District of Columbia Interagency Council on Homelessness

Strategic Plan 2015-2020

WE ARE WASHINGTON DC

HOMEWARD DC

2015 - 2020

District of Columbia Interagency Council on Homelessness

Strategic Plan 2015-2020

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Letter from Mayor Muriel Bowser

The District of Columbia continues to grow and thrive, with more than eight hundred people moving into the District every month. Retail is flocking downtown, new restaurants and shops are appearing in neighborhoods throughout the city, and we see cranes in every direction we look.

But that is only half of the story. We face high levels of economic inequality. The District has lost a significant portion of its affordable housing stock, rent prices have risen dramatically, and it is increasingly difficult to survive on a minimum wage income. The negative consequences are seen and felt nowhere as keenly as in our homeless services system.

The District has higher rates of chronic homelessness than other similarly sized cities in America, and family homelessness has increased a staggering 50% over the past five years. The City spends millions of dollars every year to simply manage homelessness, while the root causes remain. We can do better than this. We have to do better than this. We will do better than this and create pathways to the middle class.

When I entered office on January 2, the District's homeless crisis was at the top of my priority list. I knew this was a problem that could not be fixed overnight. I charged my team at the Interagency Council on Homelessness with accelerating the development of a strategic plan to guide our efforts in the coming years. And today, I am pleased to present Homeward DC, a comprehensive, data-driven plan that lays out a bold vision:

> **Together, we will end long-term homelessness in the District of Columbia. By 2020, homelessness in the District will be a rare, brief, and non-recurring experience.**

The goals of this plan are ambitious, but achievable. Developed in partnership with nonprofit providers, advocates, persons experiencing homelessness, business partners, and the philanthropic community, this plan pulls together our community's best and brightest thinking on the issue. It is an informed plan that takes into account the experience of our prior efforts, the opportunities and constraints unique to our community, and the latest research on best practices.

My Administration is focused on solutions and committed to taking the necessary action. We will invest in housing solutions and expand economic opportunities for the most vulnerable members of our community. But government cannot do it alone. We know that growth is more sustainable when we bring everyone along. By working together, we can build pathways to the middle class and ensure that the District of Columbia is a world-class city for all of its residents.

Sincerely,

Muriel Bowser
Mayor, District of Columbia

Executive Summary

Stable housing is out of reach for far too many District of Columbia residents, many of whom have lived in the District their entire lives and are finding themselves priced out of a rapidly gentrifying urban market. In addition to the over 5,000 households that experience literal homelessness on any given night in the District, thousands more are living in doubled-up and often unstable (if not unsafe) situations, and over 40,000 are severely cost burdened, paying more than half of their monthly income for housing. For these District residents, any number of catalyzing events – a healthcare crisis, domestic violence, job loss – can land them at the shelter door.

In the last few years, the District has been especially challenged by the growing number of families that are experiencing homelessness. While struggling to meet the needs of families, we have also reduced our capacity to meet the needs of other vulnerable subpopulations, notably disabled single adults experiencing chronic homelessness – many of whom are elderly, and many of whom have been living on the streets of DC for a decade or more.

The Challenge Ahead of Us

Because of rising housing costs and the loss of affordable housing stock, it has become increasingly difficult for people to quickly exit shelter and return to permanent housing. As the average length of time people spend in shelter increases, we require more shelter units to simply serve the same number of households in a given year, as fewer units turn over and become available for new households. This has led to a situation where the District is spending millions of dollars on motel rooms to simply meet the emergency shelter needs of families.

Dramatic increases in shelter expenditures in recent years have had the cyclical effect of limiting our ability to invest in the housing solutions that help families and individuals exit shelter. In turn, the amount of time households spend in shelter continues to increase, which increases our shelter capacity needs. The challenge ahead of us is to meet the shelter needs of households (as required by District law) while we simultaneously work to shift more of the resources within the homeless services system towards permanent housing solutions. Investing our resources in permanent housing is not only better for the clients we serve, but it is also better for the community and District taxpayers.

The Vision

Homeward DC lays out a bold vision:

Together, we will end long-term homelessness in the District of Columbia. By 2020, homelessness in the District will be a rare, brief, and non-recurring experience.

Ending homelessness as we know it today does not mean that no one will ever experience a housing crisis again. Changing economic realities, the unpredictability of life, and unsafe or unwelcoming family environments may create situations where residents are temporarily homeless. However, we can dramatically change the way we respond to households in crisis. This plan builds on the efforts of the past by laying out a roadmap for transforming our homeless services system into an effective crisis response system that is

focused on preventing housing loss whenever possible, quickly stabilizing and safely sheltering individuals and families that do become homeless, and quickly facilitating the connection back to permanent housing and community support networks.

The plan is built on three major goals:

1. **Finish the job of ending homelessness among Veterans by the end of 2015.** Through targeted interventions, we have reduced homelessness among Veterans in the District by 20 percent in the past four years. With increased Federal funding and local funding allocated in the District's Fiscal Year (FY) 2015 budget, we have the resources to get the job done. Ensuring that Veterans who have served our country have a safe, stable place to call home is not only a priority; it will also serve as a proof point: when resources are invested in the right interventions, and when we use data to guide our decisions and measure our progress, homelessness is solvable.
2. **End chronic homelessness among individuals and families by the end of 2017.**[1] While it may not always be possible to prevent housing loss, no one should be sleeping in emergency shelter or on the streets for a year – much less ten years. Chronic homelessness should not exist in our community. It is costly to the people experiencing it, and it is costly to taxpayers.
3. **By 2020, any household experiencing housing loss will be rehoused within an average of 60 days or less.** By increasing investments in permanent housing and reducing the average length of stay in shelter, we will reduce homelessness in the District by 65 percent in just five years.

The Plan

Homeward DC is the result of a highly collaborative process led by the DC Interagency Council on Homelessness (ICH) between June 2014 and March 2015. While strategic plans have a reputation as documents that sit on a shelf gathering dust, this plan is intended to be different. It is built on a solid foundation of data and informed by the expertise of people on all sides of the issue. It is indeed ambitious, but it is also implementable.

The process for developing the plan included five separate but interrelated activities:

1. A review of our existing system inventory to define our current capacity;
2. Identification of the program models needed within the homeless services system;
3. An analysis of how different program models work together to form "pathways" through the system (from homelessness back to permanent housing) for different subpopulations;
4. Modeling the changes to our inventory of prevention programs, emergency shelter programs, transitional housing programs, and permanent housing programs needed over the five-year plan period; and
5. Examining the annual unit costs of different interventions to identify areas for potential cost savings and enable us to align our planning and budgeting efforts.

There are no one-size-fits-all solutions to homelessness. The challenge for the homeless services system is to provide the right intervention to the right person at the right time to facilitate a connection back to permanent housing as quickly and effectively as possible. The purpose of the system modeling described above and explored in Chapter 3 was to develop year-by-year projections of the number and type of interventions needed to ensure we are investing our resources in the right ways.

1 Persons experiencing chronic homelessness are those individuals and families that have a disabled head of household, are sleeping on the streets or in emergency shelters, and have been homeless continuously for a year or more or have had four episodes of homelessness in a three-year period.

Key Strategies

Of course, implementing systems change is not just about resources. We must also undertake policy and programmatic changes, as well as examine ways to increase our efficiencies and identify cost savings. Towards this end, the plan identifies a series of action items across five key strategies:

Strategy 1: Develop a more effective crisis response system.

We need to transform our system into an effective crisis response system, where people experiencing homelessness feel safe and are supported to quickly get back on their feet. Key areas of focus within this strategy include transitioning to smaller, community-based shelters (including closing DC General by 2017), increasing the number of specialized shelter beds (e.g., medical respite), creating a day-time service center for single adults, developing and implementing a plan for year-round access to shelter, and redesigning the Rapid Re-Housing program.

Strategy 2: Increase the supply of affordable and supportive housing.

In the long run, increasing the supply of affordable housing is the single largest homelessness prevention measure we can take as a community. In the meantime, dedicated housing resources must be available within the homeless services system to help individuals and families quickly exit shelter and return to permanent housing. Key action items include:

- Aligning annual investments made via the Housing Production Trust Fund to help meet permanent housing inventory needs specified in the plan
- Determining how Medicaid resources can be used to pay for more of the services needed to help people with behavioral health issues stay in housing (which will allow us to redirect some of our local investments to additional housing), and
- Examining whether some of our transitional housing stock can be converted to permanent housing.

Strategy 3: Remove barriers to affordable and supportive housing.

We need to improve access to housing for vulnerable individuals and families by ensuring we fund Permanent Supportive Housing programs that use a Housing First model. Some programs within our system have so many eligibility requirements that we are unable to place into permanent housing the very individuals and families that the programs were funded to serve. In the months and years ahead, we will need help from both providers and private market landlords to examine their requirements and identify where they can be more flexible to ensure vulnerable District residents have access to housing.

Strategy 4: Increase the economic security of households in our system.

In order to increase the success of households in the system and reduce the likelihood of a return to homelessness, we must provided targeted employment assistance, particularly to households receiving time-limited interventions like Rapid Re-Housing.

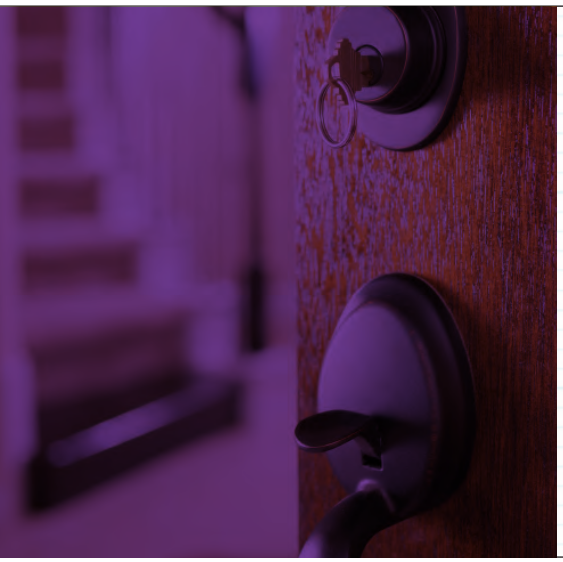
Strategy 5: Increase prevention efforts to stabilize households before housing loss occurs.

In the months ahead, we will need to increase our efforts to stabilize high-risk households before they arrive at the shelter door by implementing targeted homelessness prevention programming that incorporates the use of predictive analytics. We will also examine what more can be done to stabilize individuals and families as they transition out of other systems – including adult and juvenile justice systems, child welfare and foster care systems, and behavioral health systems.

A Living Document

Homeward DC is an evolving roadmap – not a permanent blueprint – and we must treat it as such. The process of developing this plan showed us where we have the data needed to make sound policy decisions and investment choices, and where we have gaps in our knowledge base. As we capture new or additional information, we can (and must) refine our assumptions, which will help sharpen the path forward.

Implementation of this plan will require unprecedented collaboration, but we have more commitment from partners across every sector than we have possibly ever had before. We know that homelessness is solvable when we have a common vision, every partner understands their role in the system, we keep a laser-like focus on outcomes, and we have the resources to get the job done. Together, we can ensure that homelessness in the District of Columbia is a rare, brief, and non-recurring experience.



Introduction

The District's Interagency Council on Homelessness (ICH) was established by the Homeless Services Reform Act (HSRA) of 2005 for the purpose of facilitating interagency coordination with regard to planning, policymaking, program development, and budgeting for the homeless services system in the District. Per the HSRA, the ICH is required to prepare and publish a strategic plan every five years to guide the District's efforts around preventing and ending homelessness.

There have been many successes within the District since the ICH released its last strategic plan in 2010:

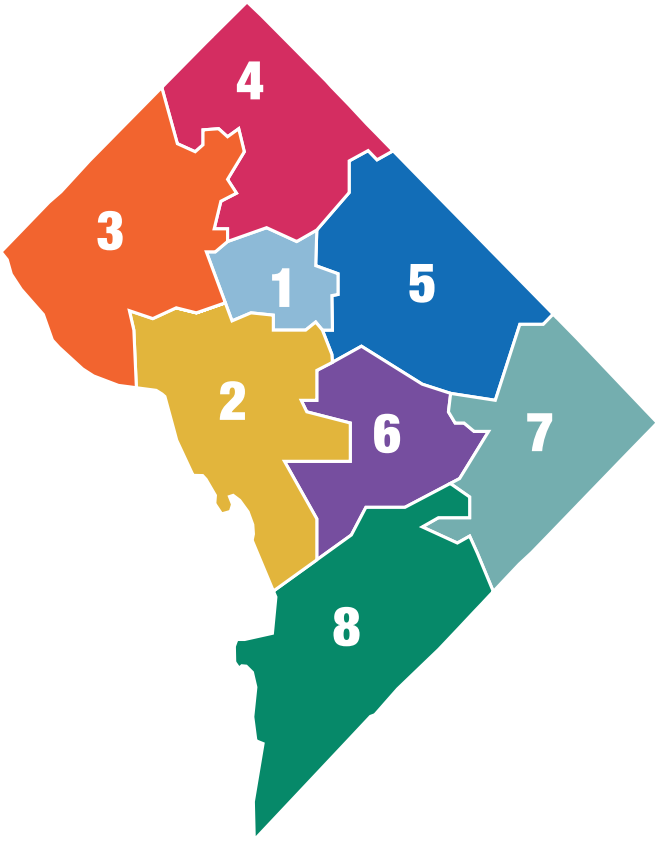
- Through targeted interventions, including the locally-funded Permanent Supportive Housing Program (PSHP) and the Federally-funded Veterans Affairs Supportive Housing (VASH) Program, we have reduced chronic homelessness among single adults and homelessness among Veterans by over 20 percent.
- The 2010 Plan called for a collaborative effort between the DC Department of Housing and Community Development (DHCD), the Department of Human Services (DHS), the DC Housing Authority (DCHA), and the Department of Behavioral Health (DBH) to release funding through a single competitive process to streamline and simplify the housing production process. We have implemented a Consolidated Request for Proposals (RFP), which is producing a solid pipeline of housing that can be used for households exiting the homeless services system.
- We have implemented systems of "Coordinated Assessment and Housing Placement" (CAHP) for both families and single adults. The Family Service Prioritization Decision Assistance Tool (F-SPDAT) is used for families who are experiencing homelessness, and the combined Vulnerability Index-Service Prioritization Decision Assistance Tool (VI/SPDAT) is used for individuals. These evidence-informed tools assist with assessing an individual's or family's service needs and with prioritizing who to serve next and with what types of resources. Data from the use of these tools allow for better projections of resource and unit needs.
- Rapid Re-Housing (RRH), a newer intervention on the national landscape, has become more widely used for both families and individuals. While we have work to do to improve RRH implementation in the District, we now have a few years of data and lessons learned to help us improve our approach.
- The ICH, as the infrastructure to support the District's collective efforts to prevent and end homelessness, has evolved and strengthened over the past five years. Now staffed with a full-time Executive Director to coordinate and advance the work of the homeless services community, the ICH

has a new committee structure with clear roles and responsibilities, clear and transparent decision-making protocols, and active participation from all sectors of the community.

Despite our progress with specific subpopulations, homelessness in the District is increasing at an alarming rate. Stable housing is out of reach for far too many District residents, many of whom have lived in the District their entire lives and are finding themselves priced out of a rapidly gentrifying urban market.

This plan attempts to build on the efforts of the past by laying out a roadmap for transforming our homeless services system into an effective crisis response system that is focused on preventing housing loss whenever possible and quickly stabilizing individuals and families that do become homeless to connect them back to permanent housing. The plan is organized as follows:

- Chapter 1 provides key context on homelessness, including information on the causes of homelessness and trends in the District compared to trends across the nation;
- Chapter 2 describes the vision and goals of the plan, the principles we will use to guide our efforts in the coming years, and building blocks of the plan;
- Chapter 3 explains the results of the modeling completed as part of the strategic planning process. Modeling serves as a planning tool to help us estimate the types and number of different interventions required for our system (on average) to respond to the needs of people experiencing homeless each year;
- Chapter 4 explains how replacement of large, District-owned shelter facilities (such as DC General) fits into overall efforts to transform the system; and
- Chapter 5 highlights the strategies we will need to undertake in the coming years to optimize the investments we make in the system.



District of Columbia Wards

Editorial Note: Throughout this document the terms “we,” “our,” or “us” refer to the ICH and the core group of stakeholders consulted during the strategic planning process, as well as stakeholders responsible for bringing this plan to fruition and the city as a whole.

1 Homelessness and Our Community

The District of Columbia has seen rising homelessness in recent years. In 2014, nearly 8,000 persons experienced homelessness on any given night in the District – 3,795 persons in families (1,231 households) and 3,953 individuals. This represents a 13 percent increase from 2013 and a nearly 20 percent increase from 2010. The majority of the increase is attributable to families experiencing homelessness. The 2014 count showed a 20 percent increase from 2013 and a staggering 50 percent increase from 2010. See Figure 1 below for Point In Time (PIT) Count trends in the District.

How do we Define Homelessness?

Homelessness takes many forms:

- When we refer to people who are **unsheltered,** we are referring to people who live on the streets, camp outdoors, or live in cars or abandoned buildings.
- Other people are in emergency shelters or transitional housing programs, a group referred to as **sheltered.**
- Another group is staying with family or friends; this group is referred to as **doubled-up.**

Different Federal agencies have different definitions. For the purpose of this plan, we are focused on the group the US Department of Housing and Urban Development (HUD) refers to as "literally homeless" – those who are unsheltered, in shelter, or in transitional housing.

The term "chronic homelessness" also has a specific meaning. Someone that is chronically homeless is a person that 1) has a disability; 2) is unsheltered or in shelter; and 3) has been homeless consistently for a year or more, or has had four separate episodes of homelessness within the last three years. In 2012, HUD changed this definition to also include families. A family that is chronically homeless has a head of household that meets all of these conditions. For more information, see Appendix 1: Definitions.

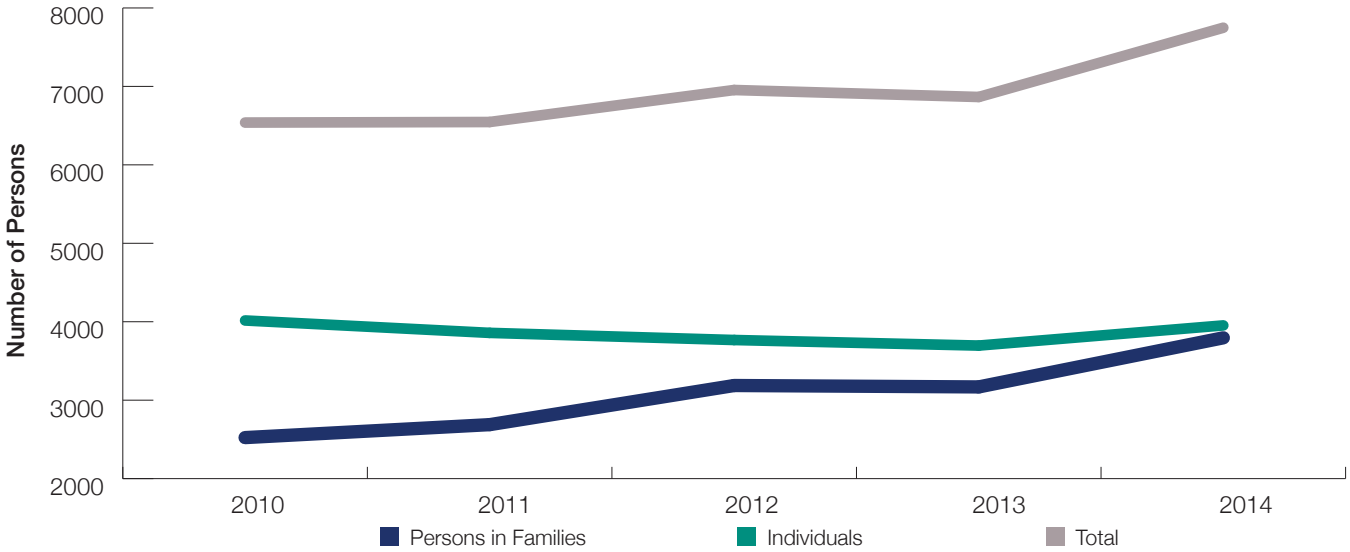
How do we Measure Homelessness?

Tracking data on homelessness has historically been challenging. To better understand the number of individuals and families experiencing homelessness in America, HUD requires communities receiving Federal homeless assistance resources to capture data in two ways:

1. **Point In Time (PIT) Count.** Every January, cities across America spend one night doing a comprehensive count of people experiencing homelessness. The PIT only captures people who are unsheltered and sheltered (in emergency shelter or transitional housing), but not people that are doubled-up. Although people flow in and out of the system throughout the year, the PIT provides a snapshot that allows us to compare changes in the population over time.

2. **Annualized Count Via Homeless Management Information System (HMIS) Data.** HMIS is a client-level database that allows us to track utilization of programs and services within the homeless services system. Our HMIS allows us to produce an unduplicated count of the number of individuals and families that experience homelessness in a given year. Our HMIS also tells us where someone was staying before becoming homeless, what types of programs and services they use, how long they were in each program, and where they went at program exit. These annualized figures reveal a more complete picture of who is experiencing homelessness than can be understood from the PIT count alone.

Figure 1: DC Point In Time (PIT) Count Trends for Total and Household Type (2010-2014)



In addition to the broad categories of family households and single adults, the PIT counts also provide details on key subpopulations:

- **Chronically Homeless Persons.** In 2014, approximately one-quarter of the persons counted during the PIT (2,029) were chronically homeless, 80 percent of which were single adults, and the remaining 20 percent of which were persons in families. On the surface, this number has remained relatively flat over the last five years. However, prior to 2013, families were not included in the Federal definition of chronic homelessness and were therefore not captured in the count. If you consider just chronically homeless single adults, there has been a nearly 24 percent reduction in population between 2010 and 2014. See Table 1 below for additional detail.
- **Veterans.** In 2014, just over 400 homeless Veterans were identified during the PIT, approximately 5 percent of the total homeless population in the District. This marks a 20 percent decrease from 2011, when the PIT first began including a specific count of Veterans.

Table 1: DC Point In Time (PIT) Subpopulation Counts (2010-2014)

PIT Subpopulation Category		2010 Count		2011 Count		2012 Count		2013 Count		2014 Count	
Chronically Homeless (Total)		2,110		2,093		1,870		2,027		2,029	
Persons in Families*	Individuals	--	2,110	--	2,093	--	1,870	263	1,764	420	1,609
Veterans**		--		515		531		499		406	

*Prior to 2013, the Federal definition of chronic homelessness did not include families. Therefore, the chronic homeless count in 2010-2012 includes single adults only.

**Prior to 2011, HUD did not require a separate count of homeless Veterans.

How Does DC Compare to Other Cities in the United States?

The PIT trends in the District look a bit different from the aggregated national trends, which show declines in the number of persons experiencing homelessness for all household types and subpopulations (see Table 2 below). The biggest difference is related to families. In the District, we have seen a 50 percent increase in homelessness among persons in families since 2010, compared to an 11 percent decrease nationally.

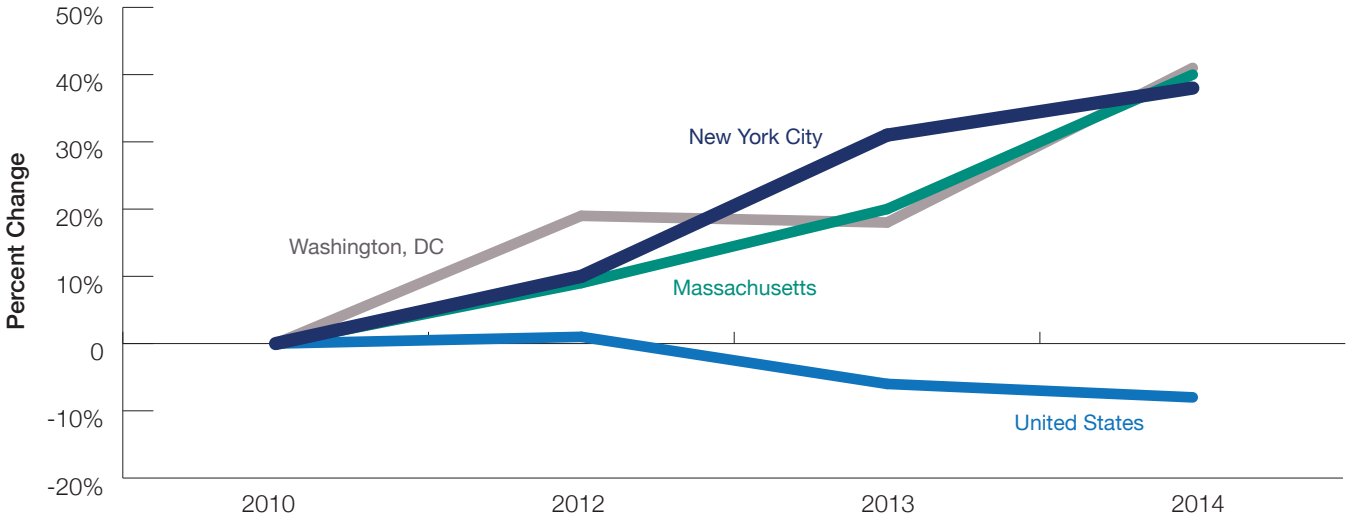
When you drill down in the data, however, the trends related to family homelessness in the District probably are not that different from other communities across the country. As explained earlier in this chapter, the PIT count reflects the number of unsheltered individuals and families, as well as the number of individuals and families in emergency shelter and transitional housing programs. It does not capture the vast number of households that are doubled-up or couch surfing. In most communities, the homeless services system has a fixed shelter budget. They may have some flexible capacity to provide overflow assistance, but typically not unlimited capacity. This means the PIT count in other communities is generally restricted by the number of shelter beds in the community. If you look at the PIT counts in other large cities across the United States, it is not atypical to see a family homeless count that has remained flat. In the District, however, the HSRA provides for a legal right to shelter when the temperature falls below freezing. This means that we have an obligation to shelter households presenting for assistance, and it also means we are capturing more of those households that would have otherwise been in doubled-up situations.

