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Agenda
Hawaii Interagency Council on Homelessness (HICH)
June 9, 2015
9:30 am to 12:00 pm
Room 325 Hawaii State Capitol
Honolulu, HI 96813

9:30 am Call to Order, Taking of the Roll.

Overview and Approval of Agenda (**Vote**).

Adoption of Minutes from November 19, 2014 (**Vote**).

I. Honolulu Aim:

A. National Goals:
- Preventing and Ending Homelessness among Veterans by 2015;
- Finishing The Job of Ending Chronic Homelessness by 2016;
- Preventing and Ending Homelessness for Families, Youth and Children by 2020;
- Setting a Path to Ending All Types of Homelessness

B. National Support: (HUD, VA, USICH)
- 25 Cities
  Mayor's Challenge
- Zero:2016
- HUD TA (Hearth Act and HMIS)

II. Revisiting the HICH Plan to End Homelessness: The HICH plan is divided into 4 sections:

A. Retool The Homeless Crisis Response System
   1. Hale 'O Malama, Coordinated Entry Housing Placement System:
   2. Data
      a. Homelink
      b. Point In Time
      c. HMIS

B. Improve Health and Stability:
   SAMHSA CABHI-States Grant;

C. Increase Access to Stable and Affordable Housing:
   1. Micro Units
   2. State Grant
   3. City Grant

D. Increase Economic Stability and Self-sufficiency:

III. Legislative Update:

IV. Public Testimony Taken: (**3 minutes per person**).

12:00 pm Adjourn (**Vote**).

Honolulu Aim:

We the leaders of Honolulu commit to ending all homelessness utilizing our local CAHP system starting with 985 Veterans and their families by Dec. 31st, 2015; 1020 individuals experiencing chronic homelessness by Dec. 31st, 2016; and for all families by 2020, reaching and sustaining functional zero.

Can homelessness among veterans ever be conquered

By Jennifer Hlad
STARS STRIPES

February 5, 2015
Stars and Stripes

New Orleans announced in early January that it was the first major city in the country to meet a goal issued by the Obama administration in 2010: ending veteran homelessness.

But despite dedicated efforts across the country to meet the goal by the end of 2015, and a renewed push last year after Michelle Obama's announcement of the Mayors Challenge to End Veteran Homelessness, there has been no standard or official definition of what "eliminating veteran homelessness" really means.

For Zero: 2016, a national campaign to end chronic and veteran homelessness by the end of 2016, "zero" means that at any point in time, the number of people experiencing homelessness won't be greater than the community's ability to place them in permanent housing.

Beth Sandor, director of Zero: 2016, said her organization recognized early that it needed a clear definition of what it was working toward.

New Orleans was one of more than 70 communities selected for the program, and in its news release about reaching the goal, defined ending veteran homelessness as "ensuring every homeless veteran who can be located is placed in permanent housing or in temporary housing with an identified permanent housing placement" within 30 days.

That doesn't mean that no veteran will ever again fall into homelessness in New Orleans, said Baylee Crone, executive director of the National Coalition for Homeless Veterans. But now, there is a system in place to find permanent housing for those veterans quickly, she said.

The philosophy of "housing first" requires moving the homeless into permanent housing quickly — and frequently requires lowering barriers to entry to that housing. For example, where people may have previously been required to complete a drug or alcohol treatment plan prior to being placed in permanent housing, now they could be placed in housing and given a case manager for access to the treatment and other services at a later time.

Though the approach is "not perfect by any means," research has shown it works, Crone said.

The key for communities and outreach teams is to know every person on the streets or in a shelter, Crone and Sandor said.

"If you don't know their name and needs, you'll never know what you need to get them into permanent housing," Sandor said.

And the fact that New Orleans has hit the goal "is a game-changer," Sandor said.

"It is a proof point," she said, "an amazing example of what's possible with good leadership, with the introduction of best practices, of knowing every single person's name, of not giving up until we get there."

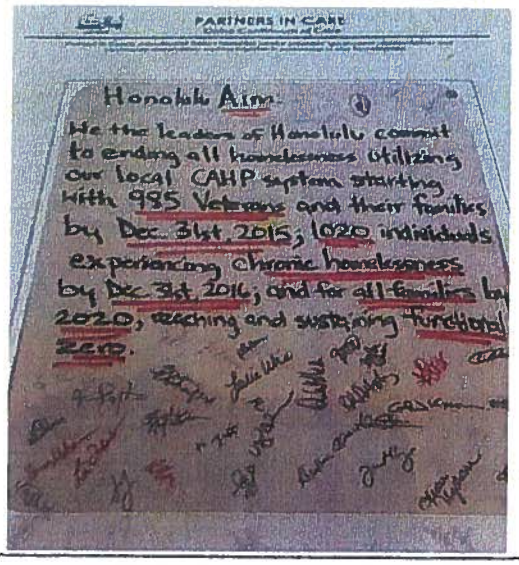
Hale O Malama:

Update to the Hawaii Interagency Council on Homelessness

June 9, 2015

Hale O Malama:

Shared Vision for Ending Homelessness in Honolulu



We believe we can achieve "Functional Zero" by permanently housing:

- ***985*** veterans and their families by ***December 2015;***
- ***1,020*** chronically homeless individuals by ***December 2016;*** and
- ***All homeless families*** by ***2020.***

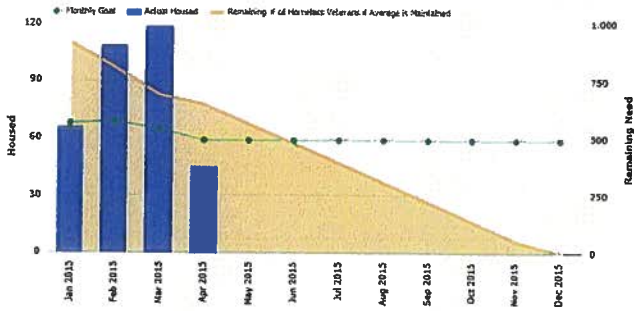
Hale O Malama:

Progress towards ending veterans homelessness

- On track to achieve 'functional zero' for veteran homelessness by Dec. 2015
- ***92%*** of housed veterans are placed into private rental housing

Honolulu CoC

VETERAN DASHBOARD



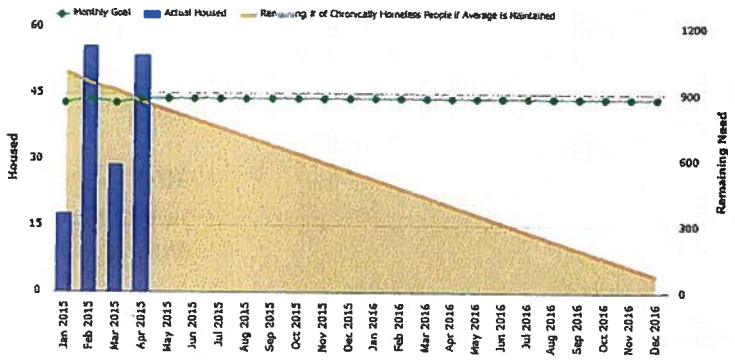
Hale O Malama:

Progress towards ending veterans homelessness

- On track to achieve 'functional zero' for veteran homelessness by Dec. 2015

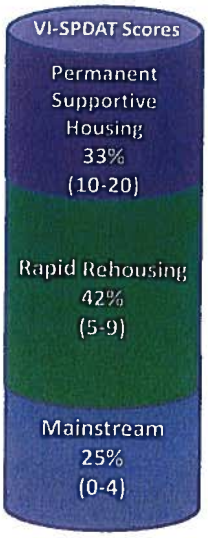
Honolulu CoC

CHRONIC DASHBOARD



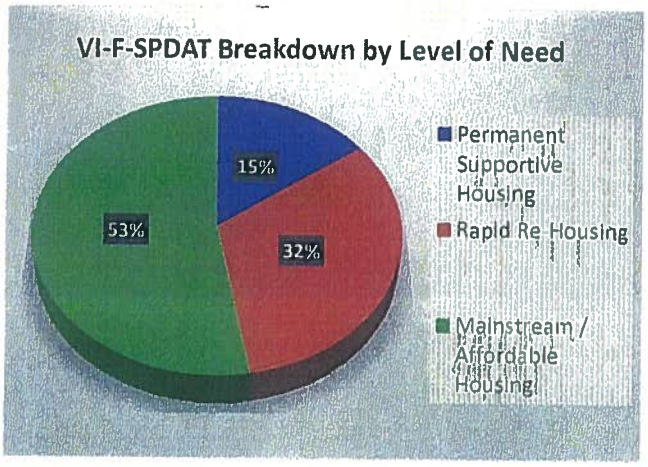
Our Federal Partners Are With Us!

What have we learned?



