**COORDINATED ASSESSMENT PROJECT**

**HOMELESS ALLIANCE OF WESTERN NEW YORK**

In July 2012, the United States Department of Housing and Urban Development (HUD) established the “interim rule” which focuses on regulatory implementation of the Continuum of Care program, including the Continuum of Care planning process. The ruling also established mandatory use of coordinated assessment, a process designed to organize homeless housing and service program participant intakes, assessment, and provision of referrals.

Under the new rule, there were a number of requirements placed upon local homeless care continuums including obligations to:

* Establish and operate a coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services;
* Require all HUD-funded programs (including former Emergency Shelter Grant, now Emergency Solutions Grant awardees and Continuum of Care awardees) to use the coordinated assessment system once developed by the homeless care continuum;
* Ensure that the screening, assessment, and referral of program participants completed by funding recipients and sub-recipients is consistent with the written standards established by the local homeless care continuum;
* Develop a specific policy to guide the operation of the coordinated assessment system on how it will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers; and
* Comply with any requirements established by HUD by Notice.

Further, the coordinated assessment system must cover a specified geographic area; be easily accessed by individuals and families seeking housing or services; be well advertised; and include a comprehensive and standardized assessment tool. The coordinated assessment system will be used for entrance into emergency shelter, transitional housing, and permanent supportive housing as well as prevention, diversion, and/or rapid rehousing. If properly implemented, system operators will know the entry criteria for all programs and will send people who meet eligibility criteria to an appropriate program. Operators will also be able to accommodate special needs and consumer preferences, wherever possible.

Aside from the requirements established by HUD, there are a number of reasons to consider implementation of coordinated assessment including reducing the burden placed on consumers who are already experiencing a high degree of stress in their lives; improving the speed at which a person or family can be appropriately housed; improving collaboration among service providers; streamlining referrals and ensuring easier access to services; prioritizing and more effectively addressing the needs of hard to serve clients; and improving system performance overall. However**,** there are also a number of challenges associated with the design and implementation this approach including but not limited to lack of available resources; capacity challenges especially related to geography; communication barriers; issues of client non-compliance, safety, and liability; external regulation; and other organizational considerations.

**This document outlines the processes undertaken by representatives from the Erie-Niagara Homeless Continuum of Care to capitalize on opportunities and address concerns in the design of their coordinated assessment process.** This work was undertaken by the Homeless Alliance of Western New York (HAWNY) and included more than forty-five representatives from thirty organizations as well as county-level departments of social services and mental health. Each session included facilitated activities used to illicit feedback from participants. A total of four sessions was completed over a period of two months. Materials generated in these sessions were used to compile this report.

**GUIDING PRINCIPLES**

Prior to beginning their work together, participants established ground rules and a set of guiding principles for coordinated assessment.

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| **GUIDING PRINCIPLES FOR COORDINATED ASSESSMENT**  Efforts should:   * Seek to minimize wait, be easy to use and understand, and focus on positive customer experiences; * Be based on an objective and standardized assessment conducted by well-trained, well-qualified professionals; * Be client-centered and client-driven with a focus on offering services that fit specific needs; and * Ensure the availability and accessibility of holistic services for all clients.   The overall goal is to develop long-term solutions for people in need rather than short term fixes.[[1]](#footnote-1) |

These guiding principles were used to review decision-making during the facilitated sessions. It is recommended that these same guiding principles continue to be used as the project moves toward implementation.

**EARLY ACTIVITIES**

In order to gain a better appreciation of the current homeless system, participants engaged in an activity wherein they mapped each segment of the care continuum from prevention and diversion through to permanent supportive housing. The chart that follows represents key responses from the exercise.

Notably, prevention and diversion services are very limited in the current homeless system. Participants felt that as the coordinated assessment system develops, there will be a need to increase focus on these types of assistance to ensure that necessary homeless housing and services will be available for highest need individuals and families. Participants also discussed the important role that county-level department of social services and mental health will play in coordinated assessment.

At present, the Erie County Department of Social Services determines the eligibility of any individual and/family that secures county funds for shelter services. In addition, the Erie County Department of Mental Health currently operates a single point of entry system that will need to act in concert with coordinated assessment.

Finally, participants stressed that specific consideration must be given to hard to serve populations including domestic violence victims, victims of human trafficking, persons with limited English proficiency, persons with disabling conditions (including senior citizens), sex offenders, arsonists, and recent felons.

Following this activity, participants were asked to identify specific concerns they had with the current system. These issues included lack of awareness about available resources; lack of understanding about the current system; difficulties navigating the system; multiple entryways into the system; inefficiencies in service provision; variable program eligibility criteria; limited capacity resulting in critical gaps in services (especially as it relates to hard to place populations); unequal access to housing for all constituencies (especially rural populations); limited use of real time information technology (e.g., bed lists, resource lists) and lack of overall cohesiveness.

