Evaluating PSH in Durham

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CITY OF DURHAM

Contents

Introduction

This report seeks to provide an in-depth analysis of Permanent Supportive Housing (PSH) programs in the Durham City and County Continuum of Care (CoC). PSH programs can and should be varied to meet the unique needs of different clientele. However, it is essential to understand the benefits and limitations of different PSH practices. This report combines qualitative interviews of high-performing PSH programs across the county with an extensive quantitative analysis of Durham CoC's Homeless Management Information System (HMIS) data. The aim of this methodology is to provide both macro-level insights for strategic planning as well as best practices for more meaningful service implementation.

Methodology

This report is informed by the following components:

- **Secondary-source research** – review of academic literature, policy white papers, reports, and program evaluations.
- **Interviews with program staff** – telephone interviews with various staff of high performing PSH programs in high performing CoCs. High performing CoCs were gathered via a ranking report of CoC performance, as well as potential comparability to the Durham CoC. PSH programs were then examined based on the priority listing of each CoC's collaborative applicant.
- **Quantitative Data Analysis** – examination of HMIS data to understand demographics, predictors of PSH enrollment, the efficacy of PSH programs, and flow of PSH eligible populations. See **Appendix 1** for more detail.

Types of PSH Housing

Single-site: a PSH model characterized by a centralized housing complex where supportive services are offered on site.

Scattered-site: a PSH model characterized by smaller, more disperse housing units. These typically resemble traditional market-based apartments, and supportive services are delivered to clients at their individual unit.

Tenant-based: a housing subsidy in which the subsidy is tied to the individual or household. Typically can move with households to other units.

Project-based: a subsidy in which the subsidy is tied to a specific unit and is not portable.

Best Practices

This section provides an overview of best practices gleaned from the research and interviews that CoC lead agencies and PSH providers can implement to ensure a high performing delivery of supportive housing. The sections following this overview go more in depth about each best practice. Keep in mind that, while these best practices are generalizable to most CoCs, it is necessary to consider how these tenets apply in the context of each community.

• **A Mix of Housing Models –** PSH programs work best when there are a bevy of different housing models. Single-site, scattered-site, tenant-based, and project-based housing programs all have their benefits and barriers. CoC lead agencies must therefore work to curate a blend of different housing models dependent on the needs of their community. This blended

approach not only makes affordable housing stock financially feasible, it provides flexibility for households to choose housing that best meets their needs.

- **Staff Competency** – Staff must be well-trained to implement housing models effectively. Housing First principles work, but staff can be reluctant to maintain fidelity. Formal qualifications vary among programs – supportive staff ranged from having associate's degrees, bachelor's degrees, master's degrees, or equivalent life experience. Aspects of developing a competent staff environment include relationship building, flexibility, and a system of consulting client cases with others in the agency. Programs can train staff on models of care such as Motivational Interviewing to help improve staff competency.
- **Collaboration of Services –** Collaboration among housing providers is essential. It is impractical for one agency to meet all necessary housing needs. Therefore, CoCs must work to ensure clear communication among providers. In addition to inter-agency collaboration, high performing PSH programs implement a robust level of intra-agency collaboration. This helps with program implementation, and it also provides agencies with an opportunity to assess their service strengths and gaps to fill via inter-agency collaboration.

Housing Type

Most housing programs employ either scattered-site housing or single-site housing. Scattered-site housing is characterized by smaller, more disperse housing units. These typically resemble traditional market-based apartments, and supportive services are delivered to clients at their individual unit. Single-site housing is characterized by a centralized housing complex where supportive services are offered on site.

Differences in PSH housing subsidies can impact PSH programming. Many PSH units are funded through Housing Choice Vouchers (HCVs), which (like any housing subsidy) can be either tenant-based or project-based. Tenant-based HCVs are tied to the individual or household and offer a level of portability and flexibility in choosing a specific housing unit. Project-based HCVs, on the other hand, are tied to a specific unit. They can offer funding consistency for a PSH program as providers can be confident the unit will remain subsidized without any additional administrative burden (such as linking a program participant to a tenant-based HCV). Several PSH programs also utilize master-leasing, where program providers sign a lease with a property manager or landlord and then sublease that unit to a PSH client. This setup formalizes the program provider as an intermediary between landlords and clients, which may prompt better communication.

Each housing type offers relative advantages and disadvantages. Scattered-site housing offers more choice by participants, who can pick the right apartment complex for them. However, tenant requirements for this housing type are often more restrictive than in single-site housing. Participants in single-site housing often report difficulties living with others in similar circumstances, citing problems staying sober or dropping maladaptive habits. On the other hand, single-site housing offers a convenient service hub for

households. A blended approach of both single-site and scattered-site housing within a CoC seems to allow service providers the "best of both worlds" for their clients.

There is also a benefit to blended populations within single-site buildings. Sandra Newson from Carrfour Housing pointed out that their agency had previously had 23 townhomes that were exclusively for homeless individuals. They realized this model was not financially sustainable, especially when the tenants were high-risk of eviction. Newson mentioned that they needed a population of tenants that were able to pay enough rent to at least partially offset the Extremely Low Income homeless units. In a SAMHSA seminar entitled "Housing, Landlords, and Systems," Greg Shinn from The Mental Health Association of Oklahoma also mentioned the importance of a mixed income approach. He pointed out that it was both financially self-sustaining for the agency and also led to more stable neighborhoods, as a blended approach meant there was less concentration of extreme poverty.[1]

Implementing a blend of different types of supportive housing requires either massive housing providers or efficient coordination among smaller providers. Moreover, it is important to understand affordable housing demand from a population-based model. Different populations of affordable housing customers have different risk profiles. Understanding how to meet these needs and address the risks can inform the ways in which CoCs curate housing stock in their community.

Case Study – Carrfour and "Single-Site" Assistance

Carrfour is a large housing provider for the Miami-Dade CoC. They receive $8 million from CoC grants and have over 1700 units among 19 different communities.

Carrfour is an example of a robust single-site housing provider. Their communities are equally split between housing for homeless individuals and other affordable housing. There is no substantive difference in the housing units aside from their funding mechanisms, which contributes a greater sense of community. Supportive services are provided in each building, effectively making them a service hub for tenants.

Staff have a robust system of client staffing within the agency – frequent meetings among supportive services staff to keep everyone on the same page and frequent staffing among supervisors and supportive services staff to solve more widespread issues. This staffing extends to potential evictions – staff must send a letter to the Vice President of Operations and the Vice President of Programs on the steps the staffer has done to help the tenant avoid eviction. Most evictions have resulted from behavioral issues related to substance use. Having overturned a zero-tolerance drug policy for their communities, the buildings have seen an increase in crime. While staffing can help mediate some of these problems, these issues remain a concern.

Carrfour's size helps with its move-on policy. Carrfour will sometimes move around the funding mechanism for a unit (e.g. changing the unit from homeless designation to an affordable housing designation) so that a family can effectively "move on" without having to do an actual move. The agency moved on 57 people (out of approximately 800) in 2018.

Case Study – ForKids and Robust Supportive Services Staff

ForKids is a supportive housing program that operates primarily in Norfolk, VA. They operate a blend of owned single-site housing as well as master-leased apartments. They serve approximately 40 families.

Supportive services are an integral part of the ForKids housing program. In Norfolk, case management services are focused on connecting clients to various resources and informing them about housing processes and programs. Another worker for the program focuses on life skills. The other two sites also have a mental health specialist at each. ForKids uses an electronic file system to track notes on the same client among different workers. ForKids also employs group supervision and staffings to discuss clients.

These procedures help to facilitate collaboration among staff, and management is intentional about fostering a culture that pushes for collaboration. There are also periodic trainings to inform workers on different programs in the community. Case managers must have a bachelor's degree and some experience working in social services. The length of experience is discretionary, as management is mainly focused on finding staff with who fit a "service" culture.

Caseloads are about 15 to 20 clients – 4 or 5 PSH clients with the rest being RRH. Olson explains that ForKids tries to mix the types of clients on a caseload to avoid burnout. They know that supportive housing can be slow in terms of progress and hope that the faster success of RRH will help alleviate that. For the master leased apartments, ForKids has housing specialists. These employees – separate staff from case managers – coordinate with landlords to make sure units are in good condition. They also work as a liaison between clients and landlords in order to facilitate maintenance issues.

Staff Competency and Coordination of Services

Staff in these programs were engaged, compassionate, and motivated. Reviews of secondary-source documentation did not highlight the specific formal education that staff received. However, the literature did explain how staff operated effectively to complete the goals of the specific PSH programs. Moreover, Interviews with different programs found that supportive staff qualifications range from a bachelor's degree to equivalent life experience.

Staff often incorporated Motivational Interviewing practices to develop trust with participants. This trust went a long way in keeping clients engaged with programming and encouraged honest communication. The rapport building and healthy flow of communication enabled staff to find the best fit for housing placement. It also alerted staff to any potential issues clients would have with their living situation, should they arise. Knowing these issues allowed staff to get out ahead of problems and serve as more effective advocates of their clients to landlords.

