

Understanding the Collaborative Planning Process in Homeless Services: Networking, Advocacy, and Local Government Support May Reduce Service Gaps

[AQ] Meghan Jarpe, MSW; Jennifer E. Mosley, PhD; Bikki Tran Smith, MA, MSW

ABSTRACT

Objective: The Continuum of Care (CoC) process—a nationwide system of regional collaborative planning networks addressing homelessness—is the chief administrative method utilized by the US Department of Housing and Urban Development to prevent and reduce homelessness in the United States. The objective of this study is to provide a benchmark comprehensive picture of the structure and practices of CoC networks, as well as information about which of those factors are associated with lower service gaps, a key goal of the initiative.

[AQ1] **Design:** A national survey of the complete population of CoCs in the United States was conducted in 2014 (N = 312, 75% response rate). This survey is the first to gather information on all available CoC networks. OLS regression was used to determine the relationship between internal networking, advocacy frequency, government investment, and degree of service gaps for CoCs of different sizes.

Setting: United States.

Participants: Lead contacts for CoCs (N = 312) that responded to the 2014 survey.

Main Outcome Measure: Severity of regional service gaps for people who are homeless.

[AQ2] **Results:** Descriptive statistics show that CoCs vary considerably in regard to size, leadership, membership, and other organizational characteristics. Several independent variables were associated with reduced regional service gaps: networking for small CoCs ($\beta = -.39, P < .05$) and local government support for midsized CoCs ($\beta = -.10, P < .05$). For large CoCs, local government support was again significantly associated with lower service gaps, but there was also a significant interaction effect between advocacy and networking ($\beta = .04, P < .05$).

[AQ3] **Conclusions:** To reduce service gaps and better serve the homeless, CoCs should consider taking steps to improve networking, particularly when advocacy is out of reach, and cultivate local government investment and support.

KEY WORDS: collaborative planning, continuum of care, homelessness, regional networks, service gaps

Homelessness has long been recognized as a major public health concern.¹ Research has shown that it can be a cause, as well as a consequence of poor health,² and being homeless puts people at increased risk for serious illness

(eg, human immunodeficiency virus, tuberculosis),³ substance use, mental illness,^{3,4} physical and sexual assault,⁵ and increased mortality.^{3,6} Over the last 10 years, increased research, prevention, and intervention efforts have resulted in a steady reduction in the total rate of homelessness nationally—with an overall 18% decrease between 2007 and 2016.⁷ Concentrated efforts set by the Obama Administration in 2010 with the release of the Federal Strategic Plan to Prevent and End Homelessness have produced even larger reductions—a 27% decrease in chronic homelessness, a 23% decrease in family homelessness, and a 47% decrease in veteran homelessness.^{8,9} These strategies have been led by the federal Department of Housing and Urban Development (HUD), which remains the major funder for homeless services in the United States, with great leeway to set funding allocations and services in accordance to local needs.

[AQ4] **Author Affiliation:** School of Social Service Administration, The University of Chicago, Chicago, Illinois.

The authors gratefully acknowledge funding by the Center for Health Administration Studies at The University of Chicago and research assistance by Kathryn Ray.

[AQ5] The authors declare no conflicts of interest.

Supplemental digital content is available for this article. Direct URL citation appears in the printed text and is provided in the HTML and PDF versions of this article on the journal's Web site (<http://www.JPHMP.com>).

[AQ6] **Correspondence:** Jennifer E. Mosley, PhD, School of Social Service Administration, The University of Chicago, 969 E. 60th St, Chicago, IL 60637 (mosley@uchicago.edu).

Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

DOI: 10.1097/PHH.0000000000000812

While these statistics are promising, addressing homelessness is an ongoing task. The persistent nature of the problem has led HUD to develop a unique initiative intended to strengthen the capacity of local communities to address homelessness through reducing service gaps: the Continuum of Care (CoC) Program. Initially rolled out in 1994, this program, now mandated for every region of the United States, incentivizes service coordination and collaboration within local and regional communities and also streamlines the application for, and allocation of, McKinney-Vento Homeless Assistance Act (1987) funds, the dominant funding mechanism for homeless services in the United States. This type of service coordination has been widely called for to better address the complex health needs of people who are homeless.¹⁰

In practice, CoCs are networks of service providers, local government agencies, consumers, philanthropic organizations, and local businesses working together in the planning and administration of homeless services. There are more than 400 of them across the United States. The CoCs in local regions must submit a single application for HUD funding and are charged with the following tasks: (1) Determining service needs and gaps through a point-in-time count (conducted annually for *sheltered* homeless and biannually for *unsheltered* homeless), (2) implementing a Homeless Management Information System, a centralized database system for tracking service use, (3) establishing priority ranking of activities and initiatives for funding, and (4) management and oversight of funded projects. Although these tasks are clear, HUD gives little guidance on the CoC that should be structured and who should lead it (eg, government, a nonprofit, or a stand-alone independent agency).

[AQ7]

The purpose of this article is 2-fold. First, even though CoCs serve as gatekeepers for almost all homeless services in the United States, including the uptake of new intervention models, little is known about how they operate on a broad scale. The few studies that have looked at CoCs as a public health process have largely been qualitative case studies.^{11–15} This article adds to the knowledge base by presenting descriptive findings from the first known nationwide survey of the population of CoCs, showing how CoCs are managed and structured on a national scale.

Second, we present regression analyses to determine what CoC activities and characteristics are associated with lower reported service gaps. In the field of homelessness, service gaps are understood as the difference between the assessed need of the homeless population and available services. An example would be the number of available beds for homeless individuals in relationship to the number of currently unsheltered individuals or the existence of specific

types of programming, such as substance abuse treatment, and those that are deemed in need of it.

[AQ8]

Understanding the association between CoC characteristics and service gaps is important for 2 reasons. First, closing service gaps is crucial if people who are homeless are to receive the diverse range of services they need in order to maintain housing stability (eg, mental health and substance abuse treatment, job training, medication management).¹⁰ Without access to one of these services, the rest will often fall apart due to the complex needs of many homeless individuals and families.¹⁶ Second, CoCs were designed specifically to close service gaps through the process of increasing coordination and communication among health and human service providers and local government. This research can help inform strategies to better meet the purpose of CoCs and, in turn, the needs of the homeless population.

Collaborative Planning to Reduce Service Gaps

[AQ9]

The CoC process is part of a larger movement in public health and human service administration toward collaborative planning.¹⁷ Because of the increased specialization of organizations and the complexity of meeting many health and social needs—such as homelessness, in this case—it has become increasingly difficult for individual provider organizations to address such problems on their own.¹⁸ Improving service coordination through collaborative planning is thought to result in better client outcomes, increased access to services for clients, and greater ability to tackle the multifaceted issues that clients face.^{14,16,19} This is especially pertinent for assisting homeless individuals who often present with a complex set of intertwined chronic conditions (eg, domestic violence, mental illness, substance abuse, lack of family support for youth). The CoC model is in alignment with a syndemic approach to prevention, which focuses on the connections between co-occurring conditions.

Achieving the goals of collaborative planning, however, may be easier said than done. This article assesses what elements of the collaborative process may help collaborative governance bodies, such as CoCs, meet their potential in addressing service gaps. Specifically, we look at degree of internal networking, CoC-led advocacy, local government investment, and support, while controlling for the size of the network itself.

Networking

Networking is commonly understood as the process of interacting with other people to cultivate mutually beneficial relationships, exchange information, or enhance learning. Collaborative planning processes

depend on networking to meet their goals of improving communication and engaging in collective decision making. Research has shown that for such collaboration to be successful, there needs to be trust, commitment, and accountability among stakeholders,^{20,21} and success is facilitated by having the same participants work together over long periods of time.²² Networking may also facilitate greater knowledge of the different services available in the community. However, devoting time to process goals, such as improving communication, rather than to outcomes goals, such as raising money, may be seen by some as a waste of time. Here we assess whether CoCs that report a greater extent of organizational networking report lower service gaps than CoCs that report a lower amount of networking among members.

