Massachusetts Interagency Council on Housing and Homelessness

Regional Networks to End Homelessness

Pilot Project

Final Evaluation Report
February 15, 2011

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Introduction

In 2008, the *Special Commission Relative to Ending Homelessness in the Commonwealth* charged the Interagency Council on Housing and Homelessness (ICHH) with launching and monitoring the Regional Networks to End Homelessness Pilot. The ICHH responded by releasing a Request for Responses (RFR) inviting stakeholders from around the state to test innovative strategies that could inform emerging statewide housing approaches to ending homelessness. The goal of the pilot was to demonstrate how greater regional coordination and local innovations can improve the Commonwealth's ability to eradicate homelessness. A central hypothesis was that network-organizing would more fully integrate service providers around key innovations at the regional level and engage a broader range of stakeholders in support of housing-focused approaches.

In all, ten Networks were funded to participate in the demonstration, reaching every community in Massachusetts[1]: Some Regional Networks used ICHH funds to expand upon proven best practices such as Housing First approaches to chronically homeless adults. Others tested new innovations focused on the delivery of targeted, flexible resources. In all cases, Networks sought to build new partnerships and match their innovations to regional needs and conditions through the network model.

The Ten Regional Networks

- Boston Regional Network
- Cape and Islands Regional Network
- Merrimack Valley Regional Network
- Metro Boston Network
- MetroWest Regional Network
- North Shore Housing Action Group (NSHAG)
- South Coast Regional Network
- South Shore Regional Network
- Western Massachusetts Regional Network
- Worcester County Regional Network

The purpose of this evaluation was to monitor and assess the Networks' progress toward goals identified by the ICHH, with results that could inform continuous learning within and across Networks and surface best practices for broader replication. Since this report has high relevance for the field and includes recommendations that have the potential to be transformative, documentation which follows includes considerable detail about the Networks' innovations and their implementation in regional settings. It is a record not only of *what* was achieved but also of *how* it was achieved, based on a close account of what worked, what didn't and why.

[1] Of the ten Networks, eight were funded with state resources, and two with support from the Paul and Phyllis Fireman Charitable Foundation.

Background

Important historical and environmental factors influenced the course of pilot implementation and its results. After the original ICHH network design was conceptualized and implemented (starting in 2008), three major changes occurred:

- The Commonwealth and the country entered the worst economic crisis since the Great Depression, with elevated levels of homelessness in the state. This rise in aggregate demand had the effect of compromising potential reductions in demand for shelter and per-case costs;
- Significant changes occurred at the state level, including the transfer of Emergency Assistance (EA) and shelter operations from the Department of Transitional Assistance (DTA) to the Department of Housing and Community Development (DHCD). Some Networks reported that the transfer delayed collaborative efforts between the Networks and DTA, now DHCD, staff. Other Networks found the transfer rejuvenated partnerships and elevated key staff members who made collaboration possible;
- A major federal initiative (Homelessness Prevention and Rapid Rehousing Program (HPRP)) was launched, introducing $44 million in new funding into the state. This created greater opportunity for Networks to impact practice – both because of a (theoretically) better capacity to integrate services around the Network model and because of the opportunity to integrate substantial federal funding into the new housing first approaches.

In addition, the Regional Networks started with different assets and faced different regional challenges:

Existing partnerships and ways of working affected the types of connections Networks decided to build and the kind of innovations they thought would be most successful (based on resources across the region, gaps in services, etc.). Each Network was funded at a different level, based on the assessed need in the community (as determined by Point in Time data counts). Funding in turn played a role in what Networks could do and affected relationships between partners.

Due to their "starting position," some Networks were able to leverage existing connections and resources more effectively than others. For example, members of the Western Massachusetts Regional Network had already developed connections through the Western Massachusetts Interagency Council which facilitated Regional Network start up. The Boston Regional Network built upon partnerships and working groups from existing City efforts including the Boston Interagency Council on Housing and Homelessness and the Mayor's

Leading the Way III Homeless Plan. Worcester County shelter providers designated the Central Massachusetts Housing Alliance as the lead rehousing agency for the Region prior to the start of the Pilot. That partnership laid the groundwork for effective work with landlords. The Boston Regional Network and the Worcester County Network had large cities as their Convening Agency which allowed them to leverage significant resources, although it added a layer of bureaucracy (e.g., procurement requirements, administrative functions).

Not all Regional Networks launched their effort at the same time: the South Coast Regional Network withdrew its initial response to the RFR because the Network determined that more work needed to be done to bring Network members together to target their efforts. When the Network was ultimately funded, they made significant progress as a cohesive region, but remained in their infancy relative to the specific processes they would employ to work together. Boston utilized existing partner networks to develop a strong service strategy, but lag-time hiring a Coordinator slowed their launch.

Where external factors or "starting positions" are relevant to the identification of best practices and lessons learned through the pilot, this is also noted below in the Summary of Findings by Goal.

Summary of Findings by Goal

The ICHH set out broad goals that the Regional Networks were required to address as they tested the viability of new approaches. These were:

1) Reduce the Need for Shelter and Achieve Housing Placement Outcomes
2) Collect Data and Measure Impacts
3) Create Opportunities for Broad-based Discussion with Diverse Stakeholders
4) Implement a Regional System that is a Model for Accountability and Transparency to Consumers and the Public
5) Build Systems Change and Accountability

The ten Networks funded for the pilot developed work plans under each of these Goals and reported regularly on progress toward them. This provided a framework for tracking and comparing Regional Network progress and has guided evaluation research and reporting.

Following is a summary of findings of the Regional Networks to End Homelessness Pilot Evaluation, including lessons learned under each of the five Goals.

1. Reduce the Need for Shelter and Achieve Housing Placement Outcomes

The overarching purpose of the Regional Network effort was to prevent and end homelessness by reducing the need for shelter and achieving positive housing placement and retention outcomes. The ICHH encouraged each Network to focus on strategies for individuals and families that were aligned with the recommendations from the report of the *Special Commission Relative to Ending Homelessness*. Specifically, the ICHH asked Networks to prioritize low-threshold housing options for Tiers 3 and 4 chronically homeless individuals and to implement innovative approaches for families focused on prevention, diversion, and rapid rehousing. For both of these populations, the ICHH asked Networks to create linkages and partnerships to increase the efficiency and effectiveness of their work.

This section documents the Regional Networks' progress toward the goal of reducing the need for shelter and achieving housing placement outcomes, organized as follows:

1. Strategies Focused on Individuals
- A. Homelessness Prevention Strategies for Individuals
- B. Rapid Rehousing and Stabilization Strategies for Individuals
- C. Low Threshold Housing for Chronically Homeless Individuals

2. Strategies Focused on Families
- A. Homelessness Prevention Strategies for Families
- B. Diversion Strategies for Families
- C. Rapid Rehousing Strategies for Families

1. Strategies Focused on Individuals

Five Regional Networks tested innovations to prevent individuals from becoming homeless. Two Networks tested triage models to ensure appropriate rapid rehousing and stabilization services for individuals. In addition, eight Networks developed plans to pursue low-threshold housing strategies for unaccompanied chronically homeless adults in their region. Figure 1 below describes outcomes of these efforts across all regions. A description of specific Regional efforts follows.

Table1

	Individuals: ICHH-Funded Interventions				
	Assessed or pre-screened	***Total # individual service plans created***	***Chronically homeless individuals housed***[2]	***Tier 1 & 2 individuals rehoused***	***Received prevention***
Boston	338	176	44	N/A	N/A
Cape and Islands	N/A	N/A	27	46	N/A
Merrimack Valley	136	103	107	N/A	N/A
Metro Boston	210	14	18	N/A	28
MetroWest	877	98	N/A	97	107
North Shore	342	N/A	16	43	276
South Coast	37	51	N/A	N/A	7
South Shore	1507	686	58	208	N/A
Western Mass	336	80	33	N/A	N/A
Worcester County	1004	150	18	35	8
State Total	**4787**	**1358**	**321**	**429**	**426**

Note: Since ICHH funds were often matched with other resources, Networks counted interventions that used at least some ICHH flexible funds or ICHH-funded staff. N/A refers to activities that were not funded through ICHH for that particular Region.

A. Homelessness Prevention Strategies for Individuals

Several Regional Networks implemented strategies to prevent individuals from becoming homeless, mainly through interventions characterized as "early warning." The majority of individuals served by these Networks qualified as "Tier 1," that is, people experiencing a short-term housing disruption who require modest support to become stably housed. Network strategies included identifying at-risk individuals through community-based nonprofits and/or through the housing court system.

Court-based programs established by Networks served both individuals and families. Each of the court-based prevention projects sought to provide financial, legal, clinical, and/or mediation services to households at risk of eviction. These services were not new to communities;

[2] The number of "chronically homeless individuals housed" counted in this table does not match the number of chronically homeless individuals included in the *Home & Healthy for Good* (HHG) data provided in Appendix 9. The discrepancy is due to several factors, including: difference in time period during which data was collected, and regions counted individuals who were assisted through triage with ICHH funds but did not receive stabilization services through ICHH funds.

existing tenancy preservation programs provide families with similar supports[3]. However, court-based work was now linked to a wider range of services and supports.

Networks that piloted this intervention included Metro Boston, Western Massachusetts, Merrimack Valley and the North Shore. Metro Boston, North Shore, and the Western Massachusetts Networks increased their presence in the court system particularly in district courts that had been previously underserved and expanded other previously existing practices such as the Tenancy Preservation Program (TPP).

Most Networks found that providers had to develop new partnerships or work in new ways to implement prevention and other interventions effectively for both individuals and families. The Cape and Islands Regional Network convened providers on a regular basis in a Client Coordination Council to jointly address how to better serve the needs of homeless and at risk individuals using evidence based practices. This degree of region-wide coordination among providers was new and became a model for other Regional Networks.

B. Rapid Rehousing and Stabilization Strategies for Individuals

Network strategies to house and stabilize homeless individuals included regional coordination to identify lists of potential clients. The Boston Regional Network worked with the City of Boston ICHH to engage shelter providers, the Boston Public Health Commission, as well as the Boston Housing Authority and the Department of Neighborhood Development in producing a long-term shelter stayers list[4]. Long term shelter stayers as a group utilize a high proportion of funding and services, leaving individual shelters less able to serve the needs of the majority of their clients who only necessitate short-term emergency stays and can be rehoused quickly. The final list generated by the Boston Regional Network was 569 individuals. The goal of the Network is to house all 569 by December 31, 2012. As of November 5, 2010, the Network had housed 128 individuals.

The South Shore and Worcester County Networks tested triage models designed to quickly assess homeless individuals' needs and ensure the appropriate identification of supports necessary to achieve rapid rehousing and stabilization. In line with a tiered approach, triage

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[3] For example: payment of rental arrears (typically up to 6 months); payment of utility security deposits and arrears; payment of first and last month's rent and security deposits for new apartments; short-term, shallow rental assistance; referrals to employment, childcare, health and other community based services.

[4] Discussions took place during the Third Quarter of 2010 at both Leadership Council and City of Boston ICHH meetings around the criteria for developing the list, the role the Boston Housing Authority would play in matching names on the list to their public housing and Section 8 waiting lists, the role other agencies and groups such as Boston Health Care for the Homeless would play in adding information about each individual on the list, and how the list would be managed.

involves early assessment of individuals upon intake at shelter so that staff and clients can quickly determine opportunities and barriers for rehousing. Once this assessment is complete, a rehousing plan is developed and potential resources identified.

When implemented effectively, triage yields customized plans that are more likely to result in housing placement and stabilization successes for homeless adults. The South Shore Network developed and implemented a triage system for both families and individuals that became a model for other Networks. Factors for success included appropriate staffing levels as well as an overall culture shift among staff from a focus on shelter management to a focus on triage and rapid rehousing. The South Shore Network's lead triage agency, Father Bills & MainSpring, restructured and boosted its staffing in order to conduct triage more effectively. This resulted in more staff available to meet with homeless individuals as they enter shelter, and allowed for the creation of rehousing plans more rapidly than in a standard shelter model.

Building and strengthening ties between the South Shore Network's triage teams and halfway houses and other community-based programs also contributed to more effective placements. Over the course of the pilot, triage team members conducted site visits to explain their triage model, learn more about community resources and strengthen collaboration. Assessments and weekly triage staff case conferences improved knowledge of sub-populations and the development of targeted strategies for particular clients.

The Worcester County Regional Network, with SMOC and Community Healthlink as key service providers, in partnership with the Worcester Police Department, created a closed-referral process for the People In Peril (PIP) shelter located in downtown Worcester. This marked the first critical step in achieving their goal of reducing shelter capacity through implementing triage and completing housing placements with wrap-around case management services. In Worcester, those seeking shelter receive an immediate assessment for placement, as well as a clinical and housing needs assessment. The new model provides limited short-term respite beds, and implements a triage team comprised of staff from both the South Middlesex Opportunity Council (SMOC) and Community Healthlink that meets daily.

Rapid Rehousing and Stabilization Strategies: Challenges

Across all Networks, the principal barrier to continued implementation of effective triage is limited funds for staffing. Current state shelter contracts for homeless individuals do not explicitly provide funding for this type of activity.

A significant policy-related barrier during the demonstration period was HUD's standard for qualifying chronically homeless individuals for supportive housing. HUD units are a primary source of supportive housing for the chronically homeless. Though clients retain their homeless priority on housing waitlists when rehoused with short-term subsidies, they do not maintain

their status as chronically homeless. This prevents chronically homeless individuals from moving into temporary housing settings and later taking advantage of HUD-supported units.

C. Low Threshold Housing for Chronically Homeless Individuals

Networks that focused on achieving housing placement outcomes for chronically homeless individuals benefitted from the support of the Massachusetts Housing and Shelter Alliance (MHSA)[5]. Based on its *Home & Healthy for Good* initiative, MHSA provided technical assistance on organizing and implementing low-threshold housing placement projects, including data collection and outcome analysis to Networks which helped both the Networks and the ICHH track housing placement and stabilization efforts. In particular, MHSA liaisons worked directly with Networks to implement *Home & Healthy for Good* best-practices for unaccompanied chronically homeless adults. These best-practices promote targeted intake and referrals, manage effective case files, create a sustained client contact system, and collect required eligibility documentation from the Department of Housing and Urban Development (HUD) in addition to outcome data.

MHSA's support for Regional Networks included:

- Delivery of training and other technical assistance on Housing First, chronic homeless definitions and data collection;
- Training in and promotion of low-threshold housing;
- Regular participation in local, regional and statewide meetings associated with regional planning and low-threshold housing;
- Collection of cost-related data for cost-benefit analysis;
- Training in new models of case management and service provision within low-threshold settings;
- Improved homeless data reporting with local agencies;
- Statewide data collection from various regions and assistance in improvement of data collection capacity.

Collaboration with law enforcement played a part in some Networks' efforts to reach out and identify potential clients. The Metro Boston Network worked closely with local police to identify and locate chronically homeless individuals and link them to housing. In some areas, HomeStart case managers rode in police cruisers to accomplish this. The Metro Boston Network also created a Housing First Consortium, consisting of the Edinburg Center in Waltham, the Waltham police department, the Somerville Homeless Coalition, Brookline

[5] The Paul & Phyllis Fireman Charitable Foundation provided funding that allowed the Regional Networks to participate in the Home & Healthy for Good initiative developed by the Massachusetts Housing and Shelter Alliance (MHSA).

Community Mental Health Center, Eliot Community Human Services, Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation (CASPAR), the Cambridge Police Department, participants from the faith community, and others.

All Networks adopted new protocols for stabilization services as they were able to house many more people. Through its regional providers, the Boston Regional Network implemented a Critical Time Intervention (CTI) approach that emphasizes intensive work with clients during their first nine months in housing. CTI is an evidenced-based practice designed to prevent recurrent homelessness by connecting people early with needed community-based resources. Pine Street Inn and the Boston Public Health Commission have trained staff in this model and are implementing it now.

The Merrimack Valley Regional Network's coordinated efforts to identify and stably house chronically homeless individuals in their region resulted in a demonstrable decrease in nightly bed usage rates at the Lowell Transitional Living Center (LTLC)[6]. The Network attributed its housing stability success to prioritization of benefits and income maximization strategies as well as the use of representative payee services. Representative payee services can be critical to success in stably housing people who have extremely low incomes and very little financial cushion. In order to keep pace with the number of individuals rehoused, the Network determined that representative payee services in the region needed to be expanded. As a result, the Network's Convening Agency, Community Teamwork, Inc., has begun to develop a strategy for addressing that gap.

Low Threshold Housing for Chronically Homeless Individuals: Challenges

Limited availability of flexible funding hampered Network efforts to provide long-term housing stability for chronically homeless adults. In part, this is because funding for community-based supports that are so critical to keeping these individuals stable and housed is limited. Housing resources utilized for rehousing chronically homeless individuals often come from stable funding sources such as HUD. But adequate funds for home-based services and stabilization are not often included within those funding streams.

More work still needs to be done in most regions to broker relationships with the mainstream training and employment system in order to help recently housed individuals move closer to self-sufficiency. Also, many Networks will need to expand client coordination and case conferencing to ensure that effective data and resources are shared across providers and the region as a whole. During the pilot, some Regional Networks did not feel that it was appropriate to use the short-term resources of the ICHH without knowing where future

[6] The LTLC recorded a 20% reduction in nightly bed usage during the period between August 2009 and May 2010.

funding for long-term housing assistance would come from. This resulted in targeting more "sustainable" chronically homeless individuals rather than serving some of the most vulnerable.

2. Strategies Focused on Families

All the Regional Networks were charged with developing and implementing innovative approaches to end family homelessness through prevention, diversion and rapid rehousing. Figure 2 below describes outcomes of these efforts across all Regions. A description of factors for success associated with specific Regional efforts follows.

Table 2

	Families: ICHH-Funded Interventions			
	Assessed or pre-screened	***Diverted***	***Received Prevention***	***Rehoused from shelter/motel***
Boston	386	41	289	N/A
Cape and Islands	N/A	16	242	30
Merrimack Valley	507	14	100	N/A
Metro Boston	N/A	34	817	18
MetroWest	142	43	61	N/A
North Shore	1422	8	1171	180
South Coast	N/A	19	63	N/A
South Shore	917	34	24	23
Western Mass	N/A	57	345	N/A
Worcester County	42	27	230	N/A
State Total	**3416**	**293**	**3342**	**251**

Note: Since ICHH funds were often matched with other resources, Networks counted interventions that used at least some ICHH flexible funds or ICHH-funded staff. N/A refers to activities that were not funded through ICHH for that particular Region.

A. Homelessness Prevention Strategies for Families

All 10 of the Regional Networks implemented homelessness prevention innovations for families categorized as either "early warning" or "front door" prevention.

- ***Early Warning Innovations***

Four of the ten Regional Networks established court-based prevention programs that work with families on the brink of eviction to prevent their imminent homelessness[7].

