**Vermont Coalition to End Homelessness - Coordinated Entry Workgroup**

**Monday, January 27, 2014, 10:30am – Noon**

**10:30 - 10:40 Introductions and Review Agenda (Sarah)**

Rick DeAngelis, Vt Housing & Conservation Board

Renee Weeks, Upper Valley Haven

Meg Macauslan, Champlain Valley Office of Economic Opportunity (CVOEO)

Angus Chaney, Agency of Human Services

Elizabeth Eddy, BROC

Karen (?), Community Links in Rutland

Carol Flint, Central Vt Community Action Council

Deborah Hall and Sarah, Rutland Co Housing Coalition

Erin McSweeney, Economic Services/GA

Paul Dragon, Sarah Phillips and Lynne Munzberg, Vt Office of Economic Opportunity

Kathy Metras, Northeast Kingdom Community Action (NEKCA)

MaryEllen Mendl, Vermont 2-1-1

Auburn Watersong, Vermont Network Against Domestic and Sexual Violence

Brook Salls, Good Samaritan Haven

Julia Paradiso, COTS

Brian Smith, Department of Mental Health

Richard Rankin, Data Remedies (HMIS Administrator)

**10:40 –10:50 Review Group Workplan & Goals (Sarah/All)**

* Adopt Workgroup Goals - **DRAFT GOALS FOR CONSIDERATION:**

The VCEH Coordinated Entry Workgroup will develop/plan a coordinated intake and assessment (i.e., entry) system for the Balance of State Continuum of Care. The plan will:

* + meet HUD’s requirements
  + address the following:
    - How the system is accessed
    - How clients are assessed
    - How clients are assigned to a provider
    - How the entry system and services are held accountable, managed, and evaluated
  + Be useful and flexible – with an aim to streamline access, assessment, and referrals for housing and other services.
  + Fit the region, population(s), culture, resource picture, provider capacity and client needs in our Continuum of Care
  + Be client-focused (vs. program-focused)
  + Keep in mind the end goal of permanent housing

The Workgroup will strive to use a planning process that is inclusive and open.

* Adopt Timeline

**There was little discussion on the draft timeline and goals. There were no objections to adopting both.**

**10:50 to 11:00 Models from the Field**

* Is there any additional discussion since the meeting on 1/15? Is there anything of interest from the homework to highlight?

**We reviewed the minutes.**

**King County – helpful to read a model for something very abstract – it seems that we maybe have some of these pieces in place already?**

**Mary Ellen – has models to share, will forward to Sarah to share**

**11:00 to 11:20 Review “Initial Key Questions” (Paul)**

**These questions were discussed at the last meeting, and hopefully at some local Continuums of Care. Additional points for discussion?**

* What obstacles must be overcome to build cooperation from stakeholders?
* Are other system changes needed, at least informally, in addition to coordinated entry to meet expectations and HUD outcomes?
* Which gaps in services, infrastructure, and other resources are reconcilable? Which ones are intractable?
* What population(s) will the system serve? All or just families? Homeless and at risk, or just homeless? How will the current environment affect the breadth and depth of the coordinated entry system at implementation? When could the system include all populations if choosing to serve just one population initially?
* What realities about the population(s) to be served, the geographic area, service providers, and budgets must be taken into consideration to determine which coordinated entry model will work best?

**In addition to what was discussed on 1/15:**

**Depending on the population – the process would be different. e.g., in-person screening could be difficult for some BUT face-to-face is better for others – we may have a model that shifts based on the population**

**Many people do prefer face-to-face due to trust issues – especially folks with persistent mental illness**

**Is it possible to “meet people where they are at”? mobile entry points?**

**Common screening tool – are there samples? (yes, Chittenden and others) What would be the scope of tool/purpose? Something for discussion.**

**How can we utilize technology for coordinated access? What are the challenges? This would make for a very flexible system – forefront of discussion. Aggregated central system that is not in HMIS but links in terms of the type of information collected (i.e., uses HMIS “universal” data points)**

**HMIS workgroup and Coordinated Entry workgroup – two groups with planning happening in parallel. How are we moving forward concurrently – recognize our limitations and integrate as best we can?**

