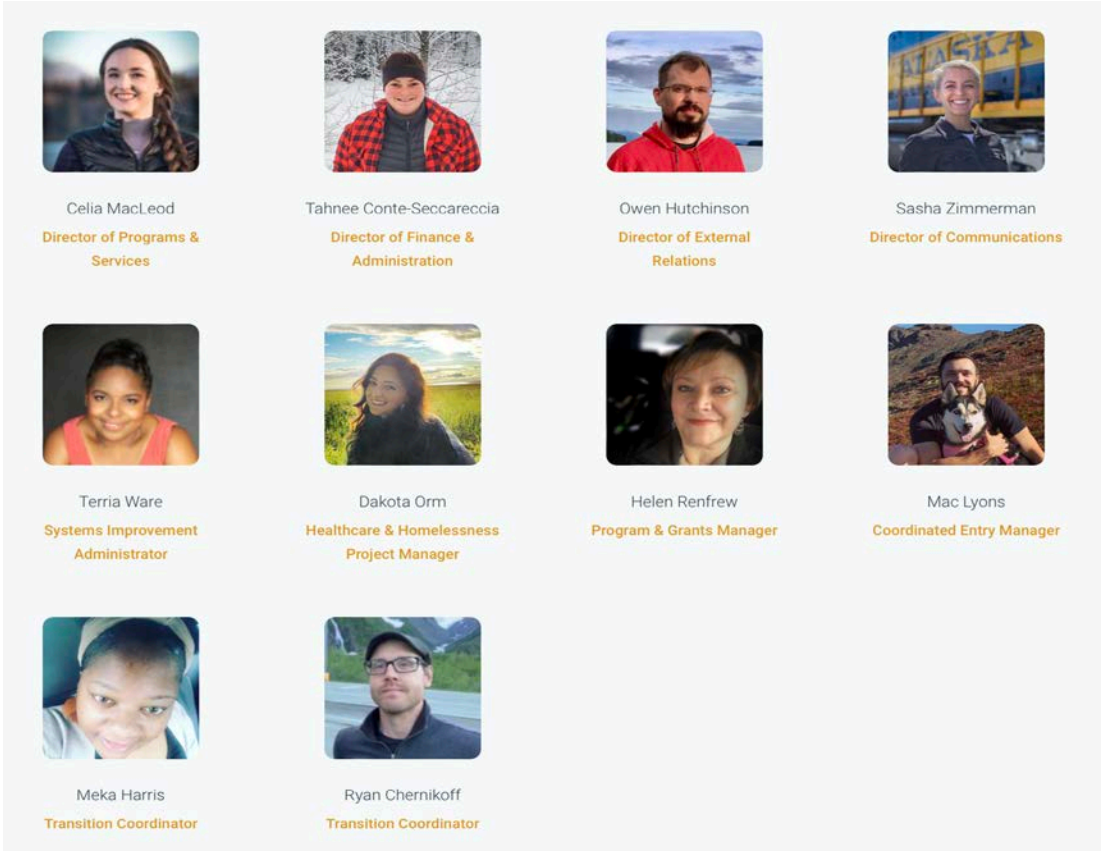
ANCHORAGE COALITION TO
END HOMELESSNESS

IMPLEMENTING THE MASS CARE EXIT STRATEGY

FEBRUARY 2022

ACEH Board of Directors (pictured left to right): *Jacob Lyon, Russ Slaten, Bill Falsey, Emily Edenshaw, Richard Mandsager, Nathan Johnson, Judith Crotty*
Not Pictured: *Niki Tshibaka and Christopher Kolerok*



Who We Are:

The Anchorage Coalition to End Homelessness is an organization of professionals working hard everyday under the leadership of a dedicated board to make homelessness in Anchorage rare, brief and one time.

Meg Zaletel
Interim Executive Director

Snapshot Of What We Want To Accomplish

Identify what is being done.

Identify what partnerships are are needed.

Identify what is missing.

