2018–2021

Strategic Plan

Approved by the Health Care for the Homeless Board of Directors
May 23, 2017

HEALTH CARE for the HOMELESS

“Our goals are ambitious and bold. Some might even say they’re near impossible. But the community has spoken loud and clear: The problem of homelessness is urgent and unacceptable—and we cannot aim for anything less.”

—Keiren Havens
Chief Strategy Officer

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Our Approach

In January 2017, Health Care for the Homeless engaged in a five-month strategic planning process to develop a plan to shape the agency's direction over the next four years: 2018–2021. The process was guided by three principles: our mission, our community and our core values.

1. Our Mission

During our last strategic planning process in 2012, we as a community recrafted the agency mission statement. During this latest strategic planning process in 2017, agency leadership—the Board of Directors and senior leadership team—determined that the stated mission remains a powerful driver of the agency's work and agreed not change it.

Health Care for the Homeless works to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy and community engagement.

2. Our Community

Agency leadership chooses to define the Health Care for the Homeless community broadly and inclusively. We believe that real change happens when we bring people together, listen to one another and unite to act on shared goals and values. Putting our approach into practice, we designed a strategic planning process that reflected our community and included:

- Staff members
- Board members
- Clients
- Volunteers
- Foundations and institutional funders
- Fellow service providers
- Social justice organizations
- Government agencies
- Landlords and property managers
- Philanthropists
- Community activists and residents

3. Our Core Values

Our six core values are the collective promise we make each day to ourselves, to each other and to the people we serve. They guide our work and relationships. They hold fast when we shift direction or change. They undergird our culture. And they ground us in what is good, right and true.

Dignity: *Fostering respect and compassion*

Authenticity: *Practicing open and honest communication*

Hope: *Finding and focusing on people's strengths*

Justice: *Building a healthy community that includes everyone*

Passion: *Challenging ourselves and the world around us*

Balance: *Caring for ourselves and helping others do the same*

"I appreciate being the place where you can come when other places turn you away or you feel they may not want you. Not only will we want you, but we'll try our absolute best to help."

—staff member

Our Process

With assistance from our strategic planning consultant, Dr. Robert Sheehan, Jr., we collectively envisioned a world where our mission was complete. We considered our current state, as an agency and as a country. Then we designed an ambitious, aspirational plan to propel us forward into that more perfect future state. The result is a strategic plan that:

- is grounded in the needs of the community and in an assessment of the current political and social environment
- boldly advances our mission and core values
- envisions the agency's role in the local, state and national landscapes
- creates a shared understanding of our work
- articulates aspirational goals and themes for achieving these goals

Staff Participation

Health Care for the Homeless staff members engaged in strategic planning in a variety of ways—in small groups and as individuals, anonymously and publicly.

- 50% of our workforce (128 staff members) completed an online, anonymous survey
- 32 staff members self-nominated during an election for four non-management seats on the strategic planning committee
- Elected staff representatives gathered input from their colleagues through:
  - a series of lunch-hour conversations at various sites
  - one-on-one conversations
  - an in-service training for all staff
  - break-out group discussions during an all-staff meeting

  Additionally, they advised the Chief Strategy Officer throughout the planning process
- Two management team meetings were dedicated to briefing and engaging agency directors
- Leaders on the agency's strategy team helped design and support implementation of the strategic planning process (Directors of Community Relations, Development, Government Relations and Human Resources; Vice President of Communications; Chief Strategy Officer)
- All members of senior leadership—the Executive Team and the agency's three vice presidents—served on the strategic planning committee

Client Participation

The Consumer Relations Committee (CRC) of the Board of Directors elected two client representatives to represent client perspective and voice on the strategic planning committee. The CRC led efforts to engage clients throughout the strategic planning process. CRC members partnered with staff to administer written surveys across all clinic sites, including the mobile clinic, garnering 85 completed surveys. The CRC also facilitated strategic planning discussions during several client group meetings.

Community-wide Participation

More than 55 foundations, fellow service providers, social justice organizations, government agencies and landlords participated in the strategic planning process through a community survey, one-on-one conversations with leaders of the agency's strategy team and strategic planning committee or by attending a community forum on housing. These entities included:

- Abell Foundation
- Ammerman Family Foundation
- Annie E. Casey Foundation
- B'more Housing for All
- Baltimore City Council
- Baltimore City Health Department
- Baltimore City Mayor's Office
- Baltimore City Public Schools
- Baltimore Medical System
- Baltimore's Promise
- Behavioral Health Systems Baltimore
- Bon Secours Health System Baltimore
- Baltimoreans United in Leadership Development
- CareFirst BlueCross BlueShield
- Catholic Charities of Baltimore
- Centers for Medicare & Medicaid
- Charis Contractors, LLC
- Constellation-An Exelon Company
- Dayspring Programs
- Disability Rights Maryland
- Govans Ecumenical Development Corporation
- The Harry and Jeanette Weinberg Foundation
- Heritage Crossing Association
- Homeless Persons Representation Project, Inc.
- Hope Home Solutions
- House of Ruth Maryland
- Jacob and Hilda Blaustein Foundation
- Johns Hopkins Medicine
- Johns Hopkins Bloomberg School of Public Health
- Johns Hopkins University
- LifeBridge Health
- Loyola University Maryland
- Maryland Department of Health
- Maryland Department of Human Resources
- Maryland Department of Veteran Affairs
- Maryland General Assembly
- McDaniel College
- Mercy Health Services
- Midtown Community Benefits District
- Mosaic Community Services
- Old Goucher Community Association
- Park Heights Renaissance
- Project PLASE, Inc.
- Public Justice Center
- St. Vincent De Paul of Baltimore
- The Team Edge Properties, LLC
- Total Health Care
- University of Maryland, Baltimore
- University of Maryland Medical System
- University of Maryland School of Nursing
- University of Maryland School of Social Work
- Ultimate Homes Realty
- Upton Planning Committee, Inc.

Strategic Planning Committee

The committee comprised 24 members, spanning the Board of Directors, senior staff, non-management staff, clients and community partners. The committee met on four occasions over four weeks for a total of 20 hours.

Thomas Lansdale, MD, Chair, Board of Directors (Physician, Seasons Hospice and Palliative Care)
Dennis Pullin, FACHE, Committee Chair, 2nd Vice Chair, Board of Directors (President, MedStar Harbor Hospital & Senior Vice President of MedStar Health)
Kevin Lindamood, MSW, President and CEO

Sister Helen Amos, RSM, Executive Chair, Board of Trustees, Mercy Health Services
Jan Caughlan, MSW, LCSW-C, Vice President of Behavioral Health
Leonard Croft, Client Access Associate, Elected Staff Representative
Tonii Gedin, DNP, RN, Chief Quality Officer
Jeff Garrett, Community Advocate, Client
Wanda Gibson Best, Executive Director, Upton Planning Committee
Athena Haniotis, Community Advocate, Client
Keiren Havens, Chief Strategy Officer
Dan Hendricks, Lead Benefits Specialist, Elected Staff Representative
Nilesh Kalyanaraman, MD, FACP, Chief Health Officer
Chelsea King, Member, Board of Directors (Senior Manager, Product Innovation, Inovalon, Inc.)
Elena Marcuss, Esq., Secretary, Board of Directors (Partner, McGuireWoods, LLP)
Maria Martins-Evora, MSW, Chief Administrative Officer
Cheryl Matricciani, CPA, Esq., 1st Vice Chair, Board of Directors (Vice President & General Counsel, Medical Mutual Liability Insurance Company of Maryland)
Dan McCarthy, Member, Board of Directors (Executive Director, Episcopal Housing Corporation)
Molly Rath, Vice President of Communications
Bilqis Rock, LCSW-C, SOAR Coordinator, Elected Staff Representative
Phill Sheldon, LCSW-C, Convalescent Care Coordinator, Elected Staff Representative
Adrienne Trustman, MD, Vice President of Medicine
George Watson, Treasurer, Board of Directors (Consultant, BW Partners LLC)
Thomas Welliver, Chief Financial Officer

Special appreciation to *Von Bradshaw*, Executive Assistant, for her logistical support of the committee.

Strategic Planning Consultant

Dr. Robert M. Sheehan, Jr. has more than 30 years of executive management experience, including 18 years as the CEO of two different national nonprofits. In addition to running Sheehan Nonprofit Consulting, Dr. Sheehan is the Academic Director of the Executive MBA program at the Robert H. Smith School of Business at the University of Maryland, College Park. He was the strategic planning consultant who facilitated our strategic planning process in 2012 and we were very glad to partner with him once again in 2017.

Our Mandate

Homelessness in America is unacceptable. This remains as true today as it was in 1985 when Health Care for the Homeless was founded. Since that time, deliberate public policy decisions continue to decrease access to affordable housing, widen the divide between rich and poor and weaken the social safety net—resulting in more families on the streets. The consequences are devastating and life-threatening for individuals, families and communities. *Our agency exists to close the gap between this shameful reality and a just society*.

As of 2016, at least 1.5 million Americans experienced homelessness and an additional 20 million were "housing burdened"—at risk of homelessness by paying more than 30% of their income for rent. Further cuts to federal safety net programs remain a real possibility over the next four years, pushing overwhelming funding responsibilities to overburdened states and cities. Congress is considering additional reductions to the federal Department of Housing and Urban Development, which would scale back an already insufficient supply of subsidized affordable housing. Following historic gains in access to health care for low-income people, both Medicaid and Medicare are under review by the current administration—threatening to reverse demonstrated progress of the past four years. Concurrent to this threat, the future of Maryland's unique "all payer" hospital waiver—a critical component of our regional health care system – faces an uncertain future.

