Final Evaluation Report

Community Rebuilders

Updated October 2024

Community Rebuilders

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Executive Summary

Introduction

For 30 years, Community Rebuilders has worked to end homelessness in Kent County. Over the past few years, the organization has been fostering new partnerships with community-based organizations (CBOs) and establishing new tools to strengthen its efforts. Community Rebuilders has leveraged the Grand Rapids-area G.R.A.C.E. (Gather Resources and Align Community Efforts) Network to lay the foundation for a cross-sector intervention that addresses not only families' housing needs, but also other social determinants of health needs—e.g., healthcare, education, and employment—that can make it difficult to maintain stable housing, well-being, and economic stability.

Community Rebuilders engaged Public Sector Consultants to conduct an evaluation of its efforts to end homelessness among Kent County families with a focus on the impact of the partnerships created through the G.R.A.C.E. Network. PSC worked with Community Rebuilders to identify potential short- and long-term outcomes related to their efforts. This report serves as the final assessment. Where data is available, the report compares each outcome measure at baseline—using data collected in fiscal year (FY) 2020 (i.e., October 1, 2019, to September 30, 2020)—to the comparison year with data collected in FY 2022 (i.e., October 1, 2021, to September 30, 2022). This report may be used by Community Rebuilders and the G.R.A.C.E. Network to inform current programming and identify potential areas for change.

Community Rebuilders Evaluation Framework

Community Rebuilders theorizes that increasing access to comprehensive cross-sector services will lead to decreased homelessness and improved health and well-being among families in Kent County. PSC worked with Community Rebuilders to develop an evaluation framework that is based on this theory of change, demonstrating how Community Rebuilders and the Network's activities will lead to these outcomes.[1] PSC examined data related to three intended impacts:

1. A systems framework is utilized to make family homelessness rare, brief, and nonrecurring.
2. A cross-sector network of shared resources improves families' well-being and increases their social capital.
3. Key systems are aligned in a collaborative alliance to coordinate services and improve social and community health and promote equity through the use of data.

Methodology

The evaluation report uses three primary sources provided to PSC by Community Rebuilders: the Homeless Management Information System (HMIS); the G.R.A.C.E. Network Signify Health platform; and the U.S. Department of Housing and Urban Development (HUD) Homelessness Data Exchange. The baseline data analyzed was collected in FY 2020 (October 1, 2019, to September 30, 2020), but the specific time frame varied by data source, with some not beginning collection until January 2020. Comparison data were collected for FY 2022 (October 1, 2021, to September 30, 2022). More information about each data source is available in Appendix B.

[1] See Appendix A for the full evaluation framework.

PSC conducted interviews with G.R.A.C.E. Network partners and facilitated discussion groups with clients to more fully assess the short and intermediate outcomes set forth in the evaluation framework. PSC interviewed eight G.R.A.C.E. Network project partners, including project staff within Community Rebuilders, to gain insight into their organization's engagement with the G.R.A.C.E. Network and their thoughts about collaboration and the system framework. Additionally, PSC held two small-group discussions to examine the effect of the G.R.A.C.E. Network on Community Rebuilders' clients. These discussions took place in December 2022 via Zoom, lasted one hour, and had a combined total of 11 participants. The goals of the discussion groups were to gather feedback on the services participants accessed through the G.R.A.C.E. Network and to better understand the impact of access to services on the health and well-being of families experiencing homelessness. Information gathered from these interviews and discussion groups are shared throughout the report.

Evaluation Findings Summary

The G.R.A.C.E. Network has made tremendous efforts to implement a comprehensive and coordinated system to support the many needs of families struggling with housing security and homelessness. The data show that there are successes to celebrate as well as areas needing additional growth to meet their goals. Additionally, limited evaluation data restricted the extent of conclusive findings, especially for intended impacts one and three. A summary of evaluation findings by intended impact is below, with detailed evaluation information provided throughout the report.

1 Impact One: Incidence, Duration, and Recurrence of Family Homelessness

G.R.A.C.E. Network families are enrolled in different Community Rebuilders' programs based on their goals and needs. All families are connected to a housing support specialist who works with them to create a housing plan with short- and long-term goals to obtain and sustain permanent housing. This personalized support, along with the resources available through the G.R.A.C.E. Network, may impact the likelihood of a family returning to the homeless response system.

In 2022, more than 60 percent of families were enrolled in Supported Solutions, just over 30 percent were enrolled in Rapid Re-Housing (RRH), and 7 percent were enrolled in the Permanent Supportive Housing (PSH) program. Nearly all enrollees (98 percent) across all programs maintained their housing and did not re-enter the homeless response system. Nearly all of those enrolled in Supportive Solutions did not enter HMIS within six months of program exit (99.6 percent). All families enrolled in PSH maintained permanent housing in the six months following program exit, and nearly all the RRH enrollees who exited to permanent housing did not return to the homeless system within the following six months (94 percent). Additionally, nearly all (94 percent) of the G.R.A.C.E. Network families enrolled in RRH exited to permanent housing.

Data on the duration of homelessness for families in the G.R.A.C.E. Network specifically was unavailable for the evaluation period. Data related to the duration of homelessness for all Kent County families experiencing homelessness, including those in the G.R.A.C.E. Network, is available and is included in this report in lieu of G.R.A.C.E. Network–specific data.

2 Impact Two: Improved Family Well-Being and Increased Social Capital

The G.R.A.C.E. Network has grown exponentially since its inception and has streamlined the process of connecting families to resources. The number of referrals made by Community Rebuilders more than doubled from 318 in FY 2020 to 740 in FY 2022. In FY 2022, 62 percent of families' referrals were accepted or declined within the goal time of three days. This is a considerable increase from 35 percent in FY 2020. Additionally, most families' identified needs, including those related to housing and food assistance, were resolved or addressed. The G.R.A.C.E. Network addressed or resolved 2,216 basic needs (e.g., housing, food) and SDOH-related needs (e.g., education, language) in 2022. Also, fewer families reported not having a natural support system, something housing support specialists work to build with families that do not have one. However, the data did not show significant changes in income.

Anecdotally, participants in discussion groups overwhelmingly shared feedback that the assistance they received from Community Rebuilders had had a positive impact on almost every aspect of their lives. But as the G.R.A.C.E. Network has grown so has the demand, and results were mixed when comparing data from January through September 2020 to FY 2022.

3 Impact Three: Data Systems Used to Coordinate Services, Improve Health, and Promote Equity

The G.R.A.C.E. Network has made great strides in setting up a referral and outcome reporting system dashboard that partners use to make better decisions, address unmet client needs, and increase the overall transparency of client work. However, partners also suggested changes that could help the system better meet the needs of the partner organizations as they continue to use the service.

Impact One: Incidence, Duration, and Recurrence of Family Homelessness

Community Rebuilders' first intended impact is to ensure that a systems framework is utilized to make family homelessness rare, brief, and nonrecurring. Community Rebuilders identified short-term and intermediate outcomes to measure success toward achieving this impact. Anecdotal data showed Community Rebuilders had success over the three-year evaluation period in supporting families and connecting them to needed services.

The following short- and intermediate outcomes describe the progress toward achieving this impact.

Short-Term Outcomes

Connection to Supportive Solutions and Appropriate Services

Information gathered during the client discussion groups indicated that participants accessed housing assistance as well as other support services, such as help with utilities and food, obtaining hygiene products (diapers, toilet paper, etc.), enrolling children in school, and pursuing adult education on topics like budgeting when they worked with Community Rebuilders. One participant said,

> "I want to go back to school, and they said, 'OK, we can help with that.' Learning to budget and things like that. They help with paying bills. I like that they don't let you leave [the program] until you are self-sufficient. In the past, I was always spending on food, going out to eat and just using my money not very wisely, so with me getting information on how to budget, it's very beneficial for me personally, so I know I can save some."

Feeling Supported

Although participants did not specifically describe feeling supported to find and secure housing, the majority of discussion group participants said that Community Rebuilders support allowed them to view available housing options, receive help completing rental applications, and be referred to potential employment opportunities, along with other community resources. Frequent caseworker communication through multiple avenues, including phone, text, and email, was the main support cited by participants.

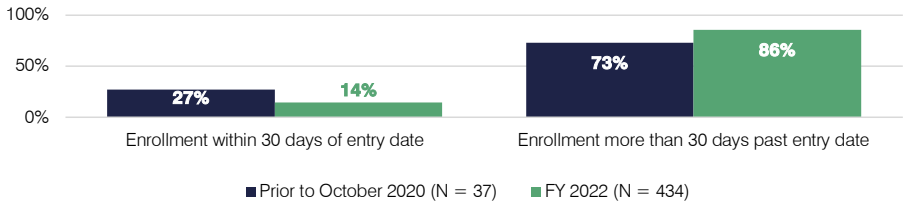
> "My caseworker is awesome. Every week she sends me new places to look at. I'm in the process of finding [housing], I had to stop working because I just had my baby. [My caseworker] is letting me know about [housing] places, and for the future places I could apply to when I go back to work. She calls me two or three times a week to check on me and if I need anything. She will send me a text, 'How are things?' She's patient, she's great."