**HUD does not require HMIS as part of coordinated entry – but likely there is some role. Most existing coordinated entry systems involve HMIS at some level**

**COTS uses a universal intra-agency screening tool (it’s agency-wide “coordinated entry”) – Julia will share the system (screenshot?) – it includes HMIS universal fields**

**Vulnerability Index – VISPDAT – as one tool that some communities are looking at. Brian shared – Sarah will forward – is this something we want to use? Different than SSOM (but that’s another tool)**

**HMIS vendors are working to make screening and assessment tools compatible with HMIS software**

**There are so many many questions from victim service providers regarding coordinated entry – Auburn is looking to other national partners to see examples of coordinated entry that include the DV network and meet DV network needs. King County? Michigan models – Brian will make connection for Auburn? Washington State? Auburn will bring some examples and thoughts from these areas back to our discussion**

**11:20 to 11:55 Basic Model & Plan – Broad Strokes (Paul)**

**Last meeting – talked about our model:**

* **Serving all populations – comprehensive vs. targetted**
* **pilot in a couple areas**
* **“hybrid model” (2-1-1 & local face-to-face)**
* **Use a common screening tool (but save deeper assessment for providers)**
* **what is the mechanism for data sharing? Can we include HMIS, without exclusively using HMIS? We will need some kind of release of info/MOU**

**Additional discussion on the above:**

**Where to pilot? “urban” AND “rural” areas – both – Rutland County? NEK? Washington County? Hartford? (remember, Chittenden will be governed by its own)**

**Our existing system includes some coordinated entry – especially regarding EA motels**

**Are there challenges to this? Can we learn from what has happened? Yes, let’s make sure that is a part of future conversation**

**Decentralized vs no-wrong door? “no wrong door” involves ALL possible entry points vs. de-centralized with multiple KEY entry points ---**

* **can we start with decentralized in our initial phase? Expand partners (“outlier providers”) as we go?**
* **Who will be the partners? Local CoCs need to decide who will be the partners – will need to decide which organizations will need to be included.**
* **Victims and survivors? Again, Local CoC is key. Clearly needs more thought.**
* **Equity in a decentralized model can be tricky – different agencies have different capacity. Training will be key to ensure uniform and consistent process. It takes expertise to “do” referrals. How will we track outcomes and follow up on referrals.**
* **In a de-centralized model, if I don’t serve a certain population typically, will I be expected to do screening for all populations?**

**What is the distinction between screening, intake and assessment? Recognize that referrals happen at multiple levels and points in the process**

**Let’s avoid setting up a system where we collect a lot of information without being able to use it appropriately to serve folks – referrals, empathy, etc.**

* **Decide on basic structure** 
  + Evaluate the possibilities, including one centralized location, multiple intake locations (a decentralized model), and a “no wrong door” approach (where any agency can conduct the evaluation and make a referral). Decide whether assessments will be done in person, by phone, or both. Decide whether/how the assessment process will integrate with 2-1-1.
    1. **Hybrid, decentralized & 2-1-1, strong role of local CoC**
    2. **In-person and by-phone**
  + Funding considerations?
    1. **Not yet discussed; clearly a need for training**
* **Approach for roll out**
  + Phased? Pilot? “soft” launch
    1. **Pilot in a few communities – let local CoC’s decide if they want to be early adopters – possible candidates (Based on workgroup participants): Washington, Hartford, Rutland, NEK districts**
* **ID Target population**
  + Will the process begin by serving everybody who becomes homeless, or will it start with one population (e.g. families with children) and then expand to serve other populations? Youth, single or coupled adults, DV, at risk (eviction), at risk (no eviction), vets, others?
    1. **All - some more conversation on role of key providers that may serve a specific subpopulation**
* **Determine forms needed**

