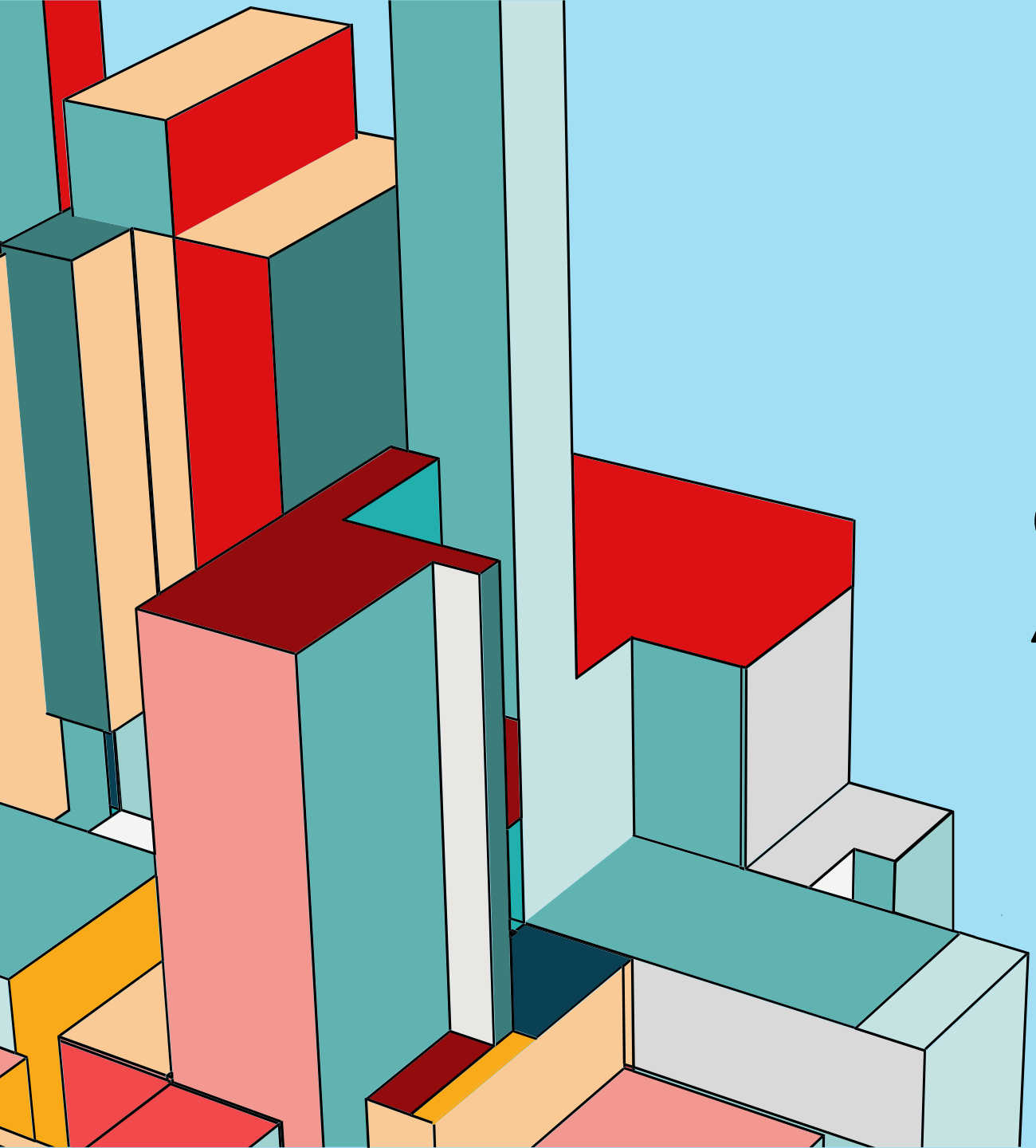
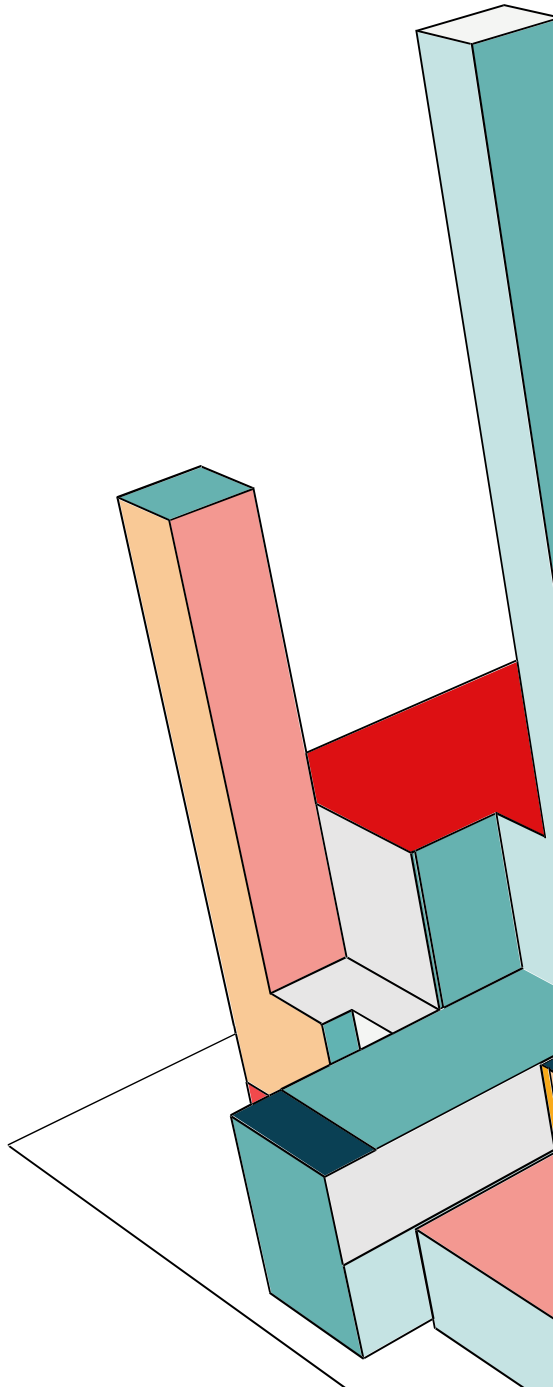


FOCUS GROUPS QUALITATIVE ANALYSIS

Danica Fraher, LMSW, MPH
Supported by Katie Good, MSSW Candidate, & Sara Fuetter

AGENDA

- Methods
- Survey Highlights
- Core Takeaways
    - Solutions
    - Diving Deeper
    - Survey Data
- HMIS Focus Group Highlights
- Discussion



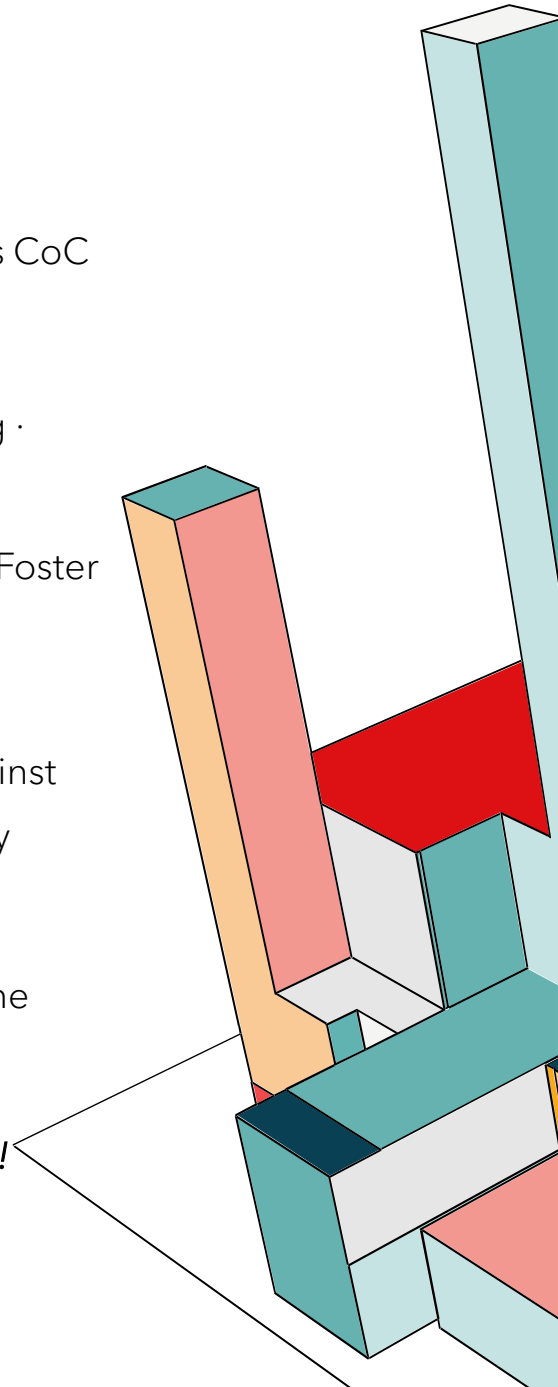
METHODS

- Data Collection 15 provider focus groups conducted March 23 – April 2, 2026, with 100 participants across CoC and non-CoC provider types. All sessions were recorded using Plaud and conducted in person.
    - CoC Providers Street Outreach · Navigation & Diversion · Coordinated Assessors · Rapid Rehousing · Permanent Supportive Housing · Emergency Shelter
    - Non-CoC Providers Non-English Speakers & Immigrants · Victim Services · Legal Systems · Youth & Foster Care · Recovery Services · Peer Support · Workforce Development · Healthcare

