NC Balance of State

Coordinated Assessment Workshops
Raleigh, NC
September – October 2014

NC Coalition to End Homelessness

CA Workshop Goals

- Start the conversation about Coordinated Assessment in your community
- Walk away with an understanding of
  - What Coordinated Assessment is
  - Why we are moving toward Coordinated Assessment
  - Identify the resources your community has to implement Coordinated Assessment
  - Identify the questions and/or challenges your community will need to address to implement Coordinated Assessment

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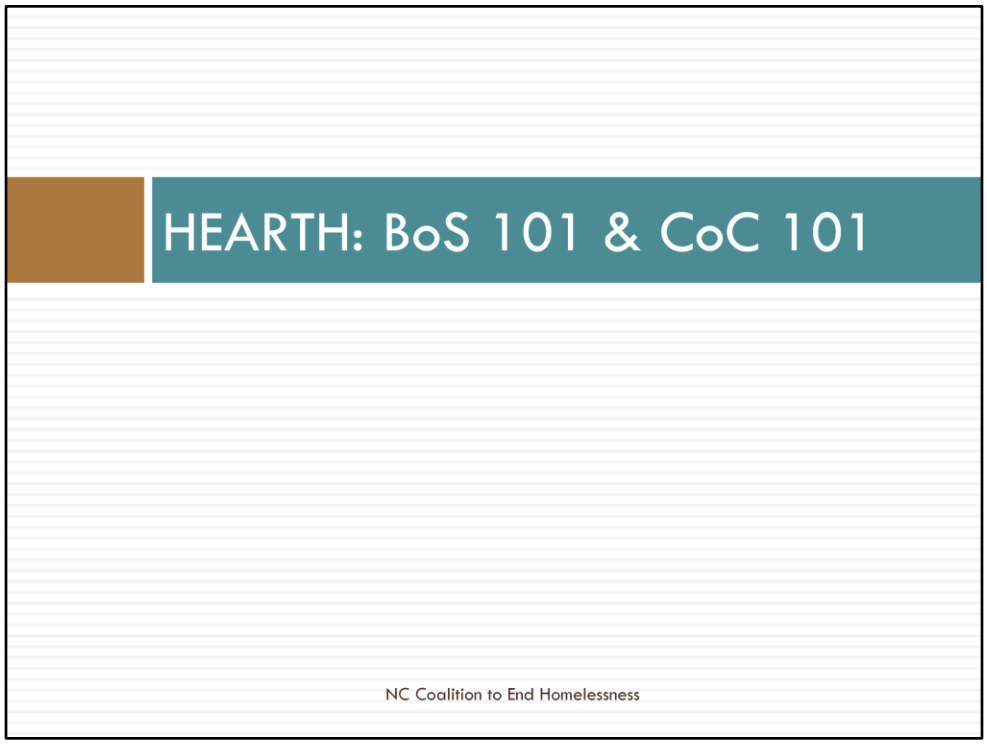
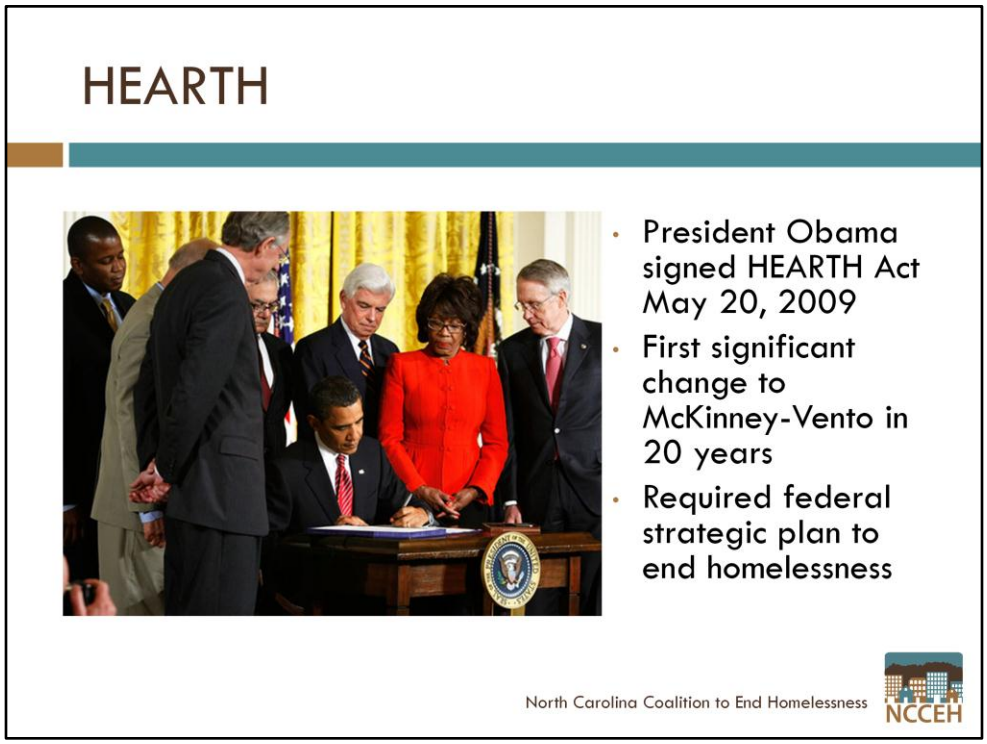

HEARTH: BoS 101 & CoC 101
NC Coalition to End Homelessness



Homeless Emergency Assistance and Rapid Transition to Housing Act, 40 pages long

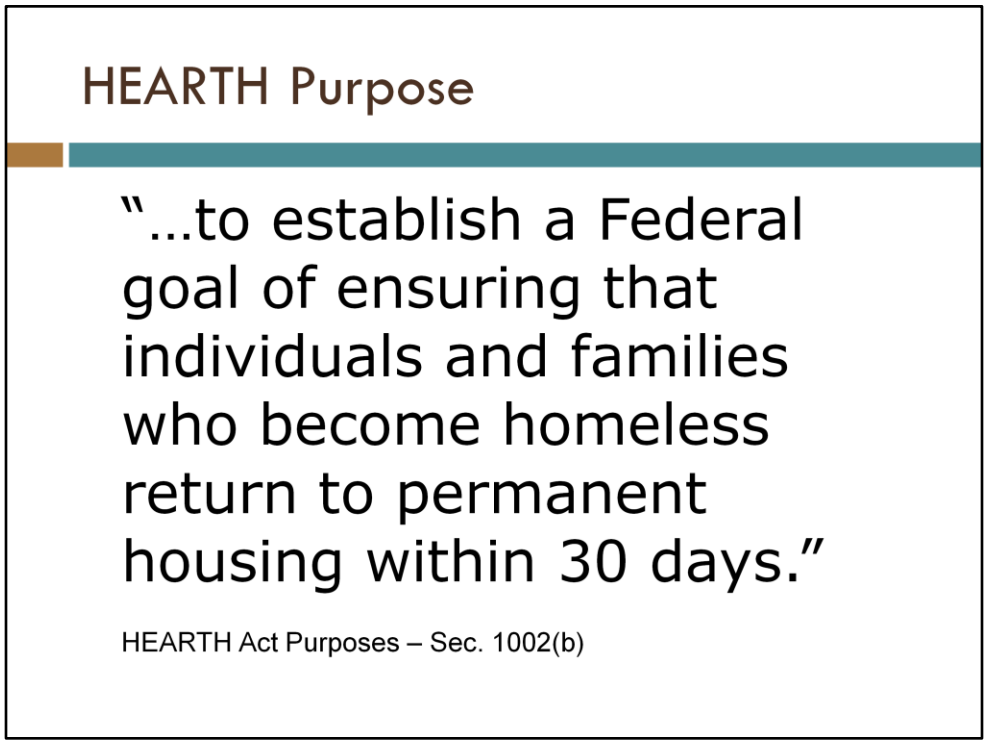
Our system is in a state of change, has changed a lot in past few years

2009: significant change to McKinney = HEARTH Act, revamps all housing programs under HUD, first change since McKinney passed in 1987

1. Required Fed Strategic Plan to End Homelessness
2. Redefines purpose of homeless programs

There are several themes highly prevalent in the HEARTH legislation

transparency & accountability
data-driven analysis and decision-making
community-level responsibility rather than program-level responsibility
consumer-focused approach / housing first principles

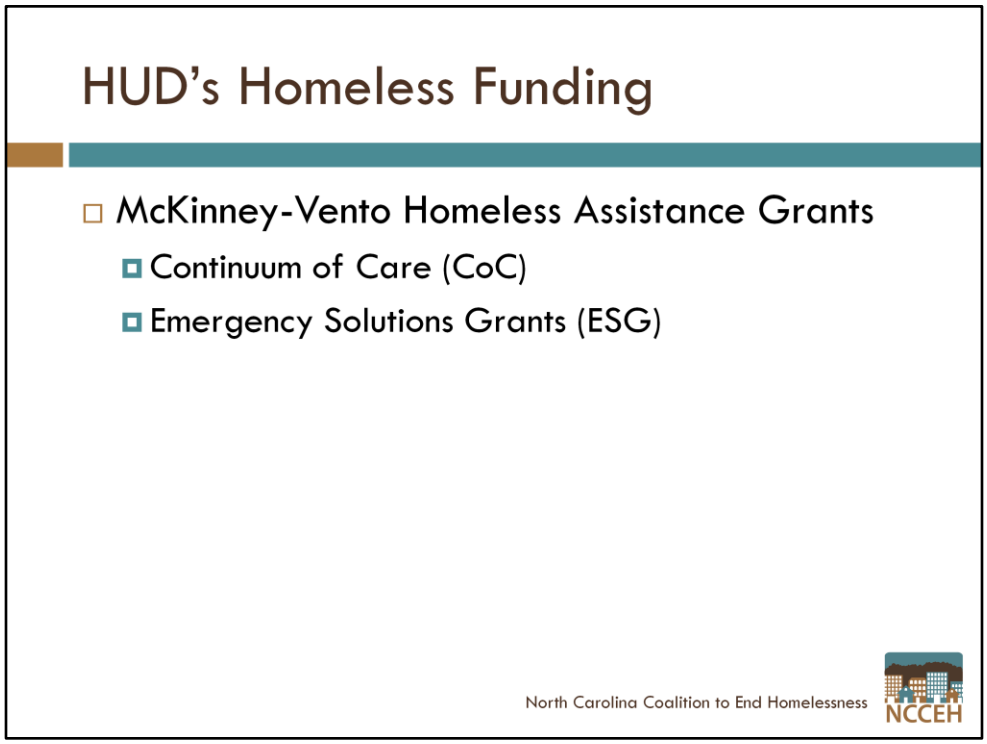


The HEARTH Act makes it an explicit federal goal that people who become homeless quickly move back into permanent housing.

Goal = for anyone who becomes homeless, get them out of homelessness in 30 days

Pretty ambitious

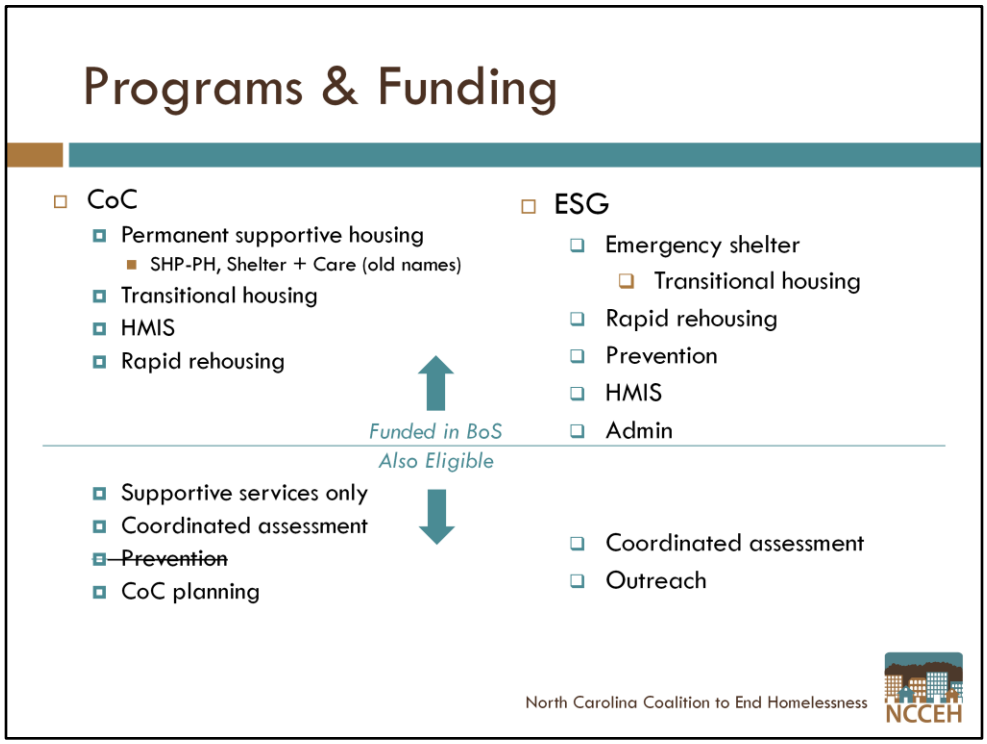
What we mean when we say we will end homelessness is this… Not that no one will become homeless – people will still have housing crises, but when they do they will return to permanent housing ASAP



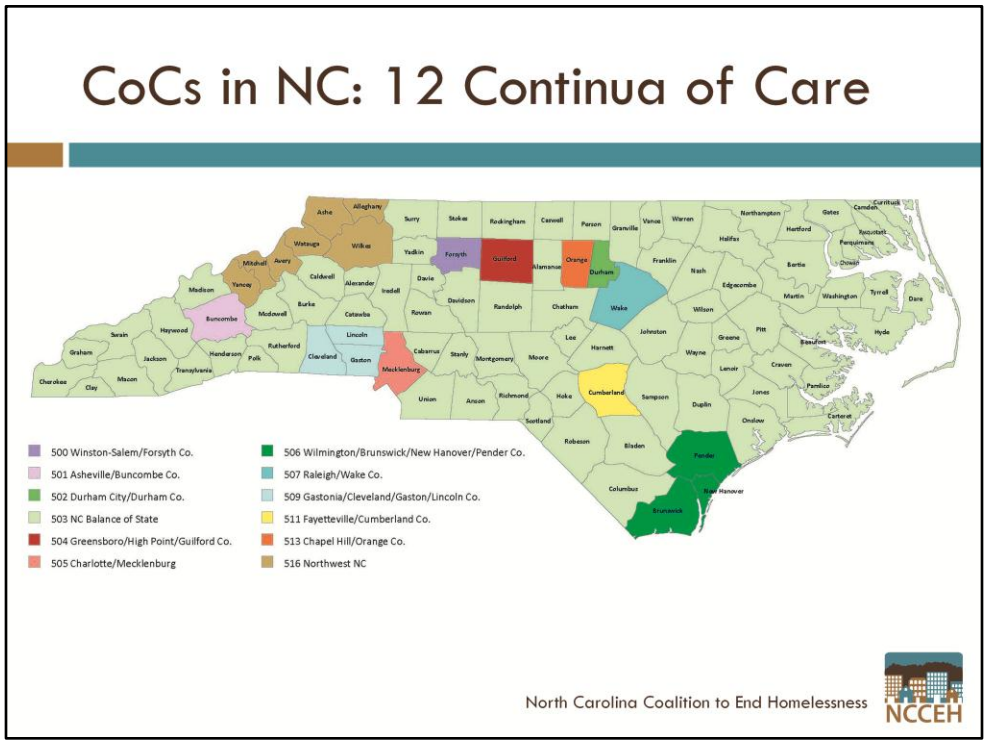
HUD funding through McKinney (more on process later):

CoC grants – national competition

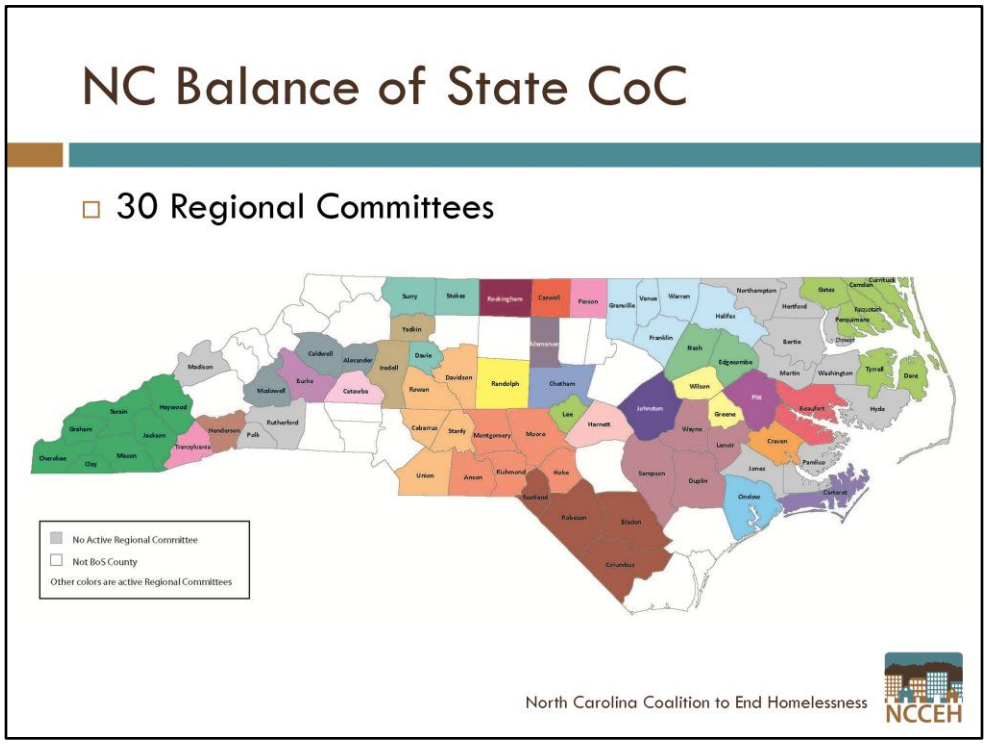
ESG – block granted to state, run through NC DHHS



Everything on top of the blue line = programs and services funded within BoS (current and renewal projects)



Currently, there are 12 CoCs in NC. Before the Balance of State was created, there were more than 30 CoCs.



Balance of State area is quite large; it includes 79 mostly rural counties.

