J-Bill: Unlocking the Opportunity to Establish a Permanent Funding Source for Housing for the Homeless and Victims of Domestic Violence

Why do it?

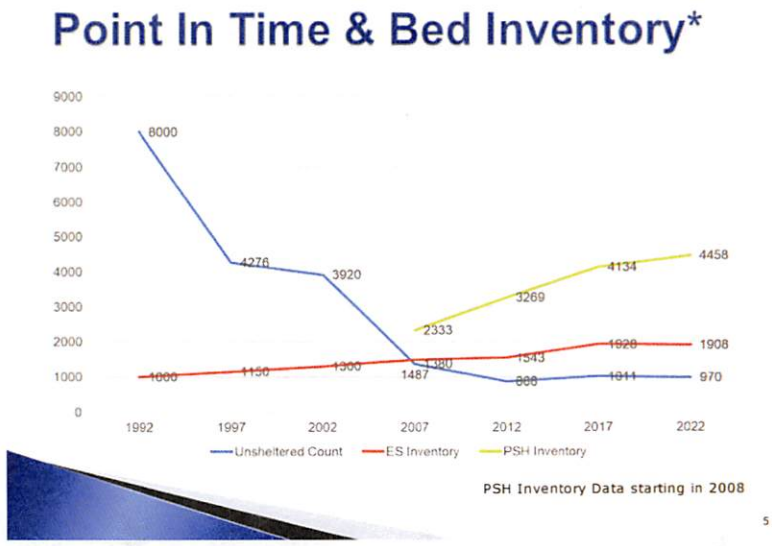
1) Public Safety
   Reduces the homeless population in Jail[1]
   Reduces the burden of police officers to police homelessness
2) Support Businesses
   Downtown businesses rate homelessness is #1 impediment to success[2]
3) Combat Affordable Housing Crisis *(Over 550 units of housing in MDC[3])*
4) Increase ability to secure federal, state, and private grants *(MDC received $36,524,000 in FY 22-23')*
5) Leverages Emergency, Transitional and Permanent Housing resources to achieve their best and highest use

What would the J Bill do?

1) Give Duval the right to impose a tax on the sale of food, beverage and alcoholic beverages in certain restaurants (1%) and and (2%) in hotels/motels on food and beverages only, to strategically fund support services, healthcare, job training and housing. Implementation would need additional legislation and a majority vote by Council[4].
2) Empower the City Council to develop specific goals and targets to ensure data-driven and performance-focused efficiency.

Results & Duval Expectations

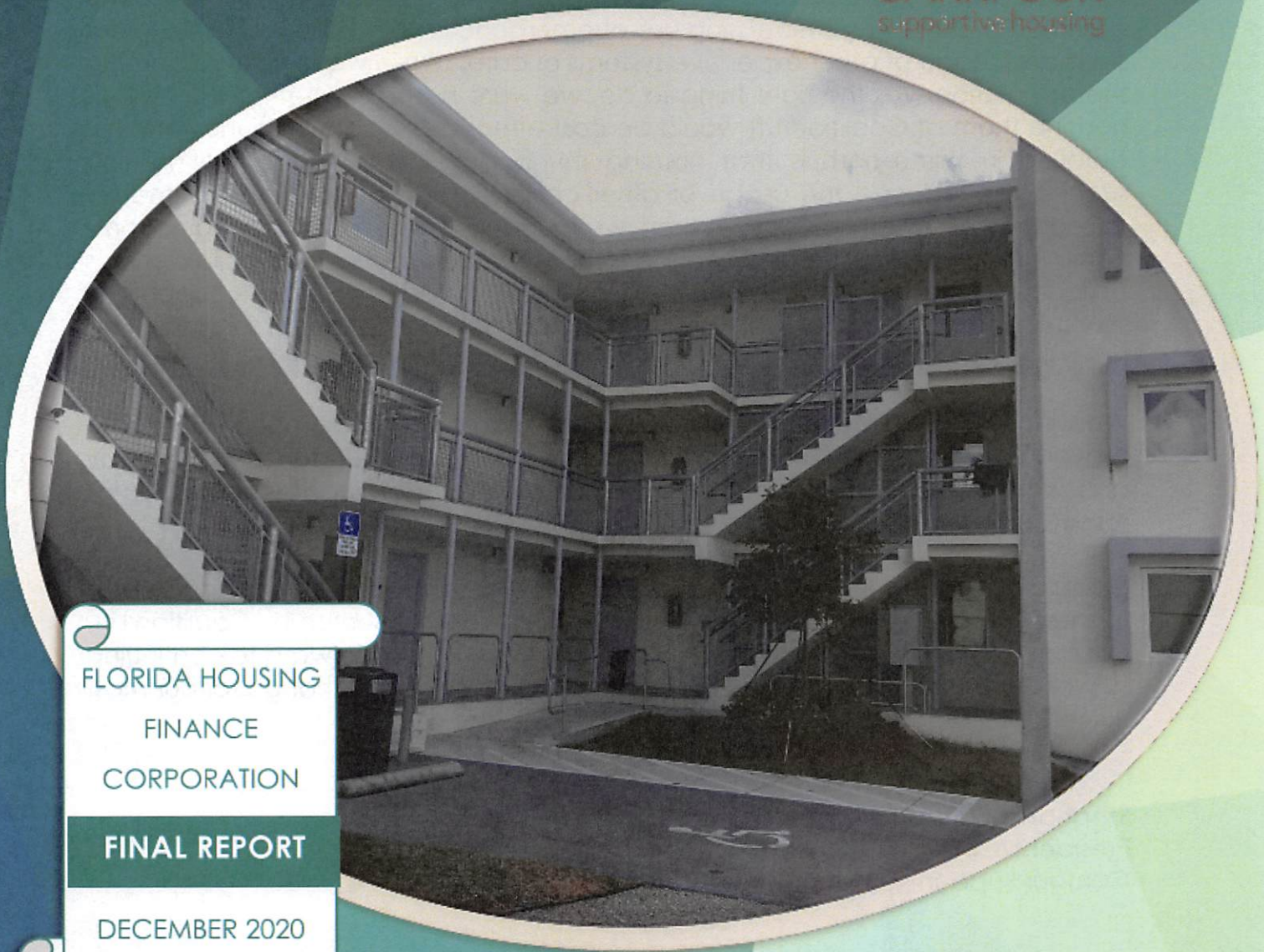
Miami-Dade implemented their assessment in 1994 with Commission action. Their unsheltered homeless population has gone from 8000 to as low as 759, currently at 980. For 2022-2023, $40MM for homelessness and domestic violence services ($9MM from hotels/ motels for tourism) is projected.



1. *Florida Housing Financial Corporation Final Report, Coalition Lift Supportive Housing Pilot Project, December 2020*
2. *2023 Downtown Vision DTJax Survey Summary*
3. *Priority Home: Miami-Dade Country Community Homeless Plan, 2023*
4. *2023 Florida Statutes, 212.0306*

COALITION LIFT SUPPORTIVE HOUSING PILOT PROJECT

CARRFOUR
supportive housing



FLORIDA HOUSING FINANCE CORPORATION

FINAL REPORT

DECEMBER 2020

Carrfour Supportive Housing

WWW.CARRFOUR.ORG

(305) 371-8300

Dear Friends, Neighbors, and Colleagues,

Our work with the most vulnerable members of our community forces us to face harsh realities that are never more than a few steps, blocks or neighborhoods away, regardless of where we live in America. The residents of Coalition Lift are mothers, fathers, sons, daughters, sisters, and brothers. They are all of us. Their personal stories -- like those of millions more surviving precariously without a stable home -- reflect the daily realities for those left behind without a safety net.

With Coalition Lift, we set out to explore whether providing affordable housing combined with intensive on-site services to our most at-risk neighbors saves the community money by decreasing use of emergency room visits, jail stays, shelter stays and usage of other expensive systems of care. While we knew that housing this population was the right thing to do, we were not sure whether the cost of housing them at Coalition Lift would be cost effective. What we found, which is detailed in this report, is that housing this population in supportive housing successfully reduced the usage of other costly systems of care and ultimately saved the community money. In short, we found that supportive housing not only significantly improves the quality of life for those served, but also saves taxpayer's dollars. We now know that providing an array of targeted on-site supportive services and stable, sustainable, affordable housing is not just better for those who have lived on the streets of our communities -- it's better for all of us.

We will never reclaim the lives lost before this integrated model of care became proven and accessible. We can, however, embrace that understanding today and work together to inform policy and decisions regarding the allocation of resources.

Coalition Lift was a true collaborative effort. We are grateful to our partners and funders for not only impacting the lives of those who were served by Coalition Lift, but also for bringing this important research to life. We look forward to continuing to work together to ensure that this research brings systemic change for our most vulnerable neighbors.

Stephanie Berman-Eisenberg
President/CEO
Carrfour Supportive Housing

PROJECT TEAM:

- **Sandra Newson**, LCSW, Vice President of Resident Services, Carrfour Supportive Housing
- **Dr. Tina Fadil**, Psy.D., LMHC, Director of Clinical Services, Carrfour Supportive Housing
- **Dr. Francisco Quintana**, Ph.D., Clinical Supervisor, Citrus Health Network
- **Matthew Hyrne**, MS, Client Service Coordinator, Carrfour Supportive Housing
- **Loreinys Perez**, MS, Client Service Coordinator, Carrfour Supportive Housing
- **Trino Morgado**, Peer Specialist, Citrus Health Network
- **Hector Hernandez**, Peer Support Specialist, Carrfour Supportive Housing
- **Olivia Baez**, Citrus SOAR Liaison, Citrus Health Network
- **Armando Miguez**, Targeted Case Manager, Citrus Health Network
- **Corin Calzado**, Nurse Case Manager, Citrus Health Network
- **Patty Longo**, Property Manager, Carrfour Supportive Housing
- **Alex Lopez**, Clinical Therapist, Citrus Health Network

RESEARCH PARTNERS:

- University of South Florida (USF) Policy & Services Research Data Center (PSRDC)
- Behavioral Science Research Institute

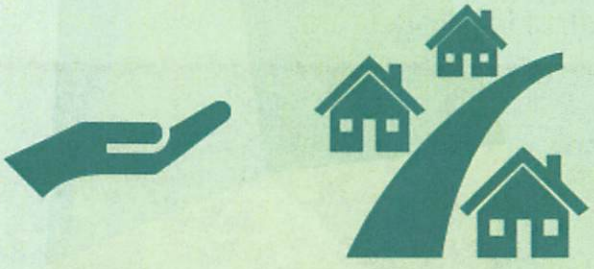
FUNDING FOR THE RESEARCH WAS SUPPORTED BY THE FOLLOWING ORGANIZATIONS:

- Florida Housing Finance Corporation
- Miami Dade County Homeless Trust
- JP Morgan Chase
- Health Foundation of South Florida
- Corporation for Supportive Housing
- Citrus Health Network

BACKGROUND

Carrfour Supportive Housing's (Carrfour) mission is to end homelessness in Miami Dade County by developing permanent supportive and affordable housing for individuals and families and is among the leading developers for supportive housing for the formerly homeless in Florida. Carrfour is different from other developers for several reasons:

- Carrfour is mission-driven
- Carrfour is client-centered
- Carrfour is a not-for-profit whose revenues are reinvested into developing new housing
- Carrfour is involved in all aspects of supportive housing -- from development to operations and delivery of supportive services



Carrfour has been deeply embedded in Miami Dade County's (MDC) efforts to end homelessness and has been an active participant in the MDC Continuum of Care (CoC) since its inception over 25 years ago. Carrfour staff serve as members of the Homeless Trust Board, CoC Subcommittee, Provider Forum, and the CoC Services and Housing Committee and are active participants in shaping the Continuum's policies, strategies, and funding initiatives. Carrfour is the CoC's provider with the largest capacity for housing with 23 programs providing Permanent Supportive Housing and Rapid Rehousing Programs for formally homeless individuals, Veterans, and families. Carrfour has been working alongside Citrus Health Network (CHN) and MDC's Homeless Trust, along with other providers to find solutions to end homelessness among the most vulnerable in our community. This shared commitment, along with the results of a 2010 study addressing the recidivists to the 11th Judicial Circuit Criminal Mental Health Project, reinforced the understanding that a comprehensive, systems-change approach was needed to break the cycle of homelessness and recidivism among those high needs/high utilizers within the chronic homeless population.

INDIVIDUALS WHO ARE CHRONICALLY HOMELESS IN MIAMI DADE COUNTY

One of Florida's most densely populated and diverse urban areas, Miami Dade County is home to **nearly 2.7 million individuals** - most of whom are ethnic minorities. According to recent estimates, **Hispanics account for 71.0% of the population, Blacks (non-Hispanic) 17.6%, and Asians (non-Hispanic) 1.5%.** Over 94 different languages are spoken, of which English, Spanish, and Haitian Creole are the most common. Approximately 52.9% of residents were born in a foreign country, and 25% of households are "linguistically isolated" - meaning all members over the age of 14 speak a non-English language and have difficulty with English. As the most densely populated county in Florida, there is also a wide income disparity, with nearly 18% of residents living at or below the poverty level.

Unlike the persons who are economically or periodically homeless, individuals who are chronically homeless (and who, by definition, suffer from serious substance abuse, mental illness, or chronic physical illness) require a much greater level of intervention and care to successfully overcome their homeless condition. When left untreated, this population exhausts scarce community resources with their need for emergency healthcare, law enforcement and judicial involvement, and other publicly funded systems of care. In addition, individuals who are chronically homeless are typically more resistant to services and more difficult to engage into treatment programs. **Over 60% of persons who are chronically homeless live with life-long mental illness and more than 80% live with lifetime chronic substance abuse problems.** Finally, the lives of persons who are chronically homeless are compromised by persistent unemployment, thus increasing their isolation, and decreasing their opportunities for social inclusion. Even when placed in housing, individuals who are chronically homeless have greater difficulty adhering to treatment regimens, integrating into society, and complying with social norms. Innovative treatment, case management, life skills training, and other supports are critical needs for this population.

THE PILOT STUDY

In response to the need for a systemic change in the way the State of Florida responds to this population, Florida Finance Housing Corporation (FHFC) issued a Request for Proposals to develop a supportive housing program with a research component for "Housing for High Needs/High Cost Individuals who are Chronically Homeless" in 2014. Carrfour was the successful applicant for this funding to develop one of three pilot sites to demonstrate the effectiveness of providing Permanent Supportive Housing (PSH) to high utilizers of crisis services experiencing housing instability. Pilot sites were in Miami Dade, Duval, and Pinellas counties. Each pilot site was identified in a community with a comprehensive and coordinated approach to identifying, assessing, prioritizing, and serving chronically homeless persons with significant needs. As the lead applicant and developer, Carrfour, was responsible for coordinating all aspects of Coalition Lift and the Coalition Lift Advisory Board.

The USF PSRDC served as the over-arching pilot evaluation partner and BSRI provided local evaluation support to the Miami site. The study sought to recruit and engage high needs/high utilizer individuals and monitor them for 2 years post housing placement, tracking comprehensive costs and client-level outcomes.

THE ADVISORY BOARD

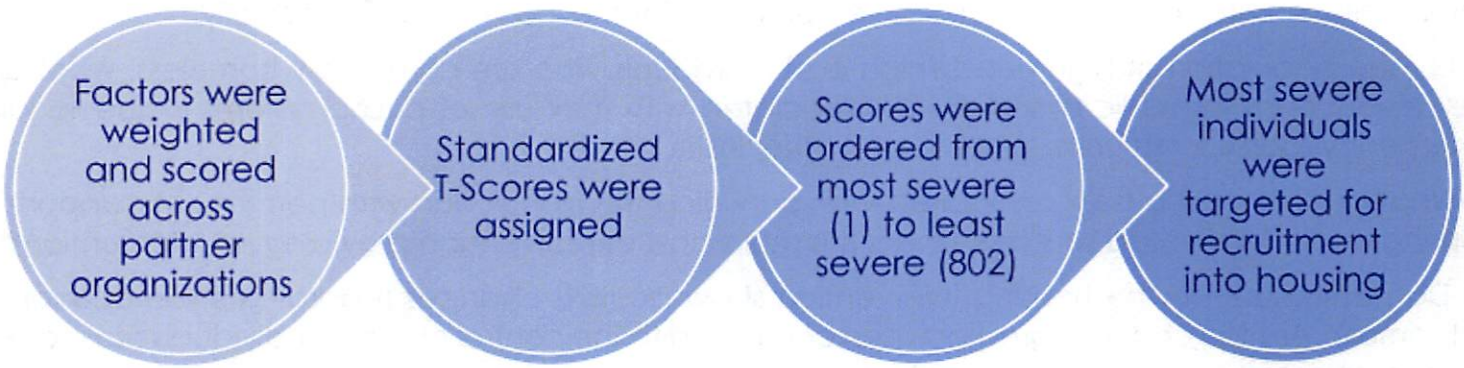
The Coalition Lift Advisory Board was involved in the development, implementation, and evaluation of this demonstration project. The Advisory Board met monthly during the project to address barriers, needs, and concerns of implementation as well as monitored the research component of the project. The Coalition Lift Advisory Board organizations included:

- Carrfour Supportive Housing (Carrfour)
- Citrus Health Network (CHN)
- Behavioral Science Research Institute (BSRI)
- University of South Florida (USF) Policy and Services Research Data Center (PSRDC)
- Miami Dade Homeless Trust (MDHT)
- Camillus Health Lazarus Specialized Outreach Team
- 11th Judicial Circuit Miami Dade County Jail Diversion Program
- Thriving Mind South Florida

THE TARGET POPULATION: MIAMI DADE COUNTY HIGH UTILIZERS (HU)

Criminal Justice Information System (CJIS)	Homeless Management Information System (HMIS)	Jackson Health System (JHS)	Florida Department of Children and Families (DCF) / Thriving Mind South Florida	Miami Dade County and City of Miami Beach Outreach Teams
•Bookings, jail stays, diversion programs	•High VI-SPDAT, homeless system stays, outreach team identification	•High emergency department and related costs	•High utilization of behavioral health services	•Individuals utilizing the Homeless System the longest (longest time street homeless)

The Miami Dade County "high utilizer population" was developed from five local sources of information: the Miam Dade County Criminal Court system, the Miami Dade Homeless Trust Continuum of Care's Homeles Management Information System (HMIS), Jackson Memorial Hospital (JMH) – which is the leading publicly funded hospital, Thriving Mind South Florida (Thriving Mind) – which is the local managing entity for the Florida Departmen of Children and Families Mental Health and Substance Abuse program, and the local Homeless Outreach team (Miami Dade County and the City of Miami Beach), that work closely with local police departments. The JMH lis was based on high rate of emergency room visits coupled with costs.



The HMIS list was a combination of those who scored highest on the VI-SPDAT[1] (measuring high health issues, leve of vulnerability), those with long length of stays in the homeless system (measuring high utilizers) and outreach/police expert lists of long-term street homeless who continued to remain on the streets. Thriving Mind and the Court systems extracted the highest utilizers for their respective programs. The Court list was based or homeless persons who had a high rate of arrests (bookings), combined with high jail costs, and involvement in ja diversion programs. The Thriving Mind list was based on high utilization of behavioral health services.

[1]VI-SPDAT: The VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Toole) is a survey administered to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk homeless persons.

Individuals from the HU list were offered housing placement as part of their participation in the Coalition Lift Pilot Study. If available, units in the Lift building were offered. Additionally, individuals could be placed in other permanent supportive housing (PSH) within the County. Some individuals passively refused housing in that they did not act or attend follow up appointments with the housing team to gather documents or meet other housing requirements. These individuals were considered homeless during the duration of the study. Key outcomes and research questions are shown below. Lift findings are indicated in the main report and comparisons are discussed in Appendix B.

KEY OUTCOMES

- Reduced annual costs in expenditures associated with their use of public systems including jails, emergency rooms, crisis units, shelters, and other institutions.
- Positive changes in avoiding homelessness and retaining permanent housing, attaining and maintain income through income or benefits, reduced criminal justice involvement, and improved social connection including contact with family and friends.
- Reduction in the use of illegal drugs or chronic alcohol abuse.
- Improvement in mental health status.
- Increased utilization of primary healthcare services outside of emergency rooms.
- Improvement in physical health status.

