North Dakota Continuum of Care & Coordinated Entry

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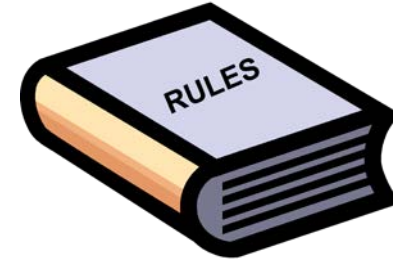
Setting things straight right off the bat…

▶ We're pretty smart, but we're not the tried and true CoC experts

▶ ND is currently seeking a new Collaborative Applicant

▶ HUD has a lot of resources on the HUD Exchange website

▶ Find your friends in other CoCs that are doing this stuff well already and ask them for help!

Definition of COC

- Continuum of Care (CoC) - A group of representatives of relevant organizations that are organized to plan for and provide, as necessary, a system of outreach, engagement, and assessment; emergency shelter; rapid re-housing; transitional housing; permanent supportive housing; and prevention strategies to address the various needs of homeless or at risk of homelessness persons for a specific geographic area.

- CoC Steering Committee - The HUD designated primary decision making group and oversight board of the CoC, made up of representatives from each of the 8 regions, a couple of at-large members and advisory members. We make sure the full CoC has quarterly meetings, oversee our Homeless Management Information System (HMIS) administrator, and develop a homeless response system to meet the needs of people/families/youth experiencing homelessness.
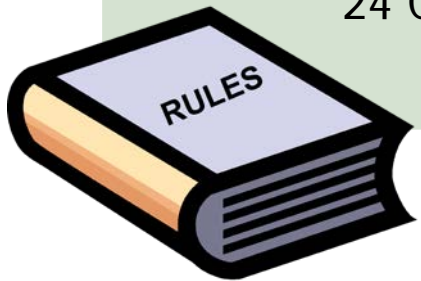
Continuum of Care Interim Rule

- The Continuum of Care Interim Rule says CoCs have to:
  - Plan, coordinate and monitor housing and services for persons who are homeless within the CoC region including operating a coordinated entry system.
  - Set and evaluate how Emergency Solutions Grants (ESG) and CoC funding is used within the CoC geography.
  - Establish & operate a single HMIS (data system) within the CoC geography.

CoC: Terms and Context

CoC Program Interim Rule

- Implements the CoC Program
- Major provisions: how to establish and operate a CoC, how to apply for funds, and how to use the funds