Envisioned System[#] After Mass Care Closure =
Total Capacity 1198
441 to housing
658 to shelter/navigation
97 to residential treatment

Sockeye Inn Complex Care Shelter – 120 beds

Brother Francis Shelter – 75 beds*

Gospel Rescue Mission – 43 beds

Salvation Army McKinley Annex – 15 women%

Salvation Army Booth House - 30 veterans%

Special Populations Shelter - 120 beds^^

Navigation Center - 200 beds~

Downtown Hope Center – 55 beds for women

Midtown Substance Misuse Treatment - 68 beds

Clitheroe Substance Misuse Treatment - 29 additional beds for men

PSH/Workforce Housing Project 1 - 93 units

Hope Suites Housing - capacity for 72 women

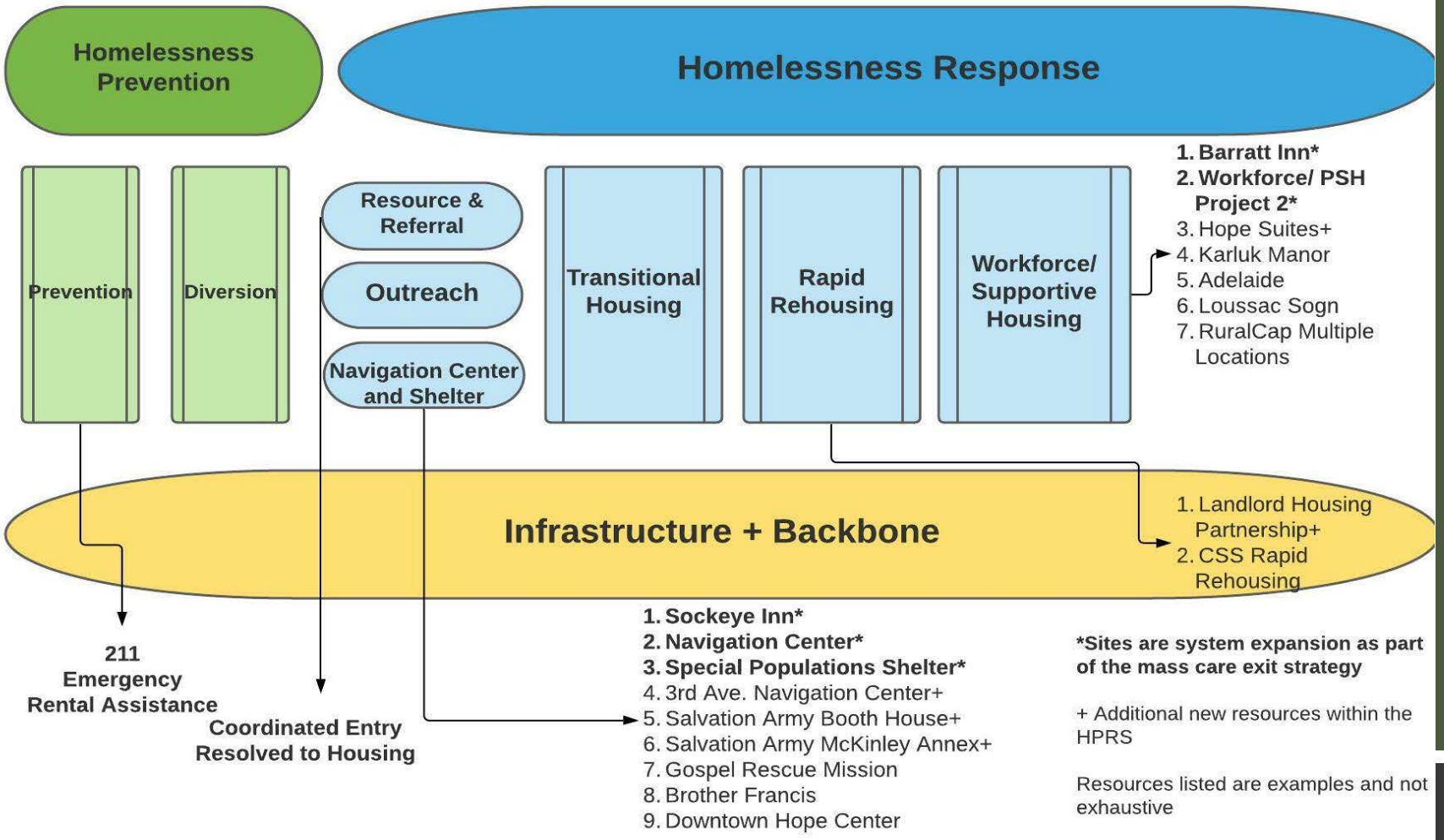
PSH/Workforce Housing Project 2 - 125 units*^^

Landlord Housing Partnership - 100 units*

Coordinated Entry Resolved to Housing - 50 clients

[#]As of 2/3/2022
*estimated numbers
% March 1st planned opening
^^No identified location
~RFP issued 1/28/2022
Bold underlined text indicates specific projects identified by the facilitation group as part of the mass care exit strategy

