

VHA Homeless Program Office

VA'S ROLE IN COORDINATED ENTRY AND COMMUNITY ENGAGEMENT

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Topics

1. National Progress to Date
2. Coordinated Entry Core Concepts
3. Overview of Coordinated Entry Requirements
4. Overview of the Coordinated Entry Specialist Positions
5. Partnering with VA
6. Question & Answer



Opening Remarks

- Guidance reflects a year-long process.
- Incorporates input from NHCs, VAMCs, and Federal Partners.
- Appreciative of past and current work.
- Sense of urgency and also ongoing process of continuous learning.
- Strengths and collective knowledge.
- Deep level of collaboration.
- Strategic use of resources.
- Coordinated Entry is a system change where VA is a critical partner.



What We Have Accomplished Together

- 140 VA Medical Centers coordinating with approximately 400 CoCs in a very intentional way.
- Understanding of the dynamics of complex areas like rural geography and Balance of States.
- At least 2 white papers and over 20 webinars and new training materials with VAMCs and community partners.
- Specific tools like CoC to VAMC crosswalks and the HUD-VASH CES FAQs.
- Keeping CES at the forefront of conversation with internal and external partners, at all levels of leadership.
- Working diligently to get it right: consults with over 100 communities/VAMC partnerships.
- Peer learning and sharing on a variety of topics that has directly enhanced our collective knowledge.



CES 101

COORDINATED ENTRY SYSTEM (CES) CORE CONCEPTS



What is Coordinated Entry?

An approach to *coordination* and *management* of a crisis response system's *resources* that allows users to make *consistent decisions* from available information to efficiently and effectively *connect* people to *interventions* that will rapidly *end* their homelessness.



Why Coordinated Entry?

