

# AN ACTION PLAN TO END VETERAN AND CHRONIC HOMELESSNESS IN BOSTON: 2015-2018



2015

MAYOR MARTIN J. WALSH



June 2015

Dear Friends,

The City of Boston is incredibly lucky to have a network of providers that delivers among the most high-quality and comprehensive services for homeless individuals in the United States. We are proud of the fact that we have one of the highest sheltering rates in the nation.

But we must do better. And we will.

In this plan, we commit to ending veteran and chronic homelessness. Achieving these goals will require a change in the way we care for our most vulnerable populations, and how we deliver that care. The root causes of homelessness are complex, and intertwined with issues that many Bostonians struggle with on a daily basis, such as addiction, mental illness, and unemployment. But I firmly believe that we can achieve these goals.

In the wake of the unexpected closure of the Long Island Shelter, the generosity of many Bostonians, from local businesses to individuals, proved to me that we have the collective will to take care of those most in need. The partnerships that were formed and strengthened during this challenge now present us with the opportunity to make real systemic change.

The plan outlined on these pages is ambitious, and while the work will not be easy, I believe that we can and must do it. I thank the Mayor's Task Force on Individual Homelessness, our network of service providers and agencies, and the Boston community for their thoughtful response and call to action. I am proud that we will continue to work collaboratively as we develop, implement, and deliver high quality policy strategies, housing, and services to help end homelessness in the city of Boston. I urge you to join us.

Sincerely,

A handwritten signature in blue ink, appearing to read 'M. Walsh', with a long horizontal line extending to the right.

MAYOR MARTIN J. WALSH

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## I. INTRODUCTION

As a community, Boston cares deeply about the safety and well-being of our most vulnerable neighbors. Our homeless services and housing providers are among the best in the country. Boston's network of providers serves 1,720 homeless individuals in shelter on a single night and shelters 10,883 homeless individuals over the course of the year.<sup>1</sup> Together, our dedicated efforts have resulted in one of the lowest rates of urban street homelessness in the United States. To truly solve homelessness in Boston, however, the City and its partner providers must implement critical system reforms.

## STATE OF INDIVIDUAL HOMELESSNESS IN BOSTON

Ending long-term homelessness among individuals in Boston is within our reach. According to the U.S. Interagency Council on Homelessness (USICH), ending homelessness is achieved when individuals who fall into homelessness experience it as a brief crisis and quickly move forward on a path to housing. By converting existing resources, targeting new investments, and enhancing collaboration, Boston will transition from simply managing the problem to actually solving it. Reaching this goal will be challenging, but by working together, Boston can end chronic homelessness (Figure 1).

The Boston network of providers and City agencies meets regularly on initiatives related to the collective goal of housing Boston’s most vulnerable populations. Over the last two years, the Boston network has devoted specialized attention to individuals persistently living on the street, long-term stayers in shelter, and veterans, as well as high users of emergency services (HUES). As an example of the success of these collaborations, the following outcomes have been achieved:

- 191 long-term shelter stayers have been housed;
- 391 homeless individuals have been rapidly rehoused;
- 67 highly vulnerable individuals on the street have been housed;
- 640 homeless veterans have been housed;
- Emergency department use among the HUES cohort was reduced by 54% after permanent supportive housing placement; nights hospitalized were reduced by 31%.<sup>2</sup>

FIGURE 1. HOMELESSNESS IN BOSTON



Boston has steadily increased the number of housing units for homeless individuals by targeting resources and committing to new investments. Despite these efforts, however, the demand for shelter services has recently increased:

- The average length of stay in emergency shelter increased from 112 nights in January 2013 to 168 nights in June 2014;<sup>5</sup>
- After six years of decline, the number of chronically homeless individuals increased in 2014 and again in 2015;<sup>6</sup>
- On October 8th, 2014, the 450-bed emergency shelter on Long Island was unexpectedly closed due to failing bridge infrastructure.

The closure of the Long Island shelter required a focused effort to ensure that all shelter guests would have uninterrupted access to shelter and food. The Boston Public Health Commission (BPHC), in partnership with the city's emergency response system and homeless provider network, established several temporary shelters. Within 48 hours of the closure, BPHC converted its South End Fitness Center into a 200-bed shelter. In addition, homeless shelters such as BPHC's Woods Mullen shelter, Pine Street Inn, New England Center for Homeless Veterans, Boston Rescue Mission, and Pilgrim Church made overflow space available to accommodate additional guests. For female guests, BPHC established two women-only temporary shelters at St. Francis House and Boston's Health Care for the Homeless Program, supplementing the capacity of BPHC's Woods Mullen shelter and the Pine Street Inn's women's shelter. In January 2015, BPHC opened the first 100 beds for the new BPHC Southampton Street Shelter. Another 150 beds were added in mid-April 2015, and with construction expected to be completed by the end of June 2015, the Southampton Street Shelter will be able to accommodate more than 400 guests on a nightly basis.

In April 2015, BPHC also reopened two treatment programs, Wyman Reentry and Transitions, at 201 River Street in Mattapan, replacing 75 of the displaced recovery beds. BPHC's other recovery programs, Project SOAR and Safe Harbor, will add 40 beds total in the Southampton Street Shelter building upon the completion of construction in June 2015. The City is also providing relocation help and renovation funds to the four privately-operated programs that were housed on Long Island. Volunteers of America's two residential recovery programs, Hello House and Rebound, have re-opened in newly renovated facilities. Bay Cove Human Services is close to securing a new home for its Andrew House/Bridge to Recovery detox center, and the City is working actively with Victory Programs to find a site for Joelyn's Family Home. This array of temporary, overflow, and new facilities has been sheltering between 600 to more than 750 additional individuals each night since October. In addition to the homeless provider network, there was an outpouring of support from the private sector, both individual and corporate, resulting in more than \$370,000 in grant and in-kind donations (see Appendix J).

The abrupt transition from Long Island to alternative shelters in the city was difficult for both guests and providers. It brought into focus the fragility of the shelter system in Boston, and helped all providers realize that, on any given day, we are one shelter closure away from a crisis. It also exposed the need to provide better support to certain subpopulations, especially homeless women and young adults. Most importantly, it gave us an opportunity to reevaluate the system that we were operating before October 2014 and, with renewed focus, to analyze ways to improve the system, rebuild it, and become more deliberate in our efforts to move our guests into permanent housing.

**This crisis has become a monumental opportunity to redesign our homeless response system.**

## MAYOR'S TASK FORCE ON INDIVIDUAL HOMELESSNESS

Mayor Martin J. Walsh established the Mayor's Task Force on Individual Homelessness in December 2014 and charged the group with developing recommendations to address eight goals.<sup>7</sup> This Task Force, chaired by Felix G. Arroyo, Chief of Health and Human Services in the City of Boston, and Sheila Dillon, Chief of Housing in the City of Boston, is comprised of service providers, business leaders, clergy, philanthropy, and local, state and federal government officials.<sup>8</sup>

Beginning in January 2015, the Task Force quickly organized subcommittees and formulated a shared vision to redesign Boston's homeless response system. During a 90-day process, the Task Force engaged experts who have facilitated effective reform in other parts of the country. For example, city officials from Houston visited Boston to present details to the Task Force on how Houston led a dramatic system reform that reduced chronic homelessness by 57%, reduced veteran homelessness by 70%, and reduced street homelessness by 50% in less than four years. At the end of March, a third-party facilitator conducted two consumer focus groups at Pine Street Inn and Woods Mullen to gain consumer insights on the major systems change recommendations in the plan.

An Action Plan to End Veteran and Chronic Homelessness in Boston: 2015-2018 synthesizes these sources of information into goals, strategies, and recommendations that reflect both national and local best practices.

### SECTION 1 Endnotes:

1. Data from the 2015 Point in Time count submitted to the US Department of Housing and Urban Development, and the 2014 Annual Homeless Assessment.
2. The timeframe for housing placement of these 42 chronically homeless HUES clients was between 2010-14. Health care service utilization in the year prior to housing was compared to utilization between the date of move-in and the end of follow up (August 27, 2014). Source: Impact of Permanent Supportive Housing on Hospital Utilization for Homeless Individuals who are the Highest Users of Emergency Services: Progress Report for High Users of Emergency Services (HUES) to Home, September 2014.
3. As of the most recent point in time count on February 25, 2015.
4. Out of the total number of persons who used the emergency shelter system over the course of 2014.
5. Boston Homeless Management Information System (HMIS) data.
6. Definitions of chronic homelessness and other key terms are provided in Appendix A.
7. Eight Task Force goals are listed in Appendix B.
8. See Appendix I for a complete membership listing of the Mayor's Task Force on Individual Homelessness.

## II. GOALS

The plan has two goals: to end veteran homelessness by 2015, and to end chronic homelessness by 2018.

