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An Environmental Scan and System Analysis of the Homeless Response System in St. Louis County, MN Continuum of Care (CoC)

Prepared by:
Patty Beech Consulting
222 E Superior Street #324
Duluth MN 55802
218-525-4957; pattybeechconsulting@gmail.com

Project Leadership

St. Louis County Continuum of Care (CoC):
Heading Home Governing Board

St. Louis County CoC Evaluation and Planning Committee

St. Louis County CoC Housing Response Committee

St. Louis County Housing and Homeless Program Team

Laura Birnbaum
Housing and Homelessness Programs Team Supervisor

Courtney Cochran
Continuum of Care (CoC) Coordinator

Kevin Radzak
Housing and Homelessness Program Specialist

Stacy Radosevich
Senior Planner

JoAnn Solin
Housing and Homeless Unit Support

Data Collection Assistance Provided by:
Institute for Community Alliances

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I. Project Overview

The St. Louis County Public Health and Human Services division, acting as staff for the Duluth/St. Louis County Continuum of Care (CoC) engaged Patty Beech Consulting to:

- Identify existing homeless system assets and gaps within the St. Louis CoC.
- Identify existing relationships and partnerships between organizations that strengthen the system of services for people experiencing or at risk of homelessness.
- Identify strategies, resources and partnerships that could improve outcomes.

Research Questions

- What organizations, and resources exist to support the homeless response system?
- What are the gaps in the homeless response system?
- What organizations or systems are not engaged that could be?
- What new stakeholder connections and resources are needed?
- What are opportunities to improve the SLC Homeless response system?

Methodology

Planning was led by the CoC Evaluation and Planning Committee with input from the CoC Housing Response Committee, Heading Home Governing Board, and key stakeholders.

Environmental Scan

Multiple data sources were collected and analyzed to document the needs of people without housing stability, the existing resources, and the ways people experiencing homelessness are connected to and supported by regional resources.

System Map

A system map was developed to illustrate the general participant flow through the SLC homeless response system, the capacity of shelter and housing resources for homeless people, key system outcomes, and important data points related to need.

Key Informant Interviews

Phone interviews were conducted with twenty-one key stakeholders to better understand the strengths and weaknesses within St. Louis County's homeless response system and to assess areas of opportunity for improving the local response to homelessness.

Interviews with Persons with Lived Experience

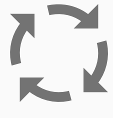
The project team had difficulties completing interviews with persons with lived experience of homelessness due to limitations caused by the pandemic. A phone interview was completed with one person with lived experience whose story is included in this report. It is recommended that input from persons with lived experience be integrated into future planning initiatives to improve the local response to homelessness.

St Louis County Continuum Care Homeless Response System

Outreach: Engages with people experiencing homelessness on the streets, vehicles and other public places.

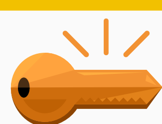
Homelessness Prevention: Helps individuals and families who are about to lose their housing to remain housed where they are or to move to new permanent housing.

Emergency Shelter: Short-term, safe place to sleep for people experiencing homelessness



Coordinated Entry System: Matches people who are homeless to the County's transitional, rapid rehousing and permanent supportive housing programs.

Transitional Housing: Temporary housing and services for people experiencing homelessness. Typically two years or less.



Rapid Rehousing: With financial assistance and support services, helps households obtain permanent housing and increase income so they can remain housed on their own.

Permanent Supportive Housing: Helps individuals and families with disabilities maintain permanent housing with rental subsidies and support services.

II. Environmental Scan

Data Highlights

- Homelessness disparately impacts People of African Heritage, People who are Black or Indigenous, and other People of Color, who make up 18% of the people in poverty in St. Louis County but 42% of the population served in the homeless response system.[1] On the Coordinated Entry Priority List, 44% of households are People of African Heritage, People who are Black or Indigenous, or other People of Color.[2]
- The total number of people who are homeless continues to increase. The number of sheltered and unsheltered homeless people increased 25% from 2015 – 2020.[3]
- 46% of people counted in the 2020 Point in Time Count were unsheltered. 54% were sheltered in Emergency Shelter or living in Transitional Housing.[3]
- A total of 2,188 households were served by programs for homeless people in the County in the year ending September 30, 2020.[4]
- Adults without children continue to have higher rates of homelessness than families. Of all households served by homeless programs, 82% were households without children.[4]
- As of September 30, 2020, there were 1,888 households experiencing homelessness on the Coordinated Entry System (CES) Priority Lists.[2]
- 94 households exited the CES Priority Lists and entered permanent housing between April 1 and September 30, 2020.[2]
- People without housing experience high levels of disabilities.[2] Of all households on the Coordinated Entry Priority List, 73% have a disability of long duration.[5]
- Multiple episodes of homelessness are common. 60% of households on the CES Priority list meet Minnesota's definition of long-term homelessness.[2]
- Financial, credit and background issues are the top challenges to securing housing.[6]

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[1] American Community Survey 2013-2017 5-year estimates; HMIS Core Report, 10/1/2019 – 9/30/2020
[2] HMIS Coordinated Entry Monitoring Report 4/01/2020 – 9/30/2020.
[3] https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=&filter_Scope=CoC&filter_State=MN&filter_CoC=MN-509&program=CoC&group=PopSub
[4] HMIS MN Core Homeless Programs Report – All St. Louis County CoC Programs, 10/1/2019 – 9/30/2020
[5] See definition of disability of long duration in the Appendix, page 33.
[6] Wilder Research Center, 2018 Homeless Survey Results for St. Louis County.

Areas for Focus

- Address the root causes of homelessness and prevent more episodes of homelessness among People of African Heritage, People who are Black or Indigenous, and other People of Color.
- Increase emergency shelter beds or prioritize shelter beds for unsheltered people.
- Increase permanent supportive housing resources for homeless adults without children, especially those with long histories of homelessness, disabilities, and barriers to securing rental housing.
- Expand resources to meet the needs of households experiencing housing instability but waiting on the CES Priority List. Expand diversion and navigation activities.[7]
- Increase referrals to permanent supportive housing from the CES lists.
- Reduce episodes of homelessness and returns to homelessness. This will decrease the number of people experiencing homelessness and the number experiencing long-term homelessness and chronic homelessness.[8]

Key Questions

- What do people of African Heritage, People who are Black or Indigenous, and other People of Color identify as solutions to reducing homelessness within these populations?
- Are there people whose episodes of homelessness could be prevented so that more shelter beds could be available for unsheltered people?
- What diversion, access, and/or navigation resources could be utilized to assist people on the CES Priority List whose wait for housing is too long?
- How can more permanent supportive housing be created for singles who are hard to house due to disabilities including substance abuse disorder and mental illness?
- What strategies are effective to keeping households housed and preventing returns to homelessness?
- How can we ensure that strategies are culturally responsive and trauma-informed?

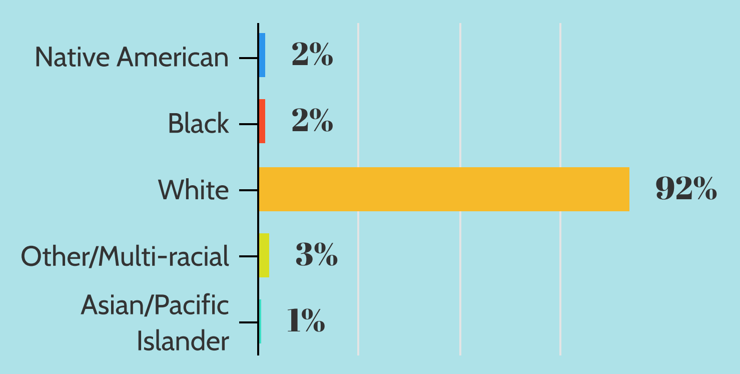
[7] Diversion prevents homelessness for people on the CES lists by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them retain or return to housing. Housing navigation is the process by which homeless clients that have entered the CES system are provided ongoing engagement, document collection, and case management services to facilitate a match to a housing resource.

[8]. See definitions of long-term homelessness and chronic homelessness in the Appendix, pages 32-33.