Program staff in effective PSH programs were also dedicated to the effective coordination of services. This was especially important as other aspects of the PSH programs were often flexible and individualized. Therefore, robust coordination among all service providers was necessary in order to deliver a similar quality of service.

Moreover, a high-quality relationship with service providers could quicken service delivery and address barriers to care. For example, in an evaluation of Child Welfare Housing programs, staff with strong landlord relationships were able to cut down time on certain verification forms and other paperwork processes. A SAMHSA seminar about service collaboration cautioned that inter-agency collaborations need clear channels of communication as well as clear policies and protocols to be truly effective.

Coordination occurred within agencies as well. Case managers in many effective PSH programs reported that other staff members were able to address their clients' issues if need be. An example of this coordination could be one staff member taking clients from multiple caseloads to a certain service provider, or a case manager intervening in a crisis if the client's assigned case manager was off site. It is important to note that this intra-agency coordination was more efficient with more robust communication and case consultation among staff – case managers could not advocate for the needs of a client on a separate caseload if they did not know what those needs were.

Move-on Policies

"Move-on" refers to the process by which PSH programs facilitate client transition to more independent subsidized or market-based housing. Understanding when to initiate move-on can be a difficult process. While Permanent Supportive Housing can and should be a long-term housing option, providers want to ensure proper move-on strategies to facilitate independence among current participants and open spots for future participants.

Due to the nature of move-on, program providers often employ strategies that approach the process on a client-by-client basis. Each client will have unique housing needs, and they will also have different resources to try and meet those needs. Typically, however, housing needs for move-on clients reflect a less intensive service provision of PSH: healthy relationships with landlords, intermittent follow-up case management, financial assistance (especially surrounding initial move-in costs), and mental health services.[2]

With this knowledge in mind, ideal move-on candidates are often already demonstrating some level of independence within a PSH program. These clients have been able to manage substance use or mental health concerns and often have strong support systems for when they move. Some programs have formalized these characteristics into assessments to be completed between staff and move-on candidates.[3]

What is Move-On? Why is it important?

"Move-on" refers to the strategies of transitioning a client from PSH to independent housing.

PSH programs typically have high retention rates. While prematurely moving a client out of a PSH unit should be avoided, program providers must have formal move-on strategies to ensure units are available for those who need it. This is especially important in an environment in which PSH supply is not meeting demand.

Housing Type, Voucher Type, and Move-on

There is not specific discussion in the literature of the particular move-on challenges of scattered-site versus single-site PSH. However, potential concerns can be extrapolated from the unique characteristics of each housing type. Residents of single-site PSH may have a greater baseline service need, which could mean a longer transition to independent living. However, the proximity to service staff could facilitate a stronger transition when that time comes. Conversely, scattered-site clients may be used to the habits of successful independent living such as landlord interaction or accessing needed services outside of one's apartment. However, scattered-site staff must be diligent about providing supportive transition services as well as facilitating service follow-up post move-on.

There are also potential challenges associated with move on for clients with different types of housing subsidies. Clients with tenant-based subsidies will have an easier time securing independent housing as their subsidy will be able to transfer with them. This is not the case for project-based subsidies. These subsidized units are typically kept as PSH units, and thus the household must transfer to a different subsidy (or increase their income to meet market-rate rent) in order to complete move-on.

Lessons from Interviewed Programs

Provider strategies on staff competency and rapport building can help address the varied needs for clients who are ready for move-on. For the Homeward Bound program in Asheville, NC, a big part of move-on is investigating different housing subsidies as opposed to increasing client income. Since many Homeward Bound clients are receiving disability benefits (such as SSI or SSDI), it is unlikely that their income will change significantly. Acquiring housing subsidies such as Housing Choice Vouchers is therefore essential to facilitate a successful move.

Staff with the Place of Promise program in Patterson County, NJ had a similar strategy of finding housing that met the needs of their potential move-on clients. One of their clients was an older veteran who needed more substantial care – traditional independent housing subsidies such as Housing Choice Vouchers would have been insufficient for this client's needs. Case managers from Place of Promise collaborated with the client to link them to an assisted living facility where they could receive the care they needed on a regular basis.

Even though move-on is a client-based decision, programs can facilitate a move-on dialogue to prompt client thinking in that process. Homeward Bound uses the language of "graduating" to ease client concerns about being pushed out of a program. They also start this dialogue from enrollment so that clients are constantly prompted to think about what stable housing looks like for them. When ForKids in Norfolk, VA employed this approach, they noticed a sizeable reduction in length of stays. Clients had been in the program for up to a decade, but after using this strategy clients stayed 2 to 5 years before exiting to stable housing.

Having more housing options can streamline the move-on process. Some Housing Authorities collaborate with PSH programs to provide specialized Housing Choice Vouchers to facilitate move-on. This process is as short as a few months for Shelter Care Ministries in Rockford, IL, which allows staff to have more confidence in starting move-on conversations. Good Shepard Housing Foundation reports that a dearth of housing vouchers in Prince William County is one of the main reasons they have so few people move-on. Expanding capacity for affordable housing will make the transition out of PSH programs easier.

Once clients have been formally moved-on, success is reliant upon continuing to meet the financial obligations of housing. A reduction of social security benefits or losing a housing choice voucher can damage the stability of a client who has moved-on. Ensuring some level of follow-up service provision and connecting moved-on clients to eviction-diversion services when facing these situations may be effective tools to ensuring permanent move-on success.

Challenges and Evictions

Discussing exits from PSH programs into homelessness is difficult in the context of best practice programs, as such exits are quite rare. As a staff member from Shelter Care Ministries put it, "We don't really have negative exits…we try to do anything and everything to help clients be stable." This framework can be a radical shift in perspective for many program providers. The following section highlights how best practice programs have implemented this framework within their programs. Prominent among this implementation are strategies to reduce and address evictions.

There are common concerns that contribute to evictions. Highest among these is behavioral concerns associated with substance use. While Housing First principles assert that everyone is housing ready (thus placing no treatment requirements on housing), behavioral issues stemming from substance use and untreated mental health issues were commonly cited as factors in evictions. For example, Carrfour removed a zero-tolerance drug policy in their units to comply with Housing First principles. They subsequently noticed an uptick in criminal behavior at their housing complexes, most notably resulting from substance using friends of tenants. ForKids experienced a similar situation, noting that the concentrated aspect of single-site housing can exacerbate difficulties for tenants who are in recovery. The Place of Promise program noted that this issue persisted in scattered-site housing too, as apartments in "troubling neighborhoods" could enable relapse and behavioral concerns that would lead to eviction.

Program providers have taken steps to address these concerns. Many leverage good rapport building to implement a sort of "graduated sanctions" approach. That is, when issues start to crop up, case managers that have built a relationship with clients are able to mediate the problem in a way that does not necessitate eviction. Providers only elevate the consequences if the initial approach does not work.

For example, ForKids staff noticed that many of the concerns stemmed from substance using friends of tenants, not the tenants themselves. To address these concerns, ForKids established a formal protocol. In these cases, protocol is to first facilitate a dialogue with clients (e.g. asking something such as "do you see that this guest's behavior could damage your hard work in obtaining housing"). After exhausting that dialogue staff will then try to move the client to a different unit to alleviate the issue. Often this move can be a "reset" for clients without experiencing the longer detriment of a formal eviction.

Many other providers echoed this sentiment regarding moving clients to a different unit should problems escalate. This approach requires either that the program has master-leased the unit, owns the unit, or has a strong working relationship with the property managers. Shelter Care Ministries utilizes master-leasing for its units. If clients have trouble with a unit that would traditionally lead to an eviction, Shelter Care staff instead do whatever they can to relocate folks to another unit, noting that the particular unit "just wasn't the right fit." ForKids notes that sometimes, landlords "are just done with a client." However, a strong professional relationship prompts landlords to discuss the issue with staff first instead of immediately evicting the client.

Even if clients are evicted from a unit, many programs will continue to provide supportive services. Homeward Bound has created a team to provide more intensive services with untreated mental health and substance abuse, noting that those two components were

providing challenges with stable housing. Should a client be evicted, Homeward Bound continues to provide supportive services as they look to re-house the client. Successful programs understand that challenges in one housing situation does not preclude future housing success, and they facilitate wrap-around services in the event of an eviction.

