Combined CES and CES Evaluation Committee Meeting
February 6, 2020 | 1:00 PM – 3:00 PM
1331 Garden Highway, Suite 100, Sacramento, CA 95833 | NIC Main

Attendance:

<table>
<thead>
<tr>
<th>Member</th>
<th>Area of Representation</th>
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<tbody>
<tr>
<td>John Foley</td>
<td>Sacramento Self Help Housing</td>
</tr>
<tr>
<td>Steve Watters</td>
<td>First Step Communities</td>
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<tr>
<td>Shelly Hubertus</td>
<td>Waking the Village</td>
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<tr>
<td>Josh Arnold</td>
<td>Volunteers of America</td>
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<tr>
<td>Peter Muse</td>
<td>Veterans Resource Center</td>
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<tr>
<td>Tina Glover</td>
<td>SACOG</td>
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<tr>
<td>Ragan Kontes</td>
<td>Salvation Army</td>
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<tr>
<td>Robynne Rose-Hayner</td>
<td>Wind Youth Services</td>
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<tr>
<td>Monica Rocha-Wyatt</td>
<td>Behavioral Health Services</td>
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<tr>
<td>Julie Field</td>
<td>Sacramento County DHA</td>
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<tr>
<td>Howard Lawrence</td>
<td>ACT</td>
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<td>Peter Bell</td>
<td>Wind Youth Services</td>
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<table>
<thead>
<tr>
<th>Staff</th>
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<tbody>
<tr>
<td>Michele Watts</td>
<td>SSF Chief of Programs</td>
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<tr>
<td>Keri Arnold</td>
<td>SSF Referral Specialist</td>
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<tr>
<td>Joe Concannon</td>
<td>SSF CES Program Manager</td>
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<tr>
<td>Christine Wetzel</td>
<td>SSF Referral Lead</td>
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I. Welcome & Introductions: John Foley, Chair

A. Update on CESH Work report from Systems Committee

- Joe Concannon, SSF  2:05 PM  Information

John Foley and Joe Concannon described the content of the first Systems Committee meeting. They presented the concept of the two committees meeting together at points during the
System Mapping and CE Redesign phases of the Homebase contract to prevent duplicate efforts and to ensure providers familiar with Coordinated Entry (CE) are included those phases of the project. Joe described Homebase timeline and potential timing of Homebase recommendations coming to the Committee.

**B. Review of Discussion with Santa Clara County CoC and Feedback on Re-Design**

<table>
<thead>
<tr>
<th>Presenter: John Foley, Chair</th>
<th>2:15 PM</th>
<th>Information</th>
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John asked for observations on the discussion with Santa Clara CoC on their CE program. He shared that it was interesting how Santa Clara required all programs receiving County funding to participate in CE. The CoC also didn’t use case conferencing for the general population and instead relied on county-wide coordinated outreach to get clients ready for housing.

Joe suggested that having the County as the administrator of the CoC programs made it easier for all County departments and providers to buy into CE. He said that it was also good to hear about Santa Clara County’s formal diversion program. He explained that a similar program was asked for in the community meetings the solicited ideas for the HHAP funding.

Peter B. brought up the “smart shelter” model (identifying clients who are most vulnerable via Coordinated Entry, move that client into a shelter, get the person doc ready with the intention of moving client to stable, Permanent Supportive Housing (PSH)). Committee members discussed the “smart shelter” model, e.g. what implementation would look like, how turnover rate at shelter would be advantageous to all, etc.

**C. Refresher – HUD Requirements for Prioritization and Overview of the Current Processes**

<table>
<thead>
<tr>
<th>Joe Concannon, CES Program Manager, SSF</th>
<th>2:10 PM</th>
<th>Discussion</th>
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Joe presented the slides below to refresh the Committee’s understanding of how the Coordinated Entry Referral process (VI-SPDAT, Community Queue, Types of Programs (via HUD), Documentation requirements for each program, Referral Process into PSH &RRH, CoC Hotlist Alerts, Case Conferencing for Coordinated Entry) is operating at SSF. There were no questions.
D. How Case Conferencing is Working in the TAY and Veteran Subpopulation Working Collaboratives.
- Presenter(s): Shelly Hubertus, Waking the Village, Peter Muse, Veterans Resource Center.