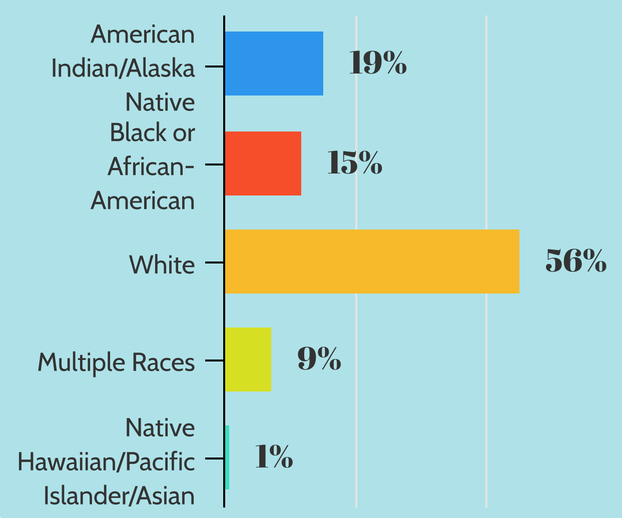
St. Louis County Continuum of Care
Racial Disparities in the Homeless Response System

The information on this page compares the race of the general population and the population of people in poverty in St. Louis County with the racial percentages of people seeking and receiving assistance through the homeless response system in St. Louis County.

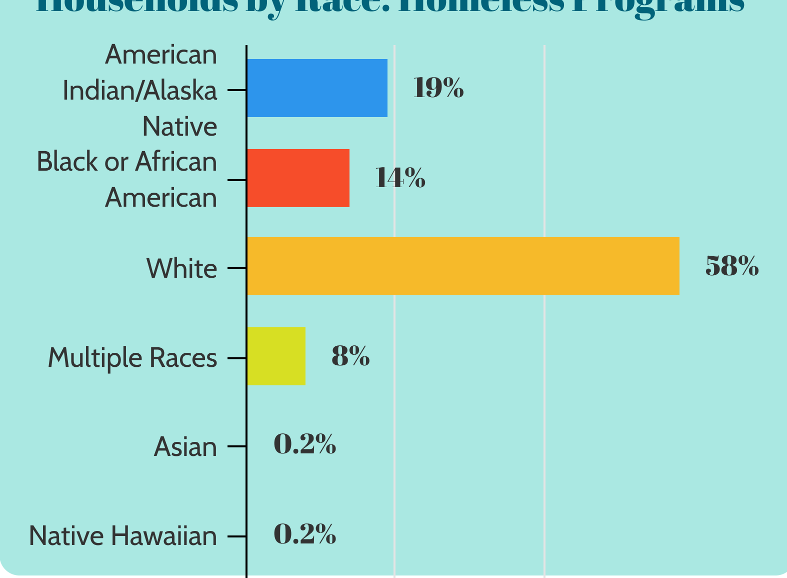
Race of General Population



Households by Race on Coordinated Entry Priority Lists



Households by Race: Homeless Programs



Exits from Homeless Programs to Permanent Destinations

22% of American Indian households

25% of households of Multiple Races

41% of Black or African American households

44% of White households

American Indian people and People of Color are:

8% of people in the county

18% of people in poverty

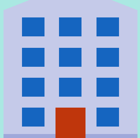
39% of people who are unsheltered

42% of people in the county's homeless programs

Data Sources: CoC Racial Equity Analysis Tool 2.1: https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/
MN HMIS Core Homeless Programs Report for St. Louis County : 10/1/2019 - 9/30/2020, Institute for Community Alliances
Coordinated Entry (CE) Monitoring Report for St. Louis County: 4/1/2020 - 9/30/2020, Institute for Community Alliances

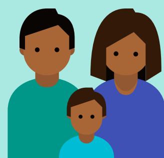
St. Louis County, Minnesota
Homeless Point in Time (PIT) Count Overview
January 22, 2020

284 Unsheltered People



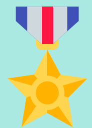
328 Sheltered People

Emergency Shelter - 192
Transitional Housing 136



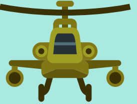
17 family households
25 adults and
18 children

52 family households
61 adults and
93 children



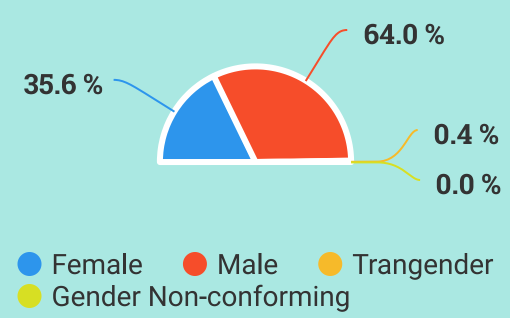
4 unsheltered veterans

15 sheltered veterans

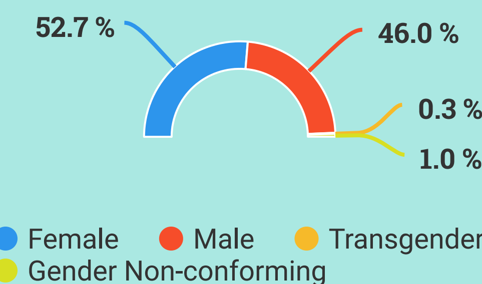


612 Total Homeless People

Gender of Unsheltered People



Gender of Sheltered People

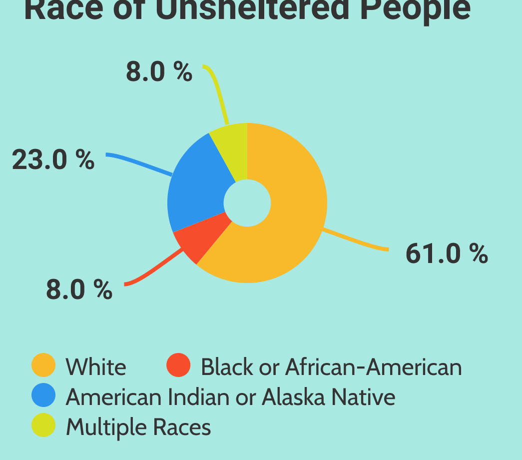


The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. It is conducted nationwide as part of HUD's requirement for receiving Continuum of Care funds.

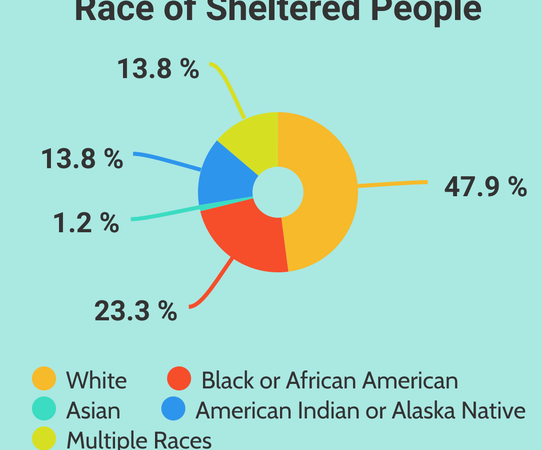
Data Source: https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

St. Louis County, Minnesota
Homeless Point in Time Count Overview
January 22, 2020

Race of Unsheltered People



Race of Sheltered People

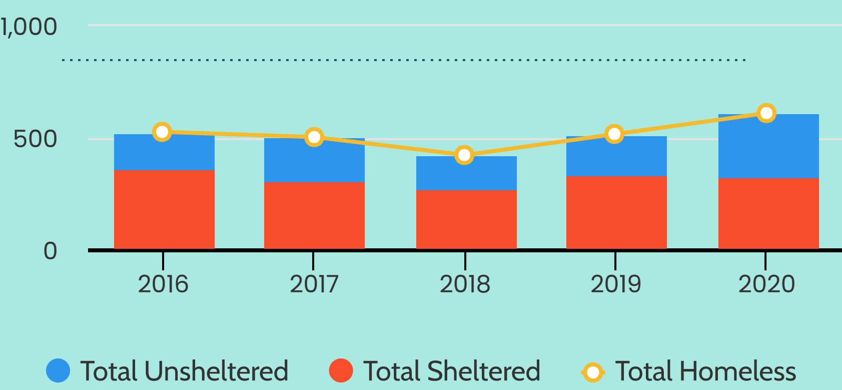


39% of Unsheltered People are American Indian or People of Color.
52% of Sheltered People are American Indian or People of Color.

