Balance of State Continuum of Care
Coordinated Assessment System Policies and Procedures

Contents

OVERVIEW

Overview of Coordinated Assessment

The CoC Interim Rule defines several responsibilities of the Continuum of Care (*578.7 (a) (8)*). One of these responsibilities is to establish and operate either a centralized or coordinated assessment system, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area. This centralized or coordinated assessment system provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

Another responsibility of the Continuum of Care, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, is to establish and consistently follow written standards for providing Continuum of Care assistance. At a minimum, these written standards must include:

(i) Policies and procedures for evaluating individuals' and families' eligibility for assistance under this part;

(ii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

(iii) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid re-housing assistance;

(iv) Standards for determining what percentage or amount of rent each program participant must pay while receiving rapid re-housing assistance;

(v) Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance;

A coordinated assessment system is defined to mean a coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. This definition establishes basic minimum requirements for the Continuum's coordinated assessment system.

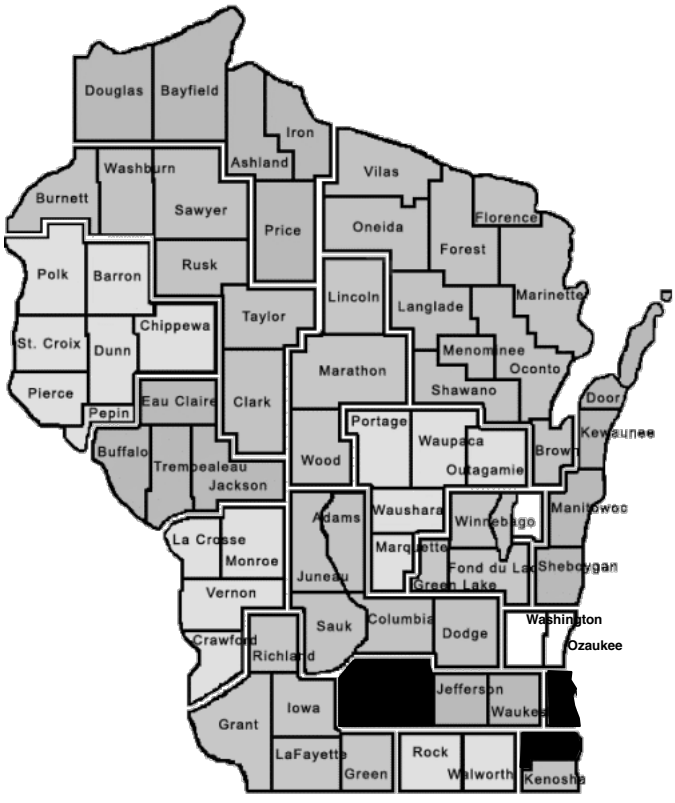
Coordinated assessment systems are important in ensuring the success of homeless assistance and homeless prevention programs in communities. In particular, such assessment systems help communities systematically assess the needs of program participants and effectively match each individual or family with the most appropriate resources available to address that individual or family's particular needs.

Timeline of WI BOSCOC Coordinated Assessment Activities

Coordinated Assessment Activity	**Date**
Development of Standard Forms	
Homelessness Verification	June 2013
Certification of Disabling Condition	October 2013
Regional roundtable discussions at Balance of State meeting	November 2013
Local CoCs complete coordinated assessment questionnaires	March 2014
Development & Approval of Program Standards	
Transitional Housing	August 2014
Permanent Supportive Housing	August 2014
ESG-Funded Rapid Re-Housing	November 2014
Presentation of draft Coordinated Assessment System Policies & Procedures	February 2015
Feedback period from BOS membership	February-May 2015
Presentation of BOSCOC Coordinated Assessment System	August 2015
Comment period from BOS membership	August-September 2015
BOSCOC Membership vote to approve Coordinated Assessment System	November 2015
Implementation of BOSCOC Coordinated Assessment System	January 1, 2016
Proposed Implementation of Coordinated Assessment System for Emergency Shelters	July 1, 2016
Proposed Implementation of Coordinated Assessment System for Homeless Youth	January 1, 2017
Proposed Implementation of Coordinated Assessment System for Mainstream Resources	TBD

Geographic Area

The Wisconsin Balance of State Continuum of Care covers 69 of Wisconsin's 72 counties and extends from the shores of Lake Superior in the northwest to portions of the Chicago metro area in the southeast. The population for the continuum is 3.8 million and it covers an area of 52,533 square miles. This geographic area includes urban, suburban, and rural areas.



