# Chapter 5

## A Formal Statement of the HHS
## Comprehensive Plan to End Chronic Homelessness[1]

**Mission:** To end chronic homelessness in a decade.

**Goals:**

**Goal 1.**
***Improve access to treatments and supports***

Objective:
Expand the capacity of HHS programs to assist persons experiencing chronic homelessness.

Strategies that Help Homeless People

➢ Develop approaches in relevant programs to strengthen outreach and engagement activities that will facilitate enrollment in treatment and service programs of individuals who are chronically homeless.

**Examples:**
*a) Encourage mainstream programs that support outreach and case management to identify chronically homeless persons as potentially eligible candidates for these services. Where appropriate, pursue new funding to expand services such as increased outreach, increased case management/enrollment assistance, or ombudsman programs for homeless persons that will advocate for service access.*

*b) Investigate approaches that expedite eligibility processes (such as reducing or simplifying documentation requirements, and/or use out-stationing where applicable) or advances in technology and communications that expedite the exchange and processing of information, including rural areas or where providers are distant from clinic sites and Disability Determination Offices.*

➢ Implement approaches in relevant programs that facilitate prompt eligibility review for persons identified as chronically homeless or at risk of becoming chronically homeless.

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1. It is assumed throughout this document that no strategies will be implemented without seeking and attaining all relevant legislative and/or regulatory changes needed to ensure that all programs within HHS continue to operate within their given authority and mission. It is also assumed that, to the extent the strategies seek to impose any requirements on applicants as conditions of given awards, before doing so, programs will confirm that their authorizing authority and program/administrative regulations permit such imposition of conditions. It is further assumed that no proposals will be implemented without resolving any inherent budget implications.

***Examples:***

*a) Relevant Operating Divisions could establish an interagency agreement with the Social Security Administration (SSA) to provide cross training for people working with homeless individuals on appropriate medical documentation needed to determine disability.*

*b) SSA should be encouraged to designate appropriate contacts in Disability Determination Service offices who would work with individuals serving as homeless ombudsmen in HHS programs to identify barriers to eligibility and work collaboratively to rectify them.*

*c) Promote the inclusion of homeless shelters among the entities conducting eligibility and enrollment functions for mainstream programs.*

➢ Explore ways to maintain periods of program eligibility and/or avoid loss of coverage for individuals who are chronically homeless.

**Example:**
*Encourage States to "suspend" and not "terminate" Medicaid eligibility for individuals who are institutionalized so that the individuals do not have to initiate the application process over again upon their release.*

Strategies to Give Service Providers Tools, Training or Technical Assistance

➢ Develop toolkits and blueprints that describe exemplary outreach, enrollment, and service delivery approaches for persons experiencing chronic homelessness, disseminate them and support their use in in-service training.

**Examples:**
*a) Develop interagency agreements between relevant Operating Divisions (e.g., the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, etc) and the U.S. Department of Housing and Urban Development (HUD) to develop tools that explain the basic eligibility requirements for mainstream programs and health and social service resources available to homeless persons. These tools should be designed for use by both individuals who are homeless and providers/persons who assist them.*

*b) SAMHSA is developing a blueprint on ending chronic homelessness.*

➢ Provide training and technical assistance for mainstream service providers on steps that can be taken to end chronic homelessness.

**Examples:**
*a) Repeat the "We Can Do This" training conference (SAMHSA's 2001 training on ending chronic homelessness among persons with behavioral health problems) on a biennial basis and emphasize the participation of*

*mainstream service providers as sponsors and presenters to encourage the inclusion of chronically homeless persons in their activities.*

*b) Identify annual meetings of homeless-specific grantees (e.g., annual Health Care for the Homeless Conference) and of associations representing mainstream programs (e.g., meetings of the American Public Human Services Association) and capitalize on opportunities to present approaches to improving access for persons experiencing chronic homelessness.*

*c) Promote the availability of technical assistance documents on services and policy issues related to chronic homelessness via internet access, distribution at relevant meetings, and to academic settings offering instruction on the issue of homelessness.*

➢ Support the homeless-specific service providers assisted by HHS in developing and establishing administrative arrangements with mainstream providers to ensure that their homeless clients can effectively use the mainstream programs for which they are eligible.