152 people were chronically homeless

54 people were chronically homeless

Point in Time Count 2016-2020



Data Source: https://www.hudexchange.info/programs/coc/ coc-homeless-populations-and-subpopulations-reports/

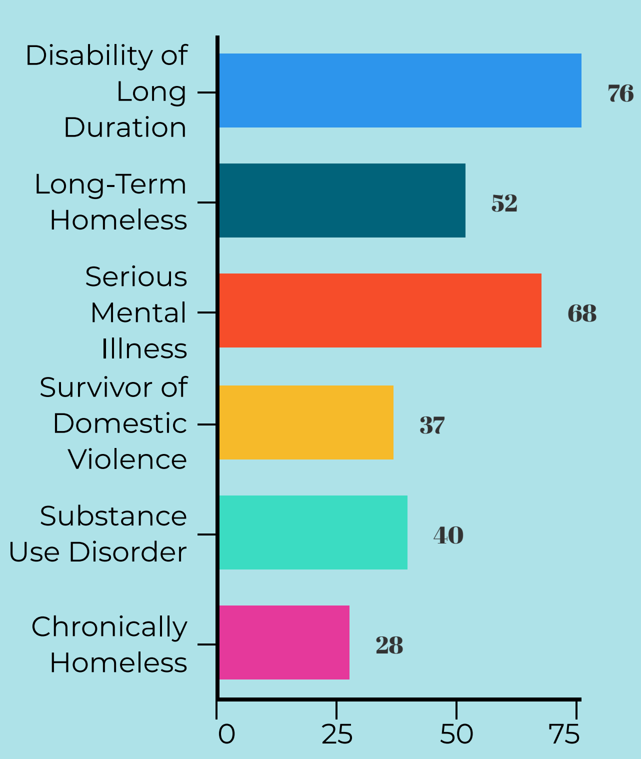
Data Reporting by Patty Beech Consulting, pattybeechconsulting@gmail.com

St. Louis County CoC: Core Homeless Programs Report

Data for All Programs

Organizations with HUD or State of Minnesota funding to provide services or housing to people who are homeless collect data in the Homeless Management Information System (HMIS). The Core Report summarizes all the data collected.

Percent of Households in Each Subpopulation



Exits to Permanent Destination

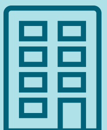
29% of American Indian households
53% of African-American households.
51% of White households

Key Data

3,170
Homeless People Served

2,188
Households Served

1,354
Households Exited

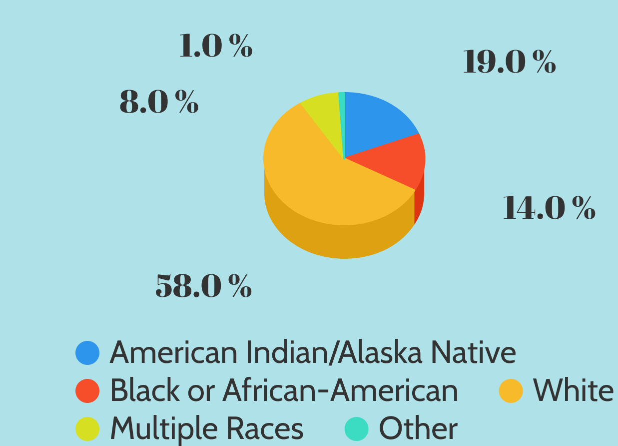


38%
Exited to a Permanent Destination

5%
Exited to Homelessness

43%
Homeless at Entry

Households by Race



St. Louis Co. CoC: Coordinated Entry System Report

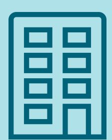
Coordinated Entry System (CES) Data

CES is used to prioritize households for vacancies in housing for homeless persons. Each household is assessed and given a score that indicates their level of vulnerability. They can then be referred to a housing type that meets their need. CES data are collected in HMIS. This report summarizes CES data from 4/1/2020 - 9/30/ 2020.

Key Data

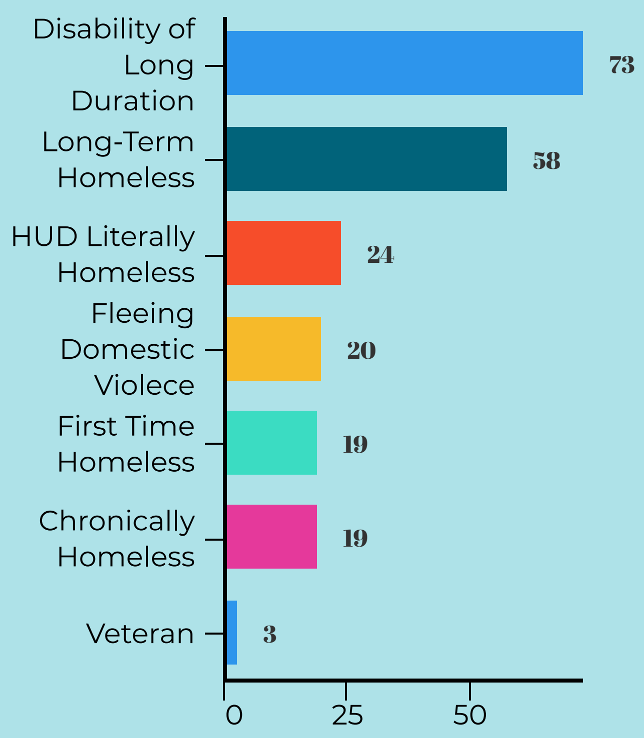
1,888
Households Assessed

541
Households Exited

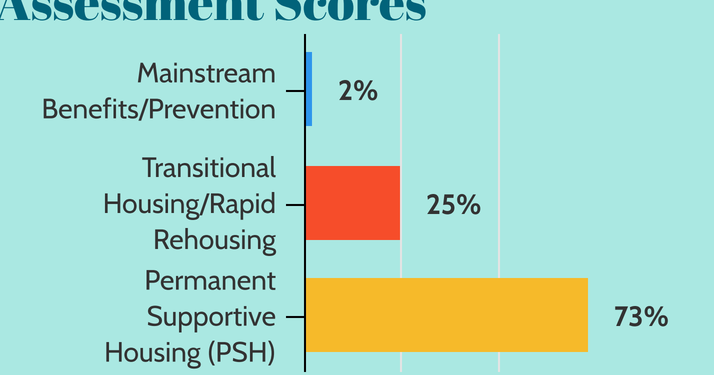


94
Households were Housed in Permanent Housing

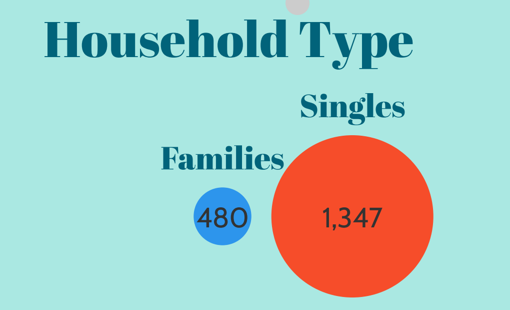
Percent of Households in Each Subpopulation



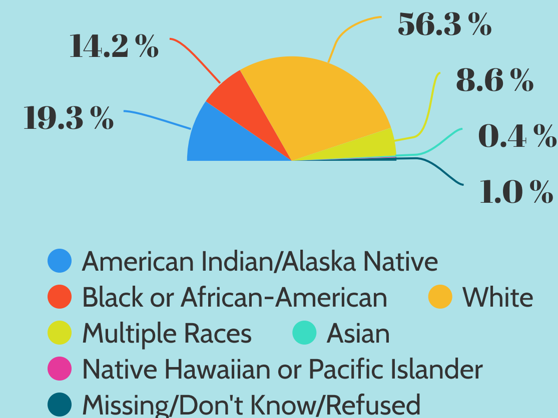
Housing Needs Based on Assessment Scores



