The Way Home

Changing the Path for Houston's Homeless

ACTION PLAN
2015-2017 UPDATE

The Way Home is the collaborative model to prevent and end homelessness in Houston, Pasadena, Conroe; and Harris, Fort Bend, and Montgomery Counties.

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In 2014, The Way Home unveiled its first Action Plan, covering the journey of Houston, Harris County & Fort Bend County's Continuum of Care (CoC) that began in 2012. The impact of homelessness in The Way Home CoC's geographic region was incredible: more than 7,100 individuals were homeless on a given night and more than 53% of them were unsheltered. The City of Houston was spending more than $103 Million annually on chronically homeless individuals – 75% of the public resources for homelessness on less than 20% of the homeless population.

This Action Plan Update retains the historical information and provides some updates to the 2014 plan. Part I of this document provides the "30,000 Foot View" of homelessness in Houston, Harris County, and Fort Bend County; where we were and where we will go. Part II wades into more technical waters, beginning with a timeline of significant events and milestones, and continuing on through detailed charts for each subpopulation that encapsulate our progress through 2015 and maps out the work to be done in 2016 and 2017.

Just before publication, the US Department of Housing and Urban Development (HUD) notified The Way Home that its geography is increasing; Montgomery County and the City of Conroe will transfer from the Balance of State CoC to The Way Home. This addition adds more than 1,000 square miles to The Way Home and while it will present some challenges, also provides the opportunity to deliver the successful strategies of The Way Home into a new and larger area.

Part I

HOUSTON HAD ONE OF THE LARGEST HOMELESS POPULATIONS IN THE NATION.

