CHIP

Coordinated Entry Workgroup Meeting #6

Monday, September 26, 2016

I. *Present:* Terri Garcia (*Southeast Community Services Center*), Colleen Gore (*Wheeler Mission Ministries*), Lena Hackett (Community Solutions), James Hicks (*IHA*), Mary Jones (*UWCI*), Leslie Kelley (*Horizon House*), Kaley Martin (*Community Solutions*), Lisa Osterman (*Community Solutions*), Calli Pugh (*UWCI*), Rachel Sample (*CHIP*), Susan Solmon (*Salvation Army*), Karin Thornburg (*Midtown*), Kay Wiles (*HIP*), Alan Witchey (*CHIP*)

II. NOFA Update

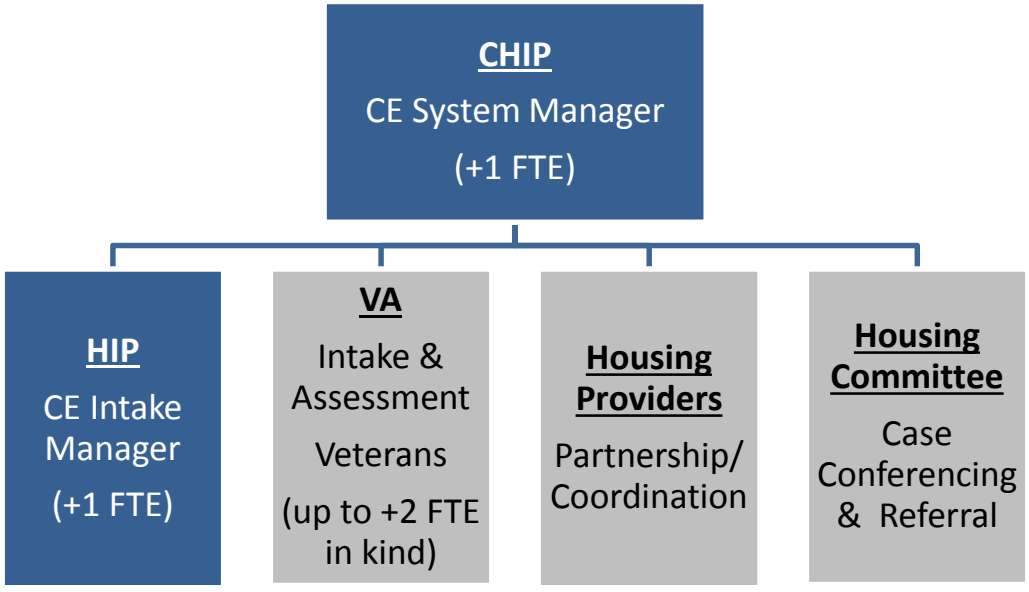
a. The NOFA application was submitted, and notifications should be made by the end of the year.

b. The following budget was included in the NOFA application.

BUDGET ITEM	AMOUNT
System CES Manager (salary and benefits)	$60,000
CES Intake Manager (salary and benefits)	$55,000
Overhead (rent, supplies, etc.)	$16,874
Promotion	$5,000
TOTAL	**$136,874**

III. CE Model Update

a. Participants reviewed the current model of CE for Indianapolis. Based on the urgency of the NOFA application and recommendations from HUD, this workgroup, along with other Blueprint groups, decided to focus on the coordination of assessment and coordination into housing. The current model that went into the NOFA application is included below.



The thinking behind this model is to expand capacity, including leveraging existing resources at partners, like the VA, to align with the work. While there is agreement around this big picture,

the next steps is to develop a process map that includes concrete details about what this actually looks like in the community.

i. In this process, Housing Providers (second gray box) – specifically related to PSH, Transitional, and RRH – would be responsible for the following:

-Provide eligibility information and unit information to System Lead Entity

-Route any requests for housing through System Lead Entity

-Provide updated information on unit availability on an ongoing basis

-Report required data in HMIS

-Collaboratively advocate for right-sized resources, with System Lead Entity

-Accept referrals

b. When looking at what other communities are doing related to CE, there are three types of models. Many communities start at the actual homelessness point and do routing into shelters/diversion and coordination into housing; some focus only on the diversion piece; and some, like Indianapolis, focus primarily on the coordination into housing component.

i. The basic components of coordination into housing include:

*Intake Data Collection (HMIS UDEs)

*Program Eligibility Information

*Vulnerability Index/Prioritization Assessment

IV. Reviewing Assessment Tools

a. There are a limited number of assessment tools being used by other communities. They include

-Vulnerability Index and Service Prioritization and Decision Assessment Tool (VI-SPDAT)

-Downtown Emergency Service Center's Vulnerability Assessment Tool (DESC VAT)

-100 Homes' Vulnerability Index

-National Alliance to End Homelessness Comprehensive Assessment Tool (details included in Appendix)

i. Hennepin County seems to utilize all of the assessment pieces in a single approach that includes a 1) Diversion Screening, 2) Shelter/Program Intake, and 3) VI-SPDAT. Additional details about their approach are included in the Appendix.

b. With funding for assessment into housing, it is time to decide on assessment tools given the system needs and staffing structure. The data required to make choices about housing are probably similar to the data required to make choices for an individual earlier in the process. UDE data should exist for individuals from HMIS-user agencies. There are questions about how to capture UDE data for agencies that don't use HMIS – what does that process look like?

i. Participant Comments/Questions included:

1. Our community is changing how we offer services, so there are a lot of resources going to support CE.

a. VA is already collecting this information and funded to do so. We need to be sure their in-kind contributions align with the work at the community level.
b. Wheeler updated their data system and will be doing daily CE data sets in October.
c. HIP is looking at its funded services to see how they fit.
d. The ESG and Housing Trust Fund applications are changing, so housing service providers will be required to do CE in order to get funding.
e. We could look at the MOUs for the agencies.