**MAP OF CURRENT HOMELESS SYSTEM**

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| --- | --- | --- | --- | --- | --- |
|  | **Prevention** | **Emergency Shelter** | **Rapid**  **Re-Housing** | **Transitional Housing** | **Permanent Supportive Housing** |
| **How Do People**  **Find Out About Programming?** | Service Providers, Community Centers, Food Pantries, Soup Kitchens, Call Centers, Courts, DSS, Jails | Friends, relatives, Churches, Agency Referrals, Police, Hospitals, DSS, Jail, Hotlines (211 and Crisis Services), Housing Court, Food Pantries, Outreach Workers, American Red Cross, | City Mission, Salvation Army, Matt Urban, Little Portion Friary, St. Luke’s, Word of Mouth, DSS, Haven House, Temple of Christ, Love In, Catholic Charities, Providers, Municipalities, Police Departments, Community Mission, YWCA, Niagara Gospel Missions, Heart, Love & Soul | Religious Organizations, Schools, Jails/Prison, Outpatient Services, Rehabilitation, Agency to Agency Referral, Emergency Shelter, Other supportive Organizations, Word of Mouth, Self-Referral, Health-Related, Shelters | Other/current participants in program; Others linked with output providers or shelters; Care Coordination, Health Homes, Jails, Hospitals, 211 |
| **Current Programming** | Catholic Charities; Erie ESG (narrow focus young moms with kids); HOPWA – Regional Funds through Evergreen, American Red Cross | 12 programs; 449 year round beds; 55 Code Blue beds available 11/15- 3/15 for unsheltered homeless persons on nights where temperature is expected to fall below 20 degrees. | Four Programs: Buffalo (B), Erie (E), Tonawanda (T), & Niagara (N) | Need updated information on number of programs and year round beds (program slots) | Need updated information on number of programs and year round beds (program slots) |
| **How Do People Access Programming?** |  | Hotlines (Crisis Services, 211); Walk-ins, DSS | Program Dependent  B – Primarily shelter referral  E – DSS, Call, Walk-in  T – Catholic Charities  N –Case Manager – Community Mission and YWCA | 211  Referral  On-Site | Referrals is made by anyone (usually counselor, CC) to ECDMH SPOA, Direct referral process for those programs who aren’t liked with SPOA, Self-referrals |
| **Homeless Individuals** |  | Singles more likely to access walk in assistance | B-Matt Urban (Individuals)  Salvation Army (Families)  E –Open to anyone outside Buffalo is preference  T – Individuals, DV  N – Open to all homeless | Specific programs serve only individuals; few serve both individuals and families | No difference in engagement process. Traditional SHPs could house both individuals or families. |
| **Homeless Families** |  | Families more likely to come through DSS or other programs | B- Salvation Army  E –Open to anyone outside Buffalo is preference  T – Families, DV  N- Open to all homeless | Specific programs serve only families; few serve both families and individuals | Individual can come to us as a referral and we found out they are in a family and place them as a family. Traditional SHPs could house both individuals or families. |
| **Special Populations or Considerations** |  | Mental health, Non-English or Limited English Speakers, Refugees, Sex Offenders, Arsonists, Domestic Violence, LGBT, Family Size, Family Dynamics, Physical Disability (Mobility, Self-Care), Active Substance Abuse, Youth who are Unaccompanied | B- Families with school aged children; individuals (35-40 years)  E – Originally Domestic Violence  T = Domestic Violence  N = No targeted sub-populations; re-entry | Parole, Veterans, Sexual Offenders, Domestic Violence, Individuals who are Undocumented | Usually identified by specialty provider – i.e., addictions, mental health, HIV/AIDS, legal and offenders |
| **General Comments** | Importance of homeless-specific prevention and diversion programming; current lack of this type of programming in community (Erie and Niagara); Diversion ensures that those most in need have access to services |  |  |  | Barriers: Pregnancy, medical condition, handicapped accessibility. Availability and long wait-lists; sometimes the definition of homelessness and disability can be a barrier to services. |

Participants were then asked to articulate what improvements they would want to see in a coordinated assessment system. These included flexible access; 24/7 availability; use of a standardized assessment tool; a well-trained, neutral staff to complete assessments; up-to-date resource information; transparency in program criteria; use of a scoring mechanism to determine most appropriate referrals, and evaluation on all aspects of the process.

**COORDINATED ACCESS MODELS**

Systems of coordinated access have a number of essential components including a client engagement process; points of physical access to the system; an application process; a mandatory common assessment tool; use of eligibility criteria for housing and services; referral procedures; an oversight mechanism; and evaluation processes.

