INTERAGENCY COMMISSION ON HOMELESSNESS
Meeting Summary Notes
Wednesday, December 15, 2016

Welcome | Introductions | Approval of September 14 meeting notes

Homeless Resource Day (HRD)
The 6th Annual HRD renamed the Nadim Khan Memorial Homeless Resource Day was another successful event. HRD is a “one-day, one stop” event where individuals and families experiencing homelessness can access benefits, medical care, behavioral health, resources, veteran services, a variety of social services, giveaways/donations, and personal care. There were 367 households served. This year prescreening for housing was added to the services provided at HRD. A total of 77 VI-SPDAT surveys were completed, and of those 31 new persons experiencing homelessness were identified. The Commission reviewed highlights of the HRD final report and noted the increase in guests who reported as permanently housed. This trend will be studied next year.

Update on the Winter Overflow Shelter
The Silver Spring overflow shelter will support 70 clients.

2017 Point in Time (PIT) Count
The point in time is an annual survey and count of homeless persons in Montgomery County who are residing in sheltered and unsheltered environments. This annual count is a federal requirement by Housing Urban and Development (HUD). These numbers are reported each year to HUD and Congress and affects the federal funding we receive in Montgomery County.

• The 2016 PIT count is expected to increase because of the results of the Outreach Blitz
• Waitlist for the shelters has somewhat decreased
• The numbers of homeless individuals have remained the same
• 2017 PIT is scheduled on January 25th
  - Training will be provided the same evening of the count and on-line
  - Outreach will occur in teams for the entire county with the support of Outreach Programs
  - Teams will be outdoors counting approximately from 9 p.m. – 1 a.m.
  - If interested in volunteering and for more information, please contact Kim Ball at Kim.Ball@montgomerycountymd.gov

Gaps in Chronic Homelessness
Montgomery County is committed to providing permanent housing to all County residents experiencing chronic homelessness by December 31, 2017.

Per directive from the U.S. Department of Housing and Urban Development (HUD), for Montgomery County to effectively end chronic homelessness, there should be no more than three unhoused chronically homeless individuals or families in the County at any time.
**Chronic Homelessness Definition**

As approved by the Montgomery County Continuum of Care, chronic homelessness is determined in Montgomery County by following the Federal definition, which was revised at the end of 2015. Under the new definition, for an individual to be chronically homeless, they must:

1. Have a disability, and
2. Live in a place not meant for human habitation, or a safe haven, or in an emergency shelter; or
3. Live in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility, and
4. Have been homeless continuously for at least 12 months or on at least four separate occasions in the last three years where the combined occasions must total at least 12 months. [Each period separating the occasions must include at least seven nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.]

Chronically homeless families are those in which the head of household meets the above definition.

**Estimated Count**

To plan the steps to end chronic homelessness in Montgomery County, it is essential to have both an accurate count of those who currently meet the definition as well as a good estimate of those who are likely to meet the definition in the future. To that end, the Interagency Commission on Homelessness (ICH) and the members of the Continuum of Care have spent the past several months focused on compiling and reviewing data.

This effort has included:

1. Performing a name-by-name review of the existing list of clients in the County’s Homeless Management Information System (HMIS).
2. Organizing more than 80 volunteers to do an “Outreach Blitz” over three days in October to identify and assess unsheltered individuals throughout the County. During the Blitz, 231 individuals were identified by the volunteers, and 142 of these individuals completed VI-SPDAT surveys. Fifty-five (55) of the individuals engaged as part of the Outreach Blitz were not in the HMIS system, so they were each added; 69 of the individuals who were engaged had HMIS records that had been closed, so these were reopened.
3. Working with direct-service providers, including faith-based organizations, to engage and assess individuals who may be homeless but are not accessing County-funded programs.
4. Reviewing both HMIS and outreach records to check duplication.

