaps Analysis Framework b. Breakout Rooms c. Vote on Proposed Gaps Analysis Framework d. Next Steps	**Presenter(s):** Homebase	**Time**: 40 minutes
C. COVID-19 Response & Racial Equity	**Presenter(s):** Scott Clark, SSF	**Time:** 30 minutes
D. Coordinated Entry Committee Update: Access Points	**Presenter(s):** Peter Bell, SSF	**Time:** 10 minutes
III. Review of new agenda items for next meeting		
IV. Announcements		
V. Meeting Adjourned		

For questions about accessibility or to request accommodations please contact Alicia Music at amusic@sacstepsforward.org or 916-993-7055. Two weeks advance notice will allow us to provide seamless access.

Sacramento County Department of Behavioral Health Services, Mental Health Division, Housing Resources Visual Map Analysis

Overview

Using a variety of data collection methods, the System Performance Committee (SPC) has developed a Visual Map depicting the housing resources connected to the Sacramento County Department of Behavioral Health Services, Mental Health Division (SCDBHS).[1] In keeping with the priorities identified by the SPC, the following analysis focuses on access, referral processes, and connections to other systems of care.

Limitations

The SCDBHS Housing Resources Visual Map is the result of a qualitative research process, including qualitative interviews, project-specific surveys, and Committee feedback. During this process, some agencies may have interpreted key definitions in different ways or otherwise misreported a project's referral partnerships or participation in this system. As much as possible, Homebase contacted providers and systems leaders to review the Visual Map and Analysis; however, there may still be cases where information in these materials differs slightly from current operations.

Key Takeaways

- Overall, access to housing resources in the SCDBHS system is primarily dependent on the acuity of an individual's mental health need. Mental health providers connect clients to housing as one portion of a larger mental health treatment plan.
- The SCDBHS system has a variety of housing resources, including flexible housing funding and dedicated beds within built projects.
    - Flexible housing funding is available to individuals with a range of mental health needs, while beds within built projects are reserved for high acuity individuals participating in a Full Service Partnership program.
- The SCDBHS system is connected with other homeless housing systems in a variety of ways, including shared access points (CE), shared ability to refer into housing programs (CE, SHRA, VA, WellSpace Health), and combined referral processes (CE).

Access

Access Points are defined as agencies that connect clients to a mental health screening, which are required to receive services in the SCDBHS system. There are

[1] For more information about the methodology for data collection in this process, please see the SCDBHS Mental Health Vision Housing Resources Visual Map: Methodology & Kumu Guide.

20 Access Points total and they are administered by community-based organizations, healthcare clinics, and SCDBHS teams.

- Four Access Points offer opportunities for drop-in appointments or self-referral.
    - Three Access Points accept drop-in clients, specifically Wellness & Recovery North, Wellness & Recovery South, and El Hogar Guest House Homeless Clinic. These sites are also outpatient clinics.
    - The Mental Health Access Team is a mental health services triage team open to service requests from anyone, including self-referrals. To receive services from the Mental Health Access Team, individuals can call toll free, fax, or mail a service request.
- Five Access Points are administered by homeless providers, specifically Wind Youth Services, Volunteers of America, Sacramento Self-Help Housing, Next Move, and Salvation Army.
- Three Access Points provide direct connections to the criminal justice system, with specific attention to the juvenile justice system.
- Two Access Points primarily serve senior populations, including SacEDAPT Clinic and the SAFE Program.
- The Intensive Placement Team is another mental health services triage team, primarily focused on referrals from hospitals.

Assessment & Referral Process

Each client accessing the SCDBHS system will be screened for their mental health acuity at an Access Point.

- If the client has a low mental health acuity, but self-identifies as homeless, they will be referred to non-mental health housing services, including the Community Support Team, Next Move emergency shelters, Wind Youth Services emergency shelter, St. John's emergency shelter, Sacramento Self Help Housing, 2-1-1, and Coordinated Entry.
- If the client is an adult or TAY with mild-medium acuity, they will be entered into the Electronic Health Record (EHR) by the Mental Health Access Team and referred to a mental health provider focused on mild-medium mental health services (including Regional Support Teams and Outpatient Services).
- If the client is a TAY with high acuity, they can be entered into the EHR by the Mental Health Access Team or Intensive Placement Team. The individual will then be referred to a TAY Full Service Partnership provider and begin case management.
    - While the client receives case management, they will be required to meet with the SCDBHS Mental Health Division Contract Monitor to complete a LOCUS assessment and a needs assessment. This needs assessment

includes a review of the individual's housing needs.
    - If the TAY receives a 4+ score on the LOCUS or a clinical recommendation from their case management team, they will remain in the Full Service Partnership program.
    - If the TAY does not receive a 4+ score on the LOCUS or a clinical recommendation from their case management team, they will be re-directed to the mild-medium acuity mental health providers for assistance.
- If the client is an adult with high acuity, they will be entered into the EHR by the Intensive Placement Team and referred to an adult Full Service Partnership or TCORE program. They will begin case management with that program.
    - While the client receives case management, they will be required to meet with the SCDBHS Mental Health Division Contract Monitor to complete a LOCUS assessment and a needs assessment. This needs assessment includes a review of the individual's housing needs.
    - If the adult receives a 4+ score on the LOCUS or a clinical recommendation from their case management team, they will remain in the Full Service Partnership or TCORE program.
    - If a client has specific cultural needs (e.g., linguistic), they will be referred to Asian Pacific Counseling Center (also known as Transultural Wellness Center).
    - If the adult does not receive a 4+ score on the LOCUS or a clinical recommendation from their case management team, they will be re-directed to the mild-medium acuity mental health providers for services and case management.

