

MEMORANDUM

March 21, 2012

TO: Health and Human Services Committee
Planning, Housing, and Economic Development Committee

FROM: Linda McMillan, Senior Legislative Analyst 

SUBJECT: **Prioritizing Housing for Medically Vulnerable Homeless People**

At this session, the joint Committee will have an opportunity to hear presentations on and discuss the issue of how services are provided to medically vulnerable homeless individuals (adults). Providing permanent supportive housing to homeless people with medical and mental health conditions is an important component of an effective Housing First program. Generally, people are identified in three ways: they come to a shelter or service provider, they are hospitalized and need a place to go at discharge, or they are found through outreach efforts that locate those who are living on the streets. This joint Committee meeting is a follow-up to the December meeting when the HHS Committee was briefed by Bethesda Cares, Inc. on the results of their 3-day outreach and survey efforts conducted from November 7 to 9. Slides from the December presentation are attached at © 52-64.

Expected for this session:

Uma Ahluwalia, Director, Department of Health and Human Services
Nadim Khan, Chief, DHHS Special Needs Housing
Stacy Spann, Executive Director, Housing Opportunities Commission
Susie Sinclair-Smith, Executive Director, Montgomery County Coalition for the Homeless
Susan Kirk, Executive Director, and John Mendez, Outreach Specialist, Bethesda Cares, Inc.

1. Department of Health and Human Services

The Department of Health and Human Services (DHHS) will provide the joint Committee with an overview of the data from the recent Council of Government's Point-in-Time Survey of the homeless population, survey information on medical and mental health conditions

reported by unsheltered people counted in the point-in-time survey, and a recent survey conducted in five county shelters. DHHS will also inform the Committee of services available to homeless people through two community clinics, hospital discharge planning, and shelter and supportive housing based nursing visits. The presentation slides are attached at © 1-18. Some highlights are:

- In 2012, Montgomery County identified 600 homeless individual adults. This includes 130 who were unsheltered and 328 who were using emergency shelters. (© 2)
- This is a 20% decrease from 2011 and a 13% decrease from 2010. There is some concern that 2011 produced an over-count (there was a 9% increase from 2010 to 2011) so it is important to note that the 2012 count is the lowest since 2008. (© 2)
- Of the 130 unsheltered individual adults, 15 (11.5%) reported one or more medically fragile conditions. The most common was Hepatitis C (7 people), followed by frostbite, heat stroke, liver disease, and mobility problems. (© 5)
- DHHS conducted a survey of 348 homeless adults in 5 county shelters and found that 128 (37%) reported one or more medical conditions.
- The survey shows that 98 (28%) reported mental illness with 67 (19%) reported a co-occurring substance abuse and mental health disorder; 55 (16%) reported mobility problems, and 25 (7%) reported a serious brain injury. “Other” reported by 165 (47%) included diabetes and high blood pressure. (see © 6-7)
- County staff manage about 200 hospital discharges of homeless people each year. From July 2011 through February 2012, 115 discharges were managed. Of those, 50 people were placed in shelters and 65 were referred to friends or family, skilled nursing, and group homes. (© 15-16). Discharges can be very time intensive and it can be difficult to find housing for people who no longer need to be in the hospital but still need day-to-day assistance during their recovery.
- DHHS nurses visit 14 sites on a regular basis including temporary shelters, transitional shelters, and congregate permanent supportive housing. (© 17).

The Bethesda Cares, Inc. survey focused on homeless people living on the street, 74% of whom reported experiencing long-term chronic homelessness. They found that 44% percent of those interviewed were assessed to be in medically vulnerable states based on health conditions, length of time homeless and other factors, putting them at risk for death on the streets. In addition, 33% of those surveyed reported co-occurring disorders.

2. The Cost of Not Providing Housing to the Medically Vulnerable Homeless – MCCH Creative Housing Initiative Pilot Project (CHIPP)

In addition to ethical arguments in favor of permanently housing the homeless and providing medical care, studies are showing that providing permanent supportive housing to medically vulnerable homeless people is also cost effective. While housing costs increase, they are more than offset by reduced emergency room visits, hospitalizations, and criminal justice costs.

In 2008, the Montgomery County Coalition for the Homeless (MCCH) launched its Creative Housing Initiative Pilot Program. Susie Sinclair-Smith, Executive Director of MCCH, will provide the joint Committee with an overview of this program. A report on this pilot program is attached at ©19-32.

MCCH housed 16 medically vulnerable homeless people in units purchased at a condominium development. The 16 were selected from 40 people who were identified and referred from service providers. Placement did require a criminal background check, income verification, and documentation about hospital use and incarceration in a local jail. A full-time Case Manager and part-time Case Aide were hired to assist the participants in obtaining resources

MCCH reports on the one-year costs for the group of 16. The report notes that 2 of the original 16 people died during the course of the year.

- 68% of the 16 were male and 32% female
- 69% were African American and 31 Caucasian
- The average age was 52 years old. Ages ranged from 30 years old to 69 years old.
- Most had been homeless about 5 years.
- 70% had a dual diagnosis of mental health and substance abuse disorders.

Unfortunately, the MCCH report compares two-years of costs prior to housing to one-year of cost in the CHIPP program, so there is not a one-to-one comparison.

- MCCH reports that in the two-years prior to housing the cost of public services in Montgomery County was \$951,921. The cost for one-year of CHIPP and public services was \$695,098.
- Prior to housing through CHIPP, the largest cost was hospitalizations; \$612,520 over two-years.
- In the one-year CHIPP pilot, the largest cost was still hospitalization at \$273,355. However, this is less than ½ the amount of the prior two years and MCCH notes that only 4 clients accounted for all the hospitalization cost, including one who received a kidney transplant.

- 13 of the 16 participants maintained housing for the entire year. As previously noted, 2 died. In addition, 1 client left the program to move to a nursing home.
- All clients participated in case management and obtained some form of benefits. All were linked to appropriate medical treatment. All with a history of incarceration had reduced recidivism.

While there are some problems with the comparison in this report, many other studies support MCCH's conclusion.

Attached at ©32-33 is a brief from the Denver Housing First Collaborative and Colorado Coalition for the Homeless that compares 24-month pre-housing costs to 24-month post-housing costs.

- The participants averaged nearly 8 years of homelessness prior to the program. More than 80% maintained their housing for 6 months and 77% for the two years of the program.
- Per person costs for emergency services were \$43,239 prior to housing and \$11,694 after housing. Emergency room visits were reduced by 34% and inpatient nights were reduced by 80%. Detox visits were reduced by 82%.
- After factoring in all the costs associated with Housing First, there were per person savings of \$4,745.

Attached at ©34 is the Executive Summary from the 2007 Greater Portland, Maine report "Cost of Homelessness, Cost Analysis of Permanent Supportive Housing." It reports on the results of housing 99 formerly homeless people.

- The cost of services was reduced by 50% for those in the program (from \$28,045 to \$14,009) including a 62% reduction in emergency room visits, a 66% reduction in ambulance transport costs, a 59% reduction in health care costs, and 62% reduction in incarceration costs.
- After factoring in the cost of housing there was still a per person savings of \$944.

3. Using a Vulnerability Index

The joint Committee has previously discussed the need for good Housing First assessment tools in order to determine priority and speed up the process for appropriate housing placement. Bethesda Cares, Inc. and many other organizations that are involved in the 100,000 Homes effort are using Common Ground's Vulnerability Index that is based on research from Boston's Healthcare for the Homeless. A fact sheet from Portland, Oregon on their use of the Index is attached at © 37-40 and a summary of the items assessed is attached at © 41.

Bethesda Cares, Inc. has collected Vulnerability Index assessment data on 54 individuals experiencing street homelessness in the local area. Their data shows:

- Among the most medically vulnerable homeless, the average age is 50 and the average length of homelessness is 7.3 years. The national average from jurisdictions using this index is 5.71 years.
- Collectively, those surveyed reported a total of 30 Emergency room visits reported over the previous 3 months and 24 inpatient hospitalizations over the past year.
- 50% of the most medically vulnerable street homeless reported having no health insurance, so area hospitals are providing uncompensated care for repeated emergency room visits and inpatient hospitalizations.

Using the Index does allow a comparison to national data from those using the Index. Bethesda Cares report that the percentage of those with a history of or current mental is 57% locally and 45% nationally; substance abuse is 59% locally and 57% nationally. The percent of people over age 60 is 9.25% locally and 10.5% nationally. The percent of people with Tri-Morbidity (mental health/substance abuse/physical conditions) is 18.5% locally and 22.1% nationally.

Both Mr. Mendez and Ms. Sinclair-Smith will provide the joint Committee with comments on the used of a vulnerability index and this index in particular. Ms. Sinclair-Smith had experience in the District of Columbia with using the Vulnerability Index to prioritize housing placements.

If the joint Committee concludes that it would be beneficial for the Housing First system to use this Index, it may want to have further discussion on how such a change would be made in order to have consistent assessment at all points of intake.

4. Housing Options – Housing Choice Vouchers

There are several programs in Montgomery County that provide permanent supportive housing to formerly homeless people. Among them are Housing Initiative Program (DHHS), Shelter Plus Care, Safe Havens, Coalition Homes (MCCH), and congregate facilities such as Cordell (MCCH), Lasko House (HOC), and Seneca Heights (MCCH). Many of these resources are full and have very little turnover (which should be considered a success). There is a need for additional resources which is acknowledged in the County's Continuum of Care (CoC) application.

The CoC submitted last June noted that there are currently 116 permanent housing beds for chronically homeless people. The County wants to have 229 in place in 5 years and 389 in 10 years.

Permanent supportive housing can also be provided through the use of Housing Choice Vouchers and wrap around services. Housing Choice Vouchers (previously Section 8) can allow people to rent a market rate unit (within guidelines) from private landlords. Most recently, VASH vouchers have assisted veterans in finding rental housing.

Bethesda Cares, Inc. has proposed that 10% of Housing Choice Vouchers that become available during a year be set aside and preference be given to allocating these vouchers to chronically homeless who rank highly on the Vulnerability Index. The argument being that these are the people most critically in need of housing and not only can their condition be improved but the cost of providing services can be reduced.

The Housing Opportunities Commission is the administrator for the Housing Choice Voucher Program. HOC administers about 6,030 vouchers. There is some turnover in the program each year, usually somewhere between 300 to 500 vouchers. Under the proposal, this would mean 30 to 50 Housing Choice Vouchers would be set aside for the chronically homeless. The CoC from last June said that as of January 2010, there were 16,800 people on the HOC waiting list for Housing Choice Vouchers. HOC only opens it waiting list periodically because it is so large. While most of the households on the waiting list are not homeless, they are low-income households with a high cost burden for housing.

Stacy Spann, Executive Director of HOC, will provide the joint Committee with comments on the suggestion that some vouchers should be held and a preference be given to allocating them to medically vulnerable chronically homeless people and the impacts of having such a preference program.

As background for this topic, attached at © 42-49 is a “white paper” from the Arizona Coalition to End Homeless, “Local Preferences in Housing Choice Voucher Programs.” The Arizona Coalition argues that a set aside of vouchers is in line with HUD’s goals of ending homelessness and reducing the number of families and individuals with severe housing needs. Preferences can be established that meet HUD requirements and are based on data and the use of a vulnerability index would identify the pool of participants that meet the HUD definition for chronically homeless. Public Housing Authorities could open their waiting lists for this targeted population. The white paper does note that in addition to a Housing Choice Voucher, people in this targeted population will need support and wrap-around services.

Council staff notes that Housing Choice Vouchers that become available are at times already set aside in the development of certain projects that house the chronically homeless, such as Cordell, because ongoing rental assistance is needed to make the project financially viable. These become project-based vouchers rather than tenant-based and so they do not follow the person if they choose to move to other rental housing. The Arizona Coalition specifically says, “scattered site, tenant based rental assistance provided through the Housing Choice Voucher program is a viable solution to ending long-term and vulnerable homelessness when coupled appropriately with navigation services.”

Also attached at © 50-51 is an excerpt from the Code of Federal Regulations regarding the ability for Public Housing Authorities to implement preferences for Housing Choice Vouchers (HCV).

5. Budget Considerations

If there is a decision to try to set a preference that would provide Housing Choice Vouchers to medically vulnerable chronically homeless people, there will also need to be a discussion of capacity of wrap-around services to support them. The County's HIP Voucher program assumes case management in its costs and project-based vouchers are used in programs that also already have a service component. Programs like Shelter Plus Care are funded assuming a wrap around service provider.

The HHS and PHED Committee's will be holding a joint worksession on April 20 to review the Housing First funding in the Executive's recommended budget and Council staff suggests that the worksession include a discussion of how services would be provided if the number of chronically homeless people are housed through Housing Choice Vouchers. As is the case in other cost-benefit studies of human service needs, while there will almost certainly be savings to the system, the savings may not accrue directly to the county but the county may have to fund the up front cost. For example, additional service contracts may have to be locally funded, unless Federal, State, or private funding is available, while savings from reduced hospitalizations and emergency room visits would accrue to hospital and Medicaid or other systems that cover the hospital costs of the uninsured.