Household Type



Households by Race



III. System Map and Housing Intervention Assessment

Data Highlights

- St. Louis County's Emergency Shelters operate at full capacity.[1]
- Average length of time homeless is increasing.[2]
- Many households (48%) stayed with family or friends before becoming homeless (defined as staying in a shelter or in a place not meant for human habitation).[3]
- In 2020, 751 people experienced homelessness for the first time.[4]
- In Duluth, the average wait time for a housing referral for households on the CES Priority Lists is 14 months. The average wait for permanent supportive housing is 6+months. In Northern St. Louis County waits are much shorter.[5]
- 165 people entered shelter from an institution: jail, corrections, hospital, psychiatric hospital, substance abuse treatment, halfway house, foster care/group home. [6]
- 42% of people who exit Emergency Shelter return to homelessness[7].
- 21% of all people who exit the homeless response system return to homelessness within one year.[7] Families return to homelessness at much lower rates.
- 90% of people who receive Rapid-Rehousing assistance exit to a permanent destination. In Transitional Housing, 75% exit to a permanent destination.[8]
- 45% of people who participate in Permanent Supportive Housing exit to a permanent destination when they leave Permanent Supportive Housing.[8]
- Just 34% of people served in the homeless system exited to rental housing, with or without a subsidy. For Rapid Rehousing, 48% moved to a rental unit with no subsidy.[8]

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[1] HMIS Data SLC-FED-10-BED-239 10/1/2019 – 9/30/2020
[2] HUD Performance Profile MN-509: Duluth/St. County CoC:
[3] Wilder Research Center, 2018 Homeless Survey Results for St. Louis County
[4] HUD CoC System Performance Measures – Duluth/St. Louis County CoC 10/1/2019 – 9/30/2020
[5] HMIS Coordinated Entry Monitoring Report 4/01/2020 – 9/30/2020.
[6] HMIS Annual Performance Report (APR) SLC Emergency Shelter 10.1.2019-9.30.2020
[7] HMIS Data SLC MN-00-SAG-054 10/1/2019 – 9/30/2020
[8] HMIS Annual Performance Reports: All Programs, Permanent Supportive Housing, Transitional Housing, Rapid Rehousing 10/2/2019 – 9/30/2020

Areas for Focus

- Decrease the number of people who are unsheltered.
- Reduce returns to homelessness.
- Improve rate of exit to permanent destinations for participants in Permanent Supportive Housing.
- Reduce discharges to Emergency Shelter from jail, corrections, hospitals, substance abuse and mental health treatment.
- Increase affordable rental housing options, including rental subsidies, for people leaving the homeless response system.
- Maintain or increase Transitional Housing, particularly for the populations that are successfully achieving housing stability through participation in TH.
- Maintain or expand Rapid Rehousing to increase successful transitions from the homeless response system to permanent housing.
- Increase Permanent Supportive Housing for singles who face the highest barriers to their physical health, mental health, substance abuse, and criminal background.

Key Questions

- To determine whether there should be a focus on decreasing the length of time homeless (staying in an emergency shelter or transitional housing), are increased stays increasing the number of households that move to a stable housing situation?
- Where do people go when they leave Emergency Shelter?
- Why are some participants in St. Louis County's homeless response system returning to homelessness? What is working to increase housing stability for families that isn't working as well for singles without children?
- How can more episodes of homelessness be prevented to decrease the demand for the homeless response system?
- Can the informal shelter system (family and friends) be supported so that fewer people leave doubled-up situations for homelessness?
- Are there ways to transition long-term participants in Permanent Supportive Housing to other forms of affordable housing with less support, so more PSH beds become available for people in Emergency Shelter or unsheltered?

St. Louis County CoC Provider Agencies

Region Served	Homeless Prevention	Emergency Shelter	Transitional Housing	Rapid Rehousing	Permanent Housing (Permanent Supportive Housing & Other Permanent Housing)

North	• AEOA
	• Bois Forte Human Services
	• Range Transitional Housing
		• Advocates for Family Peace DV
		  ○ Hotel/motel vouchers for persons fleeing DV
		• AEOA
		  ○ Bill's House
		  ○ Hibbing ES
		  ○ Hotel/motel vouchers
		• Bois Forte Human Services
		  ○ Hotel/motel vouchers
		• Range Transitional Housing
		  ○ Hotel/motel vouchers
			• AEOA
			• Range Transitional Housing
				• AEOA
				• Bois Forte Human Services
					• AEOA
					• Bois Forte Human Services
					• Another Path LLC (Housing Support)
					• Range Mental Health Center
					• Range Transitional Housing

Countywide (North & South)	• St. Louis County Public Health & Human Services		• MACV	• MACV	• Hearth Connection (LTHSSF Program)

Sources: 2020 St. Louis County Housing Inventory Count (HIC), Key Informant Interviews

South	• CHUM
	• Life House
	• Salvation Army
		• AICHO DV
		  ○ Daabinoo'Igan DV Shelter
		• Bob Tavani Medical Respite House
		• CHUM
		  ○ Congregate shelter
		  ○ Family shelter
		• Life House
		  ○ The Loft
		• Loaves and Fishes
		  ○ Dorothy Day House
		  ○ Olive Branch
		• Lutheran Social Services
		  ○ Another Door Bethany Crisis Shelter
		• Safe Haven DV
		• Union Gospel Mission
		  ○ Martin Inn Emergency Room
			• Center City Housing Corp.
			• Life House
			• Lutheran Social Services
			• Salvation Army
			• YWCA of Duluth
				• CHUM
				• Life House
				• Salvation Army
					• AICHO
					• Center City Housing Corp.
					• CHUM
					• Drew Shaine LLC (BDS Housing Support)
					• Duluth HRA
					• Lutheran Social Services
					• MACV
					• New Opportunities (Housing Support)
					• October Allen (Grace Place Housing Support)
					• Union Gospel Mission
					• Wolf Family, Inc. (Housing Support)

		Total Year-Round ES Beds: 199	**Total TH Beds: 169**	**Total RRH Beds: 101**	**Total PSH & OPH Beds: 993**

Housing Inventory Count (HIC) Reports provide an inventory of housing conducted annually during the last ten days in January. The HIC report tallies the number of beds and units available on the night of the count by program type. It includes beds dedicated to serve persons who are homeless as well as persons in Permanent Supportive Housing.

Sources: 2020 St. Louis County Housing Inventory Count (HIC), Key Informant Interviews

Available Intervention Types

There is a broad range of services available to individuals experiencing or at risk of homelessness in St. Louis County. These include programs and projects that offer temporary and permanent housing, as well as a variety of services. This section briefly describes the available resources in the community but is not intended to be comprehensive as additional resources are continually being added[1]. Intervention types include:

Outreach and Engagement – Existing outreach efforts include outreach staff and programs targeted to adults and youth countywide – providing ongoing outreach, engagement, assessment, and connections to housing and services. Outreach models differ in the North and South regions of the county because of the differing geography, needs, and resources that exist between the rural and urban areas. Outreach is a critical step in connecting households to CES and other resources that can support their housing stability. There have been continued efforts to expand outreach, and new outreach positions were recently added in two Duluth agencies.

Emergency Shelters – There are eleven (11) shelter providers in St. Louis County. Eight (8) providers serve the South (Duluth) and three (3) providers serve North St. Louis County. This includes two (2) domestic violence shelters, one (1) medical respite house, and one (1) shelter for youth ages 15-19 in the South. There is one (1) site-based shelter located in Virginia, MN, and the remaining shelter options in the North are primarily voucher-based services that temporarily shelter persons experiencing homelessness in hotels or motels. There are approximately 199 year-round emergency shelter beds available throughout the county.

Transitional Housing – There are eight (8) transitional housing providers in St. Louis County. This includes one (1) provider who serves veteran households. It also includes a Safe Harbor program in the South that serves underage victims of sex trafficking and other forms of commercial sexual exploitation and a young mother's program

This includes a program for survivors Additionally, there is one (1) transitional housing provider who specifically targets veteran households.