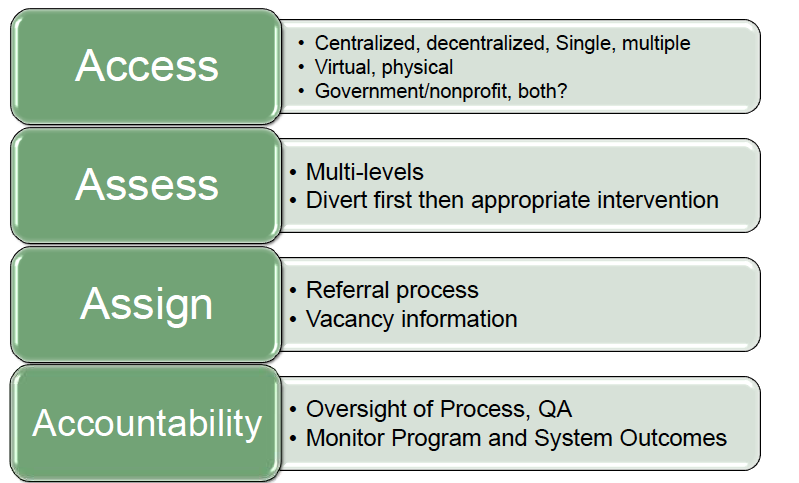
There are five basic models of coordinated access currently in use by care continuums across the United States today including centralized; mixed/hybrid, phone-based; mobile; and decentralized models. These models exist on a continuum from highly structured (Centralized) models to highly unstructured (Decentralized) models. A description of each is provided below.

1. **Centralized** – Clients go to a single, physical location to be “intaked” into the system and to participate in a standardized assessment conducted by a single staff team. Following intake and assessment, clients are referred to the service provider from whom they will receive assistance.
2. **Phone-Based** – Clients participates in system intake and a standardized assessment via a phone-based system. They can call into the phone-system from anywhere in a particular geography. Following intake and assessment, clients are referred to the service provider from whom they will receive assistance. Phone operators also assist with initial client-provider contact.
3. **Mixed/Hybrid** – Clients are able to select from different locations and/or from different modes of assistance (e.g., phone, web-based) to participate in system intake and a standardized assessment. Following intake and assessment, clients are referred to the service provider from whom they will receive assistance.
4. **Mobile** – A mobile case manager comes to the client to complete system intake and a standardized assessment. Following intake and assessment, clients are referred to an appropriate service provider and transported (as needed) to program location. A single team is responsible for all procedures.
5. **Decentralized (also known as “No Wrong Door”)** – Each provider within a care continuum is responsible for system intakes and assessment using a standardized tool. A client can go to any location within the care continuum for initial service. Referral to an appropriate service provider is made through a coordinated system.

Participants were asked to reflect on each of these models and to consider which model(s) best addresses current issues within the homeless system and/or reflect their desires for coordinated assessment. Participants suggested that a hybrid model would likely serve the interests of the local continuum of care – especially if the model included a phone-based component for intake and/or standardized assessment.

Following this, the facilitation team reviewed the coordinated assessment models used by 25-30 communities and selected five communities (Columbus, Ohio; Los Angeles, California; Dayton, Ohio; Omaha, Nebraska; Houston, Texas) to review with the group. Selections were based on the size of the city, size of the homeless population, or unique features that could be beneficial for the local coordinated access approach. This information will be used as part of a straw man activity which compared each model by looking at their approach to access (e.g., type of model used, virtual or physical, governmental, non-governmental, or both); assessment (e.g., use of diversion, levels of intake and assessment); assignment (e.g., referral process, vacancy information; eligibility determination); and accountability (e.g., oversight process; systems and outcome monitoring). This template was developed by the Coalition for the Homeless in Houston, Texas.

**TEMPLATE FOR COORDINATED ASSESSMENT**

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In Columbus, Ohio, coordinated assessment for homeless families is operated through a single downtown location of the YWCA. YWCA staff members are responsible for completing system intake and a standardized assessment tool through the local Homeless Management Information System (HMIS). Initial focus is on identifying opportunities to place families into rapid rehousing or diversion programming. Once intake and assessment is complete, YWCA staff members are responsible for referral to all homeless services through the development of a stabilization plan. The system is overseen by the Community Services Board, which contracts directly with the YWCA. The primary benefit of this system has been to close “side doors” to the homeless system to ensure that families in highest need get immediate and appropriate assistance.

Local participants identified the following strengths in the Columbus model including the use of HMIS for standardized intake and assessment; focus on cost-effective strategies including diversion and rapid rehousing; efforts to complete all intake and assessment activities at one location; and the development of a single point of entry to ensure high need families have ready access to housing and services. Participants also identified some areas of concern related to the ability of a single entity to serve the needs of families throughout an entire care continuum; challenges with accessibility (rooted within a single geographic location); and concerns about program eligibility and the ability to allow for client determination related to program philosophy.

