Guide to Resource Mapping and Assessing Community Needs

NOVEMBER 2024

INTRODUCTION: Resource mapping and assessing community needs are essential for organizations striving to build a comprehensive system of care for people experiencing homelessness. Analysis of both quantitative and qualitative data enables these organizations to better understand the community's needs and identify service gaps. By leveraging data sources and engaging in strategic partnerships, organizations can work toward building a more resilient and supportive system of care.

What Is Resource Mapping?

Resource mapping is an activity your organization and partners can engage in to identify existing resources and funding streams and to map out what additional support is needed to build a whole-person system of care. The necessary collaborative partners will vary and may change over time based on the goals and the focus population(s) you intend to serve. Collaboration is vital because it is unlikely that a single organization will offer every service that people experiencing homelessness need.

Using Data to Understand the Needs of the Population You Serve

To begin this process, you will need to understand and access available data sources to identify unmet needs. Quantitative and qualitative data are invaluable in summarizing and addressing existing gaps. Quantitative data can point us to trends in current systems, but it is important to remember that it does not always tell the whole story. This is where qualitative data comes in—these data help us tell the story behind the numbers and give statistics deeper meaning by asking people about their needs. Included below

are sources that can be used to support a community's efforts to define gaps and engage other systems in collaboratively addressing the whole-person care needs of people who are experiencing homelessness.

Quantitative Data

Data reported as information that can be represented numerically, counted, or measured are considered **quantitative** data. For example, data stored in the Homeless Management Information System (HMIS), Stella, the Point-in-Time (PIT) Count, and the Housing Inventory Count (HIC) are sources of quantitative data with which communities serving people experiencing homelessness are often familiar. Other sources of quantitative data that represent the health-related needs of the community include the following:

- **Community Health Needs Assessment Data**
  Under section 501(r)(3) of federal law, nonprofit hospitals, also known as charitable hospitals, are required to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs that are identified through the CHNA. These federally required CHNAs must
  - take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
  - be made widely available to the public.[1]

  Communities can locate their nonprofit hospital's CHNA using a search engine by entering the hospital's name and adding "CHNA" to the search. Once you have located your area's CHNAs, you can look for data that document any unmet needs and for ways the hospital intends to invest in addressing these needs. Not every CHNA has specifically assessed the needs of people experiencing homelessness. This illustrates why it is important for providers who serve this population to participate in future CHNAs to raise awareness of these needs and advocate for additional funding.
- **High Utilizer and Emergency Response Data**
  Because of the extensive data that must be collected to manage health conditions and bill for care, hospitals have a wealth of data on utilization. Being unhoused can correlate with poorly managed physical and behavioral health conditions and can contribute to the high utilization of both hospitals and emergency response systems. Hospitals and EMS partners can identify high utilizers and provide data that can be used to estimate utilization costs and make the financial case for more impactful, lower-cost programming to serve these populations, such as medical or mental health respite or supportive housing. Community leaders, such as Continuum of Care (CoC) administrators, can work with hospital executives and health departments to request support in accessing these data.
- **Medical Examiner and Public Health Data**
  Many jurisdictions collect data on drug overdose deaths, though the availability of data regarding individuals' housing status varies in each community. Communities can use available data to further illustrate the need for harm reduction, alcohol and drug treatment programs, recovery community programs, and housing for individuals who use substances. Many communities also have a suicide

mortality review committee that collects and reviews data to assess risk factors and trends and may have data related to housing status. For more details on assessing homeless mortality, access this toolkit produced by the National Health Care for the Homeless Council.

