



**SACRAMENTO  
STEPS FORWARD**

Ending Homelessness. Starting Fresh.

**Combined CES and CES Evaluation Committee Meeting**

December 19, 2019 | 1:00 PM – 3:00 PM

925 Del Paso Boulevard, Suite 200, Sacramento, CA 95815 | Sequoia Room

Attendance:

<b>Member</b>	<b>Area of Representation</b>
John Foley	Sacramento Self Help Housing
Jill Fox	Volunteers of America
Veronica Williams	Volunteers of America
Angel Doney	Veterans Resource Center
Peter Muse	Veterans Resource Center
Bridget Alexander	Waking the Village
Gabriel Kendall	2-1-1
Benjamin Uhlenhop	Next Move
Cindy Cavanagh	Sacramento County
Monica Rocha-Wyatt	Behavioral Health Services
Stephen Watters	First Step Communities
Kayla Aanerud	Hope Cooperative
Howard Lawrence	ACT
Peter Bell	Wind Youth Services
Tanya Tran	SHRA

<b>Staff</b>	<b>Title</b>
Lisa Bates	SSF Chief Executive Officer
Michele Watts	SSF Chief of Programs
Greg Schuelke	SSF CoC Program Manager
Ya-Yin Isle	SSF Chief Strategic Initiatives Officer
Joe Concannon	SSF CES Program Manager
Christine Wetzel	SSF Referral Specialist

<b>I. Welcome &amp; Introductions:</b> John Foley, Chair			
<b>A. Review and comment on notes from the October 28, 2019 meeting.</b>	- Joe Concannon, CES Program Manager, SSF	1:10 PM	Information
There were no comments on the notes from October. Joe noted that the Combined CES Committee will meet again on the regularly scheduled meeting date for the CES Committee going forward. That			

will be the first Thursday of the month starting on February 6, 2020. The CE Committee will continue work with Homebase on defining the issues for CE Redesign, monthly meetings may be needed to support this process.

<b>B. CE Assessment/Re-Design Update (Part 1)</b>	Presenter(s): Program Manager and Meadow Robinson, Homebase	1:15 PM (15 minutes)	Information
Meadow Robinson presented the slides shown below. There was discussion about how to improve access to the CE system through drop-in hours, whether CE could ever be staffed to a level that would support referring into shelters and how a funded diversion program would benefit the current system.			
<b>C. Sister Community Presentation: Santa Clara County Continuum of Care</b>	- Presenter(s): Meadow Robinson, Homebase, Santa Clara CoC via telephone	1:30 PM (30 minutes)	Discussion
See notes below			
<b>D. CE Assessment/Re-Design Update (Part 2)</b>	Presenter(s): Program Manager and Meadow Robinson, Homebase	2:00 PM (10 minutes)	Information
See notes below			
<b>E. Review of Data Summaries on Clients Entering Coordinated Entry</b>	- Joe Concannon, CES Program Manager, SSF	2:10 PM (15 minutes)	Discussion
See notes below			
<b>F. VI. Announcements</b>			
<b>G. VII. Meeting Adjourned</b>	Next Meeting – February 7, 2020 – 1 pm		

# Combined CE Committee: Re-Design Input Part 2

December 17, 2019



# Agenda

## I. Proposed Timeline

## II. Hear from Santa Clara (1:30-2:00)

## III. Answering Common Questions

1. What can a community (and clients) expect from a functioning CE?
2. How can Sacramento better manage the inflow of clients into CES?
3. What agency does the community have around prioritization?

## III. Next Steps and Contact Information



# Proposed Timeline



What can a  
community (and  
clients) expect from  
a functioning CE?



