District of Columbia
Coordinated Assessment and Housing Placement (CAHP)
Policy and Procedures Manual

Overview:

The housing system can feel like a maze for individuals experiencing homelessness. Trying to determine who to talk to, how to get there, and where to begin can seem confusing and overwhelming. Coordinated Assessment and Housing Placement for Single Individuals -- or Coordinated Entry -- establishes a system where housing placement isn't a matter of talking to the right case manager, at the right agency, at the right time.

Instead, Coordinated Assessment and Housing Placement represents standardized access and assessment for all individuals, through a coordinated referral and housing placement process to ensure that people experiencing homelessness receive appropriate assistance with both immediate and long-term housing and service needs. The entire Coordinated Entry process uses a "no wrong door" approach, while doing so through a standardized process from initial engagement to successful housing placement.

In a data-driven and evidence-informed manner, providers across the District of Columbia are establishing strategic partnerships to better serve our fellow community members experiencing homelessness.

Assessment:

More than 45 agencies representing more than 500 staff conduct assessments for the District of Columbia's Coordinated Assessment and Housing Placement system. Providers utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as the common assessment, currently utilized by more than 130 communities nationwide, to screen any single individual experiencing homelessness. (Individuals not identifying themselves as homeless -- residing on the streets, in shelter or transitional housing -- and families do not receive an assessment through this process). The assessment takes approximately 10 minutes to administer, and can be conducted by any provider who has been introduced to the tool through a 30 minute video (or attended a training by its creator, OrgCode Consulting, Inc.) followed by a two hour training on how to record its results within the Homeless Management Information System (HMIS).

All assessors receive standardized messaging so that the assessment process and its results are communicated clearly and consistently across the community. This messaging (see attached "Suggested Coordinated Entry Messaging" form) contains the following components:

- The 10 minute duration of the assessment
- That the assessor will share the recommended housing intervention with the individual who is screened and provide basic information about resources that could be a good fit (see attached "District of Columbia Coordinated Entry System Resource Manual")
- An acknowledgement that there are very few housing resources that are immediately connected to the assessment, so that the primary benefit of completing the assessment is to help determine a better sense of the individual's needs and resources to which they can be referred
- Assessment information will be shared with providers conducting assessments in D.C. and the housing providers connected to the Coordinated Entry system so that the individual does not need to complete the assessment multiple times, that housing providers can identify people to target for housing resources as they come available, and for planning purposes.

If an individual agrees to participate in the coordinated entry process described in its messaging, then they are asked to sign the release of information before proceeding with the assessment.

Release of Information:

The same Release of Information is utilized by all providers to input all Vulnerability Index/Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessments and full SDPAT assessments within the HMIS. It is based on the nationally adopted, HIPAA-compliant Release of Information available on the 100,000 Homes Campaign website at http://100khomes.org/resources/sample-health-information-release, with D.C. specific language to share the results from the VI-SPDAT pre-screen assessment and full SPDAT. It also includes language pertaining to the District of Columbia Mental Health Information Act. It was approved by the Veterans Affairs Central Office, Community Resource and Referral Center, and team leaders from the Coordinated Entry System.

Individuals who do not sign the release of information do not complete the assessment. Individuals who are not able to complete either a VI-SPDAT or full SPDAT may be referred to the Housing Assignment Review Panel.

Universal Registry in HMIS:

Whether the VI-SPDAT is first conducted on paper or directly inputted within HMIS, all VI-SPDAT assessments must be recorded in HMIS within 48 hours of when the information was first collected. At each Coordinated Entry Assessment/Navigation meeting, the results from the universal registry contained in HMIS will be run publicly.

Training:

Ongoing monthly trainings will be posted at www.coordinatedentry.com/training where staff can register for any open "VI-SPDAT Training for Single Individuals" session. The two hour training will include an overview of the Coordinated Assessment and Housing Placement system, the Release of Information, VI-SPDAT assessment and how to record its results within the Homeless Management Information System (HMIS). Additional trainings to address data quality concerns and continuous quality improvement will be offered as needed. To retain HMIS licensure, all staff who have completed training must conduct at least 1 VI-SPDAT assessment per year, and properly record its assessment results within the HMIS. Failure to do so will require an additional "refresher training" prior to re-licensure.

