Coordinated Access Task Force

Recommendation Report
to the
Rochester/Monroe County Continuum of Care

Coordinated Access Task Force (CATF)
The Coordinated Access Task Force (hereinafter, "CATF") was established in April 2013 to bring together community stakeholders in Rochester/Monroe County to devise strategies to implement a "Coordinated Intake and Assessment System" for homeless services.

In March 2013, the City of Rochester accepted the *Homelessness Resolution Strategy Rochester and Monroe County Final Report* from Housing Innovations, Inc. (hereinafter, "the Homeless Resolution Strategy Report"). This report was the culmination of a study conducted by Housing Innovations. The impetus for this study was the need to examine the strengths and gaps in services in the community for individuals in danger of becoming homeless or homeless already. The purpose of the study was the identification of the program and facility elements required to establish a comprehensive system for rapid housing and re-housing solutions for the homeless and those at risk for homelessness. A key aspect of this study was a focus on a coordinated intake and assessment system as a mechanism for process improvement.

The Homeless Resolution Strategy Report included the following elements:
1. Best practices that may be used across the system.
2. Rationale and potential models for implementation of a Coordinated Access System across all services/programs.
3. An approach to eliminate the use of hotels.
4. Estimates of number and types of emergency shelter, diversion opportunities, rapid re-housing and permanent supportive housing options needed to address community need.

These recommendations are integrally linked to one another and as a result, the Homeless Resolution Strategy Report provides a blueprint for the Rochester/Monroe County community to transform the current homeless system to create an improved community response that is *person-centered*, *outcome-driven* and designed *to avoid episodes of homelessness via diversion or shortening the length of time* a household remains in the homeless system.

CATF Recommendations to the Rochester/Monroe County Homeless Continuum of Care

This report of the recommendations from the CATF to the Rochester/Monroe County Homeless Continuum of Care focuses on the community's efforts to move forward in implementing a Coordinated Access System as delineated in the recommendations of the Homeless Resolution Strategy and further as required by the U.S. Department of Housing and Urban Development (HUD) under the HEARTH ACT and Interim Rules for the Continuum of Care and Emergency Solutions Grants Programs.

Definition of Coordinated Access

Coordinated intake/access is defined as a common set of processes across a system to access a defined set of resources. It consists of four major processes – access, assessment, assignment/referral to services and accountability/oversight. Ideally, this system paves the way for more efficient homeless assistance systems by:

1. Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);
2. Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and
3. Improving data collection and quality and providing accurate information on what kind of assistance consumers need (National Alliance to End Homelessness, 2012; Wagner, 2013).

Rationale for Coordinated Access

1. In 2013, the Homeless Resolution Strategy Report noted that Monroe County is progressive in serving homeless individuals and families, but could build on this success by implementing emerging strategies such as Coordinated Access to ensure greater outcomes.
2. By implementing a coordinated entry process, Monroe County can help to ensure that individuals and families who are homeless or at-risk of homelessness can access the appropriate service quickly and efficiently.
3. The community has identified the need to eliminate the use of hotels for emergency placements and to develop an adequate supply of diversion, rapid re-housing or other exit strategies to address the needs of homeless individuals and families.
4. In Cleveland, which implemented diversion at the front door of shelter when they began HPRP in 2009, 25% of families and about 20% of single adults have been diverted.
5. As of August 30, 2012, US HUD and HEARTH Act require communities receiving HUD funds to take part in a Coordinated Access system.

Summary of Recommended Model

VISION STATEMENT

"To create a coordinated access system to better assist the homeless and those at risk of becoming homeless in the greater Rochester and Monroe County."

The vision for Coordinated Access locally is to

1. Reduce episodes of homelessness and the number of bed placements through coordinated diversion strategies and tactics;
2. Ensure that everyone who needs emergency shelter is able to access and receive services; and
3. Decrease the length of homeless episodes by moving households to permanent housing as quickly as possible.

Realizing this vision would require implementation of a community-wide system including the following components:

1. **Clearly Identified Leadership**
   Coordinated access operating under an authority dedicated to ensuring participation, coordination and accountability of service providers.

2. **Diversion**
   Implementation of a two-level intake strategy that first screens for diversion possibilities and second for shelter or housing placement.

3. **Community-wide Coordination and Communication**
   Formalized mechanism to ensure coordination and communication among service providers *and* systems.

4. **Multiple Points of Service Access**
   Coordinated intake process with consistent and common message.

5. **Common Screening and Assessment Tool(s)**
   The use of common tools across all providers.

6. **Community-wide Use of the HMIS**
   To share information, avoid duplicative assessments and identify available beds in real time.

7. **Consistent Communication With Homeless Households**
   Community awareness/education for potential consumers' regarding access to services.

8. **Staff Training**
   Initial orientation to new processes, ongoing training in tools and practices.

Recommended Model: Process of Development

In March 2013, the City of Rochester convened community stakeholders, including homeless service providers and other community representatives into an ad hoc committee called the Coordinated Access Task Force (CATF) to develop a set of recommendations for moving the greater Rochester community to a coordinated access model. The CATF is compromised of stakeholders across the homeless services continuum and community partners. Appendix 1 is a roster of the membership. In June 2013, the Rochester/Monroe County Homeless Continuum of Care formally established the CATF as an Ad Hoc Subcommittee of the CoC.

The CATF conducted its work from March – November 2013. The work of the CATF included analyzing the current state of homeless household access to homeless services. The CATF engaged strategic techniques, including an in-depth SWOT analysis, to identify gaps, duplications and strengths in the current system. CATF members informed their discussions by the reviewing the Homeless Resolution Strategy Report and the work of the National Alliance to End Homelessness. Opportunities for service system enhancement via coordination drove development of the recommended path to lead the change from the existing to desired state of coordinated access in the greater Rochester Community.

