“My life was a wandering; I never had a homeland. It was a matter of being constantly tossed about, without rest; nowhere and never did I find a home.”

—Jan Amos Komenský, Labyrinthe světa a ráj srdce (Labyrinth of the World and Paradise of the Heart)

THE FIRST OF A two-part series, this article, which was adapted from a longer white paper, examines current public housing authority (PHA) collaborations in Housing First models. The second part of the series, to be published in the May-June 2016 issue of this magazine, will focus on future directions for successful collaborative programming.

BY LISA A. BAKER, JILL ELLIOTT, JULIE WILLIAMS MITCHELL AND MARK THIELE ON BEHALF OF THE NAHRO COMMUNITY REVITALIZATION AND DEVELOPMENT COMMITTEE’S HOMELESSNESS TASK FORCE

Many Paths, One Destination—New Directions and Opportunities for Ending Homelessness: Part One of a Two-Part Series

Published by National Association of Housing and Redevelopment Officials Washington, D.C.

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Introduction and Background

According to the U.S. Department of Housing and Urban Development (HUD), on any given night over 600,000 people are homeless; it is estimated that approximately 2.3 to 3.5 million Americans experience homelessness annually. The truth is that anyone can be homeless, and there are myriad ways in which people end up homeless. Some of these ways include:

- Having a low or fixed income and becoming unable to pay escalating rent costs;
- Moving for a new job that is no longer available on arrival, or arriving and being unable to find housing;
- Fleeing domestic violence;
- Having trouble adjusting to civilian life following a military discharge;
- Being unable to rely on family support;
- Being disabled or having a chemical dependency that interferes with daily functioning.

Homelessness is often divided into two major sub-types:

- **Short-term homelessness**, which occurs due to an unforeseen circumstance (e.g., job loss, loss of housing without notice, domestic violence, unexpected injury and healthcare bills, etc.); and
- **Chronic homelessness**, which involves long-term and/or repeated episodes of homelessness, often in conjunction with disabilities and/or substance abuse issues.

Some population types are more likely to experience homelessness than others. According to the National Alliance to End Homelessness (NAEH), veterans make up 33 percent of the chronic homeless population. Victims of domestic violence, aged-out foster youth, those with early childhood trauma and victims of extreme violence are much more likely to experience repeated bouts of homelessness than the general population; 92 percent of homeless women have experienced physical or sexual assault at some point in their life. Thirty-six percent of those experiencing homelessness each year are families, and it is estimated that over 50,000 children spend six months or more on the street each year.

Rising housing costs and changing wage patterns mean that risk of homelessness is increasing in all household sizes across America, encompassing the “working poor” and, in some high-cost areas, reaching even into higher income worker populations. As more households earn less—even as they work more hours, often hold down more than one part-time job, and work in more unstable jobs without employer-paid benefits—the “working poor” segment is expanding faster than any other demographic in this country. They are slipping further behind and blurring the lines between households who may have experienced only short-term home-
lessness and those who have traditionally been seen as more susceptible to chronic homelessness.

**Responses to Homelessness**

**Traditional Model:** The best description of the traditional response to homeless programming comes from the United States InterAgency Council on Homelessness (USICH) in the article, “Retooling the Homeless Crisis Response System:”

“Historically, people experiencing homelessness have had to navigate an uncoordinated set of services and programs to obtain assistance, with many of the available programs and services oriented towards managing the symptoms or experience of homelessness rather than providing rapid connections to stable and permanent housing that would end homelessness. Often, permanent housing was only offered at the end of a linear process or the achievement of particular service milestones. This resulted in many individuals and families remaining in homelessness, when—for any number of reasons—they could not achieve the high barrier to entry into permanent housing.

In many jurisdictions, traditional models have siloed services in which shelter and transitional programs exist separately from those that concentrate on permanent housing. Often, they also require separate assessments and applications for assistance while putting the responsibility on the individual to cobble together his or her own way out of homelessness.”