- ***3,393 households surveyed***
  - *3,025* Individuals
  - *368* families with children
- ***PSH households more vulnerable***
  - *74%* report being attacked/beaten compared to *37%* for all homeless
- ***Majority of families simply need more affordable housing***
  - *53%* of families surveyed fall in the 'mainstream' category

Understanding the Needs of Homeless Families



- Primary need is affordability of housing
- Less need for intensive case management or supportive services
- Rapid Re-Housing or Shallow Subsidies offer alternative options to shelter

Oahu Point in Time Count: 2009-2015

YEAR	Number Sheltered	Percentage Sheltered	Number Unsheltered	Percentage Unsheltered	TOTAL COUNT
2015	2,964	60%	1,939	40%	4,903
2014	3,079	65%	1,633	35%	4,712
2013	3,091	68%	1,465	32%	4,556
2012	3,035	70%	1,318	30%	4,353
2011	2,912	69%	1,322	31%	4,234
2010	2,797	67%	1,374	33%	4,171
2009	2,445	67%	1,193	33%	3,638

Other Data Points

- Emergency Shelter Vacancies - Oahu

	May 2014	May 2015
Vacant Beds	142	149
% of Vacant Beds	14.91%	15.65%

- Emergency Shelter Turnover – Oahu

	May 2014	May 2015
# Enter Shelter	115 households	124 households
# Exit Shelter	109 households	128 households

Exit Destination from Emergency Shelter

	Numbers Exited	Percentage Exited
Permanent Housing	49	33%
Temporary Housing	21	14%
Unknown / Other Destination	79	53%
TOTAL	149	100%

INTRODUCTION: A PARADIGM SHIFT

This was a milestone year for the state of Hawai'i's homeless services network. Collaborative efforts across governmental agencies and service providers have secured new resources for enhancing the state's capacity to end homelessness. There was a synergy around making system-level changes to improve the coordination of care and to adopt a "housing-first" philosophy in programming. The housing-first approach emphasizes providing support for stable housing as an important first (rather than last) step in a transition to independently sustained permanent housing. Several evidence-based strategies—such as the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), the Rapid Rehousing Program, and the Pathways Housing First Model—are being piloted on a small scale while planning for system-wide implementation is underway.

Hale 'O Malama, the "House of Care" initiative, is the catalyst of these changes. n October 2013, Hawai'i embarked on this venture as a part of the 25 Cities Initiative sponsored by the U.S. Departments of Veteran Affairs (VA) and Housing and Urban Development (HUD) and the U.S. Interagency Council on Homelessness. The federal initiative provides technical assistance to cities, aiming to end homelessness for veterans and chronically homeless individuals through a housing-first approach. Key local collaborators include the Hawai'i Interagency Council on Homelessness, the State's Homeless Programs Office, the City's Office of Housing, and O'ahu's Partners In Care—the organizations defined by HUD as Continuum of Care organizations for homelessness.

In recognition of the fact that efforts to implement system-level changes should employ a data-driven and evidence-based approach, Hale 'O Malama has identified the critical need to build a coordinated assessment and housing placement system for Hawai'i where all potential homeless service users will be assessed by a common tool and matched with appropriate services based on the results. In the past 12 months, over 1,300 people have been assessed by VI-SPDAT. The housing placement system currently focuses only on the permanent supportive housing option and has successfully found homes for 29 chronically homelessness individuals, including veterans.

In the past few months, additional funding has become available through State Legislature appropriation, and a federal grant was awarded to the State Department of Health to help accelerate the adoption of a housing-first approach to end chronic homelessness in Hawai'i. The Pathways Housing First model, an evidence-based housing-first program, is now being piloted to provide supportive services to chronically homeless individuals with substance abuse issues and/or mental health disorders. Additional resources have recently been committed by the City Council for the Housing First initiative. Private foundations and business communities have contributed substantial resources for capacity-building and direct services to help in ending homeless for everyone in Hawai'i.

The collaborative and policy changes that are currently underway represent a major paradigm shift, one that has the potential to radically restructure the homeless service system in the state of Hawai'i. However, a systemic change of this magnitude will take time and should be guided by a detailed understanding of the problem. Homelessness is an extremely complicated issue, and high-quality data are necessary and useful to evaluating the impact of these systemic changes. While these impacts have not yet taken full effect, the data presented in this report will represent a baseline to which future change can be compared. Through the next several years, regular monitoring of data related to the homeless system will help practitioners and policy-makers alike better understand the extent of the need for services and the effectiveness of new and ongoing programs, as well as the different needs of distinct populations of homeless individuals and families.

The 2014 *Homeless Service Utilization Report* is the ninth annual report produced by the Center on Family at the University of Hawai'i at Mānoa and the Homeless Programs Office in the Hawai'i State Department of Human Services. This year, the report aims to provide data related to four types of programs that have been implemented in the state of Hawai'i and are intended to address homelessness. Results from the system- and program-level analysis will be presented. As in previous years, the report includes usage information about shelter programs and outreach programs. Shelter programs provide temporary shelter for homeless individuals and include both emergency shelters and transitional shelters. Typically, emergency shelters are designed for short-term immediate shelter needs and transitional shelters allow a more extended stay with the intention of transitioning residents into more stable permanent housing. Outreach programs are often the first point of contact for many homeless individuals. The primary goal of outreach programs is to identify homeless individuals and connect them with services.

This year's report also includes data related to two newer federally-funded programs. The first is the Rapid Rehousing Program, which uses a housing-first philosophy and is designed to provide financial and housing support services to homeless individuals and families who are living in either 1) situations not meant for human habitation or 2) emergency or transitional shelters. The goal of the Rapid Rehousing Program is to transition these individuals and families as quickly as possible into permanent housing situations. Finally, the report will provide data related to the Homelessness Prevention Program. Unlike the other three programs, which target homeless populations, the Homelessness Prevention Program is targeted towards individuals and families who may have homes but are at risk of becoming homeless.

COORDINATED ENTRY POLICY BRIEF

An effective coordinated entry process is a critical component to any community's efforts to meet the goals of *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*. This policy brief describes HUD's views of the characteristics of an effective coordinated entry process. This brief does not establish requirements for Continuums of Care (CoCs), but rather is meant to inform local efforts to further develop CoCs' coordinated entry processes.

Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require that CoCs establish a *Centralized or Coordinated Assessment System*. In this document, HUD uses the terms *coordinated entry* and *coordinated entry process* instead of *centralized or coordinated assessment system* to help avoid the implication that CoCs must centralize the assessment process, and to emphasize that the process is easy for people to access, that it identifies and assesses their needs, and makes prioritization decisions based upon needs. However, HUD considers these terms to mean the same thing. See 24 CFR 578.7(a)(8) for information on current requirements.

HUD's primary goals for coordinated entry processes are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how people present. Most communities lack the resources needed to meet all of the needs of people experiencing homelessness. This combined with the lack of well-developed coordinated entry processes can result in severe hardships for people experiencing homelessness. They often face long waiting times to receive assistance or are screened out of needed assistance. Coordinated entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources.

HUD has previously provided guidance regarding prioritization for permanent supportive housing (PSH) in Notice CPD-014-12 *Notice on Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status*. This brief builds upon that Notice and provides guidance for using coordinated entry to prioritize beyond permanent supportive housing (PSH).

Qualities of Effective Coordinated Entry

An effective coordinated entry process has the following qualities:

- **Prioritization.** HUD has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC, including PSH, Rapid Rehousing (RRH), and other interventions.
- **Low Barrier.** The coordinated entry process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. In addition, housing and homelessness programs lower their screening barriers in partnership with the coordinated entry process.

- **Housing First orientation.** The coordinated entry process is Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.
- **Person-Centered.** The coordinated entry process incorporates participant choice, which may be facilitated by questions in the assessment tool or through other methods. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions.
- **Fair and Equal Access.** All people in the CoC's geographic area have fair and equal access to the coordinated entry process, regardless of where or how they present for services. Fair and equal access means that people can easily access the coordinated entry process, whether in person, by phone, or some other method, and that the process for accessing help is well known. Marketing strategies may include direct outreach to people on the street and other service sites, informational flyers left at service sites and public locations, announcements during CoC or other coalition meetings, and educating mainstream service providers. If the entry point includes one or more physical locations, they are accessible to people with disabilities, and easily accessible by public transportation, or there is another method, e.g., toll-free or 211 phone number, by which people can easily access them. The coordinated entry process is able to serve people who speak languages commonly spoken in the community.
- **Emergency services.** The coordinated entry process does not delay access to emergency services such as shelter. The process includes a manner for people to access emergency services at all hours independent of the operating hours of the coordinated entry intake and assessment processes. For example, people who need emergency shelter at night are able to access shelter, to the extent that shelter is available, and then receive an assessment in the days that follow, even if the shelter is the access point to the coordinated entry process.
- **Standardized Access and Assessment.** All coordinated entry locations and methods (phone, in-person, online, etc.) offer the same assessment approach and referrals using uniform decisionmaking processes. A person presenting at a particular coordinated entry location is not steered towards any particular program or provider simply because they presented at that location.
- **Inclusive.** A coordinated entry process includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence. However, CoCs may have different processes for accessing coordinated entry, including different access points and assessment tools for the following different populations: (1) adults without children, (2) adults accompanied by children, (3) unaccompanied youth, or (4) households fleeing domestic violence. These are the only groups for which different access points are used. For example, there is not a separate coordinated entry process for people with mental illness or addictions, although the systems addressing those disabilities may serve as referral sources into the process. The CoC continuously evaluates and improves the process ensuring that all subpopulations are well served.

