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

**Monday, March 24, 2014, 10:30am – Noon**

<https://www4.gotomeeting.com/join/734192335>

(Toll-free): 1 866 899 4679

Access Code: 734-192-335

Audio PIN: Shown after joining the meeting

Meeting ID: 734-192-335

**10:30 - 10:40 Introductions and Review Agenda**

MaryEllen, Renee Weeks, Meg Mc, Linda Anderson, Ashley Bride FHC, Lucie Fortier, Brooke, Lily Sojourner, Auburn, Sarah and Paul, Erin McSweeney, Julia

**10:40 –10:50 Our Timeline – HUD response to deadline question (psst: it’s not August)**

What is our timeline? Are there other timelines/calendars to consider?

Still use pilots – how long do we want them to try it out?

Recommend Pilots to start in Spring 2015 – better time to institute system changes (i.e., outside of cold weather) –

* Could adopt some elements in “pilot” communities this August/September 2014

Run pilots for at least 6 months? 6 months gives a good review – 2, 4 and 6 month reviews – potentially bring other communities on in Fall 2015

Spring of 2016 – goal for all communities on board

Let’s be sure to create time for changes before full implementation

**\*\*OEO will make some draft revisions to our workgroup’s timeline to review next month\*\***

**10:50 to 11:10 Screening vs Intake vs Assessment**

* What is the difference? What will we be trying to accomplish?
* Also, from previous conversation: Can the client lead the way through their story? Can we think about the questions we are asking – is it client-centered that leads us down a bevy of questions that misses the client story

**Screening** – Initial review – where else can they get services/help? E.g., Reach Up Substance Abuse

* Burlington – common CHG screening tool – someone at Harbor Place (GA), completes screening tool (basic demographics, basic barriers) – an onsite coordinator looks at the form and assigns case management, collects the required HMIS data points (universal data points)

**Assessment** – deeper, drives a client-plan, reciprocal process

**Intake** – intake into someone’s program – formal registration for process

**Housing Review Teams** – these groups assign or affirming case management and assigning/approving financial resources? In-depth “case consultation model” – use a common financial checklist (program-level eligibility screening)

Coordinated Entry – systemic screening vs. program specific screening – how do we get folks to the right place (make the right referral)?

Why do we want a screening tool?

* Decisions about needs and community resources on a common criteria
* Customer service – not making folks “shop around” – getting folks there in a seamless way, quick turnaround

What do we want to screen for?

* Level of housing need – emergency housing…vs other
* Vulnerability –
	+ VISPDAT
	+ Self Sufficiency Outcomes Matrix (SSOM)
* Housing Support Services vs. Broad Services to maintain and sustain housing? i.e., food, child care, employment
* Depth vs timeliness – screening should be light vs. assessment (deeper)
* If we are sharing a screening tool, what is it that we want to be universally screening for? What are the emergent needs from a homeless systems perspective?

**FUTURE QUESTIONS – Staff capacity and training related to screening? Accepting/Rejecting Referrals? Client Choice**

**11:10 to 11:50 Mapping the Coordinated Entry System**

* Review map created by subgroup
* How can we dig deeper to add in assessment, intake, referral 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?
* Next steps in understanding our existing system and the model we want to move to…
* What resources do we want to coordinate?
	+ Housing (e.g., supportive, market rate, affordable, permanent, and transitional) - What are the resources? Local, state & federal?
	+ Services (medical/mental health, job training, education, etc.)
	+ Prevention services (rent and case management assistance)

Can we share this with Local CoCs to start to map – good resource for local CoCs

* ID gaps in resources
* Demonstrate the path (arrows) between specific providers
* Will show what organizations will be imperative in coordinated entry implementation – the “key providers” in our decentralized system
* Can we get our pilot areas to do this and bring back to our group?

How can we support local/pilot CoCs in doing this?

* Blank form/template

**11:50 to Noon Communication Points for Local CoCs during the next month (Sarah/All)**

Was discussed at BoS CoC - general

* **Send out updated timeline and one-pager to local CoCs**
* **Discussion Points:**
	+ **Share our new timeline - Remind/Share our pilot approach**
	+ **Map Exercise/Template – pilots share back with us**
	+ **Share our conversation on Screening vs Assessment vs Intake – GET FEEDBACK**
		- **Which resources?**
		- **How “deep”?**
		- **Client choice?**
		- **Provider choice? (saying no to referrals)**