## Systemic Benefits

- **Cost savings** to mainstream systems that can be reinvested
- Improved **access to data** (both for advocacy and systemic realignment)
- Improved **connection to prevention/diversion**
- Coordinated **landlord outreach**
- Improved **geographic coverage**
- Increased **competitiveness for funding**

## Provider Benefits

- Improved **performance outcomes**
- **Decreased duplication of intake and assessment efforts** (more time to actually serve client's needs)
- Simplified **client identification**
- Reduced **competition for existing units**
- Increased **competitiveness for funding**

## Client Benefits

- Increased **transparency to the system** (don't have to know someone)
- Decreased **repetition** (don't have to repeat your story at every program)
- Improved **outreach and geographic coverage**
- Improved **performance outcomes**
- Improved **prioritization** for those with the greatest needs and vulnerability

# Measuring CE Outcomes

- Many communities across the country have implemented the coordinated entry system and found success in making strides towards ending homelessness. Each community defines success differently.
  - *Example Successes: SPMs, locally established metrics (i.e., veterans), greater collaboration, client experience, buy-in from elected officials, etc.*
  - *Example Communities: Marin County, St. Joseph (Missouri)*

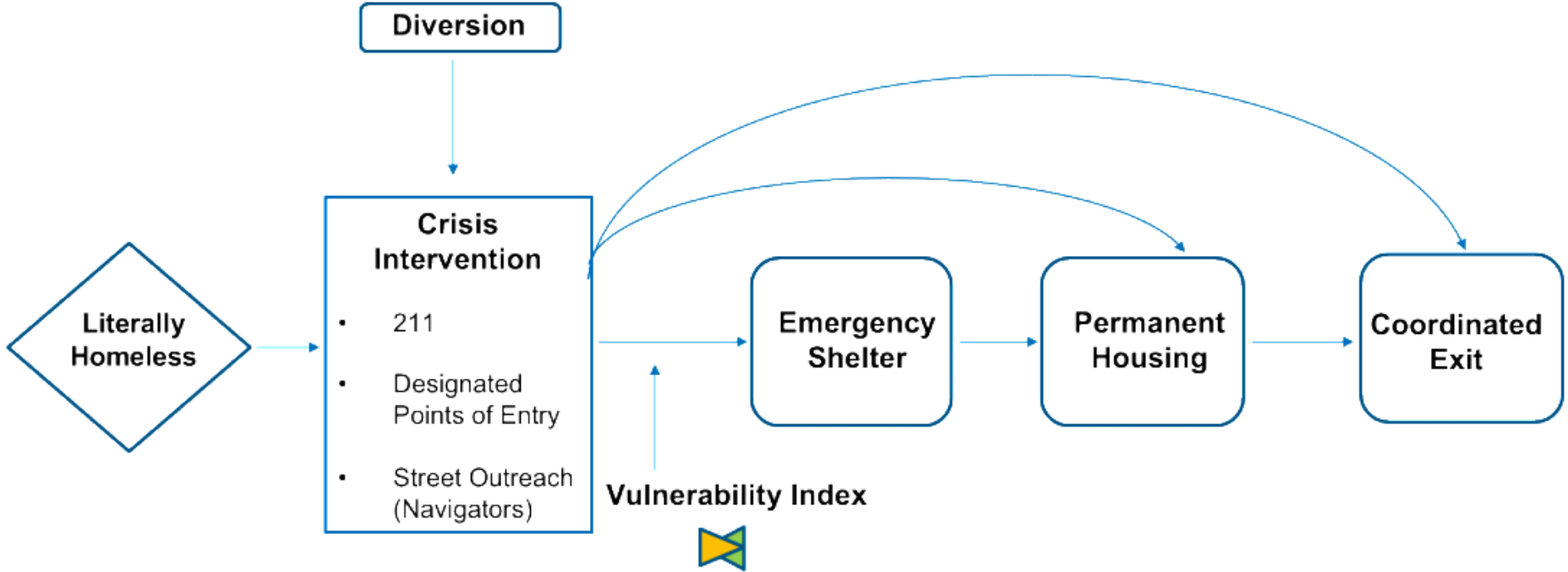




# How can Sacramento better manage the inflow of clients into CES?

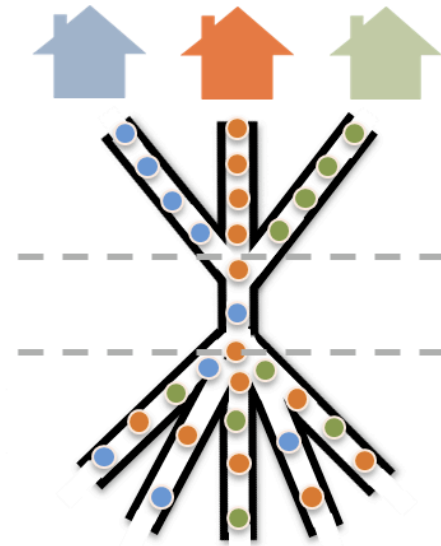


# Sacramento Housing Crisis Resolution System



# Promising Practices from Other Communities

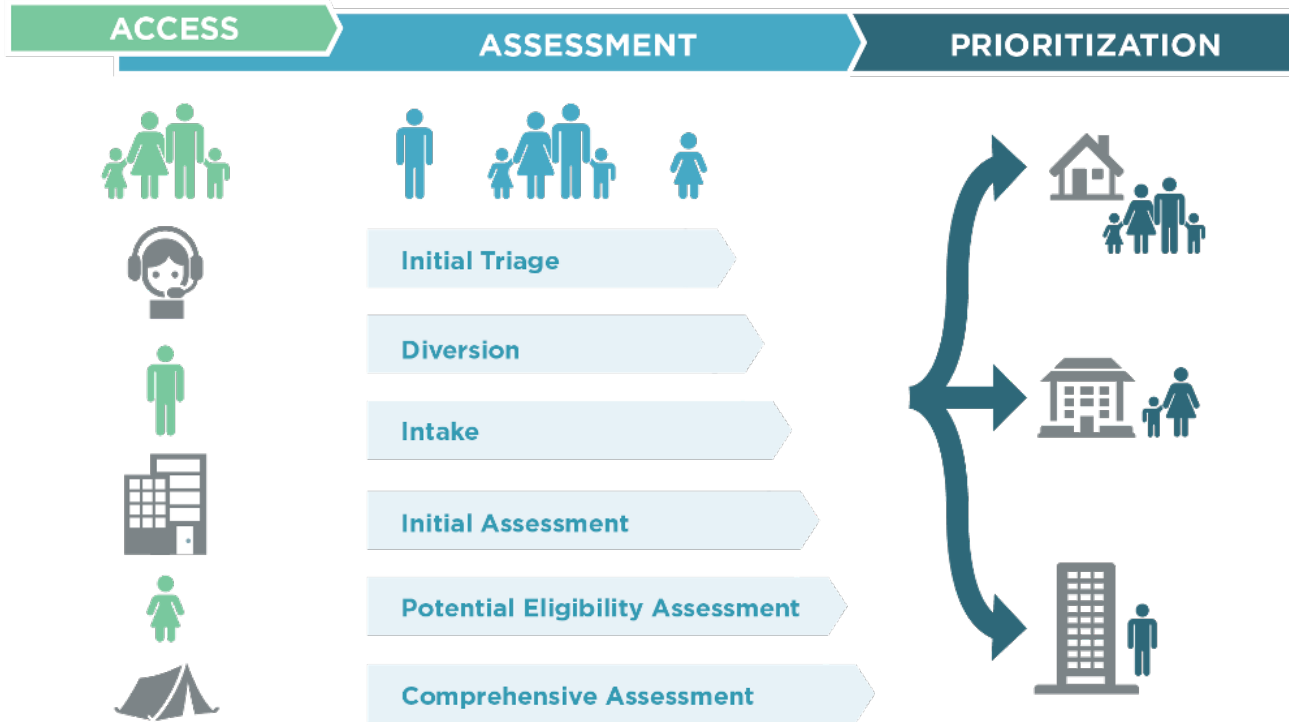
- Transparency and visibility of access points
- Co-locating access points at well-known provider agencies
- Establishing and publicizing “drop-in hours,” in addition to scheduled assessment appointments
- Geographic diversity
- Expanding staff capacity in response to flow
- Phased assessment