Housing Resources

Each mild-medium and high acuity mental health provider in the SCDBHS system has access to housing resources. Programs serving higher acuity clients (i.e., TCORE and Full Service Partnership programs) have access to more intensive housing resources, including some limited referral ability into built projects.

- There is no universal process for connecting clients to specific housing resources, although housing need is taken into consideration when a client is triaged into a case management program. Each program is responsible for assessing and meeting their client's housing needs.
- For mild-medium acuity mental health providers, the flexible housing funding is typically limited to 9 to 12 months of support and requires that the client develop a housing plan.
    - In mild-medium programs, the flexible housing funds can be used for homelessness prevention and room and board, but it cannot usually be used for long-term housing.

    - If clients are being serviced at a mild-medium acuity mental health program, but their mental health impairment is impacting their ability to get housed, they can be re-assessed for eligibility for the Full Service Partnership.
- Six of the adult Full Service Partnership programs connect their high acuity clients to housing using flexible funding only.
    - Flexible housing funding attached to Full Service Partnerships can be used for longer-term housing than the flexible funding available to mild-medium acuity providers.
- Turning Point, Telecare ARISE, and Hope Cooperative/TLCS Full Service Partnership programs can refer clients into a variety of built projects.
    - Of the 16 built projects accepting housing referrals for Full Service Partnership clients, 56% (9 out of 16) also accept referrals from other sources.

Connections to Other Systems

The SCDBHS system is connected with other homeless housing systems in a variety of ways, including shared access points (CE), shared ability to refer into the same built units (CE, SHRA, VA, WellSpace Health), and combined referral processes for specific housing resources (CE, DHA).

- The SCDBHS and the Coordinated Entry systems share a number of Access Points, including homeless service providers, El Hogar Homeless Clinic, and Wellness & Recovery.
    - Additionally, the SCDBHS system is in the process of ensuring that all mild-medium and high acuity mental health providers have the ability to administer the VI-SPDAT to clients that need a high level of housing intervention than what is available through the SCDBHS system. These providers will also begin entering information into HMIS.
- The SCDBHS Full Service Partnership programs refer into several built projects that also accept clients from other sources, including the Coordinated Entry System, SHRA waitlists, the Veteran's Administration, and WellSpace Health.
    - These shared housing projects demonstrate the strength of Sacramento's housing providers in braiding many sources of funding together.
- For the PACT PHP Expansion and New Direction programs, clients are connected to case management services from SCDBHS and intensive housing from the Continuum of Care as part of a combined access process.
    - Clients must meet the eligibility requirements for both programs to participate, which lead to combined access, assessment, and referral process.
    - While still in process of development and logistically challenging, these

programs could serve as models for a more blended homeless housing system of care in the future.

Suggested Questions for Further Analysis

1. For clients with low mental health acuity that self-identify as homeless, where should SCDBHS Access Points be referring them for housing support?
2. Are there opportunities to better connect clients with high mental health acuity, currently enrolled in CoC projects with SCDBHS case management?
3. Given the overlap between Coordinated Entry and SCDBHS Access Points, are there opportunities to better triage individuals at these shared locations and target diversion or problem-solving resources?
4. Can the PACT PHP Expansion and New Direction programs' shared referral processes be applied to any other housing programs in order to best leverage SCDBHS expertise in mental health-focused case management and other sources of housing funding?

Proposed Gaps Analysis Framework

Overview

Homebase compiled feedback about gaps analysis framework priorities from the Systems Performance Committee (marked with *), feedback from SSF (marked with ^), and questions that other communities have explored through Gaps Analyses.

The recommended focus for the gaps analysis was determined by prioritizing: 1) interest in the answer by stakeholders, including the Systems Performance Committee, 2) the feasibility for answering the question fully and accurately (*i.e.,* data availability), and 3) the value of the answer for driving systems change. Ultimately, the questions were bucketed into three overarching themes and research questions.

