Coordinated Access for Veteran Households
Policies and Procedures Manual

Contents

Vision Statement

Veterans facing homelessness in Chicago will quickly move into permanent housing through a coordinated process that links them with customized interventions based on individual needs.

This system will:

- Provide low-barrier, low-threshold points of entry that take into consideration transit issues, regional preferences, and other barriers to access experienced by the Veteran populations.
- Be person-centered, as evidenced by a consistent respect for consumer choice, safety, and cultural preferences.
- Be flexible enough to respond to changing needs.
- Utilize a consistent assessment tool across all points of access. The assessment will be made available via multiple methods, such as over-the-phone and in-person.
- Rely on the Homeless Management Information System (HMIS) as a centralized and accurate database that has real-time availability of resources.
- Reduce barriers by increasing program accessibility, limiting restrictive program criteria and turnaways, and focusing on matching the person in need to the right resources.
- Coordinate with other systems of care, locally and regionally,, including but not limited to the health care system, the criminal justice system, and suburban Cook County.

Goals and Guiding Principles

The goal of the coordinated access system for Veterans is to rapidly connect households with previous active military service to appropriate housing interventions based on need. The following guiding principles are utilized to achieve this goal:

Collaboration: Moving away from a program-centric to a system-centric solution to ending Veteran homelessness requires a strong commitment to a team approach. All key partners must work together on behalf of Veterans, ensuring our system-wide response meets the needs of people with varying needs and strengths. This requires clear protocols, transparent decision making processes, and inclusive meetings to work through challenges and review progress.

Communication: Open communication amongst all key partners will aid in building and maintaining a shared action plan to end Veteran homelessness. Additionally, communication with the larger system, through activities like sharing ongoing results and updates will support transparency and provide opportunities to evaluate and improve upon the coordinated access system.

Evidence Based Practice: System implementation decisions will be evidence based, necessitating the need for ongoing, timely, accurate, complete HMIS data entry. This will allow the community to measure outcomes and make decisions to improve quality and effectively target resources.

Housing First: The Chicago system will utilize low-barrier housing options that prioritize connecting people to housing first, before focusing on other stability-related goals. The system will also ensure that these households have access to the supports and services they may need to maintain their housing. This strategy ensures that households with challenges and no income are housed without needing to complete any particular program or achieve specific outcomes prior to accessing housing.

Prioritizing the Most Vulnerable: The process of matching Veterans to resources will center on serving the most vulnerable with the most service intensive interventions by making resources available to those who need them most. The Vulnerability Index (VI) assessment, provider clinical judgment, and progressive engagement strategies will guide prioritization. Veterans who are not immediately connected to an

intervention that meets their needs for capacity or other reasons will be able to transition from one intervention to the next when deemed necessary by having the opportunity to be re-matched to a more appropriate housing intervention through the System Integration Team process.

Urgency: The system will respond to the needs of Veterans experiencing homelessness with the sense of urgency, with consideration for the instability faced by Veterans experiencing homelessness. This will involve a timely processes for assessing, matching, and housing Veterans.

Coordinated Access Overview

Background

In order to standardize access to housing and services, Chicago has established a coordinated access process utilizing one tool that can be administered at a wide variety of locations. This "no wrong door" or decentralized approach aims to quickly identify Veteran households in need of housing and match households to an appropriate intervention. Through a broader community process, the Chicago Continuum of Care has developed recommendations for a coordinated access system for all populations that is in its final developmental stages. The Veteran coordinated access process and broader coordinated access planning body – the Coordinated Access Steering Committee – work to ensure continuity in policy and practice decisions as much as possible.

Chicago is working to meet the federal benchmarks and criteria for ending veteran homelessness.

Structure

TEAMS

Community Team

The Community Team, led by two co-chairs, is composed of staff from emergency shelters, transitional housing, outreach, and housing programs. Any provider is welcome to participate in community team meetings to help shape the direction of coordinated access implementation and create solutions for specific Veterans. This team meets regularly to address areas for system improvement and shall meet no less than once per month.

Two co-chairs serve one year terms that are staggered by six months. This allows for the inclusion of different leaders over time from various types of programs and continuity of leadership. Community team members will be asked to volunteer to serve as a co-chair with consideration for agencies that have not yet had a representative serving as a chair.

Co-chairs are expected to lead Community Team meetings, and must be able to be present to do so for a minimum of 75% of the meetings. They are also expected to channel policy recommendations to the leadership team when appropriate, and to share feedback about implementation of policies with the Leadership Team.