Table 2: National Point In Time (PIT) Trends (2010 – 2014)

PIT Category	2010 Count	2014 Count	Percent Change
Total	640,466	578,424	-10%
By Household Type			
Individuals	398,515	362,163	-9%
Persons in Families	241,951	216,261	-11%
By Subpopulation			
Chronically Homeless	107,183	84,291	-21%
Veterans	74,770	49,933	-33%

A comparison of the District's numbers against other communities that guarantee persons experiencing homelessness a legal right to shelter shows that DC is not an anomaly. In other right to shelter jurisdictions, family homelessness has increased by roughly 40 percent since 2011 (see figure 2 below).[2]

Figure 2: Percent Change in Family Homelessness in Right to Shelter Jurisdictions



Source: Dept. of Housing and Urban Development, Point-in-Time Homeless Counts

2 Corinth, Kevin C. 4 Charts that Expose the Invisible Side of Homelessness, AEI Ideas: The Public Policy Blog of the American Enterprise Institute (blog). American Enterprise Institute, November 10, 2014. https://www.aei.org/publication/4-charts-expose-invisible-side-homelessness/.

US Department of Education (ED) data offers further evidence of increasing family homelessness across the country. For the purposes of its homeless assistance programs, ED uses a definition that includes doubled-up households. ED's counts register a 34 percent increase in family homelessness across the country over a 3-year period.[3] See Table 3.

Table 3: ED Count of Homeless Children/Youth (School Year 2009/2010 – School Year 2012/2013)

Jurisdiction	SY 09/10	SY 12/13	Percentage Change
United States	938,948	1,258,182	34%
Disctrict of Columbia	2,499	3,766	51%

Accessing Affordable Housing

In 2014, DCHA completed an outreach campaign to an estimated 70,000 households on its waitlist to confirm continued need for housing assistance, removing households that had moved, no longer met income eligibility requirements, or had been housed through another program. Approximately 41,000 households have affirmed their need for housing assistance and remain active on the waitlist.

Causes of Homelessness

Thirty years ago, homelessness was predominantly experienced by single adults. Homelessness among children did not exist in the same way it does today. Economic downturns have historically led to an increase in the number of people experiencing homelessness. In the last three decades, however, with ever-growing income inequality in the US, the number of people experiencing homelessness has remained high even in good economic times.

The increase in homelessness is the result of a convergence of three key factors: the loss of affordable housing; wages and public assistance that have not kept pace with the cost of living; and the closing of state psychiatric institutions without the concomitant creation of community-based housing and services.

Housing Affordability in the District

A number of recent studies confirm that the District is not only one of the least affordable cities in America, but that there is a severe shortage of housing that is affordable to households at the lowest income levels.

The issue of housing affordability in the District of Columbia is particularly glaring when the District's minimum wage is compared to its housing wage, which is the minimum hourly wage a full-time worker must earn to afford a two bedroom rental home at the HUD-estimated Fair Market Rent (FMR).[4] As shown in Table 4, a person earning the 2014 minimum wage in the District would need to work nearly three full-time jobs –approximately 120 hours a week – to afford a decent two bedroom rental home.[5]

3 State and Local Educational Agencies count students that are sheltered, unsheltered, and living in hotels/motels and/or doubled-up situations. This count is more expansive than HUD's count (which does not include families who are doubled-up) and results in a different nationwide trend for family homelessness. See: http://eddataexpress.ed.gov/.

4 The conventional public policy indicator of housing affordability in the United States, and the one used by HUD for its programs, is the percent of income spent on housing. To be considered "affordable," rent must be 30 percent of household income or less. Households that are spending more than 30 percent are considered rent burdened, and of course, the higher this percentage goes, the more at risk the household is for housing loss.

5 The National Low Income Housing Coalition annually calculates a Housing Wage to assess affordability of housing across the nation. The Housing Wage allows the Coalition to capture the gap between wages and rents. For the District, the National Low Income Housing Coalition calculates a Housing Wage of $28.25 in their Out of Reach 2014 report available at http://nlihc.org/oor/2014.

Table 4: Housing Wage vs Minimum Wage in the District of Columbia

2014 Housing Wage	$28.25
2014 Minimum Wage	$9.50
Disparity (housing wage: minimum wage)	2.97x

To determine the extent to which District residents are impacted by the lack of affordable housing in the region, the Urban Institute recently assessed the cost burden for District households and concluded that just over half of the renter households in the District are cost burdened (spending more than 30 percent of their income on housing costs), including 41,700 households (28 percent) that are severely cost burdened (paying more than 50 percent of their income on housing costs).[6] See Table 5 for further detail.

The lack of affordability disproportionately affects lower income households because extremely low-income renters face enormous competition for affordable units. According to the Urban Institute study, higher-income households occupied 40 percent of the units that would have been affordable to the poorest tenants.

Table 5: Share of Income Paid in Rent Each Month and Cost Burden Rates in the District (2009-2011)

Number of Renter Households Paying:			Percentage of Renter Households Who Are:		
Less than 30% of income	30-50% of income	50% or more of income	Total	Cost burdened	Severely cost burdened
74,000	33,900	41,700	149,600	51	28

Wages and Economic Mobility

With respect to poverty and economic mobility, the District is very much a tale of two cities. Census Bureau data shows both a significant rise in income for the typical DC household and a rise in the number of people living in poverty.[7] In 2013, approximately 115,550 DC residents (18.9 percent) lived below the poverty line – less than $24,000 for a family of four. This represents a 25 percent increase in the number of people living in poverty since 2007. Unfortunately, this increase is largely driven by a significant rise in the number of people living in deep poverty (those living at below half of the poverty line – less than $12,000 for a family of four). The increase in the number of people living in deep poverty accounts for more than two-thirds of the increase in the overall number of people living in poverty. In 2013, one in 10 residents in the District lived in deep poverty.

The increase largely reflects falling wages and a scarcity of jobs for residents without a college degree. An analysis of Census Bureau data (2007-2013) shows that wage and job growth in the District has been very uneven and only those residents with the most advanced education are making economic progress.[8] District labor market data confirms this assessment: the majority of opportunities (65 percent of job openings advertised online) had a minimum education level requirement of a Bachelor's Degree – significantly higher than other cities around the country. In contrast, only 18 percent of advertised jobs in the District have a minimum education requirement of High School Diploma or the equivalent, even though almost a third (31.6 percent) of the available candidates in the District have High School Diplomas or the equivalent (see Table 6).[9]

6 The Urban Institute's report on Housing Security in the Washington Region assessing American Community Survey (2009-11) is available online at http://www.urban.org/publications/413161.html.

7 DC Fiscal Policy Institute, 2014. Poverty in DC Has Jumped Significantly Since 2007. By Jenny Reed and Wes Rivers. Accessed March 06, 2015. http://www.dcfpi.org/wp-content/uploads/2014/10/ACS-Write-Up.pdf.

8 DC Fiscal Policy Institute, 2015. Left Behind: DC's Economic Recovery is Not Reaching All Residents. By Ed Lazere and Marco Guzman. Accessed February 19, 2015. http://www.dcfpi.org/left-behind-dcs-economic-recovery-is-not-reaching-all-residents.

9 DC Networks: Labor Market Analysis. Available at https://www.dcnetworks.org/vosnet/

Table 6: Education Level of Available, Potential Candidates vs Requirements on Advertised Jobs (on February 18, 2015)

Minimum Education Level	Potential Candidates*		Job Openings**	
	Count	Percent	Count	Percent
Less than High School	385	3%	--	--
High School Diploma or Equivalent	4,218	32%	701	18%
1 to 3 Years at College or a Technical or Vocational School	2,415	18%	--	--
Vocational School Certificate	1,366	10%	54	1%
Associate's Degree	659	5%	147	4%
Bachelor's Degree	2,410	18%	2,552	65%
Master's Degree	1,441	11%	338	9%
Doctorate Degree	294	2%	122	3%
Specialized Degree (e.g. MD, DDS)	156	1%	--	--
*Candidate Source: Individuals with active resumes in the workforce system (District Labor Market Data)				
**Job Source: Online advertised jobs data (District Labor Market Data)				

The Costs of Homelessness

The literature on the costs of homelessness is extensive and consistent: homelessness results in increased use of emergency rooms, hospitals, jails, and courts, in addition to the significant costs associated with shelter and other homeless services. Due to growing pressure on the shelter system and other public systems (and consequently on public tax revenue), many communities have recognized the importance of redirecting resources towards permanent housing solutions. Communities that have completed cost studies have found that these other publicly funded systems experience significant cost savings when vulnerable individuals are placed in housing – often enough to offset the full cost of housing and services.[10]

Accordingly to a 2010 national study, average homeless system costs for individuals was lower than those for families, who typically have higher daily costs and stay in shelter longer. Accordingly, the emergency shelter system is a particularly expensive response to family homelessness.[11] As seen in Appendix 8: Program Model Unit Costs, this trend holds true in the District. Shelter is the single most expensive intervention provided within the homeless services system. For adult individuals, however, the distribution of costs is skewed. According to the same 2010 study, a large percentage of individuals touch the homeless services system very briefly and then do not return. In contrast, a small percentage of individuals (the chronically homeless population) consumes over 80 percent of total system costs.[12]

For individuals, the most significant costs related to homelessness typically lie outside of the homeless services system. Health care is the largest component of costs due to frequent and avoidable emergency room visits, inpatient

10 To review cost studies from around the country, visit the US Interagency Council on Homelessness (USICH) research database: http://usich.gov/usich_resources/research_and_evaluation/cost_effectiveness_studies/

11 Khadduri, Jill, Josh Leopold, Brian Sokol, and Brooke Spellman. Costs Associated With First-Time Homelessness For Families and Individuals. March 2010. Available at http://www.huduser.org/portal/publications/povsoc/cost_homelessness.html

12 Ibid.

13 Corporation for Supportive Housing. Summary of Studies: Medicaid/Health Services Utilization and Costs. Available at http://pschousing.org/files/SH_cost-effectiveness_table.pdf

14 Culhane, Dennis, Stephen Metraux, Thomas Byrne, Magdi Steno, and Jay Bainbridge. "The Age Structure of Contemporary Homelessness: Evidence and Implications for Public Policy" Analyses of Social Issues and Public Policy 13.1 (2013): 1-17. Available at: http://works.bepress.com/dennis_culhane/124

hospitalization for medical or psychiatric care, sobering centers, and nursing homes.[13] This has serious implications, in part because US Census data confirms an aging trend among the single adult homeless population. Specifically, the age group in the single adult population facing the highest risk for homelessness was 34–36 in 1990, 37–42 in 2000, and 49–51 in 2010.[14] As this population continues to age, healthcare needs will increase, as will risk for mortality. These numbers mirror the trend in the District, where the median age of the chronically homeless population is 53.

In addition to behavioral health issues, homeless individuals also suffer significantly from physical disabilities and chronic illnesses – at a rate three to six times higher than the general population.[15] As seen in the District's data, this includes high rates of asthma, heart disease, kidney disease, diabetes, HIV/AIDS, and cancer. These individuals are frequent users of emergency medical services. George Washington University Hospital is tracking a cohort of 57 individuals that had, as of Fall 2015, used their emergency room over 2,600 times in an 18-month period. To better understand these costs at the system level, the ICH is currently working with the District's Department of Health Care Finance (DHCF) to conduct a data match and examine actual claims data. However, one thing is clear: homelessness is costly – not only for the individuals experiencing it, but for taxpayers as well.

The Federal Response to Homelessness

As our understanding of homelessness has grown over time, the Federal response to homelessness has changed. When homelessness first became a significant issue in the United States, the spike in the number of people experiencing homelessness was viewed as a short-term crisis. The response was emergency shelter. Later, the strategy of a "continuum of care" was implemented, the theory being that people experiencing homelessness would progress through a set of interventions, from outreach to shelter, into programs to help address underlying problems (i.e., transitional housing), and ultimately be ready for permanent housing.

Years of research and practical experience have led to interventions that are focused on moving people immediately from homelessness into permanent housing ("Housing First"), with the goal of providing the right dosage of housing assistance and supportive services needed for each individual or family to help them maintain that housing.

In 2009, Congress passed the Homeless Emergency Assistance and Transition to Housing (HEARTH) Act, which was the first major update to Federal homeless assistance programs since the McKinney-Vento Act was passed in 1987 in response to the homelessness crisis in America. The HEARTH Act builds upon the knowledge gained over the past two decades and provides communities with new tools to encourage systems transformation. The HEARTH Act also mandated that the US Interagency Council on Homelessness draft a comprehensive national strategy to prevent and end homelessness. The plan, entitled Opening Doors, established specific goals around ending Veteran homelessness, chronic homelessness, and homelessness among families and youth. The DC ICH adopted much of the Federal framework to guide the development of this plan.

15 Wright, JD. "Poor People, Poor Health: The Health Status of the Homeless." In Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. Under the Safety Net: The Health and Social Welfare of the Homeless in the United States. New York: WW Norton & Co, 1990: 15-31.

2 Strategic Plan Overview

As described in Chapter 1, stagnating incomes have not keeping pace with the cost of housing for low-income households. In addition to the over 5,000 households that experience literal homelessness on any given night in the District, thousands more are living in doubled-up situations, and over 40,000 are severely cost burdened, paying more than half of their monthly income for housing. For these District residents, any number of catalyzing events – a healthcare crisis, domestic violence, and job loss – could lead to housing loss and land them at the shelter door.

This plan is not intended to be a comprehensive housing affordability strategy for the thousands of District residents that struggle every day to pay their rent. Rather, it is a targeted strategy to transform the homeless services system into an effective crisis response system and to end long-term homelessness in the District. It is clear, though, that the only way to create a truly healthy and vibrant community is by ensuring housing options are available that are affordable to every District resident at every income level.

Developing the Plan

Homeward DC is the result of a highly collaborative process led by the DC Interagency Council on Homelessness (ICH) between June 2014 and March 2015. Feedback was solicited from government representatives, nonprofit partners, advocates, persons experiencing homelessness, business partners, and the philanthropic community. The ICH engaged consultants from the Corporation for Supportive Housing (CSH), Abt Associates, and Community Solutions to provide support on different pieces of the plan, largely around data analysis, modeling, and costing.

The Plan relies heavily on data collected through the District's Homelessness Management Information System (HMIS), but is supplemented by data from other agencies. The Community Partnership for the Prevention of Homelessness (TCP) (the District's HMIS administrator) worked closely with the ICH and consultants to assist with the cleaning and analysis of data. The ICH Strategic Planning Committee provided input and feedback throughout the planning process, and all of the ICH committees assisted in reviewing portions of the Plan related to their focus areas. See Appendix 2: DC Interagency Council on Homelessness for more detail on the ICH structure.

All ICH meetings are open meetings, and additional meetings were held to solicit feedback from stakeholders that are not regular ICH participants. The consultants helped facilitate a series of meetings on "hot topics" such as year round access to shelter, strategies for improving Rapid Re-Housing programming, conditions in our low barrier shelters, and future uses of our transitional housing stock. The ICH held specific meetings to solicit feedback from clients of the homeless services system, and TCP organized focused meetings with providers. See Appendix 3: Strategic Planning Process - Public Meetings for an overview of the meetings held in conjunction with the planning process, and Appendix 4: Community Organizations Participating in Planning Process for a list of community organizations that participated in the planning process.

Vision and Guiding Principles

For years, communities have been developing plans to end homelessness. The District has developed two such plans in recent history. Today, there is more data on the households we serve and more research on best practices than ever before to help guide our efforts. However, part of the challenge of such plans relates to the idea of what it actually means to end homelessness, and public perception of whether this is truly an attainable goal. Accordingly, it's important to first clarify what is meant when we talk about ending homelessness.

The Vision

An end to homelessness does not mean that no one will ever experience a housing crisis again. Changing economic realities, the unpredictability of life, and unsafe or unwelcoming family environments may create situations where individuals, families, or youth could experience or be at-risk of homelessness.

The Federal government has defined an end to homelessness to mean that "every community will have a systematic response in place that ensures homelessness is prevented whenever possible, or is otherwise a rare, brief, and non-recurring experience."[16] In accordance with this definition, we have established a vision to end long-term, chronic homelessness, and to create a system that quickly stabilizes households that do experience housing loss and connects them back to permanent housing as quickly as possible.

While a plan to end homelessness does not guarantee an end to poverty in our community, having a safe, stable place to call home is an important first step in any household's journey to increase income, improve health, and increase overall well-being.

Measuring Our Progress

To assess our progress towards this vision over the next five years, we will use the following topline measures:

- **We will end homelessness among Veterans by the end of 2015 (as measured by our PIT count).**[17] Over the last few years, Veteran homelessness has been the only area in the Federal homeless assistance budget that has seen consistent increases. Accordingly, Veterans are the one subpopulation for which there is demonstrable progress, both here in the District and nationally. With the supplemental permanent housing resources dedicated for Veterans in the District's FY 2015 budget, the District should have the resources to get the job done. Ending Veteran homelessness will serve as an important proof point: when the resources are invested in the right interventions, homelessness is solvable.

The Vision

Together, we will end long-term homelessness in the District of Columbia. By 2020, homelessness in the District of Columbia will be a rare, brief, and non-recurring experience.

16 US Interagency Council on Homelessness, http://usich.gov/action/what-it-means-to-end-homelessness/

17 As discussed in Chapter 1, the Federal government requires all communities receiving Federal homeless assistance resources to conduct a count of sheltered and unsheltered individuals and families every other year in January. The District of Columbia conducts a count every year in order to have a more accurate trend line. As such, the measures are intended to be a statement of where we will be at the end of the calendar year, as measured by the PIT Count the following January (with the numbers typically released in the spring of the same year).

- **We will end chronic homelessness among individuals and families in the District of Columbia by the end of 2017 (as measured by our PIT count in January 2018).** As explained in Chapter 1, chronic homelessness has a specific definition. It refers to those individuals and families that have a disabled head of household and have been living on the streets or in shelters continuously for a year or more or have had multiple episodes of homelessness. The District is well-positioned to achieve this goal given current work to implement a system of coordinated entry and prioritize access to resources for our most vulnerable households. If the necessary resources can be identified, the District will be able to end homelessness for this highly vulnerable group of residents, all of whom are disabled, many of whom are elderly, and many of whom have been living on the streets for a decade or more.
- **By 2020, households experiencing a housing crisis will be rehoused within an average of 60 days or less (as measured by HMIS data in January 2020).** While the District will strive to prevent homelessness whenever possible, it would be unrealistic to suggest that no household will ever again experience a housing crisis. And, because anyone in shelter is defined as homeless, there may always be some amount of homelessness in the community. However, the District can dramatically change its response to homelessness by working to quickly stabilize individuals and families and move them back into permanent housing as quickly as possible. By reducing average length of stay in shelter to 60 days or less, we will reduce homelessness in the District (as measured by our PIT count) by at least 65 percent by 2020.

Guiding Principles

Achieving an end to long-term homelessness in the District of Columbia will require commitment to some key principles:

- **Homelessness is unacceptable, and it is expensive.** Homelessness did not always exist in America the way it does today. And here, in our nation's capital, it is particularly unacceptable. A response focused on shelter is both expensive and ineffective. We have learned much about what works, and it is time to invest in solutions.
- **There are no "homeless people,"** but rather people who have lost their homes and deserve to be treated with dignity and respect. We believe deeply in the strengths and assets of people who are experiencing homelessness, believe in the value of having their voices at the planning table, and remain committed to supporting each and every individual in fulfilling their potential.
- **Person-Centered Response.** We aim to provide person-centered, trauma-informed care that respects the dignity and ensures the safety of all individuals and families seeking assistance. Progressive engagement that is respectful of participant choice and attuned to participant safety and confidentiality needs will inform data collection efforts, level of services provided, and location/type of housing accessed.
- **Everyone is ready for housing.** We must be committed to developing programming that responds to the needs of our clients instead of expecting clients to adapt to the programs that exist. We must embrace the Housing First philosophy as a system.
- **Homelessness is fundamentally about a lack of housing** that is affordable to households at different income levels. We did not lose our affordable housing stock overnight, and we will not build our way out of the deficit overnight. While this plan is focused more on the resources and policy changes required within the homeless services system, significant and sustained investment in affordable housing throughout the District, particularly for households at 0 to 30 percent of Area Median Income (AMI), will be essential to increasing housing stability in our community.
- **Data-driven decision-making and strategic use of resources are essential** for transforming our homeless services system, including: 1) targeting assistance to ensure that the most intensive interventions are matched to those with the greatest needs; 2) a commitment to measuring our performance and using that information to guide our investment decisions; and 3) examining ways to identify, capture, and reinvest cost savings across the system.
- **Better coordination of mainstream anti-poverty programs** is critical to create a stronger safety net and to prevent individuals and families from losing their housing in the first place, especially at transition points between youth and adult systems of care.

- **There is strength in collaboration.** Homelessness is a not a challenge for the government alone to solve. The government has a significant role, but other partners must be at the table, too. We need providers to examine how their programming fits into the overall system and whether changes are needed. We need philanthropic funders to align their giving to help meet gaps in the system. We need developers who are willing to develop affordable housing, landlords who are willing to rent to households that have experienced homelessness, and employers who are willing to hire them. We need faith-based partners and other community groups to consider how they can provide mentoring and moral support to struggling neighbors. Ending homeless in our community will require all of us to work together.

Building Blocks for the Plan

While strategic plans have a reputation for being documents that sit on a shelf gathering dust, this plan is intended to be different. It is built on a solid foundation of data and informed by the expertise of people on all sides of the issue. It is indeed ambitious, but it is also implementable. The plan is an evolving roadmap – not a permanent blueprint – and we must treat it as such. The process of developing this plan showed us where we have the data needed to make sound policy decisions and investment choices, and where we have gaps in our knowledge base. As we capture new or additional information, we can (and must) refine our assumptions, which will help sharpen the path forward.

The process for developing the plan included five separate but interrelated activities:

1. A review of our existing system capacity;
2. Identification of the program models needed within the homeless services system to achieve goals related to ending homelessness;
3. An analysis of how different program models work together to form "pathways" through the system (from homelessness back to permanent housing), including generating assumptions about the relative percentage of households that travel each unique pathway and the average length of time at each stop along the pathway;
4. Modeling the changes to our inventory needed over the five-year plan period to help us achieve the goals of ending chronic homelessness and ensuring any new households that become homeless are quickly rehoused; and
5. Examining the annual per unit costs of both existing program models and the "ideal" program models to help ensure that we can align our planning and budgeting efforts.

Each of these building blocks is described in more detail below.

Existing System Capacity: Housing Inventory Count Review and Clean-Up

The Housing Inventory Count (HIC) is a point-in-time inventory of specific projects within a community's homeless services system that provides beds and units dedicated to serve persons who are homeless.[18] HUD requires communities receiving Federal homeless assistance dollars to capture this information every January in concert with the PIT. Per Federal guidance, projects are categorized into the following categories: Emergency Shelter, Transitional Housing, Safe Havens, and Permanent Housing. Within the Permanent Housing category, beds/units are further broken down into three types: Rapid Re-Housing, Permanent Supportive Housing, and Other Permanent Housing.[19]

18 According to HUD, beds and units in the HIC must be dedicated to serving homeless persons. US Department of Housing and Urban Development. "Notice CPD-14-014: 2015 HIC and PIT Data Collection for CoC and ESG Programs." October 2014.

19 Communities may track additional information as long as they can aggregate information for HUD reporting.

The information is intended to assist planning efforts, so HUD requires communities to include beds/units regardless of funding source, but only those slots/units *dedicated* to households experiencing homelessness. For the purposes of the HIC, a project with dedicated beds/units is one where: 1) the primary intent of the project is to serve homeless persons, and 2) the project verifies homeless status as part of its eligibility determination. In other words, beds or units that may be available to a homeless individual or family but are not explicitly set-aside for the population are not included.

Because the HIC is intended to capture units regardless of funding source, providers receiving local or private resources sometimes use different definitions and report information that is inconsistent with the Federal definitions and categories. In addition, providers sometimes report beds/units that were used during the reporting year to house an individual or family experiencing homelessness but that are not dedicated, which skews our understanding of the actual turnover opportunities available each year to house new clients entering the homeless services system. Therefore, to ensure we were starting with an accurate count of what we actually have in our inventory, our consultants worked with TCP to scrub the 2014 HIC. Instead of having providers classify their own programs, the consultants conducted telephone surveys to understand the design features, eligible participants, program policies, etc. of a particular program and then used this information to determine where reclassifications were needed. This analysis was used to define the system's baseline capacity. A summary of our inventory is included in Appendix 5: District of Columbia 2014 Housing Inventory Count (HIC).