Timely Access to Permanent Housing

For Kent County families in need of permanent housing who were enrolled in a permanent housing resource in FY 2022, the number of days between when the family was identified as homeless and their resource enrollment ranged from one to 516 days, with an average of 115 days and a median of 93 days.

In FY 2022, 14 percent had a connection to a housing resource within 30 days of being identified as homeless, compared to 27 percent prior to October 2020 (Exhibit 1).

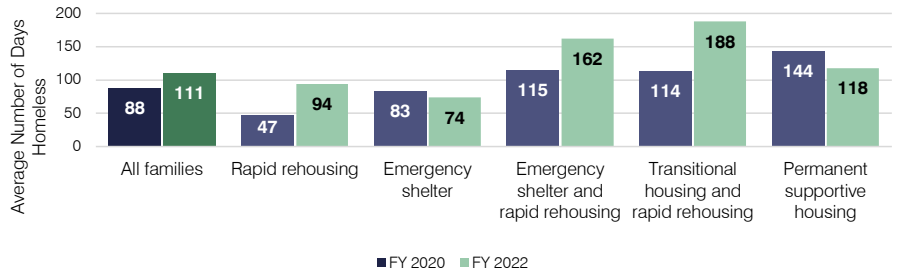
EXHIBIT 1. Percentage of Program Enrollees Connected to Housing Resource by Time Frame



N varied by time period.
Source: HMIS, analyzed by PSC.

In FY 2022, 609 Kent County families were served by the homeless system. These families were homeless for an average of 111 days. Families who were only enrolled in a rapid rehousing program were homeless for an average of 94 days and families in an emergency shelter were homeless for an average of 74 days (Exhibit 2). Families who were in both an emergency shelter and a rapid rehousing program were homeless an average of 162 days, those whose pathway consisted of both transitional housing and rapid rehousing were homeless an average of 188 days, and those enrolled in permanent supportive housing remained homeless for an average of 118 days.

EXHIBIT 2. Average Days Homeless by Housing Pathway



Ns varied by time period and housing pathway and are shown in Exhibit 3.
Source: HUD Exchange Stella Performance module, CoC code: MI-506, analyzed by PSC.

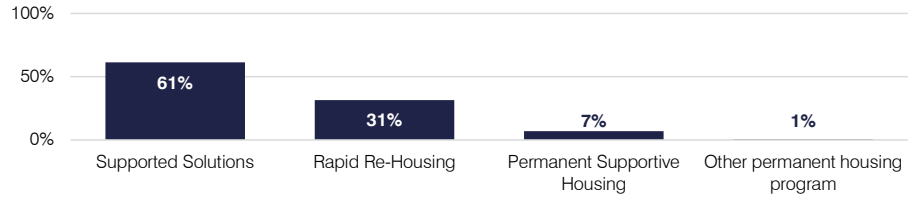
Intermediate Outcomes

Community Rebuilders provided data for families enrolled in the G.R.A.C.E. Network in FY 2022 regarding exits to permanent destinations and returns to the homeless system. These data were not available in FY 2020 for comparison.

Connection to Permanent Housing

Community Rebuilder provides a variety of housing services and programs that can help them connect to permanent housing. For the families enrolled in the G.R.A.C.E. Network in FY 2022, 61 percent were enrolled in Supported Solutions, 31 percent in RRH, and 7 percent in PSH (Exhibit 3).

EXHIBIT 3. Percentage of G.R.A.C.E. Network Families Enrolled in Community Rebuilders' Programs by Program Type in FY 2022

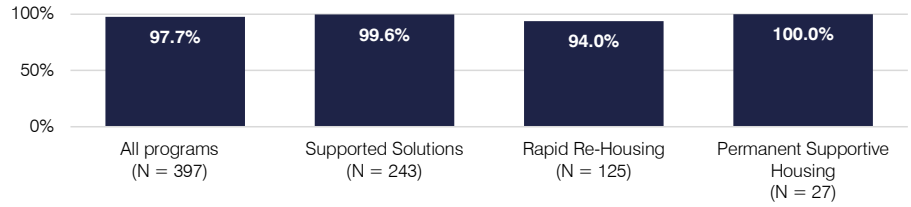


N = 397.
Source: Data from HMIS and GRACE Network compiled by Community Rebuilders and analyzed by PSC.

Returns to Homelessness

Nearly all (98 percent) of the G.R.A.C.E. Network families that received housing assistance from Community Rebuilders in FY 2022 did not re-enter the homeless system within six months of exiting their housing assistance program (Exhibit 4).

EXHIBIT 4. Percentage of G.R.A.C.E. Network Families That Did Not Enter the Homeless System Within Six Months of Program Exit



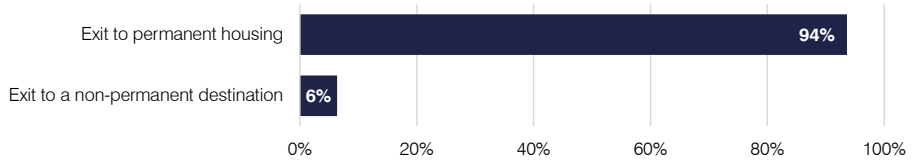
Note: N varied by program type.
Source: Data from HMIS and GRACE Network compiled by Community Rebuilders and analyzed by PSC.

By program, 99.6 percent of G.R.A.C.E. Network families enrolled in Supported Solutions did not enter the homeless response system in the six months following their exit from the program, 100 percent of families enrolled in the PSH program maintained permanent housing during the six months following program exit, and both families in other permanent housing programs did not return to the homeless system in the six months following their program exit. For families enrolled in RRH, 94 percent did not re-enter the homeless system.

Exits to Permanent Housing

Nearly all (94 percent) of the 125 G.R.A.C.E. Network families enrolled in RRH exited to permanent housing (Exhibit 5).

EXHIBIT 5. Percentage of RRH Program Exits by Destination Type



N = 125
Source: Data from HMIS and GRACE Network compiled by Community Rebuilders and analyzed by PSC.

Impact Two: Improved Family Well-Being and Increased Social Capital

The second intended impact of the G.R.A.C.E. Network is that a cross-sector network of shared resources improves well-being for families and increases their social capital. Over the three evaluation years, the G.R.A.C.E. Network has grown exponentially and has streamlined the process of connecting families to resources. The number of referrals made by Community Rebuilders more than doubled from 318 in FY 2020 to 740 in FY 2022. In FY 2022, 62 percent of families' referrals were accepted or declined within the goal time of three days. This is a considerable increase from 35 percent in FY 2020. Anecdotally, participants in discussion groups overwhelmingly shared feedback that the assistance they received from Community Rebuilders had had a positive impact on almost every aspect of their lives. But as the G.R.A.C.E. Network has grown so has the demand, and results were mixed when comparing data from January through September 2020 to FY 2022.

The following short- and intermediate outcomes describe the progress toward achieving this impact.

Short-Term Outcomes

Increased Number of CBOs Involved

As of September 30, 2022, the G.R.A.C.E. Network included 30 CBOs providing services in the areas of:

- Housing access and support
- Food security
- Education
- Early childhood education and care
- Transportation support
- Health and recovery
- Economic stability and employment[2]

[2] See Appendix D for the list of G.R.A.C.E. Network partner organizations.

More than half of the organizations (17) joined the G.R.A.C.E. Network in FY 2020, with four more joining in FY 2021 and the remaining nine joining in FY 2022. Although the G.R.A.C.E. Network has grown over the past few years, during partner interviews, interviewees expressed the desire to grow the G.R.A.C.E. Network further to include even more community partners. Interviewees stressed that without a full representation of community services, staff members find themselves using multiple systems to make referrals, duplicating their work.

Timely Referral Acceptance

In FY 2022, Community Rebuilders made 740 service referrals for 401 families, with 57 percent of referrals accepted by the referred organization and 43 percent declined, meaning that the referred organization did not accept the referral. In FY 2022, it took an organization an average of 13 days to accept or decline a referral, a 16-day improvement over the 29 day average in FY 2020. It took less time on average for organization to accept a referral (11 days) than to decline (15 days) (Exhibit 6).