RESEARCH

Research questions cover two broad areas: Does the provision of permanent supported housing to "high needs/high cost" individuals who are chronically homeless result in cost savings to the community, and result in better qualitative outcomes for the individuals? Specifically:

A) For the population of high needs/high cost individuals who are chronically homeless, what are the annual costs in public expenditures associated with their use of public systems including jails, emergency rooms, crisis units, shelters, and other institutions?

B) What are the cost offsets associated with providing this population with permanent, supported housing and coordinated services, and is this more cost effective than providing no intervention?

C) Do participants in the housing intervention show positive changes regarding socio-economic outcomes? Are the changes greater when compared to the control group of individuals not placed into the permanent housing program?

D) Do participants in the housing intervention realize improved outcomes for primary and behavioral health care indicators? Are the changes greater when compared to the control group of individuals not placed into the permanent housing program?

Coalition Lift – A Housing First Model

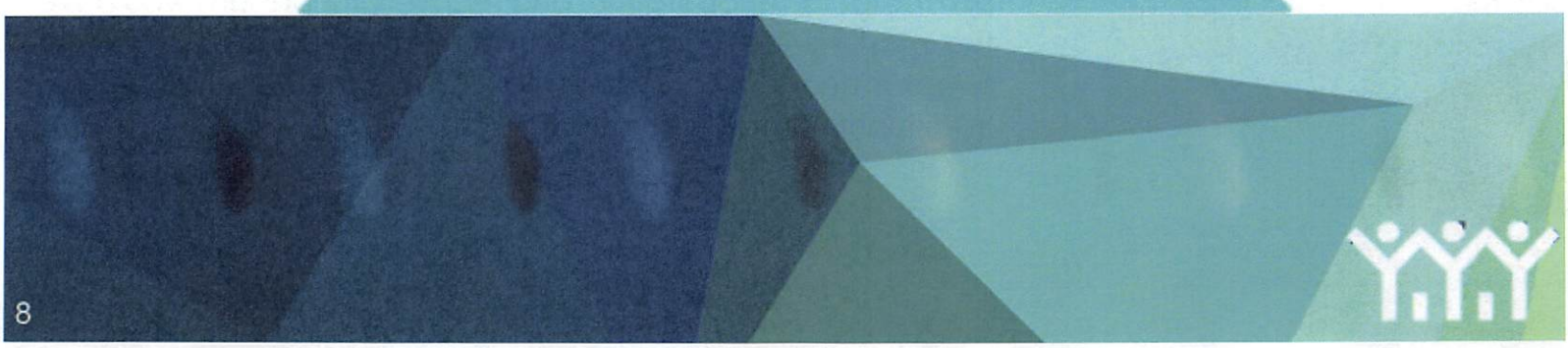
The "Housing First" philosophy is deeply rooted in the mission and vision of Carrfour and has been fully integrated into all programs. The approach is guided by the belief that people need basic necessities such as food and a place to live, before attending to other needs such as employment or primary/ behavioral health care. In other words, Housing First does not mandate participation in services once housed to obtain or retain housing.

PARTICIPANT IDENTIFICATION

The HU list was disseminated among partners to identify when an HU entered their purview or was identified on the streets through homeless outreach teams.

Once a participant was identified, the Coalition Lift Team would accompany the outreach teams to develop relationships with these individuals. This process involved many contacts, interactions, and meetings as trust was not easily developed.

The Coalition Lift Program was explained to the individual and housing was offered. Individuals interested in becoming housed were invited to the program site to see their new home, and meetings/ contacts continued until the individual was ready to be housed. This soft transition from homelessness to housing improved success immediately.



THE COALITION LIFT HOUSING EXPERIENCE

Coalition Lift is a comprehensive site-based permanent supportive housing (PSH) program utilizing evidenced-based practices through a multidisciplinary team with Carrfour and Citrus Health Network (CHN). Residents of this program have access to a wide array of community- based resources and services designed to meet the complex needs of persons who are homeless and dealing with many issues affecting their housing stability. Services focus on promoting housing stability and achieving other personal goals related to well-being and recovery.

Coalition Lift utilizes a modified "Assertive Community Treatment" (ACT), adapted from the National Program Standards for ACT Teams, written by Deborah Allness, M.S.S.W. and William Knoedler, M.D., and the Assertive Community Treatment Implementation Resource Kit, Draft 2002 from the SAMHSA's Center for Mental Health Services and the Robert Wood Johnson Foundation initiated Evidence-Based Practices website. ACT is a client-centered, recovery-oriented mental health service delivery model for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

THE IMPORTANT CHARACTERISTICS OF THE ACT PROGRAM ARE:

Services are delivered by Carrfour and Citrus Health Network as a team of multidisciplinary mental health/case management staff. Intensity of services are based on client need and a mutually agreed upon plan between the client and ACT staff.

Services are individually tailored with each client and emphasize relationship building, managing symptoms, and achieving goals towards living independently without supports.

The ACT team is on-site rather than expecting the client to come to the program. Services that are provided outside of the program offices are in locations that are comfortable and convenient for clients, such as community garden, resident's living room, walks in the neighborhood and nearby coffee shops.

ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of care.

RESIDENTS AT COALITION RECEIVE THE FOLLOWING EVIDENCE-BASED SERVICES:

Intensive Case Management: A team-based approach that helps clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing primary health and mental health needs, engaging in meaningful activities, and building social and community relations.

Motivational Interviewing (MI): A goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. SAMHSA's Homelessness Resource Center (SAMHSA HRC 2012) notes that because MI is rooted in an understanding of how hard it is to change learned behaviors, it offers addiction/homelessness providers a useful framework for interacting with people who are homeless and struggling with substance use, mental illness, and traumatic experiences.

SSI/SSDI Outreach Assessment and Recovery (SOAR): A strategy to help clients attain benefits, such as Social Security Disability benefits.

Trauma Informed Care (TIC): An evidenced based framework for addressing individuals who have experienced some form of trauma. Research shows that homelessness itself can be viewed as a traumatic experience; and being homeless increases the risk of further victimization and re-traumatization (Hopper, Bassuk, and Olivet 2010).

Additional services onsite include:

- Peer Support Services
- Nursing Case Management
- Mental Health/Outpatient Substance Abuse Services
- Employment and Training Services
- Health and Wellness/Recreation/Community Building Activities

STUDY MEASURES

Key research questions for this study included whether models such as Coalition Lift reduce costs associated with persons who homeless and high utilizers of services. In addition to costs, the study also captured data related to holistic client-level health and social outcomes including physical health, behavioral health, social support, and employment/recreational time.

These elements below were used to capture cost data:

Cost Type	Cost Source	Cost Description
Physical Health Costs		
	Medicaid[2] Ambulance Physician Other physical health Non-psychoactive medication	Medicaid managed care and fee for service encounter/claims data.
	Jackson Health System (JHS) Hospital inpatient Hospital outpatient Emergency department	Extract from Jackson Health System records for care not paid by Medicaid plus Medicaid managed care and fee for service encounter/claims data.
Mental Health Costs		
	Department of Children and Families (DCF)/Medicaid Case management Crisis services Treatment	Mental health service data from the DCF SAMHIS and FASAMS data sets.
	Medicaid Physician Antipsychotic medication Other psychoactive medication	Medicaid managed care and fee for service encounter/claims data.
	Medicaid/JHS Hospital inpatient Hospital outpatient Emergency department	Extract from Jackson Health System records for care not paid by Medicaid plus Medicaid managed care and fee for service encounter/claims data.
Substance Use Costs		
	DCF Crisis services Detoxification Recovery support	Substance use service data from the DCF SAMHIS and FASAMS data sets.
Criminal Justice		
	Criminal Justice Information Systems (CJIS) Jail stays	Cost of jail stays from the Criminal Justice Information Systems (CJIS).

[2] Medicaid claims data is obtained through the Agency for Health Care Administration (AHCA)

Housing Service Costs		
	Homeless Management Information Systems (HMIS) Shelter stays Shelter day services	Shelter stays and other services from the Homeless Information Management System (HMIS).
	Coalition Lift Costs Operations Services	Housing costs associated with operating pilot site, modified ACT team, and onsite support services.
Housing Income/Reimbursement		
	Leasing/Housing Subsidy Income Revenue via reimbursement for filled Units at Lift	Total costs of the housing subsidies for 34 units from both CoC and Section 8 vouchers.

THE COALITION LIFT MODEL: WHAT DOES IT COST?

The table on page 14 shows the total costs for Coalition Lift as well as increases in housing service and operational costs over the study period. Specifically, operational costs increased consistent with costs of living and with all 34 units filled (e.g. more maintenance). Service costs increased to reflect lessons learned about how to best operate the Coalition Lift model for these residents. Service cost increases are notable as Coalition Lift successfully housed and engaged individuals for this study at the highest rankings of the HU list. Specifically, in the study, 79.5% of residents at Lift were in the top 150 of 800 on the high utilizer list compared with 45.2% of residents at PSH being in the top 150.

The total costs for the Coalition Lift Program including operations, supportive services, and administration for the period of **January 1, 2019 until December 31, 2019, was $582,181 ($17,123 annually per 34 persons)**. The 2019 year was used because it reflects the time of highest service costs and full program capacity and is thus the best indicator of total costs for the Lift housing model.

	2017	2018	2019
Housing Operations	$115,433	$211,991	$246,438
Housing Services	$204,500	$283,000	$335,743
TOTAL HOUSING COSTS	**$319,933**	**$494,991**	**$582,181**
Housing Services mentioned above include:			
Case management	$175,000	$198,000	$267,243
Education	$200	$7,000	$1,000
Employment	$2,000	$12,000	$1,500
Food	$1,300	$12,000	$12,000
Medical services	$16,000	$25,000	$29,000
Transportation	$5,000	$16,000	$12,000
Utility	$5,000	$8,000	$6,000
Life Skills		$5,000	$2,000
Substance use services			$5,000

Total housing cost per person in 2019 is $582,181/34 = **$17,123**

An additional case manager was hired to assist in overseeing the residents and with relocating individuals who had units but forgot or did not trust the unit was theirs at first.

An additional peer support specialist was hired to provide these services 7 days a week.

Better Way of Miami began providing onsite substance use services as individuals were not attending appointments offsite even with transportation assistance.

Seminars were provided to residents based on identified needs including how to clean apartments and appliances, cooking meals, and other life skills.

For Lift sustainability considerations, the program also looked at housing subsidy revenue based on actual reimbursement rates for the 34 units from both the HUD CoC Grant through Miami Dade County Homeless Trust (26 units at $1020 /unit) and Project Based Voucher Program through Miami Dade County Public Housing and Community Development (8 units at $896/unit) which is $404,256 per year. These types of subsidies can continue to offset the cost of providing all these services to this high utilizer population.

FINDINGS

Findings below discuss Coalition Lift residents. Those in the study but housed in other PSH as well as those who remained homeless are discuss in Appendix B. Public Services cost data analysis of this initiative was done by Policy & Services Research Data Center (PSRDC) staff in the Department of Mental Health Law and Policy at the University of South Florida.

A total of 21 individuals in Lift had two (2) years of residency at the end of the study period. To establish baseline cost and utilization data, administrative data was gathered two years prior to admission into the Coalition Lift Pilot. As a comparison, this same data was also gathered and aggregated for two years following admission into the Coalition Lift Pilot.

Based on the available data, the total costs in the two years prior to admission for the 21 individuals with at least two years of residency was **$1,882,368 or $44,818** per person per year. The largest costs were related to physical health at **$1,513,335** followed by mental health at **$172,991** and jail stays at **$171,000** and shelter stays at **$23,233**. The shelter costs were relatively low because many of the participants were recruited from the streets and were not living in shelters prior to admission.

The table below is a breakdown of costs by service area two years prior and two years post move in. The biggest reduction was for physical health which was reduced by **$984,933 (65.1%).** Shelter costs dropped by **$22,352 (96.2%).** Jail costs also dropped by **$35,400 (20.7%)** and mental health cost decreased by **$115,958 (67.0%)** while substance abuse costs increased possibly due to better access to services. Overall, there is a pattern of fewer crisis services used and more case management and proactive care.

Overall savings of **$27,292 per person per year** were realized for these systems of care. Extrapolating that to the entire 34 units yields a saving of $927,925 per year to the community.

Source	Coalition Lift	21 Clients with at least 2 years of residency			
		2 Years Prior	*2 Years Post*	*Difference*	
MED	Ambulance	$ 632	$ 1,032	$ 400	63.3%
MED/JAX	Hospital Inpatient	$ 809,982	$ 178,623	$ (631,359)	-77.9%
MED/JAX	Hospital Outpatient	$ 84,373	$ 82,384	$ (1,990)	-2.4%
MED/JAX	Hospital Emergency Department	$ 394,445	$ 149,106	$ (245,340)	-62.2%
MED	Physician	$ 12,632	$ 7,066	$ (5,566)	-44.1%
MED	Other Physical Heath	$ 7,204	$ 3,143	$ (4,061)	-56.4%
MED	Non Psychoactive Medications	$ 204,066	$ 107,048	$ (97,018)	-47.5%
	Total- Physical Health	$ 1,513,335	$ 528,402	$ (984,933)	-65.1%
DCF/MED	Mental Health- Case Management	$ 226	$ 6,828	$ 6,602	2920.4%
DCF/MED	Mental Health- Crisis Services	$ 18,513	$ 724	$ (17,789)	-96.1%
DCF/MED	Mental Health- Treatment	$ 4,800	$ 23,912	$ 19,113	398.2%
MED	Physician	$ 1,436	$ 1,069	$ (367)	-25.5%
MED/JAX	Hospital Inpatient	$ 144,685	$ 10,272	$ (134,414)	-92.9%
MED/JAX	Hospital Outpatient	$ 789	$ 654	$ (135)	-17.1%
MED/JAX	Hospital Emergency Department	$ 1,877	$ 1,887	$ 10	0.5%
MED	Antipsychotic Medications	$ 172	$ 8,835	$ 8,663	5036.6%
MED	Other Psychoactive Medications	$ 493	$ 2,853	$ 2,360	478.7%
	Total Mental Health	$ 172,991	$ 57,033	$ (115,958)	-67.0%
DCF	Substance Use-Crisis Services	$ -	$ 11,830	$ 11,830	N/A
DCF	Substance Use-Detox	$ 551	$ 1,286	$ 735	133.3%
DCF	Substance Use Recovery Support	$ 1,257	$ 1,075	$ (182)	-14.5%
	Total Substance Use	$ 1,809	$ 14,191	$ 12,383	684.7%
CJIS	Jail Stays	$ 171,000	$ 135,600	$ (35,400)	-20.7%
		855 days	678 days		
	Shelter Stays	$ 10,726	$ 342	$ (10,384)	-96.8%
		414 days	14 days		
	Shelter Day Services	$ 12,507	$ 539	$ (11,968)	-95.7%
		882 days	38 days		
	Total Costs	$ 1,882,368	$ 736,108	$ (1,146,260)	-60.9%

SUMMARY

Public Services Cost Data

There were savings of $27,292 per person per year for these systems of care. Extrapolating that to the entire 34 units yields a saving of $927,925 per year to the community. The total costs for the Coalition Lift Program (housing and operations, supportive services, and administration was $582,181 annually per 34 persons).

$27,292 (Annual cost savings per person for public systems of care)

$17,123 (Annual cost per person to be housed in Coalition Lift)

$10,169 Cost savings per person per year

COALITION LIFT PARTICIPANT SURVEY DATA

In addition to comprehensive cost data, client outcomes were also collected at baseline and every 6 months thereafter, utilizing a truncated version of the SAMSHA Government and Performance Results Act "GPRA" National Outcome Measure tool [3]. Individuals completed their baseline assessment with a housing case manager within 30 days of moving into the Lift building. These individuals were then interviewed every 6 months thereafter through the remainder of the study with final interviews taking place in November-December 2019.

The following findings focus on comparisons within Lift participants while they were engaged in the study. All clients were considered homeless at baseline assessment and were housed in the Lift building at their final assessment.

LIFT PILOT STUDY PARTICIPANTS

During the study, 44 clients were living within the Coalition Lift building and housed on average 532 days. The number of days housed was calculated using the move-in date and the date of the client's final assessment. The average number of days between baseline and final assessment was 504 days. Lift included clients ages 23 to 69 years (M=51.9) and were mostly male (79.5%).

Total Housed: 44

Residents housed at one time: 34

8 Evicted, 2 Abandoned

[3] *The NOMs is the instrument mandated for all SAMHSA funded projects and measures change in a standard range of social, health, and housing related indicators.*

SURVEY FINDINGS

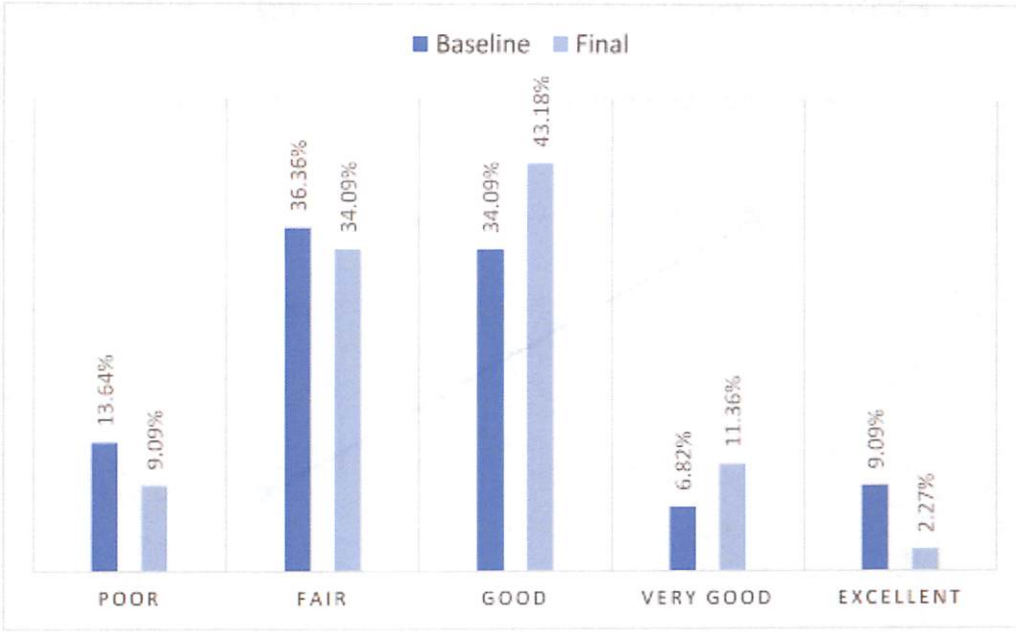
	Lift (N=44)	
	N	%
Gender		
Male	35	79.5
Female	9	20.5
Ethnicity		
Hispanic	26	59.1
Race		
Black or African American	20	47.6
Asian	-	-
White	22	50.0
	M (*SD*)	
Age	51.9	*(10.4)*
Days Housed	562.2	*(264.6)*
Days Between First and Last Assessment	569.0	*(244.2)*

MEDICAL / PRIMARY CARE

Clients were asked to rate their overall health on a scale from Poor (1) to Excellent (5).

- From the initial assessment to the final assessment, there was a slight increase in the percentage of clients (6.81%) describing their overall health as good, very good, and excellent.
- There was not a significant mean difference in overall health from baseline to final assessment, $t(43)=.095$, $p=.925$.