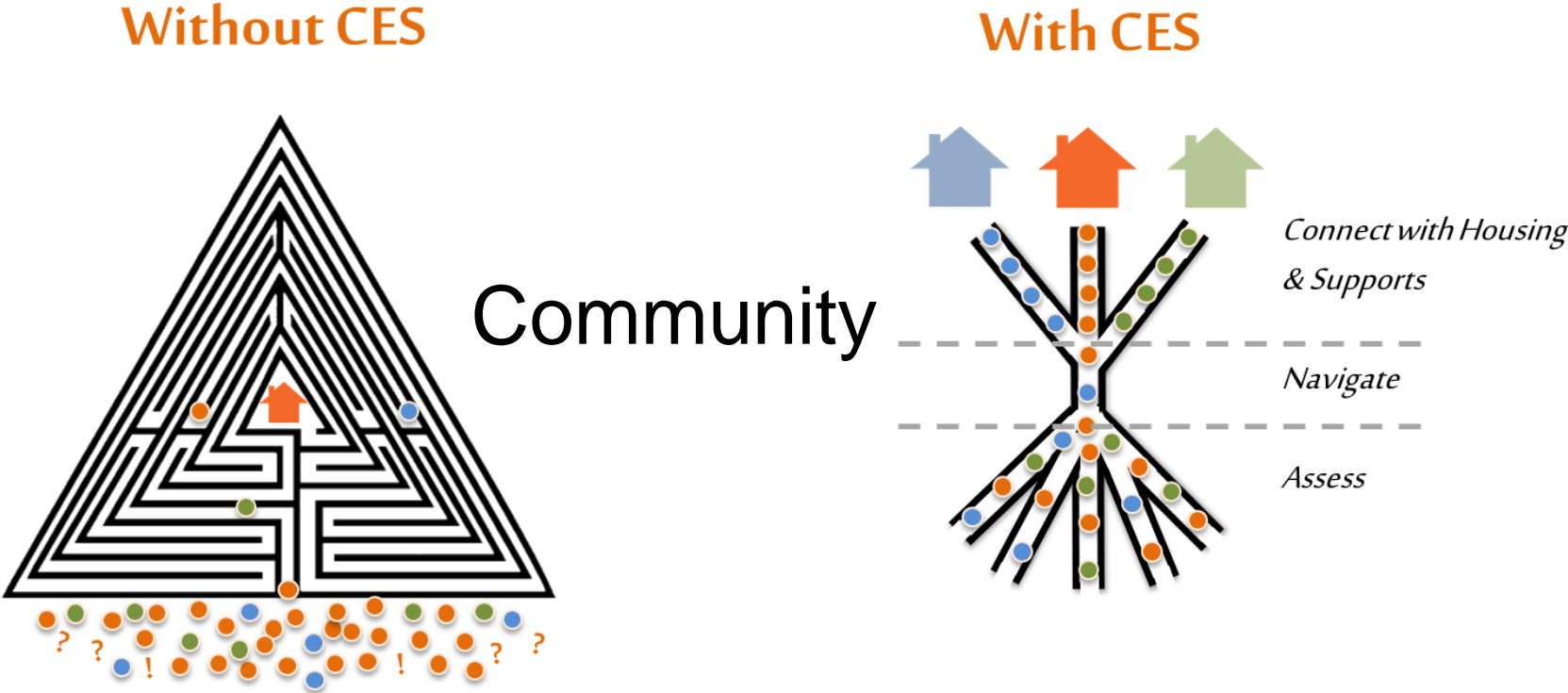


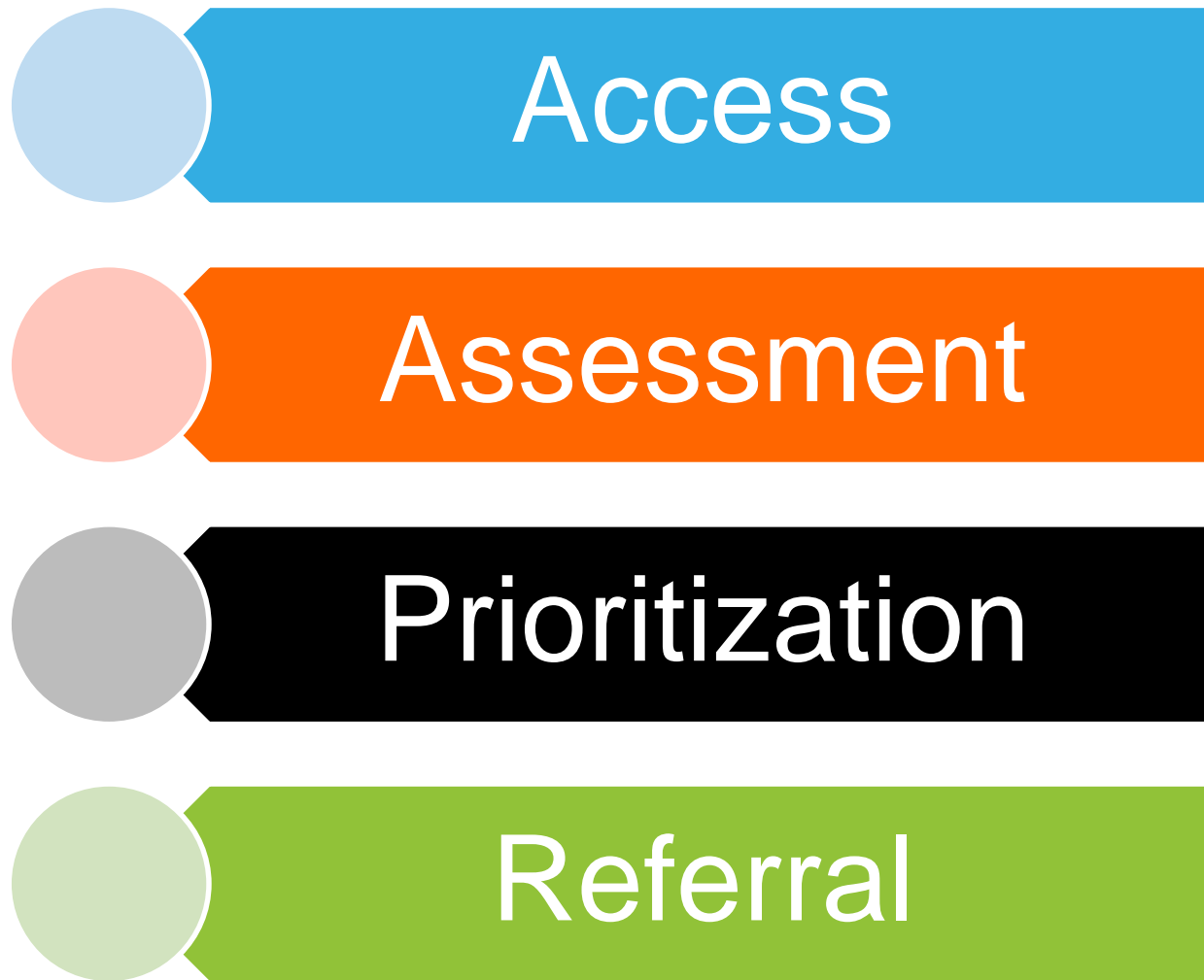
Image : Chris Ko, United Way of Greater Los Angeles



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Components of Coordinated Entry



Before and After CES

Before CES

Should we accept this person into our program?