**Example:**
*Develop program guidance showcasing exemplary practices, based on actual experiences, that demonstrates how effective collaboration can be achieved between the homeless-specific service system, including faith and community-based providers, and the mainstream system.  These exemplary practices may include co-location arrangements, financial agreements between two systems, restructuring, and/or skill-specialization agreements that recognize the differences in the systems to work with clients at various stages of readiness to benefit from mainstream services.*

➢ Establish a formal program of training for providers of services to persons experiencing chronic homelessness.

**Example:**
*Fund an expansion of the existing training centers in HRSA's Bureau of Health Professions to  provide intensive training on providing effective services, outreach and care to persons who are chronically homeless. Training could extend beyond mainstream providers to include opportunities for formerly homeless persons to become providers.  A training certificate for specific skill sets acquired in training (e.g., outreach worker) or for completing the overall curriculum could be awarded as an indication of the quality of the training process.*

➢ Provide technical assistance to States through State Policy Academies to develop and implement State-specific action plans to identify and address chronic homelessness.

**Example:**
*Expand the Policy Academy on Chronic Homelessness from an event that reaches a limited number of States to an opportunity for all States willing to implement an action plan to end chronic homelessness in their*

*State. Provide participating States with up to one year of intensive technical assistance to achieve a break-through in policy direction.*

## Strategies that Involve New or Realigned Funding

➢ As mainstream programs formulate future budgets or experience budget growth, set priorities for a sharpened focus on addressing chronic homelessness.

**Examples:**
*a) In developing budget submissions for future years, relevant mainstream programs should reflect the Department's goal of reducing chronic homelessness by including activities that will support the goal.*

*b) Direct a percentage of the growth in the community health care center funding to services to chronic homelessness.*

*c) Relevant block grant programs should actively examine how their programs can contribute to the Department's and Administration's goal of ending chronic homelessness, including the feasibility of legislative proposals that identify the inclusion of homelessness or establishing priorities for the use of any increased funding for the program.*

## Strategies for Accountability

➢ Establish a work group under the HHS Data Council that will investigate the feasibility of developing quality measures and/or performance measure(s) that can be reported by States and grantees to reflect the access of chronically homeless persons to mainstream assistance programs. Where appropriate and feasible, the measures should be uniform across these assistance programs. The work group should identify implementation issues, the frequency of reporting, and how requested reporting might vary across the different types of assistance programs to provide the Department with a baseline and ability to monitor changes over time.

**Examples:**
*a) SAMHSA has developed the following "core client outcome measure" for its discretionary programs, which may be applicable to other mainstream programs:*

*–Number of clients who are homeless (i.e. no fixed address, includes shelters) at admission to a treatment setting and at six months post-admission.*

*b) In annual reports or grant/project reports, require State and local grantees to provide timely information, e.g. no less then every two years, describing how program activities have assisted homeless persons.*

*c) HUD allows applicants for homeless grants to request funding to develop homeless management information systems (HMIS) that can provide HUD with annual performance data. These HMIS approaches could be examined as a possible source of information on the use of HHS assistance to address chronic homelessness.*

## Goal 2.
### *Improve coordination at Federal, State, and local levels*

Objectives

Develop a framework for promoting collaboration in providing services to persons experiencing chronic homelessness at Federal, State, and local levels.

Use the Interagency Council on Homelessness and other interagency mechanisms to coordinate planning, programmatic activities, and evaluation that address chronic homelessness efforts in HHS with HUD, VA, and other relevant Departments.

Strategies to Promote Collaboration

➢ Promote and incentivize coordination between all mainstream and homeless-specific HHS funding sources that address chronic homelessness.

**Examples:**
*a) Where appropriate, add a new section to applications requesting funding for mainstream assistance that requires the applicants to demonstrate how the assistance will be used in concert with other HHS support to form an integrated safety net for poor and disabled individuals and families. Require that they articulate outcomes associated with the coordination and that they have an infrastructure in place to operationalize and manage this coordination.*

*b) Develop an incentive program in which States submitting block grant applications that demonstrate a coordinated set of activities to address services to homeless people (including those who are chronically homeless) across mainstream programs are eligible for a partial bonus payment up front, with the balance of the bonus based on their achievement of a performance goal they set–e.g., number of chronically homeless people receiving comprehensive support in housing.*

➢ Provide incentives for States and localities to coordinate HHS-assisted services and housing for persons experiencing long-term homelessness.