Figure 1. Overall health among Lift clients



BEHAVIORAL HEALTH

Clients were asked the following questions regarding mental health:

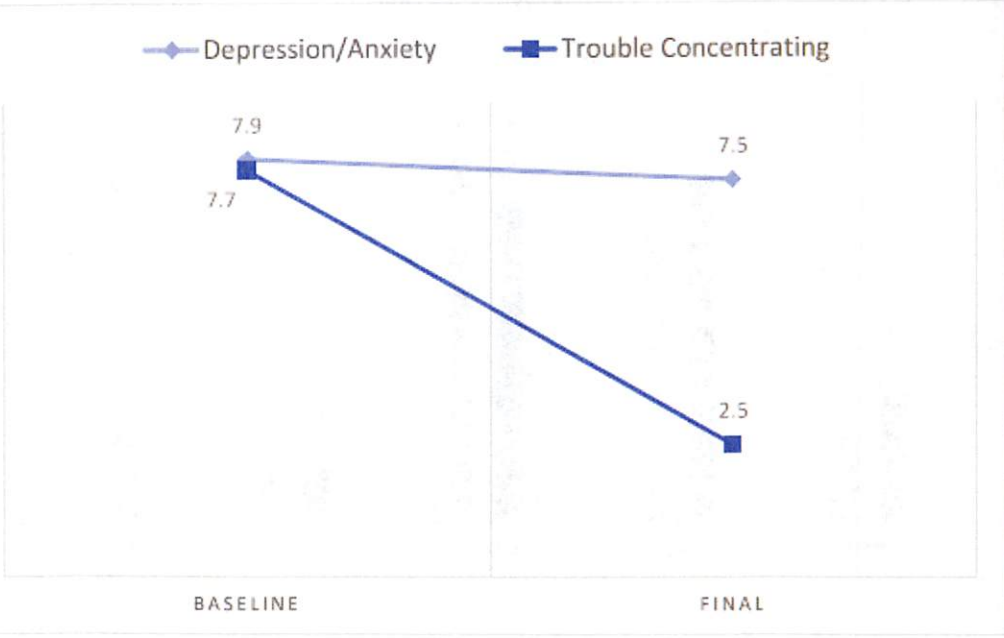
- In the past 30 days, approximately how many days have you experienced: a blue mood, sadness, despair, anxiety, or depression.

- There was not a significant decrease in the average number of days (.48) clients experienced depression or anxiety, $t(40)=-.215$, $p=.831$, from baseline to final assessment.

- In the past 30 days, approximately how many days have you experienced: trouble understanding, concentrating, or remembering?

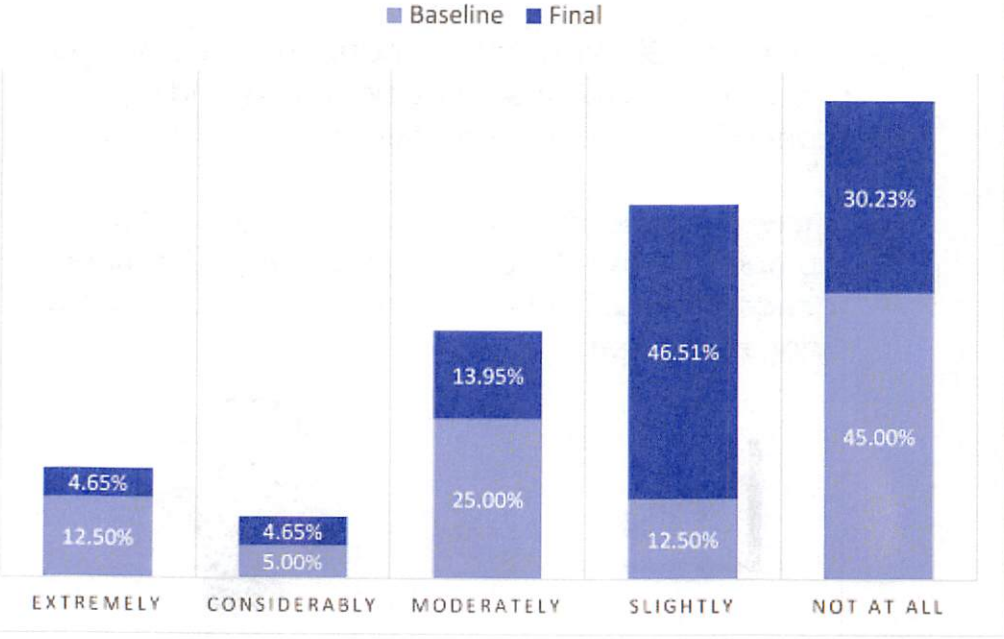
- There was a significant decrease in the average number of days (4.95) clients experienced trouble concentrating, $t(40)=-2.331$, $p=.025$ from baseline to final assessment.

Figure 2. Average number of days Lift clients experienced depression or anxiety and trouble concentrating or remembering.



- In the past 30 days, how much have you been bothered by psychological or emotional problems?
- There was an increase in clients (8.20%) who were less bothered (moderately, slightly, or not at all) by psychological or emotional problems from baseline to final assessment. This was not a significant difference, $t(38)=.859$, $p=.396$.
- When clients who were evicted or abandoned their unit were excluded from the analysis, then there was a significant decrease in how bothered clients were by psychological or emotional problems, $t(26)=2.595$, $p=.015$.

Figure 3. How bothered Lift clients felt by psychological or emotional problems.



A few individuals (n = 17) were interviewed at five unique timepoints throughout the study. The following results are from a one-way repeated analysis of variance (ANOVA) including 5 time points with 17 clients, housed on average 832 days (SD=96 days). Repeated measures ANOVAs assess whether there are differences in variables (e.g. behavioral health indicators) over time and whether the data form patterns over time that may be linear, quadratic, or cubic. These findings indicate trends but must be interpreted with caution given the lack of statistical power.

- The Lift intervention did lead to statistically significant changes in number of days of depression over time, $F(4, 52)=2.695$, $p=.041$, partial $\eta 2 = .17$. Post hoc analysis with a Bonferroni adjustment did not yield any significant differences in number of days of depression between individual time points.
- There was a statistically significant quadratic effect, where days clients felt depression or anxiety increased and then decreased after being housed 12 months ($p=.029$).

Figure 4 Average number of days Lift client experienced depression or anxiety over time

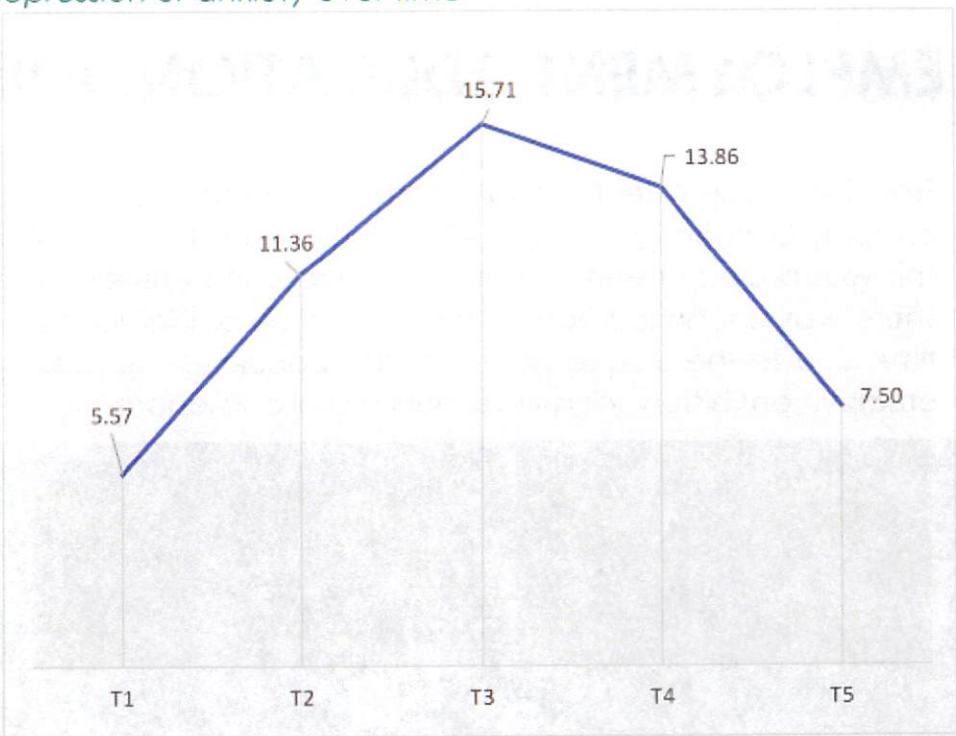
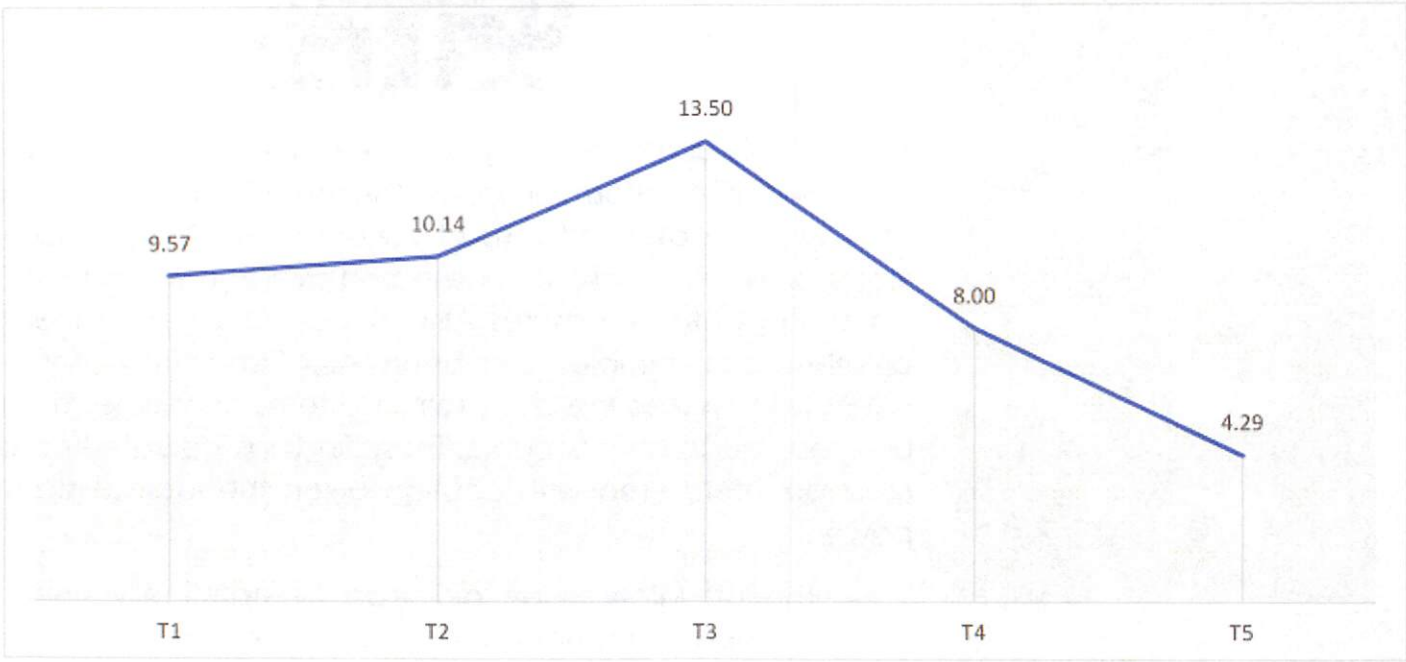


Figure 5. Average number of days clients experienced trouble remembering or concentrating over time



There was a statistically significant quadratic effect for number of days clients had experienced trouble concentrating or remembering (p=.026). After being housed 12 months, clients experienced on average less day's trouble concentrating or remembering.

EMPLOYMENT, EDUCATION, AND SOCIAL SUPPORT

From initial assessment to final assessment, there was a significant increase in clients who received disability benefits going from 47.6% at baseline to 56.8% at final assessment, $\chi(1) = 8.145$, p=.004. This was a direct result of individuals accessing entitlement benefits through the SOAR Initiative. There was not an increase in the proportion of individuals who were employed part-time or full-time due to the unique nature of the population (e.g. length of time homeless, lack of recent employment history, cognitive/behavioral challenges).

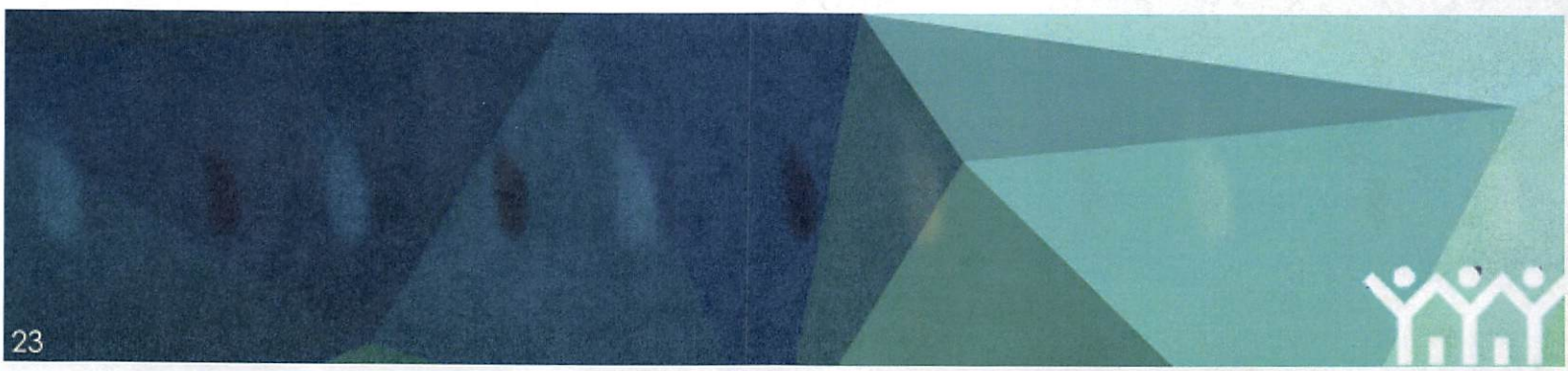
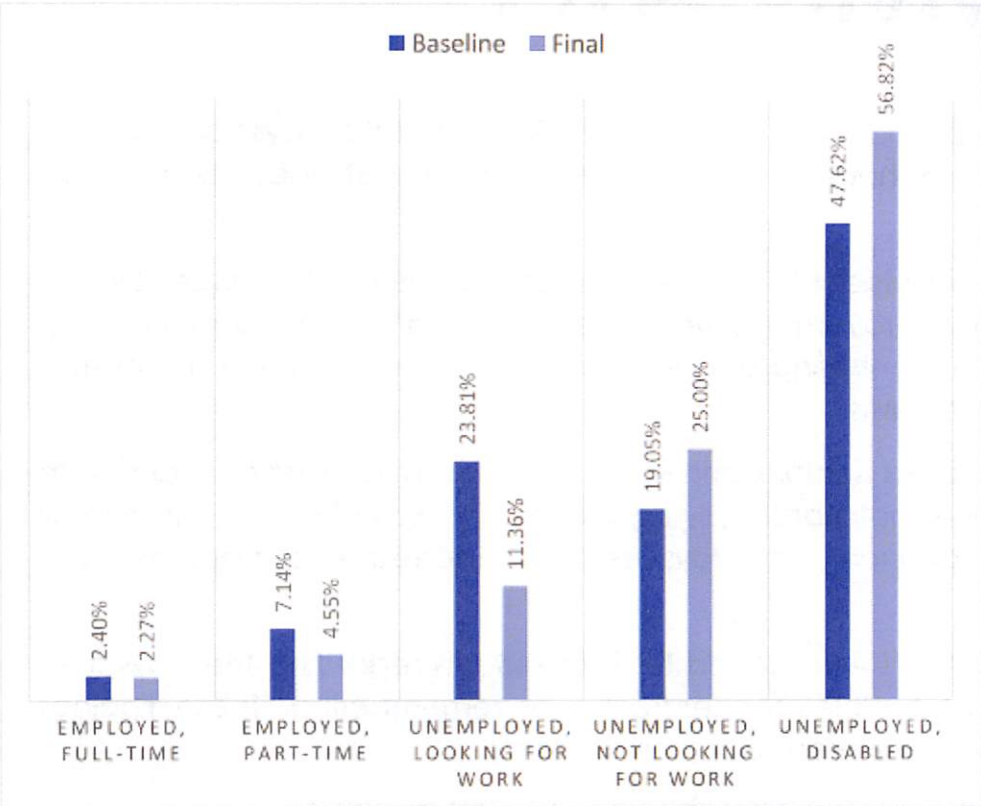


Figure 6. Employment among Lift clients



SOCIAL CONNECTEDNESS

This section addresses the client's use of social support and recovery services during the 30 days prior to the interview.

- There was an overall increase among LIFT clients who reported interacting with family and friends from initial (54.8%) to final assessment (70.5%). This difference, although large, was not statistically significant.
- Within the 70.5% who reported family and friend interactions, nearly all (91.7%) reported interacting with friends or families on a weekly or daily basis.
- A separate item asked about attendance in self-help or support group (i.e. Religious Groups, AA/NA meetings). There was an increase in both general attendance (Yes/no) from initial assessment, 27.3%, to final assessment, 31.8%, and an increase in attendance frequency among those who did attend. 85.7% attended self-help or support groups on a weekly or daily basis during the final assessment compared to initial assessment (66.7%).
- Although positive, neither of these finding was statistically significant.

SUMMARY

Survey data

Findings for participants in the study did not differ according to move-in date, days housed, age, race, or gender suggesting benefits of housing are universal for this target population of high utilizers.

A significantly larger proportion of Lift residents reported disability benefits at final assessment compared with baseline. Significant improvements were also seen regarding smaller number of days individuals reported trouble concentrating and the amount that residents in Lift reported being bothered by psychological problems.

Although individuals reported increased social connection with family and friends, and with attending support groups, results were not statistically significant. This was also true with overall health, which got better but only marginally, and days residents reported feeling depressed or anxious.

Quadratic longitudinal significant effects were found for Lift residents regarding the days they reported feeling depressed or had trouble concentrating or remembering. These findings indicate that for this group, setbacks were seen prior to improvements.

APPENDIX

APPENDIX A: Pages 27-30

Meet the Residents

APPENDIX B: Pages 31-38

Comparison Group Results

APPENDIX C: Pages 39-41

Qualitative Findings

APPENDIX D: Page 42

Add-on Study submitted to the Community Mental Health Journal

APPENDIX A:

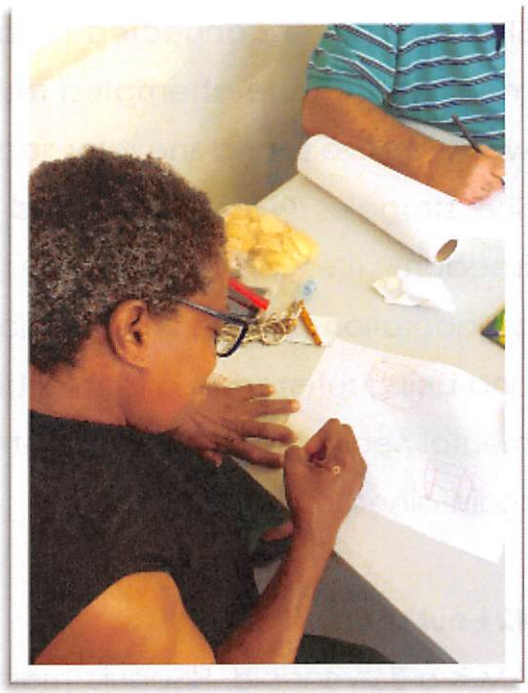
Meet the Residents

#52 of 800 "Mark"

Mark is a 62-year-old Cuban male who entered the United States on the Mariel Boatlift in 1980. He has been street homeless for over 22 years. It was also the first time he has ever been housed. Mark refused to enter the shelter in the past when he was homeless because he had four small dogs. As he was only able to enter the homeless shelters with one dog, he refused to enter the shelter or seek housing assistance. He also had an extensive substance abuse and untreated mental health problems. He entered into Coalition Lift in August of 2017 and was a relatively poor historian regarding his homeless and family history. Within a week of placement, Mark began taking care of a stray cat that was in the neighborhood. The cat gave birth to four kittens and Mark continued to care for all of them. The Coalition Lift staff utilized a local spay and neuter program so as to prevent further overpopulation. Mark is now the proud owner of four cats. The mother cat remains an outside cat and he feeds and cares for her daily. Since his placement in Coalition Lift, Mark began participating in mental health, medical, and substance abuse treatment and was open to participate in services. The Carrfour and Citrus Health Teams have worked with Mark to stabilize his housing. He was approved for Social Security Disability Benefits through utilizing the SOAR program and it is the first time he has had

income in his life. He remained in the program and is now being referred to an assisted living facility due to his needs. His cats have been rehomed and the Coalition staff continue to monitor his progress due to his limited social supports.

