Coordinated Assessment & SSVF Integration within your CoC

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2015 National Coalition on Veteran Homelessness Conference – 25 Years
May 27th – May 29th, Washington, D.C.
Technologically Innovative Approaches to SSVF Service Delivery:

*Increased Efficiencies through Integrated Technology Solutions*

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Agenda

- Integrating a Coordinated Assessment Tool with SSVF Program
  - Implementing Policies, Procedures & Compliance
  - Increased Efficiencies through Technologies & Design
Supportive Services for Veteran Families (SSVF)
Central Intake / Coordinated Assessment Introduction

Types:

- **Single Physical Point of Entry** (ex: smaller service area or rural communities w/ large geographic coverage)
- **Decentralized Coordinated Systems** (ex: HUD ESG & CoC grantees)
- **Centralized Hotlines** (ex: 2-1-1’s)

**Central Intake (CI) Methodology - PROCESS Utilizing Coordinated Assessment**

- Provide Prevention or Diversion Services
- Quickly enter into appropriate program and Affordable / Accessible Permanent Housing

**Examples of Areas Impacted:**
- Coordinated Assessment
- SSVF Program Compliance
- VA-HUD-CoC-SSVF Mandatory Reporting Elements (data & narrative)

**COMMUNITY RESOURCES, PARTNER AGENCIES - MOUs**

If there is no internal program available to potentially meet any need of the caller, then make external referral.

**External Resources**

- CSBG – Community Service Block Grant
- ESG – Emergency Solutions Grant
- PATH – Projects for Assistance in Transition from Homelessness

**If some, many or all needs can be met with SSVF and/or internal programs, then complete coordinated assessment and make referral from within the SSVF program.**

**Author:** Cathie L. Hughes © 2015
How Does SSVF Fit Into the Coordinated Assessment System?

- Access to the right program, at the right time
- Opportunities to address homelessness for low-income, high risk veteran families
- Efficiencies through coordinated data collection
- Accurate match of veteran family needs to appropriate & accessible resources
Choosing a Coordinated Assessment Tool

- Scope of Services –
  - Focus on specific need (PTSD, TBI, Sexual Assault) or all veteran families
  - Who are you serving?

- Level of Funding –
  - Eligibility (Screening) Criteria
  - Vulnerability Score vs. Length-of-Time-Homeless (Chronically Homeless)

- Validated and Reliable

- Generalizable to Target Population
Choosing a Coordinated Assessment Tool

- Growth & Expansion Capacity
- Web-based
- Seamlessly Integrated with other tools and technologies
- Compliant with Program Requirements
Building Your Coordinated Assessment & Housing Placement (CAHP) System

• Choose a vendor–
  • Does the system do what you need it to do
  • What is your goal?

• CAHP System Management –
  • Who manages system and data?
  • Who has Access (permissions)?

• Customization and Usefulness

• HMIS Integration – Yes or No?

• Housing Match Function

• Document Storage
25 Cities, Mayor’s Challenge, SSVF, CAHP System, Resources, Collaboration

• Identify and utilize resources available in the CoC & Community
• Targeting & Prioritizing SSVF Resources
• Successfully matching Veterans to appropriate housing
• Currently using the Vi-SPDAT along with the CAHP system to assess and track Veterans’ progress
• Rapid Response System: engage, warm transfer, enroll, house
All Roads Lead to Housing

• Multiple Access Points
• Single determination of placement
• Prioritization
• Access to multiple housing options
• Functional Zero
DOING MORE WITH LESS

WHILE ACHIEVING BETTER OUTCOMES

THROUGH AUTOMATION
MORE > LESS > OUTCOMES

• CASE MANAGEMENT
• DATA
• OUTREACH
• INTEGRATION
• BEST PRACTICES
• REPORTING
CASE MANAGEMENT

MORE       >       LESS       >       OUTCOMES

Interaction   Person-hours

• Reduced Recidivism
• Increased Sustainability
• Greater Independence
• Better Social Network
DATA

MORE > LESS > OUTCOMES

• Collected
• Utilized

• Man-hours
• Capitol expenditures
• Errors

• Data Validation
• Centralized Data Repository
• Improved Accuracy
• Standardization
Integrating the CoC-HMIS With Systems of Care
• Implementing Policies, Procedures and Compliance

SUPPORTING MULTIPLE SSVF PROJECTS ACROSS MULTIPLE CoCs

Provider Tree & ID #’s  SSVF staff are assigned to SSVF-01 or SSVF-02. Staff “Enter Data As” (EDA) based on the (1) SSVF Project Assigned to and (2) for SSVF-02 projects, the region of service.
Connections

• Cost
• Duplication

OUTREACH

MORE       >       LESS       >       OUTCOMES

• Expansion of Partner Network
• Greater Access to Target Population
• Increased Referrals
• Improved Relationship with Primary Supportive Services Providers
• Standardized
Outreach Strategy: 25 Cities

