The Balance of State Continuum of Care developed the following Coordinated Access standards to ensure:

- Program accountability to individuals and families experiencing homelessness; specifically those who are experiencing chronic homelessness or are high-need/high-acuity.
- Program compliance with HUD Rules and guidance.
- System access, prioritization, and housing placement consistency.
- Adequate program staff competence and training to create an environment, locally and CoC-wide, of coordination, consistency and speed in housing placement.

COORDINATED ACCESS

Coordinated Access is defined as a process designed to coordinate program participant intake, assessment, and provision of referrals. It covers the geographic area, is easily accessed by individuals and families seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.

The process of Coordinated Access can be implemented regardless of geography, housing stock, service availability, or unique community makeup. Almost any model of Coordinated Access can be applied to any community or situation, and with patience, persistence, testing, and tweaking, can be successful.

The terms "Coordinated Access", "Centralized Intake", "Coordinated Intake", and "Coordinated Assessment" are often used interchangeably, and with the exception of "Centralized Intake", more or less mean the same thing: transitioning from a "first come, first served" mentality to a mentality that says "now that you are here, let's determine, together, what might be your next step".

Coordinated Access, when implemented correctly, can help to prioritize individuals and families who need housing the most across communities. Beyond program confinement, and beyond silos, Coordinated Access can create a collaborative, objective environment across a community that can provide an informed way to target housing and supportive services to:

1. Divert people away from the system who can solve their own homelessness.
2. Quickly move people from street to permanent housing.
3. Create a more defined and effective role for emergency shelters and transitional housing.
4. Create an environment of less time, effort, and frustration on the part of case managers by targeting efforts.

5. End homelessness across communities, versus program by program.

Traditionally, the system of entry and referral to housing and service supports was based on a "first-come, first-served" basis and in some places still is. But years of research, re-thinking, and a commitment to moving away from the linear approach to housing placement and moving toward quickly placing people into appropriate housing, has shifted the way we do business.

Historic Practice is **Program** Centric	Coordinated Access is **Client** Centric
Should we accept this family into our program?	What housing and service intervention is the best fit for each family and individual?
Unique entry and assessment forms for each individual program.	Standard forms, assessment, and entry processes across all programs.
Uneven knowledge about existing programs, eligibility, and purpose in communities.	Accessible information about housing and service options in the CoC.

The intention of Coordinated Access is to:
1. Target the correct housing intervention to the correct individual (family), particularly for those with high acuity and high need.
2. Divert people away from the system who can solve their own homelessness.
3. Greatly reduce the length of homelessness by moving people quickly into the appropriate housing.
4. Greatly increase the possibility of housing stability by targeting the appropriate housing intervention to the corresponding needs.

Applying coordinated access to a community brings together the strength of programs across a community, offering a menu of services across programs. When communities come together to implement a coordinated access model, each program realizes success in a myriad of ways:

- Programs Receive Eligible Clients: Programs receive referrals for participants whose needs and eligibility have already been determined. The autonomy and unique nature of programs, as they operate within a coordinated framework become a strength, not a hindrance.
- Case Managers can concentrate on Case Management: With every program in a community providing assessment, case managers share the burden of intake and assessment. When working across case managers in a community, real efficiencies can

be realized in housing placement and case management when a common assessment is employed and agencies share the workload.

- <u>Communities readily see what additional resources they need most:</u> Lots of clients with mid-level acuity (definition of *acuity* below) signal a need for more Rapid Re-housing resources. Lots of clients with high-level acuity signal a need for more permanent supportive housing/housing first.
- <u>Time, red tape, and barriers are significantly reduced:</u> When different programs in a community follow the same process across and are aware of one another, workload is significantly reduced.
- <u>Community homelessness is significantly decreased:</u> Targeting limited resources as a community in a laser-like way leads to very fast and effective interdictions that lead to long-term housing stability.