To reach and maintain these goals, we will need to transform our homeless response system. Achieving these goals will drive us to identify and respond to subpopulations more effectively, and to not only house those who are currently chronically homeless, but also to prevent new, vulnerable individuals from becoming chronically homeless. This focus on veterans and chronically homeless individuals will impact other system outcomes, including shortening length of homeless episodes, reducing reliance on shelter, and improving housing retention.



## HOMELESS VETERANS IN BOSTON

Boston is committed to ending homelessness among veterans by the end of 2015. In July 2014, Mayor Martin J. Walsh boldly pledged to join the Mayor's Challenge to End Veteran Homelessness by 2015. At the time the Mayor made this announcement, there were 414 homeless veterans. Of those original 414 homeless veterans, only 80 remained homeless a year later: five on the street, eighteen in shelter and 57 in a transitional housing program. Over the course of that same period, a significant number of new veterans became homeless.

Because there will always be new individuals falling into homelessness, the federal government introduced the concept of "functional zero" to define what it will look like when a community has ended homelessness among veterans. In Boston, "functional zero" will mean that:

- **No veteran is forced to sleep on our streets**
- **When a veteran becomes homeless, it is rare and brief**
- **All currently homeless veterans will be housed, or on a pathway to stable housing, by the end of 2015**

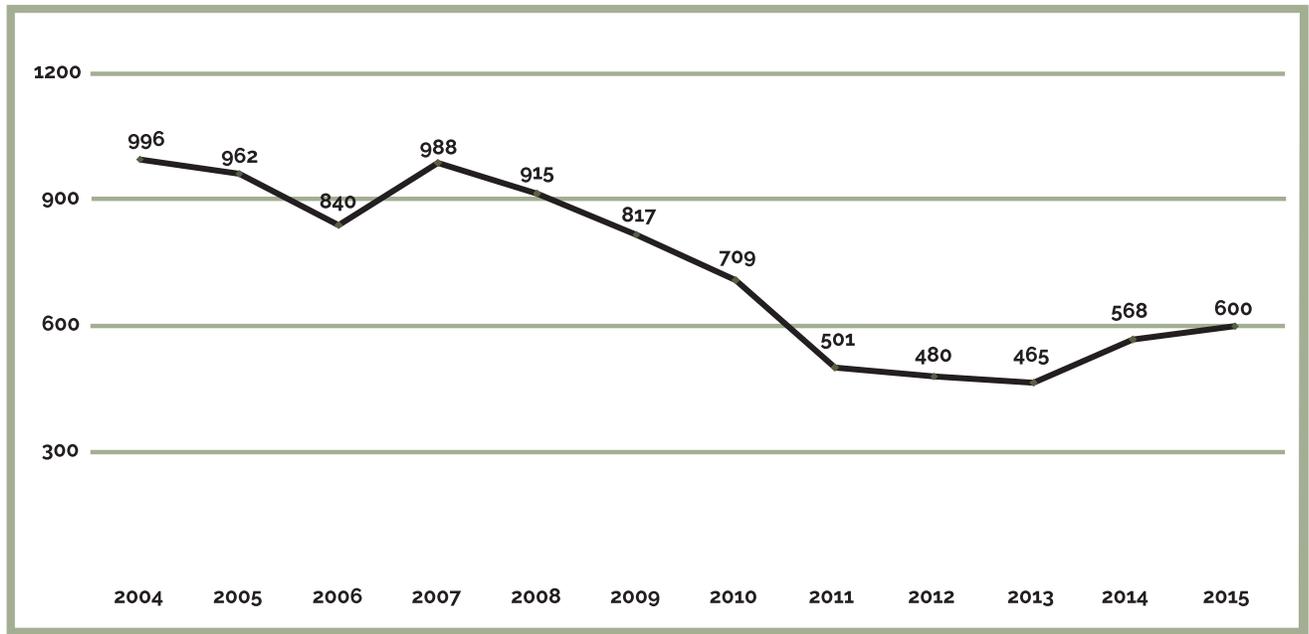
Even after functional zero is achieved, we recognize that we will need to work hard to maintain an efficient and adaptive response system that continually prevents or ends homeless episodes among veterans. Functional zero is a status that will require constant vigilance.

## CHRONICALLY HOMELESS INDIVIDUALS IN BOSTON

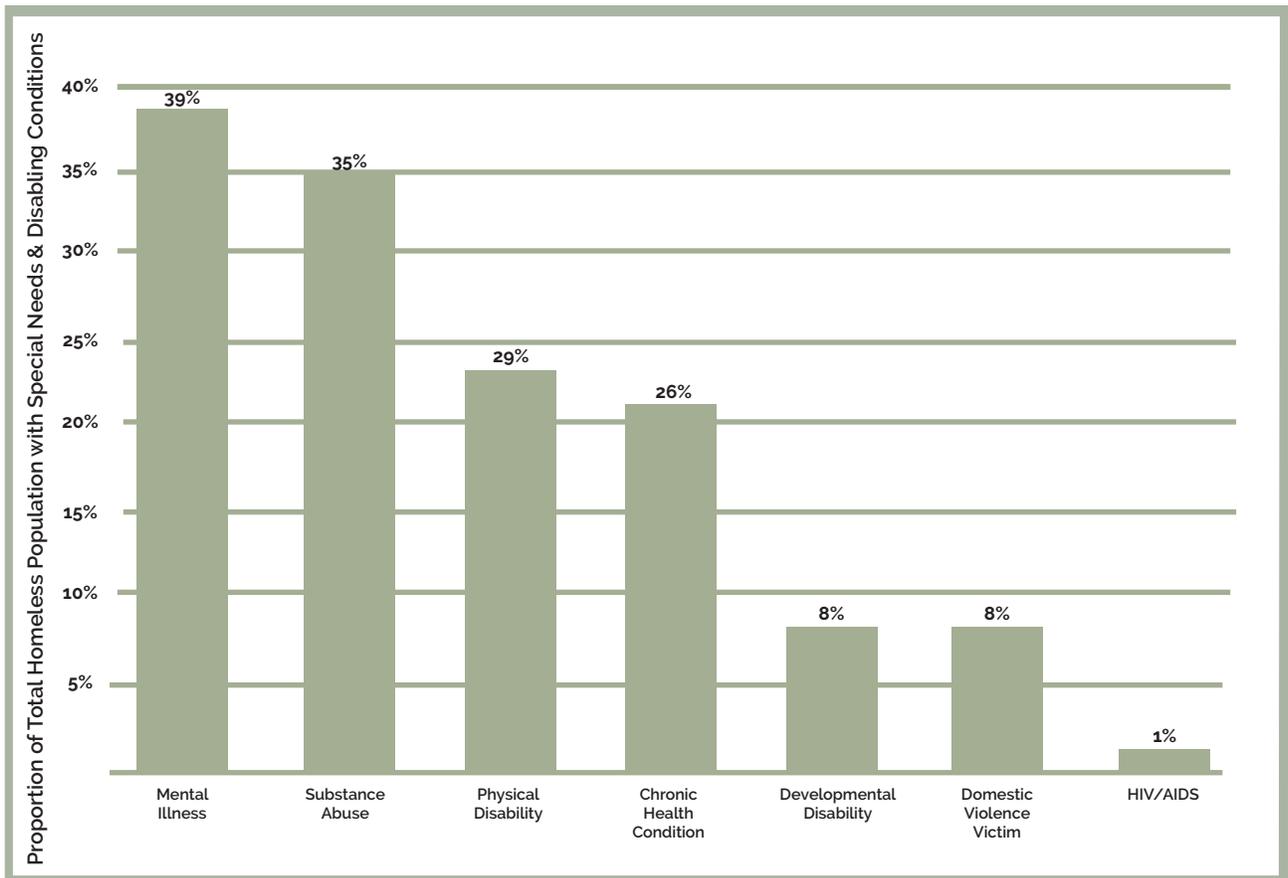
Beyond serving veterans affected by homelessness, Boston is also committed to ending chronic homelessness. On February 25, 2015 there were 600 chronically homeless individuals in Boston's emergency shelter system and on the street (Figure 2). The federal government defines a person experiencing chronic homelessness as an individual with a disabling condition who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years. For more information about disabilities among adults in emergency shelter, see Figure 3: Special Needs and Disabling Conditions.

Boston is committed to ending individual chronic homelessness by 2018. In order to meet this goal, we will need not only to raise new resources but also to improve how we use existing resources. This will entail changing eligibility requirements that prevent individuals with multiple barriers from accessing appropriate housing and targeting vacancies in permanent supportive housing to this population. Additionally, we will need to invest in creating very low-barrier permanent supportive housing for the most vulnerable as described in the following sections.

