Improving Community-wide Targeting of Supportive Housing to End Chronic Homelessness

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The Promise of Coordinated Assessment

CSH
The Source for Housing Solutions

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INTRODUCTION

A decade of research on best practices in serving families and individuals experiencing homelessness has led to significant policy responses at the local and federal level that are transforming the way we approach homelessness in this country. A key program rule instituted by HUD as part of the 2009 HEARTH Act, which governs most of the federal assistance that communities receive to address homelessness, is a requirement for communities to implement a coordinated assessment system for the delivery of housing and homeless services (including prevention resources, shelter, rapid rehousing, transitional housing and permanent supportive housing). This new systems-focused approach emphasizes centralized/coordinated intake and assessment, robust homeless prevention strategies, rapid access to permanent housing using a Housing First approach, strategic targeting, and integration with mainstream systems. As Culhane et al. (2010) noted in their flagship paper on this topic, this new model seeks to turn the homeless system "inside out"- from a fragmented and insular system that focuses on managing homelessness to a nimble crisis-response system that seeks to prevent or quickly resolve it through permanent housing solutions and connection to community-based services[1].

One of the key components underlying this approach is a tiered system of interventions based on cost and service intensity, seeking to provide the maximum number of people with the most appropriate intervention to quickly stabilize them in housing. Accordingly, supportive housing, as a highly intensive and costly intervention, should be targeted at the most vulnerable and costly individuals and families experiencing homelessness. The U.S Department of Housing and Urban Development (HUD) recently released a notice issuing guidance around prioritizing permanent supportive housing units for chronically homeless individuals and families with the highest service needs.

Creating the infrastructure and capacity necessary to successfully coordinate these targeting efforts at the community level is the key to ending chronic homelessness. Coordinated Assessment provides a promising organizing framework to realize this goal. However, the national roll out of Coordinated Assessment has only just begun and achieving community-wide coordination in practice will require significant changes in policy, practice and culture for homeless systems, mainstream services and supportive housing providers.

[1] Culhane, D., Metraux S., Byrne T. (2010) "A Prevention Centered Approach to Homeless Assistance: A Paradigm Shift?" Supplemental Document to the Federal Strategic Plan to End Homelessness. September, 2010; Available at: http://usich.gov/resources/uploads/asset_library/DennisCulhane_PrevCentApproHomelessnessAssist.pdf

OVERVIEW

Coordinated Assessment, if comprehensive and well-integrated with mainstream service systems, can help communities move toward their goal of ending homelessness by improving the speed, accuracy and consistency of the client screening and assessment process and targeting scarce resources more efficiently and accurately in order to be most effective.

This paper describes key factors within homeless systems and the supportive housing industry that impede effective targeting of supportive housing for chronically homeless populations and identifies strategies for building robust Coordinated Assessment systems that successfully address these shortcomings. The paper is broken out into four key sections:

1. It begins by illustrating how many homeless systems today unintentionally – yet systematically - exclude access to some of the most vulnerable and costly homeless populations, namely frequent users of crisis service systems (including jails, hospitals, detox facilities and other institutional settings).

2. The second section discusses ways that communities can build their Coordinated Assessment systems to improve access for highly vulnerable homeless populations.

3. The third section presents promising strategies and data-driven tools that innovative communities across the country are using to effectively target supportive housing for high-need/high cost families and individuals experiencing homelessness.

4. The final section describes various provider and system-level strategies to create efficient pathways to supportive housing for vulnerable populations.

SUPER-UTILIZERS: AN INVISIBLE *BUT COSTLY* POPULATION

One of the primary goals of Coordinated Assessment – which usually involves either a single point of entry or decentralized coordinated entry points – is to create a community-wide entry process into the homeless system. To ensure comprehensive system access, communities must move beyond traditional strategies that simply wait for clients to show up at the "front-door". Experience and research show that this passive approach may systematically exclude a small but significant subset of highly vulnerable populations due to the nature of their homelessness. Often referred to as "Frequent Users" or "Super Utilizers", these highly vulnerable individuals cycle between an array of costly public crisis systems including hospitals, jails, detox facilities, shelters and the streets[2]. They are often banned/trespassed from shelters due to behavioral issues or excluded due to legal restrictions or programmatic requirements (e.g., sobriety). There is also a subset of high-need families that experience repeat homelessness and chronic involvement with crisis health/mental health services, the court system and child welfare agencies (frequently involving out-of-home placements for children). Given the reluctance of many families to use shelter facilities and the fear of having their children taken away, homeless families are far more likely than single adults to be doubled up or living in their cars. These individuals and families, often affected by mental illness, addiction, significant trauma and complex health issues are hard to find, hard to count, hard to engage and nearly impossible to maintain on a waitlist. As a result, they remain largely invisible or inaccessible to many homeless systems.