Goals of Coordinated Assessment

Most communities lack the resources needed to meet all of the needs of people experiencing homelessness. This combined with the lack of well-developed coordinated entry processes has resulted in severe hardships for people experiencing homelessness. They often face long waiting times to receive assistance or are screened out of needed assistance. A Coordinated Assessment System helps communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. The Coordinated Assessment System also provides information about service needs and gaps to help communities plan their assistance and identify needed resources.

The Coordinated Assessment System is intended to increase and streamline access to housing and services for households experiencing homelessness, match appropriate levels of housing and services based on their needs, and prioritize persons with severe service needs for the most intensive interventions.

HUD's primary goals for coordinated entry processes are:

1. Assistance will be allocated as effectively as possible
2. Assistance is easily accessible no matter where or how people present

The Wisconsin BOSCOC members identified the following common goals for the Coordinated Assessment System:

1. The process will be easy on the client, and provide quick and seamless entry into homelessness services
2. Individuals and families will be referred to the most appropriate resource(s) for their individual situation
3. The process will prevent duplication of services
4. The process will reduce length of homelessness
5. The process will improve communication among agencies

Guiding Principles

The Coordinated Assessment System Policies and Procedures are a living document. It will be evaluated annually and changes can be made based on the information gathered through the evaluation process.

Target Population

This process is intended to serve individuals and households experiencing homelessness and those who are at imminent risk of homelessness. Homelessness and imminent risk of homelessness will be defined in accordance with the HUD definition of homelessness.[1]

[1] The definition is available here: https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

This Document

These policies and procedures will govern the implementation, governance, and evaluation of the WI Balance of State CoC Coordinated Assessment System. These policies will be reviewed annually in accordance with the WI Balance of State CoC Governance Charter.

Basic Definitions

Terms used throughout this document are defined below

- **Chronically Homeless –**
    - An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
    - An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility;
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless. (24 CFR 578.3)
- **Client –** Individual or family who accesses the Coordinated Assessment System
- **Literally Homeless (HUD Homeless Definition Category 1) -** An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution (24 CFR 578.3)

- **Imminently at Risk of Homelessness (HUD Homeless Definition Category 2) -** An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing (24 CFR 578.3)
- **Fleeing domestic abuse or violence (HUD Homeless Definition Category 4) -** Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing (24 CFR 578.3)
- **Homeless Management Information System (HMIS) -** The information system designated by the Continuum of Care to comply with the HMIS requirements prescribed by HUD. All CoCs in Wisconsin use Wisconsin Service Point.
- **HMIS Lead –** The entity designated by the Continuum of Care in accordance with this part to operate the Continuum's HMIS on its behalf. Institute for Community Alliances (ICA) is the HMIS Lead for the State of Wisconsin.
- **Housing Interventions -** Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).
- **Program –** A specific set of services or a housing intervention offered by a provider (e.g. House of Hope Rapid Re-Housing Program, Project Chance)
- **Provider –** Organization that provides services or housing to people experiencing or at-risk of homelessness (e.g. St. Vincent de Paul, Central Wisconsin CAC)
- **VI-SPDAT and VI-F-SPDAT –** *Vulnerability Index-Service Prioritization Decision Assistance Tool* and *Vulnerability Index-Service Prioritization Decision Assistance Tool for Families* are the standardized assessment tools used in the Coordinated Assessment System. The VI-SPDAT and VI-F-SPDAT are pre-screening, or triage tools that are designed to be used by all providers within the Coordinated Assessment System to quickly assess the health and social needs of people experiencing homelessness and match them with the most appropriate support and housing interventions that are available.

