**VCEH CE Committee – PSH Small Group – January 11, 2017**

Attendees: Sarah Phillips, Will Eberle, Amos Meacham, Daniel Blankenship, Renee Weeks, Elizabeth Eddy

Task: Draft referral & access protocol for PSH – both individuals and families.

Task: Finalize a recommendation on PSH Prioritization

**Access & Referral for Permanent Supportive Housing:**

Each Local Coordinated Entry Partnership will maintain a local Permanent Supportive Housing Prioritization list.

Primary Reason: Availability of PSH is based on having both a subsidy/unit AND services. Service capacity is inherently local and thus necessitates a local list.

* Use the coordinated entry process to refer onto a PSH prioritization list – e.g., housing barriers assessment must be completed. Only assessment partners and the local lead agency can refer directly to the list.
* This list can use unique IDs in place of names, etc., for confidentiality purposes
* The list can be generated in and exported from HMIS, and others can be added to the list (e.g., those working with a DV provider)
* The Lead Agency is responsible for providing support to manage the lists
* The list should be (re)generated/updated and reviewed at least monthly. Review of the list should be done by all local PSH providers.
	+ As services and vouchers become available, agencies anticipate openings and review list.
	+ Review of the list should consider eligibility for specific services/subsidies, how agencies can work together to enroll a client
* Agencies providing PSH can and should enroll folks from the prioritization list in between meetings, as needed.
* There is shared accountability for enrolling households into a PSH project from the top of the list
	+ legitimate reasons that can be considered when not enrolling the top client: eligibility for program, client choice/preference
	+ Question: do we want to name specific reasons that are not legitimate? Are there other legitimate reasons?
* Shelter + Care/VSHA can generate a statewide PSH prioritization
	+ VSHA will join each local CE Partnership (partnership agreement, data sharing agreement, ROI)
* The Local CE Partnership Agreement needs to be in place. Respective agencies need to sign the agreement. Client Release of Information needs to be in place.

**General Prioritization Agreed Upon by VCEH CE Committee:**

Chronic Homelessness + Longest History of Homeless + Most Severe Service Needs

Chronic Homelessness + Longest History of Homeless

Chronic Homelessness + Most Severe Service Needs

Chronic Homelessness

NonChronic Homelessness + Disability + Most Severe Service Needs

NonChronic Homelessness + Disability + Longest History of Homelessness

NonChronic Homelessness + Disability + In Safe Haven or Emergency Shelter

NonChronic Homelessness + Disability + In Transitional Housing

NonChronic Homelessness without Disability (HH may not be eligible for most/all (?) PSH programs)

Question: Is there a separate prioritization list for Family-specific resources? E.g., FSH has it’s own prioritization. Having a disability is not a threshold requirement for any family supportive housing?

Question: Who is referred to the PSH Prioritization list? Anyone, regardless of disability (the list would sort folks)? Is there a threshold criteria for referral to the list that we want to consider?

Question: What does “Longest History of Homeless + Most Severe Service Needs” mean? Is it “sort by” longest history, then most severe service needs? Or do we want to consider each of these equally? How do we do that?

Question: Are there other demographic characteristics that need to be pulled onto a list to facilitate assignment/referral – e.g., Vet, HH w/children, etc.?

Longest History of Homelessness = Cumulative Time Homeless (over lifetime)

Identify “Most Severe Service Needs” as the Highest # of the following identified (as part of the Housing Barriers Assessment):

[ ]  One or more trips to the Emergency Room in the past year

[ ]  One or more stays in a psychiatric facility (lifetime)

[ ]  One or more stays in prison (lifetime)

[ ]  One or more stays in a substance abuse treatment facility (lifetime)

[ ]  One or more stays during lifetime in another type of residential facility (including a nursing home or group home) (lifetime)

[ ]  Was in foster care as a youth

[ ]  Current open case with Family Services

[ ]  No income during the past year

[ ]  Survivor of domestic/sexual violence or trafficking

[ ]  Unsheltered

[ ]  Household member living with HIV/AIDS

[ ]  Acute care need (e.g., severe infection, …)

[ ]  Other High Service Need Indicator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other High Service Need Indicator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Engagement in services is something that is negotiated at the point of enrollment, it is not to be considered in the context of prioritization.*

Question: In the context of “Severe Service Need” - How does this fit with prioritization for permanent supportive housing?

* Experienced homelessness as a youth – current or past?

**Parking Lot for VCEH CE Committee –**

15% goal and Coordinated Entry – where are these efforts coming together?

Homeless preference at PHA & Coordinated Entry

Folks with intensive, severe support needs who do not want MH services, we need more options – even outside of PSH perhaps