To ensure comprehensive system access, communities must move beyond traditional strategies that simply wait for clients to show up at the "front-door".

Some examples highlight the social and financial consequences of this gap in our homeless system. The Maricopa Frequent Users Systems Engagement (FUSE) project, a supportive housing pilot for homeless frequent users of emergency health services and jails, found that *none* of the 15 individuals identified and housed through the program were known to or served by the homeless system in the year prior to enrollment[3]. In New York, the Hospital HOPE survey, conducted by 3 hospitals in the Bronx area, identified 62 homeless patients in the hospital on one night that would otherwise have been excluded from traditional point-in-time counts conducted by homeless systems. Hospital social worker reports showed that homelessness was the primary factor delaying discharges for 20 of these patients, accounting for 214 unneeded hospital days[4]. Many of these individuals constitute the "newly medically homeless" populations – patients that become homeless as a result of their hospitalization or medical situation that prevents them from being discharged to their former homes.

Recognizing homelessness as a primary cause of repeat system involvement, but frustrated with the inability of homeless systems to quickly resolve these crises, many mainstream agencies are taking matters into their own hands and partnering directly with supportive housing providers to create a pipeline of units for their

[2] In the recent HUD notice on PSH prioritization, they include high crisis service utilization as an indicator for high service need and factor for prioritization.

[3] The Bronx Health and Housing Consortium March 2014. "Hospital HOPE Survey Snapshot by the Bronx Health & Housing Consortium" Access to article available at: http://www.bxconsortium.org/uploads/2/5/2/4/25243029/hospital_hope_summary_3_14_final.pdf

[4] Maricopa FUSE http://www.csh.org/csh-solutions/serving-vulnerable-populations/health-systems-users/local-complex-health-needs-work/maricopa-fuse/

high-cost clients. In two FUSE programs operating in Washtenaw County, MI and Los Angeles, CA, hospitals are partnering with local supportive housing providers to rapidly identify, house and serve their highest-cost utilizers who are homeless or unstably housed. In these programs, patients are identified through administrative data matches or other data-driven targeting tools, engaged by case managers in hospitals, shelters, jails, detox centers or on the streets and placed immediately into housing. Such super-utilizer programs have emerged in several communities across the country including Denver, CO, Maricopa County, AZ, New York, NY, San Francisco, CA, Los Angeles, CA, Louisville, KY, the State of Connecticut and many more.

Similarly, child welfare agencies are starting to partner with family supportive housing providers to identify and rapidly house chronically homeless families with recurrent involvement in the system using similar targeting strategies. In 2007, CSH launched the Keeping Families Together (KFT) pilot, which placed 29 homeless, child-welfare involved families in New York City into permanent supportive housing. Child welfare agencies identified homeless families with recurrent or long-term system involvement and used vulnerability assessments to prioritize the highest need families for immediate referral to supportive housing providers. This pilot became the basis for a five-year, $25 million federal demonstration project sponsored by the Department of Health and Human Services, Administration for Children, Youth and Families to bring the KFT model to scale in five additional communities – Broward County, FL, Memphis, TN, Cedar Rapids, IA, San Francisco, CA and the state of Connecticut. The initiative will house close to 500 high-need homeless families involved with child welfare systems in supportive housing.

These are extremely promising trends, demonstrating that mainstream systems are recognizing the importance of housing for improving client health, recidivism, parent/child well-being, employment and other outcomes and taking responsibility (financially and operationally) for addressing these issues. It also illustrates that supportive housing providers are increasingly integrating with mainstream systems, leveraging new funding streams and prioritizing units for highly vulnerable and costly individuals experiencing homelessness. However, in most cases, prioritization decisions and coordination activities are occurring at the provider-to-provider or provider-to-system level (e.g. between supportive housing providers and hospitals) rather than at the community-level (through Coordinated Assessment systems). As a result, supportive housing providers - and their supply of units – may become bound to system-specific funding streams and priorities. Ideally, as Coordinated Assessment systems mature, they should play a central role in such efforts to ensure that supportive housing resources are targeted to the highest-need families and individuals across the *entire* community as opposed to one jail, one hospital or one system. Furthermore, by expanding the reach of Coordinated Assessment to include non-homeless systems, communities can significantly increase resources to end homelessness. The following sections discuss ways that communities can build and refine their Coordinated Assessment systems to achieve broader access for highly vulnerable homeless populations, more precise targeting of supportive housing resources and more streamlined pathways to supportive housing.