24 CFR Part 578
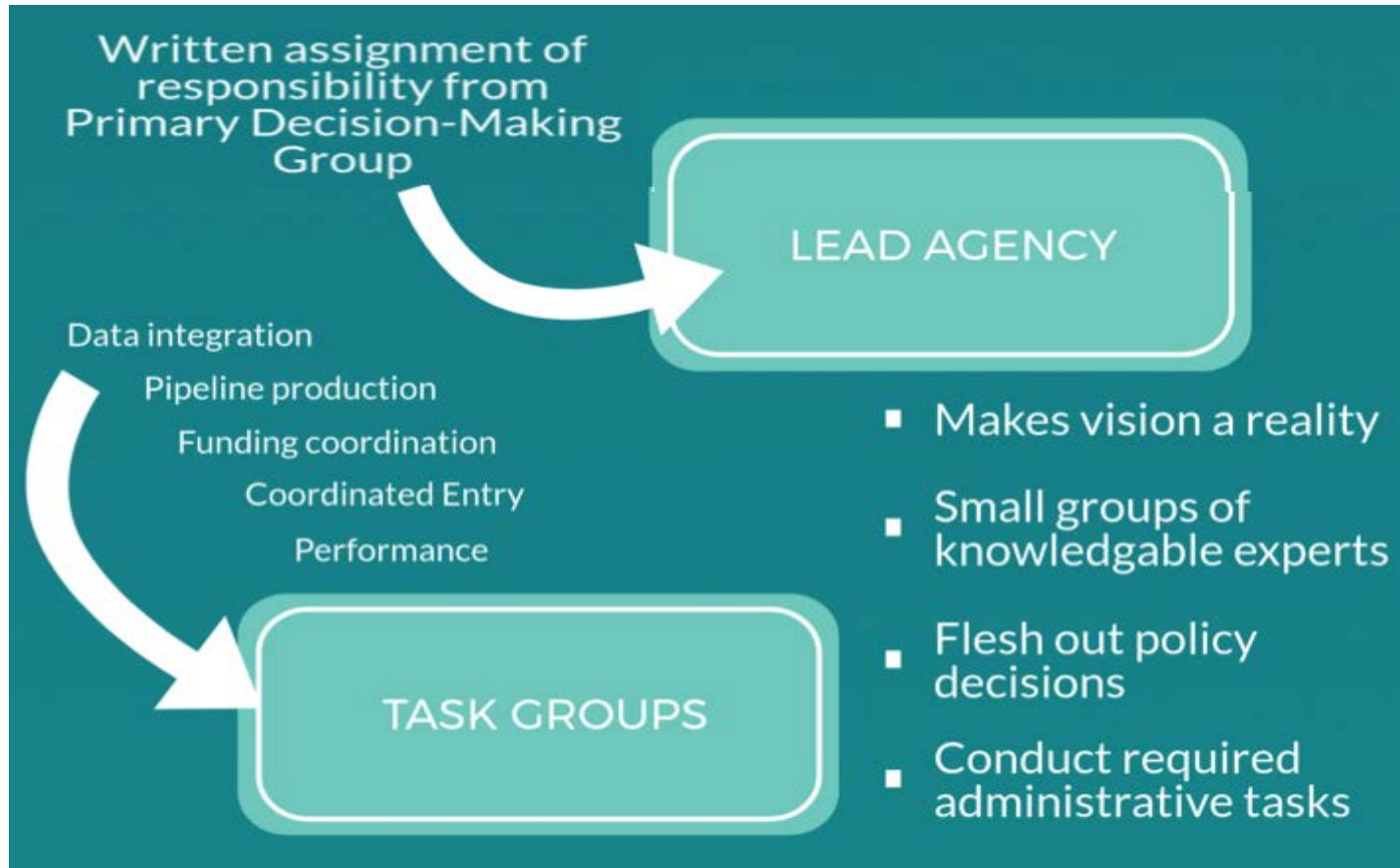
HEARTH Act

CoC Program $

- Funding for:
  * Permanent supportive housing
  * Rapid Rehousing
  * Transitional Housing
  * Support Services (mostly Coordinated Entry)
  * HMIS (data system)

CoC

- Planning body for defined geographic area
- Responsible for establishing and operating a system to prevent and end homelessness for the defined geographic area
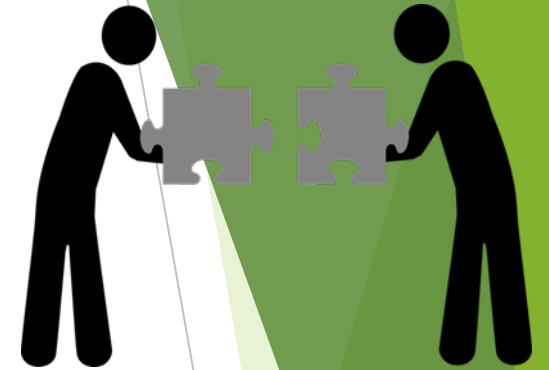
Delegation of Responsibilities

Bringing the Rule to Life

What implementation looks like in North Dakota:

- Cross-sector planning & needs assessment
  - System Coordination including operating a coordinated entry system
  - Point-in-Time Count
  - Annual Gaps Analysis
  - Provide input on funding and decisions for state and local planning processes
- Convene and conduct meetings and trainings
- Establishing, monitoring and evaluating performance targets
- Govern a statewide HMIS with other CoCs and statewide partners
- Apply for CoC funds and coordinate CoC Program funding competition

Who's involved in CoC

Continuum of Care (CoC) includes people who work together at a system level to prevent and end homelessness:

- Nonprofit homeless providers
- Victim service providers
- Faith-based organizations
- Local and state government entities
- Businesses
- Advocates
- Public housing agencies
- Schools/ school districts
- Social service providers

- Mental health agencies
- Hospitals
- Universities
- Affordable housing developers
- Law enforcement
- Organizations that serve homeless and formerly homeless veterans
- Homeless and formerly homeless persons
- You!