All of the questions that have been raised but that we are not recommending for answering in the gaps analysis have been included in the supporting document, *Questions Raised for the Gaps Analysis Not Recommended for Inclusion by Homebase.*

Proposed Questions for Analysis

a) **What is the difference between the need of individuals experiencing homelessness and the current bed/unit capacity of the system in Sacramento County?**
   i. Purpose of Analysis: inform how to allocate local and state funding moving forward to address current housing gaps*
   ii. Analysis
      (1) Who is being served and who is not served by the current system (incl. subpopulations and demographic breakdowns)?^ *(HIC, PIT, HMIS)*
      (2) What is the number of estimated additional short-term and permanent beds/units would it take to shelter or house the individuals experiencing homelessness in Sacramento (factoring in utilization, turnover and effectiveness)? *(HMIS, HIC, PIT, movement analytical tool)*

b) **How do individuals experiencing homelessness access Sacramento's systems of care that most often serve people experiencing homelessness?**
   i. Purpose of Analysis: (1) identify recommendations to improve client experience of access and (2) identify recommendations to improve efficiency of connection to needed resources
   ii. Analysis
      (1) Where are individuals experiencing homelessness first entering the system of care (i.e., where are they logging their first enrollment)?* *(HMIS, lived experience survey, lived experience focus groups)*
         (a) Based on qualitative data, who is not accessing the system or how long does it take before individuals experiencing system do access the system? (*outreach worker focus groups*)

(2) Where can individuals go to enter the different systems of care (i.e., list of drop-in Access Points across the systems that regularly serve people experiencing homelessness)?* *(project matrix, system maps, project surveys, qualitative interviews, environmental scan documents)*

(3) Where do the systems of care intersect or interact? How can leverage these intersections to improve access to housing? *(project matrix, system maps, project surveys, qualitative interviews, environmental scan documents)*

c) How do individuals experiencing homelessness connect to housing within Sacramento's systems of care?

i. Purpose of Analysis: (1) identify disparities in experience and outcomes that could be addressed through targeted intervention, and (2) identify scalable practices for improving connections to permanent housing destinations

ii. Analysis

(1) How is client progression through the system of care impacted by demographics/subpopulation (e.g., length of time from entry to housing)?* *(HMIS, lived experience focus groups)*

(2) What are system-level housing outcomes and how do housing outcomes differ by demographics/subpopulation (including VI-SPDAT scores)? *(HMIS, Tableau tool)*

(3) For projects having more success exiting clients to permanent housing destinations, what are some of the promising practices that could be leveraged by projects of the same type? *(HMIS, Tableau tool, qualitative interviews/focus groups)*

Questions Raised for the Gaps Analysis Not Recommended for Inclusion by Homebase

Overview

The following is a list of questions brought forward by the Systems Performance Committee (indicated with a *) or Sacramento Steps Forward (indicated with a ^) over the past seven months for consideration in the Gaps Analysis.

Over the past nine months, the Systems Performance Committee and Sacramento Steps Forward have asked several questions for exploration and analysis as part of the Gaps Analysis. As Homebase aggregated these questions, it omitted:

1. Questions that could easily be answered with the systems mapping work products (e.g., how are projects filling vacancies?),
2. Questions that ask to evaluate or determine a specific practice (e.g., some VI-SPDAT access points require clients to complete a housing plan and meet with a case worker 3 times, in your opinion, is this a good policy?),
3. Questions that are being addressed by the Coordinated Entry Evaluation (e.g., what does it mean to be a CE Access Point?), and
4. Questions that repeat similar concepts as the questions included in the Proposed Gaps Analysis Framework (e.g., SPC members asked four separate questions that all related to where folks should "go" when they first become homeless).

The recommended focus for the gaps analysis was determined by prioritizing: 1) interest in the answer by stakeholders, including the Systems Performance Committee, 2) the feasibility for answering the question fully and accurately (i.e. data availability), and 3) the value of the answer for driving systems change. Ultimately, the questions were bucketed into three overarching themes and research questions.

While many of the questions omitted from the framework may be interesting, they did not meet one or more of the above three criterion. However, any omitted question can still be included should SSF or the Systems Performance Committee see notable value.

Questions that Could be Answered Fully

These questions were both of interest by stakeholders as well as feasible to answer fully. However, it was unclear whether these questions met the third criterion: value for driving systems change. Note that some of these questions may by answered indirectly through the proposed gaps analysis framework which includes questions adjacent to those listed below.

a) How do temporary housing locations/supports (i.e., emergency shelter, transitional housing, rapid re-housing, or street outreach) connect clients to permanent housing?
b) Should any inference be made about the success in moving clients to permanent housing destinations for TH vs. RRH?^
c) What assessments are being used to determine eligibility for housing projects in Sacramento?
d) For projects using another form of prioritization besides Coordinated Entry, what is driving the design of the prioritization (i.e., all funding source based or something else)?^

e) Can we develop a high-level summary of the eligibility matrix, focused on # of units, subpopulation, funding amount, and timeframe of funding?^
f) What are clients' impressions of access and flow through the system?*
g) Why might there be difficulty in moving from one project type to another (e.g., someone in emergency shelter is more likely to subsequently enroll in emergency shelter)?*
h) Why are projects reporting referrals to agencies that have closed or currently only accept referrals from specific agencies (e.g., HARTS)?
i) How should individuals get access to emergency shelters (referrals or walk-ins)?^
    i) What are other communities doing?^
    ii) How does the practice of requiring referrals to emergency shelter impact access to housing resources?
j) How do you get localities with multiple layers to work together (e.g. with a major city and a county)?^
k) Are there any locations where barriers to entry could be reduced or simplified?
l) Do we need to add the notion of good problem solving, crisis management, diversion techniques as a way to manage inflow into the system of care?^
m) What are some successful examples from other communities on how to best facilitate flow between different systems serving individuals experiencing homelessness?^
n) How does point of entry to the system of care correlate (or not) with housing outcomes?
o) What is the shelter turnover rate? How close are we to the HUD goal of a one-month stay with an exit to PH at the end?*
p) How do integrate additional housing projects into Coordinated Entry?*
q) What are some predicting factors for returns to homelessness?*

Questions that are Difficult to Answer Fully

These questions were also of interest and would likely help drive system change. However, each would be difficult to answer each question fully and accurately given limitations in information and data. More detailed descriptions are included below.