**FIGURE 2. NUMBER OF CHRONICALLY HOMELESS INDIVIDUALS IN BOSTON**



**FIGURE 3. SINGLE ADULTS IN EMERGENCY SHELTER: SPECIAL NEEDS & DISABLING CONDITIONS**

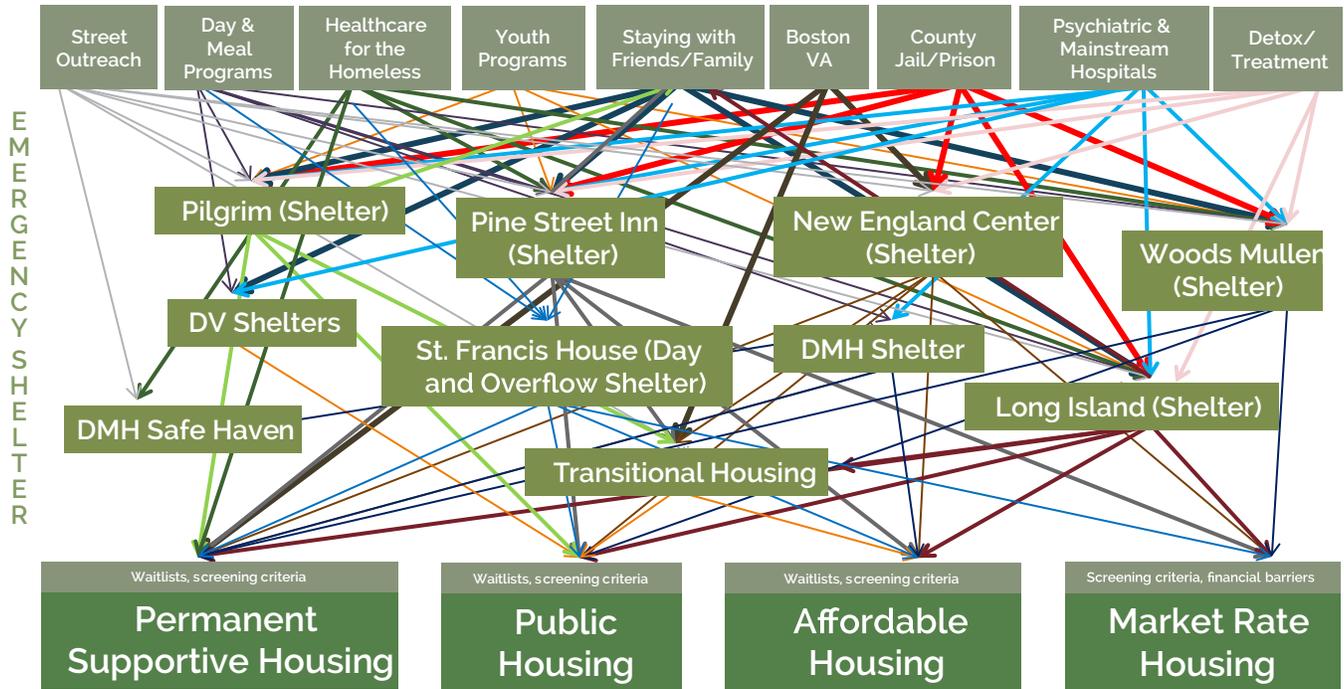


Source: 2015 City of Boston Annual Homeless Census

### **III. STRATEGY**

The primary strategy of this action plan is to redesign Boston's homelessness response system. Boston's current response to homelessness is a collection of effective, yet fragmented, programs that offer a variety of services to individuals experiencing homelessness. To make progress toward ending homelessness, we must shift from a group of independent programs to one single integrated system founded on Housing First principles (see Appendix D).

**FIGURE 4. BOSTON'S FRAGMENTED RESPONSE SYSTEM**



Source: Modified from CSH's "Coordinated Access-Houston: The Shift"

Figure 4 is a representation of the complexity of Boston's homelessness programs and resources. We have a vast array of services that currently operate separately but need to operate together to provide a seamless integrated system that can achieve a collective impact, and ultimately end veteran and chronic homelessness.

## We need to shift strategies...



Source: Modified from Houston's Plan to End Chronic Homelessness by 2016

## SYSTEMIC REDESIGN

Redesigning the homeless response system will mean radically transforming how the system operates, from the first night someone experiences homelessness until the day they regain stability in independent housing. The new components this system redesign will encompass are: **Front Door Triage**, **Coordinated Access**, **Rapid Rehousing**, and **Permanent Supportive Housing** (Figure 5).

**Front Door Triage** is the immediate response to homeless individuals upon entry into the homeless system, including individuals on the street or entering emergency shelter. The triage design will be modeled on an emergency room triage system and will provide a differential response based upon vulnerability and individual need.

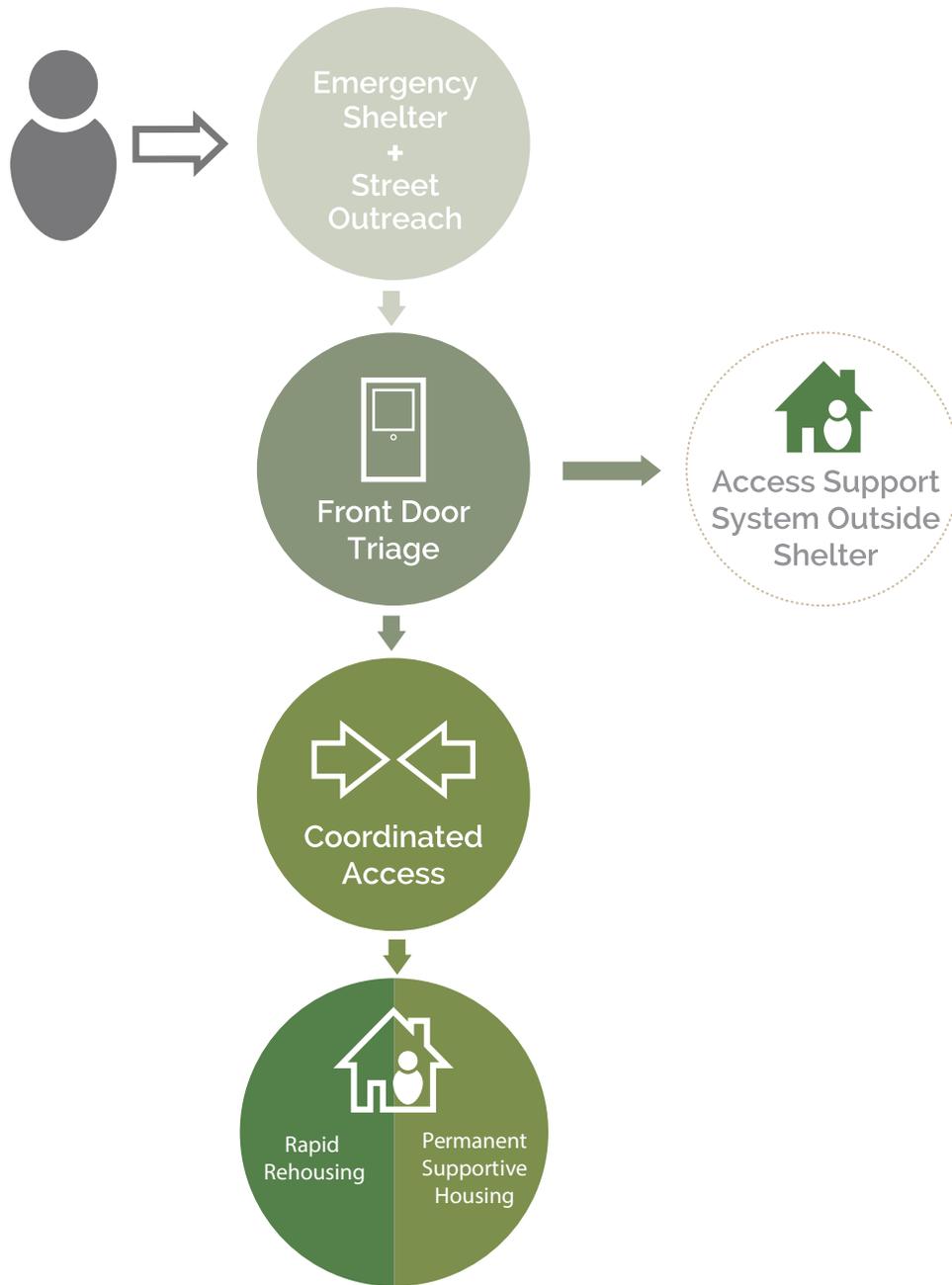
**Coordinated Access** is a centralized online data system that matches homeless individuals to housing vacancies based on need.<sup>9</sup> The Coordinated Access system will centralize vacancies to permanent supportive housing units and will use data to drive outcomes.

**Rapid Rehousing** is an approach that moves homeless households to housing as quickly as possible by providing the amount, type, and duration of assistance needed to stabilize the household.<sup>10</sup>

**Permanent Supportive Housing** combines subsidized rental housing with individualized support services. Permanent Supportive Housing is an intensive intervention that is typically reserved for individuals with complex barriers who need a high level of support in order to achieve stability in housing.<sup>11</sup>

In order to make systemic change at this scale, we need to institute a change management strategy. Houston designed a layered structure of accountability through steering committees, working groups, and leadership teams with a "culture of yes" as a principal philosophy within each of those bodies. Similarly, Boston needs to determine how to support change management for this large-scale system redesign in a manner that will work for our community. The remainder of this plan discusses the recommended reforms and leadership commitments necessary to achieve this transformational change.