Prioritization for Chronic Homelessness: HUD has released (updated from the July 2014 document) guidance for the prioritization of chronically homeless individuals and families, which is outlined after the "definitions" section of this document. For a look at the full notice, please go here: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

Before we go too much further, for an excellent tutorial on the intention of Coordinated Access and Common Assessment, try OrgCode's Video Tutorial here: http://vimeo.com/64190826

And the HUD Coordinated Entry Policy Brief:
https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

<u>Coordinated Access in the WV Balance of State Continuum of Care: History and Updates</u>
For the past 3 years, the WV BoS CoC has embarked on a "no wrong door" approach of Coordinated Access utilizing an HMIS-generated, CoC-Wide "By-Name List" (BNL) based on VI-SPDAT scores that communities utilize to place people into housing locally. This approach has met with moderate success due to the fact that communities do not often maintain the fidelity of the referral and housing process, prioritization meetings often turn into case conference meetings regarding client issues, and/or lower acuity persons are targeted for housing versus higher acuity persons.

For this reason, beginning in the Fall of 2016, the West Virginia Balance of State CoC will pilot a centralized intake process throughout the CoC. Partnering with West Virginia University, the WV BoS CoC will create a hotline and two assessment and referral "hubs" in the BoS which will maintain the CoC-wide By-Name List and refer clients directly to open beds in their respective counties. Assessment, triage, referral, and warm transfer for housing placement will happen both virtually through HMIS and through phone communications, eliminating time, confusion, and inefficiencies that current exist in the current coordinated access process.

DEFINITIONS:

Acuity – When utilizing the VI-SPDAT Prescreens, acuity speaks to the presence of a presenting issue based on the prescreen score. In the context of the Full SPDAT assessments, acuity refers to the severity of the presenting issues. In the case of an evidence-informed common assessment tool like the SPDAT, *acuity* is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Centralized Intake – The process by which one entity (shelter, drop-in center, other agency) creates a physical place and dedicates staff to the purpose of conducting all assessments and intakes in a coordinated assessment system, and processing all referrals for program-eligible individuals to appropriate housing and service interventions.

Chronically Homeless – (1) An individual who: (i) is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (iii) can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 USC 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability; (2) an individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, or other similar facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of the household has been homeless.   24 CFR 578.3.

Comparable Database – HUD-funded providers of housing and services (recipients of ESG and/or CoC funding) who are not permitted, by law, to enter into HMIS (only victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database that is comparable to HMIS. The term "comparable" has yet to be defined in the HMIS Data Standards Manual or HMIS Data Dictionary, but was defined under the HEARTH Act and ESG Interim Rule as: "a comparable database that collects client-level data over time (i.e. longitudinal data) and generates unduplicated aggregate reports based on the data" (page 32) (https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConf

ormingAmendments.pdf) The recipient or subrecipient of Continuum of Care funds may use a portion of those funds to establish and operate a comparable database that complies with HUD's HMIS requirements. (§578.57 of the CoC Interim Rule)

Coordinated Access – "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The CI&A system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." 24 CFR Section 578.3. It is the responsibility of each CoC to implement Coordinated Access in their geographic area. OrgCode Coordinated Access Video: https://vimeo.com/64190826

Decentralized Intake – Also known as a "no wrong door" approach, when practices for initial assessment and intake are normalized across a community, clients can approach any entity and receive consistent, effective housing placement.

Disabling Condition – (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter, or other homeless assistance, by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program wait lists.

Family - includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or (2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) An elderly family; (iii) A near-elderly family; (iv) A disabled family; (v) A displaced family; and (vi) The remaining member of a tenant family. 24 CFR 5.403.

Homeless – means (Category 1) an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low- income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution; (Category 2) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing; or (Category 4) Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing. 24 CFR 578.3.

Housing First – An approach to **quickly and successfully connect** individuals and families experiencing homelessness **to permanent housing** *without preconditions* and **barriers to entry**, such as sobriety, income, treatment or service participation requirements. Supportive services are **offered** to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. OrgCode Housing First 101 Video: https://vimeo.com/64412408

Permanent Supportive Housing (PSH) – Means community-based housing without a designated length of stay, and includes both permanent supportive housing and rapid re-housing. To be permanent housing, the program participant must be the tenant on a lease for a term of at least one year, which is renewable for terms that are a minimum of one month long, and is terminable only for cause. Permanent supportive housing means permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3.

Rapid Re-Housing (RRH) –An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are housing identification and relocation, short-and/or medium term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 "Homeless" paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400. (24CFR§576.104 *& Core Components of Rapid Re-Housing*, National Alliance to End Homelessness)

SPDAT – (Service Prioritization Decision Assistance Tool) the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting or Balance of State CoC staff on the SPDAT. The SPDAT can be completed on paper or in HMIS and attached to a client record.