1) How does eligibility impact client flow across the different systems?
    - *Without a single, shared data system or a deeper understanding of eligibility criteria across the different systems of care, it is difficult to develop a meaningful answer to this question. Referrals between systems are happening on both an informal and formal basis, between individual agencies, projects, and systems administrators. Any response to this question would depend on anecdotal stories from qualitative interviews and/or focus groups.*

2) Can we include cost factors into this analysis (e.g., how much does it typically cost to move someone through the system of care?)*
    - *In 2019, Homebase attempted to identify an average cost per client within the CoC-funded programs to support the work of the Project Review Committee. Ultimately, the analysis was not fruitful given the number of caveats for each program. Comparing costs across funding streams would pose an additional layer of difficulty in this type of analysis. Assessing average cost per individual has been the basis for entire studies in other communities and is outside the scope of our work at this point.*

3) How long does it take people to get into the "right" program that will be able to support them into permanent housing?*
   - *Given the limitations of HMIS, it would be difficult to answer this question in a way that would lead to meaningful systems-level change. Even at the individual level, we might only know what program was "right" years after the program is accessed, and even then an individual might point to multiple programs that changed his or her trajectory. Making the assumptions necessary to undertake this analysis at the system level would obscure the information the question appears to seek. For example, the focus is on length of time, and for a system analysis we would need to assume everyone's length of time homeless started at HMIS entry (clearly incorrect for many people). Also, we would need to assume that the program was able to support a person into permanent housing was whatever program was accessed immediately prior to permanent housing, which may also be simplistic and incorrect.*

4) Do other communities have a similarly decentralized process for accessing housing resources?
   - *While we can answer this question generally and provide a few case studies of how different communities approach the question of access, ultimately the geographic spread of the community; size of the homeless community; relationship between cities, County, and the CoC; and availability of funding resources make it difficult to compare if Sacramento is more or less decentralized than other communities.*

5) What level of support should a community provide to CES given the scope of the problem (e.g., for this size PIT we should have/typically see xx access points, xx referral/outreach etc)?^
   - *Please see the response for #4 above.*

COVID-19 Response: Race & Ethnicity Assessment

September 10, 2020

SACRAMENTO STEPS FORWARD

COVID-19 Response: Race & Ethnicity Assessment

Race plays a role in the incidence of homelessness, with Black, American Indian, and Native Hawaiian individuals more likely to become homeless.

This analysis examines if race played a role in the COVID-19 response effort and outcomes (assessments, referrals, enrollments, denials, exits).

Based on HMIS data available as of August 28, 2020

Examines individuals who completed a COVID-19 Response Shelter Survey for Adults Only Households

SACRAMENTO STEPS FORWARD

COVID-19 Response: Race & Ethnicity Assessment

Analysis includes adults with known race, as self-reported.

HMIS categories:

- White
- Black or African American
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Asian

Proportions do not include those of unknown race, which represented 3.7% of adult assessments.

HMIS categories:

- Data not collected
- Client doesn't know
- Client refused

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A note on statistical significance

Statistical significance was evaluated using Pearson chi-squared tests with a 0.05 significance level. This provides a sense as to how well the observed numbers match what we would expect, but it is not meant to indicate by itself that there is or is not a disparity. Other factors such as the quality of data and opportunity for bias in data entry must also be considered. In addition, even if something is not statistically significant per this test, it may still be important or significant in other ways.

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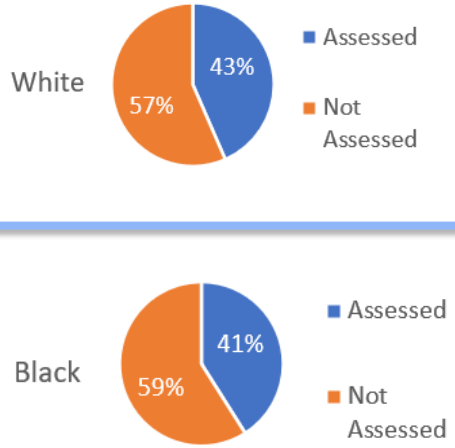
Adults experiencing homelessness compared to adults who received a COVID-19 assessment

Race of adults without children **experiencing homelessness** on the last day in March 2020

White	1,581	53%
Black or African Am..	1,061	36%
Multi-Racial	146	5%
American Indian or ..	104	3%
Asian	39	2%
Native Hawaiian or..	54	1%



Race of adults without children **assessed** between April 5 & August 27

White	687	55%
Black or African A..	435	35%
Multi-Racial	54	4%
American Indian or..	43	3%
Asian	21	2%
Native Hawaiian o..	16	1%

A slightly smaller proportion of Black and multi-racial adults were assessed. The differences are not statistically significant.