- **Referral to projects.** The coordinated entry process makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, RRH, PSH, and transitional housing (TH), as well as other housing and homelessness projects. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals, while other housing and services projects determine the extent to which they rely on referrals from the coordinated entry process.
- **Referral protocols.** Programs that participate in the CoC's coordinated entry process accept all eligible referrals unless the CoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.
- **Outreach.** The coordinated entry process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.
- **Ongoing planning and stakeholder consultation.** The CoC engages in ongoing planning with all stakeholders participating in the coordinated entry process. This planning includes evaluating and updating the coordinated entry process at least annually. Feedback from individuals and families experiencing homelessness or recently connected to housing through the coordinated entry process is regularly gathered through surveys, focus groups, and other means and is used to improve the process.
- **Informing local planning.** Information gathered through the coordinated entry process is used to guide homeless assistance planning and system change efforts in the community.
- **Leverage local attributes and capacity.** The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, inform local coordinated entry implementation.
- **Safety planning.** The coordinated entry process has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence have safe and confidential access to the coordinated entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).
- **Using HMIS and other systems for coordinated entry.** The CoC may use HMIS to collect and manage data associated with assessments and referrals or they may use another data system or process, particularly in instances where there is an existing system in place into which the coordinated entry process can be easily incorporated. For example, a coordinated entry process that serves households with children may use a system from a state or local department of family services to collect and analyze coordinated entry data. Communities may use CoC Program or ESG program funding for HMIS to pay for costs associated with coordinated entry to the extent that coordinated entry is integrated into the CoCs HMIS. A forthcoming paper on Coordinated Entry and HMIS will provide more information.

- **Full coverage.** A coordinated entry process covers the CoC's entire geographic area. In CoCs covering large geographic areas (including statewide, Balance of State, or large regional CoCs) the CoC might use several separate coordinated entry processes that each cover a portion of the CoC but in total cover the entire CoC. This might be helpful in CoCs where it is impractical for a person who is assessed in one part of the CoC to access assistance in other parts of the CoC.

The remainder of this brief clarifies a few aspects of the coordinated entry process that deserve further explanation and emphasis, including how communities prioritize people in their coordinated entry process, how communities think about and address waiting lists, and considerations for the assessment tools and processes that communities implement. This document also clarifies some of the considerations to be made at the local level as communities further develop their process.

Prioritizing people who are most vulnerable or have the most severe service needs

One of the main purposes of coordinated entry is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. HUD's policy is that people experiencing chronic homelessness should be prioritized for permanent supportive housing. In some cases PSH projects are required to serve people experiencing chronic homelessness and in other cases, HUD provides incentives for projects to do so. HUD is strongly encouraging communities to fully implement the prioritization process included in Notice CPD-014-12.

In addition to prioritizing people experiencing chronic homelessness, the coordinated entry process prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. When considering how to prioritize people for housing and homelessness assistance, communities can use the following:

- Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing;
- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs
- The extent to which people, especially youth and children, are unsheltered
- Vulnerability to illness or death
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

Communities should decide what factors are most important and, to the greatest extent possible, use all available data and research to inform their prioritization decisions. The coordinated entry process is meant to orient the community to one or two central prioritizing principles by which the community can make decisions about how to utilize its resources most effectively. This prioritization ensures that across subpopulations and people with different types of disabilities, those most vulnerable or with the most severe service needs will be prioritized for assistance. The prioritization may not target a category of people with a particular disability. However, individual programs, including CoC funded projects, may restrict access to people with a

particular disability or characteristic. In these cases, the coordinated entry process should ensure that people are only referred to projects for which they are eligible. At the same time, providers should ensure that eligibility criteria are limited to those required by Federal or local statute or by funding sources.

Communities should take care to ensure that their prioritization process does not allow people who are more vulnerable or who have more severe service needs to languish in shelters or on the streets because more intensive types of assistance are not available. Evidence indicates that one of the most important factors to successfully ending an episode of homelessness is the speed with which the intervention is made available to the person (see discussion of assessment tools below and HUD's February 2015 report on assessment tools). This means that if a person is assessed as being highly vulnerable, that person may be prioritized for PSH, but if PSH is not available or the PSH has a long waiting list, that person should be prioritized for other types of assistance such as RRH or TH. CoCs should not assume that because a person is prioritized for one type of assistance, they could not be served well by another type of assistance. However, CoCs should be aware that placing a household in transitional housing can affect their eligibility for other programs. For example, people coming from transitional housing are not eligible for most rapid re-housing funded under the ESG and CoC Programs and placement in transitional housing can affect a person's chronic homelessness status.

Addressing waiting times through coordinated entry

Long wait times make homeless assistance less effective and reduce the overall performance of a community's homeless assistance system. When a community faces a scarcity of needed resources, they should use the coordinated entry process to prioritize which people will receive housing assistance rather than continuing to add people to a long waiting list. For example, if a community has enough permanent supportive housing to serve 10 new households per month, but 30 households are assessed as needing PSH every month, the coordinated entry process should be adjusted to prioritize approximately 10 households for PSH each month. The other 20 households should be prioritized for other resources available in the community, such as RRH, TH (taking care to consider the impact of placement in TH on an individual's chronically homeless status or future eligibility in other programs), housing subsidies, or other mainstream resources. Short waiting times of a few days or weeks might be necessary to properly manage utilization, but waiting times for homeless assistance of several months or years should be eliminated whenever possible. Although PSH is almost always the most effective resource for people with high levels of vulnerability and high service needs, including those experiencing chronic homelessness, the lack of available PSH should not result in people languishing in shelters or on the streets without further assistance.

Most communities face a gap between need and availability based on limited resources. Communities should be proactively taking steps to close these gaps that are identified through the coordinated entry process. For example, if there is insufficient PSH available in the community, the CoC should be working with PHAs, other affordable housing providers, and Medicaid-funded agencies to increase the supply of PSH. To the maximum extent possible, existing PSH should be targeted to chronically homeless people based on the severity of their service needs (as described in Notice CPD-014-12). Where there are individuals in PSH who no longer need a high level of services, the CoC should pursue "move up" strategies that help those individuals shift to another form of housing assistance, freeing up the PSH assistance for another prioritized household.

Implementing effective assessment tools and processes

HUD does not endorse any specific assessment tool or approach, but there are universal qualities that any tool or criteria used by a CoC for their coordinated entry process should include. HUD outlined some of these qualities in the Notice CPD-014-12 and is building on those qualities in this brief. HUD recognizes the need for guidance as both the process and the tools continue to evolve, so some of the qualities have remained the same, while others have had changes and additions that reflect HUD's evolving understanding of the assessment process and what is most effective. Please refer to HUD's February 2015 report on assessment tools for further information.

At its core, the assessment process is not a one-time event to gather as much information about a person as possible. Instead, assessments are performed only when needed and only assess for information necessary to help an individual or family at that moment. Initial assessments happen as quickly as possible regardless of where households are residing–streets or in shelter, and the assessment process uses tools as a guide to start the conversation, not as a final decision-maker. Following are several principles that communities can use to ensure an effective assessment process:

- **Phased assessment**. The assessment tools are employed as a series of situational assessments that allow the assessment process to occur over time and only as necessary. For example, an assessment process may have separate tools that assess for each of the following:
    - Screening for diversion or prevention
    - Assessing shelter and other emergency needs
    - Identifying housing resources and barriers
    - Evaluating vulnerability to prioritize for assistance
    - Screening for program eligibility
    - Facilitating connections to mainstream resources

  These assessments will likely occur over a period of days or weeks, as needed, depending on the progress a homeless household is making. The different assessments build on each other so a participant does not have to repeat their story. There will also be instances where a participant should be reassessed or reprioritized, particularly if they remain homeless for a long period of time.

- **Necessary information.** The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless. For example, a coordinated assessment process would only assess for a particular disability to determine if that household could be referred to a program that requires a particular disability as part of its eligibility criteria.

- **Participant autonomy.** The protocol for filling out assessment tools provides the opportunity for people receiving the assessment to freely refuse to answer questions without retribution or limiting their access to assistance.

- **Person-centered.** The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need. The process also incorporates participants' strengths, goals, and protective factors to recommend options that best meet the needs and goals of the people being assessed.
- **Cultural competence.** Staff administering assessments use culturally competent practices, and tools contain culturally competent questions. For example, questions are worded to reflect an understanding of LGBTQ issues and needs, and staff administering assessments are trained to ask appropriately worded questions and offer options and recommendations that reflect this population's specific needs.
- **User-friendly.** Tools are brief, easily administered by non-clinical staff including outreach workers, minimize the time required to utilize, and easy for those being assessed to understand.
- **Privacy protections.** Privacy protections are in place to ensure proper consent and use of client information.
- **Meaningful recommendations.** Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services. Participants being assessed should know exactly what program they are being referred, what will be expected of them, and what they should expect from the program. The coordinated entry process should avoid placing people on long waiting lists.
- **Written standards and policies and procedures.** The CoC has written standards describing who is prioritized for assistance and how much assistance they might receive, and the policies and procedures governing the coordinated assessment process are approved by the CoC and easily accessible to stakeholders in the community.
- **Sensitive to lived experiences.** Providers recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness. The tool minimizes risk and harm, and provides individuals or families with the option to refuse to answer questions. Agencies administering the assessment have and follow protocols to address any psychological impacts caused by the assessment and administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot. Those administering the tool are trained to recognize signs of trauma or anxiety.