Transitional Housing (TH) – housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.

VI-SPDAT – (Vulnerability Index-Service Prioritization Decision Assistance Tool) the evidence-based Prescreen utilized by all projects in the WV Balance of State CoC to determine initial acuity (the presence of an issue) and utilized for housing triage prioritization and housing placement.

ORDER OF PRIORITY FOR CoC-FUNDED <u>DEDICATED</u> CHRONICALLY HOMELESS BEDS (full notice here: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf**)**

A critical role of any Coordinated Assessment System is to provide the quickest access to housing and supports for persons who are most likely to die on the streets. In the West Virginia Balance of State CoC, these people would be considered those individuals and families who meet the criteria for chronic homelessness and have the highest acuity scores on the VI-SPDAT. Given the questions asked on the VI-SPDAT as to length of time homeless, the presence of

mental health and acute health conditions, and risk factors, the VI-SPDAT tool is an excellent tool for the WV BoS CoC to use for the prioritization of people for housing. The following is the priority by which all Chronically Homeless individuals and families will be prioritized for permanent supportive housing for projects with dedicated beds for those experiencing chronic homelessness.

STANDARD: Programs receiving CoC-funded Permanent Supportive Housing which have beds that are dedicated to serve individuals and families who are identified as chronically homeless are required to follow the order of priority in accordance with the Order of Priority section of Notice CPD-16-11, and per the agreed-upon Order of Priority as established by the WV Balance of State CoC when selecting participants for housing. Recipients must exercise due diligence when conducting outreach and assessment to ensure that persons are served in order of priority as adopted by the Balance of State CoC. Chronic Homeless status is clearly indicated on the CoC-wide prioritization list, making adherence to the following priority simple and straightforward.

CRITERIA:

1. First Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 with the Longest History of Homelessness AND with the Most Severe Service Needs (as found through the acuity score on the VI-SPDAT).
   a. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four (4) separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and
   b. The CoC or CoC Program recipient has identified the chronically homeless individual or head of household, who meets all of the criteria of the definition for chronically homeless, and as having the highest VI-SPDAT acuity score.

2. Second Priority – Chronically Homeless Individuals and Families with the Longest History of Homelessness for which both of the following are true:
   a. The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and,
   b. The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

3. Third Priority – Chronically Homeless Individuals and Families with the Most Severe Service Needs
   a. The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not mean for human habitation, a safe

haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year; and

    b. The CoC or CoC program recipient has identified the chronically homeless individual or the head of household who meets all the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe service needs.

4. Fourth Priority – All other Chronically Homeless Individuals and Families.

    a. The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not mean for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the cumulative total length of those separate occasions equals **less than** twelve months; and

    b. The CoC or CoC program recipient has not identified the chronically homeless individual or the head of household, who meets all of the criteria in paragraph (1) of the definition for chronically homeless, of the family as having severe needs.

PRIORITY CHART: <u>DEDICATED</u> CHRONICALLY HOMELESS BEDS

	Prioritization Language	Translation
First Priority	Homeless Individuals and Heads of Households in families with a disability, defined as chronically homeless with total homelessness equaling at least 12 months continuously or 4 separate occasions of homelessness that equal at least 12 months in cumulative total and having severe service needs (history of high utilization of crisis services including but not limited to ERs, jail, and psychiatric facilities; or significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing).	1. Chronically homeless and 12 continuous months of homelessness or 4 occasions of homelessness over 3 years equaling 12 months cumulatively. 2. Having severe service needs (high incidences of ER, jail, behavioral and physical health needs on the VI-SPDAT) as indicated from the VI-SPDAT score. <u>Long-time homeless with very high needs.</u>
Second Priority	Homeless Individuals and Heads of Households in families with a disability, defined as chronically homeless with total homelessness equaling at least 12 months	1. Chronically homeless and 12 continuous months of homelessness or 4 occasions of homelessness over 3 years equaling 12 months cumulatively.