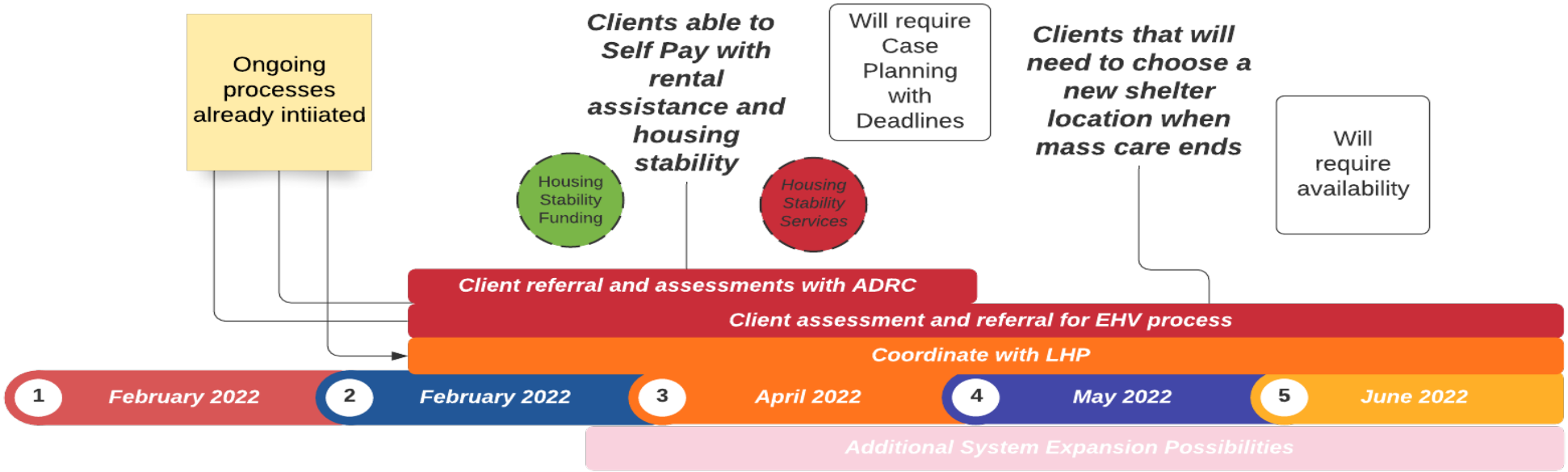
Single Adult Homeless Prevention Response System



The mass care exit strategy is not a fundamental alteration of the homeless prevention response system or the community's plan to address homelessness. Instead, it optimizes and expands services for clients to better meet their needs while leveraging and coordinating a wider variety of resources toward making homeless rare, brief and one time.

Timeline: Mass Care Exit

February 2022



Additional options not yet underway or in development:

- Special Populations Housing or Shelter
- Navigation Center under construction
- Second PSH/Workforce Housing Location Operational
- Possible Continuation of Mass Care Non-congregate capacity

Mapping the Current Shelter Capacity for Single Adults = Total Capacity at 1,027

- Mass Care – 855 beds includes Sullivan and hotels
- Brother Francis Shelter – 59 beds for individuals with medical needs or additional care
- Gospel Rescue Mission – 43 beds for individuals who maintain sobriety and commit to provided programs
- Downtown Hope Center – 55 beds for women

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Problem Statement:
How To Transition Approximately 800+ People Experiencing Homelessness (PEH) Into Suitable Placements When Mass Care Facilities Close

THE SOLUTION TO HOMELESSNESS IS HOUSING.

- Anchorage continues to experience a very tight rental market with low vacancy rates
- Even with dedicated resources for shelter outflow, finding appropriate homes for clients is moving slower than anticipated
  - Clients needs for support increase with longer stays in shelter or length of time unsheltered
- Rental assistance is available, but units are not, making each rental unit available competitive
  - Clients experiencing homelessness are not usually picked when units are competitive
  - Long wait lists for housing programs
- Clients in mass care continue to have unmet needs that complicate finding appropriate housing or placement.
- Workforce issues persist to find enough staff to fulfill the need for case management and to staff new programs that have been identified to be brought online.
  - Exacerbated by COVID-19

Funding For Housing

THE SOLUTION TO HOMELESSNESS IS HOUSING.