**Examples:**
*a) Permit applicants to use grant funds to support interagency collaborations that address chronic homelessness, including expenses for FTEs associated with partnership activities, incentive funds, flexible fund reserves, contributions to HUD continuum of care activities, etc.*

*b) In competitive applications for services (such as community health centers, some Ryan White programs, SAMHSA's Grants for the Benefit of*

*Homeless Individuals), give bonus points to applicants willing to address chronic homelessness via partnerships with other types of providers, notably housing providers.*

*c)  Permit States and communities to experiment with various approaches to creating a coordinated, comprehensive system of services to address chronic homelessness (e.g., establish an infrastructure that supports coordination, have flexibility in the use of funds, forge systemic relationships between providers for effective client referral, conduct cross-system training) and introduce new service technologies (e.g., assertive case management models, critical time intervention approaches).   This might be done as pilot projects, under existing authorities, such as the recent Medicare+Choice arrangements with preferred provider organizations.*

➤ Permit flexibility in paying for services delivered to individuals experiencing chronic homelessness, particularly involving services from different funding streams.

**Examples:**
*a) Explore the authority for appropriate grantees to designate a percentage amount of an award that can be used flexibly and to assist in providing timely, comprehensive services to a person who is chronically homeless, e.g., to secure a critical service that is only available from another provider.*

*b)  Allow States to blend a small portion of funds from multiple, relevant HHS assistance programs to target homelessness.  The Listening Session presenters referred to the application of this concept to homelessness as a 'mini-waiver.' This could be done through a multi-program waiver or through relief from cost allocation rules for this portion of the funds. One large-scale version of this was attempted with the flexible authorities proposed in legislation reauthorizing the Temporary Assistance for Needy Families program.  The intent of such flexible waivers and authorities is a relaxation of rules would be to permit States to experiment with adaptive uses of these assistance programs to respond comprehensively and flexibly to the needs of poor and disabled clients.  Persons experiencing chronic homelessness should be included in this consideration.*

*c)  Develop a pilot program that covers multiple mainstream programs and allows funds to be pooled for a specific purpose.  For example, multiple systems could contribute resources to pay for continuity of case management.  As the chronically homeless client progresses from homeless-to-housed or receives services from different systems, the case manager would remain constant, ensure consistency of a treatment plan, and be empowered to work with each system.*

<u>Strategies to Improve Coordination</u>

➣ Establish an ongoing body within HHS to identify, monitor, and coordinate Departmental activities to address services to eligible persons experiencing homelessness, including those with long term and repeated patterns of homelessness, and coordinate these efforts with other Federal agencies.

**Example:**
*Charge and rename the Secretary's Work Group on Ending Chronic Homelessness to serve in this capacity. Subcommittees of the Work Group could address and advise on specific facets such as chronic homelessness or homelessness among families with children. The Work Group could also ensure that the activities undertaken by the Department are periodically assessed and adjusted to achieve long-term outcomes, e.g., ending chronic homelessness.*

**Goal 3**
***Prevent additional chronic homelessness***

<u>Objectives</u>:
Promote programs and policies designed to ensure that persons returning to the community from institutional or other sheltered settings (including foster care) do not become homeless.

Promote programs and policies that address the service and housing needs of persons identified as at-risk of housing loss who are currently participating in HHS assisted mainstream programs.

<u>Strategies to Reduce the Incidence of Homelessness</u>

➣ Identify both the risk and protective factors for homelessness and preventive interventions that could be used to identify and prevent homelessness among persons at risk.