Emboldened by collective experience of the past 32 years, we embrace the urgency of our founders, even as current social and political realities threaten to undermine our progress. Rooted in the struggles and successes of the people we serve, we have learned much about homelessness and how to end it. Over the next four years, we will boldly champion the strategies we know to be effective in improving health and ending homelessness.

Our Definition of Health Care

From the beginning, Health Care for the Homeless has understood contemporary homelessness as a symptom of poverty, the lack of affordable housing and restricted access to health care. Cuts to the federal Department of Housing and Urban Development between 1979 and 1989 fueled a reemergence of homelessness not seen since the Great Depression. This surge gave rise to a patchwork of public and private emergency interventions such as emergency shelter, transitional housing and the Health Care for the Homeless program. The same people who needed housing also needed access to health insurance and specialty care. The result? If people experienced homelessness, chances were great they also were sick.

Life on the street is brutal. People experiencing homelessness are three to four times more likely to die prematurely and twice as likely to have a heart attack or stroke than people who have housing. The lack of shelter, food, income, hygiene and health care makes it nearly impossible to be healthy. Their life expectancy is just 48 years. This population's circumstances required going far "above and beyond" traditional models of care. In fact, it required *redefining* health care.

Whole-Person, Team-Based Care

Over the past three decades, we have developed a multidisciplinary model of health care with the ultimate goal of ending our clients' homelessness. Delivering this demanding degree of care requires providers from across medical, dental and behavioral health professions. They must collaborate closely with one another in order to best serve clients living in very traumatic circumstances.

In 2016, we introduced multidisciplinary, integrated *care teams*—teams whose members focus their collective attention on their clients' progress toward key outcomes. Each team shares a panel of clients, collaborating to develop goals and a care plan with each client. We modeled our care teams after *patient centered medical homes*, an evidence-based practice that is taking hold across the health care industry. Together, medical and behavioral health staff track and monitor high-risk conditions among our clients, and institute care practices known to reduce the risk and manage the care of chronic illnesses. Now, with more locations, disciplines, clients and staff than ever before, we rely heavily on data and metrics to refine our practices. While we have basic roadmaps from the health care industry, we are charting our own path—and testing and refining it along the way, tailoring it to meet the specific needs of our client population. We are committed to sharing our practices and our data, as well as our successes and our failures, in order to improve the health care delivery systems for vulnerable populations across the country.

Housing is Health Care

From our earliest days, we argued that individuals had to be housed in order to get healthy. Meanwhile, public policy dictated that people with significant medical and behavioral health problems were not "housing ready." As a result, many sick individuals stayed on the streets and suffered significant health consequences. Frustrated by this reality, we worked with our clients individually to apply for governmental disability assistance to secure modest room rentals. Our newly housed clients' improved health and stability supported our assertion: *Housing is health care*.

In recent years, "housing first" has gained traction. Housing first proponents posited that people should be placed in housing right away—without the precondition of treatment—and given intensive supportive services to remain stably housed. Health research from across the country backed up this approach, while also revealing significant reductions in emergency room usage, hospitalization and public safety costs.

We at Health Care for the Homeless made our own forceful case for housing first in 2005, as part of a partnership with Baltimore City to place 30 people living in a downtown park in scattered-site private apartments and providing intensive social services. When all the participants remained housed a year later, the federal Substance Abuse and Mental Health Services Administration and Baltimore City funded the expansion of the model. Since then, we have helped more individuals and families get housed and stay housed—100 people alone in 2016.

The Power of Housing + Health Care

Health Care for the Homeless has created a powerful and unique combination of whole-person, team-based care with supportive housing services. Case managers and outreach workers refer clients for housing through the Baltimore City Coordinated Access System. Benefits specialists help clients secure income to defray housing costs. Teams of clinicians and peer advocates help clients locate and move into housing, coordinate medications, provide transportation to appointments and grocery shopping, assist with paying bills and manage relationships with landlords. Development team members raise funds for move-in kits for newly housed clients. All 240+ staff members advocate for policies that increase access to affordable housing.

But the fundamental problem remains: *There isn't enough affordable housing.*

The Time is Now

Urgency, coupled with the passion and commitment of our community, spurred the strategic planning committee to create aggressive, "near-impossible" goals to address the gap between the way things are *now* and the way things *should be*. Everyone deserves to have a home, and so we commit the next four years to developing housing and supportive services to get—and keep our clients housed.

Across the community, the call for Health Care for the Homeless to create affordable housing stock is loud and pervasive. We hear it from our elected officials, our fellow advocates and, most importantly, from our fellow community members. This commitment to housing development brings us full-circle: Disinvestment in affordable housing created contemporary homelessness. Only reinvestment in housing and comprehensive supportive services can end it. The mandate is clear: The time is now.