GOVERNANCE

CoC Interim Rule
(https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf)
578.7 (a) (8) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

ESG Interim Rule
(https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf)
576.400 (d) Centralized or coordinated assessment. Once the Continuum of Care has developed a centralized assessment system or a coordinated assessment system in accordance with requirements to be established by HUD, each ESG-funded program or project within the Continuum of Care's area must use that assessment system. The recipient and subrecipient must work with the Continuum of Care to ensure the screening, assessment and referral of program participants are consistent with the written standards required by paragraph (e) of this section. A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system.

HUD Coordinated Entry Policy Brief
Appendix A and at: https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

WI Balance of State Continuum of Care Bylaws
(http://westcap.org/wp-content/uploads/2014/01/The-BOS-Bylaw-August-2013.pdf)
Article II, Section 3 The responsibilities of the Corporation include, but are not limited to:

a. Those responsibilities outlined and defined by relevant federal law;
b. Coordinate, or be involved in the coordination of, all housing and services for persons experiencing homelessness within the Corporation's geographic area;
c. Establish and operate the HMIS within the Corporation's geographic area;
d. Establish and operate, or designate, the centralized and coordinated assessment to be used within the Corporation's geographic area.

State of Wisconsin ETH Program Desk Guide
(http://www.doa.state.wi.us/Documents/DOH/eth/ETH%20PROGRAM%20GUIDE.docx)
Each local continuum of care is required to develop and/or operate a centralized or coordinated intake or assessment system if any agencies in the continuum of care receive ETH funding.

Recipients and subrecipients must participate in the centralized intake for their continuum of care. If there is not yet a centralized intake, a recipient or sub-recipient must participate in its implementation and eventually its use.

Recipients and subrecipients must use the CoC's centralized or coordinated assessment system to evaluate client eligibility. ETH recipients must ensure the CoC's system is consistent with the written standards for determining ETH assistance. Note that victim service providers that receive ETH funds may opt to not use the CoC's system.

Coordinated Assessment System Procedures

This section outlines and defines the key components of the coordinated assessment system and how the coordinated assessment process will work.

Accessing the Coordinated Assessment System

Because of the diversity and size of the BOSCOC, access to the coordinated assessment system follows a "No Wrong Door" approach. The principles of this approach are:

- A client can seek housing assistance through any of the participating housing providers and will receive integrated services.
- Clients should have equal access to information and advice about the housing assistance for which they are eligible in order to assist them in making informed choices about available services that best meet their needs.
- Participating providers have a responsibility to respond to the range of client needs and act as the primary contact for clients who apply for assistance through their service unless or until another provider assumes that role.
- Participating providers will provide a proactive service that facilitates the client applying for assistance or accessing services from another provider regardless of whether the original provider delivers the specific housing services required by a presenting client.
- Participating housing providers will work collaboratively to achieve responsive and streamlined access services and cooperate to use available resources to achieve the best possible housing outcomes for clients, particularly for those with high, complex or urgent needs.

Establishing a Designated Lead Agency

Each local coordinated assessment system (LCAS) will designate a lead agency (DLA) to manage the non-WISP prioritization lists and to serve as the contact person for the Coordinated Assessment Committee. The DLA will ensure that all agencies participating in the Coordinated Assessment System have the appropriate contact information in order to access the non-WISP Prioritization Lists in a timely manner. The DLA is responsible for communicating any changes in contact information to the Chair of the Coordinated Assessment Committee.

Initial Screening

The coordinated assessment system utilizes a standardized assessment tool, The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT and VI-F-SPDAT). This tool assists the provider in consistently evaluating the level of need of individuals and families accessing services.

