CSH
The Source for
Housing Solutions

Framework to Inform the Greater Seacoast's Plan to Prevent and End Homelessness

As presented by CSH to the Greater Seacoast
Coalition to End Homelessness

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ABOUT CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

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ACKNOWLEDGEMENTS

INQUIRIES

If you are interested in learning more about the Greater Seacoast's Plan to Prevent and End Homelessness, please contact Maria Sillari at msillari14@gmail.com. For information on CSH, please visit www.csh.org for additional on-line resources and materials. If you have questions or comments regarding this document, please contact Susan Starrett at susan.starrett@csh.org

INTRODUCTION

The Corporation for Supportive Housing (CSH) is pleased to present this report to the Greater Seacoast of New Hampshire, both the government and its housed and homeless citizens. Committing to conduct a thorough, thoughtful, and intentional review of implementation strategies to end homelessness is risky. To do it in an open and authentic manner is laudable. CSH witnessed this throughout the process and hopes that the same authenticity comes through in this document.

CSH also appreciates the willingness of the Greater Seacoast Coalition to End Homelessness to undertake the Charrette process as a method of analyzing, discerning, and ultimately making difficult decisions about moving forward on complicated issues.

This report is intended to inform the next body of work under the three issue areas identified and examined through this process; to lay a framework for the next level of work under the Plan to Prevent and End Homelessness; and to increase the success of the work happening in the Greater Seacoast.

SUCCESS OF PREVENTING AND ENDING HOMELESSNESS TO DATE

The region served by the Greater Seacoast Coalition to End Homelessness mirrors that of the United Way of the Greater Seacoast, and encompasses all of Strafford County, NH, 27 cities and towns in eastern Rockingham County, and Kittery and Eliot, Maine, totaling approximately 260,000, with 112,000 living in Strafford County and 148,000 in eastern Rockingham and Kittery and Eliot, Maine.

The most recent Point In Time (PIT) count identified over 300 people experiencing homelessness on one day in January 2014. Of those, 150 men, women and children were staying in the greater Seacoast region's emergency shelters and transitional housing programs, while as many as 60 or more remain unsheltered, and more than 120 were doubled up with family or friends.[1]

Throughout the course of the year, more than twice as many people (over 800), experience at least one episode of homelessness, staying in one of the Seacoast's homeless shelters, including over 150 children under the age of 18.[2] Approximately 60% of the Seacoast's homeless population is male, and 12% could be identified as "long stayers", i.e. spending more than 180 nights in shelter over the course of 365 consecutive nights.

Contributing Factors to Homelessness
Most often, people experiencing homelessness face multiple barriers to economic and health security and have little support and resources in the community. The most common contributors to homelessness in the greater Seacoast region include the high cost of housing and inadequate income.

High cost of housing. In New Hampshire, 38,187 renters are Extremely Low Income (ELI), earning $24,116 a year or less. 81% of New Hampshire's renters are cost-burdened—60% *severely* cost-burdened--paying half or more of their income on housing. Coupled with this, there is a shortage of over 23,000 units that are affordable and available to households earning less than 30% of New Hampshire's area median income. In the Seacoast, 30% AMI is $25,290.[3]

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[1] 2014 Point-in-Time Count January 29, 2014, New Hampshire Department of Health and Human Services, Bureau of Homeless and Housing Services

[2] Annual Homeless Assessment Report, October 1, 2013 through September 30, 2014

[3] Sources: NLIHC tabulations of 2012 American Community Survey Public Use Microdata Sample (PUMS) housing file; 2014 Out of Reach report; NH Housing 2014 Rental Cost Survey

Inadequate income. While New Hampshire fared better than many states during the recent recession, and saw both the percentage and number of people living in poverty decline between 2012 and 2013[4], 8.4% of the people in the Seacoast Region were living in poverty between 2008 and 2012. This equates to $11,490 for an individual, $15,510 for a family of two, and $23,550 for a family of four.

In November 2011, the Greater Seacoast Coalition to End Homelessness held a HEARTH Act Implementation Clinic, led by staff from the National Alliance to End Homelessness. The Clinic brought together over 35 stakeholders, including funders, board members and state officials, and participants identified three strategies they felt could be successfully implemented to prevent and reduce homelessness in the Seacoast Region: Coordinated Intake, Targeted Prevention, and Expansion of Rapid Rehousing.

In August 2013 the Coalition implemented Coordinated Intake—now termed Coordinated Access. Hosted and operated by Community Action Partnership of Strafford County, the program has successfully been fully incorporated into the organization and in its first year of operation provided assistance to over 1,400 callers. That same summer, Families in Transition opened a permanent supportive housing facility, with a maximum of 14 beds, for single women and single mothers with children.

The communities served by the Greater Seacoast Coalition to End Homelessness are:

Rockingham County	**Strafford County**
Brentwood	Barrington
Deerfield	Center Strafford
E. Kingston	Dover
Epping	Durham
Exeter	East Rochester
Fremont	East Wakefield
Greenland	Farmington
Hampton	Gonic
Hampton Falls	Lee
Kensington	Madbury
Kingston	Middleton
New Castle	Milton
Newfields	Milton Mills
Newington	New Durham
Newmarket	Rochester
Newton	Rollinsford
North Hampton	Somersworth
Nottingham	Strafford
Portsmouth	
Raymond	**York County**
Rye	Eliot
Rye Beach	Kittery
Seabrook	
South Hampton	
Stratham	
West Nottingham	

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[4] What is NH? 2014 data set, NH Center for Public Policy Studies

THE CHARRETTE PROCESS

To condense planning time while involving a broad range of stakeholders, the Greater Seacoast engaged the Corporation for Supportive Housing (CSH) to facilitate this work using the CSH Charrette process. The CSH Charrette is specifically designed to

> *"To achieve great things, two things are needed; a plan, and not quite enough time."* -Leonard Bernstein

help communities address key issues in ending homelessness at the local level. Similar to a traditional architectural Charrette, the CSH Charrette provides a fast-paced but thorough exploration of the critical aspects of developing plans and action steps. CSH Charrettes capitalize on local and external expertise as well as the community organizing principle of engaging stakeholders in a dynamic process.

The goal of this Charrette was to produce a feasible set of recommendations to inform the creation of the community's Plan to Prevent and End Homelessness, benefitting from the support of stakeholders throughout its implementation. After the Charrette process, the community can begin the process of developing an annual action plan leading to implementation.

Summit Planning Committee: The Summit Planning Committee came together following a kick-off meeting on September 3, 2014, and met for just over two months to determine issue areas, conduct community outreach (including two public meetings the first week in October), and help secure experts. (*See Appendix A for list of Committee members and Charrette participants*).

Charrette Week kicked off on November 18, 2014 with one full day of intense dialogue at the Cottage by the Bay in Dover, NH. The conversation focused on three issue areas:

- Increase Access to Primary and Behavioral Health Care for Persons Experiencing Homelessness
- Improve Coordination and Increase Capacity of the Homeless Services Network of Community-Based Organizations and Providers
- Increase Access to Permanent Housing

Each conversation occurred in a "fishbowl" setting with a group of experts sitting in a circle surrounded by outer circles of community stakeholders. For the first hour, the local and external experts engaged in a dialogue that encouraged thinking of new systemic and programmatic responses in the issue areas. Experts from diverse communities and organizations drew from their experiences and expertise to exchange views and craft suggestions for moving forward. (*A full list of experts with their biographies is in Appendix B.*)

While the expert dialogue occurred, the rest of the Charrette participants observed the discussion without comment. Half way through, the conversation among the experts ended and CSH facilitated audience observations and feedback. During this time, the experts were not allowed to respond, and community members were given ample opportunity to agree with or challenge the experts and to offer other suggestions on the issue areas. The purpose of this part of each fishbowl session was to engage a broad range of community members in the discussion and benefit from their expertise and experiences.