- Rental assistance and housing stability funds are available:
  - Intensive Case Management – rental assistance - $2M
  - AHFC – housing stability funds which include rental assistance and other supports – approx. $3.4M to be coordinated with the mass care exit strategy
    - Additional funding for Housing Stabilization and Recovery Program is also available through AHFC with at least 6 Anchorage based organizations receiving a notice of intent to provide funding at $440,000 per organization (~$2.6M)
  - Emergency Housing Vouchers – 96 vouchers statewide
  - Landlord Housing Partnership – $450,000 in incentive payments for landlords
- **Funding for rental assistance is not the issue, it is the lack of available units. These resources are time limited, use it or lose it funding. If housing units are not found the money cannot be spent.**

What Does a Successful Exit from Mass Care Look Like:

Acknowledging that at the current rate of placement not every client from mass care will move to housing when mass care closes, there are a variety of ways to measure success of the implementation of the mass care exit strategy:

- Client obtains a housing placement with necessary supportive services to maintain the placement;
- Additional capacity in the establish shelter providers or with new shelter providers is identified and ready to accept clients and facilitate providing the necessary supportive services;
- Additional capacity in established supportive housing programs or with new supportive housing programs, ready to accept clients and provide the necessary services to maintain housing;
- Client obtains eligibility for services to meet the clients needs while awaiting placement in an independent home or Assisted Living Home and secures placement in a specialized shelter for complex needs;
- Client receives an Emergency Housing Voucher and is able secure a unit and move in;
- Client receives rental assistance and housing stabilization services and moves to a Single Room Occupancy unit or apartment;
- Client working with Coordinated Entry can identify an informal resolution, such as staying with friends or family, and exit shelter;
- Client connects with or reconnects with behavioral health supports while in shelter to better stabilize for potential housing placement; and
- Client is active on housing program wait lists for units while actively receiving necessary supportive services

Homeless Response System Design

- Providers – Housing, Shelter and Support Services
  - Direct provision of services to clients
  - Funded through HUD, CoC and philanthropic dollars with some additional funds available 2021 forward through the alcohol tax
- Government
  - MOA – provides HUD funding through ESG, CDBG and HOME funds and alcohol tax/AHD operating funds as grants to providers
  - SOA – funding to providers through SNHG, BHAP, etc.
  - AHFC – public housing authority that provides rental assistance to clients and funding to providers
- Philanthropy
  - Provides primarily one-time special project funding to various providers
  - Rasmuson and the Homelessness Leadership Council continue to engage additional partners to support the homeless prevention response system
- CoC
  - Provides CoC HUD funding to Providers
  - Is the designated community convener and subject matter expert on homelessness and manages the Homeless Management Information System (HMIS)
  - Provides Technical Assistance (TA) to local providers and leverages availability of national TA resources to support best practices within the Homeless Prevention and Response System

HUD Designated Continuum Of Care

The Anchorage Coalition to End Homelessness is Anchorage's HUD designated Continuum of Care.

- What is the Continuum of Care (CoC)?
  - The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

Key Successes that Lay the Groundwork for Implementation

- Resolution of the Anchorage Assembly and Mayor's Office in support of an Exit Strategy to End Mass Care and Implement an Integrated Client and Community Centered Approach to Addressing Homelessness was unanimously approved by the Assembly on November 1st planning for a mass care closure date of June 2022.
- Appropriation of $6M by the Municipality of Anchorage for capital investments into 3 planks of the exit strategy – Complex Needs Shelter, Workforce/Permanent Supportive Housing, and a Single Adult Shelter/Navigation center.
- An adopted multi-faceted community plan to address homelessness, Anchored Home.
- **Partnership is critical to success** – some examples of how the community is partnering:
  - Philanthropy partnering on capital and property ownership opportunities.
  - Catholic Social Services, Agnew:Beck, Mental Health Trust Authority working collaboratively on shelter for complex needs.
  - RuralCap working collaboratively on workforce housing and permanent supportive housing models.
  - United Way standing up the Landlord Housing Partnership.
  - Current providers through Intensive Case Management, outreach, and coordinated programs connecting clients to services.