- Analytic Approach 14 focus groups were analyzed using rapid framework analysis – deductive coding against CE redesign problem domains, combined with inductive coding for emergent themes. Pre and post survey analysis. Human-led, AI-assisted.

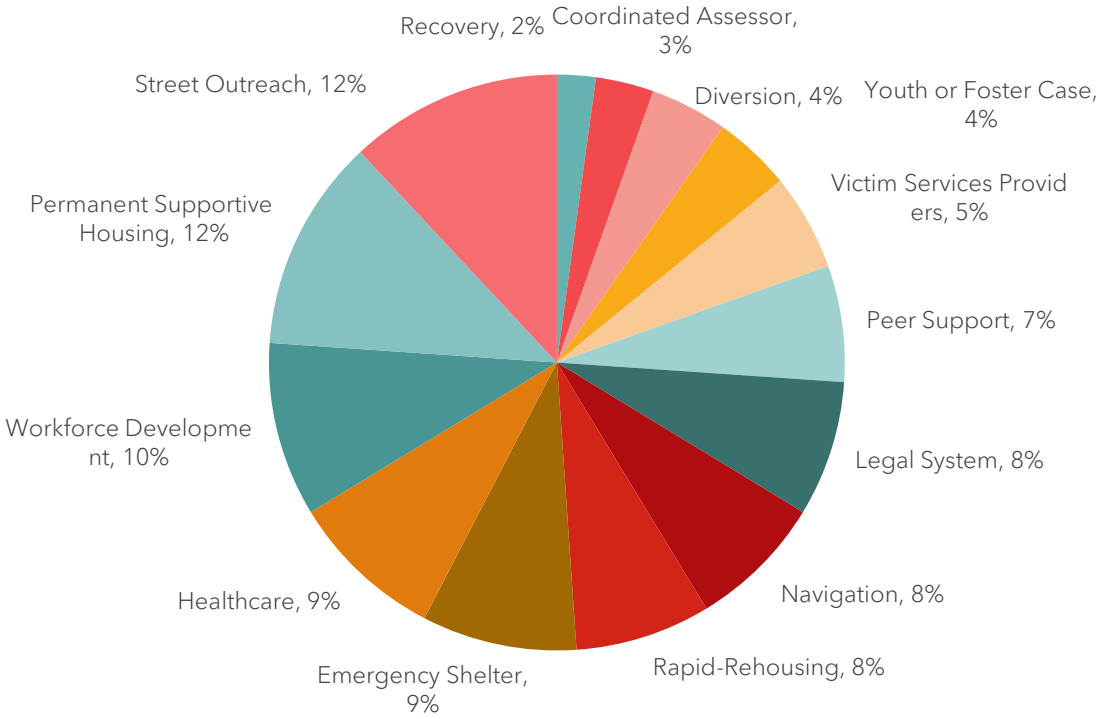
- Note One dedicated HMIS focus group (5) was conducted separately; these findings are not included in the thematic analysis above but will be shared separately as part of the Clarity transition review.

Special thanks to Katie Good and Sara Fuetter for their help with checking transcripts and survey analysis!

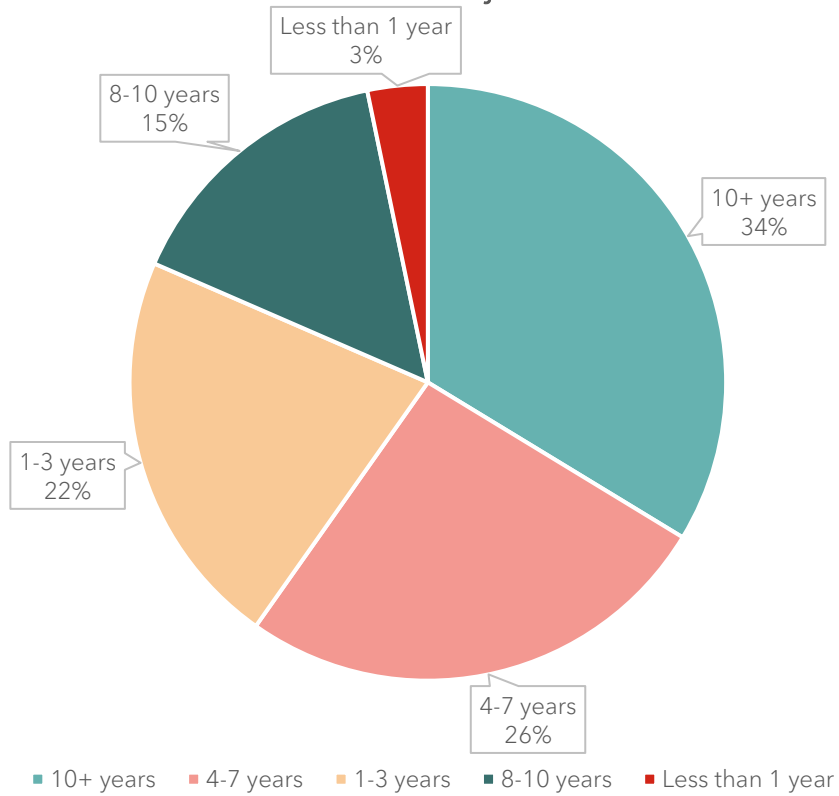


WHO WAS IN THE ROOM?

What best describes your primary work or your organizations primary focus?

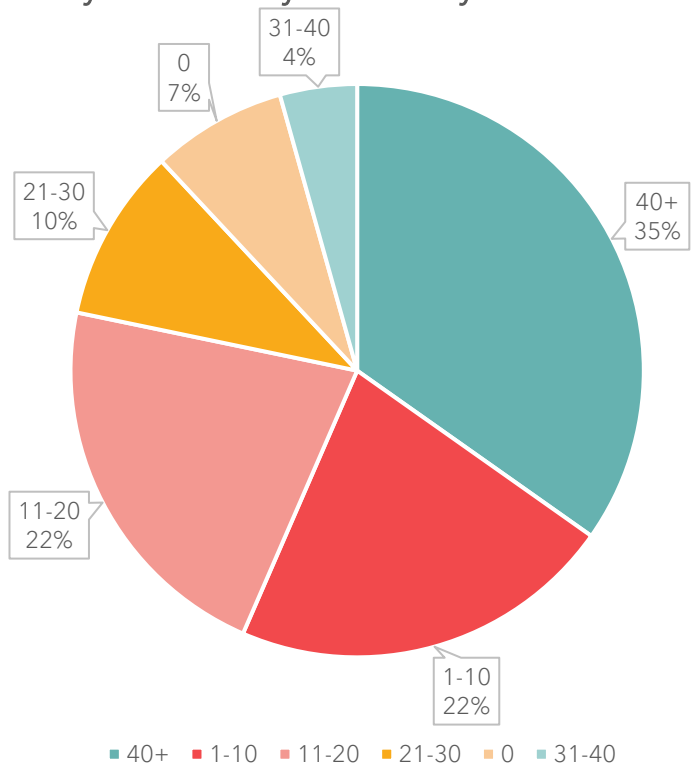


How many years have you worked with people experiencing homelessness or in adjacent services?