	continuously or 4 separate occasions of homelessness that equal at least 12 months in cumulative total and <u>NOT</u> having severe service needs.	2. NOT having severe service needs from the VI-SPDAT answers and score. <u>Long-time homeless with not as high of need.</u>
Third Priority	Homeless Individuals and Heads of Households in families with a disability, defined as chronically homeless with 4 separate occasions of homelessness that equal less than 12 months in cumulative total and having severe service needs (history of high utilization of crisis services including but not limited to ERs, jail, and psychiatric facilities; or significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing).	1. Chronically homeless with 4 occasions of homelessness over 3 years equaling less than 12 months cumulatively. 2. Having severe service needs (high incidences of ER, jail, behavioral and physical health needs on the VI-SPDAT). <u>Less time homeless with very high needs.</u>
Fourth Priority	Homeless Individuals and Heads of Households in families with a disability, defined as chronically homeless with 4 separate occasions of homelessness that equal less than 12 months in cumulative total and NOT having severe service needs.	1. Chronically homeless with 4 occasions of homelessness over 3 years equaling less than 12 months cumulatively. 2. NOT having severe service needs from the VI-SPDAT answers. <u>Less time homeless with not as high of need.</u>

ORDER OF PRIORITY FOR CoC-FUNDED <u>NON-DEDICATED</u> CHRONICALLY HOMELESS BEDS

STANDARD: For CoC-funded projects that do not prioritize beds for chronically homeless individuals and families, the following order of prioritization shall be in place in accordance with the Prioritization Order established in Notice CPD-14-012.

CRITERIA:

1. First Priority – Homeless Individuals and Families with a Disability with the Most Severe Service Needs.

a. An individual or family that is eligible for PSH who have been living in a place not meant for human habitation, a safe haven, or emergency shelter for any period of time including persons exiting an institution where they have resided for 90 days or less but were living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately prior to entering the institution and has been identified as having the most severe service needs.

2. Second Priority – Homeless Individuals and Families with a Disability with a Long Period of Continuous or Episodic Homelessness.
    a. A long period of homelessness is defined as persons who have been living in a place not meant for human habitation, or a safe haven, or in an emergency shelter continuously for at least 6 months or on at least three (3) separate occasions in the last 3 years where the cumulative total is at least 6 months.
    b. Those exiting an institution where they have resided for 90 days or less and meet the criteria in section (a) above immediately prior to entering the institution.
3. Third Priority – Homeless Individuals and Families with Disability Coming from Places Not Meant for Human Habitation, Safe Havens, or Emergency Shelter
4. Fourth Priority – Homeless Individuals and Families with a Disability Coming from Transitional Housing

PRIORITY CHART: PSH BEDS <u>NON-DEDICATED</u> FOR CHRONIC HOMELESSNESS

	Prioritization Language	Translation
First Priority	Literally homeless from the street, shelters, or safe havens, eligible for CoC PSH, or having exited an intuition after 90 days or less and previously homeless prior entering the institution.	<u>Any length of time homeless with a disability and very high needs.</u>

Second Priority	A long period of homelessness is defined as persons who have been living in a place not meant for human habitation, or a safe haven, or in an emergency shelter continuously for at least 6 months or on at least three (3) separate occasions in the last 3 years where the cumulative total is at least 6 months. Those exiting an institution where they have resided for 90 days or less and meet the criteria in section (a) above immediately prior to entering the institution.	Long-time homeless with a disability, regardless of needs.
Third Priority	Individuals and Families who are literally homeless or coming from the aforementioned definition of living in institutions 90 days or less and having been previously homeless, with a disability,	Literally Homeless with a disability regardless of length of time homeless of severity of service needs.
Fourth Priority	Individuals and Families with a disability coming from Transitional Housing.	Coming from transitional housing with a disability, regardless of length of time homeless of severity of service needs.

CLIENT INTAKE PROCESS THROUGH COORDINATED ASSESSMENT

PROCESS: The program will be an active member of the CoC Coordinated Assessment system as it is locally implemented. The program will have minimal entry requirements to ensure the most vulnerable of the population are being served. The program will ensure active client participation and informed consent. All programs will utilize the VI-SPDAT as the initial Prescreen for the Coordinated Access system.

STEPS:

1. All adult program participants must meet the eligibility requirements by appropriate program.

2. Programs may require participants to meet only additional program eligibility requirements as they relate specifically to federally, state-guided, and Continuum of Care, eligibility in writing (not local or agency-mandated additional assessments, criteria, or stipulations).