- Different forms and assessments.
- Program-specific decision-making.
- Ad-hoc referral process between programs within CoC geography.
- Uneven knowledge about available housing and services within the CoC geography.

Program-centric

After CES

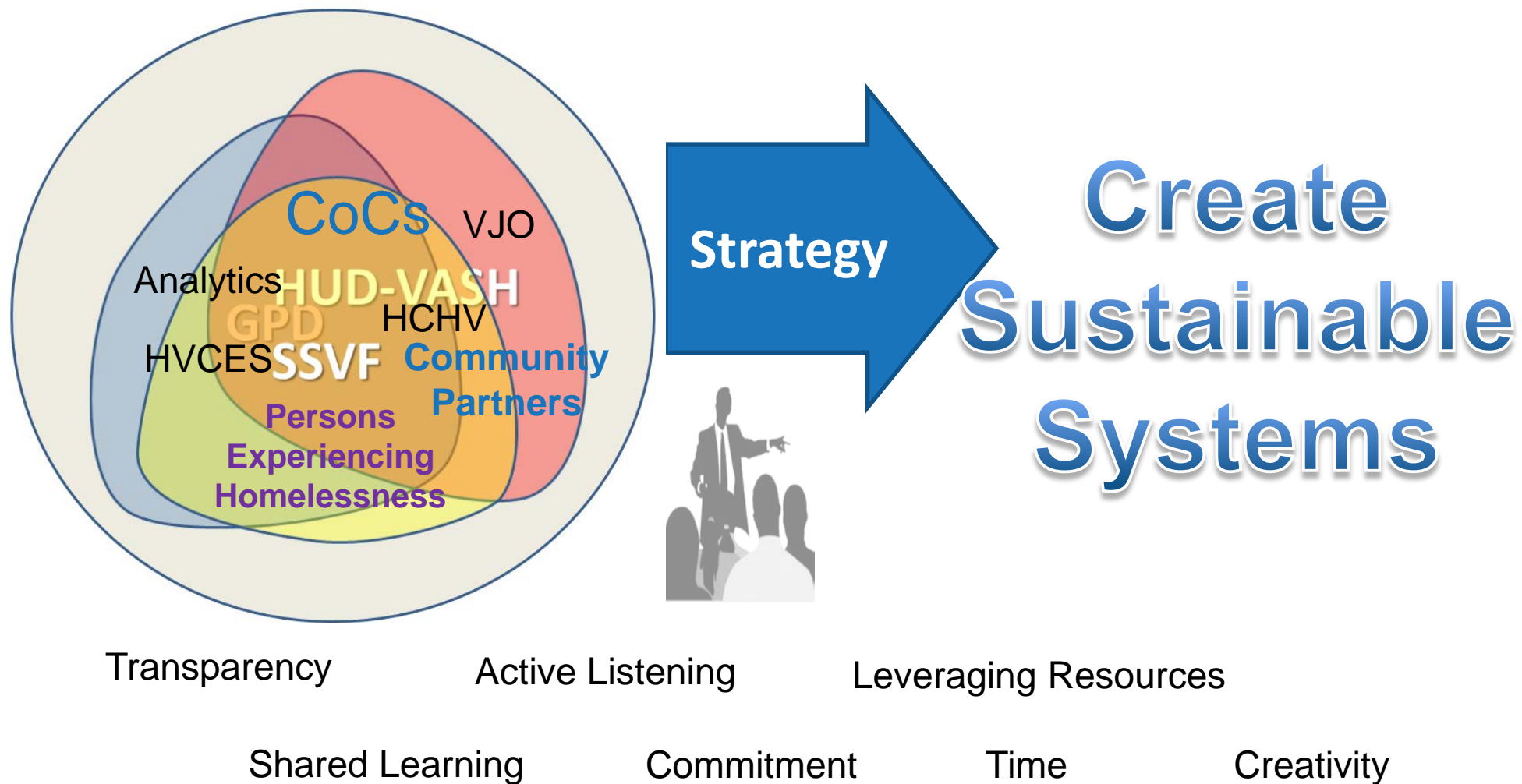
Of all of the housing/service strategies available, what would be the best to help this household?

- Standard forms used by every program.
- Community agreement on how to triage based on household's needs.
- Coordinated referral process across the CoC geography based on written standards for administering assistance.