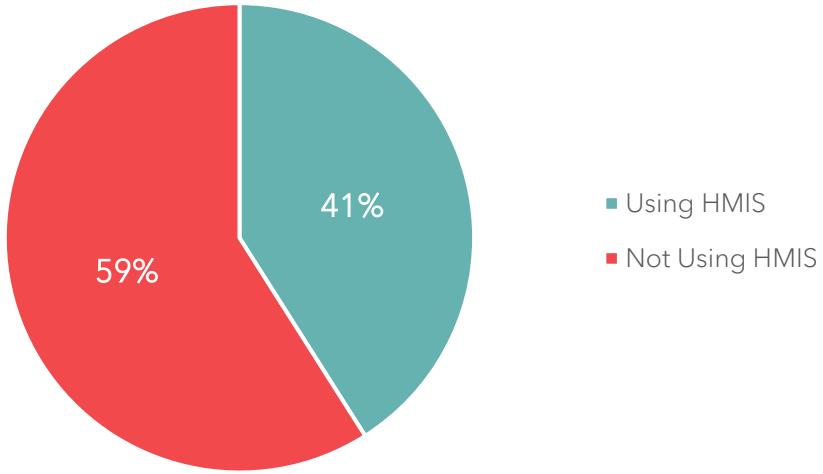


SURVEY DATA HIGHLIGHTS: CASELOADS AND CARE COORDINATION

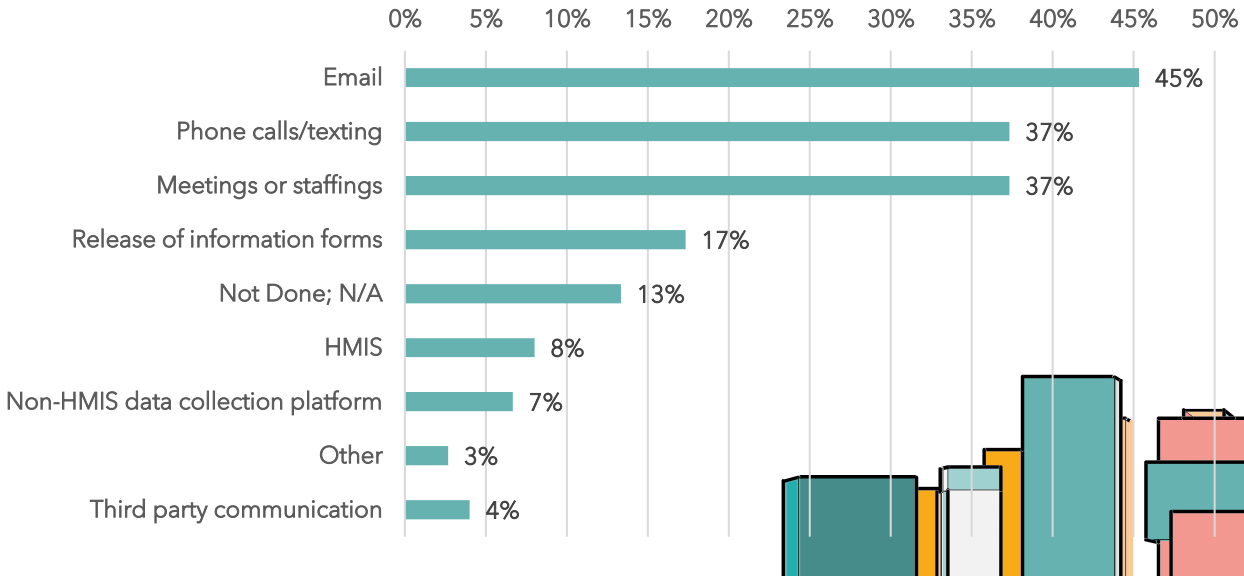
How many clients do you directly serve at one time?



Share of Providers Using HMIS



How do you coordinate care with other providers for clients that do not use the same data and software systems as you?



WHAT PROVIDERS TOLD US

The Coordinated Assessment does not reflect true vulnerability.

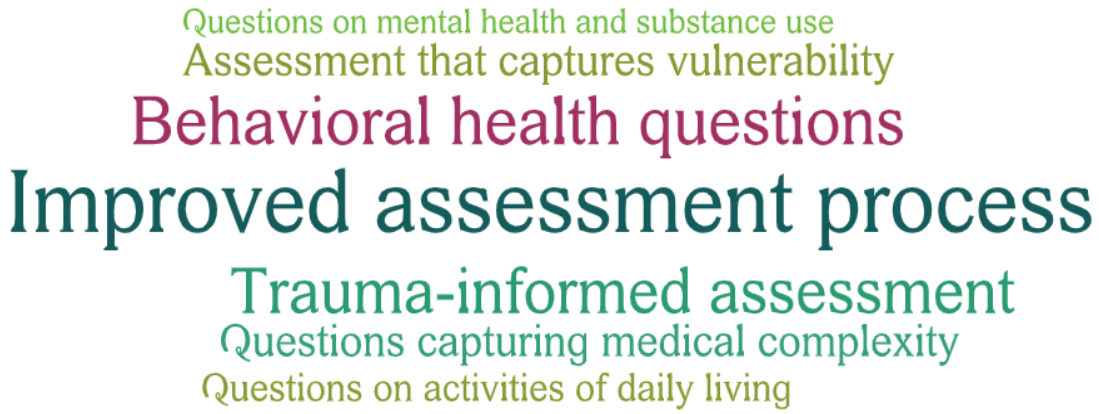
The process itself is causing harm that undermines long-term engagement.

Some of the most vulnerable people in our community have no pathway to Coordinated Entry.

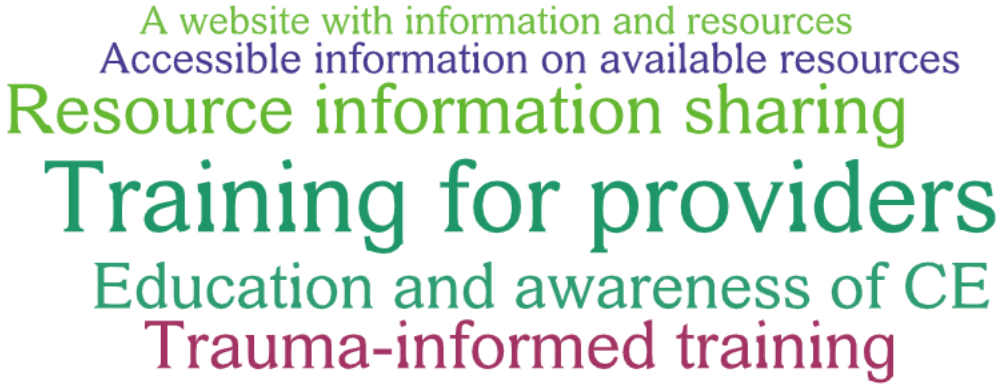
People are not being connected to the right interventions.

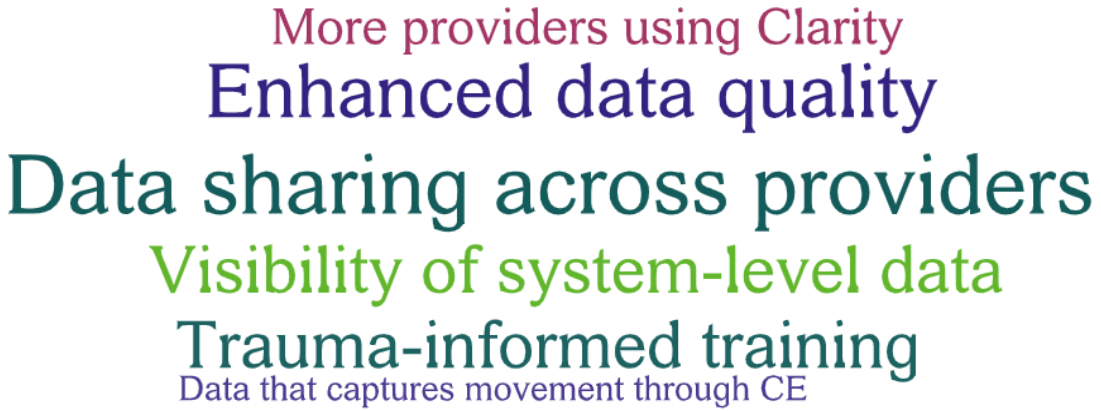
Getting people housed is the beginning of the work, not the end. The infrastructure to sustain housing is largely absent after placement.