Leadership Team

A leadership team consisting of representatives from the City of Chicago Department of Family and Supportive Services, Housing and Urban Development Regional Office, Jesse Brown VA Medical Center, All Chicago, CSH, Chicago Housing Authority and Supportive Services for Veteran Families meet regularly and oversee the Chicago Ending Veteran Homelessness Initiative (EVHI). This group sets the course for coordinated assessment implementation, is tasked with communicating key decisions, and collaborates with the Community Team for the purpose of seamlessly implementing appropriate protocol and changing the

course when data supports the need to do so. By tracking what needs to be accomplished and how, the Leadership Team positively impacts system level changes.

The leadership team shall communicate their decisions to the Community Team on an ongoing basis, and shall share system changes with the larger system at least once per quarter, either in writing or at an in-person forum.

System Integration Team

This System Integration Team is led by the System Facilitator, CSH, and includes representatives of parties directly implementing the initiative by serving clients. This team's purpose is to ensure that each Veteran household is appropriately served and includes case conferencing on behalf of Veteran households with various challenges. This team shall meet as frequently as once a week and no less than once a month.

COORDINATING ENTITIES

Outreach Coordination

The VA Community Resource and Referral Center (CRRC) will dispatch outreach staff to the location of the Veteran for the purpose of completing an assessment or engaging the Veteran who is not open to or able to visit the CRRC on his or her own.

The Center for Housing and Health (CHH) will connect Veterans in route to permanent supportive housing to an outreach worker in cases when the household will not be able to obtain documents or attend appointments with their housing provider without this support.

System Facilitator

CSH was selected by the Chicago Department of Family and Support Services (DFSS) to staff the Ending Veteran Homelessness Initiative as the System Facilitator. The main functions include managing and coordinating the implementation and operation of the coordinated entry system for Veterans who are experiencing homelessness.

WORK GROUPS

Five work groups were established as part of the Initiative Action Planning process in February, 2016. These groups welcome participation, so please click on the group that is of interest to you to learn more or join the group, including: (1) assessment, (2) Grant and Per Diem, (3) landlord engagement, (4) outreach and (5) homelessness prevention.

All groups meet regularly to make progress on established work plans and will share results with the Community Team in person on a monthly basis. This information will also be shared with the Leadership Team.

Tools

Assessment Tool

The Chicago Continuum of Care determined that the Vulnerability Index will be used as part of the coordinated entry system. This assessment provides separate assessment tools for households of varying ages and sizes. There is one assessment for single adults over the age of twenty-five, one assessment for families with children, and one assessment for single youth between the ages of eighteen and twenty-five. These assessments are included in the Appendix.

Homeless Management Information System

Per HUD, "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. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards." Chicago uses a platform called Service Point that is offered by a vendor named Bowman. All Chicago serves as the CoC's designated HMIS Lead Agency.

One List

A by-name registry called the One List is part of the Homeless Management Information System managed by All Chicago. This list is used to track how many Veteran households are experiencing literal homelessness in Chicago, the programs in which they are currently enrolled (e.g., emergency shelters, transitional housing, outreach affiliations), the permanent housing programs to which they have been matched, and their progress towards permanent housing.

This registry includes both an active list of all Veterans in the process of moving towards permanent housing as well as an inactive list as a way of maintaining data on all Veterans who cannot be found at this time. Veterans are moved from the active to inactive list after providers have searched for 90 days without finding the household.

Once a Veteran household in the Inactive List is identified and reports experiencing homelessness as part of the contact, the household is immediately transferred back to the active list to receive supports in pursing permanent housing.

Initially, Veterans were added to this One List by combining data provided by the Jesse Brown VAMC, the Central Referral System, and HMIS. At this time, Veterans are added to the One List solely through HMIS entry. As Veterans enter and exit the system daily, the One List number fluctuates.

Identifying, Assessing, and Engaging Veterans

Overview

A range of providers will assess Veterans on HMIS using the common assessment and Vulnerability Index for the purpose of connecting Veteran households to housing. These providers include emergency shelters, interim housing programs, outreach teams, the Jesse Brown VA, and Jesse Brown VA's Community Resource and Referral Center (CRRC). Completing an assessment for a Veteran household will enter the household into the Veteran Initiative and trigger the matching process through the One List within one business day.

Assessments

Training

To complete an electronic version of the assessment, staff members who are new users must first be trained on HMIS. Once trained on this system, providers must also complete the Veteran initiative training sponsored by All Chicago prior to having access to enter information into HMIS and view the status of Veterans in the initiative.