FIGURE 5. TRIAGE AND COORDINATED ACCESS SYSTEM



SECTION 3 Endnotes:

9. For more information or guidance from the U.S. Department of Housing and Urban Development on this topic, please review this policy brief: <https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>.
10. Based on definition available at: <http://www.buildingchanges.org/coordinated-entry-toolkit/key-terms>.
11. Based on definition available at: <http://www.cceh.org/glossary>.

## IV. RECOMMENDATIONS

The Mayor's Task Force developed recommendations to redesign Boston's homelessness response system based on a Housing First approach, which promotes connecting homeless households to housing first, regardless of their characteristics, and subsequently offering services that stabilize the household once in housing.<sup>12</sup> The Task Force recommends four key systemic changes to align our response system with a Housing First model.

## 1. DESIGN AND IMPLEMENT A TRIAGE SYSTEM AT THE FRONT DOOR OF THE HOMELESS RESPONSE SYSTEM BY 2016.

A triage system at the front door of the homeless response system (i.e. emergency shelter and street outreach) will offer calibrated intervention, depending upon the specific needs of each person. To do so, we will need to have specialized services and staff readily available to address the range of needs that people have when they first encounter the homeless system, including substance abuse specialists, resources for youth, programs specific for women, and disability specialists, among others. In addition, the staff at the front door will need access to prioritized emergency spaces at detox centers, residential treatment, youth programs, domestic violence shelters, nursing homes, and other systems of care that would better serve some individuals who find themselves at the front door.

To further develop the front door triage system, an interagency working group will:

- Conduct a gap analysis of resources needed at the front door of shelter, including resources needed within the front door triage system as well as referral slots needed in other systems of care;
- Collaborate with state partners to undertake a statewide response and align City policies to reduce the number of homeless individuals arriving from outside of Boston seeking housing and services;
- Explore alternatives to shelter that reconnect people with formal and informal support systems and make recommendations related to those pathways;
- Consult an existing or newly formed consumer advisory board made up of homeless or formerly homeless individuals to ensure the system is informed by consumers of homeless services;
- Use those findings and integrate recommendations outlined in the following paragraphs to design the front door triage system, determine policies, and develop an implementation plan for front door triage to be executed by the end of 2016;

### Unaccompanied Youth or Young Adults

While the Mayor's Task Force highlights homeless youth and young adults as a priority population, we recognize that additional work is needed to develop a comprehensive intervention plan to prevent and end youth homelessness. A strategic plan to engage and divert unaccompanied youth or young adults from homelessness, particularly LGBTQ youth and young adults of color at greatest risk of adult homelessness, should be developed, using the following criteria:<sup>13</sup>

- Analysis of effective interventions for this population, including identification of appropriate housing, education and employment pathways for young adults;
- An engagement and diversion strategy for unaccompanied youth and young adults;

- Engagement with systems upstream in order to divert at-risk youth and young adults from the streets and emergency shelters;
- Strategies to increase and encourage connectivity to family, community, educational and employment support and mentoring as pathways off the streets and out of shelter.

## Untreated Substance Use Disorders

Some individuals fall into homelessness due to untreated substance use disorders, and would have the capacity to resolve their own homelessness if provided access to recovery services at a crisis point. However, treatment and recovery resources are scarce and often unavailable. As a result, individuals remain homeless for extended periods of time without access to the services they need.

To better support individuals who are homeless due to untreated substance use disorders, the Mayor's Task Force recommends the following:

- Develop real-time tracking for the availability of treatment beds to facilitate referrals from the front door of shelter and integrating substance abuse specialists in emergency shelters.
- Collaborate with the Boston Public Health Commission and the Mayor's Advisory Committee on Recovery Services to analyze the gaps in resources and gaps in linkages between homelessness and recovery services, and recommend improvements to be instituted by the end of 2016.

## Discharge Planning

Front door triage efforts need to include reducing the number of discharges to emergency shelter from other institutions. Boston's shelters should be the option of last resort, but they are often used as a solution for institutions without housing solutions of their own. In 2014, 978 individuals in Boston's emergency shelters were known to have been discharged from hospitals, jails, substance abuse treatment centers, detox, psychiatric facilities, foster care homes, and other systems of care without stable housing.<sup>14</sup>

To improve discharge planning and coordination, an interagency working group including City and State agencies, shelter and other service providers, will build upon the work of "HUES to Home" and the discharge planning subcommittee of the "Long Term Stayers" working groups to:

- Collect and analyze data to identify the systems of care that discharge the largest number of individuals to homelessness and where there is potential for the greatest impact;
- Foster partnerships with key liaisons in other systems of care and institutions to improve pathways to stability rather than homelessness;
- Implement strategies to reduce discharges to homelessness, including shelter diversion agreements.

## Street Outreach

In partnership with the network of street outreach service providers, the City of Boston has identified the most vulnerable individuals who are living on our streets. A committed group meets every month to collaborate on moving these individuals off the street as quickly as possible; however, more must be done to serve this population that is both the most vulnerable and the most visible in our city. The City will convene concerned community members, new private partners, street outreach providers, in addition to housing providers, to develop a robust plan to further our efforts to create housing opportunities specifically for highly vulnerable people sleeping outside.

## 2. COORDINATE ACCESS TO HOUSING RESOURCES FOR HOMELESS INDIVIDUALS IN BOSTON BY 2016.

Today, housing resources are scattered across many different agencies and systems. Due to the lack of a concerted systemic effort to house the most vulnerable individuals, many are unable to navigate the system and are passed over when appropriate housing opportunities become available. Many homeless consumers feel that they are going into their housing search completely blind – as one consumer stated, "Searching for housing in Boston is like pin-the-tail-on-the-donkey."

To change how housing resources are allocated, we need to develop a Coordinated Access system that tracks housing placements through a centralized online database. To do this, we will use and integrate client data from the existing Homeless Management and Information Systems (HMIS), which tracks detailed information about homeless individuals, including demographics, benefits, disability, prior living situation, exit destinations, as well as other crucial information. This data will be used to match homeless individuals to available housing units based on need.

The Coordinated Access system will:

- Match homeless individuals, based on their specific needs, to the right housing and service resources;
- Close all "side doors" to permanent supportive housing. "Side doors" are access points that are not centralized by or accountable to the Coordinated Access system, and therefore likely would not target the most vulnerable individuals for available units. Coordinated Access will close the side doors by centralizing vacancies and ensuring that each permanent supportive housing vacancy is being utilized by the right person;
- Centralize vacancies within the Continuum of Care (HUD-funded housing targeted to homeless individuals) and other permanent supportive housing;
- Ensure that the most vulnerable individuals are first in line for the permanent supportive housing units and services that meet their needs;
- Use data to drive outcomes and create accountability among all homeless and housing providers.

Using best practices we learned from participating in the Mayor's Challenge to End Veteran Homelessness, such as housing individuals from targeted lists of the most vulnerable individuals derived primarily from HMIS data, and understanding the successes achieved to date in other cities, Boston is ready to take these ideas to scale. To accomplish this, Boston will need new investment in technology.

Building the Coordinated Access system is the first priority for the system redesign described in this action plan, as the other components of the system depend upon its success.

### 3. INCREASE RAPID REHOUSING OUTCOMES BY 2016.

The Boston community will need to increase efforts to reduce reliance on shelter and prevent new people from becoming chronically homeless through rapid rehousing. The data show that the majority of homeless individuals are not chronically homeless but instead experience "crisis homelessness".<sup>15</sup> Many of those individuals will resolve their own homeless episode with little to no intervention, but others will need some assistance in order to regain stability. The Boston network has previously defined "extended stayers" as people who live in shelter between 120 and 364 days, and therefore are at risk of becoming chronically homeless. Rapid rehousing is an important tool to move people back to housing and prevent non-chronically homeless individuals from falling into chronic homelessness.

In addition, achieving successful rapid rehousing outcomes will be accomplished by increasing income among formerly homeless individuals. For those who can work, employment is often an essential component of stability. The Boston Employment Network was formed in 2015 to improve employment outcomes for homeless individuals through three strategies:

- **Engaging and educating employers;**
- **Training staff and sharing resources; and**
- **Developing best practices.**

The Task Force urges the Boston Employment Network to propose recommendations for consideration and implementation by 2016.

