Santa Clara County CoC
Coordinated Assessment Work Group
Meeting Minutes
November 9, 2017

Attendees:
Elizabeth Olivera (FSH), Laura Foster (Bill Wilson Center), Esmeralda Torres (YWCA), Samantha Rose (DST), Trinh Nguyen (AACI), Valerie Kang (MidPen Housing), Nikka Rapkin (HomeBase), Kathryn Kaminski (Office of Supportive Housing)

1. **Welcome and Introductions**

2. **CoC Updates**

    a. Upcoming trainings
        i. 11/16 – Eligibility Documentation - Will include new standardized forms to support eligibility documentation.
        ii. 12/13 – All About Housing
    b. CoC NOFA was submitted in September
    c. AHAR draft submitted at the end of October. Final will be submitted to HUD by 12/1. Thanks to everyone who worked with BitFocus on this data!

3. **Coordinated Assessment Updates**
    a. Annual CAS evaluation in progress
        i. Scheduled 2 focus groups with consumers, 1 focus group for providers
        ii. Provider survey will be circulated via listservs. Please encourage staff to complete surveys. Multiple responses per agency are fine.
        iii. In the process of conducting key informant interviews.
        iv. Data analysis.
    b. New policies underway
        i. Some changes to meet the January deadline for compliance with CAS requirements, including transitional housing policies and procedures
        ii. VAWA policies and policies and procedures to meet new requirements for 2017 awards.
    c. Other
        i. Prevention VI-SPDAT is now in use with Homelessness Prevention pilot project with Destination: Home
        ii. Justice Discharge VI-SPDAT is now being used by custody officers
    d. VI-SPDAT data
        i. Steady inflow of new assessments into the system
        ii. Since June, 2% higher total number of Families/Children VI-SPDAT and 2% decrease in individual since inception – This means a significant increase in families being assessed.
        iii. Decrease in Vets being assessed
        iv. No significant changes in racial and ethnic demographics
        v. New data points
            1. Of the family VI-SPDATs, 60% have child who is 5 years old or younger.

2. Of the total unduplicated households, 105 families have a pregnant family member, 40 single adults, 121 Transition Aged Youth, 3 children. Youth being assessed have higher pregnancy rates than other categories.

vi. Scores – Slight increase in those eligible for housing intervention, slight decrease in those not eligible for housing intervention.

vii. Does this reflect what agencies are seeing in practice?

1. Yes, it reflects what we are seeing with families.

viii. Referrals – We have made 600 referrals to PSH and 1,200 referrals to RRH. Over 1,160 unduplicated households receiving referrals. 13% of households being assessed are receiving referrals. There has been a significant increase in RRH referrals.

4. **Draft Policy Revisions**
   a. Addition of description of Transitional Housing and policy related to Transitional Housing used as bridge housing
      i. No feedback
   b. Eligibility Requirements for Transitional housing
      i. To qualify for TH
         1. For CoC-funded programs and others participating in the CAS, be the highest priority household available within the target population served by the program, as identified through coordinated assessment.
         2. For Veterans Affairs (VA) Grant Per Diem (GPD) programs, be the highest priority household available within the target population served by the program that received approval by the VA, if applicable.
         3. Other eligibility criteria created at the program level.
         4. For CoC-funded programs, must meet the HUD definition of homeless in the CoC Program Interim Rule under Category 1, 2, or 4.
      ii. Does the CoC have a policy for when a person qualifies under category 4 and how a non-DV agency handles working with them? Are they entered anonymously? We will follow up on this question. There is work underway supporting how DV survivors are integrated into CoC. We will revisit the policies around this.
   c. VAWA
      i. New VAWA regulations are required to be implemented in CoC programs with 2017 NOFA.
      ii. Two major changes
         1. CoCs must have an emergency transfer plan.
         2. New lease provision requirements (more info at later date about lease provisions).
      iii. Trainings coming soon.
      iv. QAS Updates - Emergency Transfer Plans
         1. Limited burden on participant – The participant submits a written request stating that they meet the eligibility requirements.