During this process, three main areas of emphasis were identified:

1. The Need for a Common Assessment Tool
2. A Clear Process
3. Data and Reporting Considerations

Need for a Common Assessment Tool

The CATF review of the current state of the homeless system identified that different tools are used by providers to screen and assess households for services/needs. The desired state for the system is the use of common screening and assessment tools to consistently identify needs and, barriers and to appropriately match individuals and families to the best housing and services options based upon such an assessment. The common tools need to incorporate elements across the continuum, starting with screening and diversion and through emergency placement and exit from the system. Items to consider in the development or selection of common tools included determining how much information should be required or is necessary for an emergency placement, incorporating required HMIS and DHS elements and the use of a tool that can be built upon at each step in the process. Additionally, the elements within the tools, along with the administering of the tools with households must be based upon a trauma-informed approach. Tools currently being used in the local system as well as evidence-based tools should be reviewed to inform the selection of common tools to be used. Any tools selected must be supported with training for the users.

A Clear Process

The CATF review of the current state of the homeless system identified that there are multiple points of contact and access to the system. These points include contacting 2-1-1/LIFE LINE, shelters or DHS by phone, including after-hours calls and walk-ins to DHS or shelters. There is no consistent process or message given among these multiple points of contact which may impact the placement or services that a household receives. It was noted that youth providers currently have a coordinated system in place for referrals for youth. The desired state for the system is a process that is coordinated across identified points of access, using a common tool to identify barriers and needs that allows for effective diversion or placement into the most appropriate service. Items to consider in the development of a process included identifying a clear path to follow for screening, diversion and placement, identification of the designated access points, the “buy-in” of providers and ensuring that the process includes all households, regardless of their funding support or current/past behaviors. Additionally, the process must be supported by common tools, consistent practices, training and community awareness.

Data and Reporting Considerations

The CATF review of the current state stressed the importance of HMIS as the data collection mechanism for the homeless system. The community has a high rate of participation among providers in HMIS, with only a few shelters remaining outside of this system. The desired state for the system is the use of HMIS to support the process and for quality improvement. Items for consideration in the development of the data system for coordinated access include incorporating the common assessment tools into HMIS to allow for building upon the assessment at each step in the process, potential for real time bed availability component to HMIS, using data to monitor providers (accountability considerations) and the ability to track outcomes, including a households’ movement through the system and system performance over time.

The CATF broke into work groups to address each of these aspects. Each group was charged with developing recommended strategies for implementation to move to the desired state for the Coordinated Access System. Below is a summary of recommendations for each area of consideration.

Recommended Common Diversion and Screening/Placement Tool

The Tools Work Group recommended the use of a tool that can be progressively built upon. The recommended tool incorporates:

1. Ease of administration to obtain the necessary information to inform the decision to divert or move to placement;
2. Trauma-informed, including immediate identification of safety concerns; and the
3. Ability to identify certain special populations, such as victims of domestic violence, veterans and youth to triage appropriately.

The recommended common tool identifies opportunities for diversion is Appendix 4.
Intake is envisioned to occur in a two-part process:

1. Screen for diversion and
2. Intake for shelter services

The CATF recommends conducting a pilot project to test the screening tool for the initial diversion screen (see Page 7, "Recommended Coordinated Access Pilot to Test Model in early 2014").

Recommended Process – System Access

The subcommittee identified the key aspects of the process to be developed:

1. The process must be user-friendly.
2. The process must be timely and responsive.
3. The process must be structured to allow for equal access to all, *regardless* of a household's funding source(s) or current/past behaviors.
4. Screening/Diversion at the front end should be conducted at a limited number of points of contact to ensure consistency.
5. The process must be supported with adequate resources to accommodate the need for diversion and placement options and those conducting the screening and assessment must be aware of such resources.

The Process Subcommittee focused on the available resources in the community that may be available to ensure a smooth experience from entry to exit for homeless individuals and families. The benefits and challenges to decentralized and centralized models of coordinated access were examined and it was determined that a hybrid model involving 2-1-1/LIFE LINE, DHS and potentially three access points to serve the different needs of homeless individuals would best serve the community.

Recommended Data Collection and Reporting

The Data & Reporting Subcommittee identified several components as priorities:

1. The database should be accessible, preferably web-based, to allow for use by multiple providers at multiple locations. This is as opposed to a costly and location-centric stand-alone application.
2. Using a series of simple questions, the tool should be able to assess eligibility for appropriate services immediately and in a standardized manner across all homelessness service providers.
3. The tool should be affordable, practical and/or part of an existing process or resource, as no dollars have been specifically identified to pay for it.

With these components in mind, two (2) Data Collection and Reporting options have been identified:

1. Homeless Management Information System (HMIS)

The first is the Homeless Management Information System (HMIS). This system has a feature called *Eligibility Point* that ensures households are eligible for programs and services. The eligibility module uses customizable assessment and priority ranking filters to quickly assess eligibility while creating referrals to appropriate services via the existing HMIS database. Additional information is available at:

http://www.bowmansystems.com/products/servicepoint/eligibility

The cost of using this option is approximately $5,000 a year with an additional $600 training fee during start up.

The main advantage of the HMIS web-based system, already in use by many local providers, is that it can be accessed anywhere the internet is available. Another is the extensive experience of Bowman, the local HMIS database vendor, in helping communities use their database as a platform for a Coordinated Assessment system. Communities that have seen reductions in homeless since its implementation include Dayton, Ohio and several counties in Tennessee.

Although HMIS is currently web-based, a disadvantage is that it requires purchase of a license making it less accessible to those providers who do not currently use HMIS. This creates a barrier to entry for many providers outside of the local homeless arena or for those who have chosen to not participate in HMIS.