**Housing First Model:** Instead of assuming a linear progression to “housing readiness,” Housing First offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the supportive services and connections to the community-based supports people need to keep their housing and avoid returning to homelessness. Housing provides a stable foundation from which a person or family can access needed services and supports to begin the recovery process and pursue personal goals.

The distinguishing characteristics of Housing First include a non-siloed and community-based approach. It is also characterized by a locally agreed upon coordinated entry mechanism and appropriate placement in programming designed to lead to permanent housing in the shortest time possible. It focuses on preventing homelessness where possible (e.g., homeless prevention or rapid rehousing) and it may involve short-term shelter (such as for victims fleeing domestic violence) and/or transitional housing as in the traditional model. The difference is that the shelter is meant to be a short-term solution; it should be coordinated with and lead directly to permanent or permanent supportive housing.

**The Role of Public Housing Authorities in Combating Homelessness**

Public housing authorities (PHAs) serve the most vulnerable populations in America. As the role of providing affordable housing has morphed over time into serving extremely low-income populations, PHAs have been in the front lines for decades in preventing and ending homelessness—a role for which they have not always been acknowledged.

That role is becoming more recognized as the country continues to see the loss of deeply affordable housing units, chronic underfunding of housing operations, housing production programs that don’t reach deeply affordable levels without additional subsidy, as well as the loss of
Housing Choice Vouchers (HCVs) after years of stagnant allocations coupled with lower utilization caused by escalating rents. These issues are exacerbating homelessness and hampering PHAs’ ability to provide the housing stability that social services, medical programs and short-term housing providers need in order to have a strong permanent housing backbone that can make real inroads to ending homelessness. As we will see in the Houston model, recent federal investment in Veterans Affairs Supportive Housing (VASH) in both project-based and tenant-based vouchers really show how a dedicated commitment to housing with wrap around services can make a major difference in this battle.

Despite the funding difficulties, there are many ways in which PHAs can continue to play this role. PHAs also have the ability to take on new roles as well as look to new programs and funding sources through partnerships and collaborations. PHAs are uniquely positioned to serve as program hubs providing the permanent housing and using their existing infrastructure to further collaboration in client centered partnerships.

Collaboration: Continuous communication has been a regular theme in successful PHA collaborations. PHAs have recognized this and, throughout the country, have often led or co-led local teams working on homeless initiatives.

Collective impact initiatives depend on appropriate stakeholders working closely together and encouraging team members to do what they do best in a way that supports and is coordinated with the actions of the group. Successful collaborations link government, service providers and funders together. Fixing only one point on the continuum—such as faster intake—won’t make much difference unless all parts of the continuum improve at the same time. This opens the door to true alignment. No single organization, however innovative or powerful, can accomplish this alone.

Ending homelessness requires the accountability and experience of a collaborative team.

Industry advocates and technical assistance (TA) providers have been important in creating and providing training, tools and support to the field. "100,000 Homes," the boot camps and the “25 Cities initiative” are all examples of efforts to provide technical assistance and peer support to national efforts to end homelessness.

Forward-thinking PHAs across the nation are Continuum of Care (CoC) partners and/or lead agen-
cies and NAHRO has convened industry leaders and provided conference panels that propel the conversation forward, including NAHRO’s joint work with the United States InterAgency Council on Homelessness (USICH). Some examples of existing tools and toolkits include:

- The Corporation for Supportive Housing (CSH) provides a particularly useful toolkit on its website at www.csh.org/phatoolkit. The tool provides multiple detailed examples of initiatives from PHAs nationwide.
- USICH also provides a highly detailed guidebook to PHAs on ending homelessness at usich.gov/usich_resources/pha_portal/

**Innovation**—In many cases, PHAs are leaders in producing innovative and collaborative solutions to the challenge of homelessness. Some examples:

- Creating one-stop shop/mass briefings that leverage multiple resources to allow expedited assistance for the most vulnerable homeless individuals and families;
- Using triage tools such as the Vulnerability Index (VI) to standardize targeting and improve timely access to available resources (dedicated vouchers, HUD-VASH, SSVF, rapid rehousing, etc.);
- Working with street outreach to identify homeless on the streets and target appropriately to chronically homeless individuals, linking households to the right intervention with the right level of care;
- Working to create coordinated entry/access system(s) across the CoC to connect homeless individuals and families regardless of where they enter or present in the system;
- Committing Project-Based Vouchers (PBVs) to permanent supportive housing programs;
- Pursuing alternate funding streams, such as ESG, CDBG funding or CoC dollars;
- Developing and working with rapid rehousing programs;
- Seeking waivers for special programming;
- Processing redesigns such as form simplification and/or elimination and streamlining to better and more quickly serve the target population;
- And, where funding and circumstances allow, creating a dedicated position supporting homeless initiatives.

As demonstrated by the case studies below, PHA collaboration in ending homelessness can and does take many forms. In some cases, giving preference for chronic homelessness in voucher wait lists and supporting a Housing First model for rapid acceleration of wait list time is successful. In other communities, project-based vouchers (PBVs) for the homeless ensure financial support for the development that accepts the homeless household with little or no income. In high cost areas, project-basing vouchers can also mean that affordable housing is available in an escalating market. And PBVs have the advantage of creating a “special needs” wait list where PHAs and partners can marry needed social supports to affordable housing. In many communities, PHAs develop new housing units with homeless and special needs components, whether or not the project uses PBVs as a funding tool.

**On the Horizon—Current Case Studies and Opportunities**

**Houston, Texas: Declaring an Effective End to Veteran Homelessness**

PHAs are a major lifeline to the community, especially for those of extremely low- and low-income. In most communities, its resources are the link between mainstream social services that are crucial to supporting homeless households’ needs and ability to seek improvement in their health and lives. PHAs are critical partners in the CoC and bring infrastructure and support to community collaboration models of leadership. Houston, Texas, is one example of this leadership.

On June 1, 2015, Houston, which is the fourth-largest city in the country and has the second-highest population of veterans, reached functional zero on veteran homelessness. The city accomplished this through federal and local leadership on the issue. Houston’s mayor, Annise Parker, delivered the message that by working together as a team, the city’s various stakeholders could transform the response to veterans’ homelessness. Over 30 agencies across the city and Harris County were able to retool and deploy resources more quickly and effectively in order to house over 3,650 homeless veterans in just over three years, wrapping partnership and collaboration around the ability to use HUD-VASH vouchers and PHA expertise as part of the response.

At the center of Houston’s success is its Coordinated Access
Step 1: Housing assessors based at assessment hubs, in the call center, or on outreach teams conduct housing assessments and vulnerability index assessments.

Step 2: The results of these assessments are used to determine the appropriate intervention and to prioritize referrals.

Step 3: The assessment determines the housing match, and whether rapid rehousing or permanent supportive housing best matches the need and which housing program is appropriate based on program eligibility.

Step 4: The recommended intervention and eligible programs are discussed with the family, resulting in a housing referral.

Step 5: Households are then connected with a Housing Navigator, who helps them through the process of acquiring housing.

The goal is to go from referral to move in within 30 days.

Fargo, North Dakota: Medical Respite Saves Lives and Reduces Costs

The health needs of homeless persons are complex and are compounded by social, cultural and financial barriers (Roche, 2004). They suffer higher rates of uncontrolled acute and chronic illness and mortality as compared to the general population (Baggett et al., 2010). In national studies, overall prevalence rates of chronic medical illnesses range from one-third to one-half of surveyed homeless populations (Zerger 2002). Lack of control is four–six times higher for the homeless with asthma, cardiovascular disease is two–four times higher, and diabetes is up to two times higher than individuals who are in stable housing (Bonin et al. 2004, Zerger 2002).