Building Comprehensive System Access

In order to ensure accessibility to super-utilizers and other hard-to-reach homeless populations, Coordinated Assessment systems must incorporate more aggressive outreach strategies either directly or through partnerships with street outreach teams. In addition to the challenge of physically locating frequent users, engagement is often further complicated by a lack of trust in service providers or symptomatic behavior that is interpreted as service resistance. Building comprehensive system access will require strong linkages and coordination with mainstream public systems (e.g., through discharge processes) and proactive strategies that include persistent street outreach as well as in-reach into institutional settings. These activities can be conducted either directly by Coordinated Assessment staff or homeless outreach workers or facilitated through tight front-line coordination with institutions (jails, hospitals, detox/residential treatment facilities) and other mainstream agencies (court systems, child welfare agencies, health clinics).

To facilitate efficient identification, referral and assessment processes, Coordinated Assessment systems need to develop direct and regular lines of communication with mainstream entities. Lead agencies should create formal data sharing agreements that allow for effective and timely information exchange between systems. In Austin, TX the Coordinated Assessment plan calls for part or full-time co-location of assessment specialists and in-reach activities at jails, hospitals, child welfare agencies and other intersecting systems. Screening and assessments can be conducted while individuals are in jail or hospitalized and Coordinated Assessment staff members should be integrated into the pre-release or discharge planning process. In addition, given the unpredictable nature of crises among frequent users, to effectively meet the needs of systems serving this population (emergency rooms, jails, law enforcement, ambulance services) Coordinated Assessment staff and services can offer

Improving Coordination between Health and Housing Systems: VA Homelessness Risk Assessment

To improve VA's ability to identify Veterans who are at risk of homelessness—or experiencing homelessness but are not accessing services—the National Center, in collaboration with the VA National Clinical Reminders Committee, developed the Homelessness Screening Clinical Reminder (HSCR). This tool, which was implemented in FY 2013, is used to conduct an ongoing, universal screen for homelessness and risk among Veterans accessing healthcare services through the Veterans Health Administration (VHA). This type of tool can be replicated in other hospitals and health settings to improve identification of high utilizers of emergency health services that are homeless or at risk.

The HSCR is comprised of two primary questions intended to assess current housing instability and imminent risk of housing instability:

1.In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household? ("No" response indicates Veteran is positive for homelessness.)

2.Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household? ("Yes" response indicates Veteran is positive for risk.)

Read more here.

extended hours on nights and/or weekends to accommodate urgent referrals and facilitate diversions. At the most advanced levels, cross-system coordination would also include data integration activities or recurrent data matches between homeless data systems (i.e., Homeless Management Information System) and corrections, health or child welfare data systems to identify homeless frequent users. These types of agreements and strategies can help Coordinated Assessment systems broaden and expedite access to emergency shelter or supportive housing for hard-to-reach populations, prevent homelessness before it occurs and help crisis care systems avoid costly admissions or delays in discharges.

Effective integration and coordination will require an equal commitment from mainstream systems to shift policies, practices and resources to identify and address the housing needs of clients in day-to-day operations. One key step would be to incorporate housing status or homelessness as a standard measure that is tracked and monitored in health, correctional, human services and educational settings. For example, homelessness can be included as a "vital sign" in hospital ED screenings or critical indicators in child welfare assessments or jail discharge plans that trigger special actions or intervention. This can include priority access to intensive services, referral for jail in-reach programs or coordinated discharge planning that includes pre-release assessments and housing applications with Coordinated Assessment staff so that housing is identified prior or as close to discharge as possible. Mainstream agencies serving homeless high utilizers should appoint one or more staff members responsible for resolving clients' housing crises and acting as primary liaisons managing communication with Coordinated Assessment systems.

In addition to integration on the front lines, high-level cooperation between systems at the executive and administrative levels is necessary to overcome bureaucratic obstacles, create collaborative financing structures and bring about the culture change necessary to sustain these efforts. Leadership from these various systems - health/mental health, child welfare, criminal justice, substance use treatment, workforce development and schools - should be represented in the local Continuum of Care (CoC) and actively involved in building Coordinated Assessment systems from planning to implementation to evaluation. Moreover, mainstream systems can and must be enlisted to contribute their resources and funding to help finance and create supportive housing, particularly funding for services that will enable providers to successfully support the long-term housing and service needs of frequent users.