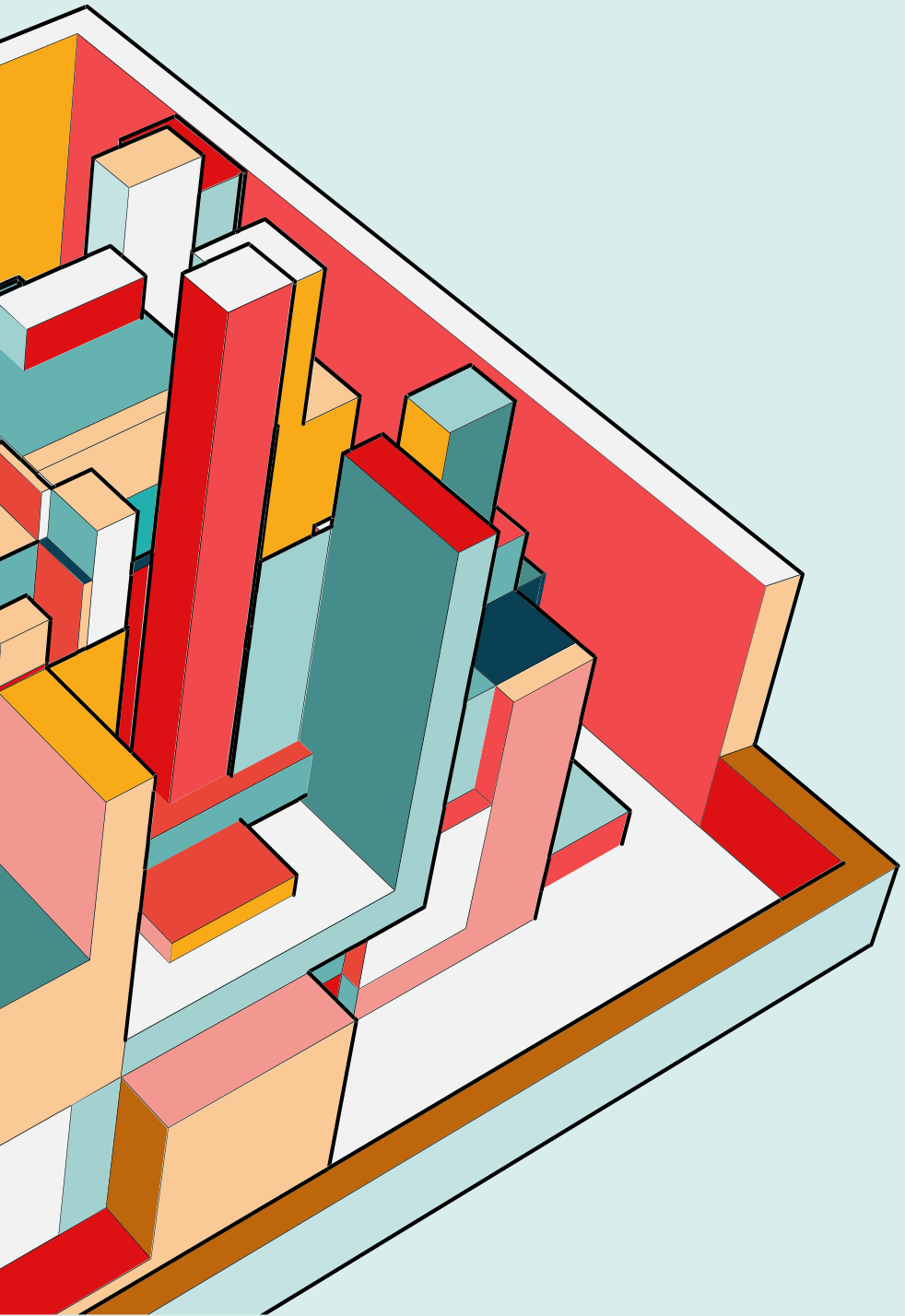
The transition to Clarity has created a significant disruption for providers that needs immediate attention alongside the redesign.



"What do you want to see in our new Coordinated Entry system?"







CORE TAKEAWAYS

Fourteen focus groups.
95 providers.
CoC and non-CoC alike.

What we heard was consistent, specific, and actionable. Providers did not just name the gaps— they showed us what needs to be built.

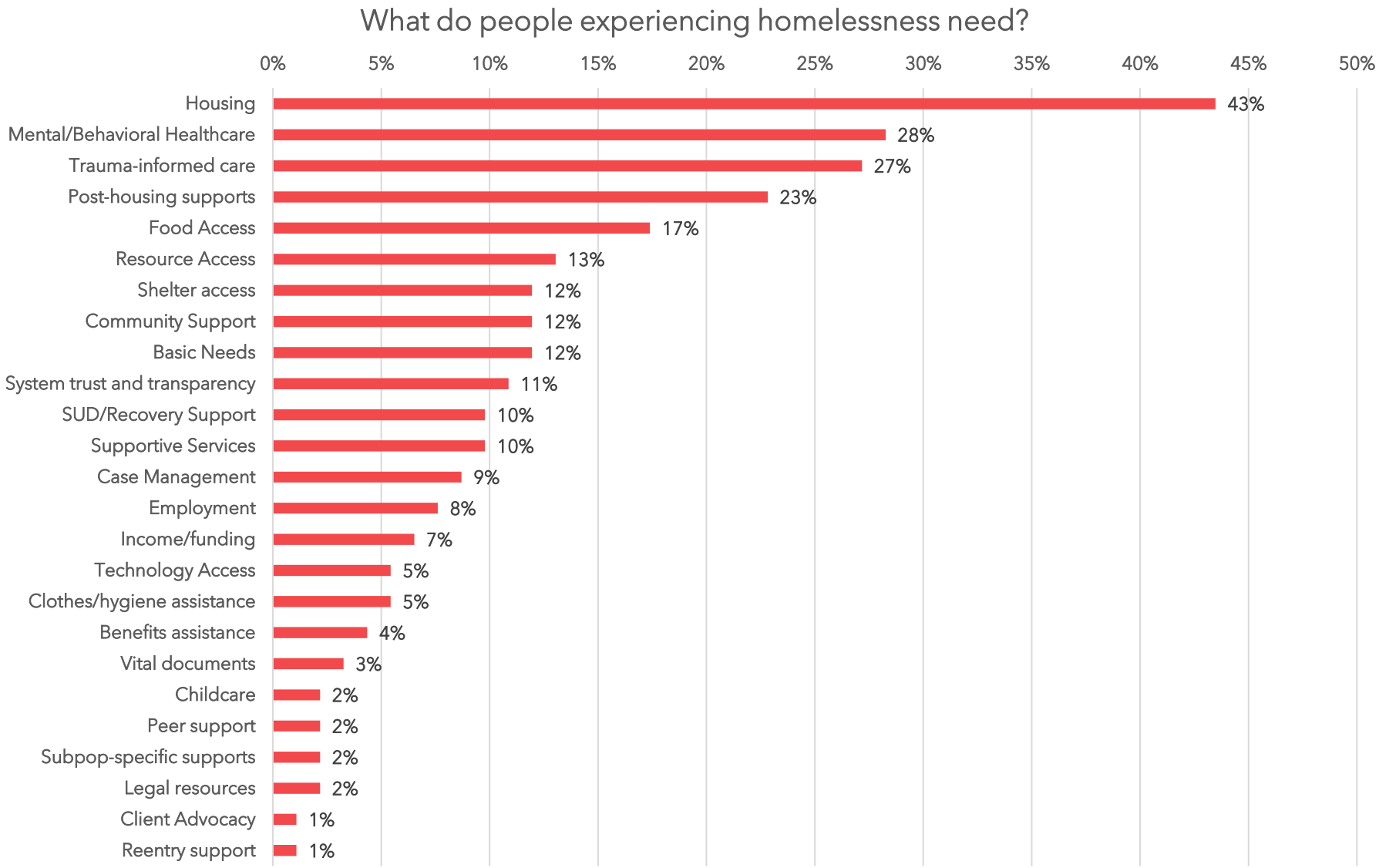
PROVIDER-ESCALATED OPPORTUNITIES: ACCESS

Expanding CE access to underconnected sectors – recovery, legal system, victim services, foster care pipeline

Expanding HMIS access and training to non-CoC providers – the structural data integration gap

Cross-system consent mechanisms – the legal/privacy barrier to care coordination

RESOURCE MAPPING: WHAT DO PEOPLE EXPERIENCING HOMELESSNESS NEED?



