CHIME

Child Homelessness Intercept Mapping & Engagement

Health & Well-Being Report

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Executive Summary

Child Homelessness Intercept Mapping and Engagement (CHIME) began when a consortium of Boston community leaders came together to draw attention to the needs of accompanied children experiencing homelessness (i.e., children 0-18 experiencing homelessness with a parent or legal guardian). CHIME, funded by Dana-Farber Cancer Institute, is an interactive community strategy highlighting cross-system collaboration among state and municipal executive offices and departments, community leaders, front line staff, and people with lived experience to improve services for accompanied children experiencing homelessness. The Health & Well-Being Gear Executive Summary represents the fourth of six planned CHIME mappings.

Critical Gaps.

- Children (0-6) who are experiencing homelessness do not have a direct path to early childhood services despite increased risk factors. The screening and eligibility processes have no centralized hub to screen and refer children to early childhood programs.

- Many children experiencing homelessness after age 7 did not have ready access to emotional support or mental health services that address or prioritize their needs. Participants noted that even shelters with their own on-site therapists do not see children, just the parents.

- There is no centralized repository of existing programs to support physical health and mental health of children, which impairs the ability of both staff that work at agencies and organizations, including schools, shelters, hospitals and caregivers to find resources and receive a warm handoff.

- The lack of integrated and coordinated systems that facilitate data sharing results in families sharing the same information repeatedly contributing to child and family re-traumatization as well as challenges accessing services and receiving a warm hand-off.

- Accessing the health care system in a timely manner can be difficult. Specifically, access to pediatric developmental and behavioral health services is challenging with long wait times for appointments. The health care system can be challenging to navigate especially for parents experiencing homelessness who have multiple competing demands (i.e., housing, employment, and basic needs). There is variability in the capacity of pediatric

primary care practices to play the role of medical home and facilitate care coordination. There are few programs to help families navigate and access services for the physical and mental health of their children.

Opportunities.

- There are many existing resources available to Massachusetts and Boston families but are not specific to children and parents experiencing homelessness who may face additional barriers and challenges. A digital repository of resources with an embedded eligibility determination function would support homeless families and professionals in finding, accessing, and coordinating available services. Existing resource-focused databases could be leveraged to develop the platform (e.g., Mass 211, FindHelp).

- There may be resources (e.g., MA Family TIES) to help serve as a bridge for children aged 0-3 to 3-5 for service transition if families and providers reach out, given the lack of awareness of early childhood services outside of early intervention for young children with developmental challenges.

- 50 individuals attended the CHIME Health & Well-Being mapping in Boston and there was clear dedication and motivation to improving health & well-being supports for children experiencing homelessness. Some attendees shared it was their first time focusing specifically and intentionally on children in families experiencing housing instability or homelessness and they aimed to do so moving forward.

Priorities for Change. Based on the gaps and opportunities identified, participants determined and began Action Planning the following three Priorities for Change:

1. Develop a Boston-specific, regularly updated comprehensive online resource repository including a decision-tree.
    a. Develop an electronic information sharing and referral system.
    b. Develop an individualized family plan that integrates information sharing across agencies.
2. Create a high-quality, well-trained and supported workforce.
3. Ensure every child experiencing homelessness has a peer navigator.

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INTRODUCTION

In 2021, a consortium of Boston community leaders came together to draw attention to the needs of accompanied children experiencing homelessness (i.e., children 0-18 experiencing homelessness with a parent or legal guardian). With funding from the Dana-Farber Cancer Institute and championed by Massachusetts First Lady Lauren Baker, the Child Homelessness Intercept Mapping and Engagement (CHIME) project kicked off in June 2022 at Boston College with more than 80 state, city, academic, and community leaders. From the launch of CHIME through the September 2023 Health & Well-Being mapping, more than 220 unique individuals had attended the kickoff and/or one or more CHIME mappings.

The purpose of this report is to provide a summary of the fourth of six CHIME Mappings held in Boston, MA, at City Year Greater Boston Building on September 26th and 27th, 2023. Championed by Mary McGeown, Undersecretary for Human Services, the convening is part of an innovative exploration to develop collaborative systems of support for children 0-18 experiencing homelessness with a parent or legal guardian. Fifty key state, municipal, and community leaders as well as 3 caregivers and 2 children who experienced homelessness participated in the convening. This report (and accompanying electronic file) includes:

- A brief review of the origins and background for the mapping;
- A summary of the information gathered at the mapping;
- A map as developed by the group;
- A description of resources;
- Identified gaps and opportunities;
- Priorities and action planning matrices as developed by the group; and
- Observations, comments, and recommendations to help Boston achieve its goals.

Background

CHIME was developed by Kathleen Kemp, Ph.D. and Patricia A. Griffin, Ph.D. It is a systems level intervention and Policy, Systems, and Environmental (PSE) Change approach designed to improve access to services and positive experiences for accompanied children experiencing homelessness. PSE Change approaches aim to sustain long-lasting, equitable changes within communities to provide all residents with opportunities for improved health and safety. CHIME provides an organizational framework to identify and address the critical issues impacting accompanied children experiencing homelessness through a PSE Change lens.

CHIME leverages the experience and research behind two evidence-informed practices: the Sequential Intercept Model (Munetz & Griffin, 2006)[1] mapping workshops and the Aspen Institute's Two-Generation (2Gen) framework (Aspen Institute, 2021)[2]. More than 20 years ago, Dr. Patty Griffin, as part of her work with the National Substance Abuse and Mental Health Services Administration's GAINS Center for Behavioral Health and Justice Transformation[3], developed the mapping workshops as a systems-level, interactive intervention to help community stakeholders identify service and policy gaps and opportunities to address the needs of their target population. Policy Research Associates, Inc. expanded, formalized, and widely disseminated the mapping workshops[4].

The Aspen Institute 2Gen approach focuses on the whole family to understand the multiple dimensions required to facilitate pathways to success.

The 2Gen framework structures child and family services and support into six gears: Economic Assets (including shelter and housing), Early Childhood Education, K-12 Education, Health & Well-Being, Social Capital, and Post-Secondary and Employment Pathways. Using this multi-dimensional framework, CHIME identifies practices, services, and policies in each 2Gen gear that affect accompanied children and their caregivers experiencing homelessness.

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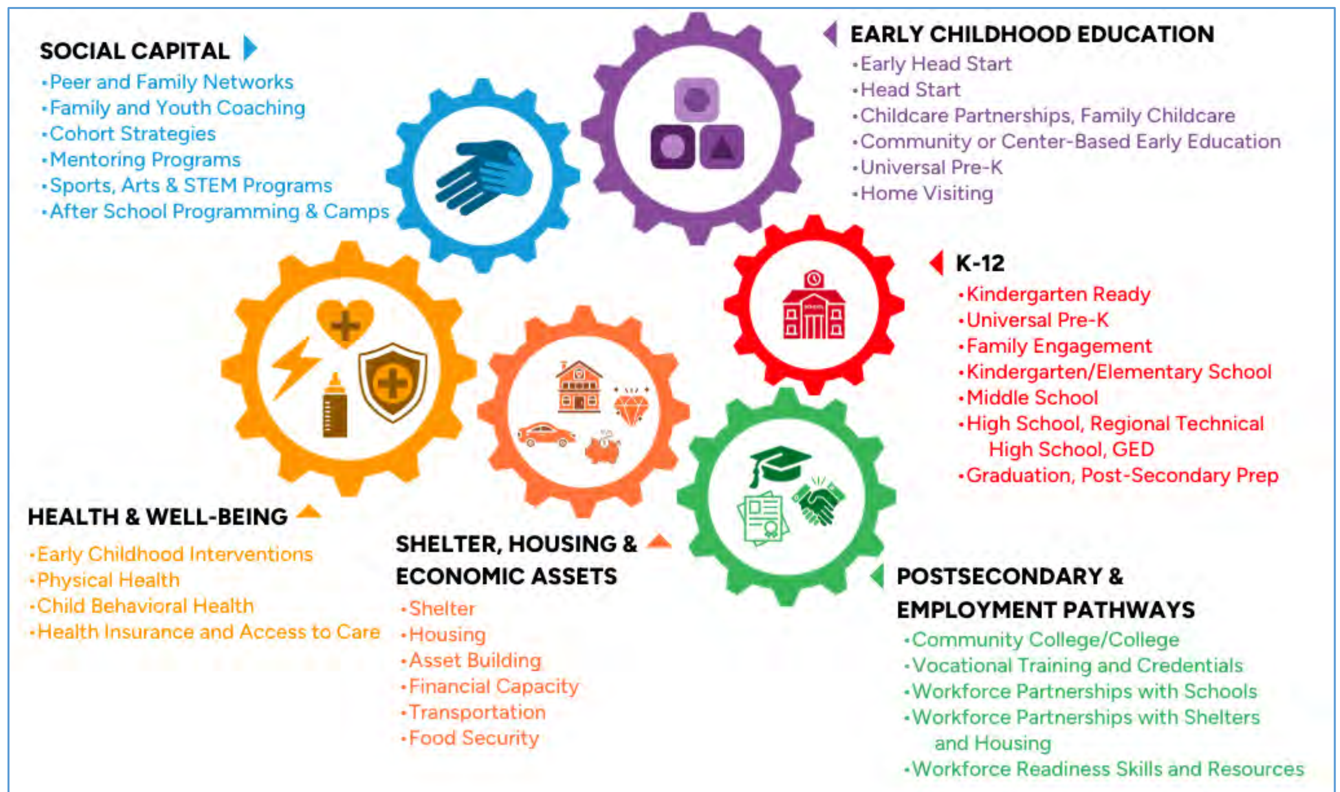
[1] The Sequential Intercept Model (SIM) is a framework and tool to facilitate cross-systems collaboration developed by Drs. Mark Munetz and Patty Griffin and implemented by Policy Research Associates, Inc.

[2] https://ascend-resources.aspeninstitute.org/resources/state-of-the-field-two-generation-approaches-to-family-well-being/

[3] https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

[4] https://www.prainc.com/wp-content/uploads/2017/08/FFS-SIM-508.pdf



CHIME is an organizing tool and interactive community strategy to assess current resources and plan for action-oriented problem solving and improving services for accompanied children experiencing homelessness. During the mapping process, facilitators, community leaders, front line staff, and people with lived experience collaborate to achieve three primary objectives:

1) Map the local systems serving accompanied children experiencing homelessness including resources, gaps, and opportunities.
2) Develop priorities based on community input and gain agreement from CHIME participants on the priorities to action plan.
3) Develop action plans to make measurable improvements on coordination of services for homeless children and families.

Why Focus on Accompanied Children Experiencing Homelessness?

At the time of the Health & Well-Being mapping in September 2023, 25% of children were living in poverty in Boston and an estimated 6,000 children were experiencing homelessness. The Federal McKinney-Vento Act[5] by the U.S. Department of Education defines homeless children as those who “lack a fixed, regular and adequate nighttime residence,” including those: sharing housing due to loss of housing or economic hardship (i.e., doubled up); living in motels, trailer parks or campgrounds; living in emergency or transitional shelters; abandoned in hospitals;

[5] https://nche.ed.gov/mckinney-vento-definition/

primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; living in cars, parks, public spaces, abandoned buildings, substandard housing, bus, or train stations; and migratory children who qualify as homeless because they are living in circumstances described above.

In fact, Boston ranks 4th in the country for the rate of family homelessness at the time and experienced a 46% increase in family homelessness between 2007 and 2022.[6] Yet, this staggering increase in family homelessness does not account for the high scope of current Bostonians recently falling into homelessness due to the growing cost of living and worsening housing affordability crisis nor the growing number of migrant, immigrant, refugee, and asylum-seeking (MIRA) families entering the state who are also experiencing homelessness. Between August 2022 and August 2023, Boston witnessed a 97% increase in the number of families in the shelter system, which led to a state of emergency declaration by the governor in August 2023. The state ultimately called for a temporary shelter expansion to accommodate the need, increasing available units from 3,500 to 7,500, and are in the process of removing temporary units as occupying families exit shelter.

Multiple systems are impacted by the increase in family homelessness. After Massachusetts changed its emergency shelter eligibility policy for homeless families in 2012 that included the addition of a new criterion to document homelessness - staying in a location "not meant for human habitation" - a Boston Children's Hospital study revealed 65% of kids who presented to the emergency department had no medical complaint but identified homelessness as the primary reason for presentation (Stewart et al., 2018). Homelessness is a preventable health-related social need that has a wide impact on children's physical, mental, social, and academic health and well-being. Children who experience homelessness are:

- Two times more likely to not get enough food to eat (Burt, 1999).
- More likely to experience each of the 11 ACEs with 68.1% reporting four or more ACEs compared to only 16.3% who reported no homelessness in childhood (Radcliff et al., 2019).

It is, therefore, not surprising that children who experience homelessness:

- Are four times more likely to have a developmental delay and two times more likely to have a learning disability (Burt, 1999).
- Endorse disproportionately higher rates of self-injury and are three times more likely to have attempted suicide than housed youth (Perlman et al., 2014).
- Are at risk for higher rates of hospitalizations and poor child health (Sandel et al., 2018).
- Experience a mortality rate more than ten times that of youth in the general population (Auerswald et al., 2016).