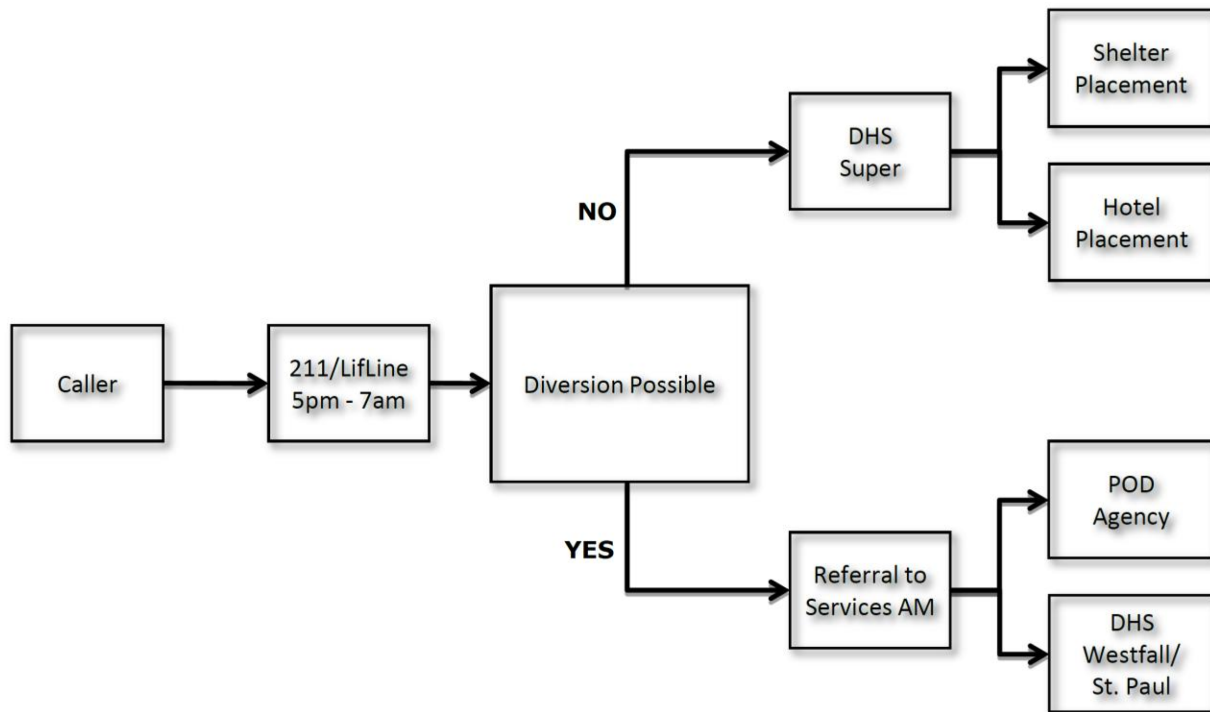
2. 2-1-1/LIFE LINE Information & Referral Telephone Service

The second option is to use 2-1-1/LIFE LINE in an effort to bridge the gap between those community providers who do not currently use HMIS. 2-1-1/LIFE LINE uses a database called **I Carol** which provides area wide information on providers and their services. Given 2-1-1/LIFE LINE's proven ability to provide excellent comprehensive information and referral services 24 hours per day/seven days per week, some discussion has begun on how 2-1-1/LIFE LINE could perhaps take the lead on providing a Coordinated Access or at least help buttress whatever solution is used. This is the newer of the two options evaluated during this time period. Therefore, further discussion will be required to properly assess its strengths and weaknesses.

Recommended Coordinated Access Pilot to Test Model in Early 2014

Upon Continuum of Care acceptance of the above recommendations, the CATF further recommends conducting a pilot in early 2014 to test the efficacy of the new tool and process. Due to the uncertainty of available funds, the committee focused on the available resources in the community that may be available to ensure a smooth experience from entry to exit for homeless individuals and families. The committee believes that a successful pilot could involve collaboration with 2-1-1/LIFE LINE and DHS that would merge the current after-hours system with 2-1-1/LIFE LINE. This pilot could test the effectiveness of the assessment tool and if it is a

realistic option to have 2-1-1/LIFE LINE screen, divert or assist with DHS placement. A high level diagram of the proposed process follows.



Implementation Considerations

1. Determination of oversight and coordinating entity for Coordinated Access for implementation, ongoing training, technical assistance and accountability.
2. Estimate of fiscal impacts of increased hospitality bed nights on local shelters.
3. Determination of pilot sites and timeframe.
4. Need for and provision of ongoing training for staff at the shelters for proper use of the Common Assessment form.
   a. Note: 2-1-1/LIFE LINE Lifeline has the training and capability (all 2-1-1/LIFE LINE staff is cross trained and has interpreting services available) but would need additional staff and training to access to HMIS. 2-1-1/LIFE LINE would train staff on diversion and be able to place people at appropriate locations on the night of contact.
5. DHS involvement in process after hours (and the following day) to determine eligibility for shelter payment.

6. Goal of not moving people after their initial placement.
7. The critical need for all agencies to agree to take a certain percentage of households' hospitality (and potentially take households who have previously exhibited behaviors that warrant discharge).
8. The committee discussed the idea of a drop-in center for overnight emergencies.
9. Determining how households reach the emergency placement if they lack transportation resources.
10. Identifying capacity for agencies to a) be trained in a centralized diversion and placement process and b) accept after hours walk-ins.

