Central Vermont
A path forward for the homeless during COVID-19
05/28/2020/updated 05/31/2020

Lead Organizations
Capstone, Downstreet, Good Samaritan Haven, Vermont AHS, WCMHS

Other Groups to Engage
CVHH&H, Blueprint for Health (VCCI), Family Center of Washington County, WCYSB, HomeShare, justice centers, recovery residence operators, CIRCLE, Turning Point, SASH, CVMC, People's Health and Wellness, and others as appropriate.

Local Collaborators
Rick DeAngelis, Will Eberle, Toni Grout, Jackie Jones, Sue Minter, Joan Marie Misek, Mary Moulton, Eileen Peltier, Tanya Crawford-Stempel

Purpose
This proposal is a collaborative effort of local service partners in Washington county to outline a plan to address both the step-down phase (moving guests out of expensive hotels until there is a vaccine or resumption of general health safety) and the longer-term plan for addressing homelessness during this pandemic and beyond.

Table of Contents:

1. Key Assumptions and Suggestions

The following are key assumptions and perspectives held by the Local Collaborators based on collective expertise, in-the-field analysis, and public relations that inform our proposal.

- The state emergency voucher program expansion and the shelter relocations that occurred to "flatten the curve" are not a sustainable solution for the state or hotel guests

- COVID-19 has presented a unique opportunity to better understand Vermont's homeless population, their needs, and potential for long-term success, and therefore the opportunity is ripe to design improved solutions
- Collaborative proposals that include housing and services equally invested in solutions are needed to create reliable systems change and radically reduce homelessness
- Data collected from the current emergency hotel shelter population presents the most current analysis and insight into local homelessness and should be used to inform any solutions
- Solutions to homelessness must allow for varied housing and services models. (Person-centered solutions require choices)
- Plans during the step-down phase of the pandemic should inform the long-term strategy
- Some level of additional investment by the state will be required. The step-down phase will be costlier than the longer-term plan
- The universal understanding of the impact of ACEs on children and the inadequacy of family shelters highlights the need to prioritize families with children first
- Physical, mental, and financial health are all risk factors for homelessness
- Existing public and private housing stock that is either vacant or offline will be used first whenever possible
- Community support is critical to success. Reducing NIMBYism, mobilizing and harnessing community volunteer capacity and investment must be included in any solutions-based approach
- This health and economic crisis must be recognized as an opportunity to leap forward with respect to reducing and preventing homelessness; we should not accept a return to the unsafe conditions that existed pre-COVID

2. Analysis of Washington County Data

The data that follows are derived from a collection from a surveys of hotel guests, AHS data on hotel guests, and the Coordinated Entry intakes available. In the Coordinated Entry system, there are three levels of case management needs: long-term, medium-term, and short-term. "Long-term" case management needs are determined by the severity of a disability, length of homelessness, or inability to maintain housing in the past. A long-term case manager should expect to be with a household for more than 2 years. "Medium-term" case management often means that individuals can't afford an apartment without subsidy and may need a case manager for 6 months-2 years. This

may be a result of previous rental struggles or assistance in learning to manage an apartment. "Short-term" case management clients have the financial means to support their own apartment and have never been evicted. Their case management support would be minimal and last for no more than 6 months.

As of 5/30/2020 per the CE list (smaller than total hotels guests as not all want to do the CE intake). As of June 1, we anticipate the hotel guests who have not done a CE intake to depart without engaging us.
Using the CE list:

154 motel hh
126 singles- 82%
28 families – 18%

92 Households With income 43%
Of the 92 – 59 SSI or SSDI

Long term- 98 HH – 64%
Medium- 44 HH – 29 %
Short-term 15 HH – 10%

82% need studio or one bedroom

6% can afford FMR at 40% of their income
3 % can afford FMR at 50% of their income

Using the entire hotel guest list as of 5/26/2020, the count of guests in the Washington County hotels include:

- 234 Households
- 133 Long-term
- 10 HH evicted 3 or more times
- 96 HH claim a disability that significantly impacts
- 27 HH long-term simply because of length of time homeless.
- 73 HH with children
- Youth HH (18-24) -40 total 29 youth without children, 15 With children
- 62+ - 20 individuals

3. Step Down Strategies - Proposal for short-term (during the COVID-19 pandemic)

Given the cost and the challenges associated with providing shelter in hotels during COVID-19, we understand the need to transition away from the emergency hotel model as soon as possible and move people to a more appropriate, more affordable location with services. We are also aware of the State's desire to mitigate health dangers and actions that jeopardize the future of our most vulnerable, requiring the continued use of hotel shelters, but at a smaller scale.

Below are several solutions that we believe will work well in Washington County for the defined populations that will help the state succeed in the transition while mitigating the health and long-term consequences on our most vulnerable in the era of COVID-19. The timeline and associated costs of this plan are for the state fiscal year 2021.

A. Move Vulnerable Populations to Quality Inn & Maintain families at the Hollow with Local Support

We recommend that when feasible vulnerable populations that need continued hotel shelter be relocated to the Quality Inn or stay at the Hollow Inn with an Emergency Assistance (EA) voucher. We believe these will be more appropriate settings than the Econolodge and the Hilltop. Additionally, we would request VRS be available to this population for us to work toward a more appropriate solution with those guests who would be able to thrive in an independent apartment setting. If VRSs are provided for this population at a cost of about $11,000 per household per year we could move from the costlier hotels to VRS and then within 12 months likely receive permanent housing choice vouchers through VSHA. With the VRS vouchers available, we will work aggressively with landlords to get this population permanently housed as quickly as possible.

The largest cost of this program would include Vermont Rental Subsidy (VRS) Voucher about $11,000 a year or a hotel EA voucher about $20,000 a year per household. We believe that the food program currently operating is a strong benefit but could be scaled back over time. A full cost estimate of the programs is attached.

Here is our recommended approach to the different populations in the hotels.

i. Medically Vulnerable

This population is defined as individuals who are over age 60 and/or have underlying health conditions as identified by the Centers for Disease Control and Prevention (CDC)[1]. We are aware of 16 individuals over the age of 60 currently residing in hotel shelters that fit this definition. Our medical team is assessing the hotel guests to identify additional guests with underlying health conditions. We anticipate, in total,

about 30 people. We feel it is pertinent to continue to house these vulnerable persons in the hotel shelters during the COVID-19 pandemic.

ii. Sustain Families at the Hollow

Although this population is not medically vulnerable for COVID-19, we believe it essential to keep families with children housed in order to avoid additional ACE's. There are 38 families at the Hollow now. With the extraordinary impact of the pandemic on young children, we believe housing first is critical. Similar to the request above for the medically vulnerable, with VRS and case management funds, we recommend prioritizing permanent housing for these families along with services from the Family Center.

iii. Re-open GSH Seminary Street Shelter and continuing the "Nest"

GSH has two shelter resources available for housing up to 25 individuals. The level of staffing and operational resources currently awarded to GSH through the supplemental HOP program for one motel are sufficient for supporting these environments.

GSH Seminary Street – We recommend re-opening the shelter at 105 N. Seminary Street in Barre to serve up to 15 people who are currently hotel guests. The focus will be on people with high needs as per the CE list.

GSH Transitional – "The Nest" – The Shelter will continue to provide housing for up to 10 individuals within three transitional apartments on Nelson Street in Montpelier. The focus is on individuals who are preparing to transition from Shelter to living independently or into in permanent shared living arrangement. Life skill training is available through this site through WCMHS.

iv. Provide Semi-Congregate/Shared Living Housing

A recent survey of the residents of the Econolodge indicates that most of the respondents are interested in a room with a shared kitchen and bathroom. We also know that many shelter guests of the Good Samaritan Haven value the sense of community that they find there. We are now working to develop such an environment for up to 40 individuals and couples without children who are low to medium level needs as identified on the coordinated entry (CE) list. Our hope is such an option could be available for the winter of 2020-21.