The Los Angeles Coordinated Assessment model incorporates the use of the 2-1-1 phone line as well as six regional solutions centers responsible for addressing the needs of walk-in clients. The 2-1-1 phone line receives referrals from homeless service providers and engages in pre-screening and appointment setting for the solution centers. The six solution centers are located in Antelope Valley, San Gabriel Valley, San Fernando Valley, Downtown, West, and South Los Angeles and include at least two Housing Stability Specialists that provide standardized assessment and coordinated services.

The model calls for staff members to prioritize diversion, rapid rehousing, and use of Section 8 Housing, where possible. An accounting clerk is also available at each of the solution centers to expedite use of these strategies. All homeless housing and service referrals come from the Solution Centers. The system is run by a Program Coordinator who is responsible for ensuring standardized assessment and associated services while also coordinating distribution of Section 8 vouchers to the family solutions centers. The system is monitored through a city/county agency known as the Los Angeles Homeless Services Authority. This body is also responsible for system and outcome evaluation.

Local participants identified two primary strengths in the Los Angeles Coordinated Assessment model including use of greater options for intake and assessment and the ability to book appointments for assessment activities. They also felt that the system was likely expensive to operate and was unlikely to address the need given Los Angeles’s large geography and sizable homeless problem. Participants also expressed concern about the ability to intake, assess, and house participants in the same day.

The coordinated assessment system operating for men, women, youth, and families in the Dayton, Ohio area is operated through four shelter-based locations. Assessment activities include the completion of a common, standardized intake and assessment through the local HMIS system. This assessment is completed for all Homeless services. Staff members refer to centralized waiting lists for rapid rehousing, transitional housing, and permanent supportive housing with established priorities for hard to serve homeless individuals and families. These programs did have the right to decline referrals. County government oversaw the coordinated assessment process with monthly meetings of assessor organizations. Based on these activities, Dayton, Ohio claims that it has eliminated its chronic homelessness problem.

Local participants appreciated that the Dayton, Ohio model has prioritized chronic homelessness and hard to serve populations while using a common intake and assessment in its HMIS. They did, however, express concerns client preference and challenges of capacity. There were also concerns expressed related to the county overseeing a process that it runs from an accountability perspective.

The Omaha, Nebraska coordinated assessment model is physically based in a mall and known as “Home BASE.” There is also an opportunity to call into the 2-1-1 phone line to schedule an appointment or to receive initial assistance through a partner shelter. Comprehensive screening for prevention/diversion, navigation, and emergency shelter and standardized intake takes place through Home BASE with immediate entry into the HMIS. Following screening, clients are referred into diversion or housing with a common assessment undertaken by the provider. Home BASE also maintains a housing interest pool for coordinated referral to streamline the process. Home BASE is a program of Heartland Family Services Program. It won its contract to provide these services through a competitive Request for Proposals (RFP) and works closely with the local homeless coalition.

Local participants were generally less interested in this model as they believed that it was a complex process for clients to navigate and did not have their interests at heart. They also expressed concern about the fact that referral to diversion or housing takes place before a full assessment is completed. As such, it is possible that clients may need to be moved to a different entity to address their needs. Some possible benefits include the ability to enter the system through various points including a shopping mall.

Finally, the Houston, Texas model of coordinated assessment was reviewed. This model is based out of a housing resource center with assessments also conducted by 2-1-1 phone line operators. Additional satellite hubs are also slated to open in the future. The model uses a team approach with participants drawn from the provider community. Each team includes three (3) housing assessors responsible for conducting standardized assessments and two (2) housing navigators responsible for determining housing placements. All client data is entered immediately into HMIS via a common assessment tool. Housing navigators also maintain a housing list (including a waiting list) in the HMIS system for use after a housing determination is made. This assessment to housing process initially took seven (7) days but has been reduced over time. The project is overseen by the Coalition for the Homeless.

Local participants liked the following aspects of the Houston coordinated assessment model – use of a small, centralized team for assessment (especially as address concerns about lack of awareness or resources); engagement of provider community in assessments; 24/7 access to program using the 2-1-1 phone link; linkage to other services outside homeless system via the 2-1-1 phone line; and use of housing specialist and navigator positions. Nevertheless, they felt that seven days was a long time from assessment to housing and there was likely a large underserved population.