#3 of 800 "Shay"



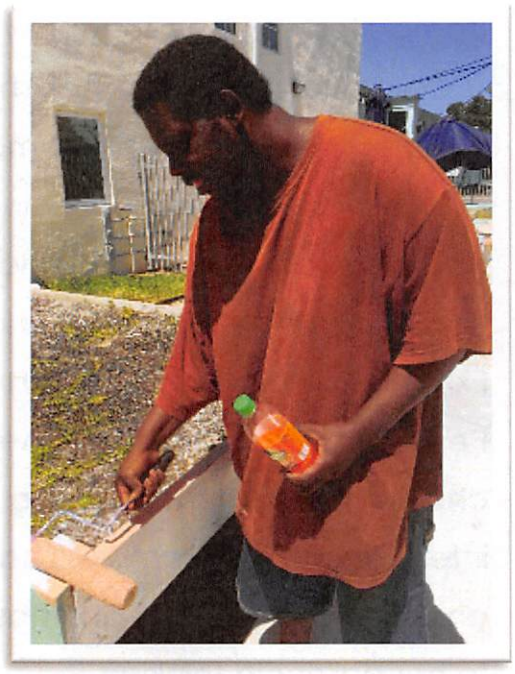
Shay is a 49-year-old African American female who is known to many providers as she has been street homeless for over twenty years. It is believed that she was homeless as a foster youth, but the documentation is limited due to her refusal to enter into shelter settings. She reports that she has never been housed. She entered foster care at age six after allegations of sexual abuse and aged out of foster care as her parents never completed services to reunify with her as a child. She reported that she left to the street as a teenager and never returned home. Shay spent many years both on the streets and in and out of jail. She has a crack cocaine addiction, and this has contributed to her homelessness and legal difficulties. Furthermore, she has significant mental health concerns and is diagnosed with Schizoaffective Disorder, Intermittent Explosive Disorder, and Bipolar Disorder. She is also diagnosed with Borderline Personality Disorder. Due to her dual diagnosis, her path to recovery has been challenging at times due to her aggressive behavior and primitive social interactions. For example, Shay has been known to spit, urinate, or defecate on others when upset. She has also been in several physical altercations due to her paranoid thinking.

Once she was identified as a participant, the providers working with her were cautious of her possible success in the program as she has never been able to maintain housing or remain in a shelter setting. She entered Coalition Lift in October of 2017 and has developed relationships. She has developed relationships with the staff at Coalition, has verbalized that she feels "loved" and "cared for," while expressing similar feelings towards her treatment team. Shay has never connected before; her longest period of sobriety was three months when she attempted residential treatment. Her residential treatment was short lived, and she relapsed.

She struggles with stability and often self-sabotages her relationships and freedom (i.e. participating in criminal activity). Despite advocacy and collaboration between the judicial system and Coalition Lift, she is incarcerated and being referred to a mental health program due to her extensive legal and mental health history. Her stay at Coalition Lift was the only time she has ever maintained housing.

#24 out of 800 AM

AM is a 36-year-old, Hispanic male of Mexican descent. He grew up in California and lived in San Francisco. As a youth, he discussed having a difficult childhood consisting of abuse and neglect, interfamilial tension, parental divorce, and severe community violence. He left his father's home as a teenager, before completing high school and was homeless on the streets of California for many years. Even homeless, he was able to graduate high school and had expressed this was the only thing that kept him alive. He admitted that his family did



not attend his graduation as they believed that he was not going to attend. He gravitated to criminal activity, his friends became his family unit, and would practice graffiti art. AM had limited social relationships and was very much a loner. He maintained on the streets entering there as a youth and eventually started using drugs. He reported that he eventually entered into residential treatment and he began to see himself. Once he completed treatment, he moved to Florida in order to start over. However, his homelessness continued, and he remained homeless on Miami Beach for many years. AM became involved in the legal system in Florida due to theft and was placed on Probation. Due to his homelessness, he was unable to pay restitution, as he could not maintain stable employment or housing. He continued to cycle in and out of the legal system. His substance abuse continued, and he entered into Coalition Lift on October 10, 2017. He was initially guarded, as he spent over twenty years homeless despite his young age. He would not trust anyone and continued his criminal activities. With time and support, he began trusting staff, connecting with others, and feeling like he belonged. Once this shift started, a noticeable change was observed in AM. He was able to pay off his Probation and has not had any legal issues since 2017. He entered into psychotherapy and began addressing his childhood traumas, he reconnected with his family in California, found employment, and started college. He has decided to pursue a degree in Social Work as he feels and expresses that he is alive today because of Coalition Lift. He has been on the Dean's List since he entered the local college in Miami Dade. He is stable, has pursued courses to become a Peer Specialist and is completing his hours. He wants to give back to society, share his experiences, and he is often supportive of his neighbors. He has dreams of owning his own home, having a family, and living independently. When speaking with AM he will let you know that he never expected to live to his current age. He is a survivor.

APPENDIX B:

In addition to focusing on the cost-benefit of the Coalition Lift model within Miami Dade County, this study also examined how the Lift model compared to two other groups: persons housed in traditional PSH within the County, and persons who passively refused housing and remained homeless.

Findings below reflect a comparison of the Lift program to the two other groups using both cost data and survey data. However, when interpreting findings, it is critical to note that the two resident groups (Lift and community PSH) are not equivalent in terms of ranking or severity of issues. Rankings from the initial high utilizer (HU) list indicated that a higher proportion of Lift residents were in the top 150 (79.5%) compared to those housed in other PSH (45.2%). This was done by design in most cases as the severity of challenges presented by individuals higher up on the list meant that traditional community housing program were not a good fit for these individuals. Specifically, Lift's onsite programming and supports, carefully trained case management and property management staff, and cultural competency with the target population provided a supportive environment with flexible, available services necessary to successfully house these residents.

Additionally, individuals were not static once placed and some individuals moved from community sites to Lift or from the non-housed group to either Lift or community PSH. These individuals were counted in the original group they came into and were later separated during analysis. Second, individuals who were approached for housing availability did not overtly turn down the opportunity, thus the non-housed group was very challenging to fill.

Part A: Cost Comparison Data

The tables below reflect cost data from Lift, individuals housed in traditional community PSH, and individuals who remained homeless. For the latter two groups, data was only available at one year following initial study enrollment. Similar to Lift, substantive reductions were seen for the community housed group but were less prevalent for the homeless group.

Source		Results - Coalition Lift 21 Clients with at least 2 years of residency Annualized Pre	Post	Difference	
MED	Ambulance	$ 316	$ 516	$ 200	63.3%
MED/JAX	Hospital Inpatient	$ 404,991	$ 89,312	$ (315,679)	-77.9%
MED/JAX	Hospital Outpatient	$ 42,187	$ 41,192	$ (995)	-2.4%
MED/JAX	Hospital Emergency Department	$ 197,223	$ 74,553	$ (122,670)	-62.2%
MED	Physician	$ 6,316	$ 3,533	$ (2,783)	-44.1%
MED	Other Physical Heath	$ 3,602	$ 1,572	$ (2,031)	-56.4%
MED	Non-Psychoactive Medications	$ 102,033	$ 53,524	$ (48,509)	-47.5%
	Total- Physical Health	$ 756,668	$ 264,201	$ (492,467)	-65.1%
DCF/MED	Mental Health- Case Management	$ 113	$ 3,414	$ 3,301	2920.4%
DCF/MED	Mental Health- Crisis Services	$ 9,257	$ 362	$ (8,895)	-96.1%
DCF/MED	Mental Health- Treatment	$ 2,400	$ 11,956	$ 9,556	398.2%
MED	Physician	$ 718	$ 535	$ (183)	-25.5%
MED/JAX	Hospital Inpatient	$ 72,343	$ 5,136	$ (67,207)	-92.9%
MED/JAX	Hospital Outpatient	$ 395	$ 327	$ (68)	N/A
MED/JAX	Hospital Emergency Department	$ 939	$ 944	$ 5	0.5%
MED	Antipsychotic Medications	$ 86	$ 4,418	$ 4,332	5036.6%
MED	Other Psychoactive Medications	$ 247	$ 1,427	$ 1,180	478.7%
	Total Mental Health	$ 86,496	$ 28,517	$ (57,979)	-67.0%
DCF	Substance Use-Crisis Services	$ -	$ 5,915	$ 5,915	N/A
DCF	Substance Use-Detox	$ 276	$ 643	$ 368	133.3%
DCF	Substance Use Recovery Support	$ 629	$ 538	$ (91)	-14.5%
	Total Substance Use	$ 904	$ 7,096	$ 6,191	684.7%
CJIS	Jail Stays	$ 85,500	$ 67,800	$ (17,700)	-20.7%
	Shelter Stays	$ 5,363	$ 171	$ (5,192)	-96.8%
	Shelter Day Services	$ 6,253	$ 269	$ (5,984)	-95.7%
	Total Costs	$ 941,184	$ 368,054	$ (573,130)	-60.9%

Source		Other Housed- 11 w/ 1 yr N=11 Pre	Post	Difference	
MED	Ambulance	$ 558		$ (558)	-100.0%
MED/JAX	Hospital Inpatient	$ 65,383	$ 33,385	$ (31,998)	-48.9%
MED/JAX	Hospital Outpatient	$ 17,497	$ -	$ (17,497)	-100.0%
MED/JAX	Hospital Emergency Department	$ 19,938	$ 7,641	$ (12,297)	-61.7%
MED	Physician	$ 1,126	$ 4,865	$ 3,739	332.0%
MED	Other Physical Heath	$ 223	$ 11,169	$ 10,946	4908.5%
MED	Non-Psychoactive Medications	$ -	$ -	$ -	N/A
	Total- Physical Health	$ 104,726	$ 57,060	$ (47,666)	-45.5%

DCF/MED	Mental Health- Case Management	$ 1,988	$ 234	$ (1,754)	-88.2%
DCF/MED	Mental Health- Crisis Services	$ 529	$ -	$ (529)	-100.0%
DCF/MED	Mental Health- Treatment	$ 1,615	$ -	$ (1,615)	-100.0%
MED	Physician		$ 1,713	$ 1,713	N/A
MED/JAX	Hospital Inpatient	$ -	$ 10,854	$ 10,854	N/A
MED/JAX	Hospital Outpatient	$ -	$ -	$ -	N/A
MED/JAX	Hospital Emergency Department	$ -	$ -	$ -	N/A
MED	Antipsychotic Medications	$ -	$ -	$ -	N/A
MED	Other Psychoactive Medications	$ -	$ -	$ -	N/A
	Total Mental Health	$ 4,131	$ 12,801	$ 8,670	209.9%
DCF	Substance Use-Crisis Services	$ 114	$ -	$ (114)	N/A
DCF	Substance Use-Detox	$ -	$ -	$ -	N/A
DCF	Substance Use Recovery Support	$ -	$ -	$ -	N/A
	Total Substance Use	$ 114	$ -	$ (114)	-100.0%
CJIS	Jail Stays	$ 53,600 268 days	$ 4,200 21 days	$ (49,400)	-92.2%
	Shelter Stays	$ 18,600 708 days	$ 158 6 days	$ (18,442)	-99.2%
	Shelter Day Services	$ 10,266 724 days	$ 851 60 days	$ (9,415)	-91.7%
	Total Costs	$ 191,437	$ 75,070	$ (116,367)	-60.8%

Source		*Street 1yr N=21* Pre	Post	Difference	
MED	Ambulance	$ 1,287	$ 894	$ (393)	-30.5%
MED/JAX	Hospital Inpatient	$ 107,396	$ 50,362	$ (57,034)	-53.1%
MED/JAX	Hospital Outpatient	$ 376	$ 4,686	$ 4,310	1146.3%
MED/JAX	Hospital Emergency Department	$ 151,382	$ 65,427	$ (85,955)	-56.8%
MED	Physician	$ 23,177	$ 9,596	$ (13,581)	-58.6%
MED	Other Physical Heath	$ 2,543	$ 1,031	$ (1,512)	-59.5%
MED	Non-Psychoactive Medications	$ -	$ -	$ -	N/A
	Total- Physical Health	$ 286,161	$ 131,996	$ (154,165)	-53.9%
DCF/MED	Mental Health- Case Management			$ -	N/A
DCF/MED	Mental Health- Crisis Services	$ 4,234	$ -	$ (4,234)	-100.0%
DCF/MED	Mental Health- Treatment	$ 4,307	$ 2,614	$ (1,693)	-39.3%
MED	Physician	$ 8,221	$ 3,106	$ (5,115)	N/A
MED/JAX	Hospital Inpatient	$ 65,926	$ 4,403	$ (61,523)	N/A
MED/JAX	Hospital Outpatient	$ -	$ -	$ -	N/A
MED/JAX	Hospital Emergency Department	$ 326	$ 179	$ (147)	N/A
MED	Antipsychotic Medications			$ -	N/A
MED	Other Psychoactive Medications			$ -	N/A
	Total Mental Health	$ 83,014	$ 10,302	$ (72,712)	-87.6%
DCF	Substance Use-Crisis Services			$ -	N/A
DCF	Substance Use-Detox			$ -	N/A
DCF	Substance Use Recovery Support	$ 139		$ (139)	N/A
	Total Substance Use	$ 139	$ -	$ (139)	-100.0%
CJIS	Jail Stays	$ 170,000 850 days	$ 139,800 699 days	$ (30,200)	-17.8%
	Shelter Stays	$ - 0 days	$ - 0 days	$ -	N/A
	Shelter Day Services	$ 237 20 days	$ 71 $ 5	$ (166)	-70.0%
	Total Costs	$ 539,551	$ 282,169	$ (257,382)	-47.7%

Part B: Survey Data

Key Findings

Multiple improvements were seen regarding core domains of focus including social support, employment, and mental health. Both housed groups (Lift and Community PSH) showed gains compared to those who were not housed. The Community housed group had slightly more improvement in mental health indicators. However, longitudinal analysis for Lift residents indicated approximately 12 months of negative change before improvements were noted for mental health items suggesting that the onsite mental health support provided by Lift was instrumental in contributing to these positive post-year changes.

Comparing Lift, Community, and Non-Housed Individuals

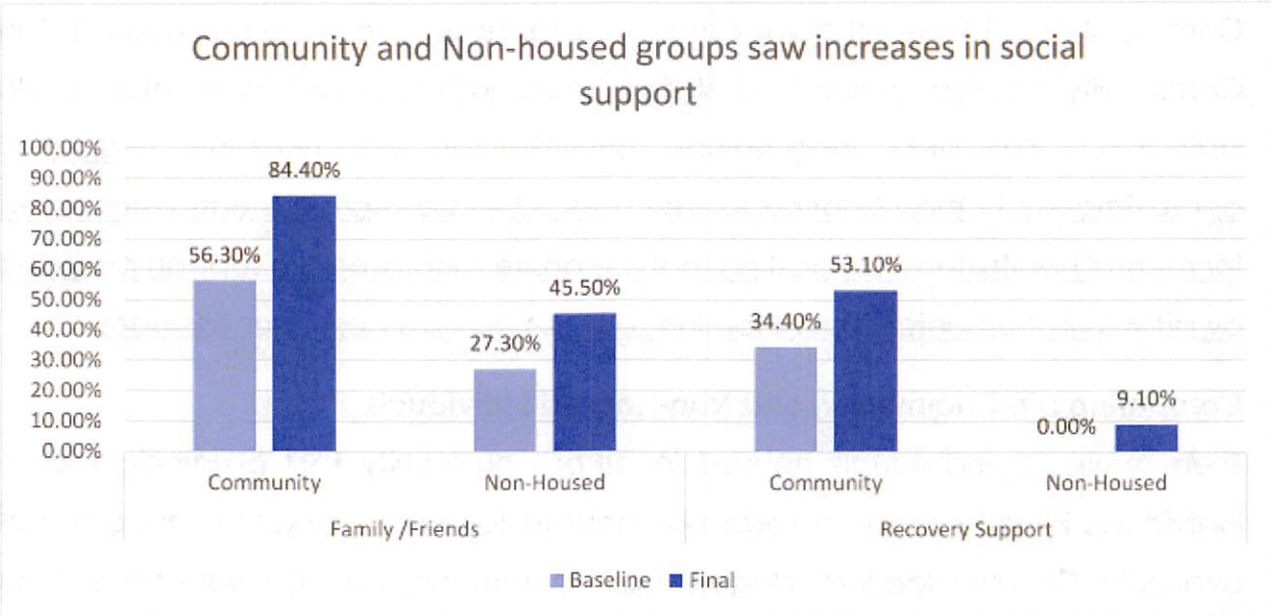
There were 32 individuals housed in other community PSH buildings and 11 individuals interviewed that were non-housed for whom longitudinal data was available. On average individuals living in community housing were housed for 733 days (SD=340 days) and the average number of days between baseline and final assessment was 310 days (SD=211 days). There were on average 312 days (SD=135 days) between baseline and the final assessment for the non-housed group. A bivariate correlation was run to test for any correlations between baseline outcomes and other factors such as days housed, and there were no significant correlations. The following findings compare participant responses from their initial and final assessment.

Social Connectedness

- Like Lift participants, more individuals in both community and non-housed groups reported spending time with family and friends at the final assessment compared with baseline. These findings were not statistically significant.

- Increases were also seen in the proportion of individuals who reported attending self- help or support groups at final assessment. These differences were significant for those in community PSH, $\chi(1) = 14.79$, $p<.001$.

Figure 7. *Social support items for Community and Non-housed participants*



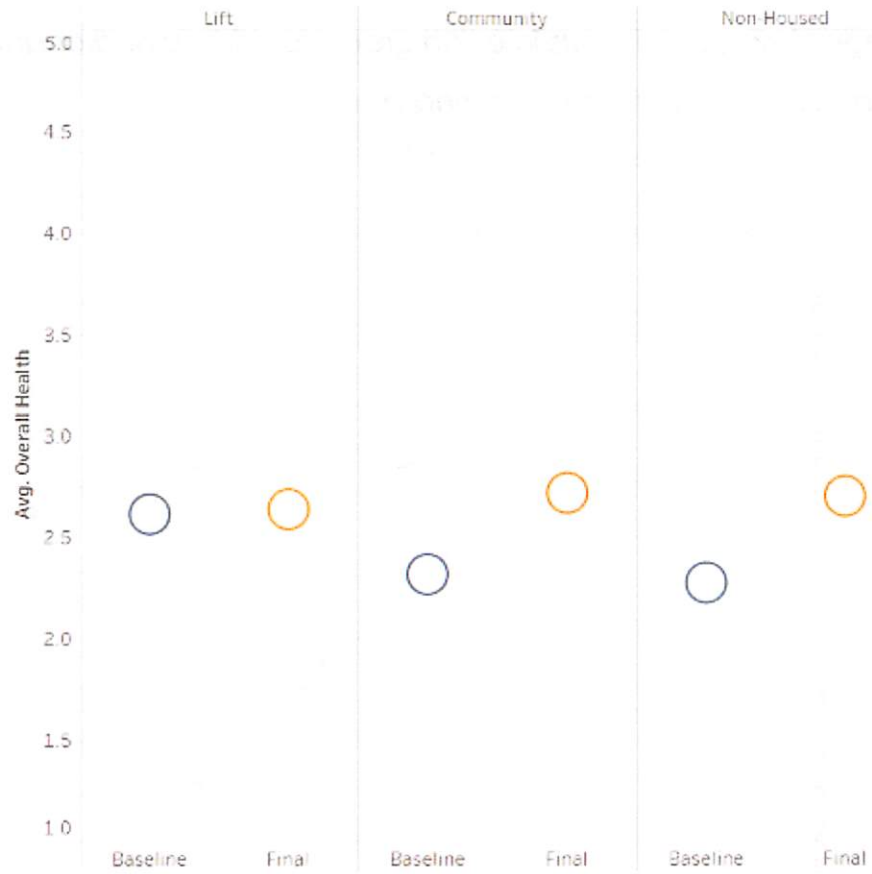
Employment

- From initial assessment to final assessment, there was an increase in the Community group regarding the number of persons employed going from 1 individual at baseline (employed part-time) to 4 individuals employed at final assessment (3 part time and 1 full time). There were no changes in the number of individuals in this group on disability with 70.0% (n = 21) at both time points.
- There were no individuals employed in the Non-housed group at either time point. One individual reported losing disability benefits with 4 individuals reporting disability at baseline and 3 individuals reporting disability at final assessment.