The following table shows the stage in the eviction process at which households were served. The responses below are aggregated from all households that answered the question: "Where in the eviction process are you?"[8]

Table 3

Stage in Eviction Process		
	Count	Percent of total
Arrearage/At Risk of Eviction	110	14%
Received 30 Day Notice	93	11%
Received 14 Day Notice	369	45%
Signed Agreement to Mutually Terminate	50	6%
Received Court Ordered 48 Hour Notice to Vacate	192	24%
Total	**814**	**100%**

Four Networks established court-based programs as part of their prevention work. The North Shore Housing Action Group (NSHAG) developed a court-based prevention program that prioritized families in subsidized housing. Network staff worked with attorneys from Neighborhood Legal Services and North Shore Community Action Programs (NSCAP) as well as a pro bono panel of attorneys to preserve tenancies in the Northeast Housing Court. ICHH-funded advocates made referrals to NSCAP's Housing Law Project, who guided the household through the appropriate legal process. Advocates helped families and landlords work out payment plans and sometimes provided the family with financial assistance. NSHAG also found that training staff about the eviction process was important. Other Networks employed similar methods with private landlords, enabling households to negotiate leases for households with barriers related to Criminal Offender Record Information (CORI), credit, or poor rental

[7] The Merrimack Valley Network did not co-locate prevention workers in the courts but took referrals for prevention services from the Haverhill section of the North East Housing Court.

[8] This question appears on Uniform Assessment Tool. See Goal 2: *Collect Data and Measure Impacts* for details.

histories. See Appendix 4 for more detail on the types of housing from which households were in process of or had been evicted.

Some Networks worked systematically to engage large private and public landlords to preserve tenancies for at-risk families. Techniques included building connections with Local Housing Authorities, cultivating landlord relationships through targeted landlord outreach and hosting of landlord fairs, and sharing of landlord relationships. In the latter case, providers in the Network who had strong relationships with a group of private landlords and/or management companies shared these connections with other Network members to help expand housing options for families.

The Metro Boston Network's work with large landlords offers a model for this type of targeted collaboration. Through the Regional Network, Affordable Housing and Services Collaborative, Inc. worked in collaboration with Peabody Resident Services Inc, local service providers and legal aid organizations to intervene with families at risk of eviction. The Somerville Community Corporation (SCC) provided resident services in the Clarendon Hill Towers, and Community Action Agency of Somerville provided services at SCC-owned properties managed by Winn Management. The Cambridge and Somerville Legal Services office of Greater Boston Legal Services provided legal assistance to the Somerville program. Collectively these providers made eviction prevention services available to the more than 1,200 families. To date this program preserved the tenancies of 118 families that were at risk of eviction for rent arrearages and other lease violations.

Some Networks, such as the MetroWest and the Cape and Islands Regional Networks leveraged their existing prevention infrastructure to deliver more effective prevention services. For example, the Cape and Islands created a telephone triage hotline that connected households at risk of homelessness to the prevention provider in the region best able to meet their needs.

Finally, all Networks sought to strengthen relationships between prevention providers and other homeless service providers in order to quickly identify households at risk. As noted earlier, the Cape and Islands Regional Network convened providers on a regular basis in a Client Coordination Council to jointly address how to better serve the needs of homeless and at risk individuals and clients using evidence based practices. Collaboration with other stakeholders in the community was also important to successful prevention work. Relationships between prevention providers and other social service providers (e.g., childcare providers) enabled families at risk to be more rapidly identified and connected with the appropriate prevention resources in their community.

- ***"Front Door" Innovations***

Within the architecture for the homeless response system, the "front door" refers to the family Emergency Assistance (EA) shelter system. Households who are looking for help by going to the "front door" are those seeking assistance at Temporary Assistance Offices (TAOs). During Fiscal Year 2010 from July 1, 2009 through June 30, 2010, 32,798 families sought help for their housing crisis at the "front door." Of those, 11,147 families filled out applications for emergency shelter and 4,432 new families were approved. This means that 28,366 families needed help but didn't qualify for EA shelter assistance.

Over the course of the pilot, all of the Regional Networks organized staff to co-locate at the TAOs in order to engage these families and provide "front-door" prevention using HPRP, private funds and other leveraged flexible funding in addition to ICHH funding. This was done in coordination with shelter diversion strategies, and oftentimes with the same staff. In the fall of 2009, DHCD developed a protocol to guide Network prevention and diversion workers in the use of flexible housing resources so that each family's housing crisis might be resolved at the "front door." Prevention efforts were targeted to families who were not EA-eligible, and diversion went to those who were EA eligible. Prevention services and support for families delivered at the "front door" included referrals to eviction prevention legal services, assistance paying rental or utility arrears to maintain the current rental, assistance seeking new housing and paying move-in costs, and short-term shallow rental support, among others.

In contrast with court-based prevention efforts, some front door programs served families who had not been a primary leaseholder at any point over the previous 3 years. Using data from the Uniform Assessment Tool's housing history chart, the following table shows the breakdown of families with an adult head of household (aged 22 or older) who submitted data on their 3 year housing history[9].

Table 4

Primary Leaseholder within Last 3 Years - Families with Head of Household (22 years old +)		
Adult Head of Household (22 years old+)	Count	Percent
Yes	734	71%
No	300	29%

[9]Collecting housing history is a new practice and a large proportion of incomplete housing history charts raises concerns about data quality. To conduct this analysis, families were included in the sample if they answered any portion of the housing history. If they did not indicate they had been a primary leaseholder in their response, they were counted as not holding a lease. Thus, the data may be skewed to represent a larger proportion of families who had not been primary leaseholders when in fact they simply did not provide that information.

Families headed by a parent aged 18-21 were less likely to have held a lease in the previous three years[10]. Given their age, young heads of households who did not maintain a tenancy in the prior three years likely never held a primary tenancy.

Table 5

Ever Primary Leaseholder - Young Families		
Young Adult Head of Household (18-21)	Count	Percent
Yes	19	41%
No	27	59%

Homelessness Prevention for Families: Challenges

Providers' ability to prevent homelessness before the family reaches the EA "front door" was hindered by limited access to flexible funds to do this work. As Networks developed protocols and guidelines for the use of their flexible funds, they encountered barriers resulting from income restrictions and per-household limits that made prevention more challenging than necessary. For example, the Metro Boston Network first adopted guidelines for family prevention work similar to the Residential Assistance for Families in Transition (RAFT) program. Strict income limits and a desire to serve many families with a small amount of ICHH funds that could be used to leverage other resources resulted in a limited pool of eligible recipients. Given the availability of few other resources and the range of families seen, the amount of funds available and income limits per family were increased. The Network was only able to do this as long as flexible client assistance resources were available, however.

Some Networks had difficulty implementing effective court-based eviction prevention programs as a consequence of high rental arrears – the Metro Boston Network recorded rental arrears above $4,000, when the per-family target average for network prevention funds initially was $900.

Qualified staff who understand housing first strategies and who have the means to implement prevention protocols were foundational to successful prevention initiatives. This applies to providers as well as to other Network partners. Court-based prevention worked better in Housing Courts than in District Courts which typically have less experience with mediation and other means to avoid eviction.

Although client coordination has proven to be an effective means of connecting clients with appropriate resources, some Networks continue to work on data sharing protocols and the

[10] The difference in proportion of families headed by an adult 22 years old or older who had been primary lease holders in the last three years and the proportion of families headed by a young adult aged 18-21 who had been a primary lease holder in the last three years is statistically significant at $p = .01$.

use of information release forms so that client stories and data can be shared ethically. Further, some staff working at court-based eviction prevention programs reported that the Uniform Assessment Tool (UAT) was too long and cumbersome for their work with clients in that setting. They recommended creating a short version of the UAT that could be used for court-based interventions.

Finally, all Networks reported that prevention efforts were hampered by a lack of affordable housing in their region. Availability of affordable housing is a critical factor in preventing homelessness for families who cannot afford their rent but have no immediately viable way to increase their incomes.

B. Shelter Diversion Strategies for Families

In addition to front door prevention, Regional Networks organized staff to co-locate at the TAOs in order to provide shelter diversion services. Diversion is defined as assistance offered after a family is determined to be EA-eligible by DHCD staff at the local TAO, but rather than entering the shelter system the family is assisted with an alternative housing arrangement. Within the architecture metaphor, shelter diversion is considered to be the "front screen door" as a way to describe that the family is on the cusp of entering shelter and would do so without diversion assistance.

The experience of the Regional Networks confirmed that the use of targeted, flexible resources for housing search assistance, help with relocation costs, and rental assistance created options for families who would otherwise have entered shelter.

Networks reported that staff's skill sets were a factor for successful diversion. Diversion staff who worked sensitively with families to develop a workable plan based on an assessment of their needs and options achieved better outcomes with clients.

Timely access to housing was also a factor for success. For some Networks, strong established relationships with landlords allowed rapid access to a steady stream of apartments for diverted families. The Central Massachusetts Housing Alliance (CMHA) of the Worcester County Regional Network and Emmaus House of the Merrimack Valley Regional Network both reported success acquiring units from landlords which were available for almost immediate rental. CMHA at times had the keys to empty apartments and were able to quickly move families into housing.

Out of 75 families identified through the Uniform Assessment Tool as having received shelter diversion, only 5 families or 6.8%, had subsequently entered shelter as of the end of December 2010. Though the sample size is small and the time since the end of the pilot period has not been long enough to draw broad conclusions, the initial results are encouraging that diversion was successful at offering families an alternative to shelter in the short-term.

Diversion for Families: Challenges

Just as access to flexible resources and qualified staff improved Networks' rate of success with diversion, limited staff and resources at the "front screen door" jeopardized the effectiveness of Network diversion strategies. At times when coverage was not available or resources ran out, families were provided with few options other than shelter. Limited resources also affected follow up. As more families were diverted over time, some Networks with significant caseloads began to experience difficulty providing effective stabilization services with existing staffing patterns.

In some cases, lack of or limited ability to speak and understand languages other than English at the "front door" and "front screen door" hampered staff's efforts to provide assistance to speakers of other languages.

Furthermore, the diversion process may take several weeks to complete, including housing search, gathering documents required for tenancy, and obtaining furniture, if necessary. Some families who wished to proceed with diversion reported that they did not have anywhere to stay while awaiting assistance and therefore entered the shelter system instead.

Lastly, Diversion providers that offered 12 months of rental support expressed concern about the "cliff effect" after the assistance ran out for families with extremely low incomes. For this reason, some Networks decided to only offer smaller amounts of diversion assistance targeted to families with higher incomes or more prospects for increased stability in the near future. In those cases typical assistance consisted of first and last month's rent and the security deposit. This more targeted diversion model assisted fewer families and it only served families who had enough resources to pay rent after the move-in costs were covered.

C. Rapid Rehousing for Families

Several Networks explored triage as a means of linking families with appropriate resources for rapid rehousing. As with homeless individuals, triage for families involved early assessment upon intake in the shelter system so that staff and clients could quickly determine opportunities and barriers for rehousing. Once this assessment was complete, staff and families developed a rehousing plan and identified potential resources.

Triage was a key innovation tested by the South Shore Regional Network based on a model that combined rapid assessment and local control of shelter placement. The protocol involved an initial placement of all families into a motel where they received a full assessment within the first week. Families were then placed into a shelter setting that best suited their geographic and service needs.

Implementation of this triage model by the South Shore Network resulted in shorter average lengths of stay in the shelter system. The Network found that keeping families local improves the likelihood that families can access other supports and be rehoused rapidly. In reviewing

client cases, triage workers in the South Shore Network took into account additional factors such as children's special needs, the location of a parent's job, or the presence of extended family support systems.

As with diversion for families, the availability of flexible funds for rapid rehousing was essential to the South Shore Network's innovative approach to triage. According to the Network, their success also depended to a large degree on the culture and commitment of Father Bills & MainSpring, the Network's lead triage agency. This agency took the unprecedented step of shifting 6% of their existing EA contract to cover costs for this triage initiative. The Network also cited the presence of a skilled triage coordinator who was experienced with families and trusted by providers, as well as a trusted Network Coordinator who brokered relationships among providers and DHCD.

The South Shore was the only Regional Network to test a full implementation of this triage model. Boston piloted a small-scale version and is currently planning fuller implementation. Other Networks have expressed an interest in beginning to plan triage, including Metro Boston, South Coast, and Merrimack Valley Regional Networks.

Rapid Rehousing for Families: Challenges

As noted above, the South Shore Network's family triage model relied heavily on the availability of flexible funds for rapid rehousing. Their experience suggests that, when flexible funds for rehousing are unavailable, triage becomes less efficient. There is less movement and flexibility in the system leading to more families in motels, more assessments to complete, and longer waits between assessment and shelter placement. Furthermore, many Regional Network partners raised concerns about the short time-frame associated with flexible funds used to rapidly rehouse families out of shelter. Many providers and advocates advised that some households with extremely low incomes would not achieve the sustainability needed to take over the full cost of the lease within a 12-18 month timeframe.

Reducing the Need for Shelter and Achieving Positive Housing Placement Outcomes: Lessons Learned

Lessons learned surfaced through evaluation research related to the goal of reducing the need for shelter and achieving positive housing placement outcomes include the following:

- Access to flexible funds greatly increased Networks' capacity to match resources with need and get the right resources to the right people at the right time;
- Triage is essential to a rapid and appropriate response;
- Regional coordination of services minimized duplication and increased the efficiency and effectiveness of service delivery;

- Qualified frontline staff and a culture of commitment to housing as the end goal resulted in customized solutions that reduced reliance on shelter;
- Collaborative partnerships with a broad range of stakeholders allowed Networks to identify and serve clients at the earliest possible stage. Specifically, court-based prevention, tenancy preservation in partnership with private and public landlords, and co-location of prevention staff and resources at local DTA/DHCD offices were shown to be among the most effective strategies for reaching at-risk households;
- Reducing the need for shelter among chronically homeless adults, including long term shelter stayers, can be achieved through Network-based collaborative efforts to identify and serve clients using housing first approaches;
- Stable sources of funding for housing and community support services are critical to achieving housing placement and retention outcomes for chronically homeless adults. Existing funding streams do not adequately cover those crucial expenses;
- Limited affordable housing continues to hamper Network-based initiatives to implement housing first approaches for families and individuals.

2. Collect Data and Measure Impacts

The ICHH committed at the outset to develop a uniform assessment tool and to work with Networks to develop the standard set of data elements that all Networks would track. Measuring the impact of the pilot innovations has been integral to the larger goal of assessing Regional Network innovations in order to determine their efficacy and potential for replication.

This section is divided into two Parts. Part I describes data gathering and reporting systems that were developed by the ICHH and the Networks during the pilot period. Part 2 describes strategies employed by the ICHH and Networks to measure the impact of the Network's housing-focused innovations.

1. Collect Data

Guided by the ICHH, the Networks and the ICHH employed a multi-pronged strategy for data-gathering and reporting, including:

A. Development and use of the Uniform Assessment Tool
B. Application of the *Home & Healthy for Good* methodology
C. Regional monthly and quarterly reporting
D. Qualitative evaluation at baseline, mid-term, and end of pilot
E. Technical assistance from a qualified regional Data Analyst

A. Uniform Assessment Tool

In July 2008, the ICHH tasked a state interagency working group with developing a comprehensive Uniform Assessment Tool (UAT) for assessing households who are at-risk of or experiencing homelessness. The working group met over the course of the following year to develop the tool. After gathering feedback from Regional Network partners and updating the tool accordingly, the ICHH released a revised version of the tool in early October 2009. Starting in October 2009 through the duration of the pilot, the ICHH required all Regional Network partners to use the Uniform Assessment tool for ICHH-funded interventions. One categorical exception was made: the ICHH required the Networks to employ the *Home & Healthy for Good* methodology for interventions with chronically homeless individuals receiving housing and stabilization services rather than requiring the UAT for that population.

The ICHH, with support from DHCD's IT Department, built a database for the UAT data to prevent duplicative costs and conflicting data collection systems. Boston, North Shore, MetroWest and a few providers from Metro Boston and Western Massachusetts Regional Networks chose to build the UAT fields into their existing Homeless Management Information Systems (HMIS) rather than using this separate database. In May 2010, Simtech Solutions, Inc

provided data exchange standards for the UAT fields configured as extensions to the HUD mandated HMIS standards. These data exchange standards made it possible for the ICHH to accept UAT data from the multiple systems in use.

While the implementation of the Uniform Assessment Tool took longer than expected, a year of field-testing yielded insights that have led to important revisions, with useful guidance from Regional Network partners and state agencies including the Department of Public Health(DPH), the Department of Mental Health (DMH), the Department of Correction (DOC), and the DHCD. ICHH staff further revised the Uniform Assessment Tool and worked with DHCD's Division of Housing Stabilization to integrate the improved tool into the forthcoming ASIST data collection system. This is the first step in scaling up implementation of the UAT so that it is truly uniform.

In addition to piloting the tool's content, the Uniform Assessment Tool effort tested the practice of collecting detailed data describing families and individuals who are at-risk of homelessness, rather than collecting data on households who have already become homeless. This broader approach was crucial to glean information about housing-based responses as a means to prevent homelessness and to understand the distinct needs of those seeking assistance. Apart from research value, collecting robust assessment data on households who are at-risk of homelessness is essential for practitioners to tailor an appropriate response based on need.

Uniform Assessment Tool: Challenges

The implementation of the Uniform Assessment Tool during the pilot period offered several lessons for future efforts. The tool's fields were not finalized until October 2009 when the grant was already several months under way. This resulted in lost data for the households served prior to that date. More importantly, when the final fields were released in October 2009, the ICHH provided them in the form of the assessment questionnaire rather than as data specifications. At that point, several HMIS vendors built the UAT questions into their systems without a standard data exchange format. To rectify this problem, Simtech Solutions, Inc volunteered company resources to develop the data exchange format, and the ICHH released it in May 2010. By releasing data specifications so late, the process created additional work for HMIS vendors who had to work backwards to adopt the standards.

DHCD did not complete the data warehouse for UAT data until late in November 2010. As a result, the pilot period ended before ICHH could return data to the Regional Networks for data cleaning and their own analysis. While some Regions were able to create regional reports from other sources of data, several Regions were unable to do this because they did not have their own regional data warehouse and had not received the regional Uniform Assessment Tool data back from the ICHH within the pilot period.

B. Application of the Home & Healthy for Good Methodology

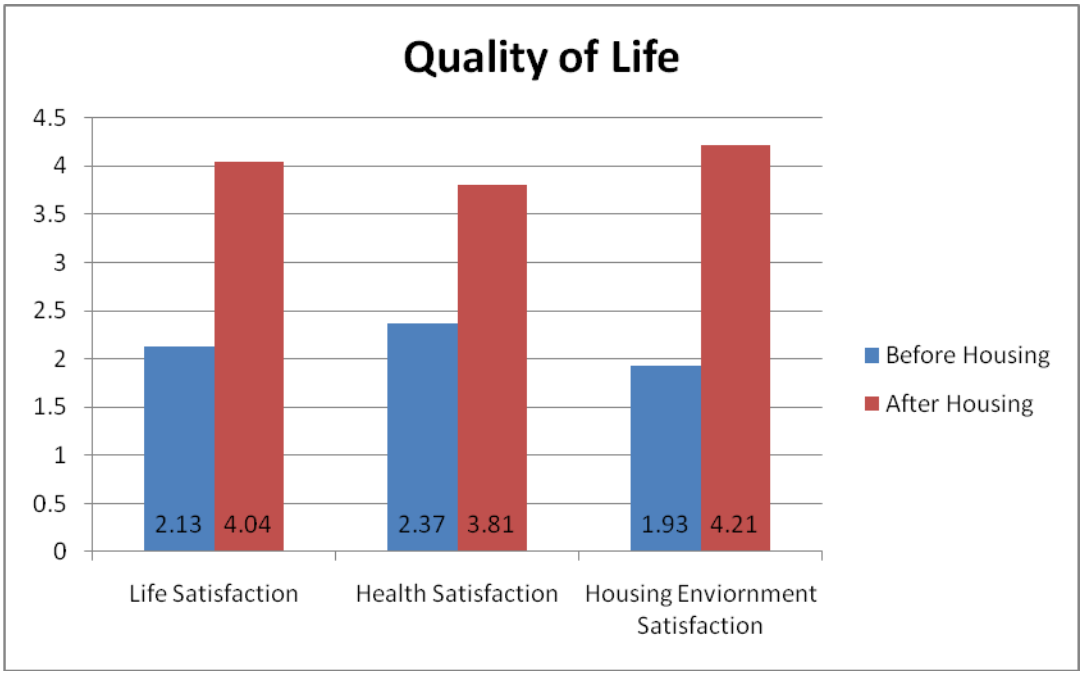
Developed by the Massachusetts Housing and Shelter Alliance (MHSA), the *Home & Healthy for Good (*HHG) methodology compares the use of emergency services by individuals as well as individuals' quality of life prior to entering housing and after entering housing. All Network providers funded to house chronically homeless individuals were required to complete *Home & Healthy for Good* interviews on a regular basis and submit these data to MHSA for analysis. The aggregate results are included under Individual Innovations above (Table 1, p. 9) and further detailed in Appendix 9.