There are approximately 169 TH beds available throughout the county.

Rapid Rehousing – Rapid rehousing provides homeless individuals and families with a short term rental subsidy, after which they take over responsibility for paying their own rent. Services include help locating housing, as well as time-limited case management focused on maintaining stability in housing. Currently, there are six (6) rapid rehousing (RRH) providers in St. Louis County, which includes one (1) RRH provider in the North, three (3) providers in

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[1] Data on providers and beds comes from the Duluth/St. Louis County 2020 Housing Inventory Count. It reflects providers and beds in the inventory as of the last week of January 2020.

the South, one (1) countywide veterans provider, and one (1) provider on Bois Forte Reservation.

There are approximately 101 RRH beds available throughout the county.

Permanent Supportive Housing & Other Permanent Housing – **Permanent supportive housing (PSH)** helps individuals and families with disabilities maintain permanent housing with rental subsidies and ongoing support services. It is designed for households with the most severe service needs, particularly those who are chronically homeless and/or have significant behavioral disabilities.

St. Louis County's **Other Permanent Housing (OPH)** provides similar programming through support services and rental subsidies with broader eligibility requirements. The region's OPH inventory is largely made up of Long Term Homeless (LTH) Housing Support programs[2].

There are eighteen (18) PSH and OPH providers in the region. This includes four (4) providers in the North (including one (1) provider on Bois Forte Reservation), twelve (12) providers in the South, and two countywide providers.

There are approximately 993 PSH and OPH beds available throughout the county.

Homeless Prevention – Homeless prevention programs and strategies are designed to assist households to avoid becoming homeless and entering the homeless response system. St. Louis County currently has seven (7) prevention providers, which includes two (2) providers in the North, one (1) provider on Bois Forte Reservation, three (3) providers in the South, and the County Public Health and Human Services who serves both regions. Additionally, St. Louis County provides funding to Legal Aid Services of Northeastern Minnesota through their FHPAP and Emergency Solutions Grants (ESG) programs to provide countywide eviction prevention services for households who are facing eviction.

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[2] Housing Support, formerly known as group residential housing (GRH), is a state-funded income supplement for housing (room and board) and housing supports (supplemental services) for eligible seniors or adults with disabling conditions. In order to prevent and/or reduce homelessness or institutionalization, this funding provides financial support for rent, utilities, household needs, and, under some circumstances, food and/or services for eligible individuals. (St. Louis County PHHS Housing Support Program Supportive Housing Program Provider Manual)

St. Louis County, Minnesota Homeless Response System

EMERGENCY SHELTER
199 year-round beds
Utilization Rate[1]
- Duluth: 103%
- North SLC: 138%

1095 people served[1]
961 people left ES[1]
16% exit to a permanent destination[1]

New ES beds coming in 2021 through a Housing Support cost neutral transfer of approx. $1.8 million

PREVENTION & DIVERSION
580 prevention clients
90% exited to a permanent destination

AT RISK OF HOMELESSNESS
751 people experienced homelessness for the first time[1]

Top reasons for homelessness:
1. Eviction or lease not renewed
2. Couldn't afford rent or house payments
3. Lost job or had hours cut[2]

Coordinated Entry Access: 2-1-1
Central Access Point to Regional Homeless Programs

CE WAIT TIME
1,888 people on CE lists[4]
Avg. wait-time: Duluth: 14+ months[4]; North SLC: 3+ months[4]
Vulnerability[4]: 73% High (PSH); 25% Medium (TH/RRH); 2% Low (Mainstream)[4]

PERMANENT SUPPORTIVE HOUSING
549 PSH beds
1172 people served[1]
45% exit to a permanent destination[1]

PSH ACCESS
799 people entered PSH [1]
59% entered PSH from homeless situations[1]
Avg. wait time for CE referral:
Duluth: 6+ months[4]
North SLC: 2+ months[4]

21% who exit the homeless response system return w/in 1 year[1]
- 31% of households w/o children return to homelessness[1]
- 4.5% of households with children return to homelessness[1]

RAPID RE-HOUSING
101 RRH beds/slots
494 people served[1]
393 people exited[1]
90% exit to a permanent destination[1]

RENTAL HOUSING
32% of people served exited to rental housing with (17%) or without (15%) a subsidy[1]

Start Here

STREET OUTREACH

TRANSITIONAL HOUSING
169 TH beds
267 people served[1]
124 people exited[1]
75% exit to a permanent destination[1]
9% of all exits return to homelessness [1]

UNSHELTERED/LITERALLY HOMELESS

612 were homeless (sheltered or unsheltered) in a one-day count[3]

46% (284 people) were unsheltered [3]

The places people stayed when they lost their last regular housing were:
1. With friends or family in regular housing they had – 48%
2. In an emergency shelter – 16%
3. Outside or some other open place, including camping – 15%[2]

DENIED SHELTER ENTRY OR EXITED
25.4% of people were turned away from a shelter because there was no space available.[2]

WARMING CENTERS
2 warming centers available during winter months in 2020—2021 as alternatives to shelter

MEETING THE NEED
- **3,170** people (2,188 households) were served in programs[1]
- **38%** leave programs to permanent destinations[1]
- **42%** of people who exit shelter return to homelessness[1]
- **73%** of people in CE have a disability of long duration[4]
- Avg. LOT homeless increased from 8.5 months to 11 months in one year (2018 – 2019)[1]

LOT = Length of Time

LEGEND
- ES Emergency Shelter
- RRH Rapid Rehousing
- PSH Permanent Supportive Housing
- CE Coordinated Entry
- TH Transitional Housing
- PH Permanent Housing

Data Sources: 1. HMIS data 10/1/2019—9/30/2020, 2. Wilder Homeless Survey 2018, 3. Point-in-Time Count 2020 4. CE HMIS Data 04/01/2020—09/30/2020
Note on CE vulnerability: Vulnerability indicated by VI-SPDAT scores: High = 9+ families, 8+ singles/youth; Medium = 4-7 singles/youth, 4-8 families; Low = 0-3 singles/youth/families.

System Map design provided by: Technical Assistance Collaborative
Prepared by: Patty Beech Consulting

IV. Key Informant Findings on Resources and Partnerships

Interview Themes:

Collaboration

- There are multiple strong collaborative efforts with many partner organizations that are effectively meeting the needs of people without housing and expanding resources.
- St. Louis County leadership has helped build strong partnerships, brought in new funding, and improved processes for connecting clients to county resources.
- Tribal services have been left out of the CoC for long time. They are still catching up.
- Culturally specific service providers are engaged in planning but are spread thin in their ability to be in spaces to advocate for policy and systems change. Engagement and support should be focused on including more American Indian people and People of Color in planning to address homelessness.
- More involvement in preventing and ending homelessness is desired from the following sectors: mental health, medical, schools, chemical health, and jail/corrections.

Homeless Response System

- Street Outreach conducted by CHUM and HDC is critical and more outreach staff would help to reach the growing numbers of people who are unsheltered.
- Emergency Shelter is one of the most impactful resources in the homeless response system. It opens doors to other resources that require that people meet homeless eligibility criteria.
- Emergency Shelters are overfilled, and more beds would reduce the numbers of people sleeping outside or in places not meant for human habitation.
- Permanent Supportive Housing is one of the most valuable resources for persons experiencing homelessness. More units would better address the high demand.
- Housing Support (GRH) beds are increasing and meeting a need, especially for single adults with little or no income. Program expansion is welcomed.
- Additional housing and shelter options for people actively using alcohol or drugs are needed. San Marco units rarely turn over for new residents.

- Case management is essential to guide people through all stages of the homeless response system. Current case managers are stretched thin and their case loads are overwhelming. Additional housing navigators would alleviate this pressure.

Racial Equity and Cultural Responsiveness

- More outreach to is needed People of African Heritage, People who are Black or Indigenous, and other People of Color.
- People of African Heritage, People who are Black or Indigenous, and other People of Color face higher barriers to accessing employment and market rate housing.
- Service providers should reflect the population being served in the homeless system.
- More culturally specific service and housing providers are needed.
- Training would help to build more culturally responsive and culturally relevant services.