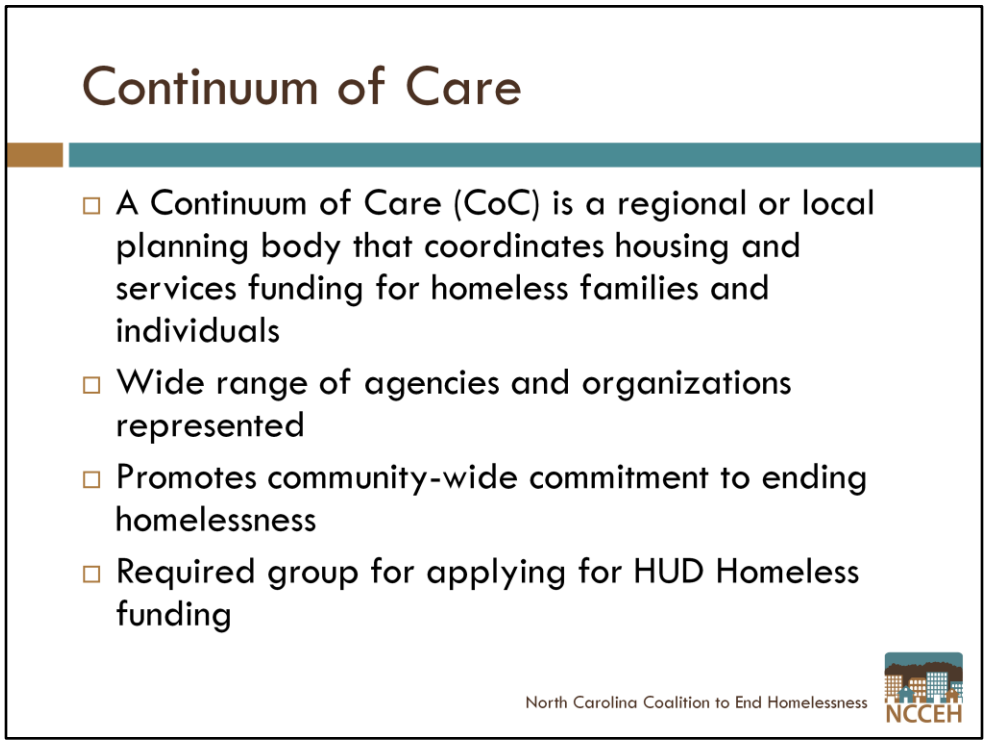
30 regional committees within BoS –

Organic shapes and sizes

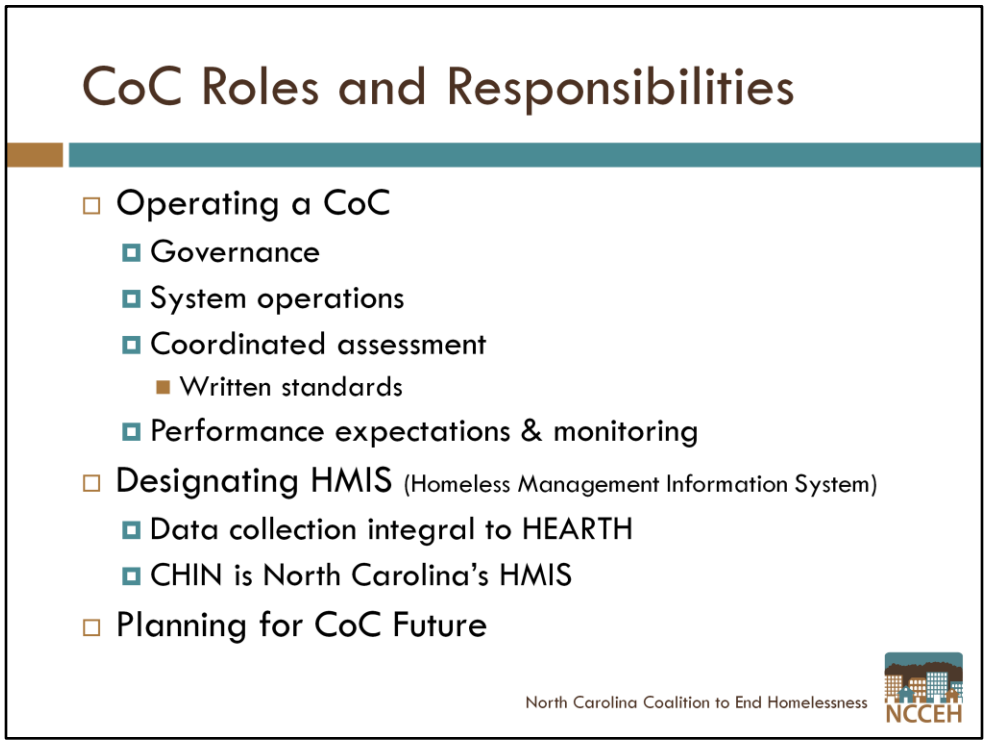
BoS structure has bottom up and top down elements

Bottom up – groundswell of activity needed to start a Regional Committee, size and shape up to community

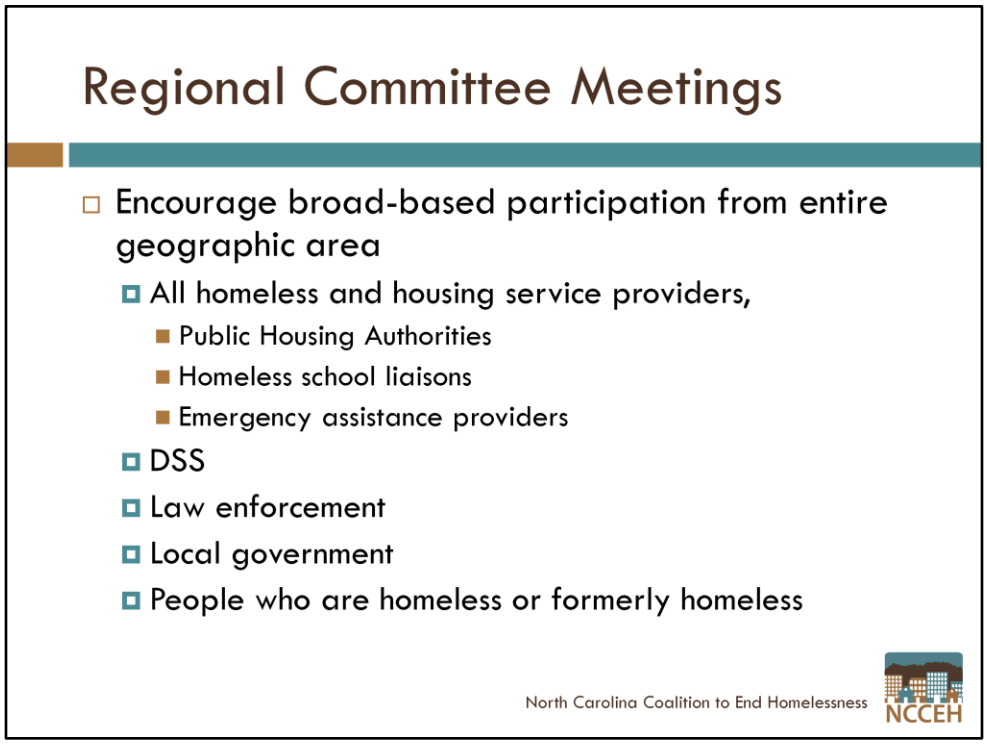
Top down – consistency of policies and procedures from Steering Committee provide consistency across CoC – we are judged/evaluated/etc. on the CoC level not the Regional Committee or program level



CoCs promote communitywide commitment
regular meetings
lots of folks at the table
everyone going in the same direction



- Administrative functions include governance, staffing of committees and workgroups and a few new components outlined in HEARTH designed to make CoCs more efficient and effective
    - Coordinate Intake/aka Coordinated Assessment
    - Written Standards – promotes transparency and accountability of the system
    - Performance Expectations & monitoring – Buy the best outcome for our money, shift resources to those doing the best job of ending homelessness
- HMIS – Homeless Management Information System required by HUD
- Planning for future – constant improvement and growth until we reach our goal



Regional Committees meet regularly

Public meetings, meeting notices published, agendas and minutes available on NCCEH.org

Multi-county Regional Committees

some monthly as individual counties/other months as RC at large

some always meet at large

Regional Lead is liaison between BoS as a whole and local efforts

Regional Lead also serves on BoS Steering Committee = BoS governance body

Regional Committee Responsibilities

- Elect Regional Lead and alternate
- Coordinate annual ESG funding competition
  - Regional ESG application
  - Competitive process for selecting project applications
- Elect representatives to CoC Scorecard and Project Review Committees
- Elect Point-in-Time Count point person
  - Coordinate PIT count
  - Submit data to NC BoS staff

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Regional Committee Responsibilities

- Submit Regional Committee plan for Coordinated Assessment
- Administer Coordinated Assessment system
- Promote HMIS and data-driven decision making in accordance with HUD guidelines
- Promote timely and accurate reporting for ESG and CoC grantees

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Benefits of Participation

- Share resources
- Establish need & gaps
- Coordinate housing & services
- Create referral networks
- Systems change coordination
- Continuum of Care (CoC) $
- Emergency Solutions Grants (ESG) $

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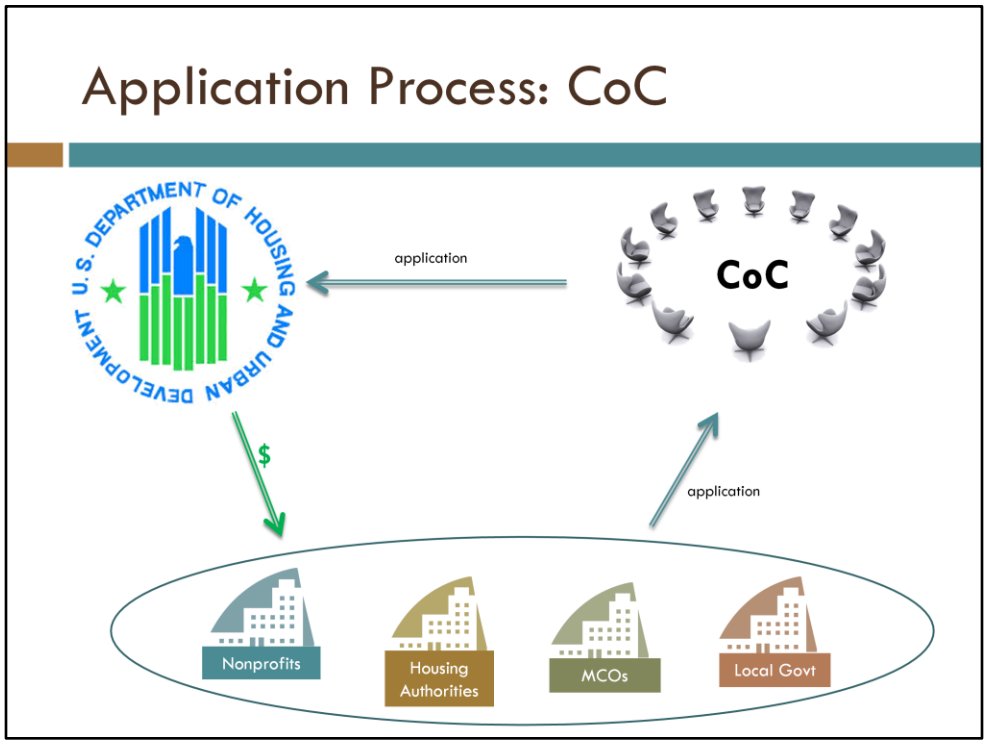


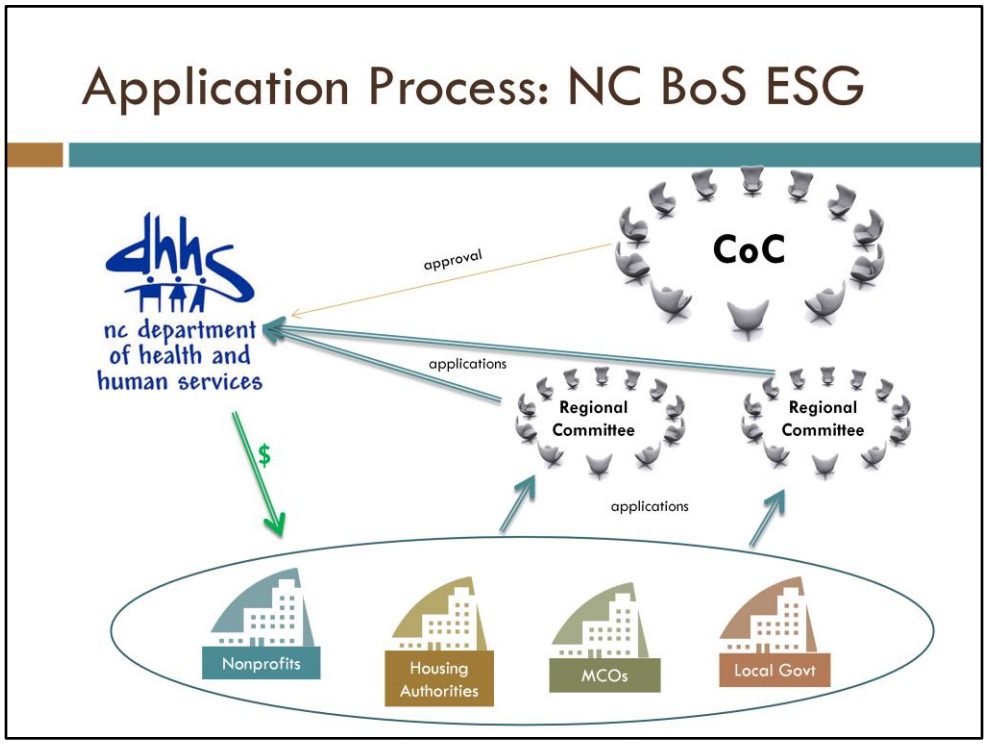
Here's how the funding process works for the CoC competition

HUD releases rules and regs for annual competition – largest competitive grant in the USA

Applications are the blue arrows, start from community agencies – competitive process at the CoC

CoC scores and ranks apps + writes collaborative application – entire packet goes to HUD

HUD makes awards, sends funds directly to grantee agencies



For ESG Regional Committees act as the Regional Lead agency (rather than CoC as in rest of NC)

In NC BoS, Regional Committees run competitive, transparent process of requesting project applications; they select projects to fund based on standards, submit these applications + regional application directly to NC DHHS.

NC BoS approves regional applications based on standards set by NC BoS Steering Committee.

NC DHHS issues contract and funds directly to approved projects.

Resources

- NCCEH
  - ncceh.org
- HUD
  - onecpd.info
- US Interagency Council on Homelessness
  - usich.gov
- National Alliance to End Homelessness
  - endhomelessness.org

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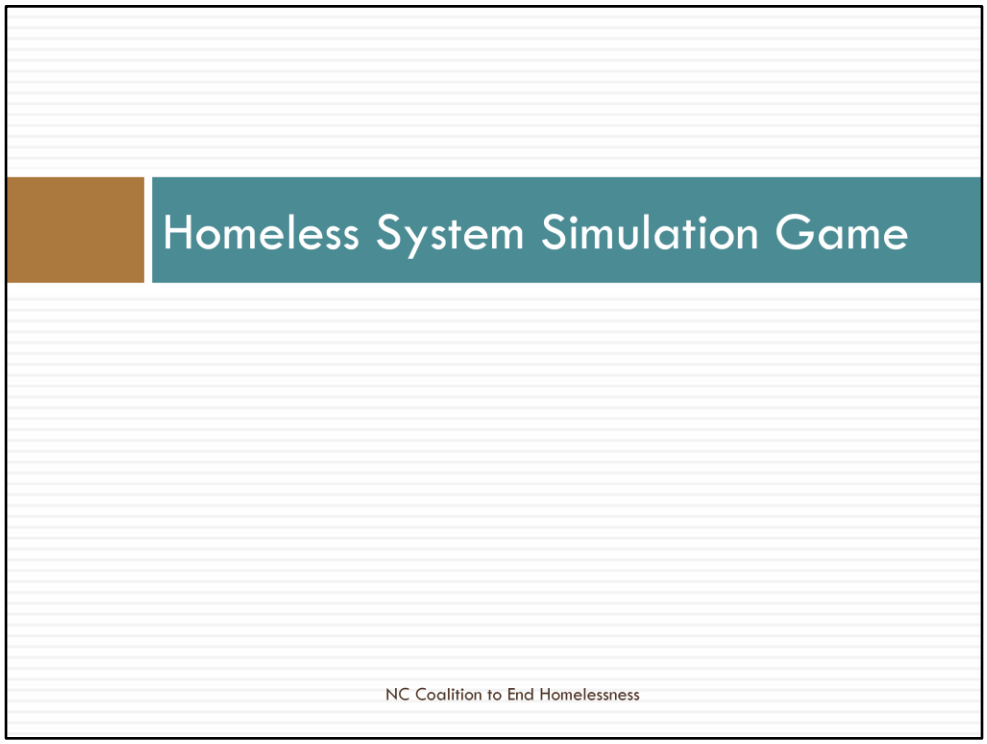
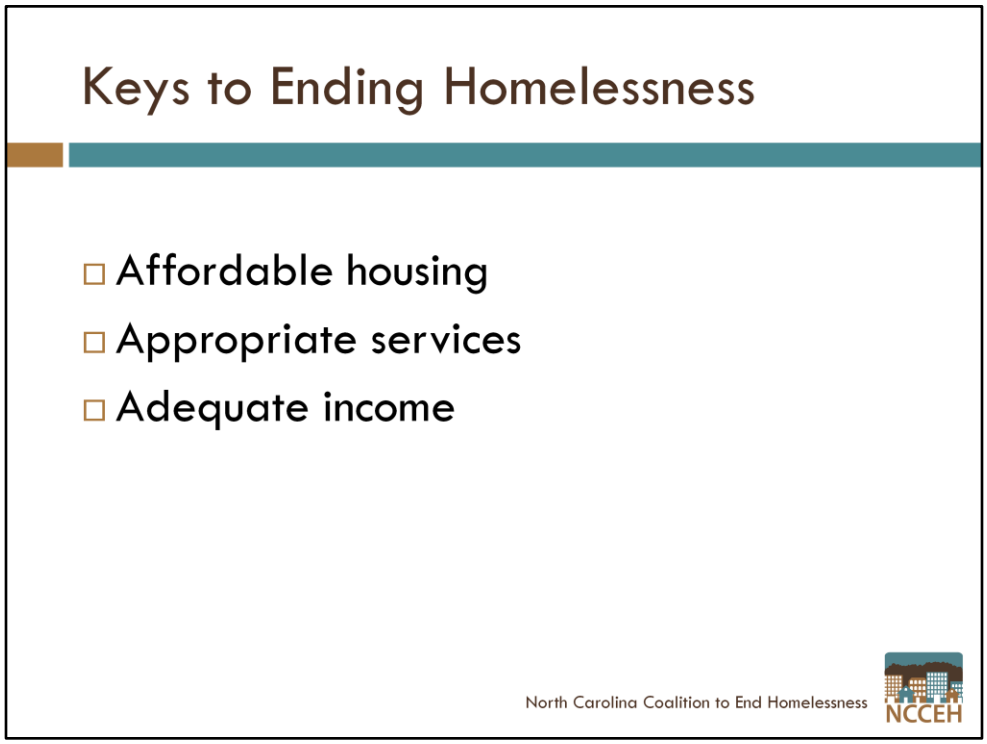

Homeless System Simulation Game
NC Coalition to End Homelessness



In order for an individual or family to move out of homelessness, they need three key things.