[6] https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

National data from the Youth Risk Behavior Survey (YRBS)[7] revealed that high school students experiencing homelessness regardless of living situation endorsed sexual assaults at twice the rate of their housed peers. Students experiencing homelessness were six times more likely to endorse being the victim of dating violence, more than four times more likely to report attempting suicide within the past 30 days and endorsed higher rates of misusing prescription medications compared to stably housed peers.

CHIME Goals

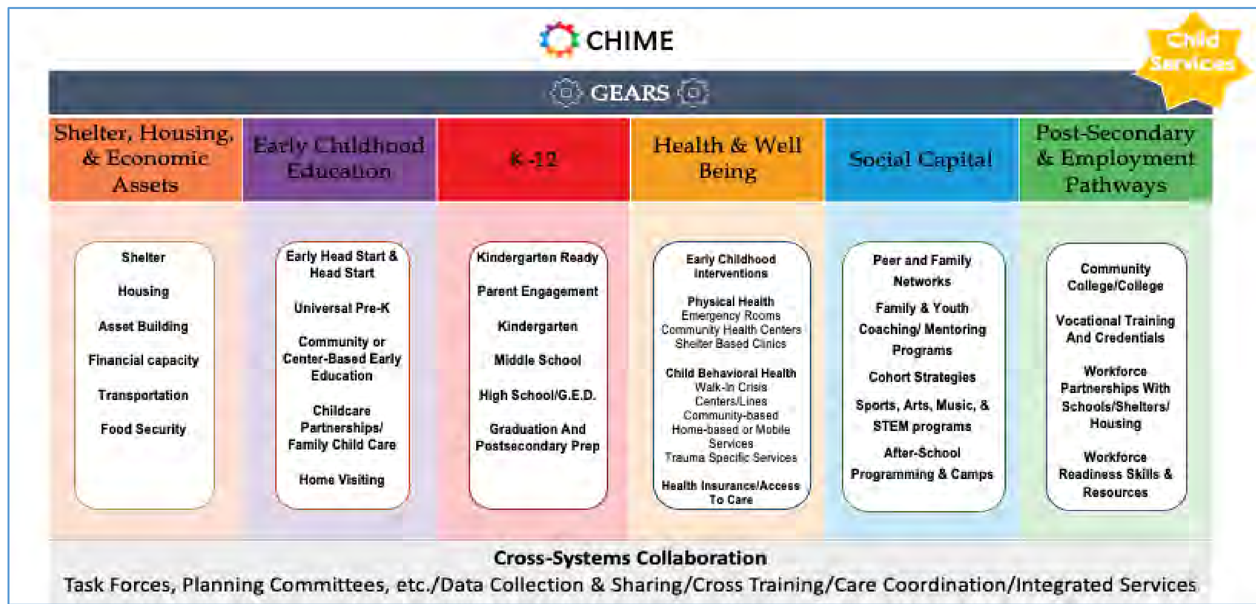
At each CHIME mapping, the facilitators, community leaders, front line staff, and caregivers with lived experience will identify current community-based services and positive experiences available for accompanied children experiencing homelessness, gaps in access to those services as well as the array of services available, and gather consensus on priorities the community identifies aimed at achieving **three overall goals**:

- Increase program capacity or prioritization of accompanied children experiencing homelessness
- Improve access and coordination of services
- Increase utilization of services

A key element of CHIME is the collaborative process. Meaningful cross-system collaboration is required to establish and coordinate effective and efficient services for accompanied children experiencing homelessness. This makes the composition of the group extremely important. While some workshops involve advertising to an entire provider community, it is essential in CHIME mappings that the organizers gather a group that represents key decision makers and varied levels of staff from the relevant provider systems along with families who are currently or have recently experienced homelessness.

In total, there will be six Boston CHIME mappings (one mapping for each 2Gen gear) and one summit that will encapsulate the work of all six gears.

[7] The 2017 YRBS survey administration had two optional questions about homelessness, with 17 states responding to those optional questions. In 2019, 27 states, not including Massachusetts, responded to the optional questions. The 2021 questionnaire, for the first time, included one standard question about homelessness.



The Aspen Institute's 2Gen gears and their actual or estimated CHIME mapping date:

- Shelter, Housing, & Economic Assets (September 15 & 16, 2022)
- Early Childhood Education (December 5 & 6, 2022)
- K-12 Education (March 30 & 31, 2023)
- Health & Well-Being (September 26 & 27, 2023)
- Social Capital (March 4 & 5, 2024)
- Post-Secondary & Employment Pathways (September 18 & 19, 2024)
- Cross-System Leadership Summit (projected Fall 2025)

The centerpiece of CHIME is the development of a systems map. As part of the mapping activity, the facilitators work with the CHIME participants to identify resources and gaps. This process is important since the landscape of services is ever changing, and the resources and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving outcomes for accompanied children experiencing homelessness by addressing the gaps and building on existing resources. The CHIME Health & Well-Being mapping led to the creation of two maps: one centered on services accessible by any accompanied child experiencing homelessness aged 0-18, and one for children aged 0-6 specifically given the number of resources exclusively available for young children. The first map – for children 0-18 – reflects the processes that all children including those aged 0-6 go through and the second map – for children 0-6 – specifically shows what is different from the larger age range. The maps reflect the understanding and experience of participants at the time of the mapping and may not be a complete picture of the entire landscape.

One critical component of CHIME is gaining consensus among participants about priorities for change and beginning to create action plans to move the priorities forward. As part of the

mapping activity, the facilitators work with the CHIME participants to identify and subsequently vote on potential priorities for change to start action planning. The final priorities receiving the most votes are then worked on by smaller groups of participants determined on a volunteer basis. Given the focus CHIME puts on cross-sector collaboration, action plans may build upon themselves at future mappings as more leaders are brought into the project. Subsequent reports will show the development of existing plans and the addition of new plans, leading to a selection of master action plans and final report to be shared at the Summit in 2025.

Health & Well Being

Identification	Screening	Planning and Accessing Care	Managing and Coordinating Care	Tracking Care

Health and Behavioral Health (0-18)

Identification

Emergency Departments
Self-identify as no where to go at discharge or presenting problem is "homeless"

Logan Airport
4 SWs

Referrals by:
Primary Care, Hospitals
Childcare Partnerships/FCCP
Early Childhood Education
Parent/Family referrals
Family Engagement Centers
Family Resource Centers
Department of Children and Families
Division of Child & Youth with Special Health Needs

Resource Lines
211; 311; Handholdma.org
Masshelpline.com/833-773-2445
Community Support Line (800) 882-1435

Crisis Teams
CBHI Mobile Crisis Intervention
Youth Mobile Crisis Intervention (North Suffolk & BMC)

Screening

@BCH additional q's on health-related social needs
-age 12+ HEADSS Assessment (ED)

@BMC meet with Social Work Team

MassHealth requires screening for **health-related social needs** includes housing in hospitals and primary care

For ages 13+ **Trauma Screening** in medical settings ask "did something scary happen in the past year?"

Planning and Accessing Care

Hospitals/Emergency Dep.
Boston Medical Center
Boston Children's Hospital

Primary Care
Boston Healthcare for the Homeless Family Care Clinic – (expanding primary care to children)*, BMC & BCH primary care, & private primary care

Accountable Care Organizations:
BMC, BCH
*some funding for families with housing instability or food insecurity

Community Behavioral Health Centers
North Suffolk Community Services
Boston Medical Center CBHC

Federally Qualified Health Centers (FQHCs)/ Integrated Care
Boston Health Care for the Homeless Program (3 sites serve children)*
Fenway CHC
South Cove CHC

Community Health Centers (CHC):
Bowdoin Street HC
Codman Square HC
Daniel Driscoll/Neponset HC
DotHouse Health
East Boston CHC
Harvard Street Neighborhood HC
South End CHC
South Boston CHC
Upham's Corner HC

Boston Public Schools Nursing & Clinics

Mental Health Outpatient
Boston Healthcare for the Homeless (7 MH clinicians, 85-90% adult clients)*

CBHI
Intensive Care Coordination
In-Home Therapy
Outpatient Therapy

Managing and Coordinating Care

BMC SW Teams

BCH SW Teams

Logan Airport
4 SWs from North Suffolk Community Services

Codman Squared
K1-12; co-located health & academic

Community Health Workers support CHCs

MassHealth
Standard Coverage
Limited-only Coverage

Family Resource Centers
Home for Little Wanderers

Tracking Care

EOHLC

WIC

DTA

Food/Clothing Resources

Metro Housing Boston Program*
Medically complexity & high cost/high need = flex services program

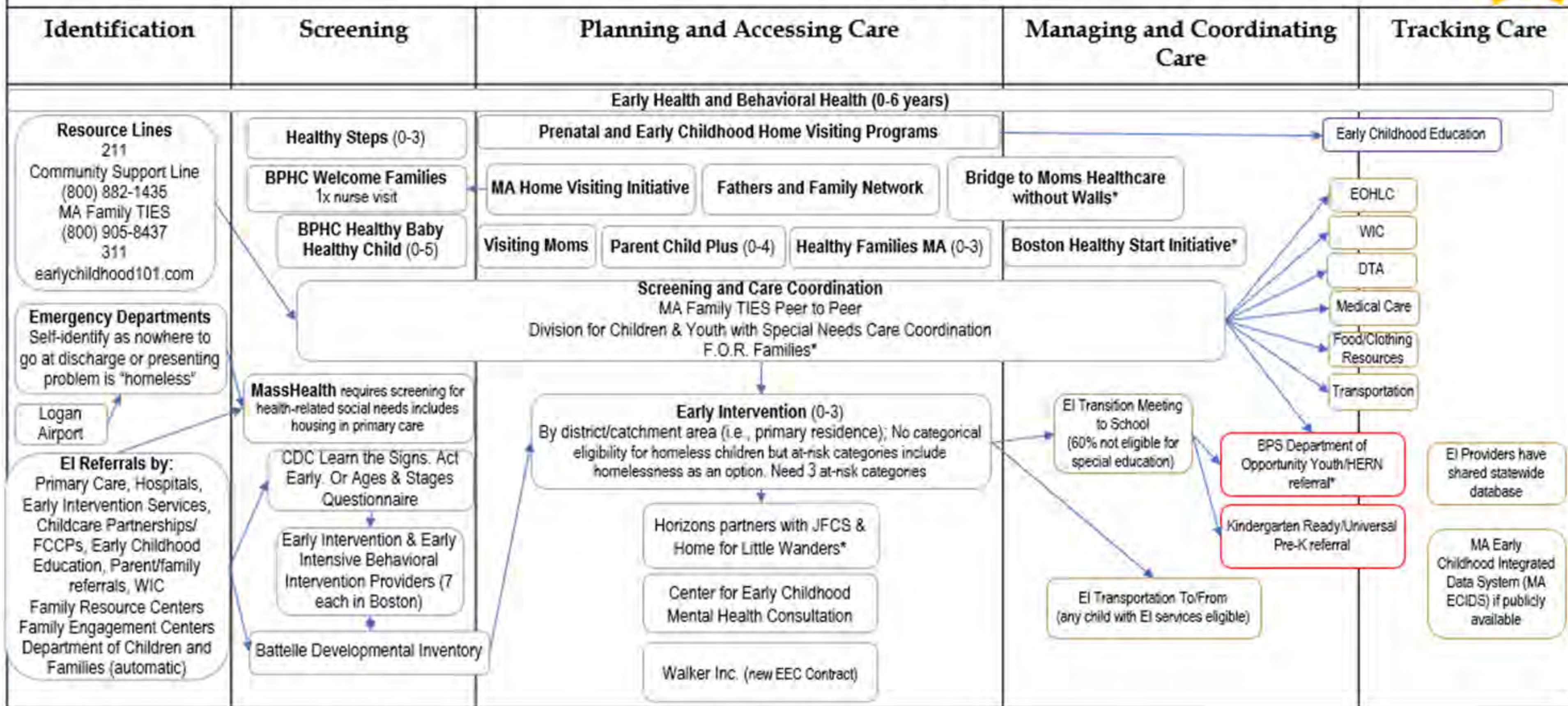
Family Welcome Center*
Brazilian Worker Center

BPS Department of Opportunity Youth/HERN referral*

Screening and Care Coordination
Division for Children & Youth with Special Needs Care Coordination; F.O.R. Families*