2:40 PM (30 min)  Discussion

TAY Case Conferencing:
There is broad Inter-agency participation with a client-centered approach (front-line staff also present). The collaborative uses the by-name list to identify the next TAY who are being prioritized for PSH (staff can also make recommendations of youth who are not on the by-name list but who is in need). Twenty to twenty-five clients are discussed at each meeting. Collaborative members develop solutions to overcome the challenges each client faces for entering the available programs.

Veteran Case Conferencing:
Veterans Collaborative operates similarly to the TAY Collaborative. Provider case conferencing was initially specific to just Veteran opportunities/housing inventories, but has since expanded to include Coordinated Entry opportunities, as well. It grew from the Homeless Veteran Challenge, Built for Zero and is supported nationally by Community Solutions. The Collaborative has set a goal of housing all, chronic, senior, veterans before moving down the list to non-seniors.

E. Open Discussion – How Can We Design Case Conferencing for the General Population?
Meeting Attendees 3:15 PM Discussion

Based on the discussion with the TAY and Veteran Collaboratives meeting attendees offered the following observations and suggestions.

- SSF should explore the possibility of trying to re-engage providers for the general population and get feedback more detailed feedback on how case-conferencing might work.
- Look into dividing by-name list (e.g. top 100 most vulnerable) into subcategories based on commonalities, e.g. families with minors grouped together, etc. Set up meetings working with providers who work with those populations.
• Regular & consistent meetings, at consistent locations, is important to keep the community on track.
• Make sure the participants acknowledge their accomplishments to garner more interest/buy-in from others.
• It is important for case conferencing include more than just housing, much in the same way the TAY case conferencing is currently structured with supportive health services at the table.
• Engaging and coordinating the Outreach and Shelter providers would help to have one voice at the table on locating clients and keeping them sheltered as they are waiting for enrollments into identified housing opportunities. The case conferencing group would need access to refer into shelter beds for this to work. Steve W. mentioned that there is discussion about a meeting to coordinate shelter providers in the River District but there has been nothing scheduled yet. Joe C. mentioned that there is a working group designing new Outreach standards with TAC, a technical assistance provider for HUD.
• There is also a need for better training across the provider community on how to efficiently get clients document ready for housing opportunities.

Next Steps:
• Investigate whether shelter providers will meet and investigate whether it is possible to allot beds to people who are next on the by-name.
• Invite the Outreach Standards working group to the next CE Committee Meeting.
• Hold a Doc Readiness workshop for providers.
• Increase the transparency of the CE Referral system.
• Investigate what data is available for clients in the By-Name-List to group them into similar populations that would benefit from similar services. (Families with children, singles needing AOD, etc.)
• Bring back information why those on By-Name-List couldn’t be housed.

F. Meeting Adjourned

Next Meeting – March 5, 2020 – 2:30 pm
(Time changed to follow TAY Community Case Conferencing Meeting)
Coordinated Entry Overview
(Prioritization and Referrals)
Coordinated Entry

Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require that CoCs establish a Centralized or Coordinated Assessment System.

Coordinated entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner.

Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources.
Prioritization

A HUD Mandate & Best Practice
Prioritization

A CoC Process
Coordinated Entry Implementation in Sacramento

**PLANNING**
2012 - 2014
- Focus Strategies
- Feasibility Study
- CoC Board Approval of Model for Access (multiple points of entry: 211, Access Points, Outreach)
- Selection of VI-SPDAT

**LAUNCH**
2015
- Outreach and other access points begin conducting VI-SPDAT
- Referrals into new programs begin

**PILOT IMPLEMENTATION**
2016
- 20+ agencies conducting VI-SPDATs
- Referral into existing programs begins in 2016
- Three more projects join in 2018

**CE RE-DESIGN**
2019
- Using one-time CESH funds SSF Contracts with Homebase to develop a System Map, Gaps Analysis and Recommendations to Re-Design CE System.
2015
Choosing the VI-SPDAT

- Most frequently used triage tool in North America & Australia
- Already built into HMIS platforms
- No clinical skills needed to conduct
- Simple training from the Lead Agency
VI-SPDAT: Vulnerability Index – Service Prioritization Decision Assistance Tool

A pre-screening, or triage, tool designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.

The VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify whom to treat first based on the acuity of their needs.

The VI-SPDAT was not intended to provide a comprehensive assessment of each person’s needs.
# The 4 Domains of the VI-SPDAT

<table>
<thead>
<tr>
<th>History of Housing</th>
<th>Risks</th>
<th>Socialization &amp; Daily Functions</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Housing and Homelessness</td>
<td>Risk of Harm to Self or Others</td>
<td>Self-Care &amp; Daily Living Skills</td>
<td>Mental Health and Wellness &amp; Cognitive Functioning</td>
</tr>
<tr>
<td></td>
<td>Involvement in High-Risk and/or Exploitive Situations</td>
<td>Personal Administration &amp; Money Management</td>
<td>Physical Health &amp; Wellness</td>
</tr>
<tr>
<td></td>
<td>Interactions with Emergency Services</td>
<td>Meaningful Daily Activities</td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td>Legal Issues</td>
<td>Social Relations &amp; Networks</td>
<td>Substance Use</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Experience of Abuse and/or Trauma</td>
</tr>
</tbody>
</table>
When should VI-SPDAT be conducted?

- After trust and rapport has been built
- After determining the household is Category 1 or Category 4 Homeless
Category 1 Homeless: Literally Homeless

Individual or family lacks a fixed, regular, and adequate night time residence

Category 4 Homeless: Fleeing / Attempting to Flee Domestic Violence

Any individual or family who:

i) is fleeing, or is attempting to flee, domestic violence

ii) has no other residence: AND

iii) lacks the resources or support networks to obtain other permanent housing
What to expect when conducting the VI-SDAT.

- This is a Self-Report tool.
- All questions result in a “Yes”, “No”, “Refused”, or one-word answers.
- Each question must be asked. Persons can elect to “skip” or refuse to answer a question.
The Various VI-SPDAT Tools

- Single VI-SPDAT: Any adult over the age of 25.
- Transition Age Youth (TAY) VI-SPDAT: Young adults between the ages of 18 to 24.
- Family VI-SPDAT: Any household with minor children.
When should a replacement VI-SPDAT be conducted?

- Change to the household unit.
- A qualifying life event has happened.
- New episode of homelessness has begun.
- Original VI-SPDAT was not conducted in household’s primary language.
- Original VI-SPDAT was conducted greater than 1 year ago.
How are the VI-SPDAT and the Community Queue connected?
Coordinated Entry Groupings

By-Name-List (5,799 People – 02/04/20)
- Is literally homeless
- Service or contact entered in HMIS within 90 days

Community Queue (3,586 People)
- Eligible for By-Name-List
- Has VI-SPDAT

Priority Queue for PSH (30 People)
- Prioritized from the CQ for vulnerability and length of homelessness. Priority Queue size is ~ 2x the anticipated openings for the month.

PSH Referrals Made
- Priority Queue client who is eligible for current program opening.
Referral Specialist accesses the Community Queue to identify eligible, documentation-ready households for programs available through HUD funding.
Types of Programs available through HUD funding:

Permanent Supportive Housing

Housing and supportive services designed to provide continuous support to participants.

Maximum length of stay is unlimited, although some participants may choose to exit or have displayed self-sufficiency and will successfully maintain stable housing.

Transitional Housing

Housing and supportive services designed to encourage stability for those who are most likely to achieve self-sufficiency through employment.

Maximum length of stay is 12 months.

Rapid Rehousing

Temporary housing Subsidy and supportive services designed to quickly rehouse and stabilize people experiencing homelessness.