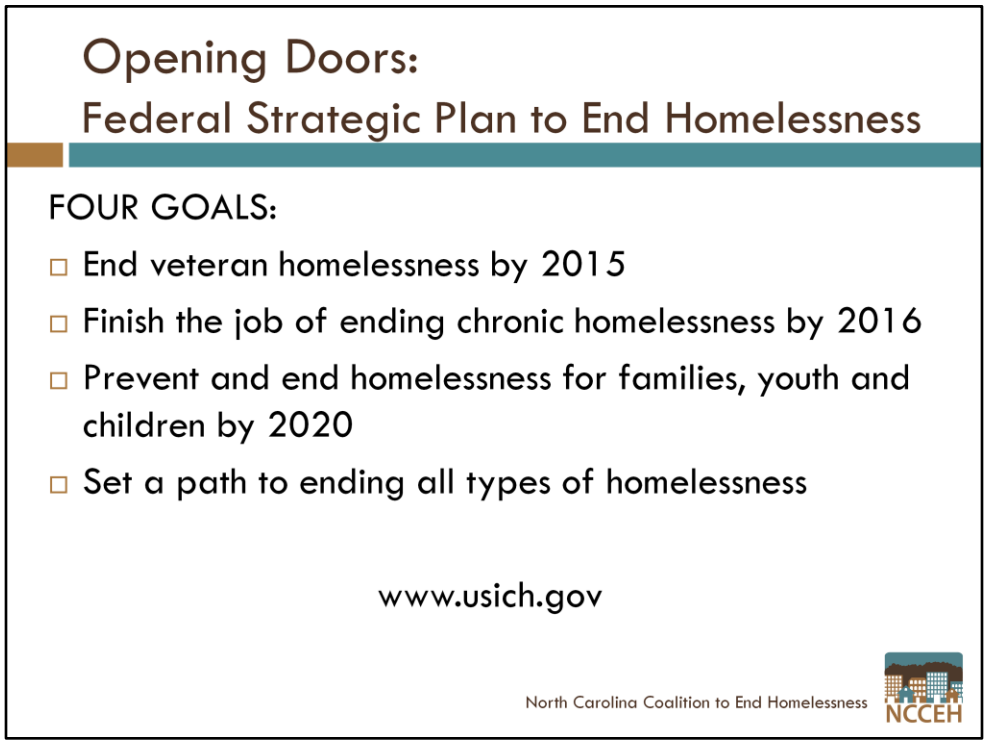
Affordable Housing = standard is 30% of income
Appropriate services = a wide range: mental health, job services, medical services, case management
Adequate income = employment or benefits (SOAR)

In order to get a family out of homelessness, we need to address all three of these needs

HEARTH Purpose

"…to establish a Federal goal of ensuring that individuals and families who become homeless return to permanent housing within 30 days."

HEARTH Act Purposes – Sec. 1002(b)



Prior to Federal Strategic Plan, there were a lot of community 10 Year Plans to End Homelessness created at local level
Released in 2010, federal plan has created a lot of energy at fed level to meet these goals

Prevent and end veteran homelessness by 2015
A lot of money coming from the VA to house homeless vets

Finish the job of ending chronic homelessness by 2016
Chronic homelessness defined as individual or family with a disability + homeless for a long time – 1 year or more OR 4 episodes of homelessness within 3 years; these are the folks people think of as homeless
A lot of success in reducing chronic homeless numbers in NC in communities that have focused on targeting and getting the right resources
"FINISH" – a lot of the research started with single adults, started with chronic homelessness; now more research about families and what works for them

Retool the Crisis Response System

- Objective 10: Transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing

www.usich.gov

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Redesigning the System

How should we invest
our limited resources?

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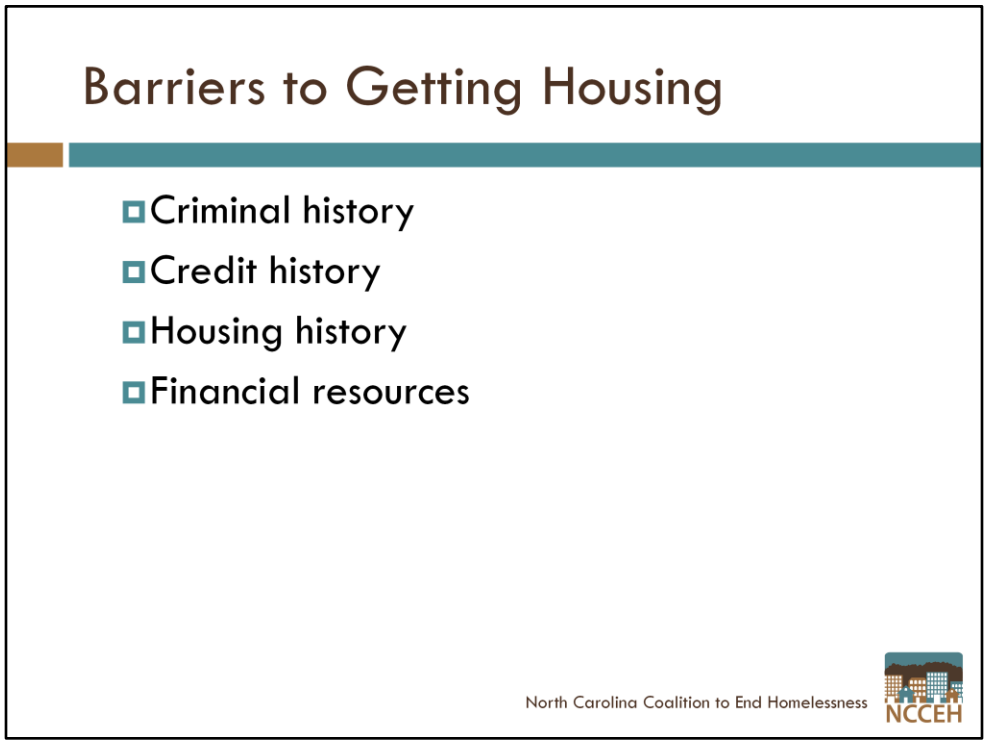


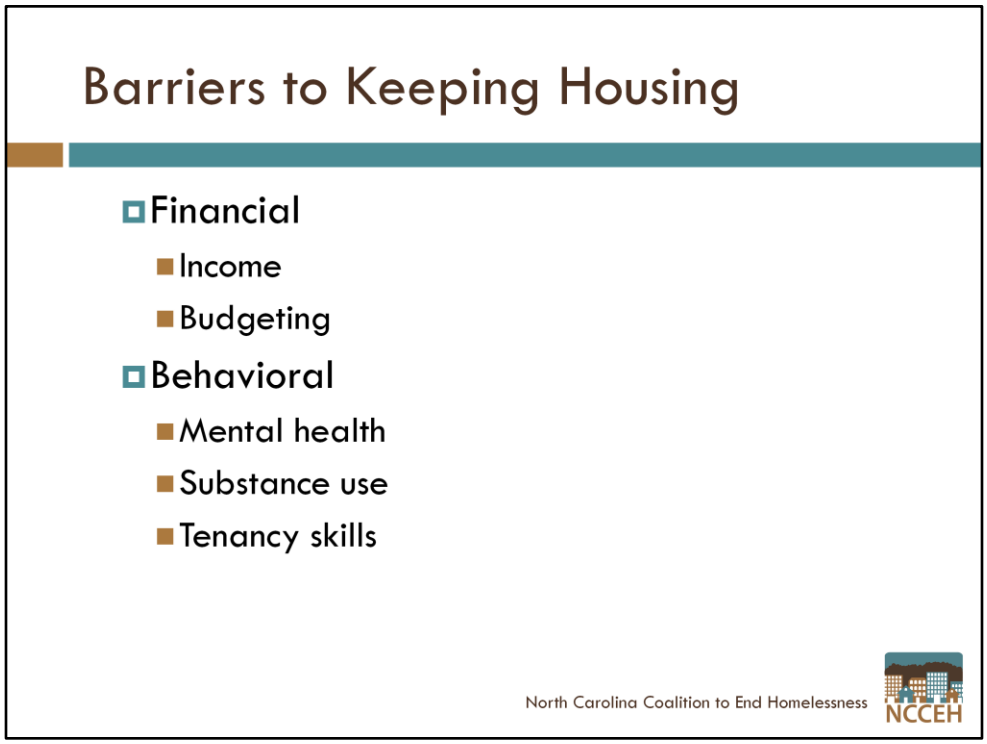
In order to target we need to do a better job of assessing barriers to getting housing and keeping housing. For a long time we focused on barriers that don't impact housing (at least not in the way we thought they did).

The biggest barriers for people who are homeless are these…what landlords screen for. Landlords screen for these because they want to make sure that the people they are renting to are going to send their check and not damage their property. They are assessing risk.

Some of the PSH/Rapid Rehousing programs are helping to mitigate these risks by developing relationships with landlords- guarantee payment, if there is a problem there is someone to call

So when we are talking about getting someone into housing we need to stop focusing on the barriers that are really barriers to keeping housing and focus on these barriers to getting housing.

But we have to think about the next step…

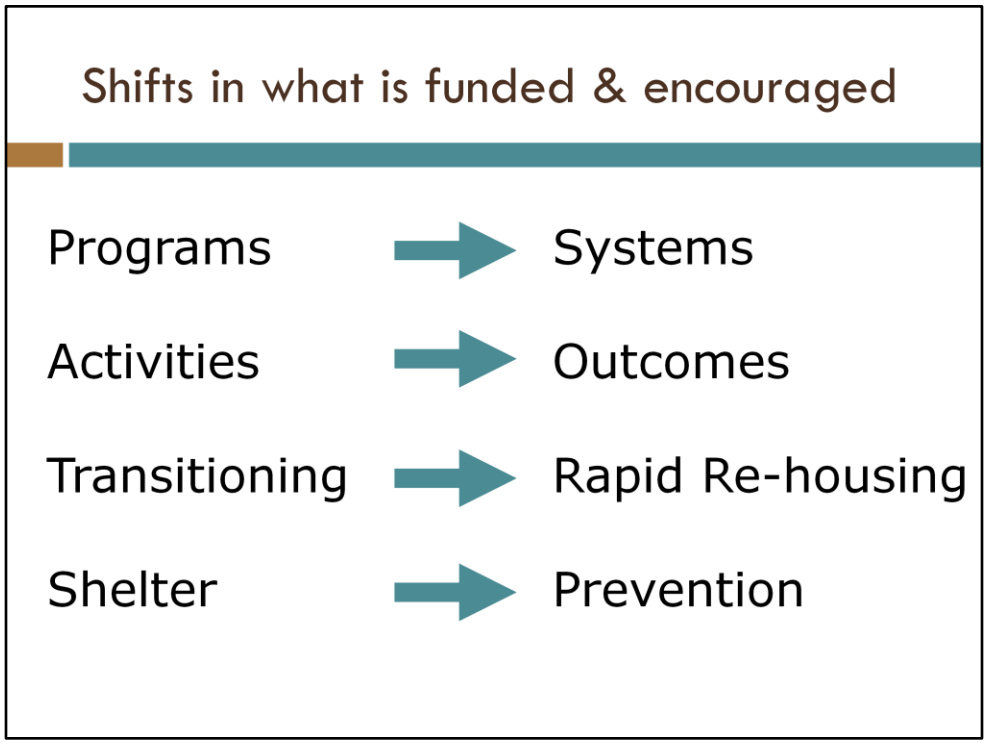


May be increasing employment/benefits

Behavioral barriers that we traditionally try to address in shelter. Sometimes we ask people to work on skills that don't affect their housing. There are people in housing that use and drink, there are people in housing that are not perfect.

Example- indv with schizophrenia that goes into room when symptoms are bad and stays in room for a day- that is not a barrier to keeping housing
If same indv turns music up really loud to deal with symptoms, then THAT is the behavior we focus on because it puts housing at risk.

This should free us from the expectations that we have put on ourselves of fixing people and creating big changes that happen but are a lot harder. We also don't need to keep people homeless while these changes happen.



The changes made by the HEARTH Act can be summarized as a number of shifts in what is funded and encouraged.

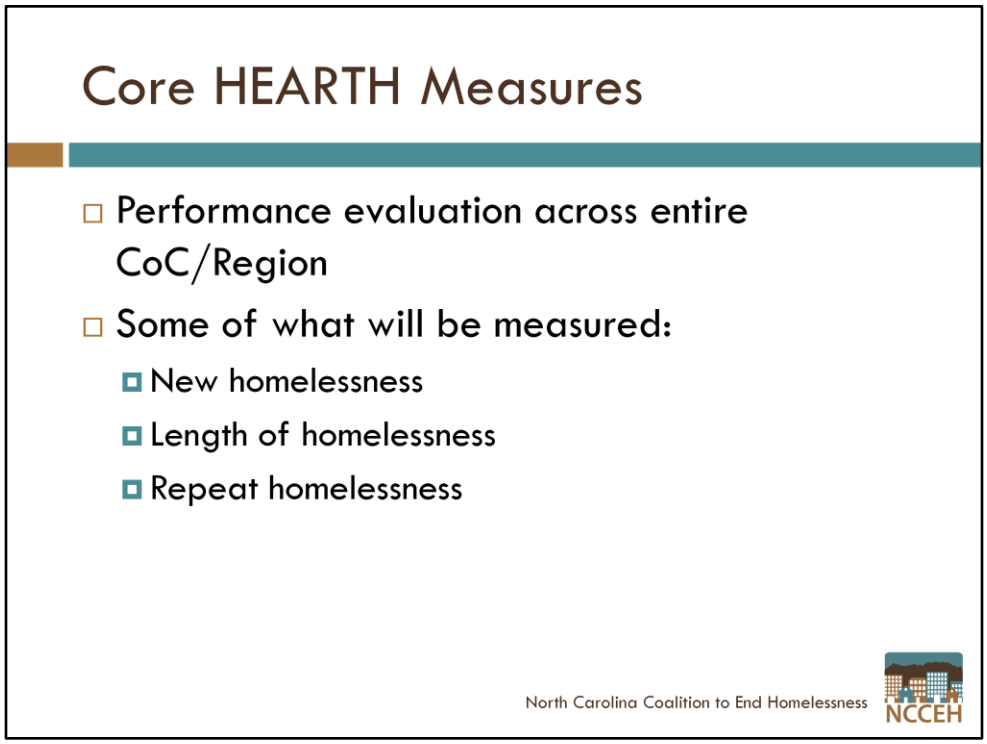
Instead of just funding and evaluating a collection of programs in a community, there is much more focus on the system. This is evident in the way administrative costs are funded, in the match requirements, and especially in the way homeless assistance is evaluated.

The HEARTH Act streamlines funding, eliminates several requirements, and shifts the emphasis from activities and compliance to achieving outcomes.

The HEARTH Act includes much more funding for prevention activities and shifts the emphasis of shelter funding from just providing shelter to preventing homelessness when possible.

Instead of helping people slowly transition out of homelessness, the HEARTH Act also places much more emphasis on rapid re-housing

When and how does the HEARTH Act make these shifts.



Ways communities are judged has also changed

Used to be: programs judged on their own performance/whether they served families, individuals, etc – all judged individually (doesn't address gaps, may be people who are slipping through the cracks)

This has changed – now judged on performance as a whole system

Now judged on

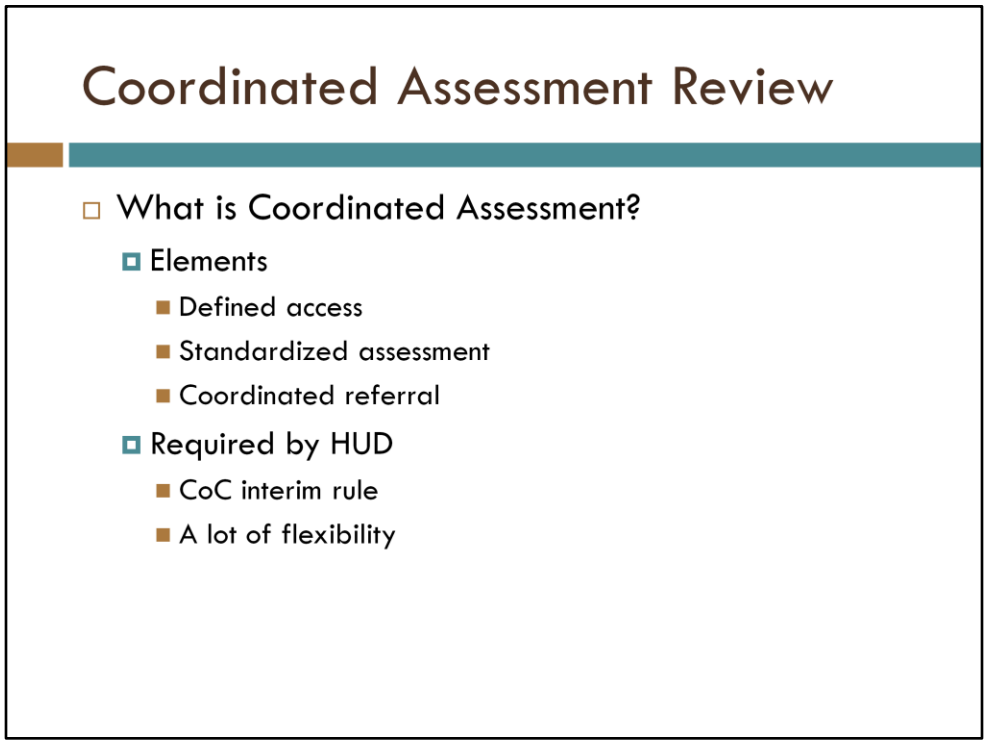
New episodes of homelessness, thus diversion

Length of time homeless (30 day goal)

Repeat episodes of homelessness – not helpful to get folks housed super quickly if they are not stabilized and return to homelessness