Main Takeaways – Best Practices

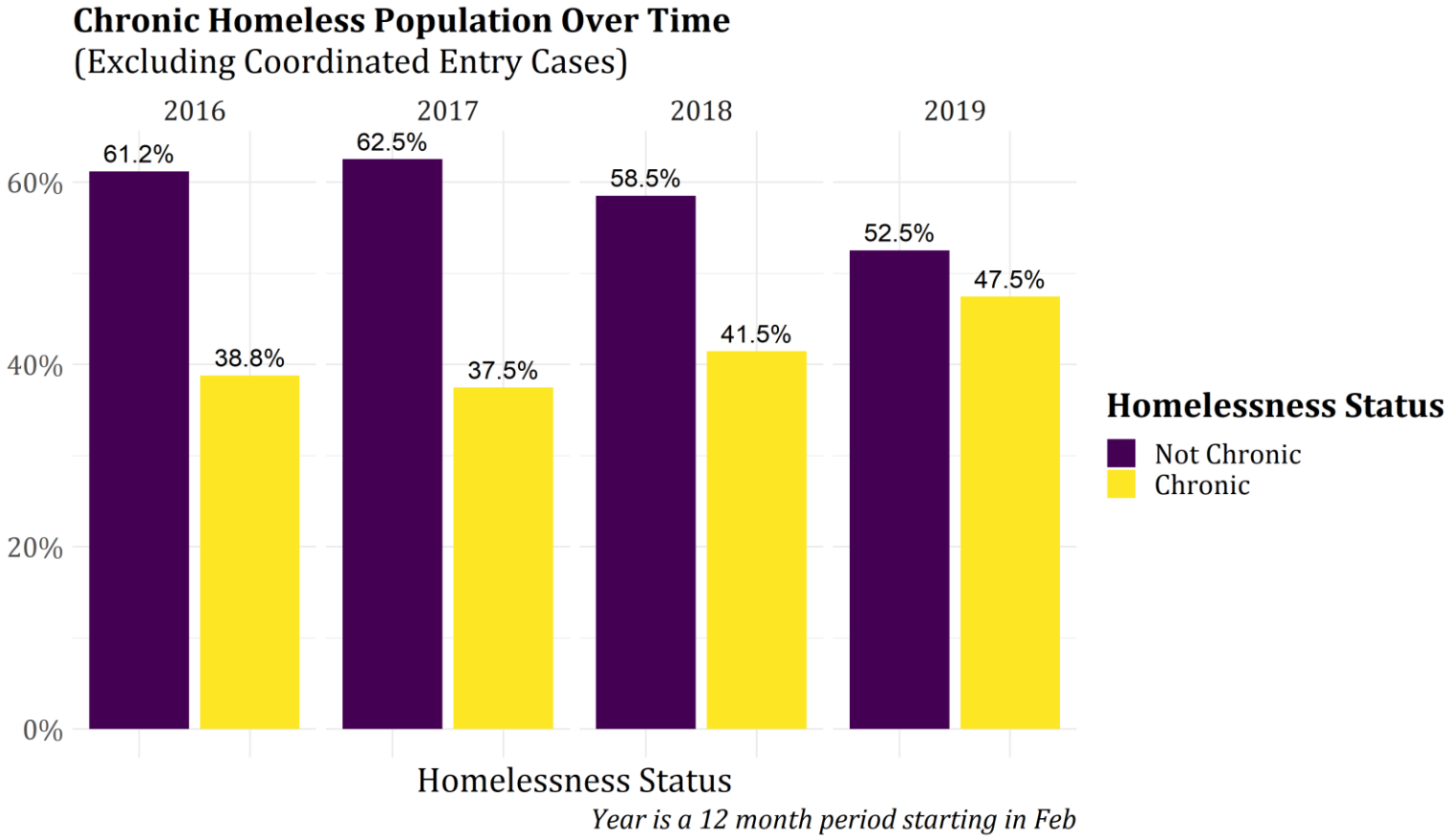
- Supportive services staff develop strong working relationships with housing staff and clients to understand and mediate potential problems.
- Single-site and scattered-site programs have different benefits and challenges with service proximity and fostering independence. Blending models allows programs to be flexible dependent on a client's needs.
- Starting move-on conversations early on normalizes the process and prompts clients to think about what stable housing looks like to them.
- Behavioral issues can lead to eviction. Should issues arise, programs can leverage rapport to mediate problems. Continuing to offer services in the face of eviction reframes the problem as a temporary setback to be addressed.

Durham's Chronic Homeless Population

Examining data from HMIS for theDurham County CoC can highlight macro-level trends in the provision of housing services. This section will elucidate the main findings of the data analysis plan found in **Appendix 1**.

Demographics

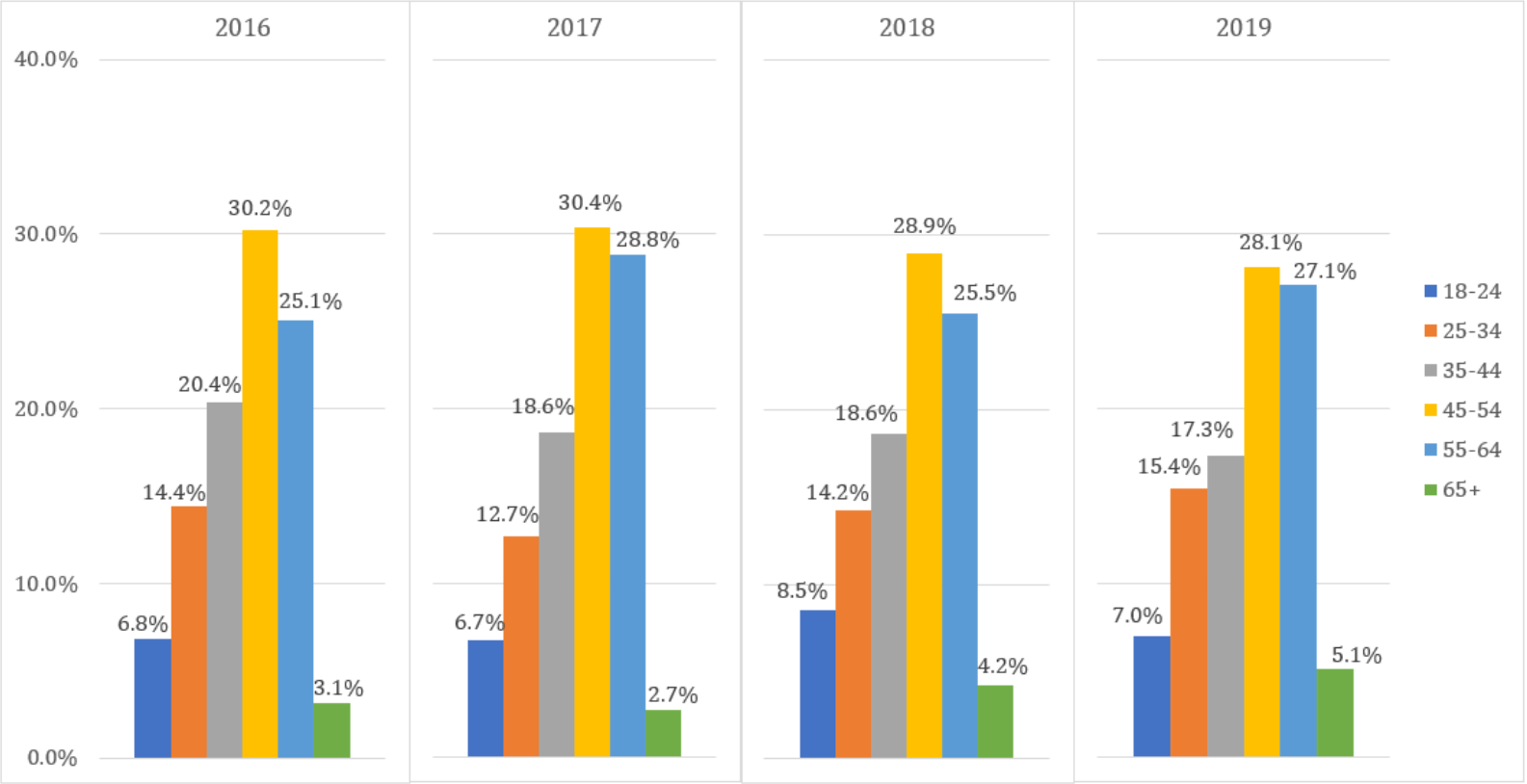
The size of the homeless population has decreased over the last 4 years. Specifically, the numbers have dropped from 775 to 582 individuals with an active homeless case in HMIS and 1518 to 1336 individuals for all HMIS cases over the last 4 years. Despite this decrease in the total population, the number of individuals experiencing chronic homelessness (defined in this report as self-reporting 12 or more months of homelessness or experiencing a HMIS homeless entry for 12 or more months) has slightly increased over time. Specifically, the number has risen from 589 to 634 individuals. The following graph shows the chronic population as a percentage of the general homeless population for each of the last four years:



The most notable changes in the chronic population over time have occurred in age and program enrollment characteristics. The age distribution is evening out, shifting from the 35 to 44 and 45 to 54 age brackets to the 25 to 34 and 65 and older age brackets. While

the increase in those 65 and older can be attributed to an aging chronic population, the 25 to 34 increase is likely due to new incidences of chronic homelessness as opposed to individuals who are already chronically homeless aging into a different age bracket.