Why people get involved in CoC

Push factors: Bring to CoC

- Knowledge about your community or population or program area

- Passion to work together for real change in our community – fewer people who experience homelessness

- Funding resources and personal connections in your community

Pull factors: Get from CoC

- New partners and allies in your area

- Training on best practices and issues

- Access to funding for programs

- Influence on local processes and state/federal resources for housing and service programs

- Support for local initiatives

- Data about community needs and resources

How HUD evaluates CoCs for funding

- **System activities and performance**
  - Data from projects and overall system (outcomes)
  - Standards and procedures
  - Planning, coordination, and outreach
  - Prioritization of highest need households
- **Project performance**
  - Outcomes that affect system performance
  - Alignment with best practices
  - Adherence to HUD and CoC rules
  - Cost effectiveness
- **Project priorities**
  - Need for project
  - Quality of project proposed/implemented

Project performance and quality score

CoC-wide performance and quality score

Continuum of Care is a Team Sport!

- To succeed, CoCs need:
  - Talented and committed players
  - Players building skills for their role
  - Players who play by the rules
  - Unselfish and creative play
  - Strong game plans
  - Helpful coaches and advisors
  - Quality equipment
  - Accurate statistics

Success is measured as a team.

JOIN THE TEAM!

Definition of CARES system

CARES: Coordinated Assessment Referral Evaluation Stabilization System.

CARES works to:

▶ Help simplify and speed the process for people to accurately locate and access needed services;

▶ Help improve the equality and accessibility of services;

▶ Help to ensure that people get the right services;

▶ Save people precious time in looking for and traveling to various service sites or filling out multiple service applications;

▶ Allow staff to focus more on serving clients and less on gathering information and filling out forms;

▶ Support interagency collaboration and coordination around a single process; AND

▶ Improve cost efficiency by replacing duplicative intake and assessment functions with a single approach and data sharing.
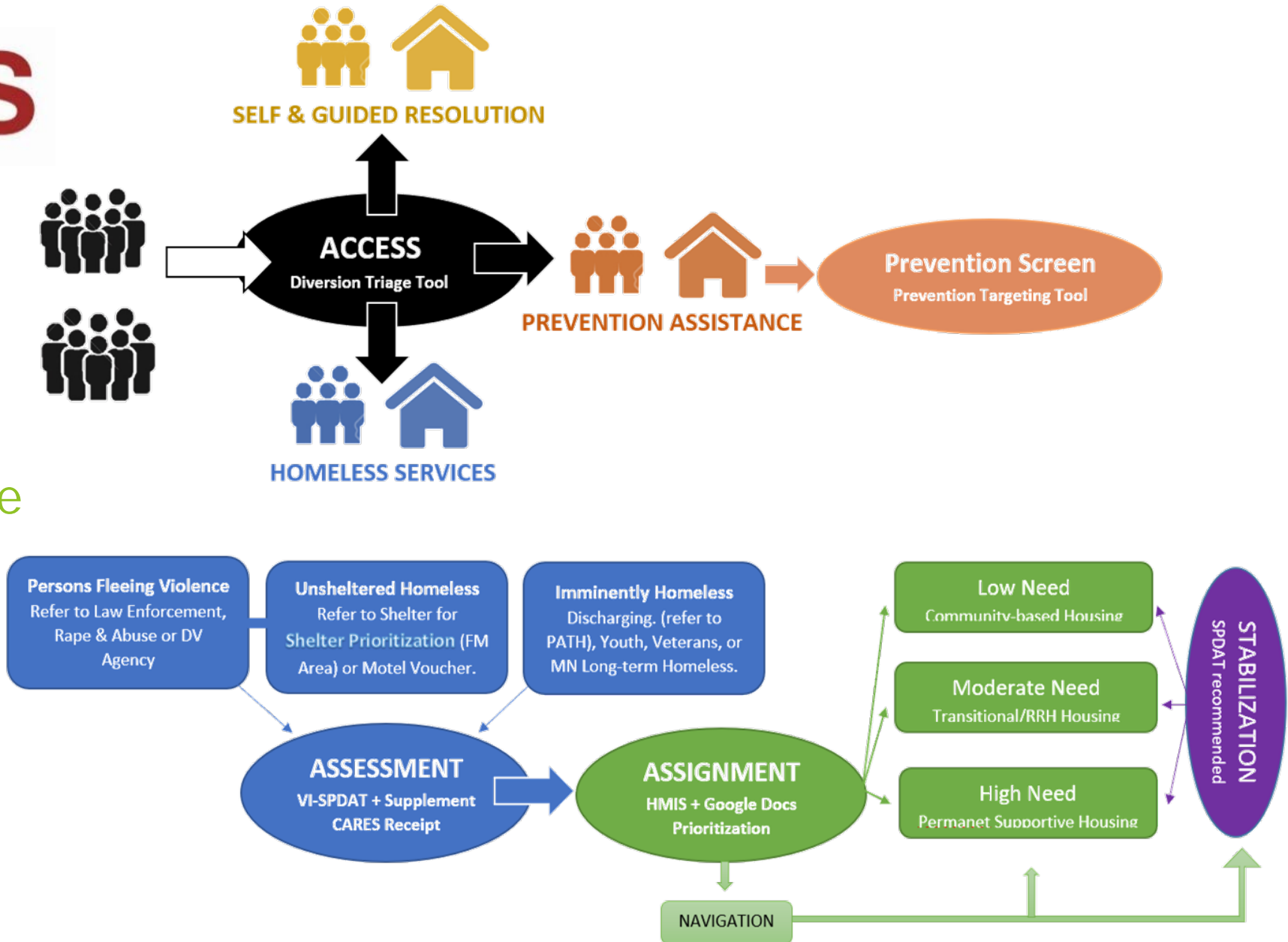
CARES