In addition to supporting employment opportunities, increasing income and securing benefits will promote financial empowerment for homeless adults who are making the transition to housing. To complement this work, enhanced attention and training should focus on benefits maximization. Boston should work to increase successful applications for a range of state and federal benefits or entitlement programs including Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Social Security Retirement and the State's Emergency Aid to Elderly, Disabled and Children (EAEDC) and Chapter 115 Veterans benefits. Evaluation of the US Substance Abuse and Mental Health Services Administration (SAMHSA) SSI/SSDI Outreach, Access and Recovery (SOAR) demonstration project suggests that homeless persons with disabilities who successfully apply for SSI increase income and improve housing stability and recovery outcomes.<sup>16</sup>

## 4. INCREASE ACCESS TO PERMANENT SUPPORTIVE HOUSING FOR THE MOST VULNERABLE HOMELESS INDIVIDUALS BY 2016.

Boston has created 4,514 permanent affordable housing units for homeless individuals through subsidy programs targeted to homeless individuals and through the homeless set aside program in affordable housing development and the BHA maintains homeless priorities within its leased and public housing portfolios. This means that there are thousands of units prioritized for homeless households in Boston.

Currently, there are 600 chronically homeless individuals in Boston. Accounting for additional individuals who become chronically homeless over the three years of this plan, we estimate we will need 950 units of permanent supportive housing targeted to chronically homeless individuals over the next three years in order to end chronic homelessness (Figure 6).

Of those 950 units of permanent supportive housing, it is estimated that 750 will become available through strict targeting of vacancies of existing permanent supportive housing units by utilizing the Coordinated Access System. In addition to those 750 turn-over units, we estimate that 200 new Permanent Supportive Housing units will need to be developed to reach a total of 950 available units. In particular, the existing portfolio of permanent supportive housing lacks sufficient units clustered in a single building that offers 24/7 on-site support for people with major barriers to stability. These new units must be "low-barrier" in that the requirements to become a tenant must not screen out the very individuals who need such housing options, including people with criminal histories, poor credit, prior evictions, mental illness, and active substance use, among other factors that prevent them from gaining access to mainstream housing resources.

New investment will be necessary to create the additional 200 units of Permanent Supportive Housing, and Boston will need significant funding from federal, state, and private partners.

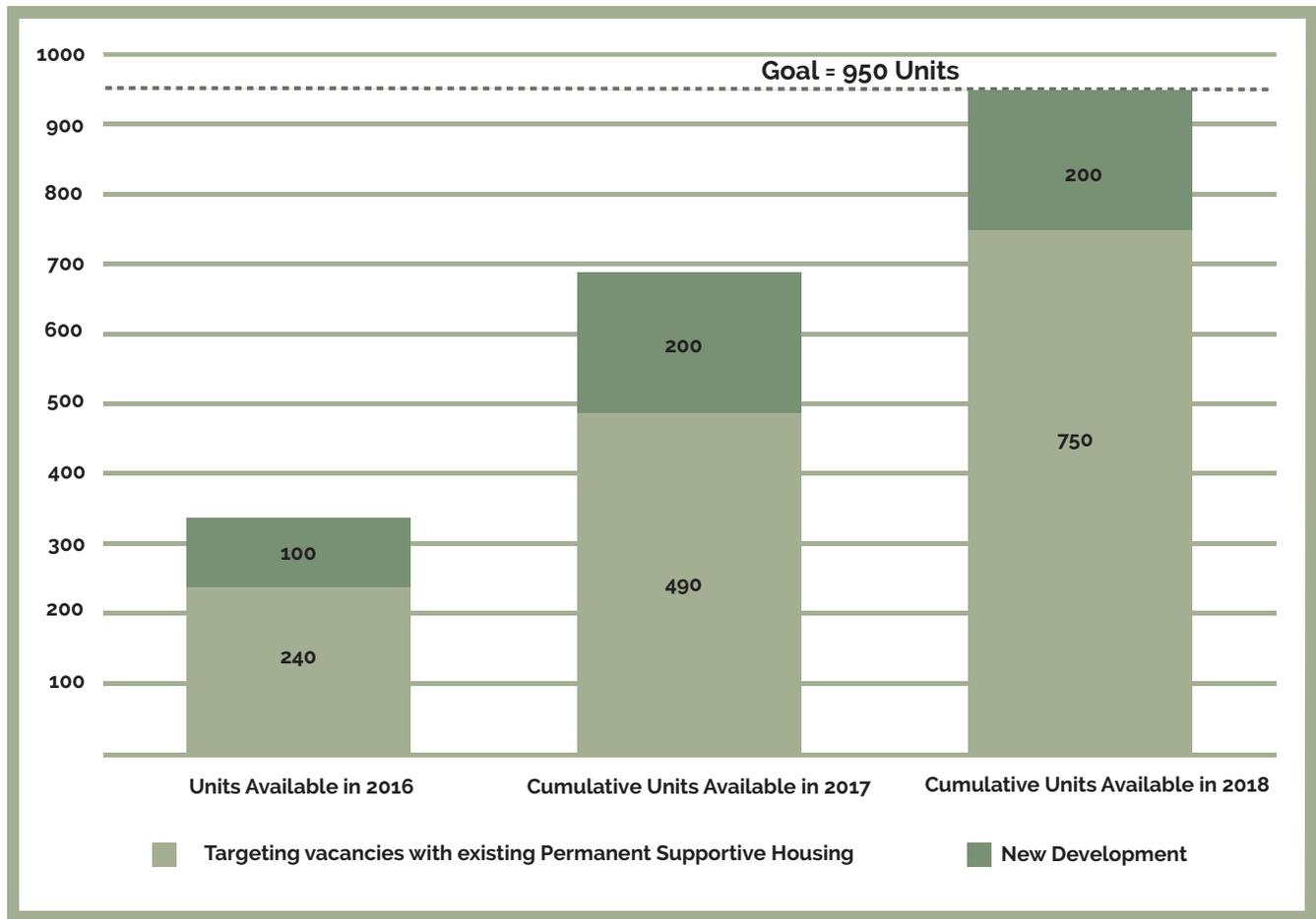
To end chronic and veteran homelessness, we will need to:

- Develop approximately 200 units of very low-barrier housing with supportive services on site using funds described in the following Budget section.
- Develop "moving on" strategies that provide housing opportunities to individuals currently residing in permanent supportive housing who no longer need intensive services. By moving people through the housing continuum as their needs change, more vacancies will open for Permanent Supportive Housing for those who need it.
- Enlist national experts to review and revise policies that currently create barriers. By the end of 2015, this team of experts will work with the City's Department of Neighborhood Development (DND) and the Boston Housing Authority (BHA) to review tenant selection, CORI mitigation, application processes, and documentation of homelessness policies.
- Enlist the same team of national experts to review and analyze policies and procedures related to the 10% homeless set-aside requirement within all

affordable housing development, as well as policies and procedures related to accessing the Continuum of Care housing resources.<sup>17</sup> This team will work in collaboration with City agencies to make recommended changes.

- Maximize opportunities available to provide tenant supportive services to stabilize formerly homeless individuals in housing through MassHealth. Some homeless providers in Massachusetts can bill MassHealth for supportive services for chronically homeless individuals and high-utilizers of emergency services. The “Community Support Program for People Experiencing Chronic Homelessness” (CSPECH) and the “Chronic Individual Homelessness Pay for Success Initiative” both provide mechanisms to leverage MassHealth for services. Boston should ensure we are maximizing these resources and explore if there are any additional opportunities for third-party billing to medical insurance through the Affordable Care Act and Massachusetts’ healthcare cost control laws.

**FIGURE 6. TARGETING 950 PERMANENT SUPPORTIVE HOUSING UNITS TO THE MOST VULNERABLE**



SECTION 4 Endnotes:

12 Definition based on MA MOU on Supportive Housing: <http://www.mass.gov/hed/docs/dhcd/legal/interagencysupportative-hs-memorandum.pdf>  
 13 For more information about the Federal Framework to End Youth Homelessness, visit: [http://usich.gov/resources/uploads/asset\\_library/USICH\\_Youth\\_Framework\\_FINAL\\_02\\_13\\_131.pdf](http://usich.gov/resources/uploads/asset_library/USICH_Youth_Framework_FINAL_02_13_131.pdf).  
 14 For more specific data, see Appendix H: Individuals in Boston’s Emergency Shelters Discharged from an Institutional Setting.  
 15 See Appendix E for data on length of stay in shelter across the Boston shelter system.  
 16 <http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls3.shtml#conclude>  
 17 See Appendix G for Existing Permanent Supportive Housing Units in Boston.

## V. BUDGET PROJECTION

The budget projection includes existing and new resources identified while drafting this plan. The budget may need to be amended during the action plan's enactment, as improved information becomes available. The City is committed to using existing resources as detailed in the "Existing Resources" column in the budget. As the City explores additional public funding, we know we cannot accomplish this plan with public resources alone. In order to end homelessness for the most vulnerable individuals in three years, this Action Plan will need significant support from private partners, funders, philanthropies, and other donors.

## BUDGET NARRATIVE

In Figure 7, the "Existing Resources" column shows the public resources that are already committed to this effort. The "New Resources Needed" column describes the total amount of new resources needed over the three full years of the plan. Once again, the budget may need to be modified as this plan is executed and additional factors, currently unknown, affect the cost of implementation.

### **Front Door Triage:**

- New resources needed include \$375,000 per year for five front door triage staff, including substance abuse specialists.
- \$50,000 investment in technology for system-wide tracking of available treatment beds.