By creating deep and broad connections with community based providers and incorporating assertive outreach strategies, homeless systems can ensure access for chronically homeless persons and families who are also the highest utilizers of public systems. These linkages not only help Coordinated Assessment systems improve identification and targeting efforts upstream but also create a more robust network of long-term service supports downstream for highly vulnerable populations. If penetration across mainstream agencies is comprehensive and housing resources are sufficiently centralized, a Coordinated Assessment process can help communities prioritize the most costly and vulnerable individuals and families for supportive housing and maximally leverage these limited resources to end chronic homelessness.

Assessment and Targeting of Supportive Housing

In addition to creating a coordinated community-wide access point(s), HUD mandates that homeless systems implement standardized screening and assessment protocols and tools to determine which intervention is the best fit for a family or individual's needs. Communities have considerable flexibility in the tools they choose to use, which can be tailored to meet local needs. Most involve a numerical scoring system that produces a summary needs/risk score that is matched to pre-determined ranges within a graduated system of interventions (rapid re-housing, transitional housing or supportive housing) based on cost, intensity and duration of assistance. A variety of tools have emerged on the market for this purpose, including the Service Prioritization and Decision Assistance Tool (SPDAT/VI-SPDAT), Transition Age Youth Triage Tool, Arizona Self Sufficiency Matrix, Hennepin Housing Barrier Tool, NAEH Comprehensive Assessment Tool, the Alliance/Prince George's County Tool and others. Once assigned to an intervention, a Vulnerability Index or other prioritization tool can be used to further assess the urgency of need to determine the appropriate provider and placement on a waitlist.

Integrating accurate data on system use and costs is critical if "right-sizing" homeless assistance based on cost-effectiveness is one of the primary goals under the new system.

Shifting to a centralized and uniform assessment process should, at least in theory, help communities more effectively target homeless resources. However, relatively little is known at this point about how these tools are working on the ground and the precision of these various assessment tools for effectively matching individuals' needs with housing interventions. In addition, successful frequent user pilots across the country have shown the importance of using data-driven and utilization-based targeting strategies for identifying hard-to-reach individuals who are not only chronically homeless, but high utilizers of costly public services. Integrating accurate data on system use and costs is critical if "right-sizing" homeless assistance based on cost-effectiveness is one of the primary goals under the new system. While cost should always be carefully balanced against vulnerability in the prioritization process, demonstrating cost-savings associated with interventions will be crucial for engaging mainstream systems, generating political will and leveraging non-homeless funding streams for these efforts.

Over the last few years, CSH has been leading several initiatives across the country that aim to develop supportive housing solutions for homeless high-utilizers (families and individuals) of public systems. These initiatives aim to increase access to quality care, improve outcomes and reduce costs associated with this population. This work has illustrated promising practices in collecting and analyzing administrative utilization and cost data across multiple systems to effectively identify, engage and rapidly house this highly vulnerable and costly population.

One method is to conduct recurrent data matches between individual-level administrative data from two or more systems to spot frequent users and generate an identified list of priority individuals. This replenishing

list of individuals can then be cross-referenced with the current shelter census or other crisis service settings to locate and assertively engage potential program participants. For example, eligibility for a super-utilizer program in Connecticut is determined through a quarterly data match between state HMIS and Medicaid data to identify the highest-cost patients who are also homeless. These lists are shared among a collaborating group of shelters and supportive housing providers within regions of the state to locate and place these individuals into supportive housing. In 2011, the match identified over 4,100 homeless Medicaid beneficiaries. The top 10%, 419 individuals, accrued over $28.5 million in Medicaid costs, equaling about $68,000 on average per person annually. These data matches can also be used to assess the nature and degree of the frequent user problem in a community, which systems are most impacted and the primary risk factors for falling in this population. In cases where an identified list-based outreach strategy is not feasible, the information gleaned from the data matches can be used to define criteria for high utilizers that can be incorporated into the Coordinated Assessment process.

The Cost of High Utilizers

The top 10 percent of homeless Medicaid beneficiaries in Connecticut accrued over $28.5 million in Medicaid costs, equaling about $68,000 on average per person annually.