1. Search & Rescue Team
2. Collaborated with existing outreach teams
3. Train community partners on Coordinated Assessment tool
4. Hired Veterans to do Outreach
5. Community Navigator(s)
6. Community Coordinator (CAHP system)
7. Warm transfers and follow-ups
8. Real Estate Professionals – Housing Specialist (Multi-Lingual)
### Outreach Strategy: Rural & Tribal

<table>
<thead>
<tr>
<th>Print:</th>
<th>Electronic:</th>
<th>Visuals:</th>
<th>Personal Contact:</th>
<th>Communication &amp; Services Coordination through:</th>
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| • Rack cards  
• Brochures  
• Fact Sheets  
• Press Releases  
• Referral cards  
• Direct Mailing  
• Feature Articles  
• Flyers | • Videos  
• E-mails  
• Radio Interviews  
• Television/News Interviews  
• Internet:  
• Websites  
• Social Media | • Displays  
• Exhibits  
• Signs  
• Marquees | • Presentations  
• Lectures  
• Meetings  
• Interviews  
• Press Events  
• Conferences  
• Face-to-Face  
• Health Fairs  
• Stand Downs  
• Veteran Events  
• Tribal Leaders  
• Tribal Program Staff  
• Formal Partnership Meetings, Ad Hoc Committees & Working Groups | • Partnerships  
• Cooperative Agreements  
• Chamber of Commerce  
• Landlords/Property Mgrs.  
• VA Systems of Care; Veterans Commission  
• CoC Stakeholders  
• Shelters  
• Transitional Facilities  
• Healthcare Agencies/Programs  
• Hospitals, Clinics, ER's  
• Community Based Services  
• Soup Kitchens, Food Banks, Thrift Stores  
• Tribal Councils |

### Staffing – Outreach Delivery Team

**Community Development & Outreach Department**  
Community Development Specialist & Peer Mentor  
Public Relations Specialist, Employment Specialist, Housing Specialist, Tribal Liaison Case Manager, Outreach Coordinator, VISTA Volunteers
• **Decision Support & Measurement Tools**

**ViSPDAT** – (Vulnerability Index – Service Prioritization Decision Assistance Tool)
- One Time Assessment conducted at Eligibility Determination Intake with EDA into potential program (HP, HP-Light, RR)
- Assesses immediate vulnerability
- Determines what program would be best for participant prioritizes needed services

**SPDAT** – (Service Prioritization Decision Assistance Tool)
- Series of domains – measure individuals on scale of 0-04 – conducted at program intake
- Assesses individual's progress on measured domains over time
- Demonstrates outcomes

**F-SPDAT** – (Family - Service Prioritization Decision Assistance Tool)
- Series of domains – measures households – conducted at program intake
- Assesses family's / household’s progress on measured domains over time
- Demonstrates outcomes

**SSOM** – (Self Sufficiency Outcomes Matrix)
- Series of domains – measures individuals or households – on scale of 0-5 conducted at conducted at Eligibility Determination Intake
- Measures across multiple points in time
- Assesses progress on measured domains over time
- Demonstrates outcomes over time

**Eligibility Assessment – Integration into the SPDAT Family**
- Customized program and service specific criteria with flexible income and assessment requirement options
- Employs commonly used groups of criteria questions as criteria sets for use on other programs or services
- Generates high-quality referrals, improves quality and consistency of referrals
- Increases referral efficiency – provides ability to send multiple referrals to eligible programs and services
Implementing Policies, Procedures and Compliance

ELIGIBILITY DETERMINATION, PVVS, PROGRAM ENTRY WORKFLOW

More Detailed Reporting Required: Continuous Process Improvement

ELIGIBILITY DETERMINATION, PVVS, PROGRAM ENTRY WORKFLOW

More Detailed Reporting Required: Continuous Process Improvement

Tools Used from Coordinated Assessment to ED

- Eligibility Assessment (complete @ CI or w/SSCC)
- SSOM (Self-Sufficiency Outcomes Matrix) – Completed at Initial Meeting w/Case Coordinator; every 30 days after program entry; 12 months after program exit
- Vi-SPDAT – Vulnerability Index – One Time (SSCC Completes)
- F-SPDAT / SPDAT (F=Family) Service Prioritization Decision Assessment Tool (CM Completes)
• Implementing Policies, Procedures and Compliance

Integrating TFA Compliance from Request to Issuing Check
INTEGRATION

MORE > LESS > OUTCOMES

- Collaborative, Coordinated, Systems of Care
- Effort
- Duplication

Partner Networks
Data Consistency
Leveraging Brain Trust
Reducing Fraud, Waste & Abuse
Use of Information Management & Technology Systems for Complete & Comprehensive SSVF Program Implementation