**Examples:**
*a) The Research Coordination Council could be requested to examine how HHS can synthesize, sponsor or conduct epidemiological and health services research on protective and risk factors for homelessness and to identify preventive interventions that could be provided in health care and human services settings that are effective at preventing at-risk clients from entering a pattern of residential instability that could result in chronic homelessness. A dissemination plan should be an integral part of a department plan.*

*b) NIH or AHRQ could sponsor investigator-initiated research to examine the organization, effectiveness, and cost of such preventive interventions. In addition, NIH or ASPE could also fund a contract for a 'meta-analysis' of existing research and evaluation studies on the histories of persons experiencing long-term homelessness to determine what is known about identifiable risk factors for chronic homelessness. Alternatively, this could be done by stimulating investigator initiated research in NIH that explores these factors and then applies them*

> *retrospectively to shelter data bases and assesses their predictive ability. The risk factors could then be promulgated as 'markers of concern' to mainstream providers so that current clients with these characteristics might have housing stability issues included in their treatment plans.*

➤ Identify and promote the use of effective, evidence-based homelessness prevention interventions, ranging from family strengthening and high-risk youth programs to specific interventions such as discharge planning, Assertive Community Treatment (ACT) and Critical Time Intervention (CTI). Develop and disseminate guidelines for these interventions in order to reduce the incidence of individuals being placed in emergency shelter or other fragile residential circumstances.

**Examples:**

*a) HRSA has recently supported a grantee to disseminate discharge-planning guidance via the Internet. The applicability of this homelessness prevention strategy could be reinforced via in-service training, letters of guidance, and other dissemination approaches.*

*b) Conduct replicability studies of ACT and CTI and provide models and guidelines for their use in community based settings, as well as their applicability to effective discharge planning.*

**An Alternate Listing**

The above approach organizes the goals and strategies under each of the original charges to the Work Group. Such an approach demonstrates the responsiveness of the Work Group to each charge, but is not the only way of presenting HHS' comprehensive approach. This alternative listing may also prove useful. Three restated goals describe the HHS plan to end chronic homelessness:

*1) Help eligible, chronically homeless persons receive health and social services;*

*2) Empower our State and community partners to improve their response to the needs of homeless people; and*

*3) Work to prevent new episodes of homelessness within the HHS clientele.*

The strategies listed previously can be aligned with each of these restated goals to present a comprehensive approach. They are briefly paraphrased and aligned with one of the above goals:

**Help eligible, chronically homeless individuals receive health and social services**

➢ Strengthen outreach and engagement activities

➢ Improve the eligibility review process

➢ Explore ways to maintain program eligibility

➢ Improve the transition of clients from homeless-specific programs to mainstream service providers

**Empower our State and community partners to improve their response to people experiencing chronic homelessness.**

➢ Use State Policy Academies to help States develop specific action plans to respond to chronic homelessness

➢ Permit flexibility in paying for services that respond to the needs of persons with multiple problems

➢ Reward coordination across HHS assistance programs to address the multiple problems of chronically homeless people

➢ Provide incentives for States and localities to coordinate services and housing

➢ Develop, disseminate and use toolkits and blueprints to strengthen outreach, enrollment, and service delivery

➢ Provide training and technical assistance on chronic homelessness to mainstream service providers

➢ Establish a formal program of training on chronic homelessness

➢ Address chronic homelessness in the formulation of future HHS budgets or in priorities for using a portion of expanded resources

➢ Develop an approach for baseline data, performance measurement, and the measurement of reduced chronic homelessness within HHS

➢ Establish an ongoing oversight body within HHS to direct and monitor the plan

**Work to prevent new episodes of homelessness within the HHS clientele**

➢ Identify risk and protective factors to prevent future episodes of chronic homelessness

➢ Promote the use of effective, evidence-based homelessness prevention interventions

**Closing Considerations**

These recommendations form a basis for the programs of HHS to explore ways in which their actions can contribute to the Administration's goal of ending chronic homelessness. They are neither prescriptive nor exhaustive of the possibilities for programs. However, in recognizing that categorical program approaches have limits in responding to the needs of a multi-problem clientele, the Work Group explicitly avoided recommendations that create additional programs or funding streams. Success is not measured exclusively by the existence of a program, but from the accumulation of operations supported by:

- ❏ a program mission;
- ❏ a management structure to carry out the mission;
- ❏ policies that guide operations;
- ❏ funding and incentives for the activities of the program;
- ❏ technical assistance to ensure credible and accountable activities; and
- ❏ outcomes that demonstrate the success of the above.

The Work Group believes the Administration's goal of ending chronic homelessness combined with the recommendations offered above accumulate to provide these six supports. Their interaction will guarantee the Department's success.