MEMORANDUM

September 15, 2021

To: Jennifer Bryant, Director
Office of Management and Budget

From: Tiffany Ward, Director
Office of Racial Equity and Social Justice

Re: REIA_Special Appropriation: #22-10 Assistance in Community Integration Services Pilot

I. **FINDING:** The Office of Racial Equity and Social Justice finds that Special Appropriation #22-10 is likely to advance racial equity and social justice in the County. Based on the Assistance in Community Integration Pilot Protocol parameters, the populations the program seeks to serve, and the racial equity considerations outlined in the County’s Interagency Commission on Homelessness Strategic Plan, ORESJ believes that the continuation of the ACIS pilot will provide necessary resources to support residents facing complex health and housing inequities.

II. **BACKGROUND:** Special Appropriation #22-10 provides funding from the Maryland Department of Health Assistance in Community Integration (ACIS) Pilot Protocol to the Department of Health and Human services to administer the county’s Housing Initiative Program. This program is a part of the County’s Continuum of Care, received initial funding in 2018, and continues to receive resources from the state to provide a range of support services to individuals facing the greatest risk of becoming or remaining unhoused.

Based on information provided by DHHS, ACIS is focused on addressing the needs of the County’s population that cycle in and out of multiple systems with chronic health conditions, mental illness, substance use disorder, and a history of incarceration and/or homelessness. These individuals share many of the characteristics of those experiencing
chronic homelessness\textsuperscript{1}. Nationally, the number of individuals experiencing chronic homelessness has increased since 2016\textsuperscript{2}, signaling an urgent need to better understand and address the systems leading to this outcome. One of the County's initiatives to serve this subpopulation is the ACIS pilot, a part of the Housing Initiative Program. The pilot reaches individuals who are Medicaid-eligible with the goal of providing low- or no-barrier stable housing and well-integrated medical care with wrap-around services. Eligibility is determined by Maryland Department of Health; participants in the pilot must be currently enrolled in Maryland Medicaid and meet at least one health criteria and one housing criteria\textsuperscript{3}.

In the County, 159 individuals have met or continue to meet these criteria and have the following demographic characteristics:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and % of participants</td>
<td>56</td>
<td>35%</td>
<td>102</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Black</th>
<th>White</th>
<th>Asian</th>
<th>American Indian/Alaska Native</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and % of participants</td>
<td>95</td>
<td>60%</td>
<td>54</td>
<td>34%</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hispanic/Latino</th>
<th>Non-Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and % of participants</td>
<td>18</td>
<td>11%</td>
</tr>
</tbody>
</table>

The Montgomery County Interagency Commission on Homelessness (ICH) Strategic Plan for January 2020-December 2023 includes an explicit emphasis on racial equity and

\textsuperscript{1} “Chronic homelessness is used to describe people who have experienced homelessness for at least a year — or repeatedly — while struggling with a disabling condition such as a serious mental illness, substance use disorder, or physical disability.” See National Alliance to End Homelessness. \url{https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/chronically-homeless/}.


\textsuperscript{3} health criteria: Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) or hospital admissions; Two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act (including, but not limited to, the following: a mental health condition, substance use disorder, asthma, diabetes, heart disease, being overweight as evidenced by having a Body Mass Index (BMI) over 25). housing criteria: Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or B. Those at imminent risk of institutional placement.
recognition of the “racial disparities and biases that lead people to become homeless and create barriers from moving out of homelessness”. While homelessness is often attributed to poverty, there are several other factors linked to its persistence. The National Alliance to End Homelessness *State of Homelessness: 2021 Edition* points to severe housing cost burden and a practice of “doubling up” as homelessness risk factors. In addition, the report explains how racial inequities exacerbate risk factors, noting that “historically marginalized racial groups are far more likely to experience homelessness as a result of segregation and discrimination in employment and housing”\(^5\). A 2018 Center for Social Innovation Report\(^6\) offers an additional set of factors influencing homelessness for people of color: 1) lack of economic capital within social networks; 2) lack of safe and affordable housing; 3) ongoing challenges obtaining a job or housing because of involvement in the criminal justice system; 4) behavioral healthcare systems not responsive to the needs of people of color; and 5) exposure to individual and community-level violence. The study suggests that based on these “complex underlying issues that drive high rates of homelessness among people of color, it is important to address multiple levels simultaneously”, pointing to the need for systems-level changes much like those outlined in the ICH Homelessness Strategic Plan.