Race of adults without children **experiencing homelessness** per January 2019 PIT count

PIT White adult	2,286	52%
PIT Black /African A..	1,239	28%
PIT Multi-Racial ad..	357	8%
PIT American India..	364	8%
PIT Asian adult	48	2%
PIT Native Hawaiia..	109	1%

Of note, the racial proportions of adults in HMIS on March 30, 2020 differs from the proportions reported in the January 31, 2019 Point In Time count.

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Adult COVID-19 assessment results (Rank 1 = highest priority)

Rank	Priority Group
1	COVID-19 positive, any age
2	Under public health/medical investigation, pending test OR has recently been exposed to a COVID-19 positive person as confirmed by Public Health (regardless of age or symptoms)
3	55+ years and pre-existing health conditions with symptoms
4	55+ years with symptoms OR 54 years and under with pre-existing health conditions and symptoms
5	54 years and under with symptoms
6	55+ years old
7	54 years and under with pre-existing conditions, no symptoms

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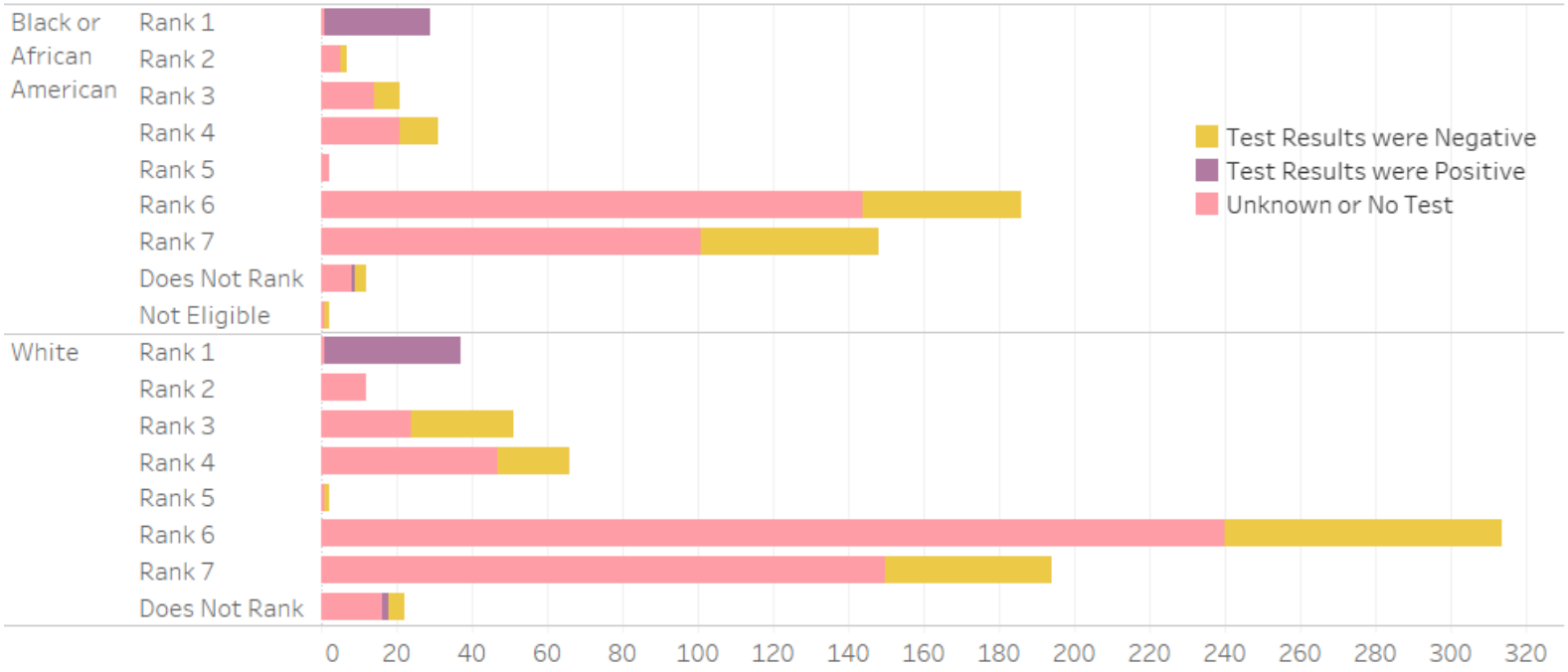
STEPS FORWARD

Adult COVID-19 assessment results (Rank 1 = highest priority)



When comparing White and Black adults, COVID-19 rankings at time of assessment show similar distributions.