Montgomery County Continuum of Care

Medically Vulnerable Homeless Singles

Presentation to the Montgomery County Council
Health and Human Services Committee and
Planning, Housing, and Economic Development Committee
By the Department of Health and Human Services
Thursday, March 22, 2012



Montgomery County Continuum of Care Point-In-Time Comparative Data 2008-2012

	2008	2009	2010	2011	2012	% Change
Total Homeless	1,150	1,194	1,064	1,132	981	-13.3%
Total Single Individual Adults	740	668	692	758	600	-20.8%
Unsheltered						
Emergency Shelters	240	127	181	226	130	-42.5%
Transitional Housing	185	157	156	140	142	1.4%
Permanent Supportive Housing	268	345	442	505	598	18.4%

MONTGOMERY COUNTY'S INVENTORY OF BEDS

	Bed Capacity	Eligibility Criteria	Prioritization for Medically Fragile
Hypothermia/Overflow/ Other Additional Winter Capacity	270	Will serve to capacity Everyone accepted	Will serve to capacity Everyone accepted
Emergency Shelter Beds	128	Everyone accepted	Set aside 5 beds for Health Care for the Homeless and Aging and Disability
Transitional/Safe Haven Beds	170	Serves mental illness, street homeless, co-occurring or employable	Safe Haven is prioritized for Mental Health and Street Homeless
Permanent Supportive	620	Program specific criteria	HHS – Housing Initiative Program (HIP) MCCH – Aurora (CHIPP), Home First 1, 2, 3, Seneca Heights Interfaith Works Becky's House HOC-McKinney 12 ³

Shelter/Housing Intake Process

- Hypothermia winter season—Every One is Accommodated
- Remainder of the year—Intake is done through the Crisis Center, Community Vision and Outreach Programs utilizing the Assessment tool for need determination
- Determination for Permanent Supportive Housing is done based on program eligibility criteria and need determination from the Assessment tool

PIT - Unsheltered Medically Fragile

- Fifteen (11.5%) of the 130 unsheltered adult homeless without children reported one or more medically fragile conditions
- The most prominent condition was Hepatitis C (7)
- Followed by:
 - Frostbite
 - Heatstroke
 - Liver disease and
 - Physical disability that limits mobility



Currently Sheltered Medically Fragile

- Medical Survey completed March 13, 2012 surveyed 348 adult homeless
- One Hundred Twenty Eight (37%) indicated one or more medically fragile conditions
- The most prominent condition was physical disability that limits mobility
- Followed by:
 - Serious brain injury
 - Other (including Diabetes and High Blood Pressure)
 - Hepatitis C
 - Heatstroke



Montgomery County's Medical Vulnerable Homeless in Emergency Shelter Survey

March 12, 2012

	Women Center	Safe Havens	MCCH Men	Rainbow	Vision Overflow	Total
HIV/AIDS	3	0	0	0	0	3
Kidney Disease	1	1	3	0	0	5
End-stage Renal Disease	0	0	1	0	0	1
Dialysis	0	0	0	0	0	0
Hepatitis C	0	1	5	3	0	9
Tuberculosis	0	0	3	0	0	3
Serious Brain Injury	1	0	19	1	4	25
Liver Disease	0	2	3	0	0	5
Cirrhosis	0	0	0	0	1	1
End-Stage Liver Disease	0	0	0	0	0	0
Physical – Limited Mobility	12	3	29	9	2	55
Frostbite	0	0	4	0	0	4
Hypothermia	0	0	5	2	0	7
Heatstroke	1	0	6	1	1	9
Other	40	13	94	4	14	165
Chronic Sub Abuse	4	0	39	2	9	54
Mental Illness	30	17	27	9	15	98
Co-Occurring SA/ MH	14	16	25	3	9	67
Ave. Age	47	48	46	52	48	

1

Outreach and Engagement Resources

**People Encouraging
People Homeless
Outreach Program**

**255 North Stonestreet
Rockville MD**

**City of Gaithersburg
Homeless Outreach
Program**

**31 South Summit Ave.
Gaithersburg MD**

**Interfaith Works
Community Vision at
Progress Place**

**8210 Colonial Lane
Silver Spring MD**

**Bethesda Cares
Homeless Outreach
Program**

**7728 Woodmont Ave.
Bethesda MD**

Outreach and Engagement Resources

Montgomery Avenue Women's Center

12250 Wilkins Avenue
Rockville MD

Homeless Veterans Pilot Program

1301 Piccard Drive
Rockville MD

Shepherd's Table at Progress Place

8210 Colonial Lane
Silver Spring MD

Healthcare for the Homeless

Two Community sites
and dedicated staff to
serve homeless adults

Health Care for the Homeless

Meet a few of our neighbors residing in County shelters:

○ Robert: 78-year-old male

Diagnosis: Schizophrenia-paranoid type, insulin dependent diabetic, incontinent after prostate surgery

○ Frank: 46-year-old male

Diagnosis: Cognitively impaired, blind, insulin dependent diabetic

○ Sandy: 53-year-old female

Diagnosis: Bipolar Disorder, seizures, Pulmonary Embolism on Coumadin, ruptured diverticulum with colostomy

Health Care for the Homeless

The Montgomery Cares Health Care for the Homeless Program

is responsible for the oversight and coordination of health services for homeless adults in Montgomery County.



Why do we need Homeless Health Care Services?

- The management of health problems for people who are homeless is far more difficult than for those who are housed
- Forty percent (40%) of people experiencing homelessness have more than one chronic disease
- In addition to multiple, complex medical issues, many homeless individuals have co-occurring mental health and substance abuse issues

The County's Health Care for the Homeless Program

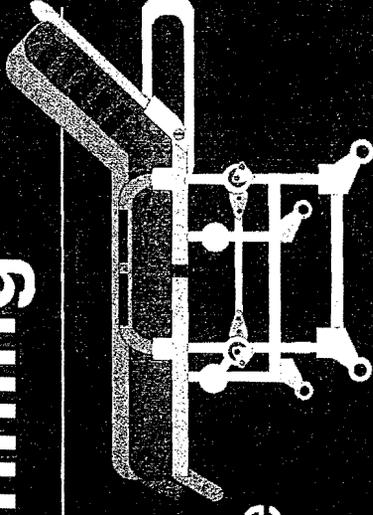
Three Components:

1. Contracting with community-based providers to ensure access to primary medical services for homeless adults
2. Hospital discharge planning
3. Shelter-based nursing support

Contacting for Primary Medical Care

- Medical services for homeless persons who are uninsured are contracted through Community Clinic Inc. (CCI) and Kaseman Clinic-Community Ministries of Rockville (CMR)
- Services include primary medical care, medical case management, and referral for dental services, behavioral health, and specialty care
- Provides an entry point into care for both street-based individuals and shelter residents
- CCI provides care for people accessing services at the Men's Emergency Shelter and Progress Place
- CMR/Kaseman Clinic provides care for people accessing services at the Wilkins Avenue Women's Emergency Shelter

Hospital Discharge Planning



- County RN staff work with discharge planners at all five community hospitals
- Provides a warm hand-to-hand transition of patients from the hospital to appropriate living situations within the community, including shelters, group homes, and Skilled Nursing Facilities
- County staff manage approximately 200 discharges per year

Hospital Discharge Data

(July 2011 through February 2012)

Hospital Discharges	
Hospital Discharges YTD	115
○ Shady Grove	32
○ Holy Cross	37
○ Suburban	21
○ Medstar Montgomery	4
○ Washington Adventist	13
○ Other (skilled nursing facilities)	18
Dispositions:	
○ Placed in shelters	50
○ Referred to:	65
● Friends/Family	
● Skilled Nursing	
● Group Homes	



Shelter-Based Nursing Support

- A Registered Nurse (County employee) is onsite at both the Men's and Women's Emergency Shelter three mornings per week, providing triage, assessments, and nursing care
- A Registered Nurse visits the Transitional Shelters and congregate permanent supportive housing programs (Cordell Place and Seneca Heights) weekly, providing medication management, education seminars, and medical case management

A total of 14 shelter sites are visited on a regular basis



Additional Homeless Health Resources in Montgomery County

- Baltimore Health Care for Homeless (HCH) is an FQHC that provides an array of services to homeless persons in Baltimore City, Baltimore County, Frederick and Montgomery Counties and several other jurisdictions within Maryland
- \$100,000 in FQHC grant funds are provided to CCI and Mobile Medical via a contract between Baltimore HCH and the Primary Care Coalition
- Funds are used primarily to serve homeless families, while the County's program focuses on single adults

Creative Housing Initiative Pilot Project (CHIPP)
Evaluation and Report
August 2011

A cost-analysis study intended to demonstrate substantial savings to public systems of care by offering permanent supportive housing to homeless adults.

Authors:

**Carolyn Amspaugh, LCSW-C; Joan Goldberg, PhD; Lee Jansky; Julie Maltzman;
Nili Soni, MSW; and Kathleen Spain.**

I. Executive Summary

In 2006 Montgomery County Coalition for the Homeless (MCCH) proposed conducting a one-year pilot project to demonstrate the effectiveness of permanent supportive housing in Montgomery County, the Creative Housing Initiative Pilot Project (CHIPP). In jurisdictions throughout the nation, studies have been conducted that demonstrated substantial cost savings to public systems of care by providing permanent supportive housing to homeless adults who were frequent users of the emergency medical and local corrections systems. However, no report existed for Montgomery County. We believed that the information compiled from this study, conducted in our county, would demonstrate substantial cost savings to our local public systems of care resulting from permanent supportive housing for homeless individuals with intensive needs that use public systems of care in excess. We projected that this data could guide policy decisions related to homelessness in Montgomery County, leading to future resources being allocated to the development of permanent supportive housing as not only a cost-saving approach but as a beneficial and humane model for needy populations.

The original plan called for MCCH to partner with the Montgomery County Department of Corrections and Shady Grove Adventist Hospital to identify 8 homeless individuals who were frequent users of the emergency medical system and 8 homeless individuals who were repeatedly incarcerated in the local corrections system for “nuisance” crimes (public drunkenness, trespassing, loitering, etc.). However upon closer review with the Department of Corrections, we discovered that this population did not exist in our community as it is not common protocol for police officers to arrest individuals for nuisance crimes. In addition, the hospital had difficulty identifying which frequent users of the emergency room were homeless. Therefore many of the clients for this project were referred directly by homeless service providers who had knowledge of a client’s past hospitalization and criminal backgrounds. Upon admittance into CHIPP, these 16 individuals were placed into one-bedroom condominiums that our affiliate organization, Coalition Homes, owns and manages. A full time Case Manager and a part-time Case Aide were hired to assist clients in obtaining vital resources and services to maintain their housing stability and overall well-being.

An outside evaluator was hired to gather and evaluate data on CHIPP participants use of multiple public systems of care, both two years prior to, and one year after their placement into permanent housing. The costs utilized in the analysis included hospitalizations, outpatient mental health, jail incarcerations and shelter costs. For the two years prior to housing, these costs totaled \$951,921. The cost of housing and services upon placement into CHIPP for one year totaled \$695,098. Even though we presumed that this was sufficient data to calculate cost savings, we soon realized that several limitations impacted the validity of this study; factors that will be discussed later in this report in Section VI: Discussions, A: Limitations. We realized that comparing two years worth of data prior to being housed to one year of data upon housing placement did not provide enough data for an accurate comparison. In addition when comparing

our study to others done across the county, the clients we served had much more extensive medical needs. The medical costs for this group after being housed did decrease slightly upon housing placement, but not at the same rate as compared to other studies. Our population had extensive legitimate medical needs, which if left untreated would have lead to unnecessary suffering and even costlier medical treatments. Yet despite the unexpected medical expenses for the first year of housing placement, we do anticipate these costs to decrease over time. Even with these statistical limitations, this study does demonstrate that permanent supportive housing is a more cost effective approach, even for individuals with serious medical complications. And permanent supportive housing will continue to be more cost effective the longer that an individual remains housed.

II. Introduction

a. Montgomery County Coalition for the Homeless

For more than twenty years, MCCH has continued to solve housing crises and work towards ending homelessness by offering direct services along the entire spectrum of housing programs and leading advocacy efforts among area service providers. Our mission- to lead the effort to end homelessness in our community by creating housing options, providing supportive services, and facilitating collaboration, education and advocacy based on the belief that every person is entitled to the dignity of a home- is the culmination of years of not just taking notice of the growing numbers of men, women and children facing homelessness in our community, but the determination and leadership to do something about it by developing and implementing long-term solutions.

MCCH applies a two-pronged approach to ensure that every person in our community has the dignity of a home. The first approach, at the core of our mission and our most urgent concern, is to provide housing and supportive services to people experiencing homelessness. This is accomplished through our nine programs: **1) Home Builders Care Assessment Center** provides year-round, 24 hours a day, 7 days a week shelter and supportive services for over 800 homeless men in our community each year; **2) Creative Housing Initiative Pilot Project (CHIPP)** is a pilot project created in 2008 to demonstrate the effectiveness of permanent supportive housing in Montgomery County for 16 homeless individuals who have been frequent users of the emergency medical and corrections systems; **3) Home First** permanently houses 30 chronically homeless individuals and provides wraparound supportive services; **4) Hope Housing**, in partnership with two other organizations, provides permanent supportive housing to 40 individuals and two families; **5) Partnership for Permanent Housing**, the County's first "Housing First" program, effectively ends homelessness for over 180 family and single adult households by combining case management with quick access to permanent housing in scattered sites throughout the county; **6) Safe Havens**, a low-demand transitional housing program, provides supportive services for 40 homeless, chronically mentally ill adults at 4 sites; **7) Seneca Heights Apartments**, a motel converted into a

state-of-the-art apartment complex, provides permanent living units for 40 single adults and transitional housing for 17 families, which will be converted to permanent housing this fiscal year; **8) Cordell Place**, MCCH's newest program, provides permanent supportive housing to 32 single men and women in downtown Bethesda; and **9) Coalition Homes, Inc.**, MCCH's affiliate organization, owns and manages 57 scattered-site housing units and one 32-unit building that provide permanent housing for formerly homeless individuals and families.