Advocacy

Second, advocacy has also been shown to serve an important function in reducing service gaps across health and human services.^{23,24} The CoC-led advocacy may target legislators, donors, the public, or local institutional elites in order to help secure new or improved access to resources and increased government support. However, despite the possible benefits of advocacy engagement, most human service nonprofits participate in advocacy at only a low level.²⁵ Advocacy and networking may also have a synergistic effect in reducing service gaps in that greater networking by nonprofits may facilitate advocacy through better connections to government officials.²⁶

Local government support and investment

Third, although difficult to measure, differences in local government support and investment may affect service gaps in that those networks with greater local government support may be better positioned and resourced to fill potential gaps.²⁷ The CoC awards come with limited funds for the management of the network, and without proper infrastructure, these networks may have a difficult time carrying out tasks that go beyond required monitoring. Local government support may also play an important role in helping CoCs effectively address emergent service gaps that are not currently on HUD's list of priority areas (eg, youth homelessness or services for immigrants).

Size of CoC network

We control for the size of the CoC as research has shown that large networks can hinder effective collaboration even as they have more capacity to take on time-consuming tasks.¹⁹ On the contrary, larger size

may allow CoCs to more effectively meet niche needs and provide more comprehensive services. In addition, we expect that small-, medium-, and large-size CoC networks may benefit from different practices. For example, small networks may benefit most from in-person networking whereas large networks may be more effective at advocating for policy improvements and funding that can help resolve service gaps. In this analysis, we measure size by HUD award size, a consistently reported measure that closely correlates with other indicators of size (such as number of participants).

Overall, we hypothesize the following:

- H1:* CoCs with higher degrees of networking are more likely to report fewer service gaps than CoCs with less degrees of networking.
- H2:* CoCs with greater advocacy involvement are more likely to report fewer service gaps than CoCs that are less involved in advocacy.
- H3:* CoCs engaged in both networking and advocacy are more likely to report fewer service gaps than CoCs that do not.
- H4:* CoCs with greater local government support and investment are more likely to report fewer service gaps than CoCs with less support and investment.
- H5:* The association of lower service gaps to local government support and investment, networking, and advocacy varies on the basis of the size of the CoC.

Methods

Data collection occurred in 2014 through a national survey directed to all CoCs in the 50 US states and 4 districts and territories. Contact information for the lead contacts of all CoCs was obtained from HUD's Web site OneCPD.info. This information was utilized to create a census of the population of CoCs. Lead contacts were informed of the study via postal service and e-mail and invited to complete an online survey. The study protocol was reviewed and approved by the SSA/Chapin Hall institutional review board at The University of Chicago, and informed consent was obtained for all participants.

More than 95% of surveys were completed online. Follow-up phone calls were made to complete data collection from respondents who had started but not finished the survey and from nonrespondents in states with lower initial response rates. In total, we identified 418 active CoCs in 2014 and received responses from 312, for a 75% response rate. Response rates did not vary by region or size. See Supplemental

Digital Content of the survey, available at <http://links.lww.com/JPHMP/A477>.

To measure the dependent variable, service gaps, respondents were asked to report on the level of service gaps within their CoC's jurisdiction on a 5-point scale ranging from "little to no" to "severe" service gaps. Similarly, all other variables in our analysis except for award size (which was obtained from HUD's OneCPD.info site) were created utilizing responses to Likert scale questions on the survey. Thinking about and reporting on service gaps are common for CoC leaders as HUD requires CoCs to perform a "gaps analysis" using data from their annual point-in-time counts as well as through data collected through Homeless Management Information System. Homeless Management Information System is a computerized data collection system that HUD-funded providers are required to use. It captures client-level information over time on the service needs of individuals who are homeless in any given region.