# Phased Assessment

## HOMELESS CRISIS RESPONSE SYSTEM

*General components & process flow*



# Community Examples: Access Points

- **San Francisco CE:** separate access points for subpopulations;
  - 6 for TAY; 2 for Adults; 3 for Families; DV access points in development
- **Santa Clara CE:** separate access point DV only; all other subpops access through same access points;
  - 6 CES access points available for VI-SPDAT drop-in/referral hours
- **Sacramento CE:** separate access point for Vets, TAY; Families, Adult Individuals, DV access through same access points;
  - Access points: Shelters, Outreach, 211 (schedules appointments at two service locations for Family/Adults/DV; one location for TAY; one location for Vets)

# Sister Community: Santa Clara County



# Questions

- How did SCC start-up CES in their community? Funding sources? Sequence and phasing of resources (PSH, RRH, Shelter, etc.)?
- How has CES improved transparency and improved functioning?
- How does SCC ensure enough access given the level of demand (including diversion, self resolution, or prevention at the front end)? And who is responsible for that access and preparation for CES?



# Questions

- What does SCC's CES assessment and prioritization look like? How are clients chosen for a program?
- Which resources (program/housing types) are currently part of CES and how did you incentivize participation by programs (both in CES and HMIS)?
- How does SCC track and address recidivism?
- How do stand-alone programs (WPC, HCH, HCV & privately funded providers) engage with CE?





What agency does  
the community have  
around  
prioritization?



# Assessment vs. Prioritization

**Assessment:** the process of documenting participant needs and strengths, identifying barriers to housing, and clarifying participant's preferences and goals

*What does the person need?*

**Prioritization:** the process of identifying which households, among all those assessed, have the greatest needs and will therefore receive accelerated assistance to available housing and services within the CoC system

*Who should the CoC serve first?*



# Prioritization and Community Agency

- **Required:** Prioritization must be based on a specific and definable set of criteria that are documented, made publicly available and applied consistently through the CoC for all populations
- **Recommended:** [HUD CPD 16-11](#) lays out a *recommended* framework for how to prioritize chronically homeless folks in (1) dedicated/prioritized beds and (2) other beds



# HUD Recommended Framework for PSH Prioritization

## CPD 16-11

**First Priority:** Homeless individuals and families with a disability with long periods of episodic homelessness and severe service needs

**Second Priority:** Homeless individuals and families with a disability with severe service needs

**Third Priority:** Homeless individuals and families with a disability coming from places not meant for human habitation, safe haven, or emergency shelter without severe service needs

**Fourth Priority:** Homeless individuals and families with a disability coming from transitional housing



# Sacramento Prioritization Framework

## Sacramento (PSH)

**First Priority:** CH

**Second Priority:** LOTH

**Third Priority:** Most severe service need as identified by VI-SPDAT (14 or higher for Individuals, Families, and TAY)

## Sacramento (RRH)

**First Priority:** VI-SPDAT score in moderate range

**Second Priority:** Not established

**Third Priority:** Not established



# Community Examples of Prioritization Framework

## Santa Clara (PSH)

**First Priority:** VI-SPDAT Score

**Second Priority:** LOTH

**Third Priority:** High Use of Services

## Santa Clara (RRH)

**First Priority:** VI-SPDAT Score

**Second Priority:** Risks Score

**Third Priority:** LOT on Community Queue



# Community Examples of Prioritization Framework

## Dallas

**First Priority:** Chronically homeless, VI-SPDAT score of 8 or greater; SPDAT score of 35 or greater.

**Second Priority:** Chronically homeless, VI-SPDAT score of 4-7; SPDAT score of 20 or greater.

**Third Priority:** Non-chronically homeless, VI-SPDAT score of 8 or greater; SPDAT score of 35 or greater

## Honolulu

**First Priority:** Chronic Homelessness, Tri-Morbidity, VI-SPDAT Score Range 9-22

**Second Priority:** Chronic Homelessness 2+ HUD Disabling Conditions (VI-SPDAT question 19-22 or 24-28):

- Mental Health (VI-SPDAT question 26A, 26B or 26C) and/or
- Physical Health (e.g. HIV/AIDS) (VI-SPDAT question 19-22) and/or
- Substance Use (VI-SPDAT question 24-25) and/or
- Developmental Disability and/or Cognitive Impairment (VI-SPDAT question 26C)