The assessment takes approximately 10 minutes to administer, and can be conducted by any provider who has been introduced to the tool through a one hour training video presented by OrgCode (available at: http://100khomes.org/resources/vi-spdat-prescreen-tool-training).

Providers that use WI Service Point should complete the one hour training on how to record its results within WI Service Point (available at: http://icalliances.org/wisconsin/recordings/).

- When an individual or family contacts a service provider for housing assistance, a Pre-Screen Form is completed as an initial screen to determine basic eligibility (e.g. screening out those who are over income or non-DV from a DV provider). This form can be completed in person or over the phone. *Appendix B*
- If the individual or family meets eligibility (homeless and below income guidelines), the VI-SPDAT or VI-F-SPDAT is completed either in person or over the phone. *Appendix C & Appendix D*
- If the individual or family meets the threshold for acuity the Universal Data Element (UDE) Form is completed, the coordinated assessment system Release of Information is signed, and the information is entered into the Prioritization List. *Appendix E & Appendix F*

Initial Screen of Domestic Violence Survivors

The domestic violence victim service providers (DVSP) in the BOSCOC may elect to administer the VI-SPDAT for their clients who are seeking services from other housing service providers in the BOSCOC. Each Local Coordinated Assessment System will determine if it wants consistency among DVSPs in administering/not administering the VI-SPDAT, or if it will allow some DVSPs to administer the VI-SPDAT and others to opt out.

If the domestic violence victim service provider or service providers elect to do so, they will follow this procedure:

- When an individual or family contacts a DVSP for housing assistance, a Pre-Screen Form is completed as an initial screen to determine basic eligibility (e.g. screening out those who are over income or non-DV from a DVSP). This form can be completed in person or over the phone.
- If the individual or family meet eligibility (homeless and below income guidelines), the VI-SPDAT is completed either in person or over the phone.
- If the individual or family meets the threshold for acuity the DVSP provides the VI-SPDAT score and a unique anonymous identifier, such as “Safe Place Client-12345,” to the designated lead agency (DLA). The DVSP destroys the paper copy of the VI-SPDAT.
- The DLA enters the client’s score and identifier into the non-WISP prioritization list.
- If and when the requested service becomes available for the client, the appropriate housing agency contacts the DVSP and references the client using the anonymous identifier.
- The DVSP contacts the client and tells him or her that the service is available and asks the client if he or she would like to receive the service. The DVSP then communicates

the client's intentions to the housing provider. The DVSP will need a signed release of information and waiver of non-disclosure in order to share the client's name with the housing provider for cases in which the client intends to use the housing provider's service.

If the DVSP decides not to administer the VI-SPDAT to their clients, the DVSP will refer these clients to another agency within the local region that does administer the VI-SPDAT.

Whether the VI-SPDAT is first conducted on paper or directly inputted within HMIS, all VI-SPDAT assessments must be recorded in either the HMIS prioritization list or the local non-WISP prioritization list within 48 hours of when the information was first collected.

If the individual/family is not prioritized for any interventions, the provider administering the VI-SPDAT should explain why and what other services will be available to them (e.g., shelter case management, connection to mainstream resources, help connecting with family or friends). The client should be referred to the appropriate emergency shelter or other housing crisis resource, where they will receive case management and other services to help them access housing. The assessment process ends for the client at this point.

Prioritization List

The HMIS Lead will work with participating agencies to create the Prioritization Lists for each Local Coordinated Assessment System (LCAS). Agencies that use ServicePoint will be able to make referrals to ServicePoint Prioritization Lists using the "Referrals" feature of the software. Anyone with a ServicePoint user license can make a referral to the ServicePoint Prioritization Lists. Individuals and families being referred to the prioritization lists do not need to be enrolled in a program at the agency making the referral. For additional guidance on using the Prioritization Lists in ServicePoint, you can access training at http://www.icalliances.org/wisconsin/.