Cross-Systems Collaboration
Massachusetts League of Community Health Centers

*Families experiencing homelessness prioritized


CHIME
Child Services
Health & Well Being
Identification
Screening
Planning and Accessing Care
Managing and Coordinating Care
Tracking Care
Early Health and Behavioral Health (0-6 years)
Resource Lines
211
Community Support Line
(800) 882-1435
MA Family TIES
(800) 905-8437
311
earlychildhood101.com
Emergency Departments
Self-identify as nowhere to go at discharge or presenting problem is "homeless"
Logan Airport
EI Referrals by:
Primary Care, Hospitals, Early Intervention Services, Childcare Partnerships/ FCCPs, Early Childhood Education, Parent/family referrals, WIC
Family Resource Centers
Family Engagement Centers
Department of Children and Families (automatic)
Healthy Steps (0-3)
BPHC Welcome Families
1x nurse visit
BPHC Healthy Baby Healthy Child (0-5)
MassHealth requires screening for health-related social needs includes housing in primary care
CDC Learn the Signs. Act Early. Or Ages & Stages Questionnaire
Early Intervention & Early Intensive Behavioral Intervention Providers (7 each in Boston)
Battelle Developmental Inventory
Prenatal and Early Childhood Home Visiting Programs
MA Home Visiting Initiative
Fathers and Family Network
Bridge to Moms Healthcare without Walls*
Visiting Moms
Parent Child Plus (0-4)
Healthy Families MA (0-3)
Boston Healthy Start Initiative*
Screening and Care Coordination
MA Family TIES Peer to Peer
Division for Children & Youth with Special Needs Care Coordination
F.O.R. Families*
Early Intervention (0-3)
By district/catchment area (i.e., primary residence); No categorical eligibility for homeless children but at-risk categories include homelessness as an option. Need 3 at-risk categories
Horizons partners with JFCS & Home for Little Wanders*
Center for Early Childhood Mental Health Consultation
Walker Inc. (new EEC Contract)
EI Transition Meeting to School (60% not eligible for special education)
EI Transportation To/From (any child with EI services eligible)
Early Childhood Education
EOHLC
WIC
DTA
Medical Care
Food/Clothing Resources
Transportation
BPS Department of Opportunity Youth/HERN referral*
Kindergarten Ready/Universal Pre-K referral
EI Providers have shared statewide database
MA Early Childhood Integrated Data System (MA ECIDS) if publicly available
*Families experiencing homelessness prioritized
Cross-Systems Collaboration
Massachusetts Interagency Coordinating Council (ICC), The Early Childhood Agenda

CHIME Mapping Narrative

The following was information learned during the CHIME Mapping of the **Health & Well-Being Gear**. In this mapping, participants were guided by facilitators to identify gaps in services, resources, and opportunities at each of five distinct process points:

- Identification of accompanied children experiencing homelessness
- Screening of accompanied children experiencing homelessness
- Planning and accessing care to meet the needs of children experiencing homelessness
- Managing and Coordinating care across systems
- Tracking care coordination and engagement

This narrative provides a description of local activities as well as gaps and opportunities identified in the areas covered by the Health & Well-Being Gear including Early Intervention, Physical Health, Behavioral Health, and Health Insurance/Access to Care. This narrative may be used as a reference in reviewing the Health & Well-Being Map.

The Gaps and Opportunities identified in this report are the result of input from both interview and workshop participants. These points reflect a variety of partner opinions and are, therefore, subjective rather than a majority consensus.

The Priorities and Action Plans identified in the report are the respective result of votes from each of the participants, and plans developed by the participants.

General Description of CHIME Health & Well-Being Mapping

On September 26th and 27th, 2023, the fourth of six CHIME Mappings was held in Boston, MA. Dr. Snehal Shah opened the event and Mary McGeown, Undersecretary for Human Services, served as the Health & Well-Being champion to welcome the participants. A total of 50 individuals attended, including 50 participants and 5 observers. Of the 50 participants, 32 were invited to complete the CHIME Community Self-Assessment Survey (see Appendix 5) and 23[8] individuals did so prior to the mapping to share information about themselves and their organizations. People with past or current lived experience of homelessness were less represented in the Health & Well-Being mapping overall compared to previous CHIME Mappings but still included 3 parents and 2 children. In the Health & Well-being mapping, 2 (6%) participating respondents reported having never experienced homelessness as a caregiver or child and 3 (9%) participants having current lived experience as parents. Participants who completed the survey self-identified in the following current roles:

[8] CHIME participants who attended a prior convening were not asked to repeat the survey. A total of 32 individuals who RSVP'd to the Health & Well-Being event were invited to complete the CHIME Community Self-Assessment Survey.

Behavioral health and/or health care services	11
Other State or Local Government Agency	6
Shelter, Housing, and Homelessness Services	2
Other	4

Pre-Mapping Survey Findings

Prior to the CHIME mapping, participants answered questions about collaboration and coordination; identification and screening; and services for children experiencing homelessness in the Boston area.

- Regarding collaboration and coordination of services, 91% of Health & Well-Being participants reported their organizations did currently collaborate with other stakeholders to meet the needs of accompanied children experiencing homelessness compared with 3% of Shelter, Housing, and Economic, 78% of Early Childhood Education, and 71% of K-12 participants.
- Regarding screening of accompanied children experiencing homelessness, 62% of participants stated their organizations did use validated screening tools compared with 30% of Shelter, Housing, and Economic, 34% of Early Childhood Education, and 33% of K-12 participants.
- Finally, 52% of Health & Well-Being participants agreed that their organizations prioritized accompanied children experiencing homelessness for service(s) within their agencies compared to 60% of Shelter, Housing, and Economic, 68% of Early Childhood Education, and 75% of K-12 participants. Of those who prioritized their services, 58% endorsed that those services were specifically designed for children experiencing homelessness. It is important to reiterate, as indicated above, the pre-mapping survey represents agencies from across multiple systems including K-12, Health and Well-Being, and Shelters, Housing and Economic Assets.

Engaging Families with Lived Experience

The involvement of parents and caregivers as well as children in families with lived experience in CHIME is essential to fully understand gaps and opportunities in the various systems supporting them and their children.

To help lay the groundwork on the importance of coordinated services for children experiencing homelessness, the **Health & Well-Being mapping started** with stories from family partners with lived experience that highlighted several important topics:

- Many parents in families experiencing homelessness have experienced deep trauma and/or mental health symptoms; some of these parents were taught to repress or ignore mental health concerns. Thus, parents did not always recognize mental health concerns when they arose or know how to seek help. Parents recognized that they needed

therapy, and it was important for all family members, not just the head of household. As a result, parents with lived experience posed these questions to the mapping participants to think about as the group began mapping:

- How can we help children who are in families that do not know how to (or do not want to) discuss mental health or access mental health support?
- How do we help parents recognize when they or their child needs MH support, and how do we normalize these discussions?
- How do we help families who need mental health supports advocate for their children?

Families experiencing homelessness are the most challenging partners to involve in a day and a half event primarily because they must prioritize meeting their and their child(ren)'s day to day needs while working towards securing stable housing, but also because it can be triggering or otherwise trauma-inducing to ask families to share their personal perspective on a system that has not adequately supported them. Across CHIME mappings, the CHIME project team has taken several trauma-informed steps to ensure people with lived experience have an opportunity to participate in each CHIME Mapping session, including:

- Providing compensation for their time in the form of Amazon gift cards and cash for each day attended, to allow for more flexibility of spending.
- Holding preparation meetings between the project manager and families and their case managers in advance of their participation, to meet each other personally, discuss the project and the mapping process, and define clear expectations and roles.
- Providing any necessary accommodations for parents or caregivers and their children prior to and/or on the day-of mapping sessions, including ensuring their case managers are in attendance when possible and providing a separate, nearby space for children and parents to sit and play at. Materials such as coloring books, snacks and juice, and other supplies are provided at the space.
- Holding individual post-mapping meetings between the project manager and families and their case managers in the week following the sessions to collect additional insight that they may not have felt comfortable sharing at the in-person event, and feedback on improvements the project team can make to best engage, prepare, and accommodate families.
- Providing interpretation services and translated materials for Spanish-speaking families.

Description of Current Resources

This list of resources reflects the knowledge, experience and expertise of mapping participants with a particular focus on resources for accompanied children experiencing homelessness and is not intended to be exhaustive.

Early Childhood Health and Behavioral Health Services (ages 0-6)

Many early childhood health and behavioral health programs and services are available to the Massachusetts community as a whole. Of those many programs discussed during the Health & Well-being mapping, **accompanied children experiencing homelessness were specifically a priority for only three programs**:

- Boston Healthy Start Initiative: mission is to promote the health and well-being of women, children, and families in the City of Boston by providing care coordination, connection to resources, health education, and advocacy. BHSI is a free and voluntary program. BHSI is open to self-identified black women in Boston who are pregnant or parenting children up to the age of 18 months.
- Massachusetts Young Children's Health Interventions for Learning and Development (MYCHILD): a collaboration of families, health centers, and child serving agencies. In partnership with 3 pediatric medical homes & Health Care for the Homeless, MYCHILD aims to young children (birth to first grade) with significant behavioral and emotional needs and provide them with individualized, coordinated, and comprehensive services. MYCHILD also aims to build the capacity of pediatric medical homes and community-based organizations to support young children with social and emotional needs through individual consultation and group training.
  More information available at: https://www.mass.gov/service-details/office-of-children-youth-and-family-programs
- Follow-up Outreach Referral (F.O.R.) Families: a home visiting program for families transitioning from homelessness to stable housing. Families receiving Emergency Assistance (EA) from the Division of Housing Stabilization at the Executive Office of Housing and Livable Communities (EOHLC), who are homeless and living in a shelter, are eligible for no-cost home visiting services. The Home Visitors conduct family assessments and make referrals for additional services.
  - F.O.R. Families Home Visitors coordinate services with an array of community-based programs and services such as WIC, Early Intervention, primary health care, domestic violence, and substance abuse treatment as well as Housing Assistance workers, the Department of Transitional Assistance, the Department of Children and Families, and the Department of Mental Health when appropriate. They provide information about school enrollment options, food, clothing, and transportation resources.
  - F.O.R. families prioritize families experiencing homelessness and have recently expanded statewide.

- F.O.R. Families, designed to specifically meet the needs of families experiencing homelessness, was diverted to only support newly arrived MIRA families due to the crisis during 2023.

The following descriptions of additional early childhood health and behavioral health programs may be helpful in thinking about the landscape of services and how accompanied children experiencing homelessness may be supported or prioritized within these programs.

City of Boston Initiatives

- Boston Public Health Commission's (BPHC) Healthy Baby Healthy Child program is for Boston pregnant and parenting (with children between the ages of birth to 5) moms and expectant fathers. Funded by the City, services (i.e., home visits) are free, voluntary, and confidential services (i.e., home visits).

MA Executive Office of Health and Human Services, Department of Public Health, Bureau of Family Health and Nutrition (BFHN)

- The Bureau includes six divisions and the Massachusetts Center for Birth Defects Research and Prevention. The bureau supports the health and well-being of individuals ages 0 to 22.
- Many programs within the bureau screen for social determinants of health including WIC, early intervention, and Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) programs.
- Programs also screen for developmental milestones and delays using the *Learn the Signs. Act Early*. program from the Center for Disease Control (CDC). This CDC tool has modules for providers and parents. Parents are encouraged to download the app that can help track milestones between visits. Training videos are also available for staff and parents on normal childhood development
- Given increasing demands for families experiencing homelessness, there is a structure being put into place to support families (Incident Command Center).
- Perinatal network is working with hospitals on a quality improvement project to improve perinatal outcomes by including a screener in the NICU with questions on social determinants of health and housing (SDOH). They are currently encouraging hospitals to use screeners already in use in other areas of the hospital, so the SDOH questions are not standardized.

  Within BFHN, the Division for Children and Youth with Special Health Needs supports the following Family Initiatives Programs:

  - **Family TIES** (Together in Enhancing Support) **of Massachusetts**. Staffed by a full-time project director, a parent-to-parent coordinator and six regional parent coordinators, Family TIES is a statewide information, referral, and parent-to-parent support

network. Family TIES provides a variety of supports and information to families whose children have special health needs and their providers including training, information about local and statewide resources and connection to parents with similar life circumstances.

  - **Family TIES** serves as the Central Directory for early intervention services (EIS) and can provide contact information for the local early intervention program or help make the call with the parent. Family TIES also provides public awareness education and can be contacted for informational sessions with staff or families. Providers/families can also call EI providers directly to schedule an assessment. They also conduct several training courses and have outreach staff who speak 5 languages (native speakers). Family TIES serves an average of 150 – 200 families per month across MA. Overall, 6,000 families are served throughout the year in MA. Federally funded by the Office of Education, Family TIES stays with families as long as they need.
- The Early Intervention Parent Leadership Project (EIPLP). Staffed by a full-time project director and three project coordinators, EIPLP works to ensure family participation across the EI service system, from the local program level to the statewide Interagency Coordinating Council and on to national leadership activities. The goal is to support families to grow lifelong leadership and advocacy skills that can be used within their families and communities. Training, mentoring, identification of opportunities and stipends for participation are offered. Information is available on the EIPLP website, or by calling (877) 353-4757.

Within BFHN, the Early Intervention Division offers the following:

- Early Intervention Services (EIS) is a program for infants and toddlers (birth to 3 years old) who have developmental delays or are at risk of a developmental delay. Homelessness may be used as one of the four developmental risk factors needed to determine eligibility for EIS. This determination is made at the clinical discretion of the EIS provider. Eligible families are enrolled in the Part C/early intervention system regardless of housing status. As of May 2023, 775 families experiencing homelessness were being served by EIS in the state. More information about EIS:
  - The Early Intervention Services (EIS) Division works closely with other BFHN home-visiting programs (e.g., FOR Families) and coordinates with EOHLC to identify families residing in EA shelters and connect early intervention services programs with the EA shelter providers.
  - There are two primary developmental screening tools being used in Boston: the CDC's *Learn the Signs. Act Early.* and Ages & Stages Questionnaire (ASQ).
    - The United Way of Massachusetts Bay's DRIVE initiative has championed developmental screenings since 2014 to the importance of screening young children.