Parking Lot Issues

Over the cycle of monthly meetings, a number of issues were identified during the CATF process that could impact the policy and/or operation of a Coordinated Access System. These issues beyond the purview of the CATF, but are items which are important to address. They include:

- Availability of diversion options
- Being cognizant of trauma-informed care (SHiFT report)
- Connecting outreach process with intake process
- Determining how coordinated access would bypass an individual agency's internal decision process
- Exporting information between systems; conducting customizable search for homeless services on 2-1-1/LIFE LINE
- Funding factors, funding streams
- How to collect data when emergency shelter stays are so short
- How to engage the chronic homeless population
- How to serve those who threaten or enact violence and/or sex offenders
- How to shelter homeless youth with acute mental health issues
- Issues related to serving longer-term sanctioned
- Need to have someone who's job who is primarily focused on coordinated access
- People may say/feel they are "sanctioned", but may not be ready/willing to engage

Recommended Next Steps

1. Submission of the CATF Recommendations to the Rochester/Monroe County Homeless Continuum of Care (CoC) for review and implementation.
2. CoC to host a facilitated discussion with the Executive Directors of area shelters and agencies to review the Coordinated Access requirement and to obtain input on moving forward with strategies to implement these recommendations.
3. Develop a cost model for implementing a pilot and continuing operations.

Appendices

1. Coordinated Access Task Force roster of participants
2. Recommendations for Best Practices, excerpted from the *Homelessness Resolution Strategy Rochester and Monroe County Final Report* (Housing Innovations, Inc.)
3. CATF Sub Committee Reports:
   a) Process
   b) Tools
   c) Data & Reporting
4. Recommended Diversion Assessment Tool

Appendix #1

CATF MEMBERSHIP ROSTER 2013

Name	Title	Organization
Mary Kruger	2-1-1 / LIFE LINE Quality Service Specialist	211 – Goodwill of the Finger Lakes
Shye Louis	2-1-1 / LIFE LINE Manager	211 – Goodwill of the Finger Lakes
Jaime Saunders	Chief Executive Officer	Alternatives for Battered Women, Inc.
Anna Valeria-Iseman		Bridge Community Development Corp
Lisa Lewis	Vice President of Residential Services	Catholic Family Center
John Paul Perez	Director, Housing Services	Catholic Family Center
Neilia Kelly	Senior Consultant	CCSI, Inc.
Valerie Douglas	Director, Counseling and RHY Services	The Center for Youth Services
Jeng Saul	Community Manager	Hillside Family of Agencies
Ryan Acuff	Advocate / Case Manager	House of Mercy
Susan Boss	Executive Director	The Housing Council at PathStone
Joel Kunkler	Director of Landlord & Tenant Services	The Housing Council at PathStone
Joshua Sankowski	Executive Assistant	The Housing Council at PathStone
Dan Condello	Financial Assistance Coordinator	Monroe County Department of Human Services
Rebecca Miglioratti	Community Homeless Coordinator	Monroe County Department of Human Services
Nikisha Johnson	President / CEO	Mercy Community Services, Inc.
Chanh Quach	Community Liaison	Monroe County Department of Planning & Development
Nicholas Coulter	Priority Services Coordinator	Monroe County Office of Mental Health
Mandy Teeter	Mental Hygiene Administrator	Monroe County Office of Mental Health
David Appleton	Assistant Supervisor	Open Door Mission
Mike Hennessy	Executive Director	Open Door Mission
Kenneth Guyer	Assistant Supervisor	Open Door Mission
Dan Sturgis	Operations	Rochester Housing Authority
Nathan Gutschow	Genesis House Program Manager	The Salvation Army of Greater Rochester
Michael Rood	Director of Social Services	The Salvation Army of Greater Rochester

Liz Jefferson	Family Services Case Manager, Susan B. Anthony Transitional Apartments	Sojourner House at PathStone, Inc.
Jim Smith	Executive Director	Spiritus Christi Prison Outreach
Chuck Albanese	Director of Community Services	Unity Health System
Cheryl Nielsen	Former Community Services Grants Coordinator	Unity Health System
Libby Louer-Thompson	Manager, Homeless & Bio-psychological Programs	Veterans Administration
Lisa DeJonge	STEPS Program Manger – Supportive Services Veteran Families Program	Veterans Outreach Center
Judy Gilbert	Director, Residential Services	Veterans Outreach Center
Jaquetta Calhoun	Homeless Housing Director	Volunteers of America
Susan Hill	Director, Permanent Housing	Volunteers of America
Barbara Lacker-Ware	Grants Administrator	Wilson Commencement Park
Carrie Michel-Wynne	Director, Housing	YWCA
Facilitation Services provided by Julie Beckley	Senior Community Housing Planner	City of Rochester

Steering Committee of the Coordinated Access Task Force 2013

Role	Name	Title	Organization
Co-Chair	Neilia Kelly	Senior Consultant	CCSI, Inc.
Co-Chair	Joel Kunkler	Director of Landlord & Tenant Services	Housing Council at PathStone
Secretary	Valerie Douglas	Director, Counseling and RHY Services	Center for Youth Services, The
	Mary Kruger	2-1-1 / LIFE LINE Quality Service Specialist	211 – Goodwill of the Finger Lakes
	Shye Louis	2-1-1 / LIFE LINE Manager	211 – Goodwill of the Finger Lakes
	Jaime Saunders	Chief Executive Officer	Alternatives for Battered Women, Inc.
	Joshua Sankowski	Executive Assistant	Housing Council at PathStone
	Nikisha Johnson	President / CEO	Mercy Community Services, Inc.
	Rebecca Miglioratti	Community Homeless Coordinator	Monroe County Department of Human Services
	Cheryl Nielsen	(Former) Community Services Grants Coordinator	Unity Health System
Facilitation Services	Julie Beckley	Senior Community Housing Planner	City of Rochester

Appendix #2

Recommendations for Best Practices, excerpted from the *Homelessness Resolution Strategy Rochester and Monroe County Final Report* (Housing Innovations, Inc.)