From the start of the *Home & Healthy for Good* initiative in 2006, MHSA has maintained a "bias toward action," focusing on outcomes rather than process indicators. *Home & Health for Good*'s goal has been to house the poorest and most disabled persons around the state and collect outcome data to demonstrate the success or failure of this effort. The *Home & Healthy for Good* evaluation tool and methodology were developed to measure quality of life indicators and cost-savings to state systems of care as a result of Housing First approaches for chronically homeless individuals.

In order to ethically conduct research focused on this vulnerable population, *Home & Healthy for Good* participants were asked to consider enrollment in the research study and informed consent was obtained from those who agreed. Participants were also asked to sign MassHealth's Permission to Share Information form so that Medicaid claims data could be analyzed. Refusal to participate in the research study did not preclude participation in any of the initiatives targeted to the population. Case managers interviewed tenants who agreed to contribute to the research study upon entry into housing and at one-month intervals thereafter. Interview questions pertained to demographic characteristics, quality of life, nature of disabilities, health insurance, sources of income and self-reported medical and other service usage.

Quality of life outcomes are based on questions that ask about life in general, as well as an individual's health and housing environment. On a monthly basis, tenants were asked the same questions regarding their quality of life in housing. The questions included choices ranging from "Very Dissatisfied" to "Very Satisfied". The responses indicated a significant increase in satisfaction in all categories after housing.

Figure 1



Home & Healthy for Good data also demonstrated that Housing First can produce savings for state systems of care (see Figure 8, p. 60).

C. Regional Monthly and Quarterly Reports

In addition to detailed assessment data, the ICHH required aggregate monthly reports from Regional Networks on family shelter diversion and homelessness prevention. These reports recorded interventions funded by ICHH separately from interventions funded exclusively with other resources. The Networks collected data from the relevant providers in the region and sent the regional total to the ICHH. The Networks also submitted a Quarterly Report with the following components:

- Benchmark progress and outcomes reported against the ICHH work plan, including aggregate client outcomes;
- Summary description of Network development activities;
- Case studies that exemplify Network best practices for implementing innovations;
- Case studies that demonstrate important challenges related to implementing innovations;
- Stories that exemplify Network best practice and/or demonstrate important challenges related to network organizing.

These reports enabled the ICHH to correlate Network efforts with effects on the shelter system on an ongoing basis. The ICHH also used information gathered from monthly and

quarterly reports to assess progress and share interim findings with outside stakeholders. Networks provided detail in quarterly reports about their respective innovations that facilitated interpretation of aggregate quantitative data. For example, specific outcomes for prevention interventions such as the number of housing subsidies or tenancies preserved through housing court intervention were far more valuable than the aggregate count of homelessness prevention interventions provided.

Coordinators and data analysts affirmed that regular reporting requirements helped providers to develop the habit of reporting on a routine basis. Networks were required to submit case studies that exemplified successes and challenges working with households to prevent or end homelessness. These stories communicated important information about quality of outcomes and policy barriers that could not be captured through numbers and graphs. Several Networks found the case studies to be useful in communicating with their Leadership Councils and in communicating successes for fundraising purposes.

Regional Monthly and Quarterly Reports: Challenges

The initiation of the pilots coincided with changes to the EA system. Due to this flux, key operational definitions evolved between the time the ICHH Request for Responses (RFR) was released and the time that the pilots began. The definition of shelter diversion in the ICHH Regional Network RFR was further refined in July 2009 at the same time as the EA system transferred from DTA to DHCD. Ultimately, the ICHH, DHCD, Regional Network Coordinators and service providers worked together to produce a synthesis, confirming a definition that Networks could operationalize and resolving implications for ICHH contracts. "Stabilization" also required clarification, since it is a specific term used in the context of the DHCD architecture to refer to services provided to households leaving homelessness for housing. The "tier" system faced similar challenges (for details, see Goal 5: *Build Systems Change and Accountability, p. 54*). At the end of the pilot period, Regional Networks reported a need for staff training on all these definitions – from program directors to front line workers.

The definition of "homelessness prevention" posed a special challenge. Here, the operational definition was so broad that the aggregate monthly count reported by Networks was meaningless without additional context. For example, one provider might count intensive legal assistance at the late stage of an eviction process for families who were income eligible for EA as "homelessness prevention," while another counted a referral to a local Community Action Agency. The former is much more targeted and resource-intensive, but such variations in intensity were not adequately defined within the simple aggregate count.

Finally, although data sharing was included in the Regional Networks' work plans, expectations for improving data sharing were not clearly defined in the RFR and were thus interpreted differently across Regional Networks. Some Networks reported improved data sharing between agencies upon referral of a specific household, and developed tools to facilitate this (e.g., use of a regional release of information form). At the same time, several providers expressed their concern about sharing detailed personal data across agencies and with the state, particularly data that reveal history of substance abuse, criminal history, child welfare involvement, or other highly sensitive information.

D. Qualitative Evaluation at Baseline, Mid-term, and End of Pilot

The ICHH evaluation team conducted site visits to each of the Networks at the start of the grant period followed by "check-in" conference calls with Network representatives at the midpoint of the pilot. Also, at the midpoint of the pilot period, Innovation Networks for Communities created and distributed a Network Health Survey to Network members[11]. Results of this qualitative research were summarized and circulated to Networks to support members' internal discussions about progress to date and opportunities for improvement. Rather than conducting final site visits for each Regional Network, the evaluation team designed a Pilot Closing Event to capture Network members' perspectives on their successes, challenges, and vision for each of the goals laid out in the RFR. Additional detail was also provided through final quarterly reports that required brief narrative analysis of success related to each of the original Regional Network goals.

The Network Health Survey was particularly helpful to Networks and the ICHH. Networks presented the information to their Leadership Councils to identify strengths, weaknesses, and strategies for improvement. The ICHH used the results as a way to validate self-reports from the Regional Networks with respect to progress made and remaining challenges.

E. Technical assistance from a qualified regional Data Analyst

The Regional Network RFR mandated that applicants hire or identify a regional Data Analyst to support data collection and performance measurement. This position was funded in one of two ways: either as part of the infrastructure costs awarded through the Regional Network contract or from outside sources. The RFR provided very little additional guidance about expectations for this position.

The Metro Boston, Western Massachusetts, South Shore and Worcester County Networks each hired a consultant or Network employee to serve as the regional Data Analyst while the other Regional Networks identified an existing staff person who would serve that role for the

[11] Survey designed for INC by Madeleine Taylor, Ph.D.

entire region. The two models produced very different results. Regions that had a dedicated Data Analyst reported more improvement in HMIS data quality, provided more detail on the impact of regional innovations, and reported improved data-driven practice among providers[12]. Regions that relied on existing staff or subcommittees were more likely to report difficulty with data quality, lack of compliance from providers in reporting client data to the Network, and greater difficulty analyzing particular regional trends reflected in the data.

Technical assistance from a qualified regional Data Analyst: Challenges

Networks reported difficulty integrating data from multiple HMIS systems in their regions and were also hampered by lack of data integration between state data collection systems (Beacon and HMIS). Several Networks observed that the advantages of having a regional Data Analyst will not be fully realized until there is either a statewide data warehouse that regions can access on demand or each region has its own data warehouse. Data Analysts were also charged with improving data quality, but encountered challenges here as well. The data axiom "garbage in, garbage out" is highly relevant when demand for a large volume of data coincides with insufficient staffing for data input and data quality assurance. Many Networks reported that the data collection burden on front-line staff and program administrators was unreasonable and resulted in poor data quality. While Data Analysts were extremely valuable, their contributions were limited by the quality of available source data.

2. Measure Impacts

The ICHH was less prescriptive about strategies to measure impacts of housing-based innovations implemented by the Regional Networks. Approaches to measuring impact varied depending on Networks' innovation design. Meanwhile, broader, system-wide impact was most effectively measured by looking at aggregate data. The ICHH analyzed data from across the Commonwealth to show systemic effects of Regional Network efforts. These regional and state-wide strategies included:

A. Measuring impact of shelter diversion on entries into Family Shelter
B. Measuring impact of housing interventions on family shelter utilization
C. Comparing length of stay data
D. Measuring housing outcomes for targeted groups of homeless individuals

It is worth noting that the intent of the pilot was to measure the impact of flexible housing-based resources on the Commonwealth's emergency shelter system. Though longitudinal study

[12] See Appendix 10 for an example of an analysis conducted by a Regional Network Data Analyst.

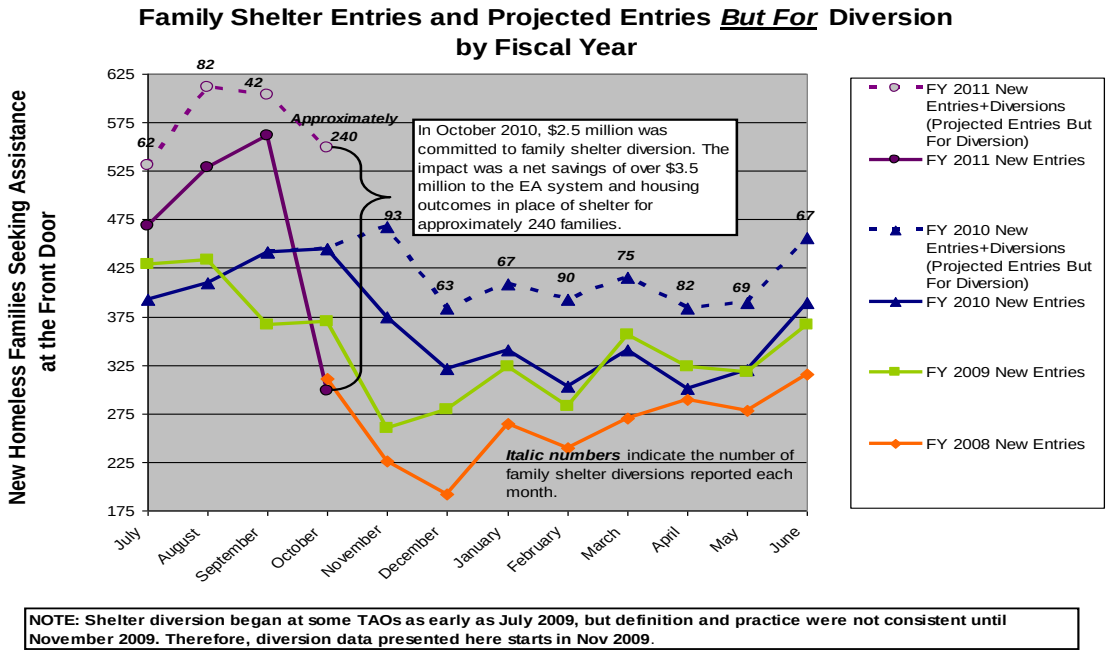
of housing outcomes will be necessary to understand long term results, the Regional Networks were not equipped with the time and resources nor had responsibility for such.

A. Measuring Impact of Shelter Diversion on Entries into Family Shelter

Since family shelter diversion is by definition a housing intervention for families deemed EA-eligible, it was possible to measure the direct impact of diversion on shelter entry. The assumption is that an EA-eligible family seeking help at the TAO would have entered shelter if not for the diversion intervention.

Figure 2 below shows the actual and projected family shelter entries for the last three and a half fiscal years. The solid color lines represent the actual new family shelter entries each month. Above the solid lines for FY2010 and FY2011 are corresponding dotted lines that describe the projected number of shelter entries there would have been without diversion interventions. The difference between the dotted line and the same color solid line represents the total number of new EA-eligible families each month who received diversion as reported by the ICHH Regional Networks (supported by all funding sources). The most dramatic impact of diversion in a single month can be seen in October 2010 when 240 families were diverted with an influx of emergency funds made available through DHCD. Because of these funds, there were fewer *actual* shelter entries in October 2010 than the month of October in the three prior fiscal years. The demand for assistance in October 2010 was higher than the month of October in the three prior fiscal years, however. October 2010 shows a projected entry of approximately 550 new EA-eligible families, over 100 more new eligible families than in October 2009.

Figure 2

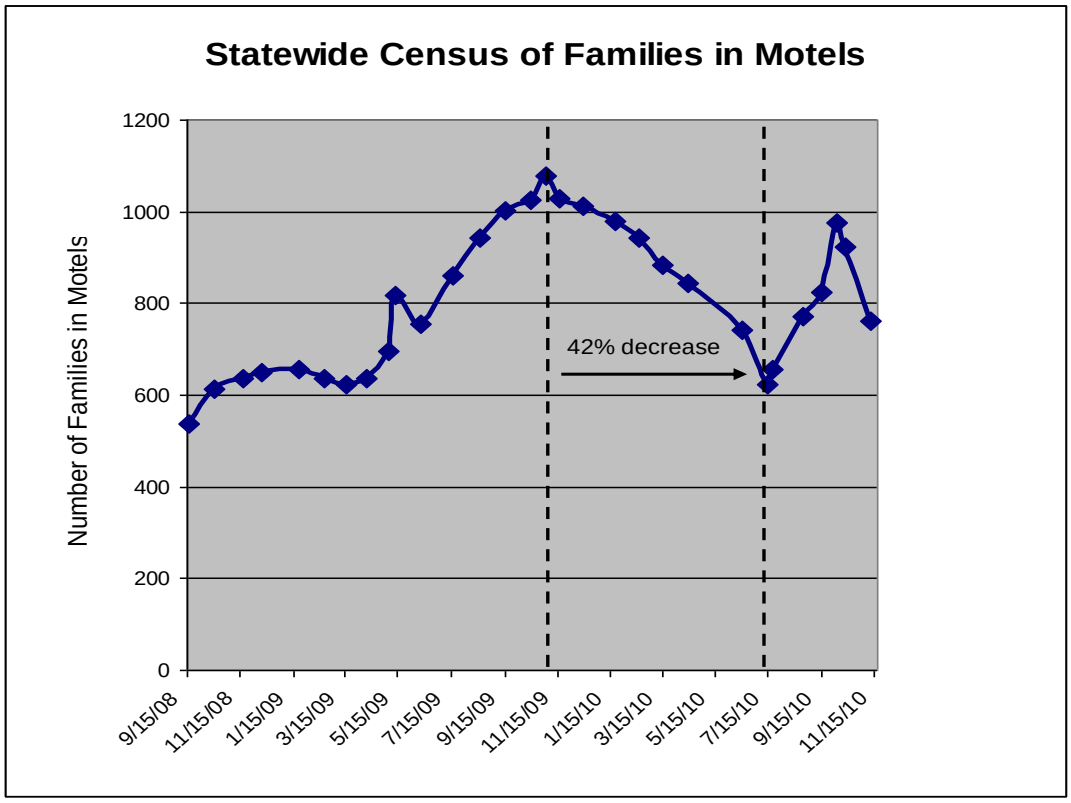


NOTE: Shelter diversion began at some TAOs as early as July 2009, but definition and practice were not consistent until November 2009. Therefore, diversion data presented here starts in Nov 2009.

B. Measuring Impact of Housing Interventions on Family Shelter Utilization

Another system-wide measure of the impact of housing interventions on the family system is the number of families in motels. Since the shelter system has been operating at over-capacity for many years, a shift in the number of families in motels reveals if the system is growing or shrinking. From the peak of 1078 families in motels on November 2, 2009 to 624 families in motels on July 14, 2010, the number of families in motels statewide dropped 42% when diversion funds were widely available.

Figure 3

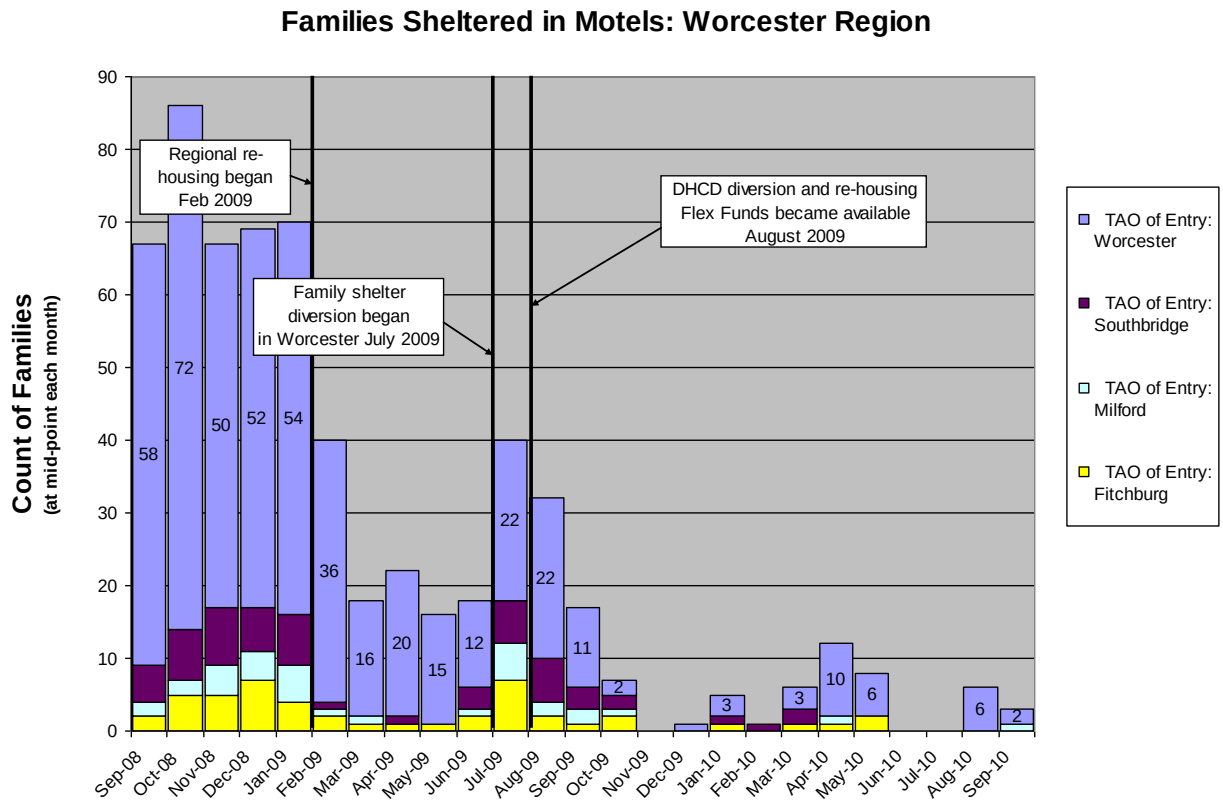


Within individual regions, motel census figures also permit a comparative measure. Here the Worcester County Regional Network stands out. Unlike most other regions that experienced a peak of families in motels in fall or winter of 2009, Worcester County experienced a peak of over 85 families in motels in October 2008 and reduced the total to only a few families in motels by the end of the pilot period. These outcomes were linked to Worcester's regional housing placement model led by the Central Massachusetts Housing Alliance (CMHA). In February 2009, when the EA system was re-procured, Worcester County was the only Regional Network that chose to structure their contracts with a lead agency responsible for all housing placements. Additionally, Worcester County experiences lower average housing costs than some regions including Boston and Metro Boston, providing Worcester County with a comparative advantage for rapidly rehousing families with extremely low incomes.