Coordinated Assessment Overview

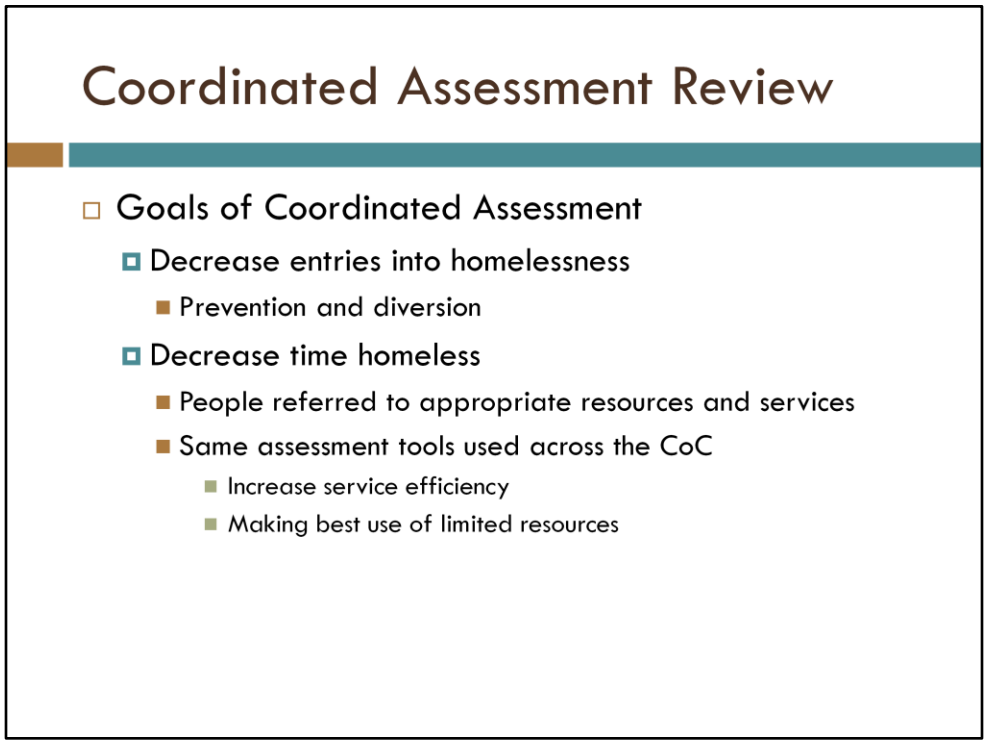
North Carolina Coalition to End Homelessness



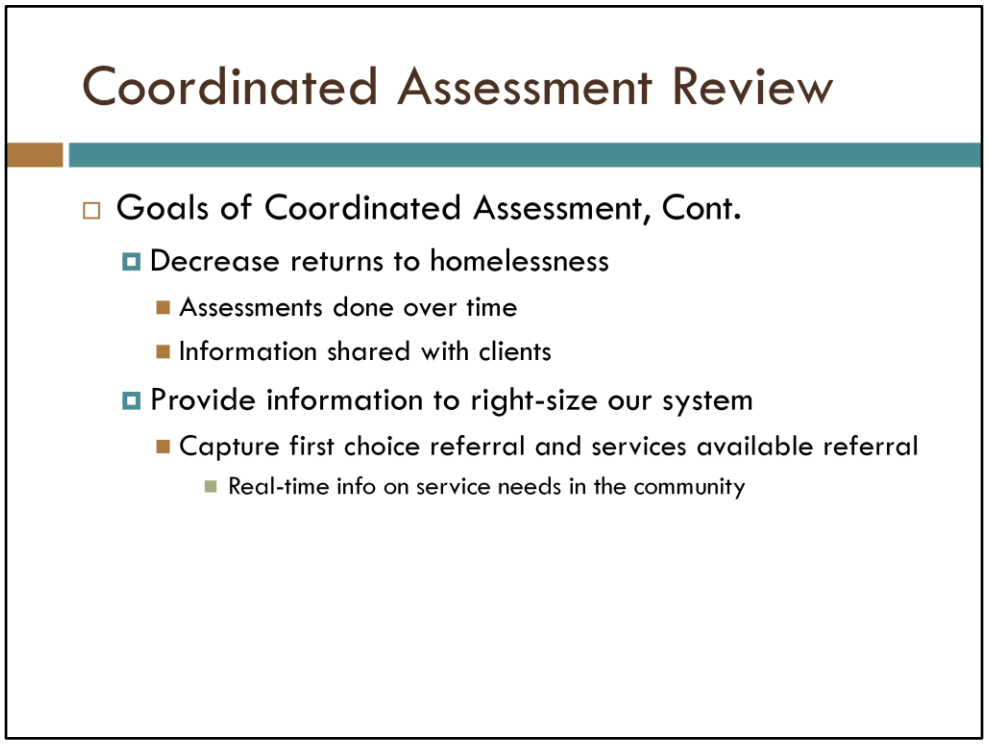
Defined access = consumers know where to go to get homeless and housing services
Standardized assessment = all people in system are assessed the same way
Coordinated referral = the system determines referrals not processes at individual agencies

HUD requires coordinated intake/access/care (many names for the same thing)
No stringent rules for how to do CA (other than having the above 3 elements); in many ways this is a grand experiment and we are "building the plane while flying"

What this means for BoS – we expect that we will try some elements of our system (locally and for the whole CoC) that will not work; we expect to have to change and adapt CA over time



Coordinated assessment will help us reach goals set by HEARTH



Right-sizing our system

We will have data on the number of people entering our system and what their needs are

We will collect information about what resources these people need even if we don't have these resources available

WHY? To know what the needs are in our community, to have info 3-6-12 months down the line that we can use to try to secure appropriate resources

Coordinated Assessment: NC BoS

- BoS Steering Committee approved the Coordinated Assessment Toolkit
  - Regional Committees will use toolkit in creating and administering local Coordinated Assessment systems
    - Intro
    - 3-part assessment tool
    - Plan

24 page CA toolkit on the NCCEH website

Coordinated Assessment: NC BoS

- Vision Statement
  - Coordinated Assessment assists the NC BoS CoC to end homelessness by increasing exits to housing, decreasing length of time homeless and reducing returns to homelessness. Consumers will quickly access appropriate services to address housing crises through a right-sized, well-coordinated agency network.

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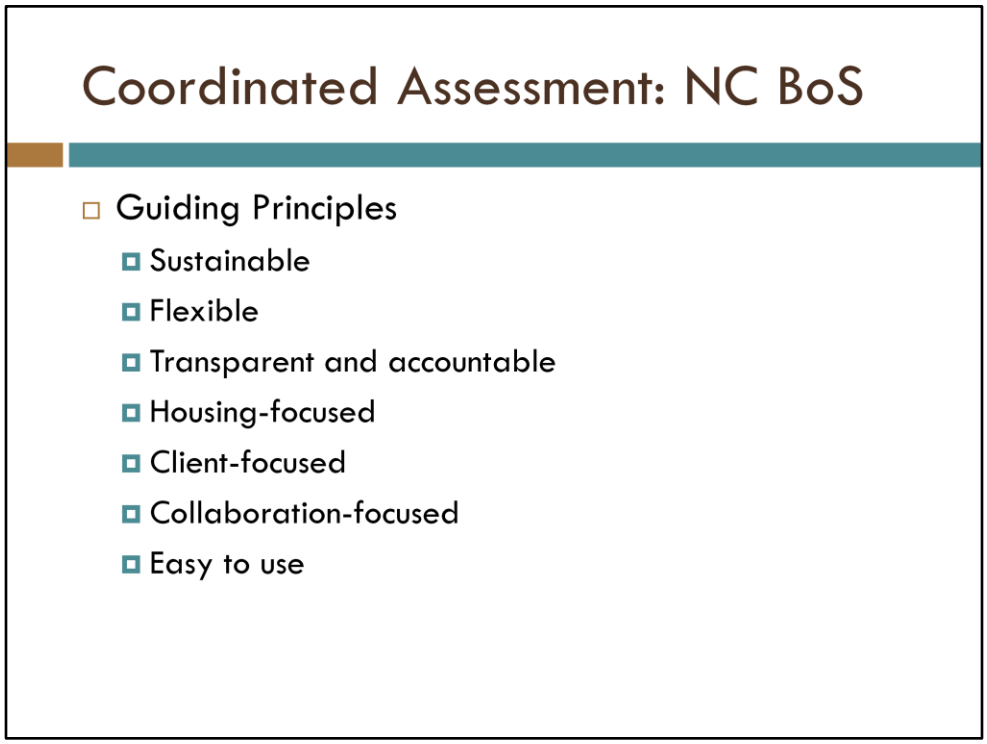
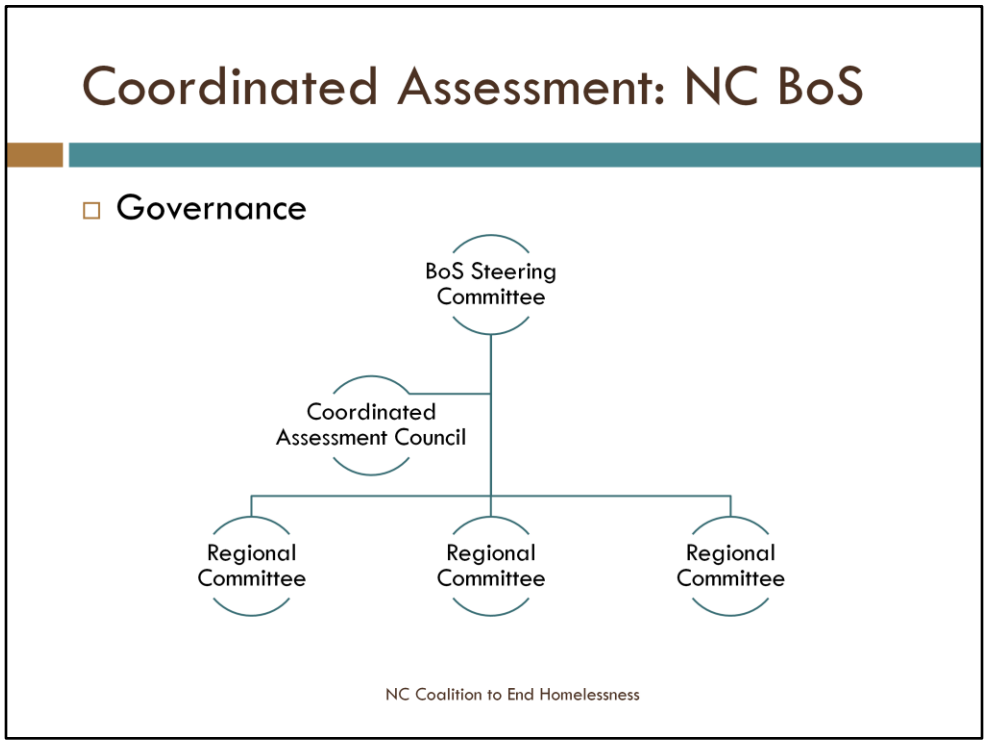


The BoS Coordinated Assessment workgroup came up with a set of guiding principles for CA in BoS

The goal is to have a system that functionally helps us serve clients better – not just checking off a box that we have CA

Sustainable – with an eye towards the fact that there is no funding source identified
Flexible – Regional Committees within BoS vary greatly in local capacity and resources; we want a system that can work for all 30 Regional Committees
Transparent and Accountable – these are HEARTH goals and good public administration
Housing-focused – keeping in mind our 30 day goal
Client-focused – thinking about our system from a client's perspective
Collaboration-focused – CA will work the best with more people at the table
Easy to use – should be intuitive for both clients and providers



The Coordinated Assessment Council (CAC) is a standing committee of the BoS Steering Committee.

The Steering Committee is the governing body of BoS – makes all policies and is decision-making body

The CAC will serve as a technical referent group for Regional Committees for coordinated assessment issues.

Coordinated Assessment: NC BoS

- Governance
  - Systems designed and administered by Regional Committees
  - Standards and governance by NC BoS Steering Committee
  - Coordinated Assessment Council (CAC) review and approve plans
    - CoC reps
    - State-level experts and partners

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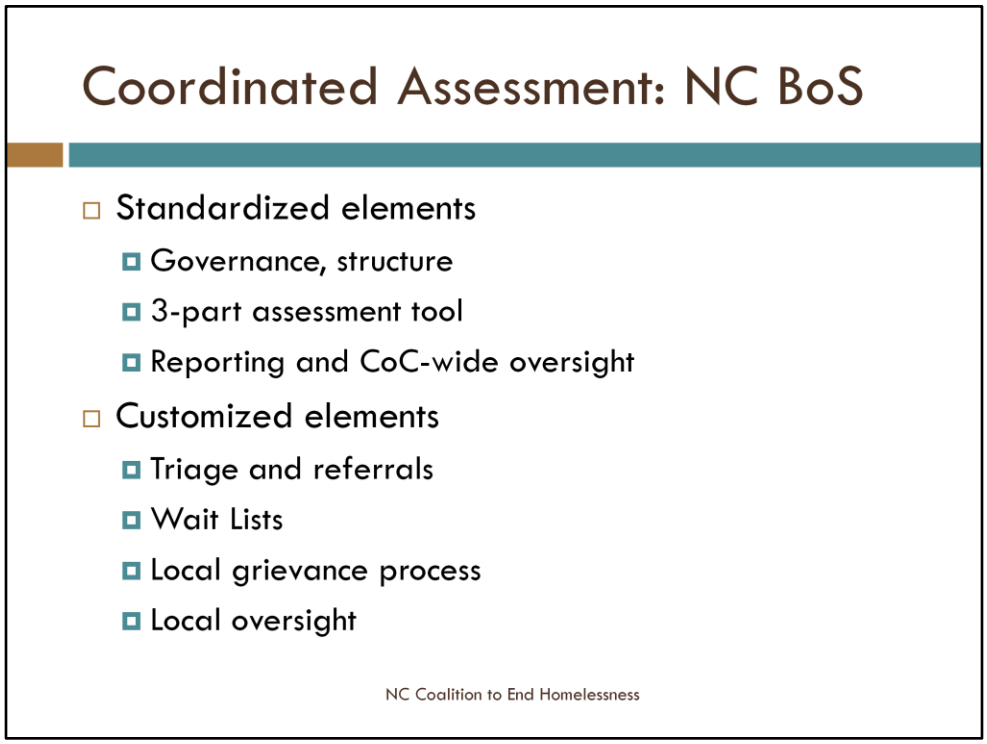
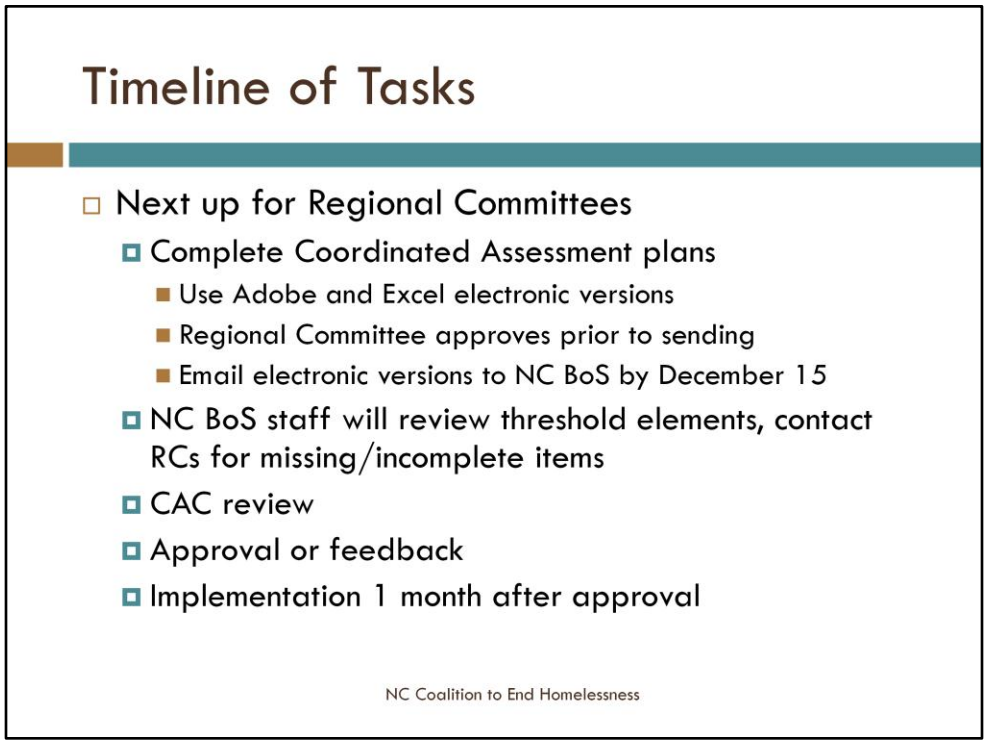


Some elements are the same across the entire 79-county BoS, others will change from Regional Committee to Regional Committee.

Standardized elements – will not change unless we change them for the entire BoS CoC
Customized elements – must be designed locally



Regional Committee plans are due to NC BoS on a rolling schedule, six weeks after workshop dates.