The second approach is to create the political and social will within our community to provide long-term solutions to the problem of homelessness. MCCH advocates on the local, state, and federal levels and regularly encourages our partners and constituents to join us in these efforts. We also focus on educating the public about homelessness, its prevalence in and impact on Montgomery County. We proposed that data from this academic study could be incorporated into an advocacy strategy that could leverage public support and financial backing to garner support to develop new permanent supportive housing projects in the county.

b. Creative Housing Initiative Pilot Project (CHIPP)

With initial funding provided by the Trawick Foundation, the Meyer Foundation and Adventist Health Care, CHIPP was officially launched in 2008 as a one-year pilot project to demonstrate the effectiveness of permanent supportive housing in Montgomery County. Supportive housing is a nationally recognized model that is designed to serve tenants with long histories of homelessness who face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder, or a chronic medical problem. CHIPP targeted 16 homeless adults who cycled in and out of area homeless assistance systems, utilizing emergency rooms, jails and other area shelters in excess. In fact the cumulative total of homelessness for this group was 56 years. These patterns of service utilization not only fail to address the underlying causes of homelessness, but are extremely costly to the public systems involved. CHIPP participants entered the program having spent a significant part of their adult life living on the streets, facing numerous barriers to obtaining permanent housing. CHIPP removed that instability by placing individuals into permanent housing quickly and then offered supportive services, such as outpatient mental health and substance abuse treatment, to help participants achieve stability. All 16 participants were housed at the Ashmore condominium complex located in Germantown, MD. These units are owned and operated by our affiliate agency, Coalition Homes. CHIPP was structured as a pilot study due to the minimal sample size (16), its lack of randomness or control group and the unknown variables associated with serving this population. Even though the academic portion of the study was time-limited, the permanent housing and supportive services will continue as long as the need exists.

A full time Case Manager and a part-time Case Aide were hired to assist participants in obtaining resources and services that were important to maintain their stability and well-being. Believing that housing is a right, the program adopted a harm-reduction

philosophy to minimize potential obstacles to sustaining housing stability. Harm reduction refers to a range of pragmatic and compassionate policies designed to reduce the harmful consequences associated with high risk activities. For example, if a resident has a substance abuse addiction, instead of terminating their housing as a result of their drug use, a harm reduction approach would be to offer treatment options as a more effective way to directly address the problem. Most of our clients voluntarily engage in outpatient treatment.

c. Other partners

As stated earlier, CHIPP partnered with the Montgomery County Department of Corrections and Shady Grove Adventist Hospital to identify 16 applicants that fit the eligibility criteria to fill our slots. However one of the early issues that we encountered was the length of time it took to find these individuals. Local hospitals were unable to refer appropriate clientele to the program since their records did not specifically identify who was homeless. Therefore, instead of utilizing hospital referrals as was hoped, we utilized referrals from emergency shelters and other sources that had clients who either self-identified as having numerous past hospitalizations or the staff knew when they were hospitalized. We focused on number of past hospitalizations as opposed to excessive emergency room usage since medical records, which was used to review a client's past hospital usage, reference only the hospital stay and purpose and do not specify how the client entered the hospital. It is not uncommon to experience set-backs in trying to target a specific population, as cited from reports conducted by the District of Columbia that targeted chronically homeless individuals¹ (The Washington Post, Sept 29, 2009, pg.B4). This study screened 40 persons to reach their target size of 16 participants. Even though CHIPP did not require clients to be chronically homeless individuals, it still had difficulty in securing appropriate referrals that did fit the eligibility requirements.² This was surprising given that the 2009 point-in-time survey showed that there were 1,247 homeless people in Montgomery County. Therefore we expanded our outreach efforts to include Washington Adventist Hospital- Outpatient Mental Health, Mobile Medical Care, Interfaith Works-Homeless Services, Volunteers of America- Street Outreach, Bethesda Cares, MCCH's Home Builders Care Assessment Center, Avery Road Treatment Center, Montgomery County Department of Health and Human Services (MCDHHS)-Assertive Community Treatment (ACT) team and MCDHHS Outpatient Addiction Services. We interviewed 27 individuals for the 16 slots. In addition to assessing applicants for independent living, the interview process was an opportunity to gather additional personal history and to inform them of CHIPP's program requirements. CHIPP staff continued the screening process by conducting a criminal

¹ A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

² Eligibility requirements include a lengthy history of homelessness, a chronic health condition (mental, physical or substance abuse related) a past history of excessive usage of public systems of care and willingness to designate the CHIPP program to become their representative payee.

background check, verifying income, and documenting hospitalization usage and/or incarceration at local jails. Once an applicant was approved, we scheduled their lease to be signed, completed the Representative Payee paperwork, and obtained financial assistance on behalf of the applicant for the security deposit and first month's rent from MCDHHS- Emergency Services. We retained applications for up to six months in case of unexpected vacancies, which occurred and will be discussed in Section VI: Limitations.

III. Literature review

a. Homelessness

In writing about homeless women, Elliot Lebow (1993) wrote that it is a mistake to think of the homeless as mentally ill or alcoholics but rather in multi-dimensions. He noted that:

The humanity of the women is under constant threat and by no means easy to preserve. Most homeless women are engaged in an unremitting struggle to remain human in the face of inhumane conditions (p.3).

Not only do they find themselves without homes, but they describe constant feelings of humiliation due to a perceived view that society views them as undeserving of decent shelter. Starting with the movement to close hospitals for the mentally ill in the 1960's, these patients became the new faces of homelessness because there were no programs in place to provide these persons and others with housing. Over the past twenty years, the homeless population has drastically increased, moving beyond just single adults but to couples and families.

In a study by Larimer, Malone, et al. (JAMA, April 2009, pp.1349-1357), the authors looked at chronically homeless individuals who accessed alcohol treatment services. They noted that these persons are three times more likely to die than the general population. When placed in a 'housing first' program, the authors found that these individuals' life circumstances improved and there was a reduction of health and criminal justice services. 'Housing first' is a nationally recognized model that centers on providing homeless people with housing quickly and then providing support services as needed to maintain housing stability. They also note that benefits continue to accrue the longer the individual is housed. CHIPP utilizes a housing first model.

Jurisdictions across the country are attempting to combat the growing homeless epidemic, resulting in a systematic shift from housing individuals and families in transitional and emergency shelters, and over time, eventually moving them to permanent housing, which ultimately prolongs their homelessness. Instead, areas are looking towards developing more affordable housing with access to supportive services and placing households as quickly as possible, decreasing the use and reliance on temporary shelters. This is due to the fact that national data indicates that while only 10% of the general homeless population fits the chronic homeless definition, they utilize

up to 50% of homeless resources such as emergency and transitional shelters. Dennis Culhane, a professor at University of Pennsylvania and a person who works with the homeless, noted that in New York alone at least \$62 million is spent annually to shelter just the hard core 10% of the homeless population, (a shelter bed in NY costing \$24,000 per year). These are the chronically homeless, older and mentally disabled adults. Permanent supportive housing is clearly a more cost-effective approach.

Phillip Mangano, appointed by Bush in 2002 as the executive director of the US Interagency Council on Homelessness, stated that he is against soup kitchens and shelters, preferring instead to invest in results that end homelessness, such as providing rental assistance for apartments. In New York City, the largest comprehensive study done to date in 2001 tracked 3,615 homeless individuals with psychiatric disabilities who received affordable housing units with supportive services. The study examined the use of shelters, psychiatric hospitals and medical services two years prior and two years into placement. Significant findings include the following:

- A homeless mentally ill person in NY uses an average of \$40,449 of public services over a year. Once placed in service enriched housing there is an average reduction of \$12,145 per year.
- There was a 33% reduction in the use of medical and mental health services.
- Emergency shelter use decreased by over 60%, saving \$3,779 a year per new housing unit constructed.

This study concluded that homelessness is costlier than providing housing. For less amount than it takes to have an individual stay in an emergency shelter for one year, that same person can be housed and obtain needed services, instantly enhancing their quality of life.

b. Supportive housing

Permanent supportive housing helps tenants end their homelessness and access the services they need to address their health and mental health problems effectively.³ Supportive housing was authorized as a demonstration project under the Stuart B. McKinney Homeless Assistance Act of 1987. It was designed to meet the needs of deinstitutionalized homeless person, homeless individuals with a mental disability or other handicap, and homeless families and children. In a permanent supportive housing environment, an affordable housing unit is made available to individuals who have needs for ongoing support services. These persons are unable to afford market rate housing and/or would be denied housing due to their criminal background or credit histories. In addition, case management services are provided to assist them to maintaining their housing and live independently. These services provide an array of support including

³ Corporation for Supportive Housing: *How Does Supportive Housing Effect Tenant Service Utilization?* Retrieved September 30, 2009, from <http://www.csh.org>.

treatment for medical conditions or referrals to community resources, employment and training services, and other benefit entitlements. The stabilizing effect of permanent housing, coupled with support services, may result in an individual taking prescribed medications, remaining on an appropriate diet, and preventing drug and alcohol relapse. In addition to acute health care expenses, supportive permanent housing can result in other cost savings to the community. These savings are achieved through such things as reduced involvement with police and other law enforcement, subsequent savings in court and jail costs, and reductions in fire department, emergency medical personnel, and ambulance expenses. Supportive permanent housing may also result in a reduction in the cost of providing mental health services delivered within the community, as opposed to accessing emergency services as a reaction to an immediate crisis.⁴

IV. Study Design

a. Methodology

This research component to CHIPP was designed as a pilot study. A pilot study is one in which all the variables are unknown and their impact on proposed outcomes is undetermined. We chose this design because there are numerous unknown variables related to homelessness and we could not account for the impact on our clients emotionally and physically once they were housed. In addition 16 is a very small number of participants, therefore a pilot study was an appropriate strategy. All 16 clients signed release forms, enabling us to go to local jails, shelters, outpatient mental health services and hospitals to obtain cost data on their usage for two years prior to being housed. Data was collected through partnerships with a wide range of other agencies including the Montgomery County Department of Health and Human Services, other homeless service providers, addiction service providers, healthcare providers, the public mental healthcare system, and the public defenders office. Due to the limitations of this study, there was no control group or random selection for the sample group.

Data was tracked on spreadsheets, entering costs related to various systems of public care (hospitals, shelters, jail, and mental health) two years prior and one-year into housing placement. We developed a second chart to record client demographics. Our third measurement tool was a qualitative instrument that was used to survey clients with more open-ended questions.

b. Sample group

This pilot study had a sample size of 16 individuals. Our hope was to sustain the same 16 individuals for the entire duration of the one-year study, but unfortunately two participants died from serious medical issues within the first year. Of the 16 participants, 8 were referred from the jail and the other 8 were clients from shelters that self-identified

⁴ The Cost Effectiveness of Supportive Housing: *A service cost analysis of Lennox Chase residents*. Adam Walsh, Dean Duncan, Laurie Selz-Campbell, and Jennifer Vaughn. UNC-CH School of Social Work, December 2007.

having frequent past hospitalizations (which was confirmed during the screening process by reviewing medical records). Housing placement began in spring 2008; two arrived in April, three in June, one in July, one in September, one in November, two in December, three in February 2009, one in March and the final in July (refer to Table 1). Among the total group, 32% are female and 68% are male; 69% are African American while 31% are Caucasian; and the average age is 51.9 years. The youngest client is only 30 and the oldest is 69 years old. All have been homeless for many years, with a mode of 5 years. Approximately 30% of the clients have a mental health diagnosis while 70% have a dual diagnosis of a mental health illness and substance abuse disorder. All have been treated by various hospitals, doctors and outpatient facilities in Montgomery County over the years or have spent substantial time in the county jail and in shelters.

Table 1: Demographics and date of entry

	DOB	Age	Race	Gender	Date of Entry	Date of Exit
Bessie	9/27/1962	47	AA	Female	4/1/2008	5/24/2009
Holmes	10/22/1940	69	AA	Male	4/1/2008	
Jasper	7/17/1949	60	AA	Male	7/11/2008	
Loretta	12/21/1951	58	AA	Female	6/3/2008	
Michelle	8/17/1961	48	AA	Female	6/3/2008	
Calvin	8/29/1964	45	AA	Male	6/3/2008	
Barbara	6/24/1957	52	C	Female	7/21/2008	
Richard	5/12/1952	57	C	Male	9/29/2008	
Elise	7/6/1963	46	AA	Female	11/10/2008	3/2/2009
Douglas	10/8/1955	54	AA	Male	12/3/2008	
Kevin	8/3/1964	45	AA	Male	12/3/2008	
John	6/13/1951	58	AA	Male	2/26/2009	
William	4/7/1954	55	C	Male	2/4/2009	
Jeffrey	9/6/1956	53	C	Male	3/26/2009	
Bradley	7/6/1979	30	C	Male	3/26/2009	
Perry	9/15/1955	54	AA	Male	7/1/2009	
	Avg. age:	51.9375				

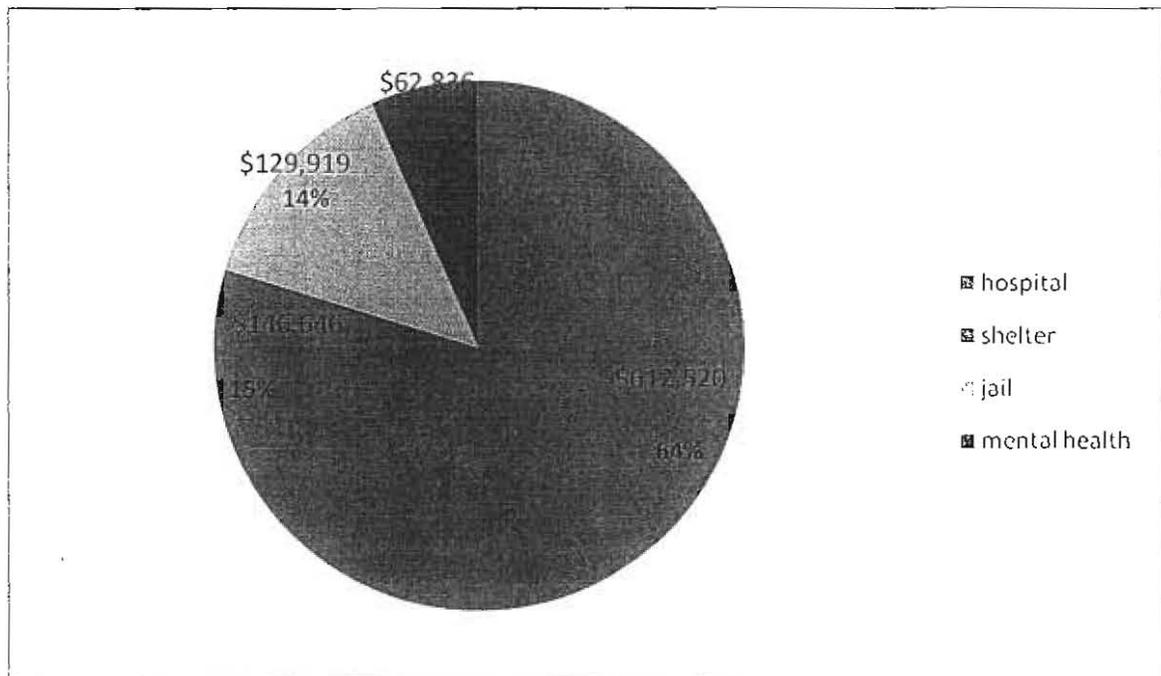
V. Findings

a. Quantitative Data

Preliminary results from this study are similar to findings across the country- permanent supportive housing is a cost-effective strategy for chronic homeless adults. Our data discovered that the total cost of usage for various public systems of care for two years prior to being housed was \$951,921. It is important to note that this is probably a conservative figure as it was not possible to capture individual doctor fees from hospital stays or treatment outside of Montgomery County. The total cost of one year of housing in CHIPP with support services was \$695,098.