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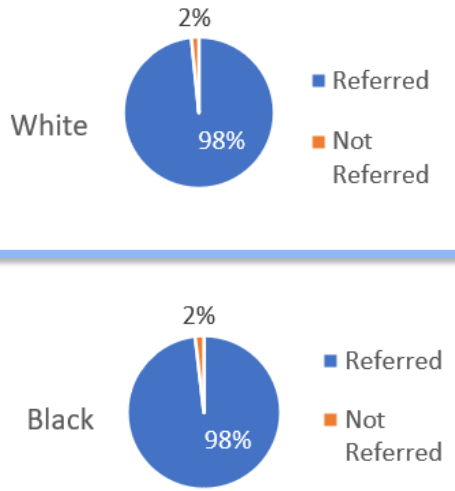
Adults who received a COVID-19 assessment compared to adults referred to a COVID-19 shelter

Race of adults without children assessed between April 5 & August 27

White	687	55%
Black or African A..	435	35%
Multi-Racial	54	4%
American Indian or..	43	3%
Asian	21	2%
Native Hawaiian o..	16	1%



Race of adults without children assessed who were referred to a COVID-related shelter

White	676	55%
Black or African American	427	35%
Multi-Racial	52	4%
American Indian or Alask..	42	3%
Asian	21	2%
Native Hawaiian or Other..	16	1%

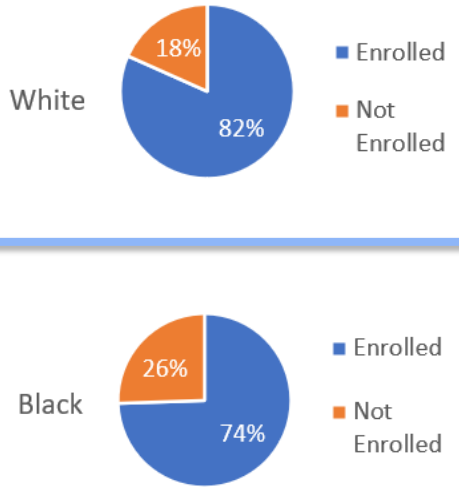
The racial proportions for those who were referred were very similar to those assessed, and differences were not statistically significant.

SACRAMENTO STEPS FORWARD

Adults referred to a COVID-19 shelter compared to adults enrolled in a COVID-19 shelter

Race of adults without children assessed who were **referred** to a COVID-related shelter

White	676	55%
Black or African American	427	35%
Multi-Racial	52	4%
American Indian or Alask..	42	3%
Asian	21	2%
Native Hawaiian or Other..	16	1%



Race of adults without children who were **enrolled** in a COVID-related program

White	552	57%
Black or African Ame..	318	33%
Multi-Racial	43	4%
American Indian or ..	29	3%
Asian	16	2%
Native Hawaiian or ..	16	2%

A smaller proportion of Black clients were enrolled than referred. The racial differences are not statistically significant (difference likely due to chance).

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Adults referred to a COVID-19 shelter who did not enroll

Breakdown of each race by proportion of reason

Denial Reason (group)	White	Black or African A..	Multi-Racial	American Indian or ..	Asian
Client did not show up or call & Referral time expired	75% 120	76% 83	100% 11	100% 12	
Client out of Jurisdiction	1% 1				
Client refused services	6% 9	10% 11			100% 3
Denied by Landlord/Property Manager	3% 4				
Disagreement with rules	6% 9	4% 4			
Falsification of Documents	1% 1				
Needs could not be met by program	3% 5	1% 1			
Other	6% 10	9% 10			
Self Resolved - Client Housed	1% 1				
Grand Total	100% 160	100% 109	100% 11	100% 12	100% 3

The majority of non-enrollments were clients that did not show up or call, regardless of race. For multi-racial and American Indian clients, client no-shows accounted for 100% of the denials.

Note: Denial totals are higher than total referred due to some individuals with multiple referrals. When calculating with distinct counts of individuals, percentages do not change more than 1% for any combination of race and reason.

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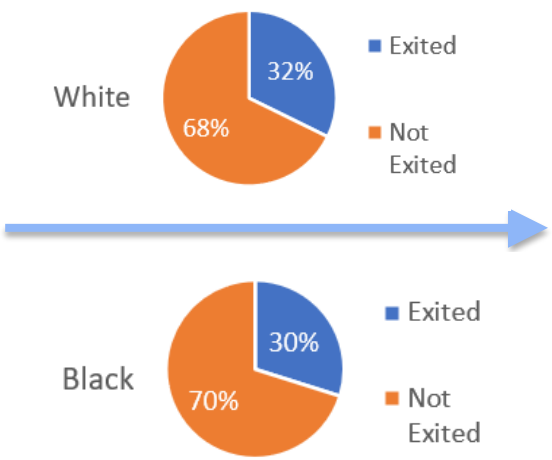
Adults enrolled in a COVID-19 shelter compared to adult true* exits

Race of adults without children who were enrolled in a COVID-related program

White	552	57%
Black or African Ame..	318	33%
Multi-Racial	43	4%
American Indian or ..	29	3%
Asian	16	2%
Native Hawaiian or ..	16	2%



Race of adults without children who exited from a COVID-19 shelter

White	178	58%
Black or African Ame..	95	31%
Multi-Racial	10	3%
American Indian or ..	6	2%
Asian	10	3%
Native Hawaiian or ..	7	2%

A smaller proportion of Black, multi-racial, and American Indian adults exited. The racial differences are not statistically significant.