The independent variable of networking reflects respondents' answers to a question asking them to rank the level of networking within the CoC using a 5-point scale ranging from "very little" to "a great deal" of networking. Responses for 2 questions about local government contributions to the CoC were combined to create a single independent variable representing local government support and investment; one reflects the level of financial investment and the other the amount of in-kind supports such as staff time. Finally, respondents rated the frequency of engaging in 9 different advocacy activities, such as issuing policy reports, serving on government coalitions, and conducting demonstrations, on a 5-point scale from "never" to "very frequently." These responses were summed (assigning zero for "never" responses) to create the advocacy frequency independent variable. An additional interaction term was created by multiplying the values for networking and advocacy frequency.

This article includes descriptive statistics and results from OLS regressions used to examine the correlates of reported service gaps. When controlling for size, basic bivariate analyses revealed important differences in the levels of networking and advocacy among CoCs of different sizes that were obscured when analyzing the full sample of all CoCs. Thus, OLS models were stratified by CoC award size.

Results

To our knowledge, this is the first national survey of the complete population of CoCs. Thus, to benchmark for future studies, we first present a comprehensive demographic picture of CoCs and how they

particular expectations for the responsibilities of CoCs, little guidance has been provided about how individual CoCs should carry out their work. As a result, there is great diversity in CoC structure as seen in Table 1.

Most CoCs (68%) grew out of preexisting entities that may have already been collaborating on a community's efforts to address problems facing the homeless population, such as a service providers' association (23%), a government agency (24%), or an advocacy organization (5%), among others. Current structure reflected this preexisting structure. For example, of the CoCs that reported that they grew out of a government agency, over two-thirds reported that their current structure is either "mostly government led" or a "collaborative in which government takes the lead." About 34% of CoCs are government led, 40% are led by nonprofits or collaboratively led, and 28% of CoCs have become independent nonprofits.

Structure was related to a few key characteristics. First, CoCs that were government-led or government-led collaboratives reported higher levels of local government investment and support. Second, CoCs with an independent organizational structure or no formal structure reported lower levels of provider networking. Third, providers had the most influence on decisions in nonprofit-led collaboratives and those with no formal structure. While none of these findings are surprising, they do help to point out ways in which structure is associated with the functioning of a CoC. However, CoC structure did not have a significant association with service gaps when accounting for our other independent variables, so it is not included in regression analyses.

One major source of variation among CoCs was their size. The CoCs vary by size on a variety of dimensions. One was geographic jurisdiction—they ranged from a single city to an entire state, including 6 states with a single CoC and 33 balance of state CoCs (eg, CoCs that comprise all areas of the state not covered otherwise). Another was HUD award size, which ranged from \$0 to \$113 million, with a mean of \$4 million and median of \$1.7 million

There was also great variation in staffing size. The median number of part-time or full-time staff members in addition to the director (if any) was 2, but many CoCs had no dedicated staff while others had up to 30 staff members. We asked respondents to report the number of any "direct" and "indirect" employees to assess the staffing levels. Direct employees work for and are paid by the CoC directly and may be part time or full time. Indirect employees work for another organization (such as a provider or a government agency) and fulfill duties for the CoC as part of their job. We find that 45% of CoCs had direct

[AQ10]

[T1] are structured (Table 1). While HUD has set forth

TABLE 1
CoCs at a Glance^a

Category	Description	Category	Description
CoC founding years	Mean: 1995 Range: 1976-2013 (modal years: 1995, 1998)	CoC age	Range: 1-38 y
Pre-CoC structure	No prior entity: 32% Government agency: 25% Service providers' association: 23% Individual service provider: 7% Coalition of interested parties: 6% Advocacy organization: 5% Other: 2%	CoC structure	Collaborative, nonprofit-led: 25% Collaborative, government-led: 24% Independent organization: 24% No formal structure: 12% Mostly government-led: 11% Collaborative, no clear lead: 4%
CoC membership	Social service agencies: 72% (average: 29 per CoC) Government agencies: 17% (average: 7 per CoC) Businesses: 7% (average: 3 per CoC) Philanthropic organizations: 4% (average: 2 per CoC)	Region type	Mixed: 43% Rural: 24% Urban: 23% Suburban: 10%
Lead contact organization	Local government office: 38% Coalition: 22% Other human services provider: 13% Homeless services provider: 7% Community action agency: 6% State government office: 4% Housing authority: 4% United way: 3% Consultant: 3% Other (research, HMO): 1%	Staffing Structure	FT director, Direct CoC employees: 27% PT director, no direct CoC employees: 25% No director, no direct CoC employees: 18% PT director, direct CoC employees: 13% FT director, no direct CoC employees: 6% No director or CoC employees: 6% No director, direct CoC employees: 5%