Staff that attend any Case Conferencing meeting or additional meetings in which Protected Health Class Information covered under the HIPAA-compliant Release of Information used in the Coordinated Entry process is discussed must have attended the training outlined above and have signed a User License Agreement prior to attendance.

Please note that additional training is required prior to certification to conduct the SPDAT, or "full SPDAT" assessment.

Housing Navigation:

Each housing navigator will serve as the primary point of contact when a high-priority individual has been matched to housing. The navigator will facilitate meetings between the individual and assigned housing agency and help collect any documentation needed for a voucher. Prior to and throughout the housing assignment process, the navigator may also do regular outreach to an individual in an effort to build rapport with him or her.

To assign housing navigators, the universal registry will be filtered from highest to lowest VI-SPDAT score. Individuals scoring 13+ will be prioritized for housing navigator assignment. Until a volunteer housing navigator system is created and the only available housing navigators are those who currently work for agencies participating in Coordinated Entry, assignment will be prioritized as follows:

1. Agency conducting the VI-SPDAT
2. Additional agency involvement recorded through VI-SPDAT process
3. Agencies that identify relationships with the individual outside of the VI-SPDAT assessment
4. Agencies with housing navigation assessment resources

For housing navigators unable to make contact with the individual following assignment, the individual may be unassigned from that agency through the case conferencing process.

Many high-priority individuals will receive housing navigation services from their Core Service Agency Community Support Workers (CSWs) or other professional or formal sources of support. For high-priority individuals who are not well-connected to community providers and may benefit from flexible peer and other community support, volunteers or peers will provide housing navigation services. A volunteer housing navigation system does not currently exist in D.C., but a peer housing navigator pilot is being designed and expected to be implemented upon receipt of outreach funding dedicated to the Coordinated Entry system, expected in 2015.

Housing Matching Prioritization Process for Permanent Supportive Housing:

The following represents the uniform process to be used across the community for assessing individuals, matching them to an intervention, and within each category, prioritizing placement into housing. This will eliminate the need to complete multiple assessments with individuals, which is burdensome both for the person being assessed and conducting the assessment.

The VI-SPDAT will be the ONLY tool used to assess individuals at the point of entry. The VI-SPDAT scores will be used to triage individuals into the appropriate category of intervention.

For individuals that score 10 or above on the VI-SPDAT, which signals need for permanent supportive housing, individuals will be prioritized based on the following criteria (*only going to the next level as needed to break a tie between two or more individuals*):

1. Medical Vulnerability: The first prioritization criteria will expedite placement into housing for individuals with severe medical needs who are at greater risk of death. This score would be based on questions 22-34 of the VI-SPDAT, with a maximum score of 5.
2. Overall Wellness: The second prioritization factor targets individuals with similar medical needs as criteria number 1, who will be prioritized when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate medical conditions. This score will be based on questions 21 through 50 of the VI-SPDAT (i.e., the "Wellness Domain").
3. Unsheltered Sleeping Location: The third prioritization criteria is the location where the individual sleeps, based on question 13 of the VI-SPDAT. Unsheltered individuals will be given priority over sheltered individuals.
4. Length of Time Homeless: The fourth prioritization factor is the length of time an individual has experienced homelessness, giving priority to the person that has experienced homelessness the longest (based on question 1 of the VI-SPDAT).
5. Date of VI-SPDAT Assessment: The final prioritization criteria will be the date of the individual's assessment, giving priority to the earliest date of assessment.

Housing Matching Prioritization Process for Rapid Rehousing:

Individuals scoring 5-9 on VI-SPDAT and recommended for rapid rehousing who are not SSVF eligible can be referred if they express interest in the program, as described through a standard script. This will explain rapid rehousing as:

- designed to facilitate movement into market rate housing as quickly as possible while providing the support needed to achieve that goal
- assistance that does not provide a voucher
- time-limited support and financial assistance to pay rent so that when the program ends, participants are able to pay the full rent independently. The length of rental assistance and support depends on each person's individual needs.
- financial assistance provided is on a case by case basis

- assistance in identifying and accomplishing other short term goals outside of housing, such as employment, connection to benefits, legal assistance/referrals, personal financial planning services, transportation services, etc.
- able to connect participants with longer term community resources to help maintain housing as well.