Agencies making referrals to the prioritization list will be responsible for following up with the individuals and families they refer in order to determine whether the individual or family is still in need of permanent or transitional housing. Follow-up contact must occur at a minimum every 90 days. If the individual or family still is in need of housing, the agency should update contact information if necessary. If the individual or family is no longer in need of housing, the agency can delete the referral to remove the individual or family from the prioritization list. Providers that contact a referral to offer services and find out the household is no longer in need, can also close a referral in Service Point, even if that provider did not make the referral.

Referral Process

It is prohibited for any HUD-funded homelessness assistance programs to serve individuals and/or families experiencing homelessness or who are at imminent risk of homelessness, without the household first going through the coordinated assessment system and receiving a referral to the prioritization list.

When a program has an opening, the responsible staff person must consult the prioritization lists in ServicePoint and contact the DLA to inquire about individuals/families listed on the non-WISP prioritization lists. Using the Order of Priority established for the program (Appendix G, Appendix H, Appendix I), program-specific requirements (e.g. single, youth, specific disability, etc.), and the VI-SPDAT score, the program will offer services to the highest prioritized individual/family.

Examples

NAME	Disability?	Homeless Status	Length	VI-SPDAT	Program/ Priority
John	MH (SSI)	Chronic	13 months	18	
Sarah	AODA (Verification)	Chronic – 4 times in 3 yr	5 months	16	
Carl	MH (SSI)	Chronic	24 months	15	
SafePlace023	None	Cat. 1 – shelter	2 months	13	
Mike	AODA (Verification)	Cat. 4		12	
Bobby	MH (Verification)	Cat. 1 - shelter	9 months	8	
Julie	None	Cat. 1 - shelter	3 months	6	
Brad	MH (SSI)	Cat. 1 – in car	3 months	6	
Jenny	None	Cat. 1 - shelter	1 month	5	

If Agency A has an opening in its Rapid Re-Housing Program, they would offer services to Bobby because he has the highest score within the suggested range for Rapid Re-Housing Programs.

If Agency B has an opening in its Permanent Supportive Housing Program which has 100% dedicated chronic homeless beds, they would offer services to Carl because he has the longest length of homelessness.

If Agency C has an opening in its Transitional Housing Program, they would offer services to John because he has the highest VI-SPDAT score.

For additional guidance on prioritization, please see the recorded webinar, "Prioritization & Recordkeeping: PSH and TH Programs," at the following link: http://www.wiboscoc.org/presented-materials.html

If a program does not take the highest prioritized individual or family from the Prioritization Lists to fill an available spot, that agency must document the reason for not accepting that referral in the ServicePoint client file. If the highest prioritized client does not have a ServicePoint client file (because the client was referred from a DVSP), the agency must provide a written explanation to the DLA. It is the responsibility of the agency not taking the highest prioritized individual or family to ensure that the individual or family has a new referral to the priority list, if needed. The individual or family remains on the Prioritization List in order to access the next available program spot, as long as the individual or family is in need of permanent or transitional housing.

Declined Referrals

One of the guiding principles of the BOSCOC Coordinated Assessment System is client choice. Individuals and families will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. If an individual or family declines a referral to a housing program, their name remains on the prioritization list until the next housing opportunity is available.

Coordinated Assessment System Policies

This section outlines and defines the policies governing the Coordinated Assessment System.

Joining the Coordinated Assessment System

All programs that receive Continuum of Care funding or Emergency Solutions Grant funding are required by their funders to participate in the Coordinated Assessment System. Other programs are encouraged and welcome to join the Coordinated Assessment System. Those programs that are not required by their funder to participate in the Coordinated Assessment System will sign a Memorandum of Understanding agreeing to participate in the system for a minimum of six months.

System Advertisement and Outreach

Outreach

Local Coordinated Assessment Systems (LCAS) are **required** to contact private and public agencies including those in the Continuum of Care, 211, VA, social service agencies and state and/or local government agencies to educate and provide information on available programs. Outreach activities are **required** to be done a minimum of once per year. These activities can be done in conjunction with the Point in Time Count or at another time as determined by the CoC. Each LCAS is **required** to coordinate with existing street outreach programs as well as private and public agencies, social service organizations, etc. for referrals, so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the Coordinated Assessment System.