Age Distribution of the Chronic Population

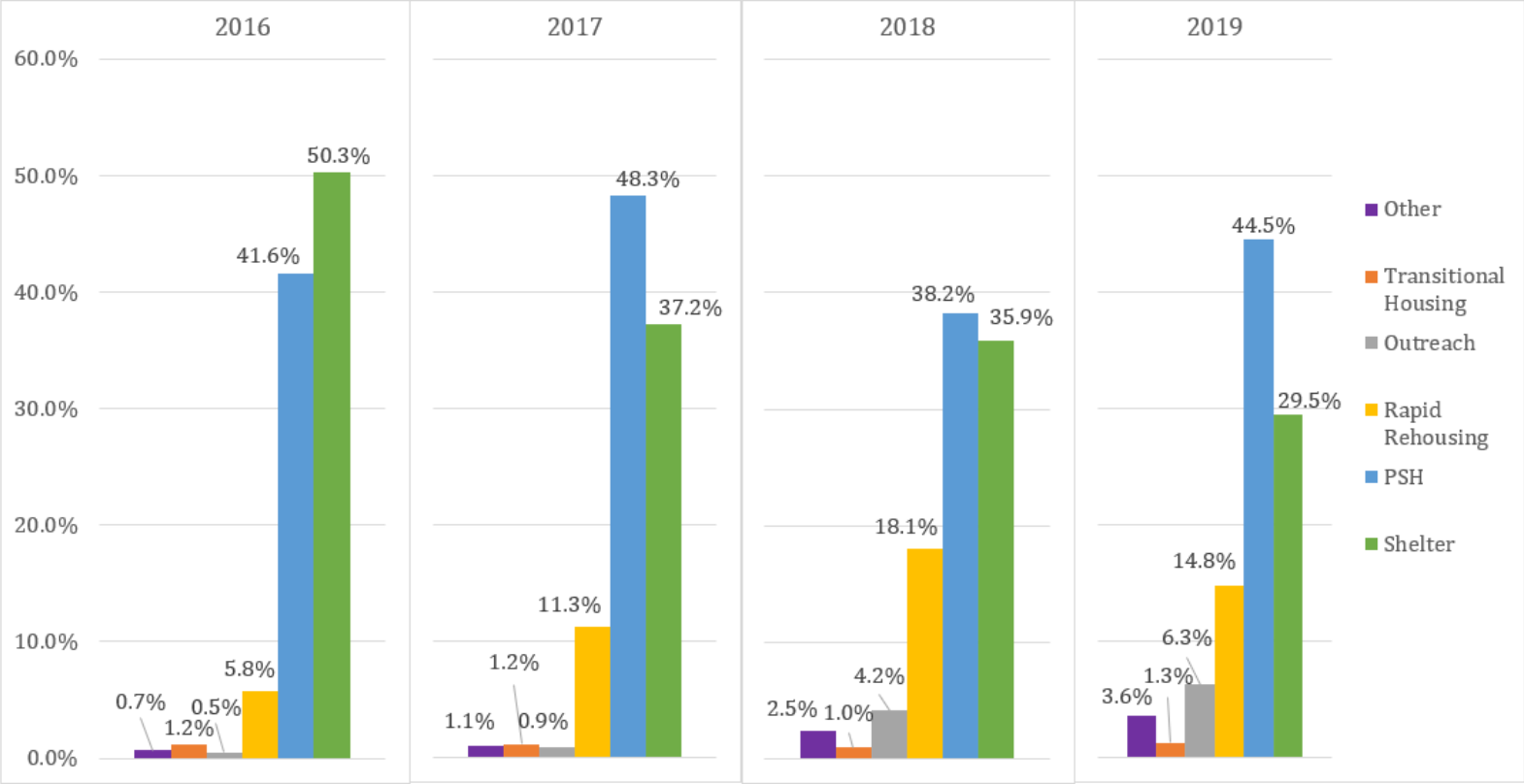


Program enrollment among the chronically homeless population is the variable with the most variation over the last four years. As a share of program enrollemet among the chronic population, the number of individuals with shelter stays has steadily dropped in the last 4 years. This is validated by the raw numbers as well – 296 chronically homeless individuals were enrolled in shelter programs in 2016 compared to 187 individuals in 2019.

Outreach cases have gone up by about six percentage points from 2016. In terms of raw numbers, this is a jump from 3 individuals in 2016 to 90 individuals in 2019. Rapid Rehousing also shot up – the program had 47 more individuals with a Rapid Rehousing enrollment in 2018 than it did in 2017.

PSH enrollment has varied over the past four years. The lowest year, 2018, had 234 individuals with a PSH program enrollment. For the past three years, PSH has been the largest share of program enrollment for the chronic population. This is likely due to the chronicity requirement for entry – whereas other programs may have a blend of chronic and non-chronic individuals, all PSH enrollees are considered chronically homeless.

Program Distribution of the Chronic Population



Aside from these differences, the chronically homeless population has remained consistent over the last four years. The population is majority Black, male, and without minor children. The population typically has had income (65.9 percent) and insurance (59.6 percent) at some point while experiencing homelessness. Table 1 (attached to this report as **Appendix 2**) lists numerous demographic variables for the chronic homeless population from 2016 through 2019.

The chronic population is also comparable to the general homeless population. Both populations are disproportionately Black and male when compared to Durham county. The chronic population is more male than the general homeless population (70 percent to 60 percent in 2019), skews older, and has a greater proportion of individuals who have a disability (72 percent to 61 percent in 2019). The chronic population has a slightly higher uninsured rate compared to the general homeless population (40 percent to 36 percent in 2019).

Durham PSH Providers

The landscape of PSH provision in Durham is varied. There are 5 single-site programs and 4 scattered-site programs for a total of 332 available PSH units. Two providers (HUD-VASH and Volunteers of America) provide PSH for the veteran chronic population, while the other seven providers offer PSH to the wider chronically homeless population. A brief summary of PSH program providers in Durham can be found in **Appendix 5**.

Caseloads in the Durham CoC are typically higher than the interviewed best practice programs. Durham PSH providers have caseloads in the range of 25 to 40 per case manager, while the programs interviewed had caseloads in the range of 10 to 25 clients per case manager. It is likely that smaller caseloads can facilitate stronger rapport-building between case managers and clients to address potential challenges.

Lessons from the Broader CoC Landscape

In the summer of 2019, Heidi Coleman, an intern for the Community Development Department conducted a qualitative study of Durham CoC service providers, former clients, and support organizations. While not specific to PSH, the findings provide insight into the landscape of service provision for Durham's homeless population. Broadly, those interviewed brought forth concerns with case management, housing barriers, and Housing First principles. Along with these four concerns, the study outlined a few trends of note.

The study first found confusion around Housing First principles. Agencies were concerned with how best to implement programs via the Housing First model. They would often then press on without strict adherence to them. Coleman notes that addressing this issue primarily relies on intervention with agency leadership, as they are the most capable of modifying programs. Moreover, having leadership that fully embrace Housing First principles normalizes this behavior for new hires.

The study also noted a need for consistent, communicative case management. Coleman found that agencies varied in the frequency and content of case management services – in some agencies, case management was based on "being available" and making referrals where other agencies made, utilized, and implemented a detailed care plan. Moreover, the study noted a need for a "home" for case management oversight. Clients with multiple case managers would need to communicate needed information to a bevy of different people. This may be difficult for certain clients, and having a more centralized communication system for case managers could help address this issue.

PSH-Specific Insights

Durham PSH providers face many of the same challenges as the best practice programs. Substance use and untreated mental health issues can pose behavioral concerns that challenge the housing stability of some residents. Staff from CASA and Housing for New Hope also mention that, in addition to drug sale and use, unauthorized visitors have been a predominant factor in negative exits. Moreover, difficulties with acquiring or increasing income can lead to problems with rent payment, which poses a serious concern for moving-on.

Move-on efforts in Durham are often client-based but rarely pursued. Five of the nine PSH providers have no formal move-on strategy. For the other four providers, potential move-on clients were targeted if they were already paying a large portion of their rent, or if they had been successfully participating in services for an extended period. Aforementioned challenges with income as well as a dearth of affordable housing in the Durham area were often cited as the most common challenges to move-on.

Housing for New Hope – a provider with both single-site and scattered-site PSH – offered insight into the unique move-on challenges of the different PSH housing models. Staff may be more hesitant to engage in move-on with single-site clients because the leasing

structure for these clients would require them to physically move to complete move-on. This move is not the case with scattered-site clients. They could stay in the same physical location while "graduating" from PSH services.

Predictors of Enrollment and Negative Exits in PSH

It is important to understand which characteristics may be effective predictors of both enrollment into PSH and successful move-on from the program. Using regression analysis reveals which characteristics may be able to predict a certain outcome of interest. The evaluation investigated two primary questions: which characteristics predict enrollment into PSH programs and which characteristics predict exits out of PSH into homelessness (what is typically called a negative exit). The complete results of this regression analysis are included in **Appendix 3** and **Appendix 4**, respectively. More detail about the methodology is described in **Appendix 1**.