Typical length of stay is 3 to 6 months; max 24 months.
# Coordinated Entry Eligibility Considerations

<table>
<thead>
<tr>
<th></th>
<th>PSH</th>
<th>RRH</th>
</tr>
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<tbody>
<tr>
<td>VI-SPDAT Score</td>
<td>11+</td>
<td>5-9</td>
</tr>
<tr>
<td>Length of Time Homeless</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Severity of Needs (4 domains)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Consumer Self-Determination &amp;</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
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<tr>
<td><strong>Doc Ready</strong></td>
<td></td>
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<tr>
<td><strong>Homeless Cert</strong></td>
<td>✓</td>
<td>✓</td>
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<tr>
<td><strong>Disability Cert</strong></td>
<td>✓</td>
<td></td>
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<tr>
<td><strong>Chronic Cert</strong></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>3rd Party Verification</strong></td>
<td>✓</td>
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Referral Process into PSH & RRH

1. Referral Specialist identifies eligible, documentation-ready households by appropriate criteria.

   **Consumer self determination and awareness of program type** (shared living, accessibility, location) are considered.

   **Length of time homeless** (current episode)

   **Chronicity** (12 continuous months or 4 episodes of homelessness within 3 years, totaling 12 months).

   **Document ready**: documents must be verified, and uploaded into HMIS

2. Referral Specialist sends referrals from Community Queue to designated point of contact at the receiving agency
BY INCLUDING HOUSEHOLDS IN THE CES REFERRAL LOG

**Please note**: Rapid Rehousing Collaborative and SSF are in the process of revisiting policy of prioritization per HUD mandates. Further, SSF is piloting Housing Conferencing within the community. This includes more detailed examination of a households severity of need & program requirements.
Referral Process into Programs with Voluntary CES Participants

- Transitional Housing (County and Veterans Affairs)
- Supportive Services for Veterans and Families (SSVF)
- Department of Human Assistance (HSP)
- Shelters (developing agreements currently)

- Eligibility is based in program requirements (ie employable, veteran, Cal-Works eligible, etc.); prioritization is based in CES standards.

*Note- Voluntary participants are not mandated by HUD to participate in CES.
CoC Hotlist Alerts

Public Notes and Alerts

Notes:
Share critical information with your peers in different projects/agencies

Alerts:
• Time-sensitive housing opportunities (managed by SSF)
• Time-sensitive warnings regarding missing or dangerous persons
CoC Hotlist Alerts
What to do if you see an alert

What it means:
This client has been identified as potentially qualified for CoC permanent housing, and we need your help getting in touch.

What it doesn’t mean:
They are guaranteed housing

How long are they considered ‘hot’?
They’ll be removed from hot list after 90 days with no contact.touches in HMIS
CoC Hotlist Alerts
What to do if you see an alert: Inform & Contact

Inform this client that they may be qualified for permanent housing opportunity and SSF would like to speak with them
*Make sure they understand this is not a guarantee of housing*

<table>
<thead>
<tr>
<th>If client is interested in exploring:</th>
<th>If the client is not interested:</th>
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<tbody>
<tr>
<td>Ask the client to contact us directly: 916-621-6733 / <a href="mailto:referrals@sacstepsforward.org">referrals@sacstepsforward.org</a> and Contact us to let us know you advised the client and with any relevant contact information for client (location, phone, etc.)</td>
<td>Please contact us directly to let us know about your conversation. Indicate which of the noted reasons the client was not interested in pursuing the opportunity.</td>
</tr>
</tbody>
</table>
CoC Hotlist Alerts
Accessing the full list

If you’d like to see the current complete** Hot List, search for the client ‘Sacramento Continuum of Care Hotlist’.

Visit FILES >> ‘Hotlist : Sacramento Hotlist’

(*does not include clients marked as ‘private’ by agency)
“Doc Ready” for Coordinated Entry
Homelessness Certification

Homelessness Certification for all Households.

Form may be completed by any Homeless Service Provider

All necessary supporting documentation attached. (Examples listed below.)

- First-hand observation
- HMIS Program History
- Third Party Homeless History Verification
- Written referral from another agency
- Discharge paperwork from an institution
- Documentation from a transitional housing program
- Documentation supporting fleeing DV

HOMELESSNESS CERTIFICATION

The Homelessness Certification is used by agencies to affirm an individual or family is experiencing homelessness at the time the certification is completed.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>MHS ID code</th>
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Number of Dependents for Head of Household (Family): 

Please read each option. Check the box of the person’s living situation and the type of verification attached:

- Currently living in a place not meant for human habitation or an emergency shelter. (Please select one of the 4 boxes below.)
  - First-hand observation by outreach worker (Please check the box that best describes your observation of the situation or family’s current living situation).
  - Can see camp or vehicle not hooked up to facility
  - Street: patio, overpass, etc.
  - Unsheltered living without permanent location