Recommendations for Best Practices

1. **Continue to implement diversion as the first response to a housing crisis and use the Shinn-Greer Tool as a way to prioritize services.**

   In some communities (including Rochester) attempts to divert households have been the first response when a household is seeking an emergency shelter arrangement. In Cleveland, which implemented diversion at the front door of shelter when they began HPRP in 2009, 25% of families and about 20% of single adults have been diverted. In the United Kingdom, about 50% of households are diverted.

   Diversion may include one-shot financial assistance, mediation services and/or assistance with relocation and housing start up costs, but most importantly if it is located at the front door to shelter; it prevents the household from entering the homeless system. It is prevention targeted to those most likely to become homeless.

   It is important to note that the Prevention efforts under HPRP are viewed by HUD and other national groups and advocates as having been ineffective and not the best use of resources. This is because these resources were not necessarily targeted correctly (households would not have become homeless without the assistance).

   However, communities must focus on diversion in order to decrease the numbers of homeless people and be successful in achieving this goal of the HEARTH Act. During the last year, researchers Beth Shinn and Andrew Greer of Vanderbilt University completed research that has validated a quick screening tool to prioritize households for prevention services that are most likely to be homeless. A brief write-up is included in Appendix 2 and the scoring elements have been incorporated in the sample Diversion Interview included in Appendix 5. Also, see Appendix 3 for a description of successful diversion and prevention programs.

2. **Adopt a rapid exit/housing first approach for the entire system.**

The new HEARTH outcomes require that all communities work to exit people as quickly as possible from the crisis of homelessness. (The federal goal is that no one is homeless for more than 30 days.) Additionally, HEARTH focuses on permanent housing exits and low rates of returns to homelessness once people leave the system. (The target is that less than 5% of people become homeless again.) In order to achieve these goals, the primary focus of the system must be on securing housing exits from the moment a person presents with a housing crisis.

The evidence cited above supports a rapid exit strategy for homeless systems. Both Rapid Re-housing and Housing First have proven that people can be stabilized once housed. Additionally, there is no empirical evidence that services while homeless or prior to being housed improve housing outcomes. Housing Planning must begin day 1 of every homeless episode and all services should be directed to achieving this goal. All programs must focus on securing housing, income and benefits and should be evaluated accordingly. Providing services once people are housed is critical in making this approach successful.

3. **Increase Rapid Re-housing.**

Rapid Re-housing (RR) has been a resounding success in communities across the country. For a relatively small investment, (average expenditures are in the range of $1,000 to $4,000 per household), the results have been remarkable, often with 90-95% of households successfully ending their homelessness permanently. The average costs of shelter and transitional housing are often much higher with far fewer successful outcomes. A number of key stakeholders noted that Rochester's own Rapid Re-housing program under the HPRP initiative was a great and effective resource. The City and County should seek to continue this service.

The National Alliance to End Homelessness reports the following data on costs for RR in an issue briefing they prepared called *Rapid Re-Housing: Successfully Ending Family Homelessness*. "In Alameda County, California, the cost for each successful exit from homelessness to rapid re-housing is $2,800. In contrast, the cost is $25,000 for each successful exit from transitional housing and $10,714 from emergency shelter. In the State of Delaware, the cost of a successful exit to permanent housing with rapid re-

housing is $1,701, compared to $6,065 for emergency shelter and $15,460 for transitional housing."

Rapid re-housing offers both one-time and time-limited financial assistance to help with debts, security costs, rents and other related housing costs. Rental assistance is usually limited to between 3 and 18 months and authorized in 90 day increments. Housing location services are a key component as are case management support services. Case management focuses on helping increase income and housing stabilization and is also time-limited. This model is sometimes referred to as Transition in Place because the services and financial assistance transition out while the household remains in the dwelling unit. See Appendix 3 *(of the Housing Innovations report)* for a description of some Rapid Re-housing program models.

4. **Use Progressive Engagement in Providing Services.**

Progressive engagement is a new approach with growing support whereby people are provided with the minimum amount of assistance required to move them to permanent housing and then given additional assistance if the initial support is inadequate. This approach is based on the fact that we do not have validated instruments to predict who needs what level of service in order to maintain housing. Thus, in progressive engagement, the provision of service is based on need, as opposed to a guess. This strategy allows for customized assistance while preserving the most intensive interventions for those with the highest barriers to housing success.

Progressive engagement will be an important principle when implementing the Coordinated Intake/Access process. Many communities have spent enormous amounts of time trying to identify the criteria to determine who gets which level of service. These efforts have mostly been for naught as the predictive tools needed do not exist (except for Diversion and the Shinn-Greer screener as noted above).

Finally, progressive engagement recognizes people's resilience, skills and abilities to manage their lives.

5. **Implement a Housing Stabilization Case Management Approach using Critical Time Intervention (CTI).**

Critical Time Intervention (CTI) is a well-researched approach to case management practice that "manualizes" a time-limited intervention to stabilize people in housing.

CTI emphasizes a focus in assessment and service planning on key issues related to housing stability as well as connections to community resources and natural supports. The practice is implemented in three phases of decreasing service intensity that begin when a person is housed lasting for a total of approximately nine months. See www.criticaltime.org for more information.

CTI has been implemented with a variety of populations moving from various settings into community-based housing of varying types. The practice has broad applicability and can be adopted and adapted as Rochester and Monroe County implement rapid re-housing and housing first strategies.