The trend towards shorter hospital stays and more procedures done on an outpatient basis is particularly problematic for homeless individuals. People experiencing homelessness may be discharged with prescriptions they cannot afford to fill, and/or with instructions for follow-up care they cannot heed—such as bed rest, nutritious food, or preparations for tests or surgery that are impossible for them to carry out. This gap in health services may lead to poor health outcomes, costly emergency room visits and additional inpatient hospital stays, all of which negatively impact the individual, the health system and the community as a whole.

Medical respite has emerged as one response to this healthcare gap. Respite care refers to recuperative or convalescent services for those who may not meet criteria for hospitalization, but who are too sick or vulnerable to be discharged to the streets. The National Health Care for the Homeless Council identifies lower mortality rates as well as a reduction in the inpatient length of stay, emergency department visits, outpatient clinic visits and readmissions to the hospital for those homeless individuals who are discharged to medical respite compared to those who are discharged to the streets. The demonstrated cost avoidance for hospitals collaborating to offer medical respite has exceeded more than $5 million annually for numerous communities including Cincinnati, Ohio, Richmond, Va., and Salt Lake City, Utah (NHCHC, 2011). There are two primary models: free-standing medical respite and shelter-based, with a wide range of intensity and type of services offered as well as facility options. Medical respite programs have been implemented in a range of settings and program models. For more information on models, see the 2015 Medical Respite Program.
Directory, which identifies 73 medical respite programs in the United States. The National Health Care for the Homeless Council has also proposed minimum standards, which are available at www.nhchc.org.

Housing-based approaches have proven successful in helping people address their health and mental health issues. Programs such as “100,000 Homes” have demonstrated that nearly 85 percent of the chronically homeless remain stably housed (Tsemberis & Stefancic, 2007). This approach is also much cheaper for taxpayers as it reduces the use of expensive, publicly funded services like emergency rooms, shelters and jails. According to a 2007 National Alliance to End Homelessness report, the annual savings was reported to be more than $15,000 per person in the communities of New York, N.Y., Denver, Colo. and Portland, Ore.

Here are several examples of collaboration with stakeholders on respite programs.

**San Diego Rescue Mission: Shelter-Based Respite Model**
The Recuperative Care Unit at the San Diego Rescue Mission has operated for six years. This unit addresses critical needs for up to 32 homeless men and women newly released from the hospital who still require medical attention. The program provides a safe, supportive environment offering meals, medical treatment oversight and follow-up care. The program also helps patients explore long-term housing options. It has demonstrated an ability to promote recovery at a fraction of the $1,400/day cost per individual. Those using the Recuperative Care Unit were more likely to follow aftercare instructions and had fewer repeat hospital visits, which saved taxpayer dollars and kept healthcare costs down for everyone. See more at http://www.sdrescue.org/our-programs/housing/recuperative-care/.

**San Francisco Medical Respite Program: Free-Standing Residential Model**
The San Francisco Medical Respite program is a 45-bed residential facility in downtown San Francisco, established in 2007 by the San Francisco Department of Public Health Housing and Urban Health Department (SFDPH). This program accepts patient referrals from local public and private hospitals and the Veterans Administration. Patients are typically triply diagnosed with medical, psychiatric, and substance issues and most have multiple chronic medical conditions. The interdisciplinary team provides urgent and intermediate care, health education services, and referrals to primary and specialty care in the community. Under the supervision of social workers, community health workers provide support services as well as case management. Respite staff members continue to follow patients throughout medical treatment and discharge planning to make appropriate referrals and assist with patient appointments as needed. Learn more about this program at http://hospital-sfgh.medicine.ucsf.edu/services/respite.html.