Correlation vs. Causation

When analyzing regression statistics, it is important to understand what the numbers mean and what they do *not* mean.

When we say that certain characteristics contribute to enrollment into PSH or a negative exit out of PSH, we are not saying that these characteristics cause these situations. Indeed, the way we have collected this data prevents us from saying such a thing with any sort of confidence.

What we *can* say is that these factors are associated in some meaningful way with our outcome of interest (enrollments or exits). This should prompt stakeholders to think about *why* these associations exist in the data. Doing so could enable programs to improve programming in a more intentional manner.

What Predicts Enrollment in PSH?

The regression output indicates several characteristics which may contribute to enrollment in PSH programs. Veteran status, history of substance use, history of developmental disability, and history of chronic health disability all have a small positive effect toward enrollment in PSH. A small positive effect means that individuals with these characteristics are more likely to be enrolled in PSH. The positive association of veteran status with PSH enrollment likely reflects the fact that some PSH programs specifically target veterans (such as the HUD-VASH program, the VOA program, and the CASA program).

Positive effects of disability diagnoses into PSH enrollment reflect the documented disability requirement of PSH programs. However, it is worth noting that mental health and physical disability diagnoses are not positively associated with enrollment. It is unclear why these two disability classifications do not have positive effects on PSH enrollment while the other disability classifications do. It is possible that individuals experiencing mental health disabilities have more interrupted contact with program providers, which could act as a barrier to PSH enrollment. Physical access issues (such as units not easily accessible by wheelchair) could be a potential barrier for individuals experiencing physical disabilities, which could potentially explain the discrepancy of that variable and other disability classifications.

The effects of insurance on PSH enrollment are curious. Having insurance of any kind has a small positive effect on PSH enrollment. Having Medicaid also has a small positive effect on PSH enrollment, though not at the same level of statistical significance (in

other words, it is possible that this positive effect is happening purely by chance). However, Medicare enrollment has a small negative effect on PSH enrollment. In other words, having insurance increases one's odds of enrolling in PSH, unless that insurance is Medicare – in which case the odds of enrolling in PSH are decreased. It is important to note that the regression is controlling for age and income, among other characteristics. Therefore, these associated characteristics of Medicare enrollees – that the fact they are older with income could make them less likely to be enrolled in PSH – are not contributing to the negative effect measured by the Medicare characteristic.

It is therefore unclear what the reason is for the discrepancy between Medicare and other general insurance. One possibility is that insurance enrollment is a proxy for health care use. Those that utilize health care services may be more likely to have a formally documented disability, easing application burden and thus streamlining enrollment into PSH. Since those with Medicare are automatically enrolled, there may be less drive to access health care services compared to an individual who enrolled in a different health insurance. This would describe the discrepancy, but it does not explain the negative association. Further research is necessary to parse out the reason behind this negative association.

What Predicts Exits into Homelessness?

Sample size concerns limit insights to be gleaned from the analysis for exits into homelessness. The same set of characteristics were analyzed on three different populations: the entire population of PSH enrollees since 2014, scattered-site PSH enrollees, and single-site PSH enrollees. Unfortunately, the sample sizes of these populations were quite small. This means that the analysis was only able to show those characteristics with large effects. The model would be unable to discern if any smaller effects of these characteristics were happening due to the actual effect of the characteristic or by random happenstance.

Despite sample size concerns, the analysis of the PSH population validates challenges revealed in the best practices portion of this report. History of substance use and justice involvement are both predictors of negative exits into homelessness. This finding matches the experiences program providers have shared: substance use can intertwine itself with behavioral issues that make it a challenge to stay stably housed. Moreover, the often-cyclical nature of involvement with the criminal justice system can further threaten housing stability and lead to negative exits.

The number of HMIS entries in an outreach program seem to be the strongest preventative factor against negative exits. The characteristic has a large effect against negative exits, and this association is found across all three population models (though for the single-site population it is more possible that this could be happening by chance). It is the only characteristic with such attributes.

In this context, outreach entries could be an effective proxy for contact and relationship building between an individual and the CoC service provision system. In other words, the outreach entries characteristic may be capturing rapport-building and client-program relationships that best practices programs found integral to success. They may also be capturing another similar effect: clients having a network of agency staff to help if a housing situation destabilizes. Moreover, this variable implies that rapport-building efforts can be effective even before a client is enrolled in a PSH program, as outreach staff and PSH staff are often different people.

Ultimately, the analysis of negative exits validate the best practices findings within a Durham context. They also empower program providers to conduct informed service work. Clients with a history of substance use or criminal justice involvement require more diligent efforts in order to avoid negative exits. Employing best practice approaches such as graduated consequences and transparent communication may help address these concerns.

Main Takeaways – Durham Homeless Population

- The chronic population of Durham is disproportionately Black, male, and without minor children.
- Compared to the general homeless population, the chronic population has a higher percentage of males, skews older, and has a greater proportion of individuals who have a disability.
- Over time, the age distribution of the chronic population has flattened, and program enrollment percentages among the chronic population has favored Rapid Rehousing over PSH.
- Durham PSH providers are varied, and face many of the same challenges as the best practice programs.
- Only 4 of the 9 PSH providers have a formal move-on strategy. When move-on does happen, it is typically client-based.
- Some disability histories are predictors for PSH enrollment whereas others, such as mental health and physical disabilities, are not. Addressing these discrepancies may facilitate more streamlined enrollment.
- Substance use and justice involvement are predictors for negative exits. Outreach efforts – a potential proxy for institutional connection – seems to be a preventative factor for negative exits. These findings validate best practice challenges in the Durham context.

Forecasting PSH Supply and Demand

From an evaluative standpoint, it is necessary to understand how current PSH practices impact the future trajectory of PSH. Understanding what the need is for PSH in the next six years would provide insight into how effective the current practices are in terms of effective service provision. Moreover, by utilizing a future-oriented framework, best practices can then be evaluated themselves by their capacity to improve the future landscape of PSH provision.

The best assessment of the future of Durham PSH supply and demand is to look at the past. For the purposes of this exercise, this report will be examining the last six years of PSH provision in the Durham CoC, which resembles the totality of quality data in the HMIS system. These assumptions will form the basis for forecasting the next six years of PSH provision in Durham CoC.

The CoC's ability to meet need for PSH services relies on the following three factors:

- Percentage of PSH clients that experience permanent, positive exits
- Number of days a client spends in a PSH program
- Number of PSH units

Increasing the percentage of clients who are positively exited, shortening the time to positive exit, and increasing the number of PSH units are interrelated mechanisms by which the CoC can increase service capacity to meet the demand for PSH services. Moreover, improving one component is likely less effective or feasible as improving all holistically. For example, a positive exit percentage of 100 percent is remarkable, but ineffective at addressing widespread homelessness if it takes decades to exit a client or if there is only 5 units available. While this example is extreme, it hopefully underscores the need for holistic improvement.

Looking at Past PSH Efforts to Calculate Capacity

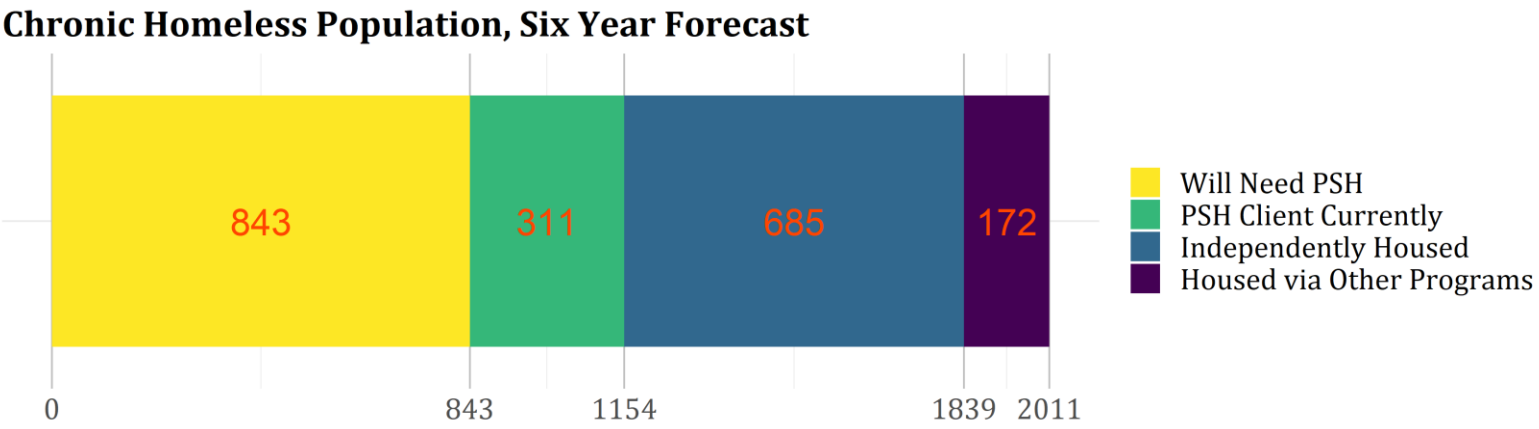
In the last six years in the Durham CoC, there were 1700 unique individuals experiencing chronic homelessness. Out of that population, 516 individuals enrolled in PSH programs. During that same time, PSH programs exited 105 individuals to permanent, positive housing situations. This means the Durham CoC had a 20.3 percent permanent exit rate for PSH over the last six years. If we include only those programs that are still active, the CoC-wide permanent exit rate lowers to 16.3 percent (79 individuals were exited out of 484 enrollees).