**LOCAL COORDINATED ASSESSMENT MODEL**

After reflecting on the models developed in other parts of the country, local participants identified the following as critical to the creation of a coordinated assessment system for the Erie-Niagara care continuum:

* Use a hybrid model (physical location, virtual and phone call center)
* Ensuring clients are housed during intake and assessment period (NYS obligation within 24 hours)
* Efforts to close “side doors” through single access points
* Provide multiple options for assessment location
* 24/7 availability - Using phone call center line and/or web based site for intake and assessment (where possible)
* Allow for appointment setting for intake and assessments
* Use a centralized professional assessment team (using funds from contracts/grant funds)
* Attempt to complete “intake” and “assessment” at one time and/or location (or use pre-screening)
* Incorporate standardized intake and assessment into HMIS
* Prioritize chronic and high needs populations via appropriate use of diversion and rapid rehousing programming
* Regularly updated eligibility criteria, bed list, and list of landlords who have units available
* Allow program philosophy to be incorporated into eligibility criteria (especially for referral process)
* Work to close side doors through closed or controlled access housing lists; shifting eligibility
* Client preference considered in referral decisions
* Care continuum-monitored process (Erie and Niagara)

**DRAFT ERIE-NIAGARA COORDINATED ACCESS MODEL**

Based on this model, participants also developed a list of key questions that must be answered in order to implement the local coordinated assessment model. These questions are included below.

**LOCAL COORDINATED ACCESS: KEY QUESTIONS**

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| **ACCESS** | Role of DSS | * DSS role in coordinated access? * What obligations related to DSS? * DSS must approve eligibility and payment * After hours contract – Crisis Services * How will DSS work with assessment team? * Addressing Niagara County |
| NYS Obligation | * If individual or family is determined to eligible for services, must secure place for them to go that day * Plan for short-term vs. longer-term sheltering * Designate shelters for short-term pre-assessment stays? * Identify funding mechanism to support model * Contingency planning – disaster, crisis, overflow * What do you do when shelter is full – use of private providers? |
| Team: Nature, Structure, Function | * Responsibilities of Team * Qualifications, experience, background of team members, skill sets * Job Descriptions * Composition of team? How many on team? * Costs of Team * Funding of team * Team Selection? * Policies and procedures for team including HMIS Protocols, assessment, eligibility determinations, referral * Training for team * Supervision of team * Liability protection for team * Team Accountability * Evaluation, performance measurement * When will team be available? * Where will team be located? DSS? Satellite locations? * After hours locations? * Who will do what, when and where? |
| **ASSESS** | Intake Process | * Design and use of diversion process – screening tool * How will diversion work? * Development of intake tool * Entry into HMIS system * What happens by whom and when? * Use of telephone intake–how does it work? Can it work? * Appointment setting (for assessment) as part of intake? * Can intake/assessment happen at same time? Is this realistic? * Examine how prevention plays into the system? |
| Assessment Process | * Assessment tool – focus primarily on housing needs/determination * Different assessment for shelter, transitional housing, permanent housing? * Determine special populations (disability, subpopulations) * Use of vulnerability index * What happens by who and when? * Use of telephone assessment – Can it work? how does it work? * Appointments for assessments? |
| Eligibility Determination | * Written standards for shelters, transitional housing, permanent housing * Eligibility criteria for programs * Addressing sanctioning/eligibility * Addressing changing program criteria * Clarity about program options, mission * Incorporation of program philosophy, focus, approach into determination * Eligibility determination process * Standardized scoring mechanism * Client options? * Discussion of client/program right of refusal |

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| **ASSIGN** | HMIS Bed List | * Bed lists up to date: shelter, transitional, permanent supportive * Maintaining bed-lists * Organizational consent – data sharing agreements in HMIS * Electronic referral through HMIS * Non-sharing entities? * HIPPA compliance – no health information in HMIS |
| Program Eligibility | * Handling “banned clients” * Determining whether “right of refusal is appropriate? * How would right of refusal work? * Policies and procedures related to “right of refusal” * Shared risk pool – even distribution of hard to serve clients |
| Referral Process | * Referral process (including special populations) * Approval mechanism – from referral to placement * Payment approvals * Client preference/ Client determination |
| **ACCOUNT** | Advisory Body | * Who answers to whom? * Introduction of Quality Standards * What standards? Whose standards? * Grievance procedures * Checks and balances on referrals * Decline procedure tracking * Tracking declines (by client if possible) * Representation of homeless continuum |
| Evaluation | * Implementation/Formative evaluation of model * Review of intake processes? * Review of team model? Is it working? * Continuous improvement? Creation of feedback loops * Examination of specific processes * Review of diversion processes * Diversion – Readmission (how often does this happen?) * Review of assessment process * Is assessment process working? * Recidivism (who, when, why) * Success of case management, housing specialist * Costs of beds, shelter, funding (Cost benefit) * Evaluation of system * Reductions in numbers of homeless clients over time * Client input into system * Reductions in length of stay; homelessness * What is client satisfaction with the system? |
| Information Usage | * Feedback into decision-making * Current system – unmet needs * Changes in gaps * Adjustments to system * Wider system advocacy (schools, NFTA) |