- There are 6 EIS providers covering the Boston catchment area: Bay Cove – Dorchester, Boston Children's Hospital, Criterion Boston, Dimock, Harbor Area/North Suffolk Community Services, and Thom Boston Metro.
    - All EIS programs assess using the same eligibility tool the Battelle Developmental Inventory. Upon referral, programs have 15 calendar days to complete the assessment and another 30 calendar days to write report/plan for a total of 45 days before an eligibility determination must be made.
    - EIS programs are required to convene a transition meeting with the school district up to 9 months ahead of time to inform the school of a child's special needs, especially with medical needs or potential out of district placement needs. Ideally, there is no gap between EIS and school; however, the ideal is often not happening.
    - Some EIS providers have preschool age programs that can connect families experiencing homelessness to school social workers as a warm handoff to ensure access to support.
    - For children who have EIS based on physical health needs and are transitioning to K-12, BPS Nurse Specialists participate in the Special Education screening process and development of an Individualized Education Plan (IEP).
    - For families experiencing homelessness in a shelter or that otherwise cannot stay at their location during the day, it's up to the creativity of the program to define "in-home" to allow for service delivery.
    - EIS must end at the age of 3 even if the transition meeting with school has not happened because the insurance coverage ends.
- EI Transportation: Any child eligible to receive EIS is eligible for transportation services regardless of insurance type. Transportation is an enabling service and is available to families to help them access EIS. Transportation could be used to help families travel to a location where early intervention services were being provided (e.g., a local library, a local playground). Transportation could not be provided to a location not used for early intervention services.
- Parent Child Plus (16 months to 2.5 years old) is an international program offered in Boston that provides school readiness to families challenged by poverty, lack of educational opportunities and language and literacy barriers, wherever families call home. In Boston, the Family Nurturing Center of Massachusetts is the provider who meets with families for half-an-hour, twice-a-week over two years on a schedule that is convenient for the family. On the first visit of each week, the ELS brings a carefully selected book or educational toy, which is a gift to the family. The program is free to Boston families.
- Resources are available for parents to learn more about health child development if they are concerned and are considering requesting EI services:

- "1, 2, 3 Grow!" is a series of videos about what healthy developmental milestones look like - and what to do and where to go if you're concerned about your child. These videos are available in 8 languages and cultures.

Within BFHN, the Pregnancy, Infancy, and Early Childhood Division (PIE) supports: Prenatal and Early Childhood Home Visiting Programs. Early childhood home visiting connects new and expectant parents with a family support specialist. The specialist may be a nurse, social worker, community health worker, or other early childhood professional. DPH offers several home visiting opportunities for families:

- **F.O.R. Families** as described above.
- Massachusetts Home Visiting Initiative (MHVI) provides evidence-based home visiting services to families across the state through local service agencies. It is part of the national Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). La Alianza Hispana: MHVI and MSPCC – Boston MHVI serve the Boston area.
  - MHVI also provides a program called **Parents as Teachers**. This evidence-based home visiting model is the comprehensive parent education model. The Revere location serves Boston.
- Welcome Family offers a one-time nurse home visit to all mothers with newborns. Welcome Family assesses mother and newborn health and well-being and provides education, support, and referrals to services as needed.
- Early Intervention Parenting Partnership (EIPP) team works with the family to assess their needs and connect the family to additional resources when appropriate. Seven catchment areas exist in MA. Riverside Community Care serves the Boston area.

Massachusetts Executive Office of Education Department of Early Education and Care (EEC) supports:

- Coordinated Family and Community Engagement (CFCE): The CFCE network helps to promote and support parent education and family engagement, early literacy and child development, collaboration and transitions between early education and care settings, at home and school, and high-quality programs and service delivery. Grantees offer a variety of home visiting in Boston, primarily through Family Nurturing Center, as well as several other locations including Boston Public Library.

Children's Trust of MA

- Healthy Families Massachusetts is a free and voluntary statewide support program for first-time moms and dads aged 23 and under. There is no health insurance or documentation status required. Young parents with a child under 12 months across Massachusetts can sign up for the program during pregnancy and continue up to the child's third birthday. Healthy Families Massachusetts is a home-based family support and coaching program. Home visitors teach parents about proper baby care, promote

nurturing and attachment, practice effective parenting skills, and ensure parents have a solid understanding of healthy child development. They also counsel parents on achieving personal goals such as going back to school or securing a job.

    - Catholic Charities Boston administers the program in Boston. With additional funding through the MHVI, important service enhancements and supports to the home-visiting programming are provided.

- Father Friendly, **previously known as Fatherhood Initiative**, works to advance activities and training that support fathers, their families, and the professionals who work with them.
    - **Fathers & Family Network** (FFN): Coordinated by Children's Trust, meetings include topical presentations and discussions as well as networking and collaboration opportunities.

Additional Community-Led Initiatives:

- BCH Young Parents Program **(YPP)** is for adolescent and young adult parents at Longwood Primary Care Center at Boston Children's Hospital. YPP is not a home visiting program and is designed as a 2Gen clinic for young parents who have children in school. YPP is not specific to homeless families, but focuses on medical, behavioral, and mental health care for all family members.
- Health Care Without Walls is specifically designed for women who are experiencing homelessness and pregnancy. In partnership with Brigham and Women's hospital, providers meet with the mother during prenatal, perinatal, and postpartum periods to assess medical needs and nurturing relationships between mother and child. Services also include case management that will follow the mother and child up to the first year of the child's life.
- Jewish Family and Children's Service's Lauren & Mark Rubin Visiting Moms® is a free service that matches volunteer with new parents during the first year of their baby's life, whether it's the first baby or a new baby in the household. Volunteers are trained and supervised and support parents who are adjusting to parenthood, isolated, or overwhelmed. Volunteers visit new parents at home and provide a weekly visit for at least two months or up until the baby's first birthday.

Childhood Health and Behavioral Health Services (0-18)

Within child health and behavioral health for children 0-18, the following programs or services were specifically designed for accompanied children experiencing homelessness and are described in the following sections:

- Boston Healthcare for the Homeless
- Brazilian Worker Center

Physical Health

- Pediatric primary care: Massachusetts has a wide network of pediatric primary care providers in a variety of clinical settings including Federally Qualified Health Centers. Community Health Centers, community-based primary care practices, and hospital-based primary care practices. Children should receive regular well child care during which they are screened for physical and behavioral health, development and academic concerns. Families and children experiencing homelessness may not be able to access regular well child care or urgent care.
  - Since 2018, primary care practices that provide care to MassHealth Accountable Care Organization (ACOs) members are required to screen patients for social needs such as homelessness, which supports the integration of medical and social care.
  - At Massachusetts General Hospital (MGH) Pediatric Group Practice and Boston Children's Hospital (BCH) Primary Care Center in Boston and Jamaica Plain, HealthySteps program, a national model, provides early childhood development support to families where they are most likely to access it embedded within the pediatric primary care office. Families have screening for health-related social needs (HRSN) when they check-in at the pediatrician so additional resource(s) needs can be identified. A HealthySteps Specialist can connect families to those resources.
- Emergency rooms: Homeless children and families may seek urgent or emergency care in hospital-based emergency departments. During these visits, pediatric patients are screened safety and behavioral health concerns as well as social needs such as housing or food concerns. in the emergency department. Emergency department staff can assist families to access the shelter system or otherwise stabilize their housing through community connections and programs.
  - As of 2025, hospitals that contract with MassHealth are required to screen for social needs, such as homelessness, in the inpatient and emergency department setting.
  - Boston Children's Hospital **and** Boston Medical Center both ask health-related social need questions. At BMC, accompanied children with families who are defined as homeless (i.e., no safe or inhabitable place to sleep that night) by the hospital meet with social work teams who help families access the Brazilian Worker Center to more efficiently access the shelter system. At BCH, social workers assist families to access the shelter system.
- Brazilian Worker Center (BWC) is currently part of a pilot project in partnership with the State of Massachusetts to provide support to newly arrived immigrants in the United States. As part of this initiative, the BWC has been designated as the Welcome Center for these newly arriving families. Emergency rooms connect newly arriving families who have

nowhere to live with the BWC to find shelter and basic needs resources.

Massachusetts League of Community Health Centers is a trade association for community health centers and are active nationally with the national association and the Bureau of primary health care which funds FQHCs. They also support Accountable Care Organizations (ACOs).

- Massachusetts League of Community Health Centers has a community health workers (CHWs) initiative to support a behavioral health training component, focusing on hard areas that CHWs interact with often and use applied learning.

Federally Qualified Health Centers (FQHCs)

- In Massachusetts, there are 52 federally qualified community health centers, of which 37 FQHCs and 13 other community health centers meet criteria for high area of need but are attached to a hospital.
  - In Boston, Boston Healthcare for the Homeless (BHCHP) has 8 FQHC locations of which 3 serve children and young adults. BHCHP's family clinic in Roxbury is open to all families experiencing homelessness in the Greater Boston area, which began offering primary care in 2023. The main BHCHP site is located at Jean Yawkey Place. Although families are not treated at this location, the pharmacy and dental are accessed by families here. Satellite locations are located across two family shelters and two-family treatment programs.
    - Fenway Community Health Center, South Cove Community Health center, and South End Community Health Center are also FQHCs who serve children.
- Many health centers are attuned to the needs of families experiencing homelessness. It was noted that the doctors can write a prescription for transportation when transportation is a barrier to services.

Behavioral Health

- Community Behavioral Health Centers (CBHCs) are described as coordinated hubs for one-stop "shopping" for a wide range of mental health and substance use services and treatment. Services include mobile crisis intervention, community crisis stabilization, and routine outpatient services. There are two CBHC hubs that serve the Boston area: North Suffolk Community Services CBHC and Boston Medical Center CBHC.
- Children's Behavioral Health Initiative (CBHI) is part of MassHealth Office of Behavioral Health. Through MassHealth, a continuum of home and community based behavioral health services are funded. This initiative also requires primary care providers to screen for behavioral health conditions at well-child visits. The initiative also standardized behavioral health assessment by requiring clinicians to use the child and adolescent strengths and needs assessment tool. Services funded include therapy, therapeutic mentors, etc., outpatient services that can also be offered in the home or school.

Schools and Mental Health

- Codman Squared, an academic partnership between Codman Square Health Center (CSHC) and the Codman Academy Charter Public School (CACPS) is the first co-located health and education partnership in the country. The goals are to improve health outcomes and increase educational attainment of Codman students to empower this next generation with the ability to live healthy, productive lives. Codman Squared integrates the health center and the school to better establish a definitive center of health and well-being for the Codman Square and the greater Dorchester community. The partnership also has extensive programming during and outside of the school year: summer internship programs, farm to school, a program to educate students about their local food environment, vision screenings, dental programs, and other health related programming.

Cross-Systems Collaboration

The Massachusetts Interagency Coordinating Council (ICC) is a federally mandated statewide inter-agency group that advises and assists the Department of Public Health on Early Intervention.

Massachusetts Office of the Child Advocate (OCA) is an independent executive branch agency that oversees all child services in all secretariats in MA and concurrently serves as a resource for families who are eligible to receive services from the Commonwealth. OCA receives data and information from agencies that allows them to have a central role. OCA conducts a lot of research and implements pilot programs to show proof of concept in an idea to the legislature. OCA has been heavily involved in how to bring innovative ideas to fruition and align them with stable funding.

Opportunities in Health & Well-Being

Cross-System

- MassHealth has a quality improvement project working on Social Drivers of Health screening with hospitals to increase screening and perhaps standardize definitions.
- Massachusetts received a grant to work on access to and coordination of services birth to 5. MA published "The Preschool Development Grant Birth-Five Strategic Plan: Laying the Foundation for a More Equitable and Coordinated Mixed Delivery System in Massachusetts." The goal of providing families with easy access and seamless navigation of a mixed service delivery system could be a model to help families experiencing homelessness.
- Screening for social needs, such as homelessness, in healthcare settings support the delivery of integrated, "whole person" care.

Early Health and Behavioral Health (0-6 years old)

- The free program by the Center for Disease Control - Learn the Signs, Act Early – has both parent and practitioner questionnaires for screening young children as well as practitioner learning modules on how to have conversations with families that encourage providers to include family as a valued team member.
- COVID created delays for access to the full array of EIS, but agencies are catching back up with referrals.
- Up to 10% of MA children are enrolled in EIS. This is higher than any other state because the criteria are broader. More than 44,000 children in MA are receiving EIS.
- Although there is no categorical eligibility for children experiencing homelessness to receive EIS, homelessness can be considered for EIS eligibility in the developmental risk factors category as well as maternal age, education, trauma, and prematurity. A combination of 4 out of the 20 listed risk factors can be used to meet criteria.
- Families do not have to go through the whole EIS eligibility process again if they move. EIS providers can provide a warm handoff, although participants were unclear how often this happens.
- Family TIES stated that they can serve more often as a bridge for children 0-3 to 3-5 for service transition if families and providers reach out for help.