2. Is there a form? Yes, a sample form is available on the HUD website, but participants are not required to use the form. Any form of written request is acceptable. No additional documentation is required.
3. CoC must retain records of all emergency transfer requests and their outcomes for a period of 5 years and will need to report on transfers each year. Will these be part of APRs? This is unknown.
4. If a client requests the transfer and is a survivor, but the perpetrator is incarcerated (no real risk of imminent harm), do they meet the eligibility criteria? No. If it was sexual assault within 90 days, they would be eligible because imminent harm is not required. This question is related to PTSD. A family may want to move because of the trauma of the experience. We will look at adding some clarity in the policies or guidance on how to determine this.
5. Process Summary - If an internal transfer is requested, they should receive at least the same priority as other emergency transfer requests. Is more guidance on this needed? No.

v. Other feedback?
   1. How would this apply to a situation in which 3 or 4 females have concerns regarding the same male tenant? Do we evict the person that is causing the distress? Does this apply to this situation?
      a. From a legal perspective – Step 1, the rules are very clear about how the emergency transfer is supposed to work. If the transfer is requested and the person qualifies, you must make the emergency transfer. Step 2, if the client has impacted the safety of other clients, you could follow your protocols for dealing with the client.

vi. Family separation – The proposed rule is that the individual who is the victim will continue to hold the TBRA.
   1. What happens if it's the perpetrator that met the eligibility qualifications? The CoC may need to develop additional guidance around this question. Perhaps we can add guidance in the QAS to say that agencies will work with the CoC if the family separation emergency transfer doesn't work (the person fleeing isn't eligible or can't take over their portion of the rent).

vii. Confidentiality – No feedback

5. Annual Assessment of Santa Clara County CoC CAS – Continued

a. <u>Match, Referral, and Enrollment</u>

i. Benchmarks
   1. Matchmakers have clear guidelines that support consistent matchmaking
   2. Minimal time from vacancy to match
   3. Maximizing successful referrals
   4. Households are referred to housing they are eligible for
   5. Households are matched with the best resources to meet their needs

ii. Strengths and challenges identified so far:

1. Widespread commitment for Housing First
2. 1,160 permanent housing referrals (over 13% if households assessed) since CAS launched!
3. Referrals denied mostly due to ineligibility (25%) and inability to locate (35%)
4. Case managers end up spending time on ineligible households
5. Households may be technically eligible but lack documentation

iii. Discussion

1. Clients don't always know what to expect. Sometimes people forget what they are told when they are given the assessment. They might be given the right information when they take the assessment, but they don't remember.
2. Is there something we can do to help the clients better understand?
    a. Maybe we should be asking clients to check in with a provider regularly. It might help with this issue and with locating clients.
3. Length of time to find the clients is not long enough.
    a. Agencies need more guidance, including best practices in finding clients. How can we find people better and faster? We need consistent protocols in terms of what is realistic.
4. Once someone is getting referred, it takes 23 days on average to get them enrolled in PSH, 48 days enrolled in RRH. This is what we want to decrease. How can we shorten this time period?
    a. Give a consistent message to the clients that they have a point person that they should check in with regularly. BWC tells clients to check in with them once/month. Don't think this is happening in most cases. More contact with clients would help.
    b. Hard for us to give them a lot of information when we do the assessment. Need some guidance on what to tell clients after we give the VI-SPDAT. Email correspondence is important in staying in touch with clients.
    c. Maybe bring in some of the people in the system of care that are not necessarily giving the VI-SDPAT involved in the process, so they can make sure to give the same info and update contact info, etc. Guidance around making sure folks are connected to email.
5. 27% referrals are denied.
    a. Is there any data related to the correlation between the denials and the length of time in the queue (the age of the VI-SPDAT)?
        i. Create some protocols around how we can update the location/contact information for clients more frequently.
    b. For the eligibility issue, can we improve the matchmaking process for eligibility? Agencies are getting ineligible referrals.

Sometimes it's a documentation issue, but it may also be an issue in the matchmaking process.

c. Can we look at the 25% that were ineligible and determine why? Did circumstances change? Were they ineligible from the start and it can be corrected in the matchmaking process?
d. In a situation in which the client was staying in shelter and then they were temporarily staying with a friend, they didn't qualify when they were referred. How do we help them?
e. For the folks that never receive a referral (the 5s and 6s), what happens to those clients? How are we doing providing services to these folks? What other support is available?
f. We always need more resources. If we had more funding, what would be most successful?
g. Are there ways in which we can ensure that the people who take the VI-SPDAT, but do not receive referrals, are receiving all of the other services for which they are eligible? Need to track what happens to these folks and what services they received, whether they self-resolved, etc.
h. Are there other local funds that will allow us to house people who are at imminent risk of homelessness? Should local funds be more flexible?
i. Need to understand the self-resolved data point better.
j. Change the front page of the HMIS interface to show contact information first, so people are more inclined to update the contact information. If the info is older than 3 months, highlight it in red to remind the provider to update it. Similar to the banner that goes up when the ROI is about to expire.

6. **Peer Learning Topic: Updating VI-SPDATs**
    a. Postponed until next meeting

7. Check out
    a. The next Coordinated Assessment Work Group meeting will January 11, 2018 from 1-3pm at The Health Trust.