Mental and Physical Health

Clients were asked to rate their overall health on a 5-point Likert scale (1- Poor to 5 -Excellent). The table below shows the average score at baseline and final assessment. There was a slight increase in overall health rating from baseline to final assessment across all groups, but the change was not statistically significant.

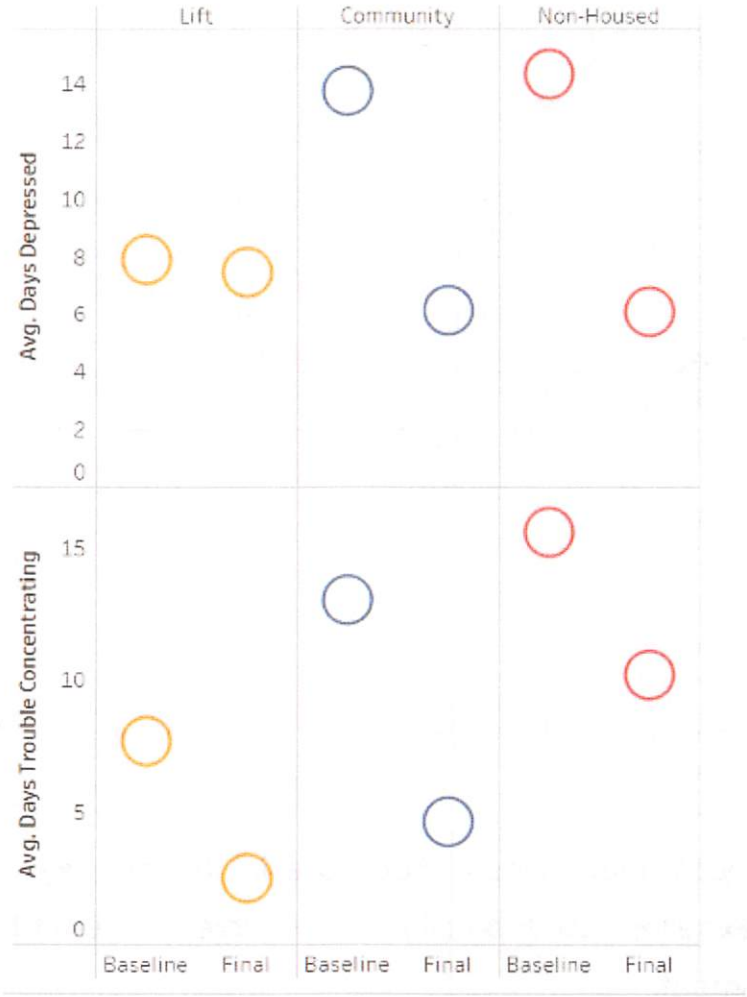
Figure 8. *Average overall health score for Lift, Community, and Non-housed participants.*



- Across all groups, there was a decrease in the average number of days participants experienced depression and trouble concentrating from baseline to final assessment.
    - There were only significant changes for those living in Lift and Community housing.

- Clients housed in other community buildings had a significant decrease in number of days depressed (M= 7.59) from baseline to final assessment, t(31)=-4.151, p<.001.
- Clients housed in other community buildings had a significant decrease in the average number of days (M=8.38) they had experienced trouble concentrating or remembering from baseline to final assessment, t(31)=-3.87, p=.001

Figure 9. *Average days participants in each group felt depressed or anxious, and days trouble concentrating or remembering among.*



- Clients housed in other Community Housing did have a significant change (M=.828) in how bothered they were by psychological and emotional problems, $t(28)=3.663$, $p=.001$.
    - 60.00% of clients reported being moderately to not at all bothered by psychological problems at baseline compared to 85.72% of clients at final assessment.

APPENDIX C:

See pdf below:

APPENDIX D:

Housing First Outcomes: A Longitudinal Pilot Study of Psychiatric Symptoms, Disability and Functional Capacity in Individuals who are Homeless and High Service Utilizers

Francisco Quintana[1], Angela Mooss[2], Simran Sandhu[3], Olga Golik[4], Thomas Jardon[4], Randel Martin [4], Adriana Foster[5]

Abstract

The Housing First (HF) approach has proven to be an effective intervention to reduce the rates of homelessness and to curb costs associated with public services utilization. Little is known on how this approach may impact overall health. Using a sample of 32 individuals who experienced chronic homelessness, mental illness/co-occurring addictive disorders, and high utilization across public service domains (e.g., jails, emergency department, and shelters), the present one-year longitudinal pilot study sought to examine the extent to which HF with supportive services leads to improvement in psychiatric symptoms, disability, functional capacity, and self-stigma. Consistent with our hypothesis, HF was found to have a beneficial effect on participants' psychiatric symptoms, disability, and certain aspects of their functional capacity. While participants' level of stigma internalization (self-stigma) did not improve over time as predicted, self-stigma and disability were both found to significantly predict psychiatric symptoms. Implications for research and practice are discussed.

Keywords: Homelessness • Serious Mental Illness • High Service Utilizers • Housing First

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MIAMI-DADE COUNTY
HOMELESS TRUST

Priority Home

MIAMI-DADE COUNTY COMMUNITY HOMELESSNESS PLAN

2023 ALIGNMENT OF PLAN WITH UPDATED PRIORITIES

Miami-Dade County Community Homelessness Plan

The Miami-Dade County Community Homelessness Plan: **Priority Home** provides a framework for Miami-Dade County to prevent and end homelessness. This document is an update to the Miami-Dade County Community Homelessness Plan which was first implemented in 1994.

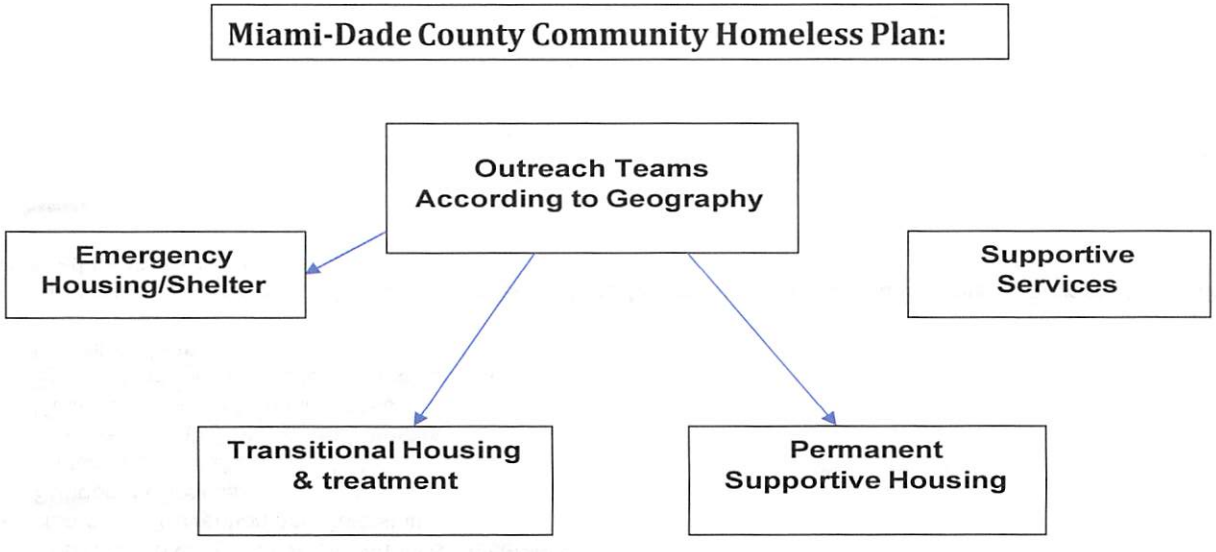
The Homeless Trust is the lead organization for the Continuum of Care, a group identified by the U.S. Department of Housing and Urban Development (HUD) to coordinate the homeless response for Miami-Dade County. The Homeless Trust reviews **Priority Home** annually to ensure continued alignment with ***All In***, the Federal strategic plan to prevent and end homelessness, HUD's System Performance Measures (SPMs), HUD's policy priorities contained within the most recent HUD funding competition, and to ensure consistency with local needs. **Priority Home** implementation strategies are updated annually as part of the **Priority Home** review process to ensure the continuum evolves and new gaps and needs are addressed.

Priority Home is an outgrowth of the "Governor's Task Force on Homelessness" which was formed in 1992 to address the issue of homelessness. At that time, in terms of services, there was little to no coordination among providers, no defined leadership on the issue and no plan or approach to address the increasing problem, leverage resources or eliminate duplication. There was limited-to-no involvement by the private sector/business community. A federal lawsuit alleging civil rights violations against the homeless wound its way through the courts, creating further confusion about how to address this issue. The Governor's Task Force recommended three (3) key activities to address the community's needs:

1) Pursue a dedicated source of funding/private sector funding
2) Create a body with diverse representation to implement plan
3) Research best practices to address homelessness and develop goals for implementation

The Governor's Task Force pursued and secured a one-percent Food & Beverage Tax (F&B Tax) on restaurants with sales of more than $400,000 a year and an alcoholic beverage license. Approved in 1992, the enabling legislation for the Homeless and Domestic Violence F&B Tax, which allocates 15% of the collections for domestic violence programs, became the first dedicated source of funding for homelessness through a tax in the country. Importantly, the F&B Tax would serve as a source of leverage for state, federal and other funding.

The enabling legislation required local legislative action. It also required the development of a plan for the use of the funds prior to approval and collection. A local Homeless Task Force was created which included many of the members of the Governor's Task Force. The result was the creation of the "Dade County Community Homelessness Plan," a continuum of care approach that called for the development of three levels of housing (emergency, transitional and permanent housing), with support services and outreach to engage clients into the system of care.



At its essence, the Miami-Dade County Community Homeless Plan was focused around the following six categories:

- Emergency Housing (Crisis Care)
- Transitional Housing (Temporary Intermediate Care)
- Permanent Housing (Advanced Care)
- Coordinated Outreach, Assessment & Placement
- Supportive Services
- Homeless Plan

Specific goals/targets were established for Emergency and Transitional Housing at the time of the Plan's approval, with a Blue Ribbon Task Force on permanent housing establishing goals for permanent housing. The parameters for a coordinated outreach, assessment and placement process were also established, providing for one entry point into the continuum of care.

The Trust Board is responsible for the implementation of the Plan, identifying gaps and needs, coordinating the system of care (including serving as the Collaborative Applicant and HMIS Lead Applicant) and allocating local, state and federal funds to assist the homeless. Its diverse board ensures stakeholder participation which is further ensured through its public, transparent processes.

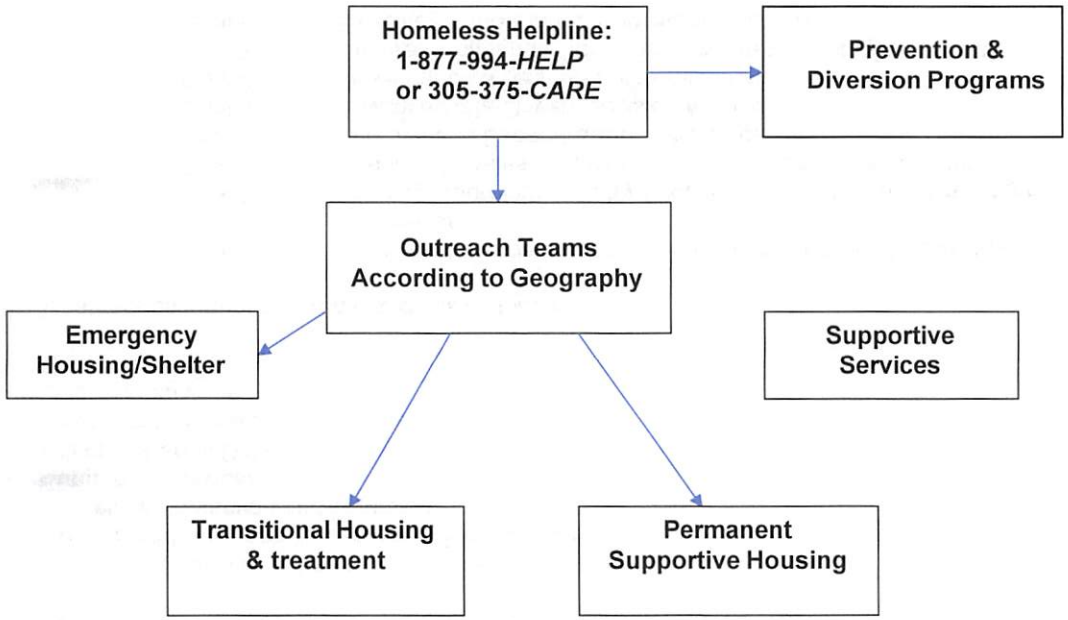
MIAMI-DADE COUNTY COMMUNITY HOMELESS PLAN/ADDITIONAL STRATEGIES:

In 2004, a Ten-Year Plan to End Homelessness Additional Strategies to the Miami-Dade County Community Homeless Plan was developed, consistent with U.S. HUD mandates at the time for communities throughout the country, and consistent with U.S. HUD's development of their own Ten-Year Plan. At that time, strategies surrounding Homeless Prevention and Rapid Re-Housing were being implemented, as well as the first of the Housing First models. Enhancements to efforts to assist chronically homeless households were also under development.

The Additional Strategies resulted in nine (9) categories for focus and action, as follows (additions identified in blue):

- Emergency Housing/Transitional Housing/Permanent Housing/Rapid Re-Housing
- Coordinated Outreach, Assessment & Placement
- Homeless Prevention and Diversion
- Supportive Services
- Effective Use of Data
- Income through Employment/Benefits
- Reduce Length of Homelessness
- System Changes to Prevent Homelessness
- Homeless Plan

Five of the areas for focus were already components of the Miami-Dade County Community Homeless Plan. Additional goals were established for these categories.


Homeless Helpline:
1-877-994-HELP
or 305-375-CARE
Prevention &
Diversion Programs
Outreach Teams
According to Geography
Emergency
Housing/Shelter
Supportive
Services
Transitional Housing
& treatment
Permanent
Supportive Housing

MIAMI-DADE COUNTY COMMUNITY HOMELESS PLAN: PRIORITY HOME

Since 2004, new U.S. HUD policies and priorities tie federal funding to the implementation of certain approaches and performance expectations. As importantly, the enactment of the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act in 2009 changed how homeless assistance is funded, further making the process data-driven and performance-focused.

In 2013, various Trust Committees and the Trust Board considered and approved additional strategies and initiatives designed to further align local activities with HEARTH-required approaches and assist the continuum of care in meeting U.S. HUD Performance Objectives and U.S. HUD Policy and Program Priorities. As a result of the CoC's own changing focus and priorities in response to the continuum's needs, an additional update was approved during a joint Board retreat in December 2013. The resulting document is called the Miami-Dade County Community Homeless Plan: Priority Home. The Plan continues the core mission and direction of the Miami-Dade County Community Homeless Plan approved in 1994 and updated in 2004, but further aligned and refined the Plan using the following updated categories (additions in blue):

- Emergency/Transitional/Permanent Housing
- Coordinated Outreach, Assessment & Placement
- Homeless Prevention and Diversion
- Supportive Services
- Effective Use of Data
- Governance & Resource Maximization
- Quality Assurance
- Homeless Plan

In 2023, categories further evolved into goals as follows:

Goal 1:	Leverage Emergency, Transitional and Permanent Housing Resource to Achieve Their Best and Highest Use
Goal 2:	Improve Coordinated Entry Access, Assessment and Housing Placement
Goal 3:	Expand Homeless Prevention and Diversion Interventions
Goal 4:	Improve and Expand Support Services
Goal 5:	Advance Data-Driven Decision-Making
Goal 6:	Governance & Resource Maximization
Goal 7:	Ensure Continuous Quality Improvement Strategies for CoC
Goal 8:	Execute on the Plan to End Homelessness

Strategies and objectives are reviewed annually by stakeholders, including the CoC Subcommittee, and made available for public comments. The Plan continues to be aligned with the objectives embedded in All In: The Federal Strategic Plan to Prevent and End

Homelessness, U.S. HUD's System Performance Measures and U.S. HUD Policy Priorities contained within the most recent U.S. HUD CoC Program Competition.

"All In" Federal Strategic Plan Objectives to Prevent and End Homelessness

- **Foundation Pillars**
  - Lead with equity
    - Ensure federal efforts to prevent and end homelessness promote equity and equitable outcomes.
    - Promote inclusive decision-making and authentic collaboration.
    - Increase access to federal housing and homelessness funding for American Indian and Alaska Native communities living on and off tribal lands.
    - Examine and modify federal policies and practices that may have created and perpetuated racial and other disparities among people at risk of or experiencing homelessness
  - Use data and evidence to make decisions
    - Strengthen the federal government's capacity to use data and evidence to inform federal policy and funding.
    - Strengthen the capacity of state and local governments, territories, tribes, Native-serving organizations operating off tribal lands, and nonprofits to collect, report, and use data.
    - Create opportunities for innovation and research to build and disseminate evidence for what works.
  - Collaborate at all levels
    - Promote collaborative leadership at all levels of government and across sectors.
    - Improve information-sharing with public and private organizations at the federal, state, and local level.
- **Solution Pillars**
  - Scale housing and supports that meet demand
    - Maximize the use of existing federal housing assistance.
    - Expand engagement, resources, and incentives for the creation of new safe, affordable, and accessible housing.
    - Increase the supply and impact of permanent supportive housing for individuals and families with complex service needs—including unaccompanied, pregnant, and parenting youth and young adults.
    - Improve effectiveness of rapid rehousing for individuals and families— including unaccompanied, pregnant, and parenting youth and young adults.
    - Support enforcement of fair housing and combat other forms of housing discrimination that perpetuate disparities in homelessness.
    - Strengthen system capacity to address the needs of people with disabilities and chronic health conditions, including mental health conditions and/or substance use disorders.
    - Maximize current resources that can provide voluntary and trauma-informed supportive services and income supports to people experiencing or at risk of homelessness. 8. Increase the use of practices grounded in evidence in service delivery across all program types.