Chart 1 shows the total costs and percentages of services for the 16 individuals two years prior to housing.

Chart 1- Total cost of services two years prior to housing



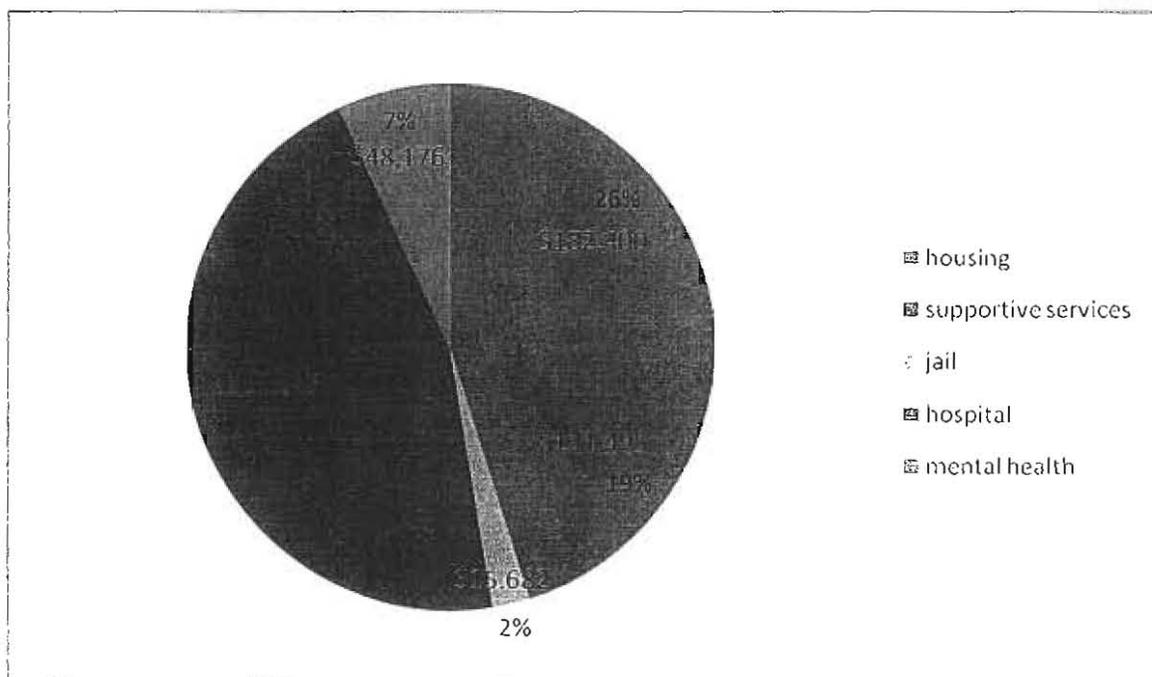
As one can see, the largest cost is hospitalization at \$612,590 or 64% of the total costs of homelessness for these 16 individuals for two years. We initially presumed this was due to unnecessary hospital visits but as we discovered, each client who accessed the hospital had a legitimate, serious medical condition.

Chart 2 compares this same information after one year of housing. The largest cost is still hospitalization but almost \$273,355 less compared to pre-housing costs. We

realized that only four clients accounted for all hospital expenses and all were medically necessary. One client, a 52 year old female, received a kidney transplant after she was housed. Her medical costs alone were over \$100,000. She spent time in the hospital, the ICU, rehab and a nursing home, ultimately leaving the nursing home and never returning to her apartment. Another client, a 60 year old male, had severe cardiac treatment and bypass surgery. While homeless, his hospital bills totaled over \$157,000. Once housed his hospital costs were only \$50,795. A third client, a 47 year old female, suffered from heart disease and spent time in the ICU, costing approximately \$33,000. And the fourth client, a 48 year old female, suffered from severe paranoia and only felt safe at the hospital. When homeless, her hospital costs totaled \$117,000. After being housed, her costs were lowered to \$57,000 in the first year and will likely continue to decrease in subsequent years. It is important to note that homeless adults with extensive periods of homelessness often go years without access to proper medical or mental health care. Therefore upon placement in our program, we immediately addressed all medical conditions, which contributed to substantial medical costs during the first year of being housed.

Other important findings are that the cost of shelter went down to zero and the cost of jail went from approximately \$130,000 to only around \$15,000. This is an interesting point since many studies note high rates of recidivism in jail due to petty crimes (public drunkenness, urinating, etc.). Clearly supportive housing was able to keep our clients, who had been jailed for more serious infractions in the past, from high rates of recidivism as well.

Chart 2: Total cost of services after one year of housing



To look at the differences even more closely, Chart 3 represents a bar graph in which the costs of two years of homelessness are compared to the one year of housing. Based on these results, we can make several presumptions for subsequent years. First, the ongoing costs of housing will decrease in subsequent years as clients become more comfortable in their new life style. Yet it is important to note that the cost of housing is very high in Montgomery County and cannot be equated to other jurisdictions. In addition, since several clients received needed medical procedures within their first year of housing, it is likely that their future medical expenses will not be so costly and will decrease. This is also attributed to the fact that staff helps them address any medical conditions in a timely manner and pursue routine preventative care.

Chart 3: Comparison of costs



Once again, it is important to note that the sample size included individuals with serious medical conditions, legitimately impacting the hospital costs two year prior and one year after being housed.

In addition, the following achievements also occurred during the pilot year:

- 86 % of CHIPP clients maintained housing for one year (13 individuals; two clients passed away during the first year of being housed and another client left the program to live in a nursing home, which was more appropriate to address her medical condition.)
- 100%(88% proposed) of CHIPP clients participated in case management
- 100 % (88% proposed) of CHIPP clients obtained some form of benefits

- 100% (88% proposed) of CHIPP clients with histories of incarceration experienced a reduction in recidivism.
- 100% (88% proposed) of CHIPP clients have been linked to appropriate medical treatment
- 75% (12 clients) of CHIPP clients reduced their reliance on and expense to other systems. This meant no shelter, less jail time and less hospitalization for most individuals. The remaining 4 clients continued to require hospitalizations due to serious medical conditions.

b. Qualitative data

While this study's main focus was cost effectiveness of housing chronically homeless individuals, we also administered a questionnaire to assess participants' feelings and experience since being housed.

This survey tool was completed by 10 residents in April of 2009. Unfortunately not all 16 clients were able to complete this survey as five moved-in after the intern started collecting data and another client passed away before she could be interviewed. The responses tended to fall under three categories- a renewed sense of independence, increased self-esteem and a desire to build healthy relationships. For most of the respondents, having their own space had a profound impact. One female client stated how she enjoys taking care of herself. Another male client stated how he felt safe and slept well through the night. With all the clients at CHIPP, independence was a recurring theme. They enjoy having their own place, being able to cook, cleaning and paying rent. Most remember how to cook and seem to enjoy it. All note that they take pride in cleaning their apartments and enjoy leisure time by watching TV. A majority felt that they were receiving what they needed, especially in regards to the home-based case management services. They liked talking with the case manager, and received assistance in areas whenever they asked. They all wanted the relationship to continue.

It was interesting to note that many clients have substance abuse issues yet for those who were in recovery, having their own home enabled them to stay away from those who are still using. Also of interest is that upon receiving housing, the majority of clients kept in touch with at least one family member. They either call one person or in some cases go to visit them. In one case, family members come to the apartment to visit the client. This is particularly important since strained or non-existent relationships with family members is a common result of homelessness. Several clients expressed a desire to interact with fellow participants so the case manager was able to connect clients to one another. Two men have coffee together on a regular basis. Some have even utilized the gym provided by the complex. And over the Thanksgiving holiday, several had dinner together and even delivered a plate to another participant who had recently returned from the hospital.

VI. Discussion

a. Limitations

This pilot study does support other findings across the country; permanent housing is a cost-effective strategy to ending homelessness. However, there are a number of limitations in this study that explain why our findings are not equal to data collected in other studies. Most importantly, you cannot compare two years worth of data prior to housing to one year after housing as the time frame needs to be equal. Also, our sample size of 16 clients was too small to be statically viable. Also, the clients in our study had substantial medical conditions and serious criminal backgrounds; other studies only allowed criminal backgrounds with minor offenses such as public drunkenness. In addition, since Montgomery County does not arrest individuals for nuisance crimes, clients in our program had more serious criminal backgrounds as compared to those in other studies. Medical expenses remained high even after being housed but all costs were attributed to needed surgeries and expensive medical treatment; treatment that if these clients were still homeless, would not have happened and consequently, these clients would have died. Our housing costs were also higher compared to other jurisdictions due to the high cost of living in Montgomery County. It was also very difficult to gather data on past and current service costs. We looked at three hospitals, jails and outpatient mental health services. Our contacts at these facilities faced time constraints as they tried to help us while doing their regular jobs, which was challenging at times. It was a very difficult process to get the information we did get and realize now that we needed more funding and more personnel just to collect the data. It would be important to continue to follow the remaining 14 clients from the initial study for one more year to see whether costs continue to decline and how clients are adapting to their homes.

b. Conclusions

This study provides preliminary data that the cost of homelessness to society is greater than the cost of housing people. Along with saving money, permanent supportive housing also provides individuals with a sense of ownership, self-worth and community. These are important human attributes that we should all be entitled to. This project served some of the neediest individuals in our homeless assistance system that due to criminal backgrounds and medical needs truly had no where else to go. Even though sadly two participants passed away after being housed, they did so with dignity. This is an attribute that cannot be measured in dollars; rather, it is measured in peace of mind. And we are grateful to have provided our clients that service.

DENVER HOUSING FIRST COLLABORATIVE

Cost Benefit Analysis & Program Outcomes Report



EXECUTIVE SUMMARY

The Colorado Coalition for the Homeless created the Denver Housing First Collaborative (DHFC) in 2003 with funding provided by a collaboration of federal agencies. The DHFC involved CCH as the lead agency, Denver Department of Human Services (DDHS), Denver Health (DHHA), Arapahoe House, the Mental Health Center of Denver (MHCD) and the Denver VA Medical Center.

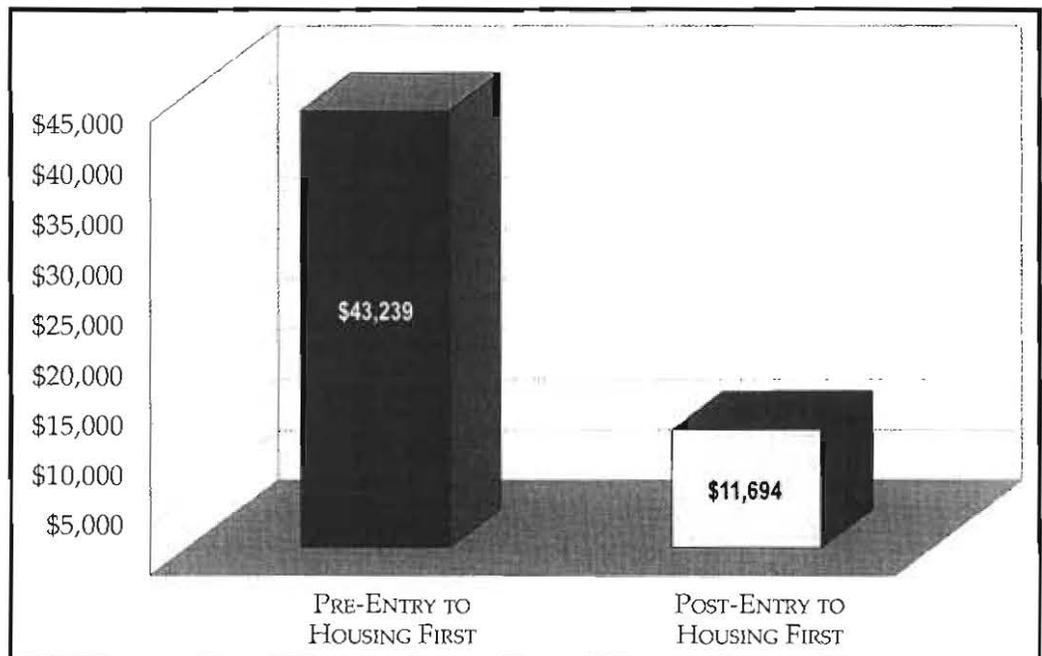
The DHFC is designed to provide comprehensive housing and supportive services to chronically homeless individuals with disabilities. Initial federal funding created the capacity to house and serve 100 chronically homeless individuals. The program uses a housing first strategy combined with assertive community treatment (ACT) services, providing integrated health, mental health, substance treatment and support services.