Among rapid rehousing referrals, the following process will be used to prioritize for placement:

Based on the quantity of available units, rapid rehousing will be targeted through an equal distribution of VI-SPDAT scores. If 10 rapid rehousing openings become available, 2 individuals scoring 9, 2 individuals scoring 8, 2 individuals scoring 7, 2 individuals scoring 6 and 2 individuals scoring 5 would be referred for placement.

The equal distribution of rapid rehousing placements will prioritize by VI-SPDAT score recommending that intervention. If 3 rapid rehousing openings become available, 1 individual scoring 9, 1 individual scoring 8, and 1 individual scoring 7 would be referred. Similarly, if 11 openings became available, 3 individuals scoring 9 would be referred, with 2 individuals from VI-SPDAT scores of 5 through 8.

For individuals that score 5 through 9 on the VI-SPDAT, which signals need for Rapid Rehousing, individuals will be prioritized based on the following criteria (*only going to the next level as needed to break a tie between two or more individuals*):

1. Date of VI-SPDAT Assessment: The first prioritization criteria will be the date of the individual's assessment, giving priority to the most recent date of assessment.
2. Unsheltered Sleeping Location: The second prioritization criteria is the location where the individual sleeps, based on question 13 of the VI-SPDAT. Unsheltered individuals will be given priority over sheltered individuals.
3. Length of Time Homeless: The third prioritization factor is the length of time an individual has experienced homelessness, giving priority to the person that has experienced homelessness the longest (based on question 1 of the VI-SPDAT).
4. Overall Wellness: The fourth prioritization factor targets individuals with medical needs, who will be prioritized when they have behavioral health conditions or histories of substance use, which may either mask or exacerbate medical conditions. This score will be based on questions 21 through 50 of the VI-SPDAT (i.e., the "Wellness Domain").
5. Medical Vulnerability: The final prioritization criteria will expedite placement into housing for individuals with severe medical needs who are at greater risk of death. This score would be based on questions 22-34 of the VI-SPDAT, with a maximum score of 5.

For veterans served through SSVF, SSVF will continue to prioritize placements from the universal registry for all eligible individuals with military service history recommended for rapid rehousing (scoring 0-9 on VI-SPDAT). Due to the amount of funding currently available for the program, a limited number of direct referrals may be made.

Full SPDAT Process:

To provide a safety net for individuals that are presumed to be highly vulnerable but score too low on the VI-SPDAT to qualify for permanent supportive housing (ie, 9 or below), those individuals would be recommended for full SPDAT assessment.

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT") is an assessment tools looking at the depth or nuances of an issue and the degree to which housing may be impacted.

For those limited instances where an assessor determines that the VI-SPDAT score may warrant a more comprehensive assessment, they may elect to complete a SPDAT. Once the SPDAT has been recorded within HMIS, if the individual scores at least 40, the SPDAT score may be considered along with VI- SPDAT when prioritizing housing navigator assignments and/or housing placement. Those who have received a full SPDAT assessment will periodically be reviewed through the case conferencing and housing match processes.

In the first year of assessments, only 2% of individuals were recommended for a full SPDAT assessment. By allowing for assessors to spend the time to complete this more in-depth analysis, the small set of individuals whose full depth of vulnerability may not be reflected within their VI-SPDAT assessment may still be considered for housing navigator assignments and/or housing placement. In a subset of these very limited instances, it is possible for a full SPDAT to produce different results than the VI-SPDAT because it is a multi-method assessment compared to the self-reported survey of VI-SPDAT.

In instances where individuals have both a full SPDAT and VI-SPDAT assessment, whenever possible, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.

Individuals who are not able to complete either a VI-SPDAT or full SPDAT may be referred to the Housing Assignment Review Panel.