1. *Reorient service provision*, creating a more <u>client-focused</u> environment.

2. *Identify which strategies are best for each household* based on knowledge of and access to a full array of available services.

3. *Link households to the most appropriate intervention* that will assist the household to resolve their housing crisis.

4. *Provide timely access and appropriate referrals* to housing programs and support services.

5. *Shorten the number of days* between onset or threat of homelessness and access to prevention or re-housing services.

6. *Provide immediate access to information* regarding housing and support services.

7. *Create an advanced system* designed to provide the best client outcomes.

8. *Collaborate when possible* with adjoining Continua of Care and tribal entities.

9. *Provide for ongoing participation* by consumers and stakeholders in the development and evaluation process of coordinated assessment.

10. *Tribal Sovereignty* is acknowledged and honored.

CARES is our Homeless Response System.

ALL stages work together to make our system:
- Access
- Assessment
- Assignment
- Stabilization

CARES

Each stage is important!

ACCESS
- Reduces new entries into homelessness.
- Assures wise use of limited resources.

ASSESSMENT
- Identifies vulnerability in a uniform and non-emotional manner to link to best response.
- Incorporates client choice.
- Provides uniform referral and instructions.

ASSIGNMENT
- Prioritizes most vulnerable and highest users.
- Helps assure wise use of limited resources.
- Helps link persons to most effective response.

STABILIZATION
- Reduces returns to homelessness.
- Makes transition to housing more positive and successful.
- Supports increased & positive linkage to services and increased income.

Tools used in Coordinated Entry

Diversion & Triage tool – a questionnaire that helps divert the person(s) from becoming homeless by finding a safe alternative for them to stay.

Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) - helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention.

Service Prioritization Decision Assistance Tool (SPDAT) - an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.

*A Prevention tool will be created within a year *

Entire System & Entire Geography

CARES needs to be the ONLY way people access homeless services across our entire system!!

- We should have full and equal geographic coverage - GOALS

- We all need to embrace evidence based practices/approaches

- If we're all on-board and moving in the same direction, it works a heckuva lot better

Why HMIS?

▶ A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

▶ It's something that homeless agencies use to coordinate care, manage their operations, and better serve their clients. It's a great way we are able to use the power of technology to help both those experiencing homelessness and the agencies trying to help.