Integrating youth into the coordinated entry process

CoCs with a network of youth serving programs should consider whether they would better serve youth by creating coordinated entry access points dedicated to underage and transition aged youth. These access points can be located in areas where homeless youth feel comfortable and safe. They can be staffed with people who specialize in working with youth. CoCs should take care to ensure that if they use separate coordinated entry points for youth, that those youth can still access assistance from other parts of the homeless assistance system and that youth who access other coordinated entry points can access assistance from youth serving programs.

Regardless of whether a CoC uses youth dedicated access points, the coordinated entry process must ensure that youth are treated respectfully and with attention to their developmental needs.

Serving people fleeing domestic violence

CoCs must work with domestic violence programs in their communities to ensure that the coordinated entry process addresses the safety needs of people fleeing domestic violence. This includes providing a safe location or process for conducting assessments, a process for providing confidential referrals, and a data collection process consistent with the Violence Against Women Act.

If the CoC's coordinated entry process uses separate access points for people fleeing domestic violence, CoCs should take care to ensure that people who use the DV coordinated entry process can access homeless assistance resources available from the non-DV portion of the coordinated entry process and vice versa. Many people experiencing homelessness have a history of domestic violence, and should be able to access appropriate DV services even if they are not accessing it through a DV coordinated entry point. Similarly, people fleeing domestic violence often have housing and homeless assistance needs that should not be limited by their decision to access a DV coordinated entry access point.

Defining coordinated entry roles in the homeless assistance system

Diverse stakeholders have different roles in a coordinated entry process. In some cases, these roles are clearly defined. Often, the roles are challenging to define and can change over time.

Homeless assistance organizations

All homeless assistance organizations should be involved in the coordinated entry process by helping people access the system and receiving referrals. Homeless assistance organizations may also provide assessments or provide space for assessments to be conducted. Emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing programs should only receive referrals through the coordinated entry process.

Mainstream housing and services

Affordable housing and mainstream services are crucial tools for ending homelessness and should be involved in the coordinated entry process. As a CoC's coordinated entry process is developed, mainstream providers can act as a source or receiver of referrals. For instance, sources of referrals could include mental health service providers, substance abuse service providers, Department of Veterans Affairs (VA) Medical Centers, jails, or emergency rooms. Receiving agencies could include public housing authorities, multifamily properties (like Section 8 PBRA, 811, and 202), mental health service providers, and substance abuse providers. Organizations acting as receiving agencies will determine the extent to which they will rely on referrals from the coordinated entry process. In some instances, certain services could be co-located with a physical access point, or a virtual access point, like a telephone service such as 2-1-1. The more mainstream programs and resources that are connected to your coordinated entry process through the coordination of referral, application, and eligibility determination processes, the more effectively your community can consistently connect homeless individuals with housing resources and the community-based supports that they need to maintain that housing.

How a provider or program is integrated into the coordinated entry process will depend on a number of factors including the makeup of the local homeless population, the patterns of service use in the community, and whether the coordinated entry process has been folded into an existing mainstream service system or if it stands alone. These decisions evolve as communities build their processes, and communities might decide to incorporate certain mainstream services over time–as a referral source, a receiving agency, or both.

Prevention and Diversion

There are many more people who qualify for homelessness prevention assistance than homeless assistance. In developing coordinated entry processes, CoCs should consider how much capacity they have to manage prevention assistance. At a minimum, ESG funded prevention assistance should be incorporated into the coordinated entry process. Communities should decide to what extent they include additional non-prevention programs and how they are incorporated.

A Note on Future Guidance

As more communities implement coordinated entry and more research on the topic is conducted, HUD is learning more about what makes an effective coordinated entry process, and the Department will continually modify its guidance and recommendations to communities. This is challenging for communities, who have to adjust their processes to stay up to date. Nonetheless, HUD believes it is important to act on the best available evidence known at the time, while also recognizing that communities need time and resources to keep up with new guidance.

In the coming months, HUD anticipates releasing the following materials related to coordinated entry:

- Summer 2015: Notice on the requirements for development and implementation of a CoC's coordinated entry process. This notice will establish requirements for coordinated entry and timelines for implementation.
- Ongoing: Technical Assistance products
    - Meeting HUD expectations and requirements
    - Special considerations for youth
    - Special considerations for people fleeing domestic violence
    - Compliance and monitoring
    - Options for funding coordinated entry
    - Advanced approaches for coordinated entry processes and systems
    - Deciding on community-specific assessment tools
    - Planning and implementation
    - Data sharing
    - CoC written standards
    - Using progressive engagement

Additionally, HUD intends to release the Emergency Solutions Grant (ESG) and CoC Program interim rules for public comment in 2015. During this time, HUD encourages CoCs, ESG recipients and subrecipients, and CoC Program recipients to submit comments on the requirements contained in the interim rules related to coordinated entry.

Resources on Coordinated Assessment

HUD's Office of Policy Development & Research February 2015 Summary Report: *Assessment Tools for Allocating Homelessness Assistance: State of the Evidence*

HUD's requirements for a *Centralized or Coordinated Assessment System* in CoC Program Interim Rule (24 CFR 578.7(a)(8)).

HUD's Office of Special Needs Assistance Programs (SNAPS) July 2013 Weekly Focus on Coordinated Assessment

HUD's Overview of Coordinated Assessment Systems Prezi and Video

Community Solutions' recorded one hour conference call with slide deck: Overview of Coordinated Assessment and Housing Placement System.

Community's Solutions' CAHP System Overview - Zero: 2016

Corporation for Supportive Housing's January 2015 Report: *Improving Community-wide Targeting of Supportive Housing to End Chronic Homelessness: The Promise of Coordinated Assessment*

National Alliance to End Homelessness Coordinated Assessment Toolkit

United States Interagency Council on Homelessness *Coordinated Assessment: Putting the Key Pieces in Place*

Hawaii Pathways Project

June 9, 2015 HICH Update

BACKGROUND

- Funded through a 3-year Cooperative Agreement* with the SAMHSA (Substance Abuse and Mental Health Services Administration). (September 30, 2013-September 29, 2016)

  ** Cooperative Agreement to Benefit Homeless Individuals or CABHI*
- **Target Population**: Chronically homeless with substance use OR co-occurring (substance use and mental health disorders)
- **CABHI 2-Year Supplemental** (September 30, 2014-September 29, 2015)
- **Target Population:** Homeless Veterans with SMI and or Substance Abuse or individuals with SMI only

  *** * *Goal: Provide HPP Services to 155 clients* * ***

UPDATES

- Project Coordinator Position – In recruitment.
- Contracts:
  - Pathways Housing First, Inc.
  - Helping-Hands-Hawaii
  - University of Hawaii-Center on the Family

Hawaii Pathways Project

Services Update

167 referrals made through ***Hale O Malama*** and other access points (i.e. Hospitals, Residential Treatment Centers, and OCCC)

37*

67 clients enrolled in the project, and receiving ***ACT-level*** case management services

12*

100%
RETENTION RATE
(80% Nationally)

32 individuals have been ***permanently housed*** with assistance through the State Housing First program

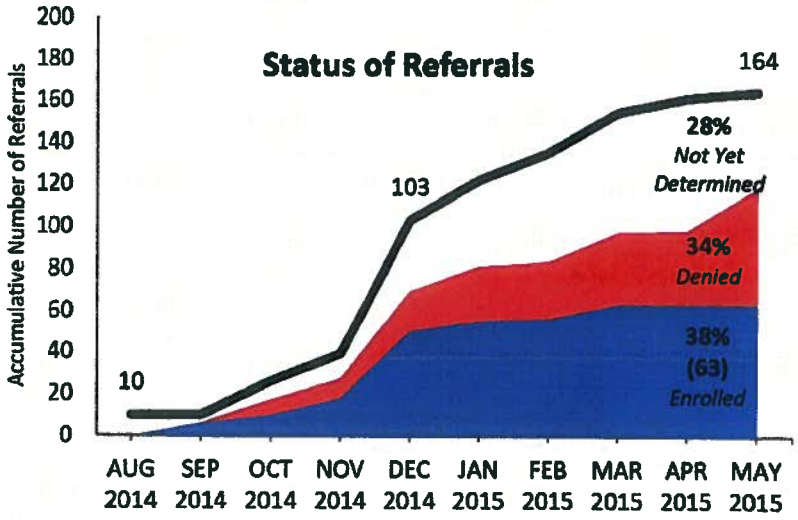
2*

*=number reported at 11/19/14 HICH Meeting

HAWAII STATE DEPARTMENT OF HEALTH

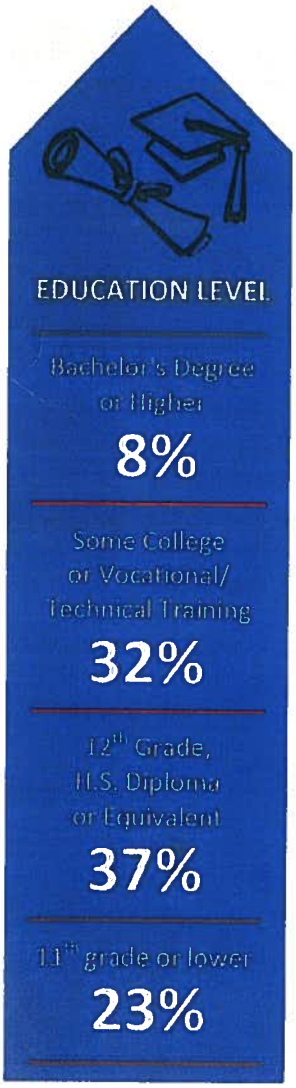
HAWAI'I PATHWAYS PROJECT PROGRESS HIGHLIGHTS