Access: System Models

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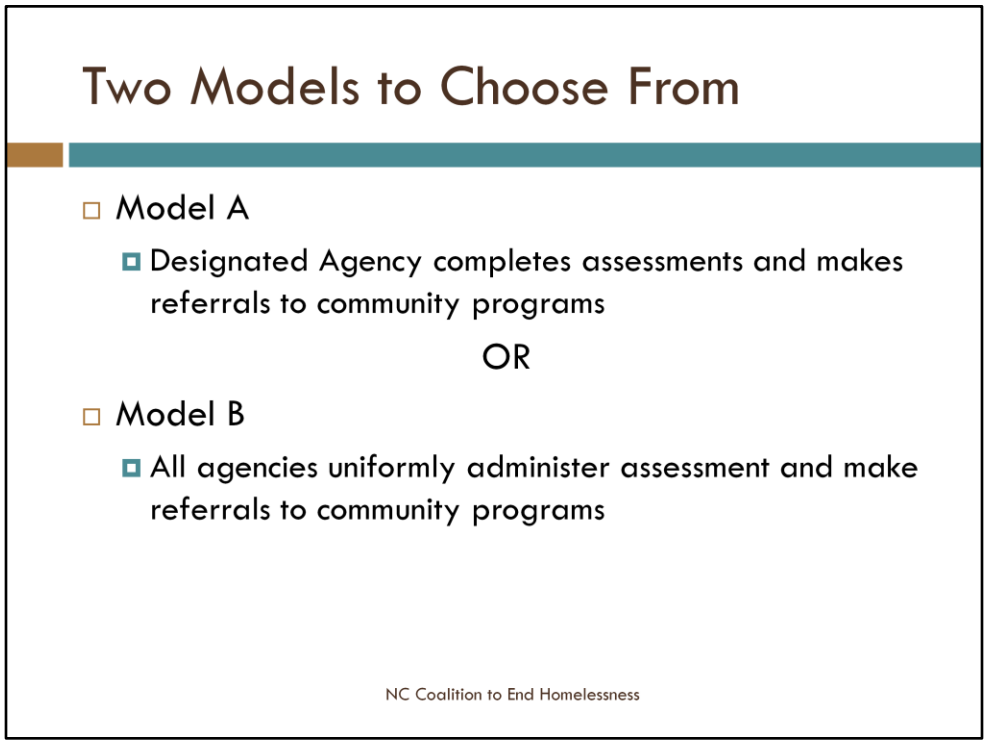
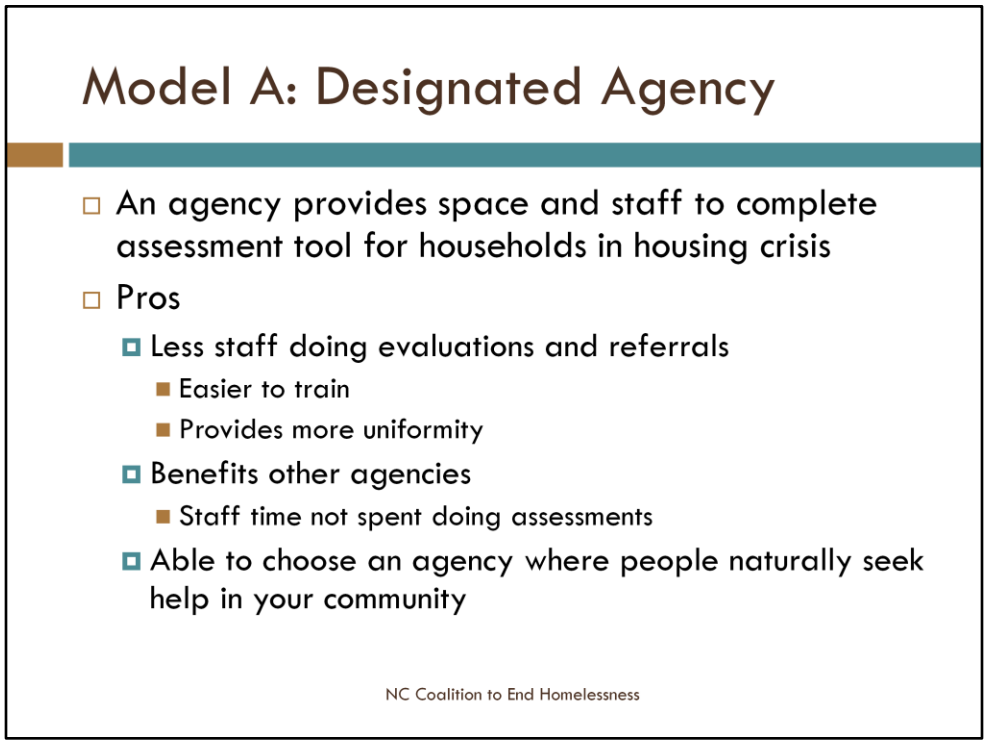
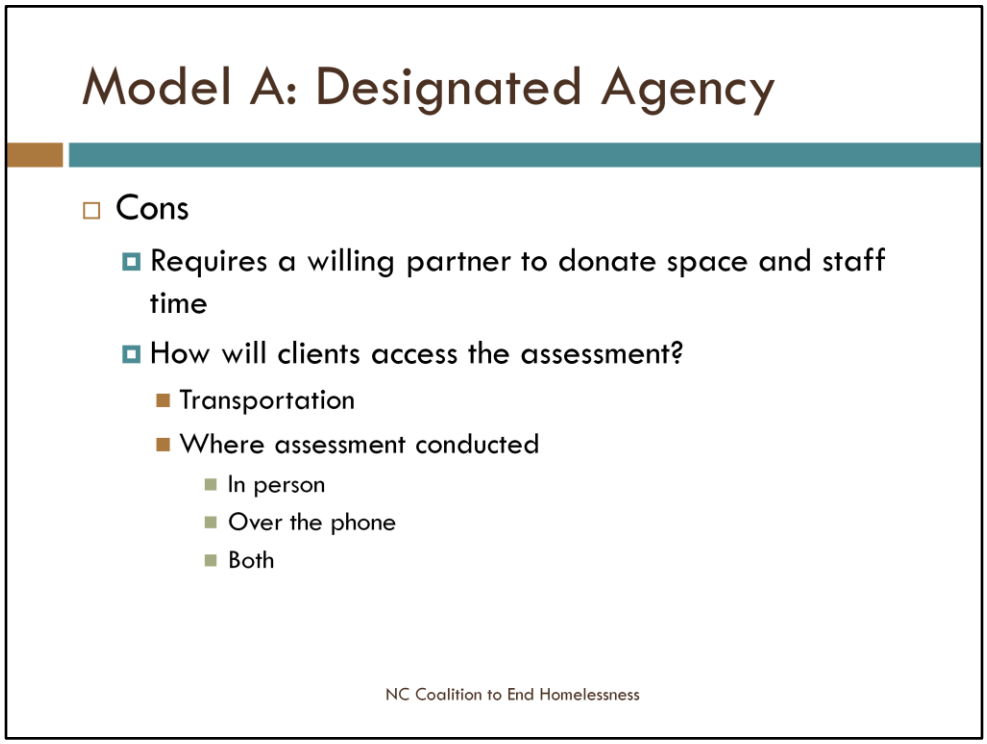


The Balance of State Coordinated Assessment Workgroup reviewed models from across the country and narrowed Regional Committees' choices down to two models. Regional Committees can choose between Model A and Model B for their community.

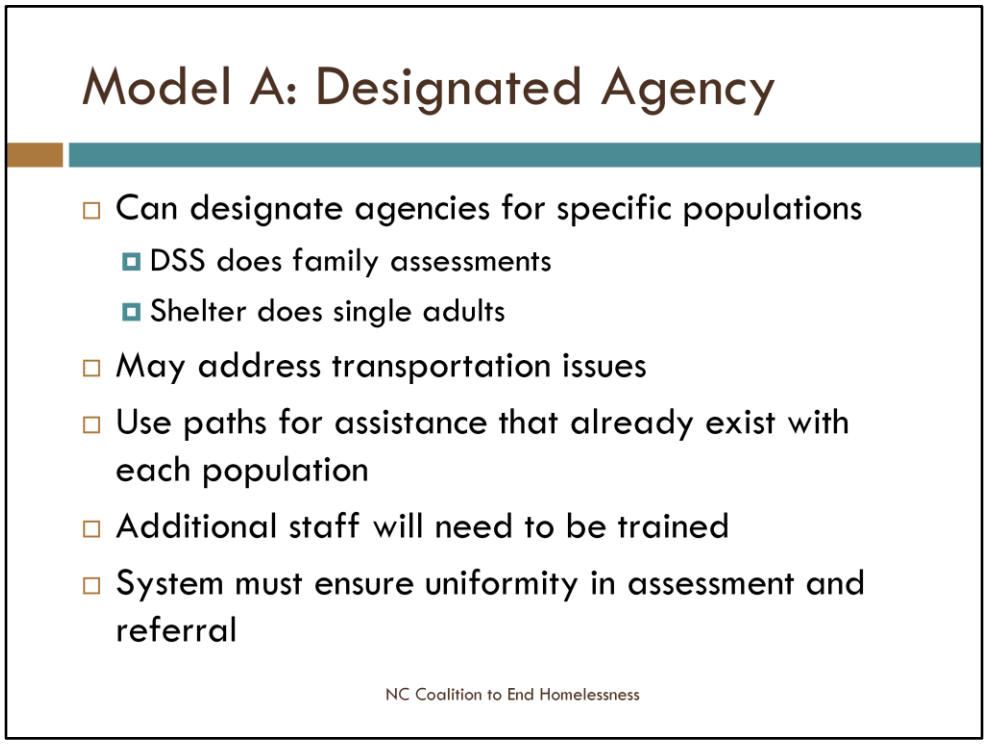


In Model A, an agency provides space and staff to act as the central Coordinated Assessment site in your community, although there are some variations to this model discussed on slide 65.

The pros to this model are that there is a smaller number of designated staff doing the assessment and referrals; so it is easier to make sure they are trained and performing these tasks in a uniform way. Other agencies will benefit because their staff can reduce the amount of time assessing referrals and use that time to go towards other activities. Communities can choose an agency that has an existing well-worn path– people in need already go there for help so it is a natural location to put the front door of your system.

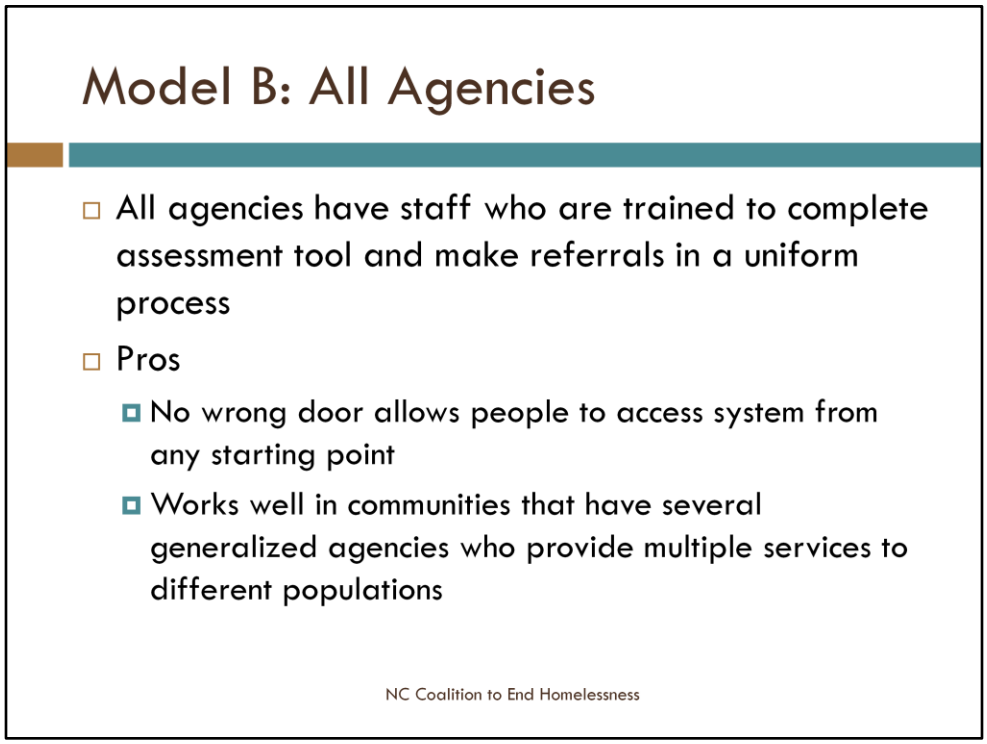


Cons to Model A are that it requires a willing partner to provide space and staff, and if your Coordinated Assessment is done in one location, this may cause access issues if there is not public transportation to that location. You can address the access issues by providing transportation resources, doing assessments over the phone or having staff go out to assess those who can't make it to the Coordinated Assessment site.



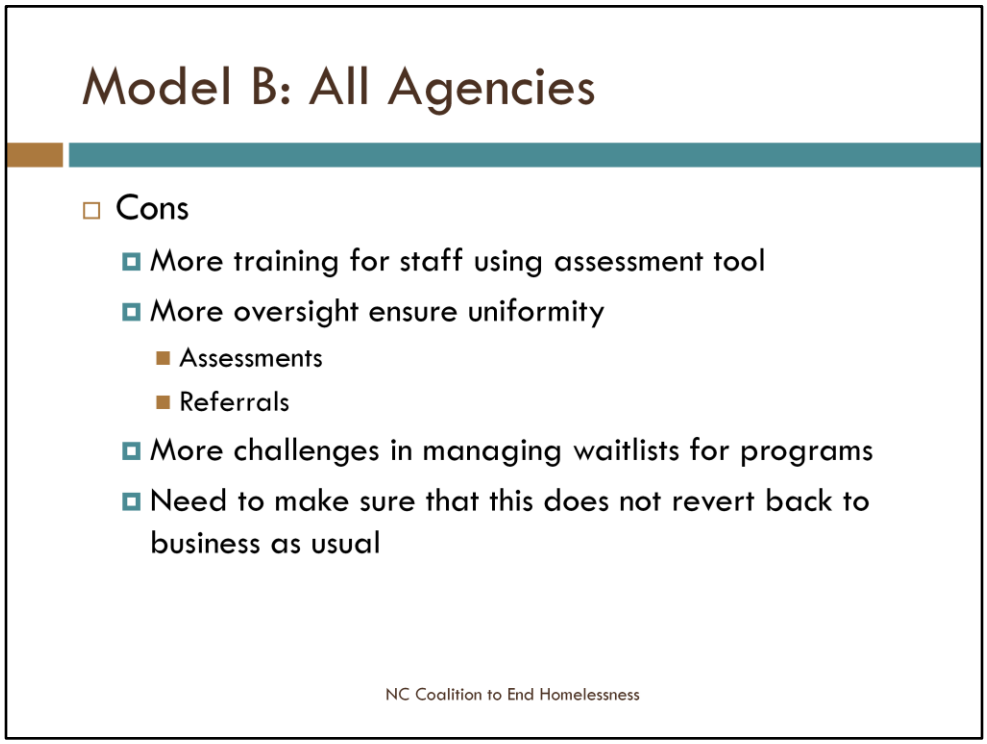
With Model A, communities can choose more than one agency to act as an entry into their system. Many communities designate one agency for specific populations (DSS for families, shelter for single adults, etc.). Having more than one agency designated may cut down on transportation issues, and this allows communities to use multiple paths that exist in their community. However, communities need to keep in mind that the more staff doing assessments and referrals will mean more over site for training and uniformity.

Another variation to this model is that one agency can provide the space for the Coordinated Assessment system and another agency can donate staff time. Please keep in mind that depending on the number of people accessing your system, Coordinated Assessment may need to be staffed throughout the week or one or two days in the week or on an as needed basis.



With Model B, communities will have all agencies completing assessments and referrals in a uniform process. This model is often referred to as a "no wrong door" model.

The pros to this model are that it allows households to access your system from any starting point in your community, and it works well with communities that have generalized agencies that are used to providing multiple services to different populations.



The cons for Model B are that with more staff completing assessments and referrals you have to make sure that you have oversight to guarantee that they are trained and completing assessments in a uniform way. Communities using Model B will also have to have a controlled way of managing the waitlists for programs so everyone who needs to be put on a waiting list is. Also, communities need to make sure that agencies don't revert back to the way they did assessments and referrals prior to Coordinated Assessment.

Regional Committee Discussion

- Which model works best for your region?
- Designate the agency(s) completing assessments in your community
- Move the programs from current map to clean flip chart page
  - Start creating new system

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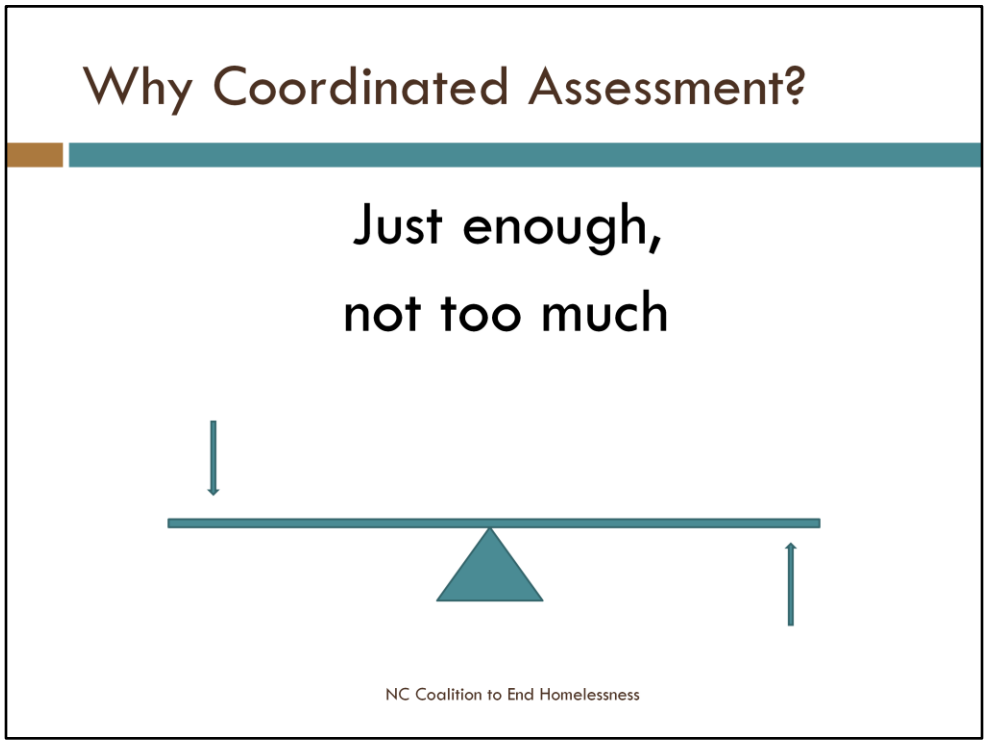
Be sure to answer these questions in coordinated assessment plans.

Assessment: Triage and Referrals

North Carolina Coalition to End Homelessness

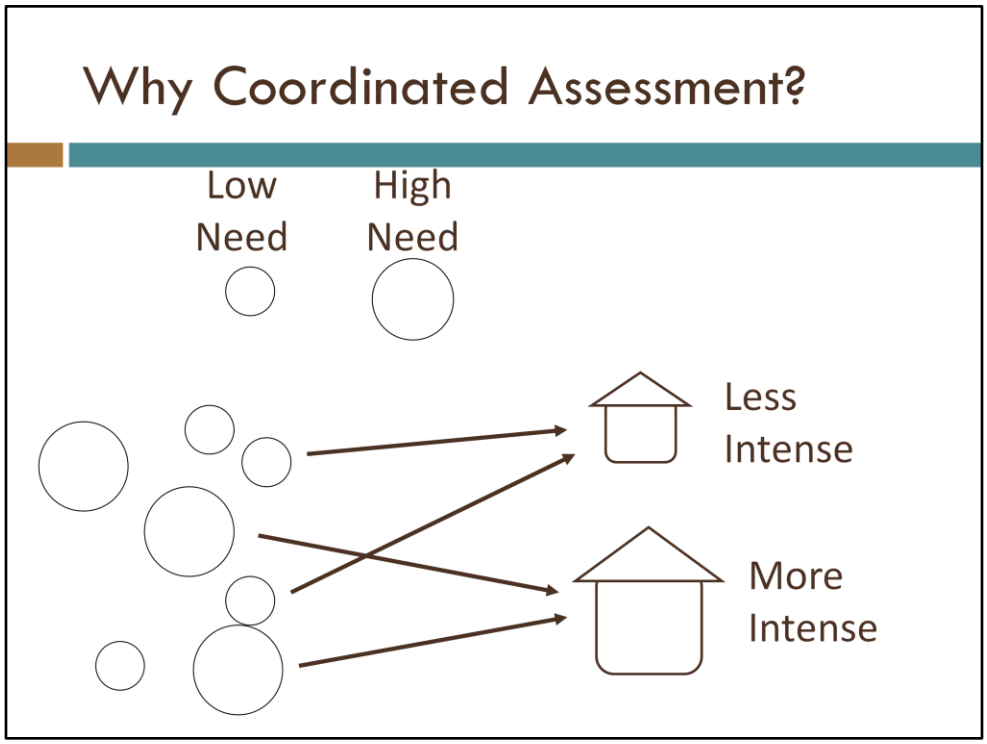


We want to give households enough to succeed and stabilize but we don't want to give them too much.