We take the total number of days clients spent in PSH programs and divide that by the number of individuals who permanently exited out of PSH to create an effective move-on rate. This rate describes the number of days per permanent exit for the CoC, while accounting for units not exited and units with negative exits. In other words, it is the total amount of housing time the CoC can expect for a PSH program to permanently exit 1 individual. Such a rate allows the CoC to effectively calculate the amount of PSH needed to meet demand: taking the effective move-on rate of PSH and multiplying it by the amount of individuals who will need PSH to exit chronic homelessness will reveal the amount of units PSH services will need to provide over a specific time period.

Using HMIS data from the past six years to calculate this rate, the Durham CoC has an effective move-on rate of 4371.7 days, or about 11.9 years. If we include only those programs that are still active, the effective move-on rate rises to 5612.2 days, or about 15.3 years. Again, this is different from a single individual's average length of stay in a PSH unit. It is also incorporating the length of stays for those who have not yet exited PSH or have exited PSH and then return to homelessness. Improving a positive exit rate or reducing the amount of time for a permanent, positive exit will lower the effective move-on rate.

Forecasting Future PSH Need

If the last six years predict the next six years accurately, there will be approximately 1700 people who experience chronic homelessness in the Durham CoC in the next six years. Out of that population, 685 will house themselves independently. This number is constituted by examining how many individuals in the last six years exited out of HMIS programs into certain housing situations* and did not return into HMIS. Separately from this number, 172 will be permanently housed through other programs (e.g. Rapid Rehousing). Given that 311 individuals are currently enrolled in PSH programs, there is a total of **1154 individuals** who are predicted to require PSH housing to permanently exit homelessness.



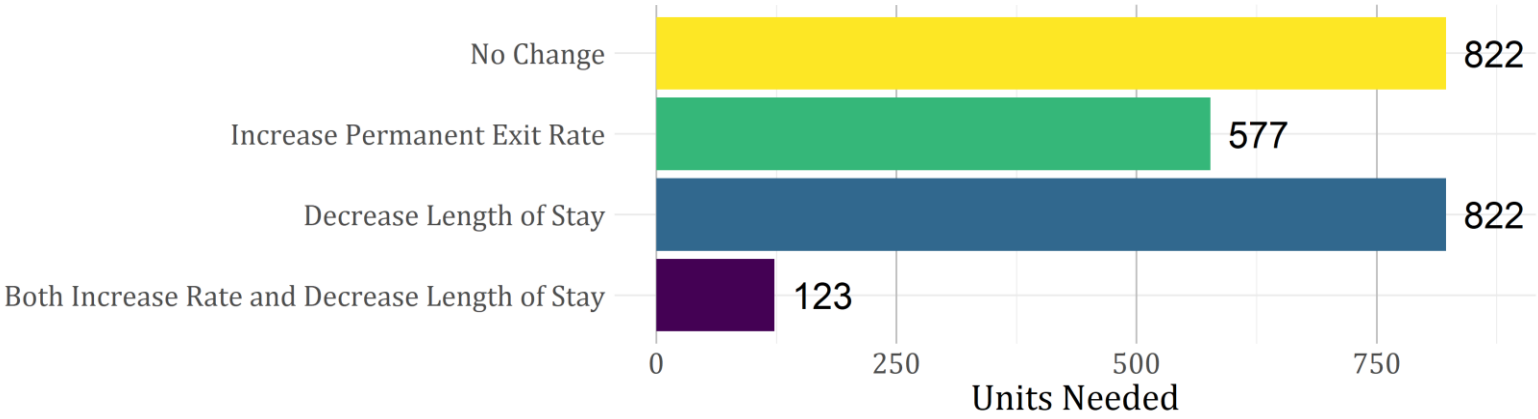
At the current effective move-on rate (4371.7 days), the Durham CoC will be unable to permanently exit all of the individuals who will experience chronic homelessness within six years. Thus, to address chronic homelessness, the Durham CoC will need to expand PSH from 332 units to 1154 units – an increase of almost 350 percent. Should the CoC increase its permanent exit rate to 53 percent (which would place Durham's exit rate to top 50 in the nation), it will have an effective move-on rate of 1725 days per permanent housing exit. This move-on rate would result in a need of 909 units – or 577 additional units – of affordable housing.

In addition to improving permanent exit rates, PSH programs could improve average length of stay to expand capacity. Remember that when the ForKids program implemented formalized move-on conversations from enrollment, they cut the length of time for

* Any housing situation that did not include Hospital, Jail/Detention Facility, Substance Use Treatment Center, Transitional Housing, or Place Not Meant for Human Habitation were included.

permanent exits in half. Currently, the Durham CoC has an average length of stay of 916 days per client. A length of stay reduction comparable to ForKids by itself would not effectively reduce the need for expanded PSH units. However, a length of stay reduction enhances the benefits of an increase in the permanent exit rate. For example, if the Durham CoC implemented the same length of stay reduction as ForKids *and* raised its permanent exit rate to 53 percent, then the CoC would only need 123 additional units to meet demand (as opposed to an increase of 822 or 577 units). In other words, increasing the permanent exit rate both improves PSH capacity outright and enables other best practices to be effective capacity builders as well.

Additional PSH Units Required to Meet Need



Limitations of the Analysis

While this analysis uses past HMIS data to predict future need, there are some limitations to the analysis that need to be noted. Of note is the fact that this analysis assumes no change in the capacity or efficiency of *other* housing programs. Improvement in other programs would ease demand for PSH and thus require fewer units to meet need. For example, it could be fair to assume that policies which improve PSH programs may also improve Rapid Rehousing programs. If Rapid Rehousing programs can permanently house more individuals, then there will be fewer individuals that require PSH to permanently exit homelessness. Of course, the converse is also true: should other housing programs permanently house fewer chronic individuals (either through implementation or by expressly focusing on non-chronic individuals), then there will be a greater number of individuals that require PSH to permanently exit homelessness.

This forecast does not aim to be a rigorous quantitative analysis. Instead, it hopes to promote a frame of thinking that coordinating groups such as the Homeless Services Advisory Committee can employ to think more broadly about homeless service strategy. It remains yet to be seen exactly how many individuals will experience chronic homelessness over the next six years. However, the interplay of length of stay, permanent exit rate, and number of units remains fundamental to understanding the capacity of PSH service provision.

Main Takeaways – Forecasting PSH Supply and Demand

- Over the next six years, the Durham CoC will see 1700 people experience chronic homelessness. 1154 of those people will require PSH to permanently exit out of homelessness.
- As things stand now, the Durham CoC will be unable to meet the PSH need for the 1154 individuals.
- Current move-on rates and lengths of stay would require Durham CoC to expand its PSH capacity by almost 350 percent.
- Increasing the rate of permanent positive exits is the most impactful means of increasing PSH capacity.
- Improving the permanent exit rate enables other best practices to be effective capacity builders.

Appendix 1 – Data Analysis Guide

This section outlines the procedure for analyzing HMIS data for the PSH evaluation. All data examined chronically homeless individuals or subsets of that population. Note that "Chronic homeless" in this context only includes an HMIS case where an individual reported being homeless for 12 months or longer at entry, or if they had an unhoused HMIS case longer than 365 days. The analysis was divided into Demographics, Predictors, PSH Population Analysis, and Supply and Demand analysis.

Demographics

Step one of the data analysis – what this report called the "Demographics" portion – aimed to examine the yearly demographic characteristics of the chronic homeless population in Durham to find potential trends. To understand the chronic homeless landscape, we calculated population percentages of the following variables from the years 2016 to present:

- Percentage of the overall HMIS population that was chronically homeless*
- Age, divided into bins
- Race/Ethnicity
- Gender
- Veteran status
- Program Type (e.g. PSH, Rapid Rehousing, Shelter, Outreach)*
- Justice Involvement
- Ever had income
- Health Insurance type (None, Medicaid, Medicare, Private)
- Disability status and type
- Does an individual have a minor child in the household?

Coordinated Entry, first established in the 2019 data, captured a more accurate picture of the Durham homeless population. However, because this data was not incorporated until the final year of analysis (and would thus unfairly skew certain data), percentages from the starred variables did not include Coordinated Entry cases to maintain consistency from year to year. The "year" time frame for this portion in a 12-month period starting in February (e.g. Feb 2016-Feb 2017, Feb 2017-Feb 2018, etc.).