"Homelessness makes you sick. Being very sick can make you homeless. If you are sick, homelessness can make you sicker."

—Kevin Lindamood
President & CEO

2018–2021 Goals

Our mission to prevent and end homelessness compels us to think boldly and creatively. Our community demands that we act with urgency because the current reality is unacceptable. Our goals are aspirational by design and we embrace them fully, knowing that we may fall short. Our commitment to our core values allows for nothing less.

1. 100% of the people we serve will have timely access to quality, whole-person health care and affordable housing.

We envision a community where:

- *1.1. Clients get the care and housing they need, when they need it*
- *1.2. We continually strive to improve the services and care we deliver*
- *1.3. Staff members are prepared and supported to do their very best work*

2. We will design and implement sustainable business models for affordable housing development and supportive housing.

We envision a community where:

- *2.1. We, through public and private partnerships, create new affordable housing units*
- *2.2. There is broad commitment and support for affordable housing*
- *2.3. Clients have homes and the support they need to participate in their communities*

3. As a result of our care, the health outcomes of our clients will rival the health outcomes of a stable population.

We envision a community where:

- *3.1. We improve the health of all clients, despite their health and housing instability*
- *3.2. Our model of care is proven to work for highly vulnerable populations*
- *3.3. Clients can manage their own care to the best of their ability*

Top Five Strengths, Weaknesses, Opportunities and Threats

By identifying our strengths, weaknesses, opportunities and threats (SWOTs), the strategic planning committee began to understand how to move the agency forward. As our strategic planning consultant Rob Sheehan advised, we would use SWOTs to create themes that would leverage our strengths, fortify our weaknesses, seize opportunities and block threats.

Strengths

S1. Passionate, driven **staff** who care deeply about the people they serve, their community and social justice
S2. A diverse and mission-driven **community** that spans individuals, grassroots organizations, fellow service providers, funders and corporations
S3. The agency's **reputation** in the community as a quality provider and advocacy partner with clients
S4. **Financial stability** that has been achieved over the past five years, as exemplified by a strong cash position, a newly-launched endowment and an investment portfolio
S5. A portfolio of health care services that includes and integrates **supportive housing**

Weaknesses

W1. Management has **insufficient change management** in place, so staff are not adequately prepared, equipped or supported to drive agency success and outcomes
W2. **Lack of a shared definition of our client population** across all teams, which limits client access, makes access inconsistent and leads to confusion among both staff and clients
W3. **Underdeveloped infrastructure and communications** appropriate for a business of our size and complexity leaves staff feeling unsupported and unclear about policies, procedures and practices
W4. **Limited staff resources and capacity** to lead ambitious initiatives, support research or participate in advocacy efforts
W5. **No staff knowledge or expertise** in housing development and property management

Opportunities

O1. Across the health care industry, there is **broad interest in population health management**, particularly for individuals with complex, chronic conditions or diseases
O2. Since our inception, we have relied on **partnerships** and have a strong network to build upon
O3. Because of the agency's reputation and mission, we are **well-positioned to lead**
O4. **Research opportunities** abound in the Baltimore area, due to the number of universities and research institutions
O5. Our **current locations are growing and expanding** to meet client demand for our services

Threats

T1. **Financing for our work** is highly dependent upon governmental funding sources
T2. The **political landscape** is bleak, with a lack of support for basic social services or housing
T3. Baltimore suffers from **competing local priorities** that are important and pressing as the federal government threatens to withdraw support for cities and states, and in turn, tighten their belts
T4. **Misconceptions about the population we serve** are surging—harmful stereotypes threaten people who deserve resources and support to be healthy and stable members of society
T5. **Organizational burnout** threatens staff in health care and in the non-profit world, where work is psychologically demanding and work-life balance can be hard to maintain

2018–2021 Themes

Themes are the descriptions of how we will achieve our goals. They will guide our annual operational plans and the measures through which we will hold ourselves accountable.

1. Build a strong agency infrastructure to recruit, retain, support and communicate with staff

We will hold ourselves accountable for:

- *1.1 Establishing and sharing annual objectives that guide agency activities*
- *1.2 Clarifying and communicating decision-making processes and decisions*
- *1.3 Ensuring that staff receive the support they need to adapt, grow and lead successfully*
- *1.4 Creating a robust training and development program*
- *1.5 Designing staffing patterns and metrics that support both client health and staff wellness*

2. Strengthen client participation and promote client leadership to keep us true to our shared mission and values

We will hold ourselves accountable for:

- *2.1 Adhering to a shared definition of our client population across all teams*
- *2.2 Improving the self-management ability of clients*
- *2.3 Systematically incorporating client perspective into work and decision-making, especially around quality improvement and population health*
- *2.4 Increasing opportunities for client participation, client leadership, self-advocacy and feedback*
- *2.5 Standardizing client transitions—from one provider to another, either within our practice or to a provider in the broader community*