DIGGING DEEPER: SOME OF THE MOST VULNERABLE PEOPLE IN OUR COMMUNITY HAVE NO ACCESS TO COORDINATED ENTRY.

Several entire provider sectors – recovery services, legal system providers, victim services, and most non-CoC providers – serve people with high acuity and complex needs but **have no functional connection to CE**.

What Providers Named:

- **Substance use treatment / recovery providers** regularly serve people experiencing homelessness and **have never successfully used CE**. One provider did not know CE served their population at all.
- **Legal system providers serve unhoused folks daily** but have **no (or limited) HMIS access, no CE training, and no formal referral pathway**.
- **Sex trafficking and exploitation are significant and underrecognized drivers** of homelessness. The **current CA does not ask** about trafficking.
- **Youth in the foster care system have no access to CE before age 18** – even when the DFPS knows homelessness is coming. They **age out and enter crisis with no bridge** – even when earlier coordination was entirely possible.
- **Undocumented individuals and non-English speakers face near-complete exclusion** – immigration fears, language barriers, and program eligibility restrictions compound at every step

"I can barely navigate these systems as a professional. I can't even imagine not having English as my first language and being thrown into all of this with no housing and no stable income. That's impossible."

– Service Provider, Non-English Speakers Focus Group

PROVIDER-ESCALATED OPPORTUNITIES: ASSESSMENT

Redesign the CE to capture critical domains - medical complexity, ADLs, trauma history, cognitive function, SMI, immigration status, social supports, and trafficking history – providers identified as most consequential and most absent

Develop **clear training and quality standards around assessment administration** – including whether and how assessors may adapt scripted language to support accurate disclosure and trauma-informed practice

Develop **structured mechanisms for information beyond client self-report** – providers uplifted **assessor observation fields** for SMI and SUD, a **pathway for third-party clinical input**, and a **proxy assessment process for clients who are unable to take an assessment** due to cognitive impairment, acute symptoms, or other barriers

Develop robust interpreter infrastructure using apps, multilingual case managers, and live interpreter technology to ensure language barriers do not compromise assessment accuracy or CE access for non-English speaking clients

DIGGING DEEPER: THE PROCESS IS CAUSING HARM THAT UNDERMINES LONG TERM ENGAGEMENT.

"Hey, do this thing. Resurface your traumas. Be triggered as we ask all of these in-depth questions about what you don't have. We're not actually going to do anything for you today. Maybe in two years we'll get you here or three months. That doesn't feel right, that doesn't feel trauma informed to me. It doesn't feel person centered, so I don't use it."

– Service Provider, Legal Systems Focus Group

Across 10 of 14 focus groups, CoC and non-CoC alike, providers described a process that causes direct harm to the people it's meant to serve.

What Providers Named:

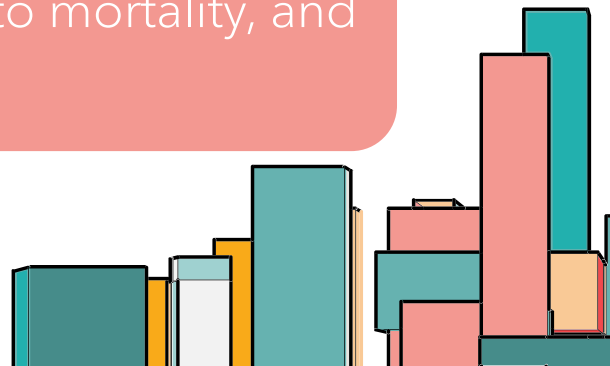
- **Being asked to disclose trauma with no immediate support or follow-up** was described as retraumatizing. Several providers have **stopped referring clients to CE entirely** as a result.
- **Clients who complete assessments and receive no response – sometimes for years – disengage from services entirely.** Providers named this hopelessness **"resignation":** accepting homelessness to avoid repeated disappointment
- **The harm isn't individual**. Providers described trust in the system eroding across the entire community when CE fails to delivery on its implied promise.
- **Front-line providers absorb this harm too. Secondary trauma and moral injury** were named explicitly across multiple groups, with no formal support structures in place.

PROVIDER-ESCALATED OPPORTUNITIES: PRIORITIZATION

Build a genuine matching system driven by client need, functional capacity, and program fit — not available inventory. The current system identifies vulnerability but does not connect people to the intervention that fits them

Develop new pathways to housing stability — some examples uplifted were harm reduction housing for people not ready for sobriety-based programs, prevention fund access for people on the verge of homelessness, and bridge housing between homelessness and independent living

Providers identified specific factors that should carry more weight: chronicity of homelessness (continuous over episodic), medical complexity and proximity to mortality, and ADL and accessibility needs.



DIGGING DEEPER: THE COORDINATED ASSESSMENT DOES NOT REFLECT TRUE VULNERABILITY.

Across 13 of 14 focus groups – CoC and non-CoC alike – providers described an assessment that systematically undercounts the people who need housing most. The tool was designed to measure engagement with the assessment process – not actual vulnerability.

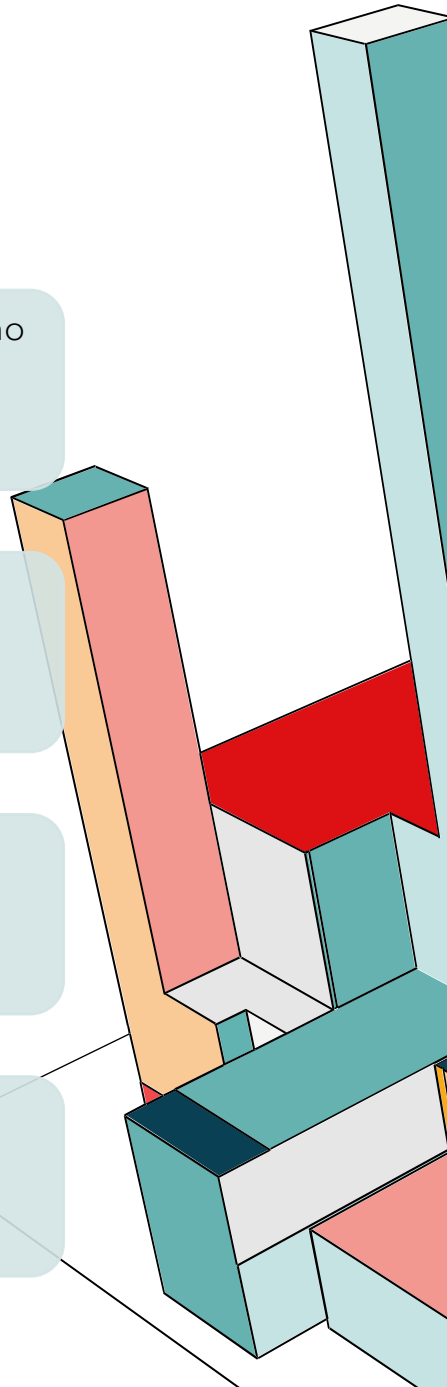
What Providers Named:

- Scores do not capture serious mental illness, medical complexity, ADLs, cognitive impairment, trauma history, language barriers, and more.
- Score variability of 10+ points for the same client depending on assessor familiarity, in person or over the phone, etc.
- The script is rigid and not trauma-informed. Assessors routinely deviate from it to help clients understand the questions and because the script alone cannot produce accurate data - but that flexibility is not formally sanctioned, creating further score inconsistency.
- CE is opaque to clients and providers alike. Clients believe they are signing up for a voucher and will hear back in a few months. Many non-CoC providers cannot navigate it either – leaving clients without a guide.

> ""Our patient had just gotten approved for SSI, over the summer, when [person who knew client] did her CA, it was a fourteen. And then we just looked in February, a new person did it who she didn't know – scored her a four."
>
> *– Service Provider, Healthcare Focus Group*

COMMUNITY-DRIVEN VULNERABLE POPULATIONS

Individuals with Medical Complexity	• All (100%, 93% Strongly, 7% Moderately) focus groups elevated individuals who meet the community definition of medical complexity. • Within this group, people with severe mental illness (57%) and intellectual disabilities (50%) were especially uplifted.
Elders	• 64% (57% Strongly, 7% Moderate) of the focus groups elevated elders in our community as extremely vulnerable.
Families with Children	• 64% (21% Strongly, 43% Moderate) of the focus groups elevated families with children in our community as extremely vulnerable.
Justice-Involved Individuals	• 50% (14% Strongly, 36% Moderately) of the focus groups elevated justice-impacted individuals in our community as extremely vulnerable.