The housing first approach has been incorporated as a priority strategy into **Denver's Road Home** – Denver's Ten Year Plan to End Homelessness. Denver's Road Home has provided funding to create a second housing first team at CCH – the 16th Street Housing First Program – to serve an additional 50 chronically homeless individuals.

The goals of the DHFC are to increase the residential stability and overall health status of chronically homeless individuals while reducing the utilization and costs of emergency services being provided to chronically homeless persons with taxpayer funds.

The Cost Benefit Analysis focused on examining the actual health and emergency service records of a sample of participants of the DHFC for the 24 month period prior to entering the program and the 24 month period after entering the program. Participants provided releases of information for their medical, psychiatric, legal and substance treatment records and associated costs for the four year period. Cost data from the clinical records were analyzed to determine the emergency room, inpatient medical or psychiatric, outpatient medical, Detox services, incarceration, and shelter costs and utilization.

TOTAL CHANGE IN EMERGENCY COSTS PER PERSON



Denver Housing First Cost Benefit Analysis Colorado Coalition for the Homeless

The findings document an overall reduction in emergency services costs for the sample group. The total emergency related costs for the sample group declined by 72.95 percent, or nearly \$600,000 in the 24 months of participation in the DHFC program compared with the 24 months prior to entry in the program. The total emergency cost savings averaged \$31,545 per participant.

Utilization of emergency room care, inpatient medical and psychiatric care, detox services, incarceration, and emergency shelter were significantly reduced by participation in the program. Only outpatient health costs increased, as participants were directed to more appropriate and cost effective services by the program.

Emergency room visits and costs were reduced by an average of 34.3 percent. Inpatient visits were reduced by 40 percent, while inpatient nights were reduced by 80 percent. Overall inpatient costs were reduced by 66 percent.

Detox visits were dramatically reduced by 82 percent, with a average cost savings of \$8,732 per person, or 84 percent.

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Incarceration days and costs were reduced by 76 percent, and emergency shelter costs were reduced by an average of \$13,600 per person.

If the average cost savings of \$31,545 per persons are projected for the 150 chronically homeless individuals currently participating in CCH's two housing first programs, the total savings would amount to \$4.7 million. If these average costs savings are projected each of the 513 chronically homeless persons estimated in Denver who are eligible for the DHFC program, the savings would amount to \$16.1 million.

When the investment costs of providing comprehensive supportive housing and services through the Housing First Program are factored in, there is a net cost savings of \$4,745 per person. Thus, the total net cost savings for the current in the Denver housing first programs are projected to be \$711,734. The projected net cost savings for all 513 chronically homeless persons, if provided access housing first programs, would be \$2,424,131.

In addition to saving taxpayers money, the local and national evaluations of the DHFC program document overall improvement in the health status and residential stability of program participants. For these persons, who averaged nearly 8 years of homelessness each prior to entering the program, 77 percent of those entering the program continue to be housed in the program. More than 80 percent have maintained their housing for 6 months.

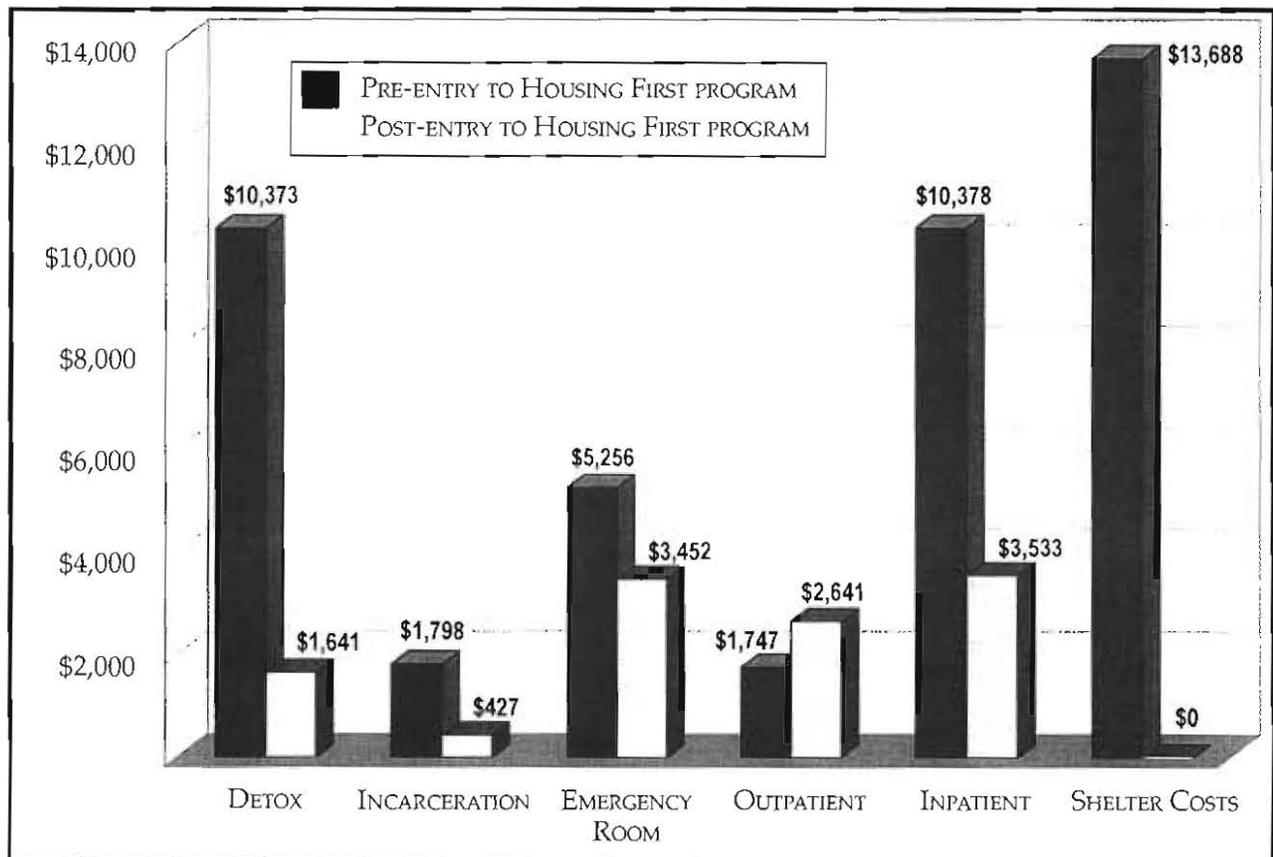
Fifty percent of participants have documented improvements in their health status, 43% have improved mental health status, 15% have decreased their substance use, and 64% have improved their overall quality of life.

In addition, the majority of participants have been assisted to obtain the public benefits for which they are eligible, or to obtain employment. The average monthly income of participants increased from \$185 at entry to \$431.

After two years of operation, Denver Housing First Collaborative approach offers tremendous promise of improving the health status of chronically homeless individuals while reducing taxpayer funded emergency costs of emergency room care, hospitalizations, incarceration and detox.

Furthermore, the overall quality of life for the community can be significantly improved as the negative impacts of individuals living and sleeping on the streets are reduced.

CHANGE IN AVERAGE SERVICE COSTS



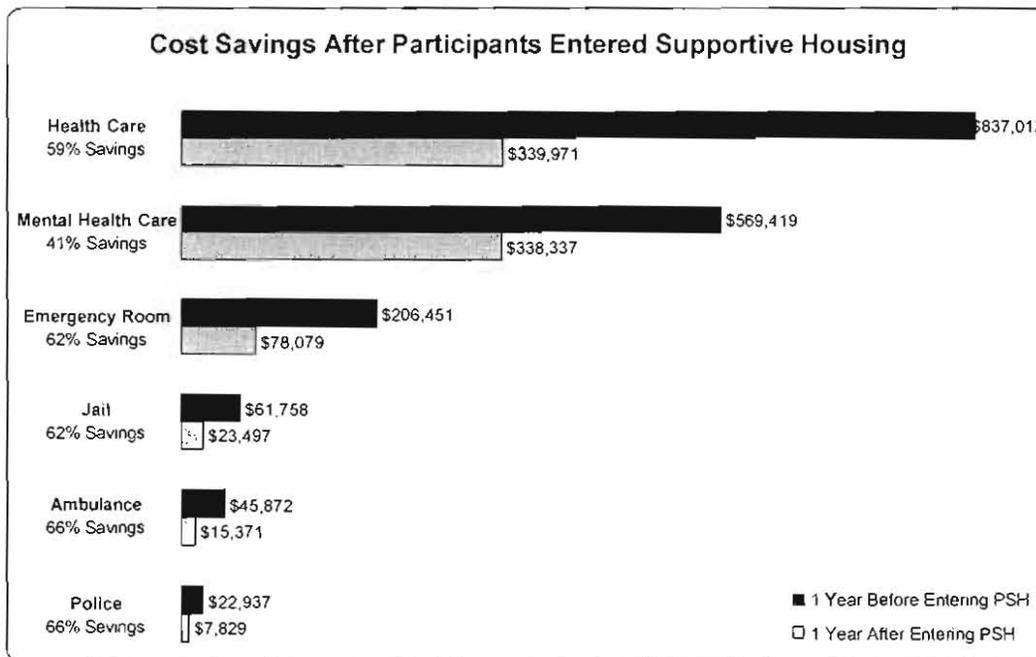
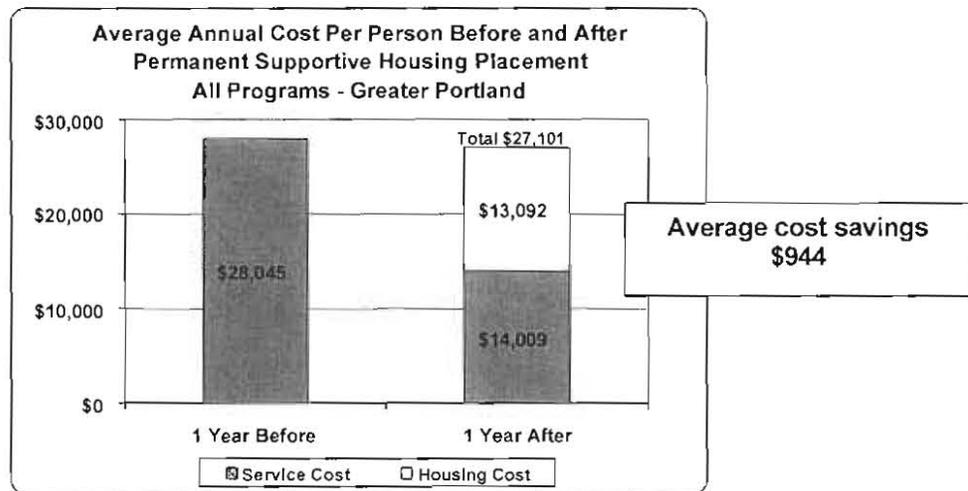
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Maine Cost of Homelessness – Greater Portland

Executive Summary

- ◆ Housing people who are homeless cuts the average costs of services they consume in half.
- ◆ After being housed, the 99 formerly homeless people in this study received 35% more mental health services at 41% LESS cost illustrating a shift away from expensive emergency and psychiatric inpatient care to less expensive outpatient community-based mental health services.
- ◆ Permanent supportive housing cut by more than half emergency room costs (62% reduction), health care costs (59% reduction), ambulance transportation costs (66% reduction), police contact costs (66% reduction), incarceration (62% reduction), and shelter visits (98% reduction).
- ◆ The average annual cost of care savings produced by the first year of living in permanent supportive housing was \$944 per person. The total annual cost savings was \$93,436 for all 99 tenants.

Permanent supportive housing appears to allow individuals significantly more efficient and appropriate service delivery with tangible cost savings. Perhaps not surprisingly, permanent supportive housing appears to improve quality of life for all involved.



Vulnerability Index: Prioritizing the Street Homeless Population by Mortality Risk

The Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals living on the street conducted by Boston's Healthcare for the Homeless organization, led by Dr. Jim O'Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street. For individuals who have been homeless for at least six months, one or more of the following markers place them at heightened risk of mortality:

- 1) more than three hospitalizations or emergency room visits in a year
- 2) more than three emergency room visits in the previous three months
- 3) aged 60 or older
- 4) cirrhosis of the liver
- 5) end-stage renal disease
- 6) history of frostbite, immersion foot, or hypothermia
- 7) HIV+/AIDS
- 8) tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition

In Boston, 40% of those with these conditions died prematurely, underscoring the need for housing and appropriate support for this group.

The Vulnerability Index is administered in a form of a survey, which captures a homeless individual's health and social status. It identifies the most vulnerable through a ranking system which take into account risk factors and the duration of homelessness. This ranking allows those with the most severe health risks to be identified and prioritized for housing and other support.

Dr. Jim O'Connell said it best:

"The painfully obvious lesson for me has been the futility of solving this complex social problem solely with new approaches to medical or mental health care...I dream of writing a prescription for an apartment, a studio, an SRO, or any safe housing program, good for one month, with 12 refills."