Coordinated Entry

- The Coordinated Entry System is improving and has created stronger partnerships and collaborations between service and housing providers.
- More units are needed for households who are waiting on the CES Priority Lists.
- The Coordinated Entry System is designed for funders and organizations that provide housing that serves people without housing. It is not user friendly for participants.

Affordable Market Rate and Subsidized Rental Housing

- Property Management rules and policies vary by property and can limit access to people who need affordable housing. The appeal and accommodation processes are time-consuming for housing advocates, navigators, and case managers.
- Advocacy and relationship building with rental property owners has been a successful method for overcoming barriers to access to market rate rental housing.
- The most common reasons for housing denials include criminal backgrounds, bad credit, and lack of references.

Resources

- Transportation is a huge barrier for people without housing, especially in Northern SLC.
- Many key resources are in short supply: mental health treatments, dental care, and domestic violence resources. In Northern St. Louis County, there are not enough mental health care providers. Getting into substance abuse treatment can take too long in St. Louis County.
- Maintaining employment is difficult due to transportation, housing instability, and mental health.

St Louis County Key Informant Themes

Areas of Racial Disparities

- Employment
- Property Management
- Build Trust with St. Louis County
- Create Stronger Connections with Corrections

Gaps

- More Street Outreach
- Sober Living Options
- Culturally Specific Services
- Staff who look like People Served
- Housing for Singles with High Barriers
- Substance Abuse Treatment - shorter waits
- Dental Care
- Utility Deposits
- Transportation
- More GRH/ Housing Support
- Furniture and Storage for Donations
- Non-phone based services for DV Survivors
- Address generational Homelessness
- Create a Collaborative Culture
- More engagement with Tribal service providers

Bottlenecks

CES

Resources for Vets with less than Honorable Discharge

Housing for people with highest barriers

Successful Strategies and Initiatives:

Key informants identified the following strategies and initiatives as working well to prevent and address homelessness in the region.

Coordinated Entry System (CES)

A key aspect of St. Louis County CoC's regional homeless response is the Coordinated Entry System (CES). CES is the pathway to regional homeless assistance programs and has centralized and streamlined how individuals and families can access transitional housing (TH), rapid rehousing (RRH), permanent supportive housing (PSH), and other permanent housing (OPH).

Households who are experiencing homelessness or who are at imminent risk of homelessness can access CES through a central access point (2-1-1), eliminating the need for households to go to multiple agencies and retell their stories to apply for programs. CES utilizes standardized assessment tools and referral practices to ensure those with the most severe service needs are prioritized for homeless programs. Households are added to the CES priority list in the South, North, or both, depending on where they want to live.

Strong partnerships are key to the success of CES in St. Louis County. Homeless program staff collaborate during weekly case manager meetings to identify the best available resources to meet the needs of households on the CES Priority Lists.

The St. Louis County CoC has continued to expand the capacity of CES through strategic and creative investments of federal and state resources. HUD CoC funding supports two CES Manager positions, one in each region, who oversee CES referrals, policies, marketing, and education. The St. Louis County CoC has also leveraged state funding, such as Housing Support for Adults with Serious Mental Illness (HSASMI), Substance Use Disorder (SUD), Community Living Infrastructure, and Long Term Homeless Support Services Fund (LTHSSF), to support outreach and navigation for households to access CES, collect needed eligibility documents, connect to resources, and identify housing.

Landlord Incentive Program

St. Louis County was one of only a few pilot projects for the Minnesota Housing Landlord Risk Mitigation Fund that started in 2016. The Landlord Incentive Program provides landlords with access to an insurance fund to incentivize renting to households with high housing barriers (poor rental or credit histories or criminal records) who they may otherwise have not rented to. Insurance funds can be used to cover costs related to lease termination, eviction, and damages to the property if the rent does not abide by the terms of the lease. This expands opportunities for housing for high barrier populations in a tight rental market.

Renters also have access to case management and supportive services to help maintain stability in housing.

The Minnesota Department of Veterans Affairs also has a similar incentive program that is available to veterans. The Homes for Veterans Housing Incentive Fund offers financial incentives and risk protection for landlords who rent to Veterans currently experiencing homelessness.

Innovative Use of Existing Funding Resources to Meet Gaps

St. Louis County utilizes existing funding sources in creative ways to meet regional gaps in the homeless response system. As stated above, HSASMI and SUD funding provide outreach and navigation services to people experiencing mental health or substance use issues. Mental health and substance use have been identified as some of the largest barriers to housing stability by community partners. St. Louis County also utilizes Family Homeless Prevention and Assistance Program (FHPAP) funds to support eviction prevention efforts through Legal Aid services, preventing households from having to access limited available homeless resources.

Housing Support Cost Neutral Transfer

St. Louis County partnered with the Minnesota Department of Human Services (DHS) to facilitate a cost neutral transfer of Housing Support base rate and supplemental service rate beds that expands available shelter and services to people experiencing homelessness within the county. Through this cost neutral transfer, a total of $1,760,218 will be distributed to AEOA, American Indian Community Housing Organization (AICHO), Bois Forte, CHUM, Life House, and Safe Haven. This steady funding stream will fill gaps in staffing and increase capacity to fund vouchers and expand available shelter beds for people experiencing homelessness. Examples of activities funded through this initiative include increased emergency shelter beds in the North and the South, including shelter for youth, single women, domestic violence victims/survivors, and Bois Forte band members. Funding will also be used to support CHUM's efforts to assist clients transitioning from shelter, increase operations of CHUM's Health and Wellness Center, provide overnight winter warming center staff, and expand food services. Safe Haven will utilize these funds to add additional crisis advocates and case managers, increase access to shelter services via Crisis Advocate phone support, and expand their Self-Sufficiency Program to support victims/survivors of domestic violence.

Areas for Focus:

- Support partnerships that are having a positive impact on preventing homelessness and increasing housing stability. Ensure that these partnerships have adequate staff and administrative capacity to be successful.
- Build a homeless response system that is focused on efficiency and convenience for people interacting with the homeless response system instead of providers.
- Incorporate culturally responsive and person-centered approaches.
- Expand resources for navigation to help people experiencing housing instability to move through the system. Navigators help people collect documents, complete forms, look for rentals, and connect to available resources. They maintain contact with people in need of homeless services and find them when there are openings.
- Create more permanent supportive housing for singles with high barriers: criminal records, substance abuse history, chronic homelessness, and mental illness.
- Reduce barriers to accessing housing through housing authorities and property management companies.
- Increase mental health crisis management resources.
- Support staff working directly with people experiencing homelessness. Increase wages for case managers, assessors, and navigators. Employ more street outreach workers.

Key Questions:

- What is needed to replicate and expand successful partnerships and bring in new resources to support them?
- What suggestions do People of African Heritage, People who are Black or Indigenous, and other People of Color have to recruit service providers who better reflect the people being served in the homeless system?
- What steps should be taken to diversify homeless planning bodies?
- How can systems that are already stretched (mental health, substance abuse, medical and criminal justice) participate in collaborative efforts to expand resources, prevent homelessness, and better meet the needs of people without housing?
- What are options for training and support to incorporate culturally responsive and person-centered approaches into all aspects of the homeless response system?
- What steps can be taken to continue to improve CES and to make it more friendly and accessible for people being served in the homeless response system??

St. Louis County Partnerships that Address Needs of People who Experience Homelessness

Key Informants and individuals who participate in the SLC CoC identified the following partnerships that specifically focus on reducing homelessness or address other needs of people who experience homelessness or are at risk of homelessness. There are many other collaborative relationships, not listed here, that also improve the homeless response system and the lives of people who receive housing or services as a result.