PROVIDER-ESCALATED OPPORTUNITIES: REFERRALS

Whenever possible, **verify program eligibility before issuing referrals** – providers elevated ADL capacity, chronicity status, and prior program history. **Develop a structured self-disclosure document for criminal history**, so eligibility is known prior to referral and avoids dashed hopes with inflexible site-based property management.

Create a formal RRH-to-PSH bridge pathway – allowing clients to be assessed for PSH and placed on the waitlist while still enrolled in RRH. Without this, PSH-appropriate clients serve their full RRH time, exit precariously, and return to homelessness with burned eligibility

Rebuild referral packet quality with durable contact information, client photos, assessor context fields, location data, and more so referrals arrive with enough information to act on

DIGGING DEEPER: PEOPLE ARE NOT BEING CONNECTED TO THE RIGHT INTERVENTIONS.

"We've had someone on the wait list for certain properties for quite a while, and he's been pulled three times. But every time he's gotten pulled, it hasn't been ADA accessible unit."

– Service Provider, Healthcare Providers Focus Group

"Drugs is a big thing too because, I've had a lot of clients tell me, 'I finally got housed, and there is so many people doing and dealing drugs there that I am trying to stay clean. I can't stay clean there. So I am back out in the woods just to be away from the drugs."

– Service Provider, Workforce Focus Group

Across all14 focus groups - the most consistent finding in this entire dataset – **providers described a system that routes people to whatever is available, not to what fits client needs.** The consequences are predictable and well-documented: returns to homelessness, lost eligibility, and clients who are harder to reach and more vulnerable the second time around.

What Providers Named:

- A significant proportion of RRH clients are better suited for PSH – and RRH placement can burn folks' PSH eligibility.
- Geographic and environmental mismatches are routine – clients without vehicles not near a transit line, individuals in recovery in recovery-incompatible neighborhoods, often placed in a completely new and unfamiliar area, far from community.
- ADA accommodation needs are not captured before referral – lining people up for ineligible opportunities.
- Which organization a client is assigned to significantly determines their outcome – an inequity the system does not track.

PROVIDER-ESCALATED OPPORTUNITIES: POST HOUSING

Housing doesn't stick without the infrastructure to sustain it – life skills, on-site behavioral health and primary care, peers and buddy systems support, benefits enrollment, and dedicated social infrastructure: shared spaces, community connection, cooking classes, programming. **These need to be funded as core components of housing, not afterthoughts.**

Establish minimum PSH standards – staffing ratios, de-escalation capacity, structured onboarding, and dedicated wraparound services. Currently, program quality varies widely and outcomes are largely unmonitored. Standards create accountability and protect the people we house.

Build partnerships to create housing options for people who need a higher level of care – Examples uplifted were regulated and staffed group homes and long-term care settings for high-complexity individuals. Providers also escalated the need for hospice-level care. The system currently has no appropriate destination for people who are dying.

DIGGING DEEPER: GETTING PEOPLE HOUSED IS THE BEGINNING OF THE WORK, NOT THE END.

Across all 14 focus groups – CoC and non-CoC alike – providers described housing placement as the beginning of a largely unsupported transition, not a successful outcome.

What Providers Named:

- People go from tent to apartment with no preparation. Lease literacy, budgeting, cooking, housekeeping, managing conflict – life skills – no one teaches this and its expected on day one.
- The social community that kept people alive while unhoused disappears at move-in. Isolation is a clinical crisis trigger, not just a service gap
- Behavioral health and primary care need to be on-site and ongoing – not referred out and hoped for
- Benefits enrollment and SOAR applications are deferred until after placement – guaranteeing financial and healthcare access instability from day one
- Community building is not a nice-to-have. Cooking classes, shared spaces, peer connection – providers described these as the difference between housing that holds and housing that fails

"I think when we see a lot when folks move in out of homelessness, coming from encampments, coming from a space of living in community, being constantly busy in survival mode, that takes up all of your day.

Then they move in and now they don't have an occupation. They don't have something to keep them busy and loneliness sets in. Mental health kind of starts to deteriorate even more. Substance use maybe uptakes... I have arrived and this supposed to be the solution to all my problems, and it isn't."
– Service Provider, PSH Focus Group

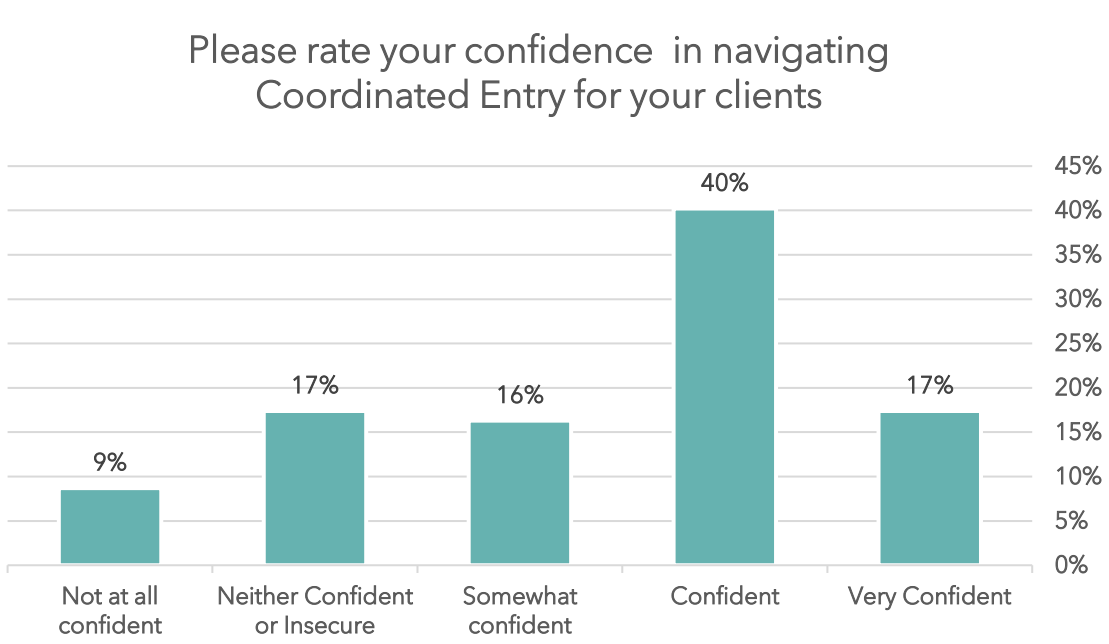
PROVIDER-ESCALATED OPPORTUNITIES: SYSTEMS INFRASTRUCTURE AND COMMUNICATIONS

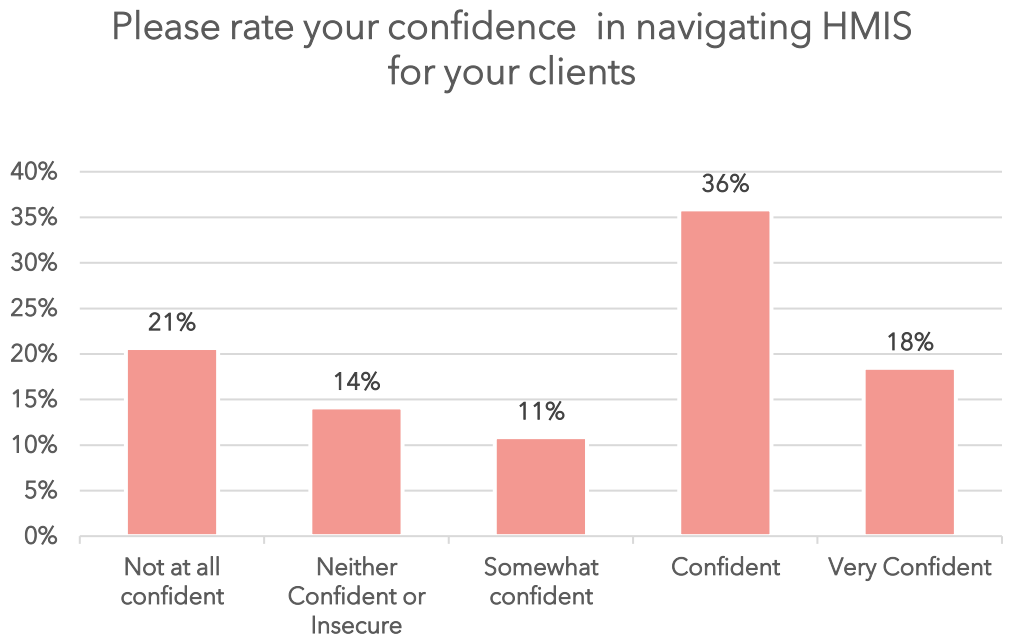
Establish a minimum viable Clarity product as an immediate priority – providers working with a shared client should be able to see each other's notes, services, and vital documents on file, and identify care team members from other organizations. **This baseline functionality enables care coordination now, while the broader transition continues.**

Invest in ongoing, robust system literacy training for CoC and non-CoC providers – CE mechanics and content, chronicity, and how eligibility is (and is not) determined. **Pair this with plain language client-facing materials** that explain what CE is, what it does, and what people can realistically expect.