Following the intensive public process, CSH distilled the information into draft recommendations for each of the three issue areas. This was presented at an open community meeting on November 19, 2014 at Cottage by the Bay in Dover, NH. At this session, CSH heard input on how well the recommendations did or did not reflect the learnings from the Charrette process. The feedback session also tested the recommendations to gauge their likelihood for implementation. The feedback session for Greater Seacoast was highly productive with helpful comments from everyone who attended. CSH staff incorporated the feedback in this final report and presented it to the Summit Planning Committee on December 18, 2014.

THE NATIONAL CONTEXT

Federal Plan to Prevent and End Homelessness

In 2010, the U.S. Interagency Council on Homelessness (USICH) published Opening Doors: Federal Strategic Plan to Prevent and End Homelessness and can be accessed by visiting www.usich.gov. Opening Doors notes that while communities across the country have made significant progress; homelessness continues to be a problem that we must begin approaching differently to effectively prevent and end homeless in our communities. As the plan states, "no one should be homeless – no one should be without a safe, stable place to call home". The goals of the plan are to:

- Finish the job of ending chronic homelessness by 2016;
- Prevent and end homelessness among Veterans by 2015;
- Prevent and end homelessness for families, youth and children by 2020; and
- Set a path to ending all types of homelessness.

It is important that local plans to prevent and end homelessness align with Opening Doors. (See Appendix E to identify how local plan to prevent and end homelessness can align with Opening Doors.) It is essential to remember that the Greater Seacoast plan is part of the larger national context of plans to end homelessness and these documents should help guide your implementation as your move forward in turning the recommendations of this plan into an action plan.

HEARTH Act Legislation

In 2009, the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) was signed into law at a federal level and significantly changes the manner in which resources for homelessness can be used and how communities performance is evaluated. The HEARTH Act requires local agencies and key stakeholders to work closely together to share data and coordinate services to prevent homelessness and move households experiencing homelessness into permanent housing rapidly. Additionally, communities will be evaluated on reducing the overall number of people experiencing homelessness, reducing the recidivism of people returning to homelessness, and reduce the length of time that people remain homeless (i.e. length of time living in places not meant for

human habitation, staying at a shelter and/or transitional housing). Communities will be required to have a coordinated assessment process to connect the households at-risk and experiencing homeless to the most appropriate housing intervention, i.e. prevention, diversion, shelter, permanent supportive housing, rapid re-housing, affordable housing, etc. It is important that the Greater Seacoast plan contain HEARTH Act required measures (length of time homeless; recidivism; access/coverage (thoroughness in reaching persons experiencing homelessness); and overall reduction in number of persons experiencing homelessness. Under the HEARTH Act competitiveness for funding will be determined by the strength of the community outcomes and performance and not just on individual agency performance so it is imperative that there is a focus on increased performance, outcomes and collaboration among all partners in the local homeless system. The HEARTH Act requires communities to have a Plan to End Homelessness, which reinforces the importance of the work of the Charrette and the work the community will be doing to move this effort forward to ensure that the Greater Seacoast is competitive for federal funding.

RECOMMENDATIONS

These recommendations represent ideas presented in the Fishbowl sessions that will have the most impact on creating the Greater Seacoast's Plan to Prevent and End Homelessness. During the fishbowls a total of 39 recommendations were made (See Appendix C for the complete list of recommendations). During the feedback session, participants prioritized the 39 recommendations into a list of 9 recommendations – 3 from each Issue Area. The 9 recommendations are presented in this report.

Issue Area 1: Improve Access to Primary and Behavioral Health Care for Persons Experiencing Homelessness

With a national awareness and push towards affordable healthcare that integrates primary and behavioral healthcare, there are new models that could better serve persons who are experiencing homelessness. Across the country, many hospital emergency departments are treating individuals who visit hospitals multiple times a year, often because of complex physical, mental, and social needs. These frequent users often experience chronic illness, mental health, and substance abuse disorders and homelessness, all of which can contribute to frequent emergency department visits. Emergency departments are a community resource and are the only health care resource that by law must serve everyone—but they also provide the most expensive health services in our communities. Frequent users' hospital visits can account for disproportionate costs and time for emergency departments, contribute to emergency department overcrowding, and drain state and county health care resources. Persons experiencing homelessness and mental illness/chronic substance abuse are at increased risk of trauma related injuries and may exacerbate their mental health conditions. Few emergency shelters and transitional housing programs admit persons who have mental health illness or chronic substance abuse issues (especially those who are intoxicated) and even fewer will admit persons who are on mental health medications. At the same time, New Hampshire has signed a settlement agreement with the U.S. Department of Justice to ensure community integration (including housing and services) for persons with serious mental illness.

> **BEST PRACTICE**
> **Community Care Teams**
>
> People experiencing homelessness often demonstrate need in more than one category of services. The absence of coordination between provider entities often undermines the benefits that one may derive from those services. In most communities the people who visit the ED most frequently are over-represented by those experiencing homelessness or at risk of becoming homeless (often between 25-35%).
>
> To overcome these barriers, various collaborative service models are being developed in communities around the country. Often called a "Community Care Team (CCT)," these initiatives are typically comprised of representatives from the agencies that most typically come in contact with, and provide services to people who are frequent visitors to EDs. By meeting face-to-face on a regular basis a CCT can review cases and create a unified action plan for serving specific individuals. The CCT model helps to overcome typical barriers of communication between agencies, reduces the likelihood of client's "bouncing" between agencies, and provides a structure for conducting more thorough follow-ups to plans created among and between agencies.
>
> Three important features of CCTs must be established up front. First, an identification, prioritization and referral mechanism is needed. Second, the CCT establishes a release of information that allows for the sharing of information between participating agencies. Third, an individual must be employed and supported to engage participants and facilitate the execution of the care plan.
>
> Agencies involved in CCTs report that their participation pays dividends far beyond the one hour spent weekly in case conference, enhancing the efficiency and quality of their services to their respective and common clients.

Key Questions:
- How can we ensure that persons experiencing homelessness have access to the Mental Health Services they need, when they need them?
- Can Health Care Systems improve their process for discharge planning to ensure that no persons are discharged into homelessness?
- How do we increase access to Health Care Services (specifically mental health / medical respite care)?
- How can we improve access to Substance Abuse Treatment and Services (specifically for populations who are ready for treatment but cannot get in to treatment)?
- Housing options limit access to the level of healthcare that is needed and vice versa; how can we work together in a collaborative system?
- How do we increase access to Home Health Care Services for persons experiencing homelessness?

"Often a small thing can make a huge difference. In the case of one patient, one health care appointment made the difference in getting both his housing and his health stabilized."
– Charrette Participant

### Primary and Behavioral Health Care Recommendations:

1. 1 Institute a Community Care Coordination Team in each Seacoast Community with a hospital (Exeter, Portsmouth, Dover, Rochester), using data driven identification of frequent visitors to the ED, housing status screening and creation of services plan triggered by standing orders and regular progress monitoring.

