Zero: 2016

from Community Solutions

One Cohesive System Built for Zero

Build a unified local system that ties together and leverages the complex network of agency programs, housing and service resources and public systems (mental and human health services) necessary to get to zero.

Resources

All resources are on the table and optimized to best match the needs of those who are homeless. Seize opportunities to fill resource gaps by thinking creatively about leveraging the strengths of the community.

Data & Resource Optimization

Data and performance management tools must be used to assess progress and drive decision-making. All resources are optimized for peak outcomes.

Best Practices

Promote and spread best practices that are proven to efficiently and effectively move people into permanent housing and ensure long-term success.

Collaboration

Collaboration is happening across the community. From political and systems leadership to front line staff – your community is maximizing impact by doing together what can't be done alone.

About this Change Packet

Below are ideas drawn from the collective depth of experience from communities across the country working to end homelessness. They are organized into categories to help provide ideas for change in your community. That said, you may have tried things that have been successful that aren't listed or have a new idea today.

This change packet isn't meant to contain every good idea out there, but rather to support and unleash your own creativity and give your community the tools you needed to get to zero.

This is a living document and we look forward to adding YOUR brilliant ideas as they come!

Special thanks to the Institute for Healthcare Improvement, our partners in learning and design

One Cohesive System Built for Zero		
Strategy Types	**Change Ideas**	**Key Questions**
Common Assessment Tool	➢ Adopt the [enter name of Common Assessment Tool] throughout the CoC as THE assessment tool. ➢ Host trainings across the CoC on the [enter name of Common Assessment Tool] ➢ Work with program level management to plan integration of the tool into existing processes. ➢ Ensure that a special effort is made to include public health and mental health providers in training and adopting the tool.	➢ Which agencies are not yet utilizing the [enter name of Common Assessment Tool]? ➢ Where are the best locations for ongoing assessment? Food Lines, Parks, Libraries, Emergency Rooms? ➢ What support do larger agencies need to integrate the [enter name of Common Assessment Tool]? ➢ Is the process after an assessment is completed clear to everyone involved?
Shared By-Name List	➢ Clear communication with VA, public health and non-profit leaders about the level of consent needed to participate in utilizing the list. ➢ Working with CoC and Community Solutions to make HMIS or Homelink the host of this list. ➢ Work with the VA to open up HMIS or other database access for VA staff. ➢ Create a database (excel or other platform) to capture all Common Assessment Tool data to create our by-name list. ➢ Streamline services by ensuring all agencies have access to input information and utilize the list.	➢ Who does not yet have access to the list? What's needed to create access? ➢ Do you need a task force of data minded people to help guide this process? ➢ Is this list being used to conduct case conferencing? ➢ How is this list being used to avoid duplication of services?
Coordinated Services	➢ Create regionalized outreach strategies coordinated across organizational boundaries. ➢ Utilize regular (weekly) case conferencing practices to coordinate navigation. ➢ Engage public systems leaders to request participation of front line	➢ Does everyone have a clear and shared sense of where outreach is happening and where it is needed? ➢ Who is missing from the table at case conferencing meetings? ➢ How are services being coordinated

	staff in coordination strategies (i.e. Public Mental Health).	with local public health agencies?
Sustainable Governance Structure	➢ Write policies and procedures for your local Coordinated Assessment and Housing Placement System (AKA: Coordinated Entry system) to be adopted by local CoC. ➢ Create a systems level body, which works to clear barriers for the design team and sets agenda for systems level changes needed. ➢ Establish clear decision-making processes.	➢ Does the design team include your HMIS provider and CoC? ➢ Is there a clear leader for the systems team? ➢ How can you ensure that decision-making processes don't slow down or get in the way of experimentation and creativity?