HMIS Assessment

The first step in engaging the Veteran in the assessment process is to review the Consent form with this person, answer any questions they have, and ask the Veteran to sign this form so that their assessment answers can be shared for the purpose of housing the household.

Staff will use the "Enter Data as" mode of the EVHI to first search for the Veteran to see if the person has already been matched to a housing provider. If not, the staff member will ask the Veteran to sign a consent form, open a new Veteran Initiative assessment, select assessment type "HUD", and complete the assessment which includes the Vulnerability Index, with the Veteran. Households with children require the Family VI, households 25 and older without children should be assessed with the Individual VI, and those 18-24 years of age without children should complete the Youth VI. Click here to view the full workflow of the Ending Veteran Homelessness Initiative.

Providers working in the field without HMIS access may complete the assessment on paper and then enter it into HMIS within one business day. The three components of the assessment include the consent form, assessment, and appropriate Vulnerability Index.

For Agencies Not Utilizing HMIS
Staff members with agencies not utilizing HMIS can connect a Veteran to a drop-in center location (see page 7 for the full listing), or request an outreach worker come to their location by contacting Laura Otunde at the VA Community Resource and Referral Center (Laura.McGee-Otunde2@va.gov) at the Center for Housing and Health to coordinate a future agreed upon date.

Outreach and Engagement

Outreach to Find Veterans
Coordinated outreach, including DFSS funded outreach partners, PATH, CRRC, Supportive Services for Veteran Families grantees, and other community outreach teams, shall take place on a weekly basis to ensure that eligible households who do not enroll in programs are identified and assessed. The day after a Veteran who is experiencing homelessness is assessed on HMIS, he or she will be included in the One List to be matched to a housing provider.

Assessment Teams
Multi-agency teams will coordinate ongoing assessment events at locations such as shelters, community centers, and food programs using HMIS aggregate data to inform their scheduled locations.

Requesting Outreach Support to Assess a Veteran
In the case where a person who is not trained or is not part of the Veteran Initiative is in communication with a Veteran who is experiencing homelessness, the Veteran can be advised to visit one of the five drop-in centers listed in the following section. If that is not possible, the person encountering the Veteran can call the Community Resource and Referral Center to request that an outreach worker come to the place of the Veteran. The phone number for the CRRC is 312-569-5750 and CRRC is staffed Monday through Friday from 9am – 5pm. Outreach staff may be available on the day requested if the call is placed prior to 2pm.

Refusal to Participate in Assessment
If a Veteran declines the opportunity to complete an assessment and would like to be connected to a housing provider, the staff member who made the request should notify the System Facilitator so that alternate plans can be made. Veterans can be connected to a housing provider outside of HMIS when necessary and the System Facilitator will inform All Chicago of any instances in which this occurs for Veterans who do or do not wish to be identified by name.

For example, if a Veteran meets with an outreach worker and identifies that s/he is willing to speak with a housing provider to learn more about their program but is not willing to complete the Veteran assessment, the outreach worker should contact the System Facilitator. The outreach worker will be connected to a housing provider to offer a warm hand-off, and All Chicago will be notified of a person meeting with a housing provider about an available a housing slot. If the housing provider will move forward with housing

this person, the provider will engage the Veteran to be able to add the Veteran's identifying information to HMIS and to demonstrate the person qualifies for their program.

Engaging Veterans Who Have Been Assessed
Providers can request that an outreach worker be assigned to a Veteran who needs support with attending appointments with their housing provider and/or collecting their needed documents. Requests should be sent to the System Facilitator at any time this is needed.

The System Facilitator will match Veterans to the Center for Housing and Health Outreach within one business day of this request and will follow up with an e-mail to link the involved parties.

The Center for Housing and Health will assign an outreach worker and follow up with this information with two business days if capacity allows, or will notify the provider if there is not capacity this week and the expected timeframe of connecting an outreach worker to the Veteran. Priority will be given to Veterans in the Center for Housing and Health Bridge program, accessing temporary SRO housing while waiting to move into their permanent supportive housing unit.

Ongoing Engagement
Veterans who are experiencing chronic homelessness who decline housing should be engaged at least once every two weeks and offered support in accessing permanent housing. If the person is in a shelter or transitional housing placement, a staff member in their program should follow up with this support. If the Veteran is not enrolled in any program, the Center for Housing and Health will connect an outreach worker to the Veteran. All engagements should be documented in HMIS. If the Veteran cannot be found for a period of 90 days, the person will move to the One List Inactive List and will move back to the One List Active List at their first encounter with a provider.