Program Models

The second major building block of the plan is our program models matrix. The matrix outlines the program models needed within three broad categories of the homeless services system to achieve goals related to the preventing and ending homelessness.

- "Front Porch Services" are those provided to residents before they reach the front door of the homeless services system (the front door being the shelter system). This may include services to both households that are *literally homeless* as well as households at *imminent risk* of losing their housing.
- "Interim Housing" refers to housing that is time limited in nature and is designed to provide a safe, stable environment for households while they work on a permanent housing solution. To help with stabilization, some interim housing may provide specialized services for individuals and families seeking support in a communal environment.
- "Permanent Housing" is housing in which the client is the leaseholder and can remain in the unit as long as they choose. The rental assistance and services provided to the client may be short- to medium-term (such as in Rapid Re-Housing) or it can be of a long-term nature (Permanent Supportive Housing and Targeted Affordable Housing).

Per Federal reporting guidance, individuals and families in interim housing programs are defined as homeless and are therefore included in the community's homeless count that is reported to the Federal government every year. Once placed in permanent housing, the household is considered housed even if they are still receiving financial assistance and services.

Table 7: Program Model Categories

"Front Porch" Services	Short-Term Placement/ Interim Housing	Permanent Housing
Daytime Service Center	**Outreach Beds**	**Rapid Re-Housing (RRH)**
Central point of access for households seeking homeless assistance services.	Very small, specialized shelter for hard-to-reach individuals, often with severe and persistent mental illness.	Short- to medium- term supportive services and housing subsidy.

"Front Porch" Services	Short-Term Placement/ Interim Housing	Permanent Housing
Street Outreach	**Emergency Shelter**	**Targeted Affordable Housing (TAH)**
Engagement services for hard-to-reach, chronically homeless individuals sleeping on the street.	Short-term emergency housing for the majority of households entering the homeless services system.	No or light touch supportive services with long-term housing subsidy or affordable unit. Not available directly from shelter. TAH may be used as a step-down strategy for PSH clients or a step-up strategy for RRH clients (as recommended by assessment).
Prevention/Diversion	**Transitional Housing**	**Permanent Supportive Housing (PSH)**
Assistance at front door of shelter system to prevent housing loss and stabilize households outside of shelter.	Therapeutic, communal environment for special populations (e.g., victims of domestic violence and individuals with substance abuse issues)	Intensive, wrap-around supportive services and long-term housing subsidy or affordable unit.

Through an iterative process, the Strategic Planning Committee first identified the universe of program types, and then fleshed out each program type to identify essential program elements, target populations, assistance timeframes, and outcome measures. For more detail on each program model, see Appendix 6: Program Models Matrix.

The program models matrix is intended to be a living document to guide our planning and implementation efforts. It helps us align our funding towards common goals by ensuring funders understand what to fund and providers understand what they need to deliver. It helps ensure we are measuring outcomes of similar programming in a consistent way. It also serves as the basis for the modeling work, which will allow us to determine how much investment in each program type is needed in future years.

Because systems change does not happen overnight, and because we cannot fund or implement all of the needed components in full at once, it is important to view implementation of the new program models as a work in progress. Some of the program models, like Rapid Re-Housing and Permanent Supportive Housing, are already in place in the community. We may not have enough of that program type, and/or not all programs within the community may operate in accordance with the ideal version of the program outlined in the matrix, so the work ahead will involve improving programming and increasing our inventory. Other program models are new and represent missing pieces in our system (e.g., Targeted Affordable Housing). Still other program models, like a Daytime Service Center and Outreach Beds, represent important transitional components that will help us meet needs before other models exist at the capacity needed.

It is important to note that the essential program elements identified in the matrix are intended to reflect ideal program components that should be included in the program type, especially for any new program that a provider is designing or a funder is supporting. Some of the elements identified are cost neutral (e.g., use of a common assessment tool and practices for how program vacancies are filled), but it is important to acknowledge that other elements are not. In some cases – especially those involving facility size/configuration – existing programs may not be able to incorporate certain program elements at all (e.g., a program that provides daytime services may not have the space necessary to offer clients lockers for storage or shower and laundry facilities to help meet hygiene needs). In other cases, providers will not be able to adapt programming unless contracts include the necessary resources (e.g., moving from 12- to 24-hour access in low barrier shelters and reducing caseload sizes). *Funders and providers will have to work closely together to examine where changes can be implemented immediately and where time, resources, capacity building, and/or statutory changes will be required.*

Permanent Housing Pathways

The next piece of our work was to consider how the program models fit together to form a pathway through the system for an individual or family experiencing homelessness. This work included a significant amount of data analysis and deliberation by stakeholders. We examined the needs and characteristics of individuals and families in our system, as well as how households currently move through the system. Based on analysis of our data, movement through the system is currently not as planned or purposeful as we would desire, and our outcomes reflect this lack of focus and intentionality.

In order for our system to operate more efficiently and more effectively, we need to minimize the number of moves a household has to make and minimize the length of time at any step prior to placement in permanent housing. As such, the Strategic Planning Committee worked with consultants to 1) identify specific pathways for both individuals and families; 2) estimate the percentage of households that travel along each pathway; and 3) identify an average length of stay at each step. The pathway assumptions and the sources of data used to generate those assumptions are provided in Appendix 7: Assumptions for Pathways. The figure below, for example, shows a common pathway for families entering the system.

Figure 3: Sample Housing Pathway

System Transformation: Inventory Modeling

We calculated the number and types of units required in an "optimal" system through assumptions based on the relative size of groups using each pathway to exit homelessness, as well as average length of stay at each step. We were also able to envision how we might reach an "optimal" system over a five-year time period. This information forms the foundation of *Chapter 3: System Transformation.* It is important to remember that the models are a planning tool. Knowing that we will not be able to fund or fully operationalize everything at once, we will have to make choices about what to prioritize in the early years of implementation and what to delay for later years.

As the plan is implemented, the models should be updated annually, because the extent of what we are able to accomplish in one part of the system will impact capacity needs and performance in other parts of the system. For example, if we are unable to fund all of the permanent housing interventions needed in a given year, we will not be able to reduce our shelter investments

on the scale projected. Likewise, the models will be impacted by our progress in reducing the average length of stay in shelter, as well as any increases or decreases in the number of individuals and families that enter the system each year. It's not imperative that we implement changes in the exact amount and on the specific timeline suggested by a given model, but *it is imperative* that we continue to measure our progress, update the models annually, and use the information to inform our planning and budgeting discussions.

Cost Analysis

Finally, we examined unit costs for different program models. We deconstructed program budgets to identify the average per unit cost for existing program models, and we examined existing programs in the community that closely resemble the future models to construct average unit costs for those new models. These costs are summarized in Appendix 8: Program Model Unit Costs.

Currently, budgets for programming within the same program type are highly variable. The range and intensity of support provided varies from one program to the next. Additionally, caseloads and case management rates, as well as facility costs, vary. While there will always be some variation between programs, the per unit costs will help us align our planning and budgeting by better understanding how many units or slots a particular funding resource can provide. In addition, they will help funders standardize contracts across providers to ensure that providers are resourced to do the job we are asking them to do, and at the same time, ensure we are being strategic with how we use our limited resources. In addition, this alignment will allow us to more easily interpret variations in performance when we see it.

It is important to note that although it is possible to calculate an overall cost for the "optimal" system, we felt it would be misleading to put a single number in the plan for a few important reasons. First, the model is based on the landscape in our community as of 2015, but needs may very well change. As discussed in Chapter 1 of this plan, homelessness is largely driven by environmental factors outside of the homeless services system. If the number of people experiencing homelessness changes, or if the characteristics of households we see in the system change, the type or volume of programming needed may change, which would impact costs.

Second, not all of the resources needed for the optimal system need to be new resources. As a community, we have to be committed to looking at inefficiencies that currently exist in our system to capture (and reinvest) cost savings. We also have to be committed to measuring performance and reallocating resources from programs that do not consistently deliver on outcomes to those that do. Further, we know that housing people who have experienced long-term homelessness would save resources in other parts of the District's budget. These resources could potentially be captured and reinvested in additional housing for future years during Plan implementation.

Lastly, changes in the Federal landscape may impact our local resource needs and investment decisions. For example, the Affordable Care Act created significant opportunities to leverage Medicaid to pay for some of the services needed for people experiencing homelessness. While we have policy and capacity building work to do before we can take full advantage of this opportunity, in time, we will be able to leverage those Medicaid resources in new ways. Similarly, as Federal priorities change, different funding opportunities may emerge. For example, we have seen a surge in funding in recent years for Veterans experiencing homelessness. For all of these reasons, it is helpful to have a general strategy mapped out over the five-year plan period, but wiser to analyze the size of the gaps, review possible funding sources, and make specific budget recommendations on a shorter horizon. Recommendations from the Strategic Planning Committee on the highest priority items for FY 2016 are included in Appendix 10: Highest Priority Year One Budget Items.

3 System Transformation

As explained in Chapter 2, ending homelessness does not mean that no household will ever experience a crisis that leads to housing loss; instead that we will have a system that: 1) prevents housing loss whenever possible, and 2) provides households experiencing homelessness with supports to access permanent housing as quickly as possible.

Accordingly, the challenge ahead of us is to "right size" our system. For both families and single adults, we are inadvertently growing our shelter inventory to meet housing needs in the community, which means homelessness is growing. Instead, we need to invest more in the portion of our continuum that funds permanent housing options. The challenge is that we cannot simultaneously use the same dollar to fund shelter and housing, and we must meet the shelter needs in our community while we are working to bring more housing online. As people experiencing homelessness are more quickly and successfully reconnected to permanent housing solutions, we can then start to contract our shelter inventory naturally. This chapter provides a roadmap for how to accomplish that objective.

The Importance of Length of Stay and Unit Turnover in Systems Change

Homeless assistance programs are all designed differently. On one end of the continuum is emergency shelter programs, which are typically high volume, high turnover programs. On the other end of the continuum is the most intensive type of assistance, permanent supportive housing (PSH), which typically has very low turnover.

Emergency Shelter. In the District, because of rising housing costs and a shrinking affordable housing base, it has become more and more difficult for people to quickly exit shelter. As the average length of stay in shelter increases, the system requires more shelter units/beds to simply serve the same number of households.

For example, the current average length of stay in shelter for families is six months. With an inventory of 100 units, we could serve 200 households each year. However, if we reduced average length of stay in shelter down to three months, we could serve 400 households each year with those same 100 units. In other words, we would double the number of families served with our shelter inventory without spending any additional resources on shelter. This is extremely important from a cost perspective, because those resources that would otherwise be used for additional shelter units can be redirected to pay for the housing assistance needed to help families exit the system (our primary goal regardless of how long the family is in shelter or how much expense is incurred in shelter).

Permanent Supportive Housing. On the other side of the continuum are low-turnover programs, like PSH. In the District, we have a turnover rate of 12 percent in our PSH program for single adults – meaning just over one-eighth of the inventory turns over each year, becoming available for a new client. Because our inventory is quite large, however, we will eventually reach a point of equilibrium where the units turning over each year are adequate to meet the needs of new individuals entering the system. For PSH programs serving families, however, the annual turnover rate is less than 1 percent.

This means the District needs to fund additional units or vouchers every year to keep pace with the needs of new families entering the system and requiring PSH to exit homelessness – while continuing to fund the PSH units funded in previous years. This situation is not financially sustainable. As we implement this plan, we will need to examine methods for increasing positive turnover so that more of the existing inventory is available to meet the needs of new families each year.

System for Households with Children

In 2014, 1,466 unique families received services in the homeless services system. This includes families that were in emergency shelter or transitional housing at the beginning of the year, as well as new households that entered shelter during the year. For the purposes of system modeling, this figure represents our "annual demand" for the family system, which is an estimate of the number of family households within the homeless services system that will require a combination of shelter and housing assistance to end their homeless episode and return to permanent housing.[20]

One important challenge with our homeless services system today results from an insufficient supply of emergency shelter as well as a lack of housing resources to support rapid transitions out of shelter. As of the writing of this plan, the District has only 369 units of family emergency shelter in our permanent inventory.[21] Under the HSRA, the District of Columbia has a legal obligation to provide shelter to any District resident who needs it when the temperature falls below freezing. Once our permanent shelter capacity is full, the District must then start placing families in overflow shelter, which in recent years has taken the form of motel rooms.[22] Therefore, in 2014, the District paid for over 500 additional units of emergency shelter for families. For a variety of reasons (e.g., building maintenance costs, supportive services costs, security costs, and no client contributions), emergency shelter for families is the single most expensive intervention within the homeless services system. See Appendix 8: Program Model Unit Costs for more information on the costs associated with various interventions.

Emergency shelter for families is an entitlement benefit that is not funded as such, and failing to adequately plan and budget for shelter needs has caused significant inefficiencies within our system. One such inefficiency is that resources get diverted away from the permanent housing options needed to help households quickly exit shelter. When we have people flowing into the system but not flowing out, not only does our count of homeless families rise, but we also inadvertently grow our spending on shelter, which continues to limit our ability to invest in permanent housing solutions.

Pathways, Length of Stay, and Inventory Counts

Per our vision statement, when we are able to get to a state in which no household is without a home for more than 60 days, we will have dramatically reduced the number of shelter beds needed in our system to meet annual needs, and consequently, we will significantly reduce the number of households experiencing homelessness at any point of time in the District.

To make this happen, we will need to: 1) minimize the number of moves a household has to make on their pathway back to permanent housing, and 2) minimize the length of stay at any step prior to placement into permanent housing. As described in Chapter 2, using a variety of data sources, the ICH Strategic Planning Committee defined these pathways and estimated the relative percentage of families expected to use each pathway to resolve their housing crisis. This information is summarized in Table 8 below. Also, see Appendix 7: Assumptions for Pathways for additional information on these assumptions.[23]

20 This figure was used to estimate demand over the five-year period for the modeling exercise, though as reiterated through the plan, we will need to update the model each year as new data becomes available.

21 This includes 121 units through community-based shelter programs (under the designation of temporary shelter) and 248 units at DC General. There are an additional 40 units at DC General but they were taken offline following the FY 2014 hypothermia season because they did not meet the private room standards.

22 While congregate settings are permissible for individuals, private rooms that meet a specific set of standards are required for families.

23 These estimates are a starting point and will be updated/refined annually to reflect our growing understanding of the needs of the households in our system. Further, these estimates are intended to guide planning and budgeting decisions, but actual placement decisions are made on a case-by-case basis based on assessment results and consultations with clients.

Table 8: Housing Pathways for Families

Pathways for Family Households Presenting Each Month	Broad Estimate (each mo)	Detail Estimates (each mo)
Prevention/Diversion	5%	5%
Emergency Shelter (ES) Only	3%	3%
Transitional Housing (direct from Virginia Williams or via ES)	20%	10%
Transitional Housing with Rapid Re-Housing at Exit		10%
Rapid Re-Housing (one-time assistance)	63%	3%
Rapid Re-Housing (medium-term assistance)		40%
Rapid Re-Housing (medium-term assistance) with Targeted Affordable Housing at Exit		10%
Rapid Re-Housing Intensive		10%
Permanent Supportive Housing (via ES)	9%	9%

It is important to note that the District already has a fairly narrow front door on the family side of its homeless services system. According to Virginia Williams Family Resource Center (VWFRC) data, DHS diverted nearly 40 percent of households seeking shelter between November 2014 and February 2015. This suggests that the families that do end up in shelter are those with few/no other options. As a result, the Strategic Planning Committee made a conservative estimate about the percentage of *additional* households we would be able to successfully divert from the shelter system (5 percent). Likewise, the Strategic Planning Committee made a conservative estimate regarding the percentage of households expected to be able to resolve their housing crisis on their own after a short shelter stay (3 percent).

Another key variable is the estimated average length of assistance in each program along a particular pathway. As described in the text box at the beginning of this chapter, length of stay is one of the biggest drivers impacting our shelter capacity needs. Currently, our average length of stay for families in emergency shelter is six months. The model assumes that we will decrease length of stay gradually over time – to five months by the end of 2016, four months by the end of 2017, three months by the end of 2018, and two months by the end of 2019. See Appendix 9: Length of Stay Assumptions by Year, 2016 - 2020 for more detail on length of stay assumptions by year. A 65 percent reduction in average length of stay over a five year period is an ambitious goal, but one that we think is achievable.

After finalizing the assumptions, we were then able to model the changes to our homeless services system inventory over the five-year period. As Table 9 below illustrates, if we are able to successfully hit our targets around reducing length of stay in shelter, we should be able to naturally contract our shelter system over the plan period. In a right-sized system, we would have between 200 and 250 shelter units.[24]

24 While the chart specifies 215 units, it is important to note that there are many variables at play, and we do not wish to provide a sense of false precision. The model is our best projection based on currently available data, but systems change is not an exact science. If we are unable to decrease length of stay to two months, and/or if annual demand increases over the plan period, our shelter capacity needs will be greater than the projected 215 units.

Table 9: System Conversion – Annual Projections for Family System Inventory

Program Type	2014 Inventory/ Actual (Baseline)	FY 2016 Inventory/ Projected Need	FY 2017 Inventory/ Projected Need	FY 2018 Inventory/ Projected Need	FY 2019 Inventory/ Projected Need	FY 2020 Inventory/ Projected Need	Difference (2014 to 2020)
Prevention/Diversion	160	184	184	184	184	184	24
Emergency Shelter*	915	677	565	454	343	215	(700)
Transitional Housing	420	294	294	220	220	220	(200)
Rapid Re-Housing	682	847	664	664	664	664	(18)
Rapid Re-Housing Intensive	0	220	220	220	220	220	220
Permanent Supportive Housing	765	897	1,029	1,161	1,293	1,425	660
Targeted Affordable Housing	0	147	287	419	545	665	665

In addition to improving the efficiency of our operations at the front door, one of the biggest drivers for reducing length of stay is ensuring we have invested adequate resources in permanent housing interventions each year (i.e., RRH, PSH, TAH). Additionally, each type of resource should be available throughout the year so that we can immediately match a household entering the system to the right permanent housing intervention.

If we are able to meet the annual demand for assistance and reduce the average length of stay in shelter to two months, we will have reduced family homelessness (as measured by the PIT count) from over 1,200 families in 2014 to 435 in 2020 – a 65 percent reduction in five years (see Figure 4). Further, if we consider only those households in emergency shelter,[25] we would be down to 215 households at a single point in time in 2020 – a 76 percent decrease from 2014.

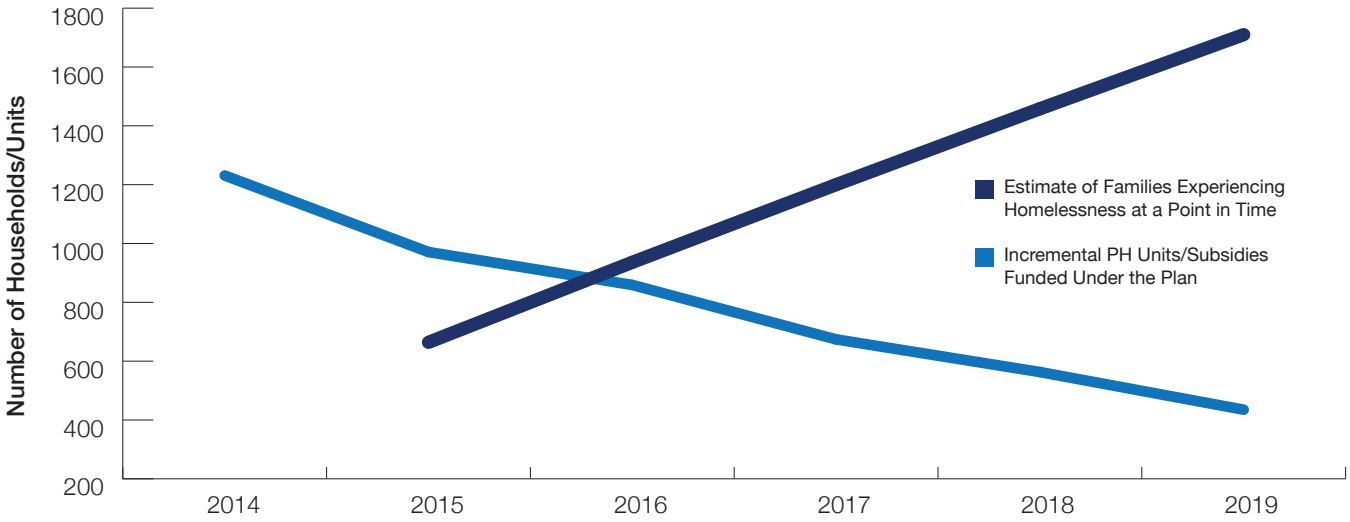
*Emergency shelter includes both permanent and overflow capacity. In 2014, we had 409 units of permanent shelter capacity and 506 units of overflow capacity. The 409 permanent units included 40 units at DC General that were taken offline following the FY 2014 hypothermia season because they did not meet the private room standard.

Interpreting Inventory Projections

As explained throughout this document, we capture and report information on our homeless services system inventory to HUD in January each year. However, it's important to view the projections in Table 9 and Table 11 as a planning tool to help guide our resource investments. That is, ideally the FY 2016 budget will include resources to fund as much of the gap in permanent housing resources (between the baseline and the FY 2016 projected inventory) as possible. If we fully fund the permanent housing interventions at the scale suggested, and if we are able to reduce average length of stay in shelter by the amount indicated for FY 2016 (from six to five months), and if demand for shelter stays steady, we would expect to be able to reduce our shelter and transitional housing capacity by the amounts indicated by the end of the year. Of course, because the HIC is updated in January, we wouldn't expect to see the changes from the FY 2016 investments fully realized until the 2017 HIC. As such, there will always be a one-year time lag with regard to measuring how our investments translate into inventory changes.

25 Per Federal guidelines and definitions, households in transitional housing are defined as homeless because tenure in the unit is temporary and the household must move at the end of the program. These moves can be destabilizing, and often, people exit back into homelessness. Still, transitional housing can be an important part of a community's system of care if targeted effectively to populations that need or want a communal environment while they stabilize. If we are able to improve the performance of our transitional housing programs to ensure a more seamless transition into permanent housing, it would be more feasible to consider clients in transitional housing programs to meet the vision statement of having a safe, stable home.

Figure 4: Reductions in Family Homelessness Under the Strategic Plan



Meeting Annual Demand without Unit Turnover

As illustrated in Table 9 above, one of the biggest challenges to meeting our annual demand within the family system is the investment of new PSH and TAH housing resources every year. A majority of households entering the homeless services system are assumed to be able to obtain and maintain housing with short- to medium-term assistance (i.e., RRH). However, a certain percentage is assumed to need ongoing assistance to maintain housing. Currently, there is virtually no turnover on these long-term units/subsidies, meaning we will need a new allocation every year to meet annual demand.[26] As discussed in Chapter 5, a key strategy in the coming years will be a targeted effort to help families increase household income, which would facilitate more turnover in these permanent housing slots. The extent to which we could reasonably expect to increase turnover in a high cost housing market like the District is an unknown variable, but it is important to note that additional investment in permanent housing units/subsidies will be required every year (up to 2020 and beyond) if we do not.

System for Individuals

The same modeling process was used to map out the transformation for the portion of the system that serves single adults. The same general concepts apply, but there are some additional complexities due to the large number of chronically homeless individuals currently in the system.

As explained in Chapter 1, a chronically homeless individual is someone with a disabling condition that has a chronic history of homelessness (specifically, the individual has been continuously homeless for a year or longer, or has had four separate episodes of homelessness within a three-year period). The majority of our unsheltered population meets this definition.[27]

26 According to HMIS data, turnover in family PSH units in 2014 was less than one percent.

27 As with the broader count of persons experiencing sheltered and unsheltered homelessness, we know that the PIT provides a snapshot of those individuals experiencing chronic homelessness but does not capture the total number of individuals experiencing chronic homelessness in our community during the course of the year. On the night of the PIT, for example, we may miss individuals who are in institutions (hospitals or jail) or in more hidden locations (abandoned buildings or cars). We also know that some people will "become" chronically homeless during the course of the year as their length of time homeless or the number of episodes of homelessness that they have experienced pass the thresholds established by the Federal definition. Because chronic homelessness is not a universal data element captured in HMIS, most communities in the country do not have annualized figures related to chronic homelessness. As a participant of the Zero 2016 initiative, the District is currently working with partners at the Federal level to generate a more specific count of individuals and families experiencing chronic homelessness (referred to as our "takedown target") using our HMIS data so we may know exactly how many households we must place each month to achieve our goal around ending chronic homelessness. For the purposes of modeling for this plan, we include assumptions related to the percentage of new clients entering the system each year that will need the most intensive interventions (PSH and TAH) – which serves as a proxy for individuals otherwise experiencing or who are at risk of chronic homelessness. We will be able to include the more refined estimates of chronic homelessness during the first update to the plan, though we will begin using the data to guide our implementation work as soon as they become available.