From this list of questions, a three-month implementation action plan was developed and is available in the final pages of this document. Members of the Homeless Alliance of Western New York (HAWNY) staff will take primary responsibility for a number of the activities included in this plan. This includes commencing conversations with the Erie County Department of Social Services related to their role in the coordinated assessment process; initiating grant writing and fund-raising activities; securing program eligibility criteria and identifying gaps in available services (especially for special populations); securing up-to-date bed-list information; initiating modifications to the local HMIS system (related to intake, assessment, and bed-lists); training new HMIS participants; and securing necessary organizational consents.

In addition to this staff support, four committees of will be formed to assist with activities related to initial implementation of the coordinated assessment model. HAWNY staff members will coordinate committee activities.

## ACCESS COMMITTEE

Responsibilities:

* Establish qualifications for the community-based coordinated assessment team (a group of professions who will be completing intakes and standardized assessments for all homeless clients)
  + Team responsibilities, qualifications, educational or professional backgrounds, skills sets
  + Team member job descriptions, team composition
* Finalizing coordinated assessment team model based on decisions made by HAWNY/Erie County Social Services
* Establishing training, supervision and evaluation protocols for coordinated assessment team
* Developing initial budget for start-up and sustainability plan for use in grant writing and fund-raising activities

### Persons with the following experience are encouraged to participate:

### Program Management

### Program Design

### Human Resource Functions

### Training Development

* Program Budgets
* Grant Writing and/or Fund-raising

### Time Required:

* Available mid-July to early Sep, attend meeting every other week
* Able to review and provide comments through emails or online share documents

## ASSESS COMMITTEE

Responsibilities:

* Develop intake tool for use in coordinated assessment process
* Review and revise the current intake tools
* Incorporate vulnerability assessment (as needed)
* Establish protocols for use of intake tools based on approved coordinated assessment team model
* Finalize the Assessment tools
  + Review and revise the current assessment tools
  + Incorporate vulnerability assessment (as needed)
  + Establish protocols for use of assessment tools based on approved coordinated assessment team model
* Review and revise current written standards based on intake and assessment protocols
* Develop policy on the right of refusal (client /provider) and sanctioning
* Develop a standardized scoring mechanism to determine placement

### Persons with the following experience are encouraged to participate:

### Intake and Assignment Design

### Program Design

* Policy Writing/Organizational Governance
* Rubric Design

### Time Required:

* Available mid-July to late-Sep, attend meeting every other week
* Able to review and provide comments through emails or online share documents

## ASSIGN COMMITTEE

Responsibilities:

* Develop policies and procedures for coordinated assessment referral process including, but not limited to:
* Overall referral process based on approved coordinated assessment model
* Payment approvals
* Incorporation of client choice/client preference
* Right of refusal (client/program) and sanctioning
* “Shared risk pool” concept or incentive model for hardest to serve clients
* Finalize referral policies based on coordinated assessment model

### Persons with the following experience are encouraged to participate:

### Program Design

* Policy Writing/Organizational Governance
* Law or Legal Studies

### Time Required:

* Available mid-Aug to late-Sep, attend meeting every other week
* Able to review and provide comments through emails or online share documents

## ACCOUNT COMMITTEE

Responsibilities:

* Develop oversight policies and processes for coordinated assessment including but not limited to:
  + Goals and purpose of Advisory Board
  + Advisory Board membership characteristics and recruitment
  + Advisory Board meeting schedule
  + Coordinated assessment functionality
  + Grievance procedures
* Develop evaluation process including but not limited to:
* Documentation of oversight policies and processes
* Documentation of evaluation process

### Persons with the following experience are encouraged to participate:

### Program Design

* Policy Writing/Organizational Governance
* Law or Legal Studies
* Research/Evaluation

### Time Required

* Available mid-Aug to late-Sep, attend meeting every other week.
* Able to review and provide comments through emails or online share documents