Drop-In Centers

The following drop-in centers are available to any person who served in the active military who is experiencing homelessness, Monday through Friday, from 9am - 5pm. Appointments are not needed. Veterans should be encouraged to drop in to complete an assessment so that they can be connected to a permanent housing provider if they have not completed an assessment within the last six months.

NORTH

Heartland Health Outreach

4750 N. Sheridan Suite 531, Chicago, 60640

WEST

Community Resource and Referral Center
1141 S. California, Chicago, 606012

OR

Jesse Brown VA Walk-In Clinic

820 S. Damen, HUD VASH Wing of the Damen 8th Floor, Chicago, 606012

DOWNTOWN

Volunteers of America

47 West Polk Street, Suite 250-2, Chicago, 60605

SOUTH

Featherfist
2255 East 75th Street, Chicago, 60649

Matching Veterans to Housing Providers

Matching Protocols

Program Availability
Permanent Supportive Housing Providers must complete an online survey each time a new unit or set of units become available to share program and eligibility criteria. Click here to access the survey.
Note: This survey is managed by All Chicago, and eligibility criteria for each program is added to HMIS for matching purposes.

Rapid Rehousing Providers must share with the System Facilitator the number of matches their programs can accommodate each week. If a provider's capacity changes, *the provider must update the System Facilitator immediately.*

Matching
Veterans who are assessed through HMIS will appear on the One List the following business day. The System Facilitator will match households the first business day that the Veteran appears on the One List to a housing program the household appears to be eligible for based on assessment answers and program criteria.

Veterans experiencing chronic homelessness facing heightened barriers are matched to supportive housing programs in order of their VI score.

Veterans facing limited barriers such as not being impacted by a mental health condition or substance use disorder **and** not experiencing chronic homelessness are matched to rapid rehousing programs.

Veterans matched to rapid rehousing programs who present barriers that suggest they should be progressively engaged will be discussed at System Integration Team meetings. Any provider can bring a case to discuss with the group for the System Integration Team to determine if supportive housing would be more appropriate for the household. Any changes to an original match will be determined by the System Integration Team and documented in meeting logs and HMIS.

Follow Up Protocol
*Please see the Housing Provider Protocols in the Appendix. This document details the follow up protocol, HMIS status updates, Active and Inactive lists, and steps in the process of attempting to find, engage, and house Veterans.

SSVF Real-Time Self Matching Pilot Protocols

Outreach Protocol
SSVF grantees will work together to establish an outreach schedule and will continue to coordinate targeted outreach plans to locate and assess Veterans who are experiencing homelessness. At a minimum, all grantees will conduct targeted outreach once a week. Grantees will participate in EVHI assessment team efforts.

HMIS data on project locations (entries) of Veterans will be shared weekly to support the decision making process of where SSVF grantees will focus their efforts.

Matching Protocol
SSVF grantees will each identify staff members to match appropriate, eligible Veterans to their program. Staff will be trained on self-matching and scoring Vulnerability Index surveys prior to matching Veterans.

The identified staff member will match Veterans to their program by using the following conditions:

- The Veteran meets the agency SSVF eligibility criteria (via the Eligibility Module set up in HMIS)
- Unless the agency is Thresholds, the Veteran does not meet both criteria:
  - Impacted by a mental health condition
  - Under 30% AMI
- The single Veteran who is experiencing chronic homelessness has a VI score of 0 or 1 and does not appear to require supportive housing, and singles who are not experiencing chronic homelessness can have any score if the provider determines the Veteran can be best served by a rapid rehousing intervention
- The family is not experiencing chronic homelessness, has a score of 0 to 5, and appears to be an appropriate fit for a rapid rehousing intervention
    a. All families experiencing chronic homelessness will be matched to supportive housing if capacity allows

If the assessor requires any clarification about when to match the Veteran to their agency, they will contact the System Facilitator with questions.

When the assessor finds that the Veteran is not an appropriate fit or is not eligible for SSVF, they will submit the assessment through HMIS to be matched the following day, following standard protocol.

This process will begin as a 60-day trial period. At the end of 60 days, the Leadership Team and SSVF grantees will determine if the desired outcomes are achieved and whether it should continue until prioritization becomes necessary due to scarce resources. SSVF grantees will share program capacity updates on a quarterly basis or more frequently as needed if the program is nearing capacity.

