# CASPS Meeting – 6/27/19

Attendees

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**Welcome/Introductions** – Sasha, HomeBase

- We are going to look at a last round of data and do some brainstorming for solutions

**Agenda**

- See slides

**System Performance Analysis** – What we've seen in recent meetings and will discuss today

- Those 45 years old + are less frequently referred to RRH. Remaining questions: Are their VI-SPDAT scores lower? If so, why?
- Single, 45+, male-identified persons are more frequently denied from PSH than we expected – Why?
- Are there differences in reasons between genders for denials?
- What is the reasoning behind referrals rejections related to lack of eligibility?
- Are people with lower scores more frequently resolving homelessness prior to receiving a referral?
- Do race and ethnicity correlate with referral denial?

**CASPS values recap**

- See slides

**Areas already identified for improvement**

- Access for LGBTQI+ persons (especially youth); Spanish and Asian-language speakers
- People self-report disabilities more at initial intake than they do on VI-SPDAT; how to improve comfort levels and promote consistency and cultural competency in assessment?
- Single people age 45+ issues (see above)

**Date dive**

- Equity in age for RRH referrals
    - We've seen that single, 45-year-old+ people are less likely to be referred
    - Singles, 45+ do not have lower VI-SPDAT scores (doesn't explain discrepancy)
    - Attendee concern: The Health Trust sees a lot of people who are scoring in RRH range but, in fact, have higher than RRH score needs. Not sure if this issue is relevant to this particular concern but wanted to raise it.
    - OSH notes that this problem is being looked at across programs and in different ways. The CAWG meetings are a good venue to raise these issues.
    - Attendee (Veteran's Administration): We primarily serve 58-year-old+ men and a lot of these referral issues are pressing on us too. There is a lot of tension between the question-asker for assessments and the discomfort of interviewees (especially around question 22 – drugs and alcohol). Can we incorporate interviewer judgment in a different way?
    - OSH notes that it is looking into this issue as well.
    - This may be an issue of not enough housing resources available to single people 45+ in RRH. Though, we should then see the same results for single people under age 45.
    - SCC is looking at doing a gaps analysis as part of the community planning.
    - Are there ways that frequency of contact with the system may be playing into this? Not sure if being removed from the queue for this reason would show up in a year's worth of data, however.
- PSH – age and gender
    - Are people 45+ more likely to be male-identified?
    - Yes, there are more male-identified persons in the older age-ranges.
    - It is unclear whether it significant enough to explain the denial discrepancy in PSH.
    - Reasons for denial were similar across gender: lack of eligibility/client couldn't be located/show/up/call (and "other")
    - 290 registry requirements can make this an issue if most are men.
- Eligibility denial discussion
    - Overall: A lot of the eligibility denials were actually more properly described with drop-down options aside from ineligible.

        - Several of the current options were not previously available – some of their continued use may just reflect providers not being used to the current, available options.
        - Attendee suggestion: An email to all providers that reminds about best practices and available options for entering/updating contact information and using the proper denial designations might go a long way to addressing these issues.
    - Many eligibility denials were based on 290 or unclear criminal conviction/ "sex offense" status or citizenship documentation issues.
        - This may be accurate but there is also a possibility that providers are not fully understanding what is and is not a requirement.
        - The matchmakers generally push back on these kinds of denials to make sure; they are the ones who know the program requirements and funding streams best.
        - Attendee: Can we build into Clarity something to address lack of social security number issue?
        - OSH: We can provide some guidance on this issue to make sure all matchmakers have most up to date funding requirements. Possibly within the spreadsheet they currently use, rather than Clarity, could be updated to note whether each program requires citizenship confirmation and/or lack of 290.
        - Attendees are curious if the 290 and documentation issues also reflect an inventory issue.
    - If clients are housed through another program it is most often THU.
        - Attendee suggestion: This speaks to a broader issue: increased education for high-level program design decisionmakers around HUD requirements and definitions of homelessness to make programs better respond to these perimeters. For example, a client can advocate to be in THU but end up in a shelter. Right now, you need a case manager who knows the ins and outs of the programs to really advise you and this is not a client-centered approach.
        - OSH: This is something we are currently working on, particularly with THUs and SLE housing programs. HUD reps are involved, though they don't have guidance on everything. But we can make strong cases and document them, i.e., a lot of THUs are more like institutions and should probably be considered as such for HUD requirements.
    - If clients are returned to the queue because they are currently incarcerated it seems to be that it is often unclear how long they will be incarcerated; not sure if there is a good way to address this, since charging decisions, etc. can vary and take a while.
    - Client housed – denied because client self-resolved by VI-SPDAT
        - This data is pretty limited for a variety of reasons.
        - OSH: The overarching issue is, do we have a better way of understanding when people self-resolve? We have to make assumptions based on

people not able to be found. This would be really valuable info to have if we could figure out a way to capture.