3. Launch ambitious advocacy and capital campaigns to secure the resources and support we need to achieve our goals

We will hold ourselves accountable for:

- *3.1 Creating a bold vision that will inspire the community to act on behalf of our mission and clients*
- *3.2 Growing the number of donors, the size of their gifts and the total amount of funding from the community*
- *3.3 Crafting an influential leadership role in advocacy and policy to support clients' access to housing*
- *3.4 Strengthening our network of advocates, policy experts, decision makers and supporters in the geographical areas we serve*
- *3.5 Expanding an advocacy program that leverages the strengths of staff, clients, board members, donors and community partners*

4. Develop the data, systems and practices to monitor, report and improve our outcomes

We will hold ourselves accountable for:

- *4.1 Setting challenging performance goals and sharing progress and results with our community*
- *4.2 Equipping and training staff to capture and use data to inform delivery of optimal care*
- *4.3 Caring for clients in ways that prevent disease and prioritizing those with chronic conditions*
- *4.4 Ensuring that we meet standards for safe and effective care*
- *4.5 Constantly adjusting our practices to do better, particularly by incorporating evidence-based practices*

5. Create new partnerships to generate innovation, research and publication in health care and housing

We will hold ourselves accountable for:

- *5.1 Investing in our capacity to identify trends in our data and population*
- *5.2 Increasing agency knowledge and capacity to support housing development*
- *5.3 Establishing new partnerships that result in expanded housing for clients*
- *5.4 Collaborating with experienced partners to conduct research that supports our goals*
- *5.5 Sharing information that has the potential to improve care or access to housing for vulnerable populations*

"Health Care for the Homeless is the most caring spot in the city for people struggling with housing instability. A place where such people are treated with dignity and where they can access essential wrap-around support and quality health care without judgement."

—Jennifer Pelton, Public Justice Center

Appendix I: Key Steps and Timeline

Community input came in the form of surveys, group discussions and one-on-one meetings—from an estimated 450 people. The strategic planning committee drew on this input to (a) create goals; (b) identify agency strengths, weaknesses, threats and opportunities; and (c) delineate themes.

Timeline: January–May

Jan. 24	Management team meeting: Introduction to strategic planning Board of Directors meeting: Introduction to strategic planning
Jan. 27	Senior leadership team (Executive Team and vice presidents) meeting with Rob Sheehan
Feb. 15	Launch of online community survey
Mar. 1	Staff election of four staff representatives to the strategic planning committee Launch of staff survey Strategy team leaders begin to hold one-on-one meetings with community leaders
Mar. 9	All-staff meeting: Breakout group discussions on lowest-scoring core values from staff survey (led by elected staff representatives)
Mar. 10	Consumer Relations Committee discussion Launch of client survey
Mar. 15	Women's Group and Men's Group: Client-led discussions
Mar. 16	Convalescent Care Program residents' meeting: Client-led discussion
Mar. 17	Baltimore County advocacy meeting: Client-led discussion Senior leadership team: Introduction to "Mission Metrics"
Mar. 21	B'More Housing for All, Diabetes Group, Spanish Group: Client-led discussions
Mar. 30	All-staff in-service: "Dream big: What is your vision for our community? How should the agency make that vision a reality?" (led by elected staff representatives)
Apr. 3	First strategic planning committee meeting
Apr. 4	Community meal and conversation: Agency's role in housing Management team meeting: Presentation of surveys and results
Apr. 17	Second strategic planning committee meeting
Apr. 19	Staff lunch-time discussions on draft goals with elected staff representatives (Fallsway clinic)
Apr. 20	Staff Lunch-time discussions on draft goals with elected staff representatives (West Baltimore clinic)
Apr. 24	Staff Lunch-time discussions on draft goals with elected staff representatives (201 E. Baltimore St. location)
Apr. 25	Board of Directors meeting: Discussion of draft goals with Rob Sheehan Management team meeting: Discussion of draft goals Email to community members eliciting feedback on draft goals
Apr. 26	Staff discussions on draft goals with elected staff representatives (Convalescent Care Program)
Apr. 27	Third strategic planning committee meeting
May 4	Final strategic planning committee meeting
May 23	Board of Directors meeting and approval

Appendix II: Staff Perspectives: Living Our Core Values

An early step in the 2017 strategic planning process was the administration of an online, anonymous staff survey. The survey contained a set of questions designed to assess how we are living our shared six core values. We used a scale of 1–10, with 10 being the highest score.

Our average score across all six core values was 7.4. Staff felt that the agency scored the highest (8) for the value of Hope: Finding and focusing on people's strengths. Coming in last, with a score of 6.5, was the value of Authenticity: Practicing open and honest communication. (See graph of core value scores in Appendix IV.)

