What does Connecticut's system for addressing homelessness look like now, and what needs to change?

The strategies of the federal *Opening Doors* plan are organized around five themes:

- Increase access to stable and affordable housing
- Retool the homeless crisis response system
- Increase economic security
- Improve health and stability
- Increase leadership, collaboration, and civic engagement

We have adopted these themes as a framework for briefly examining the current systems in place that significantly impact, or are impacted by, homelessness, and identifying what needs to change if we are to be successful in reaching the four goals of the plan. These ideas are by no means an exhaustive list, and should not be viewed as prescriptive, but rather as a way to focus and consider potential strategies that move us from where we are to what we all want to do: put in place the framework to prevent and end homelessness in Connecticut.

While we have suggested a number of ideas, we have not laid out how it should be done, or even precisely by whom or to what degree. This is deliberate. The next step of the Opening Doors - CT effort will be, through a reconstituted Reaching Home campaign (Reaching Home 2.0), to engage, guide, and support the efforts of Connecticut government, communities, philanthropy, providers, and advocates in a process to answer these questions. As a guiding framework, Table 1 of the section on Laying the Groundwork for Action shows how different population groups are targeted within each of the strategies. Table 2 of that section shows what systems would most likely be involved. Through the planning and implementation process, the feasibility of the strategies will be assessed, with some strategies taking longer to operationalize. We recognize that some strategies may prove not to be feasible to implement at scale.

Opening Doors - Connecticut
Summary of Strategy Ideas

INCREASE ACCESS TO STABLE AND AFFORDABLE HOUSING AND SUPPORTIVE HOUSING

Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need

Expand and target rent subsidies.

Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes.

Embed strategies to end homelessenss within cohesive State and municipal housing policies that set clear outcome targets.

Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing.

RETOOL THE HOMELESS CRISIS RESPONSE SYSTEM

Recalibrate our response to housing loss

Within an overall policy framework support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization.

Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings.

Strengthen the capacity of Connecticut's HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors-CT process.

Align state and local activities.

INCREASE ECONOMIC SECURITY

Foster housing retention through income growth and employment

Link workforce system resources (skill & job development) with the housing assistance system to create effective pathways to employment for vulnerable populations.

Align public and private sectors to ensure effective systems coordination with shared goals.

Expand income growth for persons with disabilities.

IMPROVE HEALTH AND HOUSING STABILITY

Reduce medical vulnerability and frequent use of health care systems

Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services.

Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations.

Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost.

Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems.

Support the housing stability of vulnerable families, children and youth

Assess the feasibility of deploying a “systems navigator” function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery.

Incentivize the creation of service-supported affordable housing for families.

Develop targeted outreach strategies to identify youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort.

Expand the range of housing options for youth and young adults facing housing loss.

Break the cycle of homelessness and re-incarceration

Target housing resources and other supports to prevent and end homelessness among people leaving incarceration.

Align housing resources and other supports to prevent and end homelessness among people leaving incarceration.

INCREASE LEADERSHIP, COLLABORATION, AND CIVIC ENGAGEMENT

Lead, manage and monitor the change process

Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors - CT that builds upon existing partnerships between the public, private, and nonprofit sectors.

Develop operational plans at the state and local level with specific actions linked to resources and responsible parties.

Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard.

Develop outcome measures at both the system level and at the program level.

As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platrform for integrating key data across HMIS and human services.

Increase Access to Stable and Affordable Housing and Supportive Housing

Fundamental to ending homelessness is the availability of rental housing that is affordable to households with extremely low incomes. These are incomes below 30% of area median income (AMI), a level that ranges from a low of $24,200 (family of 4) in Windham to a high of $37,700 in Stamford.

The National Low Income Housing Coalition reports that there were 128,577 Connecticut households with extremely low incomes in 2009. Of these, 79% (92,266) were "severely burdened," meaning they spend more than half their income on rent and utilities. For every 100 Connecticut households with extremely low incomes, there are only 38 affordable and available rental units.[31] Some of these units provide permanent supportive housing targeted to people experiencing, or at risk of, homelessness. As of February 2011, there were more than 4,500 units of supportive housing across Connecticut, including close to 200 units targeted specifically to homeless Veterans.[32]

The affordability of housing to households with extremely low incomes can be achieved through the provision of a rent subsidy or through some form of operating subsidy that enables the owner of the housing to cover the difference between a rent level that is affordable to the tenant and what it costs to operate the housing. Rent subsidies can either be tenant-based or project-based.

Three primary rent subsidy programs operate in Connecticut: the HUD Section 8 program, the State Rental Assistance Program (RAP), and the HUD Shelter Plus Care (S+C) program. The waiting lists for all of these subsidy programs are long and favor those in a stable housing situation. Because an individual or family experiencing housing instability and homelessness moves frequently, the odds are against their securing a rent subsidy if and when they come up on a waiting list, because they likely will have moved in the meantime.

Additionally, individuals who have faced long-term homelessness often face barriers that preclude them from accessing subsidized housing, such as poor credit history, previous incarceration, or active substance use. These barriers can sometimes prevent vulnerable individuals and families who need housing the most from even getting on a waitlist, never mind making it to the top of the list.

At any given time, public housing authorities (including the Connecticut Department of Social Services) face multiple demands to direct subsidies to particular projects, programs, or special initiatives and to still make vouchers accessible to the general public. Without an overarching vision and set of guiding principles, a housing authority has no framework from which to make decisions for deploying this precious resource. The key is striking a balance between subsidy targeting and open access in order to achieve greater impact.

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[31] National Low Income Housing Coalition. (2011, March). Congressional District Profiles. NLIHC tabulations of the 2009 American Community Survey PUMS housing file. Washington, D.C.

[32] Permanent supportive housing inventory compiled by Partnership for Strong Communities and updated by Corporation for Supportive housing February 2011.

Beyond the issue of subsidy deployment is subsidy scarcity. There are simply not enough rent subsidies available to address the housing needs of the thousands of Connecticut families with the very worst case housing needs. And for persons in need of supportive housing, rent subsidies are only half the equation – the other half is services.

Rent subsidies are of limited use in communities where there are few apartments available in which to use them or the existing housing stock is in poor condition or inaccessible to transportation and other services. The development of mixed income rental housing and supportive housing through new construction or building renovation addresses this issue. While development of housing takes time, new housing also brings with it the opportunity to make an even greater impact in the lives of the tenants and the surrounding community by using the housing as a place for hosting or co-locating programs in health, recreation, financial asset-building, skill-building, child care or employment.

The primary developer of housing that includes units serving extremely low income households in Connecticut is the nonprofit community (including public housing authorities), both because it is within their mission to do so and because they often have the greatest experience navigating myriad public-sector financing systems for multifamily rental housing. More recently, some for-profit developers have agreed to establish set-asides of units serving very low- income households because of public incentives.

Over the past few years, the Connecticut Housing Finance Authority (CHFA) and the Connecticut Department of Economic and Community Development (DECD) have offered incentives in their scoring of funding applications to development projects that target units to households with incomes below 25% AMI or to homeless households receiving services. However, these incentives are not linked to the requisite rent subsidies and service funding to make the units work for their intended purpose. Developers also face unpredictability in the state housing finance process. Rather than each project having to navigate multiple sources of gap funding with separate processes, a process that puts the development in the middle and brings the resources to it would create greater efficiencies for the both project and the funders.

Objective: Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need

Expand and target rent subsidies

1. Create new rent and operating subsidies.
2. Maximize the impact of rent subsidies by linking them to State and local prevention, rapid re-housing, and permanent supportive housing initiatives.
3. Utilize project-based rent subsidies in mixed income housing that provides set-aside units for households with extremely low incomes and for households receiving supportive housing services.