# Dynamic Prioritization

“It’s so easy for us to convince ourselves that putting people on a waitlist is helping them. But it isn’t. There are some people who are never going to get housed. We’re putting people on a waitlist to nowhere.”

- Anonymous Community in Abt Report

- **Individuals with the highest needs are always served first.**
- All available housing resources are offered to the highest acuity persons, even if they may be better-served in the future by a different housing intervention.
- Case conferencing with providers and CE operator to determine need
- Non-Prioritized Groups: (1) Diversion attempted before shelter entry, (2) Develop self-resolution strategies, (3) No assessment until in shelter for a set period of time, (4) Some progressive engagement after long shelter stay





# Discussion



# Input & Discovery

1. What components of Sacramento's CE needs further development?
2. Do we need to refine our prioritization policy and case conferencing tools?  
If so, to what extent?
3. What changes to the response system does the CE Combined Committee recommend?



# Next Steps

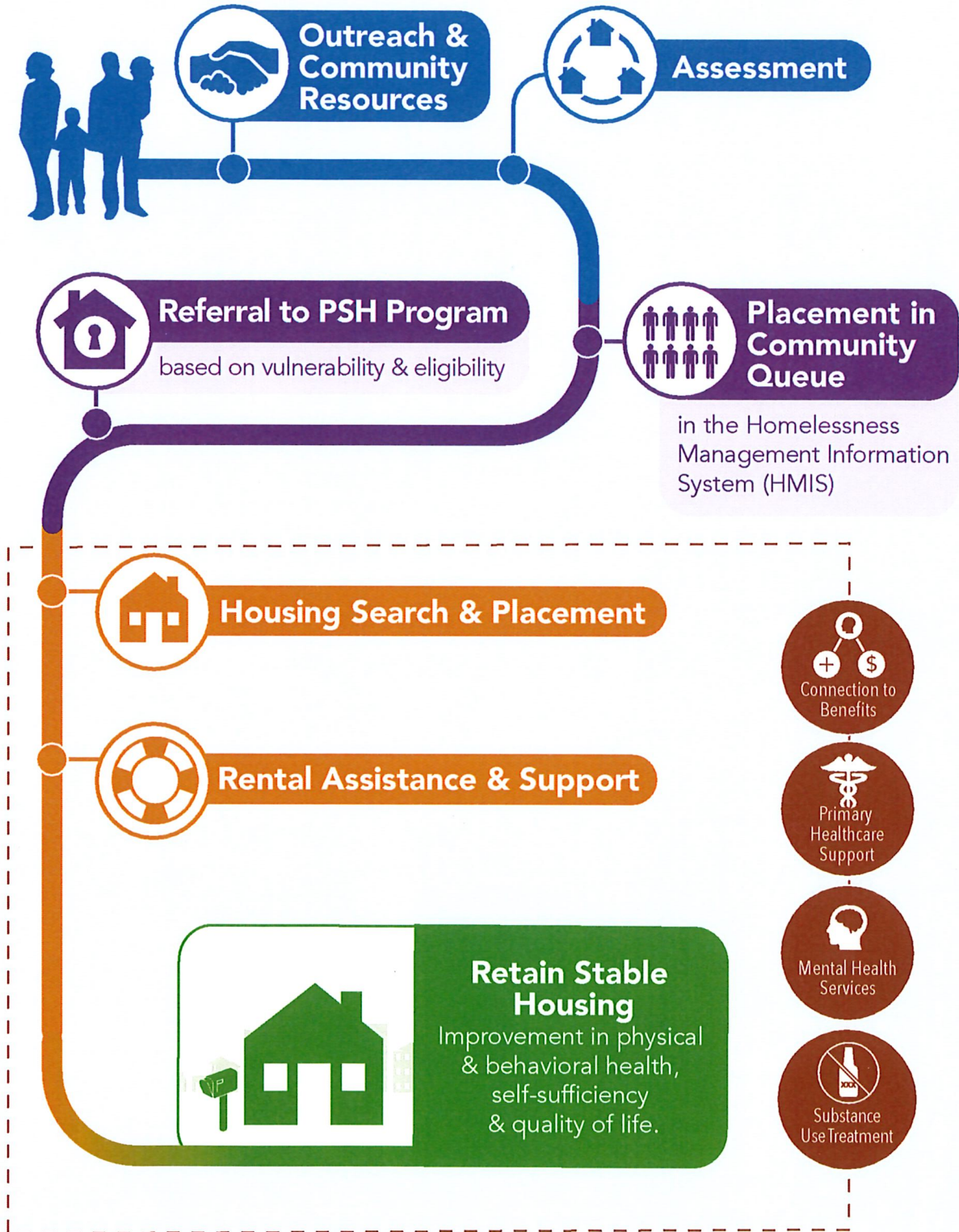
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# PERMANENT SUPPORTIVE HOUSING SYSTEM MAP IN SANTA CLARA COUNTY