- **Single State Agency Treatment Episode Data Set**
  This dataset is reported to each state's substance use treatment authority. It records admissions and discharges from state-funded or federally funded treatment for substance use disorder, including information on demographics. Each state's data can be used to better understand treatment access by age, sex, race/ethnicity, and employment status, allowing your system of care to address disparities and document treatment outcomes.
- **Health Center Uniform Data Systems**
  These data are managed by area Federally Qualified Health Centers (FQHC), also known as community health clinics. Each year, these clinics are required to report on a core set of information, including patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenue. Demographic data are captured, and types of health and behavioral health conditions are treated. Working with an area FQHC to gather more detailed information about the health and behavioral health needs of people who are unhoused can further define gaps in the existing system of care.

Qualitative Data

This type of data represents information and concepts not represented by numbers. They are often gathered through interviews and focus groups. Qualitative data can help achieve a greater understanding of quantitative data based on interviewees' experiences, perceptions, and sensemaking of phenomena and trends. Qualitative data can be secured the following ways:

- **Focus Groups**
  Communities can coordinate focus groups where community partners and people with lived expertise are gathered and interviewed about any area that needs further understanding beyond qualitative data. Often a community will hire a third party (evaluator or consultant) to facilitate focus groups because this individual can bring greater objectivity to the topic of inquiry and reduce bias and preconceived notions. When working to secure attendees who have lived experiences of homelessness and health or behavioral health conditions as well as attendees who belong to racially marginalized communities, it is valuable to enlist the support of trusted community stewards such as street outreach workers; peer recovery specialists; clergy; and "by us, for us" organizations (e.g., the Urban League, Boys and Girls Club, tribal- and Latine-serving organizations, tribal governments).
- **Individual Interviews (i.e., Key Informant Interviews)**
  These interviews can complement findings from focus groups and may need to be offered to partners who have a high level of understanding of the topics of inquiry. Hiring a third party to conduct these interviews can also improve participants' receptiveness and responsiveness.
- **Surveys**
  A survey may be helpful if you want to reach a large group of people to identify trends. Surveys allow you

to ask questions uniformly and collect specific data points. You can also survey at different times to see if responses vary or change. One limitation of surveys is that you do not get to ask follow-up or clarifying questions, so data may not be as rich as if you were to collect them in other ways.

TIPS FOR COLLECTING QUALITATIVE DATA

- Acknowledge that communities have experienced harm by researchers engaging in racist practices, biases, and exclusion in the name of "research." Explore the NIH Research Ethics Timeline to learn more about past harms. Discuss strategies to avoid repeating harm in your process.
- Ensure people with lived expertise are equal partners in the design of surveys used to collect information, in the analysis and synthesis of data, and in decision-making.
- Compensate people (equitably) with lived expertise for their time and contributions, paying them the same rate as other subject matter experts or consultants. Provide payment options such as cash, gift cards, checks, direct deposits, or payment apps.
- Address other barriers to participation by persons with lived experience, such as providing resources for transportation or childcare, if needed.
- Include people with lived expertise as contributors and authors in publications summarizing findings.
- Examine the purpose of collecting qualitative data, and ensure it is used to propel systems and programmatic changes. Plans to disseminate findings and planned changes resulting from the findings should be made public to promote accountability.
- Collect qualitative data from persons served continuously rather than only once to help improve the quality of policies and practices and strengthen responsiveness to the focus population's emerging needs and wants.

After the initial data collection, it is important to implement systems change that addresses both the quantitative and qualitative findings. Planned changes must be cocreated and designed through collaborative partnerships that include the multiple systems serving people experiencing homelessness. Plans should be presented for initial feedback and during implementation so that continuous quality improvement is an inclusive and transparent process.

Building Collaborative Partnerships for Resource Mapping and Systems Alignment

Why Do Communities Need to Engage Partners to Map Resources?

People experiencing homelessness have needs beyond what one organization can address. No single organization offers the entire array of services; housing; benefits and entitlement; and legal, economic, and educational resources required to meet the whole-person care needs of the population it serves.

Resource mapping can be utilized to determine how partnerships can be leveraged to close identified gaps and to serve people who are experiencing homelessness more holistically. To learn more about building collaborative partnerships, see Building Connective Tissue for Effective Housing-Health Initiatives, a research article from The Brookings Institution on housing-health partnerships. See **Table 1** below for a list of sectors to engage when addressing the holistic needs of a community's homeless population.