According to our HMIS data, the District's chronically homeless population looks very similar to the chronically homeless population in cities across America. People who experience chronic homelessness are generally older males and have significant medical and behavioral health needs. During our 2014 PIT count, 1,609 individuals were identified who met the chronic homeless definition. This group typically needs the most intensive – and costly – interventions to obtain and remain in housing. Their needs have remained unmet for years because the interventions required to support their exit from homelessness have not been funded at scale, but also because some PSH continues to have significant barriers to entry (i.e., eligibility requirements that screen out the most vulnerable).

We also have a new group of individuals who enter the homeless services system each year in need of assistance. We refer to this inflow as our "annual demand." Because the needs of people experiencing chronic homelessness are more severe and require a more intensive intervention than the majority of individuals that enter the system on an annual basis, it was necessary to consider these groups separately for the purpose of the modeling. Failing to do so would lead us to overstate the number of more intensive interventions we need each year to meet the needs of individuals in the system. Consequently, the model separates out the investments required to meet the needs of our long-term homeless population (referred to as "surge" funding because it is intended to help us make up for past underinvestment), as well as the investment needed to address anticipated inflow each year (which will help prevent newly homeless individuals from experiencing long-term homelessness).

Pathways, Length of Stay, and Inventory Counts

Similar to the work done for families, the Strategic Planning Committee defined the pathways and estimated the relative percentage of individuals expecting to use each pathway to resolve their homelessness. Table 10 below shows these percentages for both for individuals newly entering the system as well as our long-term population.[28]

28 These estimates are a starting point and will be updated/refined annually to reflect our growing understanding of the needs of the households in our system. Further, these estimates are intended to guide planning and budgeting decisions, but actual placements decisions are made on a case-by-case basis based on assessment results and consultations with clients.

Table 10: Housing Pathways for Single Adults

Pathways for Single Adults Presenting Each Month (Annual Demand)	Broad Estimate (each mo)	Detail Estimates (each mo)
Prevention/Diversion	10%	10%
Emergency Shelter (ES) Only	30%	30%
Transitional Housing (TH) (direct from Coordinated Entry or via ES)	10%	8%
Transitional Housing (via ES) w/ Targeted Affordable Housing at Exit		2%
Rapid Re-Housing (one-time assistance)	43%	8%
Rapid Re-Housing (medium-term assistance)		33%
Rapid Re-Housing (medium-term assistance) with Targeted Affordable Housing at exit		2%
Permanent Supportive Housing (from street or using outreach beds)	7%	4%
Permanent Supportive Housing (via ES)		3%
Pathways for Long-Term (Chronic) Homeless		
Rapid Re-Housing	10%	10%
Permanent Supportive Housing (from street or outreach beds)	60%	20%
Permanent Supportive Housing (via ES)		15%
Permanent Supportive Housing (via TH)		25%
Targeted Affordable Housing	30%	30%

In contrast to the family system, we are currently doing very little work to prevent or divert individuals from shelter. Because congregate settings can be used to provide shelter (versus a private room), the District has more flexibility in terms of how to meet the shelter needs of individuals (e.g., through churches and recreation centers). Therefore, while diversion from shelter has not been as critical from a cost containment perspective, it is important to think about how we can do a better job of helping individuals avoid loss of housing. Given that we are not currently doing any targeted prevention for individuals at the front door of the system, the Strategic Planning Committee was more liberal with their assumption regarding the percentage of single adults that we could successfully serve with prevention assistance (10 percent). Likewise, because we are also not currently doing any work to divert individuals, we have individuals entering the system who may have other options (e.g., staying with a relative or friend). Consequently, we actually see in our data that a significant percentage of single adults resolve their episode on their own and exit shelter. The Strategic Planning Committee used these data to inform our assumption about the number of individuals requiring emergency shelter assistance only (30 percent). The remaining assumptions about pathways are based on a combination of our data and practical experience. See Appendix 7: Assumptions for Pathways for more detail on the sources for these assumptions.

The next step, again, was to estimate the average length of time needed at each step in a given pathway to help an individual resolve his or her homelessness. Just as length of stay in shelter is the biggest driver of our shelter capacity needs in the family system, the same is true for individuals. Currently, average length of stay for individuals is just over five months.[29] Our long-term homeless population

29 Shelter stays of individuals are broken up with multiple entries and exits. HMIS data over a two-year period (January 2012 through December 2014) shows that individuals average 7.44 stays over 151 days.

consumes the greatest amount of shelter resources on the individuals side, so the most important step we can take to begin reducing length of stay in our single adult system is to house our long-term homeless population.

While the shelter costs for an individual are not as high as they are for a family, failing to provide adequate permanent housing options does have other impacts in our community. In addition to the fact that allowing people to sleep on the street is inhumane, we know that this group has significant healthcare needs and are high utilizers of emergency services (e.g., large numbers of emergency room visits and frequent ambulance use). Providing housing to people who have experienced long-term homelessness would save resources in other parts of the District's budget, which could potentially be captured and reinvested in additional housing for future years of the plan. Table 11 below shows the year-by-year change in our inventory to get to a right-sized system, again assuming that we will be able to gradually reduce average length of stay in shelter to 60 days by the end of the plan period.[30] See Appendix 9: Length of Stay Assumptions by Year, 2016 - 2020 for length of stay assumptions by year.

Table 11: System Conversion – Annual Projections for Single Adult System Inventory

Program Type	2014 Actual Inventory/ (Baseline)	FY 2016 Inventory/ Projected Need	FY 2017 Inventory/ Projected Need	FY 2018 Inventory/ Projected Need	FY 2019 Inventory/ Projected Need	FY 2020 Inventory/ Projected Need	Difference (2014 to 2020)
Prevention/Diversion	0	292	292	292	292	292	292
Emergency Shelter	2,186	2,186	2,186	1,562	1,197	978	(1,208)
Emergency Shelter - Seasonal	840	526	9	0	0	0	(840)
Outreach Beds	0	0	38	44	44	44	44
Transitional Housing	893	875	656	613	613	438	(455)
Rapid Re-Housing	65	2,571	2,600	2,487	2,487	2,487	2,422
Permanent Supportive Housing	3,174	3,690	4,362	4,277	4,202	4,135	961
Targeted Affordable Housing	0	350	1,021	1,319	1,604	1,873	1,873

During the planning process, we examined three different scenarios – one that looked at ending long-term homelessness by the Federal target of 2016, another by 2017, and a third by 2020. After looking at these scenarios, the Strategic Planning Committee felt that the 2017 model balanced the urgency needed to house this group of individuals combined with the reality of the time needed to identify the resources, administer the resources, and ensure providers have the capacity to absorb and serve this volume of clients. This is why the projections above include steep increases in the most intensive housing interventions (PSH and TAH) in FY 2016 and FY 2017. Some PSH units in the Housing Production Trust Fund pipeline are expected to come online in 2017, and those units will be an important resource to help meet the inventory needs for the chronically homeless population. Ultimately, achieving our goal of ending chronic homelessness will require a significant infusion of tenant-based subsidies during the first two years of plan implementation.

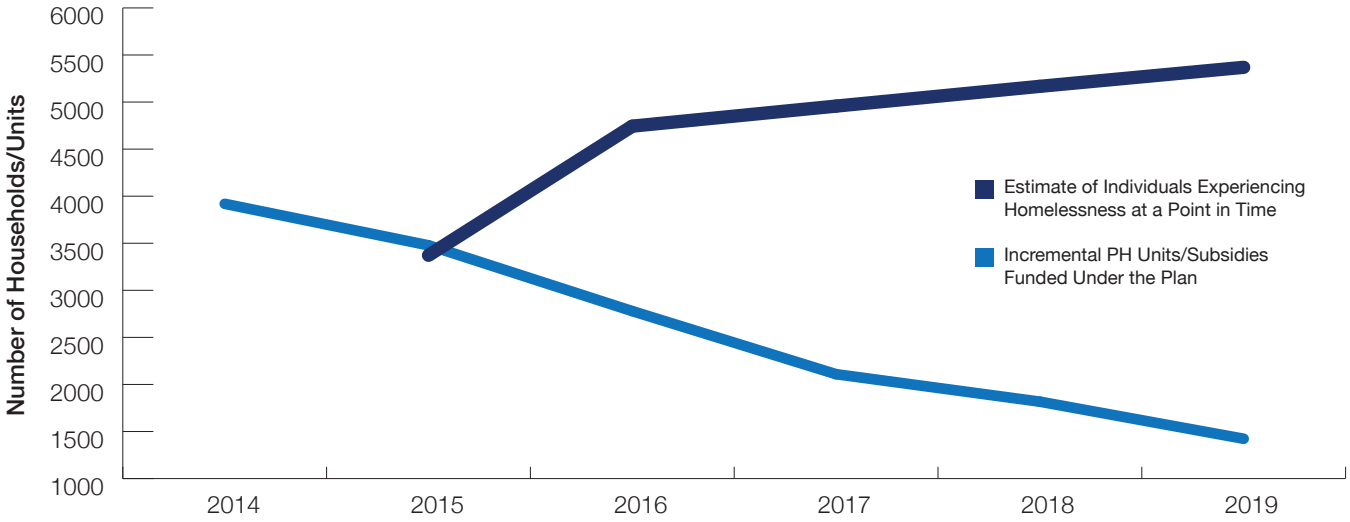
30 The system conversion table combines resources needed for the long-term population with resources for individuals who are expected to enter the system each year. Appendix 9: Length of Stay Assumptions by Year, 2016 - 2020 provides a more detailed breakout of the resources needed for each group, but in practice, there is no distinction in how we would use resources to serve these two groups. We will continue to use our Coordinated Assessment and Housing Placement system protocol to assess and place clients based on unique needs, not length of time homeless.

Annual Demand and Unit Turnover

The impact of unit turnover is illustrated well within our system for individuals. As illustrated in Figure 5 below, a significant investment in PSH and TAH is required during the first two years of the plan to meet the needs of our chronically homeless population. Following this surge in funding, however, our PSH inventory will be at a scale that will allow us to meet the needs of new individuals entering the system and needing PSH based purely on turnover. In 2014, our PSH turnover rate for individuals was 12 percent. As shown in Table 9, according to projections, our PSH inventory needs will peak in FY 2017 and then decrease slightly afterwards. However, it is important to note that the modeling assumes that units remain dedicated for use by the homeless services system upon turnover and that they are targeted correctly via the CAHP system. As noted in Chapter 5, we have work to do to ensure both of these conditions are satisfied. If not, we will need additional investments in the out years to meet annual demand.

In contrast, TAH is a new program model, so we are starting 2015 with an inventory of zero. Even if we realize a similar rate of turnover, it will take time before the stock is big enough that we are generating adequate turnover to meet annual demand. This is why PSH investment levels off over the plan period but TAH investment continues to grow. It's important to point out, of course, that the only type of turnover that helps is positive turnover (i.e., individuals moving on because they no longer need the assistance). In contrast, negative turnover – or recidivism – increases inflow back into the shelter system and increases our annual demand.[31]

Figure 5: Reductions in Homelessness Among Individuals Under the Strategic Plan



31 According to our HMIS data, about 4 percent of the turnover is considered negative turnover, but this recidivism is accounted for in the estimate of individuals entering into shelter each year

System for Unaccompanied Youth

In June 2014, the DC Council passed the *End Youth Homelessness Amendment Act*,[32] which charged the ICH with developing a plan to end youth homelessness. While the needs and circumstances of vulnerable youth are well understood in a general sense, the District – like most communities around the country – does not have robust data on unaccompanied homeless youth. Subsequently, it is difficult to identify the true size of the population, the specific characteristics and needs of the population, and ultimately, the gaps in our service system. The tools we use for data collection in the adult system (particularly the PIT count) are not as effective for unaccompanied youth, in part because youth may be more likely to double-up than sleep on the streets or enter shelter. With regard to administrative data systems (e.g., HMIS), youth are sometimes not as forthcoming with information for fear of getting themselves or their parents into trouble, and there can also be challenges related to release of information for minors, particularly in cases where a parent is unable or unwilling to provide consent.

The challenge of creating a plan without better data is illustrated by an experience that played out during the 2014 winter planning process. Concerned about what would happen if unaccompanied minors presented and the District did not have adequate shelter capacity, advocates asked for additional shelter resources for youth. While we know that there are a substantial number of vulnerable youth in our community and that the needs are great, our HMIS data suggested that we have vacancies in our youth programs every week. At the time, it was unclear whether this was a data quality issue (i.e., the beds are full but the data was not being entered or updated in HMIS), a sign that our system is too difficult for youth to navigate and that youth are unable to access available resources, or if the greatest need was not for emergency shelter but some other type of assistance.

To ensure we are able to develop a plan that can actually be used to guide policy and investment decisions toward tangible results, the ICH borrowed a strategy from the adult services system and began work on developing a system of coordinated assessment and referral for homeless youth. The focus of the first 100 days of the initiative was to begin use of a common assessment tool and referral protocol to ensure that unaccompanied youth experiencing homelessness and presenting anywhere in the community could be quickly matched with available shelter resources. Knowing that the need for assistance may at times be greater than available resources, the team also established a prioritization protocol that allows the District to ensure that youth who have no safe place to stay are the highest priority for shelter resources.

The team focused on shelter placements as the first step, knowing that it is difficult to engage youth and assist them with the range of services that may be needed if they do not have a safe place to sleep. Because not all youth seek services proactively, the McKinney-Vento liaisons in our high schools were trained on this assessment tool so they can help us identify vulnerable youth. As we move forward, the next step is to examine how we connect youth entering the homeless services system to the broader range of services that may be needed throughout the community. Not only will we create a system that is easier for our youth to navigate, but in time, we will also have better data on the size and characteristics of the population, as well as the specific needs of the population. Similar to the process used for the adult system, this data will allow us to understand the pathways that youth use to connect with stable housing and to determine where we need to invest our resources. The work group has already begun to uncover significant gaps in our system for unaccompanied youth, though we have additional work to do to quantify the needs.

Our objective is to develop a more detailed plan to end youth homelessness at the first annual update of this plan – once we have fully operationalized the coordinated assessment system for youth and captured data for a full year. In the meantime, we will also increase youth-specific outreach services and resources to support family reunification, as the vast majority of youth who experience homelessness return to live with a family member. (See text box below for more detail on different youth subpopulations addressed as part of the youth plan.)

32 Passed as part of the Fiscal Year 2015 Budget Support Act of 2014.

What do we mean by "unaccompanied youth"?

Different Federal agencies have different definitions for youth. Unaccompanied youth typically refer to individuals under the age of 18 who present as an individual (i.e., not as part of a family household) and lack parental, foster, or institutional care. Some definitions of youth include transition-aged youth between the ages of 18 and 24, who are technically adults and may take advantage of programming available via the adult system, but for whom the existing adult programming may not be developmentally appropriate.

For the purposes of this plan, people under the age of 24 are treated as follows:

a) **Transitioned-Aged Youth, Presenting as Head of a Family Household.** In the District of Columbia, families with a head-of-household between ages 18 and 24 represent a significant part of the family system (approximately 45 percent). In order to avoid duplication across subsystems, this group was included in the modeling for families, and their needs are being addressed through the family system. Two of the pathways (Transitional Housing with Rapid Re-Housing at exit, and Rapid Re-Housing Intensive) were identified with the needs of this particular group in mind.

b) **Transitioned-Aged Youth, Presenting as an Individual.** Individuals between the ages of 18 and 24 were included in the modeling done for the adult system to ensure we have adequate capacity and resources to meet need. However, many of our youth-serving agencies do serve this population. Acknowledging that our large, low barrier shelters are not very healthy environments, particularly for young people, youth coordinated entry work includes a focus on this population to ensure we can capture better data on the characteristics and needs of this group. As we are develop a plan to end youth homelessness, we will continually examine the best practices for serving this group and refine our models accordingly.

c) **Unaccompanied Minor, Presenting as a Head of a Family Household** (i.e., parenting teens). With the advent of youth coordinated entry work, we are beginning to uncover a gap in our system. As explained above, all homeless families are intended to be served through the Virginia Williams Family Resource Center (VWFRC). According to our HMIS data, only a handful to parenting teens have presented at VWFRC over the past year. However, our school-based partners report anecdotal information that they observe a number of homeless parenting teens who appear to be couch surfing. As of the writing on this plan, we are working to use the youth coordinated entry initiative to better understand the size, needs, and appropriate solutions for this population. Once we have more data, we will determine whether it makes sense to address the needs of this group through the family system or the youth system.

d) **Unaccompanied Minor, Presenting as an Individual.** This group – youth under the age of 18 who are disconnected from a family household – are not included in the modeling work for the adult system, but have been the primary focus for youth coordinated entry work. This group's needs will be reflected and addressed in the youth strategy.

4 Shelter Redevelopment

Shelter will always be an important part of addressing homelessness. Housing loss cannot always be prevented, and it is important that we shelter families and individuals in a safe and respectful environment that allows them to quickly stabilize and return to permanent housing.

Currently in our homeless services system we face challenges related to both quantity of shelter and the quality of shelter. As explained in previous chapters, we have dramatically increased our spending on shelter in recent years, which has the cyclical effect of limiting our ability to invest in the housing solutions that help families and individuals exit shelter. Because of our growing need for shelter, the District confronts numerous challenges. In order to meet capacity needs, we are using very large, old, District-owned facilities. The facilities have aging plumbing, heating, and cooling systems and crumbling infrastructure, and they come with significant annual price tags for maintenance, paid for by the Department of General Services (DGS) and the Department of Human Services (DHS). Food preparation and preservation space does not exist in most of our shelters. Security and staffing costs are also necessarily high when you have a large number of people living in a relatively small space. Most importantly, however, conditions in the vast majority of the District's shelters are simply unacceptable and offer very little to help reduce the trauma of whatever life events have led individuals and families to shelter.

Unfortunately, even these large facilities do not adequately meet the demand for shelter in the District, and as we move into winter each year, we have had to identify greater overflow capacity each year to meet needs. On the single adult side of our system, this has taken the form of sheltering individuals in recreation centers and churches. Due to more stringent privacy requirements for families, meeting the overflow need has meant placement in motels.

Chapter 3 of the plan provided an overview of how we will right size our inventory over the five-year plan period. As explained in that chapter, closing these large facilities is not simply a matter of housing the individuals and families currently in them, as we have new individuals and families entering our system on an annual basis and we must have adequate capacity to meet this ongoing need for shelter. As such, our strategy to transition out of these large facilities must be carefully orchestrated and planned as part of the larger system transformation called for in this plan.

In the District and across the country, best practices show that both individuals and families can be more successful when shelter is provided in smaller, neighborhood-based settings where programming can be tailored to meet the

needs of clients and where clients can more readily access services and support networks in the community. For families, we envision facilities that shelter between 25 and 40 households per site, and for single adults, we envision facilities that shelter between 80 and 100 adults per site.

Families and DC General Replacement

In October 2014, the District published a strategy to close DC General. This document set out the beginning of a plan that is consistent with the ICH vision, which is to provide smaller scale, service-enriched, community-based shelters. The ICH vision for closing DC General attempts to balance the need to ensure we have adequate shelter capacity with the need to ensure we do not overinvest in District-owned facilities that are difficult to repurpose for other uses.

As illustrated in Table 12 below, the strategy to close DC General would enable us to replace the units at DC General in smaller facilities throughout our community at a one-to-one ratio. The plan includes two different options – one in which the District would lease turnkey buildings from private owners and developers for use as shelter, and a second in which the District would construct new facilities on District owned land. In accordance with the plan, DGS issued a rolling solicitation in October 2014 for offers from private owners and developers.

While some solid offers from private developers have materialized, the timeline for new construction can take anywhere from 18 to 24 months, so waiting indefinitely to see what the private market produces will inhibit our ability to transition out of DC General by a specified date. As such, the ICH is recommending that the District include capital funding in the FY 2016 budget to enable DGS to move forward with new construction for a portion of the replacement capacity, thereby ensuring we have a concrete plan and timeline to exit the current facility. If the District plans on new construction for a portion of the units and moves forward on this option immediately (i.e., beginning October 1, when FY 2016 resources would become available), under the best-case scenario (18 months for new construction), all of the units would be online by April 2017. Under a 24-month timeline, the units would be online by October 2017. This means we will operate in DC General for two more winters. Because we still will need overflow capacity during this time period, we can bring new facilities online as they become available by transferring operating dollars away from motel overflow to the new facilities. When all of the new units are delivered, we can close DC General. This of course assumes that we are meeting the specified targets for reducing length of stay in shelter, which is the primary trigger for reducing our capacity need. It also assumes that we are able to meet year-round need, including any increase of inflow into the system, through these new units or available overflow. If either variable changes, we will need to revisit options during FY 2016 and FY 2017 to ensure we are able to adequately meet the shelter needs of families.

In contrast, if we do meet targets for reducing length of stay and inflow does not increase, as the table below shows, we will actually have more shelter in our system than is needed. In this scenario, we would be able to convert some of the existing shelter to another use. For example, the existing 121 units of community-based shelter are small apartments, which could be converted to permanent housing.

Table 12: DC General Closure in Context of Systems Transformation

	FY 2015 10/1/14 – 9/30/15	FY 2016 10/1/15 –09/30/16	FY 2017 10/1/16 –09/30/17	FY 2018 10/1/17 –09/30/18	FY 2019 10/1/18 –09/30/19	FY 2020 10/1/19 –09/30/10
Anticipated Need (per modeling)	915	695	579	465	354	226
DC General	248	248	**Transition Years: at least 248 units through DC General and Replacement Facilities**			
DC General Replacement Facilities					248	248
Existing community-based shelter*	121	121	121	121	121	121
Overflow needed	546	326	210	96	--	--

Year-Round Access to Shelter for Families

An extremely important issue that must be addressed in the early months of plan implementation concerns when during the year families have access to shelter. As written in the HSRA, the right to shelter is currently limited to hypothermia conditions only. Because the needs have been so great in recent years, and because our shelter facilities have remained full following hypothermia season and largely throughout the summer, DHS has had limited ability to place families in shelter outside of hypothermia season. This creates challenges both for our system and for the families we serve. Families turned away during the summer may spend months couch surfing, or worse, living in dangerous or unhealthy situations. We do not have exact data on the number of households that present at VWFRC for assistance during the summer and return again during hypothermia season, but is likely some percentage of households do, and by the time they return, their situations have often deteriorated, making it much more difficult to help them stabilize.

In addition, the surge of families we see entering our shelter system each winter is difficult for our front door team to manage, which limits the effectiveness of our prevention and diversion efforts. If families were assisted as their crises occurred (versus waiting until winter), not only might we be able to prevent problems from compounding, but we might also be able to normalize caseloads throughout the year, meaning staff could provide more intensive assistance to those households they are working with at any given time.

Unfortunately, it is difficult to know whether we would see the same number of households with placements more evenly distributed throughout the year, or if placements in the spring, summer, and fall would mirror what currently happens in the winter months, ultimately increasing our shelter capacity needs. Any change in policy must be carefully defined and implemented as part of a comprehensive array of strategies designed to meet the needs of vulnerable families in the District. As defined in Chapter 5, DHS, working with other ICH partners, will take the lead in defining an approach over the coming months. Further, any changes in demand will need to be addressed in the annual update to the model to ensure we are planning and budgeting appropriately to meet shelter and housing assistance needs throughout the year.

Shelter Replacement for Individuals

Similar to the situation with DC General, we have a handful of very large (350+ bed) District-owned facilities that are used to provide shelter to single adults in congregate settings. In addition to the fact that these facilities are simply too large to provide appropriate programming in a safe, healthy environment for clients, the buildings themselves face many of the same challenges that are seen at DC General – aging systems, crumbling infrastructure, and never-ending maintenance needs. In addition, except when a daytime hypothermia alert is in effect, these low barrier shelters for single adults are only open from 7pm to 7am, meaning clients must leave each morning and spend the day navigating the city to simply get their basic needs met, while ensuring they get back to the shelter in time to secure a place to sleep each evening.

As articulated in the program models matrix (Appendix 6: Program Models Matrix), the ICH envisions shelter for single adults that looks and functions very differently (i.e., smaller, service-enriched, community-based facilities that operate 24 hours a day, 7 days a week).[33] In smaller settings, programming can be specialized to meet the unique needs of different subpopulations, including victims of domestic violence, seniors, members of the LGBTQ community, members of language and cultural minority groups, and individuals being discharged from hospitals or nursing homes that require more intensive care (e.g., medical respite

33 It is not assumed that the current low-barrier facilities could immediately adapt programming to meet the new emergency shelter model. A key piece of operationalizing the plan will be to identify the elements of the new model that are cost-neutral and not impacted by facility size/configuration (and therefore can be implemented right away). We will also need to identify changes that will be required to the HSRA to allow implementation of the new model. As we construct and move to new facilities, however, we will be able to transition fully to the new emergency shelter program model.

beds). Understanding that we will not be able to replace all of our large facilities at once, we propose a staggered redevelopment schedule (see Table 13 below). It is important to note that the table below does not cover all of the shelter facilities in the District, but those with the most pressing needs and which can be addressed within the five-year plan period.[34]

Table 13: Shelter System Infrastructure

Category	Facility	Population	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	Legend
Major System Maintenance/ Upgrades	NY Avenue	Single Adults (M)	•					• Recommended Capital Investments
	801 East	Single Adults (M)	•					
								▫ Move out of location
Replace Facilities	John Young	Single Adults (W)	▫					
	Open Door	Single Adults (W)	▫					
	DC General	Families	•		▫			
	NY Avenue	Single Adults (M)		•	•	▫		
	Harriet Tubman	Single Adults (W)				•	▫	
	801 East	Single Adults (M)					•	

As explained in Chapter 3, if we are able to meet our targets for reducing average length of stay in shelter, we will reduce our shelter capacity needs over time, which will allow us to replace these large facilities with fewer smaller facilities. Housing people who are experiencing chronic homelessness is a significant first step in this regard, as this group of individuals consumes a significant portion of our shelter beds throughout the year. Accordingly, the replacement strategy for each facility will need to be fleshed out in more detail as we move forward, depending on the resources available to meet the housing needs of our adult single population in the early years of plan implementation and the success with which we are able to accelerate exits from the system. If we are unable to accelerate housing placements and reduce the need for shelter, then we will not be able to reduce shelter capacity as we transition to new facilities.