Predictors

Step two of the analysis aimed to build a model of predictors to determine which characteristics predict enrollment into PSH. The population of examination for this section was the same as the previous section: chronically homeless individuals from the past 4 years. With a power of .8 and an n of 2365, our model was powerful enough to measure a t test effect size of .08 and an f test effect size of .009, or "small effect" sizes. The regression model is as follows:

$$Program\_PSH = B1*predictors\_vector + B2*controls\_vector + E$$

Program_PSH is an indicator variable where 1 means that a client has been enrolled in PSH. The predictors vector is a set of variables that include the list of demographic variables, as well as the number of shelter entries and outreach entries into HMIS for a

client. The controls vector is a set of variables that include overall time in HMIS and indicator variables based on the case year.

Substantive knowledge primarily drives the selection of predictor variables. A correlation matrix and f test comparisons for single regressors validates their explanatory power in the model and checks for any potential collinearity problems. Case year variables were included to account for any year-to-year noise that could affect the variables (e.g. an economic recession or systemic-wide change in CoC procedure).

PSH Population Analysis

This component aimed to examine case exits by different provider programs and program type. We calculated the percentage of permanent, positive exits and the percentage of negative exits (i.e. return to homelessness) for each provider program. We further calculated these percentages for Durham-wide scattered-site PSH programs and single-site PSH programs.

We also looked at what characteristics may predict a negative exit from that program. This will allow CDD to assist service programs so that they may alleviate any potential challenges revealed in the predictive model. The regression model looks the same as in the enrollment analysis, except the outcome of interest in this case is an indicator variable where 1 means that a client has returned to homelessness after being enrolled in a PSH program.

Lastly, this portion investigated length of stay (days of HMIS case) by positive exits, negative exits, and individuals who have not yet exited the system. We then attempted to examine time-based trends with this information to understand how length of stay has adjusted over the years. The findings of this information served as the basis for analysis in the stock vs. need section.

Stock vs. Need

This component examined the flow of PSH eligible and enrolled populations in the Durham area. Utilizing length of stay estimates from the previous section, we will develop a base level of “person-days” for a positive exit. It is important to note here that a “positive exit” for this portion of the analysis means a case exited out of homeless permanently.

We then determined the amount of people who experienced unhoused chronic homeless in a year. That forms the base of the PSH need. From this base, we then must find the proportion those individuals who would be best served by PSH (as opposed to another housing option). We then multiply that by our base “unit-days” factor will get a grand total of PSH “unit-days” that would address need. Comparing this need to the stock of PSH housing available will give an inclination of how much the PSH stock needs to be expanded.

Appendix 2 – Demographics Table of Durham Chronic Homeless Population

		2016	2017	2018	2019
	n	589	565	612	701
Program Enrollment, including CE (%)	*Other*	4 (0.7)	6 (1.1)	15 (2.5)	90 (12.8)
	Outreach	3 (0.5)	5 (0.9)	26 (4.2)	40 (5.7)
	PSH	245 (41.6)	273 (48.3)	234 (38.2)	282 (40.2)
	RRH	34 (5.8)	64 (11.3)	111 (18.1)	94 (13.4)
	TH	7 (1.2)	7 (1.2)	6 (1.0)	8 (1.1)
	Shelter	296 (50.3)	210 (37.2)	220 (35.9)	187 (26.7)
Race (%)	*Other*	0 (0.0)	1 (0.2)	1 (0.2)	1 (0.1)
	AIAN	4 (0.7)	3 (0.5)	7 (1.1)	11 (1.6)
	Asian	2 (0.3)	1 (0.2)	1 (0.2)	1 (0.1)
	Black	436 (74.0)	433 (76.6)	468 (76.5)	530 (75.6)
	HawaiianPI	1 (0.2)	1 (0.2)	1 (0.2)	1 (0.1)
	White	131 (22.2)	118 (20.9)	124 (20.3)	141 (20.1)
	Hispanic	15 (2.5)	8 (1.4)	10 (1.6)	16 (2.3)
Gender (%)	*Other*	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)
	Female	165 (28.0)	176 (31.2)	195 (31.9)	216 (30.8)
	Male	424 (72.0)	389 (68.8)	417 (68.1)	484 (69.0)
Age at Entry (%)	*18-24*	40 (6.8)	38 (6.7)	52 (8.5)	49 (7.0)

	25-34	85 (14.4)	72 (12.7)	87 (14.2)	108 (15.4)
	35-44	120 (20.4)	105 (18.6)	114 (18.6)	121 (17.3)
	45-54	178 (30.2)	172 (30.4)	177 (28.9)	197 (28.1)
	55-64	148 (25.1)	163 (28.8)	156 (25.5)	190 (27.1)
	65+	18 (3.1)	15 (2.7)	26 (4.2)	36 (5.1)
Insurance Type (%)	*Not Insured*	267 (47.8)	218 (39.4)	246 (40.6)	257 (37.2)
	Insured	80 (14.3)	111 (20.0)	101 (16.7)	131 (19.0)
	Medicaid Only	133 (23.8)	157 (28.3)	183 (30.2)	210 (30.4)
	Medicare Only	33 (5.9)	26 (4.7)	23 (3.8)	26 (3.8)
	Both Medicaid and Medicare	46 (8.2)	42 (7.6)	53 (8.7)	67 (9.7)
Type of Exit - PSH (%)	*Other*	458 (77.8)	451 (79.8)	559 (91.3)	677 (96.6)
	Permanent Positive	63 (10.7)	53 (9.4)	18 (2.9)	6 (0.9)
	Temporary Positive	9 (1.5)	8 (1.4)	4 (0.7)	3 (0.4)
	Negative	59 (10.0)	53 (9.4)	31 (5.1)	15 (2.1)
Type of Exit - RRH (%)	*Other*	555 (94.2)	501 (88.7)	501 (81.9)	635 (90.6)
	Permanent Positive	15 (2.5)	42 (7.4)	82 (13.4)	54 (7.7)
	Temporary Positive	8 (1.4)	13 (2.3)	11 (1.8)	1 (0.1)
	Negative	11 (1.9)	9 (1.6)	18 (2.9)	11 (1.6)
Outreach Entries (mean (SD))		0.02 (0.15)	0.04 (0.20)	0.09 (0.29)	0.13 (0.35)

Shelter Entries (mean (SD))		3.22 (5.13)	2.77 (4.99)	2.74 (4.77)	2.35 (4.03)
Veteran Status (%)	*Not a Veteran*	410 (69.6)	380 (67.5)	445 (73.3)	504 (73.5)
	Veteran	179 (30.4)	183 (32.5)	162 (26.7)	182 (26.5)
Justice Involvement (%)	*No Justice Involvement*	547 (92.9)	536 (94.9)	574 (93.8)	675 (96.3)
	Justice Involved	42 (7.1)	29 (5.1)	38 (6.2)	26 (3.7)
Ever Had a Disability - Any (%)	*No*	167 (30.4)	163 (30.4)	169 (28.6)	189 (28.2)
	Yes	383 (69.6)	374 (69.6)	421 (71.4)	481 (71.8)
Ever Had Disability - Mental Health (%)	*No*	323 (57.6)	302 (55.0)	306 (50.7)	356 (52.0)
	Yes	238 (42.4)	247 (45.0)	298 (49.3)	329 (48.0)
Ever Had Disability - Substance Use (%)	*No*	425 (75.9)	410 (75.1)	473 (78.3)	537 (78.5)
	Yes	135 (24.1)	136 (24.9)	131 (21.7)	147 (21.5)
Ever Had Disability - Developmental (%)	*No*	544 (96.5)	532 (96.4)	587 (96.4)	658 (95.2)
	Yes	20 (3.5)	20 (3.6)	22 (3.6)	33 (4.8)
Ever Had Disability - Chronic Disability (%)	*No*	480 (85.0)	472 (85.4)	499 (81.9)	539 (78.1)
	Yes	85 (15.0)	81 (14.6)	110 (18.1)	151 (21.9)
Ever Had Disability - Physical Disability (%)	*No*	351 (63.2)	333 (60.9)	360 (60.3)	413 (60.7)
	Yes	204 (36.8)	214 (39.1)	237 (39.7)	267 (39.3)

Does Client Have a Minor Child (%)	*No*	524 (89.0)	478 (84.6)	513 (83.8)	594 (84.7)
	Yes	65 (11.0)	87 (15.4)	99 (16.2)	107 (15.3)
Has Client Ever Had Income (%)	*No*	212 (36.4)	170 (30.2)	169 (27.8)	197 (28.2)
	Yes	370 (63.6)	392 (69.8)	438 (72.2)	501 (71.8)