If a family needs $1000 to stabilize, and we gave them $2,000, then we wasted $1000 that we could have spent on another family. BUT, if we give this family $500 instead of $1000, then we wasted $500 because we didn't give them enough to stabilize.

This is a challenge for us in the new system, and Coordinated Assessment will help us to make sure we understand a household's needs and refer them to the "just right" program.

For programs that require a certain length of stay- like 1 year or 24 months (TH) in order to be "successful" in the program, that may be too much for some people. More than they need.

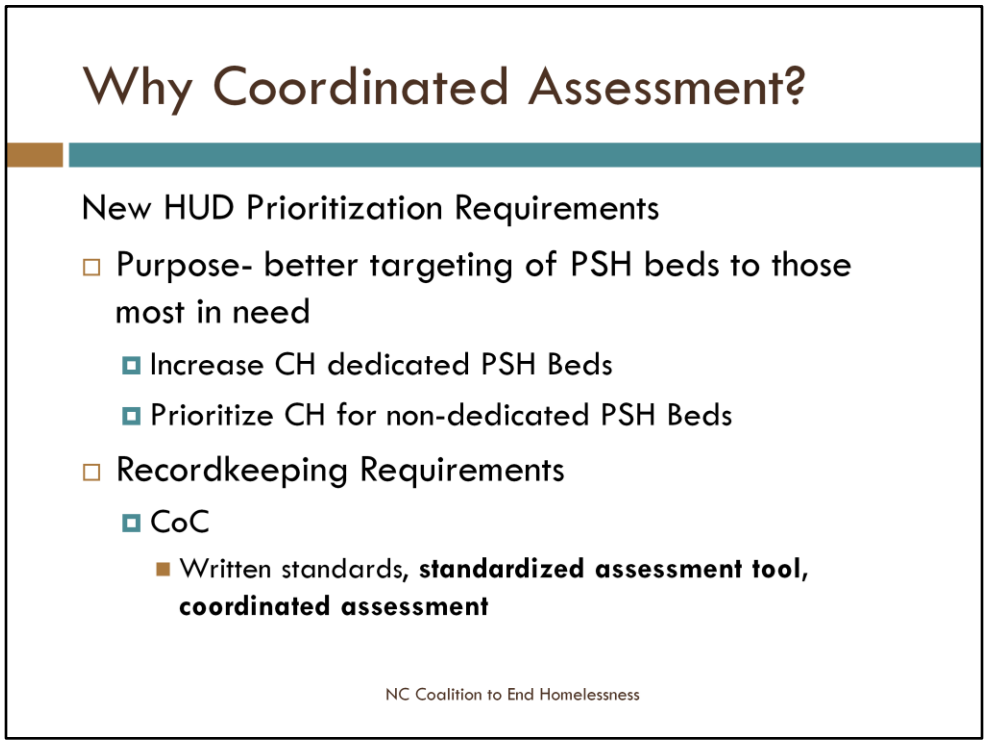


Another challenge is targeting resources.

We have to get better at targeting resources. We have to identify individual's and place them in programs based on their needs.

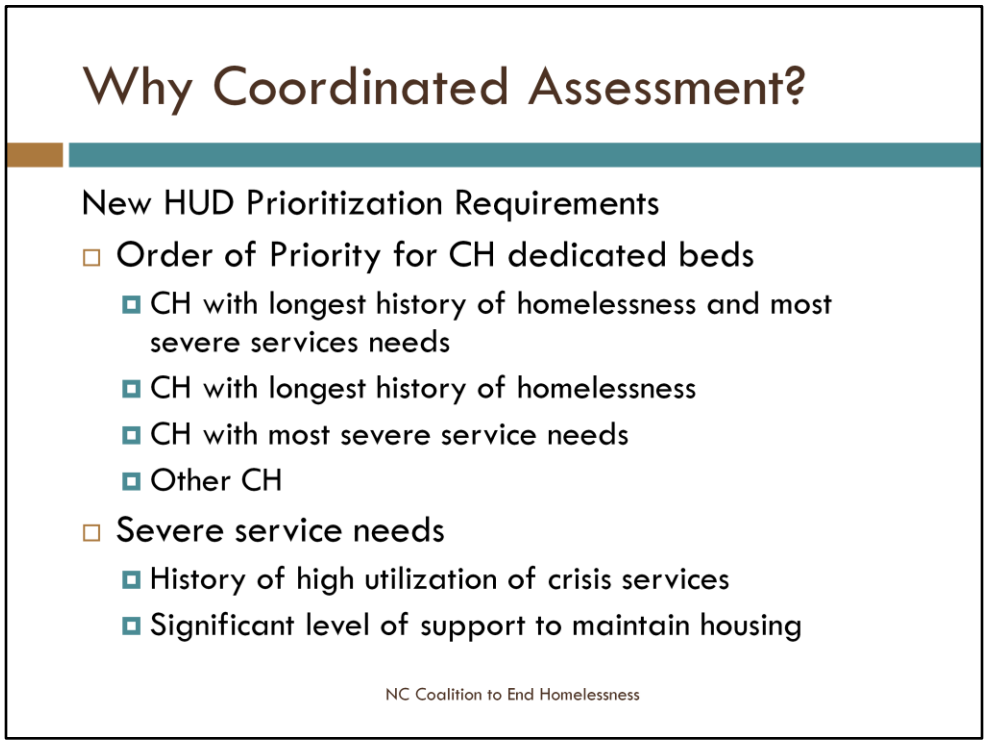
This is not what is happening now. Right now, we are taking a lot of low need individuals and families and putting them through our intensive programs, like TH, and the ones that we feel like may not be successful, we are not letting them into those programs. For good reasons, but we need to adjust.

Coordinated Assessment will provide us with an assessment tool to quickly triage households who access our system and refer them to the most appropriate services to meet their needs.

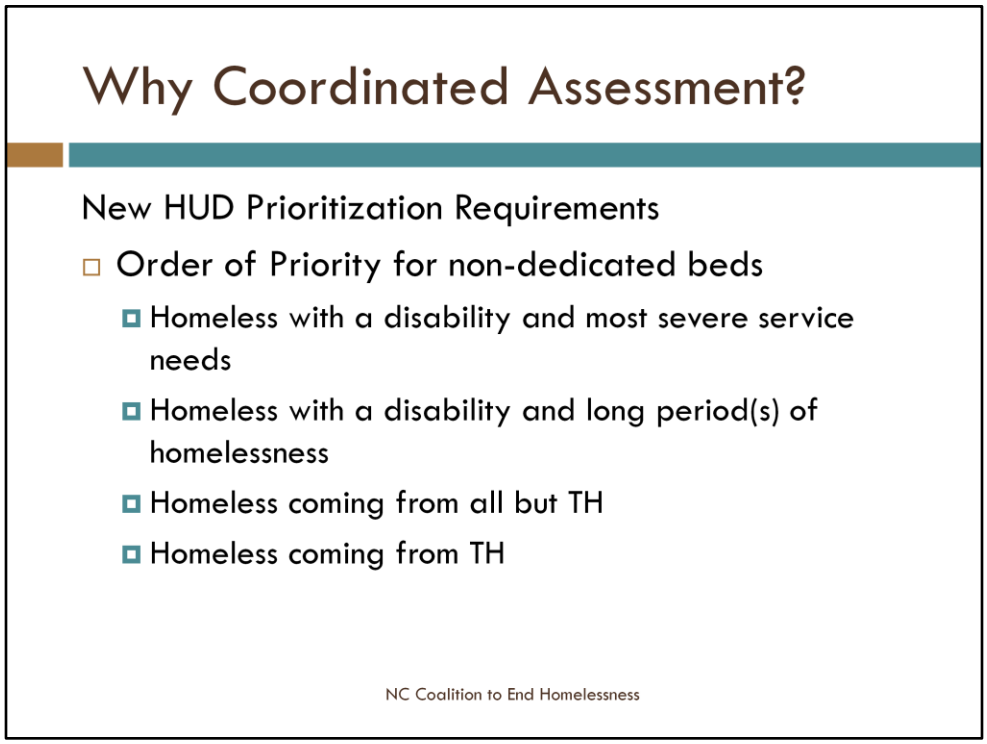


Coordinated Assessment is also necessary because of new policies from HUD that require targeting and prioritization.

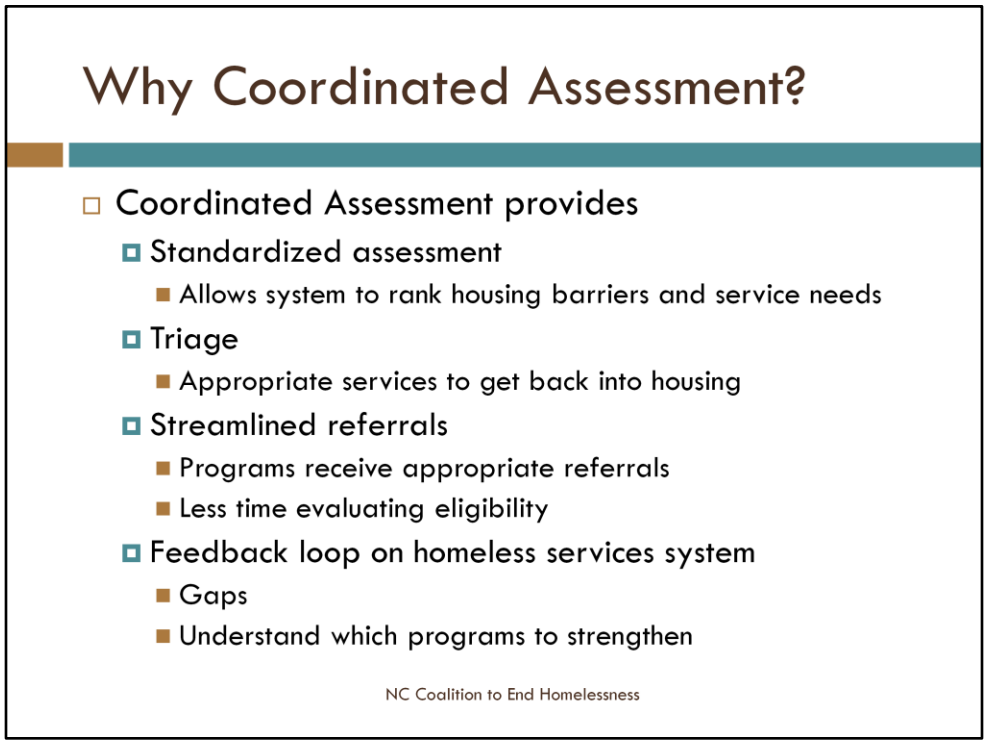
For example, in order to end chronic homelessness, HUD is requiring that CoCs better target their PSH beds to the chronic homeless and those most in need. In those new policies, HUD is requiring that CoCs have a standardized assessment tool to determine need and a coordinated assessment process to assess everyone who may need PSH in your community's system.



HUD provides a specific order to prioritization for PSH beds designated for the chronically homeless and those not designated for the chronically homeless (shown on next slide). In our current system, we do not have a uniform way to assess service needs and compare that to service needs of others. Coordinated Assessment will provide us with a uniform assessment to determine this ranking and prioritization.

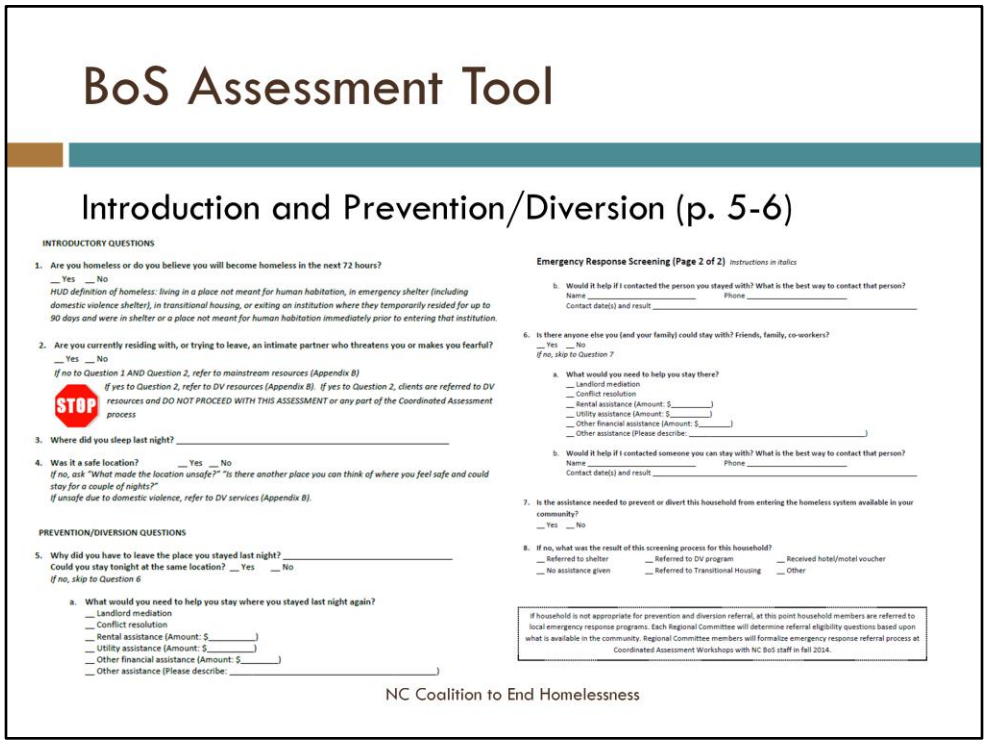


Continued example of HUD's new prioritization policies.



Coordinated Assessment is required, and it is a good idea. Coordinated Assessment is a tool that has the potential to provide your community:

- A standardized assessment that will allow you to evaluate and compare service need and vulnerability to allow you to prioritize who needs to be housed first. The system will not be based on first come, first serve. You will now be able to house the most vulnerable first.
- The assessment tool will help you to quickly triage households into the most appropriate programs to get them back into housing.
- The Coordinated Assessment process will allow your system to assess and refer people in a more standardized way. This allows programs to receive more appropriate referrals from the beginning and reduces the amount of staff time in assessing and evaluating referrals.
- Coordinated Assessment will also provide your community with a mirror of how your system is doing. You will be able to see what populations that you are and are not currently serving. You will be able to see what resources you may need more of and what resources aren't not functioning at full capacity and could be repurposed.



So let's take a look at the actual assessment tool that all Balance of State Regional Committees will use. The assessment is made up of 3 parts.

The first part is the Introduction and Prevention/Diversion screen. This screen is a short (two pages) assessment that allows communities to make sure that they are prioritizing access to shelter beds to those who really have no other option than an emergency shelter bed. The idea here is to try to assess whether there is another safe place for someone to stay the night rather than coming into the shelter system. This could be a doubled up situation or staying with family. Some people may need a staff member to call and speak to their potential destination (mom, dad, uncle, etc.) to facilitate them returning or going to a living situation. Others may need some financial assistance (grocery card, rental assistance) to facilitate a housing placement. Even if your Regional Committee cannot provide these resources, it is important to keep a record of what could have diverted a household for feedback for your community.

If the household does not have another place to go and needs the shelter bed, then you will ask the necessary shelter eligibility questions to refer them to a shelter bed.

Things to note:

- There will be an online training for this screen that staff will need to complete to administer the screen.
- If someone answers "yes" to question 2, STOP and refer them to the appropriate domestic violence agency in your community.
- If someone is currently homeless and sleeping outside (street, woods, place not meant for habitation) you can skip the prevention and diversion screen and move directly to next part of the assessment tool.

BoS Assessment Tool

Introduction and Prevention/Diversion (p. 5-6)

- Purpose
  - Quickly assess clients at front door
    - Need access to DV services
    - Need shelter bed

    OR
    - Have someplace safe to stay tonight?
- Can reduce number of people entering shelter

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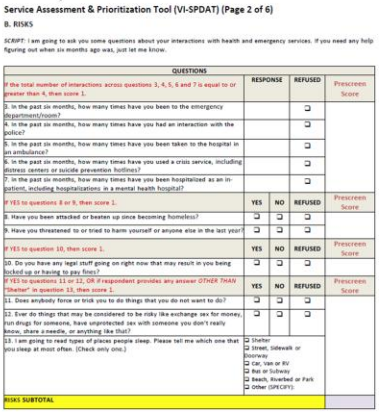
BoS Assessment Tool

VI-SPDAT (p. 7-12)



Service Assessment & Prioritization Tool (VI-SPDAT) (Page 2 of 6)

B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when six months ago was, just let me know.

QUESTIONS	RESPONSE		REFUSED	
If the total number of interactions across questions 3, 4, 5, 6 and 7 is equal to or greater than 4, then score 1.				Prescreen Score
3. In the past six months, how many times have you been to the emergency department/room?			❑	
4. In the past six months, how many times have you had an interaction with the police?			❑	
5. In the past six months, how many times have you been taken to the hospital in an ambulance?			❑	
6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines?			❑	
7. In the past six months, how many times have you been hospitalized as an in-patient, including hospitalizations in a mental health hospital?			❑	
If YES to questions 8 or 9, then score 1.	YES	NO	REFUSED	Prescreen Score
8. Have you been attacked or beaten up since becoming homeless?	❑	❑	❑	
9. Have you threatened to or tried to harm yourself or anyone else in the last year?	❑	❑	❑	
If YES to question 10, then score 1.	YES	NO	REFUSED	Prescreen Score
10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	❑	❑	❑	
If YES to questions 11 or 12, OR if respondent provides any answer OTHER THAN "Shelter" in question 13, then score 1.	YES	NO	REFUSED	Prescreen Score
11. Does anybody force or trick you to do things that you do not want to do?	❑	❑	❑	
12. Ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, or anything like that?	❑	❑	❑	
13. I am going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)	❑ Shelter ❑ Street, Sidewalk or Doorway ❑ Car, Van or RV ❑ Bus or Subway ❑ Beach, Riverbed or Park ❑ Other (SPECIFY):			
RISKS SUBTOTAL				

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The second part of the assessment is the VI-SPDAT. This is a tool that has been evaluated in numerous communities as a triaging tool. The VI-SPDAT is meant to assess and score a household. The household's score will determine which housing program they will be referred to. The VI-SPDAT evaluates housing barriers, service needs and vulnerability.