In the Meantime: Addressing Critical Needs for Individuals

Understanding that we will operate in current facilities for at least a few more years, it is imperative that we invest in the system repairs and upgrades that are needed to ensure that these facilities meet minimum health and safety standards, and that we create systems and protocols to ensure a more timely response to routine maintenance requests. The suggested timeline for these system upgrades is provided in Table 13 above.

In addition, until we can transition to the smaller, community-based shelter model, the ICH recommends that the District establish a daytime services center for individuals to help meet the service needs of individuals who are unsheltered or staying in low-barrier shelters. Similar to the way VWFRC functions for families, a daytime service center would: 1) serve as a point of access for our coordinated entry system, 2) allow us to begin doing more homelessness prevention and diversion work with single adults, and 3) enable us to more effectively connect adults experiencing homelessness with employment assistance and other supportive services.

34 The Community for Creative Non-Violence (CCNV) operates a shelter and other services from within the Federal City Shelter, a building at 425 Second Street NW, which is owned and maintained by the District Government. The District is actively working in partnership with CCNV to develop a strategy to improve, redevelop, or replace the facility. The needs of the individuals currently sheltered in the portions of the building operated by CCNV were included in the modeling exercise described in Chapter 3, and any work to improve, redevelop, or replace the facility will be done in the context of the larger systems change strategy set forth in the plan.

5 Getting from Here to There: Key Strategies & Transition Planning

This chapter focuses on the strategies that will be necessary over the five-year period to right size our system inventory as described in the Chapter 3 and achieve our vision of making homelessness a rare, brief, and nonrecurring event for households in the District. By pursuing action items across five key strategies, we will reduce inflow into our system and accelerate exits out of the system:

- Strategy 1: Develop a more effective crisis response system;
- Strategy 2: Increase the dedicated supply of affordable and supportive housing;
- Strategy 3: Reduce barriers to affordable and supportive housing;
- Strategy 4: Increase the economic security of households in the system; and
- Strategy 5: Increase homelessness prevention efforts.

For each strategy, we summarize key action items, lead agencies (and/or community partners), and an anticipated timeline.

1. Develop a More Effective Crisis Response System

Homelessness is a crisis for the individuals and families experiencing it. Unfortunately, our current emergency shelter system often adds to the trauma people are experiencing instead of reducing it. Our system needs to be transformed from a system where people live for months and often years to an effective crisis response system, where people feel both safe and secure and are supported to quickly get back on their feet.

Key areas of focus within this strategy include not only action items to improve the actual physical conditions of our shelters, but also actions to improve our operations to ensure we are able to more quickly stabilize families and individuals experiencing homelessness and accelerate the connection back to permanent housing.

Action items	Lead Agencies/ Partners	Target Timeline
a. Work with community stakeholders to develop and implement a strategy for year round access to shelter for families.	DHS	April 2015
b. Work with providers and community stakeholders to capture and incorporate better data in shelter replacement planning discussions on the size, characteristics, and needs of special populations that are not well reflected in current homeless services system data (including, but not limited to, victims of domestic violence, undocumented immigrants and other language and cultural minority groups, and members of the LGBTQ community). Work with stakeholders to ensure programming is culturally appropriate and rooted in best practices (e.g., trauma-informed care).	DHS, TCP	Ongoing

Action items	Lead Agencies/ Partners	Target Timeline
c. Conduct an analysis of the Transitional Housing stock in the community. Identify projects that can be converted to emergency shelter or temporary therapeutic housing; provide technical assistance to help providers with the conversion process.	TCP, DHS, DHCD, and private funders	August 2015 (analysis complete); conversions will occur in phases.
d. Develop a project management plan for each shelter facility replacement project as part of the ICH annual work plan, including a communications strategy and stakeholder engagement process.	DHS and DGS	Ongoing
e. Develop written protocol and electronic tracking tools to improve management of shelter facility maintenance requests.	DHS and DGS	June 2015
f. Develop a Daytime Services Center for single adults to serve as a central point of access for our CAHP system, to offer more robust programming and services (e.g., employment, mental health and substance use treatment) and to help bridge the gap until we have 24-hour shelter facilities for individuals.	DHS, DBH, DOES, TCP	November 2015
g. Work with healthcare partners to increase the number of medical respite beds within the shelter inventory.	DHS, TCP, Hospitals, FQHCs	January 2016
h. Clarify and document roles, responsibilities, and protocol related to coordinated assessment and referral procedures for families; ensure protocol provides clear access points (beyond VWFRC) for victims of domestic violence.	DHS	September 2015
i. Implement improvements to the Family Re-Housing and Stabilization Program (FRSP), the District's Rapid Re-Housing Program for families, including: - Clarifying the roles and responsibilities of different partners with regard to client assessment, housing navigation support, housing inspections and rent payments, case management support, employment support, and landlord liaison support; - Facilitating stronger, more consistent use of a progressive engagement model; - Creating dedicated employment supports for households receiving RRH assistance; - Building the capacity of providers to effectively support families in the program and regularly monitoring providers to ensure the quality of case management services; - Enabling use of a longer-term shallow subsidies for households to help bridge the income/housing cost divide; - Developing consistent criteria for program exit; - Creating written policy and protocol to improve transparency; and - Conducting an evaluation to learn more about family housing stability following exit from FRSP.	DHS with CFSA, DOES, DCHA, TCP	September 2015

2. Increase Dedicated Supply of Supportive and Affordable Housing

Increasing the supply of supportive and affordable housing is central to our efforts to prevent and end homelessness. As discussed throughout the plan, reducing length of stay in shelter is key to our ability to meet the annual demand for shelter while at the same time reducing our spending on shelter. We will only be able to reduce length of stay if we have the housing resources available throughout the year to quickly match individuals and families entering the system to the right housing intervention.

While we do need to ensure we have enough dedicated housing resources within the homeless services system to help individuals and families quickly exit back to permanent housing, at the same time, it's important to note that we must be careful about making the shelter system the pathway to affordable housing in the District. With 40,000+ households on the waitlist for housing assistance at DCHA, it's critical that the District continue to expand the supply of affordable units and subsidies more broadly throughout the community as well. In the long run, increasing affordable housing is the single largest homelessness prevention measure we can take as a community.

In addition to making new investments, there are several other steps we can – and must – take to ensure we are able to meet our annual permanent housing inventory targets. Significant commitments to affordable housing have already been made via the Housing Production Trust Fund, but those units only help if they are aligned with need and targeted correctly. Likewise, there are resources currently within the system than can be repurposed to help us meet the annual demand. In order to pay for this plan, it will be critical that we optimize every last dollar going into the system and put our funds towards their highest purpose.

Action items	Lead Agencies/ Partners	Target Timeline
a. Align the annual Housing Production Trust Fund investments (via the Joint RFP process) to help meet the PSH and TAH inventory needs specified via the Strategic Plan; ensure dedicated units are filled via the coordinated assessment system and prioritize Housing First PSH programming.	DHCD, DCHA, DBH, DHS, DHCF, DOH	Annual/Ongoing
b. Complete an analysis of the housing units/slots that are part of the dedicated inventory (as reported through the HIC). Work with funders and providers to ensure all new and turnover opportunities are filled via the CAHP system.[35]	TCP, DHS, DBH, DCHA, and private funders	June 2015 (initial analysis complete); work is ongoing
c. Develop common protocol to assist with the identification of individuals and families ready to "move on" from PSH.	DHS, TCP	January 2016
d. Conduct an analysis of the Transitional Housing stock in the community. Identify projects that can be converted to help meet the PSH or TAH need, and provide technical assistance to help providers with the conversion process.	TCP, DHS, DHCD, and private funders	August 2015 (analysis complete); conversions will occur in phases.
e. Conduct a crosswalk of eligible services under our State Medicaid Plan against needed services in PSH. Identify gaps and, as applicable, needed changes to the State Plan to enable PSH providers to bill Medicaid for services provided. Repurpose service funding in DHS PSHP budget to increase housing investments.	DHCF, DHS, DBH, and TCP	September 2015 (analysis complete); cost savings anticipated in FY 2017

35 The modeling included an analysis of the turnover rate of different program types within the homeless services system. We assumed 100 percent of turnover opportunities on dedicated units/slots would be used to house someone from within the homeless services system, and further, that they would be allocated via the CAHP system to ensure interventions are targeted as effectively as possible. Ensuring we maximize use of turnover opportunities reduces the new investments needed each year to meet annual demand. If we do not harness 100 percent of the turnover opportunities, this will increase the need for new/incremental investments.

Action items	Lead Agencies/ Partners	Target Timeline
f. Develop a Comprehensive Housing Affordability Strategy for the District to help stabilize households and slow down the annual flow into the homeless services system.	DHCD, DCHA, DHFA	December 2015 (strategy complete); implementation is ongoing
g. Assist with education and outreach to combat "NIMBYism" in our community.	Advocates, Faith-based community	Ongoing

3. Reducing Barriers to Supportive and Affordable Housing

Having an adequate supply of housing does not help us if our clients are unable to access it. Our experience to date with our CAHP system has provided evidence that many of the programs within our system have so many barriers and eligibility requirements that we are unable to place the very individuals and families that they were funded to serve. In the months and years ahead, we will need help from both providers and private market landlords to examine their requirements and look at where they can be more flexible with their standards to ensure vulnerable District residents have access to housing.

Action items	Lead Agencies/ Partners	Target Timeline
a. Ensure the Permanent Supportive Housing programs funded are using a Housing First approach and limiting eligibility requirements to those associated with the funding source.	DHS, DHCD, DCHA, DBH, TCP, and private funders	Ongoing
b. Assist clients with addressing barriers related to credit, rental, or criminal histories	Legal service providers, housing service providers	Ongoing
c. Examine requirements related to credit, income, and criminal history; identify where flexibility can be increased to serve vulnerable individuals and families that are receiving case management support.	Private market landlords	Ongoing
d. Coordinate to create a point of entry for obtaining identification documents and streamline application procedures to remove barriers for residents without a permanent address.	DHS, DMV, DOH, DDS	January 2016

4. Increase Economic Security of Households

We need to do more to increase the economic security of households falling into the homeless services system. This is particularly essential for households provided with Rapid Re-Housing assistance. Rapid Re-Housing is an important tool that allows us to help people move quickly from shelter back into permanent housing, but it is not intended to be a long-term housing affordability program. In order to increase the success of families and individuals in the program, and to reduce the likelihood of a return back to homelessness, we must provide targeted employment assistance to these households both quickly and intentionally.

While particularly important for our Rapid Re-Housing households, increasing income – whether earned or unearned – is critical for all of the households we serve. Households are, of course, healthier and more stable when they have the resources needed to pay for basic necessities such as food, transportation, and medical care. However, helping households increase income is critical for the homeless services system as a whole to be able to meet the needs of new individuals flowing into the system every year. In interventions such as PSH and TAH, the client household is contributing 30 percent of whatever income they have towards their housing cost, so to the extent that we can help households increase income, it allows the system to maximize its resources to serve more households. Further, as described in Chapter 3, increasing positive turnover within intentional "move on" strategies helps us meet more of the need with our existing inventory.

Action items	Lead Agencies/ Partners	Target Timeline
a. Develop and implement strategy for providing targeted job training and placement assistance for individuals and families in the shelter system, with a particular focus on households assessed for RRH assistance.	DOES, DHS, UDC, employment services providers	July 2015 (strategy complete); work is ongoing
b. Coordinate with the District Government during the planning phase of large projects to ensure the District can provide a pipeline of trained/work-ready applicants.	Developers, employers, WIC, DOES	Ongoing
c. Provide capacity building support to providers and/or create a dedicated SOAR team to help clients navigate the SSI/SSDI application process.	DHS, DBH, and DDS	Ongoing
d. Ensure clients in housing are receiving all benefits for which they are eligible.	Homeless service providers, legal service providers	Ongoing

5. Increase Homelessness Prevention Efforts

Current homelessness prevention programs, such as the Emergency Rental Assistance Program (ERAP), are certainly helpful in aiding low-income families that have emergency assistance needs, but they have not been evaluated and may not be reaching those most likely to enter the homeless services system. In the coming months, we must move forward with implementation of evidence-based, predictive analytics tools and strategies, similar to those being used in New York City, to better target diversion and prevention resources to those households most at-risk of becoming homeless.

In addition, we need to move further upstream to help stabilize high-risk households before they arrive at the shelter door. It is particularly critical that we examine what more can be done to stabilize individuals and families as they transition out of other systems – including adult and juvenile justice systems, child welfare and foster care systems, and behavioral health systems.

Action items	Lead Agencies/ Partners	Target Timeline
a. Implement targeted homelessness prevention programming that incorporates the use of predictive analytics tools and strategies.	DHS	June 2015
b. Identify tools and procedures to ensure households receiving DCHA assistance that are struggling with housing stability (e.g., nonpayment of rent, lease violence) are connected to existing community-based case management and supportive services.	DCHA with DHS, DBH, CFSA	September 2015
c. Evaluate effectiveness of models like Wayne's Place and Generations of Hope for assisting youth aging out of foster care. Continue expansion of promising models and practices.	CFSA	Ongoing
d. Implement use of a common assessment tool to identify individuals with behavioral health conditions at greatest risk of homelessness to use as a factor in prioritizing housing resources.	DBH	June 2015
e. Conduct analysis of clients in shelter system with recent history of incarceration. Review client discharge planning process and identify steps to improve process and targeting of assistance.	ORCA, DOC, CSOSA	January 2016

Performance Management

As discussed in Chapter 2, we will use the following topline measures to assess progress of the plan:

- End homelessness among Veterans by the end of 2015 (as measured by our 2016 PIT count);
- End chronic homelessness among individuals and families by the end of 2017 (as measured by our 2018 PIT count); and
- Ensure households that experience a housing crisis in the future are rehoused within an average of 60 days or less by the end of 2019 (as measured in January 2020 by HMIS data).

The theory of change underlying this plan is that by using the modeling described in Chapter 3 to guide our investment choices, and the strategies described in this chapter to optimize those investments, we will be able to achieve these broad goals.

Of course, we will need a much more detailed performance management strategy to measure our progress and guide our efforts. Much of the data we will need is contained within our HMIS, but some of it is maintained by other District agencies in their administrative databases. Just as no one agency is responsible for addressing homelessness on its own, no one agency is independently responsible for providing the data necessary to assess progress. The Data and Performance Management Committee has already begun efforts to generate baseline data on the program model outcomes measures and to create a performance management infrastructure that allows us to regularly review the performance of individual providers as well as the system as a whole.

Next Steps

The ICH will turn immediately from development of this plan to implementation, using the ICH committee structure to manage the work and coordinate the efforts of partners. We will organize plan briefings with community stakeholder groups to ensure partners understand the vision and strategies in the plan, as well as the roles they are being asked to play. As mentioned above, we are moving immediately to develop a performance management infrastructure, including not only generating and sharing performance data, but acting on that data through technical assistance and training activities to help providers improve the quality of their services. Lastly, we are committed to making this plan a living document, incorporating feedback and new ideas as they emerge, revisiting our assumptions against new data as it becomes available, and updating the models and strategies on an annual basis.

Conclusion

Despite some important successes, homelessness in the District has been increasing in recent years at an alarming rate. Stable housing is out of reach for far too many District residents. However, while homelessness has grown, so has our understanding of it. Today, we have more data on the households we serve and more research on best practices to guide our efforts. Perhaps most importantly, we have more commitment from partners across every sector than we have possibly ever had before.

This plan attempts to build on the efforts of the past by laying out a roadmap for transforming our homeless services system into an effective crisis response system focused on preventing housing loss and quickly reconnecting households to permanent housing. Implementation of this plan will require unprecedented collaboration. However, we know that homelessness is solvable when we have a common vision, when every partner understands their role in the system, when we keep a laser-like focus on outcomes, and when we have the resources to get the job done. Together, we can ensure that *homelessness in the District of Columbia is a rare, brief, and non-recurring experience.*

Appendix 1: Definitions

This appendix provides definitions and explanations of terms used in the plan.

At Risk of Homelessness: For individuals and families who do not meet the definition of "homeless" under any of the categories established in the Federal Homeless Definition final rule, the McKinney-Vento Act was amended to allow homeless prevention assistance to be provided to persons who are "at risk of homelessness."

Individuals and families may qualify as "at risk of homelessness" under three categories, as defined by the Federal government, including: 1) individuals and families; 2) unaccompanied youth and children; and 3) families with children and youth.

- Individuals and Families. An individual or family that: (i) Has an annual income below 30 percent of median family income for the area, as determined by HUD; (ii) Does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; and (iii) Meets one of the following conditions: (A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance; (B) Is living in the home of another because of economic hardship; (C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; (D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, state, or local government programs for low-income individuals; (E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the US Census Bureau; (F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
- Unaccompanied children and youth. Specifically, a child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e– 2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- Families with children and youth. Specifically, a child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

The At Risk of Homelessness definition, and corresponding recordkeeping requirements, was published in the interim Emergency Solutions Grants program rule on December 5, 2011.

Affordable Housing: Housing for which the occupant(s) is/are paying no more than 30 percent of their income for gross housing costs, including utilities. Households that pay more than 30 percent of their income for housing may have difficulty affording necessities such as food, clothing, transportation and medical care and are considered

cost burdened by HUD. Households that pay more than 50 percent of their income for housing are considered severely cost burdened.

Area Median Income (AMI): The median divides the income distribution into two equal parts: one-half of the cases falling below the median income and one-half above the median. HUD uses the median income for families in metropolitan and non-metropolitan areas to calculate income limits for eligibility in a variety of housing programs. HUD estimates the median family income for an area in the current year and adjusts that amount for different family sizes so that family incomes may be expressed as a percentage of the area median income. Income limits for the District can be found at http://www.huduser.org/portal/datasets/il/il14/index_il2014.html.

Chronically Homeless: As defined in HUD's CoC Program interim rule at 24 CFR 578.3, a chronically homeless person is:

- An individual who: 1) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; 2) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and 3) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
- An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria for a chronically homeless individual, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless].

Client: As defined in the HSRA, a client is an individual or family seeking, receiving, or eligible for services from programs offered by the District CoC.

Coordinated Assessment and Housing Placement (CAHP) System: Also referred to as coordinated entry or coordinated intake. Per the HEARTH Act, HUD has required that all CoCs establish and operate a CAHP system. A CAHP system is a client-centered process that streamlines access to the most appropriate housing intervention for each individual or family experiencing homelessness. Within a CAHP system, clients are prioritized through a process that is data-driven and real time. A CAHP system must be able to capture client specific information and communicate the data needed to facilitate a housing match/referral. In addition, the data collection and communication platform provides a portal to inform local policy and resource decisions. A CAHP system can be broken down into four key components: 1) Assessment, 2) Navigation and Case Conferencing, 3) Housing Referral with Choice, and 4) Data Collection and Communication.

Continuum of Care (CoC): The entity authorized to carry out homelessness planning for a community. Under the HEARTH Act, the CoC must include representatives from nonprofit homeless assistance providers, victim service providers, faith-based organizations, government, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, and organizations that serve Veterans and homeless and formerly homeless individuals. Responsibilities of the CoC include the operation of the CoC, designating and operating an HMIS, and Continuum of Care planning. The designated CoC for the District of Columbia is the DC Interagency Council on Homelessness. The Collaborative Applicant for the District (i.e., the legal entity designated by the CoC to apply for and administer funding on behalf of the Continuum) is The Community Partnership for the Prevention of Homelessness.

Under the HSRA, a continuum of care refers to the comprehensive system of services for individuals and families who are homeless or at imminent risk of becoming homeless, designed to serve clients based on their individual level of need. The Continuum of Care may include crisis intervention, outreach and assessment services, shelter, transitional housing, permanent supportive housing, and supportive services.

Crisis Intervention: Under HSRA, this is assistance to prevent individuals and families from becoming homeless, which may include, but need not be limited to, cash assistance for security deposits, rent or mortgage payments, credit counseling, mediation with landlords, and supportive services.

Culturally Competent: Under the HSRA, refers to the ability of a provider to deliver or ensure access to services in a manner that effectively responds to the languages, values, and practices present in the various cultures of its clients so the provider can respond to the individual needs of each client.

Cost Burdened: HUD considers households that pay more than 30 percent of their income for housing and may have difficulty affording necessities such as food, clothing, transportation and medical care as cost burdened.

Day Program: Defined by the HSRA to mean a facility that provides open access to structured activities during set hours of the day to meet the supportive services needs of individuals and families who are homeless or at imminent risk of becoming homeless.

Emergency Shelter: Defined by HUD to include any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

Under the HSRA, "shelter" refers to severe weather shelter, low barrier shelter, and temporary shelter:

- **Severe weather shelter** is used for the purpose of protecting lives in extreme hot and cold weather.
- **Temporary shelter** is used for the purpose of meeting short-term housing needs and other supportive service needs. It refers to:
    a) A housing accommodation for individuals who are homeless that is open either 24 hours or at least 12 hours each day, other than a severe weather shelter or low barrier shelter, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter and supportive services; or
    b) A 24-hour apartment-style housing accommodation for individuals or families that are homeless, other than a severe weather shelter, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter and supportive services.
- **Low barrier shelter** is used for the purpose of sheltering and engaging individuals who avoid temporary shelter because of identification, time limit, or other program requirements. It refers to overnight housing accommodation for individuals who are homeless, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter to individuals without imposition of identification, time limits, or other program requirements.

Engagement Services: Services and/or programs geared towards connecting or reconnecting persons who are homeless or at imminent risk of becoming homeless to needed social supports.

Family: Under the HSRA, family means:

a) A group of individuals with at least one minor or dependent child, regardless of blood relationship, age, or marriage, whose history and statements reasonably tend to demonstrate that they intend to remain together as a family unit; or

b) A pregnant woman in her third trimester.

Family Median Income (FMI): See Area Median Income (AMI) definition above.

Family Service Prioritization Decision Assistance Tool (F-SPDAT): The F-SPDAT is an evidence-informed approach to assessing a family's acuity and was developed by OrgCode Consulting. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person or family's life where support is most likely necessary in order to avoid housing instability.

Harm Reduction: A set of strategies that reduce negative consequences of substance use and that incorporate a spectrum of strategies from safer use, to managed use, to abstinence.

HEARTH Act: The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act was signed by President Obama on May 20, 2009. The HEARTH Act amends and reauthorizes the McKinney-Vento Homeless Assistance Act with substantial changes, including: a consolidation of HUD's competitive grant programs, the creation of a Rural Housing Stability Assistance Program,

a change in HUD's definition of homelessness and chronic homelessness, a simplified match requirement, an increase in prevention resources, and an increase in emphasis on performance.

Homeless: Under HSRA, the definition is limited to individuals and families that:

1. Lack a fixed, regular residence that does not jeopardize the health, safety, or welfare of its occupants, and lack the financial ability to immediately acquire one; or
2. Have a primary nighttime residence that is: 1) A supervised publicly or privately operated shelter or transitional housing facility designed to provide temporary living accommodations; or 2) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Under HUD's *Homeless Definition Final Rule,* the term is more expansive, establishing four categories of homelessness for use by the homeless assistance programs administered by HUD under the McKinney-Vento Homeless Assistance Act. These categories are:

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; 2) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, state, or local government programs for low-income individuals); or 3) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
2. An individual or family who will imminently lose their primary nighttime residence, provided that: 1) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; 2) No subsequent residence has been identified; and 3) The individual or family lacks the resources or support networks (e.g., family, friends, faith-based or other social networks) needed to obtain other permanent housing;
3. Unaccompanied youth under 25 years of age, or families with children and youth, that do not otherwise qualify as homeless under this definition, but that: 1) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a); 2) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; 3) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and 4) Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or
4. Any individual or family that: 1) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; 2) Has no other residence; and 3) Lacks the resources or support networks (e.g., family, friends, faith based or other social networks) to obtain other permanent housing.

Homeless Management Information System (HMIS): A software application designed to record and store client-level information on the characteristics and services needs of people experiencing homelessness. Each CoC maintains its own HMIS, which can be tailored to meet local needs, but also must conform to HUD HMIS Data and Technical Standards.

Household Type: The composition of a household upon entering a shelter program. People enter shelter as either an individual or as part of a family.

Housing Inventory Count (HIC): Required by HUD, the HIC is a point-in-time inventory of all of the dedicated beds and units within a Continuum of Care's homeless services system, categorized by type of project and population served.