Another data-based strategy for targeting services is to use de-identified administrative data to develop predictive models that can be used in multiple venues to identify persons at highest risk of long-term homelessness and repeat hospitalization, recidivism or chronic child welfare involvement. The Economic Roundtable developed the Tenth Decile Triage Tool, a rigorously tested tool that identifies the one-tenth of homeless persons with the highest public costs and ongoing acute crises based on various characteristics (length of homelessness, medical diagnoses, past ER or inpatient admissions, etc.). This tool is being used in 14 hospital and jail systems across LA county. Hospital and jail staff survey homeless patients or inmates that come through their systems. Individuals that score in the top 10th decile are immediately referred to the local homeless system for expedited placement into supportive housing following discharge. In other parts of the country, a similar predictive tool is being developed and tested by the Urban Institute that identifies homeless families who are most at risk for long term homelessness and repeat involvement with the child welfare system.

Coupling Coordinated Assessment processes with other data-driven targeting strategies can help communities improve both access to and targeting of limited supportive housing resources for the most vulnerable and costly individuals experiencing homelessness. Testing and refining targeting strategies to fit local need and capacity is especially important in light of the new movement toward a "progressive engagement" model of homeless assistance. Progressive Engagement calls for providing all households seeking assistance with the least amount of assistance possible to start and adding more as needed on a phased basis[5]. This strategy differs from the traditional triage model, which assigns individuals a predetermined level of assistance or full intervention based on an initial assessment. A few communities have built their rapid re-housing programs around the Progressive Engagement model and demonstrated

[5] More resources and information on this strategy are available at: http://usich.gov/population/families/progressive_engagement/

cost savings and successful outcomes for some moderate to high-need families and individuals[6]. As a result, other communities with inadequate supportive housing units to meet demand are starting to further experiment with this strategy, extending it to chronically homeless populations. However, given the variation in service needs of chronically homeless subpopulations, especially over the long term, communities should tread carefully with such experiments. To be sure, research has shown that there is a subset of high-need homeless populations that require more intensive, long-term services and/or housing subsidies in order to maintain stability. Thus, while the Progressive Engagement approach may seem tempting from a potential cost-savings perspective, inaccurate targeting can result in a waste of homeless resources, loss of public trust in the homeless system and tragic outcomes for extremely vulnerable homeless populations[7].

Tracking and evaluating the impact of these various assessment tools on client and community-wide outcomes is critical to identifying best practices and fine-tuning system processes. In addition to front-door assessment tools, communities should strive to incorporate broader data-driven targeting strategies that engage multiple systems and improve cost-based prioritization of supportive housing.

Effective Targeting & Assessment

Tools & Examples Available at csh.org

CSH is supporting several national initiatives utilizing innovative data-driven strategies to target supportive housing to high utilizers of publicly funded crisis services. Learn more at csh.org.

FUSE

Social Innovation Fund

Child Welfare & Supportive Housing Resource Center

[6] For examples see: http://usich.gov/resources/uploads/asset_library/Michelle_Flynn.pdf;

[7] See Washington Post articles on consequences of poor targeting: http://www.washingtonpost.com/local/rapid-rehousing-a-new-way-to-head-off-homelessness/2013/08/18/655507bc-ff89-11e2-96a8-d3b921c0924a_story.html and http://www.washingtonpost.com/local/dcs-plan-to-end-homeless-crisis-prompts-a-different-struggle/2014/08/30/4a1bdf6c-1e40-11e4-ae54-0cfe1f974f8a_story.html

Creating Effective Pathways into (and out of) Supportive Housing

Aside from improved targeting, the systems-approach toward homeless assistance seeks to create more efficient paths to permanent housing. In order to accomplish this, communities need to consolidate housing resources and create processes that improve the flow of clients through their homeless systems. Among other things, this will entail unclogging front-end bottlenecks by rapidly exiting people from shelter and expediting entry into permanent housing as well as clearing back-end blockages by "moving-on" long-term stayers in supportive housing that no longer need those supports to maintain housing stability. Supportive housing providers have an important role to play in creating robust Coordinated Assessment systems that align with these national system transformation goals. Successfully targeting and prioritizing supportive housing for high-need chronically homeless populations requires that these resources, as well as the referral and intake process, are centralized or coordinated. It will also require important shifts in provider policies, practices and culture that can help improve the flow of tenants into - and out of - supportive housing.

Closing the Side Doors

Currently, there are front doors, side doors and back doors into supportive housing in most communities. Providers generally coordinate with several community organizations or programs for referrals, administer their own intake and assessment process and base priority on a first-come first-serve basis, funding decisions or personal relationships. In order to allocate these scarce resources more efficiently across the entire community of individuals and families in greatest need, supportive housing providers must be willing to commit their units to the community-wide process of managing homeless resources. Public and private funders of supportive housing are also an important part of this equation since many providers are often beholden to various funding rules and regulations that restrict units to particular target populations.