What the Coalition is Addressing in its Role as the CoC:

- Participation in the facilitation group with the MOA (Admin and Assembly) and Rasmuson on behalf of philanthropy
- Design and implementation of Anchorage's first shelter specifically designed for individuals with medical needs
- Implementation of workforce and permanent supportive housing units through a hotel conversion
- Supporting the Landlord Housing Partnership to make connections between case mangers and identified available units
- Working with Anchorage Disability Resource Center to case conference for clients who may require higher levels of care – Personal Care Services (PCS) or an Assisted Living Home (ALH)
- Deployment of Emergency Housing Vouchers (EHVs)
- Designing a rental and housing stability program for AHFC to administer to support clients exiting mass care
- Leveraging HUD (ESG, CDBG, HOME), State, Muni and philanthropic dollars to support the mass care exit
- Coordinated Entry of clients in mass care for prioritization into placement
- Ongoing support for PSH projects proceeding outside of the facilitated mass care exit strategy
- Ensuring data completeness for individuals in mass care

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Participating in the facilitation group will bring on new system resources to provide housing or specialized opportunities for PEH leaving mass care.**
  - Currently there are 5 planks to the exit strategy.
    - No identified location or solution for special populations.
  - Still needing to identify additional housing units beyond the 93 within the first housing project underway.
  - Need to address the increased census of mass care from when the exit strategy was adopted.
  - What additional partnership is required:
    - Better coordination of MOA resources that can support operations of an expanded Homeless Prevention Response System
    - Additional capital investments from MOA, SOA and philanthropy to increase housing units available
      - MOA – HOME-ARP funds for the additional acquisition of properties that can be converted to rental units
    - MOA support for external PSH projects
    - CoC provide additional information about hotel conversions and other means to increase available rental units

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Coordinated Entry of clients in mass care for prioritization into appropriate placements so providers and case managers know who is qualified and eligible to expedite placements and outflow from mass care.**
- Coordinated Entry prioritizes clients for placement based on length of time homeless and need.
- Complete CE assessments help ensure complete data into the Homeless Management Information System (HMIS).
- What additional partnership is required:
  - Providers – ensuring that all new clients and current clients in shelter and mass care have a complete and up to date Coordinated Entry assessment.
  - MOA – data entry and completeness for all mass care locations
  - CoC – ensure sufficient funding and capacity of HMIS vendor for new projects and data clean up

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Ongoing support for PSH projects proceeding outside of the facilitated mass care exit strategy that continue to expand the availability of permanent supportive housing in Anchorage.**
- Provided a letter of support for PSH project by Providence that will service individuals experiencing chronic homelessness.
- Enter a Memorandum of Understanding about the utilization of Coordinated Entry for placement of individuals into the project when units become available.
- What additional partnership is required:
  - MOA support for use of funds available through the SOA
  - Identifying providers that want to explore operating PSH projects to increase services provided to individuals experiencing chronic homelessness

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Supporting the Landlord Housing Partnership to make connections between case mangers and identified available units and assist the LHP to recruit private landlords willing to lease to clients will increase available units and successful housing placements.**
- Promotion of the LHP to the business and landlord communities to recruit landlords and educate them about the program, supports and incentives available.
- Convening case managers to educate them about available units and programmatic requirements attached to units for making matches with clients.
- What additional partnership is required:
  - Private Sector Landlords – identify available units
  - Community – promote the need for units and the incentives available to increase availability of units for PEH
  - Providers – obtain rental assistance and housing stability through AHFC programs for clients
  - LHP – clarity on unit eligibility criteria – i.e. does a client require a security deposit, case management, etc.

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Working with Anchorage Disability Resource Center to case conference for clients who may require higher levels of care – Personal Care Services (PCS) or an Assisted Living Home (ALH) – to help clients receive necessary services to either live independently or in an appropriate setting.**
- ACEH convenes with case managers and ADRC to review clients who are identified in the Homeless Information Management System as having medical needs to screen their eligibility for PCS or ALH services.
  - For clients likely to qualify, case managers work with ADRC to assist the client through the process.
    - To date, 30 clients have been found eligible for services or found housing.
  - Case conferencing also addresses immediate unmet needs of identified clients as well.
    - To date, 59 clients have been discussed in case conferencing
- What additional partnership is required:
  - CoC, SOA – identify opportunities for State sponsored care coordination and the possibility of prioritizing clients for General Relief while awaiting eligibility determinations and how to utilize approved benefits while still in shelter awaiting a housing placement
  - MOA – overlay necessary services to meet client needs while still in mass care
  - CoC – identify means to support providers to receive Medicaid reimbursement for eligible services

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Implementation of Anchorage's first shelter specifically designed for individuals with complex needs.**
  - Over 150 individuals with medical needs have been identified within the homeless prevention response system.
    - Individuals needing PCS/ALH care will likely remain in shelter longer while awaiting eligibility for benefits and appropriate housing placements (6-18 months)
  - Utilizing the Coalitions Healthcare and Homelessness grant, the Coalition in partnership with Catholic Social Services, Agnew:Beck, Rasmuson and the Alaska Mental Health Trust Authority are designing this specialized shelter.
  - This shelter will address a long-standing gap within the continuum of care.
  - What additional partnership is required:
    - MOA – full utilization of the rooms as authorized by the Assembly for mass care to start providing appropriate care to this identified population
    - MOA – utilization of HUD funding through CDBG-cv funding or other sources to overlay necessary services while operating as mass care or as a shelter to meet client needs
    - State of Alaska – streamline Medicaid eligibility, care coordination, and ensure payment of services in a shelter setting

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Deployment of Emergency Housing Vouchers (EHVs) will provide up to 9 years of rental assistance for qualifying individuals to be stably housed.**
- Identify clients through Coordinated Entry (CE) that qualify for EHVs and assist case managers in the application process.
- Help connect case managers and clients with appropriate housing opportunities that will accept EHVs.
- Leverage EHVs for placing Home for Good permanent supportive housing clients into appropriate long term housing.
- What additional partnership is required:
  - AHFC – continued coordination with the approval of identified clients to begin housing search and leveraging additional funding to make EHVs more competitive in the tight rental market
  - Providers - Engagement with ACEH in the referral of clients on the CE list so that more clients are getting access to EHVs

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Implementation of workforce and permanent supportive housing units through a hotel conversion adds additional housing units that can leverage current rental assistance and housing stability funds as well as ongoing HUD funding.**
- Working with philanthropic partners to explore financing options for a 93 unit hotel to convert into Single Room Occupancy (SRO) units and some efficiency apartments.
  - All units will be leased month to month for clients.
  - Allows clients to establish a positive rental history as well as save for a more traditional rental unit when available.
- Developing operating budgets including identifying sustainable funding for operations with housing providers that include RuralCap and NeighborWorks Alaska.
- What additional partnership is required:
  - MOA – assessment and utilization of 2021 HOME/HOME-ARP grant funds to jump start the project
  - AHFC - Developing financially feasible rental housing for qualifying households is challenging in the absence of project-based rental assistance. Most HOME-assisted rental projects rely on tenant rents to cover all or a portion of the debt service and project operating costs. Work with AHFC to identify or obtain project-based rental assistance for units funded with HOME funds.
  - Philanthropy or Housing Provider – identification of an owner and operator of the property.

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

Designing a rental and housing stability program for AHFC to administer to support clients exiting mass care

- The MOA appropriated $3.4M in emergency rental and housing stability funds to AHFC specifically to support the exit of mass care.
  - Funding parameters set by Emergency Rental Assistance 1 from the federal government:
    - Up to $1,100 a month in rental assistance for up to 12 months
    - Up to $8,000 per household for housing stability assistance – i.e. case management, moving costs, etc.
  - In addition, there are companion statewide funds available in Anchorage
- Determining the most effective way to deploy the additional resources to assist in bringing online additional rental units given the identified barriers to deploying other available rental assistance.
- What partnership is required:
  - AHFC – identify eligible activities for these funds that support the mass care exit
  - CoC, Providers – identify opportunities/units that qualify and connect clients

How Each Area Contributes to a Successful Exit of Mass Care and Implements Anchored Home:

- **Leveraging HUD (ESG, CDBG, HOME), State, Muni and philanthropic dollars to support the mass care exit through funding new and expanded operations for shelter and housing.**
- Identification of available and upcoming funding sources to ensure that new operations can be sustainably funded.
- What partnership is required:
  - MOA – commit to use remaining HUD funds to support the mass care exit strategy and provide a grant process for allocation of alcohol tax/AHD operating dollars to allow projects to seek funding
  - Philanthropy, CoC, MOA – work on proposals to state and federal partners to fund identified gaps
  - HUD, CoC – Technical assistance to ensure all funding available through HUD maximized to support the exit strategy

We look forward to our continued partnership in the next 6 months to exit mass care.

The work we do now will live on in a continually improving homeless prevention response system.

Thank you!

Questions, Comments & Ideas!

We will be holding a live online presentation of this slide deck and having a discussion on February 11, 2022 from 10:00am-12:00pm. However, acknowledging that time in a meeting is time not spent helping clients and that many of our partners have many demands on their time, please feel free to email or connect with us to discuss any aspect of this plan in more detail or how we can partner.

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