6. **Improve practice and capacity in Permanent Supportive Housing (PSH) model.**

<u>Target PSH to the People with the Highest Needs</u>. This community has created over 1,100 units of PSH and is to be commended for it. Going forward, in order to achieve the goals of this plan, improved targeting will be needed to ensure that the people with the highest needs are accessing this resource. A number of stakeholders reported that the units are being used as a substitute for Section 8 and not necessarily serving people with long-standing, serious disabilities, especially in the family units. Coordinated intake/access will provide a mechanism to manage this targeting process.

<u>Build PSH Provider Capacity</u>. The turnover rate reported in the Continuum of Care's 2011 AHAR (Annual Homeless Assessment Report) for PSH projects for single adults is 33%, which is high as compared to the national average of 12%. Further analysis revealed that about 40% of these exits are negative, with people going to unknown destinations, temporary housing arrangements, hospitals, jail or prison. A number of providers and other community stake holders reported that PSH providers are having difficulty with housing stabilization supports for tenants. Further training and program development in the Housing First model and how to assist tenants to meet tenancy obligations and reduce barriers to successful housing stability is needed. Training in the CTI model described above would also be beneficial. Additionally, programs receiving public funding should be evaluated on their rates of success on quality housing exits (see recommendation below).

<u>Integrate Supported Employment in PSH Programs</u>. As noted in the introduction to this section, Supported Employment has demonstrated success in engaging persons with

disabilities and high needs in competitive jobs. This model emphasizes access to competitive employment based on client choice and a "work first", as opposed to job readiness, approach. Key to its success is the provision of "follow along supports" once people are employed. PSH is uniquely positioned to implement this approach given the ongoing services provided.

Implement "Moving On from PSH" Interventions. Unlike single adults, family units are turning over at a very low rate (close to zero). New York City has successfully implemented programs to assist people in moving on from PSH after they have stabilized and if they are interested. These initiatives have required designated affordable housing units and/or set asides of Housing Choice Vouchers given the high cost market and very low incomes of the people moving on from PSH. Given the preciousness of this resource and the need to generate greater positive turnover, the community should consider implementing a "Moving On" initiative.

7. **Implement data driven decision-making and evaluation through measurement of outcomes.**

As noted in the introduction, the current focus in homeless services is on the achievement of outcomes including reductions in the numbers of homeless people, rapid access to permanent housing, low rates of returns to homelessness and success in increasing incomes through employment and the receipt of public benefits. Additionally, cost effectiveness is a priority given the limit on available resources.

In order to achieve these outcomes, communities are adopting data driven decision-making processes using their Homeless Management Information Systems (HMIS) and other local databases. They are looking at outcomes on these indicators for the system as a whole as well as by sub-populations (e.g., families, single adults, young adults etc.). Additionally, these analyses are "drilling down" to evaluate various system components (e.g., shelter, RR, transitional housing and permanent supportive housing) as well as individual programs within these cohorts.

Rochester recently changed HMIS administrators and should request and receive regular reports on key indicators and compare changes over time. Additionally, individual programs that are publicly supported should be evaluated and funding made contingent upon successful achievement of benchmarks for these outcomes. It is important to note that HUD has stated publicly that the outcomes and benchmarks for transitional housing

should be the same as for Rapid Re-housing programs. (Mark Johnston, HUD Assistant Secretary Remarks at NAEH Conference, 2012).

Measures and indicators to track include:

- Reductions in shelter/street census – this is a system indicator, all of the others can be reviewed on system, component and individual program levels.
- Reductions length of stay/time homeless.
- Reductions in returns to homelessness.
- Increased exits to permanent housing.
- Increases in income.
- Increase in rates of receipt of public benefits.

The community will need to establish benchmarks/standards for each indicator. An example of an evaluation framework is attached in Appendix 4.

Additionally, evaluation should look at cost per permanent housing exit. This is calculated by dividing the total annual program budget by the number of people who exit to permanent housing in a year.

8. Ensure Leadership and Accountability for this plan.

Every community in America that has successfully implemented an ambitious plan such as this one has had an identified leader who is accountable and responsible for its implementation. Without leadership and clear responsibility it will be extremely difficult, if not impossible, to successfully execute the plan. The community wants to continue to build on its successes and be model for other jurisdictions and will be one if provided with the required leadership.

Appendix #3a

CAFT
Process Sub Committee Report
2013

Consolidated Pilot Recommendations

Due to the uncertainty of available funds, the committee focused on the available resources in the community that may be available to ensure a smooth experience from entry to exit for homeless individuals and families. The committee discussed the benefits and challenges to decentralized and centralized models of coordinated access.

It was determined that a hybrid model involving 2-1-1/LIFE LINE, DHS, and potentially three access points to serve the different needs of homeless individuals would best serve our community. The Sub Committee believes that a successful pilot could involve collaboration with 2-1-1 / LIFE LINE and DHS that would transfer the current afterhours system to 2-1-1 / LIFE LINE.

This pilot could test the effectiveness of the assessment tool and if it is a realistic option to have 2-1-1 / LIFE LINE, screen, divert or assist with DHS placement. Please see the illustration below for possible call flow.

Considerations for the pilot:

1. 2-1-1 / LIFE LINE has the training and capability (all 2-1-1 / LIFE LINE staff are cross trained and have interpreting services available) but would need to step up to access to HMIS. 2-1-1 / LIFE LINE would train staff on diversion and be able to place people at appropriate locations on the night of contact.

2. DHS will need to be involved after hours, and the following day, to determine eligibility for shelter payment.

3. Ideally, persons would not have to move after their initial placement.

4. It is critical for all agencies to agree to take a certain percentage of persons hospitality (and potentially take persons who have previously exhibited behaviors that warrant discharge). The committee discussed the idea of a drop in center for overnight emergencies.