Stimulate the development of supportive housing and of mixed income communities that include units affordable to households with extremely low incomes

1. Provide flexible, debt free capital.
2. Link capital, project-based subsidies, and services funding for the development of new permanent supportive housing.
3. Streamline the funding process at the State level.
4. Build capacity to develop and operate units at the local level.

Embed strategies to prevent and end homelessness within cohesive State and municipal housing policies that set clear outcome targets

1. Establish clear statewide and municipal housing policies that incorporate benchmarks for preventing and ending homelessness and that are used to align and target State and municipal housing resources that may be administered by multiple departments and agencies.

Aggressively leverage and compete for Federal rent subsidies, housing development dollars, and service funding linked to housing

Retool the Homeless Crisis Response System

Connecticut's current homeless service system is comprised of these elements:

- **Street outreach.** Street outreach workers build trusting relationships with homeless individuals living on the streets that gradually lead to their acceptance and openness to seeking help. It is an essential component in addressing chronic homelessness. Outreach programs have various levels of funding and composition depending on the community. The Connecticut Department of Mental Health and Addiction Services (DMHAS) uses federal and state funds to contract with a network of organizations to provide homeless outreach services.

  The U.S. Department of Veterans Affairs (VA) system in Connecticut has ramped up its outreach to homeless Veterans through drop-in services at shelters and soup kitchens, clinics at its medical centers, a VA Connecticut homeless hotline and national call center, and other strategies as part of its plan to end Veterans homelessness.

- **Emergency shelters.** Connecticut's 2,189 state-funded emergency beds are spread among 24 shelters for homeless adults without children, 10 for homeless families, and 18 that serve a mixed population of both. In 2010, most Connecticut shelters operated above capacity. Shelters have differing admission criteria, services, length of stay policies, and philosophies. Many in-shelter services were developed out of necessity when mainstream and community-based organizations failed to sufficiently meet the complex needs of homeless individuals.

  The state-funded domestic violence shelter system is operated separately from emergency shelters, primarily taking referrals from domestic violence hotlines, local police and other service providers. There are 18 domestic violence shelters providing 226 beds. Length of stay is limited to 60 days.

- **Transitional housing** programs are intended to facilitate the movement of homeless individuals and families to permanent housing within 24 months. There are 75 HUD and State-funded transitional housing programs, 13 specifically for families, 47 for single adults, and 15 for a mix of both. Some of these programs are comprised of single buildings, some as scattered apartments. In the newest model, "transition in place," the services transition away but the client stays in the housing, eventually assuming the lease as the transitional housing unit becomes their permanent home.[33] More than 2,248 adults and children utilized HUD-funded transitional housing programs in Connecticut in 2010 (17% of all sheltered homeless persons).

  The Veterans Administration currently funds 158 privately-operated transitional housing beds in Connecticut that serve Veterans, all within single buildings.

[33] This is similar to the medium-term rental assistance and services model in some rapid re-housing programs.

- **Prevention and Rapid Re-Housing**[34]. Connecticut currently has three such programs using State-administered funds: Housing First for Families is a small program of the CT Department of Social Services (DSS) designed to help families find housing and re-house families who are targeted for re-unification with their dependent children upon placement in housing. DSS's Beyond Shelter Connecticut operates in twelve locations and provides up to one year of coordinated follow-up services to households transitioning from homelessness to permanent housing. It does not offer rental assistance. The Homelessness Prevention and Rapid Re-Housing Program (HPRP) is a 3-year (2009-2012) Federal stimulus act program operating in five Connecticut cities and six regions and providing housing assistance and services for both prevention and rapid re-housing.

  Of these three programs, HPRP is the most comprehensive in scope and scale. The United Way of Connecticut's statewide 211 system, which has provided universal screening services for HPRP, received over 47,000 requests for housing or shelter services during the program's first year. While HPRP is a time-limited program, this intensive experiment in delivering prevention and rapid rehousing services statewide holds important lessons for future work of this kind.

  The VA has developed an operational plan for enhancing and expanding its homelessness prevention activities. Components of this plan include engagement of soldiers returning from Iraq and Afghanistan and their families who are homeless or at risk; expanded legal support to Veterans through the CT Veterans Legal Center to prevent evictions and foreclosure; intervening with jail diversion for Veterans facing charges or re-entering the community after incarceration; expansion of the HUD-VASH (Veterans Affairs Supportive Housing) case management program to ensure housing stability for previously homeless Veterans; and a new Veteran Families Program that will help community agencies provide housing assistance to Veteran households.

Historically, Connecticut's first emergency shelters were created to serve as temporary safe harbors for increasing numbers of deinstitutionalized people and others turning up on Connecticut's streets. During the 1980s, in city after city across the United States, people died in the cold. Faith communities and social service organizations mobilized, and cots and mattresses turned up in church basements, firehouse floors and town-owned property all over Connecticut. More and more communities were pressed to create new emergency shelters in response to the mounting crisis. By 2010, there were 2,189 emergency shelter beds and 1,472 transitional housing beds across Connecticut.

Most shelters and transitional programs were originally conceived as primarily responding to the needs of people while they are in housing crisis. But the term "housing crisis" implies a single precipitating event that results in housing loss and entry into a shelter. In reality, shelter use is more often a stop (often repeated) in a longer experience of housing instability, which may include stays with relatives or friends and frequent moves from place to place. Because housing loss is so intertwined with issues of income, health, safety, social and family supports, and the cost of housing, resolving housing loss is usually not as simple as providing a family with a referral to an apartment.

[34] See the section on "How many people will need housing assistance during the Opening Doors timeframe (2010-2014)?" for a description of Prevention and Rapid Re-Housing Strategies.

There is now increasing agreement that getting back into a stable housing situation is the first essential piece to addressing these other issues – after all, it is difficult to get back on your feet when the ground is made of quicksand. The second piece is doing what it takes to stay there. Yet, too often, our concept of the homeless assistance system as one of crisis response means we focus considerable attention on the role and function of temporary settings such as emergency shelters and transitional programs but miss the boat in dedicating the resources and attention needed to get people into stable permanent housing and help them stay there.