** True exits reflect clients who are no longer in any COVID-19 shelter, as opposed to those who exited but subsequently re-enrolled or those who switched shelters.*

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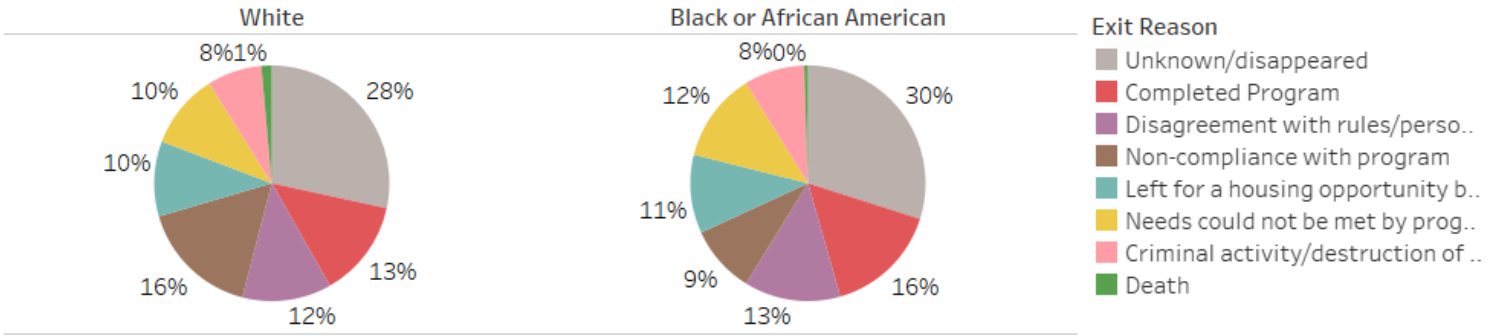
For adults who exited, proportion of client race for each exit reason

	White	Black or ..	Multi-Rac..	American..	Asian	Native H..	Grand To..
Unknown/disappeared	56%	35%	2%	2%	2%	2%	100%
Completed Program	56%	35%	2%	5%	3%		100%
Criminal activity/destruction o..	63%	32%	3%		3%		100%
Disagreement with rules/pers..	51%	40%	4%	4%	2%		100%
Non-compliance with program	70%	23%	4%	2%		2%	100%
Left for a housing opportunity ..	56%	28%	4%	4%	4%	6%	100%
Needs could not be met by pro..	45%	38%	4%	6%	6%	2%	100%
Death	71%	14%			14%		100%
Grand Total	58%	31%	3%	3%	3%	2%	100%

For adults who exited, reason for exit by race for White and Black clients



Note: this page includes all exits and some clients had more than one exit (re-entries or moves between shelters)

SACRAMENTO STEPS FORWARD

For adults with true exits, proportion of client race for each exit destination

	White	Black or African American	Multi-Racial	American Indian or Alaska Nati..	Asian	Native Hawaiian or Other Pacifi..	Grand Total
Unknown	63% 96	30% 46	3% 4	1% 1	3% 4	1% 2	100% 153
Place not meant for habitation	62% 36	26% 15	3% 2	3% 2	2% 1	3% 2	100% 58
Housed with family or rental by client & permanent housing, including rapid reho..	48% 28	38% 22	5% 3	5% 3	2% 1	2% 1	100% 58
Hospital or corrections facility	48% 10	43% 9	5% 1		5% 1		100% 21
Emergency shelter or transitional housing	45% 5	18% 2			18% 2	18% 2	100% 11
Deceased	60% 3	20% 1			20% 1		100% 5
Grand Total	58% 178	31% 95	3% 10	2% 6	3% 10	2% 7	100% 306

Black clients were over-represented in successful exits (38%) when compared to the proportion who exited (31%). White clients were under-represented in successful exits (48%) compared to the proportion who exited (58%).

SACRAMENTO STEPS FORWARD

Ethnicity

Ethnicity of adults without children **experiencing homelessness** on the last day in March 2020 per HMIS

Hispanic/ Latino	16%
Non-Hispanic/ Non-L..	84%

Ethnicity of adults without children **assessed** between April 1 and August 30

Hispanic/Latino	198	15%
Non-Hispanic/Non-L..	1,123	85%

Ethnicity of adults without children assessed who were **referred** to a COVID-related shelter