From the early successes of its *Street to Home* program, Common Ground has consistently observed that putting names and faces – and now medical conditions – to formerly anonymous street homeless individuals inspires action. The commitment of housing resources and the expedited housing placement of the medically-fragile, have been the direct, concrete results of the use of the Vulnerability Index. The Vulnerability Index has been used in New York City, Los Angeles County's infamous Skid Row, Santa Monica, and New Orleans as a powerful force for change.

This simple and replicable tool, rooted in solid scientific research, helps mobilize communities to act decisively, organize around individuals' housing needs, and solve a seemingly intractable problem.

How to Use the Vulnerability Index in Your Community

Common Ground uses these techniques to strip away the anonymity of street homelessness and reframe homelessness as a public health issue:

1. Assemble community stakeholders (service providers, housing providers, police, business improvement districts, political leadership) to educate on the use of the Vulnerability Index, gain support for the concept, and identify an area of focus
2. Conduct a count of those sleeping outside between the hours of midnight and 6:00 am. The purpose of the count is to create a baseline understanding of the numbers of homeless individuals in an area, and to determine the number of surveys that the project should expect to complete. The average response rate is 83% of those counted.
3. Train volunteers on how to administer the survey (attached) and how to take a good digital photograph.
4. Administer the survey between 3:00 am and 6:00 am for at least three consecutive mornings.
5. Enter the data into a spreadsheet or database.
6. Analyze the surveys to calculate risk factors and establish housing priority list
7. Brief community on the findings.
8. Develop and implement a housing action plan based on results.

Portland, Oregon
Vulnerability Index Fact Sheet
Common Ground Institute for Portland's Bureau of Housing and Community Development
October 24, 2008

In January 2005, the City of Portland and Multnomah County launched a 10-Year Plan to End Homelessness. This plan emphasized immediate placement into permanent housing, along with essential support services and rent assistance, for chronically homeless people. Since the roll-out of the 10-Year Plan, 1,408 chronically homeless adults have moved into permanent housing. However, we know we have many more people living on our streets who need our help. To better inform local planning and system coordination efforts, Portland's Bureau of Housing and Community Development has partnered with Common Ground Institute to implement Common Ground's Vulnerability Index.

The Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals conducted by Boston's Healthcare for the Homeless organization, led by Dr. Jim O'Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street. The Vulnerability Index is administered in a form of a survey, which captures a homeless individual's health and social status. It identifies the most vulnerable through a ranking system which takes into account risk factors and the duration of homelessness. This ranking allows those with the most severe health risks to be identified and prioritized for housing and other support.

From the early successes of its Street to Home program, Common Ground has consistently observed that putting names and faces – and now medical conditions – to formerly anonymous street homeless individuals inspires action. The commitment of housing resources and the expedited housing placement of the medically-fragile, have been the direct, concrete results of the use of the Vulnerability Index. The Vulnerability Index has been used in New York City, Los Angeles County's infamous Skid Row, Santa Monica, New Orleans, and Washington, DC, as a powerful force for change.

By surveying people who are living on our streets here in Portland using the Vulnerability Index, the Bureau of Housing and Community Development now has health and housing data on the individuals living on the streets and in some of our community's shelters. This data will allow Portland to take immediate action on behalf of the most vulnerable people who are living on our streets, as well as identifying and implementing system improvements.

Vulnerability Index - Process

This week, Common Ground staff worked in collaboration the City of Portland's Bureau of Housing and Community Development, and almost 70 volunteers from 25 different organizations to create a by-name list of all those sleeping on the streets and in shelters in selected high concentration areas of Portland. In addition to systematically gathering the names, pictures, and dates of birth of individuals sleeping on the street, the teams also captured data on their health status, institutional history (jail, prison, foster care, hospital, and military), length of homelessness, patterns of shelter use, healthcare and income sources. Common Ground then used information from the Vulnerability Index surveys to identify individuals who are the most vulnerable in our community.

On Monday, October 20, 2008, more than 100 people attended information and surveying training sessions led by Common Ground. Starting Tuesday, October 21, for three consecutive days, 13 teams of 3 or more volunteer surveyors methodically canvassed Portland from 6 am to 8 am and attempted to administer a 45 question survey to everyone observed sleeping outside. Each team was led by an

experienced street outreach worker and included a volunteer from our medical community. 646 surveys were administered. 407 pictures were taken as part of the survey. 302 (47%) individuals met at least one high-risk criterion from the Vulnerability Index. Each person who agreed to participate signed a confidentiality/release of information form, which included specific authorizations related to photographs.

Portland Findings:

646 People Surveyed

47% of All Surveyed Are Medically Vulnerable (302 people)

Vulnerability Index: At-Risk Indicators

Indicators	People in Portland, of Surveys
Tri-Morbid*	231
Over 3X Hospital or ER admits in last year	218
Over 3 ER Visits in last 3 months	275
Age Over 60	19
HIV/AIDS	20
Cirrhosis/End Stage Liver Disease	72
End Stage Renal Disease or Dialysis	29
Frostbite/Hypothermia (Exposure Related)	91

* Tri-Morbid definition: Co-occurring psychiatric, substance abuse, and chronic medical condition.

Other Chronic Health Conditions	People in Portland, of Surveys
Heart Conditions	133
Cancer	47
Diabetes	75
Emphysema	57
HEP C	158
Asthma	155
Tuberculosis	38
Serious Head Injury/Brain Disease	To Be Determined

Age

- The average age is 42
- 38 people are vulnerable and over the age of 55
- Age Range:
 - Under 19: 15
 - 20-29: 89
 - 30-39: 126
 - 40-49: 219
 - 50-59: 126
 - Over 60: 19
- 23 people met the mortality risk criteria specific for people under the age of 25

Years Homeless:

- The average years homeless is 5
- The average years homeless for the Vulnerable Cohort is 7.24
- The longest reported length of homelessness for a single individual is 41 years

Gender

- 77% of people are male

Race

- Of the people surveyed, 65% are White, 15% are African American, 8% are American Indian/Alaskan Native, 10% are Hispanic and 1% is Asian

Veterans

- 22% (N=129) of the people are veterans
- 5% of the 129 veterans reported receipt of VA benefits
- 45 veterans are vulnerable

Hospitalizations/Emergency Room Visits

- 217 people reported at least 3 hospitalizations in the last year, out of all surveyed
- 274 people reported at least 3 ER visits within the past 3 months, out of all surveyed
- A total of 730 ER visits in the past 3 months were reported by respondents at an estimated cost of \$492/visit for an estimated cost of over \$1.43 million per year
- A total of 460 inpatient hospitalizations in the past year were reported by respondents

Income

- 88% of the most vulnerable, had no documented income other than food stamps
- 21% of the most vulnerable, reported panhandling as a source of income

Health Insurance

- 63% (N=408) of people are uninsured
- 199 people in the Vulnerable Cohort are uninsured (66%)

Mental Health/Substance Abuse/Dually Diagnosed

- 229 vulnerable individuals reported or were observed to have mental illness only
- 279 vulnerable individuals reported or were observed to have a history of substance abuse only
- 217 vulnerable individuals reported or were observed to be dually diagnosed

History of Jail/Prison

- 80% of people reported having been to jail
- 30% of people reported having been to prison.

Foster Care History

- 182 individuals reported having been in foster care
- 58% (N=100) are vulnerable

Victim of Violent Attack:

- 45% of the people reported being a victim of violent attack since becoming homeless

HIV/AIDS

- 3% (20) of individuals report HIV/AIDS.

For more information on Portland's Vulnerability Index Data

Contact: Liora Berry, 503-823-2391 or lberry@ci.portland.or.us

Coordinator, Ending Homelessness Initiative

Bureau of Housing and Community Development

City of Portland

Common Ground Institute

Founded in 1990, Common Ground's mission is to end homelessness through innovative programs that transform people, buildings, and entire communities. Common Ground pioneered the concept of supportive housing – affordable housing with on-site social services – as a solution to homelessness, and today we are one of the largest developers of supportive housing in the United States. As program innovators, we address the needs of individuals and families who are most at risk of becoming homeless, as well as those who are chronically homeless. We bring together service providers, government agencies, landlords, businesses, and members of the community to support homelessness prevention and housing initiatives.

In 2007, Common Ground launched its Common Ground Institute (CGI), a national technical assistance initiative designed to bring innovative methodologies and hands-on field support to communities seeking solutions to homelessness. The Institute's overarching goal is to end homelessness by collaborating with government leaders, local organizations, and private developers in strategically situated communities. In each city, CGI pursues four objectives in support of this goal: create housing, build knowledge, test and model innovative solutions, and promote effective practices.

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At Risk Qualifiers:

More than six months on the streets and at least one of the following:

- Tri-morbidity (a combination of at least one from each category below) (+1)
- More than 3 hospitalizations or ER visits over a year (+1) - Question 18 + Question 19
- More than 3 Emergency Room visits in the past three months (+1) - Question 18
- 60 years or more of age (+1) - Question 10
- HIV+/AIDS (+1) - Question 20/F
- Kidney Disease / ESRD or Dialysis (+1) - Question 20/A
- Liver Disease / HEP C / Cirrhosis / End stage liver disease (+1) - Question 20/D
- Cold weather injuries (frostbite, immersion foot, hypothermia) (+1) - Question 20/B

Tri- Morbidity

- **Mental Health + Serious Medical Condition + Substance Abuse**
- **Client must have at least one condition in each of the following areas to qualify for tri-morbidity**

Mental Health Qualifiers:

- Being treated / receiving counseling for mental health issues - Question 20/S
- Taken to the hospital against your will for mental health reasons - Question 20/T
- Observed signs or symptoms of Mental Illness - Question 20/U

Serious Medical Condition Qualifiers:

- Kidney Disease / ESRD or Dialysis - Question 20/A
- Liver Disease / HEP C / Cirrhosis / End stage liver disease - Question 20/D
- Heart Disease/ arrhythmia/ irregular heartbeat - Question 20/E
- HIV+ / AIDS - Question 20/F
- Emphysema - Question 20/G
- Diabetes - Question 20/H
- Asthma - Question 20/I
- Cancer - Question 20/J
- Hepatitis C - Question 20/K
- Tested Positive for TB - Question 20/L
- Observed signs or symptoms of serious physical health condition - Question 20/M

Substance Abuse Qualifiers:

- Ever abused alcohol or drugs, or told you do - Question 20/N
- History of injection drugs - Question 20/P
- Has been treated for alcohol or drug abuse - Question 20/Q
- Consumed alcohol everyday for the last 30 days - Question 20/O
- Observed signs or symptoms of alcohol or substance abuse - Question 20/R

Time Considerations:

- Length of time homeless
 - Vulnerability is triggered at 6 or more month homeless
 - Database should be able to conduct real-time assessments of vulnerability as someone's length of time homeless increases.
- Age
 - Age over 60 is a determinant for vulnerability
 - Database should be able to conduct real-time assessments of vulnerability as someone's age increases



Ending Homelessness with Mainstream Housing Resources

Whitepaper 2 of 3 Local Preferences in Housing Choice Voucher Programs

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VISION
The end of homelessness in Arizona.

MISSION
To serve as a leader in the efforts to end homeless in Arizona through advocacy, education, and coordination with local communities.

AZCEH Introduction and Whitepaper Vision

The Arizona Coalition to End Homelessness (AZCEH) provides leadership in statewide efforts to end homelessness through advocacy, education and coordination with local communities and initiatives. AZCEH activities include its annual statewide conference; coordination of focused service initiatives such as Arizona StandDown for homeless veterans and Project H3: Home, Health, Hope for long term vulnerable homeless individuals and families; and providing education opportunities for service providers, policy makers and advocates working on behalf of men, women and children experiencing homelessness.

AZCEH coordinates collaborative whitepapers as one of many tools in our advocacy and education efforts. This series of whitepapers seek to inform policy makers, service professionals and advocates on strategies to end homelessness with existing mainstream housing resources. We hope that these papers will serve as impetus to change agents and community leaders to call for systems change through the adoption of the policies and practices suggested herein.

In Whitepaper 1, we unveil the abundance of Housing Choice Vouchers available in Arizona to serve individuals and families experiencing homelessness through a reprioritization of turnover vouchers. This paper also discusses some of the policies and practices used by public housing authorities to maintain and update their waiting lists and the disparate impact of such policies on persons experiencing homelessness. Finally, the first whitepaper emphasizes the importance of making sure mainstream government resources are the last resort for individuals and families in need in order for these finite resources to have maximum impact in our communities.

The second whitepaper explores the creation of local preferences for individuals and families experiencing homelessness in Housing Choice Voucher programs. This paper will demonstrate the alignment of such policies with federal, state and local guidelines. It will lay out the mechanics for public housing authorities to implement these preferences and will look at examples of such strategies here in Arizona and across the country.

Our third and final whitepaper in this series explores the importance of coupling client centered, wrap-around supportive services with the Housing Choice Voucher program for formerly homeless individuals and families. The Housing Choice Voucher program is a tremendous resource for ending homelessness in communities, but our public housing authority partners are not expected to solve this problem alone. The third whitepaper will focus on the role of “Navigators” in Project H3: Home, Health, Hope, and how this unique service delivery system integrates best practices from existing supportive services and natural support systems to improve outcomes using “housing first” and recovery principles.

Whitepaper 2: Local Preferences in Housing Choice Voucher Programs

As part of its 2010-2015 Strategic Plan, the U.S. Department of Housing and Urban Development (HUD) has established several laudable goals to guide its work. Two of HUD's sub goals describe the outcomes HUD aims to achieve around preventing and ending homelessness:

- End homelessness and substantially reduce the number of families and individuals with severe housing needs.
- Utilize HUD assistance to improve housing stability through supportive services for vulnerable populations, including the elderly, people with disabilities, homeless people, and those individuals and families at risk of becoming homeless.