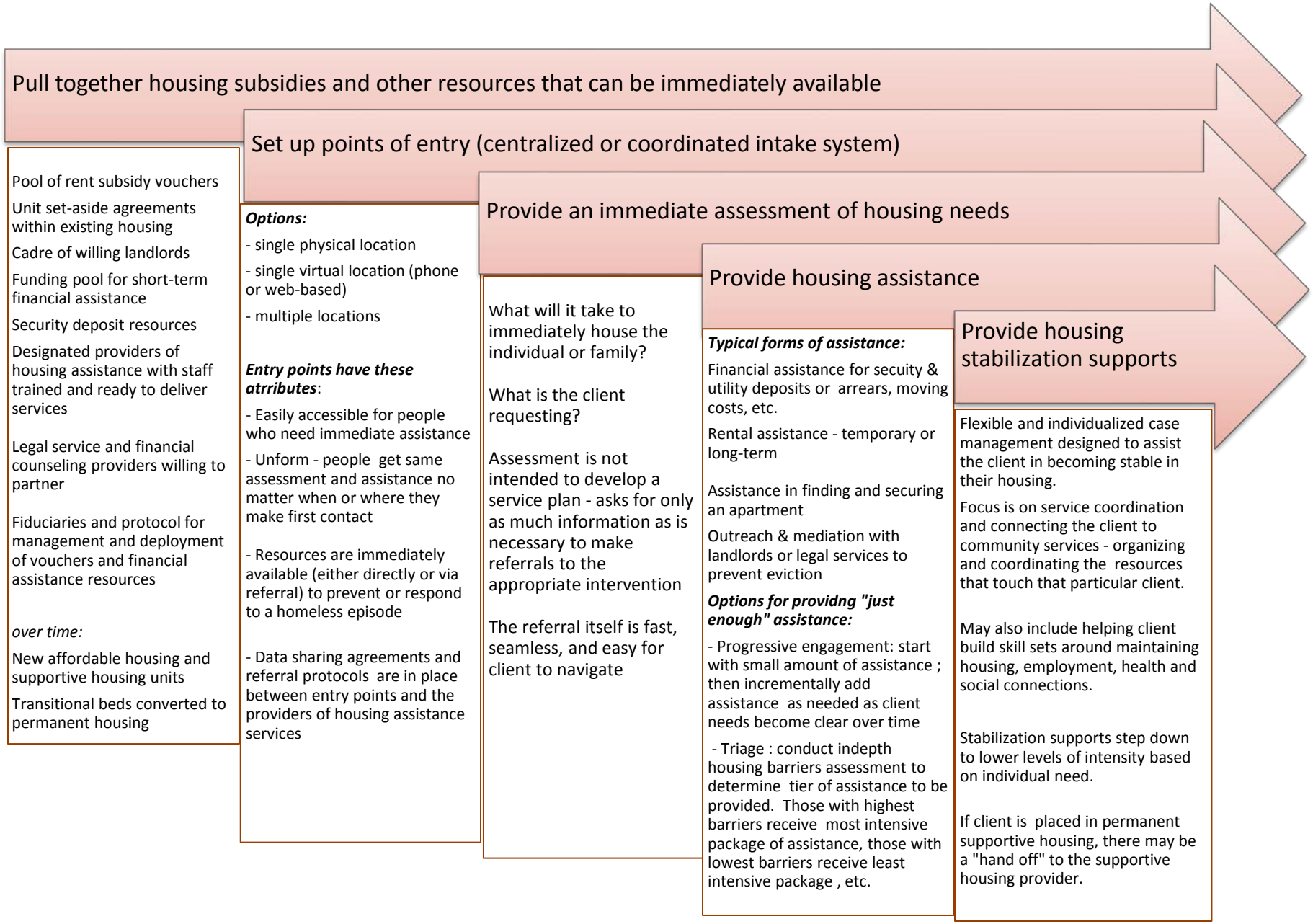
If we reframe the homeless assistance system as a *housing* assistance system, then we organize our attention and resources around the end goal and not around the crisis. Shelters would continue to serve their essential functions of safety and comfort, but as a temporary resource while work is happening to help the family or individual get into stable housing as quickly as possible and to help them stay housed.

Recalibrating the homeless assistance system means adjusting methods, priorities, roles and relationships at the local level. What form this will take will vary community by community, but there are some basic principles that apply. The goal is to shift the balance of the system overall toward greater housing-focused responses.

Based on national best practices, we have illustrated the five elements essential to making the shift:

1. Pull together housing subsidies and other resources that can be immediately available
2. Establish a centralized, or at least a coordinated, intake system
3. Provide an immediate assessment of housing needs
4. Provide housing assistance
5. Provide housing stabilization supports

The demands of the recalibration process are challenging, particularly at a time when the shelter system is operating above capacity and hundreds of people are turned away from shelter every day. Addressing an issue this complex can only happen by tapping the brainpower, skills and resources of many people and disciplines working in tandem at the community level within a consistent policy framework. It is not the sole responsibility of traditional providers of homeless services.


Pull together housing subsidies and other resources that can be immediately available
Set up points of entry (centralized or coordinated intake system)
Provide an immediate assessment of housing needs
Provide housing assistance
Provide housing stabilization supports
Pool of rent subsidy vouchers
Unit set-aside agreements within existing housing
Cadre of willing landlords
Funding pool for short-term financial assistance
Security deposit resources
Designated providers of housing assistance with staff trained and ready to deliver services
Legal service and financial counseling providers willing to partner
Fiduciaries and protocol for management and deployment of vouchers and financial assistance resources
over time:
New affordable housing and supportive housing units
Transitional beds converted to permanent housing
Options:
- single physical location
- single virtual location (phone or web-based)
- multiple locations
Entry points have these atrributes:
- Easily accessible for people who need immediate assistance
- Unform - people get same assessment and assistance no matter when or where they make first contact
- Resources are immediately available (either directly or via referral) to prevent or respond to a homeless episode
- Data sharing agreements and referral protocols are in place between entry points and the providers of housing assistance services
What will it take to immediately house the individual or family?
What is the client requesting?
Assessment is not intended to develop a service plan - asks for only as much information as is necessary to make referrals to the appropriate intervention
The referral itself is fast, seamless, and easy for client to navigate
Typical forms of assistance:
Financial assistance for secuity & utility deposits or arrears, moving costs, etc.
Rental assistance - temporary or long-term
Assistance in finding and securing an apartment
Outreach & mediation with landlords or legal services to prevent eviction
Options for providng "just enough" assistance:
- Progressive engagement: start with small amount of assistance ; then incrementally add assistance as needed as client needs become clear over time
- Triage : conduct indepth housing barriers assessment to determine tier of assistance to be provided. Those with highest barriers receive most intensive package of assistance, those with lowest barriers receive least intensive package , etc.
Flexible and individualized case management designed to assist the client in becoming stable in their housing.
Focus is on service coordination and connecting the client to community services - organizing and coordinating the resources that touch that particular client.
May also include helping client build skill sets around maintaining housing, employment, health and social connections.
Stabilization supports step down to lower levels of intensity based on individual need.
If client is placed in permanent supportive housing, there may be a "hand off" to the supportive housing provider.

Objective: Recalibrate our response to housing loss

Within an overall policy framework, support community or regional-level development of a coordinated system of response centered on homelessness prevention, housing assistance, and housing stabilization.

The following are potential elements of a coordinated system, some of which may need further evaluation:

1. Local leadership and decision-makers need to be involved in designing an integrated model.

2. Create formal partnerships and delineated roles – which parts happen by traditional homeless service providers, which happen by other community or statewide agencies.

3. Dedicate staff in order to coordinate the process: to forge and sustain partnerships, facilitate meetings, track outcomes, and keep everyone on task.

4. Enlist support:

    - Best practice support: coaching, problem solving, sharing between communities
    - Data support – to calibrate progress toward outcomes, conduct data matching to target highly vulnerable individuals for assistance

5. Pull together resources: rent subsidies, flexible funds for financial assistance to be used with prevention and rapid re-housing strategies, staff dedicated and skilled in providing housing placement and stabilization supports, willing landlords.

Target housing assistance to those most likely to enter or remain in shelter or in unsheltered settings

1. Analyze and adopt sets of key risk factors for different populations (youth, families, Veterans, individuals, etc.) to more accurately triage and target homelessness prevention and re-housing programs to clients most likely to enter or remain in shelter.

    Develop the key risk factors through a collaborative effort of state agencies, non-profits operating statewide, and local and regional service providers. These risk factors would then help to establish priorities for funding by the State and alignment of various programs within different agencies.

    The actual use of the risk factors for targeting would primarily happen at the local level, although cross-system data matching at the State level could help in identifying individuals and families with multiple risk factors (the FUSE initiative is an example).

2. Use a data driven approach to target and place highly vulnerable individuals into permanent supportive housing.

    - Establish data tracking on length of homelessness in order to identify and target chronically homeless individuals.