Health and Behavioral Health (0-18 years old)

Planning and Accessing Care

- **Boston Healthcare for the Homeless** is in the progress of expanding primary care services to children – have always done episodic but now moving to full spectrum.
    - Also provides family therapy and limited therapy for children (85-90% are adult caseloads). Mostly available via telehealth.
- **Codman Squared** is an academic partnership between Codman Square Health Center (CSHC) and the Codman Academy Charter Public School (CACPS) and "the first co-located health and education partnership in the country." This may be a model for providing mental health services for children experiencing homelessness because school staff noted that many students from low-income backgrounds receive most of their medical care at school, but more information is needed about the program.
- **Healthy Baby Healthy Child (HBHC)** also has a presence in Boston Public Schools. HBHC will have clinics in 7 schools across Boston. In these schools, HBHC could potentially be a resource if there was additional funding for a staff member to support continuity of care.
- **Families with lived experience** (i.e., paid peer services) is a currently untapped resource for staffing navigator and case management positions to support children and families experiencing homelessness.

Managing and Coordinating Care

- There are a few existing resource-focused databases that are publicly available and may aid in helping to improve knowledge and access to programs for both staff and families with children experiencing homelessness:

- **Children's Trust** collaborates with FindHelp, a resource to help find services, to pinpoint programs in MA. FindHelp will help connect to families who do not know how to reach out.
- **MA Family TIES** has a directory of resources for families of children and youth with special needs.
- **Massachusetts 211** has a resource directory and already collaborates with the Unaccompanied Homeless Youth Commission and State Plan to End Youth Homelessness for unaccompanied children.

- **Healthy Families at Catholic Charities** has an intake and outreach coordinator, who can assess eligibility for programs and connect families to resources. The current position does not provide full navigation services but can provide warmer handoffs and possibly be built upon.
- **FQHCs** will use their own mailing address for clients applying for MassHealth if needed.
- Some EIS home visiting programs can give families housing verification needed to facilitate certain applications.
- **F.O.R. Families** prioritizes families experiencing homelessness and is expanded statewide.
- Care coordination has a billable code for children with complex health needs. Participants wondered if the definition could be broadened to include socially complex situations.

MIRA-specific

- The **Association of Haitian Women in Boston (AFAB)** is an active organization supporting Haitian families experiencing homelessness.
- **MassHealth** provides limited to standard coverage for pregnant and postpartum up to 12 months for undocumented women.
- If documentation can be provided, the status of **Permanently Residing Under Color of Law (PRUCOL)** increases eligibility for MassHealth and legal assistance.
- Health law advocates including Health Care for All are working to improve healthcare access (PRUCOL eligible for MassHealth).
- There are opportunities to engage faith-based providers who are active with new arrivals.
- **Catholic Charities** has a contract to help support families newly arriving to the airport.
- **Refugee Immigration Ministry** is an interfaith organization that works with refugees and new arrivals 2 connect individuals to a wider community. They also provide housing, transportation, food, acculturation, and friendship.
- **Immigrant and Refugee Health Center at Boston Medical Center** provides health care at one central point of entry where any immigrant can be connected to BMC 's medical, mental health, and social services.
- **Found-in-translation.org** offers medical interpreter training for low-income and homeless bilingual women. Women are trained to be cultural brokers and translators for compensated roles.

Gaps in Health & Well-Being

Cross-system

- Federal funding often goes directly to state agencies which makes it hard to advocate for changes. State workers/agencies and 501c3s have limited opportunity for advocacy. The restrictions are bound by law.
- Across Health & Well-being and all other gears, there are various eligibility criteria for different programs that have a significant impact on the families' journey. Overall, there was a concern about how to support warm handoffs and warm welcomes for families entering shelter. Both for families entering EA but also to help connect families to other services while maintaining appropriate levels of privacy.
- Additionally, there is no central location where providers and families can find resources and understand the eligibility, duration, or type of services provided. For providers, this can impact their relationship of trust with the family when a referral is made to a no longer functional program. For families, this leads to unequal access to and knowledge about programs their children may benefit from.
- When families are displaced out of their hometowns, which is common given the lack of shelter capacity, they lose their sense of community and foundation.
- The definition of specialized healthcare needs often prevents families from communities of color from accessing services because the children may not have complex developmental or medical disorders by definition despite their complex social health and trauma needs. However, there is also a capacity issue if those items are included.

MIRA-specific:

- A gap across the system is serving families who are unable to read and write in their native language as well as children and families who speak blended languages due to their travel history. Interpreters often have a difficult time understanding and communicating with families.
- Across new arrivals, there is heightened racism experienced by black and brown families.
- There is a lack of shared understanding or training of cultural norms, trauma experienced, or medical needs of new arrivals.
- Overall, there is a lack of reflective practice and supervision to help support staff with secondary traumatic stress and burnout.
    - For staff witnessing anti-immigrant protests, there is limited support for the resulting vicarious trauma.

Identification

- According to the Massachusetts Bureau of Family Health and Nutrition, there is no standardized definition of homelessness and no standardized count of homeless children and families utilizing social services across Health & Well-being providers.
- All youth complete a physical health screening with pediatricians or community health

centers, where questions are asked about housing (e.g., “have you been struggling with housing in last 12 months?”). However, there is no standard process for communication between child health providers (i.e., pediatricians) to share information or navigation to support families with post-health screening.

- Each provider has their own medical record system but there is no way for families to opt-in to a shared data system that is accessible by all providers (e.g., Health Information Exchange Maximizing the Ability of Health IT and AI to Improve Patient Safety).
- For EIS eligibility, children experiencing homelessness without a disability may be eligible if they meet 4 out of the 20 listed risk factors. However, participants noted that many parents may not want to tell a stranger who conducts the assessment their personal issues, resulting in a gap between what is technically possible and what actually happens. Relatedly, it was unclear if standard screening questions were being asked to identify these 20 specific risk factors or whether a family had to spontaneously disclose information related to those risk factors in order to be identified as eligible.
- Families with lived experience noted the State’s definition of “acutely homeless” may impact their ability to access services their children need and may also feel invalidating of their experience of homelessness. Families with lived experience added acute homelessness and double-up situations can be equally traumatizing. Doubled up children and their needs are often lost, especially if they are told they are not homeless.
- Although emergency room staff reported frequently connecting families to the Brazilian Welcome Center to access emergency assistance shelters, families with lived experience noted that connection depends on who the staff person is, describing discrepancies between policy and practice.

MIRA-specific

- For families placed at motels and hotels, the emergency assistance system does not staff the hotels with providers who can support submitting applications, providing food, transportation, and support for children.

Screening

- There is a lack of staff in shelters with the temporary expansion of the EA system. Some locations have one worker helping all the families, and they cannot dive into the needs of each. Often, families do not know how to navigate services and occasionally may not know how enter information in an online browser.
- Shelters do not regularly screen for children's mental health needs. Participants were not sure if it was a knowledge gap, coordination gap, capacity gap, and/or otherwise.
- When screening does occur, providers often used deficit-based questions. The responses are not shared resulting in repetitive screening and re-traumatization.
- Across providers, there is not enough awareness of early childhood mental health concerns to make appropriate and needed referrals.

- Early childhood services have no centralized hub to screen and refer children out to appropriate services (hub and spoke model).
- The EIS Division reported receiving regular updates on children and families in EA shelters from EOHLC, allowing them to immediately contact the network of providers operating in those areas and say we are aware of "x kids" in a particular shelter with the expectation they make the connection. However, there was no data or process to determine whether EIS providers actively follow through on the requests.
- Participants noted a particular gap in the implementation of developmental screenings at primary care and private settings.
- Some families reported they felt unheard when sharing their developmental and behavioral concerns with their child's pediatrician. They reported feeling pediatricians are not taking their concerns seriously and not referring their children to appropriate providers and supports.
- Training around disparities and bias in healthcare especially for those children and families on MassHealth was also highlighted as a need.

Planning and Accessing Care

Early Childhood Services (0-6)

- Overall, early childhood services generally are not well advertised. Thus, families may not be aware of available services or the benefits of their child receiving services.
- **Early Childhood Mental Health Consultation** (ECMHC) is a reactive crisis-management approach that is done on an individual/classroom level, thus does not adequately support children or those working with children and does not reach all early childhood programs.
- **Early Intervention Services** (EIS) is a reimbursable service; because eligibility criteria cut off at age 3 insurance immediately stops paying even if child has not had transition meeting with the school. During COVID, EIS received funding to extend eligibility age to October of first eligible school year, but this is no longer available.
- There is often a reliance on the creativity of the EIS program to define "home" especially when family is not able to stay at the shelter during the day. Participants also noted only one shelter allows EIS to come on site to provide services and generally only when there are multiple families in need.
- EIS programs are not allowed to have waitlists. However, because there is a staffing shortage, children are found eligible and may be receiving some services but not everything they need.
- Requesting an assessment for EIS was identified as a time-consuming burden on inquiring families, as the process may take numerous phone calls for an initial screening, adding another layer of complexity for families navigating multiple services.
- Child's name can only be in state database one time for EIS, which results in having to be discharged by one provider to be picked up at next. Due to the number of times families experiencing homelessness move, this impacts the continuity of care during a vulnerable and time limited opportunity. The **Office of Special Education Programs** stated when children are highly mobile or moving across MA, they are not to be treated as new entry.

The Office highlighted that they expect EIS programs will take a child as they move, resulting in a new provider and services the next day. There was no available data to look at follow through rates and provider and individual experiences varied on EI service transitions.

  - Participants noted that for families experiencing homelessness, if their shelter is moved to a new catchment area or the family moves for other reasons, the families have the burden of finding a new provider.

- Participants raised the issue that although EIS programs are supposed to coordinate handoffs with schools, there may be inconsistency in follow-through across programs and staff.
- Participants also noted 60% of children who receive EIS prior to school enrollment are not eligible for special education services; all children require a meeting but may be referred to childcare or other programs instead.
- For students with health needs transitioning from EIS to school, the IEP process includes a screening with a nurse specialist. However, some students may be screened out by the MTSS process before meeting with the nurse specialist.
- EI Transportation: Although transportation services are available to EIS regardless of insurance type, families who are enrolled in an EIS program outside of their catchment area (e.g., family resides in a shelter in Norton and chooses to enroll in EIS program assigned to Framingham). In these cases, the EIS program is not required to provide transportation to the family.

Health and Behavioral Health (0-18)

- Children experiencing homelessness after age 7 did not have any mental health services that addressed or prioritized their needs. Participants noted that even shelters that have their own on-site therapists, like St. Mary's, do not see kids, just the mothers.
- Big picture, sustainability for behavioral healthcare is challenging. Clinicians generally cannot come near enough billing to support their salary due to missed appointments. With billing only reaching 70% of their full-time salary, clinicians cannot dedicate their caseloads to the behavioral health needs of children experiencing homelessness without additional funding.
- The lack of capacity within the mental health system for outpatient treatment services results in a long backlog, often over 3 months, of people requesting services. This is especially true for child mental health services.
- Children with complex medical needs placed in shelters further from their home community are a significant barrier to their medical care and access. The healthcare system does not have an easy way to accommodate displacement. The shelter system does not prioritize placement needs medical facilities for medically complex children.
- FQHCs serve many families experiencing homelessness. However, barriers still exist including: transportation needs to clinics; not all shelters having on-site clinic due to staffing shortages; inability to bill for case management to address social needs; and that many currently available resources are driven by grants which is not sustainable.

- CBHI services have long waitlists, high staff turnover, kids in families experiencing multiple providers, mismatch on cultural sensitivity, and other challenges. Additionally, staff from outside agencies and families need to know the correct lingo to qualify for CBHI services more easily and with less barriers.
- For families in scattered site shelters or newly housed families, transportation is a huge need.
- Phones are a critical need and can be a huge barrier especially for telehealth.
- Accessing ACOs' programs for families experiencing homelessness (i.e., funds for diapers, car seats, and food) can be cumbersome.
- There are many more requests for basic needs (diapers, strollers, food, etc.) and culturally appropriate food than can be accommodated.
- Pre-pandemic, people were kicked off MassHealth frequently and the paperwork to reinstate was considerable. This process was exacerbated by homelessness. Participants were concerned this practice was returning post-pandemic.

Transition to School

- EIS has less restrictive eligibility qualifications/determination than Special Education, so some children experiencing homelessness lose services as they enter K-12 realm.
- Participants also raised the issue that although EIS programs are supposed to coordinate handoffs with schools, there may be inconsistency in follow-through across programs and staff.
- For students with health needs transitioning from EIS to school, the IEP process includes a screening with a nurse specialist. There were two potential gaps noted:
    - Some students may be screened out by the MTSS process before meeting with the nurse specialist.
    - The nurse specialist does not currently ask any questions about housing status. However, during the mapping, the BPS nurse program director noted a willingness to add a question to the nurse screening process. Participants were supportive of this initiative because nurses are often trusted by families to share sensitive information.

MIRA-specific

- Families newly arriving with children who experience developmental delays have limited access to services.
- MassHealth provides "limited-only" crisis care eligibility for families newly arriving, which prevents the ability to access a wider range of services.
- There are MassHealth enrollment and eligibility challenges for families with newly arriving children. For example, errors are made on MassHealth applications including misspellings of names, which makes refilling prescriptions more difficult. Many families are eligible for the Full Version of MassHealth but are receiving the Limited Version, which, among other issues, results in copays at pharmacies that can be avoided.

- Parents often have their own medical issues and have difficulty getting prescriptions for themselves, including knowing where pharmacies are located, reading prescription labels, etc., which impedes their ability to help their child.
- Newly arriving families also frequently lack eligibility for benefits such as SNAP and Section 8.
- Many state forms are only available in English.
- There is a lack of immigrant-informed care among healthcare staff.