### **Coordinated Access:**

- New resources needed include \$675,000 per year for three data management staff and five housing navigators. The data management staff will be responsible for managing the integrated Coordinated Access and HMIS data systems, and ultimately to provide real time data to track outcomes. The housing navigators will assist clients in connecting with landlords who have available units, executing leases, and moving into housing.
- An estimated \$400,000 will be needed for building out and implementing the Coordinated Access data system that is fully integrated with HMIS. The City's Department of Neighborhood Development, the Department of Innovation and Technology, and the Mayor's Office of New Urban Mechanics are currently working together to develop the design, scope, and final budget for this project.

### **Rapid Rehousing:**

- New resources needed include \$2.6M for rapid rehousing assistance and staffing, as well as to evaluate best practices.
- In Year 1, the community will need to evaluate the outcomes and best-practices of rapid rehousing in Boston, based on the experience with existing rapid rehousing programs. Year 1 will also be used to procure funds, hire staff, and build out infrastructure.
- In Years 2 and 3, the additional funds will serve 700 households total, almost doubling the number of households served with existing Rapid Rehousing funds each year.
- With this additional investment, data modeling estimates that Boston will have sufficient rapid rehousing resources to aid the goal of ending chronic homelessness by preventing additional individuals from becoming chronically homeless.

## Permanent Supportive Housing:

- The Department of Neighborhood Development (DND) contracted the Corporation for Supportive Housing (CSH) to develop a data model that calculated the absolute need for Permanent Supportive Housing and Rapid Rehousing in Boston. The model relies on critical data such as the number of chronically homeless individuals, the estimated number of people who become chronically homeless over the course of a year, as well as the number of permanent supportive housing units that become available over the course of a year. The model estimated that over the three years of this plan, Boston will require 950 Permanent Supportive Housing units dedicated to its most vulnerable individuals.
- The online Coordinated Access system will be able to target vacancies in units dedicated to chronically homeless individuals within the existing permanent supportive housing portfolio. To determine the number of turnover units available, modeling assumed that 10% of units dedicated to chronically homeless will become vacant each year, yielding 240 vacancies in the first year, 250 in the second year, and 260 in the third year (the increase is due to additional units developed in Years 1 and 2). Over three years, estimated turnover within existing permanent supportive housing will yield 750 available units.
- In addition to those 750 turn-over units, it is estimated that 200 new Permanent Supportive Housing units will need to be developed to reach a total of 950 available units. In particular, the existing portfolio of permanent supportive housing lacks sufficient units clustered in a single building that offers 24/7 clinical support on-site and has no barriers to entry.
- DND commits \$6M to development costs of these units which will leverage public funds from state and federal sources. DND estimates that it costs \$60,000 of DND funding per unit to leverage sufficient other development costs, thus DND's \$6M commitment will leverage approximately 100 units. Further, the budget projects an additional initial need for \$6M of private funding for Permanent Supportive Housing in order to leverage additional funds required to develop the additional 100 units. These units must be low-threshold, meaning there are no eligibility barriers for tenants with complex needs and therefore the funding used to create this housing must be extremely flexible.
- Commitment for stabilization services will also need to be leveraged from other sources, including services funded by the Continuum of Care, state and federal agencies including the Department of Mental Health, Department of Public Health, Department of Developmental Services, MassHealth, and the U.S. Department of Veterans Affairs. Stabilization service providers estimate that the total cost to provide stabilization services to a chronically homeless individual is approximately \$11,000 per year. The Chronic Individual Homelessness Pay for Success Initiative is a model for billing MassHealth for stabilization services and will be a critical resource to create these units of permanent supportive housing (see Appendix C).

- The budget also includes the need for \$350,000 in private, flexible resources for a "whatever it takes" stabilization fund to pay for one-time costs such as furniture or other necessities that can't be paid for through public funds.

### Change Management:

- \$150,000 for outside expertise to design and implement the Coordinated Access system, create performance-based contracts, streamline procurement processes, enhance collaboration with private funders, among other efforts. This could include continued work with Corporation for Supportive Housing (CSH) or other experts in the field.

**FIGURE 7. SYSTEM REDESIGN: BUDGET PROJECTION FOR THE THREE FISCAL YEARS 2016-2018**

| System Component                        | Individuals Assisted                                   | Existing Resources   | New Resources Needed   | Total New Resources Needed |
|---|--|--|--|----------------------------|
| Front Door Triage                       | 8,500 new people per year                              | None   | \$375,000 per year for 5 front door triage staff, including substance abuse specialists  | \$1,175,000                |
|   |  |  | \$50,000 investment in technology for system-wide tracking of available treatment beds   |                            |
| Coordinated Access                      | 5,950 new people per year                              | None   | \$675,000 per year for 3 data management staff and 5 housing navigator staff   | \$2,425,000                |
|   |  |  | \$400,000 for build of IT platform   |                            |
| Rapid Rehousing                         | 700 additional individuals; 1,800 total individuals    | \$1,300,000 per year from Emergency Solutions Grant (ESG) and Supportive Services for Veteran Families (SSVF) grants   | \$2,600,000 for rapid rehousing to serve 700 additional individuals and evaluate best practices  | \$2,600,000                |
| Permanent Supportive Housing            | 200 highest-barrier individuals; 950 total individuals | \$17M per year from Continuum of Care grant; \$6M from DND for housing development costs for 100 very low-barrier units; leverage services funded by MassHealth and other state and federal agencies | \$6,000,000 initial private funding campaign for siting 200 very low-barrier units   | \$6,350,000                |
|   |  |  | \$350,000 for flexible stabilization fund  |                            |
| Change Management                       | 8,500 new people per year                              | None   | \$150,000 for outside expertise to implement the Coordinated Access system, performance-based contracts, streamlined procurement processes, collaboration with private funders, etc. | \$150,000                  |
| Existing Resources Committed: 2015-2018 |  | \$60,900,000*  | New Resources Needed: 2015-2018  | \$12,700,000*              |

\* Budget figures are provisional, and subject to change during the plan years 2015-2018.

# APPENDICES

## APPENDIX A: DEFINITION OF KEY TERMS

**Chronic Homelessness:** The U.S. Department of Housing and Urban Development (HUD) defines a person experiencing chronic homelessness as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

**Coordinated Access** is a centralized online data system that matches homeless individuals to housing vacancies based on need. The Coordinated Access system will centralize vacancies to permanent supportive housing units and will use data to drive outcomes.

(<https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>).

**Front Door Triage** is the immediate response to homeless individuals upon entry into the homeless system, including individuals on the street or entering emergency shelter. The triage design will be modeled on emergency room triage and will provide a differential response based on vulnerability and individual need.

**Literally Homeless Individual:** an individual sleeping in a place not designed for or used as a regular sleeping accommodation, living in a shelter designed to provide temporary living arrangements, or exiting an institution where (s)he resided for up to 90 days and resided in shelter or a place not meant for human habitation immediately prior to entering that institution. Source: Definition summarized from the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.

**Housing First:** The Housing First model moves homeless participants from the streets immediately into permanent housing. With stable and supportive treatment services, program participants are better able to focus on the core mental and physical issues that led them to homelessness. Housing First can be contrasted with a continuum of housing "readiness," which typically subordinates access to permanent housing to other requirements.

**Rapid Rehousing:** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Rapid re-housing is replacing the former approach of "housing ready."

(<http://www.buildingchanges.org/coordinated-entry-toolkit/key-terms>)

**Permanent Supportive Housing:** Permanent supportive housing combines rental housing with individualized health, support and employment services. People living in permanent supportive housing have their own apartments, enter into rental agreements and pay their own rent, just as in other rental housing. The difference is that they can access, at their option, support services – such as the help of a case manager, help in building independent living skills, and connections to community treatment and employment services – designed to address their individual needs.

## APPENDIX B: TASK FORCE GOALS

| TASK FORCE GOALS   | SYSTEM COMPONENT(S)  |
|--|--|
| 1. Provide appropriate relocation for and service improvements to the Long Island Shelter, and implement improved communication during this transition period                                | Coordinated Access<br>Front Door Triage<br>Rapid Rehousing<br>Permanent Supportive Housing |
| 2. Reduce and work towards eliminating the number of individuals who live in shelter for longer than 180 days  | Coordinated Access<br>Front Door Triage<br>Rapid Rehousing<br>Permanent Supportive Housing |
| 3. Undertake a statewide response and align City policies to reduce the number of homeless individuals arriving from outside of Boston seeking housing and services                          | Front Door Triage  |
| 4. Reduce the number of individuals living on the street   | Coordinated Access<br>Rapid Rehousing<br>Permanent Supportive Housing                      |
| 5. Improve discharge planning, outlining necessary proposed changes to ensure that discharges of individuals leaving state and other systems of care do not disproportionately impact Boston | Front Door Triage  |
| 6. Develop an unaccompanied youth and young adult engagement and diversion plan  | Front Door Triage  |
| 7. Improve the way shelter, housing, and service needs of homeless women are addressed across the system   | Front Door Triage  |
| 8. Propose resources and potential sources needed to obtain improvements and recommended goals   | Coordinated Access<br>Front Door Triage<br>Rapid Rehousing<br>Permanent Supportive Housing |

## APPENDIX C: CHRONIC INDIVIDUAL HOMELESSNESS PAY FOR SUCCESS INITIATIVE

A communication from the Corporation for Supportive Housing, originally posted at: <http://www.csh.org/2014/12/massachusetts-chronic-individual-homelessness-pay-for-success-initiative-first-in-nation/#sthash.RrDToUeD.dpuf>. Republished here with permission.