Table 1. Potential community partnerships

Healthcare partners	Recovery community organizations
Community mental health agencies and systems	Benefits and entitlement acquisition (VA, SSI, SSDI, SNAP, TANF, Medicaid, Medicare, General Assistance programs)
Substance use treatment providers	School-based partners
Harm-reduction providers	Domestic violence, sexual assault, and dating violence providers
Criminal-legal system partners	Employment and adult education
Multicultural providers	Child welfare system
Transportation partners (e.g., mass transit)	Other poverty-alleviation partners

How Do You Map Resources?

A crosswalk tool can help map the resources available to address the holistic needs of people experiencing homelessness and identify resource gaps. **Table 2** shows a crosswalk that can be modified for your collaborative partnership and used for resource mapping. You and your partners may add or change fields in the table. Other useful columns include service capacity, hyperlinks to referral processes, hours of operation, intake hours, length of services, linked memorandums of understanding, sources of data collected, and notes on whether there is a data-use agreement between this system and others.

Healthcare agencies, social service systems, state or local housing agencies, and other community partners may provide the services included in the crosswalk. Resources offered by partners may be available only to distinct populations or in distinct geographic areas, so it is important to note those specifications to identify populations who may not be served. Collecting information on available resources enables partners to better identify the obstacles to fully utilizing existing capacity as well as ways to make their cases to local or state government agencies that additional resources are needed to close those gaps. See the State Medicaid-Housing Agency Partnership Toolkit for more on cross-system partnerships and resource mapping.

Table 2. Crosswalk tool

What service is provided?	What funding sources are currently paying for these services?	What agency currently offers these services?	What funding mechanism(s) are used for this service?	For what eligible population is the service covered?	In what geographic areas are these services offered?	Who is the key point of contact (name, email, phone, website)
Outpatient treatment and medication-assisted treatment	• SAMHSA block grants • State Opioid Response (SOR) • Medicaid	Recovery Support Connections	• Annual SOR grant • Medicaid contract	Low-income and Medicaid-covered adults	City of Milwaukee	Georgina Smith gsmith@rsc.org (608) 222-2222 recoveryconnections.org
Benefits and entitlement support (SOAR)	• SAMHSA • Managed care organization (MCO)	Milwaukee Coalition	• Annual contract	Adults experiencing or at risk of homelessness	City of Milwaukee	Lera Finely finelyl@mco.org (608) 222-2223 milwaukeecol.org

Identifying Key Collaborative Partners in Your State

The following list will help you find system partners in your area that typically offer resources and services for people experiencing or at risk of homelessness:

- HUD CoC grantee contacts by state
- Medicaid state plan information
- SAMHSA grant awards by state

- State housing finance agencies
- State and regional community action associations
- Crisis response and 988 operators
- Harm-reduction services
- Recovery residences
- Oxford Houses
- SOAR programs
- State Offices of Rural Health
- Health Care for the Homeless clinic directory
- Single state authority for substance use
- Peer Recovery workforce certifications by state
- Recovery community organizations

Additional potential partners include the following:

- → **Traditional homeless CoC providers,** such as street outreach and PATH programs, shelter operators, affordable housing operators and landlords, housing authorities, permanent supportive housing, rapid rehousing, and recovery housing providers
- → **"By us, for us" organizations,** including those serving Black, Brown, Indigenous, and other socially disenfranchised populations and faith-based organizations. These partners are often led by trusted leaders in their community and contribute to meeting the basic needs of many populations experiencing homelessness through food pantries, safe parking sites, and other resources.
- → **Health-care partners,** including managed care organizations, community mental health clinics, community health clinics, street medicine and mobile unit operators, hospitals, and public health organizations. These partners will be a necessary part of bringing the full array of health care-related resources to communities.
- → **Benefits, entitlement, employment, and education partners,** including those who manage TANF and SNAP; area SOAR programs; local Social Security offices and Disability Determination divisions; Veterans Benefits Administration; Department of Vocational Rehabilitation; community colleges; and programs funded through the Department of Labor, SNAP Employment and Training
- → **Others** such as Community Action Agencies, philanthropic organizations, food banks, local libraries, parks departments, and law enforcement agencies