▶ One of the explicit goals of an HMIS is to gain a clearer understanding of the prevalence of homelessness and to track client service needs over time. Understanding the complexities of needs that people experiencing homelessness face, can help plan for a more responsive system of homeless service provision.
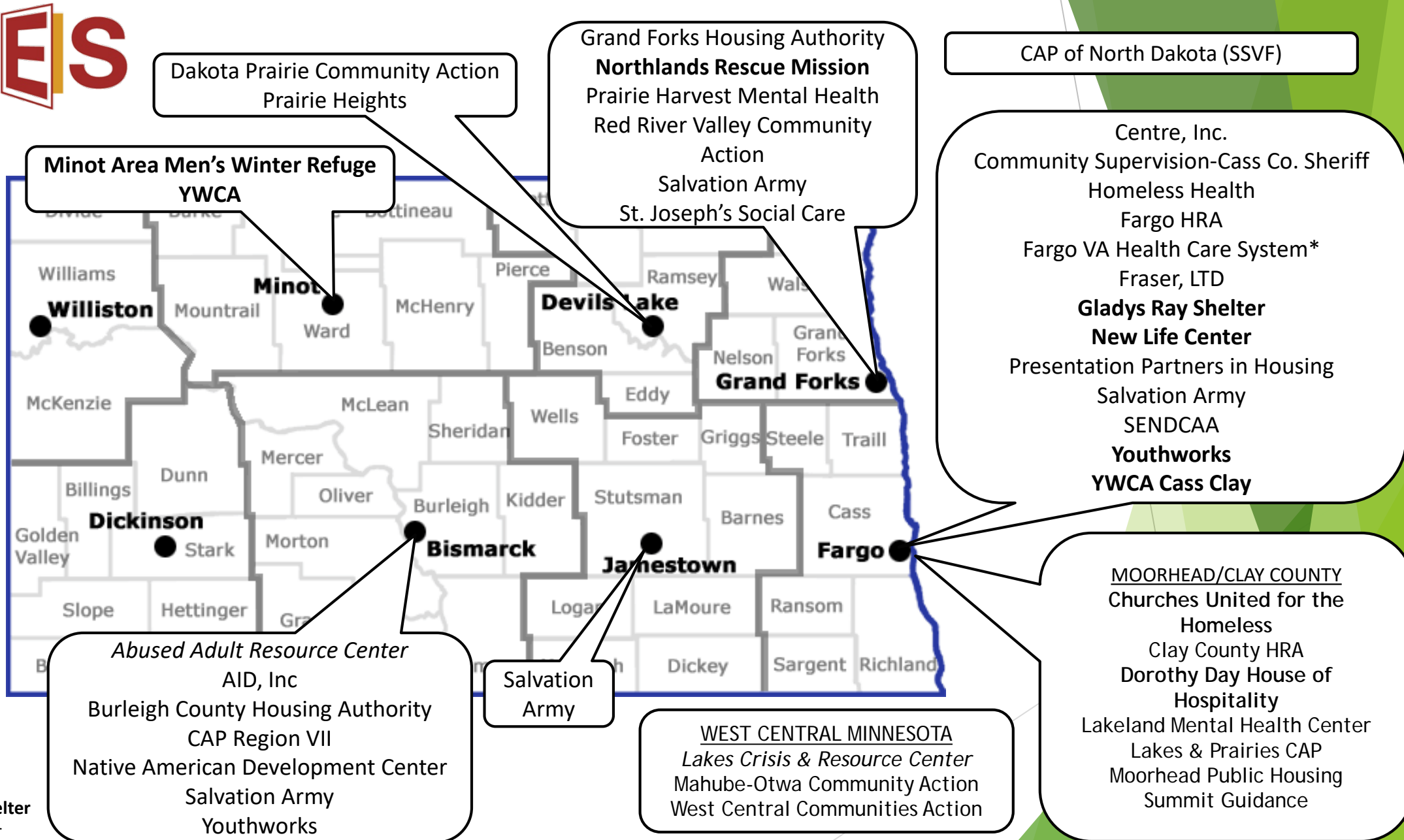
DATA IS IMPORTANT, FRIENDS

Why do we need good data in HMIS?