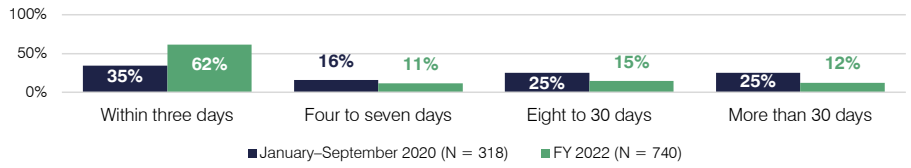
EXHIBIT 6. Average Number of Days Between Referral and Referral Acceptance or Declination

	January–September 2020	FY 2022	Percentage Change
Total number of referrals	318	740	**133%**
Average number of days to respond to referral	29	13	**-55%**
Average number of days to respond to accepted referrals	17	11	**-35%**
Average number of days to respond to declined referrals	66	15	**-77%**

Source: Signify Health, Referral Report, analyzed by PSC.

One G.R.A.C.E. Network goal is for partners to accept eligible referrals within three days.[3] Nearly two-thirds of referrals (62 percent) were accepted or declined within three days in FY 2022. This is up from 35 percent between January and September 2020. While about one-quarter took more than 30 days to complete in 2020, only 12 percent took that amount of time in FY 2022 (Exhibit 7).

EXHIBIT 7. Referral Decision by Length of Time



N varied by time period. Source: Signify Health, Referral Report, analyzed by PSC.

[3] The goal of referrals being accepted within three days was based on Community Rebuilders' referral history and may not fit as well for agencies that are providing non-crisis-related services.

Nearly a third of the referrals made were to programs within Community Rebuilders, 12 percent were made to EuzenConnect, and 5 percent each were made to Cherry Health and Head Start for Kent County (Exhibit 8). The Community Food Club accounted for the largest percentage of referrals (one-third) in FY 2020, but only received 2 percent of referrals in FY 2022. This decrease indicates improvement in the Network's understanding of the food club's program to make more appropriate referrals.

EXHIBIT 8. Top Organizations Receiving Referrals

Organization	Baseline: January–September 2020	Comparison: FY 2022	Difference
Community Rebuilders	26%	31%	5%
EuzenConnect	3%	12%	9%
Cherry Health	8%	5%	-3%
Head Start for Kent County	3%	5%	2%
Goodwill Industries of Greater Grand Rapids	14%	4%	-10%
Great Start Collaborative & Parent Coalition	3%	2%	-1%
Health Net of West Michigan	8%	2%	-6%
The Community Food Club	33%	2%	-31%
Family Promise of Grand Rapids*	N/A	34%	N/A

N = 318 (baseline); 740 (comparison). Source: Signify Health, Referral Report, analyzed by PSC.
* Family Promise of Grand Rapids received 255 referrals in FY 2022, of which 82 percent were declined. The organization is no longer with the G.R.A.C.E. Network.

The average length of time to accept or decline a referral varied by organization regardless of reporting period. In FY 2020, the average number of days for referral completion ranged from nine for Community Rebuilders to 36 for Cherry Health and from zero for Kent County Community Action to 55 for Mel Trotter Ministries in FY 2022. In FY 2022, the average number of days for a referral to be declined ranged widely from zero days for the Urban League of West Michigan to 163 days for Head Start for Kent County (Exhibit 9).

EXHIBIT 9. Average Number of Days to Address Referral by Organization

Baseline: January–September 2022		Comparison: FY 2022	
Range of Average Number of Days for Referral Completion	Range of Average Number of Days to Decline Referral	Range of Average Number of Days for Referral Completion	Range of Average Number of Days to Decline Referral
9–36 days	7–229 days	0–55 days	0–163 days

Source: Signify Health, Referral Report, analyzed by PSC.

Of the five organizations receiving the most referrals in FY 2022, EuzenConnect had the largest percentage of accepted referrals (97 percent), followed by Community Rebuilders (86 percent) and Head Start for Kent County (79 percent). Less than a quarter of the referrals to Cherry Health were accepted (Exhibit 10). EuzenConnect averaged one day to accept and decline referrals. Head Start for Kent County had the largest average number of days to accept and decline referrals, 52 and 163 days, respectively.

EXHIBIT 10. Percentage of Accepted and Declined Referrals by Organization, FY 2022

	Number of Referrals	Percentage of Accepted Referrals	Average Number of Days to Accept Referral	Average Number of Days to Decline Referral
EuzenConnect	87	97%	1 day	1 day
Community Rebuilders	229	86%	9 days	27 days
Head Start for Kent County	34	79%	52 days	163 days
Cherry Health	36	22%	18 days	30 days
Family Promise of Grand Rapids*	255	18%	8 days	4 days

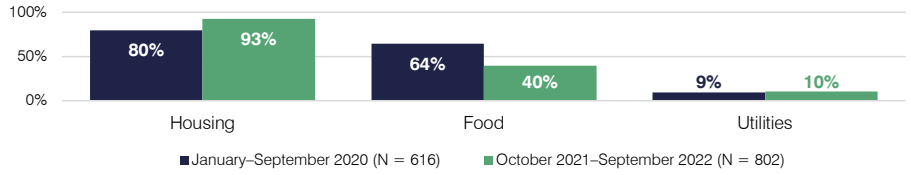
Note: Asterisked organization Family Promise of Grand Rapids received 255 of Community Rebuilders 740 referrals in FY 2022. Of those, 82 percent were declined. The organization has since been removed from the G.R.A.C.E. Network.
Source: Signify Health, Referral Report, analyzed by PSC.

Basic Survival Needs

G.R.A.C.E. Network partners provided a variety of services to help families meet their basic needs, including housing, food, and utilities. In the baseline year, between January 1 and September 30, 2020, 1,044 basic needs were identified by Network partners among 616 program enrollees, an average of 1.7 needs per enrollee. In the comparison year, 1,431 basic needs were identified among 802 program enrollees, an average of 1.8 needs per enrollee. In 2022, 1,252 basic needs were addressed or resolved.

In FY 2022, nearly all enrollees (93 percent) identified at least one housing-related need, 40 percent identified a food security need, and 10 percent had a utility need (Exhibit 11). A smaller percentage of enrollees identified housing needs during the baseline period in FY 2020 (80 percent) while a larger percentage identified food needs (64 percent).

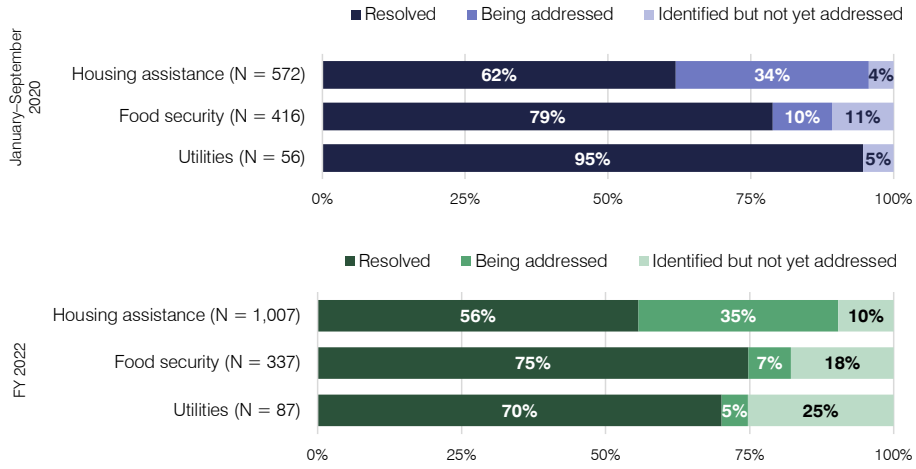
EXHIBIT 11. Enrollee-Identified Basic Needs



N varied by time period.
Note: Percentages total more than 100 because enrollees could have more than one need.
Source: Signify Health, Needs Report, analyzed by PSC.

The percentage of these needs that are being addressed or were resolved in FY 2022 ranged from 75 percent of utility needs to 91 percent of housing needs. Between January and September 2020, a higher percentage were being addressed or were resolved—ranging from 89 percent of food security needs to 96 percent of housing needs (Exhibit 12).

EXHIBIT 12. Percentage of Basic Needs Met

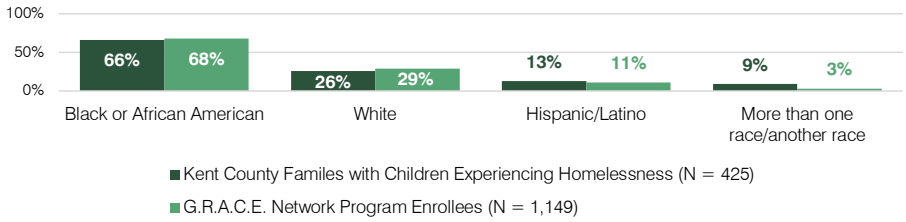


N varied by need and time period. Source: Signify Health, Needs Report, analyzed by PSC.
Note: Percentages may total more than 100 due to rounding. In the baseline data, needs were assigned a status of identified, addressed, or resolved. In the comparison year, a new status of "unaddressable" was included. Unaddressable needs are those that were identified but that the client indicated they did not have the capacity or desire to address. Of the 1,632 identified needs, 181 (11 percent) were unaddressable. These needs are not included in the comparative data analysis.