1. 2 Pursue options for provision of Medical Respite Care in the Seacoast Region, beginning with needs assessment and making business case for participating hospitals, considering evidence from numerous emerging models.

1. 3 Improve access (lower threshold) to Mental/Behavioral Health Services for people experiencing homelessness and the portability of services across jurisdictions (break down geographical boundaries).

Issue Area 2: Improve Coordination and Increase Capacity of the Homeless System Network of Community-Based Organizations and Providers

Building capacity for providers within the homeless system requires clearly defined roles and responsibilities, communication strategies and coordination among all parties. Successful coordination processes can help communities move toward their goal of ending homelessness by eliminating duplication and matching people with the housing and services they need, while quickly connecting to those resources.
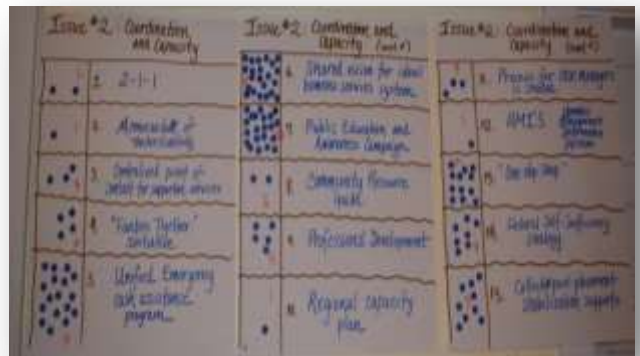
Key Questions:
- What gaps exist in the coordination of care and services?

- How do we better coordinate care provided to persons experiencing homelessness?
- How can the various sectors work together, and include those who have experience homelessness?
- All service organizations collect data about the persons they serve. How do we better coordinate the collection of that data in order to more fully understand the challenges people face, the services they receive, and to track outcomes from a systems perspective?
- Case management means different things to each person, agency, and system. How do we standardize Case Management services based on best practices to ensure the best possible outcomes for the persons being served? What would a job description for case management need to include?
- What service barriers exist within the homeless system that prevents people from ending their episode of homelessness?
- How do we improve access to services? Can the existing coordination efforts do this? Do we need to create/refine an existing effort to improve access to services?
- Are people being served most appropriately with the inventory of services available?
- Is there anything missing? If so, why and what is the best way to address that?

Coordination and Capacity Recommendations:

"As providers we need to stop being so tied to our priorities, because when we stick to our priorities we fragment. We need to find better ways to coordinate and be more nimble, and funders need to allow organizations and collaborations to try new things without penalizing them if they don't work at first."
- Charrette Participant

2.1. Create a unified emergency cash assistance program that pools funding from multiple sources (i.e. faith, civic, philanthropy) to streamline these resources, reduce the difficulty in navigating the process, and allow for expediency and flexibility in mixing and matching resources to best benefit the client.

2.2. Create a shared vision for the ideal homeless services system involving a systems analysis process, developing a Program Models Chart, mapping how persons flow through the system and developing projections for housing and services that meet the needs of persons experiencing homelessness.

2.3. Create a Public Education and Awareness Campaign to tell the story of persons experiencing homelessness and the outcomes of the Homeless System (i.e. host a Project Homeless Connect).

Issue Area 3: Increase Access to Permanent Housing

Housing is a fundamental need that every resident has; a safe, decent, affordable place to call home. Housing options for many in our community who annually earn less than 80% or below of Area Median Income are fewer and are accompanied by barriers such as accessibility, affordability, poor quality and insufficient quantity.

Our challenge is to think outside the box to develop innovative ways of overcoming barriers to accessing current housing units, developing new units, improving housing quality, balancing housing costs with incomes, and developing new housing options that are effective at preventing and ending homelessness.
Preventing homelessness in our community requires us to close the front door of the Homeless Prevention and

Response System. Existing cash financial programs are extremely important in helping those who are living in poverty maintain their permanent housing. Homeless prevention requires us to target financial resources and services on those who are most at-risk for becoming homeless. Prevention can help our community reduce the size of our homeless population by aiding households to preserve their current housing situation. This ultimately reduces the number of   people entering the Homeless System and the demand for shelter and other programmatic housing beds.

Permanent Supportive Housing and Rapid Re-Housing are innovative and proven solutions to some of communities' toughest problems. Both models combine affordable housing with services. Permanent Supportive Housing helps people who face the most complex challenges

to live with stability, autonomy and dignity. Whereas Rapid Re-Housing targets individuals who have less complex challenges reintegrate back into community once becoming homeless and connects with mainstream services necessary to retain permanent housing.

Permanent housing is defined as housing where tenants have leases that confer the full rights, responsibilities, and legal protections under Federal, state, and local housing laws. Tenants are educated about their lease terms, given access to legal assistance, and encouraged to exercise their full legal rights and responsibilities.

People who are experiencing homelessness face many barriers- poor credit, criminal records, behavioral issues stemming from addictions and mental illness – topped off with insufficient transportation, lack of financial stability, childcare, employment options and constrained community based supports. Ensuring that persons experiencing homelessness have access to the necessary services to help them live independently in the community is a necessity.

Key Questions:
- How can we improve access to Public Housing Resources?
- Even with such a tight private rental market, are there opportunities to open up more units through landlord outreach, a risk mitigation pool, or other tools?
- How do we engage open market landlords and Housing Authorities to participate in ending homelessness? Do they have a role in stabilizing and preventing people from becoming homeless?
- How do we engage mainstream resources to provide housing stabilization services and supports? What role do mainstream resources play while persons are in the homeless system and once they have been permanently housed?
- For people experiencing homelessness or are on the verge of homelessness, incomes barely meet the costs of current housing – are there promising practices in terms of rent assistance and subsidies that can help provide affordable housing?
- How should we target our limited prevention resources to support the goals of reducing annual instances of homelessness?
- What are the critical points/systems where   homelessness can be prevented? How can we integrate these other systems into our prevention strategy?

BEST PRACTICE
Working with Public Housing Authorities

PHA's administer a powerful resource for creating supportive housing for homeless and extremely vulnerable populations – through Housing Choice Vouchers and their public housing stock. Particularly in today's difficult funding environment, capacity and experience serving extremely low-income individuals and families, make them critical partners in our efforts to create supportive housing and end homelessness.

http://www.csh.org/news/focusing-on-public-housing-authorities-role-in-ending-homelessness

> *"People experiencing homelessness need to be allowed to make mistakes, just like everyone else, and not lose their housing because of it."*
> – Charrette Participant

- How do we increase access to and production of Permanent Supportive Housing? Are there creative development opportunities worth exploring for deeply affordable and permanent supportive housing?
- Do stakeholders understand the housing first approach? Do most agencies support a housing first approach? If not, what is the typical response? Does it work as well or better than housing first?
- How do we target the Chronically Homeless, a sub-population that is most in need of Permanent Supportive Housing?
- Do community members and local business understand the cost-savings of Permanent Supportive Housing and Rapid Re-Housing versus a costly homeless system? How do we illustrate this and generate support?

Permanent Housing Recommendations:

3.1 Develop a coordinated outreach program for landlords, including peer-to-peer education and outreach, to educate them about the value/benefits of supportive services for tenants.

3.2 Define and quantify categories of homeless populations in order to prioritize planning and implementation of housing solutions.

3.3 **Create a shared Seacoast advocacy platform to increase permanent housing options for persons experiencing homelessness** by partnering with Housing Action New Hampshire.