Person-centric



VA, CoC, Stakeholders, and Partners Working Together



Source: Slide Adapted
from Ken Mueller



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VHA Deputy Undersecretary for Health Operations and Management
(DUSHOM) Memorandum

OVERVIEW OF COORDINATED ENTRY REQUIREMENTS



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DUSHOM Memo

- Memo outlining expectations for VA Medical Center staff and VA funded housing and services programs for Veterans experiencing homelessness released October 17, 2017.
- Available through the HUD Exchange:
<https://www.hudexchange.info/resources/documents/VA-Participation-in-Coordinated-Entry-Guidance.pdf>

Department of Veterans Affairs

Memorandum

Date: OCT 17 2017

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: VA Medical Center Participation in the Continuums of Care Coordinated Entry System (VAIQ#7844648)

To: Network Director (10N1-23)

1. The purpose of this memorandum is to issue guidance regarding the roles and responsibilities of the Department of Veterans Affairs (VA) VA medical centers (VAMC) homeless programs in each of their local Continuums of Care (CoC) and the CoC's coordinated entry systems. VA's Federal partner, the Department of Housing and Urban Development (HUD), requires that all communities develop and operate a coordinated entry system (CES) for all homeless individuals, including Veterans. CES is a critical element in our continued efforts to end Veteran homelessness because it ensures coordination of community-wide services for Veterans experiencing homelessness, system-wide awareness of the availability of housing and services, and easy access to and appropriate prioritization for these resources by Veterans who are in critical need. VA's participation is essential to the success of this national effort. There are several key components to a fully-developed CES: case conferencing, By-Name-Lists (BNL), assessment tools, and data sharing.

2. The CoC framework is designed to promote a community-wide commitment to the goal of ending homelessness, including Veteran homelessness, making local VA support and participation essential to the CoC process. The Veterans Health Administration (VHA) Homeless Program Office requires all VAMC homeless programs to be fully engaged with each of their local CoCs and actively collaborate in their collective plans to end Veteran Homelessness.

3. Community case conferencing is one key element essential to an efficient coordinated entry process. Each VAMC's homeless program team is required to actively participate in person or through conference calls in the case conferencing meetings taking place amongst the community partners within their local CoCs. Specifically, each VAMC homeless program team is required to assign at least one staff person to consistently attend the CoC case conferencing meetings and act as a bridge of communication between the CoC providers and the VHA homeless program.



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Overview of DUSHOM Memo

- **Background:**

- HUD requires all communities develop and operate a coordinated entry system (CES) for all homeless individuals, including Veterans.
- CES is a critical element in our work to end Veteran homelessness.
- VA's participation in their local CES is essential to this national effort.
- The DUSHOM memo outlines the expectations for VAMC participation.

- **Purpose of the guidance:**

- Establish the roles and responsibilities of VAMCS in each of their CoCs and the CoC's CES.
- Establish expectations on VAMC's participation in several key components of a fully-developed CES: case conferencing, by-name-lists, assessment tools, dedication of VA resources, and data sharing.

Policy

- Engagement and Active Collaboration with CoC on Their Collective Plans to End Veteran Homelessness
- Community Case Conferencing Participation
- By-Name List Participation
- Utilization of Assessment Tool
- Dedication of VA Resources to CES
- Data Sharing



Assessment and Planning of Continuum of Care Activities

COMMUNITY PLANNING AND CASE CONFERENCING POINTS OF CONTACT



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VA Partnership with CoC Boards and Board Activities Requirements

- Policy requires all VAMC homeless programs to be fully engaged with each of their local CoCs.
- At a minimum, this means participating in a formal decision-making body on decisions that impact Veteran homelessness.
- Per VA Legal Counsel, VHA employees are legally permitted to participate and serve on CoC boards. This includes participating fully in the role of a CoC board member.
- This POC should have decision-making authority as it relates to the VA's ability to coordinate housing and services for homeless Veterans with that CoC and also assumes responsibility for communicating CoC goals and priorities to VA leadership.



Participation in Community Case Conferencing Requirements

- Successful coordinated entry systems are supported by consistent, inclusive community case conferencing meetings.
- Case conferencing allows for case coordination and problem-solving to occur with all community partners who are serving Veterans experiencing homelessness in that community.
- Case conferencing also provides an opportunity for the community to collectively make service prioritization decisions.
- VAMCs must have at least one person assigned to participate consistently in each CoC's case conferencing meetings.
- This POC is expected to be the bridge of communication and have decision-making authority regarding housing options.
- This POC is expected to come prepared to each case conference meeting with the most current client information allowable to share per Routine Use #30 and other relevant privacy guidance.