JAN 12 2012 HOMELESS COUNT

7,187
Homeless in shelters and on the streets on any given night

+

1,412
Homeless in jail on any given night

of which

1,286
Homeless veterans

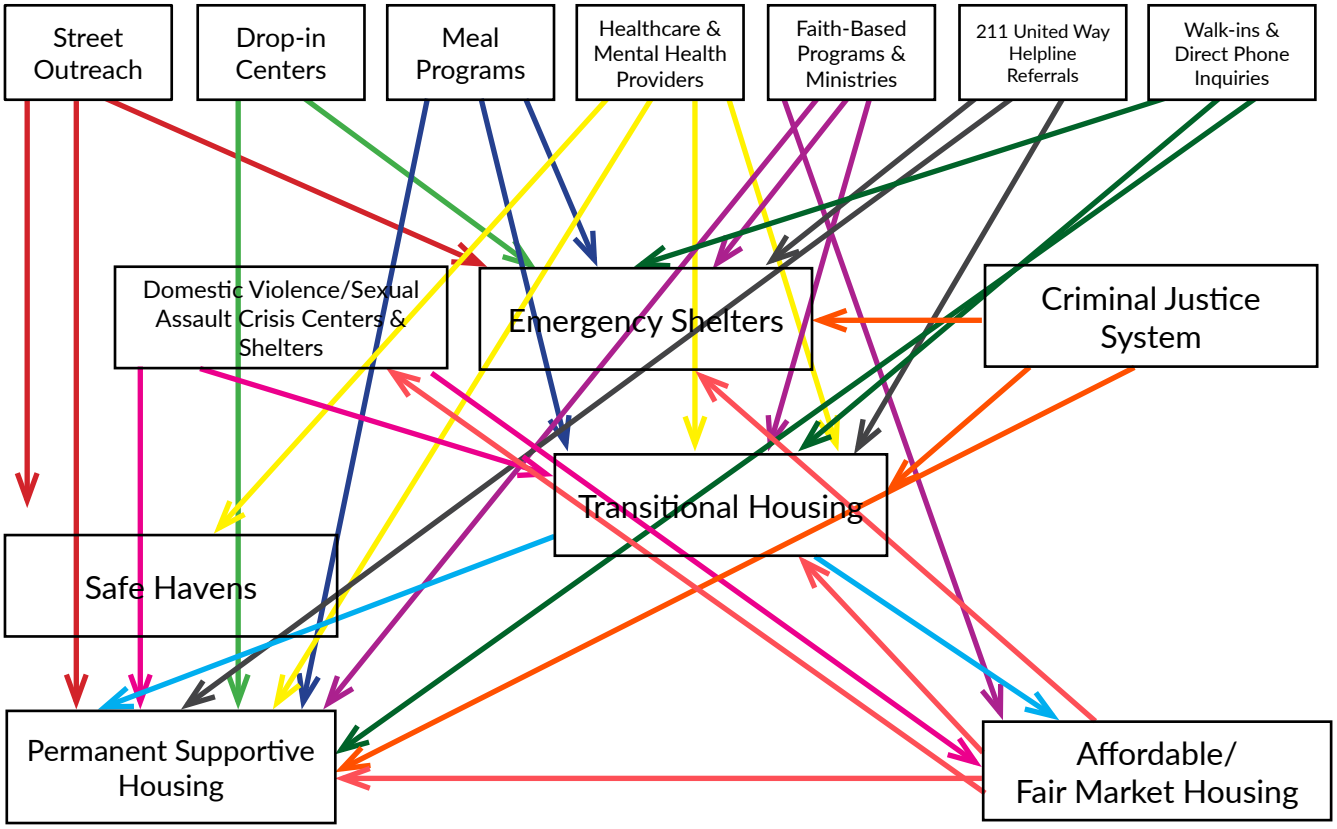
1,422
Chronically homeless people

540
Homeless families

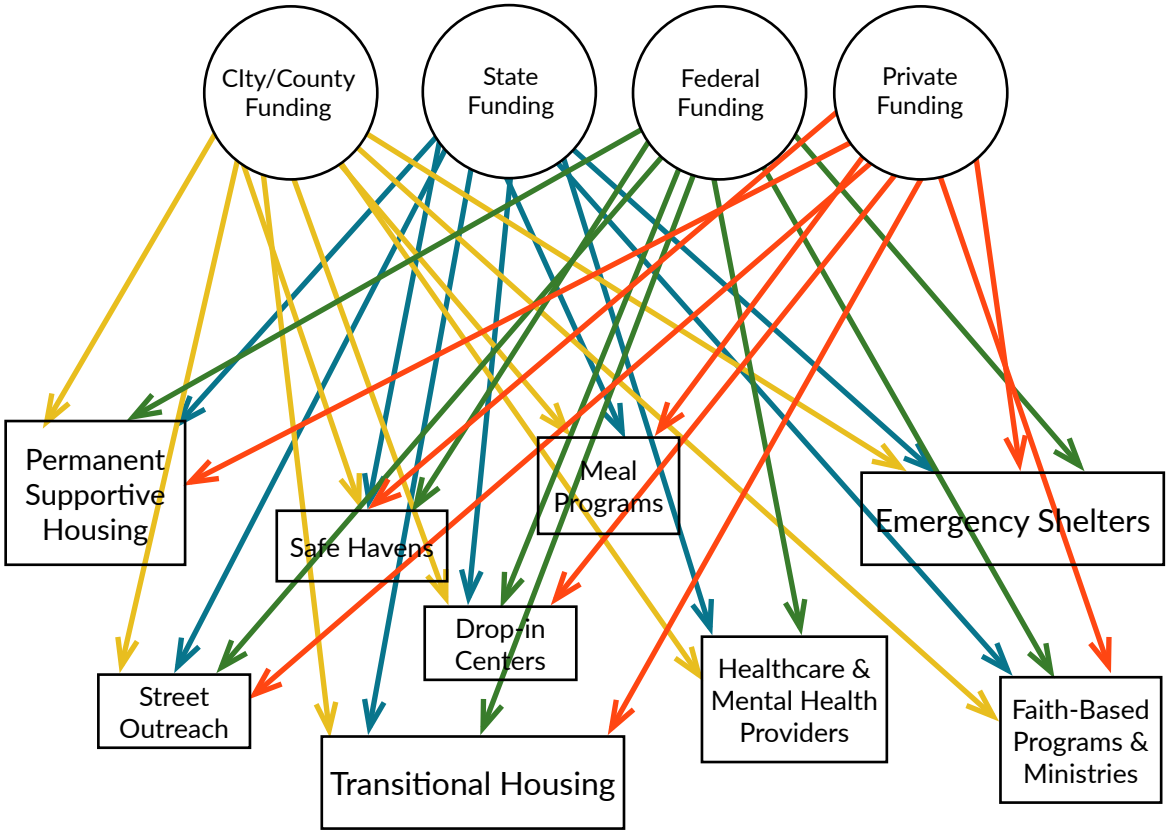
IMPACT

- In 2012, Houston had the **6th largest homeless population** in the U.S.
- Chronically homeless individuals comprised less than **20%** of the homeless population and used **75%** of the public resources
- **$103 Million** was spent annually on fewer than 1500 chronically homeless individuals
- **Half** of those living on the street used emergency rooms as their primary healthcare provider
- The life expectancy of a homeless person living on the street is reduced by **25 years**
- **20%** of homeless youth do not attend school

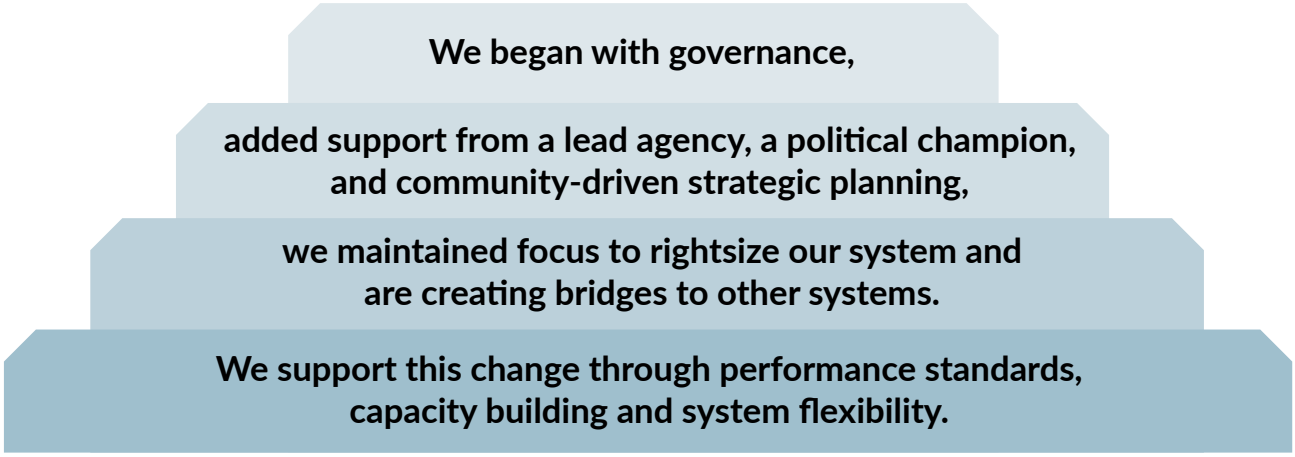
The path for homeless individuals to end their homelessness was anything but clear:



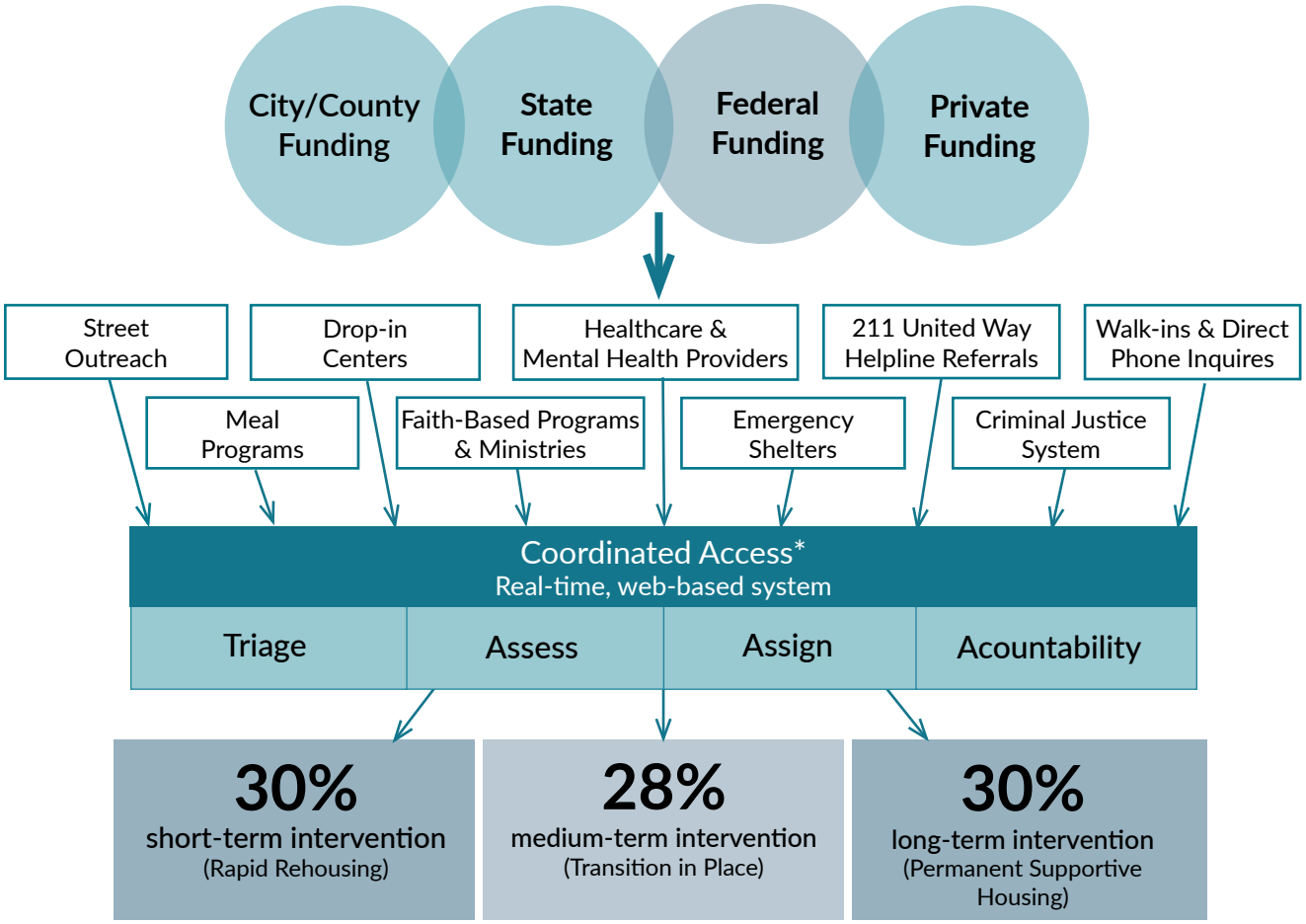
Funding for these services was not efficient either:



We took a layered approach to redesigning our community's homeless response system.



Our homeless response system is now driven by coordinated, data-driven decision making that matches our resources to the community need for quality affordable housing and stabilizing supportive services.

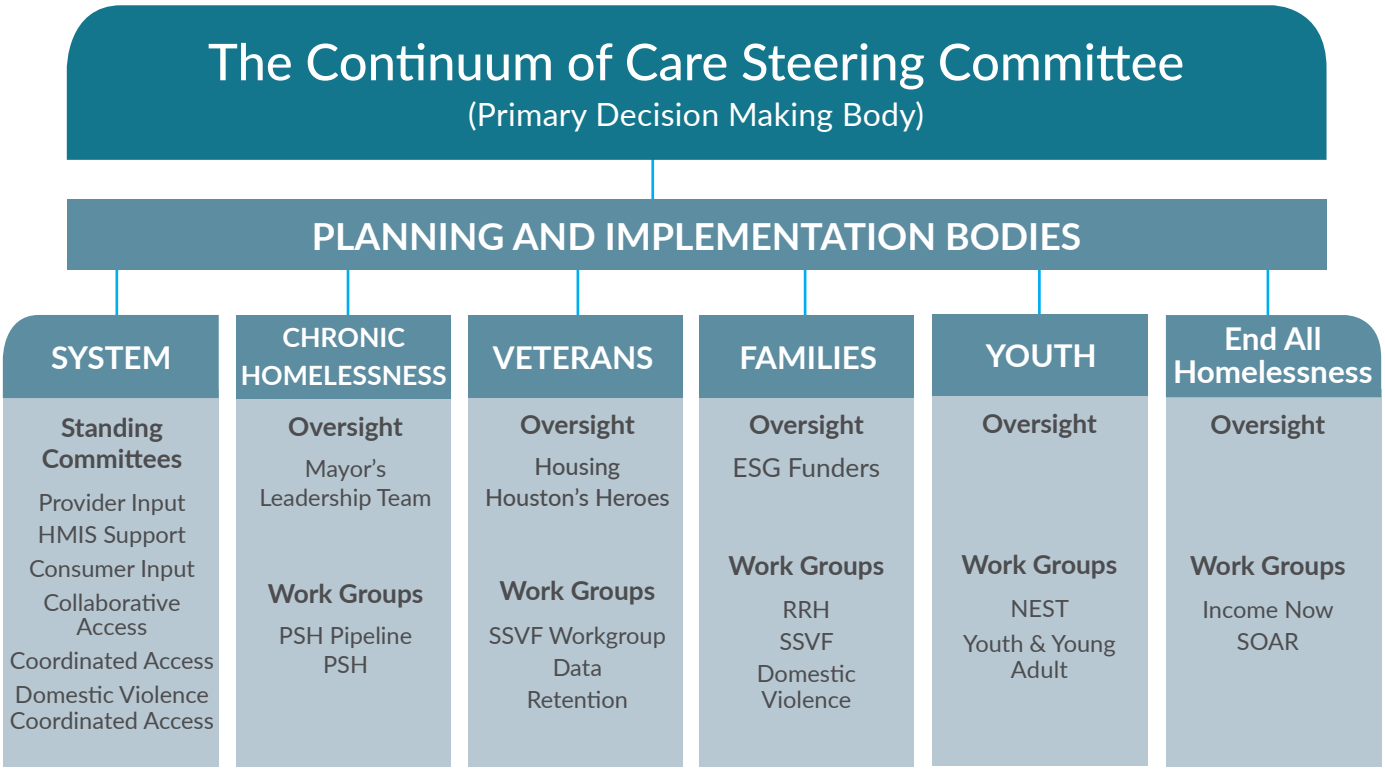


* 12% of the homeless population will solve their homelessness on their own.

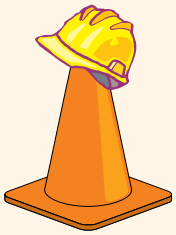
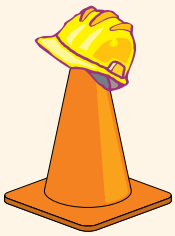
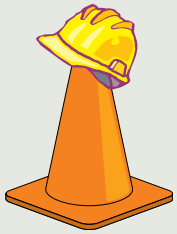
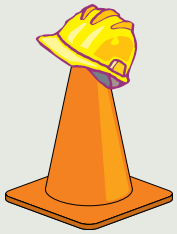
With this new system, we will:

- End Chronic Homelessness by 2016
- End Veteran Homelessness by 2015
- End Family Homelessness by 2020
- End Youth Homelessness by 2020
- Set a Path to End All Homelessness

We use a new governance structure to support system-wide transformation and accountability:



The Way Home Progress Overview

	2012	2013
Chronically Homeless Individuals	 Housed: **612**	 Housed: **712**
Homeless Veterans	 Housed: **682**	 Housed: **1,397**
Homeless Families	 Planning Work	 Planning Work
Homeless Youth/ Young Adults	 Planning Work	 Planning Work
Overall System Progress *(Point-In-Time data)*	 **7,187** homeless individuals a **15% reduction** from 2011	 **6,359** homeless individuals a **12% reduction** from 2012

* Defining "Success": The Way Home has two permanent housing options: Permanent Supportive Housing (PSH - for chronically homeless individuals and families, including veterans), and Rapid Re-housing (RRH - for non-chronically homeless families, including veterans). Success, also called "retention" is defined as the percentage of people who exited either PSH or RRH and are now living stably and independently, who did not re-enter homelessness. We averaged the retention rates from the 6, 12, 18, and 24 month points for each of our permanent housing options.