Based on this review, as of December 1, 2016 it is estimated that there are **currently 274 individuals in Montgomery County who are chronically homeless** or will meet the definition in the 13 months between now and December 31, 2017. This count includes **160 individuals who have been confirmed as chronic** either through existing documentation or provider reports, and **114 who are “at-risk”**, meaning they are very likely to be determined to meet the definition over the next 13 months.
At Risk is defined as below:

- A Client who meets the disability and household requirements but has not met the time requirement such that they are up to three months short of the continuous year
  OR
- A Client who meets the disability and household requirements but has not met the time requirement such that they have 3 episodes of homelessness summing a minimum of 9 months of homelessness
  OR
- A Client who meets the household and time requirements but has not met the documented disability portion of the definition where a provider strongly suspects the presence of a disability condition and is actively working on getting said disability documented
  OR
- A Client who met the definition of Chronicity in terms of documented disability, household requirements and time homeless but have been institutionalized for more than 90 days

The count of at-risk individuals includes the above for the federal chronic homeless definition, but are expected to pass the threshold during 2017.

There are currently no chronically homeless families in the County.

Existing Resources to House Chronically Homeless Individuals
Between existing resources and two new programs that are now underway, it is anticipated that 100 chronically homeless individuals will receive placements in Permanent Supportive Housing (PSH) programs in the County by December 31, 2017. These 100 units will come from three different sources.

The first source is existing PSH programs which prioritize placement for chronically homeless individuals, which are expected to account for 63 units. There are currently 653 PSH units for singles and 339 units for families which are part of the Continuum. For a variety of reasons, including relocation, reunification with family, and death, a percentage of the County’s existing PSH units turn over each month and is available to new tenants. Over the past 6 months, the monthly turnover of PSH in the County has been 4.85 per month. As such, by December 31, 2017, (over a 13-month period) this would be 63 PSH units available through turnover.

The second source is the new Keys First program, funded through HUD contract, which has 25 total placements, and as of December 1, 2016 includes 20 open PSH units for chronically homeless individuals. And the third source is the new Progress Place site, which is anticipated to have 17 PSH placements for chronically homeless individuals.

Need for New Placements
The goal is to house 274 chronically homeless individuals in 13 months. Through the anticipated annual turnover of 63 existing PSH units, the new Keys First capacity of 20 and the new Progress Place capacity of 17, there is a total of 100 existing or planned PSH placements which can be expected to provide housing for 100 chronically homeless individuals over this period. This leaves a gap of 174 units needed (274 - 100 = 174).
Ideas to Meet the Gap

Strategies to meet the gap of 174 units will include exploring opportunities for new housing and supportive services resources, and as well as looking at leveraging existing programs, which may include some realignment. Some potential opportunities and target numbers could include:

1. “Move-Up” program, designed to enable stable tenants who are currently in a PSH program but no longer need regular social services to transition to non-PSH subsidized housing with limited after care. At this point, the space in the PSH program would be made available to new chronically homeless individuals who need the more intense level of services provided in the PSH model.

To identify current PSH tenants who might be good candidates for a move-up to less intensive programs, all PSH providers have been asked to complete an Acuity Scale form their tenants by December 31, 2016.

Based on the results of this survey, it is hoped that up to 50 current PSH tenants will be identified who could transition to a subsidized housing units at 30% or 40% AMI with significantly reduced ongoing service needs.

If services are discontinued for this group of program participants and no additional housing resources are made available, an additional 9 chronically homeless individuals could be housed.

To make a move-up model work, some combination of Moderately Priced Dwelling Units (MPDUs) or rental subsidies or housing choice vouchers will be required for the formerly homeless individuals who are making the transition a less service connected housing placement.

2. Rapid Re-housing program – in this model, tenants are given time limited rental assistance along with an appropriate level of social services support. This is best suited to persons who have or can obtain a sufficient and reliable income and don’t require much if any ongoing supportive services. While the number of chronically homeless individuals who will have both the potential income and limited need for services is low, this model has been successfully implemented in other jurisdictions. The County has had a successful Rapid-Rehousing program targeting families, but has not fully engaged on such an effort for individuals.

Programs may need to be restructured to be more flexible. Flexibility would allow RRH programs to serve chronically homeless individuals who do not need an on-going housing subsidy or long-term case management.

Successful RRH programs typically include a job development/ employment component. Agencies providing vocational services will be asked to accept referrals for individuals experiencing or at risk of chronic homelessness.

It was recommended that we explore collaborating with Workforce Montgomery – is a coordination of public and private-sector policies and programs that provides individuals with the opportunity for a sustainable livelihood and helps organizations achieve exemplary goals, consistent with the societal context. The agency helps meet the needs of the underemployed and unemployed, and Section 3 housing – it is a means by which HUD fosters local economic development, neighborhood economic improvement, and individual self-sufficiency. Section 3
is the legal basis for providing jobs for residents and awarding contracts to businesses in areas receiving certain types of HUD financial assistance.

**Action:** Amanda Harris asked that agencies to inform Special Needs Housing if they or other agencies provide employment, job development or vocational services for those experiencing homelessness. Not enough to provide permanent supportive housing (PSH). There is a need to increase income so that persons going into PSH can sustain their housing.

**Action:** Increase membership of the Interagency Commission on Homelessness (ICH) to include Workforce Montgomery and other agencies that provide employment services.

3. **Additional PSH** - between the required rental subsidy and social services support, it costs approximately $22,000 annually to provide a PSH placement for a chronically homeless individual in the County. The average monthly rental subsidy for a single chronically homeless person is approximately $1,200 ($14,400 annually), and best practice case-management ratios for the services in this setting are approximately $8,000 annually. There are several potential funding sources for an expansion of the County’s current PSH programming:

<table>
<thead>
<tr>
<th>Housing Voucher</th>
<th>Supportive Services – Case Management</th>
<th>Annual Total per client</th>
</tr>
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<tbody>
<tr>
<td>$14,000</td>
<td>$8,000 (Medicaid Waiver would decrease number by half)</td>
<td>$22,000</td>
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Uma Ahluwalia reported that there are indications that Federal Government will approve the Medicaid waiver will be approved but the locals must meet the match. The locals will pay the 50% match for case management. It is an open-ended entitlement if the local government can meet the match for case management. At the time the application was submitted, the County could afford to house 30 clients with unmatched, uncommitted, unrestricted funds. Once the application is approved we can house as many clients as we can match.

a. **Use of Unspent Funds** - Many programs maintain a certain vacancy rate and have unspent funds at the end of the fiscal year, so it is possible that the utilization rates for these programs can be adjusted upward to increase the number of people served without requiring additional funding

b. **Reallocation of existing Emergency Service funding**

c. **Dedication of Recordation Tax Revenue**

4. **Partnership with Community Hospitals and Managed Care Organizations (MCOs)**— Explore the use of Medicaid and other non-traditional methods of funding housing support services:

a. Medicaid cannot cover room and board but MCOs can pay for “value-added services” and “in lieu of services” which may include housing support services and outreach

b. Health Homes could be used to supplement housing support services

c. Maryland global budgeting waiver creates an incentive for hospitals to reduce costs for high utilizers. Housing First programs reduce the number of Emergency Room visits, thus reducing healthcare costs

d. As an example, Bon Secours Hospital in Baltimore owns and operates low to moderate income housing
5. **Purchase of new MPDUs** – in addition to adding MPDUs for a move-up strategy listed above, an additional 15 MPDU units targeted to chronically homeless individuals at 30% AMI and below could be combined with social services funding.

6. **Other New Housing Options** –
   a. An adjusted number of units targeted through any of the above suggestions,
   b. Targeted ask through the HUD Super NOFA process,
   c. Realignment of existing programming in the County, or
   d. New programming or funding streams identified as part of the planning process.

7. **Social Services Programing** – all the options to address the gap include the need for some level of supportive services, ranging from minimal (as part of a move-up effort, or short term rapid-rehousing), all the way through long term regular intensive engagement provided by multiple providers.

   In looking at all the options, an initial step will be to look at existing programs to pay for or supplement the services provided in PSH settings.

   Several programs operated by agencies focused on behavioral health, aging and disability, and public health currently offer extensive services to the chronically homeless population. Increased coordination with these agencies could make the supportive services for formerly chronically homeless tenants more efficient, and could also provide a wider array of support services to these tenants.

   Within the population of people experiencing chronic homelessness, there are sub-categories of individuals with high acuity service needs.