*December 9, 2014*

*Yesterday was an exciting day for the Commonwealth of Massachusetts, the Massachusetts Housing and Shelter Alliance, the United Way of Massachusetts Bay and Merrimack Valley, and Santander Bank. Even more so, it was a very exciting day for hundreds of chronically homeless people who will have their lives changed forever because forward-thinking leaders came together, collaborated, innovated and made the "Chronic Individual Homelessness Pay for Success Initiative" a reality in Massachusetts.*

*CSH is a national nonprofit active in 33 states and we see what is unfolding across the country. Massachusetts is on the cutting edge of efforts to end homelessness.*

*Groundbreaking investments such as this Pay for Success Initiative are emphasizing accountability while providing the resources to fund the housing and services we know end and prevent homelessness. Beyond the much-needed supportive housing it will create, Massachusetts will continue a transformation in the way services are delivered, away from over-reliance on crisis health and shelters and toward more permanent solutions that provide the stability people need to end their homelessness.*

*Supportive housing works. So much so that we have witnessed a nearly 50% decline in the number of chronically homeless individuals over the past decade as supportive housing has taken hold and proliferated.*

*Supportive housing is a perfect match to the Pay for Success structure. Since its beginning, supportive housing has relied on data-driven outcomes and has operated under a paradigm of delivering results and savings. In other words, it's a good bet that this Initiative will succeed.*

*CSH is pleased to invest \$500,000 of the combined \$2.5 million dollars in private capital in the Massachusetts Chronic Individual Homelessness Pay for Success Initiative, leveraging an additional \$1 million in philanthropic support for a total of \$3.5 million. This Initiative complements CSH's role as a federally-designated national provider of Pay-for-Success expertise and technical assistance.*

*Initiatives such as this just don't happen. They require thought-leaders who want to work together to make a difference. Like any arrangement based on multi-millions of dollars, they require hours of painstaking negotiation and patience.*

*They require the extraordinary leadership and political will that have been exhibited by Governor Deval Patrick and the Commonwealth of Massachusetts.*

*They require the experience and gravitas of lead partner, the Massachusetts Housing and Shelter Alliance, an agency that has the background and know-how to guide us.*

*They require the commitment of philanthropic and private investors such as the United Way of Massachusetts Bay and Merrimack Valley and Santander because these organizations add the proficiency to serve as fundraising intermediaries and strong financial advisors and managers.*

*They require the helping hands of the experts at the Harvard Kennedy School Social Impact Bond Technical Assistance Lab who provide pro bono technical assistance to state and local governments implementing Pay for Success, and are assisting Massachusetts in developing the procurement and the data analysis strategy for this Initiative.*

*And, most importantly, they require a fundamental belief in the promise of supportive housing to bring our most vulnerable neighbors the stability and dignity they long for and deserve.*

## APPENDIX D: HOUSING FIRST APPROACH

The Housing First approach promotes connecting homeless households to housing first, regardless of their characteristics, and subsequently offering services that may help stabilize the household once in housing.<sup>21</sup> According to the National Alliance to End Homelessness, Housing First models include the following elements:

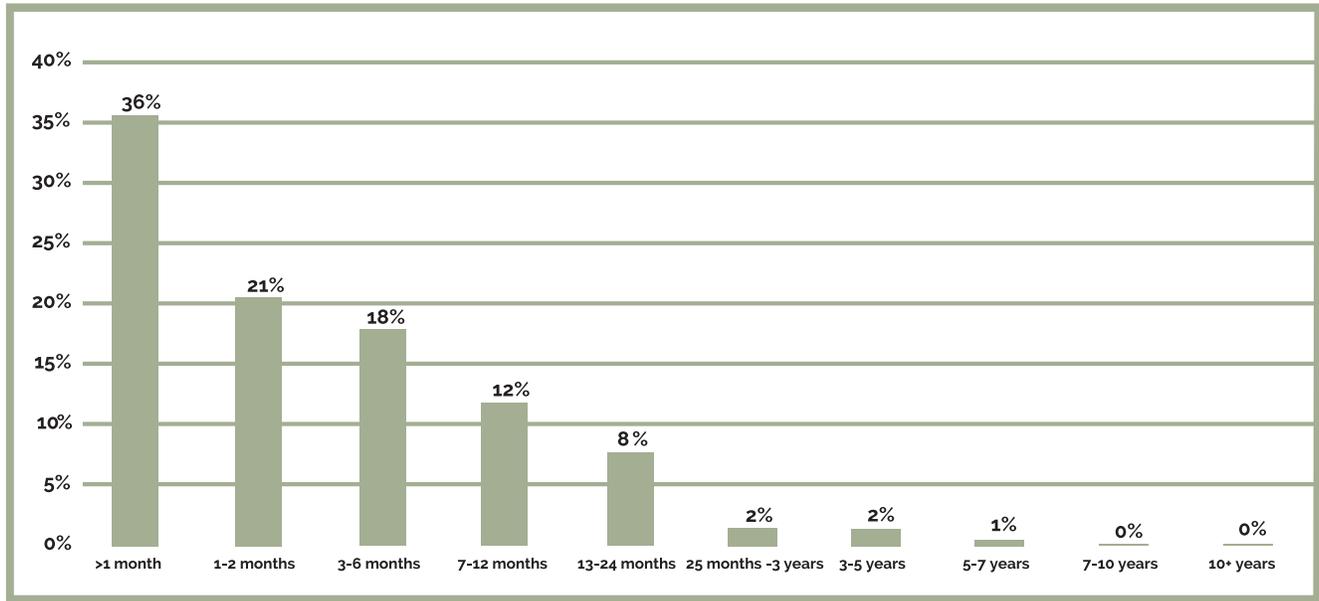
- A focus on helping individuals and families access and sustain rental housing as quickly as possible in permanent housing;
- A variety of services delivered primarily following a housing placement to promote housing stability and individual well-being;
- Such services are time-limited or long-term depending upon individual need; and
- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them do so successfully.<sup>22</sup>

Housing First principles have been fully endorsed and validated by homeless experts, the U.S. Department of Housing and Urban Development, and most local officials and providers alike. However, while stakeholders generally agree that the Housing First philosophy makes sense, many of our local policies still operate counter to housing first practices. Several recommendations found in Section IV of this report address changes necessary to implement Housing First across our system.

<sup>21</sup> Based on definition found in MA MOU on Supportive Housing: <http://www.mass.gov/hed/docs/dhcd/legal/interagencysupportative-hs-memorandum.pdf>

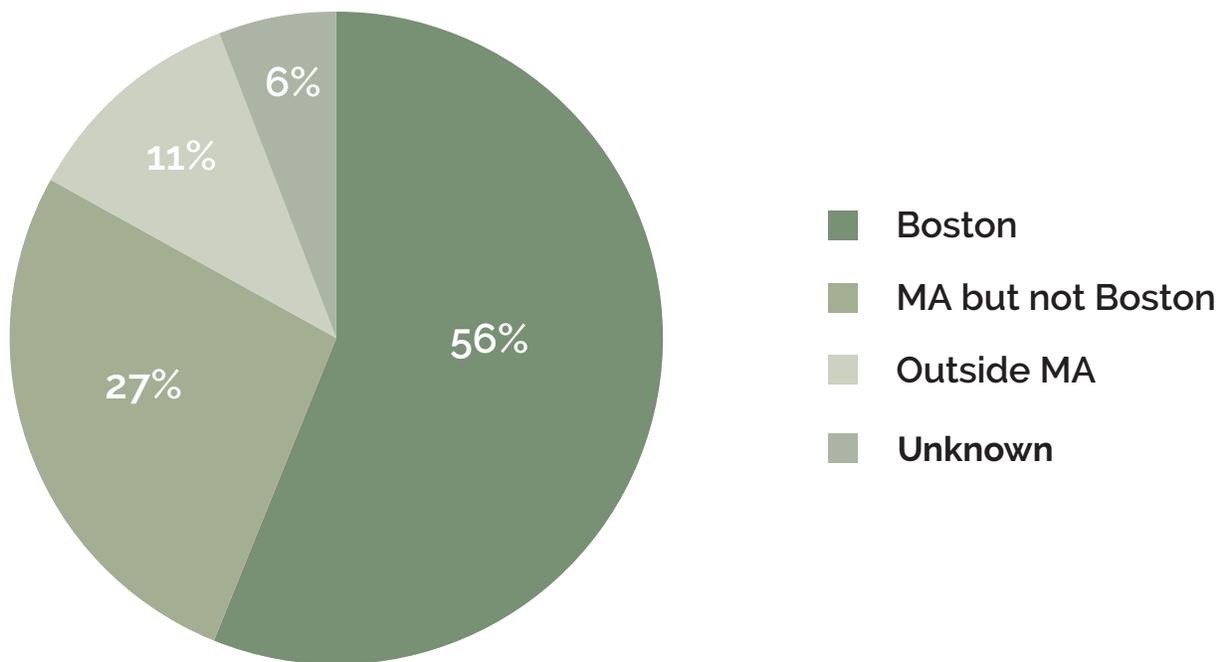
<sup>22</sup> Based on information provided at: <http://www.endhomelessness.org/library/entry/what-is-housing-first>