Things to note:

- There is an online training available at orgcode.com that all staff administering this assessment must take.
- It is recommended that systems wait 14 days from shelter entry to administer the VI-SPDAT in order to allow the households who can exit our system without a program to do so. If this wait period does not work for your community (due to shelter time limits or a lack of shelter beds), then you can change the timing but will need to include that change and the reason why in your plan.
- If someone staying on the streets, woods, or a place not meant for human habitation, you can administer the VI-SPDAT without waiting.

BoS Assessment Tool

VI-SPDAT (p. 7-12)

- Purpose
  - Triage tool for people in shelter
    - Assess housing barriers
    - Assess service needs
- Assigns score to each household
  - Score ranges provide triage to program type
  - Mechanism to rank waitlists
    - By vulnerability and service need

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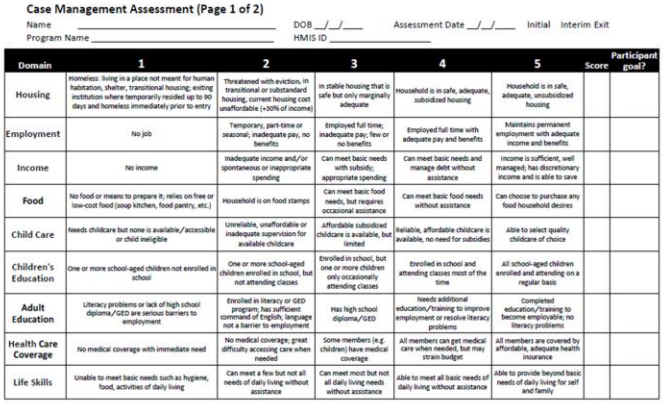
BoS Assessment Tool

Case Management Assessment (p. 13-14)



Case Management Assessment (Page 1 of 2)

Name _____ DOB __/__/____ Assessment Date __/__/____ Initial Interim Exit

Program Name _____ HMIS ID _____

Domain	1	2	3	4	5	Score	Participant goal?
Housing	Homeless: living in a place not meant for human habitation, shelter, transitional housing; exiting institution where temporarily resided up to 90 days and homeless immediately prior to entry	Threatened with eviction, in transitional or substandard housing, current housing cost unaffordable (+30% of income)	In stable housing that is safe but only marginally adequate	Household is in safe, adequate, subsidized housing	Household is in safe, adequate, unsubsidized housing		
Employment	No job	Temporary, part-time or seasonal; inadequate pay, no benefits	Employed full time; inadequate pay; few or no benefits	Employed full time with adequate pay and benefits	Maintains permanent employment with adequate income and benefits		
Income	No income	Inadequate income and/or spontaneous or inappropriate spending	Can meet basic needs with subsidy; appropriate spending	Can meet basic needs and manage debt without assistance	Income is sufficient, well managed; has discretionary income and is able to save		
Food	No food or means to prepare it; relies on free or low-cost food (soup kitchen, food pantry, etc.)	Household is on food stamps	Can meet basic food needs, but requires occasional assistance	Can meet basic food needs without assistance	Can choose to purchase any food household desires		
Child Care	Needs childcare but none is available/accessible or child ineligible	Unreliable, unaffordable or inadequate supervision for available childcare	Affordable subsidized childcare is available, but limited	Reliable, affordable childcare is available, no need for subsidies	Able to select quality childcare of choice		
Children's Education	One or more school-aged children not enrolled in school	One or more school-aged children enrolled in school, but not attending classes	Enrolled in school, but one or more children only occasionally attending classes	Enrolled in school and attending classes most of the time	All school-aged children enrolled and attending on a regular basis		
Adult Education	Literacy problems or lack of high school diploma/GED are serious barriers to employment	Enrolled in literacy or GED program, has sufficient command of English; language not a barrier to employment	Has high school diploma/GED	Needs additional education/training to improve employment or resolve literacy problems	Completed education/training to become employable; no literacy problems		
Health Care Coverage	No medical coverage with immediate need	No medical coverage; great difficulty accessing care when needed	Some members (e.g. children) have medical coverage	All members can get medical care when needed, but may strain budget	All members are covered by affordable, adequate health insurance		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living	Can meet a few but not all needs of daily living without assistance	Can meet most but not all daily living needs without assistance	Able to meet all basic needs of daily living without assistance	Able to provide beyond basic needs of daily living for self and family		

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Finally, the 3rd part of the assessment is the case management matrix tool. This tool will be used by staff in housing programs in the Balance of State to assess where participants currently stand on a number of life areas. This tool is meant to provide a common language between staff at all housing programs in the CoC and is a tool that can be used to establish goals for person centered plans.

This tool is to be administered at program entry, housing entry, every 6 months for as long as they are in the program, and 12 months after exit if you are able.

There will be an online training about the case management tool for staff to complete.

The case management tool will also provide feedback to Regional Committees about how effective their programs are in helping to meet participant's goals and stabilize their housing.

BoS Assessment Tool

Case Management Assessment (p. 13-14)

- Purpose
  - Uniform progress evaluation
- Performed over time
  - Program entry
  - Housing entry
  - Every 6 months while in program
  - 12 months after assistance ends
- Feedback on programs and case management goals

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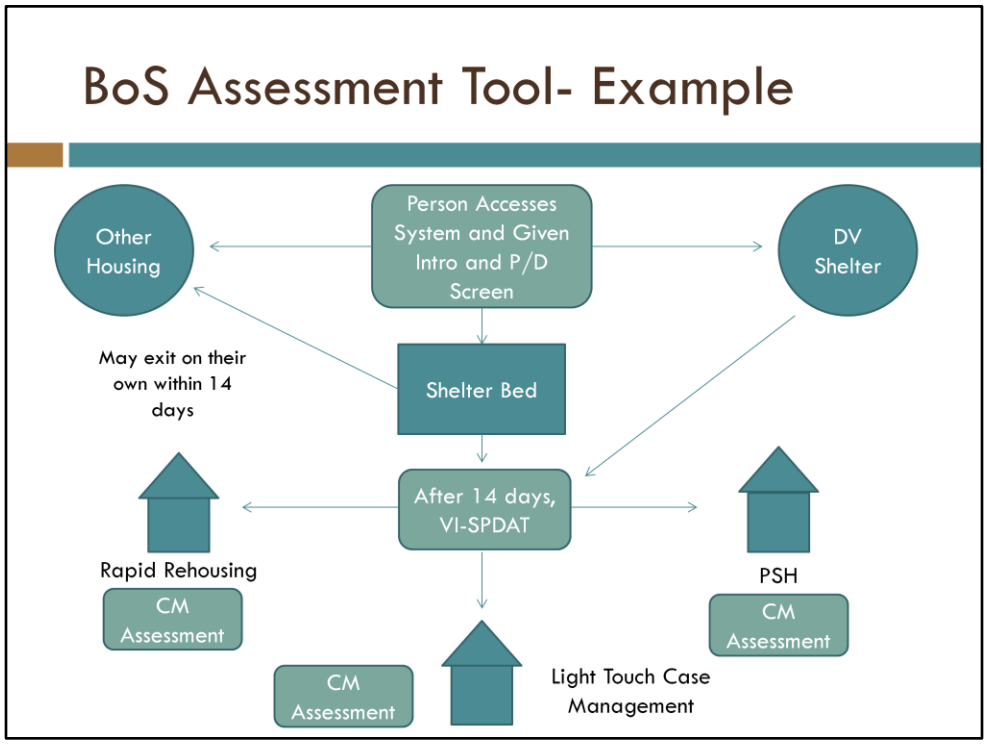
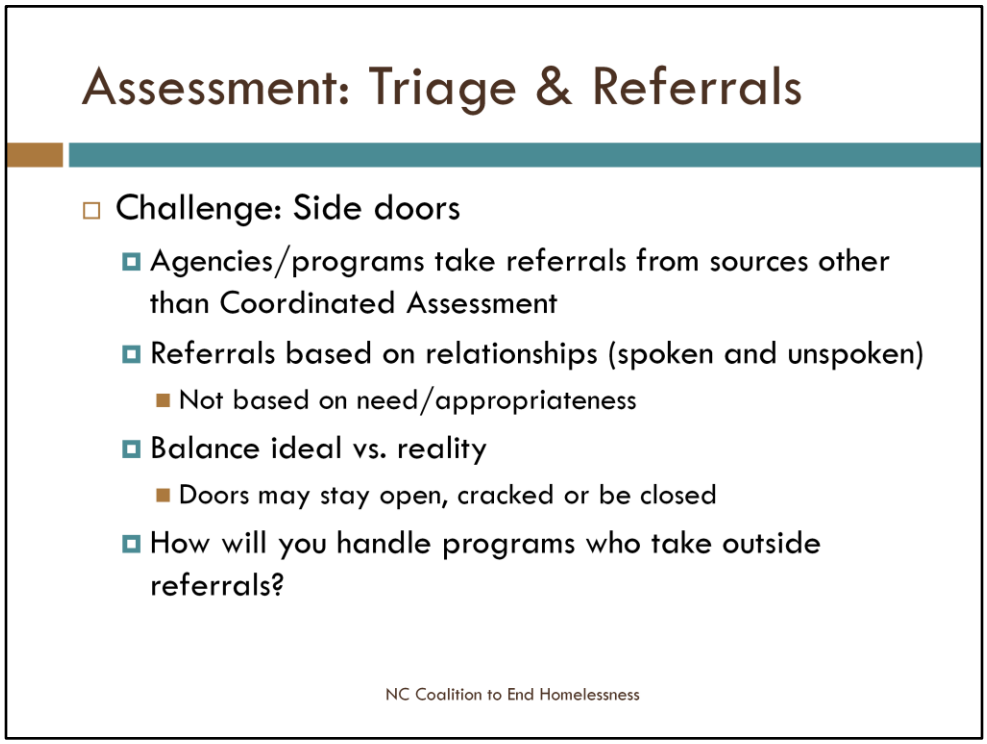


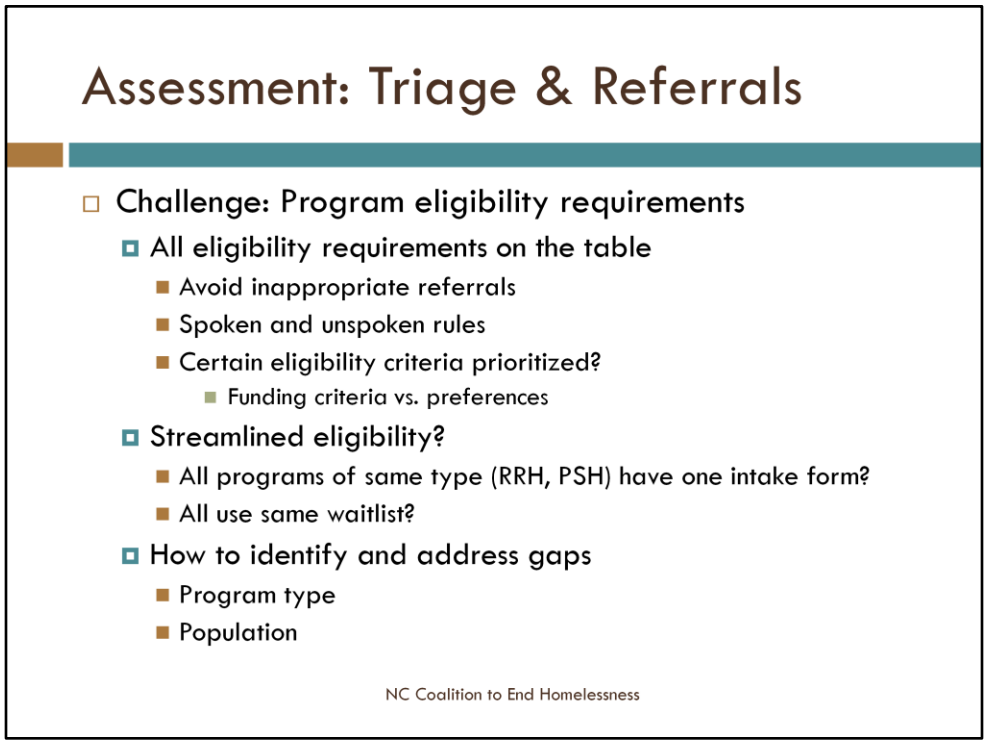
This is an example of how the three parts of the assessment tool can work together in your system.



The next step after assessing households is making referrals based on those assessments. The referral process brings with it some challenges that Regional Committees will need to think through.

The first challenge is side doors. Side doors refers to agencies who take referrals outside of the assessment process. These may be based on informal (Emily at the shelter likes me so she gets my clients into a bed faster) and formal (the VA reserves several shelter beds to hold for veterans) relationships.

Side doors may be known ahead of time or discovered once Coordinated Assessment gets underway. Communities will need to think through which side doors they are going to target to close and which side doors they know exist and are going to make smaller or keep in operation with the goal of closing them in the future. Regional Committees will need to think through how they will work with agencies who take outside referrals. One way to manage an open side door is to request that the agency report how many referrals they received from Coordinated Assessment and how many they received from other sources.



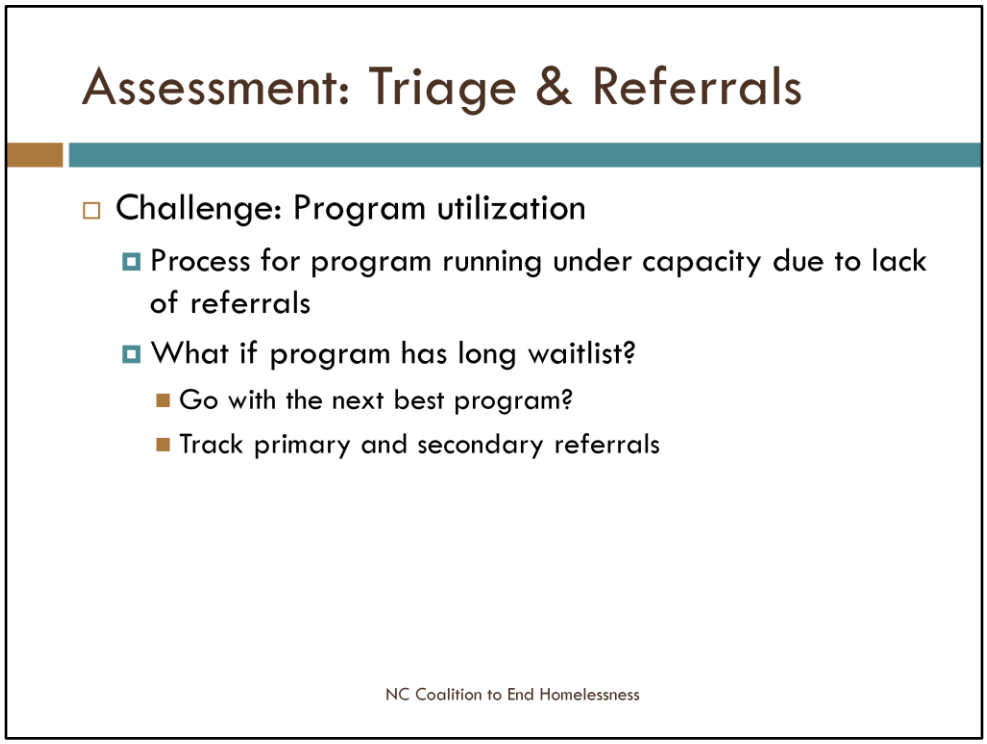
Another challenge with referrals are program eligibility requirements. For example, a household may score for rapid rehousing but because your community's eligibility requirements around rapid rehousing (require income, sobriety and/or only takes families) you cannot refer that household to the most appropriate program.

When thinking through eligibility requirements, communities need to make sure that program report all of their requirements to make sure referrals are made appropriately. This includes spoken (income requirements) and unspoken (we don't like to accept households with more than 3 children) rules. Your Regional Committee will need to be able to evaluate which criteria gets prioritized. For example, we know that HUD requires that PSH referrals come from Category 1 or Category 4 homeless situations and they have to have a disability. Programs will need to still abide by these rules to be in good standing with their funder. However, some PSH programs require that participants have Medicaid. This is not a HUD eligibility requirement; so the Regional Committee can discuss this requirement with the PSH program if they have a number of households who are assessed for PSH but don't currently have Medicaid benefits.

Other eligibility issues to think through:

- Are there ways to streamline eligibility in your community? Can all RRH or PSH programs have the same forms and documentation requirements?
- Can all of the same program types use the same waitlist so multiple waitlists don't need to be kept?

It is important to also think through how you will identify and address gaps. Through Coordinated Assessment your community will likely become aware of a need for a certain type of program (i.e. we need more RRH because more households are getting assessed for it) or a need to address a certain population that is not currently being served (i.e. single parent households with fathers). When your community identifies a gap, how will you come together to address it?



Another challenge with referrals that communities may have is program utilization. With referrals based on the need of the households presenting for services, your community may find that some programs are utilized fully. This may because that type of program is not needed as much or that the program serves a niche population that is not presenting for services. How will your community deal with a program that is regularly running under capacity? Will you all be able to discuss transferring some of the resources from that program to another that is in higher demand?

On the other end of the spectrum, how will your community handle a high demand program. You want to make sure that you don't create long waiting lists for people to stay in shelter and wait months for programs. Other communities have started to do the next best referral in these situations. For example, someone score for PSH but the wait list for that program is at 3 months. Rather than having this person wait for a PSH bed, the staff refers them to the next best program RRH to see if that could get them stabilized in housing. In communities that have done this, they make sure to record the primary or "best" referral based on score and the secondary or "available" referral to provide that information back to the Regional Committee.

Assessment: Triage & Referrals

- Questions for plan
  - Who will perform assessments?
  - How will referrals be made?
    - Staff or committee
  - How will your community handle side doors?
  - Are there ways to streamline referrals in your community?
  - How will you gather program requirements?
  - What advantages and challenges does your community have in supporting this process?

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Be sure to answer these questions in the coordinated assessment plan.