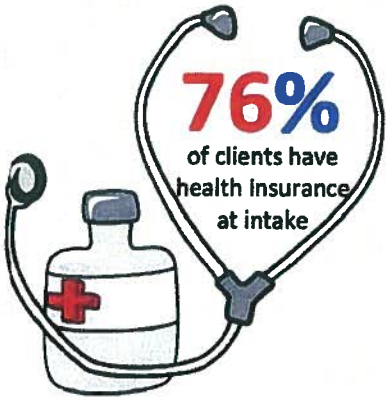
AUG 2014-MAY 2015

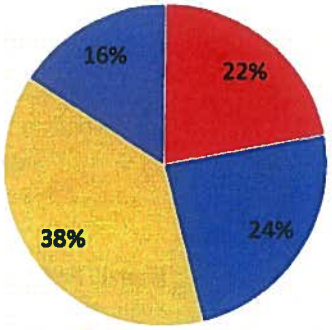


Diagnosis	Percent of Clients
Substance abuse	**35%**
Co-occurring substance abuse and mental disorders	65%
Substance abuse	**100%**
Mental illness	41%
Severe Mental Illness	**37%**
Most Common Diagnosis	
Posttraumatic stress disorder	**35%**
Other and unspecified alcohol dependence, unspecified	33%
Amphetamine and other psychostimulant dependence	**22%**
Amphetamine or related acting sympathomimetic abuse	21%
Opioid type dependence	**17%**
Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	16%

Referral Source	Percent of Referrals
Hale 'O Malama Coordinated Intake System	**59%**
Substance abuse treatment providers	17%
Hospitals	**13%**
Community mental health providers	6%
Other	**5%**





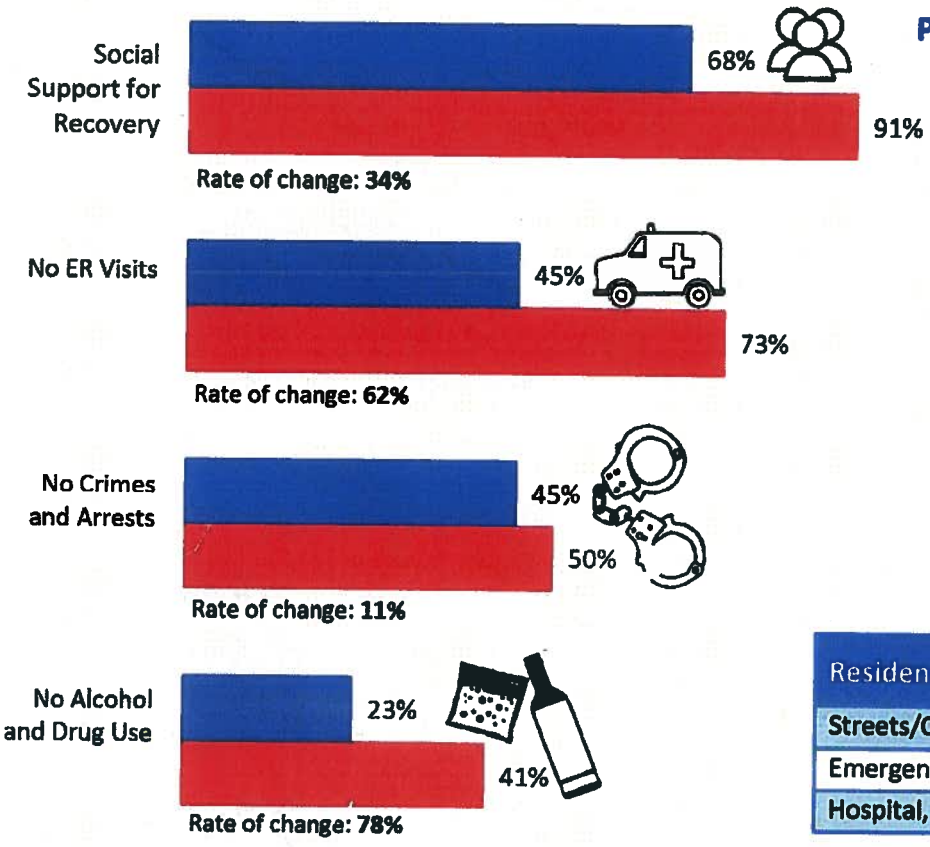


VI-SPDAT Score	Percent of Clients
10	27%
11-12	14%
13-14	30%
15-16	29%

4 or more homeless episodes in the past 3 years: **24%**

81%
Homeless for 12+ mo.
Median: **72 mo.**

CLIENT OUTCOME RATES BETWEEN INTAKE AND 6-MONTH



HAWAI'I PATHWAYS PROJECT PROGRESS HIGHLIGHTS *SEPT 2014-MAY 2015*

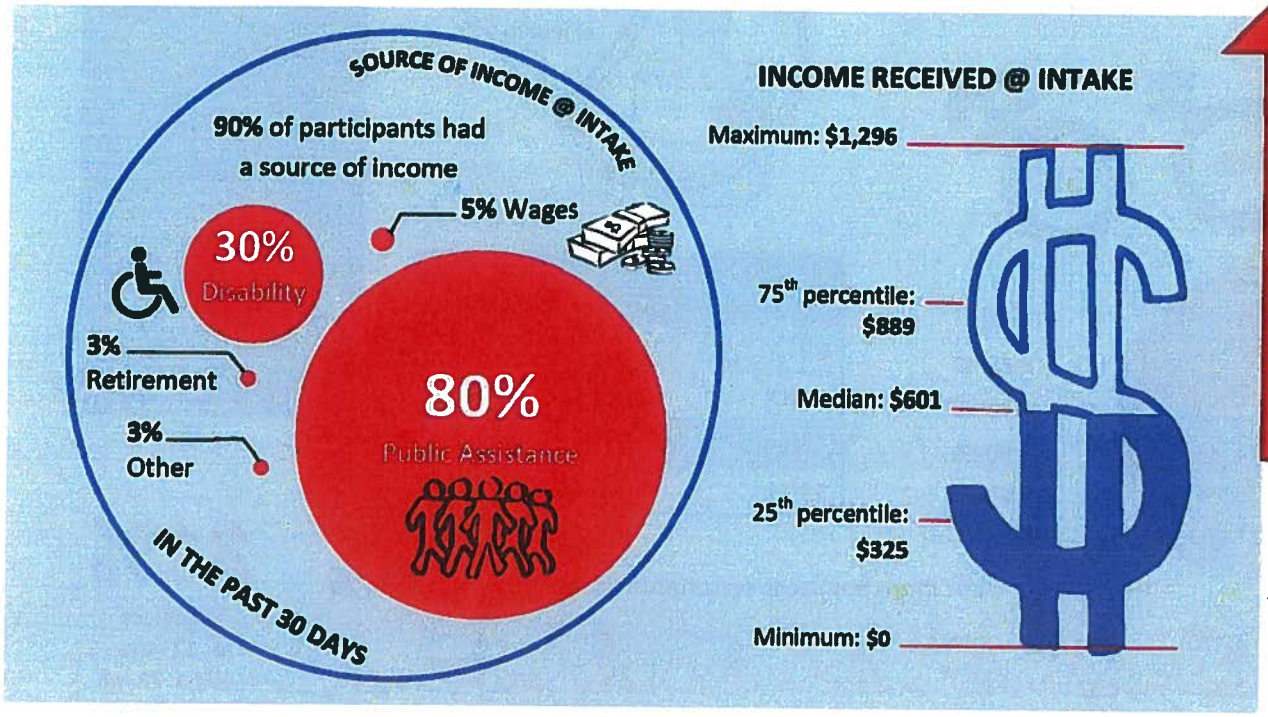
ID, Other Document, and Public Program Applications	# of Clients
Applied for one or more IDs/Programs	**25**
Received for one or more IDs/Programs	**18**
Birth Certificate	*4*
State ID	*5*
Social Security Card	*3*
Disability Bus Pass	*6*
General Assistance	*2*
SNAP	*6*
Medicaid	*3*

Residence Prior to Intake	# of Clients	%
Streets/Outdoors	45	71%
Emergency Shelter, Safe Haven	10	16%
Hospital, Residential Treatment	8	13%

Current Housing Status	# of Clients	%
Homeless	39	62%
Bridge Housing	5	8%
Permanent Housing	19	30%

56 Days

Average number of days it took from program intake to moving into independent rental apartments or units located across O'ahu. The range is 8 to 160 days.



Hawai'i Pathways Project Evaluation, Center on the Family, University of Hawai'i. June 9, 2015.

Making a Fundamental Connection: Housing is Healthcare

BILL & MELINDA GATES *foundation*

David Wertheimer, Bill Pitkin

November 19, 2014

Not long ago, a homeless mother was asked if, due to the expansion of Medicaid coverage under the Affordable Care Act, she would like to receive insurance that could meet the full range of her family's healthcare needs. "I already have a doctor," she responded. "He's at the local hospital emergency room."