- Improve effectiveness of homelessness response systems
  - Spearhead an all-of-government effort to end unsheltered homelessness.
  - Evaluate coordinated entry and provide tools and guidance on effective assessment processes that center equity, remove barriers, streamline access, and divert people from homelessness.
  - Increase availability of and access to emergency shelter—especially non-congregate shelter—and other temporary accommodations.
  - Solidify the relationship between CoCs, public health agencies, and emergency management agencies to improve coordination when future public health emergencies and natural disasters arise.
  - Expand the use of "housing problem solving" approaches for diversion and rapid exit. 6. Remove and reduce programmatic, regulatory, and other barriers that systematically delay or deny access to housing for households with the highest needs.
- Prevent homelessness
  - Reduce housing instability for households most at risk of experiencing homelessness by increasing availability of and access to meaningful and sustainable employment, education, and other mainstream supportive services, opportunities, and resources.
  - Reduce housing instability for families, youth, and single adults with former involvement with or who are directly exiting from publicly funded institutional systems.
  - Reduce housing instability among older adults and people with disabilities—including people with mental health conditions and/or with substance use disorders—by increasing access to home and community-based services and housing that is affordable, accessible, and integrated.
  - Reduce housing instability for veterans and service members transitioning from military to civilian life.
  - Reduce housing instability for American Indian and Alaska Native communities living on and off tribal lands.
  - Reduce housing instability among youth and young adults.
  - Reduce housing instability among survivors of human trafficking, sexual assault, stalking, and domestic violence, including family and intimate partner violence

HUD System Performance Measures

- Length of Time Persons Remain Homeless (Reduce Length of Time Homeless)
- Extent to which persons who Exit Homelessness to Permanent Housing Return to Homelessness within 6 to 12 months (Reduce Recidivism) / Extent to which persons who Exit Homelessness to Permanent Housing Return to Homelessness within 2 Years (Reduce Recidivism)
- Number of Homeless Persons (Reduce Homelessness)
- Employment and Income Growth for Persons in CoC Program Funded Projects (Increase Financial Resources)
- Number of Persons who Become Homeless for the First Time (Homeless Prevention)

- Successful Placement from Street Outreach (Outreach Coverage) / Successful Placement In or Retention of Permanent Housing (Stably House)

HUD Policy Priorities (FY 2022 Continuum of Care Competition)

- Ending homelessness for all persons
- Use a Housing First approach
- Reducing Unsheltered Homelessness
- Improving System
- Partnering with Housing, Health, and Service Agencies
- Racial Equity
- Improving Assistance to LGBTQ+ Individuals
- Persons with Lived Experience
- Increasing Affordable Housing Supply

THRIVE 305

The Miami-Dade County Community Homeless Plan is also aligned with Miami-Dade County's Thrive 305 Action Plan, an effort led by the Mayor's Division of Innovation and Performance in partnership with the Miami Foundation, which prioritizes housing that people can afford[1] and supports overarching goals Environment, Equity, Economy and Engagement.[2]

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[1] https://www.miamidade.gov/initiative/thrive305/home.page

[2] https://www.miamidade.gov/initiative/thrive305/strategic-planning-objectives.page

Miami-Dade County Community Homelessness Plan

2022: PRIORITY HOME

Goal 1:	Leverage Emergency, Transitional and Permanent Housing Resource to Achieve Their Best and Highest Use
Goal 2:	Improve Coordinated Entry Access, Assessment and Housing Placement
Goal 3:	Expand Homeless Prevention and Diversion Interventions
Goal 4:	Improve and Expand Support Services
Goal 5:	Advance Data-Driven Decision-Making
Goal 6:	Governance & Resource Maximization
Goal 7:	Ensure Continuous Quality Improvement Strategies for CoC
Goal 8:	Execute on the Plan to End Homelessness

Goal 1:

Leverage Emergency Shelter, Transitional Housing and Permanent Housing to Achieve Their Best and Highest Use

Strategy	Strategy Objectives
1.1 Analyze ES, TH and PH inventory and allocate resources to highest need clients	A. Redesign CES intake assessment to ensure housing first orientation; low barriers to entry; streamlined and welcoming intake process B. Train providers to utilize pre-Critical Time Intervention (CTI) practices C. Tailor shelter and housing spaces and services for unaccompanied youth 18-24 Identify crisis housing options for adult-only households (at least one adult household member has special needs better served in a non-congregate shelter) D. Reduce reliance on hotel/motel for families with minor children and increase percentage of families who move from hotel/motel directly to Permanent Housing (PH) E. Enforce compliance with Miami-Dade CoC Coordinated Entry policy F. Strengthen housing navigation, case management and mediation resources to shorten length of time homeless and promote successful exists G. Establish practice standards and operational protocols for temporary emergency shelter during crisis events such as public health emergencies, cold weather and hurricanes
1.2 Prioritize special populations for CoC Permanent Housing resources, including: • seniors; • persons with chronic medical conditions, disabilities, or comorbidities; • long-term stayers in ES, TH and SH; • unsheltered persons; • persons with high systems utilization; • persons fleeing DV, human and sex trafficking; • youth; • families; and • veterans	A. Reduce system-wide average Length of Time (LOT) for ES, SH & TH to 130 days or less B. Increase successful exits to permanent destinations for adult only households to 60% or more C. Prioritize unsheltered persons who meet chronic homeless definition for Permanent Supportive Housing (PSH) D. Create partnerships/interventions to serve hard-to-serve undocumented clients E. Map process from homelessness to housing to reduce redundancies and referral to placement in Tenant Based Rental Assistance (TBRA) F. Utilize rental assistance funding to target persons experiencing homelessness or those most likely to enter the homeless system. G. Implement performance improvement plans for low performers

Strategy	Strategy Objectives
1.3 Reduce unsheltered homelessness for single adults	A. Create bridge housing (RRH to PSH) to provide quick permanent housing placement for clients unable to effectively navigate a congregate shelter B. Develop shared housing solutions C. Strengthen partnerships with the Managing Entity for street-based substance abuse and mental health treatment to unsheltered adults and provide more timely access to detox and/or treatment resources as needed/requested D. Develop specialized housing strategies and locations to house sex offenders/predators E. Partner with mainstream systems to coordinate discharge planning efforts (hospitals, jails, prisons, crisis units); review and update discharge planning protocols and coordination F. Develop and invest in new peer support programming, including employing persons with lived experience G. Expand coordination with PATH Program, Healthcare for the Homeless grantees and Miami-Dade Public Library System and others to ensure those community resources are able to function as Coordinate Entry System (CES) access points for persons seeking crisis housing services H. Diversify street outreach teams to meet the unique needs of unsheltered individuals, including those with substance abuse and severe mental illness; engage with non-CoC affiliated groups who regularly engage persons experiencing homelessness; promote and facilitate coordination and collaboration amongst outreach teams I. Reinforce importance of using Homeless Management Information System (HMIS) workflow to log contacts and engagements for unsheltered persons J. Enhance diversion/mediation for single adults with targeted training to intake staff and identification of a flexible fund to support modest financial assistance tied to housing crisis resolution K. Establish specialized and streamlined engagement strategies for direct placement of unsheltered clients from the streets to Rapid Rehousing
1.4 Assess Transitional Housing needs and recalibrate TH investments based on results	A. Use system data to determine effectiveness of Transitional Housing (TH) in meeting system performance objectives B. Restrict TH program models for populations most likely to benefit from longer-term temporary housing programming (e.g. unaccompanied homeless youth, safety for survivors of domestic violence, and assistance with recovery from addiction) C. Assess need for Transitional Housing-to-Rapid Rehousing (TH:RRH) program model D. Support Mental Health Diversion Facility development, and operations
1.5 Sustain an effective end to Veteran homelessness	A. Limit Veteran access to CoC resources only when Veterans are ineligible for VHA-funded housing and services (CoC resources include housing choice vouchers, RRH, Diversion) B. Continue conferencing with VA, SSVF partners and other stakeholders C. Continue maintaining veteran by-name list D. Collaborate with other stakeholders to fill targeted system gaps (i.e. United Way Mission United) E. Monitor GPD length of stay and adjust as necessary F. Promote diversion strategies for vets using Rapid Resolution techniques

Strategy	Strategy Objectives
1.6 End homelessness among persons experiencing ***chronic homelessness***	A. Maintain by-name lists for chronically homeless households and continue to staff case conferencing as needed B. Create HMIS-based flag to document and highlight clients with verification of ***chronic homeless*** status C. Assign likely chronic clients with insufficient documentation to specialized case management to secure ***chronic*** verification D. Use a low-barrier, Housing First approach for permanent housing programs; train CoC to utilize CTI model E. Expand and enhance use of outreach teams to document unsheltered homelessness and record verification of ***chronic homeless*** status in HMIS
1.7 End youth homelessness and family homelessness	A. Continue targeted case conferencing meetings for high vulnerability youth and family cases B. Coordinate with CoC Youth Voice Action Council (Youth Action Board) Sub-committee to further develop youth system of care; explore funding to provide stipends for youth w/lived experience C. Support and coordinate with Housing Our Miami-Dade Youth (HOMY) collective D. Continue using TAY-VI-SPDAT youth vulnerability instrument and F-VI-SPDAT family vulnerability tool as part of the CE process E. Continue to pursue goals outlined as part of 100-Day Challenge, including rapid placement of all youth experiencing homelessness, emphasis on connections to employment/education/behavioral health connections as needed; promote permanent connections for youth F. Review Youth Homelessness Plan annually and adopt modifications as needed G. Apply for U.S. HUD Youth Homelessness Demonstration Project, Family Unification Program (FUP) vouchers and other youth-focused solicitations as opportunities arise H. Assess feasibility of creating new Coordinated Entry (CE), Emergency Shelter (ES), TH:RRH, PH, shared housing, host homes or other innovative model(s) to serve youth I. Coordinate with Public Child Welfare Agency (PCWA) to coordinate FUP and FYI referrals J. Collaborate with Miami Homes for All to continue youth focused Point-in-Time Count (iCount) K. Enhance diversion for youth and families with minor children
1.8 Reallocate underperforming, unsatisfactory or cost-ineffective CoC projects to provide new PSH or RRH	A. Rate renewal grants using modified HUD Rating and Ranking tool; develop formula to determine cost effectiveness B. Assess project-level performance using System Performance Measures (SyS PM) together with Performance Evaluation Committee and HUD Technical Assistance to identify trends and recommend action steps/strategies for performance improvement, particularly length of time homeless, exits and returns
1.9 Incorporate Housing First approach into all housing types	A. Investigate service participation requirements in targeted programming, including volunteerism B. Eliminate admission criteria that create barriers to entry (such as poor credit history, poor rental history, criminal convictions, engagement in therapeutic goals, use of alcohol/drugs; sobriety requirements) C. Build capacity of provider community to conduct housing planning, navigation and documentation maintenance; D. Map process from homelessness to housed, look for process improvements to reduce length of time homeless E. Create system to flag lease violations and notify CoC partners about opportunities to troubleshoot involuntary housing exits to reduce returns to homelessness
1.10 Review inventory of RRH programs and allocate funds based on demonstrated ability to	A. Coordinate referral process for RRH using CoC Housing Coordinator B. Monitor RRH programs to ensure appropriate level of support services and housing navigation C. Explore RRH models that provide longer lengths of stay for households with more complicated housing barriers

Strategy	Strategy Objectives
successfully serve priority populations	D. Review RRH admission criteria and eliminate any provider-defined criteria that inhibit immediate access to enrollment E. Continue collaboration with Emergency Solutions Grant (ESG) partners; build capacity to encourage new RRH providers F. Continue collaboration with State Housing Initiatives Partnerships (SHIP) entitlement jurisdictions G. Continue collaboration with HOME Investments Partnership Programs Entitlement Jurisdictions H. Continue collaboration with SSVF providers I. Continue to advocate for rental assistance as a priority for EFSP funding J. Continue to advocate use of Thriving Mind transitional funding for rental assistance K. Continue using local, state and HUD funding to maintain/increase RRH inventory L. Maintain RRH for survivors of domestic violence, human and sex trafficking M. Ensure DV RRH providers collect UDEs in homeless module of their MIS N. Use RRH to bridge households waiting for PSH O. Perfect mobile rapid rehousing
1.11 Review inventory of PSH programs and allocate funds based on demonstrated ability to successfully serve priority populations; expand Other Permanent Housing (OPH)	A. Promote the importance of homeless set-asides as an integral part of affordable housing development B. Continue collaborating with PHAs to establish homeless set-asides C. Partner with PHA's on U.S. HUD voucher opportunities D. Promote and expand continuum-wide, coordinated Move-Up/Move-On strategies E. Acquire and operationalize county-owned facility in West Miami-Dade for use as permanent housing for single adults with special needs F. Further maximize the use of federal surplus property to serve households experiencing homelessness. G. Assess feasibility of hotel purchase and renovation for use as housing for persons exiting homelessness H. Partner with developers on Florida Housing Finance Corporation development/financing and referral opportunities; work with developers/property managers to reduce barriers to entry (credit, income, background, etc.); better target clients for ELI referrals using HMIS I. Support community, statewide and federal efforts to expand affordable housing J. Assess need for specialized PSH programming among sub-populations (e.g. seniors, unsheltered singles adults with mental illness, substance abuse and other special needs). K. Expand HUD-Assisted Multifamily Housing Homeless and Move-Up Preference partnerships L. Acquire and renovate properties to serve as new permanent housing for persons experiencing homelessness M. Enhance partnerships with Assisted Living Facility/Independent Living Facility operators for clients who need enhanced housing and service supports N. Further explore master leasing opportunities O. Evaluate provider and government-owned parcels for homeless housing development
1.12 Coordinate mainstream resources and systems to ensure homeless clients access support services	A. Partner with VA, Federally Qualified Health Centers (FQHC) and Managed Care providers to provide support services to disabled persons in PSH B. Use Food and Beverage (F&B) tax to fund gaps in support services to leverage new PSH C. Support Medicaid pilots providing comprehensive support services to disabled persons D. Operationalize MOU with CareerSource South Florida, and the Beacon Council's Community Ventures Program, Head Start, Early Head Start and Project Up-Start programs. E. Enhance partnerships with The Alliance for Aging and the Advocacy Network on Disabilities

Strategy	Strategy Objectives
	F. Enhance continuum-wide legal services G. Enhance continuum-wide SOAR participation and track linkage to benefits H. Work to establish regular, on-site Homeless Courts to address legal issues that may prevent people experiencing homelessness from obtaining housing assistance
1.13 Create new Permanent Housing Options for Medically Needy and Frail persons who cannot live independently	A. Collaborate with Assisted Living Facilities; PACE Centers; Long-Term Care providers B. Use Federal funding sources to leverage set-asides C. Acquire/purchase, rehabilitate or build new units of Permanent Housing

Goal 2:
Improve Coordinated Entry Access, Assessment and Housing Placement

Strategy	Strategy Objectives
2.1 Reconfigure coordinated entry system to achieve more comprehensive impact.	A. Ensure comprehensive outreach strategy is in place to identify and continuously engage all unsheltered individuals and families; create and maintain shelter wait list, prioritizing of high need households B. Coordinate RRH, PSH and OPH referrals through Housing Coordinator C. Review cultural competency and racial equity of SO efforts D. Address racial and other system disparities E. Leverage technology to achieve greater tracking efficiencies (mobile tablets document engagement, assessments, contacts & referrals) F. Provide regular training to ensure effective use of vulnerability tool, street engagement and implementation of Evidenced based Practices (EBPs) such as Housing First and Motivational Enhancement Therapy (MET). Make diversion the first intervention by identifying alternate housing arrangements. G. Ensure a pathway to permanent housing is defined and supported, even when clients refuse shelter or shelter is not available. H. Enhance collaboration with DV system for placement into ES, TH, RRH and PSH I. Expand coordinated entry system capacity with accessible after-hours procedures J. Continuously offer comprehensive services to unsheltered persons who refuse all services (MET, street medicine, involuntary examination, housing navigation) K. Engage faith-based groups, housing advocates and others to enhance landlord connections and volunteer opportunities, and dissuade street feedings L. Revisit legacy street outreach programs to ensure effectiveness and maximize successful triage/exits.Ensure side door for an CE are closed
2.2 Utilize specialized outreach to serve persons refusing all services.	A. Continue specialized behavioral health, primary care, legal services outreach, particularly for unsheltered persons refusing all services. Enhance street outreach with team specializing in substance use disorders and mental health B. Continue collaboration with Thriving Mind's PATH program C. Continue collaboration with Healthcare for the Homeless grantee, Camillus Health Concern D. Continue collaboration with VA and SSVF providers E. Continue collaboration with law enforcement focused on homelessness (City of Miami HEAT Team, Miami Beach HOT team) F. Support specialized Access Points for persons fleeing DV, human/sex trafficking and youth, unsheltered; ensure Access Points are trained in diversion

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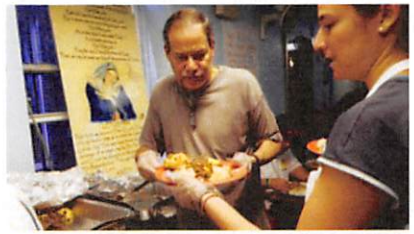
	G. Evolve partnerships with community-based organizations to ensure engagement that works toward the goal of ending homelessness
2.3 Improve discharge planning from jails, crisis centers, hospitals & institutions serving homeless youth	A. Assess discharge planning protocols and update memorandum of agreement in partnership with discharging institutions (jails, crisis units, hospitals) (staff at the court, jail, Mosher case staffing meetings, public hospitals) B. Include key funders and stakeholders in By Name List (BNL) case staffing meetings C. Develop data integration collaborative of mainstream data systems to understand trends and costs of high system users
2.4 Maintain toll-free helpline for centralized access to the CoC	A. Utilize technical assistance to improve Homeless Helpline; ensure metrics are regularly collected (# of calls, calls answered, average speed of answer, abandoned calls, average handle time; average hold time) B. Seek to expand Homeless Helpline to provide dedicated phone access point for youth; ensure appropriate staffing
2.5 Maintain a system-wide central waitlist for placement into CoC funded PH and homeless set-aside permanent housing programs	A. Coordinate RRH, PSH and OPH referrals through Housing Coordinator. B. Maintain Order of Priority referral process that complies with HEARTH and HUD guidance on Coordinated Entry
2.6 Expand on indoor meal programs as a means to engage homeless individuals	A. Coordinate indoor food distribution with community stakeholders and access points
2.7 Improve landlord outreach, engagement and retention	A. Maintain and consider expansion of risk mitigation fund to further incentivize landlords/property managers and expedite permanent housing placement B. Develop Navigator Certification Program C. Conduct quarterly engagement meetings with existing/prospective landlords D. Utilize SEEFA membership to gain and retain landlord leads E. Promote RentConnect (social media, landlord phone bank, PHA landlord engagement) F. Develop marketing materials to reach landlords G. Develop a centralized, system level landlord tracking tool; enhance house navigation services

Goal 3:
Expand Homeless Prevention and Diversion Opportunities

Strategy	Strategy Objectives
3.1 Expand rent/utility assistance and other interventions to prevent homelessness	A. Use SHIP, State Challenge grant, ESG, TANF, F&B, and EFSP to fund homelessness prevention initiatives B. Establish and support Miami-Dade Community Action and Human Services Centers CoC homeless prevention assistance walk-in sites C. Assess HP eligibility barriers and identify policy changes to serve extremely low income, vulnerable households beyond those with a third-party notice to vacate D. Create and implement a common assessment for homelessness prevention eligibility and priority determinations E. Coordinate with Miami Dade jurisdictions to identify strategies to reduce inflow into the homeless system
3.2 Establish a system-wide Diversion/Problem-Solving intervention for individuals and families at risk of homelessness	A. Integrate diversion/problem solving protocols into all initial intake assessments. Identify alternate housing arrangements for households able to resolve their housing crisis with modest solution-oriented, problem-solving supports. B. Investigate the design, funding, and administration of a flexible financial assistance fund C. Train CES access point staff in mediation and other problem-solving strategies

Goal 4:
Improve and Expand Support Services



Strategy	Strategy Objectives
4.1 Improve CoC-wide knowledge and use of Marchman and Baker Acts, and Guardianship Program	A. Invite Thriving Mind to present at Providers' Forum B. Provide enhanced training, including Pre-Critical Time Intervention, to street outreach teams and access points C. Develop encampment plan to include specialized Street Outreach with focus on Alcohol and Substance Abuse intervention
4.2 Maximize the use of mainstream and other community-based resources	A. Continue and expand collaboration with Head Start, Catholic Legal Services, Veterans Affairs, Faith-Based Organizations, Managed Care, Greater Miami Legal Services, OIC of South Florida, PACE Centers, Career Source, Parent to Parent, Advocacy Network on Disabilities B. Provide training to providers, including CareerSource to improve employment outcomes. C. Develop and prioritize training, employment and volunteer opportunities for people experiencing homelessness. D. Maintain Homeless and Youth Homeless Resource Guides E. Support the State Opportunity Work Tax Credit in state legislature F. Establish a work group to study the barriers to success and develop expedited trauma informed, pathways for vulnerable persons living on the streets or in shelters suffering from severe and persistent mental illness to residential placement, such as MH assisted living facilities, long term residential treatment, beyond the homeless continuum G. Encourage and promote workforce development initiatives for persons experiencing homelessness, including creating sustainable solutions at Verde Gardens, particularly the farm and farmer's market, to facilitate employment and income growth for homeless/formerly homeless households;
4.3 Pursue alternative to inpatient/residential treatment programs for the mentally ill and substance users	A. Support the construction and operations of the Mental Health Diversion Facility B. Share data with Thriving Mind to assess the effectiveness of the Orders of Priority for Referral to PH for formerly homeless persons exiting treatment C. Use Outpatient Assisted Treatment when possible
4.4 Adopt client-centered service methods tailored to meet the unique needs of individuals and family	A. Assess feasibility of adding stand-alone support services to legacy S+C program B. Provide Evidence Based Practice (EBP) training, including Critical Time Intervention and Pre-CTI C. Expand training opportunities in Safety Planning Protocols for CoC providers D. Provide training on Fair Housing requirements and implementation of strategies to further Fair Housing E. Collaborate with other systems to promote wellness (i.e. SAMH Managing Entity, Ryan White, Victim Services)