Create transparency infrastructure – a real-time dashboard showing referrals, housing placements, and active BOLO/engagement status, visible on the Clarity front page. Pair this with **clear, accessible documentation of how referral and placement decisions are made**, and sustained **provider learning convenings for shared resource knowledge**.

SURVEY DATA HIGHLIGHTS: CONFIDENCE WITH HRS SYSTEM





DIGGING DEEPER: THE TRANSITION TO CLARITY HAS CREATED A SIGNIFICANT DISRUPTION FOR PROVIDERS THAT NEEDS IMMEDIATE ATTENTION ALONGSIDE THE REDESIGN.

There is no data with the referrals. Communication, context, location. There is none. And I just feel like we took such a big step back, losing HMIS while migrating over to Clarity."

– Service Provider, RRH Focus Group

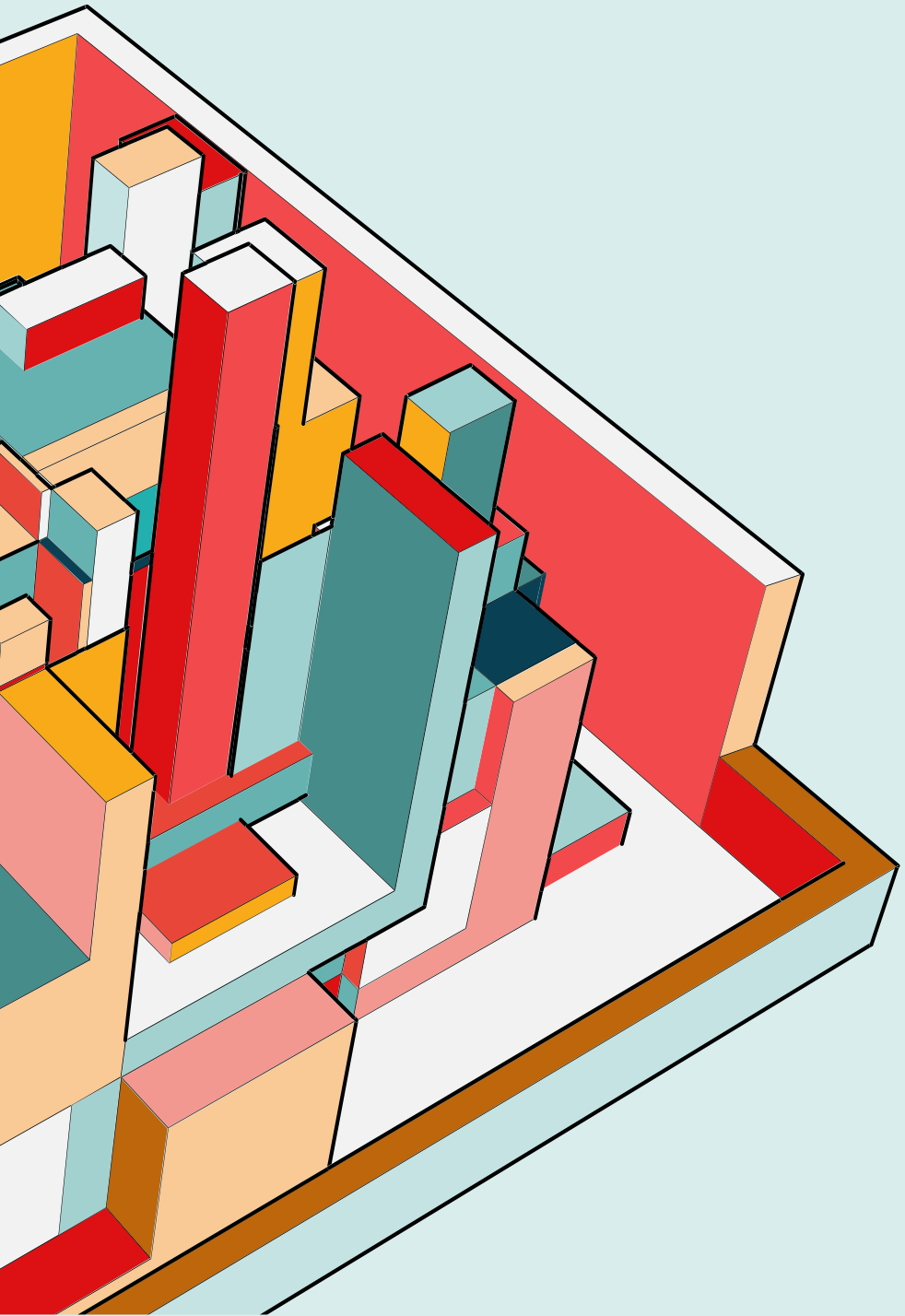
"I hate this new system, not going to lie. I despise it so much. It also feels like all of the information that was on HMIS hasn't been fully transferred yet, and there is so much missing and it frustrates the hell out of me because I go on there and am like, oh, there is nothing on this but I know this client has been experiencing homelessness for seven years."

- Navigation/Diversion Service Provider

Raised in 5 of the 6 CoC provider groups, the transition from Wellsky to Clarity has created **significant operational disruptions**, with **workarounds that are neither sustainable nor equitable**.

What Providers Named:

- **Client photos, locations, contact information, vital documents, and case manager contacts were lost in transition** – providers described navigating tab after tab only to find blank records
- **Cross-agency notes and client histories are inaccessible** or missing entirely, **preventing care coordination across the system**
- **Referrals arrive with no information**. Providers receive referrals for clients who are ineligible, unlocatable, already housed – one provider described trying to find someone outside and not having any idea what they looked like.
- Under Wellsky, providers could see case managers working with a client and reach out, but **now only the organization name is visible – if you don't know anyone there, you are dead in the water.**

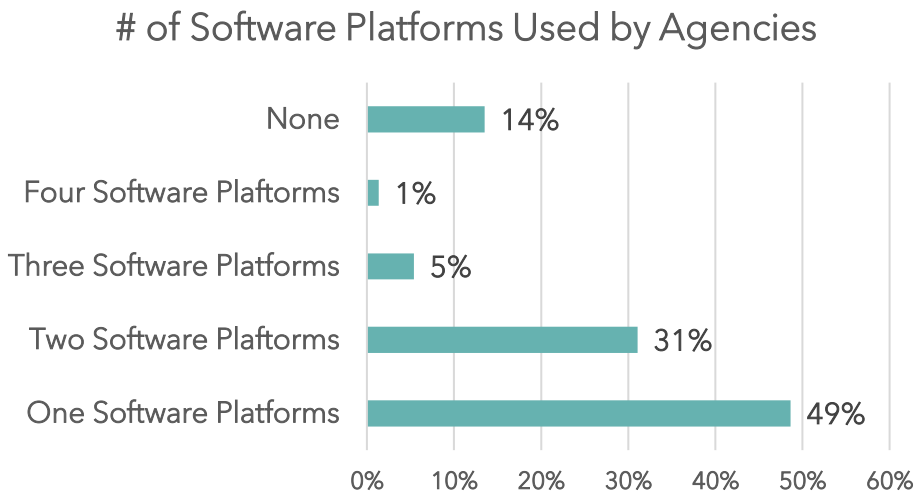


HMIS FOCUS GROUP

Completely different set of questions with five HMIS-super users.