Figure 4 below describes the census of Worcester County families sheltered in motels. The stacked bar categorizes families by the four Temporary Assistance Offices in the Worcester County region through which they entered. Most families in the region entered the shelter system through the Worcester city TAO. The graph shows a sharp decline of families sheltered

in motels starting in February 2009. By the end of the pilot there were only a few families still in motels. This shows that Worcester significantly reduced local reliance on shelter through diversion and rapid rehousing.

Figure 4



The ICHH shared these local analyses with Networks and updated them upon request. Several Networks found the graphs useful in analyzing and improving provider practice and providing context for Leadership Council decisions.

C. Comparing Length of Stay Data

Some regions used reduction in length of stay as a measure of progress toward reducing the need for shelter. The South Shore Regional Network provides a good example. The Data Analyst for the South Shore tracked exit destinations and compared the average length of stay in shelters within the South Shore region at the beginning of the pilot to the average length of stay at the end of the pilot. From that, the Network was able to draw conclusions about the

impact of their triage model on exit destinations and the average length of stay in the individual shelter system in the region.

Comparing Length of Stay data: Challenges

Networks had difficulty measuring length of stay for families since most families were placed in motels prior to entering shelter. Families in motels were not tracked in HMIS leading to a distortion in length of stay data. Because the state's EA eligibility system (Beacon) and HMIS do not currently interact, there's no single system tracking families throughout their duration of stay in the system. Though the Data Analyst for the South Shore devised a tool to patch together data sources in order to calculate the true length of stay, this was a laborious process and was performed at the beginning and end of the grant rather than on a regular basis. Further, exits from the shelter system are not consistently recorded on a timely basis, skewing data describing average length of stay.

D. Measuring Housing Outcomes for Targeted Groups of Homeless Individuals

As discussed above, the *Home & Healthy for Good* evaluation methodology provided rich data about outcomes for individuals housed through the ICHH grant as well as the associated cost savings to emergency services. Similarly, Networks that tracked a particular group of individuals were able to show the impact of their efforts by reporting on outcomes for those individuals. For example, Boston reported that, as of September 30, 2010, 108 out of 569 people who were identified as long-term shelter stayers had moved to housing. The Cape and Islands Regional Networks' service providers identified 63 homeless individuals who were living in the downtown area of Hyannis. One year later, only 13 of those individuals who were still living in the area remained homeless.

Measuring Impact of Housing Interventions on Shelter Utilization: Challenges

Some of the Network's work plans referred to reduction in Point in Time data as a way to measure success. Point in Time data are only collected annually, however, which is not frequent enough to be useful for an 18-month pilot. Additionally, the downturn of the economy influenced the number of families and individuals experiencing homelessness. It is difficult to calculate the positive impact of interventions when the level of need greatly eclipses available resources. For example, the Cape and Islands Regional Network set an ambitious goal of reducing the number of homeless shelter beds for individuals from 60 to 40 beds, but were unable to take beds offline during the period of the pilot. Though the Network did not reach its desired outcome, the result may be due to rising demand rather than failed housing efforts.

Measuring Impacts: Limitations

While the evaluation produced substantial *qualitative* evidence of the relationship between Network organizing and improved service delivery[13], it did not produce *quantitative* evidence. The UAT tracked referral source and referral destination, but these data do not describe outcomes due to regional collaboration.

Measuring the impact of "homelessness prevention" proved especially challenging. Regional Networks were unable to scale their homelessness prevention efforts to actual need since the group of households "at-risk of homelessness" is broadly defined and extremely difficult to measure. For example, although some work plans asked for "% of families assisted through early warning prevention," none of the Networks was able to report on this measure because data that describe numbers of families at-risk is unavailable. This is in addition to the fundamental challenge of measuring the efficacy of homelessness prevention interventions without evidence of the counterfactual (Would this household have become homeless without this intervention?).

Finally, and importantly, a universal and overarching challenge in measuring impacts was in truly measuring outcomes. Regional Networks recorded outputs – for example, the number of households rehoused – rather than outcomes – the long term housing results for families served.

Collect Data and Measure Impacts: Lessons Learned

Lessons learned surfaced through evaluation research related to the goal of collecting data and measuring impacts include the following:

- Both qualitative and quantitative reporting helped the ICHH and the Regional Networks gauge progress and identify and communicate successes related to client-level innovations and network development;
- The UAT will need to be further developed to include standard, follow-up outcome measures to track changes in housing status, employment status, income, education attainment, children's school enrollment, etc;
- The *Home & Healthy for Good methodology* is an effective tool for measuring quality of life indicators and savings to state systems of care as a result of Housing First approaches for chronically homeless individuals;

[13] For example, the Network Health survey found that 70 percent of Network members believed that, compared to earlier collaborations, the Network does a better job at matching resources with need regardless of where a household first seeks help. These results, combined with additional qualitative data, including the network development case studies that Networks submitted to the ICHH, support this thesis

- Real-time access to the data they enter for their own reporting or programmatic purposes will improve Networks' capacity to adjust practices based on real outcomes;
- Data systems continue to be implemented based on funding streams and are not integrated, limiting Networks' and the ICHH's ability to understand outcomes of all efforts within a Region.

3. Create Opportunities for Broad-based Discussion with Diverse Stakeholders

The Regional Networks supported through the ICHH pilot were charged with creating broad-based cross-sector partnerships – consistent with the Commission's recommendation to build on existing networks of service providers but also to reach out to engage private, public, faith-based and other multi-sector partners in region-wide efforts to end homelessness. Central to this approach is the engagement of organizations and people that are not traditionally involved in homeless services or housing related activities in order to provide new opinions, resources, approaches, and innovative ideas that have not previously been tried, to address the needs of homeless individuals and families.

Networks deployed four principal strategies to promote broad-based region-wide engagement and learning. These were:

1. Network decision making with diverse multi-sector participation
2. Network coordination
3. Engagement of partners with the capacity to reach key constituencies
4. Deliberate focus on some stakeholders

1. Network decision making with diverse multi-sector participation

Every region that came forward to participate in the pilot created a Leadership Council to guide the planning and implementation of a coordinated regional approach to end homelessness. Leadership Council composition varied across Networks but all regions assembled an array of stakeholders – social service providers, housing providers, municipal leaders, philanthropies, business leaders, workforce development and training providers, faith-based organizations, veterans service organizations, community leaders, housing, homeless, and disability advocacy groups, housing courts, law enforcement, homeless or formerly homeless consumers, domestic violence specialists, McKinney-Vento educational liaisons, and regional offices of state agencies.

The Leadership Council in turn selected the region's Convening Agency – an entity with the capacity to broker partnerships and build relationships across sectors. Convening Agencies served as fiscal agents and managed contracts with sub-grantees but also played an important role in promoting consistent, coordinated engagement by funded partners and by other stakeholders.

With plans that required monitoring and implementation at every level, each Network also developed an internal committee structure including, in most cases, a network steering or executive committee as well as sub-committees focused on key elements of the work - for

example, the coordination of housing-focused interventions for individuals and families, data-gathering and sharing, resource development, and outreach. To varying degrees, these committees also created contexts for new forms of collaboration and learning that benefited from the participation of an array of organizations and individuals.

In many regions, Leadership Councils were most actively engaged in the Network's formative period and then in the last months of the pilot as Networks focused on strategies to fund their work going forward. In both instances, Leadership Council members' experience and connections were leveraged to advance the process. Overall, Networks benefited from the active engagement of Council members with influence in specific sectors or with particular constituencies, including business, government and the faith community. Leadership Council chairs included several mayors and municipal leaders, such as Mayor Ambrosino of Revere (Metro Boston), and Worcester City Manager Michael O'Brien (Worcester County Network). The Merrimack Valley Regional Network was co-chaired by the mayors of Haverhill and Lawrence, and the City Manager of Lowell. The South Coast Regional Network was co-chaired by Representative James Fagan and the North Shore Housing Action Group was co-chaired by Representative Mary Grant and Representative Steven Walsh.

Over the course of the pilot, most Leadership Councils met at least quarterly with member participation varying over time and by region[14]. Networks with the most active and effective Leadership Councils tended to be those which set out clear expectations of Council members even if these changed over time. Revisiting Council composition to ensure that "holes" were filled as individual engagement shifted also helped to ensure that network planning reflected a diversity of perspectives. For example, the Western Massachusetts Regional Network adjusted its Leadership Council later in the pilot to include the director of a local Community Development Corporation (CDC), an additional consumer, the director of Health Care for the Homeless and the director of the largest individual shelter who had not previously been active in the Network.

The Western Massachusetts Regional Network also used "targeted engagement" as a means of energizing Leadership Council members. During the summer of 2010, the Western Massachusetts Network Coordinator and Leadership Council members conducted an analysis of types of stakeholders that had been active in Network efforts. They cross-referenced this against their initial membership goals and discovered weaknesses, including low participation by the faith and business communities. At subsequent Community Engagement Committee meetings, specific individuals from these groups were identified as potential new members. Committee members took shared responsibility for contacting each person and asking them to become involved.

[14] The South Shore Network met twice a year as a group.

All Leadership Councils and some sub-committees included representatives from state agencies. Coordination with local DHCD staff was essential to the success of regional efforts to divert families from shelter. In some cases, Network efforts to build closer relationships with other state agencies such as the Department of Children and Families (DCF) and the Department of Elementary and Secondary Education (DESE) also led to more effective interventions for families. For example, the Brockton DHCD staff was closely involved in the design, planning and implementation of both the shelter triage and the shelter diversion models implemented successfully by the South Shore Network. Triage planning in that region now includes representatives from DCF and DESE in partnership with the South Shore Network's Family Committee and Unaccompanied Youth Coalition.

At the level of client services, the executive directors and staff of Convening Agencies played a pivotal role in shaping the quality and extent of region-wide collaboration. In its final report to the ICHH, the South Shore Regional Network pointed to the role of the United Way of Greater Plymouth County as a neutral convener. The Network Coordinator, as United Way staff, led the Region's negotiation with DHCD, a role which would have been more difficult for provider agencies to play given that they are DHCD shelter vendors.

Several Networks changed their internal committee structure over the course of the pilot. The Metro Boston Network created a streamlined Operations and Data Committee and established new working groups, including a Triage Working Group drawing lessons from the South Shore Network's pioneering triage system. The Cape and Island's Regional Network added a Housing Committee to promote greater collaboration among the region's housing providers and improved linkages with social services. Its Client Coordination Council had already become a model for other Networks, allowing providers to coordinate support for families and chronically homeless individuals within their region.

The Boston Regional Network created the Boston Family Shelter Providers Group (BFSPG) which was facilitated by Homes for Families, an advocacy organization on the Networks' Leadership Council. Similar to the Cape and Islands Client Coordination Council, the goal of the BFSPG was to improve coordination and promote efficiencies among family shelter providers in Boston. The group worked to facilitate the development of a coordinated and targeted system to link families with vacancies at the Boston Housing Authority and created clearer communication channels between shelter providers, the Regional Network, state and city agencies, MBHP and other key stakeholders.

The Boston Regional Network integrated their Network effort with the Mayor's Leading the Way III Initiative. Networks that had large cities as their conveners like the Boston Regional Network and the Worcester County Network were embedded in large bureaucracies, but that allowed them to benefit from the ability to leverage a wider range of resources.

Network decision making with diverse multi-sector participation: Challenges
Network engagement in some regions dwindled over time and had the effect of narrowing the number and kinds of perspectives brought to bear in network planning and decision making. Results of the Network Survey administered in April 2010 showed that some Leadership Council and committee members were out of touch with current network activities. Most Networks developed plans to address this by adjusting membership and/or member responsibilities and by improving internal communications.

In some Networks, service coordination continued to occur mainly among shelter or homeless service providers despite evidence that collaborations among employment, education, housing and other mainstream service providers improve outcomes for families.

Finally, members' participation in new planning and decision-making structures were "low cost" investments but not "no cost" investments. Public figures on Leadership Councils raised Network visibility, but had many competing demands on their time. For most frontline staff, participation in Network sub-committees competed with the daily requirements of their job.

2. Network Coordination

The Coordinator's role is to ensure that the Network's strategies to end homelessness are implemented as planned through region-wide, multi-stakeholder collaboration. Responsibilities of the Regional Network Coordinators during the pilot included: creating and maintaining a directory of network partners and client access points, minimizing duplication of services by serving as a point of contact for the network both internally and externally, ensuring the use of shared tools (e.g., data tools, uniform guidelines and client release forms) across multiple partners, supporting network decision making and follow-through, coordinating outreach efforts and preparing quarterly and other reports to the ICHH.

Coordinators' location within Networks varied. In some Regions, Coordinators were employed as internal staff by Community Action Agencies (MetroWest, Merrimack Valley and North Shore). In other regions, independent contractors were hired (South Coast, Cape and Islands, and Western Massachusetts). Networks with Coordinators in place early in the pilot were better able to sort out Network work plans and timelines and implement proposed innovations quickly. Their ongoing contribution, however, was to encourage broad-based engagement, maintain basic Network systems and respond to Network coordination demands as these arose. High performance Coordinators tended to be those with strong organizational skills combined with other abilities such as facilitation and communications expertise, managerial ability or capacity for "big picture' thinking, in addition to content knowledge or sector experience.

Most Coordinators were eager to learn from each other especially in areas that included Network data gathering and reporting and sustainability planning. Regular exchanges were facilitated during the pilot period through monthly conference calls hosted by the Director of the ICHH.

ICHH funds for regional coordination were used to create and update directories of Network partners and client access points which continue to be essential to region-wide coordination. These funds also supported the development of wikis and blogs that facilitated Network communications (see below Goal 4: *Implement a Regional System that is a Model for Accountability and Transparency*).

Finally, ICHH-funded regional coordination was essential to launching and sustaining the South Shore Network's highly successful family triage model, although day to day operations were funded by converting existing EA resources with no additional ICHH funds.

Network Coordination: Challenges

Demands on Coordinators were great, especially as Networks became the lead entities for coordinating region-wide work that drew on funding streams beyond that of the ICHH. Some Networks underestimated the time and effort required for Regional Network coordination and failed to build in the necessary salary and supports for Coordinators. In the case of the MetroWest Network, Network coordination was added to the existing scope of staff members at SMOC and the United Way which limited the amount of time they could devote to Network development and outreach.

In addition, Coordinators who focused the majority of their attention on coordinating connections among homeless service providers were generally less able to fulfill other responsibilities such as the cultivation of broader connections among stakeholders. In its final quarterly report to the ICHH, the Merrimack Valley Regional Network reported that, over time, the Network's multi-stakeholder committees met less and less as the Network transformed into a narrower service delivery network. The Network and its Coordinator committed to strengthening multi-stakeholder committee work in the future.

3. Partners with the capacity to reach key constituencies

ICHH funding for the Regional Networks allowed for the engagement of a core group of partners who were jointly and directly responsible for implementing the Network's innovations focused on prevention, diversion, and rapid rehousing[15]. Agencies that were contracted to do

[15] Funded partners were required to be charitable, non-profit, community-based, public purpose agencies.

the work also collaborated with a variety of unfunded partners to reach key constituencies and/or implement innovations.

As a first priority, Networks funded agencies to ensure geographic coverage so that all families and individuals within the newly designated region would have access to a coordinated system of supports. These partnerships built on existing entities (such as Workforce Investment Boards) and regional planning processes (such as the Consolidated Plan process, the Continuum of Care, and the Plan to End Homelessness) but extended beyond these collaborations.

The number of funded partners in each region varied. In some cases, including the North Shore and MetroWest Regional Networks, a single dominant regional entity was tapped to implement most of the region's pilot interventions by hiring new staff or leveraging existing staff in their agency (NSCAP and SMOC). Both NSCAP and SMOC co-located staff in strategic access points, such as the Lynn Housing Authority and Neighborhood Development (LHAND) and the Framingham TAO[16]. In others, Network funding was used to engage a wide array of partners which covered the geographic region but also brought in agencies with special expertise relevant to the Network's pilot interventions. For example, the Metro Boston Regional Network funded 13 entities in total including specialists in Housing First approaches (HomeStart and Heading Home), court-based prevention (Community Dispute Settlement Center, Just-A-Start/Mediation for Results, Tri-CAP, Elliot Community Services and the Somerville Tenancy Preservation Collaborative), tenancy preservation and diversion (Affordable Housing Services Collaborative, Inc., Brookline Community Mental Health Center, Community Action Program Inner City, Community Service Network, Housing Families, Inc., Just-A-Start/Mediation for Results, and Somerville Tenancy Preservation Collaborative[17]) and domestic violence (Second Step and HaborCOV). Flexible funds were available to each of the listed agencies. The Metropolitan Boston Housing Partnership, Inc. and the Cambridge Multi-Service Center also used flexible funds to prevent homelessness.

The Networks' engagement of unfunded partners began through the creation of multi-stakeholder Leadership Councils whose members were committed to policies and practices of inclusion. The challenge was to develop a strong, flexible network of collaborators at the client level that could quickly mobilize to address different clients' needs. State agencies counted among these unfunded partners. Unfunded partners also included shelter providers whose collaboration was important to systems change.

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[16] Lynn Housing Authority and Neighborhood Development was the co-convener for NSHAG and made HPRP resources available for NSHAG clients. Similarly, the United Way of Tri-County was the co-convener for the MetroWest region.

[17] The Somerville Tenancy Preservation Collaborative includes Somerville Community Corporation (Lead Agency), Cambridge & Somerville Legal Services, Community Action Agency of Somerville, Somerville Homeless Coalition, and Somerville Mental Health Association.

The quality of collaboration among regional partners was critical to each Network's capacity to get the right resources to the right people at the right time. Equally important, entities which collaborated at the client level became learning partners. This helped Networks surface and communicate lessons learned within their region and across regions about effective collaboration and the infrastructure needed to support this.

A history of cooperation prior to the pilot helped some Networks. The Cape and Islands Regional Network reported that their capacity to immediately begin distribution of ICHH funds for diversion and prevention was due, in part, to their previous experience working together.

While just under half of respondents to the Network Health Survey in April 2010 indicated that their agency partnerships had changed as a consequence of joining the Regional Network, a much larger proportion of respondents reported that their partnerships had deepened (70%). Evidence from case studies that Networks submitted quarterly to the ICHH and from Peer Learning Sessions conducted over the period of the pilot suggests that time and resources devoted to building and deepening Network connections yielded higher personal satisfaction with the work in addition to more efficient coordination. Frontline staff from several regions reported that the ability to call on familiar providers from other agencies within their region was an important success of the Network model and that strengthened relationships had created a new level of trust between service agencies.