- Improve access to supportive housing by encouraging the use of data for the prioritization and targeting of people who are high utilizers of resources (jails, hospitals, detox, etc.).
- Use a standardized vulnerability index tool across outreach programs to identify and prioritize for supportive housing those with highest mortality risk.
- Create statewide or regional centralized waiting lists and referral systems for supportive housing.
- Train shelter providers, supportive housing providers, and homeless outreach workers on Housing First strategies and strategies for engaging and overcoming service resistance among chronically homeless individuals.
- Map out the housing placement process at the local/regional level for people experiencing chronic homelessness to track and reduce the number of steps and days from homelessness to housing placement.

Strengthen the capacity of Connecticut's HMIS system to meet the expanded data-matching, reporting and research needs identified in the Opening Doors – CT process

Connecticut is fortunate to have one of the few statewide Homeless Management Information Systems (HMIS) in the country. CT HMIS documents the number of people who come in contact with State-funded emergency shelter and transitional housing programs, as well as people who come in contact with other residential assistance programs funded by HUD, such as HUD-funded transitional housing, permanent supportive housing, and services-only initiatives. The CT Coalition to End Homelessness (CCEH) oversees management of the CT HMIS data system, and, through a consultant, provides technical support to localities. HMIS is funded by grants from HUD, the State of Connecticut, and user fees. Demands on the HMIS system are high and will increase significantly over the next few years as communities need timely data to recalibrate programs. This is likely to place considerable pressure on CCEH staff time and resources.

There is a need to strengthen the capacity of the CT HMIS system to monitor progress under HEARTH, synthesize and analyze data, conduct data matching for targeting of program interventions, provide regular benchmark reports to the state and local communities, and serve as a resource for research and program evaluation.

Align state and local activities

1. Develop a shared set of *guiding principles* for moving to a coordinated system of response that is centered on homelessness prevention, housing assistance, and housing stabilization.

2. Adopt a common set of *outcome benchmarks* with the three HEARTH Act outcomes and the four Opening Doors goals as the core (overall reductions in homelessness, reductions in shelter lengths of stay, reductions in returns to shelter.)

3. Develop a *uniform housing needs assessment tool* that would be embedded in HMIS.

4. Work to answer the question, "what would a state-wide centralized intake process that links statewide (211), VA, and regional *points of entry* look like, who takes the lead in development of it, and who ultimately manages the system?"

Increase Economic Security

There is a substantial body of research and practice that documents the connection between poverty, housing instability and poor health. Insufficient income and lack of affordable housing ensure the continuation of a costly yet avoidable cycle of institutional or high-cost 'care' and social disengagement.

The current array of programs and agencies that support income and provide employment services for homeless and vulnerable populations are defined by a complex set of distinct federal and state funding programs and policies:

- ***Income support*** programs provide direct financial assistance to a narrowly defined set of eligible populations (often tied to presence of a disability, or family with dependent children). These are primarily federally funded programs disbursed either directly to eligible individual recipients (such as Supplemental Security Income –SSI) or as a block grant administered by the state (such as Temporary Assistance for Needy Families - TANF).

- ***Workforce development*** programs are funded primarily with federal funds that are administered through five regional Workforce Investment Boards (WIB's). Eligibility for these services is determined primarily by income, with additional consideration based on training needs. Primary populations served are youth, dislocated workers and disadvantaged adults. Demand for One Stop job support services vastly exceeds the system's capacity to deliver.

Given the complexity of program entry requirements (eligibility determination and the application process), the "self-serve" nature of the mainstream workforce system can make it very difficult for people experiencing homelessness to negotiate the resources and services available through this system. The first step is securing, or retaining, stable housing. But once in housing, people often need assistance in both accessing the services of the One Stop System as well as other supports that will help ensure their success in employment.

Recent promising practices and priorities in workforce development tend to emphasize the importance of linking education and training more closely to jobs.[35] These approaches generally involve a combination of:

1. **Education and training** (often through community colleges) that give workers a post-secondary credential

2. **Direct ties to employers** in industries that provide well-paying jobs in key sectors (such as health care, construction, retail trade, etc.). The direct involvement of employers, plus the

[35] Holzer, Henry J. (Fall 2009). "Workforce Development as an antipoverty strategy: What do we know? What should we do?. *Focus*, Vol. 26, No. 2.

availability of jobs at the end of training, help improve the match between the skills acquired and the demand side of the labor market.[36]

3. **A range of additional supports and services** to help workers deal with problems that arise (such as child care and transportation)

In some cases, there is a nonprofit organization that serves as a **labor market intermediary** to bring together workers, employers, training providers and sources of supports needed to make this process work. Intermediaries help overcome employer resistance to hiring workers by providing more information on positive worker skills and attributes, and by screening applicants they refer to these employers. If the basic skills of workers are not sufficient for their participation in the needed occupational training, the potential workers take remedial skill-building programs, which may include a program to build employment "soft skills". Intermediaries provide not only job placements with employers but in some cases post-employment services to support job retention.

Another promising practice is **transitional jobs** for adults who have little formal work history. These provide 6-12 months of paid experience in nonprofit or for-profit settings. Transitional job strategies incentivize employers to "try out" individuals that they might otherwise reject, particularly persons with criminal justice histories, persons with disabilities disengaged from the labor market, and persons needing more skill development. They also provide a time-limited opportunity to try out someone's job performance abilities and skills (and to provide additional supports to the person during this period as part of a skill development component). Individuals who "make it" in transitional jobs stand a much better chance of being hired by the employer. At minimum, transitional jobs provide job experience that can act as a bridge to another job.

The VA system has a variety of programs to assist Veterans in securing employment and stable income supports. The VA-CT Homeless Program partners on a regular basis with the Veteran Benefits Administration to conduct benefit workshops for Veterans to discuss eligibility and enter claims. Vocational support is provided by the VA CT Supportive Employment program. The program has employment specialists embedded within the VA Homeless Program. These specialists are Veterans who have experienced job loss and/or homelessness.

An increasing number of providers of affordable and supportive housing have formed direct collaborations with workforce systems and individual employers to increase rates of employment and job retention among their tenants, including formerly homeless individuals. These efforts offer some instructive lessons on successfully forging these housing-employment collaborations:[37]

1. Make sure the right people are at the table

[36] An example of this is the Jobs Funnel, which is a pre-employment preparation, job training and placement service for Hartford and area residents seeking employment in the construction fields. The name "Jobs Funnel" is taken from a process individuals go through – funneling into the system to gain specific work competencies and trade-related certifications.

[37] Michon, Stephen (The Dignitas Group). September 2005. *Charting Progress, Sharing Lessons: A Report on Passports to Success,* prepared for the Corporation for Supportive Housing and program partners.

- At minimum, involve the One-Stop operator, the housing service provider, the local office of the Bureau of Rehabilitation Services, and the lead vocational staff at the local behavioral health agency.

- Director level representatives need to be the participants in the planning and design of the effort, and high-level relationships must be an ongoing part of the project, from program design to implementation. This participation can be institutionalized via a steering committee.

2. **Take time to talk goals and learn cultures**

   - Define shared goals, and understand organizational cultures upfront (what is each organization's target population, eligibility criteria, policies and regulations?). The key to success is to find commonalities and work from there. Spend time up front cross-training direct care staff.

3. **Don't forget accountability: draw up an MOU**

   - A memorandum of understanding can lay out agreements on the roles of each partner in providing services, staffing, financial commitments, and how the partners will communicate. Two specific ideas are: Director communication via a monthly interagency meeting, which includes reports on program activities and outcomes. Direct care staff holding bi-weekly case meetings.

   - Choose measures that track the more gradual impacts of the program; track not only employment gains, but also changes in source of income, credentials enrollment and completion, and employment retention. Agree upon common definitions of income data; include income received from informal jobs.

