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

**Monday, June 23, 2014, 10:30am – Noon**

**10:30 - 10:35 Introductions and Review Agenda**

Renee Weeks, Upper Valley Haven; MaryEllen, 2-1-1, Auburn & Amber, Vt Network Against Domestic & Sexual Violence; Brooke, Good Samaritan Haven; Paul & Sarah, Vt Office of Economic Opportunity; Deborah & Sarah, Rutland Homeless Prevention Center; Ashley, Fair Haven Concerned; Erin McSweeney, Economic Services/General Assistance; Lily from AHS Field Director for Barre/Morrisville;

**10:35 –10:45 Report Back from Local Continua of Care Meetings**

Renee – Looking at the Map to see what resources we have in our community. Use the map to help identify who needs to be part of the coordinated entry system in the community. Screening vs assessment – very supportive of a ‘screening tool’

Brooke – Washington county conversations between potential lead partners – CVCAC and Good Samaritan Haven; CVCAC (now Capstone) is looking at how to rework their own staffing infrastructure to expand entry staff

Deborah – Rutland – 19th mtg, talked about the development of the screening tool. Sarah, Rutland HPC, eligibility/intake worker is a key resource. The community health team will be a big part of the referral process here.

Paul – Presentation last week on 100,000 Homes Campaign with Linda Kaufmann. The Campaign uses a common screening and assessment process. This is a housing first approach. The screening process is about screening in and prioritizing housing for folks who are the “most vulnerable”, chronically homeless and typically “hit the systems” hard (the 1 out of 7) – use the Vulnerability Index (VI-SPDAT). Outreach workers personally interview homeless persons over a short period of time and then work to help secure permanent housing quickly. The campaign works through the Continua of Care in a “coordinated entry” fashion (common tool, multiple partners/programs, streamline entry).

**10:45 – 11:00 The Results We Expect to Achieve**

Some ideas from NAEH on results one might look to achieve with coordinated assessment/entry (in red). Taken from: <http://www.endhomelessness.org/library/entry/coordinated-assessment-evaluation-tool>

* The number of organizations doing individual intake and assessment decreased
* There are no “side doors” in the community
	+ These two (above) may not be as relevant in our “coordinated entry” system (vs centralized). **Maybe this speaks to more transparency and equal access.**
	+ These (above) might not capture it, but is there a measure about about the organizations participating in coordinated entry –
	+ Key sites on board (a project milestone)
	+ **# of organizations who refer and know about coordinated entry**
* **Average length of stay in homelessness is decreasing**
* **Rate of exits into permanent housing for every intervention has increased**
* **New entries into homelessness have decreased**
	+ These three results are driven by a lot more than coordinated entry – they are very resource dependent with lots of external factors influencing them
	+ Will coordinated entry support these goals? Or just track these goals?
	+ Do we have this data? No, so there are data-development issues around measuring these results
	+ **Let’s come back to these results – these are good**
* Consumers are most often naming the designated intake point(s) as a response to question number two on the Coordinated Assessment Questionnaire
* The number of organizations consumers had to work with before getting into permanent housing has decreased (Coordinated Assessment Questionnaire question number six)
	+ **Can we get to customer satisfaction in a different/better way?**
* There is a centralized wait list now (if there wasn’t before) or no wait list at all
	+ Does this make sense for us for our communities?
	+ Is there an example of when/how this makes sense for us?
	+ Waitlist for shelter is an organization-level measure, not so much a coordinated entry measure
	+ “Waitlist” for case management? Is that a community level measure? Maybe, maybe not
* Do we want to standardize eligibility to programs? Is that a result this group is trying to achieve?
	+ Eligibility is tied to funding sources, program models, ultimate implementation of programs is at the organization-level
	+ Will this be something we keep “bumping up against”? (yes, probably)
	+ It may be problematic at this point to develop common eligibility criteria – homeless shelters very difficult (baseline exists)

**11:00 to 11:30 A Look at Screening Tools (Deb Hall) - Deb and Sarah from Rutland Homeless Prevention Center reviewed some example screening tools with the group**

What is a screening tool? To gather information about population; administration options; accessibility/cost, data – what are the options available to the client?

An assessment (not screening) establishes the nature/severity of problem(s), strengths/social supports and readiness to change.