The April 2010 Survey also asked Network members whether their ICHH Regional Network did a better job of matching resources with need regardless of where a family or individual first seeks help, compared to earlier (pre-ICHH) collaborations in their region. Overall, 70 percent of survey participants responded positively.

New ways of working also required new funding allocations that can be challenging to negotiate among partners. The case for network organizing was made by the Western Massachusetts Regional Network in this description of a Network best practice which they submitted as part of their quarterly report to the ICHH in September 2010:

The Network's successful organizing can best be captured in the continued development of relationships among our family and individual providers. In the face of unexpended Network funds that required reallocation, providers engaged in a collaborative decision making process that reflected 18 months of relationship-building. Individual providers as a group agreed to reallocate funds to the family providers, recognizing the current level of crisis in family homelessness. Family providers across the region recognized the extraordinary demand in Hampden County and agreed to allocate funds to this sub-region. And within Hampden County, family providers examined how the funds would be disbursed most quickly with the greatest impact and agreed to allocate funds to providers on that basis. This seamless and cohesive process was an outgrowth of months of bringing people around a table, building

connections and confidence in our shared investment in each other and our work. There is no stronger testament to the value of the Network's existence[18].

A similar case was made by the South Shore Network in this way:

The formation of the regional network has helped the South Shore Region to move forward with plans discussed over the past year for greater family provider collaboration. This collaboration was fledgling, but lacked staff capacity and follow-through to make it happen. With the creation of the regional network, the South Shore Network Family Committee was formed. It has grown in a few months from the region's handful of family shelter providers to a committee of 20-25 representatives of those involved in family shelter and diversion.

Within a short period of time the committee has put together a family shelter triage plan, presented it to DHCD, and secured approval to move forward. Without the regional network structure it would have been very hard to advance this—there wouldn't have been staffing to move it forward and, more importantly, it would have fallen to the lead shelter provider to advance this alone rather than as part of a collaboration via the network[19].

Partners with the capacity to reach key constituencies: Challenges

The social and physical geography of particular regions created challenges for some, such as overlapping service areas between the Metro Boston and Boston Regional Networks and, in Western Massachusetts, a multiplicity of jurisdictions combined with long distances between populations. The Worcester County Regional Network reported that bridges were created between the City of Worcester and northern Worcester County but not as effectively with southern Worcester County.

Whereas all other Regional Networks had a convening agency that also funded outside partners, the North Shore and MetroWest Regional Networks created new programs within their convening agencies that were physically co-located at client access points. The North Shore and MetroWest's programmatic design made it more difficult to bring other service providers to the table.

Anecdotal evidence suggests that success on the ground with the Networks' innovations combined with the visible commitment to Housing First approaches by the Patrick-Murray Administration led to increasing engagement by unfunded partners over time. Results of the April 2010 Network Survey showed no significant difference overall between the responses of funded versus unfunded partners on measures that included member engagement and commitment to the work of the Network.

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[18] Quarter 6 Network Development Case Study October 2010

[19] Quarter 5 Network Development Case Study July 2010

4. Deliberate focus on some stakeholders

Depending upon opportunity and need, Networks targeted specific categories of stakeholders for greater engagement. Over the course of the pilot, stakeholder groups that emerged as priorities for Regional Networks included:

- Landlords
- Local Housing Authorities
- Law enforcement
- Domestic violence providers
- Housing courts
- Workforce development program providers
- Faith-based community
- Business community
- Philanthropies
- Public media
- State office holders and other public officials

Examples of successful initiatives include the Metro Boston Network's initiative with law enforcement; the Western Massachusetts Regional Network with public media, the Boston Regional Network with the Boston Housing Authority, and the Merrimack Valley Regional Network with local elected officials.

The Worcester Regional Network's initiative with landlords led by the Central Massachusetts Housing Alliance (CMHA) stands out as a highly strategic and successful effort to engage landlords through a central point of contact. Several other Networks, including the Cape and Islands Regional Network, the Boston Regional Network, the Metro Boston Regional Network and the North Shore Housing Action Group also sought to develop better connections with housing providers.

Most Networks also took deliberate steps to connect with the faith-based community. Episcopal City Mission, One Family Inc and the Paul and Phyllis Fireman Charitable Foundation supported the creation of Faith-based Action Grants in seven of the regions. The result has been the creation of unique and targeted efforts to educate and engage the faith community around regional housing- focused approaches to end homelessness.

Deliberate focus on some stakeholders: Challenges

Networks reported far greater success serving clients than they did engaging clients in regional planning. Homes For Families partnered with ICHH to provide additional technical assistance to facilitate meaningful consumer engagement in some Regional Networks but with limited

success. Overall, less than half of respondents to the April 2010 Network Health Survey agreed that their Network included meaningful client participation.

Create Opportunities for Broad-based Discussion with Diverse Stakeholders: Lessons Learned

During the pilot, all Networks created opportunities for broad-based discussion and multi-stakeholder engagement. Networks' ability to sustain and support new collaborations will depend on the resources they have available for network infrastructure, such as coordination and communications, as well as on members' continuing commitment to the Network model and the diversity of capacities it engages.

Relevant lessons learned from the pilot include:

- Multi-stakeholder participation in responses to the initial ICHH RFR catalyzed the Regional Networks; the creation of common goals was key;
- Coordination with other planning groups (e.g., Continua of Care, 10-year planning groups, and local-level interagency groups) allowed regions to plan and leverage resources more effectively;
- Leadership Councils with broad-based multi-stakeholder participation are effective decision making structures for Networks as long as consistent engagement can be maintained;
- Leadership Councils also have an outreach function which should be cultivated. Councils should include members who can serve as influential advocates for the Network's housing-focused approaches and the public policies that support them;
- There is some evidence that neutral conveners (conveners which are not DHCD vendors) can secure provider buy-in to the Network model more effectively than conveners which are not DHCD vendors;
- Client coordination committees that assemble providers from around the region measurably improved Networks' capacity to deliver the right resources to the right person at the right time;
- Stronger connections with landlords and other housing providers improved Networks' ability to effectively divert or rapidly rehouse families and individuals;
- Coordinators played a critical role in developing and maintaining region-wide systems for efficient collaboration;
- Networks need to explore more ways to promote meaningful client involvement in network planning and decision making.

4. Implement a Regional System that is a Model for Accountability and Transparency to Consumers and the Public

Integral to the larger goal of getting the right resources to the right people at the right time was the Regional Networks' ability to serve people from diverse backgrounds with different and unique needs. Networks were required to develop and implement plans to promote equal participation and access to services in their region and to have clear plans for informing the public, including homeless and formerly homeless persons, about the Regional Network's strategies and activities and opportunities to support these.

The Regional Networks adopted four principal strategies to meet this goal:

1. General Public Outreach
2. Special Events
3. Client Resource Directories
4. Targeted Engagement of Consumers

1. General Public Outreach

All Networks developed communication strategies to share Network information broadly within their region. Most Networks developed special committees or working groups to plan and implement outreach activities. For example, the Boston Regional Network created a Public Relations Subcommittee to seek feedback and share information about the Network. The Western Massachusetts Regional Network created a Community Engagement Committee with the specific goal of building broad community support for the Network's housing first vision.

The Regional Networks reached out to the broader public through conventional media outlets such as radio, television and newspapers as well as through web-based media. All Networks prepared and distributed press releases to regional and local newspapers, and developed factsheets that described their new region and Network. The Merrimack Valley Regional Network publicized their new Network through a letter that went out to large target audiences, including churches and other regional providers. The South Shore Network created an Outcomes Report Card that allowed them to share progress with legislators, stakeholders, and the public.

Each of the Networks used online platforms to provide an explanation of services available through ICHH/Network funds. Those that had no explicit overview of services and capabilities used links to websites managed by relevant partners.

The South Coast Regional Network, the Merrimack Valley Regional Network and the Western Massachusetts Regional Network developed and maintained blogs which provided an opportunity for web-based dialogue with regional stakeholders. Other types of communication systems included wikis, list serves, and websites housed on Convener sites. The more developed online platforms provided a dynamic environment for Network updates. Some Networks posted meeting dates and times, as well as meeting minutes and summaries. Others posted quarterly report summaries and best practice case studies.

In all Networks, coordinators took the lead in implementing Network outreach strategies. The Western Massachusetts Regional Network developed a particular effective communications strategy led by their coordinator. Their successes included the creation of a blog with 170 subscribers across the region and state, the production of a DVD to communicate their Housing First mission and its positive impact across the Western region; and the regular production and delivery of materials to local and regional media outlets that summarize Regional Network activities and opportunities to engage.

2. Special Events

Five Networks hosted regional engagement events with support from the Paul and Phyllis Fireman Charitable Foundation and One Family, Inc. These events offered an exceptional opportunity to explain Network strategies, describe Network innovations and promote housing focused approaches. In April and May 2010, the Cape and Islands, Western Massachusetts, Merrimack Valley, Metro Boston and MetroWest Networks held public engagement events attended by legislators, the press, faith communities, business people and other community members.

Many Networks also hosted fundraisers and other events that engaged consumers and the public. For example, in August 2010, the South Coast Regional Network supported the city of Fall River in their first ever Project Homeless Connect event. The event was well-attended and supported by local vendors and volunteers, with pre- and post coverage in a regional newspaper. Plans have been made to hold Project Homeless Connect events in other areas of the region in 2011.

3. Client Resource Directories

All ten Networks developed client resource directories. Network members reported that such shared tools and coordination improved their ability to locate and access resources that could benefit clients.

The North Shore Housing Action Group (NSHAG) launched its "North Shore Portal" during the 18-month pilot phase. The Portal allows anyone (clients, churches, non-profit organizations,

for profit organizations, etc) to type in a key word to find a list of all agencies in the Region that provided that service/resource. NSHAG also engaged "tertiary" access points such as churches and schools, to connect them to resources in the rest of the region.

As noted earlier, the Cape and Islands Network implemented a 24/7 Homelessness Crisis Hotline and created a Client Coordination Council. Both brought agencies as well as frontline staff together to more effectively target resources available in the community. The Cape and Island's Client Coordination Council included 100 case workers from over 40 state agencies and community-based providers to discuss resources and strategies.

By the 5th Quarter, the Boston Regional Network reported that they had made significant strides getting the name and message of the Network out to providers with clients who could benefit from the Network's housing-focused interventions. Initially, the Network had difficulty developing a clear, up-to-date client resource list due to the large number of providers/sources in their region and shifts in funding availability. In order to overcome this barrier, the Network leveraged other city funds to create a central homelessness prevention resource line hosted out of the Metropolitan Boston Housing Partnership.

4. Outreach to Consumers

Several Networks made deliberate efforts to reach out to particular groups of consumers. The Merrimack Valley Regional Network reported a need to fully integrate Veteran benefit training across their region to better understand services that are available through the Veterans Administration. The Metro Boston Network linked with representatives from the Department of Children and Families, the Department of Housing and Community Development, and the Department of Transitional Assistance to better serve clients who are victims of domestic violence.

Most Networks reported that they were less successful than they had hoped in reaching out to consumers. The Boston Regional Network reported that they developed a feedback form for use with clients but had no success with this strategy. The MetroWest Regional reported that they did not successfully market their program to special populations, such as disabled, linguistic minorities or those in localities at greater distance from the region's urban centers, because they were unable to dedicate staff time for a Coordinator to lead the work. Other Networks wrestled with issues of confidentiality in contexts where consumers are invited to participate. The South Coast Regional Network described this as a concern in relation to Project Homeless Connect, that is, how to publicize who will attend without breeching the privacy of consumers.

In peer-discussions at the Pilot Closing Event in September, Network members confirmed that consumer engagement continues to be challenging. Participants noted that consumers who have been successfully housed can be very effective at outreach and messaging, but it is difficult to find participants and develop meaningful roles for them. Barriers include language, literacy,

cultural issues, and lack of transportation and email access as well as interest in remaining connected to the homeless world after being rehoused and stabilized.

Implement a Regional System That Is a Model for Accountability and Transparency to Consumers and the Public: Challenges

In the eighteen months of the pilot, the Regional Networks focused the main part of their effort on implementing Network innovations to reduce the need for shelter and developing Network systems to support this. Several Network members acknowledged that implementing a regional system that is a model for accountability and transparency to consumers and the public competed with other priorities and thus was emphasized less overall.

With a few exceptions, Networks will need to devote greater attention to public outreach, including media outreach, in the future. All Networks acknowledged the need for more effective strategies to engage consumers.

Implement a Regional System That Is a Model for Accountability and Transparency to Consumers and the Public: Lessons Learned

Lessons learned surfaced through evaluation research related to the goal of implementing a regional system that is a model for accountability and transparency to consumers and the public include the following:

- Regional coordinators play an essential role in outreach planning and implementation and need adequate staff time to devote to this;
- Peer exchange and additional training will improve the skills of Coordinators who have less experience with public media campaigns and the use of web-based platforms;
- Cross-Network peer learning and the dissemination of best practices will help Network Leadership Councils develop more robust outreach plans. This should include peer learning and the dissemination of best practices related to meaningful engagement of clients.

5. Build Systems Change to Create Sustainability

The *Special Commission Relative to Ending Homelessness in the Commonwealth* recognized that ending homelessness would require a shift to a new system in which housing is the immediate goal. For that purpose, the ICHH encouraged the Regional Networks to test innovative practices to prevent and end homelessness and to customize those practices to provide the right resources to the right people at the right time. The ICHH also expected Networks to build commitment among key stakeholders to change the way services and housing are organized, delivered, and accessed. Networks were asked to be dynamic and iterative throughout the pilot in order to surface and implement new ways of working that could inform ICHH's policy and practice recommendations to the Commonwealth.

As is the case with all of the goals, the ICHH expected each Network to identify goals and benchmarks related to systems change and sustainability that were unique to their region. While these differences resulted in each Network focusing on slightly different ways to achieve success, there were some common themes in the systems change and sustainability goals they identified, including: transform individual programs into networks of solutions and establish seamless access points; become "region-centric" by operating collectively using a systems approach that is strategic in its orientation and use of resources; increase cost effectiveness and efficacy; promote a culture of shared learning across the Region; and utilize data to evaluate progress and modify strategies toward results-based activities.

The Regional Networks employed five principal strategies to meet these goals:

1) Changes to the service delivery system
2) Coordination and joint planning among stakeholders
3) Communication strategies to share information broadly
4) Data sharing within the Region and with external partners
5) Re-purposing shelter resources
6) Development of additional resources for the Network

Details of many of these strategies have already been documented in this report. The emphasis in this section is on the broader impact of these efforts on overall progress toward systems change and sustainability in the Commonwealth.

1. Changes to the Service Delivery System

One of the most important changes in the way services are delivered to homeless and at-risk individuals and families was the co-location of diversion and prevention workers at the DTA/DHCD offices across the state. The impact of this model on the broader homeless service system was significant. The prevention and diversion program allowed Networks to test the effectiveness of locating case management and direct client assistance very close to the "front door" of shelter, and test the types of resources families need when they present at that location. Networks were able to assess whether families seeking shelter would be interested in a housing alternative and would accept short-term rental assistance with case management instead of shelter. In addition, Networks assessed whether some families seeking shelter at the DTA/DHCD offices could maintain their housing with prevention services and avoid homelessness altogether.

Results of the pilot show that many clients took advantage of diversion and prevention programs located at the DTA/DHCD offices and were successfully prevented from becoming homeless or diverted into housing. There is also strong evidence that there are cost savings associated with prevention and diversion (see below section 5) and that the program led to improved collaboration among stakeholders, especially among diversion workers, prevention workers and DHCD/DTA staff in local offices and at Central Office.

Prevention and diversion providers were also at the forefront of determining the usefulness of the Tier system recommended by the *Special Commission Relative to Ending Homelessness in the Commonwealth*. Drawing on flexible direct client assistance funds, providers serving both individuals and families used the Uniform Assessment Tool to assess each household's unique needs and determine the scope of services necessary to prevent an unnecessary shelter stay and achieve housing stability. For example, one family may have experienced a temporary loss of employment and only require short-term rental support, whereas another family may have greater barriers to employment and housing stability and would benefit from longer-term rental support with intensive stabilization support. Each Network used their client assessments to determine which households fit which Tier and which resources were most appropriate for them based on their particular needs and assets.

Uniform Assessment Tool data shed light on how the Tier system was used by Networks to guide decisions regarding the types of services households received. Overall, Networks targeted most prevention and diversion resources to Tier 1 and 2 households who have fewer barriers, with rapid rehousing strategies targeted mainly to Tier 3 and 4 households who may have more complex housing barriers and require greater rehousing support.

Table 6: Count of Service Types by Tier[20]

Service Type	# of Records with No Tier Recorded	Tier 1	Tier 2	Tier 3	Tier 4	Total
Prevention	104	211	144	43	35	**537**
Diversion	7	31	29	9	1	**77**
Rapid Rehousing	58	20	26	22	44	**170**
Total Records	**169**	**262**	**199**	**74**	**80**	**784**

While the South Shore Network implemented triage for both shelter systems, their family triage model represented a new way of interacting with DHCD. Typically, EA shelter placements are managed by Central Office. The South Shore Network contended that if DHCD allowed local control over placements, Network partners would be better able to ensure the most strategic placements according to families' particular needs, ultimately resulting in shorter shelter stays. Implementation of family triage required DHCD's Placement Unit staff to work with a lead staff person from the Network on a daily or even hourly basis. New communication channels developed that allowed Network partners to better understand DHCD's processes and requirements, and allowed DHCD staff to work with other experts from the community to ensure the best possible placements for each family. (Additional information about the Networks' implementation of triage is included in this Report under Goal 1: *Reduce the Need Shelter and Achieve Housing Placement Outcomes*.)

Analysis of outcomes for chronically homeless individuals who were rehoused shows the success of this model with respect to quality of life improvements, as well as for cost-savings to emergency systems of care (see below Figure 8). As people entered housing, they were asked three quality of life questions by their case manager with follow up on a monthly basis. Responses indicate a significant increase in satisfaction across all categories: life in general, health, and housing environment (see also under Goal 2: *Collect Data and Measure Impacts*, Figure 1).

[20] The number of Tier 3 and Tier 4 families included in this table represents a small portion of Tier 3 and Tier 4 families in the homelessness system. The remainder of families was either served with HPRP or shelter. Similarly, this table shows only the subset of UAT records that provided reliable data for service type.

Changes to the Service Delivery System: Challenges

The Tier system had mixed success. In a broad sense, the concept of Tiers provided a useful framework for matching resources and interventions to different levels of need, but there was little detail provided in the *Special Commission* report about how to make such distinctions in practice. Providers tended to sort households into two broader groups: those with fewer economic challenges and less intensive service needs (Tiers 1 and 2) in contrast with households with more economic challenges, housing barriers, and intensive service needs (Tiers 3 and 4). Some providers, such as the Metropolitan Boston Housing Partnership added detailed criteria to the definition of each Tier to help staff make determinations[21]. Front line staff from other agencies reported difficulty determining Tier upon assessment and found the Tier determination became clearer only over the course of working with the client.

Overall, providers tended to report that most homeless families did not fit the description of Tier 1 and Tier 2, but had complex economic challenges (Tier 3) and some with additional intense service needs (Tier 4). The *Special Commission* report estimated that 50% of homeless families at any given time are Tier 3 and 25% are Tier 4. This suggests that improving access to employment and asset development is crucial to the pursuit of preventing and ending homelessness.