**Fargo, N. Dak.: Hybrid Model with Housing Authority Participation**
Case management needs and the ability to provide seamless program delivery dictates that there should be variety and flexibility within models to create the least amount of patient disruption. This is especially true for clients whose disabilities include physical mobility issues. Stakeholders in Fargo, N.Dak. have created one such hybrid variation. Plans for the Fargo Medical Respite program include provision of recuperative care in both a local emergency shelter (New Life Center [NLC]), along with a two-bedroom apartment of the Fargo HRA. The shelter has the capacity to admit individuals who are less medically complex while the apartment setting will be used by individuals with mobility issues or who are more medically complex because the building has an elevator and on-site support services.
Community partners include Fargo Housing and Redevelopment Authority (FHRA), Sanford Health, New Life Center, Homeless Health, the North Dakota Department of Health and more than a dozen other community agencies. Admission criteria have been developed and case managers in the hospital will screen all patients who’ve been identified as homeless to determine whether they meet criteria for transfer to the medical respite program. These case managers will perform comprehensive assessments as required by homeless programs known as VISPDATs and help patients fill out Medicaid applications. One registered nurse (RN) project manager will provide plan care oversight for medical respite patients admitted to either unit. Skilled nursing and therapy services will be provided by the health system’s home health division. Each participant will have an established provider at the local federally qualified health center to ensure that medical needs of patients are addressed in an on-going manner even when transitioned into permanent housing. Billable expenses will be funded by Medicaid for all who are eligible for the expanded plan and grant funds from other sources will cover the expenses for those who are not Medicaid-eligible. Creating programming in this manner is a client-centered approach instead of a funding-based approach and also allows programs to reap economy of scale cost reductions and leverage resources from more traditional Continuum of Care (CoC) programs, along with new funding streams created through changes in Medicaid.

In this model, the recommended length of stay is approximately 45 days, which enables the Medical Respite staff to complete the assessment and develop a plan to transfer to housing with all of the support services in place. If approved for housing, upon completion of the medical respite program, the participant will transfer to a housing property if a unit is available. Participants must be available to meet with medical respite staff and home health providers for scheduled appointments; missing two scheduled meetings could result in discharge from the medical respite program.

A respite coordinator will follow the coordinated assessment protocol to assist program participants with the transition from the medical respite program into permanent housing, and provide ongoing evaluation and support for six months following permanent housing placement. Participants who achieve identified treatment goals will be discharged from the medical respite program into the area housing authority mainstream housing programs that accept VISPDATS which includes SPC, Single Room Occupancy (SRO) units, Cooper House, and the high rises. HUD has approved transfer to a FHRA permanent housing unit which best fits the unique needs of these participants and approved a limited number of applicants who can come through the HUD VISPDAT model. With encouragement from staff at the State Department of Health, a grant application has been submitted with a request to access funding from the Money Follows the Person (MFP) Housing Program to give each participant a small stipend to help them set up their new home as they transition into permanent housing. Participants will be assisted with transfer into FHRA mainstream homeless programs thru the coordinated assessment protocol.

North Dakota state health department representatives believe that the hybrid medical respite program is ideally suited to meet the criteria for comprehensive case management, coordination, health promotion, transitions across the continuum and referral to social support services within the community as defined within the Patient Protection and Affordable Care Act (PPACA).

City of West Sacramento, Yolo County, Calif.: “Bridge to Housing”—A Model for Working with Chronic Homeless in Encampment Settings

The North Levee area had an established community of approximately 71 people experiencing homelessness, along with 47 dogs and 22 cats. Members of
this homeless community lived there, without trash service, sanitation or running water, for an average of 4.5 years, with some members having been homeless for more than 10 years. The City of West Sacramento had worked previously to clear the area of homeless camping on several occasions; however, without other alternatives, the homeless continued to return to the site after each instance. In 2014, the West Sacramento Police Department reached out to representatives of public, private and faith-based agencies to think about a different and more effective way to work with the North Levee homeless encampment.

Yolo’s Continuum of Care, the 10-Year Plan Commission, the cities, county and Yolo Housing had been working through how best to make the transition from a traditional housing landscape to a Housing First model. The North Levee project gave members the opportunity to field test Housing First and identify the most successful components and lessons that could be utilized in the future. The result was “Bridge to Housing,” a time- and population-limited effort designed to test a Housing First model for Yolo County. It was one of the first large scale efforts to end an encampment and one of the first to work with people in a Housing First model without “cherry-picking” client populations, such as those eligible for VASH, seniors or disabled. This allowed partners to look at presenting issues of chronically homeless needs and available resources without the artificial lens of a single program.