**Screening** 🡪 **intake** 🡪 **assessment**

Screening tool to establish eligibility and triage services? **YES**

* + 1. **We will potentially become smarter about making referrals and understanding homeless needs**
    2. **Must be short**
  + Primary assessment to determine referral? **YES? Enough for referrals but not comprehensive? Enough for presumptive eligibility?**
  + Comprehensive assessment to develop household action plan? **Not yet, perhaps phase in over time?**
  + Client forms – informed consent, ROI to share info; client grievance form? **Not yet decided/discussed**
  + MOU/A for partners? **Not yet decided/discussed**
* **Role of HMIS or other database capabilities**
  + **Not yet determined; Agreed that technology will play a role**
* **Integrate Prevention and Shelter Diversion**
  + Identify prevention and diversion resources that should be available.
    1. **Needs future conversation – Housing First model is an area we have developed in Vt – how will we integrate Housing First?**
* **Communications Plan**
  + Stakeholder participation
  + Communication with VCEH and Chittenden CoC?
    1. **Is this further down the road? An in person meeting with all stakeholders statewide?**
    2. **Do we have the right level of coordination with Chittenden?**
    3. **Sarah will reach out to Chittenden CoC and providers to discuss possibilities**
  + How other points of contact connect to system (schools, hospitals, recovery centers)

**HOW WILL WE KNOW WE ARE SUCCESSFUL? AND, WHAT IS OUR BASELINE DATA?**

**11:55 to Noon Communication Points for Local CoCs during the next month (Sarah/All)**

**PLEASE PRESENT AT THE LOCAL CoC MEETINGS PRIOR TO OUR NEXT MEETING 2/24:**

* + 1. **Share the Coordinated Entry Workgroup Goals/Purpose:**

*The VCEH Coordinated Entry Workgroup will develop/plan a coordinated intake and assessment (i.e., entry) system for the Balance of State Continuum of Care. The plan will:*

* + *meet HUD’s requirements*
  + *address:* 
    - *How the system is accessed*
    - *How clients are assessed*
    - *How clients are assigned to a provider*
    - *How the entry system and services are held accountable, managed, and evaluated*
  + *Be useful and flexible – with an aim to streamline access, assessment, and referrals for housing and other services.*
  + *Fit the region, population(s), culture, resource picture, provider capacity and client needs in our Continuum of Care*
  + *Be client-focused (vs. program-focused)*
  + *Keep in mind the end goal of permanent housing*

*The Workgroup will strive to use a planning process that is inclusive and open.*

* + 1. **Share the Coordinated Entry Framework (and reasoning) Proposed by Workgroup**
* **Hybrid: Central (Phone – 2-1-1) & De-centralized (In person, multiple, key community providers) - additional community partners can be added on as it unfolds**
* **For all populations (not limited to subpopulations such as families with children, Vets, youth, victims, etc)**
* **Looking for a few local CoCs/districts to pilot starting in August**
* **Will use a common screening tool (not a comprehensive assessment)**
* **Will involve data sharing – including, but not limited to, HMIS**
  + 1. **Get feedback from local CoC – are we headed in the right direction? Are there major concerns?**
    2. **Identify whether the local CoC would like to be an early adopter/pilot site**
       - **Start to ID who the KEY partners will be for local screening sites**
       - **Invite others to participate in workgroup**
    3. **Circulate some examples of screening tools (Send to Sarah:** [**sarah.phillips@state.vt.us**](mailto:sarah.phillips@state.vt.us) **who will post on website)**
    4. **If possible, start a conversation on “how we will know we are successful” and what are the results we hope to achieve?**

**NEXT MEETING, MONDAY, FEBRUARY 24 at 10:30am**

**NEXT MEETING AGENDA ITEMS – PLEASE FORWARD OTHERS**

* **Map out the Existing Assessment and Intake Process**
  + Create a map of the existing assessment, intake, and referral process and how people move through the system within it. What are the flaws with this process and how can they be addressed with a more coordinated approach? What are the good aspects that should be included in the new model?
  + Regional data? Gaps in network?
* **Sketch out a Preliminary Needs Assessment/Screening Tool – Forms?**
* **Role of HMIS or other database capabilities?**
* **How will other points of contact connect to system (schools, hospitals, recovery centers)?**
* **Integrate Prevention and Shelter Diversion**
  + Identify prevention and diversion resources that should be available. And, to what extent these are part of the coordinated entry system

**HOMEWORK**

* Review Models (if not completed)
* Review Screening Tools
* Discuss with Local CoC Members