FRICTIONS THAT SURFACED

1. **Dual-system paralysis.** Many providers use HMIS only for contract-required reporting. Case notes, assessments, and actual care coordination live in other systems. Until Clarity can replace those systems functionally, this will not change regardless of training investment.
2. **Training access is a structural bottleneck.** One provider could not get a training slot and gave up. Another launched a new shelter and is using an Excel spreadsheet because staff won't have Clarity access for four to six weeks due to trainings being unavailable. The training-as-prerequisite-to-access model is producing real data loss right now.
3. **ROI burden without ROI benefit.** Providers described clients signing seven ROIs for one service episode across different agencies. The ROI is not functioning as intended — it's creating paperwork without producing meaningful consent or data governance.
4. **No visibility into who else is serving a client.** One provider described a client who had been working with another agency for four months with no knowledge on their end. Another described staff unaware that a client on the BOLO list was in shelter. These are coordination failures, not edge cases.



"We had people who have been working with other agencies offsite, and we had no idea for four months."

— Service Provider, HMIS Focus Group

PROVIDER-ESCALATED HMIS OPPORTUNITY AREAS

"I think within five years if Clarity's going the way it is, I could see [ORG] getting rid of Apricot working in Clarity solely. If everything that's in there is actually built out and it works the way we think it's going to work, there wouldn't be a reason for us to use Apricot."

– Service Provider, HMIS Focus Group

1. Train-the-trainer model: Train agency HMIS admins deeply; let them train their own staff. Decouple training completion from system access. Reduces ECHO burden, increases reach, addresses the bottleneck directly.

2. Cross-org visibility in Clarity: Case notes, service transactions, care team directories, and BOLO dashboards. Providers said clearly: if Clarity can do what Apricot does, they will consolidate. This is the unlock.

3. Mobile functionality: Both provider-facing (outreach) and client-facing apps had strong consensus and excitement. The geolocation feature already exists in Clarity and is underused – a near-term win with training alone.

4. CoC report/assessment template library: Agencies building on each other's Lookr reports and custom assessments would accelerate adoption and reduce duplicated effort across the CoC.

SUMMARY: FOCUS QUESTIONS, ANSWERED

WHAT DO PEOPLE EXPERIENCING HOMELESSNESS IN AUSTIN/TRAVIS COUNTY NEED?

People experiencing homelessness need housing that actually **fits their circumstances – matched to their clinical needs, functional capacity, and life situation**. They need that **housing to come with the supports that make it stick**: behavioral health, life skills, benefits, and community. And they need **a system that is navigable without insider knowledge – accessible across language, culture, and system involvement**.

WHAT RESOURCES ARE CURRENTLY AVAILABLE FOR PEOPLE EXPERIENCING OR AT RISK OF HOMELESSNESS?

Inconclusive. The focus groups were designed to capture provider experiences with the CE system and what we are missing – not an inventory of available resources. Survey responses only gathered resources that were needed in the community, not that are presently available.

SUMMARY: FOCUS QUESTIONS, ANSWERED

WHAT IS THE GAP BETWEEN THE NEEDS OF PEOPLE EXPERIENCING HOMELESSNESS AND CURRENTLY AVAILABLE RESOURCES IN OUR COMMUNITIES?

This can be answered only partially, because we do not have a list of available resources from this focus group data.

What this data did illuminate was that the **gap is not just about resource scarcity – it's about mismatch**. Providers described a system where **the wrong interventions are being offered to the wrong people, where high-acuity individuals are placed in programs that cannot support them, and where entire populations** – recovery, legal system, victim services, foster care – **have no pathway into the system at all.**

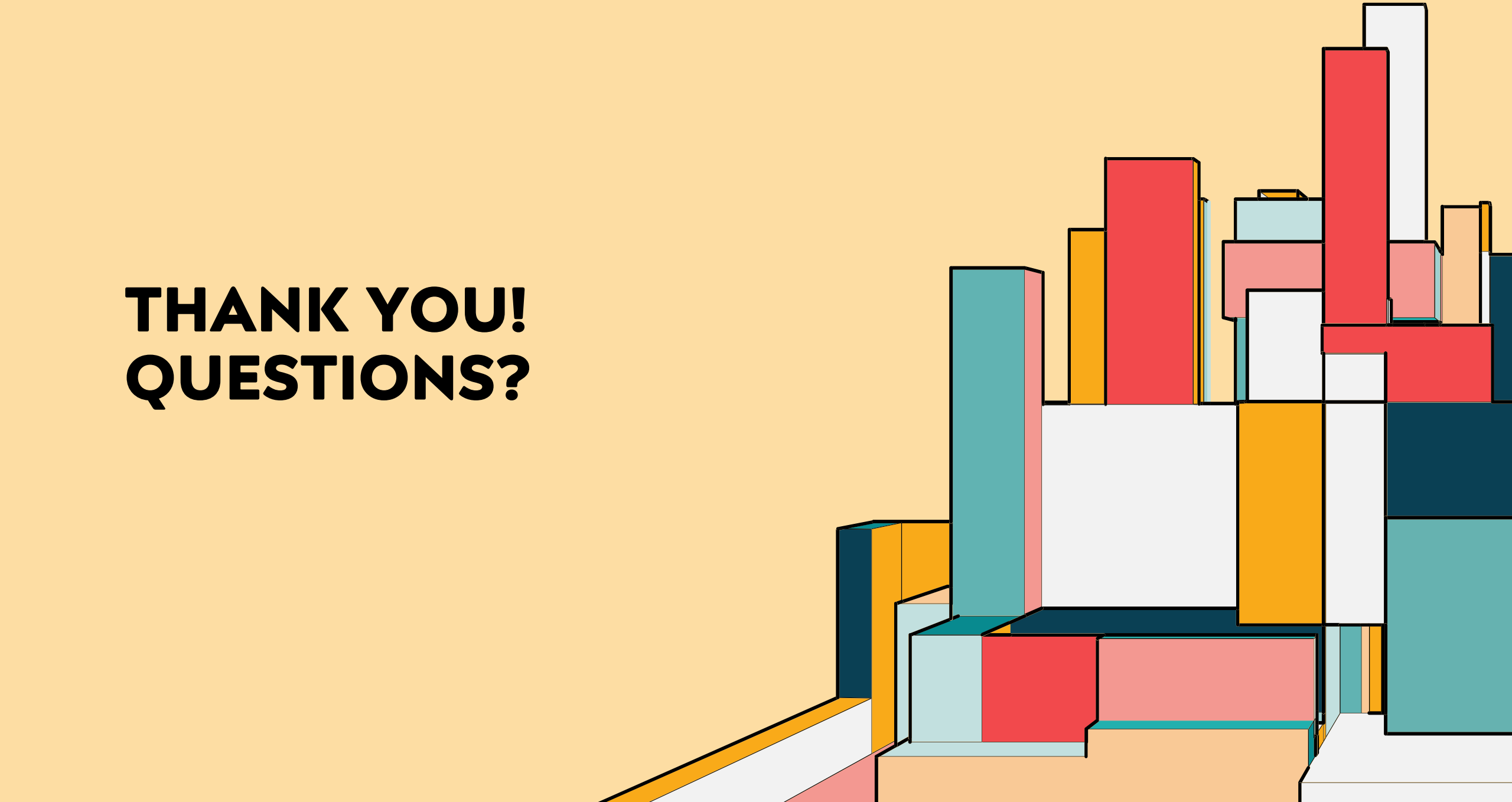
The gap between need and response is widest for people with the most complex circumstances: serious mental illness, medical complexity, trauma histories, and justice involvement.

WHAT ARE THE FAILURES AND SUCCESSES OF OUR CURRENT COORDINATED ENTRY SYSTEM?

The current CE system **consistently fails to match people to the right intervention, produces assessment scores that do not reflect true vulnerability, and leaves entire provider sectors with no pathway in**. The process itself causes harm through **silence, false hope, and re-traumatization**. **Post-housing infrastructure is largely absent**, making returns to homelessness predictable rather than exceptional.

This analysis was designed to identify gaps and opportunities for redesign. A separate process is needed to systematically capture what is working well.

THANK YOU!
QUESTIONS?



METHODS FOR FINDING COMMUNITY-DRIVEN POPULATIONS

- Developed a cross matrix of every iteration of vulnerable groups that providers elevated
- Examined “number of “mentions” across groups. This also accounted for group agreements.
  - Strong = 5+ mentions
  - Moderate = 3-4 Mentions
  - Minor = 1-2 Mentions
- Grouped when inner-related: Ex: Medical complexity definition was inclusive of many areas of health need.
- Pulled all who were identified as extremely vulnerable by at least half of all provider groups (50% S + M ratings).