3.3.a. Advocate for the New Hampshire Housing Trust Fund to have annual appropriations with an incremental increase and pursue targeted funding for the homeless.

3.3.b. Convene Seacoast region public housing authorities to revise their administrative plans to allow for best practices and a homeless priority for project based public housing and rental assistance vouchers.

3.3.c. Advocate changing the Qualified Allocation Plan to include a 10% set-aside or a minimum of 1 unit for the homeless in all new affordable housing projects utilizing the LIHTC program.

3.3.d. Increase low income housing related to federal and state funding sources, (i.e. PHAs, CDBG, HOME, HOPWA, LIHTCs), addressing exclusionary zoning.

Implementation

A plan is only as good as its implementation. In addition to the previous recommendations on specific strategies, CSH recommends the following to help ensure a successful implementation of the plan.

Implementation Recommendations:

4.1 **Create the infrastructure to implement the Plan.** Greater Seacoast Coalition on Homelessness employs one part-time person to work on multiple tasks. In communities across the country, plans that are implemented well often are a result of paid full time position whose job is to "work" on the plan. Consider seeding one position that is fully focused on plan implementation with other organizations' staff to support the coordination for other subcommittees. Foundations that support systemic change and bigger impact work would be appropriate places to approach for seed funding resources.

4.2 **Consider how you phase out each of the action areas and strategies.** Assign timelines and remember that not all of the work will happen immediately. Create a table for each action area and strategy that you develop with attainable timelines, how you know you are successful, and person(s) responsible. Prioritize what you need to do and can do. (*See Appendix D*)

4.3 **Repurpose existing committees instead of creating new committees.** There will be meetings to work out the details of implementing the plan, if there are existing committees doing work, attach those committees to the plan rather than creating parallel processes. For example, the Steering Committee could become the group that manages the overall implementation. Also, once a committee has done its work, do not be averse to ending that committee.

4.4 **Create early wins and projects.** This will keep people engaged and interested. Ideas include:

4.4.1 Identify the longest shelter stayers in all the shelters and prioritize them for housing placement and assistance to get out of the shelter with a "whatever it takes" approach.

4.4.2 Work with providers to create a functional and comprehensive resource guide (either printed and/or electronic).

4.4.3 Tell the public the successes of the Coordinated Assessment Process and what it has shown you about persons experiencing homelessness within the Greater Seacoast.

4.5 **Engage elected officials**. A few local elected officials participated in the Community Meetings and the Charrette. Identify opportunities for them and other elected officials to be publicly involved in the implementation of the plan – whether through a ribbon cutting ceremony, a press conference, etc.

4.6 **Create a Consumer Advisory Council.** Persons experiencing homeless and/or formerly homeless should have a say in the plan's implementation. A council that is led and directed by people who understand the causes and solutions to homelessness is a tremendous enhancement to any plan implementation effort.

CONCLUSION

It is an honor to present this report to the Greater Seacoast Coalition to End Homelessness partners, key stakeholders, and all Charrette participants. Through this intensive and inclusive community process, CSH witnessed the many strengths, opportunities and challenges in the Greater Seacoast and the recommendations of this Report outline a plan for capturing and addressing them to assist the community in preventing and ending homelessness. This Report and the Implementation Plan that the community will develop as a result, should be treated as living documents that are flexible and responsive to community needs as well as tools to evaluate efforts moving forward. Coming together as a community to create a plan to prevent and end homelessness is an audacious goal that at times may feel overwhelming; however, Greater Seacoast has thoughtful, passionate and committed leaders from elected officials, agency staff, government partner, individuals experiencing and at-risk for homelessness and many others to undertake the task of providing housing and services to the most vulnerable in the community.

CSH used the notes collected through the fishbowl discussions, community feedback and observations to create the 'word cloud' below (created via www.wordle.net). Within the word cloud the larger the word, the more often that word appeared in the notes taken from community feedback before the Charrette and the notes during the Charrette week. For the Greater Seacoast Charrette, the word "Housing" was used most frequently of any word, serving as a great reminder that this work goes beyond creating plans, housing options, appropriate services, discharge planning, and many other tasks, but most importantly it involves touching people's lives to help them access and maintain housing.

APPENDIX A: STEERING COMMITTEE MEMBERS AND PARTICIPANT LIST

Greater Seacoast Coalition Steering Committee Members
Maria Sillari, Director
Greater Seacoast Coalition on Homelessness

Betsey Andrews-Parker, Executive Director
Community Action Partnership of Strafford County

Mary Oplinger, Executive Director
Fair Tide, Inc.

Martha Stone, Executive Director
Cross Roads House

Helen Taft, Executive Director
Families First Health and Support Center

Craig Welch, Executive Director
Portsmouth Housing Authority

Lauren Wool, Senior Director Community Impact
United Way of the Greater Seacoast

Summit Planning Committee Members
Maria Sillari, Director
Greater Seacoast Coalition to End Homelessness

Pati Frew-Waters, Executive Director
Seacoast Family Promise

Sandra Beaudry, Program Director
Cross Roads House in Rockingham County

Betsey Andrews-Parker, Executive Director
Community Action Partnership of Strafford County

Lauren Berman, Welfare Director
City of Somersworth in Strafford County

Susan Durkin, Clinical Director, Healthcare for the Homeless
Families First Health and Support Center

Mary Oplinger, Executive Director
Fair Tide, Inc.

Lauren Wool, Senior Director Community Impact
United Way of the Greater Seacoast

Participant List
DAY 1 –November 18, 2014

Betsey Andrews-Parker, Community Action Partnership of Strafford County
Mary Anzmann, NH Housing Finance Authority
David Balian, Towns of Barrington and Northwood Welfare Department
Tara Ball, Seacoast Family Promise
Keith Bates, Rockingham Community Action
Sandra Beaudry, Cross Roads House
Lauren Berman, Somersworth City Welfare
Cindy Boyd, United Way of the Greater Seacoast
Alix Campbell, Community Action Partnership of Strafford County
Adam Cannon, City of Portsmouth
Jennifer Carroll, Seacoast Family Promise
Cleo Castonguay, Society of St. Vincent DePaul, Exeter
Michelle Claflin, Community Partners and ServiceLink
Judy Clark, Seacoast Family Promise
JoAnne Coles, NH Division of Children, Youth and Families
Sandi Coyle, Seacoast Public Health Network
Dianne Dean
Ramona Dow, United Way of the Greater Seacoast/CASH Coalition/Portsmouth Catholic SHARE Program
Susan Durkin, Families First Health and Support Center
Emily Edgerly, Families First Health and Support Center
Meghan Farrell, United Way of the Greater Seacoast
Drew Fitch, Atlantic Development, LLC
Maggie Fogarty, American Friends Service Committee
Pati Frew-Waters, Seacoast Family Promise
Ellen Groh, Concord Coalition to End Homelessness
Suzan Harding, Portsmouth Regional Hospital
Marion Harris, The Salvation Army
Tracy Hayes, Rochester Police Department
Carol Heald, Child and Family Services of NH
Martha Jo Hewitt, Tri-City Consumers' Action Co-Operative
Sr. Helene Higgins, Catholic Charities NH
Anne Holliday, Anne Holliday, CPA, PLLC
Barbara Holstein, Rochester Youth Reach
Ashlee Iber Imenti, Workforce Housing Coalition of the Greater Seacoast
Tory Jennison, Health and Safety Council of Strafford County; Rochester Youth Reach
Christine Johnson, York County Community Action Corporation
Paul Kayne, Portsmouth Catholic SHARE Program
Erin Kelly, Child and Family Services of NH
Chris Kozak, Community Partners
Allan Krans, Dover Housing Authority
Kelly Mann, Portsmouth Housing Authority
Todd Marsh, Rochester City Welfare
Robin McLane
Brianna McLaughlin, Child and Family Services of NH Street Outreach Program