Hispanic/Latino	181	14%
Non-Hispanic/Non-L..	1,082	86%

Ethnicity of adults without children **enrolled** in a COVID-related shelter

Hispanic/Latino	119	14%
Non-Hispanic/Non-L..	714	86%

Ethnicity of adults without children who **exited** from a COVID-19 shelter

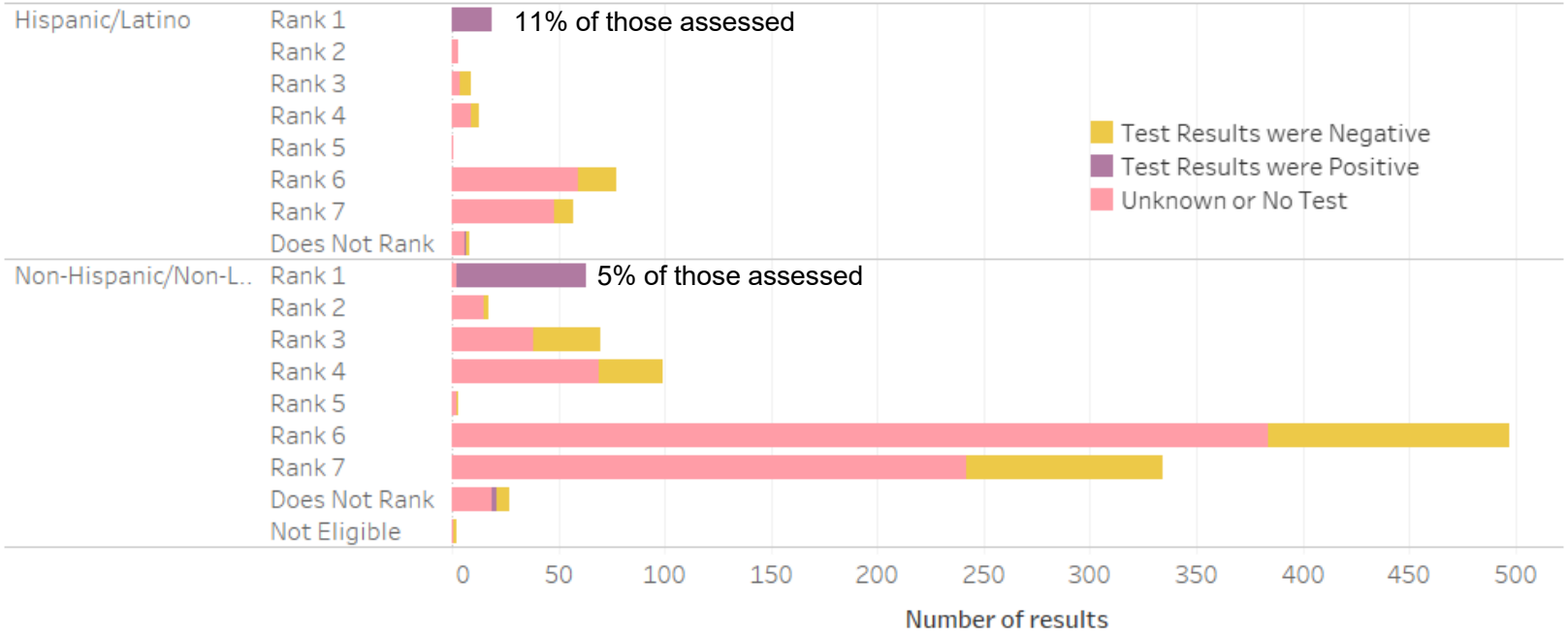
Hispanic/Latino	13%	47
Non-Hispanic/Non-L..	87%	313

No significant differences were found for ethnicity.

SACRAMENTO STEPS FORWARD

Ethnicity

Adult COVID-19 assessment results (Rank 1 = highest priority)



SACRAMENTO STEPS FORWARD

Problem-Solving Access Points

Peter Bell, Coordinated Entry System Manager

SACRAMENTO
STEPS FORWARD

Overview

1. Sacramento needs publicly visible and accessible locations for people experiencing homelessness.
2. People can be diverted from homelessness with problem-solving resources.

SACRAMENTO STEPS FORWARD

Community-wide Access Points

Community Access Points include:

- Multiple locations (easy to navigate to)
- infused with services (braided or otherwise)
- drop-in hours
- Coordinated Entry access and assistance with “doc readiness”
- Sub-population and General

SACRAMENTO STEPS FORWARD

Problem-Solving Resources

- Financial and non-financial resources to support clients exiting homelessness
- Training and tools to support in developing problem-solving plans
- Ongoing opportunities for collaboration and skills training
- Infusing **Access Points** with problem-solving resources

SACRAMENTO STEPS FORWARD

What should be funded?

1. Problem-Solving Resources
2. Access Point Staffing:
    a. Intake
    b. Outreach
3. Other services?

SACRAMENTO STEPS FORWARD

CESH System Mapping & Gaps Analysis: **September Progress Report**

Data Collection Phase	Description of Progress Made in September
Data Phase 3: Non-HMIS, Non-HIC Homelessness Providers	• 4 additional surveys distributed to homelessness prevention programs. • Qualitative interviews with Angel Uhercik, Nina Acosta, and Neil Kutz completed to better understand the Sacramento County Department of Human Assistance system. • Qualitative interviews with several SHRA staff members to better understand the SHRA system.

Work Product	Description of Progress Made in September
WP 1: Visual Maps	• Final analysis of the Behavioral Health Visual Map presented to the SPC. • Draft of the SHRA Visual Map completed and distributed to community partners for review. • Draft of Department of Human Assistance Visual Map completed and distributed to community partners for review.
WP 2: Project Access Matrix (previously "Eligibility Matrix")	• Information from 4 additional homelessness prevention programs added to the Access Matrix. ○ Please note, a Revised Project Access Matrix Analysis will be distributed to the Systems Performance Committee in October.
Completed Systems Mapping Work Products	• WP 1 – Coordinated Entry Visual Map (pg. 7-11, here) • WP 3 – Tableau Movements Analytical Tool (pg. 2-6, here)
Gaps Analysis	• Draft Gaps Analysis Framework brought to the Systems Performance Committee for review and feedback.