Housing Assignment Review Panel:

The Coordinated Assessment and Housing Placement Community Team, as part of its regular Case Conferencing meetings, will periodically review cases of individuals with high vulnerability (defined below) who are unable or unwilling to complete a VI-SPDAT or SPDAT assessment. The purpose of convening as a review panel is to provide a safety net for individuals where the tool did not reveal the full depth and/or urgency of the situation, not a side door to the process. Assessors/case managers will have to demonstrate professional judgment in this process. Those that repeatedly refer a large percentage of individuals to the review panel may be subject to additional training and/or other measures. A review panel will be used to allow for some element of individual attention and conversation in this process, but at the same time still maintain a uniform, transparent process. The following represent parameters for this review panel:

No more than 5% of placements can be made through the review panel process.

A client MAY be referred the next Community Team Case Conferencing meeting for review if one or more of the following conditions are met:

1. A severe medical condition. For purposes of referral to the review panel, a severe medical condition is defined as:

    a. End Stage Renal Disease or Dialysis
    b. End-State Liver Disease or Cirrhosis
    c. History of Frostbite, Hypothermia, or Immersion Foot
    d. HIV/AIDS
    e. Congestive Heart Failure
    f. Cancer
    g. Diabetes

2. <u>A severe mental health condition</u>. This may either be diagnosed or observed by the assessor/case manager/outreach worker. This may include suicidal ideation or attempts.
3. <u>Evidence of self-neglect</u>. Observation by the assessor/case manager/outreach worker is sufficient to meet this condition.
4. <u>Old age</u>. The individual is 65 years of age or older.

It is important to note that a client may be referred to the review panel for any of these reasons *regardless of whether the individual participated in the VI-SPDAT or SPDAT process*. It is also important to note that these criteria will be reevaluated on an ongoing basis.

The review panel process will be person-centric, not program-centric (i.e., the end result will not always be PSH placement, but rather to match a highly vulnerable person to the appropriate housing resource). For example, an individual with extreme medical needs may be referred to the review panel because he/she is

at risk of dying, but if only a housing subsidy is needed (without intensive wraparound services), the individual should not be placed in PSH but rather prioritized for an intervention such as Section 8 or a Local Rent Supplement Program (LRSP) voucher.

The only guarantee related to the review panel process is that the individual will receive a review. Not all cases will have immediate placement. In some instances, the review panel may determine that the initial score and position on the registry is correct given the severity of other cases. In other situations, the review panel may determine that a higher score is warranted, though immediate placement is still not feasible. In still other situations, the review panel may determine that immediate placement is needed to reduce risk of death.

Housing Providers:

Organizations that provide housing to those experiencing homelessness and would like to dedicate all or some of their housing vacancies to coordinated entry follow the process outlined below:

1. Identify if the housing is permanent supportive housing, rapid rehousing, or affordable/one-time assistance housing. All housing must be permanent.

2. The Housing Provider will fill out the eligibility requirements for each of their programs that they will be dedicating to the coordinated entry process. See (see attached "District of Columbia Coordinated Entry Housing Inventory Form")

3. The Housing Provider will notify the Coordinated Entry Community Leadership Team when they have open and currently available housing inventory.

4. The Housing Provider commits to following the Housing Matching Prioritization Process for Permanent Supportive Housing and Rapid Rehousing.

5. The matches will be made live in coordinated entry meetings where a Housing Provider can chose to be present or receive referrals following the meeting via email. A Housing Provider will receive three matches for every one opening/vacancy they have. This is to promote choice on behalf of both the individual referred and the Housing Provider. Matches will be made by the Leadership Team in HMIS for individuals to be referred to each Housing Provider.

6. Upon receiving the referrals, the Housing Provider first contacts the Housing Navigator, followed by the Assessor to coordinate contact with the individual and set up intake appointments.

7. The Housing Provider commits to working with the Navigator/Assessor to locate the individual and engage with them to see if the housing referral provides a good match.

8. The Housing Provider commits to communicating with the Community Leadership Team when each match does not lead to successful program entry and providing reason(s) why they were not housed so that the individual can be unassigned from the Housing Provider in HMIS.

9. The Housing Provider commits to communicating with the Community Leadership Team when each match does lead to successful program entry and providing the date the individual moves into housing.