



PROJECT **H3**

home, health, hope

A Community Collaboration By:



Project H3 Biannual Community Briefing

Action Packet:
We can all spare some “change”

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Change Bucket: Outreach Transformation to Include Navigation Services

Street and shelter outreach has traditionally focused on mass delivery of basic needs items, such as food, water, clothing and blankets, to begin an engagement process of building rapport with homeless individuals and families. Once rapport has been built, practitioners tend to engage in motivational interviewing with participants in an effort to increase the desire to change while minimizing fear. Limited by a shortage of housing resources and a limited set of services predefined by the Continuum of Care, successful outreach relies heavily upon the internal motivation of the homeless individual as, once decided upon changing, it will take weeks and sometimes months to enter the Continuum of Care and one must submit to acceptable behaviors once in it.

This limited environment then favors quantity over quality as greater quantity increases the odds that, upon bed availability, a motivated participant will be ready to fill it. Once having entered the Continuum of Care, the participant is generally “handed off” to it and outreach moves to the next set of potential candidates. For this reason, outreach is usually measured by *process outputs*, such as number of contacts, items distributed or those accepting referrals, as opposed to *outcomes*, such as those obtaining and retaining permanent housing.

In a prioritized, housing-first environment, one in which the most vulnerable and long-term homeless are identified; outreach must transform to include navigation. Navigation is the basic idea of assisting a vulnerable homeless person into permanent housing and coordinating for the wrap-around services required to help the individual maintain housing and reach their highest level of independence over time. This non-traditional role favors quality over quantity as the prioritized system encourages targeting those most in need regardless of their motivation levels at the time of contact.

This change bucket explores the potential of transforming existing and developing new outreach strategies that employ navigation as a means to ending homelessness for vulnerable people experiencing long-term homelessness.



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Change Bucket: Community Wide Use of the Vulnerability Index to Prioritize Permanent-Supportive Housing

According to HUD, a *Chronically Homeless* person is a disabled individual who has been homeless for one year or longer or experienced homelessness 4 times in the past 3 years. According to Common Ground, a *vulnerable* person is an individual possessing at least one of eight critical health factors that increase the risk of premature death coupled with at least 6 months on the streets.

Among the 262 street-living homeless individuals surveyed by Project H3 over one week in April 2010, those deemed “non-vulnerable” (N=156), as a result of the Vulnerability Index survey, showed an average of 5.2 years on the streets while 11% reported less than one year of homelessness, thus failing to meet the chronic homelessness or vulnerable definitions. This clearly demonstrates that the vast majority of those surveyed met the basic definition of chronic homelessness yet failed to meet vulnerable conditions increasing risk of premature death. However, those found to be vulnerable (N=106) averaged 7.8 years on the streets and less than 5% reported having been homeless for less than one year and thus, while vulnerable, fail to meet the chronic homelessness definition. The Vulnerability Index appears to produce a narrower, more reliable population of those most in need who are also chronically homeless.

Scarcity is the basic economic problem of having unlimited human need coupled with limited resources to meet such needs. Its existence inherently creates competition for limited resources. Let’s assume Maricopa County has just 100 Permanent-Supportive Housing resources available to chronically homeless people. Using the above results, clearly 240 of the 262 surveyed would qualify for the 100 units. Unit scarcity then drives competition and those with fewer vulnerabilities are likely the first candidates to get the limited resources, leaving the most chronic (7.8 years compared to 5.2) and most likely to die prematurely as a result of homelessness, on the streets. Conversely, if one assumes the Vulnerability Index is used to qualify housing placement, then 101 first qualify for the 100 unit resource.

This change bucket explores the universal adoption of the Vulnerability Index as a community-wide tool to prioritizing limited Permanent-Supportive Housing resources to create greater abundance while reducing competition which places the most vulnerable at the greatest disadvantage.



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Change Bucket: Hospital to Home (H2H)

The Vulnerability Index, as developed by Common Ground, is based on research conducted by Dr. Jim O’Connell and his colleagues from Boston’s Health Care for the Homeless program. Some of his research has shown among homeless people who experienced premature death on the streets that each averaged just 10 days from their last contact with a hospital to the day of their actual death. Also revealed was an average of just 17 days from their last contact with detoxification facilities and the day of their death. This is strong evidence that healthcare and crisis response systems should be critical partners in assessing risk and connecting the most vulnerable to housing resources. It is believed that housing provides a solid foundation for effective healthcare and without it, risk factors for premature death increase.

Common Ground has now launched the Hospital to Home (H2H) initiative currently comprised of 8 communities focused on improving the health of people experiencing homelessness and reducing unnecessary healthcare costs. Healthcare providers are working alongside homeless outreach and housing providers to create integrated medical homes with traditional “bricks and mortar” homes.

The typical partnership entails hospital and outpatient care providers working to develop Care Management Teams, fund respite beds, link individuals to primary care and homeless outreach and provide patient navigation. Housing providers and outreach staff work to inform discharge planning, secure permanent housing, link individuals to primary care and social services and provide patient navigation. Integrated care is critical to reducing the cost of frequent users of emergency systems and improving health outcomes.

Dr. O’Sullivan of Maricopa County’s Health Care for the Homeless is working on an initiative called Circle the City which is intended to connect medically vulnerable homeless people to permanent housing and reduce hospital burden in terms of time and cost.

This change bucket explores the development of Hospital to Home initiatives designed to identify and house the most vulnerable and long-term homeless with hospitals and crisis response systems as a primary partner.



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Change Bucket: Partnering Mainstream Housing Resources

Housing Ends Homelessness

A “Housing First” approach to ending homelessness is no longer new technology. Studies from across the country have repeatedly shown the success and cost effectiveness of rapidly housing individuals and families experiencing homelessness in permanent, affordable housing with appropriate client-centered, wrap-around support services. The development of permanent supportive housing options with a “Housing First” approach can be accomplished through a combination of strategies which must include the re-prioritization of existing mainstream housing resources in our communities.

Housing Choice Voucher Program

The Housing Choice Voucher (HCV) program, formerly known as Section 8, assists very low-income individuals and families to afford decent, safe, and sanitary housing in the private market. Housing choice vouchers are administered locally by public housing agencies (PHAs). PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

Local Preferences

PHAs have the discretion to establish local preferences to reflect the housing needs and priorities of their particular communities. Local preferences determine the order in which applicants are served from the PHA waiting list for the program. Local PHAs should prioritize this critical resource to those individuals and families with the worst case housing problems in their communities. This most often requires prioritizing just a small percentage of the annual vouchers that become available in a community in a given year.

PHAs should adopt a local preference for individuals and families experiencing homelessness who have been determined to be vulnerable according to the Common Ground Vulnerability Index.

Targeted Opening of PHA Waiting Lists

PHAs maintain lengthy waiting lists for their Housing Choice Voucher programs and rarely open them for new applicants. Individuals and families experiencing homelessness struggle to navigate the application and waiting list process when PHAs do open their waiting lists.

PHAs may elect to open their waiting lists for targeted applicants, including those individuals and families to whom the PHA has provided a local preference. PHAs may also elect to close their waiting list while still accepting new applications that meet specific criteria.

PHAs should exercise their administrative flexibility in opening and maintaining waiting lists for their Housing Choice Voucher programs in order to facilitate the application of local preferences for vulnerable homeless individuals and families.

This change bucket explores developing long-term partnerships with Public Housing Authorities and other Mainstream Housing Resources.