3. The only reasons programs may have the option to disqualify an individual or family from program entry are:
   a. All program beds full.
   b. If the housing has in residence at least one family with a child under the age of 18, the housing may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the project so long as the child resides in the same housing facility. (CFR 578.93).
4. Additionally, programs may not disqualify an individual or family from program entry for lack of income or employment status.
5. Programs cannot disqualify an individual or family because of evictions or poor rental history.
6. The program explains the services that are available and encourages each adult household member to participate in program services, but does make service usage a requirement or the denial of services a reason for disqualification or eviction.
7. The program will maintain Release of Information, Case notes, and all pertinent demographic and identifying data in HMIS. Paper files can also be kept as long as they are stored in a secure location.

TOOLS

Several tools are available in the successful implementation of a coordinated access process. Important tools and concepts in the process are follows, with the specific tool that is utilized in our Continuum of Care:

Tool or Concept	Specific Solution Used by WV BoS CoC
A common assessment tool at entry into the homeless service system.	Individual, Family, and Youth VI-SPDATs.
A common process for prioritization for housing.	CoC-Wide Centralized Intake and HMIS Prioritization List.
A common referral mechanism across programs.	ServicePoint and ResourcePoint Module in HMIS.
A common community-level process for housing placement.	Warm Transfer from CoC-Wide Centralized Intake.

A common tool for case management and housing stabilization.	Individual and Family Full SPDATs.
A common method to measure results of the process.	ServicePoint HMIS.

ASSESS

PROCESS: The program will be an active member of the CoC Coordinated Assessment system as it is locally implemented. All programs will utilize the VI-SPDAT Prescreen as the initial triage assessment for Coordinated Access. Whenever possible, the VI-SPDAT should be completed in HMIS. When not possible, the VI-SPDAT should be completed in its paper form and then entered into HMIS for each client. For providers not using HMIS, or not permitted by law to utilize HMIS (Domestic Violence Providers), the VI-SPDAT can be completed on paper and staff can communicate acuity score and basic characteristics to the local prioritization committee or team for inclusion in the housing process without divulging name and identifying information.

STEPS:

1. All programs will use one of the VI-SPDAT Prescreen Tools as the initial assessment for people experiencing homelessness entering the system.
2. There is a specific VI-SPDAT for Individuals, one for Families, and a forthcoming one for Youth housed in ServicePoint HMIS.
3. Anyone can utilize the VI-SPDAT Prescreens in any program without formal training, but training can be obtained from WV Coalition to End Homelessness/WV Balance of State CoC staff. It is recommended that the program refer new case managers to the How-To videos for the VI-SPDAT produced by OrgCode prior to administering the VI-SPDAT tool to clients.
   a. VI-SPDAT Version 2 Singles - https://vimeo.com/126560448
   b. VI-SPDAT Version 2 Families - https://vimeo.com/126591317
4. The Prescreen, as a first assessment at entry, provides each program with the ability to determine, across dimensions, the acuity of an individual or family.
5. In the case of an evidence-informed common assessment tool like the VI-SPDAT, acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT score shows the *presence* of these issues, and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

   Wellness: Chronic health issues and substance use.

Socialization and Daily Functioning: Meaningful daily activities, social supports, and income.

History of Housing and Homelessness: Length of time experiencing homelessness, and cumulative incidences of homelessness.

Risks: Crisis, medical, and law enforcement interdictions. Coercion, trauma, and most frequent place the individual has slept.

Family Unit (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup, and childcare.

6. Based upon the Prescreen Acuity Score of the VI-SPDATs, the CoC can arrive at best possible housing intervention that applies, as follows:

VI-SPDAT V.2 Individuals

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing/Housing First	9+
Rapid Re-Housing	4-7
Diversion	0-3

VI-SPDAT V.2 Families

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing/Housing First	9+
Rapid Re-Housing	4-8
Diversion	0-3

VI-SPDAT Transition-Aged Youth (TAY)

Intervention Recommendation	VI-SPDAT Prescreen Score for **Youth**
Long-Term Housing w/High Service Intensity	8+
Time-Limited, Moderate Intensity	4-7
Diversion	0-3

7. Scores on the VI-SPDAT populate the CoC-wide prioritization list in HMIS, allowing the CoC Centralized Intake to assign appropriate, eligible persons to community agencies, case managers, and others with housing resources to house individuals, families, and youth by acuity.