   - Use a data system that multiple partners can access and share.

4. **Outreach to tenants starts at home**

   - The best way to reach tenants is to begin outreach at the housing site, where feasible. That means One Stop and BRS staff go to the housing site to make one-on-one contact with tenants. This could be done through informal orientation meetings at the housing site, or career development staff scheduling open-ended time at the housing site, with housing staff introducing them to tenants as they come and go.

5. **Prioritize job development in the design and startup phase. Jobs should be available to tenants from the start.**

State agencies have also begun to form more strategic alliances to advance connections between housing and employment. An example is the HomeWork collaboration between the Department of Mental Health and Addiction Services, the Corporation for Supportive Housing, and the Bureau of Rehabilitation Services of the Department of Services Social Services. Funded through a federal Medicaid Infrastructure Grant, the initiative targets supportive housing providers and their

employment partners in three cities (Bridgeport, Hartford and New Haven) with a package of staff trainings, benefits coordination services, cross-sector case conferences, and other systems connections. The goal of this work it to expand employment opportunities for persons receiving Social Security benefits to return to work. Successes can generate an incremental revenue stream through the federal Ticket to Work program, which providers can then reinvest in the program.

For people who are chronically homeless and persons with severe disabilities, access to Social Security benefits can be critical to ensure a stable source of income. SSI/SSDI Outreach, Access and Recovery (SOAR) is a technical assistance initiative providing strategic planning and assistance to local providers to increase client access to Social Security benefits.

Objective: Foster housing retention through income growth and employment

Link workforce system resources (skill development, job development) with the housing assistance system to create effective pathways to employment for vulnerable populations

1. Establish collaborative partnerships between housing organizations and the workforce system to integrate employment services and housing assistance activities at the local level.

2. One approach could be establishing a few initiatives at the local/regional level to test, evaluate and demonstrate collaborative and cross-sector approaches to substantially increase the income of vulnerable populations, based on promising practices and lessons learned. Prioritize initiatives that serve families and individuals entering or in housing who have experienced a high degree of housing instability, with special attention to programs serving ex-offenders, youth, and persons with disabilities. Document outcomes on employment, job retention, and wage gains.

Align public sector programs to ensure effective systems coordination with shared goals

1. Develop a common set of outcome benchmarks for measuring progress in income growth and employment among people receiving housing assistance who were formerly homeless.

2. At the state level, undertake a review of program eligibility and termination criteria across the range of State benefit programs that people experiencing or at risk of homelessness may access for employment training and opportunities. Identify changes that should be made to create incentives for work, earning and retaining income while maintaining access to health coverage, housing assistance, child care, etc. until a household is earning enough through employment to be financially stable.

Expand income growth for persons with disabilities

1. Create statewide access to effective programs, including Ticket to Work, HomeWork, and SOAR.

Improve Health and Housing Stability

We have divided this theme into three parts, and discuss each in turn:

- Reduce medical vulnerability and frequent use of health care systems
- Support the housing stability of vulnerable families, children and youth and Veterans
- Break the cycle of homelessness and re-incarceration

Objective 1: Reduce medical vulnerability and frequent use of health care systems

Many of Medicaid's highest cost beneficiaries are individuals with complex and co-occurring health and behavioral health challenges experiencing homelessness and housing crisis.[38] For these individuals, homelessness exacerbates chronic illnesses by increasing exposure to trauma and high-risk behaviors and, in turn, results in social isolation and difficulties accessing the coordinated primary and behavioral health services needed to manage and expedite recovery. In this sense, homelessness serves as a virtual tri-morbidity, imposing additional ill-effects on health status in and of itself.

A significant factor contributing to the unsustainable growth in healthcare spending (particularly Medicaid spending) is the avoidable use of the most costly services by a small subset of individuals with complex health and behavioral challenges, and who, despite their repeated encounters with emergency and inpatient health care services, experience little or no progress in their health and clinical conditions. These individuals are often very poor, homeless or unstably housed, and living alone—they have multiple, co-occurring chronic medical conditions and behavioral health disorders. Adequate housing is a significant determinant of health and health costs. Arguably, homelessness coupled with frequent use of emergency health care services is a substantial driver of increased Medicaid spending in the state overall.

The passage of the Affordable Care Act (ACA) in 2009 has already begun to reshape aspects of our health care system, including service delivery, access, and financing, in ways that are creating unique opportunities to improve health outcomes for extremely vulnerable populations. With a substantial focus on expanded access and quality as core to achieving planned reductions in overall health care costs, there are opportunities at the state and local levels to test and implement new and more effective approaches to addressing the unmet health needs of persons who have not been well served by these systems.

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[38] Linkins, Karen W., Jennifer J. Brya, and Daniel W. Chandler. (2008) Frequent Users of Health Services Initiative: Final evaluation report. Oakland, CA: Corporation for Supportive Housing; and Raven, Maria C., Emily R. Carrier, Joshua Lee, John C. Billings, Mollie Marr, and Marc N. Gourevitch. 2010. Substance use treatment barriers for patients with frequent hospital admissions. Journal of Substance Abuse Treatment, 38, 22-30.

One of these opportunities is to use Medicaid as a resource to expand services to persons living in supportive housing. Connecticut was the first state under ACA to expand Medicaid eligibility to all low-income adults. By doing so, it has already tackled one of the three challenges involved in leveraging Medicaid for services in supportive housing—how to ensure that supportive housing tenants are eligible recipients. The other two challenges are 1) how to ensure that the services in supportive housing are eligible services and 2) how to ensure that service providers are eligible providers and have the capability to participate in Medicaid.

Service eligibility may be easily determined: the key is defining payment systems for each of the three types of services provided in supportive housing: 1) housing stability supports; 2) case management; and 3) rehabilitation or recovery supports. The Corporation for Supportive Housing has estimated that the majority of service costs in Connecticut supportive housing could potentially be financed through Medicaid under a Home and Community Based Services (1915i) HCBS option.

The second challenge is a bit trickier: national experience has found that even when supportive housing providers offer services that are Medicaid reimbursable, many do not seek reimbursement due to the immense administrative costs and challenges associated with receiving payment. Many providers do not have a history of billing for Medicaid or simply lack the knowledge, infrastructure, and administrative capacity necessary to access Medicaid resources.[39] This must change.

Align state and local strategies to support the goals of improved access to health care and effective use of appropriate types of health services

1. Institute measures to track health access (as defined by enrollment in Medicaid, Medicare or other health insurance program) across the systems and agencies that work with vulnerable populations.

2. Use data to identify high-cost users. One possible approach is to target groups with greater health needs who are more likely to be disengaged from health services (for example, chronically homeless persons) or use health care resources inappropriately, such as frequent users of emergency room care.

3. Explore Health Homes as another option for linking services to housing for this population.[40] Under ACA, states can qualify for enhanced federal funding to set up health homes to better coordinate the care of Medicaid beneficiaries with chronic physical or mental illnesses. States may elect this new option by filing an amendment to their Medicaid State plan.

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[39] Culhane, D.P. and Byrne, T. March 2010. *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*. University of Pennsylvania. A White Paper commissioned by the New York Office of Mental Health and the New York City Department of Homeless Services.

[40] Rather than being a physical place, health homes are a strategy for helping individuals with chronic conditions manage those conditions better. A health home is a provider or a team of health care professionals that provide integrated health care. This means that if a person is participating in a health home, that person's health care, from primary care doctor to dentist to behavioral health professional, all share the same information and coordinate treatment based on that information. Health homes operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services and family services. The integration of primary care and behavioral health services is critical to achievement of enhanced outcomes.

Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations

1. Develop a financing strategy for new supportive housing that uses Medicaid to pay for eligible support services. Target individuals identified as high users of homeless services and health systems.

   Explore how, in the future, the service model in supportive housing could be assembled in a modular fashion, with direct links to Health Homes, Home and Community Based Services, and funds to pay for housing stability supports.

2. Build the administrative capacity of a cohort of supportive housing service providers to utilize Medicaid.

3. Build collaborations between health, behavioral health and housing systems in order to ensure an integrated system of care.

Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost

1. Establish (or expand) partnerships between housing organizations and healthcare agencies (e.g. between a community health center and a housing authority) to integrate the health services at the housing site or make direct linkages to the community health center through the use of agreements.

2. Consider testing a medical respite model[41] directly linked to permanent supportive housing in one or more communities, through a partnership between a major hospital, a homeless service and housing provider, and state government. Target individuals who are chronically homeless and frequent users of hospital systems.

Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems

1. Explore the use of data-matching between HMIS and selected health system providers, including community health centers and hospitals (inpatient and emergency rooms) to analyze frequent use between the systems and consider how that might relate to state wide technology efforts that are discussed later in this framework.

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[41] Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. These programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Medical respite care meets the post-hospital recuperative care needs for people who are homeless while reducing public costs associated with frequent hospital utilization. Medical respite needs to be linked directly to permanent housing with services in order to ensure long term stability.

Objective 2: Support the housing stability of vulnerable families, children and youth

For families with high needs, a common complaint is that the families touch so many systems – child welfare, TANF, health, education, shelters, etc. – that they become overly-"case managed", with staff from multiple agencies conducting separate assessments (on both parents and children) creating separate case plans, and keeping separate (and largely duplicative) documentation. Stabilization of these families is everyone's priority and yet no one's priority due to lack of coordination. One idea to seriously look at: someone to take the lead to coordinate and help the family navigate the care across these sectors and ensure that the sectors are not working at cross- purposes. This is not a new idea or untested, as described below.

This idea is akin to the "patient navigator" role within health care. The navigator's role is not one of direct service delivery but rather of coordination of care across multiple sectors.

A similar concept is the Differential Response System, an emerging model at the Connecticut Department of Children and Families (DCF), which is based on the concept of providing an alternative for foster care placement in cases of child neglect where poverty plays a primary role in compromising the safety of children. This alternative is centered on a community-based Services Coordination Model (SCM), which acts as a bridge to the many resources and supports that could be helpful to the family's current situation and future development. Educating the family on what services are available, helping them to be comfortable accessing services, and teaching the family how to navigate service systems for future needs is one role of the SCM. A case manager and/or family advocate helps the family to make these connections.

A third model is used in children's mental health. DCF uses a Care Coordination model for a child/youth involved with multiple agencies and identified as needing care coordination independent of any particular service received. Care coordination involves direct client contact by someone who has clinical knowledge but does not function as the clinician on the case. Rather, the Care Coordinator is the architect of the service plan along with the family, using clinical and community systems knowledge to broker and advocate for the plan.

Whether posited as a "systems navigator", "services coordination model", or "care coordinator", the common elements are those of a non-clinical function that assists the family in navigating multiple systems and supports the family in building their own navigation skills and relationships.

Assess the feasibility of deploying a "systems navigator" function that will align and coordinate services at the individual family level across sectors and at different levels of service delivery

1. The assessment would include defining and designing the function and protocol and identifying a set of shared outcomes that can be measured.

2. Consider how this navigator function would be coupled with prevention, rapid re-housing, and permanent supportive housing efforts in designated communities that are targeted to homeless families most likely to enter and return to homelessness.

Incentivize the creation of service-supported affordable housing for families

There is a growing recognition that building resident services into existing and new housing serving very low- income families supports the strength of both families and housing communities. These services may include place-based connections to employment, health care, financial literacy, child-care, and other services.

Youth

As with families, the systems that interact with homeless and at-risk youth (under 18) and young adults (18-25) have limited capacity to exchange information with each other. These systems - including schools, DCF, DSS, DOE, DOC, DMHAS, employment One Stops, and the homeless services system - tend to be fragmented in their approach to services, and have limited knowledge about the effectiveness and impact of service approaches. Local service providers specializing in youth and young adult services struggle to respond to a growing demand for services; demand far outstrips supply, and training capacity for staff is limited.

Develop targeted outreach strategies to identify and enumerate youth and young adults without permanent housing and connect them to the housing and support they need; develop partnerships with school systems in this effort

How youth and young adults are identified will be an essential component of understanding and identifying the most effective and efficient strategies that are most likely to lead to successful results. In looking at target populations, elements of a comprehensive effort would need to examine vehicles for program outreach and access, essential elements for housing and services, mentoring relationships, learning and practicing independent living skills, employment supports, and wellness services. Data matching across relevant state agencies and HMIS could map out the overlapping systems involvement.

Expand the range of housing options for youth and young adults facing housing loss.

In addition to gathering data, one approach to consider is the development of "transition in place" housing with services for unaccompanied youth and transitioning young adults who are homeless or at high risk of homelessness.

1. Consider creating a "transition in place" model through a collaborative of agencies, providers, intermediaries and consumers. Encourage alliances with providers of housing and housing subsidies, Job Corps and Youth Build programs.

Develop a way of identifying and tracking unaccompanied youth and document outcomes through a randomized study to compare outcomes for youth in the housing with similar youth not in the program.

Objective 3: Break the cycle of homelessness and re-incarceration

Every month more than 1,000 persons are released from Connecticut prisons. Many inmates experience chronic health or mental health problems, or are confronted with a lack of income and employment options, both of which will increase their likelihood of becoming homeless upon release. An additional problem is that affordable housing opportunities are often not available to persons with criminal justice histories. People who were formerly incarcerated may be deemed ineligible for particular types of housing subsidies, or may face other restrictions that interfere with their ability to access stable housing. The recently released individual must meet requirements of parole or probation rules while also facing the challenge of obtaining living-wage employment with a criminal background. Dealing with the practical challenges of adjusting to life outside of prison is particularly difficult because ex-offenders often have limited social support networks.

When ex-offenders are able to secure permanent, affordable housing linked with appropriate support services—including employment and health—the likelihood of successful reintegration is greatly increased. There are growing numbers of local Reentry Roundtables[42] across the state that have begun to effectively engage the needed partners to plan and implement strategies and approaches to ensure successful reintegration of ex-offenders into their communities. Building on effective approaches tested in Connecticut and nationally, strategies that have impact will reduce recidivism, increase housing stability, and increase income and economic security through employment.

The Frequent Users of Service Enhancement (FUSE) program is a recent approach to targeting permanent supportive housing to persons with frequent admissions to emergency shelters and Connecticut Department of Corrections (DOC) facilities. This program is being expanded to serve persons on probation or parole.

Target housing resources and other supports to prevent and end homelessness among people leaving incarceration

1. Ensure effective transitions from prison and from short-term community programs using a comprehensive approach linked with flexible funding resources.

2. Expanding upon the FUSE model, Identify priority high-needs populations based on data and criteria to be determined, and direct supportive housing with tailored support services to these groups.

3. Explore effective approaches to centralize and simplify access to supportive housing and other affordable housing resources.

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[42] Reentry Roundtables are local level coalitions focused on community engagement, advocacy, and forging of partnerships to address common needs and gaps in services for incarcerated individuals returning to their communities. The coalitions are commonly comprised of ex-offenders and representatives of community agencies, which may include the police/sheriff department, district attorney, probation/parole system, court system, municipality, workforce agency, health and human service agencies, and others. At this writing, there are six Reentry Roundtables in Connecticut: Bridgeport, Greater Hartford, New Haven, New London, Waterbury, and Windham.