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| **ACCESS** | | | | | | | | | | | | | | |
| **ACTIVITY** | **June 29th** | **July 6th** | **July 13th** | **July 20th** | **July 27th** | **Aug 3rd** | **Aug 10th** | **Aug 17th** | **Aug 24th** | **Aug 31st** | **Sept 7th** | **Sept 14th** | **Sept 21st** | **Sept 28th** |
| HAWNY Staff reviews and approves coordinated assessment project outline and draft of assessment team model | S |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff secures NYS language regarding shelter obligations | S |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff selects and schedules meeting with key participants from homeless provider community to further develop assessment team model | S |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff initiates conversations with Erie County Department of Social Services (DSS) leadership and staff related to coordinated access (include plan overview and draft model) |  | S | S |  |  |  |  |  |  |  |  |  |  |  |
| ACCESS Committee initiates conversations with provider community regarding development of assessment team model; Review draft model |  | C |  |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff discussions on diversion, after-hours, and disaster-related activities with DSS; Discuss temporary vs. longer term sheltering |  |  | S | S |  |  |  |  |  |  |  |  |  |  |
| ACCESS Committee’s first revision of assessment team model draft to include team responsibilities; qualifications; background of team members; skill sets |  |  | S | C |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff establishes draft protocols for Erie County DSS eligibility determinations and payment protocols; Begin to explore use of phone system |  |  | S | S | S |  |  |  |  |  |  |  |  |  |
| ACCESS Committee’s second revision of assessment team model to include draft job descriptions; team composition; and initial budget |  |  |  |  | S | C |  |  |  |  |  |  |  |  |
| HAWNY staff reviews information on program eligibility from ASSESS Committee; Final determination on Erie County DSS role in coordinated access |  |  |  |  | S | S |  |  |  |  |  |  |  |  |
| ACCESS Committee finalizes assessment team model (DSS decisions and eligibility); Establishes training, supervision, and evaluation protocols |  |  |  |  |  | S | S | C |  |  |  |  |  |  |
| ACCESS Committee develops initial budget and examine potential funding sources for initial start-up phase of coordinated access |  |  |  |  |  |  | S | C |  |  |  |  |  |  |
| ACCESS Committee drafts funding sustainability plan |  |  |  |  |  |  |  |  | S | C | C |  |  |  |
| HAWNY Staff initiates grant activity including grant writing, community engagement, and relationship building |  |  |  |  |  |  |  |  |  |  | S | S | S | S |

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| **ASSESS** | | | | | | | | | | | | | | |
| **ACTIVITY** | **June 29th** | **July 6th** | **July 13th** | **July 20th** | **July 27th** | **Aug 3rd** | **Aug 10th** | **Aug 17th** | **Aug 24th** | **Aug 31st** | **Sept 7th** | **Sept 14th** | **Sept 21st** | **Sept 28th** |
| HAWNY Staff selects and schedules meeting with key participants from homeless provider community to finalize assessment tools | S |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff secures eligibility criteria from programs; Committee reviews current intake and assessment process and instruments currently in use |  | S | S | C |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff develop program eligibility charts; Identifies existing challenges including gaps in services for special populations |  |  | S | S | S |  |  |  |  |  |  |  |  |  |
| HAWNY Staff provides feedback on gaps in services for special populations to DSS for use in finalizing discussions |  |  |  | S | S |  |  |  |  |  |  |  |  |  |
| ASSESS Committee reviews and revises currently available intake tools in light of June feedback; Incorporate vulnerability assessment as needed |  |  |  | S | S | C |  |  |  |  |  |  |  |  |
| ASSESS Committee reviews and revises currently available assessment tool in light of June feedback; Incorporate vulnerability assessment as needed |  |  |  |  | S | C |  |  |  |  |  |  |  |  |
| ASSESS Committee reviews decisions on team assessment model created by ACCESS Committee including current diversion system and screening tools |  |  |  |  |  |  | S | C |  |  |  |  |  |  |
| ASSESS Committee finalizes intake and assessment tools based on approved team assessment model; Establishes protocols for intake and assessment based on approved team assessment model |  |  |  |  |  |  |  | S | S | C |  |  |  |  |
| ASSESS Committee reviews and revises written standards in light of intake and assessment protocols; Drafts eligibility determination process |  |  |  |  |  |  |  |  | S | C |  |  |  |  |
| HAWNY Staff initiates modifications to HMIS system |  |  |  |  |  |  |  |  |  | S | S |  |  |  |
| ASSESS Committee discusses right of refusal (client/provider) and sanctioning; Drafts standardized scoring mechanism to determine placement |  |  |  |  |  |  |  |  |  |  | S | C |  |  |
| HAWNY Staff secure feedback on draft right of refusal and sanctioning policies as well as draft standardized mechanism from ASSIGN Committee |  |  |  |  |  |  |  |  |  |  |  | S | S |  |
| ASSESS Committee finalizes eligibility determination process including policies on right of refusal, sanctioning, and standardized placement mechanism |  |  |  |  |  |  |  |  |  |  |  |  | S | C |