ASSIST

PROCESS: The program will utilize the VI-SPDAT in ServicePoint HMIS for all clients, thereby populating the local prioritization list, by acuity, showing clients who most likely need:

1. Housing First/Permanent Supportive Housing;
2. Rapid Re-housing
3. Diversion (no or very little housing supports).

For Youth, the Transition-Aged Youth VI-SPDAT (TAY) enables the CoC to prioritize by:

1. Long-Term Housing with High Service Intensity.
2. Time-Limited, Moderate Intensity Housing.
3. Diversion (no or very little housing supports).

When a VI-SPDAT Prescreen is performed for any client or potential client entering the system for assistance, ServicePoint Users can tag the VI-SPDAT to be included in the CoC-wide prioritization list. Likewise, the WV BoS CoC Centralized Intake will provide a hotline and two hubs to provide assessment for all clients entering the system.

STEPS:

1. All programs utilize the VI-SPDAT, Family VI-SPDAT, or TAY VI-SPDAT for entrance into the housing and homelessness assistance system.
2. CoC Centralized Intake will take phone and physical referrals, while local agencies will continue to perform VI-SPDATs through outreach and a "no wrong door" approach. CoC Centralized Intake will maintain the CoC-Wide Prioritization List and make referral to HUD and other grantees within the homelessness housing and services system and place people in various housing programs (HUD, VA, Community Mental Health, etc.)
3. Every effort will be made to provide suitable triage for persons living in a place not meant for human habitation through the CoC Centralized Intake Hubs. Triage would include emergency shelter or hotel/motel vouchers. Triage is any temporary housing situation that can be utilized until more permanent housing placement can be made (RRH, PSH, TH).
4. Assuming client eligibility (which can be determined from the CoC-Wide prioritization list) clients are places into permanent housing, by acuity, as rapidly as possible on a county-by-county basis.
5. The CoC-Wide Centralized Intake makes the referral and the appropriate county provider then houses the referred individual.

ASSIGN WITH CLIENT CHOICE

PROCESS: The program will provide safe, affordable housing that meets participants' needs in accordance with the coordinated access and prioritization process, based on acuity and eligibility. The program will also provide the most barrier-free, rapid, and successful entry into housing for each eligible client, by acuity, with as few barriers to housing as possible. The program will not concentrate on only the clients eligible for their specific program, but the ability of all clients in a community to access the appropriate housing.

STEPS:

1. In providing or arranging for housing, the program considers the needs of the individual or family experiencing homelessness.
2. The program provides assistance in accessing suitable housing and is guided by client choice.
3. Housing location is completed quickly, and effectively, with client participation.
4. <u>Programs agree to accept 100% of all referrals from the BoS CoC Centralized Intake, assuming that all eligibility criteria are met for the client and the availability of units/beds. (MOUs with CoC, ESG, and VA-funded providers will be forthcoming from the CoC).</u>

The WV BoS CoC Centralized Intake will provide all referral and warm transfer to programs by county. Client choice will be at the center of any referral and placement, with the client being completely sure of the next steps of their journey from street into housing, and aware of the processes to get them there.

All referrals from the WV BoS CoC Centralized Intake will be done through ServicePoint HMIS for those utilizing HMIS. For those agencies and case managers not using HMIS, a traditional mode of phone referral will have to be performed. For referrals that take place inside HMIS, there is no need to communicate across agencies and programs otherwise, unless specific agency policies direct you to do so. <u>Additionally, in this new mode of Centralized Intake throughout the CoC, it will be imperative that all services and referrals are diligently completely and reviewed by all programs, particularly CoC and ESG-funded programs.</u>

FOLLOW-UP AND HOUSING STABILIZATION

PROCESS: The program shall provide a continuity of services to all participants following their exit from the program. These services can be provided directly and/or through referrals to other agencies or individuals. CoC-funded PSH may provide up to six months of follow-up case management under the funded program.

STEPS:
1. The program develops exit plans with the participant to ensure continued housing stability and connection with community resources, as desired.
2. The program develops a plan for the effective, timely exit of individuals whose acuity is determined to be low enough to maintain housing stability in market rate or subsidized housing outside of the PSH program.
3. The program should attempt to follow up with phone or written contact at least once after the client exits the program. A program may provide follow-up services that include identification of additional needs and referral to other agency or community resources.
4. Services may be provided to formerly homeless individuals or families for up to six months after their exit from homelessness.