Housing First: Under the HSRA, Housing First means a program that provides clients with immediate access to independent permanent housing and supportive services without prerequisites for sobriety or participation in psychiatric treatment. Clients in Housing First programs may choose the frequency and type of supportive services they receive and refusal of services will have no consequence for their access to housing or on continuation of their housing and supportive services.

HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable. To that end, a Housing First orientation is specified as one of the universal qualities that a coordinated assessment process should include. Coordinated assessment tools should not be used to determine "housing readiness" or screen people out for housing assistance, and therefore should not encompass an in-depth clinical assessment. A more in-depth clinical assessment can be administered once the individual or family has obtained housing to determine and offer an appropriate service package.

Hyperthermia Shelter: Under the HSRA, this is defined as a public or private building that the District shall make available for the purpose of providing shelter to individuals or families who are homeless and cannot access other shelter, whenever the actual or forecasted temperature or heat index rises above 95 degrees Fahrenheit. The term hyperthermia shelter does not include overnight shelter.[36]

Hypothermia Shelter: Under the HSRA, this is defined as a public or private building that the District shall make available, for the purpose of providing shelter to individuals or families who are homeless and cannot access other shelter, whenever the actual or forecasted temperature, including the wind chill factor, falls below 32 degrees Fahrenheit.

Individual: Refers to a person who is not a part of a family during an episode of homelessness.

Interim Housing: Shelter or temporary housing programs designed to provide people experiencing homelessness with a stable and safe place to sleep while they pursue permanent housing.

Length of Stay: Defined by HUD, the average cumulative number of days a household receives assistance in a given program intervention. This is measured from entry to exit (or last day of report period) within the given program.

Length of Time Homeless: Defined by HUD, the average cumulative number of days households receive outreach services, emergency shelter, and transitional housing as measured by their sum total days of program participation. For each program enrollment, this is measured from first program entry to exit or last day of report period.

Low Barrier Shelter: Defined by the HSRA, low barrier shelter is used for the purpose of sheltering and engaging individuals who avoid temporary shelter because of identification, time limit, or other program requirements. It refers to overnight housing accommodation for individuals who are homeless, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter to individuals without imposition of identification, time limits, or other program requirements.

Outreach Beds: As defined by this plan, outreach beds refer to shelter for high need individuals, often with severe and persistent mental illness, who are living on the street and are hard to reach and unwilling or unable to engage in services. The primary purpose is to provide a safe and low pressure setting for clients to build trust and begin the engagement process.

Permanent Housing: As defined by HUD, permanent housing refers to community-based housing without a designated length of stay and where the client is the

36 US Department of Housing and Urban Development (HUD), Office of Community Planning and Development. Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status. CPD Notice: 14-012, 2014.

lease-holder. Permanent housing models included in this plan are Rapid Re-Housing, Permanent Supportive Housing, and Targeted Affordable Housing. Individuals and families who are living in permanent housing are no longer considered to meet the HUD homeless definition.

Permanent Supportive Housing (PSH): Defined in the HSRA as supportive housing for an unrestricted period of time for individuals and families who were once homeless and continue to be at imminent risk of becoming homeless, including persons with disabilities as defined in 24 C.F.R. 582.5, for whom self-sufficient living may be unlikely and whose care can be supported through public funds.

Likewise, under the CoC Interim Rule, HUD defines PSH as permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.

Point-in-Time (PIT) Count: An unduplicated one-night estimate of both sheltered and unsheltered homeless populations. The one-night count, conducted according to HUD standards by CoCs nationwide, occurs during the last week in January of each year.

Progressive Engagement: Defined by the US Interagency Council on Homelessness as a case management strategy of offering a small amount of assistance initially, and adding more assistance as needed to help each household reach stability. This strategy uses the lightest touch possible for each household to be successful, knowing more assistance can be added later if needed. Assessment is critical to this strategy, but for the purpose of identifying a household's strengths and barriers, not to determine the amount of assistance they will ultimately need.

Rapid Re-Housing: As defined in the program model, the provision of housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing and achieve stability in that housing. The individual or family has a lease in their own name and may remain in the housing when rental assistance ends.

Rapid Re-Housing Intensive: A distinction used in the modeling completed as part of this plan to assist with program planning and budgeting. A rapid re-housing intensive slot has an average length of stay that is 1.5 times that of a regular rapid re-housing slot. Because assistance should always be provided through a progressive engagement model, there is no distinction from an implementation/service delivery perspective.

Safe Environment: Defined as either: 1) a physical location that protects homeless persons from harm from abuse, assault, threat, exhaustion, or the elements; or 2) a psychological/emotional "space" where homeless persons are entitled to speak, to be respected, to tell their story, to ask for help, and to be heard.

Service Plan: Defined by HSRA to mean a written plan, collaboratively developed and agreed upon by both the provider and the client, consisting of time-specific goals and objectives designed to promote self-sufficiency and attainment of permanent housing and based on the client's individually assessed needs, desires, strengths, resources, and limitations.

Severely Cost Burdened: Households that pay more than 50 percent of their income for housing are considered severely cost burdened by HUD.

Surge: As used in this plan, a significant though temporary increase in funding required to make-up for past underinvestment. In this plan, we refer to the surge in resources needed to house our long-term (chronically homeless) population.

Targeted Affordable Housing (TAH): Units or subsidies that offer long-term affordability and are dedicated for use by the homeless services system. TAH is not intended to address affordable housing broadly, but is targeted to key populations that do not need ongoing support services and that, but for long-term subsidies, could not exit homelessness or would return to homelessness.

Temporary Therapeutic Housing: Defined in this plan as temporary housing for individuals and families that are not initially assessed for PSH but have a specific health or therapeutic need that inhibits the ability to obtain or remain stably housed and have a preference for a communal living environment (which may be congregate or individual apartments in the same building, but offers shared spaces, group therapy, etc.). For example, temporary therapeutic housing may be targeted to individuals or families with a specific healthcare need (e.g., substance abuse treatment, mental health treatment, or medical respite), victims of domestic violence, refugees and sex workers experiencing severe trauma, or high need families with heads of households between 18 and 24 (i.e., those scoring on high end of RRH scale and those that are CFSA-involved).

Temporary Shelter: Defined by HSRA, temporary shelter is used for the purpose of meeting short-term housing needs and other supportive service needs. It refers to:

1. A housing accommodation for individuals who are homeless that is open either 24 hours or at least 12 hours each day, other than a severe weather shelter or low barrier shelter, provided directly by, or through contract with or grant from the District, for the purpose of providing shelter and supportive services; or
2. A 24-hour apartment-style housing accommodation for individuals or families who are homeless, other than a severe weather shelter, provided directly by, or through contract with or grant from, the District, for the purpose of providing shelter and supportive services.

Transitional Housing: Defined by the HSRA to mean a 24-hour housing accommodation, provided directly by, or through contract with or grant from, the District, for individuals and families that:

1. Are homeless;
2. Require a structured program of supportive services for up to 2 years or as long as necessary in order to prepare for self-sufficient living in permanent housing; and
3. Consent to a case management plan developed collaboratively with the provider.

Under the Interim CoC Rules, HUD similarly defines Transitional Housing to mean housing in which all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of homeless individuals and families into permanent housing within 24 months or such longer period as HUD determines necessary. The program participant must have a lease or occupancy agreement for a term of at least one month that ends in 24 months and cannot be extended. Individuals and families living in Transitional Housing are included under the HUD Homeless definition.

Trauma-Informed Care: Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and re-traumatization can be avoided.

Turnover: The rate at which units or beds become available as households exit a program model and/or homelessness.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT): The Vulnerability Index is a tool for identifying and prioritizing the homeless population for housing according to the fragility of their health. The SPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The VI-SPDAT tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person or family's life where support is most likely necessary in order to avoid housing instability. Co-occurring social and medical factors are the primary factors that contribute to homelessness. The VI-SPDAT was created through the merger of the Vulnerability Index, as owned and made popular by Community Solutions, and the SPDAT Pre-screen Tool, which is part of the SPDAT tool suite owned and created by OrgCode Consulting, Inc.

Appendix 2: DC Interagency Council on Homelessness

Full Council Members, as of 3/31/14

Government Representatives (Voting, per HSRA)

- Rashad Young, OCA (Chair)
- Brenda Donald, DMHHS (Alternate Chair)
- Raymond Davidson, CFSA
- Barbara Bazaron, DBH
- Kaya Henderson, DCPS
- Adrianne Todman, DCHA
- Polly Donaldson, DHCD
- Laura Zeilinger, DHS
- Jonathan Kayne, DGS
- Deborah Carroll, DOES
- Thomas Faust, DOC
- LaQuandra Nesbitt, DOH
- Chris Geldard, HSEMA
- Cathy Lanier, MPD
- Amy Maisterra, OSSE

CoC/Service Provider Reps

- Luis Vasquez, Catholic Charities
- Michael Ferrell, Coalition for the Homeless
- Kelly McShane, Community of Hope
- Jean-Michel Giraud, Friendship Place
- Elizabeth (Schroeder) Stribling, N Street Village
- Deborah Shore, Sasha Bruce

Advocates

- Maggie Riden, DC Alliance for Youth Advocates
- Kate Coventry, DC Fiscal Policy Institute
- Chapman Todd, Development Consultant
- Nan Roman, National Alliance to End Homelessness
- Scott McNeilly, Washington Legal Clinic for the Homeless

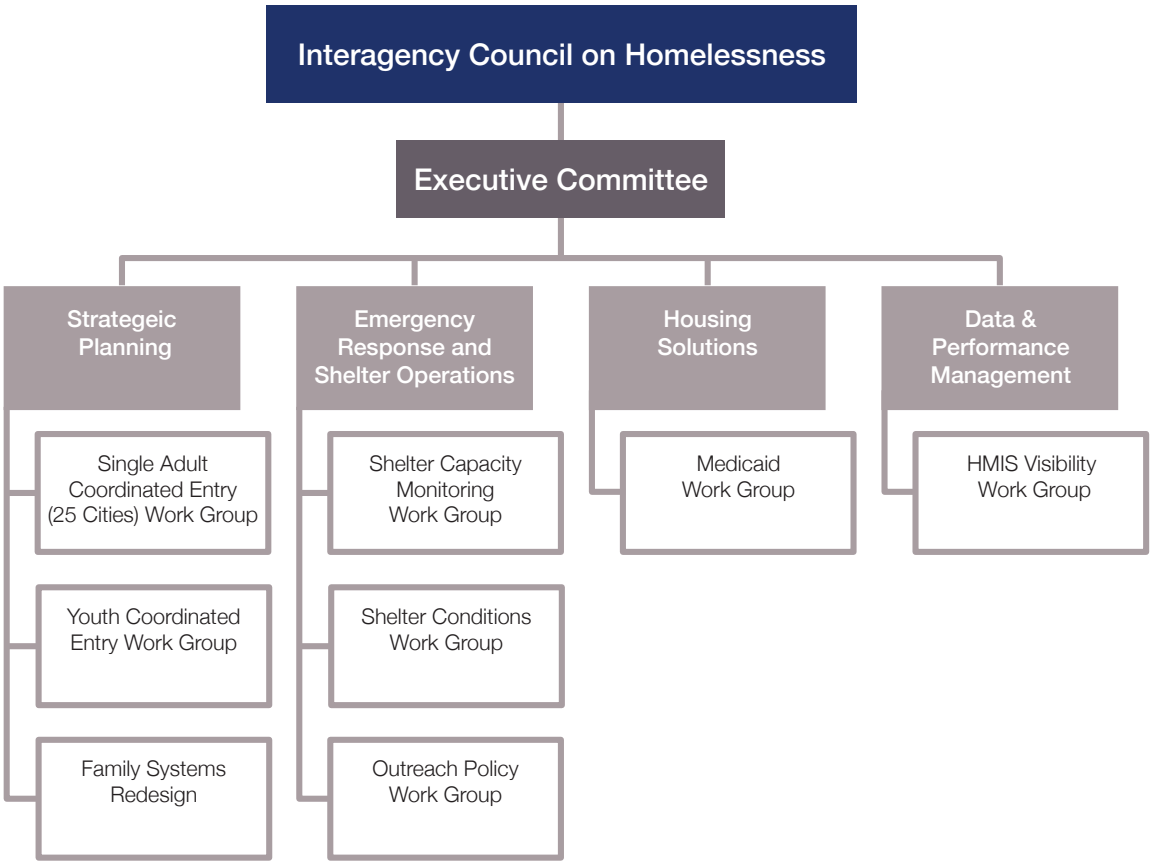
Consumer Representatives (Homeless/Formerly Homeless)

- Donald Brooks
- Cheryl Barnes
- Michael Coleman

Continuum of Care Representative

- Sue Marshall, TCP

ICH Committee Structure, 2015



Appendix 3: Strategic Planning Process - Public Meetings

Meeting Topic	Meeting Date	Meeting Participants/Notes
Environmental Scan with 10 Key Stakeholders: Facilitated by HUD Technical Assistance Provider	July 28 – August 1, 2014	Individual Meetings with Stakeholders in Washington, DC
Program Models Visioning Meeting	August 25, 2014	DC ICH Strategic Planning and Executive Committees
Housing Inventory Review Calls with 19 Agencies Operating 50 Projects	September 12 – October 31, 2014	Phone Calls with Homeless Service Providers
Review of Process	September 23, 2014	DC ICH Strategic Planning Committee
Program Models Review	October 2, 2014	DC ICH Housing Solutions Committee
Program Models Review	October 8, 2014	DC ICH Data and Performance Management Committee
Program Models Review	October 16, 2014	DC ICH Shelter Capacity Work Group
Program Models Review	October 22, 2014	DC ICH Emergency Shelter Response and Shelter Operations Committee
Pre-meeting Comment Period, DC ICH Meeting	October 21, 2014	DC ICH Meeting at 801 East Men's Shelter
Program Models and Systems Mapping Review	October 28, 2014	DC ICH Strategic Planning Committee
Systems Modeling 101	November 4, 2014	DC ICH Executive Committee
Program Models Public Meeting for Homeless Service Providers	November 20, 2014	Hosted by The Community Partnership for the Prevention of Homelessness
Systems Modeling for Families	November 21, 2014	DC ICH Strategic Planning Committee
Systems Modeling for Individuals	November 21, 2014	DC ICH Strategic Planning Committee
Systems Modeling for System	December 2, 2014	DC ICH Strategic Planning Committee
Year Round Access to Shelter – "Hot Topic" Meeting	December 9, 2014	Hosted at DHS

Meeting Topic	Meeting Date	Meeting Participants/Notes
Rapid Re-Housing – "Hot Topic" Meeting	December 9, 2014	Hosted at DHS
Chronically Homeless Placement Acceleration – "Hot Topic" Meeting	December 9, 2014	Hosted at DHS
Shelter Conditions/Redevelopment – "Hot Topic" Meeting	December 10, 2014	MLK Library
Transitional Housing – "Hot Topic" Meeting	December 10, 2014	MLK Library
Overview of Plan Process to Date	December 16, 2014	DC ICH Meeting, THRIVE DC
Systems Modeling and Cost Analysis	January 27, 2015	DC ICH Strategic Planning Committee
Systems Modeling and Cost Analysis Phone Call	February 10, 2015	DC ICH Strategic Planning Committee
DHCD PSH Pipeline Project Review Calls for 28 Projects in Development	February 9-23, 2015	Phone Interviews with Developers/Representatives of Funded Projects
Strategic Plan Draft Review	February 24, 2015	DC ICH Strategic Planning Committee
Strategic Plan Draft Review	March 3, 2015	DC ICH Executive Committee

Appendix 4: Community Organizations Participating in Planning Process

- Calvary Women's Services
- Capitol Hill Group Ministries
- Catholic Charities
- Coalition for the Homeless
- Coalition for Nonprofit Housing and Economic Development
- Community Connections
- Community of Hope
- Covenant House
- DC Alliance for Youth Advocates
- DC Coalition Against Domestic Violence
- DC Fiscal Policy Institute
- District Alliance for Safe Housing
- Echelon Community Services
- Friendship Place
- Homeless Children's Playtime Project
- House of Ruth
- Meyer Foundation
- Miriam's Kitchen
- National Alliance to End Homelessness
- N Street Village
- Pathways to Housing DC
- People for Fairness Coalition
- Salvation Army
- Sasha Bruce
- So Others Might Eat
- The Community Partnership for the Prevention of Homelessness
- Transitional Housing Corporation
- Washington Legal Clinic for the Homeless
- Willim S. Abell Foundation

Appendix 5: District of Columbia 2014 Housing Inventory Count (HIC)

EMERGENCY SHELTER	Beds with Children	Units with Children	Beds without Children	Beds with Only Children	Seasonal
HC	2881	889	0	0	0
SFHC	51	24	3	0	0
SMF + HC	4	2	24	0	0
SF	0	0	313	0	45
SM	0	0	1052	0	327
SMF	0	0	794	0	468
YMF	0	0	0	10	0
Total	2936	915	2186	10	840

TRANSITIONAL HOUSING	Beds with Children	Units with Children	Beds without Children	Beds with Only Children
HC	962	360	0	0
SFHC	123	46	2	0
SMF + HC	12	6	11	0
SF	0	0	251	0
SM	0	0	405	0
SMF	0	0	224	4
YMF*	8	8	0	0
Total	1105	420	893	4

RAPID RE-HOUSING	Beds with Children	Units with Children	Beds without Children	Beds with Only Children
HC	2214	659	0	0
SMF + HC	47	23	65	0
TOTAL	2261	682	65	0

PERMANENT SUPPORTIVE HOUSING	Beds with Children	Units with Children	Beds without Children	Beds with Only Children
HC	705 (41 UD)	194 (17 UD)	0	0
SFHC	30	11	0	0
SMHC	7	3	19	0
SMF + HC	1700	557	1922	0
SF	0	0	122	0
SM	0	0	66 (66 UD)	0
SMF	0	0	1045	0
YMF	0	0	0	0
TOTAL	2442	765	3174	0

*An additional 66 beds for SM were under development (UD) in 2014.
*An additional 41 beds/17 units for HC were under development (UD) in 2014.

	Beds with Children	Units with Children	Beds without Children	Beds with Only Children	Seasonal
Total	8744	2782	6318	14	840

	HC	SFHC	SMHC	SMF+HC	SF	SM	SMF	YMF
TOTALS WITH SEASONAL/ OVERFLOW	8864	290	19	4373	731	1850	4385	18
TOTALS WITHOUT SEASONAL	8864	290	19	4373	686	1523	3917	18

Key:

HC = Households with Children

SFHC = Single Females and Households with Children

SMHC = Single Males and Households with Children

SMF + HC = Single Males and Single Females and Households with Children

SF = Single Females

SM = Single Males

SMF = Single Males and Females

YMF = Youth Males and Femal

Appendix 6: Program Models Matrix

Overview: The program models matrix is intended to be a living document to guide planning and implementation efforts. It is intended to help funders understand what to fund and providers understand what they are expected to deliver. It also helps ensure we are measuring outcomes of similar programming in a consistent way. It is important to note that the "essential program elements" identified are intended to reflect the ideal program components that should be included in the program type, especially for any new programs a provider is designing or a funder is supporting. Some of the elements identified are cost neutral (e.g., use of a common assessment tool, how program vacancies are filled), but it is important to acknowledge that other elements are not. In some cases – particularly on issues impacted by facility size/configuration – existing programs may not be able to incorporate certain program elements at all (e.g., a program that provides daytime services may not have the space necessary to offer clients lockers for storage or shower facilities to help meet hygiene needs). In other cases, providers will not be able to adapt programming unless contracts include the necessary resources (e.g., moving from 12 to 24 hour access in low barrier shelters, reducing case load sizes). Funders and providers will have to work together closely to examine where changes can be implemented immediately and where time, resources, and/or capacity building will be required.

I. "FRONT PORCH" SERVICES

"Front Porch" services are those provided to clients before they reach the front door of the homeless services system (the front door being the shelter system). This may include services to both those already homeless as well as to those at imminent risk of losing their housing.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Daytime Service Center	Households with children (VWFRC)	Provides a central point of access whereby persons experiencing homelessness can access homelessness prevention assistance, referral to shelter, and/or other critical services.	• Use of common assessment tool, uniform prioritization policy, and common referral protocol. • Includes connection to mainstream resources (e.g., TANF, SNAP). • Services such as mediation and diversion available on site. • Bi-lingual services are available on-site. • Real-time bed availability information available – utilizing the HMIS for referral tracking. • Includes a Crisis Hotline option (after hours).	One-Time	Timeliness of Assessment/ Assistance Customer Service Experience
	Singles	Provides a central point of access whereby persons experiencing homelessness can access homelessness prevention assistance, referral to shelter, and/ or other critical services.	• Use of common assessment tool, uniform prioritization policy, and common referral protocol. • Real-time bed availability information available – utilizing the HMIS for referral tracking. • Includes connection to mainstream resources, such as employment services, health/mental health assistance, benefits application (e.g., SNAP, SSI/SSDI). • Food/meals provided. • Allows for hygiene needs to be met (showers, laundry). • Allows for safe storage of important belongings. • Group therapy and peer supports provided onsite.	One-Time	Timeliness Assessment/ Assistance Customer Service Experience
Outreach	People sleeping on the streets or otherwise unsheltered	Identify and engage hard to reach homeless individuals residing on the streets.	• Coordination with community-wide outreach network to cover assigned geography. • Relationship building to engage hard to reach homeless. • Assessment using VI-SPDAT. • Safety and Crisis Assessments conducted. • Mental health screening and connection to mental health professionals (as needed). • Assistance connecting to needed benefits (e.g., TANF, SNAP, SSI/SSDI) and services (e.g., health, substance use treatment). • Assistance obtaining identification and/or other documentation. • Coordination with police officers to engage difficult clients and de-escalate situations. • Provision of basic items to protect against the elements (blankets, socks, hats, water, etc.).	N/A	% of clients that complete the VI-SPDAT % of clients that receive peer supports % of persons served in street outreach projects that are connected to mainstream benefits/ services % of persons served in street outreach projects that exit to temporary therapeutic or permanent housing destinations % of persons who score between x and y (highest for PSH) on the VI-SPDAT assisted to become "document ready" for housing.[37]

37 Note, the range on this measure will change as we house our most vulnerable individuals and as the population changes.

I. "FRONT PORCH" SERVICES

"Front Porch" services are those provided to clients before they reach the front door of the homeless services system (the front door being the shelter system). This may include services to both those already homeless as well as to those at imminent risk of losing their housing.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Prevention/ Diversion	1) People at imminent risk of losing their housing and likely to enter shelter 2) People that are literally homeless and are seeking shelter	Prevent loss of permanent housing, and when that's not possible, identify alternative housing options to prevent the need for a shelter placement.	• Use of a common screening tool to target resources. • Case management to develop stabilization plan, using a strengths-based model. • Provision of financial assistance and services tailored to meet each household's unique needs. • Financial assistance may include rental arrears, utility arrears, security deposits, short- to medium- term rental assistance, utility assistance, and/or help with other household expenses that enable the household to remain housed. Services may include legal assistance, mediation, credit/financial counseling, and connection to mainstream benefits/services to help stabilize the household. Regular meetings with client to ensure implementation of plan and progress on stabilization. • Referrals to employment supports, adult education, literacy, financial capability services, etc. • Intentional linkage to landlord/pre-eviction assistance. • After-hours assistance. • An emphasis on mediation and connection people back to the community.	Typically one-time assistance, but up to 12 months as needed to stabilize the household.	% who avoid subsequent homelessness at 12, 18, and 24 months % of applicants screened for assistance but not provided assistance that enter shelter in the subsequent 12 month period.[38]

II. SHORT-TERM PLACEMENT (INTERIM HOUSING)

Shelter/housing that is time limited in nature and is designed to provide a safe, stable environment for households while they work on a permanent housing solution.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Outreach Beds	Single adults living on the street; extremely high need; extremely difficult to engage	Shelter for high need individuals living on the street and unwilling or unable to engage in services. Primary purpose is to provide safe and low pressure setting for clients to build trust and begin the engagement process.	• Referral by outreach worker. • Safe setting/harm reduction model. • Beds are segregated by gender. • 24-hour access. • Small facility, no more than 35 beds. • No admission or service requirements, but services available/offered (particularly mental health and substance abuse services by DBH or other skilled/licensed provider). • SOAR case management on staff or co-located at facility. • Meals provided. • Maximum Caseload of 10.	No time limit	Number of incident reports % of clients that complete the VI-SPDAT[39] % of clients placed in PSH

38 The purpose of this measure is to help validate the prevention-screening tool used by the community. If this percentage is too high, we will know we need to adjust our screening methodology.

39 Targets for outreach beds will be much lower than emergency shelters, but we will still want to track/measure progress.