This whitepaper will look closely at the use of a critical mainstream HUD resource, the Housing Choice Voucher (HCV) program, formerly known as Section 8, to achieve the first goal. We will demonstrate federal, state and local support for using the HCV program as a means to ending homelessness in our communities. The third whitepaper in this series will explore the importance of coupling client centered, wrap-around supportive services with the HCV program for formerly homeless individuals and families.

Alignment with HUD Strategy

HUD lists several strategies for accomplishing its goal to end homelessness and reduce the number of families and individuals with severe housing needs. We will focus on three of them here:

- Provide additional individuals and families with rental housing subsidies.
- Work with state and local governments to expand rental assistance and prevent homelessness.
- Improve access to HUD-funded housing assistance by eliminating administrative barriers and *encouraging prioritization of households most at risk for homelessness.*

These strategies align closely with our Whitepaper 1 example of creating housing abundance for long term, vulnerable homeless persons by reprioritizing just a small percentage of existing HCVs. In particular, the third strategy is echoed by Fred Karnas, Senior Advisor to HUD Secretary Donovan, in his declaration at the Arizona NAHRO 2010 Annual Conference that "we need to move past using boutique programs for special populations to making mainstream HUD programs work for everyone."

The HCV program does not currently work for everyone, especially for long term, vulnerable homeless individuals. The problem has less to do with cumbersome federal regulations and more to do with local policy and administration of the HCV program. Public Housing Authorities (PHAs) have a considerable amount of latitude in operating the HCV program, including how to target particular populations in their communities. To best support HUD's stated goals, PHAs should prioritize those individuals and families with the worst case housing problems for housing choice vouchers through the use of local preference systems.

What is a Local Preference?

A local preference system is a method that PHAs may use in selecting applicants for participation in the HCV program. This method targets specific populations for assistance based upon local housing needs and priorities. HUD regulations require that PHAs base local preference systems on generally accepted data sources and consider public comment. They also must detail these systems in their administrative plans. Additionally, HUD allows PHAs to limit the number of applicants that may qualify for a local preference, thereby creating a designated number of vouchers “set aside” for a target population.

Across the country, PHAs have used local preference systems to target various types of applicants, including those that reside in specified geographic areas (generally the jurisdiction of the PHA), working families, persons with disabilities, families that include victims of domestic violence, and persons who are elderly, displaced or homeless.

Historical Context for Local Preferences

Prioritizing those most in need in mainstream HUD programs is not a new concept. Prior to the Quality Housing and Work Responsibility Act (QHWRA) of 1998, mandatory “federal preferences” required PHAs to target individuals and families:

- Paying more than 50% of their income towards housing
- Living in severely substandard housing, and
- Involuntarily displaced from housing.

These “federal preferences” helped to ensure that Section 8 certificates were targeted to people with the most severe housing problems first. The reform of the Section 8 program under QHWRA provided local jurisdictions the flexibility to determine how best to target this resource in their own communities.

Reliable Data and Consistency with Plans

HUD requires that local preferences be based upon reliable and valid data on the housing needs of a community and that they be consistent with the PHA Agency Plan and Consolidated Plan for a PHA’s jurisdiction.

According to the 2010-2014 State of Arizona Consolidated Plan’s Summary of Primary Housing Needs (Page 5):

*There remains a substantial need for a range of housing options and support services for people who are homeless and at risk of becoming homeless. The January 2009 statewide homeless count recorded over 14,000 homeless persons, over 6,000 of them unsheltered. The economic recession is placing an additional burden on the state’s resources to provide housing and support services. Homeless persons and at risk homeless persons have a significant need for prevention services, emergency shelter, transitional housing, and **permanent supportive housing**.*

Arizona also lays out three priorities in its Strategic Plan:

- Priority 5: Encourage a range of services to help people move from homelessness to permanent housing and maintain independent living.
- Priority 6: Increase the number of transitional and permanent supportive housing units for the homeless.
- Priority 7: Offer services and funding to help prevent people from becoming homeless.

The City of Phoenix 2005-2010 Consolidated Plan (Page 34) states:

Without permanent housing as an end goal, the entire Continuum of Care ceases to function as a dynamic system moving people toward stability and self-sufficiency. Instead, the system becomes a warehouse for people. The only lasting solution to homelessness is access to housing that is affordable and, for certain populations, linked to necessary supportive services.

The Phoenix Plan's overall strategy for the goal to effectively transition persons who are homeless to appropriate affordable, safe and quality permanent housing includes:

- *Provide permanent supportive or permanent independent housing,*
- *Utilize rental and utility assistance to prevent and create appropriate housing settings for persons who are homeless, and*
- *Develop new facilities/programs/housing units with minimal negative neighborhood impact.*

Arizona and major jurisdictions throughout have recognized the need to prioritize persons experiencing homelessness in their housing program efforts, citing permanent, affordable housing with supports when necessary as the solution to ending homelessness. Targeting housing choice vouchers through local preferences is an ideal strategy towards the accomplishment of the goals outlined in these federal, state and local plans and offers the greatest abundance of housing resources with minimal impact on neighborhoods.

Amending the HCV Program Administrative Plan

Once a PHA has decided to create a local preference for persons experiencing homelessness in their communities, that PHA must amend its HCV program Administrative Plan. This process requires the PHA to provide an opportunity for public comment on the proposed changes, including comments from existing participants in the HCV program. Once public comments have been considered, the changes to the Administrative Plan must be voted on for final approval by the PHA's governing board.

Preference for Long Term Vulnerable Homeless

Vulnerable and long term homeless persons face myriad barriers in accessing HCV programs, but strategically crafted local policies can help ensure maximum HCV accessibility. When developing local homeless preferences, PHAs should consider the requirement of an assessment measuring the vulnerability of persons experiencing homelessness to further define their target populations. PHAs may also require wrap-around supportive services designed to assist individuals or families in complying with their obligations in the HCV program.

The primary purpose of requiring the use of a vulnerability assessment is to help to ensure that communities target those most in need for these critical and finite resources. It is important that these assessments are reliable and consistent in their use and that they address the specific concerns of the local community in their efforts to define their target populations. Communities across our state possess varied degrees of capacity and concerns around their local homeless populations which will determine the creation or selection and use of vulnerability assessments in communities.

Our recommendation for the language of a PHA local preference for long term homelessness is:

Individuals and families experiencing homelessness who have been determined vulnerable through the use of a vulnerability index. Applicants under this preference must also receive supportive services provided by an area agency designed to assist the individual or family in complying with their obligations in the HCV program.

This preference requires a pool of potentially eligible applicants that have been determined to be vulnerable through the use of a reliable vulnerability index. The Vulnerability Index™, developed by Common Ground, highlights a narrow, reliable population of those most in need, the majority of which are also chronically homeless. As the Maricopa County initiative of the 100,000 Homes Campaign, Project H3 utilized the Vulnerability Index™ to determine vulnerability amongst the street homeless population in April 2010. Consistent with national results, 43% of those surveyed in Project H3 were determined vulnerable, averaging 7.8 years on the streets. 92% of those determined vulnerable also met the HUD definition of chronic homelessness.

AZCEH recommends the use of the Common Ground Vulnerability Index™ for consistency with the 100,000 Homes Campaign promoting consistent national data on vulnerable and long term homelessness. The Vulnerability Index™ is also recommended for its ease of use and ability to be administered by volunteers, rather than clinicians, enabling a greater number of homeless people to be surveyed.

Opening the Waiting List...and Keeping It Open

PHAs currently close their waiting lists for HCV programs as soon as they have a sufficient number of families to select from when openings in these programs occur. Unfortunately, this means that the majority of Arizona PHA waiting lists for HCV programs are closed to new applications for assistance. In order for new vulnerable applicants to be eligible for local preference placement, thereby moving to the top of the waiting list for selection, these waiting lists must be open for new applications.

PHAs have options in opening their waiting lists for new applicants. First, they may choose to accept all applications from potentially eligible individuals and families. Still, the need for affordable housing in our communities is great, and the number of new applicants for admission to waiting lists is likely to range in the thousands, placing a difficult administrative strain on PHAs.

PHAs may also open their waiting lists exclusively for targeted populations, including those populations that they have identified for local preferences through the HCV program. Public notification of new waiting list openings must simply state any limitations on who may apply for assistance. In effect, this option enables each PHA to close only a portion of its waiting list instead of the entire waiting list. The PHA may continue to receive applications from applicants qualifying for a specific local preference category, i.e. long term, vulnerable homeless individuals and families, while closing its waiting list to all other groups.

Examples of PHA Partners in Ending Homelessness

Several PHAs across the country and in Arizona have employed strategies to prioritize their most vulnerable homeless for assistance in their HCV programs. Denver's PHA provides approximately 381 vouchers to special needs populations through a series of preferences for participants served by specific programs and organizations in the community. Washington D.C. has prioritized chronically homeless individuals with its HCV program through the use of the Common Ground Vulnerability Index™, ending homelessness for over 1,000 long term, vulnerable homeless in a little over two years. Salt Lake City's local and county PHAs have also used local preferences for scattered site and project-based vouchers for their homeless population, employing a vulnerability assessment to more effectively target the housing to those most in need.

Here in Arizona, several PHAs have recently created local preferences to prioritize persons experiencing homelessness in their HCV programs. In Tempe the PHA has approved a general homeless preference and is working with local service organizations to ensure that individuals and families experiencing homelessness in Tempe apply for assistance as they open their HCV waiting list this spring.

As a result of their partnership with Project H3, the Phoenix Housing Department set aside 25 vouchers in their program for long term, homeless individuals or families determined to be vulnerable by the Common Ground Vulnerability Index™. As of this writing, 14 households have been assisted with those vouchers, 2 are searching for housing and the remaining 9 vouchers will be leased up in the next 60 days.

In Glendale, the PHA updated its local homeless preference to target individuals and families surveyed during Project H3's survey week in Glendale. One individual has been housed in their HCV program as a result of these efforts with plans to identify additional candidates in the near future.

Tucson has also enrolled in the 100,000 Homes Campaign, and their 51 Homes initiative will conduct its survey week in mid-April 2011. In Tucson, the local PHA is a strong partner in the 51 Homes initiative and has led in the commitment of housing opportunities through both HUD-VASH and HCV assistance for the long term, vulnerable homeless individuals and families identified through the Common Ground Vulnerability Index™. The Tucson PHA has approved a limited local preference for this effort in their Administrative Plan which has been approved by their City Council and Mayor and PHA Board.

In Mesa, the Housing Governing Board approved the PHA's recommendation to adopt the local preference for long term, vulnerable homeless recommended by AZCEH. Additionally, the Mesa PHA has opted to open the waiting list specifically for this local preference and will continue to accept applications from those meeting this local preference. Mesa has also innovated in the area of supportive services for this population, approving Community Development Block Grant (CDBG) funds for a community service provider to provide "Navigation" services to long term, vulnerable homeless admitted to the Mesa HCV program. Our third and final whitepaper in this series will focus on supportive services ideally combined with the HCV program.



VISION
The end of homelessness in Arizona.

MISSION
To serve as a leader in the efforts to end homeless in Arizona through advocacy, education, and coordination with local communities.

Retooling Existing Resources for Systems Change and Immediate Housing Opportunities

We know that permanent, affordable housing with appropriate supports as necessary is the solution to end homelessness. Scattered sites, tenant based rental assistance provided through the Housing Choice Voucher program is a viable solution to ending long-term and vulnerable homelessness when coupled appropriately with navigation services. While we must continue to support increases in funding for targeted HUD housing programs like the Shelter Plus Care and Supportive Housing programs, much can be accomplished by simply retooling mainstream resources already available to us in our communities. PHAs can have significant impact as partners and champions of ending homelessness through careful targeting of their HCV programs as strategic tools to combat homelessness in our communities.

A note on References: For space purposes this document contains underlined hyperlinks to on-line resource information as opposed to traditional references. If you are reading a printed version, please visit www.azceh.org to obtain an electronic version to connect to on-line resources for additional information or fact-checking purposes.

Code of Federal Regulations

Title 24 - Housing and Urban Development

Volume: 4

Date: 2011-04-01

Original Date: 2011-04-01

Title: Section 982.207 - Waiting list: Local preferences in admission to program.

Context: Title 24 - Housing and Urban Development. CHAPTER IX - OFFICE OF ASSISTANT SECRETARY FOR PUBLIC AND INDIAN HOUSING, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT. PART 982 - SECTION 8 TENANT BASED ASSISTANCE: HOUSING CHOICE VOUCHER PROGRAM. Subpart E - Admission to Tenant-Based Program.

§ 982.207 **Waiting list: Local preferences in admission to program.**

(a) *Establishment of PHA local preferences.* (1) The PHA may establish a system of local preferences for selection of families admitted to the program. PHA selection preferences must be described in the PHA administrative plan.

(2) The PHA system of local preferences must be based on local housing needs and priorities, as determined by the PHA. In determining such needs and priorities, the PHA shall use generally accepted data sources. The PHA shall consider public comment on the proposed public housing agency plan (as received pursuant to § 903.17 of this chapter) and on the consolidated plan for the relevant jurisdiction (as received pursuant to part 91 of this title).

(3) The PHA may limit the number of applicants that may qualify for any local preference.

(4) The PHA shall not deny a local preference, nor otherwise exclude or penalize a family in admission to the program, solely because the family resides in a public housing project. The PHA may establish a preference for families residing in public housing who are victims of a crime of violence (as defined in 18 U.S.C. 16).