The Full SPDATs (Individual and Family) are more intensive assessments that use many of the same dimensions as the VI-SPDAT to determine the acuity of clients. The Full SPDATs require formalized training from OrgCode or the WVCEH/BoS CoC Staff. The Full SPDATs can be used to better determine the acuity of clients whose acuity is more difficult to determine via the VI-SPDAT (borderline cases, "ties" on the Prioritization List, persons not responsive to the VI-SPDAT, etc.) but is primarily a value as an intensive ongoing case management tool. Plainly put, the VI-SPDATs are used as triage and prioritization tools, and the Full SPDATs are used after program intake to measure acuity over time in order to focus case management, and as a benefit to the community for service planning.

Use of the Full SPDATs comes into play once a client in securely established in housing, after the Prioritization List and Housing Placement Phase, and right as Case Management begins in earnest.

The Acuity measure of the Full SPDATs, is calculated differently than the VI-SPDATs due to the nature of the more comprehensive assessment and the depth of questions. Acuity via the Full SPDATs is:

Full SPDAT Acuity Scale for Individuals V. 4.0

Intervention Recommendation	SPDAT Score for **Individuals**
Permanent Supportive Housing/Housing First	35-60
Rapid Re-Housing	20-34
Diversion	0-19

Full SPDAT Acuity Scale for Families V. 2.0

Intervention Recommendation	SPDAT Score for **Families**
Permanent Supportive Housing/Housing First	54-80
Rapid Re-Housing	27-53
Diversion	0-26

Full SPDAT Acuity Scale for Youth V. 1.0

Intervention Recommendation	SPDAT Score for **Youth**
Permanent Supportive Housing/Housing First	35-60
Rapid Re-Housing	20-34
Diversion	0-19

<u>ACCOUNTABILITY</u>

PROCESS: All programs should be contributing to the coordinated access process of the CoC, which will be the dual-hub centralized intake and hotline process at the end of 2016. HUD programs (CoC and ESG-funded) are required to participate in the process. Veterans Administration Programs (SSVF, GPD, HCHV) are also required to participate. For CoC Projects, participation will be directly tied to performance measurement and funding in the WV Balance of State CoC.

STEPS:

1. If a local process for coordinated access exists, providers are expected to take part if at all possible (contact WVCEH for contacts in your community).
2. If a local process does not exist, HUD CoC and VA-funded providers are expected to take responsibility for assisting the WV Balance of State CoC with the implementation in their area.
3. Every community has the ability to begin the process as all components are in HMIS. If an agency is utilizing the WV BoS CoC HMIS, then they have every ability to participate in the process, even in extremely rural areas.
4. Programs should make every effort to take as many referrals from their local prioritization process as possible, assuming that federal and state eligibility criteria are met.
5. If programs with open slots/beds are not taking 3 of every 4 referrals from their prioritization process, justification will have to be made to the local prioritization group and to the Continuum of Care if the program is CoC or ESG-funded.

WV Balance of State CoC Centralized Intake Procedure

Intake Hub 1- Martinsburg, WV
Intake Hub 2- Morgantown, WV
Intake Hub 3- Beckley, WV

Street Outreach

Centralized Intake Hotline

2

Single, Family, or Youth VI-SPDAT is Performed.

*Programs will, until further notice, continue to perform VI-SPDATs at entry.

3

All VI-SPDATS feed to the WV BoS CoC-wide Prioritization List and will be organized by tab into:
- Individual
- Family
- Veteran
- Youth

1

Centralized Intake Staff will assign beds through a combination of HMIS and phone contact, by VI-SPDAT Acuity and Geography, for:
- Shelter or Hotel/Motel Triage
- CoC PSH
- HUD VASH
- CoC, ESG, and SSVF RRH
- CoC and VA TH

5

Assuming all eligibility criteria are met, Centralized Intake Staff will make the referral and placement in HMIS, then handle the "warm transfer" or care of the client from Centralized Intake to the program's case manager. Housing Placement and Case Management will begin.

6

The CoC Independent Assessor will perform Full SPDATs as needed, monitor placement, and assist in warm transfer as needed. After placement, Centralized Intake staff move to the next highest acuity individuals, families, and youth on the list for rapid placement.