v. Utilize the COSA model for all homeless households

We believe Circles of Support and Accountability (COSA), a restorative justice model, has potential for providing support to previously homeless individuals and families. Capstone and Good Samaritan are consulting with the Montpelier and Barre Restorative Justice Programs to help us examine its adaption to our system. This will include some cost to support the administration the program for this population as yet to be determined.

vi. Collaborative Services model

Our approach to services for this population is to have core team that will use GSH for shelter/housing and oversight/management. Capstone will provide housing case management with a focus on getting homeless guests into permanent housing and WCMHS will provide mental health case management. The Clinical Case Manager will be hired by WCMHS; this non-categorical bachelor level position will focus on housing retention, voucher support, and helping to find housing for homeless clients. This Case Manager will work closely with other housing agencies in Washington County and with the WCMHS internal housing team. This Case Manager will attend the Capstone Housing Review Team meeting weekly and will have access to the HMIS system to enter assessments and participate in the Coordinated Entry system. This Case Manager will also work with the area homeless outreach team to help engage people that are hesitant due to stigma with co-occurring problems. This is a community-based position that will work with adults to stabilize in housing and other urgent needs, such as income and insurance, to move toward ongoing stable living. This position also provides clinical supervision, linking individuals in need to referrals for mental health and substance use treatment.

In addition to this core team, our local network will continue to play an active role in providing care and support to these vulnerable populations. Medical services and testing for COVID-19, as needed, will be provided by CVHHH. We will also ensure that the Vermont Chronic Care Initiative VCCI) and other regional care coordinators through community providers are aware of hotel guests as appropriate. And, the Family Center will provide additional case management services to hotel guests with families.

4. Long term vision to mitigate Homelessness

Throughout this time of COVID, the group has been meeting to address both immediate needs and to develop a clear vision of a long-term plan to mitigate homelessness. Please note, this is a conceptual vision and has not been vetted by all potential partners. That said, we believe it is important to share some directional perspective on where our region would like to be in the long term.

We envision both a HUB, as described below, along with a variety of housing choices for households. Many of these concepts exist in some form but not to the necessary

scale. The Coordinated Entry program and other services at the HUB would be connected to the Housing Choices and Services model as described below.

HUB

New Building with shared site for homelessness services including housing (see below)

- COSA program here
- Capstone housing case management (CE) here
- Downstreet landlord support and tiny house program here
- Health clinic here (PHW/CVMC)
- First floor-programming above plus shelter operations. Shelter operations focused on emergency shelter needs including connection to family style shelter noted above. Open 24 hours a day, one meal a day with expectations for work hours on-site if possible. Use RR housing model where people have jobs at the house.
- Upper floors – permanent supportive housing for high need individuals, micro apartments, on-going case management offered.
- Beautiful building that says we care about you, outdoor space, community feel. There are some interesting models we can consider.

Housing Choices

- Rental subsidy with case management
- Transitional recovery housing with services
- Emergency shelters (individual, family style)
- Transitional micro apartments with services
- Shared apartments/house with vouchers case management
- Tiny homes on private land with voucher and services
- Tiny homes connected to HUB

Services Concept

The roles for service coordination described under the step-down solutions would be utilized with some changes. Our goal is for each person to be assigned a lead case manager based on their own preference of those that work with them on their team. The lead case manager works with all partners to coordinate housing and other support needs. This is a familiar model in that it is in place in our region for coordination through One Care Vermont.

In closing, thank you for the strong efforts by the State and the AHS in particular to support our most vulnerable across Vermont. We all know that homelessness is a multi-faceted challenge and requires strong collaborations between regional partners and with the State. As we move from emergency response to more of a long-term status

quo, we believe we can both meet the needs of the COVID-19 health crisis as well as have a significant impact on reducing and mitigating homelessness in our region.