This is not an exhaustive list, but it offers an array of potential partners with which communities may seek to establish a collaborative partnership to help identify needs, gaps, and available resources.

Tips for Engaging Area Partners

An important aspect of engagement is recognizing that all system partners bring strengths to the collaboration. When engaging new partners, it is helpful to clearly identify and articulate the unmet need with which they can assist. The State Medicaid-Housing Agency Partnership Toolkit has valuable information about the necessary components of successful partnerships, which include

- a common understanding of the language and jargon used, target populations served, and goals and intended outcomes of the various systems involved in the partnership's work;
- in-depth sharing of governing policies and operational practices;
- a genuine openness to input about opportunities for coordination and program and policy changes related to the goals of the partnership;
- regular and routine communications shared among partners;
- staffing and financial resource support of the partnership's work; and
- leadership buy-in and support of the initiative needed to bring the work to fruition.[2]

Bringing all necessary systems together in a collaborative partnership can improve the analysis of available data, more clearly define needs and gaps, and identify resources to be brought together to close the gaps. At the same time, it is important to understand that **durable change will require ongoing commitments from all engaged parties**. Dedicated staff will need to be made available to maintain partner engagement, support the promotion of data use agreements, analyze data, update your resource map crosswalk regularly, and refine objectives via continuous quality improvement.

EXAMPLE OF A HEALTH AND HOUSING PARTNERSHIP

When engaging health-care partners, a HUD CoC may provide data from the last PIT count, annual performance report, and Stella. These data can be used to identify the number of unsheltered people; their gender identity, family composition (single or family with children), ages, race and ethnicity, and earnings; and whether they have any health or behavioral health conditions. In turn, health-care providers could provide data such as the number of unhoused people who died outside during the previous 12-month period and the costs associated with the top 10% of high utilizers of emergency department visits, emergency response, or inpatient bed stays. Sharing this information helps start a conversation and support the recognition of your respective roles in addressing health and housing needs in the community.

Conclusion

Communities are encouraged to use this guide to support their efforts to identify unmet needs and map available resources. By developing cross-system partnerships, communities are better able to offer comprehensive housing, health, and behavioral health care to individuals who are experiencing or at risk of homelessness using a whole-person care approach.

Endnotes

1 "Community Health Needs Assessment for Charitable Hospital Organizations- Section 501(r)(3)," Internal Revenue Service, accessed October 18, 2024, https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3.

2 Centers for Medicare and Medicaid Services. *Medicaid Innovation Accelerator Program State Medicaid-Housing Agency Partnerships Toolkit*. 2019. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/mhap-toolkit.pdf.

Learn More about the Homeless and Housing Resource Center

Providing high-quality, no-cost training for health and housing professionals in evidence-based practices that contributes to housing stability, recovery, and an end to homelessness.

Contact Us:

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Disclaimer and Acknowledgments: This resource was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services (HHS) under grant 1H79SM083003-01. The contents reflect the authors' views and do not necessarily represent the official views of, nor an endorsement by, SAMHSA, HHS, or the US government. HHRC would like to thank Rachel Post from the Technical Assistance Collaborative for contributing her expertise to this resource as the lead author. Jen Elder completed an editorial review and provided subject matter expertise and final approval. Neither have conflicts of interest to report.

Recommended Citation: Homeless and Housing Resource Center, *Guide to Resource Mapping and Assessing Community Needs*, 2024, https://hhrctraining.org/knowledge-resources.