Key Components of Effective Case Conferencing

- **Case Conferencing Goals**

1. Ensure **holistic, coordinated, and integrated** assistance across providers for all Veterans experiencing homelessness in the community.
2. **Review progress and barriers** related to each Veteran's housing goal.
3. **Identify and track systemic barriers** and strategize solutions across multiple providers.
4. **Clarify roles** and responsibilities and **reduce duplication** of services.

- **Client-Level Reviews:**

- Current Status
- Veterans Preferences
- Critical Housing Placement Barriers
- Critical Service Barriers
- Current Safety
- Next Steps

- **Tips for Management and Facilitation**

- Facilitators should ideally be able to keep the group on task while guiding solution-based discussions.
- Ask probing but respectful questions to promote efficient coordinators among attendees. For example: *"It looks like the Veteran signed a lease last month, but is still staying in a shelter. Is there anything this group can do to help expediate move-in?"*
- Foster the group dynamic by asking for feedback. If there is a need to change process or procedures, at the topic to the agenda for discussion.

By-Name-List (BNL) Maintenance

WHAT ARE BNLS, KEY DATA ELEMENTS, MAKING A QUALITY BY NAME LIST, ENSURING BALANCED DATA, AND ASSESSMENT QUESTIONS FOR COVERAGE



Participation in By-Name Lists (BNLs)

- BNL is defined as a real-time, up-to-date list of all veterans experiencing homelessness in a given community.
- Utilizing a BNL allows communities to know each homeless Veteran by name, while also facilitating timely decisions around how to best assist them with available resources.
- Where a CoC has an established BNL, VAMCs must actively participate in its maintenance.
- This may include (but is not limited to) updating current housing or homelessness status, current program enrollment status, VA eligibility status, initial identification date, most recent contact date, and pending case management issues as appropriate.



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By-Name-Lists (BNLs) and Homeless Systems Data

- A BNL is an excellent source of data for evaluating the performance of your homeless service system.
- Not only does it track all known homeless Veterans and helps match them to services, but it can also be used to provide insights on:
 - How many Veterans are homeless in your community each month.
 - How many Veterans enter the homeless system each month.
 - How many Veterans exit homelessness each month.
- All of this can be done as close to “real-time” as possible.



Requirements for By-Name-Lists Per the Criteria and Benchmarks

“...communities must have comprehensive data systems and processes for keeping track of Veterans identified as experiencing homelessness and for documenting exits from homelessness, typically captured through an “active,” “by-name,” or “master” list.

Your community’s active list must identify **all homeless Veterans**, including those who are in unsheltered and sheltered locations (i.e., transitional housing, emergency shelter, and Safe Haven), regardless of funding source. Veterans who have entered any permanent housing destination do not need to be included on the active list or should have that outcome noted on the active list. The community must be able to demonstrate that **the list has input from or is informed by all significant partners** in the effort to serve Veterans experiencing homelessness, including the CoC, local VA Medical Center, VA funded providers, shelters, outreach workers, and additional community partners, such as food programs and law enforcement. The list may be populated by other data sources, such as HOMES, HMIS, or other comparable databases.”

Helpful Terms

- **Actively Homeless** – The number of known Veterans in your community who meet the federal definition of homelessness.
- **Outflow** – Veterans who are no longer actively homeless due to the following reasons:
 - **Housing Placements** – Veterans who are no longer homeless due to being housed through a homeless service, or through self-resolution.
 - **Moved to Inactive** – Homeless Veterans who are unable to be located after 90 days.
- **Inflow** – Veterans who actively homeless due to one of the following reasons:
 - **Newly Identified Veterans** – Veterans who meet the federal definition of homelessness who have either recently became homelessness or were recently known to be homeless by your community's homeless services system.
 - **Returned to Active from Housing** – Formerly homeless Veterans who were previously housed (either through a housing placement or self-resolution) but are homeless again.
 - **Returned to Active from Inactive** – Homeless Veterans who were moved to an inactive list due to a lack of contact, but have recently been located and are still experiencing homelessness.