Equitable Service Access

According to a 2021 point-in-time estimate provided by HUD, 66 percent of families with children experiencing homelessness in Kent County were Black or African American and 26 percent were white. Similarly, of the household members enrolled in G.R.A.C.E. Network programs, 68 percent were Black or African American and 29 percent were white (Exhibit 13).

EXHIBIT 13. Household Members Experiencing Homelessness in Kent County Compared to Those Enrolled in Community Rebuilders Programs by Race and Ethnicity, FY 2022



N varied by population. Note: Percentages total more than 100 because both race and ethnicity (Hispanic/Latino) could be selected.
Source: HUD Exchange CoC Analysis Tool: Race and Ethnicity and Signify Health, Enrollment Report, both analyzed by PSC.

Intermediate Outcomes

Increased Average Income

At program enrollment in FY 2022, monthly household income ranged from $0 to $18,565, with an average monthly income of $947 and a median monthly income of $600. At program exit, monthly average income ranged also from $0–$18,565, with an average of $1,080 and a median of $794 (Exhibit 14), an increase of $132 per month in the average income. These average income amounts are very similar to those from the baseline time period in FY 2020.

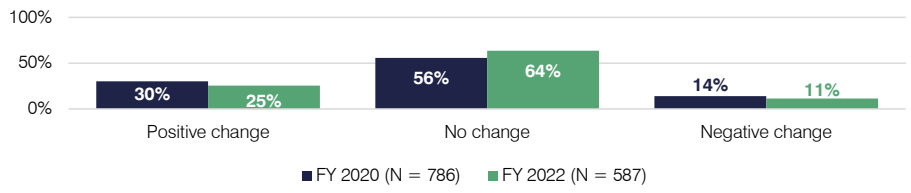
EXHIBIT 14. Monthly Income of Program Enrollees

	Program Enrollment		Program Exit		Change	
	Baseline: FY 2020	Comparison: FY 2022	Baseline: FY 2020	Comparison: FY 2022	Baseline: FY 2020	Comparison: FY 2022
Average monthly household income	$923	$947	$1,040	$1,080	$117	$132
Median monthly household income	$696	$600	$783	$794	$0	$0
Range of monthly household income	$0–$9,969	$0–$18,565	$0–$7,597	$0–$18,565	($4,675)–$4,095	($5,212)–$6,747

N = 786 (baseline); 587 (current time period)
Source: HMIS Family Client Income Audit Report, analyzed by PSC.

In FY 2022, more households gained income than lost income between program enrollment and the family member's most recent assessment (25 percent compared to 11 percent), with nearly two-thirds experiencing no change. This distribution is similar to that of the baseline time period (Exhibit 15).

EXHIBIT 15. Income Change for Program Enrollees



N varied by time period
Source: HMIS Family Client Income Audit Report, analyzed by PSC.

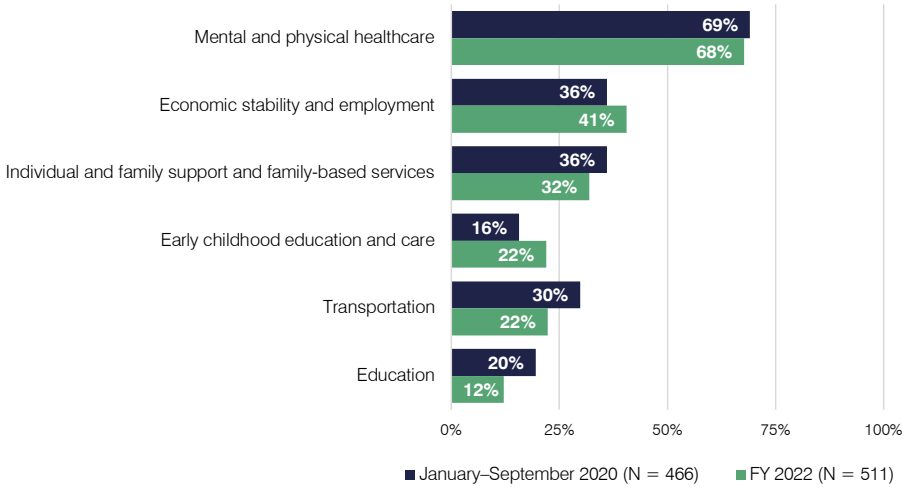
Social Determinant of Health Needs

In addition to identifying basic survival needs, the G.R.A.C.E. Network identifies program enrollees' SDOH needs in the domains of healthcare, economic stability and employment, individual and family

support, early education and child care, transportation, and education.[4] Identified needs are referred to G.R.A.C.E. Network partners for resolution. Between January 1 and September 30, 2020, 1,272 SDOH needs were identified among 466 program enrollees. Between October 2021 and September 2022, 1,912 needs were identified among 586 program enrollees. Among those needs were 489 with "unaddressable" status that are not included in the following analysis. In 2022, 964 SDOH-related needs were being addressed or resolved.

During both time periods, nearly 70 percent of enrollees identified one or more healthcare-related needs—including physical health, mental health, dental, counseling, vision and hearing, and health and dental insurance coverage (Exhibit 16). In FY 2022, more than 40 percent identified needs related to economic stability and employment, more than 30 percent identified individual and family support needs, and more than 20 percent identified early childhood education and care and transportation needs. A lower percentage of needs were identified during the comparison time period than during the baseline time period in all but two areas: economic stability and employment and early education and care.

EXHIBIT 16. Percentage of Families with Identified SDOH Needs by Type of Need

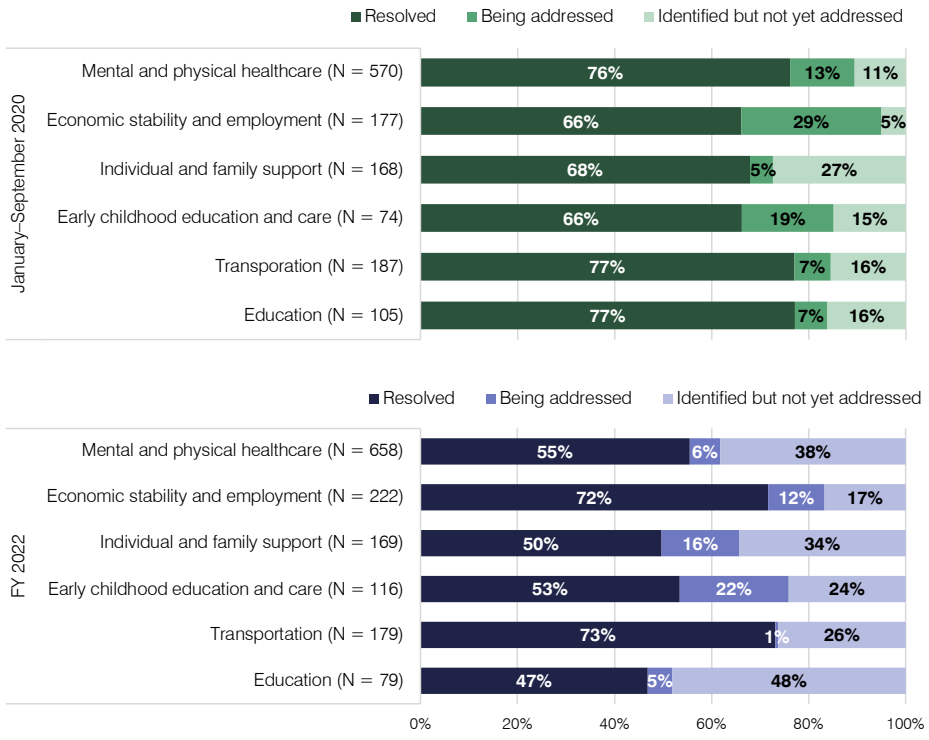


N varied by time period
Note: Percentages total more than 100 because families could have more than one need.
Source: Signify Health, Needs Report, analyzed by PSC

Between October 2021 and September 2022, the percentage of the needs that are being addressed or have been resolved ranged from 52 percent for education to 84 percent for economic stability and employment needs. Across all enrollees, the percentage of the needs that were addressed or resolved between January and September 2020 was higher than in the most recent time period, ranging from 73 percent for individual and family supports to 95 percent for economic stability and employment needs (Exhibit 17).