Abbreviations: CoC, Continuum of Care; FT, ...; HMO, ...; PT, ...

^aNumber of participating CoCs: 312. Total number of CoCs in 2014: 418.

[AQ11]

[AQ12]

employees, 49% had only indirect employees, and 6% reported no direct or indirect employees (and thus would be all volunteer-run). We did not assess the contribution of volunteer staff in this survey, although we expect that some “indirect” employees may consider their involvement in CoCs to be a volunteer work.

Finally, CoCs ranged from having 8 participant organizations to 450, with a median of 31. The majority of participant organizations are service providers at 72% of all reported member organizations, but respondents also indicated participation by government agencies, foundations, and businesses, as shown in Table 1.

In this analysis, we focused on size as measured by award size. Looking at that indicator, CoCs with larger awards engaged in more long-term planning, have stronger relationships with decision makers, and had larger staffs, including more full-time directors. While award size was an important predictor of CoC activities and relationships, in examining bivariate relationships between key factors and service gaps, there was only a weak and marginally significant correlation between size and service gaps ($r = -0.11$,

$P < .10$) (Table 2). Mean reported service gap among respondents was 2.29 on a 5-point scale. Networking was the variable most strongly correlated with service gaps ($r = -0.25$, $P < .05$), followed closely by local government investment and support ($r = -0.22$, $P < .05$). Mean reported networking among respondents was high at 4.04 on a 5-point scale, while local government investment and support were more moderate at 5.81 on a scale ranging from 0 to 10. Finally, advocacy was not significantly related to service gaps and was below the midpoint of its range; responses ranged from 0 to 31 with a mean value of 13.40.

Further investigation of relationships between these variables revealed some systematic differences across CoC sizes. To explore these further, for regression analysis, the sample was stratified into 3 size groups. The smallest CoCs were those with a most recent award of up to \$1 million ($n = 98$). The mean award size for this group was \$517 000. Midsized CoCs had awards ranging from \$1 to \$2.5 million ($n = 78$), with a mean of \$1.69 million. The largest CoCs were those with a most recent award greater than \$2.5 million ($n = 109$), with a mean of \$9.47 million.

TABLE 2
Descriptive Statistics and Correlation Matrix for Regression Analysis (n = 286)

	Range	Mean (SD)	(2)	(3)	(4)	(5)	(6)
Dependent variable							
(1) Service Gaps	1-5	2.29 (0.97)	– 0.25 ^a	– 0.22 ^a	0.02	– 0.06	– 0.11 ^b
Independent variables							
(2) Networking	1-5	4.04 (0.90)		0.28 ^a	0.16 ^a	0.52 ^a	0.07
(3) Local government investment and support	2-10	5.81 (2.36)			0.06	0.13 ^a	0.15 ^a
(4) Advocacy frequency	0-31	13.40 (6.24)				0.91 ^{a,c}	0.13 ^a
(5) Networking ^a advocacy	0-155	55.09 (30.26)					0.13 ^a
(6) Award size	0-113M	4.25M (9.6M)					

^a $P < .05$.

^b $P < .10$.