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# 2019.12.17 Summary of Feedback: Combined CE Committee Meeting

## Overview

The December 17, 2019 Combined CE Committee featured presentations from Santa Clara County and Homebase with a focus on answering questions identified by the Combined CE Committee at the October 28, 2019 meeting. This meeting is part of a larger “Discovery & Input” process by Homebase, moving toward an effective systems map, gaps analysis, and CES re-design and implementation process.

## Summary of Santa Clara Discussion

Kathryn Kaminski, the CoC Quality Improvement Manager in Santa Clara, spoke directly to the Combined CE Committee about Santa Clara’s CES, in response to a number of questions developed by the CE Committee. Kathryn works in the County of Santa Clara Office of Supportive Housing, which is also the CoC Collaborative Applicant, HMIS Lead, and CES manager for Santa Clara CoC. Major topics of discussion included:

- Santa Clara requires that county-funded housing programs participate in CES.
  - This does not include county-funded emergency shelter beds, which are not currently integrated into CES.
- Santa Clara has a locally developed prioritization scheme for PSH and RRH.
  - RRH:
    - Tier 1: VI-SPDAT score
    - Tier 2: Risk Sub-Score (subsection of VI-SPDAT)
    - Tier 3: Length of Time on Community Queue
  - PSH:
    - Tier 1: VI-SPDAT score
    - Tier 2: Length of Time Homeless
    - Tier 3: High Use of County Services
- Santa Clara does not use case conferencing, but does fund a PSH Client Engagement Team.
  - Using an approximation of the number of vacancies likely to arise soon, the PSH Client Engagement Team engages clients that are “next up” on the community queue and connects them with shelter, works to get them document ready, and determines their eligibility for different PSH programs across the system of care, not limited to CES.
  - This approach allows for a warm handoff to the PSH provider, reduces the burden on the PSH provider to coordinate doc readiness, and streamlines the process of finding folks when vacancies become available.
- Santa Clara still has difficulty meeting the need of all the clients on the community queue.
  - They are currently working on messaging about CES throughout the community, in order to ensure that clients are still receiving services and trying to find housing through other means after being assessed for CES.
  - The community queue is kept up-to-date according to a robust set of policies and procedures around when clients should be removed from the queue (including policies around continued location efforts, self-resolving clients, neutral exits, etc).
  - Santa Clara re-assesses each client annually.
- Different Santa Clara access points offer different types of diversion.
  - Santa Clara is currently piloting a “Diversion & Rapid Exit from Shelter” program focused on providing uniform, intensive diversion options at each access point.