[4] More information about the identified SDOH needs is available in Appendix B.

EXHIBIT 17. Percentage of Needs Met



N varied by response
Note: Percentages do not total to 100 percent due to rounding.
Source: Signify Health, Needs Report, analyzed by PSC.

Improved Well-Being

Community Rebuilders uses the LifeWorks survey to measure changes in well-being over time among the people it serves. The survey is conducted upon program entry and again after the client is housed or experiences another significant life change (e.g., change in income/benefits, change in household composition). The LifeWorks survey uses a five-point scale, with one as "in crisis" and five as "empowered," to measure a person's well-being in 15 different domains, ten of which were analyzed for this report.[5] An increase in LifeWorks domain scores is an indication that client well-being is improving.

[5] LifeWorks survey domains include housing, employment, benefit income, food, healthcare coverage, adult education, language/literacy, transportation, disabilities and physical health, mental health, substance use, safety, intimate relationships, child care, and education of client's children. There is no LifeWorks domain for individual and family support.

On a scale of one to five, program enrollees' change in overall LifeWorks score in FY 2022 increased an average of 0.5 points, a slightly larger increase than in FY 2020 (0.4). In FY 2022, the largest average increase was in the areas of housing (1.5), food (0.8) and child care (0.6) (Exhibit 18).

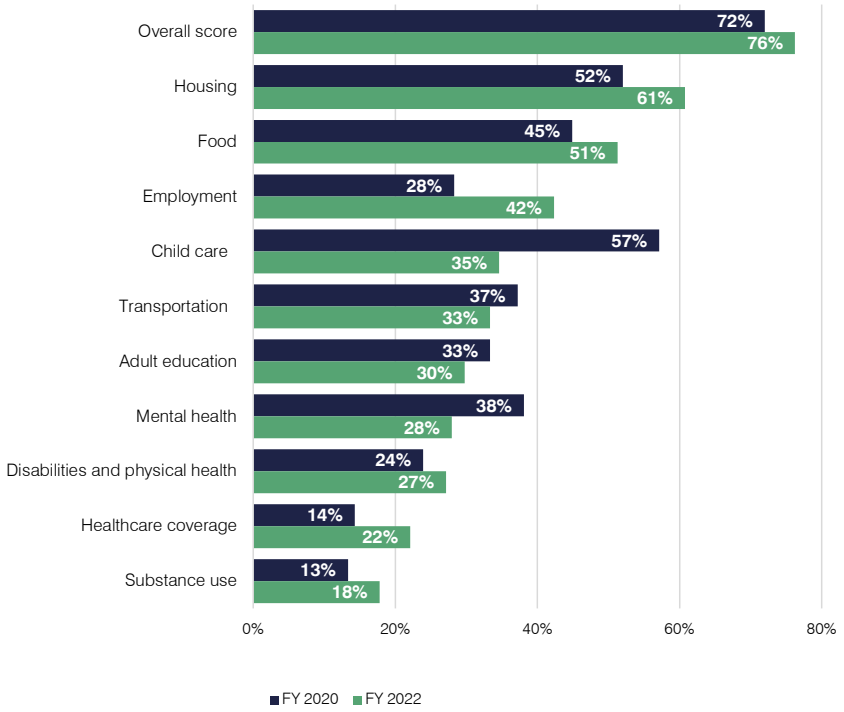
EXHIBIT 18. Average Change in LifeWorks Survey Domain Scores

	Baseline: FY 2020 (N = 50)			Comparison: FY 2022 (N = 80)		
Domain	**Average Entry Score**	**Average Reassessment Score**	**Average Score Change**	**Average Entry Score**	**Average Reassessment Score**	**Average Score Change**
Child care	3.4	4.4	1.0	3.7	4.3	0.6
Disability and physical health	3.6	3.7	0.1	3.7	3.9	0.2
Education	3.5	3.9	0.5	3.7	4.0	0.3
Employment	1.6	2.0	0.5	2.5	3.0	0.5
Food	2.5	2.9	0.4	2.4	3.2	0.8
Healthcare coverage	4.6	4.6	0.0	4.4	4.7	0.3
Housing	2.7	3.7	1.0	1.5	3.1	1.5
Mental health	4.0	4.4	0.4	4.0	4.3	0.3
Substance use	4.7	4.9	0.1	4.6	4.7	0.1
Transportation	3.6	3.9	0.3	3.8	4.1	0.3
Overall average score of ten domains	3.3	3.8	0.4	3.3	3.9	0.5

N varied by time period
Note: Average change score may not equal average reassessment less average entry score due to rounding.
Source: LifeWorks survey, analyzed by PSC.

In FY 2022, more than three-quarters of program enrollees had an improved LifeWorks survey score after receiving services. This is a slight increase from 72 percent in FY 2020. (Exhibit 19) When assessed by individual domain, the percentage of enrollees who had a positive change in their LifeWorks score varied. For surveys taken in FY 2022, nearly two-thirds of enrollees had a positive change in their housing score between their first survey and their most recent survey, and more than half had a positive change in their food domain score. The percentage of enrollees with positive increases in these two areas increased in FY 2022 when compared to FY 2020.

EXHIBIT 19. Percentage of Enrollees with a Positive Change in LifeWorks Survey Domain Scores



N varied by domain and time period; N shown is for overall score
Note: Average change score may not equal average reassessment less average entry score due to rounding. Source: LifeWorks survey, analyzed by PSC.
Source: LifeWorks survey, analyzed by PSC.

In addition to LifeWorks survey data, participants in discussion groups also overwhelmingly shared feedback that the assistance they received from Community Rebuilders had had a positive impact on almost every aspect of their lives. Mental and physical health improvements were the most common theme. Participants reported that the supports received have led to decreased stress, improved sleep quality, and reduced depression, and they have also improved their families' quality of life.

Intrinsic Needs Met

Information gathered from discussion group participants also provided insight into whether homeless families' intrinsic needs—independence, acceptance, honesty, and empathy—are being met. Participants spoke favorably about these needs being met and said that the caseworkers with whom they worked were the key component for the quality of services provided and their satisfaction with Community Rebuilders. Respect, empathy, compassion, and communication were the main caseworker traits cited by participants.

Additionally, the caseworkers were regularly cited as being willing to go above and beyond just offering housing support. Ongoing emotional support was brought up throughout the discussions.

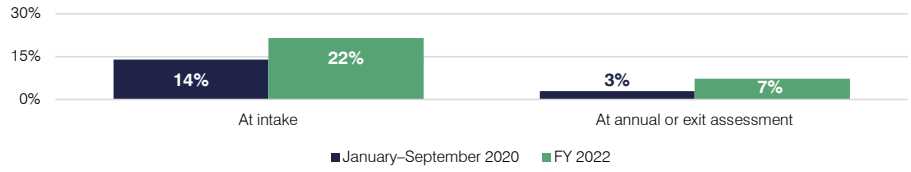
> "At Community Rebuilders, [they] made me feel like a person, like I wasn't lower, or being looked down upon. I felt like that at first, like I was lower, and then once when we were talking, they were like 'Everybody needs help sometimes,' and I felt better. I felt like a whole person."

> "I was dealing with my old landlord after a flood. There were times my water bill was $500 a month due to a continuous leak. My caseworker talked to me, calmed me down, got me resources to pay our bill, got a pack and play for my kid [to sleep in], furniture. I can call her about anything, I could call her right now. She even gives me advice about the baby because I'm a first-time mom. She was on top of it; if there was something she didn't know, she would find the answer and she would get back to me. There were times I just wanted to crawl into a dark hole, and she told me not to quit, [she told me that I needed] to get up."

Informal Networks and Supports

At an annual or exit assessment in FY 2022, only 7 percent of enrollees said they did not have a natural support system they could use when difficulties arise. This was down from 22 percent at program intake, similar to the results from the FY 2020 data (Exhibit 20).

EXHIBIT 20. Percentage of Enrollees Without Natural Supports



N varied by time period and assessment; January–September 2020, N = 39 at annual or exit interaction and 58 at intake; October 2021–September 2022, N = 68 at annual or exit interaction and 200 at intake
Note: This is not a matched analysis. The intake and exit data represent two different populations and cannot be directly compared.
Source: Signify Health platform, workflow report, analyzed by PSC.

Engagement in Services

While no discussion group participants were aware of the G.R.A.C.E. Network when asked, they all felt the benefits of the interconnectivity of the Network. Easy referrals, confidentiality agreements, and new support services already knowing the details of a participant's situation made the connection to additional community resources straightforward. Participants spoke of the ease of being able to connect with furniture resources without explaining their situation again and the relief when food pantries understood where they were coming from.