^cThis high correlation between main effect and interaction independent variables does not bias β coefficient estimates due to multicollinearity, as demonstrated by Disatnik and Sivan.²⁴

[AQ13]

[AQ14]

[T3] The OLS regression output is displayed in Table 3. For the smallest CoCs, lower service gaps were most strongly associated with networking, which was the only significant β coefficient in the model. A 1-unit increase in networking was associated with a 0.39-unit decrease in service gaps. For midsized CoCs, lower service gaps were most strongly associated with local government investment and support, again the only significant β coefficient in the model. A 1-unit increase in local government investment and support was associated with a 0.10-unit decrease in service gaps. For the largest CoCs, however, while both networking and local government investment and support were significantly associated with lower service gaps, we also found a significant interaction effect between networking and advocacy.

This interaction can best be interpreted through a [F1] graph of the fitted model (Figure). Holding local government investment constant, when a large CoC had low networking, an increase in advocacy was associated with a reduction in service gaps. However, with high levels of networking in a large CoC, an increase

in advocacy was not associated with further service gap reduction. Put differently, in large CoCs that engaged in high levels of advocacy, service gaps were all reported at approximately the same moderate level. However, in large CoCs with low levels of advocacy, those that also had low networking had the highest reported service gaps.

Discussion

These results reveal a broad array of CoC sizes, geographic ranges, structures, and practices. We find that these differences in how CoCs are designed and carried out are significantly related to network effectiveness in reducing service gaps for homeless individuals and families. Furthermore, we find that CoCs of different sizes benefit from different practices.

For the smallest CoCs (often rural), the factor most strongly associated with lower service gaps was networking. It makes intuitive sense; in areas where there are few providers, awareness of one another's efforts is key to reducing service gaps—there simply is not

TABLE 3
OLS Regression Predicting Increased Service Gaps

	Small CoCs (Adjusted $R^2 = 0.14$, n = 98)		Midsized CoCs (Adjusted $R^2 = 0.09$, n = 79)		Large CoCs (Adjusted $R^2 = 0.10$, n = 108)	
	B	SE	B	SE	B	SE
Networking	– 0.39 ^a	0.10	– 0.20	0.12	– 0.71 ^a	0.29
Local government investment and support	– 0.02	0.04	– 0.10 ^a	0.05	– 0.08 ^a	0.04
Advocacy frequency	0.01	0.02	– 0.02	0.02	– 0.12	0.08
Networking × Advocacy					0.04 ^a	0.02

^a $P < .05$.

[AQ15]

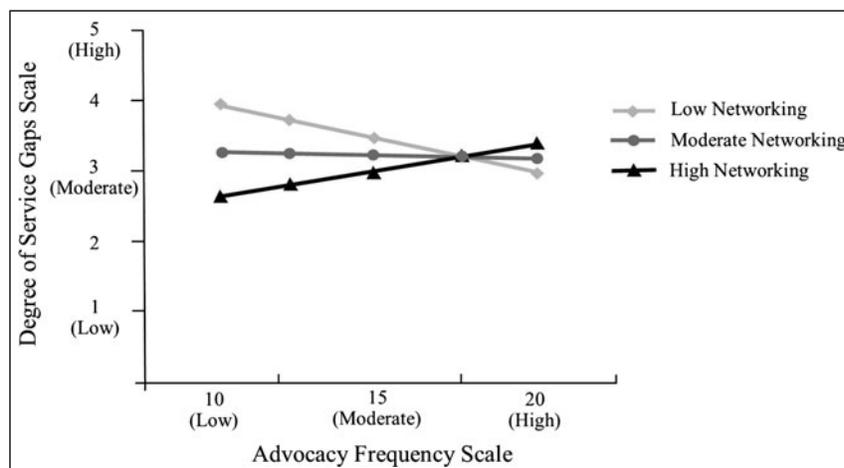


FIGURE Model-Estimated Effect of Advocacy Frequency on Service Gaps for Large CoCs at Different Networking Levels

[AQ16]

enough slack in the system for duplicated services. Smaller CoCs may be better positioned for more effective networking as well since it is possible for strong connections to be made with a smaller body of possible collaborative partners. However, for midsized CoCs, the strongest predictor was instead local government investment and support. It may be that networking can only take a CoC so far, and in larger jurisdictions and homeless services systems networking alone is unable to influence perceived service gaps. These midsized networks may have needs that only additional concrete resources can address.