The ICH Strategic Plan also articulates a set of values and strategies that support embedding racial equity in the County’s efforts to end homelessness. The housing-first and person-centered orientation of the plan encourages practitioners across the system to recognize the expertise of those with lived experience. Designing programs and systems change strategies in this way is supported by effective practice across social service sectors. Findings from a 2018 Center for Social Innovation (now known as C4 Innovations) Report explain the importance of lifting up the voices of those with lived experience and understanding those experiences within the context of the “racial inequities that lead to and exacerbate homelessness broadly.”\(^7\) The ICH Strategic Plan also includes a set of objectives and desired outcomes related to reducing racial disparities across the system\(^8\), including those that contribute to experiences of homelessness. Presuming these objectives, a similar set of outcomes, and person-centered approaches are applied to the implementation of the ACIS pilot, residents of color and those experiencing the most significant and ongoing predictors of homelessness are likely to be


\(^6\) The 2018 Center for Social Innovation Report uses a mixed-method approach focused on the experiences of six participating communities. The findings from the report are therefore not generalizable but are nonetheless instructive about the complexity of racial inequities affecting people of color experiencing homelessness.


\(^8\) Interagency Commission on Homelessness: Housing for All=Stronger Montgomery Strategic Plan.
prioritized in ways that potentially disrupt cycles of homelessness and minimize harm. This is particularly important given what is known about the disproportionate economic and health effects of the pandemic on communities of color and those with housing insecurity.

III. **DATA ANALYSIS:** Using the HUD Exchange COC Racial Equity Analysis Tool\(^9\) (version 2.1) with Montgomery County Continuum of Care data reveals racial disparities between the percent of residents in poverty and the percent experiencing homelessness. County-level data shows that Black residents are overrepresented among residents experiencing homelessness. Black residents make up 18% of the total population, but 29% of residents in poverty, and 60% of residents experiencing homelessness. The disparity and disproportionality experienced by black residents is most stark when compared to the percent of white residents in poverty and their underrepresentation among residents experiencing homelessness compared to their representation in the population overall. White residents make up 54% of the total population, 35% of all people in poverty (a larger percentage than black residents) and make up 28% of the population experiencing homeless (32 percentage points less than black residents). These disparities and disproportionalities suggest that factors other than (or in addition to) poverty deeply affect experiences of homelessness in Montgomery County.


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COC Analysis Tool 2.1 is available here: 
https://www.hudexchange.info/resources/documents/CoC-Analysis-Tool-2.1.xlsb

In looking at the ethnic composition of residents experiencing poverty and homelessness there appears to be an overrepresentation of Hispanic/Latino residents experiencing poverty compared to their representation in the population overall. At the same time, Hispanic/Latino residents are underrepresented among those experiencing homelessness compared to their poverty rate and their representation in the County population overall. Hispanic/Latino residents make up 19% of the County population, 32% of residents experiencing poverty, and 15% of residents experiencing homelessness. A similar pattern is evident in national data. Researchers suggest that the observed underrepresentation of Hispanic/Latino residents in the population of residents experiencing homelessness may be an undercount linked to recent immigrants being more likely to double up, live in substandard housing, or be fearful of entering a shelter setting if they’re undocumented or live in a household with undocumented individuals.  

Source: “Homelessness and poverty counts at the COC and State Level for MD-601 (Montgomery County Continuum of Care)”. The HUD Exchange.  
COC Analysis Tool 2.1 is available here:  
https://www.hudexchange.info/resources/documents/CoC-Analysis-Tool-2.1.xlsb

cc: Dr. Raymond Crowel, Director, Department of Health and Human Services  
Ken Hartman, Director, Strategic Partnerships, Office of the County Executive

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10 Jeffrey Olivet, et al.