(b) *Particular local preferences—(1) Residency requirements or preferences.* (i) Residency requirements are prohibited. Although a PHA is not prohibited from adopting a residency preference, the PHA may only adopt or implement residency preferences in accordance with non-discrimination and equal opportunity requirements listed at § 5.105(a) of this title.

(ii) A residency preference is a preference for admission of persons who reside in a specified geographic area ("residency preference area"). A county or municipality may be used as a residency preference area. An area smaller than a county or municipality may not be used as a residency preference area.

(iii) Any PHA residency preferences must be included in the statement of PHA policies that govern eligibility, selection and admission to the program, which is included in the PHA annual plan (or supporting documents) pursuant to part 903 of this title. Such policies must specify that use of a residency preference will not have the purpose or effect of delaying or otherwise denying admission to the program based on the race, color, ethnic origin, gender, religion, disability, or age of any member of an applicant family.

(iv) A residency preference must not be based on how long an applicant has resided or worked in a residency preference area.

(v) Applicants who are working or who have been notified that they are hired to work in a residency preference area must be treated as residents of the residency preference area. The PHA may treat graduates of, or active participants in, education and training programs in a

residency preference area as residents of the residency preference area if the education or training program is designed to prepare individuals for the job market.

(2) *Preference for working families.* The PHA may adopt a preference for admission of working families (families where the head, spouse or sole member is employed). However, an applicant shall be given the benefit of the working family preference if the head and spouse, or sole member is age 62 or older, or is a person with disabilities.

(3) *Preference for person with disabilities.* The PHA may adopt a preference for admission of families that include a person with disabilities. However, the PHA may not adopt a preference for admission of persons with a specific disability.

(4) *Preference for victims of domestic violence.* The PHA should consider whether to adopt a local preference for admission of families that include victims of domestic violence.

(5) *Preference for single persons who are elderly, displaced, homeless, or persons with disabilities.* The PHA may adopt a preference for admission of single persons who are age 62 or older, displaced, homeless, or persons with disabilities over other single persons.

(c) *Selection among families with preference.* The PHA system of preferences may use either of the following to select among applicants on the waiting list with the same preference status:

- (1) Date and time of application; or
- (2) A drawing or other random choice technique.

(d) *Preference for higher-income families.* The PHA must not select families for admission to the program in an order different from the order on the waiting list for the purpose of selecting higher income families for admission to the program.

(e) *Verification of selection method.* The method for selecting applicants from a preference category must leave a clear audit trail that can be used to verify that each applicant has been selected in accordance with the method specified in the administrative plan.

[64 FR 26643, May 14, 1999, as amended at 64 FR 56912, Oct. 21, 1999; 65 FR 16821, Mar. 30, 2000]

100,000 HOMES

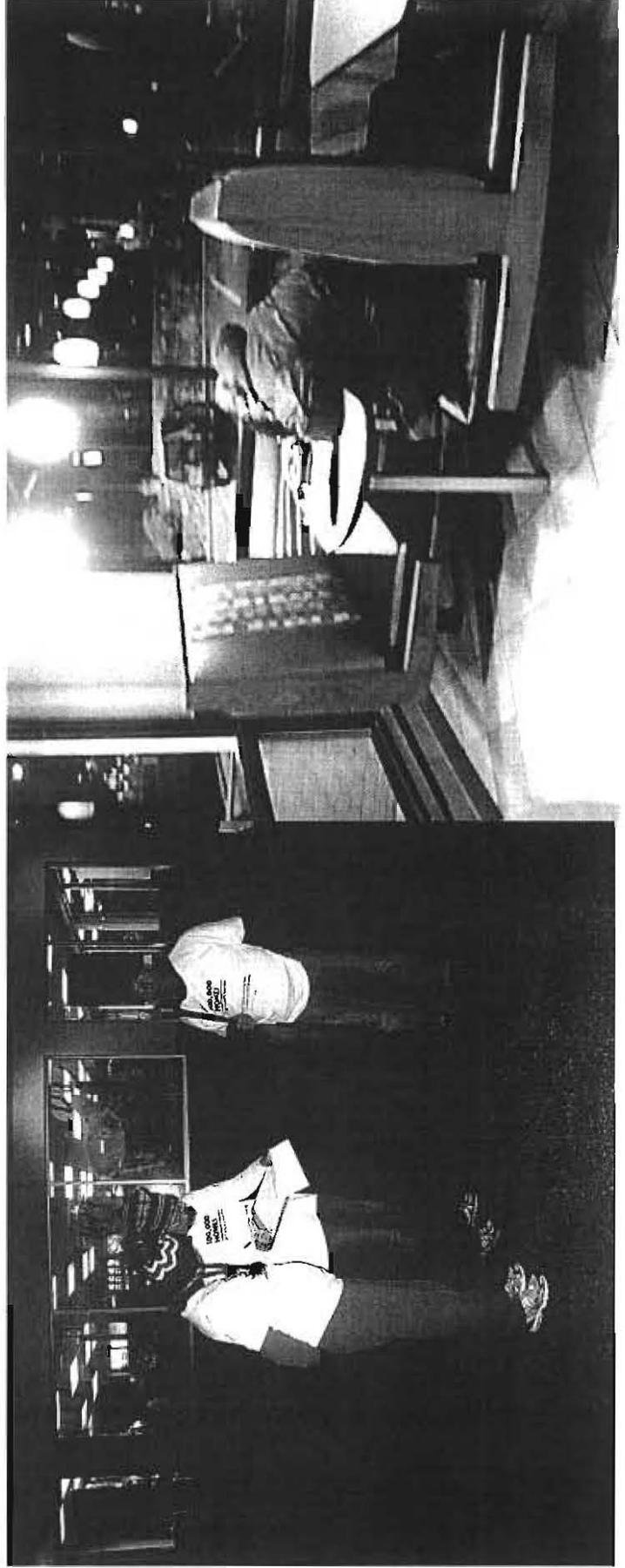
BETHESDA CHAPTER

**Montgomery County Council
Health and Human Services Committee
December 1, 2011**

100,000 HOMES

BETHESDA CHAPTER

Community Volunteers – Survey Teams



Community Volunteers



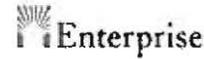
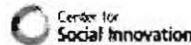
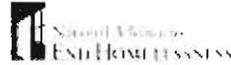
What is the national campaign?

- *A national movement to find and house 100,000 vulnerable homeless people in three years*
- Creates a conversation about a new way to prioritize, match those in greatest need of housing



PARTNERS AND SPONSORS

Bank of America



HOME FOR GOOD



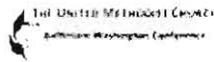
Corridor Initiative

Open Pathways



NATIONAL LEADER IN HOME OWNERSHIP

WEINGART FOUNDATION



LANGLISH FOUNDATION



invisible PEOPLE.TV



COMMUNITY SOLUTIONS

The 100,000 Homes Campaign is a national project of Community Solutions. Our mission is to empower communities and home seekers by building partnerships, sharing innovations, and connecting vulnerable people to homes and a path to the middle class. We leverage the power of experience and expertise from those who are building and operating permanent supportive housing and bringing a range of community solutions together to create and share cost-effective solutions to support our mission. We are building a national network of problem solvers, data and connected stakeholders, ideas, and to do lists that networks can solve urgent, complex and costly community challenges.

Bethesda Chapter Outcomes:

54 People Contacted

40 Participated in the Survey

Average Age: 46.8

32 Male / 8 Female

6 Military Veterans

Bethesda Chapter Outcomes

19 - Individuals reported Mental Health Issues

14 - Have Participated in Substance Abuse Treatment

20 - Sleep most frequently on the streets

6 - Sleep most frequently on buses/ metro

2 - Sleep most frequently in Shelters



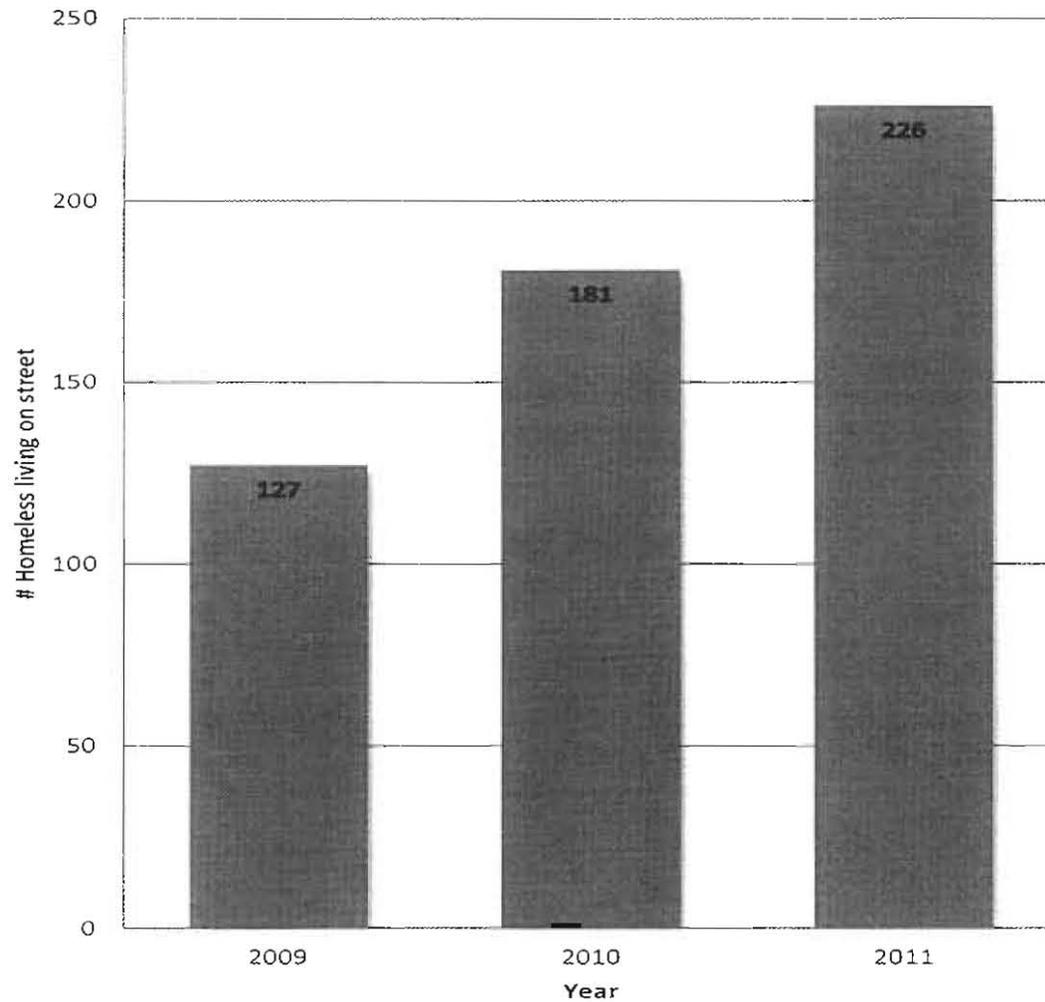
Local Goal Setting & Accountability

- Campaign is a **partnership**
- Bethesda's Goals
 - Target vulnerable individuals and families who are experiencing homelessness, living on the streets.
 - Create housing targets
 - Improve the way we house vulnerable people in our community.

Communications Contacts

- Susan Kirk, Executive Director, Bethesda Cares, Inc.
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 - 301-907-9244
 - john@bethesdacares.org

77% Increase in Homeless Population Living on the Streets in Montgomery County



Source: HUD Point-in-Time Count for Montgomery County

MONTGOMERY COUNTY
HOMELESS VETERANS
HUD – VASH HOUSING VOUCHERS

59 Veterans

Successfully Housed with Supportive Services
(Home Visits)

100%

Housing Retention Rate over the past two years

*Highest Performing, Results Driven
Permanent Supportive Housing Program in Montgomery County
*No Evictions

Ends Homelessness - Permanent Housing is a Permanent Solution



HUD VASH

Total number of Housing Assessment Tools used =

0



United States Interagency Council on Homelessness

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The Role of Public Housing Agencies in Preventing and Ending Homelessness

Home > [Our Objectives](#) > [Affordable and Sustainable Housing](#)

Public Housing Agencies (PHAs) have a very important role to play in preventing and ending homelessness. The current economic environment requires new partnerships and ways to leverage existing infrastructure/federal resources in order to benefit people at risk of or experiencing homelessness in communities across the country. We cannot wait for significant increased investments in targeted homeless assistance programs.

USICH Director of Housing Policy Kristy Greenwall provides an overview of the critical role PHAs play in helping their communities end homelessness, including 5 specific steps that PHAs can take over the next twelve months.

[Download Brochure](#)

USICH hosted a webinar on this topic on August 11, 2011.

[Watch the Webinar](#)

USICH also interviewed three PHA leaders about what it takes to build successful programs that effectively target and maintain housing stability for people at-risk of or experiencing homelessness. Charles Hillman from the

[Access to Justice](#)

[Accessing Health Care](#)

[Benefits](#)

[Applicable and Supportive Housing](#)

[The Role of Public Housing Agencies in Preventing and Ending Homelessness](#)

[Policy Key Partnerships](#)

[Opening Doors](#)

[Implementing](#)

[Collaborative/Interorganizational](#)

[Housing Activities & Components](#)

[Cooperative Housing](#)

[Rapid Re-housing](#)

[Washington & Portland Programs to Assist](#)

[How to Work with Local Leaders in Suburban](#)

[Seattle](#)

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[Improving ASP Outcomes](#)

[Collaboration, Capacity, and Planning](#)

[Homeless Crisis Response](#)

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[Job Loss](#)

[Public Health](#)



Public Housing Agency building in an urban neighborhood.