Managing, Coordinating, and Tracking Care

- F.O.R. Families, designed to specifically meet the needs of families experiencing homelessness, had been diverted to only support new immigrant families due to the current crisis.
- There is a coordinated system within EIS specifically but there is no coordinated referral system outside of EIS, so providers cannot follow referral over time to see when/if someone has been connected to care.
- Care coordination or navigator positions are difficult to fund because providers cannot bill for the time spent facilitating a warm handoff for additional services and resources. Providers and staff are motivated to do care coordination but are not afforded the time and resources needed to do it in a way that respects parents' wishes and works for community partners.
- There is a lack of internet access in shelters which limits opportunities to learn about programs, complete applications, and access to telehealth services.
- How to strengthen information sharing with family – so they feel comfortable advocating and know what to expect.
- There is a lack of trauma-informed information sharing between agencies resulting in families answering the same questions over and over.

MIRA-specific

- Overall, the system lacks cultural brokers to help bridge, link, or mediate for persons of different cultural backgrounds to produce change.
- There is limited staff capacity for interpreters working with families who have spent time in multiple countries and therefore may speak multiple languages or blended languages.
- The Emergency Assistance shelter system moves families to areas with limited resources and people that speak their language or know their culture.
- There is a lack of access to culturally familiar food in shelters resulting in children losing weight.
- Rian Immigrant Center was not taking clients at the time of the mapping.
- Participants noted that there will likely be additional ramifications for families who experienced very difficult journeys such as crossing the Panama Canal which was noted as

especially difficult and may result in high mental health needs once the initial housing crisis is resolved and basic needs are met.

- Many adult members of newly arrived families have health issues that interfere with their ability to attend to the needs of the children.

Priorities for Change

Identified Priorities for Change

The group identified 12 priority areas. The chart below shows the rank order by the number of votes and priority area of work.

RANK	VOTES	PRIORITY
1*	16	Develop a Boston-specific regularly updated comprehensive resource book including a decision tree
2	10	Develop an electronic information sharing and referral system
3	9	Create a high-quality, well-trained, and supported workforce
4	8	Create a hub/wraparound model for children experiencing homelessness including braided sustainable funding that is not medicalized
5	7	Develop a service delivery system for people with lived experience as family partners
6	6	Allowing full scope of practice on a state and city level (e.g., nurse practitioners and licensing barriers for individuals with schooling outside of the U.S.)
7	5	Create a funding line for true integrated care in pediatric settings for children experiencing homelessness
8	4	Create a better system for outreach and resource connection for doubled-up families
9	3	Bring back a joint advocacy group for families experiencing homelessness
0	0	Develop an individualized family plan that integrates information sharing across agencies
0	0	Identify successful programs with positive outcomes and upscale/disseminate
0	0	Improve ability to track outcomes for children and parents to identify successful programs

During the review of priority voting, participants decided to group priorities together that shared a similar theme. The following priorities were combined and action planned together on Day 2:

RANK	TOTAL VOTES	PRIORITY
1 & 2	26	Develop a Boston-specific regularly updated comprehensive resource book including a decision tree: • Develop an electronic information sharing and referral system • Develop an individualized family plan that integrates information sharing across agencies
3	9	Create a high-quality, well-trained, and supported workforce: • Allowing full scope of practice on a state and city level (e.g., nurse practitioners and licensing barriers for individuals with schooling outside of the U.S.) • Include people with lived experience in workforce development
4 & 5	15	Create a hub/wraparound model for children experiencing homelessness including braided sustainable funding that does not require a medical pathway: • Develop a service delivery system so every family has a family partner

<table>
<tr><td colspan="4">Priority Area #1:

Develop a Boston-specific, regularly updated comprehensive resource book including a decision-tree.

- Develop an electronic information sharing and referral system
- Develop an individualized family plan that integrates information sharing across agencies
*Participants agreed to build off aligned Early Childhood Education Action Plan (Priority Area #3)</td></tr>
<tr><td>Objective</td><td>Action Steps</td><td>When?</td><td>Who?</td></tr>
<tr><td>Identify a group to pull resources together (Boston-based) and keep it up-to-date</td><td>Identify what resources exist (leverage existing resource inventories; survey and probe experts/providers/families)
- Break down by referral vs. self-referral
- Identify resources for during and post-stabilization

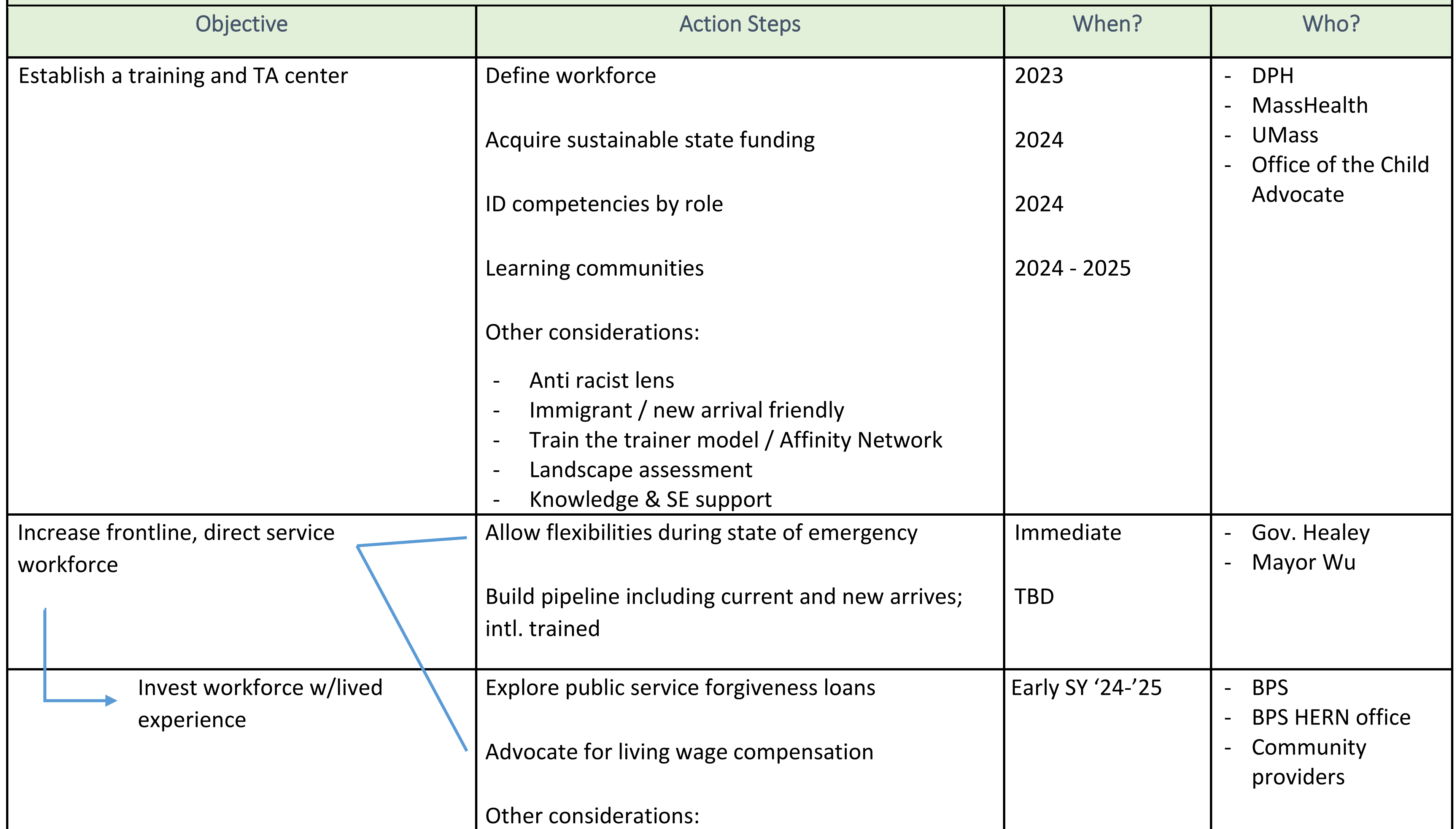
Create an inventory system. Ability for programs to filter services based on family reported needs, ages of children.

Have point of entry (intake) where information is shared by family once. If family “moves” that information goes with them.</td><td></td><td>- Utilize FindHelp, Mass 211, HealthSteps, Family TIES Resource Guide, other resources?</td></tr>
</table>

	Break down by domains with description so families/providers could determine what resources are needed.		
Build a task force to be responsible for the resource (consider: creation, updating, location where it lives, and distribution)	Identify stakeholders and develop a chart (including identifying roles; means of communication and frequency) Monitor resources to ensure they are still available or if they and/or systems have changed. Platform used to house resources alerts programs within the resource guide to submit annually their information (update phone #, staff, etc.) Create and launch (pilot) a training system for staff		- EOHLC - Identify the owner - Funder - OCA will explore possibility of putting up website (maybe off of Safe Kids Thrive) - Family Resource Centers - Recommendations from Early Education working group: o Families o United Way o EOHLC o Community Organizations o Boston Public Schools o Boston Children's o Hospital(s) o Horizons for Homeless o Children o ABCD o JBS o DTA o Mayor's Office of Early o Childhood o Safelink o Organizations serving

	Pilot test the model (FamilyAid shelters?) and gather data to advocate for funding. - Create and launch a training system for pilot		○ immigrant populations ○ Family childcare provider
Find a way to make the resource guide universally known by families, organizations, etc. and available in multiple languages	How – delivered by organizations and people family's trust Create print master list of resources (include in orientation paperwork) in addition to online repository		
Integrate resource sharing into shelter orientation	Create print master list of resources (include in orientation paperwork) Create online repository of resources (or utilize existing repositories - Aunt Bertha / findhelp.org)		- EOHLC - EA Shelter Providers (e.g., FamilyAid)
Integrate resource sharing into school registration processes	Meet with Welcome Services and Superintendent’s office Establish timeline for completion		- Boston Public Schools: Denise Snyder, Ana Tavares

Integrate resource sharing into hospital visits	Ensure housing status is documented at every visit		- Boston Children's Hospital - Mary O'Donnell (MGH/Spaulding)
Integrate resource sharing into post-shelter processes			- Boston Housing Authority
Create communication campaign	Develop marketing materials Create volunteer pool of folks to answer phone line Create mayoral challenge / endorsement		- Local TV and radio
Action Planning Participants: Shanika Bourne, Boston Public Health Commission; Pat Cameron, MA Family Ties; Elisa Cardoso, Upham's Corner Health Center; Jillian Carrington, FamilyAid; Kara Ghiringhelli, MA Dept. of Public Health; Snehal Shah, Boston Children's Hospital; Shannon Silvestri, MA Dept. of Public Health; Shakeia Skinner, Horizons for Homeless Children; Fatimah Villarreal, Horizons for Homeless Children; Madi Wachman, MassHealth			



Priority Area #2: **Create a high-quality, well-trained and supported workforce.**			
Objective	Action Steps	When?	Who?
Establish a training and TA center	Define workforce Acquire sustainable state funding ID competencies by role Learning communities Other considerations: - Anti racist lens - Immigrant / new arrival friendly - Train the trainer model / Affinity Network - Landscape assessment - Knowledge & SE support	2023 2024 2024 2024 - 2025	- DPH - MassHealth - UMass - Office of the Child Advocate
Increase frontline, direct service workforce	Allow flexibilities during state of emergency Build pipeline including current and new arrives; intl. trained	Immediate TBD	- Gov. Healey - Mayor Wu
Invest workforce w/lived experience	Explore public service forgiveness loans Advocate for living wage compensation Other considerations:	Early SY ‘24-’25	- BPS - BPS HERN office - Community providers

	- Trauma-informed - Stress first aid		
Bolster advocacy	Call to action / position statement: need for increased/sustained funding to support workforce (i.e., codify state funding) Policy letter	Immediate	- Private partners – FamilyAid? - Healthcare for All - Children's Mental Health Campaign - Mass Housing
Action Planning Participants: Régine Albin, Boston Medical Center; Melissa Deane, Boston Children's Hospital; Elaine Fitzgerald Lewis, MA Dept. of Public Health; Andrea G. Oliveria, MA Dept. of Mental Health; Lauren O'Mally Singh, Boston Public Schools; Kate Orlin, Boston Health Care for the Homeless Program;			

Priority Area #3: **Ensure every homeless child has a peer navigator.**			
Objective	Action Steps	When?	Who?
Create a hub/wrap-around model for children experiencing homelessness; including braded funding that is not medicalized	Define what peer navigator includes	Who at the table will determine when? ↓	
	Define what "hub" includes + sources of funding (i.e., beyond MassHealth)		
	Funding – tap into broader grants for long-term funding		
	Look across other states for examples of who might be doing this well		- Research/landscape review à Housing First model
	Explore advocacy partners		- Law school clinics / research that exists
Action Planning Participants: Marisol Amaya, La Alianza Hispana; Jennifer Bronsdon, MGH Revere Healthcare Center; Melissa Marlowe, MA Dept of Public Health; Christy Moulin, The Home for Little Wanderers; Cecilia Plotkin, FamilyAid; Kathryn Ratey, Suffolk Family Resource Center; Leah Scandurra-Stockman, Dana-Farber Cancer Institute			

Parking Lot

The CHIME Mappings cannot address all problems facing accompanied children experiencing homelessness. The Parking Lot is used to record issues which are not specific to children experiencing homelessness or which issues are important but cannot be addressed within a reasonable timeframe. During the Health & Well-Being mapping, the following issues were placed in the Parking Lot:

- Updating the Federal definition of homelessness among housing agencies. Participants advocated for housing agencies to use the McKinney-Vento definition of homelessness due to the significant impact of being doubled-up on children's health and well-being.
- Creating a shared language across systems and agencies.
- Increasing training and workforce development for new arrivals including English language education.