Dan Mitchell, Cross Roads House
Nancy Montgomery, NH Bureau of Elderly and Adult Services
Lena Nichols, Dover City Welfare
Robert O'Connell, My Friend's Place
Mary Oplinger, Fair Tide, Inc.
Kenn Ortmann, Community Action Partnership of Strafford County
Danielle Riss, Portsmouth Regional Hospital Behavioral Health Unit
Heather Roberge, York County Community Action Corporation
Angela Roberts, Harbor Homes Supportive Services for Veteran Families
Cheryl Robicheau, Community Action Partnership of Strafford County
Colleen Ryan, Fair Tide, Inc.
Quinn Slayton, United Way of the Greater Seacoast
Martha Stone, Cross Roads House
Erik Swanson, Community Action Partnership of Strafford County
Helen Taft, Families First Health and Support Center
Amanda Totte, Portsmouth Regional Hospital Behavioral Health Unit
Theresa Tozier, Seeds of Faith, Inc.
Ellen Tully, City of Portsmouth Welfare Department
Susan Turner, Rockingham County Community Resource Network
Jessica Vaughn-Martin, United Way of the Greater Seacoast
Jan Walsh, Fair Tide, Inc.
Senator David Watters, NH Senate
Craig Welch, Portsmouth Housing Authority
Debra Wilson, Paul School
Lauren Wool, United Way of the Greater Seacoast
Molly Zirillo, Society of St. Vincent DePaul, Exeter

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Mary Anzmann, NH Housing Finance Authority
Keith Bates, Rockingham Community Action
Sandra Beaudry, Cross Roads House
Marcie Bergan, SENH Habitat for Humanity
Cindy Boyd, United Way of the Greater Seacoast
Adam Cannon, City of Portsmouth
Michelle Claflin, Community Partners and ServiceLink
Sandi Coyle, Seacoast Public Health Network
Simon Delekta, NH Charitable Foundation
Ramona Dow, United Way of the Greater Seacoast, CASH Coalition, Portsmouth Catholic SHARE Program
Meghan Farrell, United Way of the Greater Seacoast
Maggie Fogarty, American Friends Service Committee
Christine Johnson, York County Community Action Corporation
Paul Kayne, Portsmouth Catholic SHARE Program
Allan Krans, Dover Housing Authority
Cathy Kuhn, Families in Transition, NH Coalition to End Homelessness
Robert Lister, Mayor, City of Portsmouth

Kelly Mann, Portsmouth Housing Authority
Todd Marsh, Rochester City Welfare
Briana McLaughlin, Child & Family Services of NH, Street Outreach
Dan Mitchell, Cross Roads House
Nancy Montgomery, NH Bureau of Elderly and Adult Services
Robert O'Connell, My Friend's Place
Mary Oplinger, Fair Tide
Kenn Ortmann, Community Action Partnership of Strafford County
Cheryl Robicheau, Community Action Partnership of Strafford County
Martha Stone, Cross Roads House
Erik Swanson, Community Action Partnership of Strafford County
Helen Taft, Families First Health and Support Center
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Craig Welch, Portsmouth Housing Authority
Jessica Vaughn-Martin, United Way of the Greater Seacoast
Deb Wilson, Paul School
Lauren Wool, United Way of the Greater Seacoast

APPENDIX B: CSH STAFF AND EXPERT BIO'S

CSH Staff

Susan Starrett, MPH, Senior Program Manager, CSH Consulting and Training Division

Susan Starrett has over thirteen years of experience with homeless programs and system change efforts, including comprehensive knowledge of HUD homeless assistance programs, HIV/AIDS programs, HMIS, and the HEARTH Act, with proven success in project management. Currently a Senior Program Manager for Consulting and Training at CSH, Ms. Starrett develops policies and programs to help end homelessness in communities through systems change and capacity building. She provides technical assistance, develops and delivers trainings and webinars, and creates written products for HUD Technical Assistance, HEARTH policy work and other systems change efforts. Prior to joining CSH, Ms. Starrett was the Executive Director of the Homeless Planning Council of Delaware, a nonprofit organization whose mission is to prevent and end homelessness in Delaware. Ms. Starrett led the systems transformation process of Delaware's Homeless Prevention and Response System to one focused on the prevention, diversion, coordinated assessment, and placing of persons experiencing homelessness in permanent housing. Ms. Starrett is the Board President of the Delaware Housing Coalition, Chair of the Delaware Birth to Three Interagency Coordinating Council, and member of the 2014 Class of Leadership Delaware. Ms. Starrett earned a master's degree in public health from Drexel University and her bachelors from the Pennsylvania State University.

Kevin Irwin, Senior Program Manager, CSH Government Affairs and Innovations

Kevin Irwin has over 18 years of experience in public health policy, consulting, training, teaching, research, and services delivery related to supportive housing. As a Senior Program Manager in the Government Affairs and Innovations Division, Mr. Irwin's work is focused on building and supporting research and evaluation activities throughout the organization. He has worked as a consultant/TA provider for CSH on various projects since 2003. He joined CSH full time in 2012 to support efforts that advance housing as a platform for integrating services that enhance individual and community health and well-being, facilitate systems change, and improve the efficiency and impact of public and private funding. Prior to joining CSH, Mr. Irwin spent twelve years as a Research Associate in the Yale University School of Public Health, on the faculty of the Community Health Program at Tufts University, and as a consultant for supportive housing and harm reduction programs throughout the US and overseas. The foundation of his work is comprised of several years of direct service experience that includes community outreach, drug and alcohol counseling, and supportive services in transitional and supportive housing.

Experts

Laura Archambault

Laura Archambault has been the Supportive Services Manager in the Resident Services Division at Rhode Island Housing since 2006. In this position she developed and implemented Road Home a Rhode Island Housing financed supportive housing program, organized the development and implementation of Opening Doors Rhode Island, created a universal wait list for filling PSH vacancies and oversaw 8 successful SHP/CoC program applications. Opening Doors Rhode Island was adopted by the Rhode Island Housing Resources in March of 2012. It is a document that includes the input of 130 stakeholders' expertise and experience in homelessness throughout Rhode Island. Since that time, there has been a net increase of 150 units for the Chronically Homeless, adoption of the housing first model by CoC sub-recipients, and PHA participation.   Rhode Island Housing has provided resources to implement the plan including $2.3 million for Road Home, a prioritization of homeless and those in PSH ready to move on through the HCVP program, and development funds for new PSH units.   In order to ensure these resources targeted the most vulnerable, Laura developed a Universal Wait List process in 2010 from which Road Home, CoC projects and State Rental Assistance programs pull persons to house. The process now incorporates the common assessment tool for the CoC and prioritizes people by vulnerability. Rhode Island Housing is the Collaborative Applicant for the Rhode Island Continuum of Care.

Laura is charged with writing and submitting the Continuum of Care Program consolidated application and providing guidance and information to the Continuum of Care Board.

