

10/25/2024: Listening Session Written Testimony

Provided by Sarah Bartley, SVP, Safe & Stable Housing, United Way of Massachusetts Bay

As we continue to listen to the EA Commission hearings and engage with longstanding field leaders, we have identified a few key priorities with widespread support. We agree with the United States Interagency Council on Homelessness that, *“The homelessness response system is intended to serve as a last resort, rather than the first response, as it is not designed to meet all the housing needs in a community.”* We agree that the Commonwealth must:

- 1) Create a collaborative, cross system response to homelessness prevention and diversion,
- 2) Establish family supportive housing resources for those with the most complex barriers to housing stability, and
- 3) Leverage these strategies to identify and serve unsheltered families.

1) Accelerate Reductions in Inflow with Homelessness Prevention and Homelessness Diversion Strategies:

Homelessness Prevention Initiative

- **Identify families at highest risk of homelessness**
 - Add screening questions in key systems (e.g., mental health, early childhood, child welfare, education, criminal justice, DTA, Medicaid) to identify the housing and service needs of "at-risk" families and those experiencing homelessness earlier and to connect them directly with early intervention and other supports.
 - Coordinate with/build upon the Tenancy Preservation Program (TPP) to identify high risk households and streamline access to legal/mediation, financial assistance, and services.
 - Ensure maximization of health care access and utilization for EPSDT-eligible children.¹
 - Coordinate with and maximize access and utilization to MassHealth’s Children Behavioral Health Initiative (CBHI) for children who are Medicaid beneficiaries with behavioral, emotional, and mental health needs and their families.
- **Strategic and targeted use of resources**
 - Set aside a portion of RAFT or develop homelessness prevention resources to pilot and evaluate a homelessness prevention for families at highest risk of experiencing literal homelessness such as those at or below 15% of AMI; those who have had past evictions, experienced homelessness, or had involvement with child protective services; and families who have children with disabilities.

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>

- The model should include access to intensive social, legal/mediation, and financial services for real and sustainable outcomes.
- In addition to processing requests for financial assistance, staff will explore applicant interest in additional case management support to help maintain housing stability.
- *Case management* will consist of comprehensive, high-quality services provided to those whose housing instability will predictively lead to the need for crisis intervention that uses person-centered, evidence-based practices. Once screened and enrolled, qualifying households will receive interventions to resolve tenant issues quickly and efficiently and prevent displacement. Interventions will include initial and ongoing comprehensive assessments; regularly scheduled home meetings with household members; coordination with an array of community resources; skills training, and the monitored delivery of individualized services to facilitate housing stability.
- **Eviction prevention**
 - Increase the RAFT maximum annual benefit to \$10,000 and eliminate the notice to quit requirement to ensure it is not a barrier and does not create an eviction history.
- **Use HMIS to coordinate and track homelessness prevention data**

Homelessness Diversion Initiative

- **Implement homelessness diversion locally**
 - By starting diversion and housing planning conversations at the front door, there is a possibility to divert people from entering emergency shelter through diversion and flex fund support.
 - Create a formal Diversion Initiative that includes training and is coordinated with local homelessness Continuums of Care, DHCD and MassHousing.
- Maximize opportunities to use HomeBase as a diversion tool. Simplify the approval process and expedite access to HomeBASE.
- Permanently adopt the changes to HomeBASE including increasing the maximum HomeBASE benefit and extending the amount of time families can participate in the program.
- Enhance the case management services provided by the program. Case managers should co-create and maintain an individual housing and services plan with each client; serve as a primary contact to clients; offer flexible schedules to meet client needs; conduct outreach, and employ multiple strategies using best practices that provide:
 - Assuring that those who need and are eligible for mainstream benefit programs receive appropriate assistance
 - Providing credit repair services
 - Assisting in the attainment of other basic needs (e.g., food, clothing)
 - Connection to medical care and mental health counseling; recovery treatments; child behavioral health care; employment; education; job trainings

- Collaborations with community/state agencies that help develop and implement individualized housing and service plans
- Ensure maximization of health care access and utilization for EPSDT-eligible children.²
- Coordinate with and maximize access and utilization to MassHealth's Children Behavioral Health Initiative (CBHI) for children who are Medicaid beneficiaries with behavioral, emotional, and mental health needs and their families.
- Expand HomeBASE eligibility to include families who otherwise would be imminently eligible for EA shelter. When families avoid entering shelter altogether, there will be more room for families that lack alternatives to Emergency Assistance.
- Set up system to track diversions and long-term outcomes.

2) Reduce Length of Stays and Increase Permanent Exits for Highest Cost and Acuity:

There is a need for an increase in supportive housing to meet the needs of families with complex care needs who would not be able to maintain housing independently.

Adequately funding and effective implementation would help decrease demand for beds in emergency shelter unit and allow for more families to be served on an annual basis.

In May 2024, EOHLC identified 1,200 families with children who were the longest stayers in the homeless system and dedicated housing vouchers that were provided to the Regional Administering Agencies (RAAs) to administer to households on the list. This approach can be built upon to develop a statewide list of family households with children who have the most complex and highest needs and are eligible for supportive housing.

Although a relatively small number of families, the costs in public resources and outcomes for these families and children are substantial.

The Commonwealth should pilot a statewide Family Supportive Housing pilot program for families experiencing chronic and high acuity homelessness funded through EOHLC and overseen by an interagency partnership council including public and private partners (MassHealth, DCF, DMH, DTA, BSAS, DESE) including the following components:

- A statewide identification process of families experiencing chronic homelessness and families with complex needs that prevent them from maintaining housing independently. This should include length of time homeless and service needs.
- Coordination with RAAs and local homelessness system Continuums of Care (CoCs) to align and match housing and services through a regional structure, including access options that are geographically equitable. Provide homelessness system management staffing resources and infrastructure to sufficiently staff access and coordination.

² <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>

- Identification, prioritization, and creation of additional supportive housing units dedicated for use by these households.
- Identification of non-Medicaid and Medicaid covered services that can be optimized and leveraged for case management services and other housing stability supports services.
- Ensure maximization of health care access and utilization for EPSDT-eligible children.³
- Coordinate with and maximize access and utilization to MassHealth's Children Behavioral Health Initiative (CBHI) for children who are Medicaid beneficiaries with behavioral, emotional, and mental health needs and their families.
- Development of a system with interagency partners to leverage and set aside child care subsidies and supports, behavioral health and other services for families in need of permanent supportive housing.
- Implementation of a Rapid Results/Housing Surge model to ramp up placements; something that [has been successfully done in MA](#) for specific populations in the past.

3) Ensure Zero Unsheltered Families with Children

- Outreach and identification (some households will be identified and housed through FSH pilot)
- Interim housing (TRC?)
- Rapid connection to permanent housing resources and services (rapid rehousing; affordable housing; supportive housing)

Questions to consider: How can we build upon the proposed HLC regional model to develop a well-coordinated homelessness system? The implementation of this will be important. Can it include staff dedicated to coordinating services amongst emergency shelter, mainstream and homelessness-specific housing and services providers? Can it provide backbone support for convening, case conferencing, housing matching, resource coordination, data sharing? Can it help to scale landlord engagement rather than depending on individual nonprofits for landlord engagement?

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf>