Hope House Health & Living Center
179 Corporate Drive, Bangor, Maine 04401
207.217.6713, Ext 1144 • (Cell) 207-944-9838 • Fax 207.217.6721

Penobscot Community Health Care

February 17, 2021

Re: LD 211 An Act To Support Emergency Shelter Access for Persons Experiencing Homelessness

Senator Rafferty, Representative Sylvester, and members of the Labor and Housing Committee, my name is Josh D'Alessio. I am testifying today on behalf of the Hope House Health and Living Center, in support of LD 211**,** An Act To Support Emergency Shelter Access for Persons Experiencing Homelessness.

I am a legislatively appointed member of the Statewide Homeless Council representing Region III, current vice-chair of the Maine Continuum of Care (CoC) Board, and director of Penobscot Community Health Care's (PCHC's) Hope House Health and Living Center -- a campus with a community health center for people experiencing homelessness, low-barrier shelter for adults, 48-unit transitional housing project for formerly homeless persons, and temporarily a 100-room hotel for people experiencing homelessness to quarantine, isolate, and physically distance. I also oversee two supportive housing programs: THRIVE, which provides up to one year of support for people transitioning from homelessness to permanent housing, and WISH, a peer-based program providing recovery and housing stabilization support for people experiencing challenges from substance use and homelessness.

Aside from my education and experience, my leadership position in the only homeless shelter in the state with an embedded, full-service community health center, provides unique authority on the systemic public health issues related to homelessness. I work directly in a large healthcare organization with a full-time office in the middle of a shelter. I see firsthand the opportunities to better coordinate resources and improve both housing stabilization and healthcare outcomes.

Others will testify today about this need for funds from the perspectives of the booming unsheltered crisis, the opioid epidemic hitting this population particularly hard, and recent increases to minimum wage causing shelters open 24 hours a day to make tough choices. These issues contribute significantly to the struggle shelters are now experiencing, simply to keep the doors open. I align with my colleagues on these matters but will focus poignantly on the steep increase in life and death decisions shelters are asked to make every day and the increasing inability to meet the needs of the communities we serve.

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Not so long ago, and without hyperbole, shelters existed to simply provide a safe place to sleep at night. Unskilled labor, typically someone with a big heart hoping to make a difference in the world, could work as a shelter attendant to ensure the lights were on, food was prepared, and linens cleaned. Unfortunately, the days of helping someone with a hot meal, lending an empathetic ear, and providing a warm bed are long gone. The face of homelessness has changed -- shelters are the new emergency rooms. The good news: we now have a body of science and academic research to work from. The bad news: we don't yet have the resources to implement these live-saving interventions

In addition to the 170,000 plus Mainers stressed with poverty and struggling to maintain housing, our state's skilled nursing facilities, assisted living, group homes, and other acute-care facilities are full. People at the halfway stage between living independently and state guardianship, involuntary commitment, medical respite, incarceration, and every other scenario where space is a premium and price unaffordable, are sent to shelters.

Shelters are the last safety net in our safety net.

Until two years ago, only a handful of people stayed outside during the winter. This increase in homelessness is sharp, historically unprecedented, and yet consistent with national trends (Tars & Loo, 2017). Pandemic aside, there are no signs the volume of homelessness will return to levels of yesteryear anytime soon. We cannot ignore the new problem and must adapt to meet the need and improve outcomes systemically with best-practice interventions.

Best practices, academic research, and information from high-performing communities around the country inform us, simply adding more shelters, or shelter beds, is not necessarily the answer. The National Alliance to End Homelessness suggests, "if the only response is more shelter, each new shelter will quickly fill up, and unsheltered homelessness will continue to grow… A community must consider how each person will exit to housing from that shelter" (Nagendra, 2018).

If we are going to enter the new homeless era successfully, not only do we need skilled labor to assist executing successful exits, we need to keep people alive for the opportunity.

Generally speaking, though we don't yet have an adequate supply of affordable housing, when housing *is* available, we have reasonably sufficient resources to help people get housed. We can, and do, connect people to mainstream resources, income and employment opportunities, and help navigate the legal and child reunification systems as well. **MaineHousing is one of the more progressive and forward-thinking public housing authorities in the nation and their performance-based model is successful, and one I strongly support.** Unfortunately, most, if not all, of our other shelter funders are looking for successful outcomes based on the idea of what a shelter was – provide a warm place to stay and provide some supports to help someone navigate the complexities of affordable housing applications, Social Security or resume building supports, a ride to A.A., and warm hand-offs to other mainstream resources, like SNAP, transportation, child care, and etc.

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In other words, while there is never enough money, the parts of the homeless system that are the same, have resources. What is missing from the funding formula are resources to address the volume and resource-intensive operational needs emerging from the influx of highly complex persons with acute medical and mental health needs presenting for shelter services.

Shelters are now the community emergency room and more. Just prior to the pandemic, the average length of stay at the Hope House rose 31% (average 39.2 days in 2018 to 51.4 days in 2019). This average length of stay rose sharply on an influx of people discharged from institutions who are older, have higher acuity medical conditions, and more complex social barriers. While we have a moral duty to prioritize services toward the most vulnerable, doing so has a cost. The Pandemic didn't help matters. Length of Stay is two-fold as a result.

When length of stay increases, "flow" is reduced, and shelters are unable to serve as many people, forcing many to sleep outside, which only aggravates medical matters resulting in another hospital stay that could have been avoided, before being discharged back on the streets to spin through the same systems again. Sufficient *Operation* dollars can mitigate these occurrences by providing resources that help prevent people from entering homelessness in the first place.

We have guests in the shelter in palliative and hospice care, many on oxygen therapy and dialysis, persons with developmental disabilities with guardians who cannot, or chose to not, care for them, people without quite enough documentation to be "blue papered," people struggling with opioid use disorder overdosing in our lobbies, bathrooms, and dorms, and an endless stream of people to create safety plans for, who will be staying outside tonight. It is infinitely more resource intensive for a shelter to provide supports for someone sleeping outside. When there is no room in the shelter, staff can spend an entire day with one individual on the phone negotiating with family members, providing conflict resolution supports with landlords, creating safety plans, obtaining cold-weather gear, and finding places to eat, use the bathroom, shower, and sleep. The Hope House provides these unsheltered resources to an average 15 people daily.

"It is infinitely more resource intensive for a shelter to provide supports for someone sleeping outside. "

Of note, it is these lifesaving supports provided by shelters that go unaccounted for and unfunded as agencies seek to measure outcomes in terms of numbers housed, not lives saved or quality of life improved. No one ever asks us how many lives we save.

It is no longer acceptable to have untrained staff performing these lifesaving interventions. The new generation of shelter attendant needs to be trained in overdose reversal and basic life support, have the qualified ability to recognize the danger signs of detox, hypothermia, overdose, a host of early warning signs of dangerous medical symptoms, and needs to be skilled in motivational interviewing, trauma informed care, rapid resolution, and de-escalation techniques. These skills are in addition to a strong understanding of local systems, networking, and an innate ability to earn trust and build relationships. A shelter attendant is no longer a minimum wage position.

We expect emergency department front-line staff to recognize the warning signs of a heart attack and to know how to quickly act to save a patient's life. We are asking the same of shelter staff in this new era of homelessness.

The intersection of healthcare and housing meets at our homeless shelters. MaineCare is leading a charge with the Innovator Accelerator Program (IAP) from CMS, which is currently working on a proposal to add a Permanent Supportive Housing benefit to MaineCare to provide chronically or long-term homeless MaineCare members with the support they need to acquire and maintain permanent housing and healthcare supports. Aside from the urgent need for resources now, homeless shelters will need to be prepared with staff and operational resources for this IAP eventuality, which in one form or another, is the emerging practice nationally. With this IAP, the FUSE initiative, and other recent SAMHS and Legislative efforts, the healthcare system is gearing up to meet the needs of this vulnerable population – my hope is housing resources will accompany these healthcare efforts and recognize the science of homelessness has reached a point beyond partisanship and opinion – **these are lifesaving efforts with best-practice intervention strategies.**

"…my hope is housing resources will accompany these healthcare efforts and recognize the science of homelessness has reached a point beyond partisanship and opinion -- these are lifesaving efforts with best-practice intervention strategies"

It would be easy to put this $3 million in the Homeless Solutions Rule and have it filter thorough the Emergency Shelter and Housing Assistance Program (ESHAP) to shelters without any heavy lifting. I strongly urge this committee resist the temptation to do so. I testified in favor of the Homeless Solution Rule and stand by it today. It is an excellent, effective, and progressive approach to ending homelessness in Maine. The need today, here, is about operations, not housing stabilization services. The shelters are adequately incentivized to provide permanent supportive and rapid re-housing services from not only ESHAP, but other resources as well. I strongly urge this committee to direct these funds specifically to the Operations potion of the Homeless Solution Rule Funding Formula and only the Operations portion. These funds are needed for life safety, not housing stabilization.

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We know how to solve homelessness – an adequate supply of affordable housing. While we build capacity and connect previously unrelated systems (healthcare and housing) to best practice models, we need to keep people alive and our shelter staff safe. We deinstitutionalized and eliminated "drunk tanks" in the name of liberty. However, in doing so, we sentenced people without financial means to a horrible fate when we allowed affordable housing to get away from us. This is not a partisan issue, an entitlement topic, or a "people should pull themselves up by their boot straps" matter – we've flown far past those arguments -- this $3 million is necessary and a small price to pay to keep people alive for the opportunity to reach their full potential.

Thank you for the opportunity to comment. I am grateful for the patience, knowledge, and seriousness with which this Labor and Housing Committee attends to the needs of our communities.

Respectfully,

Joshua B. D'Alessio, ~~MHA~~, LADC, CCS
he|him
Director, WISH Program Director
Hope House Health & Living Center
179 – 181 Corporate Drive, Bangor, ME 04401

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