   This population primarily consists of individuals with both behavioral health and medical issues. Additionally, there has been an increase in the number of older adults experiencing homelessness.

   Assertive Community Treatment (ACT) has been effective in providing the long-term intensive services needed to maintain housing stability. A Medical ACT team would serve this population well and is a self-sustaining model, as ACT is a Medicaid reimbursable service.

**Other Efforts Underway to Help Reach the Goal of Ending Chronic Homelessness**

Three new positions that will be central to the effort to end chronic homelessness are included in the County’s 2017 budget. These positions are:

- A Housing Coordinator who is already on-board, and will help strengthen relationships with landlords and housing developers to create more and better opportunities for affordable and sustainable housing placements for persons exiting chronic homelessness.

- An HMIS Support Specialist who will start in January 2017; this person will enable the use of the HMIS data to determine the most efficient use of resources for chronically homeless individuals and families, as well as those at risk of becoming chronically homeless.
• An Outreach Coordinator who will also start the first week of January 2017, and will be responsible for street outreach efforts county-wide including the development and facilitation of outreach strategies that reach out to individuals, build trusting relationships and work collaboratively with organizational and community partners.

The Landlord Engagement Committee is regularly meeting to craft both system-wide engagements with the landlords and developers as well as explore ways to create a risk mitigation fund for landlords who rent to chronically homeless individuals and families.

On October 27, more than 40 landlords, property managers, and other housing professionals attended the first Landlord Engagement session. The meeting was a great opportunity to kick off an intensive new effort to identify new housing options for persons exiting homelessness.

This was a public private partnership led by HHS and Interagency Commission on Homelessness. There are currently 13 participating organizations, including the City of Gaithersburg, DHCA, HHS, HOC, Interfaith Works, MCCH, NCCF, Friendship Place, Housing Counseling Services, US Vets, Department of Veteran Affairs, Every Mind and Stepping Stones.

**Diversion / Prevention Programming** – By assisting individuals with identifying alternate housing arrangements and connecting them with support, the County can divert them from entering in the community’s homeless assistance system. Diversion prevents homelessness for people seeking shelter by helping them identify immediate alternate arrangements and, if necessary, connecting them with services and financial assistance to help them retain or return to housing. Diversion is not for persons who is at imminent risk of losing housing or for persons in shelter.

The County is actively engaged with other jurisdictions that have or are implementing targeted programs designed to help individuals and families who are at risk of becoming chronically homeless, with the goal of rolling out an enhanced program at some point in 2017.

**Moving Forward**

Many studies have shown that providing people experiencing chronic homelessness with PSH saves both local and federal funds currently being spent across multiple agencies and programs. Chronic homelessness is expensive. Ending chronic homelessness in Montgomery County is both realistic and imperative. We must act quickly to end chronic homelessness to avoid a homeless crisis among other populations.

**Action:** Mr. Leventhal asked to be briefed on the diversion and prevention programming strategy of identifying alternative housing arrangements. What does this mean for the County?

**Announcements**

Priscilla Fox-Morrill announced that the Wilkins Women’s Assessment Center is moving to 2 Taft Court and is renamed the Interfaith Works Women’s Center. The Center is a 70-bed emergency shelter serving approximately 300 women per year. Case managers work with women to facilitate recovery and stability, as well as connect them with housing, medical, mental health, and social services. Clients will move-in early January. Ribbon cutting will be January 5 at 10:30a.
Jeffrey Thames inquired about ways clients could apply or receive Metro Passes and bus fare. Many have expressed the desire to come from Silver Spring to the Rockville Shelter. Jennifer Schiller from MCCH will connect with Jeffrey regarding providing tokens.

Amy Horton-Newell asked if anyone knows how to help someone get or find their Social Security number and/or Birth Certificate. Uma suggested the preparation of an affidavit from the prison system or other agency verifying the individual’s identity so that the documents are processed.

**Next Meeting**
Wednesday, March 8, 2017, | 3:30-5:30 p.m. Location Rockville Memorial Library, 21 Maryland Avenue, 1st Floor Conference Room.