2014	2015	Cumualtive
Housed: **865**	Housed: **753**	**2,942** Chronically Homeless Individuals housed since 2012 **88% success rate** in Permanent Supportive Housing*
Housed: **1,269**	Housed: **938**	**4,286** Veterans housed since 2012 In June 2015 we announced the effective end of veteran homelessness!
Planning Work	Housed: **572**	**572** individuals in families housed and/or graduated to self-sufficient housing in 2015 **90% success rate** in Rapid Re-Housing*
Planning Work	Community Conversation Resulting in Strategic plan for solving Youth/Young Adult Homelessness	• Identified strategies for solving youth homelessness: **1.** Educate & Advocate, **2.** Prevent & Divert, **3.** Reconnect, and **4.** Identify & House • Added youth/young adult Coordinated Access Hub • Obtained funding for new Youth/Young Adult Rapid Re-housing program
5,308 homeless individuals a **17% reduction** from 2013	**4,609** homeless individuals a **13% reduction** from 2014	**57% reduction** in overall homelessness from 2011 - 2016 (**from 8,471 to 3,626**)

Part II

The Way Home

2010

The U.S. Dept. of Housing and Urban Development (HUD) requests the CoC to participate in pilot CoC "check up tool" to determine priority community status.

2011

2011: HUD grants first phase of Technical Assistance (TA) to bring the CoC into compliance with HEARTH Act Interim Regulations.

2012

May: "100 in 100" initiative to house 100 homeless veterans in 100 days created the Housing Houston's Heroes workgroup.

August: 450 Community stakeholders engage in a charette process resulting in a strategic action plan for 2012-2013 and a roadmap through 2015.

September: Inagural CoC Steering Committee convenes to review the charrette recommendations, and to adopt multiple system practices including: Housing First, Harm Reduction, HUD's Equal Access Rule, and the use of evidence-based practices (EBPs) when determining funding and policy.

2013

January: CoC is selected by HUD as one of 9 communities to conduct Youth Count! pilot as part of the annual Point-In-Time count. The Urban Institute creates best practice report for counting youth based on the pilot.

May: CoC completes Registry Week of 100,000 Homes Campaign and compiles 850 unique records prioritized by the vulnerability index for Coordinated Access (CA). Mayor Annise Parker convenes leadership team, and Houston achieves elite "2.5% club status" as part of 100,000 Homes.

2014

January: CA begins as a system-wide, targeted roll-out with operations out of 5 regional hubs.

May: HUD approves third phase of TA focusing on conversion of Transitional Housing and Performance Measurement, as well as continued support for overall system change and capacity building.

July: The Way Home is introduced as the system name for the Continuum of Care and the activities and accomplishments conducted by its members/partners.

August: LGBTQ Youth Homelessness Prevention Initiative (NEST) kicks off in Houston thanks to HUD-directed TA. The Way Home was one of two CoCs chosen to pilot this initiative.

2015

September: CoC announces that it has housed more than 2,800 homeless veteran households since January 2012, which puts it on target to reach "steady state" on veteran homelessness by 2015.

December: Texas Dept. of Housing and Community Affairs (TDHCA) announces that local CoC will be responsible for managing the competitive application and funding recommendations for state ESG funds for the upcoming competition (awarded in October 2015).

January: System-wide roll-out of Rapid Re-housing begins targeting families experiencing homelessness. Ongoing: work to end chronic homelessness and reach steady state for homeless veterans.

June: The Way Home announced that it had effectively ended Veteran homelessness and obtained "steady state." This means that the vast majority of veterans have been housed, and that a system had been created with sufficient outreach engagement, housing, and support services to ensure that Veteran homelessness is rare, brief, and non-repeating.

September: The Way Home held a Youth/Young Adult Community Conversation with local and national experts, formerly and currently homeless youth/young adults, and local stakeholders, resulting in a comprehensive strategic plan to prevent and end youth/young adult homelessness.

Chronic Homelessness Workplan

Strategy	2012-2013	2014
#1 - Identify & Connect: Identify and prioritize PSH units for the most vulnerable using the Coordinated Access System.	• Registry Week launched the identification and prioritization of 850 chronically homeless individuals sleeping on the streets, using the Vulnerability Index tool. • Coordinated Access (CA) Workgroup developed standardized assessment and triage tools. • HMIS was updated to launch real-time, web-based system in January 2014. • Housed 1,107 chronically homeless/ vulnerable individuals and families in 16 months.	• Launched CA Phase 1 on January 6, 2014. ◆ First CA Hub located at the Beacon Day Shelter with 2 Housing Assessors and 2 Housing Navigators. ◆ 24 of 28 clients assessed in Phase 1 were housed (85%). ◆ 90 day average from assessment to move-in. • Launched Phase 2 on April 1, 2014. ◆ 2 CA Hubs added at VA Drop-In Center and Star of Hope Women & Family Shelter. ◆ The Beacon CA Hub expanded operations to 5 days a week, and relocated to a storefront location with office space for all staff, now a total of 3 Housing Assessors & 3 Housing Navigators. ◆ An Outreach Assessor/Navigator was added in September 2014 and a 4th Navigator added in December 2014. • CA Phone Assessment line was opened in September 2014. ◆ Calls were answered half days, 4 days per week, and was piloted with the Harris County Jail Diversion Project, as well as Harris Health System. • Increased housing placement rates by 20%. • Reduced average number of days from referral to move-in by 33%.
#2 – House: Create 2,500 Additional Units of PSH.	• Finalized financial model; 90% of resources were assembled to meet goal. • 56% of units were in the pipeline; 44% of those were operational. • City of Houston and Harris County released joint RFP for capital and operating dollars.	• Awarded nearly $20.8M in capital to new PSH projects through coordinated City/County RFP. • 65% of units were in the pipeline (422 added), additional 257 units were pending funding approval. • 417 project based vouchers awarded to support PSH units. • 3 new development partners were awarded funding for PSH projects.
#3 – Support: Create a new Service Delivery Model linked to PSH.	• New Service Delivery Model conceived and seed funding identified. • 1115 Medicaid Waiver DSRIP project approved to fund integrated care teams for PSH. • Service providers selected and planning phase concluded.	• 2 FQHCs began offering integrated care PSH services to: ◆ 150 chronically homeless, frequent users of emergency rooms, across 7 multi-family properties. ◆ 69 chronically homeless and mentally ill frequent users of jail, at 1 property. • Integrated care service enhancements were added to 1 legacy PSH property (40 units).