2. Coordination and Joint Planning Among Stakeholders

All Regional Networks engaged in efforts to promote coordination and joint planning among stakeholders. As described in earlier Sections, Network strategies included coordination with existing planning groups (e.g., Continuum of Care, 10-year Planning groups, Workforce Investment Boards), the formation of new working groups focused on particular topics or work processes and the regular convening of providers to identify and coordinate services for particular clients. Network-based coordination and joint planning also led to joint application submissions for Emergency Shelter Grant awards, the integration of federal HPRP stimulus funds to ICHH efforts, and the creation of shared tools and resource guides.

At the Pilot Closing Event in September, 2010, which convened Network leadership and other key stakeholders, Network members reflected on their work and agreed that facilitating a diverse set of partnerships had balanced and improved Network functioning. As noted earlier, results of the Network Health Survey showed that 70 percent of members believe that their Network does a better job of matching resources with need regardless of where a household

[21] "Rapid Rehousing of Motel-Sheltered Families, MBHP's Preliminary Assessment." *Metropolitan Boston Housing Partnership.* November, 2010, p. 17

first seeks help, when compared to earlier collaborations. Anecdotally, many Networks also reported a reduction in "silos" between agencies focused on serving homeless individuals and those focused on serving families.

Coordination and Joint Planning Among Stakeholders: Challenges

Despite important progress with coordination and joint planning, Networks reported that more work needs to be done to improve collaboration among key partners. The South Coast, South Shore and Western Massachusetts Regional Networks cited in their Quarter 6 reports that many service providers as well as state agencies continue to operate separately, which stands in the way of the most effective uses of all resources. The South Shore Regional Network noted that differing regional boundaries among Continuums of Care, United Way, DHCD, DCF, DMH, and others makes it difficult to and create a clear listing of regional client access points and ensure that appropriate stakeholders are engaged.

3. Communication Strategies to Share Information Broadly

Sharing information broadly can engage new stakeholders and generate wider support for housing–focused approaches to end homelessness. All Regional Networks developed external communications plans, implementing a variety of strategies that included blogs, wikis, list serves, overview documents distributed by mail or in meetings, and web pages hosted on Convening Agency websites.

Most Networks plan to enhance their media and other communication strategies going forward. Many believe that, as systems changes are made and additional steps need to be taken, stronger public and political buy-in will be required and can be built through improved strategic communications. Several Networks plan to begin this process by publicizing their Network's achievements through the pilot.

Communication Strategies to Share Information Broadly: Challenges

Although it may be too soon to a gauge the impact of Network efforts on public support more broadly, all the Networks will need to develop better systems for evaluating the impact of their communications efforts on different groups of stakeholders in order to refine their efforts. As noted earlier in this Report, none of the Networks developed strategic communications materials in languages other than English, though some providers within Networks have translated some of their own materials into other languages.

4. Data Sharing Within the Region and With External Partners

Data sharing within the region and with external partners improved Networks' capacity to match client services to need. Network Coordinators and Data Analysts served as facilitators

for data sharing, and collected and aggregated region-wide data that was shared with state agencies and Network members. In some regions, providers shared data about clients and interventions for the first time leading to more effective client coordination and reduced reliance on shelter. The Western Massachusetts Regional Network created an innovative online interactive data tool for use by providers that shows point in time data, trends, and service outcomes.

DHCD shared information about families in motels on a weekly basis with the Regional Networks allowing them to coordinate rehousing efforts, measure overall impact on the number of families in shelter, and adjust their practice based on real-time information. The MetroWest Regional Network, for example, learned that additional families had been placed in local motels from an ICHH graph of the motel census in the region. SMOC immediately visited the sites to assess the families and within a few weeks had rehoused all of them.

State agency representatives who participated in Regional Network working groups or subcommittees shared data that informed more effective strategies with specific populations. For example, the Department of Correction shared local discharge data with Regional Networks to identify gaps and improve housing outcomes for released offenders. The South Shore Network first gained access to transportation cost data for homeless children by school district from the Department of Elementary and Secondary Education. ICHH staff then helped disseminate these data to all Regions allowing Networks to further quantify the regional costs of family homelessness.

Data Sharing Within the Region and With External Partners: Challenges

Data sharing remains an ongoing challenge despite significant improvements. From a systems change perspective, data sharing within regions, across multiple partners, and across the Commonwealth is imperative for full implementation of best practices. Broad systems change relies on data analysis, and a complete spectrum of data from which to draw cannot be compiled without adequate sharing across partners. DHCD's efforts to improve HMIS data capture in Massachusetts will support advancement in this area, but all community-based partners and state agencies must commit to overcome the common challenges of securely sharing data and creating common data points.

5. Re-purposing Shelter Resources

The Regional Networks envisioned that some shelter beds might be taken off line during the pilot and explored means to accomplish this. The Worcester County Regional Network took major steps to close the PIP shelter in Worcester by operating under a closed referral system. Despite a significant drop in bed usage, efforts to close the PIP were not fully realized during the initial pilot period. However, at the time of this report the ICHH has learned that the City,

SMOC, and Community Health Link recently arrived at an operating agreement which dictates how the new triage and assessment model will work with limited emergency beds.

As noted earlier in this Report, the Merrimack Valley Network's success rehousing chronically homeless individuals resulted in a 20% reduction in the number of individuals utilizing the LTLC. Despite this, no beds have been taken off line. Merrimack Valley Network has considered recommendations to implement a triage system to help accomplish shelter bed reductions.

While reductions in shelter use continue to be an important indicator of the potential for re-purposing resources, systemic cost savings were demonstrated during the pilot in other ways. A key hypothesis underlying Regional Network design was that flexible resources and new ways of working would point the way toward more effective strategies to prevent and end homelessness that were also less costly. The ICHH worked closely with Regional Networks to document the services they provided, all of the important elements of those services, and what those elements cost from staffing, administrative, and client assistance perspectives. Data from all Regional Networks were aggregated at the ICHH level and comparisons were drawn to other existing programming in order to evaluate whether the innovations being tested offered better alternatives for families.

Homelessness prevention efforts were examined under this lens. Data from the Regional Networks showed that that the average cost of homelessness prevention provided through the pilot period was at $2,401 statewide[22]. Of the 453 families assessed with the UAT as part of the prevention interventions, by December 25, 2010, only 13 families had entered shelter, representing 2.9% of the total. Although this is an imperfect measure of the actual outcomes for families, it shows that prevention practices were effective in the short-term at averting use of the EA shelter system for the families served[23]. Further follow up and study of the long-term outcomes for these prevention interventions is warranted, though the preliminary analysis indicates a significant savings while families are able to avoid displacement into shelter.

Similarly, shelter diversion represents a significant cost-savings per family when compared to the standard EA-intervention of shelter plus flex funds. The graph below was developed in partnership with Central Massachusetts Housing Alliance (CMHA) to estimate the cost-savings

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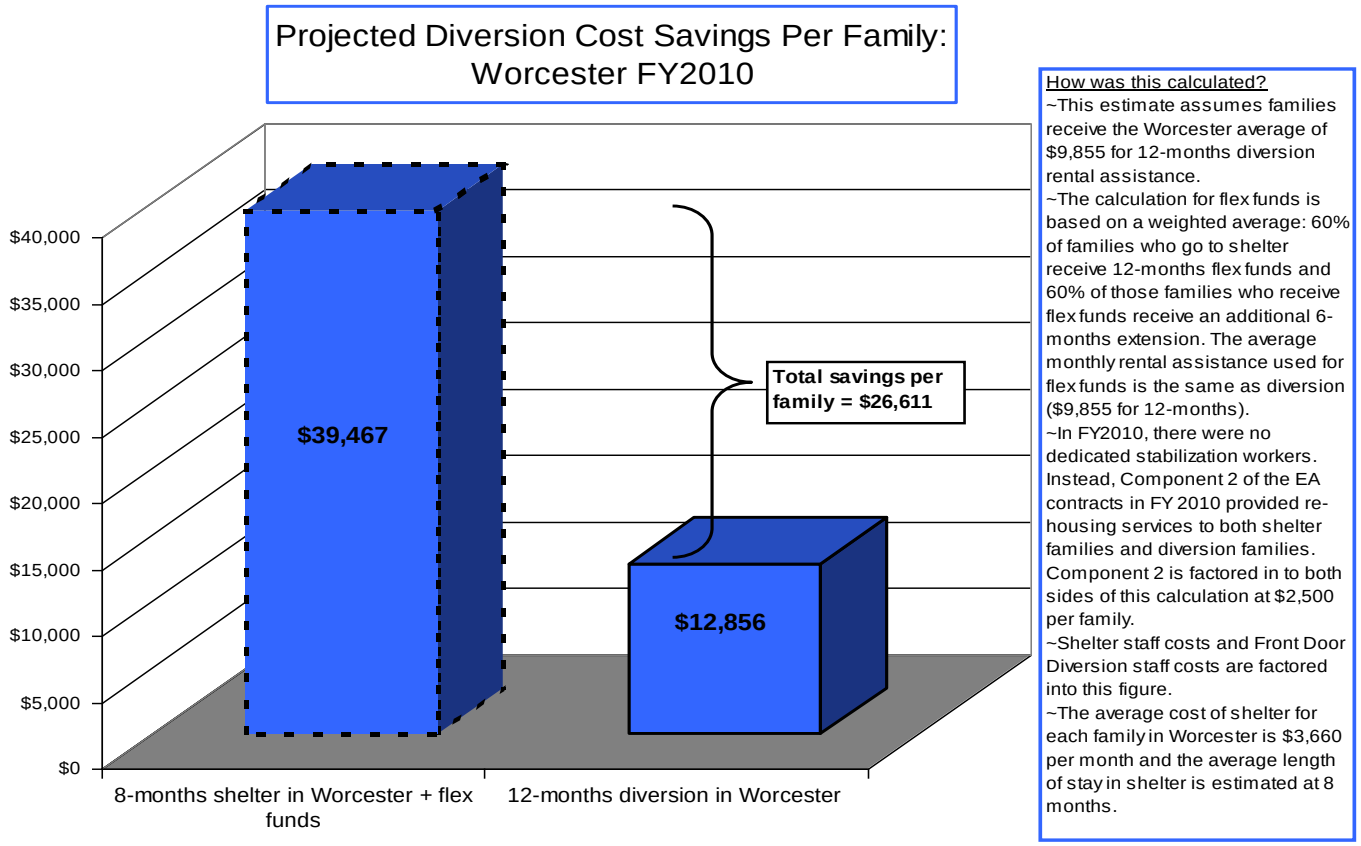
[22] The cost of homelessness prevention for families varied by region, ranging from approximately $1,400 per family (including staffing costs) to $3,000 per family (including staffing costs). Notably, Networks with higher prevention costs did not correlate with Networks in more expensive housing markets. Rather, higher prevention costs reflected services included and per-family spending limits set by those Networks.

[23] This figure could indicate that either prevention interventions were highly effective at preventing shelter entry or that prevention interventions were not targeted to families at high risk for entering shelter. See above Goal 2: *Collect Data and Measure Impacts* for a discussion of the challenges measuring the impact of homelessness prevention.

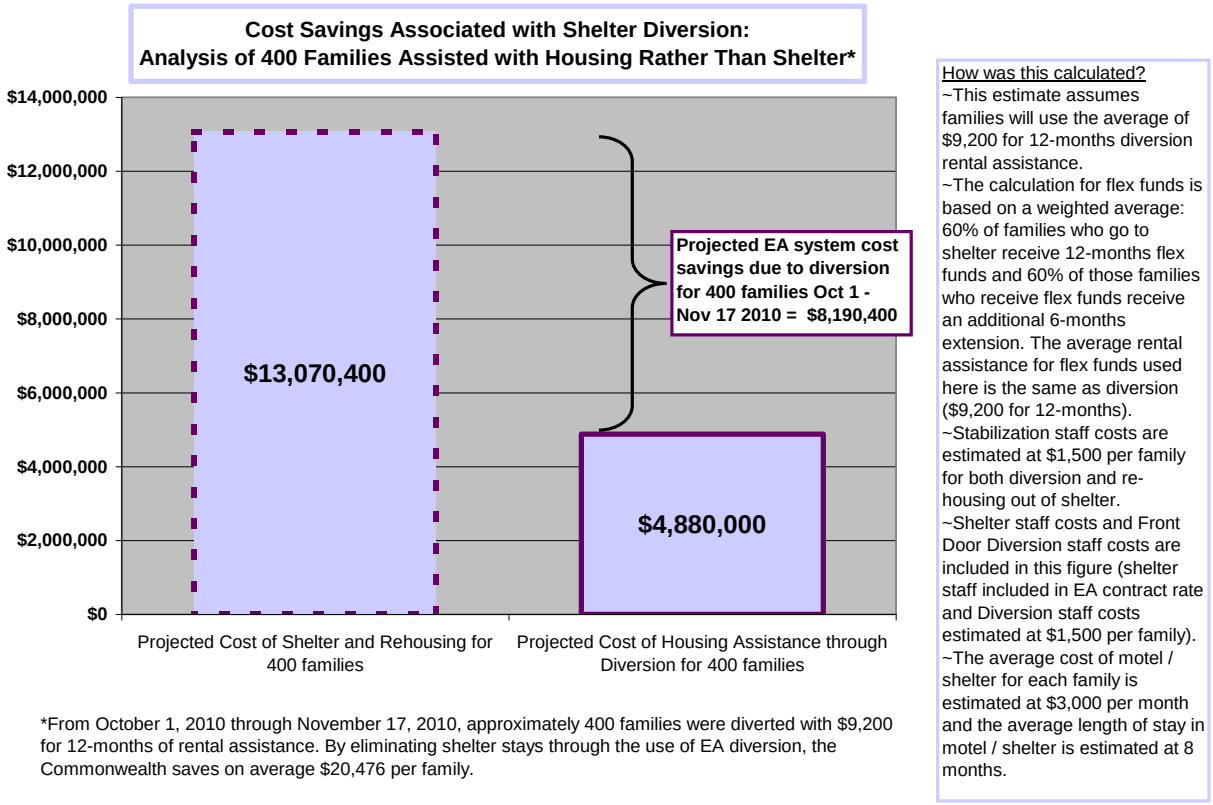
of diversion in Worcester during FY2010. By providing housing instead of shelter CMHA saved an average of $26,611 in state spending per family served with diversion.

Figure 6



At full scale, October-November 2010 rates of shelter diversion resulted in significant savings statewide. Due to changes in EA contracts in FY2011 and varying reimbursement rates across the Commonwealth, the statewide cost-savings calculation for October-November 2010 shows a lower per-family savings of $20,476. The figure below illustrates the system-wide savings from approximately 400 shelter diversions during the six week period from October 1, 2010 through November 17, 2010. By providing diversion rather than shelter, the Commonwealth could serve almost triple the number of households, with the same amount of resources, while reducing the need for families and children to enter shelter.

Figure 7



*From October 1, 2010 through November 17, 2010, approximately 400 families were diverted with $9,200 for 12-months of rental assistance. By eliminating shelter stays through the use of EA diversion, the Commonwealth saves on average $20,476 per family.

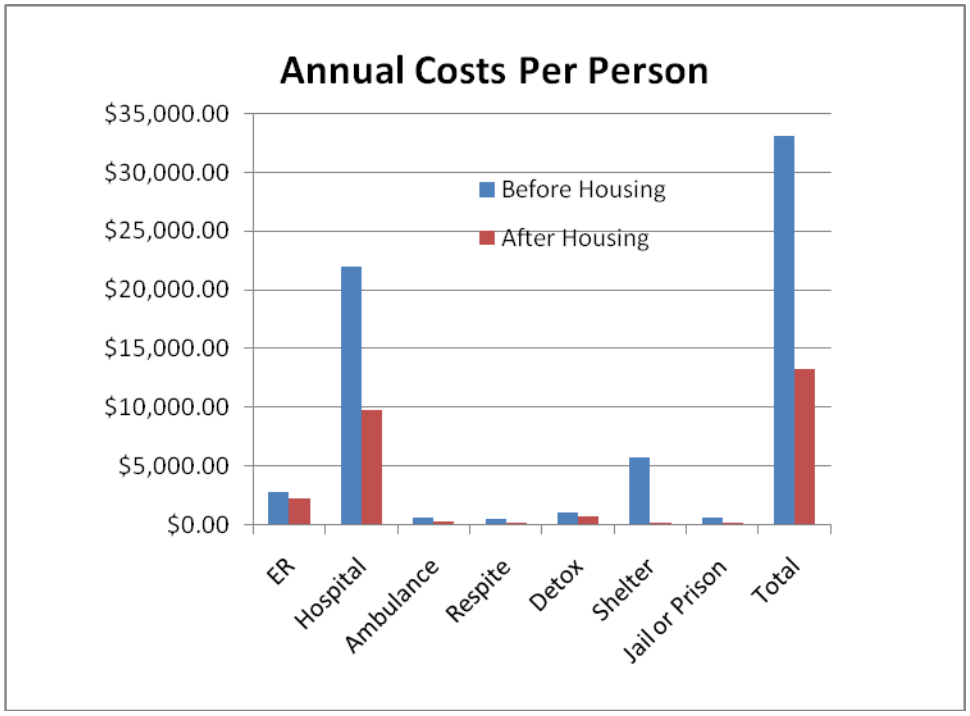
The Massachusetts Housing and Shelter Alliance provided additional evidence of cost savings associated with housing the chronically homeless population. Gathering data through their *Home & Healthy for Good* program, MHSA conducted a preliminary study using self-reported information solicited from chronically homeless individuals regarding their use of emergency systems, including ER visits, ambulance use, and time spent in hospitals, respite care, detoxification units, shelters and incarceration. The average documented annual cost for these emergency services before individuals were being placed in housing was $33,128.04 per person.[24] After individuals were placed in housing, the average annual cost for these emergency

[24] Of the chronically homeless individuals who were rehoused in the Networks, 180 signed consent forms to have their data included in a cost benefit analysis. The Massachusetts Housing and Shelter Alliance made conservative estimates of the costs associated with various medical and other services, and are based on the following:

- **Emergency Room**: Based on the Blue Cross Blue Shield Medical Cost Estimator, the average emergency room visit in 2004 in Massachusetts was $640[24]
- **Hospitalization**: The Massachusetts Hospital Association quotes an average cost of an inpatient day in a Massachusetts hospital as $1,895 per day in 2006
- **Ambulance**: The Massachusetts Division of Health Care Finance and Policy (114.3 CMR 27.03) estimates the cost of an ambulance ride to be $230

services dropped to $13,203.72[25]. This constitutes a projected annual savings of $19,924 per person in emergency services (see below Figure 8).

Figure 8



Re-purposing Shelter Resources: Challenges

The broader economic downturn made it difficult for providers to meet the demand for shelter, while achieving prevention and rehousing outcomes at a level significant enough to result in a consistent daily reduction in shelter use. There continues to be consensus among providers that reduction in shelter capacity must be done responsibly with clear evidence that

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- **Respite**: Boston Health Care for the Homeless Program estimates an average day in respite at the Barbara McInnis House to cost $400
- **Detoxification**: The Massachusetts Department of Public Health's Bureau of Substance Abuse Services estimates the costs associated with one day in detox to be $198
- **Shelter**: According to the Department of Transitional Assistance, the average cost to the state of a night in a Massachusetts homeless shelter for one person is $32
- **Incarceration**: Massachusetts Department of Correction estimated the costs associated with prison or jail time to be $123 per day

[25] MHSA calculations based on 463 follow-up interviews.

need has reduced and that there is enough flexibility in other parts of the system to accommodate fluctuations in need over time.