Maureen Beauregard

Maureen A. Beauregard is the President and founder of Families in Transition. She started the agency nearly 20 years ago working with five homeless women and their children and has grown the agency to where it is today, serving over 170 families and 180 children on each given night. She is responsible for oversight of all aspects of the agency, including programmatic, financial, fund raising, project development, and policies. Prior employment includes working for the State of New Hampshire, Division for Children Youth & Families as a social worker working with abused and neglected families. She also worked for Phoenix East as a substance abuse counselor in a halfway house. Maureen earned her Bachelors of Science Degree in Child and Family Studies from the University of New Hampshire. She is a graduate of Leadership New Hampshire. Currently, she sits on the Board of Directors of the Greater Manchester Chamber of Commerce and is an Advisory Board Member of the New Hampshire Charitable Foundations Manchester Region. Maureen is the Chairperson of the Manchester Continuum of Care, is on the Governing Council of Housing Action New Hampshire, and is the Chairperson of the New Hampshire Inter-agency Council on Homelessness. Over her career, Maureen has been granted numerous awards including the YMCA Susan B. Anthony Award, NASW Citizen of the Year Award, Pastoral Counseling's Good Samaritan Award, Citizens Bank Good Citizens Award, Girl's Inc.'s Woman of Achievement Award, NH Commission on the Status of Women – Women's Recognition Award, NH Business Review's Business Excellence Award and the Key to The City of Manchester by Mayor Robert Baines. In 2011, she was named one of six Outstanding Women in Business by the New Hampshire Business Review.

Mary Ann Cooney, RN, MSN, MPH

Mary Ann Cooney, RN, MSN, MPH, is Deputy Commissioner for the Office of Human Services at the NH Department of Health and Human Services. Her responsibilities include leadership and oversight for the following divisions: Division of Child Support Services; Division of Children Youth and Families; Division of Client Services; Division of Family Assistance; Bureau of Homeless and Housing Services; and the Office of Minority Health and Refugee Affairs. In 2008 Ms. Cooney was confirmed for a four year term by the Governor and Executive Council as Deputy Commissioner for the Department of Health and Human Services. Previously, Mary Ann Cooney was the Director of NH Division of Public Health Services. She has also held positions in both acute and primary health care, as well as director level positions in local public health. She received her baccalaureate in nursing from Saint Anselm College, a Master of Science in Nursing Administration from University of New Hampshire, and Master of Public Health from the University of New Hampshire. As Past President of the NH Public Health Association, she is a member of several professional organizations, and she has been an adjunct faculty member for the Master of Public Health Program and the University of New Hampshire.

Alison Cunningham, M.Div

Columbus House, Inc. opened its doors in 1981 to serve people who are homeless or at risk of homelessness by providing shelter and housing and by fostering their personal growth. Alison Cunningham's relationship with Columbus House goes back almost thirty years to 1987, when she served as the Evening Program Director. Although she left in 1989 to pursue other career goals, she remained active within the organization, serving on the Board of Directors until 1996. In 1998 Ms. Cunningham began her tenure as the Executive Director of Columbus House, which she continues in today.

Under Cunningham's leadership, Columbus House has shifted its focus from managing homelessness to finding the solutions to end it. The agency now supports over 300 people in permanent supportive housing across the state, has a robust Rapid Re-Housing program and has been a model for integrating services that help people regain their independence. In October 2013, Columbus House opened the first Respite program in the state, serving 12 people who are homeless in a recuperative care setting.

Cunningham currently serves on the Reaching Home Steering Committee, is the former Co-Chair of the Greater New Haven Opening Doors and has served two terms on the board of directors of the CT Coalition to End Homelessness as well as other boards and committees. She graduated from Yale Divinity School with an M.Div. in 1984 and was awarded an Honorary Degree of Doctor of Humane Letters from Albertus Magnus in 2005.

Kory Eng

Kory Eng currently serves as Assistant Vice President of Community Impact for United way of Mass. Bay and Merrimack Valley (UWMB/MV). Mr. Eng has over 12 years of experience in providing resources and opportunities for low-to moderate income families as both a Director and service provider. Prior to joining United Way Mr. Eng served as Director of Housing Programs at Quincy Community Action where he oversaw a myriad of housing services for low to moderate income families. In his current role Mr. Eng leads a team that works with over sixty non-profit organizations throughout Eastern Massachusetts in providing technical assistance capacity building and approximately 10 million dollars in strategic funding for employment, housing and family financial stability initiatives. He is prior Chairman of the City of Quincy's Fair Housing Committee and The Massachusetts Family Housing Assistance Network and currently serves as Board Chair for The Mass211 information and referral line. He is a graduate of the University of Massachusetts at Amherst.

Janet Laatsch

Janet Laatsch has a health care background as a registered nurse that extends from critical care, home care, ambulatory care and health centers. Janet attended and graduated with her MBA from the Whittemore School at the University of NH in 1991. Anxious to use some of her new skills, she took a management position at the North Shore Medical Center in Salem, Massachusetts.

At the Medical Center, her career blossomed as she continued to take on additional responsibilities. Her interest in community work grew out of the merger between the North Shore Medical Center and Atlantic Care Hospital located in Lynn, Massachusetts. She became involved in many of the grassroots community groups and coalitions, while representing the Medical Center. During this same time, the Medical Center was strengthening its relationship with the North Shore Community Health Center. Janet was sublet to the Health Center as the COO and tasked with turning the organization into a profit center within one year. It was here where she fell in love with the cultural diversity and staff dedication found at most Health Centers. Here she was involved in physician recruitment, contract negotiation, redesign, and information system development, grant writing, etc. Commuting 120 miles a day finally got to her and she took time off to spend with her family. Shortly thereafter, she elected to develop a small grant writing business and successfully wrote grants for AGCHC, health collaboratives and after school programs. Janet lived in Somersworth for 17 years and knew nothing about Goodwin Community Health until she read an article featuring the Health Center.

In 2001, she was hired on a part-time basis to research funding sources and write proposals for the Health Center. Since then, Janet has had many roles, per diem nurse, Quality Improvement/Customer Service Director, Development Director, Facilitator for the Strategic Planning Process, Marketing and Outreach roles, Director of Finance and Executive Director in 2005. Since she became Executive Director, GCH has expanded and integrated oral and behavioral health care into their existing medical services. In 2009, the Health Center purchased land and successfully received grant funding to consolidate their existing facilities into one, centrally located, 32,000 square foot building in Somersworth, which they have occupied for the past four years.

Cullen Ryan

Cullen Ryan has been the Executive Director of Community Housing of Maine, the largest housing provider for homeless populations in the state, since 2004. Cullen has a MA in Counseling and Psychological Services from St. Mary's University (Minnesota), and a background as a direct service provider for homeless and special needs

populations for 27 years with supervisory positions for 19 years. Formerly a licensed clinician, Cullen has provided direct care services, family therapy, and individual/group psychotherapy to homeless adults, families, and adolescents in a variety of clinical and non-clinical settings in three states. Very active at developing collaborations and coalition building, Cullen has continuously been a leader in local, state, and federal policy development and advocacy, actively serving on numerous committees and councils including the Statewide Homeless Council, all three Regional Homeless Councils in Maine, and task forces centered on vulnerable populations. Cullen currently chairs the Board of the Northern New England Housing Investment Fund, the Maine Developmental Services Oversight and Advisory Board, the Maine Coalition for Housing and Quality Services, and was the recent past chair of the Maine Affordable Housing Coalition.

Community Housing of Maine provides supportive housing for homeless and special needs populations throughout the state, and provides advocacy on behalf of these populations. www.chomhousing.org

Maureen Ryan
Maureen Ryan is the Administrator of the New Hampshire Department of Health and Human Services' (DHHS), Bureau of Homeless and Housing Services (BHHS) where she has worked since 2008. The BHHS coordinates state and federal funding of NH Homeless and Homeless Prevention programs and provides leadership, resources and coordination of services. Prior to joining NH DHHS Maureen was the Director of Outreach at HEARTH, Inc. in Boston MA where she oversaw the agencies homeless service programs including Outreach and CoC funded Permanent Supportive Housing, as well as the agencies Representative Payee Program, and Critical Incident Debriefing team. While at HEARTH, Inc. Maureen partnered in conducting an international research study on the precipitators of homelessness in older adults. The findings, titled The Causes of Homelessness in Later Life: Findings of a 3-Nation Study, were published in the 2005 Journal of Gerontology: Social Sciences (May 2005). Prior experience includes roles as the Director of the Lynn Emergency Shelter in Lynn, MA and managing HUD funded Transitional Housing at Shelter Inc. in Cambridge MA.

With a Master's degree in Psychology from Lesley University and an undergraduate degree in Psychology and Communications from St. Bonaventure University, Maureen has been working in the Homeless Services arena since 1997.

Helen Taft
Helen B. Taft, M.P.A. is the Executive Director of Families First Health and Support Center, a community health center, family center, and van based health care for the homeless program located in Portsmouth, NH. The agency began as a prenatal program in 1984 and Helen has been the Director since 1989. The agency opened a family center in 1990, offering parenting and support groups, as well as more intensive home visiting programs. In 1997 the agency became a full service primary care program, and then added dental services in 2002. It became a Federally Qualified Health Center in 2002 when it received its Section 330(h) Health Care for the Homeless grant for a mobile health program. In 2008, the center integrated behavioral health services with primary care and the dental program added mobile oral health for the homeless. Helen has been a member of Bi-State Primary Care Association since its beginning, and has served on the Board of Directors since September 2002 where she has been Treasurer and Vice-Chair. Helen was a founding director of the Community Health Access Network (CHAN) in 2006, a health center controlled network, and has served as the Chair of that Board of Directors. She is currently in her second year as Chair of the NH Oral Health Coalition Steering Committee.

APPENDIX C: ALL RECOMMENDATIONS

<u>Improve Access to Primary and Behavioral Healthcare for Persons Experiencing Homelessness</u>

1. Institute a Community Care Coordination Team in each Seacoast Community with a hospital (Exeter, Portsmouth, Dover, Rochester), using data driven identification of frequent visitors to the ED, housing status screening and creation of services plan triggered by standing orders and regular progress monitoring.
2. Pursue options for provision of Medical Respite Care in the Seacoast Region, beginning with needs assessment and making business case for participating hospitals, considering evidence from numerous emerging models.
3. Implement Housing Status screening at Hospital Intake and Discharge Planning Protocols that ensure housing options for identified patients.
4. Increase availability and access to Substance Use Services (IP and OP) throughout Seacoast – pursue dedicated/priority beds and facilitated access for people experiencing homeless.
5. Improve access (lower threshold) to Mental/Behavioral Health Services for people experiencing homelessness and the portability of services across jurisdictions (break down geographical boundaries).
6. Partner with health care services organizations to promote the establishment of Community Health Worker's to support health care access and utilization via New Hampshire's new (health literacy, transportation, medication management, eco-mapping, etc.).
7. Improve communication and integration between law enforcement, MH/BH and homeless systems.
8. Facilitate sharing HIPAA compliant of personal health information/data across systems through Memoranda of Understanding and Business Associate Agreements.
9. Ensure the facilitation of Medicaid Enrollment, redetermination and prevention of coverage lapse for all eligible beneficiaries.
10. Create opportunity for Seacoast to be represented in 1115 Medicaid Waiver to provide home and community based services that fund supportive services for homeless and formerly homeless population.

<u>Improve Coordination and Increase Capacity of the Homeless System Network of Community-Based Organizations and Providers</u>

1. Outline a clear and reasonable role for 211's involvement in the community as an immediate solution for information and referral. Consider the potential of 211's call center data with HMIS (Homeless Management Information System).
2. Expand the use of Memorandum's of Understanding and Business Partnership Agreements that document roles and responsibilities for intentional collaborations and partnerships to ease communication.
3. Replicate the Coordinated Access Model (one centralized point of contact for diversion and homeless housing placements) for supportive services.
4. Create a "Funders Together" initiative to identify opportunities for funders of homeless services to partner (i.e. creation of Unified Requests for Proposals) to provide flexible funding for innovative pilot projects.
5. Create a unified emergency cash assistance program that pools funding from multiple sources (i.e. faith, civic, philanthropy) to streamline these resources, reduce the difficulty in navigating the process, and allow for expediency and flexibility in mixing and matching resources to best benefit the client.
6. Create a shared vision for the ideal homeless services system involving a systems analysis process, developing a Program Models Chart, mapping how persons flow through the system and developing projections for housing and services that meet the needs of persons experiencing homelessness.
7. Create a Public Education and Awareness Campaign to tell the story of persons experiencing homelessness and the outcomes of the Homeless System (i.e. host a Project Homeless Connect).
8. Create a reliable Community Resource Guide with a regional focus that is in a format that allows for real-time updates.

9. Create professional development opportunities for staff of Homeless Service Providers to build knowledge and skills (i.e. Trauma-Informed Care, Person-Centered Approaches, Motivational Interviewing, etc.).
10. Create a plan ensuring that the system, individual providers, and consumers all have adequate tools and capacity to evaluate and improve system functionality and performance, especially as it relates to the experience of the homeless consumer.
11. Create a process for case managers across agencies, programs and systems to work collectively with shared clients to streamline services provided, de-duplicate services, and ease the demands on clients. The process must include the client as a part of the process.
12. Explore utilizing HMIS to identify shared clients across providers, shared case notes and individual service and housing plans.
13. Explore the creation of a "One-Stop Shop" model of service provision (i.e. bundling services which could include financial capability, access to mainstream benefits, employment training and readiness, etc.) that goes beyond co-location of services.
14. Explore utilizing and expanding the Federal Self-Sufficiency Strategy to address the dis-incentive for low income families to increase their income that leads to the termination of housing and services assistance.
15. Explore a collective approach for providing Post-Placement stabilization supports with the ultimate outcome of increasing individual self-sufficiency.

Increase Access to Permanent Housing

1. Develop a coordinated outreach program for landlords, including peer-to-peer education and outreach, to educate them about the value/benefits of supportive services for tenants.
2. Connect developers with peers and service providers who can demystify the housing of persons experiencing homelessness.
3. Focus on housing the Chronically Homeless population.
4. Define and quantify categories of homeless populations in order to prioritize planning and implementation of housing solutions.
5. Advocate for the NH Housing Trust Fund to have annual appropriations with an incremental increase and pursue targeted funding for the homeless by partnering with Housing Action NH. [Was combined with 9, 11, and 12]
6. Include the Workforce Housing sector in the Greater Seacoast Coalition on Homelessness.
7. Using data from the Systems Analysis retool existing programs based on identified housing needs and realign funding sources to meet the identified needs.
8. Explore the concept of home sharing to increase affordable permanent housing options.
9. Convene Seacoast region public housing authorities to revise their administrative plans to allow for best practices and a homeless priority for project based public housing and rental assistance vouchers. [Was combined with 5, 11, and 12]
10. Increase funding for homeless prevention in order to allow earlier intervention and long term support.
11. Advocate changing the Qualified Allocation Plan to include a 10% set-aside for homeless in all affordable housing projects utilizing the LIHTC program. [Was combined with 5, 9, and 12]
12. Create a shared Seacoast advocacy platform that could be used to increase low income housing related to federal and state funding sources, (i.e. PHAs, CDBG, HOME, HOPWA, LITCs), addressing exclusionary zoning, and partnering with Housing Action NH on state and federal advocacy efforts. [Was combined with 5, 9, and 11]
13. Communicate successes and demonstrate public costs and benefits by using data.
14. Explore the feasibility of the master lease model to serve populations with barriers to entering into leases.