2015	2016-2017
• Established standardized training for CA Assessors & Navigators. • Established standardized CA training for PSH providers. • Piloted the call center at primary CA Hub and with one off-site Housing Assessor. • Repurposed 4 community outreach teams as dedicated CA Assessors & Navigators targeted to the most resistant clients. • Created direct access to "Barrier Buster" funds via CA Navigators.	• Monitor the efficacy of the assessment and matching results to ensure clients are properly matched to PSH. • Add coordination to income opportunities like SOAR and Supported Employment. • Launch CA Improvement Lab to refine triage tools, business rules, system flow, staffing, etc. • Create CA Call Center for all other providers to ensure a "No Wrong Door" approach. • Connect CA to healthcare billing services. • Publish Program & System-level CA performance dashboards that highlight referral and utilization rates. • Prepare to expand eligibility based on vulnerability rather than chronicity. • Create & utilize a System Tracker and Predictive Tool to drive toward an end to chronic homelessness. • Prepare and adjust for steady state navigation and assessor demand.
• Awarded 2nd round of $20.8 M in capital for new PSH projects. • 83% of units in pipeline (added 446), an additional 162 units were pending funding approval. • Launched $15M Capital Gap Fund campaign to accelerate the development of PSH pipeline using private investments from local and national funders, and raised $5.1M. • Attracted 2 national developers to participate in local projects and build local development capacity for PSH and integrated developments. • Expanded partnership with a local property owner to convert an additional 122 units for PSH.	• Create the remaining 258 units via conversion of existing units using housing choice vouchers – 100% of units in pipeline. • Have 94% of units in operation by the end of 2017. • Raise and distribute 100% of PSH Capital Gap Funds. • Launch round 2 of the Capital Gap Fund to support inclusionary policies and more integrated development. • Develop new relationships with at least two local property owners to accept vouchers for PSH.
• Doubled the number of PSH units using the integrated care service model to 219. • Created a Managed Care Workgroup that includes the participation of 4 MCOs and the TX State Medicaid Office. • Explored opportunities to launch a pilot project to pay for integrated care teams in supportive housing, using Medicaid. • Performed a data match with UnitedHealthcare to identify frequent users in need of supportive housing and integrated care. • Identified a state funding source to take the integrated care service model to scale. Pursued private match dollars. • Applied for the extension of the 1115 Medicaid Waiver to continue to expand the integrated care service model until Medicaid eligibility is secured.	• Secure the private match necessary to utilize state funds to take the integrated care service model to scale – at more than 1,800 units. • Secure 3 additional FQHCs to begin providing services to new developments. • Launch pilot project with MCOs and the TX State Medicaid Office to fund the integrated care service package under Medicaid. • Expand data matching activities with new partners, including the TX State Medicaid Office and HUD, to document the cost benefits of PSH.

Veteran Homelessness Workplan

Strategy	2012-2013	2014
#1 - Identify & Connect: Use Coordinated Access System to identify and connect Veterans experiencing homelessness with permanent housing and services.	• Developed a standard triage tool to properly match homeless Veterans with proper housing options at the first interaction. • Placed a CA Assessor at the VA Drop-In Center to implement triage protocols and connect homeless Veterans with both VA and CoC services as appropriate. • Created protocols that support co-location or same-day appointments for all housing referrals.	• Updated VA Drop-In Center and CoC protocols to establish CA as the front door system for HUD-VASH and SSVF. • Trained VA Drop-In Center staff to act as CA Assessors. • Trained VA Homeless Clinic social worker as a designated CA Assessor. • Updated VAMC protocols to ensure all homeless inpatient and emergency room veterans were routed to a designated CA Assessor. • Housed 1,269 homeless Veteran households in 2014.
#2 – House: Target HUD-VASH vouchers to chronically homeless or vulnerable Veterans and target Supportive Services for Veteran Families (SSVF) services for Rapid Re-housing of all other homeless Veterans.	• Implemented protocols to restrict HUD-VASH to only those meeting the HUD definition of chronically homeless or vulnerable. • Implemented mass briefings and targeted outreach to issue HUD-VASH vouchers to Veterans living on the streets in one day. • Housed 101 chronically homeless Veterans in the first 100 days. • Housed another 347 chronically homeless Veterans in another 100 days. • Completed first year of SSVF and secured an additional $5M in SSVF to rapidly re-house homeless Veterans and their families. • Formed an SSVF Workgroup to standardize service delivery and connect with CA. • Housed 2,226 Veteran households in permanent housing from 2012-2013.	• Housed 883 chronically homeless or vulnerable Veterans in HUD-VASH since January 2012. • Improved attrition rate from 50% in 2012, to 20% in 2013 and 2014. • As the system approached Steady State, the HUD-VASH target population was broadened to house the most vulnerable and prevent the return to chronic homelessness. • Reached 100% utilization of HUD-VASH. • Awarded an additional $6.1M in SSVF resources to serve 1,271 Veteran households. • 70% of SSVF resources were targeted to Rapid Re-housing.
#3 – Support: Improve and Expand VA housing stabilization support services.	• Lowered case management ratios and added clinical staff to support retention	• Added 4 Housing Navigators to the VA service teams to reduce lease up times and improve retention rates. • Created integrated VA service teams comprised of case managers, peer support specialists, clinical staff, and Housing Navigators.

2015	2016-2017
• Reached Steady State, ensuring every homeless Veteran has access to appropriate permanent housing. • Dedicated a VA staff person at the Drop-In Center to full-time CA activities. • Closed the side doors on SSVF referrals – all SSVF referrals come through CA. • Refined protocols to ensure HUD-VASH availability is managed in HMIS. • Used local data to refine local definition of Steady State: approximately 900 Veterans will need housing each year. • Used CA to maintain Steady State and began work in anticipation of the shift to a prevention-oriented system.	• Finalize monitoring protocols for CA use and referral accountability. • Determine how to capture and manage referrals to GPD and other TH programs. • Use CA to maintain Steady State system.
• Refined HUD-VASH targeting to ensure full utilization of vouchers and prevention of chronic homelessness. • Continued to identify and target any remaining chronically homeless Veterans and instantly connect them to HUD-VASH.	• Maximize HUD-VASH utilization and shift SSVF resources to support more prevention activities to reduce Steady State volume. • Determine how to target GPD TH beds and connect Veterans to appropriate permanent housing options. • Modify GPD inventory to match the system needs. • Refine local outcome tracking methods and standardize metrics.
• Used Housing Navigators and peer support specialists to provide additional supports at recertification and reduce negative attrition. • Assigned VA staff to project based HUD-VASH complexes and provided on-site services.	• Develop tools to support project based service teams. • Reduce negative attrition rates. • Enhance peer engagements.