2. While the shelter coordination piece is not being funded by HUD, there are other resources coming to the table – United Way, VA, community-level resources – to make that piece more complete. There's an evolving picture of what this model looks like.
    a. As we are designing this model, we have to start with the concrete commitments and build up from there, understanding that we may get additional resources along the way.

V. Review of Current Assessment Coordination

a. Karin reviewed the current application/assessment process with PSH and RRH. People access the application on the web, complete/print it, and then send it to Karin, but some applications get sent to Brie at HIP instead of Karin. Karin pulls all of the potentially relevant information from the applications and puts it into a spreadsheet, which she uses to identify the appropriate people for programs. There is a case conferencing meeting every Tuesday to discuss the applications, but there are so many that they aren't processed in time to get a list, and there is no way to prioritize the applications. HIP is providing training/support to the shelters about completing the applications, but much more training is needed.

i. Participant Comments/Questions included:

1. If the system were resourced more fully, it would be great if we could put everyone into RRH, and if they make it, great, and if they don't, they are bounced back to the PSH pool. That system seems so much easier, but we aren't staffed for it.
2. There is the need for a feedback loop regarding the status of applications and referrals. For example, if a veteran application is sent to Lillian at HIP, who is on the Veterans Taskforce, there is no communication back as to the status or progress of that application.
3. The applications should be completed based on the clients' resource needs, then determine the programs that are the best fit instead of trying to fit people into the programs we think are right for them. It also speaks to the idea of agencies accepting referrals and sending referrals out. We should be serving people at the agency that meets their needs, not just the agency at which they presented.

4. HIP will be ready to take on the Systems Manager role in January, and all applications will be funneled through CHIP, which will also manage the lists. The case conferencing piece will remain. We still need to figure out how communication flows back and forth, as well as how prioritization will work.

b. Participants were asked about the current assessment tool and if it collects all of the information necessary to make appropriate decisions. Participant responses included:
   i. Challenges with the VI include that you have to know the person pretty well before you can complete it, and it is fairly subjective. We need a tool that accurately states the person's need level.
   ii. The Excel file application tool was originally designed for RRH. Those who complete it for RRH seem to prefer it to the VI, but those who use it for PSH prefer the VI. Since the application tool is primarily completed by Midtown staffers, perhaps it works well for mental health folks but not for people working at shelters or other agencies.
   iii. The community is required to have a common assessment tool that is used for PSH, RRH, and Transitional housing. Currently, both the application tool and the VI are being used in combination, as a sort of Part 1 and Part 2 of the assessment.
   iv. There are other communities who have been doing CE with some success. We should look at the tools they're using.
   v. While there has been some previous discussion about and testing of various tools, it was done through the RRH lens, not looking at the whole system. For that reason, participants agreed to schedule a sub-group to review various instruments and processes and develop a recommendation to bring back to the full CE workgroup at the October meeting.
      1. Participants were reminded what Joyce from HUD shared with the group at a previous meeting. HUD wants to see those with the highest need get whatever housing is first available. The current assessment is more about funneling people into types of housing.
      2. Participants prefer an assessment that triages people within particular housing types
   vi. Participants also agreed that it is important to figure out which elements of the application are critical and should be asked no matter what tool is used. Community Solutions will reach out to housing providers to identify those critical elements. Recommendations for whom to ask for feedback include RRH, PSH, and Transitional Housing providers and the Housing Business meeting (last Wednesday of the month).
      1. It may be possible to add some of those elements in HMIS to make the application process easier.

VI. Next Steps

a. The next meeting is on October 24th from 3:00-4:30 pm at CHIP.
b. Community Solutions will reach out to RRH, PSH, and Transitional Housing providers and the Housing Business meeting for feedback on the critical elements that must be included on the common assessment.
c. Community Solutions will organize a sub-group to review the various assessment instruments and processes through the common assessment lens. They will develop a recommendation for the common assessment to share with the CE Workgroup at the October meeting.

APPENDIX: Additional Assessment Information

Components of the National Alliance to End Homelessness Comprehensive Assessment Tool

1. ***Pre-screening questions*** to determine if the household will be best served through coordinated assessment or should be referred to other resources.
2. ***Questions that cover many of the HUD-required universal data elements and program data elements,*** which communities should also adjust according to their preferences.
3. ***Prevention and diversion questions*** to determine if the household can be successfully diverted from entering the homeless assistance system.
4. ***The Housing Prioritization Tool****,* which identifies housing barriers and prioritizes the people who are usually deemed the hardest to serve for system services.
5. ***Population-specific questions*** that identify consumers who need specialized services (other than veterans and domestic violence survivors, who are covered earlier on in the process).
6. ***A referral discussion section*** that incorporates consumer choice into the process. Communities will prioritize some consumers for multiple interventions as a result of the Housing Prioritization Tool.
7. ***A modified version of 100K Homes' Vulnerability Index (VI) and VI Scoring*** for those consumers who are prioritized for permanent supportive housing. Communities can substitute in other Permanent Supportive Housing prioritization tools besides the Vulnerability Index.

Summary of Hennepin County Approach

- ***Part I, Diversion Screening****:* used to help identify options for housing other than shelter. This will also collect basic demographic information about the household.
- ***Part II, Shelter/Program Intake***: used for those who were not able to find an alternative to shelter. Collects information on household needs in relation to the program they are entering, and builds on the demographic info collected in Part I of the assessment.
- ***Part III, VI-SPDAT***: This includes the VI-SPDAT (or family/youth version), as well as a few questions that attempt to further target housing interventions for the household. This section is completed after the household enters shelter, typically after 3-10 days depending on the program and population.