Information and Data Needed to Calculate Benchmarks

1. **[Number of Veterans on active list]**
2. **[Number of Veterans experiencing chronic homelessness on active list]**
3. **[Number of Veterans experiencing long-term homelessness on active list]**
4. **[Date of identification]** of each homeless Veteran. That is, the date of initial contact with a homeless Veteran in any program, including street outreach, emergency shelter, transitional housing, Safe Haven, VA Medical Center, or at any other point of entry in the homelessness system. This date includes Veterans who are experiencing homelessness for the first time and those who may be re-entering homelessness after having exited for at least 90 days.
5. **[Date of documented offer of a permanent housing intervention]** The information regarding the documented offer should also include the type of permanent housing intervention offered (e.g., HUD-VASH, RRH, PSH, other subsidy).
6. **[Date of acceptance]** or **[date of decline]** of offer of a permanent housing intervention. In the specific case of Veterans who have previously declined an offer of a permanent housing intervention but who subsequently accept such an offer, the **[date of acceptance]** of the offer serves as the **[date of identification]** for these Veterans.
7. **[Date of move-in to permanent housing destination]**
8. **[Date of move-in to TH, by type of TH]**
9. **[Yes or No, entering TH in order to appropriately address a clinical need]**
10. **[Date of removal from Active List for other reasons]** The date that an individual was removed from the active list for reasons other than moving into permanent housing.

Maintaining Your By-Name-List

- Updates should be conducted at least monthly to ensure information is current.
- If a Veteran on the active list can no longer be located after repeated attempts for 90 days or more, the status of that Veteran can be changed from “active” to “missing” for purposes of calculating these benchmarks. If the Veteran is located at a later date and is still experiencing homelessness, the date of the most recent contact would become the new date of identification.
- If it is determined that an individual on the active list is not a Veteran, that individual should be removed from the active list and not included in data and calculations for the criteria and benchmarks, but should be included on a non-Veteran specific active list.

Coordinated Assessment Tools

FEASIBILITY OF ADOPTING TOOLS, REFERRAL PROCESS VS REFERRAL WITH CAT, AND COMMUNICATING REFERRAL PROCESS IN WRITING



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Assessment Tools Requirements

- Our partner CoCs are required by HUD to implement an assessment tool that is expected to be utilized by all community partners in their assessment of homeless individuals, including Veterans.
- VAMCs are encouraged to adopt this local assessment tool whenever it is feasible.
- Where full adoption with every CoC is not feasible, VAMCS are required to work collaboratively with their CoC to communicate their own internal VA screening and prioritization process so that the VA assessment findings can be incorporated into the larger CoC prioritization system.
- This process must be clearly outlined and communicated to all community partners within the CoC providers, ideally through written policy.



Quick Snapshot from CES Assessment Updates/Op Plans

- As of the end of the initial implementation period, all 140 VAMCs have completed the assessment for a 100% response rate.
- There are 97 CoCs where VAMCs share CoC geography with one or more VAMCs (approximately 70% of all VAMCs).
- There are 61 VAMCs that cover multiple states.
- 109 of the 140 VAMCs cover a Balance of State in some form (approximately 78% of all VAMCs).
- 29 VAMCs cover 6 or more CoCs with **13 as the largest**.
- 81 VAMCs cover 3-5 CoCs.
- 29 VAMCs cover 1-2 CoCs.

**Adopting the coordinated
assessment tool from every
CoC in your catchment area
may or may not be feasible.**



Dedicating Resources

OUTLINING THE ASPIRATIONAL GOAL, RESOURCE INVENTORY, DISCUSSION OF PERCENTAGES OR NUMBERS



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Dedication of VA Resources to CES Requirements

- It is required that VAMCs dedicate a portion of available VA resources for their inclusion into the greater pool of homeless service resources accessed by Veterans through CES.
- The degree to which VA resources are dedicated is at the discretion of VAMC homeless program leadership.
- Where the full dedication of VA resources does not take place, the VAMC must work with the CoC to establish a clear process for making and receiving referrals for veterans screened through coordinate entry.
- This process must be clearly outlined and communicated to all community partners within the CoC providers, ideally through written policy.



Dedication of Resources



Questions to Consider: Program Review

- How many Veterans were assisted in our program in the last 12 months?
- In which CoCs were these Veterans located? Or, which CoCs did they return to (if located at VAMC or other area but transitioned back to CoC)?
- Approximately what percentage of homeless Veterans in the CoC did we serve?
 - Looking at the Veterans on the master list/by-name-list/active list, about how many of those had been served by our programs?
- What does all this look like for each CoC that we cover?
- Where were Veterans before they entered our program? How many were literally homeless? How many were at-risk?
- Were there any Veterans who came to our facility from unique situations such as porting or VAWA (HUD-VASH) or jail/prison (GPD)?



Questions to Consider: Program Review Cont'd.