## APPENDIX E: LENGTH OF STAY IN EMERGENCY SHELTER



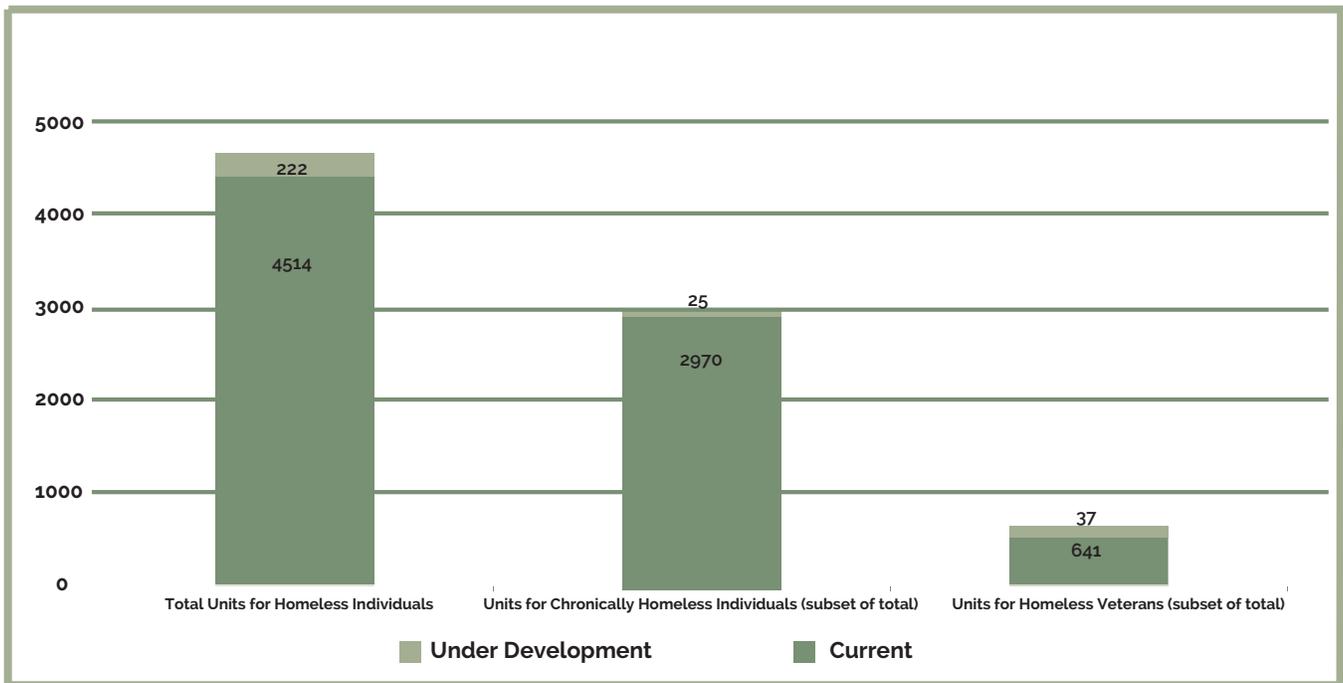
Source: City of Boston 2013-2014 Annual Homeless Census Single Adults in Emergency Shelter Length of Stay in Nights

## APPENDIX F: COMMUNITY OF ORIGIN OF HOMELESS INDIVIDUALS IN BOSTON



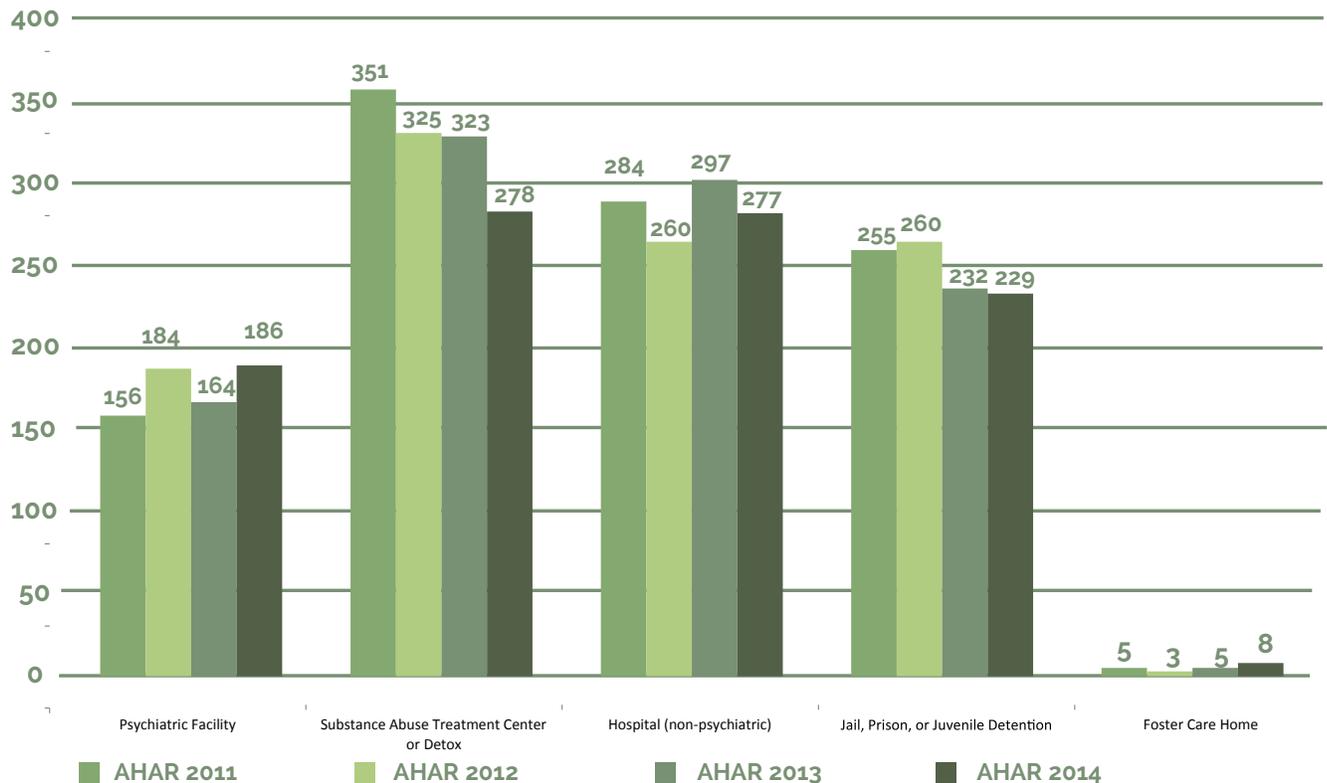
Source: Data from the City of Boston Homelessness Management Information System (HMIS)

## APPENDIX G: PERMANENT SUPPORTIVE HOUSING UNITS IN BOSTON



Source: Data from the Boston Continuum of Care 2015 Housing Inventory Chart

## APPENDIX H: INDIVIDUALS IN BOSTON'S EMERGENCY SHELTERS DISCHARGED FROM AN INSTITUTIONAL SETTING



Source: Data from the Annual Homeless Assessment Report (AHAR)

**APPENDIX I:** The City of Boston and Mayor Martin J. Walsh would like to thank the members of the Mayor's Task Force on Individual Homelessness for their hard work.

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City of Boston

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**Michael Weekes**  
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The Provider Council

**Reverend Joseph M. White**  
Pastor  
Our Lady of Good Voyage

**Tonya Williams**  
Consumer

## **APPENDIX J:**

The City of Boston and Mayor Martin J. Walsh would like to thank the hundreds of donors who gave such generous direct or in-kind support in the aftermath of the Long Island Shelter closure. Your kindness was greatly appreciated.

We would also like to acknowledge the following donors for their critical support:

### **Friends of Boston's Homeless**

**The Boston Foundation**

**Liberty Mutual**

**BNY Mellon**

**Eastern Bank**

**Stacy's Pita Chips**

**Charles River Apparel**

**Frugal Fannie's**

**P&G /Gillette USA**