HMIS Protocol
SSVF staff members will enter all assessments into HMIS the same day they are completed. In cases when the SSVF staff member will self-match, they will complete the self-referral in HMIS and update the need status the same day the assessment is completed."

Provider Follow up Protocol
If the Veteran assessed by an SSVF staff member is not matched to their SSVF program, the System Facilitator will follow up with case manager listed in the assessment and the assessor with the Veteran's housing match.

If the Veteran does not have a case manager or a phone, the assessor (SSVF staff member) will ask the Veteran to follow up with him or her to learn of the housing match and next steps. The System Facilitator will link the assessor and the housing provider as the Veteran is matched. This way, the Veteran will be able to follow up with the person who they completed an assessment with to learn of their housing match in the case when a housing provider cannot reach the Veteran directly. The SSVF provider will maintain contact as best as possible until the connection to the housing provider match is made.

Quality Assurance
The identified staff members will be required to attend a training session on self-matching. This will include learning how to score the single, family and youth Vulnerability Index, reviewing the protocol, and communication expectations.

The System Facilitator will review all of the matches for the first month and will continue to spot check assessments moving forward. The System Facilitator and HMIS staff will develop reports that address potential challenges such as dual enrollment, past TFA assistance, etc.

Matchers will reconvene after the first month of this new practice to discuss challenges and solutions.

The System Facilitator will provide an update to the Leadership Team after the first 30 days of the test period. Members of the Leadership Team, SSVF grantee representatives, the System Facilitator and HMIS staff will meet to review outcomes after the 60 day period.

Re-Matching Protocols

Veteran households who cannot be housed by a program they were matched to through the One List may require, and may be eligible for, a different housing opportunity. In order to make an appropriate re-referral to alternate permanent housing options, providers must indicate the reason the initial program was not possible by selecting the most appropriate status update and including a note in HMIS. Re-referrals will take place through the existing One List matching and referral process, and when necessary, will be discussed as part of the weekly System Integration Team meeting.

HMIS PROTOCOL DESCRIBING WHEN RE-MATCHING CAN/CANNOT OCCUR BY STATUS UPDATE

Declined
This status update refers to Veterans who have declined a housing opportunity, as opposed to Veterans whose housing applications have been denied by a provider. Examples of a need for re-matching could include:

- The Veteran was offered a specific unit and declined the unit, though the household would like assistance with housing
- The household is not willing to work with a specific provider

Follow Up Protocol

Providers who exit a client due to declining housing services will include a note in HMIS in their exit status update to indicate why the client declined with as many details as possible. This will support the re-matching process.

Veterans who decline services who are experiencing chronic homelessness must be engaged every two weeks, either by a program staff member if enrolled in a shelter or interim housing placement, or by an outreach worker if the Veteran is experiencing street homelessness. The Center for Housing and Health will

be notified as Veterans meeting this criteria are identified to connect an outreach worker to this person if one is not already engaging the Veteran.

Veterans who decline housing services due to their goal to utilize a Grant and Per Diem program as a service enriched temporary housing placement will remain on the One List. GPD providers will be asked to notify CSH if the Veteran would like to be reconnected, either to the initial placement or a new housing option if needed.

Exited to Non-Permanent Housing Destination
Veterans who are not housed by a provider can be re-matched to be engaged by an alternate provider.
Example:
A Veteran with great barriers initially matched to a rapid rehousing intervention and exited to a non-permanent housing intervention. **In this case,** the Veteran returns to the One List and the household will be re-matched to a supportive housing intervention if the household qualifies for this type of housing.

Exited, Veteran Enrolled but was Not Actively Engaged
The same protocol will be utilized in this case as is utilized for those who were never enrolled and exited to a non-permanent housing destination.

Ineligible

If a household is not eligible for one intervention, this will result in re-matching if the household is eligible for any other intervention. Reasons for re-matching could include the following:

- Veteran was assessed as experiencing chronic homelessness and does not meet the new chronic homelessness definition, so the household no longer qualifies for this Shelter Plus Care program
- The Veteran is not eligible for a specific unit in a project based program, or does not qualify for the program
- The Veteran has utilized all of the Temporary Financial Assistance that the household is eligible for at this time and cannot be served by SSVF

Follow Up Protocol

The initial provider may be asked to support a warm hand off to the next housing provider when appropriate.

Ineligible for VHA

If a Veteran referred to VASH is not enrolled due to not being eligible for healthcare services at the VA, the Veteran will be re-matched to a community supportive housing program as soon as an opening exists as prioritized by their VI score.