4. Create effective pathways to employment for ex-offenders

Align housing resources and other supports to prevent and end homelessness among people leaving incarceration

1. Define specific measures of system performance that are agreed upon by all stakeholders; ensure that performance measures are tracked within criminal justice system agencies and programs, and by community based providers serving criminal justice populations.

2. Support systems and practice changes through a combination of policy direction and financial incentives at the state and local levels that result in improved reintegration outcomes of persons exiting criminal justice systems and programs.

3. Strengthen local level community collaborations focused on successful reintegration of persons exiting criminal justice systems; support their efforts to align and link with community planning efforts to prevent and end homelessness.

Increase leadership, collaboration, and civic engagement

Reaching the four bold goals of Opening Doors, all towards preventing and ending homelessness among veterans and single adults in five years and families with children in ten years, requires bold leadership, particularly at a time when the State and local communities are struggling with the demands of the economic downturn. This time of struggle also is a time of opportunity: to think differently about how we use our resources, avoid overlap in services, and work in tandem and across systems to achieve results. Collaboration is hard work, particularly as we try to meld the efforts of sectors and agencies with different missions, different rules, and different approaches. Good leadership pushes us to collaborate in spite of these differences, and takes a problem-solving approach based on identifying common ground and driving toward a common purpose.

The participation of leaders from many different sectors – government, philanthropy, the faith community, business, health care, housing, supportive services, etc. – is critically important to building a base of civic support for efforts to prevent and end homelessness. In turn, this civic support can make the difference between support and opposition for local housing efforts, between the success or failure of advocacy efforts, and between the sustainability of new approaches or their early demise.

This *Framework* provides a guide for reaching the goals of *Opening Doors*, but is does not specify the actions needed to make it happen. The development of actionable strategies is the next step in the process. This process of development itself requires attention: how will we, as a state, organize ourselves to undertake the work ahead? And who will lead this process?

To address that question, it is helpful to understand the existing planning bodies and community networks in Connecticut specifically focused on homelessness. Each of these bodies is designed to change the systems that impact people who are homeless or at risk of becoming homeless:

1. **State-level Interagency Council on Supportive Housing and Homelessness**

   Established in April 2004 by gubernatorial executive order, the Connecticut Interagency Council on Supportive Housing and Homelessness is comprised of the leaders of ten State agencies.[43] The mission of the Council is to develop and implement strategies and solutions to address homelessness, including the development of supportive housing options and other measures designed to:

   - Reduce the number of Connecticut individuals and families that experience homelessness;
   - Reduce the inappropriate use of emergency health care, shelter, chemical dependency, corrections, foster care, and similar services; and

[43] The agency representatives are the Commissioners of the Connecticut Departments of Social Services, Economic and Community Development, Mental Health and Addiction Services, Public Health, Correction, Children and Families, and Veterans Affairs, plus representatives of the Governor's Office, the Secretary of the Office of Policy and Management or designee, the Director of the Office for Workforce Competitiveness, and the Executive Director of the Connecticut Housing Finance Authority. The Governor appoints two members of the Council to serve as Co-Chairs.

- Improve the health, employability, self-sufficiency, and other social outcomes for individuals and families experiencing homelessness

Under the executive order, the Council was charged with two primary duties:

1) Development of a plan for the creation of an additional 1,000 units of permanent, supportive housing. This plan was developed in 2004 and became the foundation for the state's Next Steps Supportive Housing Initiative.

2) Identification of other policy reforms, programs and expansions to lessen homelessness in the state. In its report to the Governor in January 2005, the Council recommended actions to remove barriers to effective discharge planning from state-operated or financed institutions such as hospitals and correctional facilities; and expand the supply of affordable housing as a means to prevent and respond to homelessness among very low income individuals and families. Major recommendations included the expansion of rental subsidies and the development of new housing.

Meetings of the full Council have been sporadic over its tenure, but a subcommittee of the Council – the Interagency Working Group on Supportive Housing – is active and meets monthly to address planning and implementation issues related to the State's collaborative supportive housing initiatives.

2. Continuums of Care

A Continuum of Care is a local or regional system for providing housing and services appropriate to the range of homeless needs in the community, from homelessness prevention to emergency shelter to permanent housing. In 1995, HUD implemented the Continuum of Care approach to streamline the existing competitive funding process under the McKinney-Vento Homeless Assistance Act and to encourage communities to coordinate more fully the planning and provision of housing and services for homeless people. Over the years, Continuums have moved toward significantly greater planning and involve more players.

At present, Connecticut has seven Continuums of Care. The Balance of State (BOS) Continuum covers cities and towns not included within other continuums. The structure of continuums continues to evolve. Two previous continuums (Middlesex County and Norwich/New London) merged into BOS in 2010 and Bristol, New Britain, and Danbury became part of the BOS in 2011. Some city-focused Continuums are thinking about expanding to have a regional scope. Under the HEARTH Act, HUD will be placing greater responsibilities on Continuums to track the performance of homeless services systems within their target areas.

3. **Community Plans to End Homelessness**

Starting in 2001, the United States Interagency Council on Homelessness challenged states and cities to create ten-year plans to end homelessness as a means to engage civic leadership and community participation in the issue. Since that time, thirteen community or regional plans to end homelessness were developed in Connecticut, with one more in process.

	Continuums of Care	Community Plans to End Homelessness
South West	Bridgeport/Stratford/Fairfield	Greater Bridgeport Area Ten Year Plan to End Homelessness (2005)
	Stamford/Greenwich	Stamford/Greenwich Ten Year Plan: A Different Time, Different Place (2007)
	Norwalk and rest of Fairfield County	Greater Norwalk Ten Year Plan to Prevent and End Homelessness (2011)
South Central	New Haven	New Haven Ten Year Plan to End Chronic Homelessness (2005) - Greater New Haven Regional Alliance
		Meriden-Wallingford Ten Year Plan to End Homelessness (2009)
		Middlesex County Ten Year Plan to End Homelessness (2007) – Middlesex County Coalition on Housing and Homelessness
Eastern		Next Stop, Home (2006) - Southeastern CT Partnership to End Homelessness
		Greater Windham Region Ten Year Plan to End Homelessness (2007)
North Central	Hartford	Hartford's Plan to End Chronic Homelessness by 2015 (2005) - Journey Home (Capitol Region)
		Building Hope Together: New Britain's Work Plan to End Homelessness (2008)
North West		City of Danbury Plan to End Homelessness (2006) Mayor's Taskforce to End Homelessness
	Waterbury	City of Waterbury Ten Year Plan to End Homelessness (2009)
		Northwest Connecticut Ten Year Plan to End Homelessness *(in development as of 2011)*
Balance of State	All communities not covered by other continuums above	

Community Plans to End Homelessness, often called "Ten Year Plans," have served as an important vehicle for engaging municipal leaders, the business community, faith communities, local United Ways and other philanthropy in efforts to end homelessness. In Hartford, a new nonprofit organization – Journey Home - was created to serve as the coordinating body for its plan. Most of the other plans are unstaffed, but are led by local steering committees. Some of the steering committees are highly active, others less so. The few that have staff support report how important it has been to keeping the steering committee focused and on task. Most of the plans focus on similar themes – housing, employment and income, services, civic engagement, and advocacy. Early plans – like those in Hartford and New Haven – were developed specifically to address chronic homelessness. Seven of the plans were developed prior to 2008; three are over halfway through their ten-year timeframe.