6. Development of Additional Resources for the Network

From the outset of the pilot, Networks were able to leverage significant additional funds to maximize both the human and financial resources available during the demonstration period. Each Network was required to match any funds requested through the ICHH RFR for administrative purposes. Most commonly, Networks leveraged case management or other support service program staffing and existing emergency assistance funds. A few Networks were able to leverage significant housing resources. For example, the Boston Network worked in partnership with the Boston Housing Authority to set aside 80 Section 8 rental vouchers, and the Metro Boston Network was able to leverage 10 rental vouchers from the Cambridge Housing Authority. The Western Massachusetts Regional Network was most successful at securing additional new funds for the Network. They received grants from the United Way of Pioneer Valley and Citizens Bank Foundation. Additional United Way funds have since been secured to continue work beyond the pilot. Seven United Ways have committed a total of $560,000. Those funds will be awarded during Fiscal Year 2011 to Networks in the relevant United Way service areas.

Development of Additional Resources for the Network: Challenges

While a few Networks were able to identify resources to sustain some aspects of their work, overall they did not have the level of success they had hoped. The ICHH provided several opportunities for Networks to share thoughts about building sustainability through monthly Coordinator conference calls and Peer Learning Sessions. Networks began exploring several sources of support, including funding requests to local, regional, or national foundations, seeking funds from private or corporate donors, instituting membership fees, and accessing HUD Continuum of Care resources. Although such efforts will continue, they have so far met with limited success. In the immediate future, Networks will rely primarily on ICHH funds and those that the United Way system has pledged.

Specific insights about Network fundraising and sustainability include the MetroWest Regional Network's observation that their Leadership Council was not as diverse and robust as they needed to get their message out successfully. The MetroWest Regional Network also noted that reporting requirements for different funding streams (e.g., HPRP, DHCD, ICHH) limited their ability to create a coherent picture of their achievements.

Build Systems Change to Create Sustainability: Lessons Learned

Lessons learned through evaluation research related to the goal of building systems change to create sustainability include the following:

- Cost savings and initial family outcomes associated with the Networks' interventions around prevention, diversion and rapid rehousing suggest that these new ways of working can pave the way for further spending on flexible housing resources;
- As new innovations are implemented, peer learning and continuous feedback between policymakers, field staff, and other stakeholders improves practices and coordination;
- Implementation of the full homeless system architecture (prevention, diversion, shelter, rehousing, stabilization) ensures people who are at-risk receive the necessary supports to avoid homelessness, and those who are homeless can gain housing stability for the long-term;
- Co-location of staff reduces duplication of services and assists in providing families with the right resources at the right time;
- Rehousing chronically homeless adults is once-again proven to improve well-being and housing stability for clients and is less costly to multiple systems of care;
- As the state shifts to housing responses, stabilization services will become increasingly important;
- The Uniform Assessment Tool can be valuable in helping to identify the right resources to help each household, but the Tier system as it stands is limited in its impact;
- Data sharing is an important and powerful tool to support implementation of systems changes that institute best practices;
- Dedicated Network Coordination allows a diverse set of stakeholders to develop shared goals, leverage multiple resources, and more effectively match resources to need.

Recommendations

The following recommendations are based upon findings of the Regional Networks to End Homelessness Pilot Evaluation including the quantitative and qualitative data analysis presented throughout this report. Some of the recommendations represent significant adjustments in how state resources are distributed over the long term; others are short-term recommendations on how practices can improve immediately. As a next step, implementation timelines, priorities, and strategies for these must be considered in partnership with the ICHH, state agencies, Regional Networks, consumers, and other advocates in respect of programmatic best practices and fiscal constraints. The recommendations are grouped by theme as follows:

- Evolving the Homeless Services Continuum
- Housing Production
- Network Coordination
- Data and Evaluation

Evolving the Homeless Services Continuum:

1. **Allocate state resources to effectively support the full DHCD architecture for individuals and families: prevention, diversion, shelter, rehousing, and stabilization.** The *Special Commission Relative to Ending Homelessness in the Commonwealth* called for a comprehensive housing first approach to prevent and end homelessness. Shortly thereafter, DHCD advanced a concept of a homelessness/housing architecture that would account for each critical aspect of housing stability and emergency responses. For the last two years, the ICHH and its member agencies have tested practices for each component of this architecture.

   Now that these experiences have begun to be analyzed, it is appropriate to focus on best practices to ensure that appropriate support for each component of the architecture is institutionalized through policy and local practice. Resource allocation should be done with a focus on increasing housing and economic opportunities. The United States Interagency Council on Homelessness (USICH) Federal Plan to Prevent and End Homelessness *Opening Doors* describes homelessness as a result of the gap between income and the cost of housing. The federal plan echoes the Commonwealth's *Special Commission* findings that ending homelessness will require closing both ends of this disparity: creating more affordable housing and increasing economic opportunity.

a. **Provide staffing and direct client assistance funds to support early-warning and front-door prevention programming for individuals and families.** Regional Networks provided evidence that prevention resources can benefit at-risk households. Importantly, this evidence also suggests that programmatic flexibility is warranted to allow households to access resources that best meet their particular needs. Resources should be allocated to targeted prevention programs that were shown to be successful through this pilot. Specifically, court-based prevention, tenancy preservation in partnership with private and public landlords, and co-location of prevention staff and resources at local TAO offices were shown to be among the most effective strategies for reaching at-risk households. In addition, pre-existing prevention infrastructures supported through the ICHH showed that community-based providers including Community Action Agencies and Regional Nonprofit Housing Agencies have expertise in reaching at-risk households before they become homeless.

b. **Provide staffing and flexible direct client assistance funds to support shelter diversion programming for families.** ICHH, DHCD, and Regional Networks must also continue to track long-term outcomes for families that receive diversion services. Family shelter diversion programming is critical to providing families with alternatives to emergency shelter. Diversion providers have shown that many families will choose to accept short-term rental support with stabilization services, thus reducing reliance on shelter. For example, in October 2010 approximately 45% of all EA-eligible families received housing through diversion instead of shelter. Anecdotally, one provider reported that a mother, upon hearing her family was eligible for housing assistance in place of shelter said: "The policy-makers finally get it."

   Flexibility in diversion resources is also critical. Over the course of the pilot period, the MetroWest Regional Network found that it could divert some families who only needed rehousing assistance (1st month rent, last month rent, and security deposit). However, in October 2010, MetroWest was constrained by EA limitations to offer every family the same level of assistance, even if it meant that fewer families could be served with the limited amount of resources. Further, best-practices from across the country demonstrate that it is valuable to assess if the current housing situation is more affordable and sustainable than an alternative or new tenancy[26]. In such cases, support to host families and

[26] "Homelessness Prevention: Creating Programs that Work." *National Alliance to End Homelessness.* July 2009, p. 21.

linkages to self-sufficiency resources might be the most effective and sustainable diversion response compared to rehousing or shelter.

c. **Continue rapid rehousing and stabilization efforts for individuals who are chronically homeless, are long term shelter stayers, and other unaccompanied adults.** The priority set by the federal government some years ago on housing chronically homeless individuals has brought significant success across the nation and in Massachusetts. Regional Networks have shown that shelters function more appropriately as an emergency setting for individuals who are chronically homeless, are long term shelter stayers, as well as other unaccompanied adults. Stable sources of funding for housing and community support services are critical to achieving housing placement and retention outcomes for this population. Existing funding streams do not adequately cover these important expenses. The Commonwealth should identify funds to provide the support services that keep homeless individuals housed, including intensive case management and representative payee services.

   The C-SPECH pilot program operated by the Massachusetts Behavioral Health Partnership shows one avenue to be successful. MBHP is able to bill Medicaid for the community-based support services for a cohort of chronically homeless clients with whom they work. ICHH should work with the Office of Medicaid to examine opportunities to expand on this model. Further, the Office of Medicaid should be given a formal seat on the Interagency Council on Housing and Homelessness in recognition of the close relationship between housing and healthcare, and the need to align those resources to support people in housing.

   Additionally, where feasible, the Homeless Individuals Assistance line item (7004-0102) should be repurposed as permanent housing resources. Pine Street Inn in Boston is currently piloting such an effort by repurposing funds that supported their Night Center for use as housing support. DHCD should work with additional shelters serving unaccompanied adults to identify opportunities and replicate any successes coming from the Pine Street Inn project.

   Lastly, Critical Time Intervention should be further tested with providers working to rehouse and stabilize unaccompanied individuals. The ICHH should facilitate training and information-sharing about this and other stabilization models with stakeholders across the Commonwealth via a Peer Learning Session.

d. **Provide coordinated stabilization services for recently rehoused families.** As Regional Networks have achieved success in rapidly rehousing homeless families through diversion or motel/shelter rehousing programs, the need for home-based stabilization services has increased. Currently, DHCD includes resources for 18-month stabilization within the EA shelter contracts, and diversion providers have supported stabilization for diverted families through DHCD, ICHH or federal HPRP stimulus funds. Those resources were limited and, over the course of the pilot, providers have discovered that many families require longer-term or more intensive support to achieve housing stability and family self-sufficiency. In the spring of 2010, DHCD convened a group of providers to develop a set of guidelines about what services should be included in stabilization programs, and how those services should be delivered. The priority must be on lease compliance, asset building, and other activities that will help families maintain their tenancies. Beyond those fundamentals, additional ICHH member agencies should be involved in ensuring adequate access to state systems of care and community-based supports that can assist in family self-sufficiency and housing stability. The ICHH should continue working to identify best practices in stabilization, including strategies to build efficiencies and coordinated regional approaches.

2. **DHCD should continue to support triage efforts within both family and unaccompanied adult service delivery systems.** Building off the successes of the South Shore and Worcester County Regional Networks, DHCD should prioritize efforts to strengthen local triage capacities. Further, triage tested throughout the pilot was an attempt to more effectively match resources with need. Making the right match should be the goal, while ensuring the system provides no more or less than what is needed. As the full architecture is developed the concept of triage should be applied to prevention, diversion, rehousing, and stabilization components as well. Inherent in this is the need for an effective uniform assessment tool (see recommendation #7).

3. **Experiences from the Regional Network pilots indicate the need for the ICHH to give additional focus to three priority populations: young families, survivors of domestic violence, and those being discharged from institutions.** The Regional Networks, in collaboration with ICHH, DHCD, and Executive Office of Health and Human Services (EOHHS) identified these sub-populations as experiencing particular vulnerabilities to homelessness. In most cases Networks didn't explicitly target these subpopulations in their work plans, but over the course of the pilot came to prioritize this work based on an improved understanding of the barriers to housing that these subpopulations face.

For example, the current response to families who are homeless due to domestic violence is fragmented between multiple systems of care. The fragmentation results in families receiving different supports based on where they first seek help. Four Networks implemented targeted efforts to reduce fragmentation, but this work must continue through the leadership of the ICHH and the Governor's Council to Address Sexual and Domestic Violence (GCASDV). The ICHH and GCASDV should continue to move toward full implementation of the Blueprint Report that outlines strategies to end homelessness for survivors of domestic violence.

Building off the efforts of the Boston, Worcester County, and Western Massachusetts Regional Networks, the ICHH should continue to partner with relevant state agencies and providers to link housing resources to those being discharged from correctional, mental health, or substance abuse programs and facilities. The ICHH should reconvene its discharge planning working group and coordinate efforts with the Massachusetts Housing and Shelter Alliance group working on discharge planning. Discharge plans and protocols should be reviewed within each state agency and contracted providers.

The Western Massachusetts Regional Network was also instrumental in identifying the challenges faced by families with heads of household between the ages of 18 and 21. This group represents 15% of the EA caseload, and many of these families do not have rental or employment histories. The ICHH should work with DHCD, DCF, DTA, DESE, Regional Networks, and others to refine our understanding of this population's service and housing needs. Targeted asset development opportunities and intensive residential supports should be made available to ensure long-term housing and financial stability.

Housing Production and Access:

4. **Continue Efforts to Make a Continuum of Housing Supports Available.** Many of the recommendations included in this section relate to implementation of short-term rental support and services because those are the types of innovations tested during the pilots. However, the demonstration was also able to highlight the need for a broad continuum of affordable housing opportunities. Short-term rental assistance will not eliminate the need for at least some families and individuals facing significant social and economic challenges to access longer-term rental subsidies. Per the report of the *Special Commission Relative to Ending Homelessness in Massachusetts*, the Commonwealth needs to "produce more affordable housing – both through actual production of physical units, and by adding considerably more housing vouchers to fill the often-wide gap between market rents and a household's ability to pay." The ICHH and DHCD should explore ways to increase flexibility in rental supports to address the needs of households with the full spectrum of social and economic circumstances. For example, consideration should be given to short-term diversion resources, medium-term rental support with asset building opportunities, as well as longer-term rental supports.

The Commission also noted that Single Room Occupancy, private developments, public housing, and specialized supportive housing were all strategies to employ. The ICHH and DHCD should continue to prioritize the development of units accessible for homeless and at-risk individuals and families according to the Commission's recommendations, and should regularly engage multiple stakeholders who can inform the Commonwealth about innovations in housing production and access for this population.

Network Coordination:

5. **Regional Networks should continue to coordinate resources across multiple client access points and facilitate broad-based discussions.** Regional Networks can continue to support the coordination of resources and staffing at prevention, diversion, rehousing, and stabilization client access points. Network coordination should be conducted with the goal of reducing duplicative services and improving matches between resources and need in timely ways. Networks should continue to build partnerships in their regions, and target consumers, local housing authorities, private landlords, and agencies serving people with disabilities for more intensive engagement. Meaningful consumer engagement is of particular concern, as Networks across the board experienced challenges during the pilot period engaging consumers, or keeping them engaged over time. The ICHH should also implement a consumer focus group to provide regular feedback and input into state-level policy decisions. The ICHH should provide ongoing technical assistance to Networks to maximize network building strategies.

Data and Evaluation:

6. **The Uniform Assessment Tool should become streamlined across state agencies that work with at-risk or homeless populations and integrated into all HMIS systems in the state based on standard data exchange formats.** The tool should be further developed to include standard, follow-up outcome measures to track changes over time in housing status, employment status, income, education attainment, children's school enrollment, etc. An effective uniform assessment and follow-up tool will help agencies target resources based on risk-factors and need, share data, and compare outcomes over time. Likewise, the *Home & Healthy for Good* tool should become the standard outcome measurement tool for all programs that house chronically homeless individuals, regardless of funding source. Uniform assessment and outcomes tracking are building blocks for performance-based contracts.

7. **The Commonwealth should continue to provide technical assistance to Regional Networks related to data and evaluation.** Working with the ICHH, Networks should continue to assess effectiveness and Network health, use data strategically to improve outcomes, lead regional planning efforts based on data, and make the case for programmatic or policy changes necessary to end homelessness. The Regional Network Coordinator should take the lead on process outcomes, and a regional Data Analyst should improve data quality, analyze impacts, and make data public to engage stakeholders and improve accountability. The federal HEARTH Act provides an opportunity in this regard as it will implement data-driven outcomes for programs receiving HUD funding. The Act also encourages CoCs to select Unified Funding Agencies (UFAs) and will offer increased administrative awards to UFAs.

   The ICHH will partner with Regions and agencies that seek to improve outcomes and outcomes tracking by providing forums for peer learning and technical assistance. Through these forums, the ICHH will lead a public process to reflect on learnings from the pilot period and national models on outcomes tracking. In addition, the ICHH will garner consensus among state agencies and providers regarding how to further define households who are "at-risk" and "at imminent risk" of homelessness. Refined definitions will be crucial to measuring successful outcomes over time for homelessness prevention and stabilization.

8. **Institutionalize a research and evaluation protocol into all facets of the Commonwealth's response to housing instability and homelessness.** Data about long-term outcomes for individuals and families receiving services through each component of the architecture must be tracked continually, with results actively informing program design improvements. The ICHH should work with all relevant state agencies to incorporate appropriate data and evaluation into programming.

9. **Long term plans should include consideration of investing in a state-wide Integrated Data System (IDS), also known as a de-identified data warehouse.** IDS allows for linkages of administrative data on health, education, housing, public benefits, and other social safety net services. By linking administrative records, researchers can study outcomes beyond the silos of state agencies to make significant policy improvements. Examples of the value provided by Integrated Data Systems across the country include a study in Los Angeles that showed housing placement for homeless individuals reduced use of services that resulted in cost-savings to county government. South Carolina used their IDS to investigate the linkages between poverty, health

conditions, crime, mental illness and success in school[27]. The states of South Carolina and Michigan both provide models for state-level IDS that have used data to improve social policy and planning. The ICHH should explore these IDS models in order to gather information about cost, implementation strategies and challenges, implications for homeless services, and to determine the feasibility or desirability of replicating the models in Massachusetts. Similarly, the ICHH should consider strategies to support case conferencing and "client sharing" techniques.

[27] Dennis P. Culhane, John Fantuzzo, Heather L. Rouse, Vicky Tam & Jonathan Lukens, "Connecting the Dots: The Promise of Integrated Data Systems of Policy Analysis and Systems Reform," Intelligence for Social Policy 2 ed., 22 Mar. 2010: 1-22

Appendix I

Evaluation Research Methods

Evaluators employed a mixed-methods approach drawing on a variety of quantitative and qualitative sources, including:

- Baseline Site Visit Reports: Baseline site visits were conducted in July-September 2009 by specialists in homelessness prevention for individuals (Massachusetts Housing and Shelter Alliance (MHSA)), homelessness prevention for families (One Family) and overall network development (Innovation Network for Communities (INC)). Baseline Reports detailed Network membership, goals, innovations and activities as well as early progress and challenges encountered with individual innovations, family innovations, network development and outcome data capture.

- Monthly reports submitted to the ICHH by all Networks with family diversion and prevention data;

- Quarterly Reports submitted to the ICHH by all Networks including:
  - Benchmark progress toward the 5 Goals and outcomes, including aggregate client outcomes;
  - Summary description of Network development activities;
  - Client case studies exemplifying Network best practices for implementing innovations
  - Client case studies demonstrating important challenges related to implementing innovations;
  - Stories exemplifying Network best practice and/or demonstrating important challenges related to network organizing

- Quarterly summary overviews generated by ICHH including aggregated client data;

- Mid-term check-in reports for all 10 Networks: In April-May 2010, Network Coordinators provided verbal reports of progress to the ICHH evaluation team.

- Network Health Survey Results: In April 2010, an online survey was distributed to all ICHH Regional Network members. Results provided evidence of overall Regional Network development and included reflections by individual Networks about where

their network building efforts had been largely successful and where work still needed to be done[28].

- Summary lessons learned reported by Networks at the Pilot Closing Event on September 23, 2010, under the five goals: Reduce the Need for Shelter and Achieve Housing Placement Outcomes; Collect Data and Measure Impacts; Create Opportunities for Broad-based Discussion with Diverse Stakeholders; Implement a Regional System that is a Model for Accountability and Transparency to Consumers and the Public; and Build Systems Change and Accountability.

[28] The Network Health Survey was designed for INC by Madeleine Taylor, Ph.D., of Arbor Consulting Partners. Reports summarizing results of the Network Health Survey (10 individual reports and 1 summary report) were submitted separately to the ICHH in June 2010.