While it's reassuring for all of us to know that emergency room visits are available to address a health crisis, hospitals were not designed to provide ongoing primary care and are neither an effective or efficient setting in which to receive basic medical treatment. With daily per patient costs that can climb well into four figures, we need better ways to meet the health care needs of vulnerable and at-risk individuals and families who are homeless.

New Ways to Look at Health These new pathways to quality health services for people who are or have been homeless was the subject of a day-long workshop at the National Academies of Sciences on November 12th in Washington, DC. Convened in partnership with the National Alliance to End Homelessness, National Health Care for the Homeless Council, and Institute of Medicine (IOM) Roundtable on Health Equity and Health Disparities, it was a ground-breaking event, bringing together a group of national experts on homelessness, housing, and healthcare policy and delivery. Exploring new opportunities to connect health services in housing for both individuals and families recovering from homelessness, it was the first time the National Academies had taken on the subject of homelessness in any significant way since 1988.
The experts agreed that the basic equation is no longer all that controversial: **Housing is healthcare.** We know that poor health can lead to homelessness. We know that homelessness is a major cause of poor health. We know that homelessness interferes with effective health care delivery. Study after study has documented not only that housing people who are homeless significantly increases their health outcomes; we also know that it dramatically reduces the costs of homelessness to the taxpayer.

Significant Cost Savings Multiple studies in Seattle demonstrated that, for high users of crisis services such as emergency rooms, jails, and detox facilities, **providing permanent housing reduces costs** from more than $4,000 per person per month to less than $1,000. The program being studied served 75 individuals a year, and clearly documented annual savings of more than $4 million. Research in Los Angeles on 163 homeless persons in the highest cost decile of health services shows that every $1 spent to house and support these individuals results in public cost savings of $2 in the first year and $6 in subsequent years.

As obvious as the solution of permanent housing is to the challenge of spiraling healthcare costs associated with homelessness, taking this solution to scale presents a daunting challenge due to multiple factors: The fragmentation of funding and service delivery across multiple systems, the rigid, inflexibility of existing funding streams, and eligibility standards for access to services that are inconsistent with the needs of those who could most benefit from them.

Challenges & Solutions Nevertheless, solutions are clearly within sight. We can now rapidly identify those clients with the greatest healthcare needs who represent the most expensive cost burdens. We know what housing and service packages will most help these individuals stabilize and recover, while cutting the cost burden of leaving them untreated. We know that **housing and health providers can successfully work together** to tailor services precisely to the unique needs of each clients.

The challenge is largely a by-product of the history of homelessness and housing systems that have not been effectively linked to health care services, and a health care system whose work has been narrowly defined in terms of treating specific illnesses, rather than promoting the overall health and well-being of individuals and families. With increased attention from policy makers, researchers and funders to the social determinants of health, it is in opportune time to reconsider the linkages between housing and health.

It was exciting for both of us to be part of the National Academies conversation, with other Funders Together to End Homelessness members such as Melville Charitable Trust and Kresge Foundation, listening to seasoned professionals from multiple systems agree that the science of both ending homelessness and promoting health have come to the same conclusion about an essential component of the solution to homelessness. When we define housing combined with the needed supportive services as a basic form of health care, the path forward to improved housing and health outcomes becomes immediately clear to us all.

Cross-posted on Funders Together to End Homelessness and the Conrad N. Hilton Foundation's websites

Details

- **Category** Poverty
- **Topics** Family Homelessness (U.S.)
- **Country** United States
- **Tags** Health, Homelessness

2014 Bill & Melinda Gates Foundation

Room For Debate: For Even the Neediest, Housing Is the Solution to Homelessness

By Rosanne Haggerty
The New York Times
February 20, 2015
New York Times

This piece by Community Solutions President Rosanne Haggerty appeared on February 19, 2015 alongside several others in a Room for Debate feature in the New York Times.

The world is full of complex social problems for which no reliable, cost effective solutions have been found. Homelessness is not one of them.

The truth is that we have known how to end homelessness for several years now, and solid research, which has been replicated repeatedly, has proven that it is far cheaper to do so than to allow the problem to persist. The cheapest, most assured way to end homelessness turns out to be deceptively simple: provide homeless Americans, many of whom struggle with disability, mental illness, or life threatening health conditions, with stable homes.

Imagine our surprise when we removed our initial restrictions and discovered that just the opposite was true.For years, people like me assumed the solution had to be something else. In the 1990s, I developed supportive housing buildings for homeless New Yorkers, where we initially screened out people with untreated mental illness, addiction problems, or poor income prospects. "Unlikely to succeed in housing," we reflected sadly.

It turned out that virtually everyone could remain in housing, given the right combination of supportive services to help them succeed. Some people needed complex services like psychiatrist visits and regular access to primary care. Others needed much simpler support, like help devising a budget or a weekly grocery list.

As shocked as we were to see some of our most vulnerable neighbors escape the streets successfully, we were even more shocked by what happened to their healthcare costs. As our tenants were connected to primary care and received consistent help in managing other challenges, they no longer made frequent visits to hospitals.

Over the next several years, many other organizations saw similar results by taking a "housing first" approach, and soon a host of scholarly studies began to document the phenomenon. A 2002 study by Dennis Culhane at the University of Pennsylvania found that supportive housing — a term for permanent housing combined with basic health and social services —reduced public systems costs by more than 40 percent in New York City, even after the cost of rent and services was taken into account. In 2009, a study published in the Journal of the American

Medical Association documented even greater savings in Seattle, where those housed saw their costs drop roughly 60 percent.

Today, a trove of studies have been published in journals across the country replicating and substantiating these results. Last year, my own organization concluded the 100,000 Homes Campaign, which helped 186 US communities move more than 105,000 homeless Americans into supportive housing over four years. An estimate we commissioned at the time from a leading firm places the taxpayer savings associated with that achievement at nearly $1.3 billion, repeating annually.

Today, we not only know that housing ends homelessness, we also know that not everyone needs the same kind of housing assistance. Permanent supportive housing is ideal for those with serious health challenges who have been homeless for long periods of time, but many others need far less help to escape shelters and the streets. This is good news because less intensive approaches like "rapid rehousing"– an approach employing short- to medium-term rental assistance– work well for many and are even less expensive than supportive housing.

By matching people to the right level of housing assistance quickly, we can end the misery of homelessness for those experiencing it while making smart use of public resources.

United States Interagency Council on Homelessness

Preventing and Ending Homelessness in the United States

The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice

Introduction

Housing First is a proven method of ending all types of homelessness and is the most effective approach to ending chronic homelessness. Housing First offers individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing. Without clinical prerequisites like completion of a course of treatment or evidence of sobriety and with a low-threshold for entry, Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions.[1] Due its high degree of success, Housing First is identified as a core strategy for ending homelessness in *Opening Doors: the Federal Strategic Plan to End Homelessness* and has become widely adopted by national and community-based organizations as a best practice for solving homelessness.

Housing First permanent supportive housing models are typically designed for individuals or families who have complex service needs, who are often turned away from other affordable housing settings, and/or who are least likely to be able to proactively seek and obtain housing on their own. Housing First approaches also include rapid re-housing which provides quick access to permanent housing through interim rental assistance and supportive services on a time-limited basis. The approach has also evolved to encompass a community-level orientation to ending homelessness in which barriers to housing entry are removed and efforts are in place to prioritize the most vulnerable and high-need people for housing assistance.

As Housing First approaches become adopted more widely, the need for clarity increases around what the Housing First approach entails and how to know whether a particular housing program or community approach is truly using a Housing First approach. Robust tools and instruments are available which can quantitatively assess and measure a housing program's fidelity to Housing First, and recent research has attempted to rigorously evaluate Housing First implementation.[2] For quick screening, policymakers and practitioners will benefit from this practical, easy to use guide to identify and assess the implementation of the core components of the Housing First approach.

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[1] Lipton, F.R. et. al. (2000). "Tenure in supportive housing for homeless persons with severe mental illness," Psychiatric Services 51(4): 479-486. M. Larimer, D. Malone, M. Garner, et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal of the American Medical Association*, April 1, 2009, pp. 1349-1357. Massachusetts Housing and Shelter Alliance. (2007). "Home and Healthy for Good: A Statewide Pilot Housing First Program." Boston.

[2] Tsemberis, S. (2010). *Housing First: The Pathways model to end homelessness for people with mental illness and addiction*. Center City, MN: Hazelden. The National Center on Addiction and Substance Abuse at Columbia University. (2012). *Unlocking the door: An implementation evaluation of supportive housing for active users in New York City.* New York. http://www.casacolumbia.org/upload/2012/20121907casahope2full.pdf

How to Use this Tool

This user-friendly tool is intended for use by policymakers, government officials, and practitioners alike to help make a basic assessment of whether and to what degree a particular housing program is employing a Housing First approach. The tool can be used as a checklist that can be reviewed during a site visit, program audit, or program interview, or as a guide and checklist when reviewing funding applications or reviewing a program's policies and procedures.