II. SHORT-TERM PLACEMENT (INTERIM HOUSING)

Shelter/housing that is time limited in nature and is designed to provide a safe, stable environment for households while they work on a permanent housing solution.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Emergency Shelter	Adult households (including singles and families with an adult head of household) that have lost their housing and need a safe place to stay while working to quickly regain permanent housing	Shelter for households that have lost their housing and need a safe, stable setting as a platform to regain permanent housing. No admission requirements but clients will be expected to participate in an assessment and engage in case management as needed to assist with re-housing. Note: System should build in capacity for overflow during peak times of need. Space configuration and hours of access for overflow may necessarily vary, though programing philosophy and service model will not.	**1. Meets Basic Clients Need** - Year-round placements. - 24-hour access. - Provision of meals. - Allows for hygiene needs to be met (showers, laundry). - Allows for safe storage of important belongings. **2. Clients Supported to Establish Housing Stabilization Plan** - Housing assessment (VI-SPDAT for singles; F-SPDAT Assessment for families) completed within 7-14 days. - Assignment to a case manager/navigator within 14 days. Data from coordinated intake shared with case managers in a timely manner. - Employment assessment completed within 30 days for clients scoring for RRH and any other clients that opt-in (should be offered to all). - Case manager responsibilities include: • Connections to mainstream benefits and services, including TANF, SNAP, SSI/ SSDI, Medicaid/Medicare (case managers expected to help clients apply for benefits and navigate systems as needed). • Housing search assistance (either directly or through coordination with a partner). • Employment assistance (either directly or through coordination with a partner). • Support mediation and connection with community. **3. Constructive and structured milieu** - Small facilities, no more than 40 units/ building for families and 100 beds/building for singles. - Customer service orientation; trauma-informed, strengths-based approach. - Structured group activities (e.g., mental health/substance abuse treatment, financial literacy training, employment support peer support, social interactions).	60 days by 2020	Number of incident reports % of clients that complete the VI-SPDAT Average length of time homeless Housing placement (% exit to PH) Client Satisfaction

II. SHORT-TERM PLACEMENT (INTERIM HOUSING)

Shelter/housing that is time limited in nature and is designed to provide a safe, stable environment for households while they work on a permanent housing solution.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Traditional Housing	For people experiencing homelessness who: • Are not initially assessed for PSH; • Have a specific health or therapeutic need that inhibits the ability to obtain or remain stably housed; AND • Prefer a communal living environment. (A communal living environment may be congregate or individual apartments in the same building, but offers shared spaces, group therapy, etc.)	**Temporary Therapeutic Residence for:** • Individuals or Families with a specific healthcare need (e.g., substance abuse treatment, mental health treatment, medical respite) • Victims of Domestic Violence • High Need Families with Heads of Households between 18 and 24 (i.e., those scoring on high end of RRH scale, those that are CFSA-involved) • Refugees and Sex Workers experiencing severe trauma	• Household holds lease and/or occupancy agreement. Occupancy agreement must comply with HUD requirements. • May have eligibility requirements based on the specific therapeutic need to be addressed (e.g., willingness/desire to participate in services), but barriers to entry should remain low. • 24-hour residential environment (safe/ structured setting, provision of meals or cooking space, access to laundry, storage, etc.) • Therapeutic counseling specialized for population (includes a combination of individual therapy, group therapy, and peer support). • Clients supported to establish and implement housing stabilization plan to secure private market housing upon program exit. Services that are tailored to the target population may include: - Employment assessment and connection to employment services and/or education/GED services (as directed by the assessment) - Financial counseling to help resolve rental arrears, debt, etc. and to establish savings plan. - Connections to mainstream benefits and services, including TANF, SNAP, SSI/ SSDI, Medicaid/ Medicare, DCPS, etc. (case managers expected to help clients apply for benefits and navigate systems as needed). - Housing search assistance (either directly or through coordination with a partner). - Assistance building (re-building) family and community support networks.	9-12 Months (on average)	100% of slots allocated via coordinated entry Reduce length of time experiencing homelessness % exit to affordable permanent housing % who avoid subsequent homelessness at 12, 18, and 24 months Average increase in income

III. PERMANENT HOUSING

Housing in which a client is a leaseholder and can remain in the unit for as long as he/she chooses. The programming provides a subsidy and voluntary services (as determined by assessment) to help the client in retaining the housing.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Rapid Re-Housing	Individuals and families that have lost their housing and are on the streets or entered shelter, including those that have a specific health or therapeutic need but do not require PSH and do not prefer a communal living environment.	Short- to medium-term subsidy and services program that helps individuals and families regain housing stability and economic viability. Services package should be tailored to meet needs of individual or family.	• Household holds lease and may remain in unit permanently (i.e., following exit from the program). • Provision of case management to conduct individualized assessment and develop stabilization plan (which includes support mapping). • Provision of financial assistance (rental arrears, security deposits, utility deposits, utility assistance, short- to medium- term rental assistance) and services (legal assistance, mediation, credit/financial counseling, and connection to mainstream benefits/services). - Subsidy can be deep or shallow and change over time based on the needs of the client. - Services, available in different doses, should be tailored to meet each household's needs. Regular meetings with client to ensure implementation of plan and progress on stabilization. • Provision of housing search assistance (either directly or through a partner). • Provision of employment assistance (either directly or through a partner). • Connection to benefits and other mainstream resources. • Serves as liaison to landlords for the program.	4 months of assistance, renewable in 4-month increments via a progressive engagement approach	% who exit to permanent housing % who avoid subsequent returns to homelessness at 12, 18, and 24 months Average number of months of assistance provided Average increase in income (employment and benefits) and/or maintenance of income Average rent burden at program exit

III. PERMANENT HOUSING

Housing in which a client is a leaseholder and can remain in the unit for as long as he/she chooses. The programming provides a subsidy and voluntary services (as determined by assessment) to help the client in retaining the housing.

Program Type	Population	Program Description	Essential Program Elements	Time Frame	Outputs/Outcomes Measures
Permanent Supportive Housing	Chronically homeless individuals and families and other highly vulnerable individuals and families (as determined by assessment)	Long-term subsidy and long-term, wrap-around support services that help individuals and families with intensive needs obtain and maintain housing stability.	• Household holds lease. Master leasing as an option for high barrier, hard to lease populations. • Subsidy can be deep or shallow and change over time based on the needs of the client. • Assessment is conducted to determine service needs. • Services are intensive, flexible, tenant-driven, voluntary, and offered in the client's housing if they so choose. • Primary focus of services is on tenancy supports that help people access and remain in housing. • Additional focus of services is to connect tenants to or directly provide tenant-driven supportive services, including mental health services, substance abuse services, physical health services, benefits assistance, employment assistance, etc. • Barriers to entry strongly discouraged (i.e., housing should be provided without clinical prerequisites for sobriety or completion of treatment, and reduced barriers for credit history and minor criminal convictions). • Annual reassessment using common assessment tool to determine households ready for "move-on". • Build and support landlord relationships.	No time limit	100% of slots allocated via coordinated entry % who avoid subsequent homelessness at 12, 18, and 24 months % connected to SSI/ SSDI and/or other sources of income % chronically homeless at entry % decreasing service need acuity (as measured by common assessment tool) % achieving service plan goals

III. PERMANENT HOUSING **Housing in which a client is a leaseholder and can remain in the unit for as long as he/she chooses. The programming provides a subsidy and voluntary services (as determined by assessment) to help the client in retaining the housing.**					
Program Type	**Population**	**Program Description**	**Essential Program Elements**	**Time Frame**	**Outputs/Outcomes Measures**
Targeted Affordable Housing	1. Individuals and families in PSH who, based on an assessment, no longer need intensive services to remain stably housed but, most likely due to advanced age and/or a disability, need a permanent housing subsidy. 2. Individuals and families that, despite actively pursuing a housing stabilization plan with the support of case management, have been unable to succeed in RRH (but who do not need PSH).	Long-term subsidy with no or light-touch services (as determined by assessment). Not intended to address affordable housing broadly, but targeted to households that do not need ongoing services and that, but for long-term subsidies, could not exit homelessness or would return to homelessness.	• Household holds lease. • May be single-site or scattered-site through a voucher. • Services are light touch (e.g., quarterly or semi-annual check-in, assistance to ensure client complies with annual recertification process for housing or other benefits) • Referrals are made using a common assessment tool and protocol.	No time limit	% who avoid subsequent homelessness at 12, 18 and 24 months Average increase in income (employment and benefits) and/or maintenance of income % who exit program via “move-on” strategy

Appendix 7: Assumptions for Pathways

Individuals

Overview of Estimates: The estimates on strategies are guided largely by the VI-SPDAT assessment results completed (over 3,200) as of the development of the plan. This does not include all individuals in the system, but provides a sizeable sample. Of those individuals assessed, approximately 28 percent were assessed for PSH, 52 percent for RRH, and 20 percent for one-time assistance. To ensure chronically homeless individuals did not skew our numbers, we examined the needs of that group separately, 60 percent of which scored for PSH. Because the tool assesses for supportive service needs rather than financial need, and because the chronically homeless population is an older cohort (average age of 51) with limited earning potential – many with physical disabilities and chronic illnesses if not the behavioral health issues that require intensive service support – the planning group felt RRH was largely infeasible for this group. As such, the group assumed 30 percent would need long-term subsidies or affordable units (TAH), and that we would try RRH with 10 percent of the population, moving them on to a different intervention via a progressive engagement model if the RRH was not enough to stabilize them. It is important to note that these estimates are a starting point and will be updated/refined annually to reflect our growing understanding of the needs of the individuals in the system. Further, it is important to note that these estimates are intended to guide planning and budgeting decisions, but actual placement decisions are made on a case-by-case basis based on assessment results and consultations with families.

Service Strategies	Individuals		Source of Estimate
	Overall Strategy (%)	Detail Strategy (%)	
Strategies for People Presenting Each Month			
Prevention/Diversion	10%	10%	Based on the experience of other communities doing more prevention work with single adults (e.g., Dayton, OH).
Emergency Shelter (ES) Only	30%	30%	Based on our 2013 Annual Homeless Assessment Report (AHAR) data, 38 percent of individuals in our system had shelter stays of 7 days or less. The 10 percent in the prevention/diversion line comes out of this group.

Service Strategies	Individuals		Source of Estimate
	Overall Strategy (%)	Detail Strategy (%)	
Transitional Housing (TH) (through CAHP or via ES)	10%	8%	Transitional Housing is targeted to individuals with a therapeutic need (e.g., substance abuse treatment) and who prefer a communal setting. Because the tool does not assess for transitional housing, we know very little about the size of this group. The next phase of our coordinated assessment work will help us learn more about the needs and preferences of individuals with regard to TH. For now, we assume it's a relatively small percentage of the population, and we assume the individuals on this pathway would have otherwise been served by RRH (which is another short- to medium- term intervention).
TH (via ES) w/ TAH at Exit		2%	
Rapid Re-Housing (RRH) (one-time assistance)	45%	8%	Based on VI-SPDAT, less the 10 percent assumed for TH.
RRH (med-term assistance)		35%	
RRH (med-term assistance) w/ TAH at Exit		2%	
Permanent Supportive Housing (PSH) (via ES)	5%	5%	Since our CAHP system is still relatively new and we are not yet to the point of assessing every individual entering the system, it's difficult to predict the percentage of individuals flowing into the system each year that would require PSH to avoid long-term or recurring homelessness. We also don't have very good national data on the incremental growth in chronic homelessness over the last 20 years, but based on research by Dennis Culhane, it is believed to be relatively small, on the magnitude of 3 to 7 percent each year.
Strategies for Long-term Homeless			
Targeted Affordable Housing (TAH)	30%	30%	40 percent of the long-term population was assessed for RRH, but 70 percent are seniors with no or limited earning potential. This group is assumed to need a permanent subsidy to obtain and remain in housing.
PSH (via ES)	60%	35%	60 percent of the long-term population was scoring for PSH as of the time the planning process was conducted. The percentage coming straight from street outreach was based on the use of the warming buses during the 2013-2014 hypothermia season. Others are assumed to be utilizing shelters more regularly.
PSH (via Outreach)		25%	
RRH	10%	10%	Approximately 16 percent of the chronically homeless population in the District is under age 40. Depending on their health conditions, with the right support, some may be able to to be stabilzed with RRH. In addition, individuals have more flexibility in terms of living arrangements, and some may be able to afford housing in a shared living situation.

Families

Overview of Estimates: The estimates on strategies are guided largely by the F-SPDAT assessment results for families in the system in 2014, but are further adjusted in accordance to conversations with the strategic planning group based on actual experience working with families in the system. Of those households assessed (which included all households that were not able to exit on their own), 9 percent were assessed for PSH, 80 percent for RRH, and 11 percent for one-time assistance. Because the tool does not assess for transitional housing, we assumed that some of the RRH households would be served in transitional housing (which is another "medium term" intervention). Additionally, we assume that the households we are able to divert as well as those that are able to resolve on their own would come out of the one-time assistance category. We also know that nearly half of the households in our systems have a head of household that is between the ages of 18 and 24. Nearly all of these households score for medium term assistance, but we assume one-half will need assistance beyond the average. These groups are split between TH with RRH at exit, and RRH intensive. It is important to note that these estimates are a starting point and will be updated/refined annually to reflect our growing understanding of the needs of the households in our system. Further, it is important to note that these estimates are intended to guide planning and budgeting decisions, but actual placement decisions are made on a case-by-case basis based on assessment results and consultations with families.

Service Strategies	Individuals		Source of Estimate
	Overall Strategy (%)	Detail Strategy (%)	
Strategies for People Presenting Each Month			
Prevention/Diversion	5%	5%	The District already diverts a significant number of households during hypothermia season. As such, the families currently entering shelter are those with few options outside of shelter. Although DHS is in the midst of implementing a more targeted prevention program, the work group was conservative regarding its estimate of additional households that could be successfully diverted and stabilized.
Emergency Shelter Only	3%	3%	Based on 2013 AHAR data, 3 percent of our families exit in 7 days or less.
TH (direct from CAHP or via ES)	20%	10%	Transitional Housing is targeted to two different types of households: 1) young households with developmental needs, and 2) households with a therapeutic need and who prefer a communal setting (e.g., domestic violence, substance use). In 2014, 48 percent of homeless families had a head of household aged 18 to 24. The following assumptions are made for TH: 1) Approximately one-quarter of young families (particularly very young heads of household) will prefer a communal setting as they transition to independence, but will need some additional support upon leaving TH (10 percent of total population). We also assume 10 percent of families with a therapeutic need will prefer a communal setting during the treatment/recovery period.
TH (via ES) w RRH at Exit		10%	

Service Strategies	Individuals		Source of Estimate
	Overall Strategy (%)	Detail Strategy (%)	
RRH (one-time assistance)	63%	3%	Based on F-SPDAT assessment data, the majority of families in our system do not need intensive supportive services and are therefore scoring for one-time assistance or medium-term assistance. Our data show that only a small percentage of households provided RRH assistance actually return to the shelter system, but anecdotally, we know many of these households struggle with being able to afford and maintain their housing after the RRH subsidy ends. With regard to young families (aged 18 to 24), we assume approximately half may need additional assistance to transition to independence (which are split between TH with RRH at exit and RRH intensive). We also assume that about 10 percent of RRH households may have difficulty stabilizing due to factors such as large family size, a physical disability, etc. They do not have intensive service needs to remain housed (and thus do not score for PSH), but may have limited long-term income growth potential. TAH is targeted to these families.
RRH (med-term assistance)		40%	
RRH (med-term assistance) w TAH at Exit		10%	
RRH Intensive		10%	
PSH (via ES)	9%	9%	Based on F-SPDAT assessment result (9 percent). According to the 2014 evaluation of the Family Housing Solutions Project, families assessing for PSH versus RRH are more likely to have "involvement in high risk and/or exploitive situations, substance use, risk of harm to self or others, mental health and wellness and cognitive functioning, and medication."

Appendix 8: Program Model Unit Costs

As explained in Chapter 2 of the plan, budgets for programming within the same program types are currently highly variable. The range and intensity of support provided varies from one program to the next, case loads and case management rates vary, and costs related to overhead and administration vary, among other factors. To help inform future planning, budgeting, and program design decisions, we deconstructed program budgets to develop unit costs for each program model.

The units costs provided in this attachment represent average base costs for program models. The costs were constructed based on a comprehensive analysis of budgets for each program category. They take into account the core components of program models, including case management services and the average cost of leasing/operations. In addition, emergency shelter costs also include an average cost for program activities that are resourced in bulk (security, food, and transportation) based on actual costs from the FY2014 budget.

To construct average unit costs for the new program models, the analysis required:

- Determining all major costs categories for the new models;
- Examining budgets from existing programming in the community that closely resembles the future models (in instances that such programming exists);
- Conducting interviews with the providers operating the programming that resembles the future models; and
- Reviewing program models/budgets from other communities to help fill gaps in information.

Through the analysis, a handful of cost drivers were identified that may impact the average costs identified in the analysis. These cost drivers include:

- **Leasing costs for buildings.** The leasing cost for a building will vary depending on location. If we are going to remain committed to having programming and services available throughout the District, it will be important to acknowledge that total program costs – particularly for the interim housing models – may be more or less than the average reflected in this analysis.
- **Increases in Fair Market Rent (FMR).** Increases to the FMR over time will impact the cost to lease rental units in the community. Over time, this may impact program models with a heavy leasing component, including RRH, TAH, and PSH.
- **Boutique Programs.** Choosing to implement a program model on a smaller scale may result in increased or decreased budget line items. For example, the costing analysis is based on average case management ratios and includes assumptions about other staff positions needed under the new program models. Program models operating on a small scale may have smaller case management ratios and fewer clients across which to allocate the cost of other positions, making their average unit costs higher.
- **PSH Lease-up Costs.** PSH programs have a higher per unit cost at lease-up due to one-time funding for security deposits, furniture, and other household items that will not be incurred on an annual basis. In addition, rental subsidy amounts are often greater during the first year of assistance and then decrease incrementally as the client is engaged in services and receiving cash and non-cash benefits (e.g., SSI/SSDI, Veterans benefits, Food Stamps), which help offset the amount of rent paid by the government.

- **Population Served.** Programs may have higher or lower than average costs due to the population served. While our coordinated assessment system should help ensure clients are effectively matched to the right type of programming, there are still varied needs within a given population. For example, a PSH program serving chronically homeless individuals with severe and persistent mental illness may have higher service costs than a PSH program serving chronically homeless individuals with physical disabilities.

Finally, the unit costs do not take into account administration/overhead costs that may be applied by administering agents (e.g., DHS and TCP). Determining administrative costs was particularly difficult as DHS takes on varied roles across different programs they fund. In some cases, DHS directly administers payments (e.g., for overflow shelter for families). In other cases, they subcontract funding to TCP (such as FRSP). And in other cases, they pay for services directly but use another entity to administer rental assistance payments (such as PSHP). The varied role DHS plays in administering, directly managing, and at times providing direct services made discerning roles and responsibilities across DHS, the CoC lead (TCP), and service providers especially complex. Therefore, it is important to remember that the program model costs represent the average base costs to operate the programs.

Further, as described above, there are a number of reasons why program costs may be higher or lower than average. The costs included in this analysis include eligible activities under local and Federal government funding streams. Programs may, of course, supplement programming offerings through the use of volunteers or via private funding vehicles (e.g., art or playtime programs for children). The expectation is that providers will look for ways to leverage government investments to stretch resources as far as possible. Likewise, it will be important for funders to examine program proposals/budgets on an individual basis to understand under what circumstances higher than average costs are warranted as well as circumstances where lower than average costs would be expected. The tables below provide additional detail on different program models.

Program Model Unit Costs: Families

Current System		
Program Model Cost		**Comments**
Prevention/Diversion*		
Per family	$2,190	
Emergency Shelter (DC General)		
Annual/unit	$53,895	
Daily/unit	$150	
Temporary Shelter		
Annual/unit	$53,595	
Daily/unit	$145	
Overflow Shelter (Motels)*		In an ideal future system, we would not need overflow shelter. However, it will give us flexible capacity as we transition.
Per family	$11,890	
Transitional Housing		Many of the TH programs in the inventory are older programs and own their buildings. Without leasing costs, the unit costs are relatively low.
Annual/unit	$18,050	
Daily/unit	$50	
Rapid Re-Housing (FRSP)		Based on actual rents paid in FY14.
Annual/unit	$29,250	
Daily/unit	$80	
Permanent Supportive Housing		Based on actual rents paid in FY14.
	DHS funded rent + services	
Annual/unit	$27,080	
Daily/unit	$75	
Annual services funding by DHS	$11,630	
Daily services funded by DHS	$30	
Targeted Affordable Housing		
(N/A)		

Future System		
Program Model Cost		**Comments**
Prevention/Diversion		Standardized average based on SSVF costs for singles and families. We have more work/ learning to do around targeted prevention; this is a starting place.
Per family	$2,500	
Emergency Shelter		Based on the current costs of our temporary shelter facilities.
Annual/unit	$53,595	
Daily/unit	$145	
		Our TH stock is an important part of the homeless services system inventory, though we are proposing to repurpose some of the existing stock to meet different needs in the continuum (e.g., PSH, shelter). For those programs that would remain as transitional (therapeutic) housing for special populations, the costs would vary significantly depending on the population served and the programming needed.
Transitional Housing/ Temporary Theraputic Housing		
Annual/unit	$ variable	
Daily/unit	$ variable	
Rapid Re-Housing (FRSP)		Because the program is short-to-medium term assistance, we may not see the leveling off of rents that we do in longer-term programs. This is an area for further analysis.
Annual/unit	$29,250	
Daily/unit	$80	
Permanent Supportive Housing		As noted in the overview, these costs represent mid-program costs after clients have stabilized. It may be necessary to create a year-one "add on" to account for the additional cost of lease-up for a new client.
	DHS funded rent + services	
Annual/unit	$27,080	
Daily/unit	$75	
Annual services funding by DHS	$11,630	
Daily services funded by DHS	$30	
Targeted Affordable Housing		Costs based on actual rent paid in LRSP. Because these clients would be stepped up from RRH or stepped down from PSH, we assume only light touch services would be needed.
Annual/unit	$19,800	
Daily/unit	$55	

Program Model Unit Costs: Individuals

Current System			
Program Model Cost			**Comments**
Hypothermia Shelter			
Season/bed	$3,760		
Daily/bed	$20		
Low Barrier Shelter			
Annual/bed	$11,015		
Daily/bed	$30		
Temporary Shelter			
Annual/bed	$10,810		
Daily/bed	$30		
Transitional Housing			See comments related to TH above under family system.
Annual/bed	$18,050		
Daily/bed	$50		
Rapid Re-Housing (Pilot)			
Annual/unit	$10,910		
Daily/unit	$30		
Permanent Supportive Housing			See comments related to PSH above under family system.
	DHS funded rent + services	HUD-funded rent/Medicaid-funded services	
Annual/unit	$15,890	$10,090	
Daily/unit	$45	$30	
Annual services funding by DHS	$6,270	$470	
Daily services funded by DHS	$15	$1	

Current System			
Program Model Cost			**Comments**
Prevention/ Diversion			See comments related to prevention/diversion above under family system.
Per individual		$2,500	
Outreach Beds			
Annual/bed		$26,880	
Daily/bed		$75	
Medical Respite Bed			
Annual/bed		$30,754	
Daily/bed		$85	
Emergency Shelter			Based on the new 100-bed program model with 24/7 access.
Annual/bed		$25,548	
Daily/bed		$70	
Transitional (Temporary Theraputic Housing)			See comments related to TH above under family system.
Annual/unit		$ variable	
Daily/unit		$ variable	
Rapid Re-Housing			Costs are based on the RRH pilot that was implemented in FY14. These costs may change as our sample of clients served grows and as we learn more.
Annual/unit		$10,830	
Daily/unit		$30	
Permanent Supportive Housing			As noted here, we have an opportunity to capture cost savings in the DHS budget by ensuring our State Medicaid Plan covers as many of the services provided in PSH as possible and by building the capacity of PSH providers to bill Medicaid. It is expected to yield greater savings among individuals served (the services families need in PSH often are not those that will be eligible under Medicaid). Still, it will be important to examine all opportunities as we move forward with the Medicaid analysis/policy work.
	DHS funded rent + services	HUD-funded rent/Medicaid-funded services	
Annual/unit	$15,890	$10,090	
Daily/unit	$45	$30	
Annual services funding by DHS	$6,270	$470	
Daily services funded by DHS	$15	$1	
Targeted Affordable Housing			
Annual/unit		$12,156	
Daily/unit		$35	

Appendix 9: Length of Stay Assumptions by Year, 2016 - 2020

The tables in this appendix provide the assumptions related to the average length of stay (also referred to as project utilization) in each program type along a given pathway for each year of the plan. Project utilization is calculated in months, except for program interventions where the subsidy is permanent (PSH and TAH), in which case it is calculated as units. The second table in each pair translates those estimates into the inventory needs based on the number of individuals projected to enter the system each year.

For example, the average length of stay in emergency shelter is projected to be six months in the first year of plan implementation. We estimate that 40 percent of households would be able to resolve their homelessness with an RRH intervention. We estimate the average length of assistance for RRH in year one is 12 months. This translates into 847 slots of RRH needed in year one. We further estimated that another ten percent would need more time to get stabilized, but not yet a permanent subsidy. The average length of assistance in these RRH Intensive slots is 18 months (another 220 slots). As described in the narrative of the plan, length of assistance is not determined up front, but through a progressive engagement case management approach. The estimates are intended to help with planning and budgeting. They will be revisited each year as we have new/better data to guide our assumptions.