Appendix 2

Average Cost of Regional Network Innovations

The following chart shows the average cost of innovations as reported by the Regional Networks. Along with their 6th Quarterly report, Regional Networks were asked to submit an estimate of the average cost of each innovation. Networks were asked to provide the cost of client assistance only in comparison to the total cost, including staffing such as case management, housing search, and ongoing stabilization services.

Networks also provided a brief description of how the innovation was implemented in their respective regions. The implementation of shelter diversion, for example, ranged from providing the upfront costs of rehousing (first month, last month and security deposit) to providing rental assistance for up to 12 months. Some Networks were only able to report from one agency in their region and/or on only some of the innovations. The overall averages were calculated as a simple mean of each response received and therefore only provide an estimated figure. Attention should be paid to the range of costs.

Note that the cost of rehousing chronically homeless individuals did not include the cost of housing, as most individuals received a subsidized unit or had other public benefits that covered the cost of housing.

AVERAGE COST OF INNOVATIONS						
	Client Assistance Only			Client Assistance Plus Staffing		
	Average	Min	Max	Average	Min	Max
Family Prevention	$ 1,669	$ 1,010	$ 2,350	$ 2,401	$ 1,149	$ 3,150
Family Diversion	$ 4,179	$ 1,530	$ 8,500	$ 5,712	$ 2,259	$ 9,017
Family Rehousing	$ 6,497	$ 1,634	$ 7,709	$ 7,393	$ 1,732	$ 7,709
Individual Prevention	$ 1,243	$ 911	$ 1,632	$ 1,362	$ 1,047	$ 1,632
Individual Rehousing Chronically Homeless	$ 887	$ 113	$ 1,495	$ 2,361	$ 828	$ 4,562

Appendix 3

Race and Ethnicity of all Household Members Served

The UAT questionnaire asked about race and ethnicity of all household members. Sample sizes are based on the number of responses to each question. The HUD standards for HMIS create "primary" and "secondary" race categories for persons who are multi-racial. The data collection tool built by DHCD allowed for multiple selection of race, but did not employ the concept of "primary" or "secondary" race. Therefore "secondary" race has no consistent meaning; it is simply a way to capture more than one race for an individual. Additionally, some respondents answered for ethnicity but not race, or race but not ethnicity, so the sample sizes differ. Neither race nor ethnicity was a required field.

Ethnicity of All Household Members		
	Count	Percent
Other (Non-Hispanic/Latino)	3047	62%
Hispanic/Latino	1669	34%
Don't Know	170	3%
Refused	2	0%
Total	**4888**	**100%**

"Primary" Race of All Household Members		
	Count	Percent
American Indian or Alaska Native (HUD)	165	4%
Asian (HUD)	53	1%
Black or African American (HUD)	919	23%
Native Hawaiian or Other Pacific Islander (HUD)	41	1%
White (HUD)	2574	65%
Don't Know	214	5%
Refused	11	0%
Total	**3977**	**100%**

"Secondary" Race of All Household Members		
	Count	Percent
American Indian or Alaska Native (HUD)	5	5%
Black or African American (HUD)	36	35%
Native Hawaiian or Other Pacific Islander (HUD)	1	1%
White (HUD)	34	33%
Don't Know	20	19%
Refused	8	8%
Total	**104**	**100%**

Housing History and Eviction Status

The following table shows reasons for risk of homelessness or reasons for current homelessness. Due to data transfer complications for this particular question, the sample was restricted to agencies with reliable data[29]. From those reliable sources, the responses are compiled for households that answered the question: "If Homeless or At Risk of Homelessness, Why?" Respondents were permitted to provide more than one reason.

Reason for Homelessness or Risk of Homelessness		
	Count	Percent
Eviction	460	45%
Asked to leave	153	15%
Other	143	14%
Overcrowded	117	11%
Domestic violence	53	5%
Health and safety	46	4%
Foreclosure	26	3%
Fire, flood, or natural disaster	21	2%
Released from correctional facility, substance abuse program, or mental health group residence	10	1%
Aged Out from DCF or DYS	4	0%
Total	**1033**	**100%**

The following table shows the type of housing from which households were being evicted. This sample was restricted to agencies that submitted data on this question. The responses answer the UAT question: "If Homeless or At Risk of Homelessness, Why? Eviction from:" (drop down list below)

[29] Due to data transfer complications for this particular question, the 460 households facing eviction who are included in this chart are fewer than the households included in follow-up questions regarding eviction.

Homeless or At Risk of Homelessness Due to Eviction Proceeding From:		
	Count	Percent
Public Housing	413	71%
McKinney Subsidy (Shelter+Care, SHP, Section 8, Mod Rehab)	87	15%
VASH (veterans subsidy)	46	8%
Apartment with attached housing subsidy	25	4%
Private Apartment - no subsidy	11	2%
Total	**582**	**100%**

The following table shows at which stage in the eviction process households were served. The responses below are aggregated from all households that answered the UAT question: "Where in the eviction process are you?"

Stage in Eviction Process		
	Count	Percent of total
Arrearage/At Risk of Eviction	110	14%
Received 30 Day Notice	93	11%
Received 14 Day Notice	369	45%
Signed Agreement to Mutually Terminate	50	6%
Received Court Ordered 48 Hour Notice to Vacate	192	24%
Total	**814**	**100%**

Using data from the Uniform Assessment Tool's housing history chart, the following shows the breakdown of families who submitted data on their 3 year housing history. It should be noted that collecting housing history was a new practice, and a large proportion of incomplete charts raises concerns about data quality. To conduct this analysis, families were included in the sample if they answered any portion of the housing history. If they did not indicate they had been a primary leaseholder in their response, they were counted as not holding a lease. Thus, the data may be skewed to represent a larger proportion of families who had not been primary leaseholders when in fact they simply did not provide that information.

Primary Leaseholder within Last 3 Years - Families with Adult Head of Household (22 years old +)		
Adult Head of Household (22 years old+)	Count	Percent
Yes	734	71%
No	300	29%

Young Families as a subgroup were much less likely to have held a lease in the previous three years [30]. Given their age, young heads of households who did not maintain a tenancy in the prior three years likely never held a primary tenancy.

Ever Primary Leaseholder - Families with Young Adult Head of Household (18-21 years old)		
Young Adult Head of Household (18-21 years old)	Count	Percent
Yes	19	41%
No	27	59%

[30] The difference in proportion of families headed by an adult 22 years old or older who had been primary lease holders in the last three years and the proportion of families headed by a young adult aged 18-21 who had been a primary lease holder in the last three years is statistically significant at p = .01.

Highest Level of Education and English Fluency of Head of Household

The table below shows the highest level of education for the head of household as recorded through the UAT. Respondents were given more response options but, for purposes of analysis, these categories have been sorted into larger groups.

Highest Level of Education Completed		
	Count	Percent of Total
No Schooling Completed	166	5%
Less Than High School Diploma or GED	632	20%
High School Diploma or GED	958	31%
Some College	232	8%
Completed Post Secondary Degree	501	16%
Refused or Didn't Know	151	5%
Blank	448	15%
Total	**3088**	**100%**

The following table shows the level of English fluency for the head of household as recorded through the UAT. In error, the question on the tool labeled the category "English Literacy" when in fact the response options pertain to English fluency. It is unclear if the mistake on the UAT affected the accuracy of responses. The sample size is restricted to the agencies that submitted data on responses to this question and should not be considered a representative sample for homeless and at-risk households.

English Fluency		
	Count	Percent of Total
Fluent	1108	75%
Sufficient for Effective Communication	83	6%
Adequate for Basic Communication	67	5%
Very Limited	50	3%
Speaks No English	41	3%
Blank	135	9%
Total	**1484**	**100%**

Employment Status and Employment History

The Uniform Assessment Tool piloted the practice of gathering data about employment status and employment history. The chart below includes only responses from those who reported some employment information. Respondents who left this section blank are not included in the analysis.

This section of the UAT asked different follow-up questions depending on preceding responses. For example, respondents were asked questions about previous employment only when they answered that they were not currently employed. Additionally, due to a design error, respondents were not able to record the answer "no" to the question "Are you currently employed?" However, a blank response cannot reliably be interpreted as equivalent to responding "no." Due to this data collection error and a low response rate to all employment questions, we cannot calculate the proportion of all households who were currently unemployed or who had prior employment history.

Employment History		
	Count	Percent
Currently Employed	523	37%
Previously Employed	404	29%
Did Not Indicate Current nor Previous Employment	478	34%
Total	**1405**	**100%**

The following table looks at the 478 respondents who did not indicate current nor previous employment and describes whether or not they reported a particular work barrier.

No Current or Previous Employment Reported - Work Barriers		
	Count	Percent
No Reported Barrier	300	63%
Yes, Has Work Barrier	178	37%
Total	**478**	**100%**

The following table describes self-reported work barriers for heads of households. A total of 403 individuals reported work barriers, though some respondents reported more than one barrier. Many respondents who reported work barriers also reported previous employment. The question on the UAT allowed for a write-in response. Those responses were later classified into the following categories:

Type of Work Barrier		
	Count	Percent of Total
Disability (Physical and/or Mental Health)	323	78%
Other	25	6%
Childcare	22	5%
Caring for Family Member with Disability	17	4%
Cannot Find Work	11	3%
English Fluency/Literacy	5	1%
Immigration Status	5	1%
Transportation	5	1%
Little or no work experience	2	0%
Total	**415**	**100%**

The average hourly wage was calculated by taking the mean of all current and previous hourly wages reported through the UAT. If both the current and previous hourly wages were reported for the same respondent, the current hourly wage was used. Erroneous data was excluded by selecting hourly wages ranging from $1-$50. The sample size of heads of households who reported their current or previous hourly wage was 245 individuals.

Average Hourly Wage
$13.05

Appendix 7

Individuals Demographics

7.1 Age Demographics of Individuals without Children as recorded through the UAT.

The table below presents the mean, median and mode age of adult individuals without children. The sample consists of 603 respondents identified as heads of households between 15 and 100-years-old who do not have children in their care. Ages were calculated by subtracting date of birth from the Assessment date or from the date April 1, 2010 when Assessment date was not reported[31].

Age - Heads of Households without Children		
Mean	Median	Mode
46.1	47	52

The table below includes a count of the number of individuals who were designated as heads of household not within families. This sample consisted of 603 records. Ages were calculated by subtracting date of birth from the Assessment date or from the date April 1, 2010 when Assessment date was not reported[32].

Age Group - Heads of Households without Children		
	Count	Percent
Minor (18 and younger)	1	0%
Young Adult (18-21)	11	0%
Adult (22-64)	565	94%
Senior (65 and older)	25	4%
Blank	1	0%
Total	**603**	**100%**

[31] April 1, 2010 was used as a proxy for assessment date because it occurred at the midpoint of the pilot period.
[32] April 1, 2010 was used as a proxy for assessment date because it occurred at the midpoint of the pilot period.

7.2. Gender Demographics of Heads of Households without Children as recorded through the UAT

The table below shows the gender demographics of heads of households without children. This data sample consists of 705 individuals who designated themselves as the heads of their households without children.

Gender - Heads of Households without Children		
	Count	Percent
Female	264	37%
Male	429	61%
Don't Know	12	2%
Total	**705**	**100%**

Appendix 8

Family Demographics

8.1. Age Demographics within Families as recorded through the UAT

The table below describes the mean, median and mode ages of heads of households with children. This sample consists of 1,448 individuals between 15 and 100-years-old who were designated as a head of household and members of families. Ages were calculated by subtracting date of birth from the Assessment date or from April 1, 2010 when Assessment date was not reported[33].

Age - Family Heads of Households		
Mean	Median	Mode
36.4	35	31

The table below shows the distribution of ages for individuals who were designated as heads of household within families. This sample consisted of 1,448 records. Ages were calculated by subtracting date of birth from the Assessment date or the date April 1, 2010 when Assessment date was not reported[34].

Age Group – Family Heads of Households		
	Count	Percent
Minor (17 and younger)	1	0%
Young Adult (18-21)	57	4%
Adult (22-64)	1375	95%
Senior (65 and older)	15	1%
Total	**1448**	**100%**

[33] April 1, 2010 was used as a proxy for assessment date because it occurred at the midpoint of the pilot period.
[34] April 1, 2010 was used as a proxy for assessment date because it occurred at the midpoint of the pilot period.

The table below shows the distribution of ages for children as recorded through the UAT. This sample consists of 1,694 records and was created by selecting individuals between the ages of 0 and 30 with relationship to the head of household marked as "child" and designated as belonging to a family. Ages were calculated by subtracting date of birth from the date April 1, 2010 (this date was chosen because it occurred during the middle of the pilot period).

Age Group of Children		
	Count	Percent
Newborn to Toddler (0-2)	256	15%
Pre-school (3-4)	226	13%
Elementary School Age (5-12)	680	40%
Teenager (13-17)	433	26%
Young Adult (18-21)	99	6%
Adult (22-30)	41	2%
Total	**1694**	**100%**

The following table simply shows the mean, median and mode ages for children as recorded through the UAT.

Average Age of Children		
Mean	Median	Mode
9.48	9	2

8.2. Gender Demographics of Heads of Households within Families as recorded through the UAT

The table below presents the gender demographics of heads of households within families. Female heads of households outnumber male heads of households by a ratio of more than 4:1. This data sample consists of 1,334 individuals designated as the heads of their households and were reported as members of families.

Gender - Family Head of Household		
	Count	Percent
Female	1065	80%
Male	230	17%
Don't Know	39	3%
Total	**1334**	**100%**

Appendix 9

Home & Healthy for Good Participant Demographics

MHSA received data on 215 people, who had been chronically homeless before being placed into housing. The breakdown by Regional Network for the 215 people is:

Western Mass	22
South Shore	11
Merrimack Valley	107 (18 from Haverhill, 47 from Lawrence and 42 from Lowell)
Cape Cod	23
Metro Boston	15
Worcester	24 (demographics only)
Boston	13

Chronic Initiatives Demographics:

Total Participant Characteristics			
		Number	**(%)**
Total Number		215	(100)
Gender			
	Male	156	(73)
	Female	59	(27)
Age			
	18-30	21	(10)
	31-50	105	(49)
	51-61	79	(37)
	62+	10	(5)
	Average Age	46	
Ethnicity			
	Hispanic	48	(22)
	Non-Hispanic	161	(75)
	Unknown	6	(3)
Race			
	African American	42	(20)
	White	141	(66)
	Native American	5	(2)

	Asian	2	(1)
	Multi	1	(<1)
	Unknown	24	(11)

Income Sources Reported			
	Supplem. Security	46	(21)
	SSDI	52	(24)
	Social Security	33	(15)
	General Assistance	21	(10)
	Employment	28	(13)
	Food Stamps	29	(13)
	None	17	(8)
	Veterans	1	(<1)
	Unemployment	6	(3)
Health Insurance			
	Private Insurance	2	(1)
	Medicare	22	(10)
	MassHealth	172	(80)
	No Insurance	12	(6)
	Commonwealth Care	2	(1)
	Unknown	26	(12)
Disability (of 186 responders)			
	Medical	117	(63)
	Mental	147	(79)
	Active Substance Abuse	36	(19)
	Multiple Disabilities	105	(56)
Served in Military		27	(13)
Average Length of Homelessness		**3.8 years**	
Housed from:			
	Street	46	(21)
	Shelters	135	(63)
	Other/Unknown	34	(16)

Appendix 10

Example of Regional Data Analysis

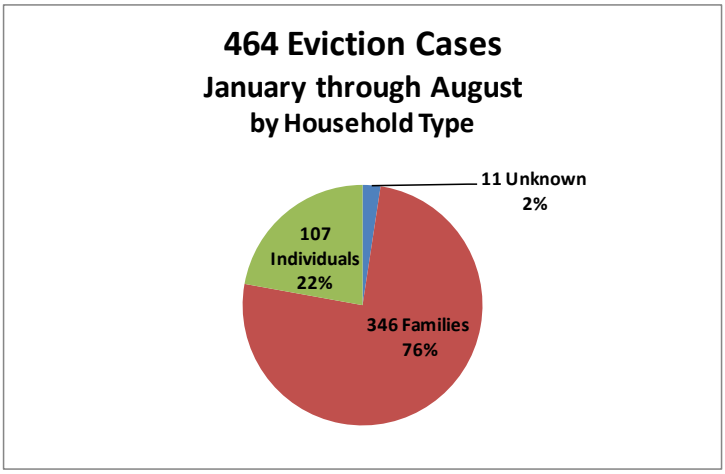
Networks that hired Data Analysts also had much more detail on outputs and outcomes for their specific regional innovations. An example follows from the Western Massachusetts Regional Network.

EXAMPLE 1: Western Mass Housing Court Outcomes[35]

WMNEH Housing Court Record of Service Data Collection Update

Each year some 5000 eviction cases are seen at the Western Housing Court in the four counties of Western Massachusetts. The Housing Court Collaboration is a new initiative of the Western Mass Network where area agencies provide staffing presence at the courts to intervene in these cases in order to preserve tenancies and prevent homelessness. Tenants receive advocacy or mediation services, are screened for eligibility for financial assistance with utilities, rent arrearages, or other needs, or referred to appropriate agencies for screening and assistance if eligible. By connecting tenants experiencing eviction with services and financial assistance right at the courthouse, hundreds of tenancies have been preserved and homelessness averted.

Since January of 2010, the Western Mass Network has been tracking these interventions. The following is a summary of **464** eviction cases, dating from January through August, 2010, where intervention was requested by a judge, tenant, or landlord. Of the **464** eviction cases recorded, the following interventions were provided (categories are not mutually exclusive):



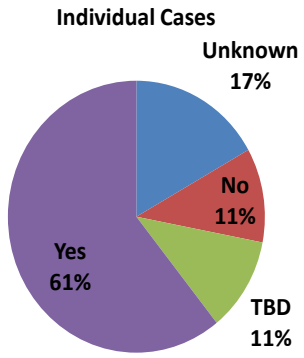
- **250** were screened for eligibility.
- **72** were provided with advocacy during mediation.
- **106** were provided with advocacy with the landlord or the landlord's attorney.

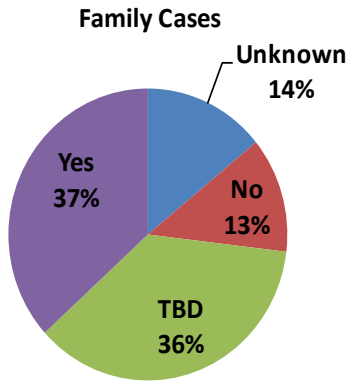
[35] Narrative and graphs prepared by Suzanne Smith, Data Analyst for the Western Mass Regional Network to End Homelessness.

- **264** cases involved a referral to a partner agency for assistance.

Overall, **207** tenancies were preserved that day in court, **59** were not preserved, **138** were continued or yet to be determined, **60** were unknown.

Was Tenancy Preserved?





Of the **138** continued cases, **39** have returned to court thus far – a few more than once. Of these, **25** resulted in the preservation of the tenancy.

The WMNEH thanks participating agencies HAP Housing, Catholic Charities, Community Action, Berkshire Housing and the Tenancy Preservation Project for their assistance in staffing the court.

Missing Information - Number Blank or Unknown

	Docket #	**HH Type**	**Date**	**Tenancy Preserved**	**1-time event**	**City**	**Race**
July, 2010 (67 cases)	8 (names)	1	0	6	40	3	7
June, 2010 (90 cases)	1	1	0	14	86	5	14