> "With my case, because of [the felony in] my background, [Community Rebuilders] went above and beyond. [My caseworker] had already informed them about my background so they wouldn't bring it up and that was a stress reliever because talking about it still opens wounds. It feels so much better because they already know. [My caseworker] would make them sign a confidential paper before telling them anything about me, which I really appreciated a lot, because with my criminal background, it's a dark thing, and if anyone tried to use it against me, she would talk to them. She was just awesome."

> "I'm not sure, but I think they all kind of work together. They didn't make you feel small. They understood certain situations. Sometimes you're afraid to ask for help because of how people judge you and I didn't have to deal with that in the services they referred me to."

Most participants also felt included in the referrals and decisions that came with the process of being engaged with Community Rebuilders. Caseworker communication and a strong referral network aided and empowered these participants to be actively engaged in their housing and resource decisions.

> "I know in my situation with my caseworker, she sends an email to let me know she is in touch with such-and-such organization, so I know. I see everything she is talking to them about in regard to me. [My caseworker] would nonstop reach out to me and ask if I had heard from this person and, if not, she would talk to them."

Two participants felt that they were somewhat left out of important decisions about their housing and were informed about updates instead of being a part of them. In one participant's experience, she was unable to visit the rental home she was referred to and was unaware of the inspection findings. Mold was found at the home during the inspection, but this information was not shared with her prior to her moving in. This has been a continuing issue about which she is working with her landlord independently from Community Rebuilders' assistance now that she has been placed in housing.

Impact Three: Data Systems Used to Coordinate Services, Improve Health, and Promote Equity

The G.R.A.C.E. Network has made great strides in setting up a referral and outcome reporting system dashboard that partners use to make better decisions, address unmet client needs, and increase the overall transparency of client work. However, partners also had suggested changes that could help the system better meet the needs of partner organizations as they continue to use the service.

The following short-term and intermediate outcomes describe the progress toward achieving this intended impact.

Short-Term Outcomes

Referrals and Outcomes Tracked, Displayed, Accessible, and Deidentified

One key theme of the G.R.A.C.E. Network partner interviews was the efficient referral process within the G.R.A.C.E. Network and ongoing connection with the families served. The G.R.A.C.E. Network provides

an up-to-date status of client services and enrollment, which avoids repeat referrals, cuts down on phone calls, and reduces wait times for the staff involved. Another benefit cited was the G.R.A.C.E. Network's ability to track and monitor the services being utilized by a client and organization.

Additionally, the central consent process used by the G.R.A.C.E. Network proved helpful by eliminating multiple release forms and avoiding repeat conversations with the families served. The process, which gives permission to work with any G.R.A.C.E. Network–affiliated organization, helped avoid time-intensive work duplication for those organizations who singularly utilize other G.R.A.C.E. Network organizations for their referrals. Those partners who refer to other organizations or receive referrals from outside the G.R.A.C.E. Network cited work duplication. This process also reduced the amount of paperwork clients referred through the G.R.A.C.E. Network had to complete to participate in the services or programs they were being referred to.

Intermediate Outcomes

Outcome Reporting Dashboards

Most interviewees regularly use the data and reporting capabilities and the monthly reports. Many found these tools helped them make better decisions, see unmet client needs, and be more aware of clients' enrollment, referral, and resolution status. The data and reporting tools increase the overall transparency of the client work and enable partners to have a more holistic view of the family receiving services.

However, interviewees also shared feedback on what could be done to make the data reporting and system more useful. Their suggestions fell into two categories, system improvements and additions. Interviewees' examples of enhancements to the existing system included improving the ease of pulling reports, adding context to the existing monthly reports, and simplifying the workflow filtering options. Additional user training and technology support may be an avenue to improve user experience with the existing system. Regarding system additions, several interviewees suggested making the G.R.A.C.E. Network interoperable with their organization's internal data systems.

Address Racial and Ethnic Equity with Data

The interviewees found the G.R.A.C.E. Network's main function to be processing referrals and accessing monthly reports focused on contacts created, needs identified, and referral status. Most interviewees have not looked at the data with an equitable outcome lens and asked for further conversation about equitable outcomes. Two common requests were for the G.R.A.C.E. Network to define equitable outcomes and provide training resources on how to highlight this aspect of the data.

Data Used to Reduce Health Disparities for Families Experiencing Homelessness

PSC asked interviewees about the G.R.A.C.E. Network's collaborative information approach to improve project partners' shared accountability for improved family outcomes overall. When interviewees were asked whether the G.R.A.C.E. Network promotes shared accountability regarding homelessness and social determinants of health, they voiced a clear desire for increased conversation. While the monthly data reports show outcomes and referrals, interviewees stated a need for more communication with all G.R.A.C.E. Network partners. They also reported wanting to develop a shared definition of accountability for each participating organization and to have intentional conversations about accountability metrics.

Appendix A: Community Rebuilders Evaluation Framework

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Appendix B: Data Sources and Limitations

Community Rebuilders provided PSC with the data for the analysis from their data reporting system as well as through three external primary sources: the Homeless Management Information System (HMIS); the G.R.A.C.E. Network Signify Health platform; and the U.S. Department of Housing and Urban Development Homelessness Data Exchange. The data analyzed was collected between October 1, 2019, and September 30, 2020, (but the time frame varied by data source) and October 1, 2020, and September 30, 2022. For FY 2020, data collection ranges are noted by each data source below. Some data included for FY 2022 did not have available FY 2020 data for comparison. In addition to this data analysis, PSC conducted interviews with Community Rebuilders' partners and discussion groups with clients to assess some of the outcomes set forth in the evaluation framework.

Homeless Management Information System

HUD requires a local database of all its CoC sites, which includes Community Rebuilders' Permanent Supportive Housing programs. HMIS is used to collect client-level data and data on the provision of housing and other services to homeless individuals and families and persons at risk of homelessness. Community Rebuilders uses HMIS data to assess changes in income and the length of time it took to connect program enrollees to services and permanent housing. HMIS data were collected for the entirety of FY 2020 and FY 2022. HMIS data on G.R.A.C.E. Network families' entry(ies) into the homeless response system were only available to Community Rebuilders staff who deidentified the information and shared it with PSC for analysis.

G.R.A.C.E. Network Signify Health Platform

The G.R.A.C.E. Network Signify Health platform (Signify Health) offers a sophisticated data collection and reporting system that allows Community Rebuilders and its partners to monitor success and guide programming. Data collected and stored in Signify Health includes information about families' identified needs, the community services they were referred to and accessed, and the LifeWorks survey data.

Community Rebuilders uses the LifeWorks survey to measure indicators of well-being over time among the people it serves. The survey is conducted upon program entry and again after the client is housed or experiences another significant life change (e.g., change in income/benefits, change in household composition). The LifeWorks survey uses a five-point scale, with one being "in crisis" and five being "empowered," to measure a person's well-being in 14 different domains. The number of respondents to the LifeWorks survey is small compared to the report population. The tool was not used prior to November 2019 and staff training on tool use was not completed until January 2020, which lead to the tool not being fully used until May 2020. In order to include the comparative data in this report, at least two surveys need to be administered to the client, and the time frame did not allow for more than one survey for many clients. The domains and scoring matrix can be found in Appendix C.

Because the Signify Health platform contains data from multiple organizations, Community Rebuilders can identify the extent to which its clients' needs other than housing are being met in the community. PSC used this data to ascertain how many and which services Community Rebuilders' clients accessed once they were enrolled in a housing program and to assess whether their needs are being met. The Signify

Health data were collected between January 1, 2020, and September 30, 2020, and again from October 1, 2021, to September 30, 2022.

Signify Health Data Limitations

The Signify Health platform is no longer being supported, creating difficulties with pulling down data reports for FY 2022. This specifically affected the analysis used in this report and limited the ability to connect G.R.A.C.E. Network families to those served in one of Community Rebuilders' housing support programs. Community Rebuilders looked up each of the 401 families in the G.R.A.C.E. Network in FY 2022 in their internal data system to confirm which housing and supports program they were enrolled in and in the HMIS data system to capture their homeless response entry data. Four of the 401 families were missing program information and could not be looked up in HMIS. Community Rebuilders completed an internal data review process to confirm the data. We acknowledge that manually looking up this data introduces opportunity for data entry error.

HUD Exchange

The HUD Exchange provides data, resources, trainings, and technical assistance support for HUD's community partners. It includes public access to aggregated HMIS data on HUD's CoC programs in areas including rates of first-time homelessness, income, and housing stability, as well as others. PSC used the HUD Exchange CoC analysis tool to assess the racial equity of access to Community Rebuilders' services. These data were collected for the entirety of FY 2020 and FY 2022.