Community Plan committees face the challenge of sustaining civic energy as political leaders, economic forces, and volunteers change over time. They also express concern their efforts happen in isolation from other communities and from what may be happening at the state level. Many have expressed an eagerness to use *Opening Doors* as a means to reinvigorate their plans, bring renewed focus to the issue of homelessness, and serve as the lynchpin between what gets planned on a statewide or regional level and what actually happens on the ground.

4. **Reaching Home Campaign**

   The Reaching Home campaign was officially launched in 2004 to build political and civic support statewide for the creation of 10,000 units of supportive housing in ten years to end chronic homelessness. Led by a steering committee and coordinated by the Partnership for Strong Communities, the campaign has been highly successful in enlisting the support of municipal leaders, legislators, state policy makers, private sector leaders, philanthropy, and others for the expansion of permanent supportive housing. Reaching Home was instrumental in providing needs data and supportive housing targets that were incorporated within many of the Community Plans.

The degree to which local Continuums and their local Ten Year Plans coordinate their efforts varies by community. Some Continuum bodies serve as subcommittees of the Community Plan; others orbit in a separate sphere. Historically, there has been little connection between the State Interagency Council and the Continuums and Community Plans.

This *Framework* that has been developed through the Opening Doors - CT initiative offers an opportunity for better alignment between all of these various bodies. It also offers an opportunity to ensure that "mainstream" systems - such as primary and behavioral health care, criminal justice, housing, education, workforce, family services, financial and legal services, and child welfare– are active participants in state and local levels of planning. Currently there is not a cohesive set of structures for fostering this alignment and engagement.

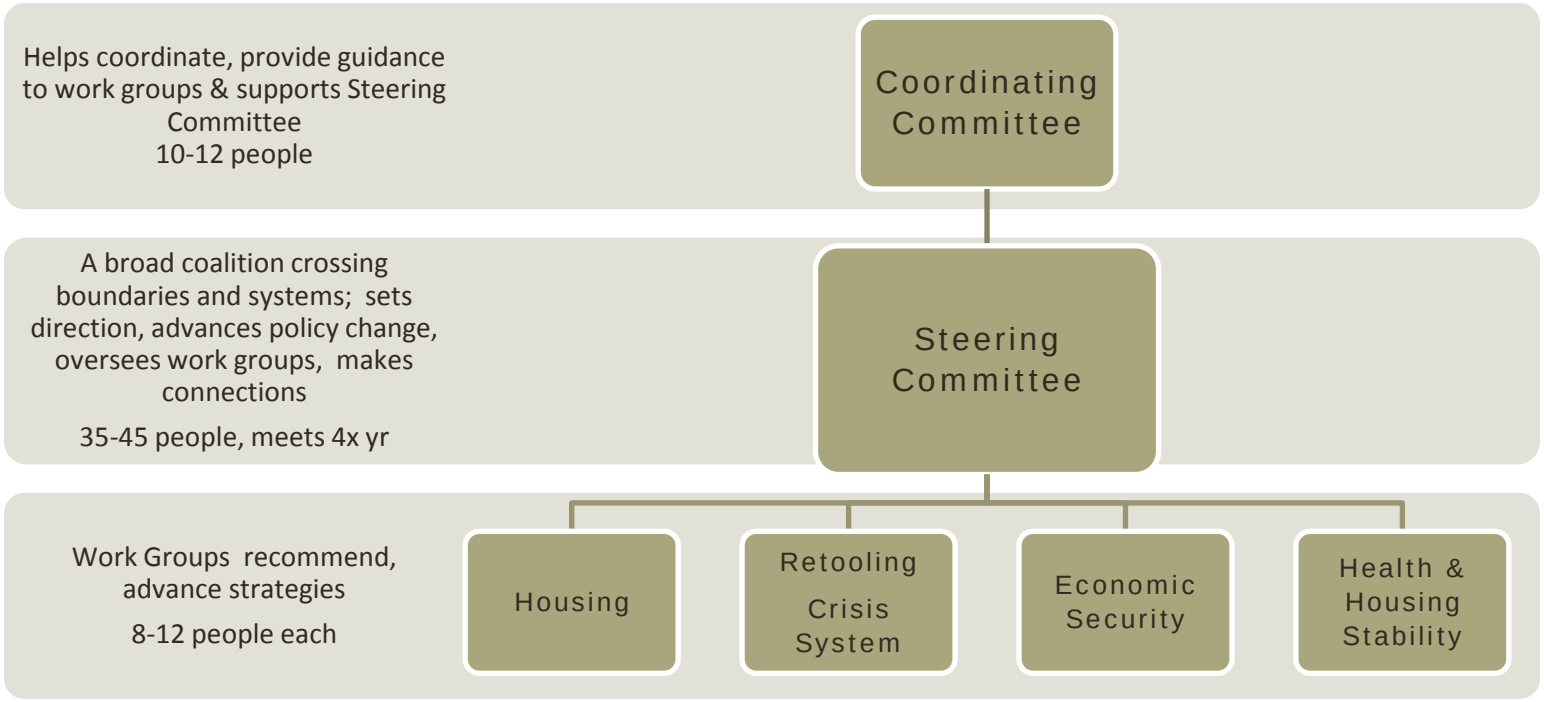
A Coordinated Approach: Reaching Home 2.0

A renewed and expanded Reaching Home Steering Committee can be the intersection of the ideas presented in this framework and the entity through which the four bold goals of this Framework can be pursued in a collaborative and coordinated way. Bringing the communities of interest together –

including the "systems" that touch the lives of those at-risk of homelessness and those experiencing homelessness - state and local government, nonprofits working locally and regionally, intermediaries, the business community and individuals who have experienced homelessness can be a catalyst for the changes necessary to end the condition of homelessness that affects too many in this State. It is a condition that shouldn't nor have to exist.

A pictorial of what this could look like: appears on the following page.

Reaching Home 2.0



Objective: Lead, manage and monitor the change process

Reaching Home 2.0 would become the leadership structure for planning and oversight of Opening Doors – Connecticut that builds on existing partnerships between the public, private, and nonprofit sectors

1. Within this leadership structure, develop structures for strategy development, for tracking progress, and for reporting up (to the state level) and down (to the local level) on progress.

2. Ensure staffing support for the process and structure. Staffing provides the grease to keep things moving and the glue to keep the process on track.

Develop operational plans at the state and local level with specific actions linked to resources and responsible parties

The *Framework* can provide a useful starting point for workgroups to develop action plans centered on the *Opening Doors* themes.

Create opportunities to ensure that the voices of people who have experienced homelessness and people working on the front lines of service delivery are heard

Develop outcome measures at both the systems level and at the program level

1. Define and adopt a common set of metrics to measure system performance statewide, including the following HEARTH ACT metrics (at minimum):
    - Reductions in homelessness at a point in time (as measured by the annual PIT count) and annually (as measured by HMIS)
    - Reductions in shelter lengths of stay
    - Reductions in returns to shelter
2. Track progress in ending homelessness and meeting annual performance targets using HMIS.
3. Develop and issue annual performance reports at the State, Regional and local levels.

As the State looks at its overall use of data and use of technology, consider the creation of a human services data warehouse to provide a platform for integrating key data across HMIS and human services.

Some of the potential uses of this type of data warehouse are:

- Analyzing regional or state demographics, trends, and outcomes
- Assessing the use of mainstream services by people experiencing homelessness and housing instability

- Calculating the cost of homelessness
- Measure what interventions work to prevent and end homelessness
- Informing statewide and community plans to prevent and end homelessness

A data warehouse can be a valuable resource for evaluating the intersection of systems of care in order to answer specific research questions, for improving client service, and for avoiding burdensome double entry into multiple systems by exporting existing data.