5. How will persons reach the emergency placement if they lack transportation resources?

6. Will agencies be able to take walk-in persons after hours?

7. Will agencies make staff available to be trained in a centralized diversion and placement process, and then support its community-wide implementation?

Coordinated Access Task Force Process Subcommittee Consolidated Pilot Recommendations

Can - and will - our community adequately use HMIS as a centralized and real time tool to avoid doubling up, have up-to-date bed availability and accurately collect demographic data using a centralized intake assessment tool that is not redundant for persons seeking services?

Appendix #3b

CAFT
Tools Sub Committee Report
2013

Background

Currently in the greater Rochester community, an individual being placed after hours (or anytime) is dependent on whether he/she is sanctioned by the County of Monroe DHS or not. Moving into Coordinated Access, this will no longer be a barrier to determining individual, or family, eligibility for shelter placement. Instead, an individual or family will need to be screened for prevention/diversion, and if the individual/family is not eligible for these services, then they are automatically eligible for homeless shelter placement – regardless of being sanctioned.

Assessment and Targeting

A well-developed assessment tool helps communities determine the best program match for each homeless or potentially homeless individual or family coming to the front door. An assessment at the intake center does not need to delve into consumer's histories very deeply; they simply need to gather enough information to determine which intervention and program are the best fit. When developing an assessment form, communities should take cues from other communities' forms, examine required data elements from HMIS and funders' data collection requirements, and gather information on:

1. Where the individual or family slept last night;
2. The individual or family's reason for coming to the center;
3. The last time/place the individual or family was in permanent housing; and
4. The individual or family's income.

Tool Development: Phase I and Phase II Diversion/Placement Interview Script

The Tools Sub Committee reviewed diversion/prevention assessment tools used by other communities that have implemented Coordinated Access, and also considered recommendations proposed in the Homeless Resolution Strategy Report. Two separate tools were created using the recommended questions. The first phase (Phase I) of the tool is designed to assess the possibility of diverting an individual or family (hereinafter referred to as the "client") from entering the homeless system, and instead, be referred for preventive services, such as landlord/tenant mediation or financial assistance (ex., rent payment assistance, utility bill payment assistance, etc.).

There will be two separate assessments that will take place;

1. The Phase I assessment for Diversion/Prevention will determine if the client is able to be prevented from entering into the traditional homeless shelter system, and is connected to services to divert their homeless situation.

Different scenarios occur for households seeking services during the business day versus after normal hours.

DHS Business Hours --in person:	When households report to DHS for services, a DHS staffer will conduct the Diversion/Prevention screening. If the client is able to be diverted from a traditional shelter, they will be referred to those services, and information from the diversion screening will be electronically transmitted (via HMIS) to the next appropriate agency.
DHS After Hours to --via telephone	If the client is not able to be diverted they will be referred the appropriate shelter for placement and a further assessment of needs
2-1-1 Business Hours –via telephone:	If the client calls during business hours the diversion/prevention assessment is completed via telephone interview: i. If the client can be diverted, they will be referred to the appropriate diversion/prevention services and their information will be transmitted electronically to the next appropriate agency (through a fax of a call report from iCarol). 2-1-1 will provide a "warm" transfer of the caller to the next agency via a fax of a call report from iCarol. The staffer at the referred agency will enter this information into HMIS before the individual arrives), and the individual will go there to complete Phase II for an assessment of their needs. The client will receive services at this location. ii. If the client cannot be diverted then they will be referred to the appropriate shelter and Phase II will be completed so the client can be linked to services to prevent them from coming back into a shelter.
2-1-1 (24/7 Service) –via telephone:	i Client calls 2-1-1 and the staffer will conduct Diversion/Prevention screening. If the client is able to be diverted from a traditional shelter then they will be referred to those services (this is usually going to be staying with a friend, staying in a hotel

if they can afford it, staying with family), and they will be referred to an agency to meet with the next business day. Their information from the diversion screening will be transmitted (through a fax of a call report from iCarol – the worker at the agency will enter this information into HMIS the next day since there is not that much information needed for a diversion screening).

If the client can be diverted they will be referred to the next agency, with all of their information from the diversion screening (Phase I) supplied to the referred agency in preparation for their contact interview (Phase II).

If the client is determined to need emergency housing, then they will be referred to a shelter for Phase II of the assessment will be completed. Conducting Phase II of the assessment interview, a case worker (or other trained staffer) will assess the household's needs and make referrals to appropriate services to prevent re-entry into the homeless services system. Phase II of the tool still needs a scoring strategy to be developed, but this will not be feasible until the diversion/prevention screening is piloted.

The following is excerpted from *One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families*

First Step: Assessment for Prevention/Diversion
Everyone coming in the door of an intake center should be assessed immediately to determine if they are eligible for prevention or diversion assistance. Prevention resources can help those families that are not yet homeless, while diversion resources can be used to assist those seeking shelter to find or maintain housing options outside of the traditional shelter system. Those families eligible for prevention and diversion may need access to financial assistance for rental and utility payments, rental arrears, etc. They may also need access to a case manager to help with conflict resolution or housing stabilization.

Referral to Shelter
Those families that do not qualify for prevention and diversion assistance may need to be referred to emergency shelter until they can be rapidly re-housed or enrolled in another more appropriate program.

Shelters should:

1. Work to minimize the amount of time families need to spend there by beginning the development of a permanent housing plan as soon as possible;

2. Have services focused on providing permanent housing as quickly as possible; and

3. Link families to community-based supports.

Appendix #3c

CAFT
Data & Reporting Sub Committee Report
2013

September – October 2013
Summary

The Coordinated Access Task Force was organized to: **"…create a coordinated access system to better assist the homeless and those at risk of becoming homeless in the greater Rochester and Monroe County."** With this in mind the subcommittee was given the task of evaluating which tool would be adopted to facilitate the Coordinated Access process.