Each LCAS is **encouraged** to provide resources/information about the Coordinated Assessment System to 24 hour establishments as well restaurants, hospitals, hot meal programs, churches, schools, check cashing locations and other places known to be frequented by the target population. In addition, each LCAS is **encouraged** to explore various outreach activities such as hosting a booth at local community events, resource fairs, festivals and county fairs to provide information and resources.

Advertisement

Advertisement is to include a **minimum of flyers** posted at those places stated above (as allowed). Other forms of advertisement can include newspaper ads, radio, websites, etc. to generate referrals and applications. Advertising is to focus on people experiencing literal homelessness and clearly state eligibility requirements in an effort to reach the target population as opposed to those who do not meet the criteria. Information about the Coordinated Assessment System will also be available on the WI BOSCOC website at www.wiboscoc.org.

Data Collection

Data will be collected on everyone that is assessed through the Coordinated Assessment System. This section, in addition to instructions embedded within the assessment tool, will detail when and how data about clients going through the Coordinated Assessment System will be collected.

Once the Pre-Screen Form has been completed and the client is deemed eligible to be assessed, the staff member will review the ServicePoint Release of Information form with the client. The staff member will explain what data will be requested, how and with whom it will be shared, and what the client's rights are regarding the use of their data. The staff member will be responsible for ensuring clients understand their rights as far as release of information and data confidentiality. If they sign the form, the staff member will begin the assessment process in ServicePoint or on paper initially with relevant data entered into the data fields in ServicePoint within 48 hours.

Some clients should never be entered into ServicePoint. These include:

- Clients who want domestic violence-specific services should never have information entered into ServicePoint. The VI-SPDAT should be done on a paper form, the score recorded, and the form shredded. If the client is being served by a domestic violence provider, that agency may enter their information into a WISP-comparable database.
- Clients who do not consent to data sharing should also never have their data entered into ServicePoint.

Access to parts of each client record or assessment form may be restricted for safety reasons or by client request.

Grievance Policy

Client Grievances

The agency completing the screening should address any complaints by clients as best as they can in the moment. Complaints that should be addressed directly by the agency staff member or agency staff supervisor include complaints about how they were treated by agency staff, agency conditions, or violation of confidentiality agreements. Any other complaints should be referred to the BOSCOC Coordinator to be dealt with in a similar process to the one described below for providers. Any complaints filed by a client should note their name and contact information so the CoC Coordinator can contact him/her to discuss the issues.

Provider Grievances

It is the responsibility of all directors, officers, and employees CoC-funded programs and ESG-funded programs to comply with the rules and regulations of the Coordinated Assessment System. Anyone filing a complaint concerning a violation or suspected violation of the policies and procedures must be acting in good faith and have reasonable grounds for believing an agency is violating the Coordinated Assessment System policies and procedures.

To file a grievance regarding the actions of an agency, contact the WI Balance of State CoC Coordinator with a written statement describing the alleged violation of the Coordinated Assessment System policies and procedures, and the steps taken to resolve the issue locally. The CoC Coordinator will contact the agency in question to request a response to the grievance. Once the CoC Coordinator has received the documentation he/she will decide if the grievance is valid and determine if further action needs to be taken. If the individual or agency filing the grievance, or the agency against whom the grievance is filed, is not satisfied with the determination they may file a grievance with the Balance of State Board of Directors President. This must be done by providing a written statement regarding the original grievance, and why the complainant disagrees with the decision made by the CoC Coordinator. The Board President will bring the matter to the Board of Directors for discussion and a final decision.

EVALUATION

Once an appropriate Coordinated Assessment model has been devised, a community must regularly evaluate its effectiveness. Communities should use the lessons derived from these evaluations to further improve their systems.[2]

The Balance of State CoC will evaluate its Coordinated Assessment system primarily by local regions but will also consider aggregate data.