Appendix C: LifeWorks Survey Scoring Matrix

Domain	1 (In Crisis)	2 (Vulnerable)	3 (Safe)	4 (Building Capacity)	5 (Empowered)
Housing	Homeless or imminently homeless	In transitional, temporary, or substandard housing, or current rent/mortgage payment is unaffordable (over 30% of income)	In stable housing that is only marginally adequate	Household is in adequate, subsidized housing	Household is in adequate, unsubsidized housing
Employment	No income	Some income from temporary/part time/sporadic employment or partial benefits	Employed or receiving benefits but income is inadequate	Income is increasing but not yet adequate to support household	Adequate income to sustain housing and basic needs
Food	No food or means to prepare it; relies significantly on other sources of free or low-cost food	Household is on SNAP or relies on some other type of assistance	Can meet basic food needs, but requires occasional assistance	Can meet basic food needs without assistance	Can choose to purchase any food the household desires
Healthcare coverage	At least one household member has immediate need for medical care or attention and has no medical coverage	No immediate need, but at least one household member has no medical coverage and great difficulty accessing medical care when needed	At least one household member has no immediate need and no medical coverage, but is able to access medical care when needed	All household members have some type of medical coverage, but it may strain budget or is less than adequate	All household members are covered by affordable, adequate health insurance
Adult education	No high school diploma/GED and is not enrolled in high school or a GED program	No high school diploma/GED, but the client is enrolled in high school or a GED program	Client has high school diploma/GED but is not seeking additional education/training to benefit employment	Client has high school diploma/GED and is seeking additional education/training to benefit employment	Client has completed additional education/training beyond high school diploma/GED (and is in a position where they are employable)
Language/ literacy	Literacy or language problems are serious, unaddressed barriers to employment or accomplishing basic day-to-day tasks	Client has serious language or literacy issues but is enrolled in a literacy or language program	Client has a sufficient command of English to where language or literacy is not a barrier to employment or accomplishing basic day-to-day tasks	Client has sufficient command of English but is seeking additional education to resolve remaining language or literacy problems	Client has no language or literacy problems
Transportation	No access to transportation (public or private)	Transportation is available but unreliable, unpredictable, or unaffordable	Transportation is available and reliable, but inconvenient	Transportation is readily available and convenient but not preferred; if client owns a car, lacks either a driver's license or insurance	Transportation is readily available, affordable, and satisfactory; if client owns a car, has driver's license and a car that is adequately insured

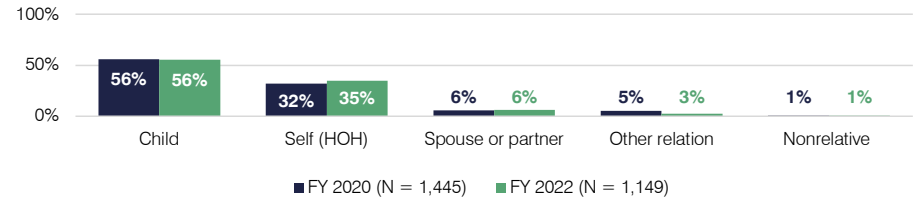
Domain	1 (In Crisis)	2 (Vulnerable)	3 (Safe)	4 (Building Capacity)	5 (Empowered)
Disabilities and physical health	Acute or chronic symptoms are currently affecting housing, employment, social interactions, etc.	No identified disability or health concerns	Sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Asymptomatic; condition is controlled by services or medication	Rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.
Mental health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulties in day-to-day life due to psychological issues	Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent issues with functioning due to mental health symptoms	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health issues	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems and concerns
Substance use	Severe abuse/dependence; problems so severe that institutionalized living or hospitalization may be necessary	Dependent on substances	Client has used within the last 6 months	Client is building capacity toward becoming independent from substances	No drug use/alcohol abuse in the last 6 months
Safety	Environment is not safe; immediate level of lethality is extremely high; possible Children's Protective Services or police involvement	Safety is threatened, but temporary protection is available; level of lethality is high	Current level of safety is minimally adequate; ongoing safety planning is essential	Environment is safe, but future safety is uncertain; safety planning is important	Environment is apparently safe and stable
Intimate relationships	Abuse is present or all relations have been severed	Partners do not relate well with one another; potential for abuse or relations being severed	Partners acknowledge and seek to change negative behaviors, are learning to communicate and support	Partners support each other's efforts	Relationship is stable and communication is consistently open
Child care	Needs child care but none is available or accessible (including family members or friends)	Child care is unreliable or unaffordable; inadequate supervision is a problem for child care that is available (including family members or friends)	Affordable, subsidized child care is available but limited (if family members or friends: availability or interest is limited)	Reliable, affordable child care is available (could be family members or friends); no need for subsidies	Able to select quality child care of choice (could be from among family members or friends)
Education of consumer's child(ren)	One or more school-aged children are not enrolled in school	All school-aged children are enrolled in school, but one or more are not attending or only occasionally attending classes or have unmet educational needs	School-aged children are enrolled in school, but one or more only attend classes most of the time or are struggling in at least 3, but not all, of their classes	All school-aged children are enrolled in school and attend classes on a regular basis, but one or more are struggling in 1–2 classes	All school-aged children enrolled, attend classes on a regular basis, and are performing well in school

Appendix D: Demographic Information

Demographic information was collected for G.R.A.C.E. Network enrollees upon program entry. The data presented in this report includes information on heads of households (HOH), age, gender, race and ethnicity, and enrollees' living situation prior to program entry and after program exit.

Data were collected from enrollees regarding their status within their household—whether they were the HOH, a spouse or partner, a child, another HOH relative, or an unrelated household member. During both the current and baseline time period, 56 percent of enrollees were the child of the HOH and around one-third were the HOH themselves (Exhibit D1).

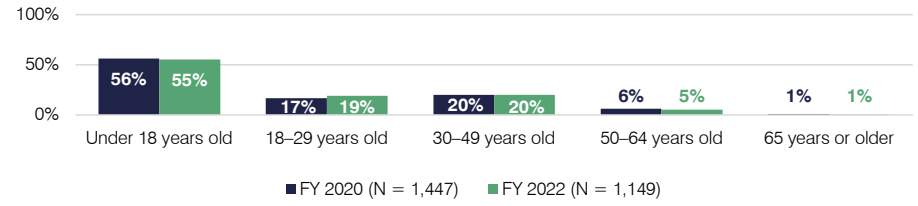
EXHIBIT D1. Enrollee Relationship to the Head of Household



N varied by time period
Note: Percentages do not total 100 percent due to rounding.
Source: Signify Health, Enrollment Report, analyzed by PSC.

Between October 2021 and September 2022, the ages of enrollees at program entry ranged from zero to 71 years old, with an average age of 19. Between October 2019 and September 2020, the average age of enrollees was also 19. In both time periods, more than half of clients were under the age of 18, and nearly 40 percent were between the ages of 18 and 49 years old (Exhibit D2).

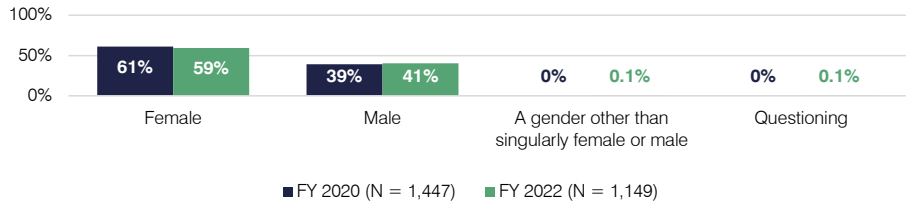
EXHIBIT D2. Client Age



N varied by time period
Source: Signify Health, Enrollment Report, analyzed by PSC.

During both time periods, around 60 percent of enrollees were female and around 40 percent were male (Exhibit D3).

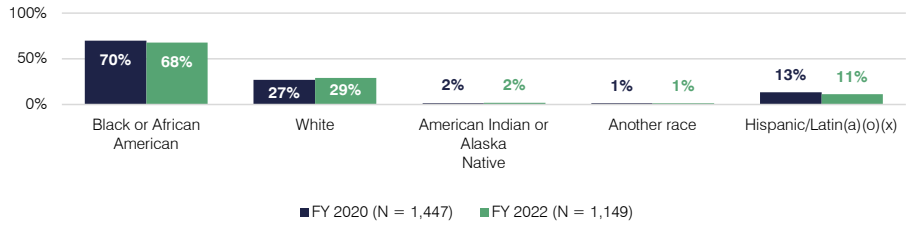
EXHIBIT D3. Client Gender



N varied by time period
Note: Percentages do not total 100 percent due to rounding.
Source: Signify Health, Enrollment Report, analyzed by PSC.