The subcommittee identified several components as priorities:

- The database should be accessible and preferably web-based to allow for use by multiple providers at multiple locations. As opposed to a stand-alone application which would be costly and location centric.
- Using a series of simple questions the tool should be able to assess eligibility for appropriate services immediately and in a standardized way.
- The tool should be affordable, practical and/or part of an existing process or resource as no dollars have been specifically identified to pay for it.

With these components in mind two choices have been identified:

HMIS

The first is the Homeless Management Information System or HMIS. This system has a feature called *Eligibility Point* that ensures clients are eligible for programs and services. The eligibility module uses customizable assessment and priority ranking filters to quickly assess eligibility while creating referrals to appropriate services via the existing HMIS data base. Additional information is available at: http://www.bowmansystems.com/products/servicepoint/eligibility

The advantage of using HMIS is that it is a web-based system and can be accessed anywhere internet is available. This tool is also familiar to many local providers who currently use the HMIS system. Bowman, who is our local HMIS data base vendor, has had extensive experience in helping communities use their data base as the tool for a Coordinated Assessment. Communities who have seen reductions in homeless since its implementation include: Dayton, OH and several counties in the state of Tennessee.

Although HMIS is web based, a disadvantage is that it requires users to own a license making it less accessible to those providers who do not currently use HMIS. This creates a barrier to entry for many providers outside of the local homeless arena or for those who have chosen to not

participate in HMIS. The cost of using this option is approximately $5,000 a year with an additional $600 training fee during start up.

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The second option is to engage 2-1-1/LIFE LINE in an effort to bridge the gap between those community providers who do not currently use HMIS. 2-1-1/LIFE LINE uses a database called **I Carol** which provides area wide information on providers and their services.

Given 2-1-1/LIFE LINE's demonstrated ability to provide excellent comprehensive information and referral services 24 hours per day/seven days per week, some discussion has begun on how 2-1-1/LIFE LINE could perhaps take the lead in providing Coordinated Access; or help buttress whatever solution is used. This is the newer of the two choices evaluated during this time period; therefore further discussion will be required to properly assess strengths and weaknesses.

Appendix #4

Recommended Diversion Assessment Tool

Suggested Phone Triage Form

Staff name: ____________________ Date: ___/___/___ Time: _____AM/PM £ Phone Call £ Walk-In

Say/Ask: "In order to determine your eligibility for our program, the **(insert Agency)** needs to collect data and information about you and your household. This information collected both on paper and electronically, is considered confidential and privileged and **(insert Agency)** will only use this information for planning purposes, in conjunction with its funder. Are you willing to provide this information?" **¨ Yes ¨ No**

1. **What is your name (Confirm Spelling?) _________________________________ Age:_________**

   Gender:_______________

2. **Are you safe right now? £Yes £No If no, why not? ____**

   ____

   If the caller is safe right now, proceed to next question.

   A. *If the caller is not safe due to domestic violence, assess immediate risk and make appropriate referrals and record.*
   B. *If the caller is not safe due to some other condition, make appropriate referral and record.*

(If walk-in, skip to # 5)

3. **Where are you calling from?____________ Is there a phone number there?__________ Alternate contact #:________________**

4. **Is that in Monroe County? ¨ Yes ¨ No If no, where? ____________________________**

   A. *If the caller was a resident of Monroe County prior to becoming homeless, proceed to next question.*
   B. *If the caller is from out of county, ask "What is your housing plan for (The stated) County?"* ____

   C. *If the caller has no feasible plan, state: "The (Insert Shelter) provides temporary shelter and/or services to families who were living in Monroe County prior to becoming homeless. Do you have housing or resources in ____________________ (county where last housing was)?* ¨ Yes ¨ No *(If yes, assist individual and/or family with accessing resources in their community).*

5. **Last address where you had housing in your name? _________________________ How long have/did you live (d) there? ______**

   (If still in housing, skip to #7) **Why did you leave? ____**

6. **Do you have a place to stay tonight? ________ Where did you stay last night? _______________________**

7. **What is the situation there?**

   ____

   ____

- *If facing* ***eviction****, ask "Have you received an eviction notice?"* ¨Yes ¨No
  When is/was court date? __________
- *If a* ***landlord or other legal problem****, ask "Have you contacted Legal Aid?"* ¨Yes ¨No
- *If a* ***utilities*** *problem, ask "Have you talked to the utility company?"* ¨Yes ¨No
- *If* ***housing is condemned****, ask "Have you contacted the City/County for assistance?* ¨ Yes ¨ No

8. **Is there anyone else you and your family could stay with for at least the next two business days so that it may be determined if you are eligible for other services and/or supports that may prevent your entry into emergency shelter:**
   £Yes £No

9. **Are you employed?** £Yes £No **If no what is your income source?** ___________ **Do you have any money left?**

   ¨Yes ¨No

   If No: Is there anyone you can borrow money from? ¨Yes ¨No ***or*** ***Have you exhausted all other resources?***

   ¨Yes ¨No

10. **How many people are in your household?** ______ **How many children in HH under 18?** ______________

11. **Race: ¨ African American ¨ White ¨ Native American ¨ Asian Ethnicity: ¨ Hispanic**

Did the household answer yes to questions 6, or 8? If the household meets either of these qualifiers and can remain where they are and prevent their need to enter shelter for at least the next two business days they are an appropriate referral. If the family is willing to participate in a screening to determine eligibility proceed to the eligibility tool. *If NO: Proceed with Eligibility and Outcome* process shelter eligibility and availability.