While Housing First proponents will emphasize categorically that communities not focus or stay “stuck” in pilot projects, Yolo’s partners found that using a pilot project to “jump start” a change in focus was sound strategy. It engaged multiple partners who had to learn to work together; it forced partners to consider barriers, such as information sharing, that increase the tendency to silo; and it was a small project using many of the collaborative best practices outlined in this report that taught lessons which could be applied globally. More importantly, seeing its success made partners want to collaborate further. As an example, the 10-Year Plan Commission is in the process of updating its plan in order to use the lessons of Bridge to Housing in a 2.0 regional/local framework, demonstrating the power of collaboration. The original project was broken down into components, which included:

- **Initial Outreach**: In September and October, outreach with residents completed three outreach...
assessments to identify participants in the program and build trust.

• **Neighborhood Clean up Day:** Requested by the homeless residents as a way to give back to the community. Volunteers from the faith community, residents, the homeless community, housing authority, county and city participated. Fifteen tons of trash were collected. Homeless participants met elected officials, social service workers and neighbors in a non-confrontational way and helped raise awareness about homelessness.

• **Moving Day! Boot Camp for Housing:** Participating members moved to housing at a master-leased motel in West Sacramento and managed by Yolo Housing. Prior to the move, there was pet washing and health care, public health and mental health assessments, immunizations, laundry, food and legal assistance, as well as transportation to the motel for participants and their pets provided by county agencies, private volunteers, faith-based groups and the city.

• **Boot Camp for Housing—Triage, Assessment, Application:** During the 109-day stay at the motel, residents received assistance in applying for benefits, including job training and assistance, chemical dependency, health insurance, disability benefits, counseling, housing voucher wait list enrollment and other services. On-site mobile medical/psychiatric helped disabled residents prepare for SSI/SSA applications. Residents also received cell phones and worked to reengage in living indoors and in community.

• **Placement in Permanent Housing:** Includes ongoing and, in some cases, intensive case management to help them succeed in their new housing. At the end of the program, almost 70 percent of graduates found permanent housing, predominantly using standard tenant-based vouchers. Almost one year into the program, they are almost all still housed. This is a phenomenal outcome using standard vouchers in non-permanent supportive housing for long term chronically homeless. At time of program inception, approximately 11 percent had income and most did not have identification or service enrollment, with the exception of some participants in the food stamp program (Cal-Fresh).

• **Example of PHA and Partner Collaboration:** Bridge to Housing was a multi-disciplinary effort that included: The County, District Attorney’s Office, Employment & Social Services Environmental Health, Mental Health, Health Services, Probation, Public Defender’s Office, Sheriff-Animal Services, Yolo Housing, City of West Sacramento, New Hope CDC, Aggie Animal Rescue Club at UC Davis, California State Parks, CommuniCare Health Centers, Dog’s Best Friend Mobile Grooming, Dog Gone Mobile Grooming, Ethan Conrad Properties, Food Bank of Yolo County, Legal Services of Northern California, Mercy Faith Coalition, Northern California Construction & Training, Petco, West Sacramento, Turning Point Community Programs, United Christian Centers, Waste Management, Yolo Community Care Continuum, Yolo County Day Reporting Center (Sacramento County Office of Education) and Elica Health Center.

This project is a good example of multi-disciplinary collaboration wrapped around the PHA’s core community components of property management, service integration and housing vouchers. It involves integration with health, mental health, community, faith-based, social services and funding into a single client centered model.

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The Homelessness Task Force is a branch of the Community Revitalization and Development (CR&D) Committee, a NAHRO national policymaking committee. CR&D addresses a broad range of issues related to the economic vitality of cities and the development and conservation of neighborhoods, including administrative, legislative, regulatory, and funding issues of community development programs and operations. More information about the NAHRO Community Revitalization and Development Committee is available at www.nahro.org.