	F. Establish youth protection protocols continuum-wide utilizing train the trainer model to ensure safety of minor children G. Develop a Guardianship pathway for CoC providers in collaboration with DCF
4.5 Improve system identification and treatment of domestic violence. Including the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, and emotional abuse (aka. sexual assault, domestic violence, or intimate partner violence)	A. Expand system training on Domestic Violence identification and resources for treatment B. Provide specialized Domestic Violence Access Points to CoC resources C. Ensure specialized shelter, transitional housing and rental assistance for persons fleeing Domestic Violence D. Increase collaboration between the Domestic Violence and Homelessness Systems and better use data to understand the intersect and meet the unique needs of survivors
4.6 Review, improve and expand as necessary supportive services provided by/through the Homeless Trust	A. Ensure new acquisitions have adequate level of supportive services relative to client needs B. Review service levels in existing projects

Goal 5:
Advance Data-Driven Decision-Making

Strategy	Strategy Objectives
5.1 Conduct bi-annual homeless census	A. Continue unsheltered and sheltered counts conducted twice annually
5.2 Conduct Point-in-Time Surveys	A. Complete PIT surveys annually, during the last 10 days in January to identify gaps and needs
5.3 Conduct annual iCount & Surveys	A. Continue youth service count (iCount), during the last 10 days in January using youth with lived experience and countywide magnet sites B. Participate in national data sharing of youth data dashboard C. Create youth-specific benchmarks to measure progress
5.4 Regularly review system performance using	A. Regularly analyze Longitudinal System Analysis (LSA) also known as Stella P B. Publicly share data and outcomes
5.5 Enhance HMIS data capturing and reporting capacity	A. Measure CoC-wide and provider performance utilizing HUD measures B. Perform data analysis to identify CoC and provider-level trends and opportunities C. Look at data warehouses that can share homeless service and mainstream resource data D. Support Housing Coordinator to input Other Permanent Housing (OPH) data in HMIS E. Perform data quality assessments monthly F. Develop training curricula for the unique needs of beginner, intermediate and advanced HMIS users G. Work towards ensuring 100% of homeless service providers (CoC and Non-CoC) contribute to HMIS; encourage use of HMIS with other training partners H. Work with United Way to use HMIS as clearinghouse for EFSP rental assistance; use as opportunity to build capacity and ready new entities to administer CoC/ESG rental assistance resources as available
5.6 Enhance technology to realize system performance improvements	A. Institute monthly tracking of System Performance Measures (SPMs) in HMIS-based dashboards B. Fully utilize SkanPoint Module to streamline client data entry C. Implement income verification system (The Work Number) D. Utilize system mapping software (ESRI) E. Explore data warehousing; use all data sources (including data from non-homeless system of care) to prevent and end homelessness F. Develop HMIS-based shared housing matching application G. Maintain Homeless Trust website to ensure it is user friendly for public, clients, providers

	H. Explore technology solutions to enhance coordinated entry/exit and diversion
5.7 Use data to access equity of interventions	A. Maintain and further develop Lived Experience Working Group to strengthen and advance racial, gender and disablism sensitivity, equity, diversity and inclusion and social justice within the homeless continuum of care. B. Engage experts to do a system analysis of equity and inclusion. Use results to inform CoC Board, subcommittee and stakeholder training. C. Develop a detailed racial equity plan and track progress D. Provide guidance to CoC members on the components they need to include in their Racial Equity Plans, in alignment of CoC goals E. Continue to analyze data to understand inequities and create solutions. F. Develop a "Commitment to Racial Equity" statement
5.8 System Performance	A. Review System Performance Measures (SPMs), isolate key areas of concern, convene stakeholders to develop a plan to improve measures. Key measures include Length of Time homeless, Exits to Permanent Destinations and Returns to Homelessness.

Goal 6:

Strengthen CoC Governance & Resource Maximization

Strategy	Strategy Objectives
6.1 Ensure CoC Board and committee composition and governing bylaws comply with federal HEARTH regulations and are representative of all stakeholders	A. Include input from LGTBQ+, Victims of Human Trafficking, Unaccompanied and Parenting Youth, Individuals with Disabilities, etc. B. Look at strategies for engaging and increasing participation by persons with lived homeless experience C. Ensure race equity and inclusion efforts are extended to committee appointments and participation D. Use Performance Evaluation Committee to continue analyzing data to improve system performance, including predicative analytics when possible
6.2 Enhance coordination with entitlement jurisdictions to ensure alignment with CoC goals/objectives	A. Established quarterly calls with ESG staff at entitlement jurisdictions; provide input annually/as requested to Consolidated Plan and Action Plan for all entitlement jurisdictions
6.3 Increase Public Education and Awareness, in impacted communities/areas.	A. Educate the City of Miami downtown business community on the Trust policies and priorities (e.g. CH); conduct on-going communication with business community on Trust's efforts and accomplishments to end CH B. Post system governance, standards, P&P and forms on Homeless Trust website; uniform policy layout
6.4 Engage governmental, leadership, advocacy organizations to note emerging trends, innovations and best practices	A. Continue collaboration with USICH, USHUD, DCF Office on Homelessness, Florida Housing Coalition, National Alliance to End Homelessness, CSH and Florida Coalition to End Homelessness
6.5 Engage local, state and federal elected leadership	A. Pursue legislative priorities • Expand F&B tax to now exempt beach municipalities (Miami Beach, Surfside, Bal Harbour) • Advocate at the state level for bridge RRH for Homeless Persons with Special Needs • Support and advocate for reforms to Florida's Mental Health Act • Good Samaritan status for homeless shelters and/or extension of sovereign immunity to shelter providers
6.6 Further leverage federal, state, local and private sector funding	A. Continued fundraising in partnership with The Miami Foundation to secure and operate dedicated permanent housing facilities which include supportive housing B. Pursue new CoC projects through the special NOFOs and annual NOFO competition C. Pursue special appropriations from the State of Florida to create additional housing interventions for persons experiencing homelessness

Goal 7:

Ensure Continuous Quality Improvement Strategies for CoC

Strategy	Strategy Objectives
7.1 Implement CoC-wide grievance procedures	A. Update Grievance Procedures B. Provide refresher in Restorative Practices training
7.2 Implement electronic customer satisfaction surveys and evaluate annually	A. Continue annual, electronic customer satisfaction survey in multiple languages and intentionally solicit feedback from clients post housing placement
7.3 Review and adjust, if necessary, local performance measures	A. Continue to align local performance measures with HUD system performance measures. B. Review and adjust benchmarks annually.
7.4 Conduct "Secret Shopper" evaluation of CoC delivery of housing and services annually	A. Conduct secret shopper activities to test the helpline and recommend improvements
7.5 Conduct annual desk audits and on-site monitoring of programs	A. Perform risk assessment of contracted providers annually B. Ensure Risk Assessment aligns with system standards and contracts C. Partner with Housing Authorities to jointly monitor ESG D. Monitor and reduce evictions and discharges to unknown destinations E. Further develop monitoring procedures F. Use HUD monitoring tools, modified as necessary G. Implement new agency monitoring tools H. Implement strengths based self-assessment I. Further develop client satisfaction survey procedures
7.6 Ensure timely grant execution, payments to providers/landlords	A. Assess and revise grant management policies and procedures B. Implement provider payment supports: 1. Implement "buddy system" policy to ensure consistent contract coverage during staff abscences

	2. Require and provide provider training on do's and don'ts of reimbursement requests a. Provide "office hours" for package corrections b. Provide "one on one" training at the beginning of the contract period and by request when there is personnel turnover at the provider level 3. Create policy regarding deadlines to submit policy adjustments 4. Create shared file for "deficiency report" to review with and have available for management a. Create a checklist of main deficiency categories 5. Notify contract manager, CEO, board members when package is returned 6. Engage HUD on impact of delays 7. Conduct review of Zengine and develop procedure for tracking key payment process milestones and consider alternate solutions a. Provide regular report to HT management on late provider submittals 8. Further engage with OMB and Ryan White sections C. Review and implement Rental Assistance Program policies and procedures D. Review and update finance policies and procedures E. Pursue paperless grant option
7.7 Conduct capacity-building training to CoC providers	A. Conduct provider training on HUD guidance and emerging best practices inclusive of Housing First; Motivational Interviewing; Mental Health First Aid; Behavioral Health Tech Training; Restorative Justice; Race, Equity, Diversity and Inclusion (REDI); LGBTQIA+/gender sensitivity, equity, diversity and inclusion training. B. Develop formal CoC training program
7.8 Review and improve disaster response and recovery plans	A. Review and update COOPs B. Improve client tracking procedures following overflow activation events C. Review emergency response plans for cold weather, hurricanes and infectious disease
7.9 Ensure Trust-owned assets are maintained	A. Make capital improvements to Trust owned assets to ensure the health and safety of residents (Homeless Assistance Centers operated by Chapman, Mia Casa, Verde Gardens Farm and Market)

Goal 8:
Execute on the Plan to End Homelessness

Strategy	Strategy Objectives
8.1 Implement the Dade County Community Homeless Plan: 1994	A. Review Homeless plan with CoC Subcommittee annually, update strategies as necessary B. Further develop Community Plan to End Homelessness: Priority Home; seek wide public input C. Review Homeless plan at joint-Board retreat

The 2023 Florida Statutes

212.0306 Local option food and beverage tax; procedure for levying; authorized uses; administration.—

(1) Any county, as defined in s. 125.011(1), may impose the following additional taxes, by ordinance adopted by a majority vote of the governing body:

(a) At the rate of 2 percent on the sale of food, beverages, or alcoholic beverages in hotels and motels only.

(b) At the rate of 1 percent on the sale of food, beverages, or alcoholic beverages in establishments that are licensed by the state to sell alcoholic beverages for consumption on the premises, except for hotels and motels; however, the tax shall not apply to any alcoholic beverage sold by the package for off-premises consumption.

(2)(a)1. The sales in any establishment licensed by the state to sell alcoholic beverages for consumption on the premises, except for hotels and motels, that had gross annual revenues of $400,000 or less in the previous calendar year, are exempt from the tax authorized by paragraph (1)(b).

2. For purposes of determining qualification for this exemption, each such establishment must determine the annual gross revenues of the business at the end of each calendar year. If an establishment's exemption status changes, the establishment must cease or begin collection of the tax effective the following February 1, in accordance with its new exemption status. An establishment must notify the tax collector of the county levying the tax of such change in writing no later than 20 days after the end of the calendar year.

3. Each newly opened establishment must collect the tax authorized by paragraph (1)(b) for 45 days commencing with its first day of business. After such time a newly opened business may cease collecting the tax if its projected gross annual revenues are $400,000 or less. Projected gross annual revenues shall be determined by dividing gross revenues for the first 45 days by 45, and multiplying the resulting quotient by 365. Newly opened businesses which cease collecting the tax must notify the tax collector of the county levying the tax within 20 days after the last day the tax is collected. A newly opened establishment which has been in business for less than 45 days as of the end of its first calendar year is exempt from the provisions of subparagraph 2. for that calendar year.

(b) Sales in any veterans' organization are exempt from the tax authorized by paragraph (1)(b).

(c) All transactions that are exempt from the state sales tax are exempt from the taxes authorized by subsection (1).

(d) Sales in cities or towns presently imposing a municipal resort tax as authorized by chapter 67-930, Laws of Florida, are exempt from the taxes authorized by subsection (1); however, the tax authorized by paragraph (1)(b) may be levied in such city or town if the governing authority of the city or town adopts an ordinance that is subsequently approved by a majority of the registered electors in such city or town at a referendum held at a general election as defined in s. 97.021. Any tax levied in a city or town pursuant to this paragraph takes effect on the first day of January following the general election in which the ordinance was approved. A referendum to reenact an expiring tax authorized under this paragraph must be held at a general election occurring within the 48-month period immediately preceding the effective date of the reenacted tax, and the referendum may appear on the ballot only once within the 48-month period.

(3)(a) The proceeds of the tax authorized by paragraph (1)(a) shall be allocated by the county to a countywide convention and visitors bureau which, by interlocal agreement and contract with the county, has been given the primary responsibility for promoting the county and its constituent cities as a destination site for conventions, trade shows, and pleasure travel, to be used for purposes provided in s. 125.0104(5)(a)2. or 3., 1992 Supplement to the Florida Statutes 1991. If the county is not or is no longer a party to such an interlocal agreement and contract with a countywide convention and visitors bureau, the county shall allocate the proceeds of such tax for the purposes described in s. 125.0104(5)(a)2. or 3., 1992 Supplement to the Florida Statutes 1991.

[1](b) For the first 12 months, the proceeds from the tax authorized by paragraph (1)(b) shall be used by the county to assist persons who have become, or are about to become, homeless. These funds shall be made available for emergency homeless shelters, food, clothing, medical care, counseling, alcohol and drug abuse treatment, mental health treatment, employment and training, education, and housing. Thereafter, not less than 15 percent of these funds shall be made available for construction and operation of domestic violence centers, and the remainder shall be used for the other purposes set forth in this paragraph. In addition, the proceeds of the tax and the interest accrued on those proceeds may be used as collateral, pledged, or hypothecated for projects authorized by this paragraph, including bonds issued in connection therewith. Prior to enactment of the ordinance levying and imposing the tax provided for by paragraph (1)(b), the county shall appoint a representative task force including, but not limited to, service providers, homeless persons' advocates, and impacted jurisdictions to prepare and submit to the governing board of the county for its approval a plan for addressing the needs of persons who have become, or are about to become, homeless. The governing board of the county shall adopt this countywide plan for addressing homeless needs as part of the ordinance levying the tax.

(c) The county and each municipality in that county shall continue to contribute each year at least 85 percent of aggregate expenditures from the respective county or municipal general fund budget for county-operated or municipally operated homeless shelter services at or above the average level of such expenditures in the 2 fiscal years preceding the date of levying this tax.

(4) A certified copy of the ordinance that authorizes the imposition of a tax authorized by this section shall be furnished by the county to the Department of Revenue within 10 days after the adoption of the ordinance.

(5) A tax authorized by this section may take effect on the first day of any month, but may not take effect until at least 60 days after the adoption of the ordinance levying the tax.

(6) Any county levying a tax authorized by this section must locally administer the tax using the powers and duties enumerated for local administration of the tourist development tax by s. 125.0104, 1992 Supplement to the Florida Statutes 1991. The county's ordinance shall also provide for brackets applicable to taxable transactions.

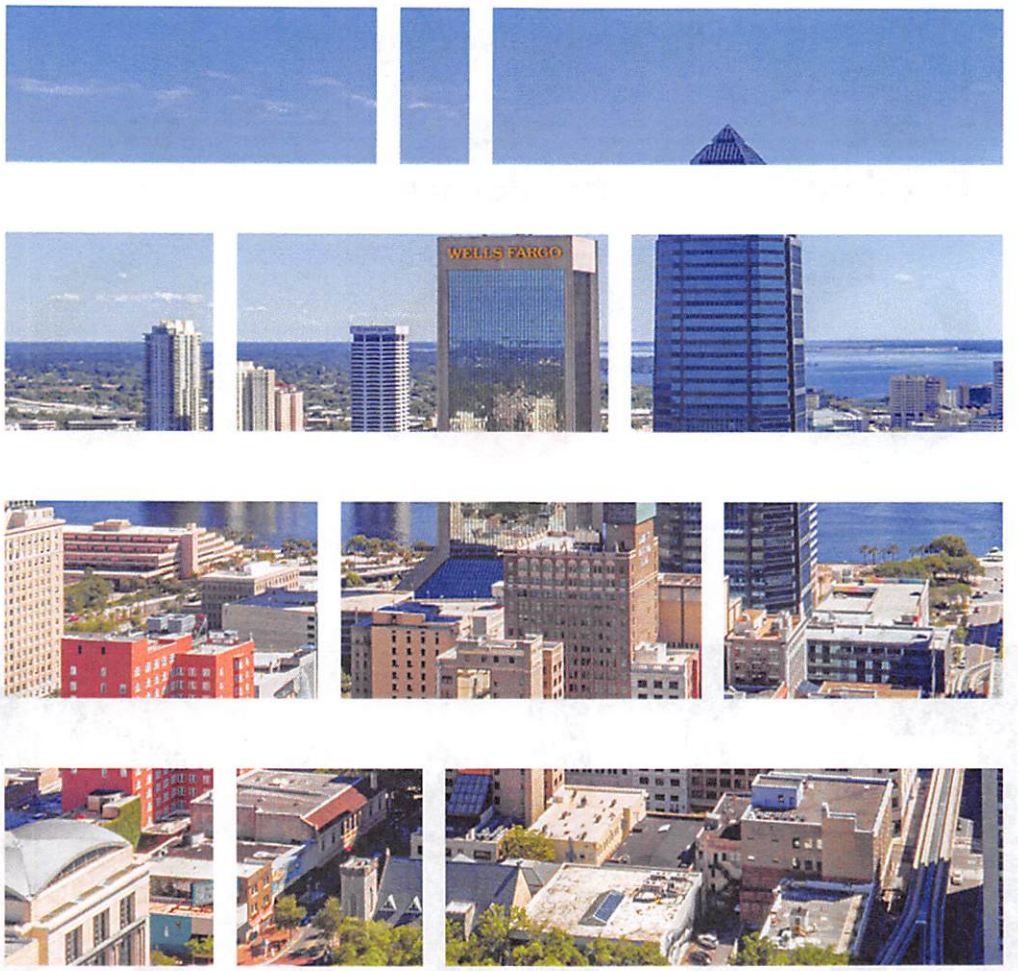
(7) Each county shall also appoint an oversight board including, but not limited to, service providers, domestic violence victim advocates, members of the judiciary, concerned citizens, a victim of domestic violence, and impacted jurisdictions to prepare and submit to the governing board of the county for its approval a plan for disbursing the funds made available for the construction and operation of domestic violence centers. Each member of the county's governing board shall appoint a member, and the county manager shall appoint two members, to the oversight board.

History.—s. 2, ch. 89-362; s. 4, ch. 93-233; ss. 1, 2, ch. 94-351; ss. 71, 72, ch. 94-353; s. 21, ch. 2023-157.

[1]Note.—As amended by s. 71, ch. 94-353. Paragraph (b) was also amended by s. 1, ch. 94-351. The ch. 94-353 version is published here as the last expression of legislative will. Paragraph (b), as amended by s. 1, ch. 94-351, reads:

(b) For the first 12 months, the proceeds from the tax authorized by paragraph (1)(b) shall be used by the county to assist persons who have become, or are about to become, homeless. These funds shall be made available for emergency homeless shelters, food, clothing, medical care, counseling, alcohol and drug abuse treatment, mental health treatment, employment and training, education, and housing. Thereafter, not less than 15 percent of these funds shall be made available for construction and operation of domestic violence centers, and the remainder shall be used for the other purposes set forth in this paragraph. In addition, the proceeds of the tax and interest accrued may be used as collateral, pledged or hypothecated, for any projects authorized by this paragraph, including bonds issued in connection therewith. Prior to enactment of the ordinance levying and imposing the tax provided for by paragraph (1)(b), the county shall appoint a representative task force including, but not limited to, service providers, homeless advocates, and impacted jurisdictions to prepare and submit to the governing board of the county for its approval a plan for addressing the needs of persons who have become, or are about to become, homeless. The governing board of the county shall adopt this countywide plan for addressing homeless needs as part of the ordinance levying the tax.

Note.—Former s. 125.0104(3)(n).