Appendix 3 - PSH Enrollment Regression

Predictors for Enrollment into PSH

	No Fixed Effects	With Fixed Effects
	(1)	(2)
Dummy.Race.Black	0.039*	0.039**
	(0.022)	(0.016)
Client.Age.at.Entry	0.002***	0.001
	(0.001)	(0.001)
Dummy.Ethnicity.Hispanic	0.052	0.103**
	(0.065)	(0.048)
Dummy.Gender.Female	0.030	0.020
	(0.023)	(0.017)
Dummy.Veteran	0.367***	0.100***
	(0.027)	(0.021)
Dummy.Single.Household	-0.484***	-0.131***
	(0.058)	(0.044)
Dummy.Ever.Justice.Involvement	-0.061	-0.037
	(0.041)	(0.030)
Dummy.Income.Ever	0.117***	0.019
	(0.022)	(0.017)
Dummy.Insured.Ever	-0.074**	0.062***
	(0.029)	(0.022)
Dummy.Insured.Ever.Medicaid	0.186***	0.044**
	(0.029)	(0.022)
Dummy.Insured.Ever.Medicare	-0.095***	-0.090***

	(0.031)	(0.023)
Dummy.Child.In.Household	-0.385***	-0.152***
	(0.064)	(0.047)
Dummy.Disability.Ever.MH	0.038*	0.017
	(0.021)	(0.015)
Dummy.Disability.Ever.SA	0.161***	0.060***
	(0.023)	(0.017)
Dummy.Disability.Ever.Developmental	0.191***	0.161***
	(0.048)	(0.035)
Dummy.Disability.Ever.Chronic	-0.037	0.062***
	(0.025)	(0.019)
Dummy.Disability.Ever.Physical	0.049**	0.023
	(0.022)	(0.016)
Shelter.HMIS.Entries	-0.019***	-0.006***
	(0.002)	(0.002)
Outreach.HMIS.Entries	-0.040	0.066**
	(0.035)	(0.026)
Days.In.HMIS		0.0004***
		(0.00001)
Dummy.2019		-0.027
		(0.017)
Dummy.2018		-0.011
		(0.016)
Dummy.2017		0.121***
		(0.019)
Constant	0.015	-0.075**

	(0.046)	(0.035)
Observations	2,072	2,072
R^2	0.275	0.607
Adjusted R^2	0.269	0.602
Residual Std. Error	0.415 (df = 2052)	0.306 (df = 2048)
F Statistic	41.050*** (df = 19; 2052)	137.381*** (df = 23; 2048)

Note: Parentheticals are Standard Errors

*p<0.1;**p<0.05;***p<0.01

Appendix 4 – Negative Exit Regression

PSH Predictors for Exits into Homelessness

	PSH Population	Scattered-Site Population	Single-Site Population
	(1)	(2)	(3)
Dummy.Race.Black	0.004	0.001	0.003
	(0.047)	(0.056)	(0.096)
Time.In.HMIS	-0.0001**	-0.0001	-0.00004
	(0.00003)	(0.00003)	(0.0001)
Client.Age.at.Entry	-0.001	-0.0003	-0.004
	(0.002)	(0.002)	(0.004)
Dummy.Ethnicity.Hispanic	0.068	0.054	0.112
	(0.156)	(0.170)	(0.475)
Dummy.Gender.Female	-0.049	-0.025	-0.096
	(0.046)	(0.057)	(0.085)
Dummy.Veteran	0.044	0.033	0.079
	(0.054)	(0.066)	(0.119)
Dummy.Single.Household	0.165*	0.187*	0.028
	(0.089)	(0.096)	(0.310)
Dummy.Ever.Justice.Involvement	0.336**	0.419*	0.244
	(0.153)	(0.217)	(0.240)
Dummy.Income.Ever.Any	-0.053	-0.080	0.129
	(0.050)	(0.057)	(0.128)
Dummy.Insured.Ever	-0.093*	-0.076	-0.120
	(0.054)	(0.061)	(0.152)
Dummy.Insured.Ever.Medicaid	0.054	0.032	0.036

	(0.052)	(0.071)	(0.098)
Dummy.Insured.Ever.Medicare	0.038	0.039	0.018
	(0.059)	(0.088)	(0.096)
Dummy.Child.In.Household	0.135	0.139	0.027
	(0.097)	(0.105)	(0.311)
Dummy.Disability.Ever.MH	-0.014	-0.004	-0.019
	(0.041)	(0.049)	(0.084)
Dummy.Disability.Ever.SA.	0.134***	0.120*	0.158*
	(0.046)	(0.061)	(0.080)
Dummy.Disability.Ever.Developmental	-0.036	-0.113	0.029
	(0.088)	(0.137)	(0.133)
Dummy.Disability.Ever.Chronic	-0.037	-0.040	-0.073
	(0.049)	(0.059)	(0.114)
Dummy.Disability.Ever.Physical	0.096**	0.053	0.215**
	(0.042)	(0.051)	(0.091)
Shelter.HMIS.Entries	-0.007	0.001	-0.018
	(0.007)	(0.010)	(0.013)
Outreach.HMIS.Entries	-0.275***	-0.268***	-0.326**
	(0.082)	(0.103)	(0.158)
Scattered.Site.PSH	0.003		
	(0.046)		
Constant	0.308***	0.317**	0.293
	(0.116)	(0.129)	(0.270)
Observations	423	296	127
R^2	0.093	0.094	0.147
Adjusted R^2	0.045	0.028	-0.014

Residual Std. Error	0.366 (df = 401)	0.364 (df = 275)	0.389 (df = 106)
F Statistic	1.957*** (df = 21; 401)	1.426 (df = 20; 275)	0.914 (df = 20; 106)

Note: Parentheticals are Standard Errors

*p<0.1;**p<0.05;***p<0.01

Appendix 5 – PSH Providers in Durham

Project and Agency	Scattered-Site or Single-Site	Project Description	Number Served
Alliance Health-DASH	Scattered-Site	Scattered site program administered through Alliance. It focuses on families in which the adult has a high vulnerability score and is chronically homeless by HUD definition.	34 total, of which 19 were adults
CASA	Single-Site	CASA provides property development and management for low-income and homeless people. They maintain transitional, PSH, workforce, veteran, disability, and HIV/AIDS specific housing. The organization operates in Wake, Durham, and Orange counties. All units are self-contained apartments.	Approximately 500 total in the 3 counties. Denson I and II are in Durham and are PSH for veterans. 20 CASA units are set aside for chronically homeless and 13 more are reserved through Alliance for chronically homeless
Durham Housing Authority-Goley Pointe	Single-Site	Mixed-use project owned and managed by DHA. There are 20 units, of which 12 are PSH, 2 are VASH, and the otheres are DHA discretion. Service referral is handled by a DHA case manager and Alliance primarily provides services.	12 in PSH, 2 in VASH

Durham Housing Authority- Home Again	Scattered-Site	Scattered site (choice voucher) shelter plus care program. Funded through CoC/HUD and DHA. Alliance is the provider partner.	23 persons served (12 adults, 11 children)
Housing for New Hope Andover Apts	Single-Site	PSH funded through HNH and CoC. Properties managed by HNH. Manager handles both Williams Square and Andover. Units are furnished and are restricted to single adults. Rent includes all utilities. 10 are prioritized to Targeted Assistance through NCDHHS.	22 served
Housing for New Hope- Streets To Home	Scattered-Site	Scattered site project. Program manager serves as case manager. Funded through CoC and HNH. Clients are referred to services through case manager who works with Alliance.	34 served
Housing for New Hope- Williams Square	Single-Site	PSH funded through HNH and CoC. Properties managed by HNH. Manager handles both Williams Square and Andover. Units are furnished and are restricted to single adults. Rent includes all utilities. They have 16 units prioritized to Targeted Assistance Program (NCDHHS).	24 served
HUD VASH (VA Program, Not CoC Funded)	Scattered-Site	Provides PSH vouchers (scattered-site) for veterans who are VA connected. It does not have a chronic requirement (and doesn't require a disability). The program operates effectively as a Section 8 voucher program. The VA provides the funding for the veteran but the housing comes through DHA projects or private landlords. The program is run entirely inside of the VA, with case managers and service providers being housed in the hospital and/or partner agencies. Case management is done by team and includes a peer support specialist, OT, H-PACT (doctors, nurses, etc), housing manager, and outreach coordinator.	Unknown, but they said that case management is often 30-40 clients at a time. It is not county-based though, so teams often cover multiple counties. 221 served over the last 6 years.

Endnotes

[1] Ann Denton and Gregory A. Shinn, "Housing, Landlords, and Systems," https://www.youtube.com/watch?v=A52vK1J0yec.

[2] Harder+Company Community Research, "'Moving On' from Supportive Housing Evaluation Report," June 21, 2016. Most of the secondary source research for this section comes from this report, which is one of the only formal evaluations of a traditional move-on process. While other evaluations of post-PSH housing interventions exist, many are of specific demonstrations or acute initiatives to facilitate independent living (with specific funding). Thus, the one-time nature of these initiatives mutes the applicability to routine PSH programs.

[3] The Corporation for Supportive Housing, "CSH Moving On Toolkit," June 2016, http://www.csh.org/wp-content/uploads/2016/06/Moving-On-Toolkit-Complete.pdf.