In the largest CoCs, networking was also important but had a significant interaction with the amount of advocacy the group does. While advocacy was not significantly associated with service gaps in small and midsized CoCs, it appears that for the largest CoCs, advocacy can be substituted for networking to result in the same level of reduction in service gaps. In particular, those CoCs that had low networking still had reduced service gaps *if they also* had higher levels of advocacy. Consider a large balance of state CoC that manages services across many counties and communities. While networking with someone across the state may not help address service gaps in any one area, the extent to which all the providers can advocate together for shared interests may be important in addressing more systemic gaps in services. While it may be expected that when networking is high and advocacy is high that service gaps would be the most reduced, this was not the case; perhaps when networking is high, advocacy focuses on topics less related to service gaps, such as the need for additional affordable housing. Nevertheless, when networking is low and may be difficult for a variety of reasons, advocacy offers an alternative avenue for CoCs to reach a

comparable level of service gap reduction. This may be a fruitful area for future research. Longitudinal data could help confirm that advocacy can indeed help make up for networking in large CoCs. Likewise, in-depth study of particular regions could be useful to show what the precise effects of advocacy are and its connection to service gap reduction.

There are several limitations to this analysis. First, these cross-sectional data do not allow us to attribute causation to any of the relationships identified. Second, self-reported data are subject to response bias. In the case of perceived service gaps, however, response bias could influence reports in either direction. These respondents are working toward improving the homeless services system in their region and may want to feel good about their progress and accomplishments and thus report lower service gaps. However, there are also incentives for respondents to embrace the idea of higher service gaps in their community in order to demonstrate need for additional funding. Confidence in our data is improved by knowing that HUD requires all CoCs to conduct a “gaps analysis,” meaning that respondents should have objective indicators at their fingertips with which to make their assessment.

Overall, given the diversity in CoCs across the nation, understanding more about how different structures and practices are related to outcomes is important information for reducing the public health problem of homelessness. While collaborative planning is an important step for more effectively and efficiently addressing the causes and consequences of homelessness, network managers can reduce service gaps (and presumably improve public health outcomes) by choosing the right collaborative practices (eg, networking, advocacy, local government support) for their size network.

Implications for Policy & Practice

- Greater infrastructure support for collaborative planning efforts done by regional Continuum of Care (CoC) networks can help reduce service gaps and improve coordination of services for people who are homeless.
- The CoC leaders may optimize practice and reduce service gaps by investing in the right mechanisms (eg, government investment, advocacy, and/or networking) for their size of CoC network.
- For small networks, devoting more attention to provider networking may be the best investment for reducing service gaps.
- For medium-sized networks, increased support and investment from local government seem to play an important role in reducing service gaps. The CoCs that do not have government in a leadership role may need to do more to demonstrate their value and needs to garner more public sector support.
- For large CoCs in which provider networking is low, taking an active advocacy role is a promising tactic for reducing service gaps.