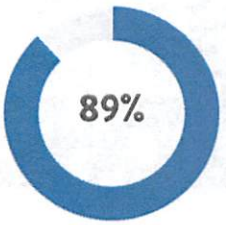
2023 DTJax Survey Summary

Published July 2023

DTJax.com/Research

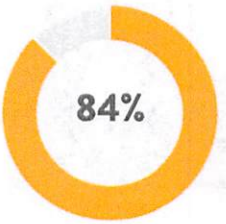
Respondents: 1,400+ Downtown Residents, Professionals & Visitors

296 Residents



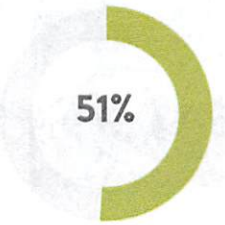
Like or love living Downtown.
(Up from 87%)

560 Employees



Like or love working Downtown.
(Up from 72%)

545 Visitors

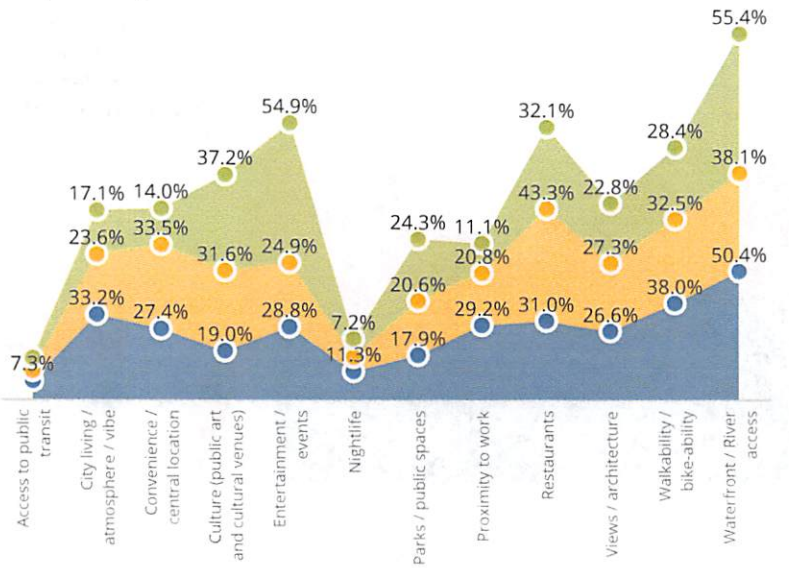


Have a favorable opinion of Downtown.
(Up from 41%)

Have an average annual household income of $80,000+.

Have obtained a four-year degree or higher.

What has the greatest POSITIVE impact on your experience Downtown?



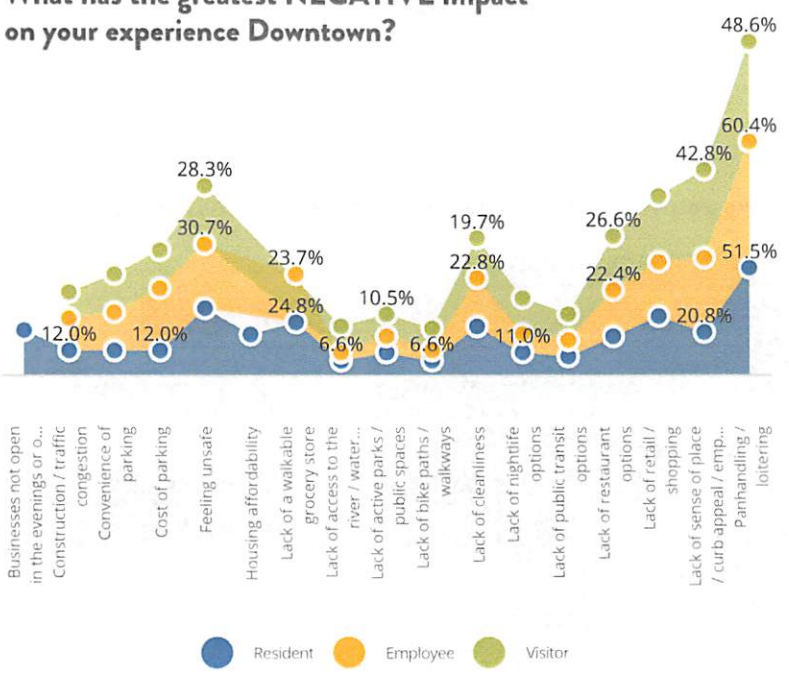
"Waterfront / River access" ranked in the Top 3 for all audiences.

Residents:
1. Waterfront / River access
2. Walkability / bike-ability
3. City living / atmosphere / vibe

Employees:
1. Restaurants
2. Waterfront / river access
3. Convenience / central location

Visitors:
1. Waterfront / river access
2. Entertainment / Events
3. Culture - public art and cultural venues

What has the greatest NEGATIVE impact on your experience Downtown?



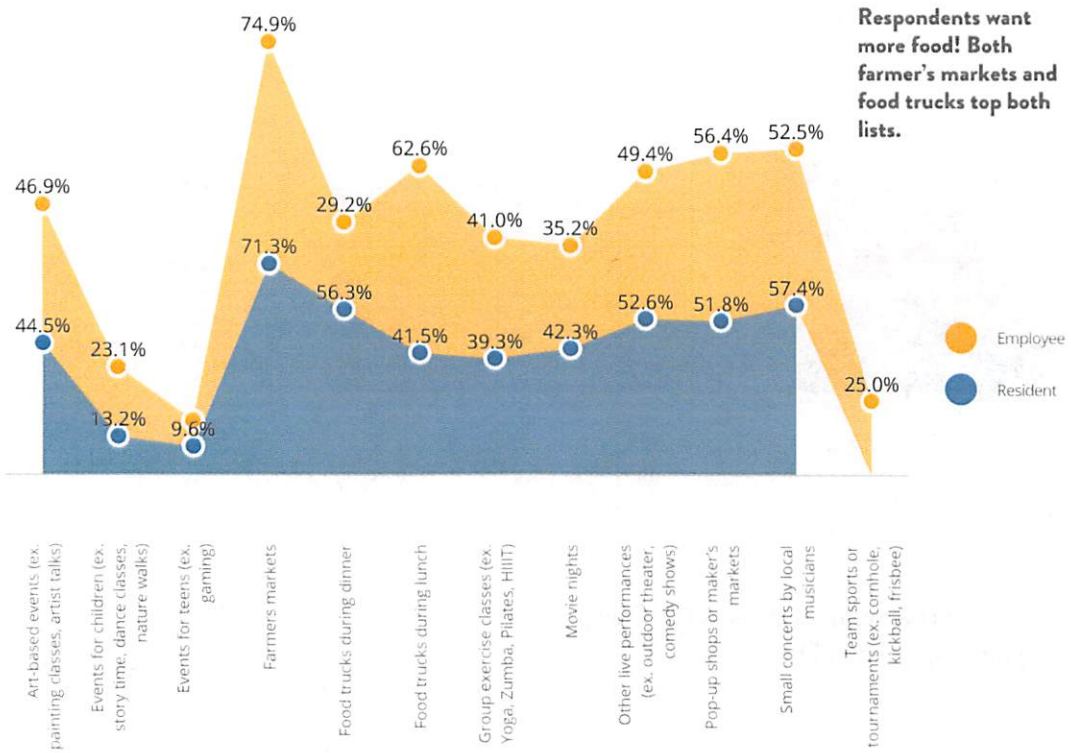
"Panhandling / loitering" was ranked the No. 1 issue for all audiences.

Residents:
1. Panhandling / loitering
2. Feeling unsafe
3. Lack of retail / shopping

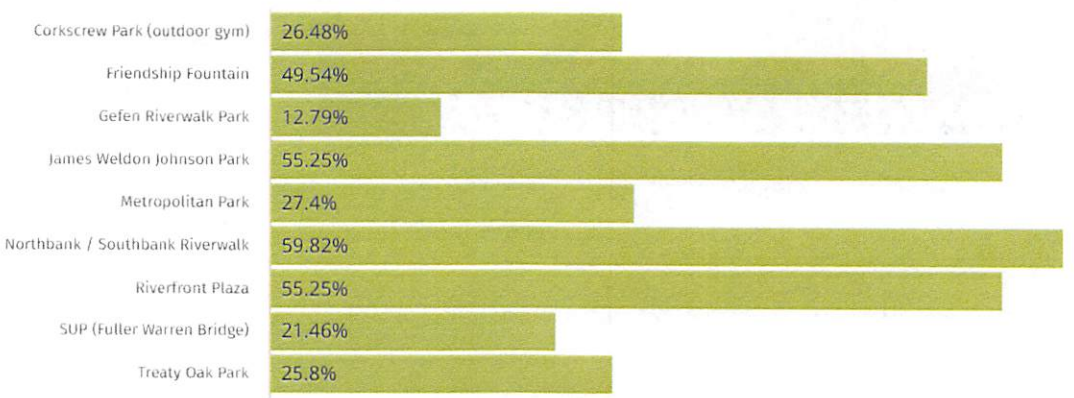
Employees:
1. Panhandling / loitering
2. Lack of sense of place / curb appeal / empty storefronts
3. Feeling unsafe

Visitors:
1. Panhandling / loitering
2. Lack of sense of place / curb appeal / empty storefronts
3. Lack of retail / shopping

Residents & Employees: If available in or near Downtown's parks, which activities would you be likely to participate in? (Select all that apply.)



Visitors: Which parks have you visited in the past year? Select all that apply.



Resident Snapshot

Most important factors in choosing to live Downtown:

1. Convenience / central location
2. Walkability
3. Proximity to events and activities

Least important: Access to public transit, Proximity to work, Cost

Most important IN-UNIT amenities:

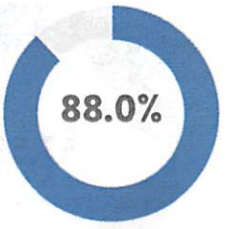
1. In-unit washer / dryer
2. Dishwasher
3. Balcony / patio

Least important: Keyless entry, Wifi thermostat, Smart home technology

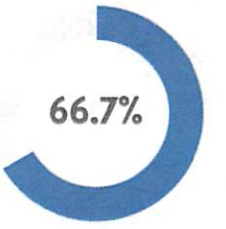
Most important PROPERTY amenities:

1. On-site parking
2. 24-hour security
3. 24-hour emergency maintenance

Least important: Sport courts, Yoga studio, Electric car charging stations

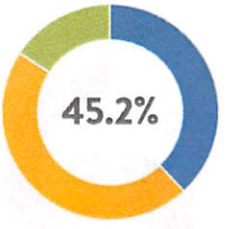


Like or love their choice of residential building / property.



Rent vs. Own.

Have lived Downtown for 3+ years.



Live in 2-person households.
(38.1% - 1-person / 15.7% - 3+ Persons)

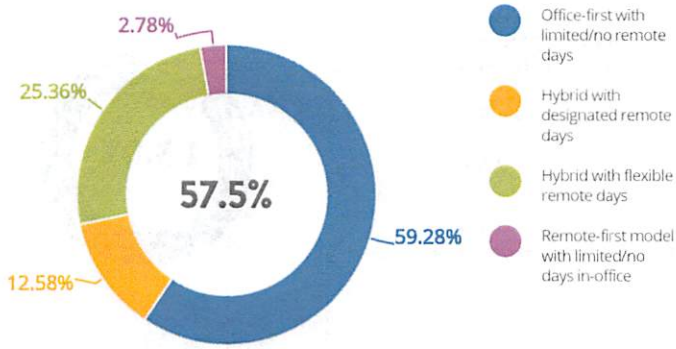
Top Work Zip Codes:

Employee Snapshot

Most important workplace amenities:

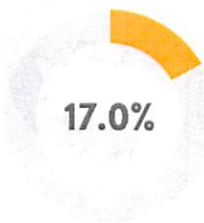
1. Easy access to parking
2. Reliable, fast Wi-Fi
3. 24-hour security

Least important: Electric vehicle charging stations, app-based digital programming, ex. mobile access, resource booking capabilities, Bike racks/storage



Work remotely part or full time.

Have a one-way commute time of 20 minutes or less. (U.S. average is 26 minutes)



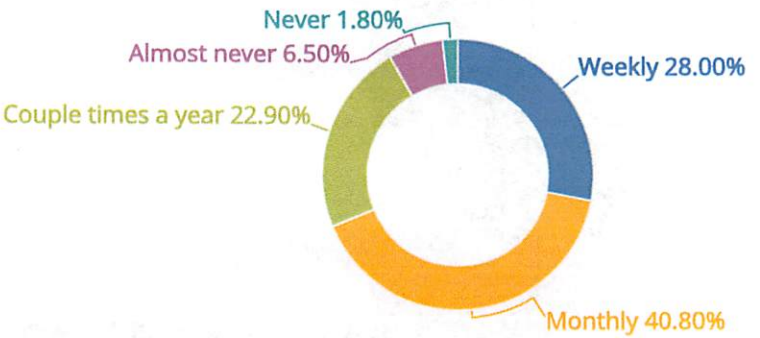
Take an alternative means of transportation at least once a month

Would be very or somewhat likely to stay Downtown after work if more dinner and/or happy hour options were available

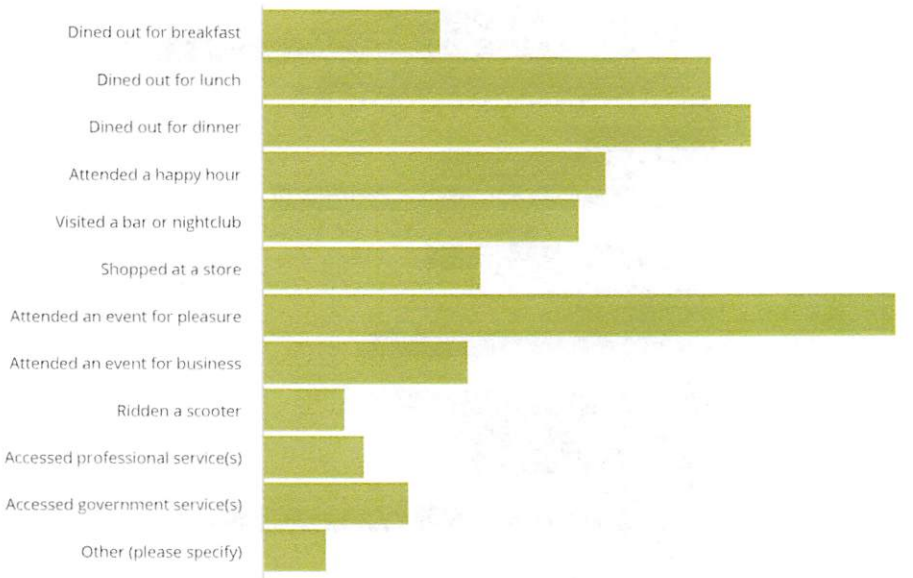
Top Home Zip Codes:

What Brings Visitors Downtown:

How often do you go Downtown for pleasure?

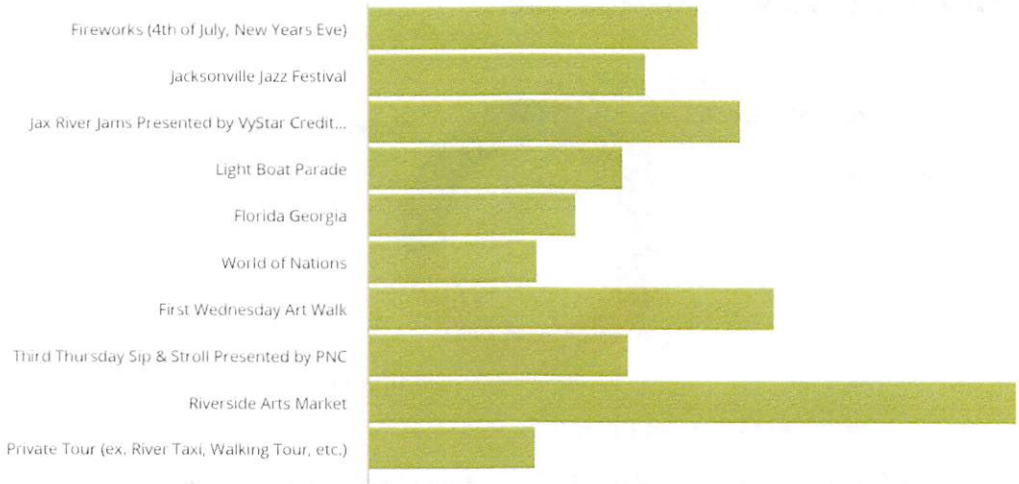


Which of the following have you done in Downtown in the past month? Select all that apply.

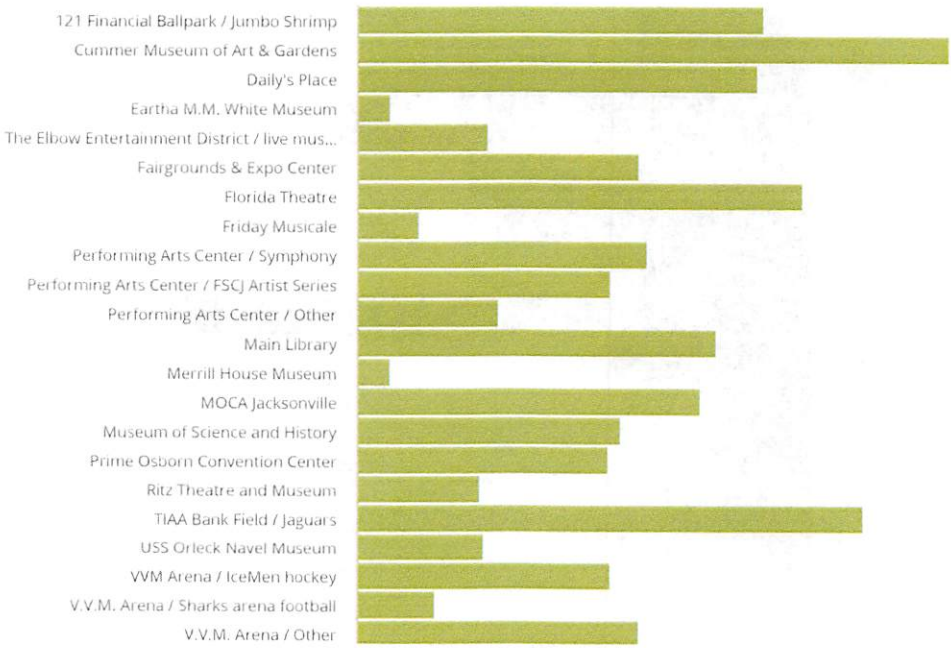


What Brings Visitors Downtown :

Which Downtown events have you attended in the past year? Select all that apply.



Which venues and events have you visited in the past year? Select all that apply.



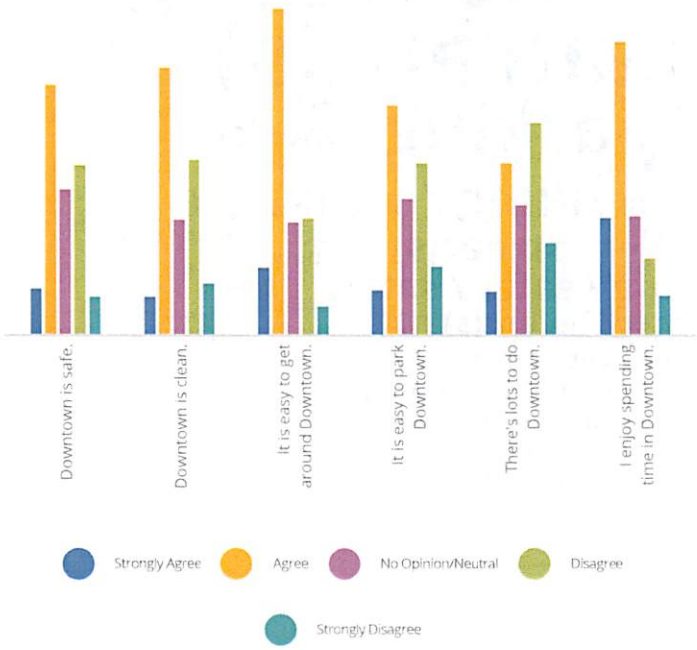
Visitors: Perceptions are up but we have a ways to go:

57.9%

Think Downtown has improved over the past five years. (Up from 52.5%).

50.7%

Have a positive opinion of Downtown (Up from 41.2%).



45.6%
Downtown is safe.
(Down from 48.1%.)

47.2%
Downtown is clean.
(Up from 44.4%)

60.5%
It is easy to get around Downtown.
(Up from 53.4%)

42.1%
It is easy to park Downtown.
(Down from 45.0%)

33.1%
There's lots to do Downtown.
(Up from 27.8%)

63.8%
I enjoy spending time in Downtown.
(Up from 59.0%)

All: If You Had a Magic Wand, What Would You Change About Downtown?