Quick Wins

During the CHIME Mappings, there can also be issues raised that have a quick resolution such as a connection between agencies or people unfamiliar with each other but looking for a particular resource one or the other can offer. During the Health & Well-Being mapping, the following issues were offered as Quick Wins:

- The BPS nurse specialist does not currently ask any questions about housing status. However, during the mapping, the BPS nurse program director noted a willingness to add a question to the nurse screening process. Participants were supportive of this initiative because nurses are often trusted by families to share sensitive information.

Other Considerations

After each CHIME mapping, the project team captures additional considerations that are raised by people with lived experience of the CHIME Executive Committee when asked for feedback based on their experience and expertise which are included in the respective report. There were no other considerations raised following the Health & Well-Being mapping.

The CHIME project team also recognizes the importance of refining our own processes and incorporating feedback from people with lived experience into future CHIME events.

Based on feedback from family participants with lived experience and other stakeholders at this and past mapping sessions, the CHIME project team plans to add or otherwise maintain the following changes to better prepare and accommodate families:

- Translate relevant CHIME materials and provide day-of interpretation services for participating families who are non-English speaking or prefer Spanish as their written language.
- During the mapping, ensure facilitation approaches are conducted through an antiracist and culturally and linguistically sustaining practice (CLSP) lens.
- Incorporate cultural humility into the CHIME values.
- Provide an opportunity to meet with a social worker prior to and/or following mapping sessions.
- Coordinate a pre-mapping discussion between the project manager with existing participating families and new participating families to build peer support.
- Make explicit mention of the priorities that families who participated in the mapping voted on with the larger group before finalizing the top priorities, to elevate the voices of those currently experiencing homelessness.

Afterword

The saying goes "It takes a village to raise a child." This may be especially true when children and families are experiencing homelessness. Support from family and community, including schools, health care systems and community-based programs, are all elements of "the village" needed to ensure that children experiencing homelessness have what they need to support their health and well-being.

Throughout the CHIME Health & Well-Being mapping, it was apparent that "the Massachusetts village" has the capacity to support the health and well-being of children experiencing homelessness. From the extensive pediatric primary care network across the state to school systems that support homeless children to programs to support the development of young children, our community understands the need for support and action. But participants in the mapping process repeatedly returned to the concept that a lack of coordination and barriers to accessing these programs prevent families from getting what they need. Could we create a web-based hub for child health programs that allows families to enter their information once to determine potential eligibility for a range of existing programs? How could we support coordination and communication between parents, healthcare, schools and child health programs? How can we make it easy for families to identify and enroll in programs that meet their needs? The ideas that were generated from the mapping have a common theme – as we evaluate gaps in current services, we recognize the need to optimize access to existing supports and programs.

This mapping process has provided us with a clear pathway forward. Equipped with a deeper understanding of the current landscape of programs to support the health and well-being of children experiencing homelessness, our village should embark on an intensive period of coordination, communication, and collaboration to create easy and efficient access to programs and services. We must leverage technology and prioritize the voice of those with lived experience as we seek solutions. We need to break down silos and create efficient networks that connect, not separate us. How do we move forward? It takes a village.

Snehal Shah
CHIME Executive Committee, Boston Children's Hospital

Appendices

Appendix 1 CHIME Health & Well-Being Mapping Participant List

Appendix 2 Health & Well-Being Acronym Glossary

Appendix 3 Day 1 and Day 2 Agendas

Appendix 4 CHIME Community Self-Assessment

Appendix 1

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Appendix 2

ABCD	Action for Boston Community Development
ACF	U.S. Administration for Children and Families
ASQ	Ages and Stages Questionnaire
BHA	Boston Housing Authority
BPHC	Boston Public Health Commission
BPS	Boston Public Schools
CCCB	Child Care Choices of Boston
CCR&R	Child Care Resource and Referral
CFCE	Coordinated Family and Community Engagement
CFV	City Funded Voucher
CHA	Community Housing Authorities (i.e., Boston Housing Authority)
CHIME	Child Homelessness Intercept Mapping and Engagement
COC	Continuum of Care
CPT	Common Planning Time
CRAFFT	Screening tool designed to identify substance use and related risks among adolescents aged 12-21
DCF	Mass. Department of Children and Families
DESE	Mass. Department of Elementary and Secondary Education
DMH	Mass. Department of Mental Health
DPH	Mass. Department of Public Health
DTA	Mass. Department of Transitional Assistance
EA	Emergency Assistance; State-funded shelter resources for families experiencing homelessness
ECE	Early Childhood Education

EEC	Mass. Department of Early Education and Care
EHIP	Early Homelessness Intervention Program
EHS	Early Head Start
EHV	Emergency Housing Voucher
EI	Early Intervention
EOE	Mass. Executive Office of Education
EOHHS	Mass. Executive Office of Health and Human Services
EOHLC	Mass. Executive Office of Housing and Livable Communities (formerly Department of Housing and Community Development, DHCD)
ESE/DESE	Mass. Department of Early and Secondary Education
FERPA	Family Educational Rights and Privacy Act
FMR	Fair Market Rent
FPL	Federal Poverty Line
HERN	Boston Public Schools Homeless Education Resource Network (within the Department of Opportunity Youth)
HIPAA	Health Insurance Portability and Accountability Act
Homeless Liaisons	Boston Public Schools staff that coordinate services to children/families experiencing homelessness
HS	Head Start
HUD	U.S. Department of Housing and Urban Development
IEP	Individualized Education Plan
JRI	Justice Reinvestment Initiative
MassHealth	Medicaid and other program administration; State's health insurance program for low-income children, families, elders, and persons with disabilities
MOH	City of Boston Mayor's Office of Housing (formerly Department of Neighborhood Development, DND)

MRVP	Mass. Rental Voucher Program
MTSS	Multi-Tiered Systems of Support
OHS	Office of Housing Stability (within the Mayor's Office of Housing)
OY	Department of Opportunity Youth
PSE	Policy, Systems, and Environmental
SEL	Social-Emotional Learning
SMI	State Median Income
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SST	Student Support Teams
STRIVE	BPS Supporting Transitions to Reach Independence through Vocational Experiences
SY	School Year
TAFDC	Temporary Assistance for Families with Dependent Children
TANF	Temporary Assistance for Needy Families
TIC	Trauma-Informed Care
UDL	Universal Design for Learning
UPK	Universal Pre-K
WIC	Women, Infants, and Children Nutrition Program
YEA!	ABCD Youth Engagement Action!
YRBS	Youth Risk Behavior Survey

Appendix 3

HEALTH & WELL-BEING MAPPING

September 26, 2023
Boston, MA

Day 1 Agenda

8:30 **Registration, Breakfast, and Networking**

9:00 **Opening**

- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks

CHIME

- The Basis of Cross-Systems Mapping
- The Ascend Model
- Five Key Areas for Interception

Cross-Systems Mapping

- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities

- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up

- Review

4:30 **Adjourn**

There will be a 15-minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately 12:30.

HEALTH & WELL-BEING MAPPING

September 27, 2023
Boston, MA

Day 2 Agenda

8:30 **Registration, Breakfast, and Networking**

9:00 **Opening**

- Remarks
- Preview of the Day

Review

- Day 1 Accomplishments
- Boston’s Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

Next Steps

Summary and Closing

1:00 **Adjourn**

There will be a 15-minute break mid-morning.

Appendix 4

CHIME Community Self-Assessment

(Pre-mapping)

This survey will help us learn about our community's collaboration, services, and activities for accompanied children experiencing homelessness (i.e., children 0-18 experiencing homelessness with a parent or legal guardian). We ask that you please complete this survey before the CHIME (Child Homelessness Intercept Mapping and Engagement) workshop. We will send this survey out again 3 months and 12 months after each CHIME mapping.

By completing this survey, you will share your thoughts on the state of Boston's resources for accompanied children experiencing homelessness. This survey will take less than 10 minutes to complete.

This survey will help guide our efforts to improve services for accompanied children experiencing homelessness. For this survey, homelessness is defined as those accompanied children who "lack a fixed, regular and adequate nighttime residence," including those:

- sharing housing due to loss of housing or economic hardship;
- living in motels, trailer parks or campgrounds;
- living in emergency or transitional shelters;
- abandoned in hospitals;
- primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
- living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings;
- migratory children who qualify as homeless because they are living in circumstances described above

We hope the questions will inform our group discussion to improve services for accompanied children experiencing homelessness.

Your participation is voluntary and confidential. No one person's answers will be shared. Your responses will only be reported in a combined format so as not to identify any one person or program.

We appreciate your participation. Please click submit to continue.

Demographics

We would like to gather responses from leaders, staff, and people with lived experience to inform the CHIME Mappings. The questions below ask about your lived experience. Your participation is voluntary. Your responses will be kept confidential.

1. Have you ever had lived experience with housing instability or homelessness as parent /caregiver or child?

    Yes/No

    1.1: (If Yes) Are you currently experiencing housing instability or homelessness as a parent/caregiver?

        Yes/No (if Yes, skip to Parents/Caregivers with Lived Experience section)

2. What field or group best represents your current role? (select one)

    Shelter, Housing, and Homelessness Services
    Childcare partnerships, pre-K, Early Head Start or Head Start
    K-12 Schools, GED, or Education
    Behavioral Health and/or Medical Services
    Post-secondary education, employment, or training program
    Mentoring, Coaching, Sports, Arts, & Camps
    Child Welfare System
    Court System
    Other State or Local Government Agency
    Other: Describe_____________________________

3. How many years of experience do you have in your field? (numeric open ended)

4. If you are representing an organization/state or city government entity/ what is your role within it?

    A. Elected official
    B. Administrator/Manager
    C. Case manager/social worker (if yes, also complete CM-specific questions)
    D. Teacher
    E. Healthcare provider (behavioral health or medical)
    F. Other: Describe_____________________________

2. Collaboration and Coordination

Please indicate your level of agreement with the statements below as they relate to services for children in families experiencing homelessness. (Strongly Disagree to Strongly Agree)

A	There is cross-system recognition that children of families experiencing homelessness would benefit from services that promote positive experiences.
B	Agencies share resources and staff to support initiatives focused on children of families experiencing homelessness.
C	Stakeholders engage in frequent communication on issues facing children of families experiencing homelessness, including opportunities, challenges, and oversight of existing initiatives.
D	Parents/caregivers with lived experience of homelessness are engaged as stakeholders on collaborations, such as committees, task forces, and advisory boards.
E	Agencies working with children of families experiencing homelessness engage in cross-system education and training to improve collaboration and coordination and understanding of different organization priorities, philosophies, and mandates.
F	Agencies working with children of families experiencing homelessness share data on a routine basis for the purposes of program planning, program evaluation, and performance measurement.
G	Agencies working with children experiencing homelessness engage in cross system training on understanding trauma and adverse childhood experiences as well as its impact on children.
H	Agencies working with children experiencing homelessness engage in cross system training on understanding child development and mental health in order to best target service needs of children.

I. Current collaborations:

I.1. My organization currently collaborates with other stakeholders (agencies/programs/services) to meet the needs of accompanied children experiencing homelessness. (Yes/No; if no, skip I.2)

I.2. What other groups of stakeholders do you collaborate with to meet the needs of accompanied children experiencing homelessness? (check all that apply)

Shelter, Housing and Homelessness Services
Childcare partnerships, pre-K, Early Head Start or Head Start
K-12 Schools, GED, or Education
Behavioral Health and/or Medical Services
Post-secondary education, employment, or training program
Mentoring, Coaching, Sports, Arts, & Camps
Child Welfare System

Court System
Other State or Local Government Agency
Other: Describe

I.3. Do you as an individual participate in any coordinating groups, committees, or task forces to meet the needs of accompanied children experiencing homelessness? (Yes/No)

I.31. (If yes) please list:

3. Identification

Please indicate your level of agreement with the statements below as they relate to your organization. (Strongly Disagree to Strongly Agree)

A	Beginning at the earliest points of contact with our organization, children are being screened for homelessness or being at risk for homelessness.
B	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for educational needs.
C	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for mental/behavioral health needs.
D	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for medical needs.
E	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for engagement in afterschool, mentoring, sports, or arts activities.
F	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for exposure to traumatic events (including adverse childhood experiences) and the potential impact on functioning.
G	Beginning at the earliest points of contact with our organization, children experiencing homelessness are being screened for developmental delays.

H. Does your organization use any validated screening tools with children under the age of 18? (Yes/no; if no, skip H.1.)

H.1. (if yes) Please select the tools your organization currently uses from the following list.