Re-affirmed: We want a screening tool

**Choosing a tool?**

* Overall quality/reliability and validity
* Ease of scoring & interpretation
* Brevity of administration time
* Self-completion
* Cost to implement

**Review of 4 Tools Below:**

**ELIM –**

* Strengths – this includes all basic demographic information, categorical separation of topics – is this level of detail good? Is it a quick tool
* There’s balance between asking information/invasive and engaging with clients – this may not strike that balance
* Tools that are strengths-based – ID contributing issues and barriers in the most empowering way possible?
* May be more detail then we need?
* Not a self-completion tool
* Is it the appropriate level of detail for applying for emergency shelter?

**CT Homelessness Prevention & Rapid Rehousing (HPRP) Screening Tool**

* All the HMIS demographic data elements (some of these are even challenging)
* Pre-screening on eligibility to make referrals
* Begs the question on how referral follow-ups are made –
* This Screening tool is a referral tool
* The name of the screener is on the form
* This is the kind of tool that the client can take with them (a copy) to present

**Homeless Prevention Screening tool (OMH, Homeless Action Committee)**

* Nice intro at the start of the tool (soft intro) – clear that you don’t have to answer any questions
* Phrased as questions from a more strength-based perspective
* Still might go beyond what we want to ask at entry point – is there a way to phrase about interest in screening? Look at the VI-SPDAT for seeing another way that doesn’t “beat around the bush” but gets to the issues at hand. Can we be clear, direct and delicate?

Can we make sure that our screening tools match up to pre-screen for eligibility? Be clear so that people understand what their options are vs. what our tool says is the strongest/best resource? Let’s get people to the right place even if the “score” is not high.

**Rutland Homeless Prevention Center – “Assessment Tool”**

* Conversational tool; focused on housing and current housing situtation
* Some general questions also to allow the client to lead the conversation
* Could be a good tool for non-housing service providers
* Conversational – invites clients to provide explanation
* Do these questions tie to eligibility? Could there be fewer questions

**11:30 – 11:50 2-1-1 & Coordinated Entry (MaryEllen Mendl)**

MaryEllen will present some information gleaned at a recent 2-1-1 training from how other CoCs are implementing coordinated entry, and the role of 2-1-1

**TABLED THIS FOR NEXT MEETING – DEEPER PRESENTATION**

**11:50 - Noon Next Steps**

 **Keep Reviewing Screening Tools as a Large Group – Next Month:**

* + - * 2-1-1 – MaryEllen will present on the role of 2-1-1, and some screening tools from communities where 2-1-1 is playing a strong role.
			* National Alliance to End Homelessness “Assessment Tool”:
				+ Discussed here: <http://www.endhomelessness.org/blog/entry/field-notes-the-new-comprehensive-assessment-tool#.U6hqYEBORpI>
				+ Tool here: <http://www.endhomelessness.org/library/entry/alliance-coordinated-assessment-tool-set>
			* VI-SPDAT: Paul would like to present this tool to the group, in part based on the presentation from 100,000 HOMES.
			* If others have screening tools they want to review with the group – please let Sarah know so they can be added to the agenda.

**Next Step: Assign a Subgroup the Task of Taking Group Feedback and Starting to Develop a Tool**

**Communication Points for Local CoCs during the next month:**

* **Keep talking about screening vs intake vs assessment -** discuss some of the points our group has been diving into around screening tool, such as: length, possibility for self-completion, pre-screening for eligibility/aligning with eligibility, basic demographics, referral tool, strengths-based.
* **Invite people to look at the tools, which will be posted on the helpingtohousevt.org website.**

**NEXT MEETING 7/28, 10:30 AM**

**SUMMER WORKGROUP TO DO LIST**

* Identify the Results Expected to be Achieved
* Sketch out a Preliminary Needs Assessment/Screening Tool & Other Forms
	+ Screening tool to establish eligibility, triage services and make referrals
	+ Client forms – informed consent, ROI to share info; client grievance form
	+ MOU/A template for partners
* ID Questions to be asked and begin mapping how referrals will work. (very basic)
* ID organizations that will host coordination or any other specific roles required
* ID Additional Staffing and Resource Needs
* ID Role of HMIS or other database capabilities; ID Data and HMIS Needs