- What resources do we have? How many slots or beds? What is our occupancy and utilization?
- Do we have a quick reference sheet of our eligibility criteria and targeting strategy for our programs that can be shared with the CoC? Are there any needs that we have that we want to share with the CoC?

Community Review/Discussion

- Discuss what was learned from the program review with your CoCs and community partners.
 - How many Veterans are on the master list/by-name list/active list?
 - What type of permanent housing intervention (PSH, RRH, fair market, etc.) do they need? How many are VHA eligible?



Questions to Consider: Community Review

- What other resources are available (ex. community RRH if Veteran not eligible for SSVF, etc.)?
- *Develop a community resource plan to meet the needs of all Veterans experiencing homelessness in each CoC.*
 - As part of that plan, the goal would be to address as much of the need as possible.
 - As part of this commitment, if there are not sufficient resources, the community and VA should explore strategies that improve targeting of literally homeless Veterans, decrease lengths of stay, or increase exits to permanent housing as appropriate.
 - VA and VA providers work with the CoC and Veteran system leadership team to identify additional resources to close any gaps.



HUD-VASH Example #1:

- **Scenario:**
 - VAMC has 20 HUD-VASH vouchers in a rural CoC.
 - CES is in early stages of development/implementation; only CoC-funded resources currently included.
 - VAMC and CoC meet regularly to plan for inclusion of Veteran-specific resources.
- **Initial Plan:**
 - Phased approach to resource dedication.
 - Initially include 5 vouchers in CES.
 - HUD-VASH will accept direct referrals and include these Veterans on BNL and in case conferencing.
 - Agree to re-evaluate and add additional resources over time.



HUD-VASH Example #2

- **Scenario:**

- VAMC has 1500 HUD-VASH vouchers through two PHAs in an urban CoC.
- CES is well-established with comprehensive policies and procedures.
- VAMC and CoC meet regularly to review data related to Veteran homelessness and HUD-VASH utilization.
- Data shows that 80% of HUD-VASH Veterans came from within the CoC catchment area and met shared definitions of homelessness.

- **Initial Plan:**

- As new voucher allocations are expected, VAMC agrees to dedicate a percentage of vouchers—rather than a fixed number—to CES.
- Based on last year's data, agree to start with 80%.
- Agree to adjust this percentage over time based on collaborative data review.



Data Sharing Guidance

UNIVERSAL RELEASES OF INFORMATION, HMIS, ROUTINE USE #30, AZURE RMS, AND SHARING AGGREGATE DATA



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Data Sharing Requirements

- Work with local Privacy Officers to create a universal release of information that, when signed by the Veteran, allows them to be added to the CoC's BNL.
- Work collaboratively with each of the HMIS agencies to ensure that all necessary agreements are established and signed to facilitate information and data sharing.
- Share aggregate data from HOMES and the Homeless Service Cube with communities on an as-needed basis. Aggregate data does not include any Veteran identifiable information.



Data Sharing

- **Universal Releases of Information** can be used to authorize disclosures to different providers or health care organizations for stated purposes over a specified period of time.
- **HMIS** - VA staff can obtain read-only access or directly enter data into HMIS if the entry contributes to the job responsibilities of the VA staff entering the data; specifically, the data entered is being used to provide needed services and coordinated care to Veterans.
- **Routine Use #30** states that VA may disclose relevant healthcare and demographic information to health and welfare agencies, housing resources, and community providers, consistent with good medical-ethical practices, for Veterans assessed by or engaged in VA Homeless Programs for purposes of: coordinating care, expediting access to housing, providing medical and related services, participating in coordinated entry processes, reducing Veteran homelessness, identifying homeless individuals in need of immediate assistance, and ensuring program accountability by assigning and tracking responsibility for urgently-required care.
- **Azure RMS** is an encrypted e-mail technology. It provides VA a secure method of exchanging information with community providers and non-VA email addresses.



Taking CES to the Next Level

OVERVIEW OF THE COORDINATED ENTRY SPECIALIST POSITIONS



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HPO's Vision for CE Specialist Positions

- Next level in our VAMC integration into Coordinated Entry Systems.
- CE policy implementation is an on-going, evolving process.
- Coordinated Entry Specialist positions were created to assist and lead this process.
- Sense of urgency and also ongoing process of continuous learning.
- Deep level of collaboration.
- Strategic use of resources.
- Coordinated entry is a complex system change where VA is a critical partner.