In order to allocate these scarce resources more efficiently across the entire community of individuals and families in greatest need, supportive housing providers must be willing to commit their units to the community-wide process of managing homeless resources

It is important to note that this does not mean that supportive housing providers need to relinquish complete control over their inventory of units or the tenant selection process. In fact, many supportive housing providers target other extremely vulnerable and frail populations that may not meet the federal definition of homeless and are referred from institutional settings outside of the homeless system – including seniors living in nursing homes or assisted living facilities, developmentally disabled persons in Intermediate Care Facilities for Individuals with Mental Retardation or group homes and individuals in state psychiatric facilities. While preserving these units for specific non-homeless populations, which could be managed through a separate referral process, supportive housing providers can work with Coordinated Assessment systems to fill those units committed to homeless households through the centralized process.

Continuums can also create flexible referral protocols that preserve some provider control over the admission process (for example by allowing a limited number of refusals each year or instituting case conferencing sessions for disputed cases).

One particular concern raised by many communities is how to balance the goal of centralizing the management of homeless resources through Coordinated Assessment while tending to the interests of health, correctional or other public systems targeting particular sub-populations of the homeless (e.g., frequent users, returning prisoners, child-welfare involved families, etc.). This is especially a challenge as homeless systems seek to develop stronger partnerships and leverage funding from these systems to support services or housing subsidies, as there may be an expectation for prioritizing housing for their referrals. However, communities are developing innovative prioritization strategies to balance these goals while avoiding side-door arrangements and preserving the integrity of Coordinated Assessment systems. For example, some communities have collectively decided to prioritize frequent users for supportive housing and are integrating weighted scoring systems into the Coordinated Assessment process that attach additional "points" for frequent users that bump them up in line for supportive housing units. Additionally, communities can weight the inventory of supportive housing units toward prioritized populations by setting aside a certain proportion of their units for those targeted populations.

The idea of a coordinated entry process for supportive housing may seem very challenging in the face of disparate funding streams and limited provider capacity. Indeed, one of the primary reasons for poor targeting of supportive housing in many communities is limited access to funding for support services. Supportive housing providers often feel that they do not have adequate capacity to successfully house and serve chronically homeless individuals who tend to have higher service needs. If supportive housing providers are going to dedicate their units to Coordinated Assessment referrals and prioritize the highest-need individuals and families, they will undoubtedly need more funding and support to increase their service capacity. With HUD's increasing commitment toward permanent housing solutions, part of this could come through the re-allocation of local homeless assistance dollars managed by Continuum of Care entities. However, building the capacity among supportive housing providers necessary to end chronic homelessness in our communities will only happen by engaging mainstream housing and services systems who have far greater resources than specialized homeless assistance funding streams. If supportive housing resources are centralized across the community under Coordinated Assessment, homeless systems will have far more leverage to tap into these funding streams on a large scale as opposed to several uncoordinated attempts to get a piece of the pie.

Widening the Door to Supportive Housing

In order to successfully house chronically homeless individuals or families through a coordinated entry system, providers may also need to change their admission policies to eliminate barriers to entry and widen the door to supportive housing. Chronically homeless individuals, especially high utilizers of crisis systems, often present with a myriad of complex needs including extreme poverty, substance use disorders, mental illness, trauma, chronic health issues, extensive histories of homelessness, and lack of social connections. Research and experience have taught us that in order to engage many of these individuals in housing or services, these offers need to be persistent and come with few strings attached. To the extent possible, supportive housing providers should adopt a Housing First approach toward admissions, which features "low barrier" or "low demand" tenant screening processes and eligibility criteria that facilitate immediate and direct access to housing from homelessness. Generally, such supportive housing models do not require complex application processes (credit checks, criminal background checks, landlord referrals), and have no

or few requirements for tenants beyond the normal conditions of tenancy (paying rent, not destroying property, refraining from behavior that would harm other tenants or staff). In addition, to increase choice and stability, housing should not be offered on a time-limited basis and providers should make creative accommodations that maximize tenancy and offer an array of housing and service options to meet the entire spectrum of need for this population. This includes single-site, scattered-site, single-adult, family, youth, harm-reduction, and recovery housing options.

Moving On

A survey of supportive housing tenants in New York suggested that 40% of tenants were capable of moving on to more independent settings[1].