During both time periods, around 70 percent of program enrollees were Black or African American, more than one-quarter were white, and over 10 percent were Hispanic/Latin(a)(o)(x) (Exhibit D4).

EXHIBIT D4. Client Race and Ethnicity

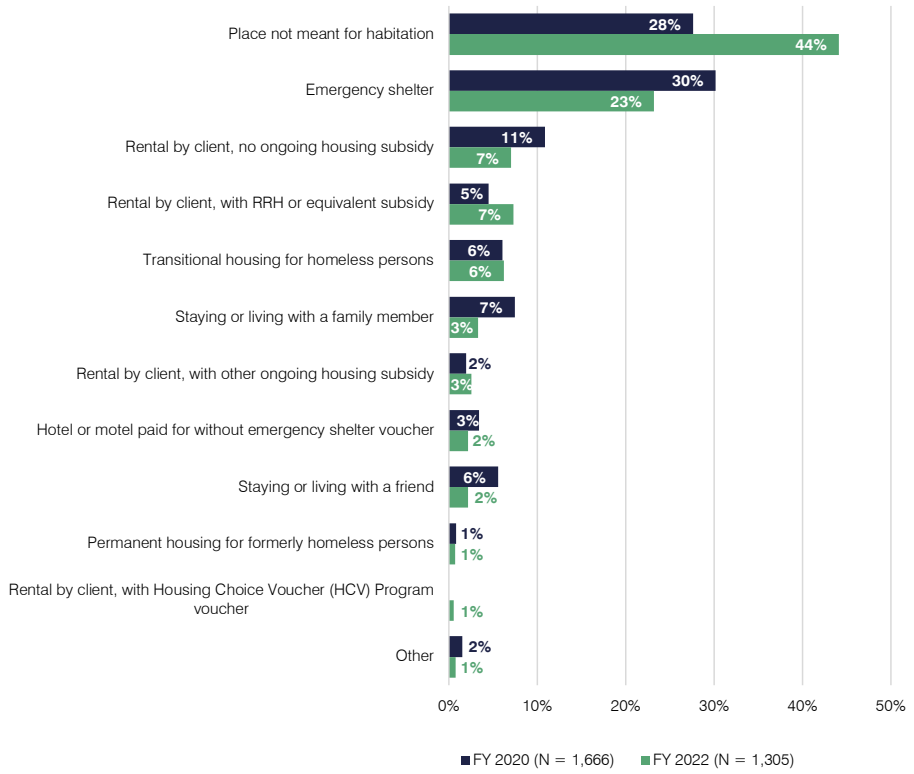


N varied by time period
Source: Signify Health, Enrollment Report, analyzed by PSC.

Living Situation

Between October 2021 and September 2022, prior to entering a Community Rebuilder's program, 44 percent of the enrolled households were living in a place not meant for habitation compared to 28 percent between October 2019 and September 2020 (Exhibit D5). Another 23 percent were living in an emergency shelter, 7 percent in rental housing with no ongoing housing subsidy, and 7 percent in rental housing with Rapid Re-housing (RRH) or equivalent subsidy.

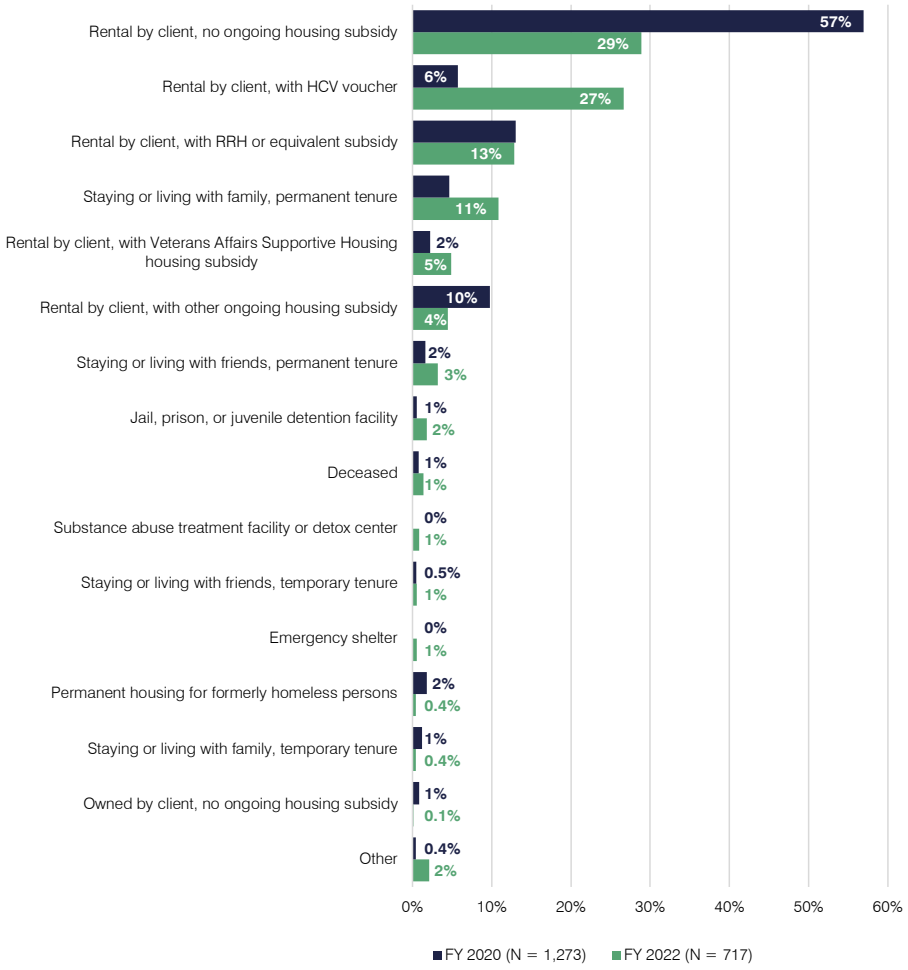
EXHIBIT D5. Living Situation Prior to Program Entry



N varied by time period
Note: Percentages do not total 100 due to rounding; number is larger than total evaluation household number because families could be enrolled in more than one Community Rebuilders program.
Source: Signify Health, Enrollment Report, analyzed by PSC.

Between October 2021 and September 2022, upon program exit, 29 percent were living in rental housing with no ongoing housing subsidy compared to 57 percent during the baseline time period (Exhibit D6). Another 27 percent were living in rental housing with an HCV voucher, 13 percent were living in rental housing with RRH or equivalent subsidy, and 11 percent were permanently living with family.

EXHIBIT D6. Living Situation at Program Exit



N varied by time period
Note: Percentages do not total 100 due to rounding.
Source: Signify Health, Enrollment Report, analyzed by PSC.

Appendix E: G.R.A.C.E. Network Partner Organizations

Organization	Website
Arbor Circle Youth Development Services	arborcircle.org/services/youth-services-and-programs/
Area Agency on Aging of Western Michigan	www.aaawm.org/
Area Community Services Employment and Training Council (West Michigan Works!)	www.westmiworks.org/
AYA Youth Collective	www.ayayouth.org/
Cherry Health	www.cherryhealth.org/
Community Food Club	communityfoodclubgr.org/
Community Rebuilders	communityrebuilders.org/
EuzenConnect	www.euzenconnect.ai/
Fair Housing Center of West Michigan	http://www.fhcwm.org/
Family Futures	familyfutures.net/
Family Promise of West Michigan	www.familypromisegr.org
Goodwill Industries of Greater Grand Rapids	www.goodwillgr.org/
Urban League of West Michigan	www.grurbanleague.org/
Great Start Collaborative	greatstartkent.org/
Head Start for Kent County	www.hs4kc.org/
Health Net of West Michigan	healthnetwm.org/
Home Repair Services	www.homerepairservices.org/
Hope Network Affordable Housing	hopenetwork.org/affordable-housing/
Hope Network Transportation	hopenetwork.org/transportation-services/
Inner City Christian Federation	iccf.org/
Kent Intermediate School District	www.kentisd.org/
Kent School Services Network	www.kentssn.org/
Literacy Center of West Michigan	literacycenterwm.org/
Meals on Wheels Western Michigan	mealsonwheelswesternmichigan.org/
Mel Trotter Ministries	www.meltrotter.org/
Priority Health	www.priorityhealth.com/
Senior Neighbors, Inc.	seniorneighbors.org/
Spectrum Health West Michigan	www.spectrumhealth.org/
TrueNorth Community Services	www.truenorthservices.org/
United Methodist Community House	www.umchousegr.org/
Well House	www.wellhousegr.org/

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