Coordinated Entry Specialists in Florida

VA Medical Center / Health Care System	Number of CE Specialists
(516) Bay Pines, FL	1
(546) Miami, FL	1
(548) West Palm Beach, FL	0
(573) Gainesville, FL	2
(673) Tampa, FL	1
(675) Orlando, FL	1
(520) Gulf Coast HCS, MS	1



What the Coordinated Entry Specialist Position *Is* and *Is Not*

Is

- Representing the VA out in the community.
- Leading efforts to end Veteran homelessness within the community, alongside CoC.
- Systems-builder, enhancer, thinker.
- Ever changing, varied tasks requiring independent thinking.
- Bridging gaps in understanding to create stronger systems of service for homeless Veterans.
- Managing multiple priorities.
- Collaboratively problem-solving systems issues with community stakeholders.

Is Not

- Sitting behind a desk.
- Focused only on VA Medical Center.
- Maintaining status quo only.
- Focused on only one homeless program.
- Traditional clinical VA social worker role.
- Data entry into HMIS.



Examples of CE Specialists Focus in Local Communities

- More engagement and contributions around BNL maintenance.
- Higher level systems thinking related to figuring out how to integrate VA and CoC systems.
- More attention to BoS and rural CoCs.
- More awareness and leadership around Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness.
- Leading efforts around diversion (Hines VAMC CE Specialist).
- How to dedicate resources to CES (Jesse Brown VAMC with HUD-VASH referrals).
- Working through local issues related to data sharing.



Thinking Ahead and Moving Forward

ACTION PLANNING AND BEING PART OF THE PROCESS



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What We Have Learned from the CE Implementation Initiative

- **Integration takes openness and time.**
 - We have to be open to new perspectives.
 - Sometimes we work at different paces and speeds; we need to recognize this.
 - Past history does not define our future.
 - We need each other.
 - We need to be curious and simultaneously take on the role of teacher and also learner.
- **We don't have all of the answers but are committed to learning together.**
 - Self-Learning
 - Organizational Learning
 - Community Learning
 - System Learning



Moving Forward

We want to continue to *learn*, and we need *your* help.

- Ask questions.
- Tell us when additional guidance and support is needed.
- Share your examples, challenges, strengths, and ideas.

We want you to continue to *share* information on your progress.

- Continue to update the Coordinated Entry Assessment and Operating Plans on the Hub.
- Work together with your CoCs and community partners to share the *USICH, HUD, and VA Community Planning Survey Responses*.



Moving Forward

- Be open and set the tone of learning.
- Ask questions and be curious.
- Reach out if there is an insurmountable barrier.
- Use a 1st approach of learning instead of compliance.
- Work together to remove barriers.
- **Stay at the table.**



Steps for Dialogue

- **Pre-Step: Internal Planning**
 - Identify the CoCs that the VAMC covers.
 - Determine the VAMC POC for each CoC.
- **Step 1: Reach Out to the CoC**
 - Introductions.
 - Identifying contacts.
- **Step 2: Planning for the Meeting**
 - Reviewing initial lay of the land.
- **Step 3: Prepare Information**
 - Gathering Information.
 - Determining additional information needed.
- **Step 4: Develop the Plan**
 - Discussions on access, assessment, prioritization, & referral.
 - VA, data, and HMIS.
 - Sharing data for master lists/BNLs and case conferencing.
 - Discussions on dedication of resources.
- **Step 5: Implement, Test, Tweak, & Revisit the Plan on a Regular Basis**

Anticipate multiple, phased, and progressive discussions along with moments of getting stuck and getting unstuck.



Ways to Frame

Beginning the Relationship

- Introductions.
- Share contact information.
- Review CoC and VAMC coverage areas.
- Form work groups/teams.
- Review roles for each team.
- Review status of CES.
- Discuss CES assessment tool.
- Discuss HMIS access.
- Discuss BNL/master list processes.
- Develop case conferencing process.

Enhancing the Relationship



- Check-in on existing relationships.
- Review enhancements and/or clarifications needed?
- Design a flow chart of CES.
- Review roles and responsibilities.
- Develop policies and procedures.



Getting Unstuck

- Preparing
 - Reflection on needs and issues.
 - Do we need help facilitating the conversation? Who could help us?
- Identify the Issues
 - What are the issues?
- Labeling Apprehension
 - Where is the apprehension or tension?
 - What is the apprehension or tension?
 - Why is it there?
- Exploring Options
 - What are our options? What are the alternatives?
- Problem Solving
 - What plan can we put in place to continuously move us forward?
- Testing the Plan/Coming to Agreement
 - How can we continue to have these conversations together and what mechanisms will be put in place so that we remain at the table?



QUESTION & ANSWER



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