Questions for Regional Leads (who will collect and aggregate data locally)

- How many "side doors" does your region have (i.e. orgs that participate in CA but also admit clients in some other fashion)?
- How many organizations in your region do not participate in CA and do their own intake/assessment?
- Have there been significant differences between what was planned, and what has been implemented in your region?
- What have been the challenges in implementing coordinated assessment, and how can the Balance of State help to address them?
- Have providers noted any trends or concerns as a result of coordinated assessment?
- Are there organizations in your region that have additional screening measures for clients referred through coordinated assessment (i.e. creating additional barriers to program entry)?
- How is the system advertised in your region? How accessible is it?
- Tell us about your outreach and advertising activities. Who, What, When and Where.

Questions for Consumers

- Thinking about the most recent time you became homeless, what could have PREVENTED you from becoming homeless? Check all that apply.
  - Rental Assistance
  - Other financial assistance
  - Help finding a job
  - Substance use treatment
  - Health care
  - Help finding an apartment
  - Mental health treatment
  - Help with budgeting
  - Case management
  - Other (please specify)

- Where did you first go to get help when you became homeless? (List name of agency)
- How did you find out about this agency (agency listed above)?

[2] Much of this section was adopted from the "Coordinated Assessment Evaluation Tool," published by the National Alliance to End Homelessness.

- It was easy for me to find services to help me when I became homeless.
    - Choose from range between 'Strongly Agree' and 'Strongly Disagree'
- I felt that the services I received while homeless were focused on helping me get into permanent housing as quickly as possible.
    - Choose from range between 'Strongly Agree' and 'Strongly Disagree'
- (If you are currently in housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?
- If you worked with multiple agencies, did the referral process go smoothly?
    - Yes/No
    - If answered no, please explain

What can we do to make it easier for people in need of services to access the help they need?

<u>Data Evaluation – Every 6 months – Regional and Aggregate BOS</u>

To assess the impact of Coordinated Assessment, these data points will be evaluated for two 6-month periods: one prior to implementation, and one after implementation. After the initial evaluation, this data will continue to be collected and analyzed every 6 months.

Program Type	**Number of Participating Organizations in Each Program Type**	**Number of Referrals Made to Program Type**	**Number of Placements in Each Program Type**	**Rate of Exits to Permanent Housing**
Prevention/Diversion	N/A, initially	N/A, initially	N/A, initially	N/A, initially
Emergency Shelter				
Transitional Housing				
Rapid Re-housing				
Permanent Supportive Housing				
Other Types of Housing/Programs				

*Rate of Exits to Permanent Housing equals the number of people that exit each program type in the given six month period for permanent housing divided by the total number of people that exited each program type within that six month period.

The following measures will be evaluated overall and by program type, as appropriate.

Measure(s)	Related Question(s)	Data Collection Process	Data Collection Process – DV
Length of prioritization list	*How long does it take for eligible individuals and families to access services?*	Review priority list. An HMIS report will be developed to determine how long a household is on the priority list before moving into housing.	
Recurrence	*Are individuals and families matched with the correct intervention? What portion of services are used by repeat clients?*	An HMIS report currently measures returns to emergency shelter. This will be used until a report can be developed that will measure returns to all program types. An HMIS report will be developed to measure repeat clients.	
Placement rates	*Of those referred, how many actually enter the program? Are programs denying access to eligible individuals or families?*	Review HMIS referrals? May be harder to determine if programs deny access to eligible families.	
Length of stay and housing stability	*Is the system helping people efficiently move into permanent housing?*	Use HMIS report to determine average length of stay for emergency shelter programs.	