	CES	SUD	SLC HSASMI	FHPAP	Clarity	CIG	LTHSSF	Health and Wellness Clinic	Health Care and Homelessness Committee	ACT	T-ACT	CoC	Housing Access Coordination	Medical Respite	Landlord Incentive Program	Vets Treatment Court	Lake Superior Diversion and Substance Use Response Team
ARC Northland																	
Ascend Services																	
AICHO																	
AEOA																	
Bob Tavani House																	
Bois Forte																	
Center Alcohol and Drug Treatment (CADT)																	
CCHC																	
CHUM																	
Duluth Bethel																	
Duluth HRA																	
Fond du Lac																	
Hearth Connection																	
Human Development Center																	
Legal Aid Service of NE Minnesota																	
Life House																	
Loaves and Fishes																	
Lutheran Social																	
Minnesota Assistance Council																	
Range Mental Health Center																	
Range Transitional Housing																	
Safe Haven																	
Salvation Army																	
HRA of Virginia																	
YWCA																	
Duluth Police																	
St. Louis County Public Health and Human Services																	
St. Luke's Hospital																	
Essentia Hospital																	
Duluth Family Practice Clinc																	
UMD School of Medicine and																	
University of Minnesota Duluth																	
St. Louis County Probation																	
City of Duluth Attorney's Office																	
St. Louis County Attorney's Office																	
St. Louis County Drug Court																	
Public Defenders																	
Arrowhead Regional Corrections																	
Sixth Judicial District																	
US Dept of Veterans Affairs																	

Partnership Descriptions

Coordinated Entry System

CES

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. All people without housing can access the system by calling 211.

Substance Use Disorder

SUD

The SUD Project's goal is to link homeless persons experiencing substance use disorders to services and and to expedite the process for this population to access and maintain safe housing.

Housing Supports for Adults with Serious Mental Illness

HSASMI

HSASMI grants provide supportive services for adults with serious mental illness who are homeless or who are exiting institutions, and who have complex needs and face high barriers to obtaining and maintaining housing.

Family Homeless Prevention and Assistance

FHPAP

FHPAP prevents homelessness , minimizes the number of days homeless and eliminates repeat episodes of homelessness. Funds are used for direct assistance or services to households who are homeless or at imminent risk of homelessness.

Clarity

Clarity is a community-based initiative to address gaps in the mental health continuum with a goal to improve individuals' access to quality and appropriate mental health and substance use care at the right time and place and in so doing decrease crisis recidivism.

Community Intervention Group

CIG

CIG is a partnership that includes: Duluth Police Department, courts, Center for Alcohol and Drug Treatment, hospitals, County , Human Development Center, and Corrections. The purpose is to reduce contact with law enforcement and corrections (i.e. help decriminalize homelessness) and to provide appropriate pathways to improved stability and well-being.

Long Term Homeless Supportive Services Fund

LTHSSF

The Northeastern Regional Project is a collaboration among counties, bands, government and service agencies offering services and affordable housing to people with long histories of homelessness and complex barriers to health, housing and stability.

Assertive Community Treatment

ACT and T-ACT

An Assertive Community Treatment (ACT) team delivers services in a collaborative team model to individuals with histories of hospitalizations and diagnosis with psychosis who have personal goals of living in the community. A T-ACT team focuses on teens.

Partnership Descriptions

Health and Wellness Clinic

The CHUM Health and Wellness Clinic, staffed by a Registered Nurse (RN) 20 hours per week, provides basic health screenings, referrals to community health providers, and health education. Through a relationship between the U of M Duluth Schools of Medicine and Pharmacy, CHUM hosts the HOPE Clinic for CHUM clients without medical insurance.

Continuum of Care

CoC

The St. Louis County Continuum of Care (CoC) is a coalition of organizations governed by the Heading Home Governing Board that coordinates the County's homeless response system and HUD CoC funding for programs for homeless families and individuals.

Health Care and Homelessness Committee

This Committee includes CHUM, Essentia Health and St. Luke's. This group's goal is to improve the quality and coordination of care for people experiencing homelessness, especially at transitions of care between CHUM and the health care providers

Housing Access Coordination

Housing Access Coordination allows The Arc Minnesota to assist adults with disabilities who are currently receiving an eligible waiver (such as Brain Injury Waiver, Community Alternative Care Waiver, Community Alternatives for Disabled Individuals Waiver, or the Developmental Disabilities Waiver) in finding and moving to independent homes of their own

Medical Respite

The Duluth Family Medical Residency Program, CHUM and Loaves & Fishes provide a safe shelter at the First Covenant Church parsonage for people experiencing homelessness and acute medical conditions.

Landlord Incentive Program

The Salvation Army and AEOA operate this program that gives incentives to landlords for renting to tenants with criminal backgrounds. Landlords can be reimbursed to cover the cost of lost rent, damages to their property, or other expenses

South St. Louis County Veteran's Treatment Court

This a special program designed to assist veterans involved in the criminal justice system who are diagnosed with a mental health or substance use disorder. The court promotes sobriety, recovery, and stability through a coordinated response.

Lake Superior Diversion and Substance Use Response Team

This program improves community outreach to overdose events by expanding outreach efforts to those with amphetamine-related substance use disorders and those who experience amphetamine-related overdoses. An Opioid Technician provides outreach and advocacy for people who are suffering from addiction.

IV. Lived Experience Interview

The project team had difficulties completing interviews with persons with lived experience of homelessness due to limitations caused by the pandemic. It is recommended that input from persons with lived experience be integrated into future planning initiatives to improve the local response to homelessness.

One phone interview was completed with an individual who has experienced homelessness in St. Louis County. Her input has been incorporated into this report and her story is included below.

A Mother's Journey through the St. Louis County Homeless Response System.

Ericka (*not her real name*) is a St. Louis County resident who has experienced homelessness. Ericka was stably housed in market rate housing with her partner, but she faced a housing crisis when the relationship ended and she wasn't able to afford rent on her own. Inability to pay rent combined with ongoing issues with property management led to her eviction during the holiday season. She leaned on Legal Aid for help fighting the eviction in court, but ultimately was ordered to pay her past due rent and court costs. Ericka wasn't aware of financial assistance that could have helped prevent her homelessness, but she said this may have helped her stay in her home at the time.

Throughout the next four years, Ericka faced homelessness while battling with addiction. During this time, she said she wasn't really looking for housing or assistance. Everything changed when Ericka found out that she was pregnant. She slept on her mom's floor and got sober, and she reached out for help.

Loaves and Fishes is credited as one of the most helpful supports in Ericka's housing journey. She stayed in their shelter throughout her pregnancy while searching for a place to call her own. "Loaves and Fishes gave me a place to bring my son home to. They were so kind and amazing. They just let me do my thing." The "amazing people" at Loaves and Fishes have "a lot of knowledge," and they helped connect Ericka to Coordinated Entry.

Ericka completed a Coordinated Entry (CE) assessment and was placed on the CE priority list for homeless programs. She shares that it's hard to explain the next steps in the process after completing the CE assessment and that there's no way of knowing how long the wait might be

before you get housing. She said she wasn't willing to wait around for her name to come up. She was actively calling any housing or programs that she might qualify for and asking for applications. After a total of five years of homelessness and five months after her CE assessment, Ericka was referred to a transitional housing program. About a year-and-a-half after that, she moved into subsidized housing where she still lives with her son.

Ericka says that her knowledge, persistence, and networking skills are the strengths she built on to get stable housing. She also credits her "amazing support system," which includes Loaves and Fishes, and most of all, she credits her son. "I do it for my kid. That's where my strength comes from. I have a kid who relies on me, and if I don't do it, no one's gonna do it for him. I can't let him fall through the cracks."

Her suggestions to improve the homeless response system include stronger agency collaboration and streamlining the process for people who need the services. Resources should be under one roof, and the response to homelessness should be a team effort among agencies, so that a person who is struggling with homelessness doesn't need to worry about how they'll get to the resources they need. "I would want to have to only go to one spot. It would be way more helpful with one or two places to go instead of like five."

"I would want to have to only go to one spot. It would be way more helpful with one or two places to go instead of like five."

Now Ericka is an advocate for others who face housing instability in St. Louis County.

"When people think of people who are homeless, they think of that guy who's dirty with a scruffy beard or the bag lady. I lived in my car for a winter one time. I made sure my car didn't look like I lived in it. Normal people experience homelessness. It's not always because people are lazy. There's so much more to the story. I really wanted to be part of making the connect between the actual person and the people on the other side."