APPENDIX D: MODEL ACTION PLAN TEMPLATE

The Action Plan, at a minimum, should identify action steps associated with each goal and strategy. The action steps should directly correspond to outcome statements that define when the action is successful. The plan should include details such as the entity with lead responsibility, names of participants, and the timeframe for accomplishments. As your community develops its Action Plan, remember that repurposing existing committees can be a good way of utilizing existing efforts without creating redundancies.

The examples below are for the purposes of demonstrating the organization of an Action Plan only. Communities are encouraged to develop a plan for each goal in their Plans to Prevent and End Homelessness. The Action Plan may include a higher level of detail or a greater number of action steps than the examples provided, but keep in mind that this is a summary document to be shared with multiple stakeholders. Detailed "to do lists" that evolve from the Action Plan can be maintained as separate documents. The Action Plan should be as clear and concise as possible in identifying the key actions and outcomes.

Goal 1: Integrate Funding for Permanent Supportive Housing

Strategy	Lead	Key Participants	Timeframe	Action Steps	Desired Outcome
Create a funder group to more efficiently fund supportive housing while reducing administration burden for applicants.	OCHS	OHA, DHS, OHCS, OIFA, VA and DoC Start with those who administer funds and RFP's so they can educate each other and establish buy-in. Then bring the decision-makers to the table.	Group start-up January 2015 – May 2015 First combined funding round 2016	Make a list of potential funding sources.	The group has the right players at the table.
				Share existing timelines and constraints.	Funders have a realistic understanding of what is possible in aligning funding timelines.
				Share existing application forms and identify opportunities to combine.	Agencies spend less time and energy on applications. Funders get clearer information and help each other during reviews.
				Be transparent about funding decisions. Post awards on all funder websites.	Agencies can clearly understand who was awarded funds and why so that they can increase their competitiveness.

Goal 2: Prevent discharging people from institutions into homelessness.

Strategy	Lead	Key Participants	Timeframe	Action Steps	Desired Outcome
Develop a Community Discharge Plan.	TBD	Community agencies, Corrections, Mental Health, Hospitals	First meeting January 2015 Plan established August 2015	Research resources for people leaving corrections, mental health facilities and persons experiencing homelessness.	The community is clear about how these resources can leverage other funds and housing programs to provide housing placement and stability for re-entry.
				Set up a peer-to-peer dialogue among hospitals.	Best practices are shared. Community agencies and hospitals develop ideas for creating respite programs.
				Explore ways to identify people who are frequent users and link those people to permanent supportive housing.	Resources and housing programs are managed to their highest and best use.

APPENDIX E: USICH DEVELOPING AND IMPLEMENTING STRATEGIC PLANS TO END HOMELESSNESS

United States Interagency Council on Homelessness

Preventing and Ending Homelessness in the United States

Developing and Implementing Strategic Plans to Prevent and End Homelessness

The U.S. Interagency Council on Homelessness believes partnerships with local communities are more important than ever. There has been unprecedented collaboration among federal agencies to implement *Opening Doors.* We want to extend and support that strong collaboration to states and local communities.

This document is part of the USICH commitment to provide communities the support to develop and implement plans to prevent and end homelessness or realign their existing plans. It also helps define the roles key stakeholders, including Continuum of Care planning bodies, can play in such plans.

State and local officials, service providers, and local advocates are critical partners in achieving the goals in Opening Doors. Effective communities are implementing strategic plans to prevent and end homelessness tailored to their local needs. USICH strongly encourages the development and implementation of these plans; and they are a requirement of the HEARTH Act of 2009. Community-wide strategic planning is a pivotal step in ending homelessness and has been shown to demonstrably result in decreases in homelessness when the plans are well-crafted and implemented.

Many communities are familiar with Ten Year Plans, which have been advocated by local, state, and national organizations and the previous and current Administrations. For those who have established Ten Year Plans, Community Strategic Plans, or Continuum of Care Plans, USICH is encouraging them to both reassess their community's progress to the goals/objectives outlined in their plan and consider revisiting their plans to align with the subpopulations, goals and timelines given in *Opening Doors* and with new opportunities outlined in the HEARTH Act. For those who do not already have a Ten Year Plan, USICH calls on communities to develop a Community Strategic Plan to prevent and end homelessness guided by best practices and aligned with Federal goals.

USICH recognizes that each community has different strengths and resources, and that the planning process will vary by community. In some communities, Continuums are in the lead. In others, the community planning process will be led by jurisdictional leaders, in others the private sector. Whichever approach is used, all key community stakeholder leadership should be involved, including Continuum of Care and provider representatives. All should be important players in the process. Additionally, sharing data between the Continuum of Care, the Consolidated Plan jurisdictions (other jurisdictions) and other planning entities is strongly encouraged to have a more effective plan. There is no one right path to a comprehensive community plan.

Below, USICH provides some guidelines as a reference for your Community Strategic Plan leaders in development of the plan or in the review of your current Ten Year Plan. These guidelines emphasize the need in Community Strategic Plans for emphasis on all homeless populations, leveraging the use of mainstream resources, and including specific, measureable, and actionable goals in particular. The success of a Community Strategic Plan is found in collaboration between all stakeholders in the planning process to inform a plan for your specific community, no matter what the path is. With the participation of communities in Strategic Planning and in implementation, USICH envisions marked progress to preventing and ending homelessness in America. For those who have Ten Year Plans already in place and are beginning realignment, and for communities looking to begin development of a Community Strategic Plan, USICH encourages community plans to:

- Align with the Federal timelines for ending chronic homelessness by 2016, ending homelessness among Veterans by 2015 and homelessness among families, children and youth by 2020;
- Emphasize all homeless subpopulations – people experiencing chronic homelessness, Veterans, families with children and unaccompanied youth;
- Inform the plan by reviewing local Point In Time, HMIS, and other market/demographic data;
- Include strategies for leveraging the use of mainstream housing, services and funding to meet the needs of those who are homeless and on the brink of homelessness;
- Embrace strategies from *Opening Doors*, which are best practices/evidence-based practices;
- Be informed by Continuum of Care leadership and providers and involve local government, political leadership, foundations, and the private sector;
- Invite action – with action plans that include specific steps, timelines, and responsible parties;
- Contain HEARTH Act required measures – length of time homeless; recidivism (subsequent return to homelessness); access/coverage (thoroughness in reaching persons who are homeless); and overall reduction in number of persons who experience homelessness;
- Include cost estimates and financing strategies;
- Contain measurable goals, performance indicators and targets that are reported on in accordance with HEARTH Act requirements; and
- Include a public relations/communications strategy to disseminate information on plan progress for education and advocacy purposes.

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