- HMIS Program History indicating individual is currently homeless.
- Third party homeless history verification
- Written referral from another agency
- HMIS Program History indicating individual is currently homeless.
- Written referral from another agency
- Newly residing in a transitional housing program, where they lived in an emergency shelter or place not meant for human habitation immediately before entering the program.
- Newly residing in a transitional housing program, where they lived in an emergency shelter or place not meant for human habitation immediately before entering the program.
- Newly residing in a transitional housing program, where they lived in an emergency shelter or place not meant for human habitation immediately before entering the program.
- Newly residing in a transitional housing program, where they lived in an emergency shelter or place not meant for human habitation immediately before entering the program.

I certify that I am a representative of one of the referenced agencies and that the above stated person is experiencing homelessness. I have attached the proper documentation as required under the U.S. Department of Housing and Urban Development (HUD) Act and understand that this information is subject to verification.

Signature: __________________________ Date: __________________________

Print Name: __________________________

Agency Name: __________________________

Job Title: __________________________

*Agency: Any non-profit agency with service design to serve individuals experiencing homelessness (e.g., shelter, health care, transition housing programs, emergency shelters, food banks, etc.)

**Receiving officer or family member’s name/initials and agency staff as part of the certification process.
Chronic Homelessness Certification

Chronic Homelessness Certification for Individuals or Heads of Households needing to verify chronicity.

Form may be completed by any Homeless Service Provider

All necessary supporting documentation attached.
  • Disability Certification
  • Verification of Homelessness History
Disability Certification

Disability Certification for Individuals or Heads of Households needing to document a disability to establish Chronic Homelessness.

Form may be completed by any Homeless Service Provider with supporting documentation. (Typically a disability benefit award letter from the Social Security Office.)

-OR-

Homeless Service Provider AND a Licensed Professional by the State of CA to diagnosis and treat a disability
Supporting Documentation for Chronic Homeless History

- HMIS Record (Printout)
- Third Party Homelessness History Verification Form
- Third Party Homelessness History Verification Letter
- Self-Certification of Homelessness - Homeless History Mapping Tool
Third Party Homelessness History Verification

Form may be completed by any Homeless Service Provider with the Individual or Family and the Third Party Verifier.

This form requires 3 signatures.

- The individual or family experiencing homelessness providing consent.
- The Third Party witnessing the individual or family's homelessness.
- The staff person witnessing the Third Party signature to their statement.
Self-Certification of Homelessness

Up to 3 months without supporting documentation stating barriers and attempts to collect Third Party Verification.

Form may be completed by any Homeless Service Provider with the Individual or Family.

Note: This is the LEAST desired method of verification.
Community Best Practices for obtaining other Necessary Documentation.

- Photo Identification Cards
- Social Security Cards
- Certified Copies of Birth Certificates
- DD214 Forms
- Income Verification
Case Conferencing for Coordinated Entry
Case Conferencing

CoC Best Practice

Operating with sub-populations
- TAY
- Veterans

Targets most vulnerable

Cross-Agency Discussions on How to House Clients
TAY CASE CONFERENCING OVERVIEW.
How Case Conferencing is Working in the TAY Working Collaborative
**Inter-agency participation**

- Capital Stars
- FSP – Full Service Partnership (Michael Young; LSCW)
- Youth Health Network
- LGBTQ
- Wind Youth
- Waking the Village
- SSF – Sacramento Steps Forward

Front-line staff – i.e., those working directly with people experiencing homelessness are the primary participants at the meeting.

Client-centered – i.e., problem-solving; using the team’s collective brain power in being mindful around housing placements and supportive services.
Commitments

- Using the by-name list to identify the next TAY who are being prioritized for Permanent Supportive Housing.
- Using the by-name list to generate the agenda for the meeting.
- Case Conferencing agenda being sent out prior to the meetings. (First & Third Thursdays of each month).
- Generating housing related next steps for all of the clients being discussed in our case conferencing.
- Identifying program openings
- Accountability – notes and assignments are sent out after the meetings
- Recording steps and progress into HMIS which includes doc readiness.
How can we design a case conferencing for General Population?