Family Homelessness Workplan

Strategy	2012-2013	2014
#1 - Identify & Connect: Use Coordinated Access System to rapidly connect homeless families to permanent housing with housing stabilization services.		• Explored the use of the Family Vulnerability Index triage and prioritization tool. • Assisted RRH providers to modify entrance criteria and determine next step assessment for all RRH referrals. • Expanded CA Hub to Star of Hope Women & Family Shelter.
#2 – House: Expand funding for RRH and access to quality affordable housing.	• Completed system mapping and identified the need for an additional 8,100 units of RRH. • CoC Steering Committee identified all available resources for RRH; ESG grantees prioritized RRH. • Updated ESG written standards to match the RRH Housing Model. • Local HUD Field Office brokered several discussions with existing HUD subsidized properties to set aside units for RRH. • Held a series of meetings with LIHTC property owners to introduce PSH, RRH, and the need for dedicated units. • Launched a pilot (HCV-TIP) project using housing choice vouchers and dedicated case management to support a transition in place RRH model.	• Designed a new RRH investment and program management infrastructure that pooled $3.5M in CoC, ESG, CDBG, and TX State HHSP funds for RRH Financial Assistance administered by the Houston Housing Authority. • Partnered with the United Way and other public and private funders to pool more than $500K for RRH Housing Stabilization Case Management. • Funded 169 affordable housing units as part of integrated PSH projects. • Partnered with a local Property Management Firm to assist in location of units. • Met with the Houston Apartment Association to discuss opportunities for education and partnership.
#3 – Support: Improve and expand housing stabilization support services.	• RRH Funders Workgroup refined RRH Program Model and written standards to reflect universal targets, use of standardized tools, and an emphasis on housing stabilization outcomes.	• RRH Funders Workgroup refined RRH Program Model and written standards to reflect universal targets, use of standardized tools, and an emphasis on housing stabilization outcomes.

2015	2016-2017
• Modified the Family triage tool based on locally established target populations and available resources. • Implemented the new CA workflow for families. • Launched CA for RRH within HMIS. • Began limited call center activities for families in outer areas of CoC.	• Modify the triage tool and matching logic to accommodate new RRH program models. • Launch electronic referrals based on available case loads. • Update RRH Triage Tool to include income assessments within CA.
• Launched new standardized RRH Program and served 572 literally homeless individuals in families. • Facilitated the alignment and investment of TX State ESG funds to support the new RRH program and a DV-RRH demonstration project. • Identified and facilitated the conversion of 89 TH units into RRH. • Explored the use and availability of Tenant Based Housing Choice Vouchers for transition in place, as well as other medium to long-term RRH models. • Funded 3 dedicated Housing Specialists and secured access to 4,279 units throughout Houston for RRH. • Created a virtual map to track RRH properties by geography for use by Housing Specialists and Navigators. • Launched Landlord Outreach and Leasing Events.	• Attract additional private funders to sustain and strategically expand RRH to end family homelessness and build a safety net system to prevent returns to homelessness. • Develop RRH Plus, RRH Diversion, and Prevention Program Models and align activities. • Continue Landlord Outreach and Leasing Events as well as landlord recognition and educational activities to maintain and strengthen relationships. • Use GIS mapping and data analysis to target landlord engagements. • Launch Landlord Liaison position on behalf of the homeless response system, to serve as an ombudsman for landlords participating in multiple subsidy programs.
• Hosted two-day housing stabilization case management training. • Launched weekly implementation and case conferencing meetings with all RRH case managers. • Explored ways to formally refer RRH clients to the United Way's THRIVE programs for ongoing supports.	• Begin case management refinement process for system RRH staff. • Host a multi-day training in conjunction with Housing Innovations for RRH case managers to help stabilize RRH clients in housing. • Ensure RRH clients are connected with income via the public workforce system. • Create and launch the RRH Plus Housing Model and Program. • Explore a RRH Light Housing Model.

Youth and Young Adult Homelessness Workplan

Strategy	2012-2013	2014
#1 - Educate & Advocate: Create a comprehensive plan to prevent and end youth and young adult homelessness that starts with youth-friendly environments to support early detection & intervention.	• Participated in first Youth Count! to better understand the homeless youth/young adult population in Houston, Harris County, and Fort Bend County. • Formalized the role of youth advocacy and affinity groups within the CoC.	• Participated in Youth Count! 2.0 and additional local comprehensive data collection efforts, revealing 513 homeless youth/young adults in Houston, Harris County, and Fort Bend County.
#2 – Prevent & Divert: Connect with up-stream systems to help youth and young adults avoid homelessness.		• Selected to participate in HUD's National Demonstration Project to Prevent LGBTQ Youth Homelessness, locally named "NEST." • Formalized the NEST Workgroup to lead demonstration efforts. • Hosted a community planning process to develop a plan to prevent LGBTQ youth homelessness among 72 participating agencies.
#3 – Reconnect: Create alternative services to support reunification with family or other appropriate support systems.		
#4 – Identify & House: Use Coordinated Access to rapidly connect homeless youth and young adults to permanent housing with housing stabilization services.	• Identified opportunities to enhance utilization rates of existing youth programs.	• Formulated a partnership with public housing authorities, the child welfare system, and Hogg Foundation to target youth aging/aged out of foster care for PSH placement.

2015	2016-2017
• Hosted Youth Community Planning "Mini-Charrette" with more than 150 stakeholders, local and national experts, and currently or formerly homeless youth/young adults. • Participated in the White House Policy Convening to Prevent and End Youth Homelessness and A Way Home America planning meetings.	• Introduce LGBTQ competency curriculum for all juvenile justice, child welfare, and homeless service provider employees. • Expand and restructure workgroups to support broader implementation of the comprehensive plan. • Conduct additional data analysis to further refine the triage tool and gain better understanding of youth/young adult risk and protective factors in matching intervention and development.
• Developed a year one action plan to prevent LGBTQ youth homelessness. • Engaged juvenile justice, the child welfare system, and homeless service providers to offer LGBTQ cultural competency training.	• Connect local ISDs to CA system. • Explore the intersection and demographics of homeless young adults in the jail/juvenile justice systems. • Expand advocacy roles and interventions for young adults aging out of foster care.
	• Create Host Homes Toolkit and expand Host Homes pilot. • Create and disseminate a family reunification tip sheet for all providers. • Create a formal family unification program.
• Created 100 units of PSH over 4 years for youth aging/aged out of foster care. • Developed a youth triage tool in partnership with Child Protective Services to identify foster youth most at-risk of homelessness. • Developed YYA-specific program models for PSH, RRH, and TH. • Restructured CoC-funded TH to support underage youth and expand YYA RRH for those over 18. • Prioritized young adults in CA.	• Add an additional 135 YYA RRH slots. • Introduce a new program model for YYA under the FUP demonstration program guidelines (PSH Light, 18-60 months). • Create a CA Hub at the YYA and overnight shelters. • Open underage youth shelter beds on the overnight campus.

Setting the Path to End All Homelessness Workplan

We know that triggers of homelessness may always exist. The Way Home will set a path to end all homelessness by creating a system that is prepared to rapidly respond to homelessness, and ensure that homelessness is rare, brief, and non-repeating. This includes forging partnerships with other systems of care.

A homeless response system can provide outreach, access to housing, and case management support; however, it should not try to replicate systems in the community that already exist. The Way Home is working to connect to other systems to ensure that individuals and families can attain and maintain housing. Connections have been created with local Managed Care Organizations, Domestic Violence organizations, and notably, the public workforce system through an initiative called Income Now (see the chart below).