Waitlists

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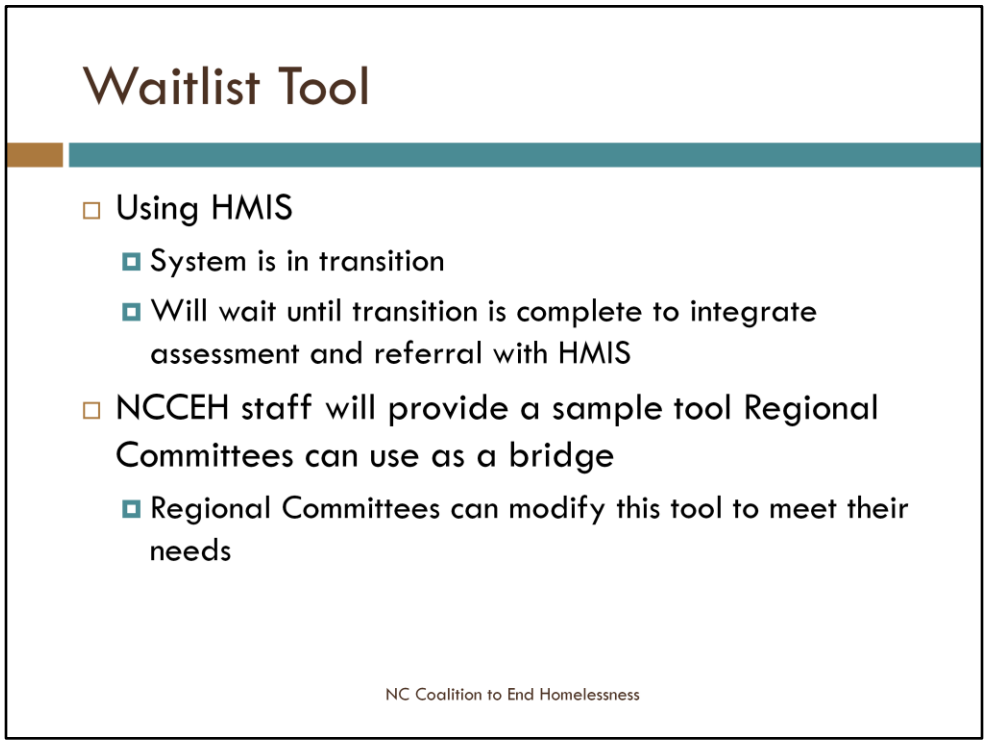
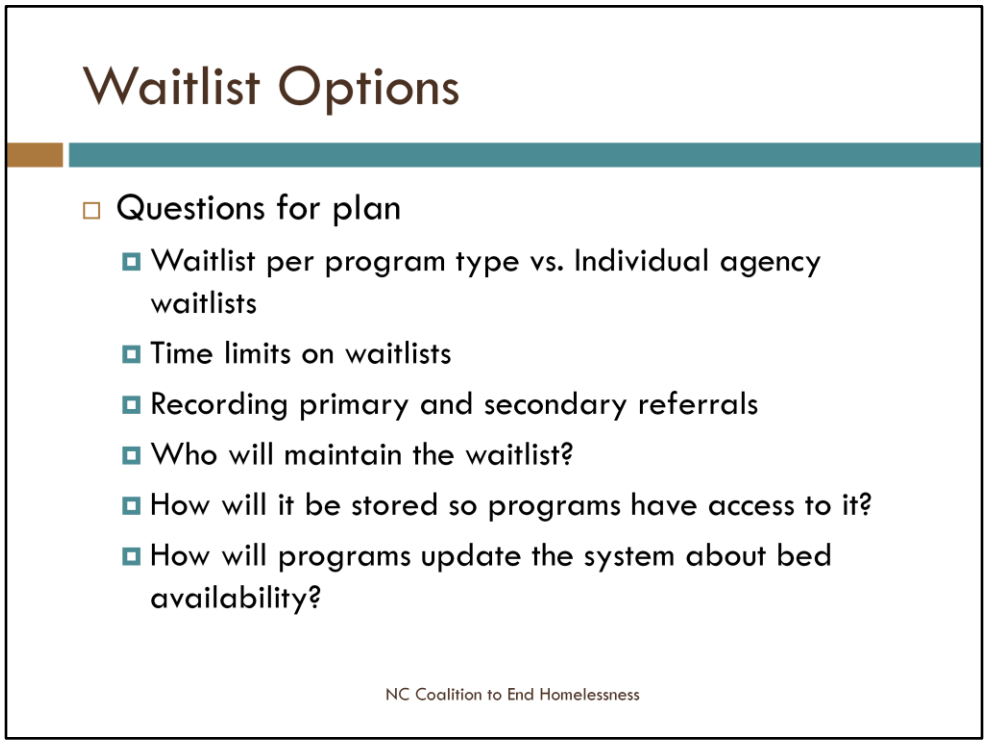


Another component of Coordinated Assessment that communities will need to think through is creating and maintaining a waitlist. Of course, if you have enough space in programs to meet the demand, a wait list will not be necessary, but for those communities that do not have enough resources to absorb all the households assessed for a particular programs, there will need to be a waitlist.

Ideally assessments, referrals and waitlists will be maintained in the HMIS system (CHIN). However, in NC the HMIS system is in a period of transition, and we will not be able to integrate the Balance of State Coordinated Assessment process until after that transition is complete (2015).

Until we are able to maintain waitlists in the HMIS system, NCCEH staff will provide a sample tool that Regional Committees can use a jumping off point in creating their own waitlists.



Some important parts of the waitlist process that communities need to think through are:

- Will your community have waitlists per agency and program or large waitlists by program type
    - Having a larger, program type waitlist can create more transparency about how programs are utilizing waitlists
- Will you put time limits on waitlists so that you limit how long they become (i.e. We will not have a waitlist longer than 3 months. If our waitlist becomes that long, we will start making secondary referrals.)
- You will need to think through who has access to the waitlist and who is in charge of maintaining it.
    - Waitlists can be stored using programs like Google Documents or Drop Box so that multiple staff can access the same document.
    - A program or particular staff will need to oversee the process of placing people on the waitlist and making sure that programs know the next referral they are supposed to take.
- How often will programs update about bed availability?
    - Shelters may need to update Coordinated Assessment staff daily about their bed availability.
    - Other housing programs may be able to update once a week or once a month depending on turnover.

- Be sure to answer these questions in coordinated assessment plans.

Grievance

North Carolina Coalition to End Homelessness

Transparency is Key

- Key to good public administration
- Required by HUD to have transparent processed for CoC including Coordinated Assessment

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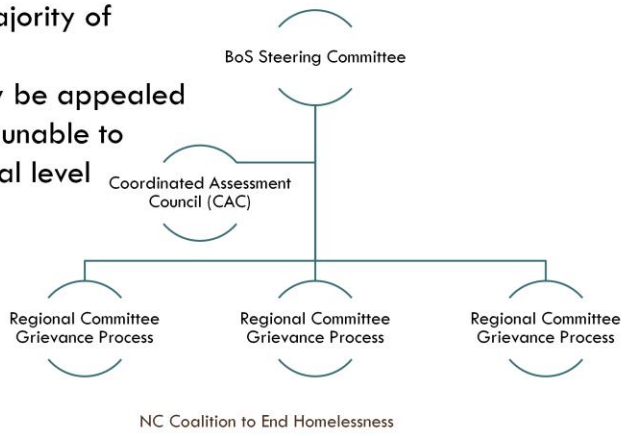
Grievance Overview

- Local Regional Committee grievance procedures will handle the majority of issues
- Concerns may be appealed to the CAC if unable to resolve at local level



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Grievance Process

- Two levels
  - Process for individuals
    - Appeal assessment
    - Appeal referral
  - Process for agencies
    - Do not want to accept referrals

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Possible Processes for Individuals

- Process
  - Accessible
  - Well publicized
- Examples
  - Case conferencing
    - Provider representatives
    - Individuals can present grievances
    - Allows quick service linkage
  - Consumer advocate
    - Register grievances
    - Report to local Coordinated Assessment committee

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Possible Processes for Individuals

- Agency process
  - Appeal referrals sent to them through Coordinated Assessment
- Examples
  - Cap on number of appeals
    - Have to accept ¾ of referrals
  - Agency responsible for finding placement at another program
  - Committee for agency appeals

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Grievance Questions

- Questions for plan
  - Process for agencies that do not want to accept referrals from Coordinated Assessment
    - This is agency grievance process
  - Process for individuals who do not agree with referral
    - This is individual grievance process

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Be sure to answer these questions in coordinated assessment plans.

Oversight

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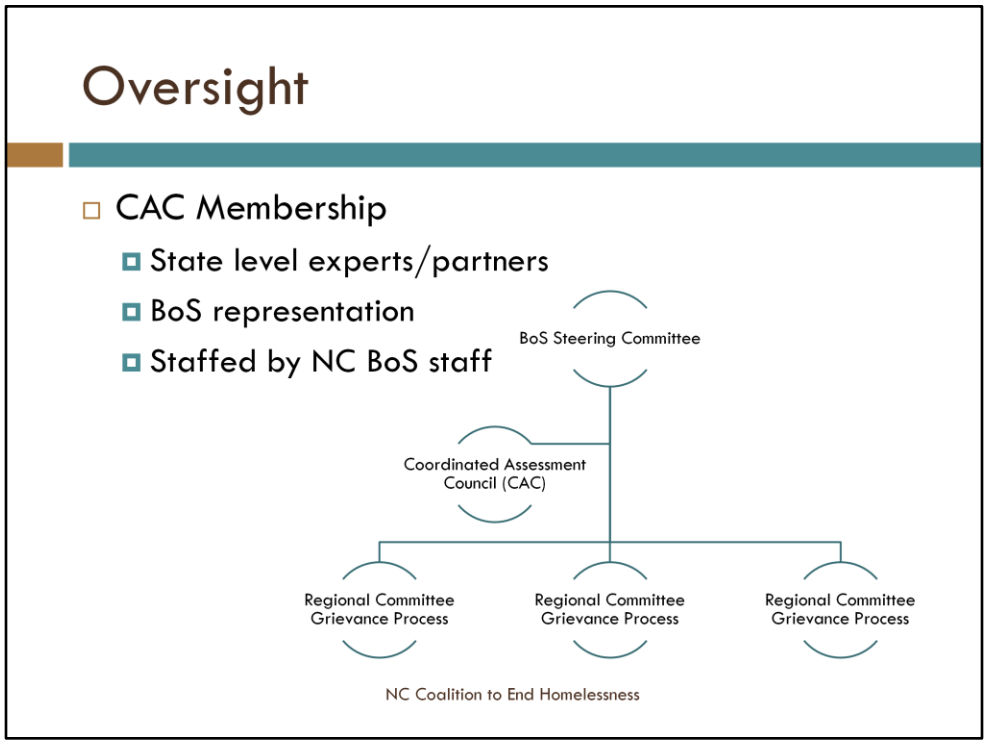
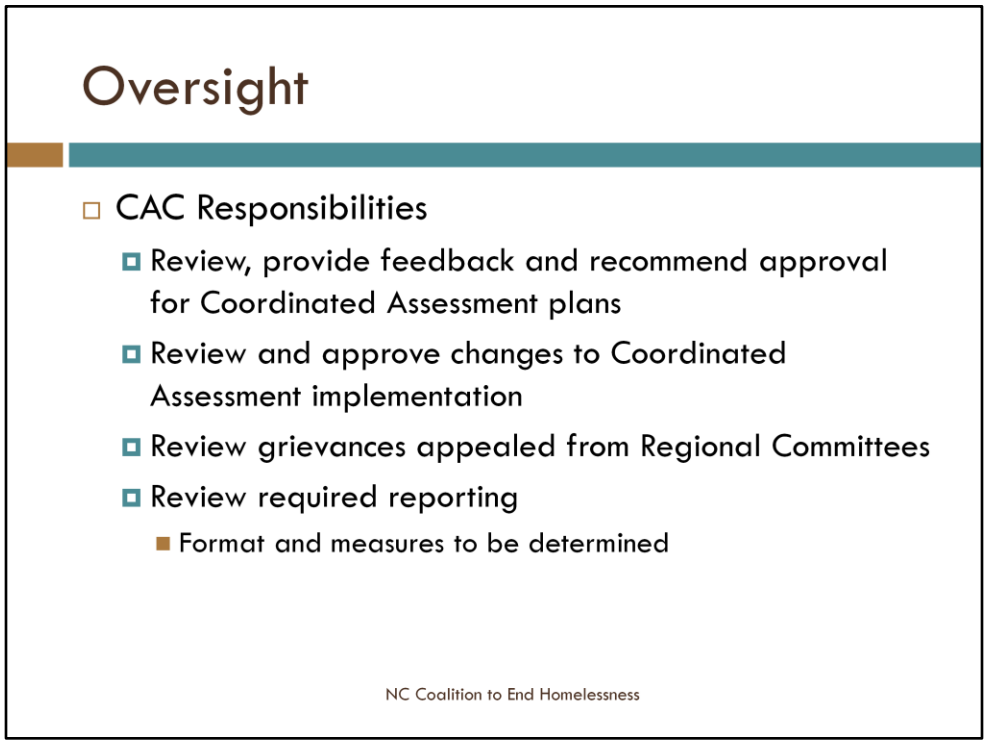
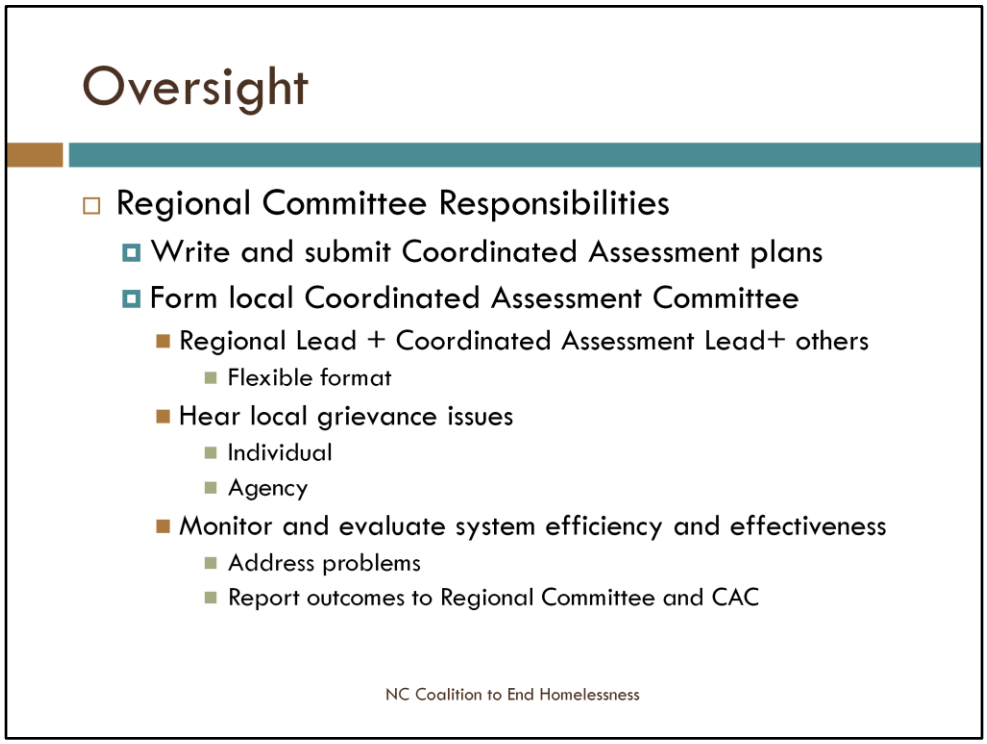


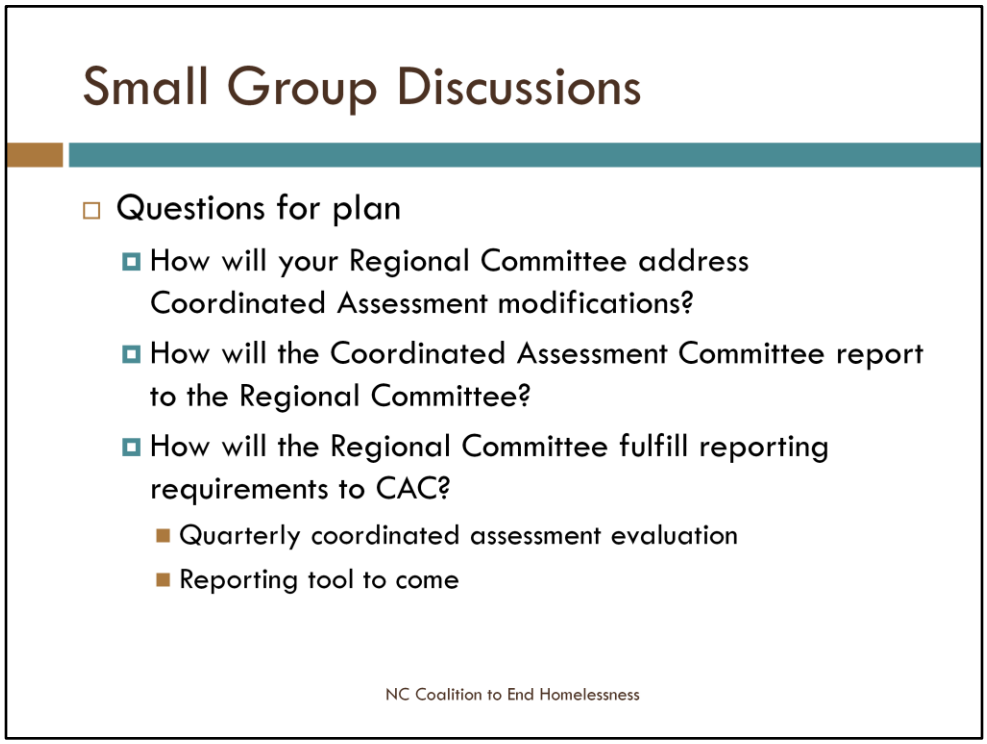
NC BoS Coordinated Assessment Council (CAC) will provide oversight of and technical assistance for coordinated assessment in BoS. The BoS Steering Committee remains the governing body of our CoC. The CAC will make recommendations for plan approval, provide ongoing oversight and resolve grievances appealed for local communities.



The CAC will provide oversight for the entire 79 county BoS CoC.



Other oversight issues must happen locally.



Be sure to answer these questions in coordinated assessment plans.

Wrap Up

North Carolina Coalition to End Homelessness

Wrap Up

- Next steps
  - Write plans
  - Approve by Regional Committee
  - Submit to NC BoS
  - Threshold review
  - Approval recommendation by CAC
  - Steering Committee approval
  - Implementation after approval in 2015

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Wrap Up

- Future trainings
  - Recorded trainings on 3-part tool
    - Required for anyone using the tool to complete trainings
    - NC BoS – Prevention and diversion screen
      - Coming soon
    - Orgcode – VI-SPDAT
      - Available now
      - http://www.orgcode.com/product/vi-spdat/
        - Click on "How to Use the VI-SPDAT" tab
    - NCCEH – Case management tool
      - Coming soon

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Wrap Up

- Materials to help with writing plans
  - PowerPoint slides with notes
    - Coming soon
  - Coordinated Assessment toolkit
    - http://www.ncceh.org/files/4622/
  - Coordinated Assessment explainer
    - http://www.ncceh.org/files/4351/

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Wrap Up

- Goal of this workshop
  - Give you what you need to write a successful coordinated assessment plan
  - Good luck!
  - Let us know if we can help
    - bos@ncceh.org
    - (919) 755-4393

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