Based on the initial responses to those questions, agency leadership dedicated the March all-staff meeting to discussions on the lowest-scoring values; authenticity and balance. Led by the four elected staff representatives serving on the strategic planning committee, the discussions sought staff input on how the agency could more fully live out its core values in its practices.

In the core values discussions, 10 themes began to emerge, along with recommendations for how to address them. Further, these recommendations repeated in other staff forums held during the strategic planning process (see next page.) The staff-identified themes reflect the structural and cultural growing pains of an agency that has doubled in size over the past five years, while also introducing innovative changes to our integrated care delivery system.

It has been a busy five years, filled with concerted investment in improving client access, staff compensation and our technology infrastructure. We have dramatically expanded our sites and services across the region. We have added new expertise and leadership. We have evolved from offering co-located health care services to a new model of integrated, whole-person care. As a result, staff identify that our business systems require greater attention and investment, as do our practices across teams and disciplines. These staff recommendations heavily influenced the agency's strategic plan.

"We have grown so much in the past five years, our infrastructure and systems need to also grow with us. Our advocacy work has a lot of room for growth and improvement. Data is [sic] something we have recently begun to collect, I look forward to us honing this skill and using it more and more."

—staff member

Staff Top 10 Recommendations

1. Create and uniformly implement policies, procedures and practices—expectations and standards across all sites and all teams should be clearly articulated and understood by staff and management alike

2. Develop and provide a training-rich environment—in care delivery, performance improvement, procedures, use of the electronic health record system, supervision, management, etc.

3. Improve communications at every juncture in the agency—between management and non-management staff, teams, supervisors and supervisees, as well as between clients and staff

4. Make transparent decision-making processes around agency practices and delineate non-management staff roles in those processes

5. Do more to support and encourage self-care for staff

6. Build a stronger advocacy program that engages clients and staff

7. Clarify and apply a consistent definition of who is eligible for our care—the definitions are currently applied differently according to discipline and individual staff member and impacts client relations, staff relations and access to care

8. Establish shared, realistic expectations of clients

9. Define the client transition processes—how a client moves from one provider to another, either within our practice or to a provider in the broader community

10. Set standardized panel sizes and staffing ratios to guide hiring needs

"Health Care for the Homeless believes that homelessness in our community can be addressed and overcome through holistic, accessible and quality healthcare; living wage incomes; and affordable housing. It is my belief they not only provide direct services to the homeless community, they work to partner with other agencies in a collaborative effort to achieve their goals."

—Jennifer Fischetti, Legislative Aide, Maryland General Assembly

Appendix III: Feedback from Community Conversation

We held a public forum on April 4, where a broad cross section of our community came together to brainstorm what greater involvement in the creation of affordable housing might look like for Health Care for the Homeless. This discussion, in turn, informed the goals and themes presented in this strategic plan.

Six groups, each led by staff and client co-facilitators, spent an hour tackling the following question: *What should Health Care for the Homeless do to increase/improve access to housing?* Below is a rollup of the ideas generated across those six discussions, grouped by theme.

1. Agency Role: Leader in The Community

- Generate and support innovative solutions to transform Baltimore's landscape
- Think **bigger!** It is not a matter of doubling or tripling…We need 100x!
- Address systemic racism
- Change dialogue from *reactionary* to *proactive*
- Mobilize our community better
- Work locally to redefine affordable housing
- Challenge stereotypes/offer data about why housing is so important
- Make sure that the community knows Health Care for the Homeless exists; generate broad community ownership
- Build a stronger sense of community so people build the kind of support systems that help them get housed
- Transform landscape of city: help to create affordable, livable neighborhoods
- Make a business case for supportive housing
- Invest in what it takes to get and keep people housed

2. Agency Strategy and Approach

- Make time for staff to participate in advocacy work
- Focus on prevention of homelessness
- Raise more private money
- Fundraise specifically for physical property purchase
- Find those who are hardest to house and find a way to house them permanently

3. Government and Policy

- Bring voice to policy change and housing funding/resources (federal, local and state)
- Fix exclusionary zoning laws
- Increase access to housing subsidies
- Increase access to employment and job skill training
- Make recommendations to city about homeless services system—impossibility of reaching HUD goals
- Change rental subsidies: *Gradual* steps of subsidy decrease with income increase
- Harm reduction in housing: You have to prove chronic homelessness. Expand eligibility to help more people. Those under 62 need better access.
- Encourage sweat equity programs
- Bring more money into Baltimore City
- Research state-funded projects in other states
- Help Baltimore develop an affordable housing strategy
- Use other cities as inspiration for affordable communities
- Get involved in Affordable Housing Trust Fund

4. Community Education

- Increase education to community (especially landlords) about process
- Expand supportive housing education
- Be a part of conversations re: neighborhood disinvestment; prevent Port Covington and the like
- Housing isn't a commodity, it's a human right. That's the message to get out.