- Referrals and Denials based on race and ethnicity
    - Generally, across race, there are no significant discrepancy in referrals or denials across race (for both PSH and RRH).
    - By ethnicity
        - For PSH we see White and LatinX-identified people are less likely to be denied for PSH than others and just as likely to be referred for RRH.
        - There is not a huge difference between ethnic groups.
        - Data is deduplicated by referral, not by client.

**Areas for Improvement Conversation**

- As noted above,
    - Cultural competency issues for LGBTQ+ and primary languages that are non-English, especially Spanish and Asian languages
    - Variance in self-reporting disability at intake versus VISPDAT
    - Single 45+ year old people are less likely to be referred to RRH
    - Single 45-64 people referrals to PSH are disproportionally denied
    - Issue of people not reporting disabilities at intake.
        - OSH: We should focus on this. Maybe the assessor can also utilize documentation outside of intake process. Maybe we could add another element to prioritization outside of VISPDAT to capture this.
        - Question: Is there variance across programs regarding whether the same person or a different person does the two interviews (intake and assessment)? Is there a way to figure out if this makes a difference? And the timing/location of the two interviews? There are numerous issues with when, where, and how the assessments are conducted and how the comfort of the client (and issues related to trauma, etc.) may impact responses.
        - Attendee suggestion: questions 21-24 ask people to acknowledge substance use AND have ability to self-reflect, this is problematic, especially for people in crisis and these folks often are. This is a place to use things like medical records to supplement self-reports.
        - OSH: We are empowered to use triage tool to take data from health, behavioral health info. But it's only based on county data (not custody and not outside of the county health services). We also want to be careful because the current tool is designed to be purely objective and consistent; introducing any subjectivity can create issues of bias, etc.
        - Attendee suggestion: Perhaps we could consider a supplemental scoring tool that puts more weight on age and better explores/weighs disabling conditions. How age plays into potential income potential (physically, practically). This may help address several of the issues we've flagged.
        - Attendee suggestion: Perhaps we can talk to other CESes to ask them if they see this issue and what they do to address it.

        - OSH: The difficulty with this is that SCC is a very unique system, particularly in terms of size/scope. For example, it is not feasible for SCC to case conference every person who comes through the system without divesting significant resources away from housing.
- We want to ensure referrals are processed consistently and fairly.
    - Attendee suggestions:
        - Based on how many folks are denied because they can't be located, Shelley's team could train RRH folks on locating clients; training should be big (get everyone) and repeated regularly, in-person.
        - Maybe we could add a field to Clarity to track when client contact info was last updated.
- Revisiting the issue of people who are referred with RRH-level scores but need more support than indicated:
    - How do we allocate resources outside of prioritization, e.g., people exiting from RRH who are usually still in a precarious spot? How do we better support them?
    - Not necessarily about prioritization on the front-end. We could adjust to make sure people who really need RRH aren't showing up in PSH and vice versa. Progressive engagement and how that looks for our system when we don't have enough resources; stepping people down from PSH to make room for those who need it most.
- Language barriers issues
    - These issues are impeding access to people who need them.
    - Attendee suggestions:
        - Language banks - (call in for translator to assist outreach worker)? Maybe the translator is out of county, even, if necessary – we can cast a wide-net.
        - Also, targeted outreach to community groups and agencies that don't do homelessness work but could be engaged/brought in through partnership.
        - Expand notion of prioritizing comfort and accessibility. How can we get these agencies resources? We can educate agencies to, for example, utilize Medicaid required translation services.
        - Partnering with medical centers around high utilizers. Think about a better way to connect with folks who use emergency rooms for primary health care.
- Overall suggestions that may help address several of these identified issues:
    - A stronger online presence for the CoC.
        - OSH: Our tech needs assessment identified need for client portal to HMIS. Clients could see who their case manager is, see if they have a referral, update contact info, maybe even see where there are open beds, get messages from case managers. This might help ease some of the self-resolution issue question and/or the unable to locate.
        - Is it possible to have a Bay Area-wide dashboard?

        - HomeBase is facilitating conversations around this with all Bay Area counties. Currently talking to privacy attorneys. There are levels: bare bones overlap analysis and then a deeper dive analysis, if possible.
    - VI-SPDAT analysis – Do we have enough to measure how effective this tool is now? Can we look at scores and see if we are really able to house people based on vulnerability? Do we have a volunteer Ph.D. expert we can tap for assistance with this?
- How can we figure out how many people are self-resolving out of the people who could not be located or who are still on the queue?
- What can we do for people who are in the low PSH range who will never be referred?

**Next Steps**

- We have wrapped up first phase of analysis.
- We will now convene a smaller task force to flesh out and identify changes that we can prioritize; we want this group to be representative of the whole CAS (matchmakers, PSH, RRH, outreach staff, intake staff, prevention staff, folks from underrepresented populations that we've identified, health care system, people who have been through CAS, front-line staff, TH, community partners/rep for new stakeholders, emergency room staff, possibly foster care, correctional system contact points). Need to work through the implications of the suggestions and will bring back to a larger group.