▶ Congressional Funding

▶ Measures progress toward goals

▶ System Performance Measures make up 60 points of the CoC Program Competition

▶ Used to inform homelessness policy

▶ Foundations, other government entities that provide funding, and other grant programs require/request data

CAR|E|S

Coordinated Assessment Referral Evaluation System

CAP of North Dakota (SSVF)

Dakota Prairie Community Action
Prairie Heights

Grand Forks Housing Authority
Northlands Rescue Mission
Prairie Harvest Mental Health
Red River Valley Community Action
Salvation Army
St. Joseph's Social Care

Minot Area Men's Winter Refuge
YWCA

Centre, Inc.
Community Supervision-Cass Co. Sheriff
Homeless Health
Fargo HRA
Fargo VA Health Care System*
Fraser, LTD
Gladys Ray Shelter
New Life Center
Presentation Partners in Housing
Salvation Army
SENDCAA
Youthworks
YWCA Cass Clay

Abused Adult Resource Center
AID, Inc
Burleigh County Housing Authority
CAP Region VII
Native American Development Center
Salvation Army
Youthworks

Salvation Army

WEST CENTRAL MINNESOTA
Lakes Crisis & Resource Center
Mahube-Otwa Community Action
West Central Communities Action

MOORHEAD/CLAY COUNTY
Churches United for the Homeless
Clay County HRA
Dorothy Day House of Hospitality
Lakeland Mental Health Center
Lakes & Prairies CAP
Moorhead Public Housing
Summit Guidance

*Statewidee Program
Emergency Homeless Shelter
Domestic Violence Shelter

Join & Participate in the CoC

▶ Become a CARES Partner

▶ Must Sign & Follow the Partnership Agreement

  ▶ Have agency Board and Executive Director sign and approve

  ▶ Follow CARES Core Beliefs

▶ Become a member of ND CoC & subscribe to the CARES newsletter

▶ Complete all required trainings, keep updated with trainings

▶ Sign the data sharing agreement

▶ Be aware and engaged in local homeless committees/coalitions

▶ Know the CARES system, help educate community and help connect those to the appropriate resources

How does this work in real life?

- LaGrave on First 42 units of Housing First - Permanent Supportive Housing for individuals who have experienced chronic homelessness

- Opened in August, 2018 and was filled by the end of November, 2018

- Utilize Coordinated Entry and HMIS to fill units!

How does this work in real life?

- ▶ Person presents at an access site (NRM, Spectra, Salvation Army)

- ▶ A VI-SPDAT is completed at an assessment site (same locations)

- ▶ Unit opens at LaGrave on First, next person selected based on score/prioritization policy

How does this work in real life?

- Coordinated entry is for more than just Permanent Supportive Housing, it's for Rapid Re-housing, too.

- RRH rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.

- RRH is an important component of a community's response to homelessness!

What Housing First means

▶ Immediate access to housing with no pre-conditions. Participants don't have to engage unless they want to.

▶ Consumer choice and self-determination – nothing about us without us.

▶ Recovery orientation.

▶ Individualized supports, person-driven.

▶ Social and community integration.

Housing First focuses on

- Finding sustainable housing as soon as possible.

  No such thing as "Housing Ready"

- Providing housing before anything else. Housing is the intervention.

  Allow people the opportunity to engage in voluntary services

- Harm reduction, not treatment or sobriety first.

  This can be a big change for providers

Housing First is not…

▶ A program. It is an approach, system-wide response to homelessness. Requires complete re-orientation.

▶ Contingent upon compliance with the lease. Not a "free pass" to avoid consequences.

▶ Judgmental.

▶ Anything like how things used to be ☺

We're ready to chat with you

- What are your initial thoughts?
    - Does anything seem 'impossible' to do you in your organization/community?
- Are you already doing Coordinated Entry in your community?
- Did you hear anything you have not heard before?
- Who are your partners?
- Who may be a challenge to get on-board?
- Tips/tricks to share?

- Remember, we're all in this *together!*

Resources

- HUD Exchange (hudexchange.info)

- Pathways To Housing, Sam Tsemberis

- YouTube – Principles of Housing First

- Community Solutions, Rosanne Haggerty

- Local and statewide resources – Presentation Partners in Housing, Jan Eliasson from Gladys Ray, and more

- Training available on harm reduction and housing first through Fargo Cass Public Health/CoF Harm Reduction Services

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