5. Client Leadership

- Ensure that people who have experienced homelessness are at the forefront of change
- Demand space at the table for ***ALL*** voices
- Support solutions that bring perspective of lived experience
- Assisting clients in becoming their own advocates.
- Help clients find their voices (support groups, advocacy trainings, help with housing searches, etc.)

6. Supportive Services

- Help clients *maintain* vouchers
- Help with BGE (educate clients and providers)
- Keep a list of clients who are open to sharing housing; facilitate clients meeting each other
- Offer mentoring programs
- Provide behavioral health programs along with employment opportunities
- Job training and help with job searches; provide jobs through government-funded programs or through partner projects; closer partnership with Our Daily Bread
- Provide/improve transportation
- Provide greater access to health care
- Be there when people get out of rent court
- Provide and increase social services support to housed people
- Expand "intermediate" services, such as the Convalescent Care Program
- Connect with those being released from prison to provide services for health and housing
- Start thinking about how we house a client from Day 1

7. Collaborations

- Partner with…
  - Communities around development
  - Developers that hire locally
  - Faith-based communities
  - Landlords (not slumlords)
  - Hospitals, especially the ER
  - Construction and development companies
- Talk to land trusts that already exist
- "Turn around Tuesday"
- Build affordable housing coalitions
- More public/private partnerships
- Intentional and strategic partnerships
- Leverage relationships to improve housing stock
- Attract local developers to participate in the Vacant to Values Program
- Connect w/real estate investment clubs and meet up
- Align w/key advocates (e.g., Mayor's Office, HABC, Downtown Partnership, Low-Income Neighbor Community Association)

8. Property Manager/Landlord Relations

- Transparency with landlords about our process with supportive housing
- Areas of concern for landlord: inconsistency with case managers, lack of substance use disorder and mental health support for tenants; newly clean tenants could relapse and affect other tenants; not knowing who to talk to at Health Care for the Homeless; inspections—rigorous details and cause delays to use certain vouchers
- Ensure tenants have consistent case managers/support (responsive and fair)
- Smooth transitions to ensure communications from client to landlord
- Utilize current landlords/property managers as resources to find vacant properties
- Encourage landlords to accept Section 8 vouchers—offer incentives

9. Housing Creation

- Take stock of available housing
- Acquire vacant houses and turn them into affordable housing
- Use Craigslist as a tool to access landlords and properties
- Own units—serve those with behavioral health needs—use assisted living model
- Utilize space for tiny homes—e.g., storage spaces; metal truck containers
- Fast track housing
- Design an "outreach shelter"—stay long enough to be connected to medical and behavioral services
- Create an "encampment hotel"

"[We] work to eradicate homelessness over time by focusing our efforts on the root causes in the cycle. The organization's efforts do not end with high quality health care services; rather, they work with members to find affordable housing, as well as steady income."

—Arin Foreman
KPMG Board Finance & Facilities Committee member

Appendix IV: Summary of Survey Results

A roll-up of the questions and answers on the community-wide, staff and client surveys:

Questions for everyone

- What work should we prioritize ("more and better")?
- Where are we needed most (geographically)?

Questions for non-staff, non-clients—*only*

- Mission and purpose of the agency in your own words

Questions for staff and clients—*only*

- How well are we living our core values?

Questions for staff—*only*

- On what activities should the agency focus?
- What are our strengths and weaknesses?

› ***"Rank in order of importance for the next four years. Our community needs more and better…"***

- Access to medical care
- Access to behavioral health care
- Access to dental care
- Access to employment, income and benefits
- Policies to support access to health care
- Policies to support access to affordable housing
- Policies to support access to employment, income and benefits

Top Three Responses

1. Access to affordable housing
2. Access to medical care
3. Access to behavioral health care

› ***"Which areas in the greater Baltimore area need our services and activities most in the next four years? Please choose three, in order of greatest need."***