Opening the Back Door

In nearly every community with supportive housing, access to units is severely limited with waiting lists that typically go out a year or longer. In large part, this is a critical supply issue that calls for greater investment in both long-term housing subsidies and the construction or acquisition of more supportive housing units. However, inefficient targeting is also a contributing factor. A 2012 analysis released by USICH noted that only one-third of the country's supportive housing units were occupied by persons experiencing chronic homelessness[8]. In the context of shrinking housing resources and the urgency of need, the industry also needs to look at less costly ways of creating more space within their current stock. While supportive housing will be, and should be, the life-time residence for many individuals with severe disabilities, studies suggest that this is not necessarily the case for a significant portion of residents. A survey of supportive housing tenants in New York suggested that 40% of tenants were capable of moving on to more independent settings[9]. CSH has led or supported a number of successful "Moving-On" initiatives in Chicago, New York, Detroit and LA where programs work to enable supportive housing tenants that no longer require intensive services or housing supports to move to more independent housing. Programs report relatively high post- supportive housing retention rates between 85 to 95 percent as well as improved client satisfaction and self-sufficiency[10].

HUD has publicly provided strong support of these "moving-up"[11] or "moving-on" strategies but to date, these initiatives operate on the periphery of supportive housing and only exist on a small scale through scattered pilots. Bringing these efforts to scale will require, first and foremost, additional resources. Programs need access to public housing units, long-term rental subsidies or other affordable housing options that provide attractive and sustainable housing opportunities for tenants. Toward these ends, CoCs can engage local public housing authorities to support a "move-up" strategy where a preference is established for formerly homeless participants residing in supportive housing who no longer require the supportive services. Once identified, these residents can move out of supportive housing units, making space for others

[8] Access analysis here: http://usich.gov/population/chronic/in_focus/
[9] http://b.3cdn.net/naeh/e9e96a83affb80593a_sqm6bpvhk.pdf ;
[10] http://www.endhomelessness.org/page/-/files/3743_file_Moving_on_from_PSH_Final.pdf
[11] See webinar hosted by CPD and PIH on implementing Moving-On strategies: https://www.hudexchange.info/training-events/courses/implementing-a-move-up-strategy-webinar/

in need of these supports, and continue to receive a housing subsidy through the public housing or Housing Choice Voucher programs. In addition, to create sufficiently strong incentives, resources are needed to support transition costs (moving costs, furniture, security deposits, etc.) and limited case management services to ensure stabilization and community connections. Finally, providers need to develop a broad network of partnerships with "friendly" landlords and community-based organizations that can provide flexible housing and connection to services for tenants that may need ongoing supports.

In addition to these post-transition resources, successful scaling of these initiatives will require that providers are able to offer services and opportunities that prepare tenants for independent living and long-term success while living in supportive housing. To be clear, "Moving On" is not about limiting the rights of tenancy, coercing tenants out of their units or otherwise violating the fundamental principle of housing choice. This is about empowering and supporting tenants to willingly take steps toward greater independence. These goals should be reflected in the overall program structure, service planning processes, staff trainings, performance measures and program evaluations. First and foremost, this means that core services must include comprehensive employment programming that includes strong linkages to employers, job/skills training opportunities and mainstream workforce development agencies. Providers can create "Moving-On" service programs or tracks that combine Critical Time Intervention with targeted employment and independent living skills training that link to "graduation" goals and Section 8 vouchers. Such efforts can be combined with Family Self-Sufficiency programs administered through public housing agencies, which assists and incentivizes families supported through Housing Choice Vouchers or public housing to increase their earned income and reduce their dependency on public assistance and rental subsidies[12]. In addition to employment, core services should also include robust recovery supports, wellness self-management practices and tenant leadership opportunities. Tenant goals and outcome measures should emphasize not only connection to services and stabilization but activation, economic advancement, recovery and self-direction of care. In addition, programs should include "graduation" rates or successful exits to independent housing as a key performance measure and consider benchmarks for optimal (rather than just low) turnover rates.

[12] Under the FSS program, low-income families are provided opportunities for education, job training, counseling and other forms of social service assistance, while living in assisted housing, so they can obtain skills necessary to achieve self-sufficiency. Services for FSS program participants are provided through local partnerships with employers and service providers in the community. In addition, for many FSS families, if the family's income and rent share go up during the program, the PHA puts money in a special FSS escrow account. The family gets the money when they finish the program.