Inactive to Active

When a Veteran who was not encountered for 90 days and moved to the Inactive List is engaged again, he or she will move back to the Active List. If their initial assessment occurred within the last six months, the Veteran will be re-connected to the original provider. If the assessment was completed over six months ago, the Veteran must be re-assessed before being re-matched.

Not Eligible for Re-Matching

Veterans who are doubled up or in any type of housing that makes them not eligible for homeless services will not be re-matched through the One List, though they can be referred to homelessness prevention resources.

Veterans who have signed a lease or live in permanent housing and are temporarily in a shelter or interim housing placement will also not be re-matched.

Housing Veterans

The Chicago Coordinated Entry system screens people in with moderate to high barriers to housing stability. It is a low barrier, person centered, easily accessible, and standardized system. Program eligibility will need to embrace these principles. Housing providers should offer housing first and assist in navigation of long term supports.

Veteran Status Confirmations

Unless otherwise specified, for City funded programs Veterans may have any discharge status and any length of active military service. Proof of Veteran status can be confirmed by the Veteran Repository. The System Facilitator will provide this confirmation to housing providers.

VA-funded programs must verify that the Veteran meets eligibility criteria by reviewing the Veteran's DD214 paperwork. This can be obtained in person at the VA Regional office or through the mail.
For Chicago veterans:

VA Regional office address: 2122 W Taylor Street, Chicago, IL
Phone number: (800) 827-1000
Veterans must go in person to request this assistance.
If the Veteran enlisted in the state of IL and is experiencing homelessness, s/he is eligible to receive his/her DD-214 on the same day as the request.

Requesting a DD-214 through the mail:
Please complete the following steps:

1. Obtain Release of Information
2. Fill out Standard Form 180 http://www.archives.gov/research/order/standard-form-180.pdf
3. Write **"HOMELESS VETERAN"** on the form.
   a. If we want the DD-214 to be returned directly to us, write our fax# on the form or our address
   b. If the veteran wants to receive the form, write PP's address (we usually provide our office address to ensure we can make a copy and give them the original)
4. Fax the completed form to **314-801-9201.**

Housing Inspections

Providers funded by the City of Chicago and/or VA conduct inspections as part of the process of locating safe and sanitary apartments for Veteran households.

HMIS Updates

All providers must update HMIS when a Veteran is housed. This will successfully remove the Veteran from the One List and help Chicago track housing outcomes.

Progressive Engagement

If a Veteran moves into housing that is currently being paid for by a rapid rehousing program, the Veteran continues to be considered as experiencing homelessness solely for the purpose of maintaining eligibility for supportive housing programs. While the person is no longer part of the One List, if a housing provider finds

that this person should be considered for supportive housing as part of the process of attempting to prevent future homelessness, this should be brought to the System Facilitator and discussed as part of the weekly System Integration Team meeting.
In cases when the System Integration Team approves moving a person from a rapid rehousing intervention to a supportive housing program, the household will be matched to HUD VASH with an explanation as to why this is needed if the household is eligible to receive healthcare services from the Jesse Brown VA. If not, the same referral process will be followed for an alternative supportive housing placement in cases where the household meets criteria for a community based supportive housing program.

Landlord Engagement Work Group

This group is made up of housing providers and co-chaired by Regina Freeman-Hodges from the Jesse Brown VA and Johnna Lowe from CSH. This group supports streamlining the process of identifying safe, affordable housing by sharing information about landlords and units while also building new relationships with landlords.

This group meets twice a month and shares information about available units. This group welcomes any Chicago providers who wish to contribute toward building relationships with landlords and/or learn about available housing resources for Veterans.

Evaluation

Feedback from Veterans

Feedback from Veterans is critical to learn how they evaluate the system and what improvements they suggest. Therefore, focus groups must be conducted with Veterans who have and/or are currently experiencing homelessness. This feedback will be used to strengthen the system response and inform planning efforts to deliver better services and align appropriate housing resources based on Veterans' needs.

Veterans will receive an annual satisfaction survey, coordinated by the System Facilitator in partnership with housing providers. The survey will allow for anonymous feedback.

System Evaluation

The leadership and community teams shall meet together quarterly, or more frequently if necessary to review data, evaluate progress, and brainstorm solutions on the topics of reaching and maintaining functional zero and operationalizing coordinated access.

Data

Client level data shall be shared monthly with the Leadership and Community Team. This will assist with transparency of data at the program and agency level without sharing identifying information of Veterans. This will also assist both teams in reviewing lessons learned and will help with the facilitation of discussions about how resources should be used based on current needs.