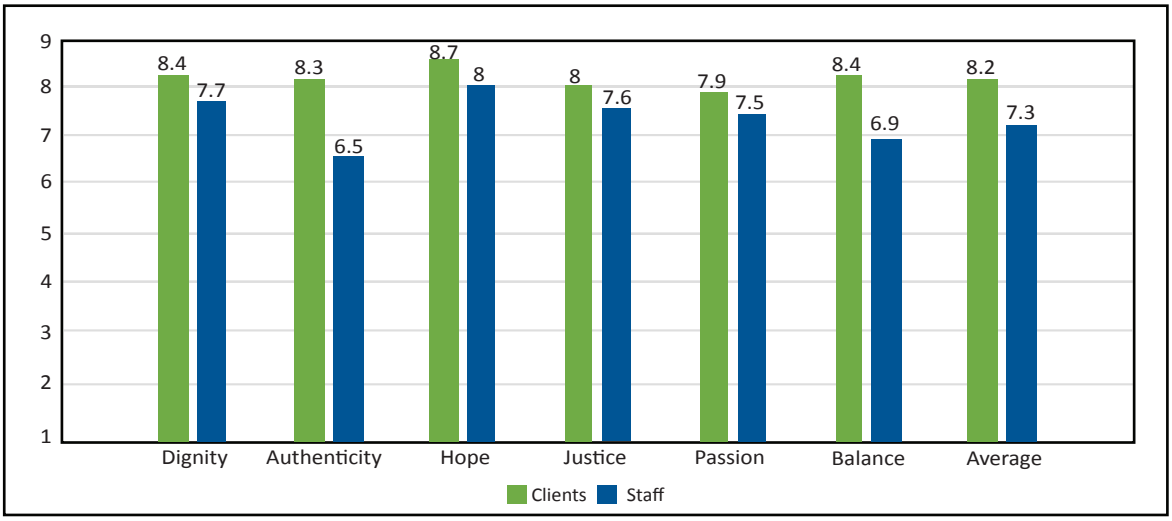
- South Baltimore
- Southeast Baltimore
- Southwest Baltimore
- North Baltimore
- Northeast Baltimore
- Northwest Baltimore
- Downtown
- West Baltimore
- East Baltimore
- Baltimore County
- Harford County

Top Three Responses

Clients	*Everyone Else*
1. Downtown	1. West Baltimore
2. East Baltimore	2. East Baltimore
3. Baltimore County	3. South Baltimore

› *How are we doing on living out our core values? (Staff and clients)*

Responses



› *Where should the agency focus? (Staff)*

- Holding steady and maintaining our current state
- Growing current services
- Adding new services*
- Developing community and hospital partnerships
- Adding new sites/service locations
- Growing our advocacy and policy work

Top Three Responses

1. Develop community and hospital partnerships
2. Grow current services
3. Grow advocacy and policy work

**Lowest scoring: Adding new sites/service locations*

› ***What do you believe are the agency's greatest strengths? Mark your top three choices: (Staff)***

- Our infrastructure and systems
- Access to our services
- Quality of our services
- Our reputation in the community
- Commitment and quality of staff
- Commitment and quality of management
- Quality of our advocacy work
- Our ability to demonstrate that our services are making people healthier and getting people housed

Top Three Responses

1. Quality of our services
2. Our Reputation in the community
3. Commitment and quality of staff

› ***What do you believe are the agency's greatest weaknesses? Mark your top three choices: (Staff)***

- Our infrastructure and systems
- Access to our services
- Quality of our services
- Our reputation in the community
- Commitment and quality of staff
- Commitment and quality of management
- Quality of our advocacy work
- Our ability to demonstrate that our services are making people healthier and getting people housed

Top Three Responses

1. Our infrastructure and systems
2. Access to our services
3. Commitment and quality of management

"Over the next 4 years, I hope...that we will continue to seek out innovative opportunities to reduce the incidence and prevalence of homelessness by having strong advocacy… and policies and creating key partnerships in the community stakeholders to address the legacy of housing discrimination in Baltimore City. In terms of innovation, I'd like to see [us] consider whether we are well positioned to provide housing as one of our services."

—staff member

Samples of Feedback from the Anonymous Staff Survey

"Our access is unmatched in my experience and we have great advocacy work."

"I came to work here based on the positive reputation that the agency keeps in the health community."

"I regularly hear from our clients that they really appreciate the care they get, and how our providers are top notch. Our management has also consistently made decisions that keeps a healthy balance between providing excellent services, supporting staff, and getting input from clients and staff."

"Our systems are sometimes confusing, unclear and inconsistent. Our procedures change constantly, and communication is always challenging. I think our advocacy falls short mostly because it's not easy to affect change for our clients. But I also think it's a matter of organization and communication. And as far as management – it's not about commitment or quality - but just about transparency and communication. I don't always feel like I'm kept in the loop and I wish things were clearer overall."

"We have greatly improved access to our services over the past several years; however, clients continue to have trouble getting in to see their providers and contacting their providers when they need to. Second, we have a limited ability to demonstrate the efficacy of our services and advocacy work, as we seem to focus our energy on providing those services and doing that advocacy work (which by itself is not a negative, it just merits consideration)…."

"I think that many decisions…do not make sense for frontline workers because they are not asked. Many systems have been changed recently to make things 'better' but have in turn made things more difficult because the process was not understood. I think the management can be more transparent in their intentions and ask what needs to be fixed before imposing unnecessary or seemingly unnecessary solutions. I do, however feel that staff is treated well and our opinions matter to some extent."

"[We need to] improve infrastructure and operations, including meeting industry best practices where benchmarking is possible, before more growth. We will not be able to sustain growth without this improvement."

“With this plan, we are committed to not letting challenges become obstacles and we will not rest until everyone has a place to call home.”

—Bilqis Rock
Staff representative, strategic planning committee

Everyone deserves to go home.

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