Building Effective Bridges to Supportive Housing

The housing needs of chronically homeless individuals and families – particularly frequent users of crisis systems - are often dire. The medical needs of homeless frequent users often preclude diversion or discharges from hospitals because they are too frail to recover from an injury or illness on the streets or in a shelter. Homeless families with open child welfare cases risk losing (or delaying reunification with) their children if they don't have access to a stable home to provide appropriate care. For individuals released from jail or prison, every minute spent on the streets or in shelters increases the likelihood of re-offending, relapse and re-incarceration.

In order to meet the needs of highly vulnerable individuals and strained community systems, Coordinated Assessment systems must be able to create effective bridges to supportive housing when units are not immediately available. Mainstream systems have created direct partnerships with supportive housing providers or created their own housing programs in response to this urgency and the inability of homeless systems to provide rapid access to housing for this population. Through strategic partnerships and creative allocation of funds, Coordinated Assessment systems can build bridges that help mitigate the supply-demand gap in supportive housing.

Coordinated Assessment systems should develop strong partnerships with crisis service programs that operate outside the homeless system but frequently serve homeless populations. This includes medical respite facilities, medical detox and crisis residential centers that provide a bridge of care and housing for medically frail and/or psychiatrically unstable homeless individuals. Coordinated Assessment systems can engage these agencies to negotiate expedited access to beds for high priority homeless individuals. Assessment staff or the responsible case management staff should coordinate with agencies on post-discharge housing plans while individuals are under their care in order to ensure a smooth transition once housing becomes available. Similarly, for households fleeing domestic violence situations, Coordinated Assessment systems should be linked to domestic violence shelters and coordinate with staff to develop housing plans that accommodate their special safety and confidentiality needs.

In addition to these partnerships, communities can also creatively blend funds to support temporary rental subsidies that create a bridge to supportive housing for high- priority individuals and families. For example, The Chicago CoC is using a portion of their Rapid Re-Housing dollars to create a bridge to supportive housing for very hard to house individuals experiencing street homelessness. Once an individual qualifies for a supportive housing unit, a street outreach worker engages with that person to access a bridge unit and helps to stabilize them in housing while all the documentation and paperwork is processed and a permanent unit is identified. In addition, if homeless systems are successful in serving high-need clients identified by mainstream systems, they may be able to leverage some of their resources to fund these bridging mechanisms. In Michigan, the Prisoner Reentry program, administered by the state Department of Corrections, funds temporary rental assistance (with wrap around supports for up to six months) for homeless parolees with a serious mental illness returning to the community until permanent housing or a voucher is secured. These types of arrangements work particularly well for scattered-site supportive housing models with mobile service teams so residents do not need to change units or case managers once the subsidy is secured.

CONCLUSION

Supportive housing plays a central role in the federal strategic plan to end chronic homelessness in our communities. However, the impact of the supportive housing industry on achieving this national goal will be determined, in large part, by the ability of communities to effectively and efficiently target this resource to those that truly need it. While there is still much work to do in building successful Coordinated Assessment systems, the framework provides a promising path forward to achieving these goals.

> *Chronic homelessness must be understood not as a separate and distinct policy problem belonging to the specialized 'homelessness' policy field, but as a problem shared by multiple mainstream public systems that stand to gain from its resolution*

The shift to a systems-approach toward homeless assistance creates unique challenges for supportive housing providers. Under this new framework, providers are expected to serve increasingly challenging and service-intensive households. Additional resources and technical assistance will be needed to incentivize and support providers in making this transition. It will also require stronger service coordination and resource integration with mainstream systems to provide the range, intensity and duration of services needed for this population. With supportive housing supply falling far short of demand in most communities, we also need greater investment in the acquisition and construction of new units. There also needs to be a concerted effort to better manage our current stock of units and create programs that help tenants who no longer need intensive services or housing supports "move-on" to more independent housing.

As we scale out Coordinated Assessment systems across the country, we are admittedly building the proverbial plane as we fly it. Acknowledging this point, and the complexity of the social problem we are trying to solve, the key to successful scaling will be to create systems that are flexible, adaptable and collaborative. Our tools, strategies and interventions must remain as dynamic as the people and the communities they serve. We need to thoroughly document and evaluate outputs, outcomes and impact in order to learn what is working, what is not and how effective solutions can be tailored to meet local needs. Finally, and most importantly, these efforts require broad-based strategies that engage the full range and resources of public systems affected by homelessness. Chronic homelessness must be understood not as a separate and distinct policy problem belonging to the specialized 'homelessness' policy field, but as a problem shared by multiple mainstream public systems that stand to gain from its resolution.