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- Planning to roll out system-wide on April 1, 2020.
- A majority of the funding for this initiative is coming from Santa Clara County, but the CoC is also leveraging HEAP, DV-specific, and prison re-entry-specific funding sources.
- Diversion will be provided on a first-come-first-served basis and tracked through HMIS.
- Santa Clara defines access point as a place where clients can be assessed with the VI-SPDAT.
- Santa Clara tracks returns to homelessness using HUD systems performance measures, but recognizes that this is not fully encompassing.
- Santa Clara takes a specialized approach to engaging stand-alone programs like Whole Person Care, housing choice vouchers, and privately funded providers in CES.
  - All homeless-specific HCVs are reserved for CES referrals.
    - The County or the CoC will often provide case management funds to accompany these vouchers.
  - Whole Person Care takes referrals from CES only.
    - Prioritization for this program is dependent on the VI-SPDAT score and other WPC-specific eligibility criteria.
  - The Bringing Families Home program also receives referrals from CES only.
    - Prioritization for this program is dependent on a family's ranking on the community queue and Child Protective Services involvement.
- Santa Clara is still working on improving their coordinated entry system and has purposefully built out a detailed evaluation process to support this effort.

### Combined CE Committee Discussion: Current Sacramento CES

- Locating single adults when they rise to the top of the community queue is a continued challenge.
  - Currently, when a client rises to the top of the queue, the SSF Matchmaker contacts the providers or programs that the individual has recently had contact with, according to HMIS.
    - This often includes the outreach teams run by WIND Youth Services, SSF, SSHH, and Sacramento County DHA.
  - Case conferencing efforts have been successful in helping locate TAY and veterans in Sacramento.
- Different entities across Sacramento County are currently exploring and piloting the “smart shelter” approach, which would designate certain shelter beds to be used after clients have been assessed, while they are waiting for referral.
  - TAY through HHAP funding; Sacramento County through the Flexible Housing Pool
- Case conferencing for TAY and veterans is working well.
  - TAY is working because all of the relevant providers (10-15 per meeting) are coming to the table, including resources outside of CES such as County Behavioral Health.
    - Meetings are every two weeks, in keeping with recommended practices.
  - The case conferencing process focuses on problem solving and answering the question, “What can we do for this person right now if we can't get them into the exact right program?” and then transferring them to the best fit as things became available.

### Combined CE Committee Discussion: Ideas to Improve Sacramento CES

- **Broadening Scope of CES**
  - Integrate diversion into CES



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- Broaden the scope of providers and partners participating in CES beyond CoC-funded providers
- Improve community messaging about the benefits of wide scale participation in CES
- Standardize trainings across the community on topics like diversion
- Leverage promising practices already working in the community and think about scaling system-wide
- Increase transparency around the CES overall for the full community, with a specific focus on access points and prioritization.
- **Access**
  - Increase client awareness around CES access points
  - Provide more than connections to assessment at the access points (e.g., more effective triage, connection to diversion, connection to other non-CoC funded services)
  - Decrease the wait time for appointments through 2-1-1
- **Prioritization**
  - Explore dynamic prioritization as a potential prioritization scheme.
    - Consider long-term risks involved with this approach including the impact of insufficient housing interventions on clients.
    - Also, continue thinking about how to prioritize inter-program transfers if dynamic prioritization is implemented.

### Outstanding Questions

1. What is the role of the Combined CE Committee during the systems map and gaps analysis process?
2. What is the capacity of Santa Clara's PSH Client Engagement Team?
  - a. How many team members are there? What is their case load?
3. What tools and/or uniform decision-making processes are other communities using around diversion efforts?
  - a. How can we use past research done by the CE Committee around other community examples (i.e., Cuyahoga County, King County) to inform these processes and/or tools?
4. How does the system of care in Sacramento define:
  - a. CoC resources
  - b. Access point
  - c. "Participating" in CES
5. Is Sacramento CES currently using dynamic prioritization? Is it being implemented for specific sub-populations only?
6. Overall, how does the full system of care function right now, including CES?

**If you have feedback or additional questions about this Combined CE Meeting or the CESH work in general, please contact:**

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