The tool is organized in two sections. The first section is a checklist of the core and additional elements of Housing First at the housing program or project level. The second section is a checklist of elements of Housing First at the community-level. Users of this tool should be aware that this tool assesses Housing First adoption along a spectrum, rather than as a simple *yes/no* or *pass/fail*. This tool is also not intended to serve as or supplant a more comprehensive housing and program quality assessment tool, but may supplement or be used in conjunction with such tools.

Quick Screen: Is permanent supportive housing Housing First?

1. *Are applicants required to have income prior to admission?*
2. *Are applicants required to be "clean and sober" or "treatment compliant" prior to admission?*
3. *Are tenants able to be evicted for not following through on their services and/or treatment plan?*

If the answer is "Yes" to any of these questions, the program is not Housing First.

Housing First at the Program/Project Level

Core Elements:

- ❑ Admission/tenant screening and selection practices promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, and participation in services.
- ❑ Applicants are seldom rejected on the basis of poor credit or financial history, poor or lack of rental history, minor criminal convictions, or behaviors that indicate a lack of "housing readiness."
- ❑ Housing accepts referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response system frequented by vulnerable people experiencing homelessness.
- ❑ Supportive services emphasize engagement and problem-solving over therapeutic goals. Services plans are highly tenant-driven without predetermined goals. Participation in services or program compliance is not a condition of permanent supportive housing tenancy. Rapid re-housing programs may require case management as condition of receiving rental assistance.
- ❑ Use of alcohol or drugs in and of itself (without other lease violations) is not considered a reason for eviction.

Additional Elements Found in Advanced Models:

- ❑ Tenant selection plan for permanent supportive housing includes a prioritization of eligible tenants based on criteria other than "first come/first serve" such as duration/chronicity of homelessness, vulnerability, or high utilization of crisis services.
- ❑ Tenants in permanent supportive housing given reasonable flexibility in paying their tenant share of rent (after subsidy) on time and offered special payment arrangements (e.g. a payment plan) for rent arrears and/or assistance with financial management (including representative payee arrangements).

- ❑ Case managers/service coordinators are trained in and actively employ evidence-based practices for client/tenant engagement such as motivational interviewing and client-centered counseling.

- ❑ Services are informed by a harm reduction philosophy that recognizes that drug and alcohol use and addiction are a part of tenants' lives, where tenants are engaged in non-judgmental communication regarding drug and alcohol use, and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices.

- ❑ Building and apartment unit may include special physical features that accommodate disabilities, reduce harm, and promote health among tenants. These may include elevators, stove-tops with automatic shut-offs, wall-mounted emergency pull-cords, ADA wheelchair compliant showers, etc.

Housing First at the Community Level

- ❑ Emergency shelter, street outreach providers, and other parts of crisis response system are aligned with Housing First and recognize their roles to encompass housing advocacy and rapid connection to permanent housing. Staff in crisis response system services believes that all people experiencing homelessness are housing ready.

- ❑ Strong and direct referral linkages and relationships exist between crisis response system (emergency shelters, street outreach, etc.) and rapid re-housing and permanent supportive housing. Crisis response providers are aware and trained in how to assist people experiencing homelessness to apply for and obtain permanent housing.

- ❑ Community has a unified, streamlined, and user-friendly community-wide process for applying for rapid re-housing, permanent supportive housing and/or other housing interventions.

- ❑ Community has a coordinated assessment system for matching people experiencing homelessness to the most appropriate housing and services, and where individuals experiencing chronic homelessness and extremely high need families are matched to permanent supportive housing/Housing First.

- ❑ Community has a data-driven approach to prioritizing highest need cases for housing assistance whether through analysis of lengths of stay in Homeless Management Information Systems, vulnerability indices, or data on utilization of crisis services.

- ❑ Policymakers, funders, and providers collaboratively conduct planning and raise and align resources to increase the availability of affordable and supportive housing and to ensure that a range of affordable and supportive housing options and models are available to maximize housing choice among people experiencing homelessness.

- ❑ Policies and regulations related to permanent supportive housing, social and health services, benefit and entitlement programs, and other essential services support and do not inhibit the implementation of the Housing First approach. For instance, eligibility and screening policies for benefit and entitlement programs or housing do not require the completion of treatment or achievement of sobriety as a prerequisite.

- ❑ Every effort is made to offer a transfer to a tenant from one housing situation to another, if a tenancy is in jeopardy. Whenever possible, eviction back into homelessness is avoided.

COMMUNITY SOLUTIONS

Contact: *Adam Gibbs • agibbs@cmtysolutions.org • 202.810.3511*

Housing First: The Cheapest, Most Effective Solution to Homelessness

What is housing first?

- Housing first is a highly effective approach to ending chronic homelessness that emphasizes providing people experiencing homelessness with permanent housing right away and then offering other services as needed.
- Stable housing puts people in a better position to benefit voluntarily from needed services over time. In contrast with less effective traditional approaches, housing first does not force homeless people to complete or comply with treatment, mental health care, employment training or other services in order to access and maintain permanent housing, but rather offers these services *alongside* housing.

Housing first ends homelessness.

- Numerous studies find that housing first ends homelessness for chronically homeless individuals faster, more often & more permanently than treatment-based approaches.[1]
- The vast majority of housing first tenants (85% on average) do not return to homelessness, remaining stably housed at rates that often exceed those of their counterparts in traditional treatment first programs.[2]

Housing first saves taxpayers money.

- Housing first measurably lowers taxpayer costs by reducing chronically homeless people's reliance on expensive services like shelters, psychiatric hospitals and the emergency room. Permanent supportive housing is far cheaper than these services.[3]
- For example, a 2014 study found the cost of homelessness in Central Florida to be $31,065 per year -- primarily from inpatient hospitalizations, emergency room fees and criminal justice costs. In contrast, the study found that providing permanent housing for these chronically homeless individuals costs just $10,051 per person/year -- **one third the cost of leaving these individuals on the streets.**[4]

Housing first is mainstream.

- Housing first was instituted as federal policy under the George W. Bush Administration and has been expanded under the Obama Administration.
- The US Departments of Veterans Affairs & Housing and Urban Development have realigned their programs to prioritize housing first -- **encouraging a +22% drop in chronic homelessness and a +33% drop in veteran homelessness since 2009.**

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[1] Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. Research on Social Work Practice, 16(1), 74-83.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. Journal Information, 94(4).

[2] Pearson, C., Montgomery, A. E., & Locke, G. (2009). Housing stability among homeless individuals with serious mental illness participating in housing first programs. Journal of Community Psychology, 37(3), 404-417.

Stefancic, A., & Tsemberis, S. (2007). Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. The Journal of Primary Prevention, 28(3-4), 265-279.

[3] Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., ... & Marlatt, G. A. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. JAMA: the Journal of the American Medical Association, 301(13), 1349-1357.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. Journal of Community & Applied Social Psychology, 13(2), 171-186.

[4] Shinn, G. (2014). The Cost of Long-Term Homelessness in Central Florida. Central Florida Commission on Homelessness.

COMMUNITY SOLUTIONS

Chronically Homeless Person- An individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.

Homeless Veteran - An individual experiencing homelessness who has served on active duty in the United States Military, regardless of discharge status.

Functional Zero (Veterans) - At any point in time, the number of veterans experiencing sheltered and unsheltered homelessness will be no greater than the current monthly housing placement rate for veterans experiencing homelessness.

Functional Zero (Chronic) - At any point in time, the number of people experiencing sheltered and unsheltered chronic homelessness will be no greater than the current monthly housing placement rate for people experiencing chronic homelessness.

Housing Placement Rate - The twelve (12) month rolling average of veterans and/or chronically homeless people that were placed into housing. This number is used to ensure that a community remains at functional zero. The monthly housing placement rate should be greater than or equal to the community's monthly housing placement goal, which is derived from the community's Take Down Target.

Take Down Target - The total chronic/veteran homeless population, plus projected inflow, that will need to be housed in order to end chronic/veteran homelessness in your community within the set timeframe. Take down targets allow communities to set monthly housing placement goals - and measure progress against those goals - in order to stay on track towards ending veteran/chronic homelessness.

Housing Placement Tool - A platform containing automated feedback loops and aggregate dashboards to collect all housing placements across the community in order to accurately track progress towards ending chronic and veterans homelessness system-wide.

Gap Analysis Tool - An Excel-based platform that allows communities to set their Chronic/Veteran Take Down Targets. The tool allows communities to develop strategies for reducing or eliminating gaps in assets by implementing one or more gap closing strategies.

Common Assessment Tool (CAT) - A set of questions used by outreach workers to quickly assess people based on acuity. The CAT is used to understand the needs of a person experiencing homelessness and to assign the most appropriate housing or service intervention based on that need. An assessment tool is considered "common" if all agencies and organizations in a community agree to use the same tool. A CAT must be backed by data, and its recommendations must be based on solid research.

Coordinated Entry/Coordinated Assessment and Housing Placement System (CAHP) - The process by which all homeless people are moved from the streets into the best housing option for their needs. A CAHP consists of a set of common procedures and tools used by partnering organizations and agencies within a community to identify, assess, prioritize, and match individuals and families experiencing homelessness with appropriate housing and service interventions.

COMMUNITY SOLUTIONS

Vulnerability Index - Service Prioritization Decision Assistance Tool Prescreen (VI-SPDAT) - The VI-SPDAT is a Common Assessment Tool that meets the CAT requirements necessary for integration within a CAHP System as part of Zero: 2016. The VI-SPDAT is designed to help a community calibrate their response based on the individual, not merely the general population category into which they may fall (e.g., vulnerable, chronically homeless, etc.). Communities may consider using the VI-SPDAT as their CAT, but it is not required. The VI-SPDAT was co-developed by Community Solutions and OrgCode Consulting.

Vulnerability Index (VI) - A street outreach tool developed by Community Solutions and rooted in leading medical research, the VI helps determine the chronicity and medical vulnerability of homeless individuals and prioritizes them for housing according to the fragility of their health. The field has evolved considerably since the VI's introduction, and Community Solutions now recommends the VI-SPDAT as a more comprehensive assessment than the VI alone.

Coordinated Outreach and Access Points - A shared process for identifying, assessing (with a CAT), and engaging the highest need/acuity clients across the largest possible geographic reach and with minimal duplication of outreach services.

Continuum of Care (CoC) - Local groups (414 nationally) set up to administer HUD funding to end homelessness in communities throughout the country.

Permanent Supportive Housing - (Long-term, not time limited, low-income housing with support services): Intended for individuals or families who need permanent housing with ongoing access to services and case management to remain stably housed.

Rapid Re-Housing - (Time limited rental assistance with moderate service supports): Intended for individuals or families with moderate health, mental health and/or behavioral health issues, who are likely to be able to achieve housing stability over a short time period through a medium or short-term rent subsidy and access to support services.

Point-in-Time Count (PIT) - A HUD required count of sheltered and unsheltered homeless persons on a single night in January. Continuums of Care must conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered homeless persons every other year (odd numbered years). Each count is planned, coordinated, and carried out locally.

Registry Week - An intensive week-long blitz to learn the names of every homeless person in the community with enough information to triage them into the appropriate permanent housing option. Communities will use this information to develop by-name files on each person experiencing homelessness on their streets to help connect people to available subsidies and appropriate housing options as quickly as possible.

Homeless Management Information System (HMIS) - A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

HAWAII

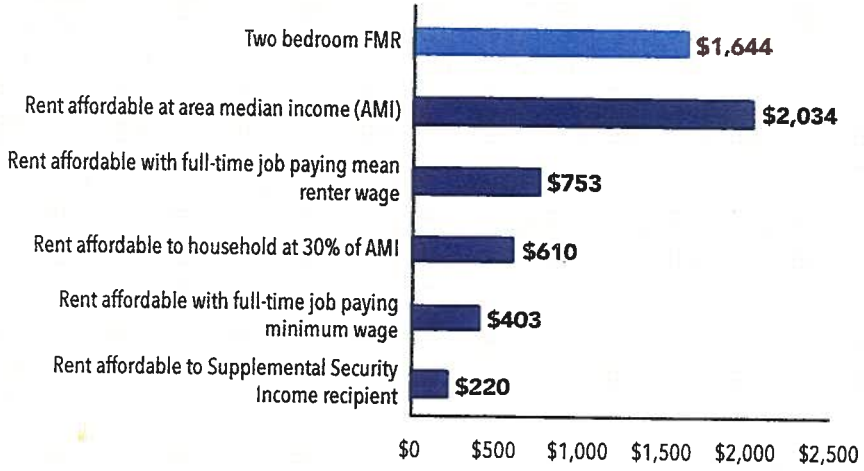
In Hawaii, the Fair Market Rent (FMR) for a two-bedroom apartment is **$1,644**. In order to afford this level of rent and utilities — without paying more than 30% of income on housing — a household must earn **$5,479** monthly or **$65,746** annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into an hourly Housing Wage of:

STATE RANKING
1st*

$31.61 PER HOUR

STATE FACTS	
Minimum Wage	$7.75
Average Renter Wage	$14.49
2-Bedroom Housing Wage	$31.61
Number of Renter Households	190,501
Percent Renters	42%

MOST EXPENSIVE COUNTIES	HOUSING WAGE*
Honolulu County	$34.81
Maui County	$24.31
Kauai County	$23.50
Hawaii County	$22.13
Kalawao County	$12.37



163

Work Hours Per Week At Minimum Wage Needed To Afford a 2-Bedroom Unit (at FMR)

4.1

Number of Full-Time Jobs At Minimum Wage Needed To Afford a 2-Bedroom Unit (at FMR)

* Ranked from Highest to Lowest 2-Bedroom Housing Wage

HAWAII

	FY15 HOUSING WAGE	HOUSING COSTS			AREA MEDIAN INCOME (AMI)				RENTER HOUSEHOLDS				
	Hourly wage necessary to afford 2 BR [1] FMR [2]	2 BR FMR	Annual income needed to afford 2 BR FMR	Full-time jobs at minimum wage needed to afford 2 BR FMR [3]	Annual AMI [4]	Monthly rent affordable at AMI [5]	30% of AMI [6]	Monthly rent affordable at 30% of AMI	Renter households (2009-2013)	% of total households (2009-2013)	Estimated hourly mean renter wage (2015)	Monthly rent affordable at mean renter wage	Full-time jobs at mean renter wage needed to afford 2 BR FMR
Hawaii	$31.61	$1,644	$65,746	4.1	$81,353	$2,034	$24,406	$610	190,501	42%	$14.49	$753	2.2
Combined Nonmetro Areas	$23.25	$1,209	$48,365	3.0	$69,075	$1,727	$20,722	$518	52,741	38%	$12.68	$659	1.8
Metropolitan Areas													
Honolulu MSA *	$34.81	$1,810	$72,400	4.5	$86,900	$2,173	$26,070	$652	137,760	44%	$15.19	$790	2.3
Counties													
Hawaii County	$22.13	$1,151	$46,040	2.9	$62,400	$1,560	$18,720	$468	22,248	34%	$11.14	$579	2.0
Honolulu County *	$34.81	$1,810	$72,400	4.5	$86,900	$2,173	$26,070	$652	137,760	44%	$15.19	$790	2.3
Kalawao County †	$12.37	$643	$25,720	1.6	100,600	$2,515	$30,180	$755	46	100%			
Kauai County	$23.50	$1,222	$48,880	3.0	$74,200	$1,855	$22,260	$557	8,380	37%	$13.52	$703	1.7
Maui County	$24.31	$1,264	$50,560	3.1	$75,100	$1,878	$22,530	$563	22,067	42%	$13.66	$710	1.8

* 50th percentile FMR (See Appendix A). † Wage data not available (See Appendix A).

1: BR = Bedroom 2: FMR = Fiscal Year 2015 Fair Market Rent (HUD, 2014).

3: This calculation uses the higher of the state or federal minimum wage. Local minimum wages are not used. See Appendix A.

4: AMI = Fiscal Year 2015 Area Median Income

5: "Affordable" rents represent the generally accepted standard of spending not more than 30% of gross income on gross housing costs.

6: The federal standard for extremely low income households. Does not include HUD-specific adjustments.

PARTNERS IN CARE

Oahu Continuum of Care

Partners in Care is a coalition of Oahu's homeless service providers, government representatives and community stakeholders working together in partnership to end homelessness.

Successes for Advocacy - 2015 Legislative Session
PIC Advocacy Committee

The 2015 State Legislative Session started out with great hope and excitement. Governor Ige announced an initiative for $100 million to the Rental Housing Trust Fund (RHTF) to create affordable rental housing along the rail line on Oahu. Conveyance tax revenues were surging due to the current housing boom, and the Rental Housing Trust Fund's 50% share was projected to hit $35 - $45 million possibly. The Administration's budget strongly supported Housing First funding to end chronic homelessness. All these aligned with Partners in Care's top advocacy priorities. Advocates fought hard for PIC issues, met with legislators, and had great success:

Results of the State Legislative Session for Housing and Homeless issues:

- ***$40 million was allocated to the Rental Housing Trust Fund for* FY 16** for construction of new affordable rental housing, statewide!
- New cap on allocations to RHTF from the conveyance tax: $38 million/year or 50% of these revenues (lower amount), beginning 7/1/15.
    - With ***approximately $80 million going to the RHTF***, this almost triples past allocations!
    - It is estimated that over 600 new affordable rental units can be produced.
- ***$1.5 million allocated to continue the Housing First Program*** to end chronic homelessness for FY 16. This allows the program to continue on Oahu, but did not provide additional funds to expand to the Neighbor Islands.
    - PIC will continue to work with the Neighbor Island providers for expansion of Housing First, and stable, two year funding.
- ***$1.7 million allocated for planning of the 902 Alder Street juvenile*** service center. With the service center moving forward, the state housing corporation, HHFDC, can also plan for 180 affordable family rental units on this site.
- The ***refundable Food and Excise Tax Credit was increased*** to help lower income people pay for basic necessities (SB 555).
- ***$1.5 million*** was also allocated to the ***artists lofts housing project*** in Kakaako to keep this project moving forward.

The money committees were conservative this year and wanted to establish more control and transparency over special funds in many departments within state government. While some programs' lost their percentage share of conveyance tax revenues, the RHTF maintained its 50% share of these tax revenues. Considering that overall, social service programs did not fare well this legislative session, housing and ending homelessness initiatives were quite successful.