Although The Way Home will always maintain a focus on housing, the partnerships we create with external systems will help us ensure that no one has to be without permanent housing for more than 30 days.

Income Now

Strategy	2015 Progress	2016-2017
#1 - Use Coordinated Access to connect households to income as quickly as possible.	• Built income assessment tool into CA in HMIS.	• Refine the electronic referral process through HMIS. • Achieve goal of 100% of referrals being made through CA and HMIS.
#2 - Right size Houston's income services to meet the community needs.	• Identified income types necessary to meet needs of the population.	• Prepare analysis of need/gap in SOAR Services and Supported Employment Services. • Build capacity in SOAR and Supported Employment Services.
#3 - Build Workforce Solutions' (the Greater Houston Area's public workforce system) capacity to serve households experiencing homelessness more effectively.	• Awarded 2 grants to support embedded staff in both systems (public workforce system and the homeless response system).	• Workforce Solutions will hire 3 Income Now Employment Navigators. • Workforce Solutions will hire 4 Income Now Employment Counselors to be embedded in CA Hub locations.
#4 - Shift Houston's culture towards an "Income Now, Income for Everyone" culture.	• Awarded Heartland Alliance grant to support training series to shift ideas about employment and individuals on SSI/SSDI and those experiencing homelessness.	• Host an 11-session training series for partners and stakeholders. • Build and administer a survey tool to assess culture shift.

Other Subpopulations

	Strategy	Implementation Status	
Non-Chronically Homeless Single Individuals	**#1 - Identify & Connect to Income** Connect non-chronic single individuals who experience episodic homelessness to income opportunities using Coordinated Access.	25% Complete	• Partnered with Heartland Connections & Texas Workforce Commission (TWC) to create Income Now - a real-time, web-based system to assess and connect individuals to training and employment opportunities. • Created an income assessment tool within CA and HMIS. All individuals now receive a housing and/or income option. • Using ~$2M in Texas Workforce Commission funds, expanded access to mainstream competitive employment in partnership with the local public workforce system (Workforce Solutions) for individuals experiencing homelessness. • Embedded assessment centers and Workforce Solutions satellite offices into homeless shelters. • Deployed Income Navigators to three high-volume Workforce Solutions offices in the Central Business District
	#2 - Support Rapid Self-Resolution Connect Income Now to the Shelter System to accomodate rapid self-resolution and expand atypical extremely affordable housing options like hostels or bunkhouses.	10% Complete	• Working with Star of Hope and Salvation Army Shelters to modify operating guidelines to serve homeless men who are working through Income Now. • Fund the expansion and renovation of Harmony House – providing needed inexpensive, pay-by-night housing.
Survivors of Domestic Violence & Human Trafficking	**#1 - Identify & Connect** Organize as a single DV CA system to ensure all clients are connected to appropriate shelter and/or permanent housing options.		• Created a DV CA Steering Committee and Work Group to develop DV-specific program models, CA triage tools, business rules, prioritization standards, etc. • Agreed to pursue redesignation as a single DV system to overcome data sharing obstacles and adopt use of a parallel, protected CA system based in HMIS. • Aligning operating and program resources to support use of a single DV-specific CA system. • Converting DV TH to DV RRH and expanding the spectrum of DV RRH to include diversion and non-shelter based services.
	#2 - House Build a Bridge to the CoC CA system to broaden permanent housing options.		• Exploring use of deidentifiers to allow DV clients access to CoC housing options via CA. • Added feature to CoC CA assessment that screens for domestic violence and connects to DV system for lethality assessment. • Identifying opportunities to partner with Human Trafficking service agencies to support access to CoC housing options via CA.

Glossary of Terms

1115 Medicaid Waiver DSRIP: The 1115 Medicaid Waiver Delivery System Reform Incentive Payment is a part of the Social Security Act (Section 1115) that gives the Secretary of the US Department of Health and Human Services (HHS) the authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs, with the purpose of using innovative service delivery systems that improve care, increase efficiency, and reduce costs, among other approaches.

Chronically Homeless Individual: An individual who has been homeless for at least one (1) year, either continuously or on multiple occasions that total one year in length, AND has a permanent disability.

Community Development Block Grant (CDBG): The Community Development Block Grant is a program of the US Department of Housing and Urban Development which funds local community development activities such as affordable housing, anti-poverty programs, and infrastructure development.

Continuum of Care (CoC): A Continuum of Care is a planning process designed to promote the development of comprehensive systems to address homelessness and provides communities with a framework for organizing and delivering services in an efficient and effective manner. The local CoC encompasses the cities of Houston, Pasadena, and Conroe; and Harris, Fort Bend, and Montgomery Counties in Texas.

Coordinated Access (CA): Coordinated Access is a standardized process for entry into the homeless response system and housing assessment which results in a coordinated referral process to prevention, housing and other related services.

Domestic Violence (DV): Domestic Violence, also known as Intimate Partner Violence (IPV), is a pattern of abusive and often violent behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner.

Domestic Violence Rapid Re-housing (DV-RRH): Domestic Violence Rapid Re-housing is Rapid Re-housing that has been adapted with consideration for safety of domestic violence survivors and staff in mind.

Emergency Shelter: An emergency shelter is any facility, the primary purpose of which is to provide temporary shelter for homeless individuals and/or families and which does not require occupants to sign leases or occupancy agreements.

Emergency Solutions Grant (ESG): The Emergency Solutions Grant is a program of the US Department of Housing and Urban Development that can be used for five program components: street outreach, emergency shelter, homelessness prevention, Rapid Re-housing assistance, and Homeless Management Information System (HMIS). ESG Recipients can also use a certain allocation for administrative activities.

FUP: The Family Unification Program (FUP) is a program under which Housing Choice Vouchers (HCVs) are provided to two different populations: families for whom the lack of adequate housing is a primary factor in the imminent placement of the family's child/children in out-of-home care, or the delay in the discharge of the child/children to the family from out-of-home care; and youth between the ages of 18-21 years old who left foster care at age 16 or later and lack adequate housing. There is no time limitation on FUP family vouchers. FUP vouchers used by youth are limited by statute to 18 months of housing assistance.

Federally Qualified Health Center (FQHC): Federally Qualified Health Centers include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid among other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

GIS: A Geographic Information System that allows users to visualize, question, analyze, and interpret data to understand relationships, patterns and trends.

Grant Per Diem (GPD): The Veterans Affairs (VA) Grant and Per Diem (GPD) Program is offered annually (as funding permits) to fund community agencies providing services to homeless Veterans, with the goal of promoting the development and provision of supportive housing and/or supportive services, ultimately helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination.

HCV-TIP: Housing Choice Voucher – Transition In Place. A housing model where families transition from homelessness to housing stability in the same housing unit, with the aid of a Housing Choice Voucher.