ASQ
Pediatric Symptom Checklist
CRAFFT
Other: Describe________

4. Services

Please indicate your level of agreement with the statements below as they relate to your organization. (Strongly Disagree to Strongly Agree)

A	Our organization prioritizes slots for our programs/services/supports for accompanied children experiencing homelessness.
B	Our organization has specific programs designed to meet the needs of accompanied children experiencing homelessness.

C	Our organization has programs with adequate capacity for accompanied children experiencing homelessness
D	Access to housing, early education, positive experiences, services, transportation, and/or other supports for accompanied children experiencing homelessness are significant priorities for my organization.
E	There is easy and consistent access to services for accompanied homeless children in our organization.
F	The services and programs provided accompanied children experiencing homelessness by my organization are culturally sensitive and designed to meet the needs of children of color and various sexual orientations.
G	Our organization offers programs for accompanied children experiencing homelessness in our clients' primary language.
H	Our organization offers gender-neutral services and programs for accompanied children experiencing homelessness who may identify as LGBTQ or transgender.
I	Our organization offers gender-specific services and programs for accompanied children experiencing homelessness who identify as girls.
J	Our organization offers gender-specific services and programs for accompanied children experiencing homelessness who identify as boys.
K	Emergency assistance, shelter, housing, educational, medical, mental/behavioral health, and other providers share information on accompanied children experiencing homelessness, to the extent permitted by law, to assist effective delivery of services and programs to children facing homelessness.

J. Does your organization prioritize any services for accompanied children experiencing homelessness? (Yes/No; if no, skip K)

J.1. (If yes) In which of the following categories does your organization prioritize services:

Shelter, Housing, and Homelessness Services
Childcare partnerships, pre-K, Early Head Start or Head Start
K-12 Schools, GED, or Education
Mental/Behavioral Health and/or Medical Services
Post-secondary education, employment, or training program
Mentoring, Coaching, Sports, Arts, & Camps
Child Welfare System
Court System
Other State or Local Government Agency
Other: Describe

K. Are those services specifically designed for accompanied children experiencing homelessness? (Yes/No; if no, skip K.1 and K.2)

K.1. (If yes) In which of the following categories does your organization provide services under:

Shelter, Housing and Homelessness Services
Childcare partnerships, pre-K, Early Head Start or Head Start
K-12 Schools, GED, or Education
Mental/Behavioral Health and/or Medical Services
Post-secondary education, employment, or training program
Mentoring, Coaching, Sports, Arts, & Camps
Child Welfare System
Court System
Other State or Local Government Agency
Other: Describe

K.2. (for each checked off) Please describe the services

If yes to question 3.C. (CM/SW) in Demographics also ask:

L.1: I am aware of and connected to an adequate number of shelter, housing, and financial support services to effectively support homeless children and their families outside of what my organization offers. (Yes/No)

L.2: I am aware of and connected to an adequate number of childcare, Pre-K, Head Start/Early Head Start services to effectively support the early education of homeless children outside of what my organization offers. (Yes/No)

L.3: I am aware of and connected to an adequate number of K-12 schools, GED, or other education services to effectively support the grade school education of homeless children outside of what my organization offers. (Yes/No)

L.4: I am aware of and connected to an adequate number of mental/behavioral and physical health and other medical services to effectively support the health and well-being of homeless children outside of what my organization offers. (Yes/No)

L.5: I am aware of and connected to an adequate number of enrichment services (i.e., mentoring, coaching, sports, arts, and camps) to support the social capital of homeless children outside of what my organization offers. (Yes/No)

L.6: I am aware of and connected to an adequate number of post-secondary education, employment, and training program services to support the employment pathways of homeless children (aged 16+) outside of what my organization offers. (Yes/No)

M: Are there any services for homeless children you are aware of but do not utilize? (Yes/no; if no, skip M.1).

M.1. If Yes, please select all that apply.

Often little to no capacity
Outcomes for past families referred are less than ideal
Other (fill-in text box)

Parents/Caregivers with Lived Experience

Your participation is voluntary and confidential. No one person's answers will be shared.

1. Identification

Please indicate your level of agreement with the statements below as they relate to your children. (Strongly Disagree to Strongly Agree)

A	Beginning at the first points of being homeless, your child(ren) was screened for school needs.
	Beginning at the first points of being homeless, your child(ren) aged 0-5 was screened for issues related to development.
B	Beginning at the first points of being homeless, your school age or teen child(ren) was screened for mental health needs.
C	Beginning at the first points of being homeless, your child(ren) or teen was screened for interest in afterschool, mentoring, sports, or arts activities.
D	Beginning at the first points of being homeless, your teen child(ren) was screened for employment, training, or college prep needs.
E	Beginning at the first points of being homeless, your child(ren) was screened for medical needs.
F	Beginning at the first points of being homeless, your school age or teen child(ren) was screened for exposure to traumatic events and its impact.

2. Services

Please indicate your level of agreement with the statements below as they relate to your children.

A	My child(ren) has been prioritized for services because they were homeless.
B	I was told about specific programs to meet the needs of my child(ren) because they were homeless.
C	Access to services and other supports for my child(ren) are priorities for me right now.
D	The services provided to my child(ren) were culturally sensitive and designed to meet the needs of people of color.
E	Services for my child(ren) were designed for children identifying as girls.
F	Services for my child(ren) were designed for children identifying as boys.
G	Services for my child(ren) were designed for children identifying as transgender or non-binary.
H	Providers asked good questions to aid in the referral and delivery of services for my child(ren).
I	I am connected to shelter, housing, and financial support services to help support my child(ren).

J	I am connected to childcare, Pre-K, and Head Start/Early Head Start services to help support the early education of my child(ren).
K	My child(ren) is connected to K-12 schools, GED or other education services.
L	My child(ren) is connected to mental and physical health and other medical services to help support their health and well-being.
M	My child(ren) is connected to and receives enrichment services (i.e., mentoring, coaching, sports, arts, and camps).
N	My child(ren) is connected to college prep or post-secondary education, employment, and/or training program services.
O	The services my child(ren) receive are offered in their primary language.

Instrucciones

Esta encuesta nos apoya en aprender sobre la colaboración, servicios y actividades de nuestra comunidad para *niños acompañados con falta de vivienda* (es decir, niños de 0 a 18 años con falta de vivienda que tengan un padre o tutor legal). Le pedimos que, por favor, complete esta encuesta antes del taller CHIME (Child Homelessness Intercept Mapping and Engagement) sobre mapeo de procesos. Puede que usted también reciba esta encuesta de 6 y 12 meses después de asistir al taller de CHIME. ¡Le agradecemos su participación!

Durante la encuesta, le pediremos que comparta sus pensamientos sobre el estatus de los recursos en Boston para niños acompañados con falta de vivienda. Esta encuesta tomará aproximadamente 10-15 minutos en completarse.

Esta encuesta ayudará a guiar nuestros esfuerzos y mejorar los servicios para niños acompañados con falta de vivienda. En esta encuesta, la falta de vivienda se entiende como la "carencia de una residencia fija, regular, nocturna y adecuada", incluyendo niños en la siguiente situación:

- compartiendo hogar debido a la pérdida de vivienda o dificultades económicas;
- viviendo en moteles, parques de casas móviles o campamentos;
- viviendo en refugios de emergencia o asistencia de alojamiento transitorio;
- abandonados en hospitales;
- residencia nocturna en un lugar público o privado no diseñado para, o utilizado habitualmente como, un alojamiento regular para seres humanos;
- viviendo en carros, parques, espacios públicos, edificios abandonados, vivienda inadecuada, estaciones de autobuses o trenes, o lugares similares;
- niños migrantes que califican como personas con falta de vivienda porque viven en circunstancias como las descritas anteriormente

Esperamos que las preguntas informen nuestro trabajo para mejorar los servicios para niños acompañados con falta de vivienda.

Su participación es voluntaria y confidencial. Las respuestas no se compartirán. Sus respuestas solo se reportarán de forma discreta para no identificar a ninguna persona o programa.

Agradecemos su participación. Por favor, haga clic en enviar para continuar.

Padres/Guardianes con Experiencia de Falta de Vivienda

Preguntas Demográficas

Su participación es voluntaria y confidencial. Las respuestas no se compartirán.

1. ¿Alguna vez ha tenido inestabilidad o falta de vivienda como padre/guardián o niño?
   Si No

2. Actualmente, ¿tiene inestabilidad o falta de vivienda como padre/guardián?
   Si No

Por favor complete las preguntas a continuación.

3. ¿Qué área o grupo mejor representa su posición actual? (seleccione uno)
   - ☐Servicios de refugio, vivienda, y falta de hogar
   - ☐Asociaciones de cuidado infantil, preescolar, *Early Head Start* o *Head Start*
   - ☐Escuelas de K-12, *GED*, orientación vocacional, o recibiendo servicios de trabajo social
   - ☐Servicios de salud conductual y/o medica
   - ☐Educación superior, empleo, o programa de capacitación
   - ☐Tutoría, entrenamiento, deportes, artes, y campamentos
   - ☐Sistema de bienestar infantil
   - ☐Sistema judicial
   - ☐Otra agencia gubernamental estatal o local
   - ☐Otro:

4. ¿Cuántos años de experiencia tiene en su área o posición actual?

5. Si está representando una organización de estado o gobierno/entidad municipal, ¿cuál es su función dentro de ella?
   - ☐Funcionario electo
   - ☐Administrador/gerente
   - ☐Administrador de casos/trabajador social
   - ☐Maestro
   - ☐Proveedor de cuidado médico/conductual (mental)
   - ☐Otro
   - ☐No aplica

6. Su género es:
   - ☐Hombre
   - ☐Mujer

	Totalmente en Desacuerdo	En Desacuerdo	Ni de Acuerdo ni en Desacuerdo	De Acuerdo	Totalmente de Acuerdo	No sé	No aplica
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades escolares.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) de 0 a 5 años fue(ron) evaluado(s) para detectar problemas relacionados con el desarrollo.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades de salud mental.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar su interés en actividades extracurriculares, tutoría, deportes o artes.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades de empleo, capacitación o preparación universitaria.							

Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades médicas.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar exposición e impacto de eventos traumáticos.							

☐Transgénero: hombre a mujer
☐Transgénero: mujer a hombre
☐Transgénero: sin identificarse como hombre o mujer
☐No binario
☐Género fluido
☐No estoy seguro/Cuestionando
☐Prefiero no contestar
☐Otro

Padres/Guardianes con Experiencia de Falta de Vivienda

Su participación es voluntaria y confidencial. Las respuestas no se compartirán.

1. Identificación

Por favor indique su nivel de acuerdo con las siguientes declaraciones en relación con sus hijos

	Totalmente en Desacuerdo	En Desacuerdo	Ni de Acuerdo ni en Desacuerdo	De Acuerdo	Totalmente de Acuerdo	No sé	No aplica
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades escolares.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s)							

de 0 a 5 años fue(ron) evaluado(s) para detectar problemas relacionados con el desarrollo.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades de salud mental.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar su interés en actividades extracurriculares, tutoría, deportes o artes.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades de empleo, capacitación o preparación universitaria.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar sus necesidades médicas.							
Desde el momento que se quedaron sin vivienda, su(s) hijo(s) fue(ron) evaluado(s) para determinar exposición e impacto							

de eventos traumáticos.							

2. Servicios

Por favor indique su nivel de acuerdo con las siguientes declaraciones en relación con sus hijos

	Totalmente en Desacuerdo	En Desacuerdo	Ni de Acuerdo ni en Desacuerdo	De Acuerdo	Totalmente de Acuerdo	No sé	No aplica
Mi(s) hijo(s) ha(n) sido priorizado(s) para servicios por falta de vivienda.							
Me informaron sobre programas específicos para satisfacer las necesidades de mi(s) hijo(s) porque no tenían vivienda.							
El acceso a servicios y otros apoyos para mi(s) hijo(s) son mis prioridades en este momento.							
Los servicios proporcionados a mi(s) hijo(s) fueron culturalmente adaptados y diseñados para satisfacer las necesidades de la gente de color.							
Los servicios para los menores de edad fueron diseñados para las que se identifican como niñas							

Los servicios para los menores de edad fueron diseñados para los que se identifican como niños							
Los servicios para los menores de edad fueron diseñados para los que se identifican como niños transgénero o de género diverso							
Los proveedores hicieron buenas preguntas para ayudar en la remisión y entrega de servicios para mi(s) hijo(s).							
Estoy conectado con servicios de refugio, alojamiento, y financieros para apoyar a mi(s) hijo(s).							
Estoy conectado/a con servicios de cuidado infantil, Pre-K y Head Start/ Early Head Start para apoyar la educación temprana de mi(s) hijo(s).							
Mi(s) hijo(s) está(n) conectado(s) con escuelas K-12, GED u otros servicios educativos.							
Mi(s) hijo(s) está(n) conectado(s) con servicios de salud mental y física, y otros servicios							

médicos para apoyar su salud y bienestar.							
Mi(s) hijo(s) recibe(n) servicios de enriquecimiento (por ejemplo, tutoría, entrenamiento, deportes, artes y campamentos).							
Mi(s) hijo(s) está(n) conectado(s) a servicios de preparación universitaria o educación de postsecundaria, empleo y/o programas de capacitación.							
Los servicios que recibe(n) mi(s) hijo(s) se ofrecen en su lengua materna.							

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