Client demographics	*Has the implementation of the system adversely impacted any populations? Has implementation changed the rates at which the chronically homeless and others with high barriers are served?*	Use HMIS report to determine client demographics for all coordinated assessment region programs.	
Bed/unit occupancy rate	*Does the community need to reevaluate where to place its resources? Are non-participating shelters and housing providers used more as a result of implementation?*	Use Housing Inventory Chart to determine bed/unit occupancy for point in time.	Use Housing Inventory Chart to determine bed/unit occupancy for point in time.
Unmet needs	*What portion of people assessed to have a need for a service are not afforded it?*	Use HMIS report to determine number of unmet needs.	
*New entries into homelessness	*Are prevention and diversion efforts working effectively?*	Use HMIS report to determine number of clients newly homeless.	

*This measure would be added to the evaluation once prevention and diversion are incorporated into the system.

To determine success:
The following factors might indicate success with coordinated assessment:

- The number of organizations doing individual intake and assessment decreased
- There are no "side doors" in the community
- Average length of stay in homelessness is decreasing
- Rate of exits into permanent housing for every intervention has increased
- New entries into homelessness have decreased due to prevention and diversion efforts
- There is a centralized prioritization list now (if there wasn't before) or no wait list at all
- The number of organizations consumers had to work with before getting into permanent housing has decreased

Things to think about when re-assessing systems[3]:

- What impact is the CoC trying to make?

[3] Source: "Performance Measurement of Homeless Systems", Tom Albanese, Abt Associates

- What indicators best reflect and convey CoC impact and achievement of the CoC's strategic plan?
- What is beyond system/program control?
- What players can be brought to the table to further improve the effectiveness of the system?
- Are the right programs collecting the right data? Is data quality sufficient?

TRAINING

Initial Training

- ✓ The Coordinated Assessment Process
  - What is Coordinated Assessment
  - Coordinated Assessment requirements
  - How the WI BOSCOC Coordinated Assessment System works
- ✓ Screening Process
- ✓ Prioritization Process
- ✓ Referrals
- ✓ Trauma Informed Care in Administering Coordinated Assessment
- ✓ Confidentiality and Fair Housing Laws
- ✓ Using ServicePoint with Coordinated Assessment
- ✓ Evaluation Process
- ✓ Outreach and Advertising

Training Plan

The Balance of State Coordinated Assessment Committee will host a training webinar that will be attended by at least one representative from each of the LCAS. This will be a train-the-trainer type webinar, and will last approximately two hours. This training will be recorded and can be distributed to each LCAS. This training will need to take place prior to the roll-out of Coordinated Assessment.

Each LCAS will be responsible for training the remaining service providers in their region. Each region will have flexibility for how this training is conducted. The training can be either in-person or via webinar. Ideally this training will take place prior to the roll-out of Coordinated Assessment, but at a minimum should occur within two months of the Coordinated Assessment start date.

The Institute for Community Alliances will work with each LCAS to provide ServicePoint training to each region individually. This will allow ICA to tailor the training to meet the needs of each LCAS. Ideally this training will occur at the same time as the regional Coordinated Assessment training. If it occurs at a separate time, it will happen within two months of the Coordinated Assessment start date.

Each LCAS will need to report to the BoS Coordinated Assessment Committee chairperson when the regional training occurred and who attended training.

On-going Training

The Coordinated Assessment Committee will record a training for new staff, which can be sent to agencies as needed. If/when on-going trainings are held, training registration information will be posted on both the ICA and BoS websites. The training documents will always be available.

Training Documents

WI BOS Coordinated Assessment How-to Guide

This guide will provide a basic overview of topics covered during the initial training. ICA staff will work with the BoS Coordinated Assessment Committee to include instructions on how to use ServicePoint for Coordinated Assessment, including ServicePoint screenshots.

APPENDICES

A. Coordinated Entry Policy Brief
B. Balance of State CoC Pre-Screen Form
C. VI-SPDAT
D. VI-F-SPDAT
E. Universal Data Element (UDE) Form
F. Prioritization List Release of Information
G. Permanent Supportive Housing Order of Priority
H. Transitional Housing Order of Priority
I. ESG-Funded Rapid Re-Housing Order of Priority
J. HUD Definitions for Order of Priority