Families System Detail

2016: Pathways and Length of Stay Assumptions (Families)										
Pathways	Families		Projected System Utilization (Avg Months of Asst each Program Type)							
	Overall Strategy (%)	Detail Strategy (%)	Emergency Shelter	Traditional Housing	Rapid Re-Housing	Rapid Re-Housing Intensive	Permanent Supportive Housing	Targeted Affordable Housing	Prevention / Diversion	Avg Length of Time Hmls
Strategies for People Presenting Each Month										
Shelter/ Diversion	5%	5%							4	0
Emergency Shelter Only	3%	3%	1							1
TH only (direct through coordinated assmt)	20%	0%								0
TH (through CA or via ES)		10%	6	12						18
TH w RRH at Exit		10%	6	12	9					27
RHH (one-time asst)	63%	3%	6		1					7
RHH (med-term asst)		40%	6		12					18
RHH (med-term asst) w TAH at Exit		10%	6		12			1		18
RRH Intensive		10%	6			18				6
PSH (via ES)	9%	9%	6				1			6
Total	100%	100%								

2016: Projected Inventory Needed	
Program Types- FAMILIES (PT-in-time Unit Count)	Proposed System for Fam (Units)
Prevention/ Diversion	24
Emergency Shelter	677
Transitional Housing	294
Rapid Re-Housing	847
Rapid Re-Housing Intensive	220
Permanent Supportive Housing	132
Targeted Affordable Housing	147
TOTAL	2,341

2017: Pathways and Length of Stay Assumptions (Families)										
Pathways	Families		Projected System Utilization (Avg Months of Asst each Program Type)							
	Overall Strategy (%)	Detail Strategy (%)	Emergency Shelter	Traditional Housing	Rapid Re-Housing	Rapid Re-Housing Intensive	Permanent Supportive Housing	Targeted Affordable Housing	Prevention / Diversion	Avg Length of Time Hmls
Strategies for People Presenting Each Month										
Shelter/ Diversion	5%	5%							4	0
Emergency Shelter Only	3%	3%	1							1
TH only (direct through coordinated assmt)	20%	0%								0
TH (through CA or via ES)		10%	5	12						17
TH w RRH at Exit		10%	5	12	9					26
RHH (one-time asst)	63%	3%	5		1					6
RHH (med-term asst)		40%	5		9					14
RHH (med-term asst) w TAH at Exit		10%	5		9			1		14
RRH Intensive		10%	5			18				5
PSH (via ES)	9%	9%	5				1			5
Total	100%	100%								

2017: Projected Inventory Needed	
Program Types- FAMILIES (PT-in-time Unit Count)	Proposed System for Fam (Units)
Prevention/ Diversion	24
Emergency Shelter	565
Transitional Housing	294
Rapid Re-Housing	664
Rapid Re-Housing Intensive	220
Permanent Supportive Housing	132
Targeted Affordable Housing	147
TOTAL	2,046

2018: Pathways and Length of Stay Assumptions (Families)										
Pathways	Families		Projected System Utilization (Avg Months of Asst each Program Type)							
	Overall Strategy (%)	Detail Strategy (%)	Emergency Shelter	Traditional Housing	Rapid Re-Housing	Rapid Re-Housing Intensive	Permanent Supportive Housing	Targeted Affordable Housing	Prevention / Diversion	Avg Length of Time Hmls
Strategies for People Presenting Each Month										
Shelter/ Diversion	5%	5%							4	0
Emergency Shelter Only	3%	3%	1							1
TH only (direct through coordinated assmt)	20%	0%								0
TH (through CA or via ES)		10%	4	9						13
TH w RRH at Exit		10%	4	9	9					22
RHH (one-time asst)	63%	3%	4		1					5
RHH (med-term asst)		40%	4		9					13
RHH (med-term asst) w TAH at Exit		10%	4		9			1		13
RRH Intensive		10%	4			18				4
PSH (via ES)	9%	9%	4				1			4
Total	100%	100%								

2018: Projected Inventory Needed	
Program Types- FAMILIES (PT-in-time Unit Count)	Proposed System for Fam (Units)
Prevention/ Diversion	24
Emergency Shelter	454
Transitional Housing	220
Rapid Re-Housing	664
Rapid Re-Housing Intensive	220
Permanent Supportive Housing	132
Targeted Affordable Housing	147
TOTAL	1,861

2019: Pathways and Length of Stay Assumptions (Families)										
Pathways	Families		Projected System Utilization (Avg Months of Asst each Program Type)							
	Overall Strategy (%)	Detail Strategy (%)	Emergency Shelter	Traditional Housing	Rapid Re-Housing	Rapid Re-Housing Intensive	Permanent Supportive Housing	Targeted Affordable Housing	Prevention / Diversion	Avg Length of Time Hmls
Strategies for People Presenting Each Month										
Shelter/ Diversion	5%	5%							4	0
Emergency Shelter Only	3%	3%	1							1
TH only (direct through coordinated assmt)	20%	0%								0
TH (through CA or via ES)		10%	3	9						13
TH w RRH at Exit		10%	3	9	9					22
RHH (one-time asst)	63%	3%	3		1					5
RHH (med-term asst)		40%	3		9					13
RHH (med-term asst) w TAH at Exit		10%	3		9			1		12
RRH Intensive		10%	3			18				3
PSH (via ES)	9%	9%	3				1			3
Total	100%	100%								

2019: Projected Inventory Needed	
Program Types- FAMILIES (PT-in-time Unit Count)	Proposed System for Fam (Units)
Prevention/ Diversion	24
Emergency Shelter	343
Transitional Housing	220
Rapid Re-Housing	664
Rapid Re-Housing Intensive	220
Permanent Supportive Housing	132
Targeted Affordable Housing	147
TOTAL	1,750

2020: Pathways and Length of Stay Assumptions (Families)										
Pathways	Families		Projected System Utilization (Avg Months of Asst each Program Type)							
	Overall Strategy (%)	Detail Strategy (%)	Emergency Shelter	Traditional Housing	Rapid Re-Housing	Rapid Re-Housing Intensive	Permanent Supportive Housing	Targeted Affordable Housing	Prevention / Diversion	Avg Length of Time Hmls
Strategies for People Presenting Each Month										
Shelter/ Diversion	5%	5%							4	0
Emergency Shelter Only	3%	3%	1							1
TH only (direct through coordinated assmt)	20%	0%								0
TH (through CA or via ES)		10%	2	9						10
TH w RRH at Exit		10%	2	9	9					20
RHH (one-time asst)	63%	3%	2		1					3
RHH (med-term asst)		40%	2		9					11
RHH (med-term asst) w TAH at Exit		10%	2		9			1		11
RRH Intensive		10%	2			18				2
PSH (via ES)	9%	9%	2				1			2
Total	100%	100%								

2020: Projected Inventory Needed	
Program Types- FAMILIES (PT-in-time Unit Count)	Proposed System for Fam (Units)
Prevention/ Diversion	24
Emergency Shelter	215
Transitional Housing	220
Rapid Re-Housing	664
Rapid Re-Housing Intensive	220
Permanent Supportive Housing	132
Targeted Affordable Housing	147
TOTAL	1,622

Individuals System Detail

2016: Pathways and Length of Stay Assumptions (Individuals)										
Pathways	Individuals		Projected System Utilization							
	Over-all Strate-gy (%)	Detail Strat-egy (%)	Outreach Beds (Avg/ Mths)	Emergency Shelter (Avg Mths)	Trans Housing (Avg Mths)	Rapid Re-Housing (Avg Mths)	PSH (Units)	TAH (Units)	Prev/ Diversion (Avg Months)	Avg Length of Time Hmls
Strategies for People Presenting Each Mo										
Prevention/ Diversion	10%	10%							4	0
Emergency Shelter Only	30%	30%		3						3
TH only (direct through coordinated assmt)	10%	0%								0
TH (through CA or via ES)		8%		3	12					15
TH(via ES) w TAH Exit		2%		3	12			1		15
RHH (one-time asst)	45%	8%		3		1				3
RHH (med-term asst)		35%		3		9				3
RHH (med-term asst) w TAH at Exit		2%		3		9		1		3
PSH (from street, using outreach beds)	5%	0%								0
PSH (via ES)		5%		4			1			4
Total	100%	100%								
Strategies for Long-Term Homeless										
TAH	0%	0%						1		0
Remaining Unhoused (in/out of ES)	67%	67%		6						6
PSH(via ES)	28%	18%		6			1			6
PSH (via Streets		10%					1			0
RHH	5%	5%				12				0
Total	100%	100%								

2016: Projected Inventory Needed		
Program Types- INDIVIDUALS (PT-in-time Unit Count)	Proposed System for Indiv (Units)	Initial Surge for Indiv (Units)
Prevention/ Diversion	292	0
Emergency Shelter	0	0
Transitional Housing	2,007	705
Rapid Re-Housing	875	0
Rapid Re-Housing Intensive	2,487	84
Permanent Supportive Housing	438	459
Targeted Affordable Housing	350	0
TOTAL	6,449	1,248

2017: Pathways and Length of Stay Assumptions (Individuals)										
Pathways	Individuals		Projected System Utilization							
	Over-all Strate-gy (%)	Detail Strate-gy (%)	Out-reach Beds (Avg/ Mths)	Emergency Shelter (Avg Mths)	Trans Housing (Avg Mths)	Rapid Re-Housing (Avg Mths)	PSH (Units)	TAH (Units)	Prev/Di-version (Avg Months)	Avg Length of Time Hmls
Strategies for People Presenting Each Mo										
Prevention/ Diversion	10%	10%							4	0
Emergency Shelter Only	30%	30%		3						3
TH only (direct through coordinated assmt)	10%	0%								0
TH (through CA or via ES)		8%		3	9					12
TH(via ES) w TAH Exit		2%		3	9			1		12
RHH (one-time asst)	45%	8%		3		1				3
RHH (med-term asst)		35%		3		9				3
RHH (med-term asst) w TAH at Exit		2%		3		9		1		3
PSH (from street, using outreach beds)	5%	0%	6				1			6
PSH (via ES)		5%		3			1			3
Total	100%	100%								
Strategies for Long-Term Homeless										
TAH	30%	30%						1		0
Remaining Unhoused (in/out of ES)	0%	0%		6						6
PSH(via ES)	60%	40%		6			1			6
PSH (via Streets		20%	2				1			2
RHH	10%	10%				12				0
Total	100%	100%								

2017: Projected Inventory Needed		
Program Types- INDIVIDUALS (PT-in-time Unit Count)	Proposed System for Indiv (Units)	Initial Surge for Indiv (Units)
Prevention/ Diversion	292	0
Emergency Shelter	0	38
Transitional Housing	1,970	225
Rapid Re-Housing	656	0
Rapid Re-Housing Intensive	2,487	113
Permanent Supportive Housing	439	676
Targeted Affordable Housing	350	338
TOTAL	6,194	1,390

2018: Pathways and Length of Stay Assumptions (Individuals)										
Pathways	Individuals		Projected System Utilization							
	Over-all Strate-gy (%)	Detail Strate-gy (%)	Outreach Beds (Avg/ Mths)	Emergency Shelter (Avg Mths)	Trans Housing (Avg Mths)	Rapid Re-Housing (Avg Mths)	PSH (Units)	TAH (Units)	Prev/ Diversion (Avg Months)	Avg Length of Time Hmls
Strategies for People Presenting Each Mo										
Prevention/ Diversion	10%	10%							4	0
Emergency Shelter Only	30%	30%		3						3
TH only (direct through coordinated assmt)	10%	0%								0
TH (through CA or via ES)		8%		3	9					12
TH(via ES) w TAH Exit		2%		3	6			1		9
RHH (one-time asst)	45%	8%		2		1				2
RHH (med-term asst)		35%		2		9				2
RHH (med-term asst) w TAH at Exit		2%		2		9		1		2
PSH (from street, using outreach beds)	5%	3%	2				1			2
PSH (via ES)		2%		2			1			2
Total	100%	100%								
Strategies for Long-Term Homeless										
TAH	30%	30%								0
Remaining Unhoused (in/out of ES)	0%	0%								0
PSH(via ES)	60%	35%								0
PSH (via Streets		25%								0
RHH	10%	10%								0
Total	100%	100%								

2018: Projected Inventory Needed		
Program Types- INDIVIDUALS (PT-in-time Unit Count)	Proposed System for Indiv (Units)	Initial Surge for Indiv (Units)
Prevention/ Diversion	292	0
Emergency Shelter	44	0
Transitional Housing	1,562	0
Rapid Re-Housing	613	0
Rapid Re-Housing Intensive	2,487	0
Permanent Supportive Housing	438	0
Targeted Affordable Housing	350	0
TOTAL	5,786	0

2019: Pathways and Length of Stay Assumptions (Individuals)										
Pathways	Individuals		Projected System Utilization							
	Over-all Strate-gy (%)	Detail Strate-gy (%)	Outreach Beds (Avg/ Mths)	Emergency Shelter (Avg Mths)	Trans Housing (Avg Mths)	Rapid Re-Housing (Avg Mths)	PSH (Units)	TAH (Units)	Prev/Di-version (Avg Months)	Avg Length of Time Hmls
Strategies for People Presenting Each Mo										
Prevention/ Diversion	10%	10%							4	0
Emergency Shelter Only	30%	30%		2						2
TH only (direct through coordinated assmt)	10%	0%								0
TH (through CA or via ES)		8%		1	9					10
TH(via ES) w TAH Exit		2%		1	6			1		7
RHH (one-time asst)	45%	8%		2		1				2
RHH (med-term asst)		35%		2		9				2
RHH (med-term asst) w TAH at Exit		2%		2		9		1		2
PSH (from street, using outreach beds)	5%	3%	2				1			2
PSH (via ES)		2%		2			1			2
Total	100%	100%								
Strategies for Long-Term Homeless										
TAH	30%	30%								0
Remaining Unhoused (in/out of ES)	0%	0%								0
PSH(via ES)	60%	35%								0
PSH (via Streets		25%								0
RHH	10%	10%								0
Total	100%	100%								

2019: Projected Inventory Needed		
Program Types- INDIVIDUALS (PT-in-time Unit Count)	Proposed System for Indiv (Units)	Initial Surge for Indiv (Units)
Prevention/ Diversion	292	0
Emergency Shelter	44	0
Transitional Housing	1,197	0
Rapid Re-Housing	613	0
Rapid Re-Housing Intensive	2,487	0
Permanent Supportive Housing	438	0
Targeted Affordable Housing	350	0
TOTAL	5,421	0

2020: Pathways and Length of Stay Assumptions (Individuals)										
Pathways	Individuals		Projected System Utilization							
	Overall Strategy (%)	Detail Strategy (%)	Outreach Beds (Avg/ Mths)	Emergency Shelter (Avg Mths)	Trans Housing (Avg Mths)	Rapid Re-Housing (Avg Mths)	PSH (Units)	TAH (Units)	Prev/Diversion (Avg Months)	Avg Length of Time Hmls
Strategies for People Presenting Each Mo										
Prevention/ Diversion	10%	10%							4	0
Emergency Shelter Only	30%	30%		1						1
TH only (direct through coordinated assmt)	10%	0%								0
TH (through CA or via ES)		8%		1	6					7
TH(via ES) w TAH Exit		2%		1	6			1		7
RHH (one-time asst)	45%	8%		2		1				2
RHH (med-term asst)		35%		2		9				2
RHH (med-term asst) w TAH at Exit		2%		2		9		1		2
PSH (from street, using outreach beds)	5%	3%	2				1			2
PSH (via ES)		2%		2			1			2
Total	100%	100%								
Strategies for Long-Term Homeless										
TAH	30%	30%								0
Remaining Unhoused (in/out of ES)	0%	0%								0
PSH(via ES)	60%	35%								0
PSH (via Streets		25%								0
RHH	10%	10%								0
Total	100%	100%								

2019: Projected Inventory Needed		
Program Types- INDIVIDUALS (PT-in-time Unit Count)	Proposed System for Indiv (Units)	Initial Surge for Indiv (Units)
Prevention/ Diversion	292	0
Emergency Shelter	44	0
Transitional Housing	987	0
Rapid Re-Housing	438	0
Rapid Re-Housing Intensive	2,487	0
Permanent Supportive Housing	438	0
Targeted Affordable Housing	350	0
TOTAL	5,027	0

Appendix 10: Highest Priority Year One Budget Items

Understanding that we may not be able to pay for or fully operationalize everything at once, the Strategic Planning Committee identified the following as the highest priority items for Year One implementation.

System	Item	Rationale
Families	Meet anticipated emergency shelter/ overflow needs	The District must meet its legal obligations under the HSRA, and it is important to have the funding necessary to do this so resources do not get diverted from other parts of the system. An effective emergency response system must respond to families when they are in crisis, not just when the weather meets certain criteria.
	Meet full permanent housing needs (RRH, PSH, TAH) to ensure households can quickly be matched throughout the year to the appropriate housing intervention.	Shelter is more expensive than any of the housing interventions, and if we do not meet the annual demand for families, we will end up paying for additional shelter costs.
	Provide capital resources needed to support closure of DC General	In order to close DC General on a specified timeline, we must move forward with new construction for a portion of the facilities.
Individuals	Meet as much of the PSH and TAH need as possible, particularly to address surge (i.e., long-term homeless) needs.	The individuals in our system experiencing chronic homelessness are medically vulnerable and need to be housed as quickly as possible. In addition, they consume a majority of the shelter resources. Housing this population will allow us to begin to contract our shelter capacity in the individuals system.
	Fund Daytime Services Center	The Daytime Services Center will serve as a bridge until we are able to move into smaller, 24/7 shelter facilities for individuals and will support the provision of critical supportive services needs.
	Begin to scale up RRH for singles	RRH is still a relatively new intervention for individuals, but the one needed at the greatest volume to address new inflow into the homeless services system. We likely do not have the capacity for full implementation in Year One, but we should begin to scale up.

Appendix 11: Operational Issues Raised During Public Comment Period

This appendix highlights concerns and suggestions raised about operational issues during the public comment period. Although the plan was not intended to cover operational issues, we felt it important to capture the feedback so we may reference it during plan implementation.

Overall

1. Ensuring that strategies adopted to address regional homelessness in partnership Montgomery County and Prince George's County are in line with and advance the goals of the strategic plan.
2. Developing a communication and outreach strategy for:
   a. Expanding role of private sector in implementing the action items of the plan.
   b. Ensuring buy-in and support for the strategic plan from the community at-large.
3. Reviewing funded programs and providers to ensure:
   a. Policies and procedures align with Housing First principles.
   b. Programs are standardized across the community regardless of provider.
   c. Guidelines are adopted for case manager to client ratios, as appropriate to the different program models, etc.
4. Developing a strategy for raising public, private, and philanthropic resources to fund the program models and action items identified under the five strategies.
5. Establishing a cycle for the annual work plan so that it is timed to inform the Mayor's proposed budget and the Council votes on the budget.

Strategy 1. Develop More Effective Crisis Response System

1. Planning for and addressing the needs of different subpopulations. Comments received pertain to:
   a. Language/cultural minority groups, including both legal and undocumented immigrants
   b. Vulnerable seniors
   c. Unaccompanied youth
   d. Single mothers
   e. Individuals with workforce development needs, including incarceration records
   f. School age children and links to schools
   g. Individuals with disabilities and/or special needs, including vulnerable mentally ill persons
   h. Domestic violence survivors
2. Coordinating with healthcare and other institutional partners for adequate discharge planning around:
   a. Senior citizens transitioning out of nursing homes
   b. Hospital discharges, including mental health facilities
   c. Courts and correctional facilities, etc.
3. Providing adequate services and security in emergency shelters for families and individuals. Comments received pertain to:
   a. Focus on housing navigation to match individuals/families and move them into housing as quickly as possible.
   b. Lack of case management services provided for both families and individuals in shelters.
   c. Need for culturally sensitive, trauma-informed security options and personnel.
   d. Need for outreach and peer mentoring services, staffed by formerly homeless who are culturally sensitive.
4. Supporting effective and rapid coordinated entry system (CAHP) for both individuals and families, including:
   a. Ensuring appropriate resources are allocated for the system.
   b. Ensuring all key agencies are represented at coordinated entry conversations.
5. Planning for program exit:
   a. Facilitating cohabitation options for individuals/families exiting shelter: for those interested in

congregate housing and/or co-habitation, ensuring stabilization options allow them to exercise housing preference.

b. Graduating families and individuals from RRH so that they can successfully assume responsibility for paying their rent upon exit.

6. Planning for improved RRH implementation to also include:
   a. Identifying appropriate support and services for individuals and families served by the program.
   b. Ensuring adequate funding of the program model to meet the identified need.
   c. Operationalizing a standard program model across all providers.
   d. Incentivizing landlords to work with RRH programs, including timely payments to landlords and provision of insurance against property damages or other losses.
7. Working with community to integrate smaller shelters into the surrounding neighborhoods.

Strategy 2: Increase Dedicated Supply of Supportive and Affordable Housing

1. Reviewing opportunities for expanding supply of supportive and affordable housing portfolio, including:
   a. District owned properties.
   b. Opportunities to purchase deteriorating housing.
   c. Zoning impediments that can be ameliorated, including enforcement of affordable housing laws and efforts to minimize waivers.
   d. Funding sources available for expanding stock.
   e. Strategies outlined by the DC Preservation Network in the report "A Strategy for Preserving Affordable Rental Housing in the District of Columbia."40
2. Identifying the specific funding sources to implement the program models outlined in the plan including:
   a. Subsidy for the TAH units and the light touch supportive services offered under TAH.
   b. Subsidy for the PSH units and the intensive, wrap-around services offered under PSH.
3. Reviewing annual turnover of RFP units to establish number of units dedicated to PSH and TAH needs, and any outstanding need from each year of implementation.
4. Strengthening non-profit sector capabilities to produce supportive and affordable housing.

Strategy 4: Increase Economic Security of Households

1. Identifying processes for ensuring families and individuals are connected to job centers.
2. Working with community businesses to expand successful job placements.

Monitoring and Performance Management

1. Screening contractors and providers for capacity, including shelter performance tracking.
2. Providing training and technical assistance to providers to ensure transition to effective models outlined in plan.
3. Managing service providers to ensure delivery quality services that are needed, including evaluating costs for homeless services with the intent to streamline costs and eliminate duplication of services between different programs serving the same clients.
4. Adopting performance measures to implement action items and meet goals of the plan, including:.
   a. Agency specific measures to ensure lead agencies are meeting their objectives.
   b. Provider and program specific measures to ensure that funded programs and providers are performing adequately.

40 Convened by Coalition for Nonprofit Housing and Economic Development (CNHED) and NeighborhoodInfo DC, the report is available online at https://dl.dropboxusercontent.com/u/95427853/DC%20Preservation%20Network/DCPN%20Preservation%20Strategy%20Paper%20FINAL.pdf.

Appendix 12: Acronym Guide

Acronym	Organization
AHAR	Annual Homeless Assessment Report
AMI	Area Median Income
CAHP	Coordinated Assessment and Housing Placement
CCNV	The Community for Creative Non-Violence
CFSA	DC Child and Family Services Agency
CoC	Continuum of Care
CSH	Corporation for Supportive Housing
CSOSA	Court Services and Offender Supervision Agency
DBH	Department of Behavioral Health
DCHA	District of Columbia Housing Authority
DCHFA	DC Housing Finance Agency
DCPS	DC Public Schools
DDS	Department of Disability Services
DGS	Department of General Services
DHCD	Department of Housing and Community Development
DHCF	Department of Health Care Finance
DHS	Department of Human Services
DMHHS	Deputy Mayor for Health and Human Service
DMV	Department of Motor Vehicles
DOC	Department of Corrections
DOES	Department of Employment Services
DOH	Department of Health
ED	U.S. Department of Education
ERAP	Emergency Rental Assistance Program
ES	Emergency Shelter
FMR	Fair Market Rent
F-SPDAT	Family Service Prioritization Decision Assistance Tool
FRSP	Family Re-Housing and Stabilization Program
FQHC	Federally Qualified Health Center
GED	General Education Development
HEARTH	Homeless Emergency Assistance and Transition to Housing Act of 2009 (Federal)

Acronym	Organization
HIC	Housing Inventory Count
HMIS	Homeless Management Information System
HPTF	Housing Production Trust Fund
HSEMA	Homeland Security and Emergency Management Agency (DC)
HSRA	Homeless Services Reform Act of 2005 (DC)
HUD	U.S. Department of Housing and Urban Development
ICH	DC Interagency Council on Homelessness
MPD	Metropolitan Police Department
OCA	Office of the City Administrator
ORCA	Mayor's Office on Returning Citizen Affairs
OSSE	Office of the State Superintendent of Education
PIT	Point In Time Count
PH	Permanent Housing
PSH or PSHP	Permanent Supportive Housing (Program)
RFP	Rapid Re-Housing
SNAP	Supplemental Nutrition Assistance Program
SOAR	SSI/SSDI Outreach, Access, and Recovery Initiative
SSI	Supplemental Security Income (Social Security)
SSDI	Social Security Disability Insurance
TAH	Targeted Affordable Housing
TANF	Temporary Assistance for Needy Families
TCP	The Community Partnership for the Prevention of Homelessness
TH	Transitional Housing
UDC	University of the District of Columbia
USICH	U.S. Interagency Council on Homelessness
VASH	Veterans Affairs Supportive Housing
VI-SPDAT	Vulnerability Index-Service Prioritization Decision Assistance Tool
VWFRC	Virginia Williams Family Resource Center
WIC	DC Workforce Investment Council

Together, we will end long-term homelessness in the District of Columbia. By 2020, homelessness in the District will be a rare, brief, and non-recurring experience.

For more information, please contact:

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