VI. Next Steps

1. Build on current strengths in preventing and ending homelessness in St. Louis County:

- Strong and dedicated partners
- Successful outreach, shelter, transitional housing, rapid re-housing, permanent supportive housing, and affordable housing program.
- Multiple, effective partnerships for planning, implementing, and expanding resources to prevent and address homelessness.
- Expanding resources dedicated to preventing homelessness and increasing housing stability.

2. Share the information in this report broadly with a range of stakeholder groups including people who interact with the homeless response system, Communities of Color, Indigenous people, government and Tribal partners, and housing and service providers. Seek input and suggestions on areas for improvement in the following areas:

- Reduce racial disparities in homelessness.
- Decrease unsheltered homelessness.
- Expand permanent supportive housing for single adults with high barriers to housing stability.
- Improve system performance, particularly in the areas of returns to homelessness, and exits to permanent destinations.
- Support continuous improvement in the Coordinated Entry System, including the expansion of housing navigation and assessment resources.
- Increase engagement of sectors that intersect with the homeless response system: criminal justice, mental health, substance abuse treatment, and health.

3. Analyze existing homeless response system funding from HUD, State of Minnesota, and local sources. Identify any areas where funds can be better aligned to meet homeless system performance goals and address high priority needs as identified by the community.

4. Use data from the Environmental Scan, System Map, and Key Informant Interviews, along with broad community input to develop specific goals and strategies to improve St. Louis County's homeless response system. Adopt a plan at the Heading Home Governing Board to guide the St. Louis County Continuum of Care (CoC)'s planning efforts.

Appendix: Definitions and Acronyms

Extent of Homelessness by Minnesota's Definition: The State of Minnesota defines as homeless "any individual, unaccompanied youth or family that is without a permanent place to live that is fit for human habitation." Doubling-up is considered homeless if that arrangement has persisted less than 1 year.

The State of Minnesota defines an individual, unaccompanied youth or family as **"Long-Term Homeless**" if they are without a home for a year or more OR have had at least four (4) episodes of homelessness in the past three (3) years. Any period of institutionalization or incarceration (including transitional housing, prison/jail, treatment, hospitals, foster care, or refugee camps) shall be excluded when determining the length of time the household has been homeless.

HUD homeless definition: HUD Funded Program- HUD established four categories of Homelessness.

Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. Has a primary nighttime residence that is a public or private place not meant for human habitation;
2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); OR
3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Imminent Risk of Homelessness: An individual or family who will imminently lose their primary nighttime residence, provided that:

1. Residence will be lost within 14 days of the date of application for homeless assistance;
2. No subsequent residence has been identified; AND
3. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Homeless Under other Federal Statutes: Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless as defined above, but who:

1. Are defined as homeless under the other listed federal statues;
2. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
3. Have experienced persistent instability as measured by two moves or more during the preceding 60 days; AND
4. Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing/Attempting to Flee DV: Any individual or family who:

1. Is fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking;
2. Has no other residence; AND
3. Lacks the resources or support networks to obtain other permanent housing.

HUD Chronic Homeless Definition: A chronically homeless individual is defined to mean a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility.

To meet the chronically homeless definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Disability of Long Duration: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is **(a)** expected to be of long-continued and indefinite duration, **(b)** substantially impedes an individual's ability to live independently, and **(c)** of such a nature that such ability could be improved by more suitable housing conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.

Physical Disability: A physical impairment which is **(a)** expected to be of long-continued and indefinite duration, **(b)** substantially impedes an individual's ability to live independently, and **(c)** of such a nature that such ability could be improved by more suitable housing conditions.

Developmental Disability: A severe, chronic disability that is attributed to a mental or physical impairment (or combination of physical and mental impairments) that occurs before 22 years of age and limits the capacity for independent living and economic self-sufficiency. Accepted forms of documentation include written verification from a state-licensed professional, such as a medical service provider or a health-care provider, the Social Security Administration, or the receipt of a disability check (i.e., SSDI check or VA disability benefit check).

Chronic Health Condition: A diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to, heart disease (including coronary heart disease, angina, heart attack and any other kind of heart condition or disease); severe asthma; diabetes; arthritis-related conditions (including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia); adult onset cognitive developments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

Mental Health Problem: May include serious depression, serious anxiety, hallucination, violent behavior, or thoughts of suicide.

Recent Institutional History: Definitions for some options:

- **Drug or Alcohol Treatment Facility**: Includes inpatient treatment and detox.
- **Foster Home:** This term applies to youth only.
- **Group Home**: Includes all facilities for people with disabilities (cognitive or physical); may also be used for corrections clients. Includes adult foster care. Placement done through social services or corrections departments.
- **Half-way House**: Includes placement for corrections clients after jail or prison OR for clients after chemical dependency treatment.
- **Mental Health Treatment Facility or Hospital**: Includes regional treatment centers (state hospitals), Intensive Residential Treatment Services (IRTS), crisis residences, and psychiatric inpatient units at local hospitals.
- **Residence for People with Physical Disabilities**: Includes nursing homes, long-term care facilities, and rehab hospitals.

Acronym List

Acronyms			
AHAR	Annual Homeless Assessment Report	**MFIP**	Minnesota Family Investment Program
APR	Annual Progress Report	**MTC**	Minnesota Tribal Collaborative
ARD	Annual Renewal Demand	**MOU**	Memorandum of Understanding
CE/CES	Coordinated Entry/Coordinated Entry System	**NOFA**	Notice of Funding Availability
CH	Chronic Homeless	**OEO**	Office of Economic Opportunity
CoC	Continuum of Care, Federal program stressing permanent solutions to housing	**OPEH**	State Office to Prevent and End Homelessness
Con Plan	Consolidated Plan	**P&E**	Performance & Evaluation Committee
CPD	Community Planning & Development (HUD office of)	**PBRA**	Project Based Rental Assistance
DHS	Department of Human Services	**PIT**	Point in Time
EA	Emergency Assistance	**PRN**	Pro Rata Need
EGA	Emergency General Assistance	**PSH**	Permanent Supportive Housing
ESG	Emergency Solutions Grant (Emergency Shelter Grant; previous name)	**RFP**	Request for Proposals
FHPAP	Family Homeless Prevention & Assistance Program	**RHSP**	Rural Housing Stability Program
FMR	Fair Market Rent	**RHY**	Runaway and Homeless Youth Act
GIW	Grant Inventory Worksheet	**RRH**	Rapid Re-Housing
GRH	Group Residential Housing	**S+C**	Shelter Plus Care
HDX	HUD Exchange (online data submission tool for reporting to HUD)	**SAGE**	Portal to enter annual progress reports for all HUD COC funded programs
HEARTH Act	Homeless Emergency Assistance and Rapid Transition to Housing	**SHP**	Supportive Housing Program
HHA	Heading Home Alliance	**SOAR**	SSI/SSDI Outreach, Access and Recovery
HIC	Housing Inventory Count	**SPMI**	Serious and Persistent Mental Illness
HMIS	Homeless Management Information System	**SRO**	Single Room Occupancy
HOPWA	Housing Opportunities for Persons with AIDS	**SSI/SSDI**	Social Security Income / Disability Income
HPRP	Homeless Prevention & Rapid Re-Housing program	**SSO**	Support Services Only
HQS	Housing Quality Standards	**SuperNOFA**	HUD's consolidated approach to issuance of Notice of Funding Availability
HRE	Homelessness Resource Exchange	**TANF**	Temporary Assistance for Need Families
HUD	U.S. Department of Housing and Urban Development	**TBRA or TRA**	Tenant Based Rental Assistance
ICA	Institute for Community Alliances (HMIS administrator)	**TH**	Transitional Housing
IHS	Indian Health Services	**VASH**	Veteran's Affairs Supportive Housing
LSA	Local System Administrator	**Veteran's GPD**	Veteran's Grant and Per Diem program
LSA	Longitudinal Systems Analysis	**Veteran's SSVF**	Supportive Services for Veteran's Families
LTH	Long Term Homeless	**VI SPDAT**	Vulnerability Index (VI) & Service Prioritization Decision Assistance Tool
LTHSSF	Long-Term Homeless Supportive Services Fund		