HHSP: Homeless Housing and Services Program. Established during the 81st Texas Legislature, and codified during the 82nd Texas Legislature, the Homeless Housing and Services Program provides funding to the eight largest cities (Arlington, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, and San Antonio) in support of services to homeless individuals and families.

Homeless Management Information System (HMIS): The Homeless Management Information System (HMIS) is a computerized data collection tool specifically designed to capture client-level, system-wide information over time on the characteristics and services needs of men, women, and children experiencing homelessness. The use of HMIS is required for homeless service providers that receive US Department of Housing and Urban Development McKinney-Vento funding.

Homeless: The US Department of Housing and Urban Development (HUD) defines homeless individuals (and families) as those who lack a fixed, regular, and adequate nighttime residence and includes a subset for 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 a place not meant for human habitation immediately before entering that institution.

Housing Assessment: A questionnaire that is completed through Coordinated Access that gathers information on an individual/family's homeless history, medical history, and other relevant information. The assessment results in a Vulnerability Index (VI) score (the higher the VI the more likely someone is to die on the street), determining the appropriate housing and/or income referral.

Housing Assessors: Housing Assessors work on behalf of The Way Home system to administer Housing Assessments to homeless individuals and families.

Housing Navigators: Housing Navigators work on behalf of The Way Home system to assist individuals and families with any and all steps (obtaining IDs, gathering, completing and submitting lease and other paperwork, etc.) to get them into housing.

HUD: The US Department of Housing and Urban Development

HUD - VASH: Housing and Urban Development - Veterans Affairs Supportive Housing. A program of the US Departments of Housing and Urban Development and Veterans Affairs that provides housing and supportive services to chronically homeless Veterans.

Income Now: Income Now is an initiative that is hosted within Coordinated Access and connects those currently experiencing homelessness with income to secure and maintain permanent housing. The initiative coordinates services and providers, including Workforce Solutions, so as to leverage the expertise and resources throughout the Houston community for the benefit of those looking to secure income as quickly as possible.

ISD: Independent School District

LGBTQ: Lesbian, Gay, Bisexual, Transgender, Questioning

LIHTC: Low-Income Housing Tax Credit. The federal government's primary program for encouraging the investment of private equity in the development of affordable rental housing for low-income households.

Managed Care Organization: A Managed Care Organization (MCO) is a health care provider or a group or organization of medical service providers that offers managed care health plans and contracts with insurers or self-insured employers to finance and deliver health care using a specific provider network and specific services and products.

NEST: NEST is the collaborative to prevent homelessness among adolescents and young adults who identify as lesbian, gay, bisexual, transgender, or questioning in Houston, Harris County, and Fort Bend County. Houston (along with Cincinnati/Hamilton County, Ohio) was selected by the US Department of Housing and Urban Development (HUD) to pilot this initiative.

Permanent Supportive Housing: Permanent Supportive Housing (PSH) is a housing first intervention that combines indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability. "Light" and "Plus" models are being explored within The Way Home based on client need.

Rapid Re-housing: Rapid Re-housing (RRH) is a housing first intervention that emphasizes housing search and relocation services and short to medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing. Intense but short term case management is provided to help families stabilize and prepare to live independently. "Light" and "Plus" models of this intervention are being explored within The Way Home based on client need.

RFP: Request For Proposals

Safe Haven: Safe Havens are defined as a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services. The Safe Haven program component is no longer eligible under the CoC Program, meaning no new Safe Haven projects will be funded. However, all existing projects that are eligible under the McKinney-Vento Act may be renewed.

SAMHSA/CABHI: Substance Abuse and Mental Health Services Administration/Cooperative Agreement to Benefit Homeless Individuals. A jointly funded program to enhance or develop the infrastructure of states and their treatment service systems to increase capacity to provide accessible, effective, comprehensive, coordinated, and evidence-based treatment services, permanent housing, peer supports and other critical services to chronically homeless individuals with substance use disorders, serious mental illnesses, or co-occurring substance use and mental disorders.

SOAR: SSI/SSDI Outreach, Access, and Recovery. SOAR seeks to end homelessness through increased access to SSI/SSDI income supports for those who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

SSVF: Supportive Services for Veteran Families. A program of the US Department of Veterans Affairs with the goal of promoting housing stability among very low-income Veteran families who reside in or are transitioning to permanent housing.

Street Outreach: Any activity that engages with unsheltered homeless individuals to provide immediate support, intervention, and connections with homeless assistance programs and/or mainstream social services and housing programs.

Supported Employment: Supported Employment refers to service provisions wherein people with disabilities, including intellectual disabilities, mental health and traumatic brain injury, among others, are assisted with obtaining and maintaining employment originally thought the primary models of job crews, enclaves, or the often preferred job coach or person-centered approaches.

Triage Tool: A triage tool is a means of assessment for homeless individuals. The VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool) is used in Houston to determine the chronicity and medical vulnerability of homeless persons (VI), and match them with the appropriate housing and support that are available (SPDAT).

Transitional Housing: Transitional Housing is an intervention designed to provide homeless individuals and families with the interim stability and support to successfully move into and maintain permanent housing.

VA: The US Department of Veterans Affairs

VAMC: Veterans Affairs Medical Center

Veteran: A Veteran is any individual who has served or is serving in any branch of the United States Armed Forces.

Voucher: A voucher is a housing subsidy from the US Department of Housing and Urban Development (HUD) that is administered locally by public housing agencies (PHAs) through a Housing Choice Voucher (HCV) program. Common vouchers issued to end homelessness include: Project-Based Vouchers (PBVs) that are tied to specific housing units; and Tenant-Based Vouchers (TBVs) used for very low-income families to afford decent, safe, and sanitary housing in the private market.

Youth/Young Adult Homelessness: Youth homelessness encompasses all homeless persons under the age of 24 and without a head of household older than 24. More specifically, homeless youth are those who are homeless and under the age of 18; homeless young adults are those who are homeless and between the ages of 18 to 24.

Continuum of Care Steering Committee Seats

City of Houston Housing and Community Development Department
City of Conroe Representative
City of Pasadena, Community Development Administration
Harris County Community Services Department
Houston Housing Authority
Harris County Housing Authority
Fort Bend County Community Development Department
Montgomery County Representative
Crisis Response System Representative
Permanent Supportive Housing Representative
Homeless Services Consumer Representative 1
Homeless Services Consumer Representative 2
Funders Together to End Homelessness Representative
The Harris Center on Mental Health and IDD
Michael E. Debakey VA Medical Center
Gulf Coast Workforce Board

FOR MORE INFORMATION, INCLUDING A LIST OF THE MORE THAN 100 PARTNERS PARTICIPATING IN THIS COLLABORATIVE EFFORT, VISIT WWW.THEWAYHOMEHOUSTON.ORG