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| **ASSIGN** | | | | | | | | | | | | | | |
| **ACTIVITY** | **June 29th** | **July 6th** | **July 13th** | **July 20th** | **July 27th** | **Aug 3rd** | **Aug 10th** | **Aug 17th** | **Aug 24th** | **Aug 31st** | **Sept 7th** | **Sept 14th** | **Sept 21st** | **Sept 28th** |
| HAWNY Staff secures up-to-date bed-list information from shelters, transitional housing, and permanent supportive housing providers | S | S | S |  |  |  |  |  |  |  |  |  |  |  |
| HAWNY Staff assesses bed-list information included in current HMIS system |  |  | S | S | S |  |  |  |  |  |  |  |  |  |
| HAWNY Staff assesses needed changes to maintain complete bed-lists in HMIS including organizational consent, data sharing, HIPPA |  |  |  | S | S | S |  |  |  |  |  |  |  |  |
| HAWNY Staff initiates work to modify HMIS including securing consents and data sharing agreements |  |  |  |  | S | S |  |  |  |  |  |  |  |  |
| HAWNY Staff identifies new HMIS participants and initiates engagement with organizational leadership |  |  |  |  |  | S | S |  |  |  |  |  |  |  |
| HAWNY Staff selects and schedules meeting with key participants from homeless provider community to discuss referral process |  |  |  |  |  | S | S |  |  |  |  |  |  |  |
| ASSIGN Committee reviews decisions on team assessment model with committee; Initiates discussion on referral process |  |  |  |  |  |  |  | S | C |  |  |  |  |  |
| ASSIGN Committee drafts referral process protocols including payment approvals and client choice/client preference |  |  |  |  |  |  |  |  |  | S | C |  |  |  |
| ASSIGN Committee reviews material on right of refusal and sanctioning from ASSESS Committee as well as draft standardized scoring mechanism |  |  |  |  |  |  |  |  |  |  |  | S | C |  |
| ASSIGN Committee discusses “shared risk pool” or incentive model for hard to serve clients; Drafts policies |  |  |  |  |  |  |  |  |  |  |  | S | C |  |
| ASSIGN Committee finalizes referral process protocols including incentives (if any) |  |  |  |  |  |  |  |  |  |  |  |  | S | C |
| HAWNY Staff initiates training of new HMIS participants |  |  |  |  |  |  |  |  |  |  |  |  | S | S |

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| **ACCOUNT** | | | | | | | | | | | | | | |
| **ACTIVITY** | **June 29th** | **July 6th** | **July 13th** | **July 20th** | **July 27th** | **Aug 3rd** | **Aug 10th** | **Aug 17th** | **Aug 24th** | **Aug 31st** | **Sept 7th** | **Sept 14th** | **Sept 21st** | **Sept 28th** |
| HAWNY Staff selects and schedules meeting with key participants from homeless provider community to discuss advisory committee and evaluation activities | S | S |  |  |  |  |  |  |  |  |  |  |  |  |
| ACCOUNT Committee initiates discussion on goals and purpose of the Advisory Board; Includes membership characteristics; additional recruitment; scheduling |  |  | C | C | C |  |  |  |  |  |  |  |  |  |
| HAWNY Staff recruits additional participants as needed |  |  |  | S | S |  |  |  |  |  |  |  |  |  |
| ACCOUNT Committee establishes initial ideas about necessary protocols for the Advisory Board including functionality and grievance procedures; Documents ideas |  |  |  |  |  | S | C |  |  |  |  |  |  |  |
| ACCOUNT Committee initiates formal discussion on oversight policies and processes especially in light of team assessment model |  |  |  |  |  |  |  | S | C |  |  |  |  |  |
| ACCOUNT Committee initiates formal discussion on evaluation process especially in light of team assessment model |  |  |  |  |  |  |  | S | C |  |  |  |  |  |
| ACCOUNT Committee discusses ideas related to formative and summative evaluation including key processes and metrics |  |  |  |  |  |  |  |  |  | S | C |  |  |  |
| ACCOUNT Committee reviews specific metrics for use in data collection (for use in grant writing and evaluation); Drafts data collection protocols |  |  |  |  |  |  |  |  |  |  |  | S | C |  |
| ACCOUNT Committee finalizes data collection protocols; Documents protocols |  |  |  |  |  |  |  |  |  |  |  | S | C |  |
| ACCOUNT Committee finalizes all Advisory Board policies protocols; Finalizes documentation |  |  |  |  |  |  |  |  |  |  |  |  | S | S |
| HAWNY Staff prepares for initial implementation of coordinated access including initial data collection and oversight |  |  |  |  |  |  |  |  |  |  |  |  | S | S |

1. There was some conversation about including a statement about the provision trauma-informed care within the homeless system as well as a comment about the use of a strengths-based assessment. Ultimately, the group indicated felt that they did not have enough information on trauma-informed care or strengths-based assessment to include these items into the guiding principles. Likewise, the group felt that it would be a good idea not to incorporate a specific strategy or philosophy of care into the guiding principles. Information on trauma-informed care and strengths-based assessment is available through HAWNY. [↑](#footnote-ref-1)