References

1. American Public Health Association. Homelessness as a public health problem. <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/31/07/56/homelessness-as-a-public-health-problem>. Published 1992. Accessed February 22, 2018.
2. Polcin DL. Co-occurring substance abuse and mental health problems among homeless persons: suggestions for research and practice. *J Soc Distress Homeless*. 2016;25(1):1-10.
3. Chambers C, Chiu S, Scott AN, et al. Factors associated with poor mental health status among homeless women with and without dependent children. *Community Mental Health J*. 2014;50(5):553-559.
4. Oppenheimer SC, Nurius PS, Green S. Homelessness history impacts on health outcomes and economic and risk behavior intermediaries: new insights from population. *Fam Soc*. 2016;97(3):230-242.
5. Gaetz S. Safe streets for whom? Homeless youth, social exclusion, and criminal victimization. *Can J Criminol Crim*, 2004;46(4):423-456.
6. Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *Int J Epidemiol*. 2009;38(3):877-883.
7. US Department of Housing and Urban Development. The 2016 annual homelessness assessment report (AHAR) to Congress. <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf>. Published 2016. Accessed February 22, 2018.
8. US Department of Housing and Urban Development. Homelessness in the U.S. continues to decline. <https://www.hudexchange.info/news/homelessness-in-the-u-s-continues-to-decline/>. Published 2016. Accessed February 22, 2018.
9. United States Interagency Council on Homelessness. Ending chronic homelessness. <https://www.usich.gov/goals/chronic>. Published 2017. Accessed February 22, 2018.
10. O'Connell JJ, Mattison S, Judge CM, Allen HJ, Koh HK. A public health approach to reducing morbidity and mortality among homeless people in Boston. *J Public Health Manag Pract*. 2005;11(4):311-316.
11. Barth TJ, Quinn RA. Serving the homeless: public administration as science, process and art. *Int J Pub Admin*. 2000;23(12):2085-2106.
12. Burt MR, Carpenter J, Denton AV, et al.; US Department of Housing and Urban Development. Strategies for improving homeless people's access to mainstream benefits and services. <https://www.huduser.gov/portal/publications/StrategiesAccessBenefitsServices.pdf>. Published 2010. Accessed February 22, 2018.
13. Burt MR, Pollack D, Sosland A, et al.; The Urban Institute. Evaluation of continuums of care for homeless people: final report. <http://www.urban.org/sites/default/files/publication/60206/310553-Evaluation-of-Continuums-of-Care-for-Homeless-People.PDF>. Published 2002. Accessed February 22, 2018.
14. Goodfellow M, Parish K. Continuum of care for the rural homeless: examination of three cases. *Sociol Viewpoints*. 2000;16:32-45.
15. Lobao EG, Murray AT. Exploratory analysis of the homeless shelter system in Columbus, Ohio. *Geogr Ann B*. 2005;87(1):61-73.
16. Rosenheck R, Morrissey J, Lam J, et al. Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *Am J Public Health*. 1998;88(11):1610-1615.
17. Varda DM. Data-driven management strategies in public health collaboratives. *J Public Health Manag Pract*. 2011;17(2):122-132.
18. Ansell C, Gash A. Collaborative governance in theory and practice. *J Public Adm Res Theory*. 2008;18(4):543-571.
19. Provan KG, Milward HB. Do networks really work?: a framework for evaluating public-sector organizational networks. *Public Admin Rev*. 2001;61(4):414-423.
20. Macgill S. Does mandated collaboration work?: an analysis of homeless planning networks. Paper presented at: the Western Political Science Association 2011 Annual Conference; April 2011; San Antonio, TX. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1767152. Accessed February 22, 2018.
21. Chertoff MJ, Green M, Odom CH. "Relationships, relationships, relationships": promoting population health collaboration across state government [published online ahead of print August 21, 2017]. *J Public Health Manag Pract*. 2017.
22. Lewis B, Bouhalanis J, Matheny E. Joined-up governance: mandated collaboration in the US homeless services. *Int J Public Sector Manage*. 2009;22(5):392-399.
23. Almog-Bar M, Schmid H. Advocacy activities of nonprofit human service organizations: a critical review. *Nonprof Volunt Sec Q*. 2011;43(1):11-35.
24. Hasbrouck L. Strengthening local health department informatics capacity through advocacy, education, and workforce development. *J Public Health Manag Pract*. 2016;22(suppl 6):S3.
25. Child CD, Gronbjerg KA. Nonprofit advocacy organizations: their characteristics and activities. *Soc Sci Q*. 2007;88:259-281.
26. Mosley JE. Keeping the lights on: how government funding concerns drive the advocacy agendas of nonprofit homeless service providers. *J Public Adm Res Theory*. 2012;22(4):841-866.
27. Sensenig AL, Resnick BA, Leider JP, Bishai DM. The who, what, how, and why of estimating public health activity spending. *J Public Health Manag Pract*. 2017;23(6):556-559.

[AQ17]