- Case Management
- Program Compliance & QA
- Needs, Services, Referrals
- Temporary Financial Assistance / Funds Management
- Coordinated Assessment
- Publicly Accessible Web based Real-time Resource Database
- Publicly Accessible Landlord / Housing Real-time Database
- Reporting – Mandatory, Program Compliance & for Program Management & Excellent Service Delivery
- 2-way Interactive, mobile phone communications – Case Management, Follow-Up, Compliance, et. al.
BEST PRACTICES

MORE > LESS > OUTCOMES

- Consistency
- Reliable, accessible resources
- Appropriate type and level of service delivery
- Program Compliance
- Scalable

- Effort
- Duplication
- Risk

- Web-based, publicly accessible
  - Housing Inventory
  - Resource Database

- Web-based, HIPPA Compliant HMIS
- Referral Network
- Integrated Temporary Financial Assistance
- Decision Support Assessments (SSOM, SPDAT family)
- 2-way Interactive mobile phone communications- email, SMS, chat
- Social Media
Best Practices

• Housing First Model
• Consistent Engagement
• Marketing:
  • Urban Areas - Billboards, Buses, PSAs
  • Rural Areas – Massive outreach, consistent communication with partners and community stakeholders, chamber of commerce memberships in each community
• Setting and managing expectations
• Creation of a specialized positions
  • Community Coordinator / Community Development Position
  • Employment Specialist, Housing Specialist, Compliance Officer, Follow-Up Specialist, Data Quality Specialist
  • Temporary Financial Assistance (TFA) Accounting
• Key point people at VA, Swords, CoC, Housing Authority, Community Partners
Best Practices

• On-Going Planned Collaboration
• Rewarding Outreach Teams & Case Workers
• Celebrating Success
• Training, training, training!
“Do What You Do Best and Partner for the Rest”

Dr. Westley Clark, SAMSHA

Formal Partnerships
- MOUs
- LOAs
- Contracts
- Grants
- Critical Pathway Providers

Informal Partnerships
- Community Based –
  - Neighborhood Services
  - Stores
  - Faith Based Organizations
  - Volunteers
Continuums of Care
- Connecting People to Resources
  - Appropriate, valid and accessible
- Aligning Resources
  - Across service areas (Housing, Employment, etc.)
  - Specific to Target Populations
    - Veterans, Domestic Violence, Teens Aging Out, Prison Re-entry...
    - Homeless, Prevention
    - Aging, Seniors & Elderly
      - Dementia, Alzheimer’s
      - Elder Abuse
    - Disabilities
      - Physical, Mental, Co-Occurring
      - Transportation
      - Assistive Technologies
    - Full Life Cycle Service Delivery
The Role of Your CoC

IT IS FEDERALLY MANDATED

• WHAT IS A CoC?
• WHAT IS IT’S FUNCTION?
• WHAT IS IT’S BENEFIT?
• HOW DOES IT EFFECT ME?
A framework that involves collaboration across agencies, target populations, and support systems for the purpose of improving access and expanding the array of, coordinated community-based, culturally and linguistically competent services and supports— that are effective, that build on the strengths of individuals, and that address each person's immediate and long(er) term needs.

Systems of care are organized into coordinated networks. And, which are....

- **synchronous** (happen at the same time) &
- **asynchronous** (services & activities occur at different times)

Examples:
- Housing / Homeless – Continuums of Care
- Health Care – Care Transitions
- Children & Families – Wrap-Around

**Guide & tracks consumers over time through a comprehensive array of human, social & healthcare services spanning all levels of intensity of care**
REPORTING

MORE > LESS > OUTCOMES

• Accuracy
• Data
• Decision Making based on results and analytics
• Program Compliance
• Thinking out of the Box – based on needs in YOUR community

• Effort
• Duplication
• Risk

• Outreach
• Finding and serving veteran families
• Eligibility Determination
• Homeless Registry
• Follow up
• Creative Design – Continuous Process & Quality Improvement !!!
Guide & tracks consumers over time through a comprehensive array of human, social & health services spanning all levels of intensity of care

Data Systems, IT, HMIS, Interactive Dialogue Communications (Email, SMS, Voice) Processes

- Facilitates collaborative partnerships, services coordination, & continuums & systems of care
- Web-enabled database for services and providers
- Configurable Assessments support the implementation of workflow and processes design
- Reporting

PARTNERSHIPS

CONTINUUMS & SYSTEMS OF CARE

Homeless Management Information Systems
What We’ve Learned

• Communication is essential

• Setting and managing expectations

• Creation of key positions including Community Coordinator position, Navigator, Housing Specialist, Resource Specialist, Employment Specialist, et. al.

• Key point people at VA, Swords, (grantee agency), CoC, Housing Authority, Community Partners, Landlords/Property Managers, Employers, et. Al.

• Training, training, training!

_________________________________________ (Discussion)
CONGRATULATIONS NEW ORLEANS!!!!!