Resources		
Strategy Types	**Change Ideas**	**Key Questions**
Permanent Supportive Housing	➢ Host event to educate PSH providers on benefits of taking referrals through your Coordinated Entry System (referrals that are explicitly made because of veteran/chronic status and by need). ➢ Host regular calls with PSH providers to get feedback on process and answer questions ➢ Implement FLOW model in partnership with PHA to free up PSH. ➢ Create a disciplined and dynamic master, by-name list. ➢ Recruit housing providers to only fill units from prioritized list.	➢ Is there a master inventory of all possible PSH in the CoC? ➢ Is there someone who is knowledgeable about PSH funding and policies that can take the lead to work through these issues? ➢ Do you have a referral process through the local coordinated entry system approach that is faster and less work for PSH providers than using traditional wait lists? ➢ What other kinds of subsidized housing could be coupled with supportive services to increase PSH supply?
Landlords/Front Doors	➢ Develop information packet to educate landlords on housing first. ➢ Designate and fund a landlord coordinator. ➢ Recruit a Landlord Champion to host a landlord meeting (or ask your mayor to host a kick off!) ➢ Collect a feel-good landlord story splashed locally, make it personal, and tell them where to find you.	➢ Has the community identified landlord champions? ➢ Why are landlords resistant to leasing to formerly homeless tenants? How can you address these concerns? ➢ How is the local housing authority engaged with landlords?
Supportive Service Capacity	➢ Train volunteers to do assessments and front-end navigation. ➢ Recruit active duty military as partners in street outreach ➢ Explore partnerships with emergency service providers (jails, ER, detox, etc) ➢ Engage public services like county mental health to participate in case conferencing and providing navigation.	➢ Has inventory been completed of all potential supportive services resources? ➢ Are there agencies currently servicing clients in a clinical model that might consider a navigation/supportive services model?

Bright Spot

David Tweedie programmed needed functionality into Service Point -- in three hours. Time to customize.

Keys to Success

- Recruit a "tech specialist" for your effort
- Make a "wish list" of system functionality
- Develop strong working relationship with HMIS provider
- Flow map your processes and identify log jams to "un-stuck"

Data and Optimized Resources		
Strategy Types	**Change Ideas**	**Key Questions**
Shared Real-Time Data to Drive Change	➢ Recruit 100% participation from community in reporting housing placements. ➢ Share successes in terms of outcomes through electronic, print and social media. ➢ Educate the team on using community dashboards. ➢ Utilize dashboards and Gap Analysis Tools to drive strategies for improvement. ➢ Make sure community Take Down Targets are up to date and communicated publicly. ➢ Provide clear and ongoing communication to providers on how to define permanent housing placements.	➢ Do you know which agencies are reporting and which are not? ➢ Who is responsible for public communications for Zero: 2016 in your community? ➢ Is data regularly being talked about in design team meetings, public meetings (i.e. City Council) and at board meetings of the CoC? ➢ How will Take Down Targets be used to advocate for needed changes and resources?
Optimized Housing	➢ Prioritize all PSH through the local CAHP/Coordinated Entry using your by-name list and	➢ Do you have a clear sense of the criteria by which clients are prioritized into housing?

	Common Assessment Tool data. ➢ VASH and SSVF housing resources are prioritized for veterans based on need as determined by your Common Assessment Tool data.	➢ Does this align with the scoring recommendations of your Common Assessment Tool?

Bright Spot

Zach Brown makes Rapid Re-Housing work for clients in West Virginia way above the top threshold for the RRI score

Keys to Success

- Prioritize securing stable income through benefits and employment
- RRH becomes Permanent Supportive Housing by providing the same level of services.
- Secure commitments from RRH providers to set aside subsidies for higher acuity clients.

Best Practices		
Strategy Types	**Change Ideas**	**Key Questions**
Housing First	➢ Host trainings on Housing First for service and PSH providers ➢ Secure commitments from service and PSH providers to adopt Housing First approach and lower barriers to entry. ➢ Inventory PSH eligibility criteria and test removing policies like required sobriety that may be creating a barrier.	➢ For those agencies not using best practices, why not? What is standing in the way of making these changes? ➢ Where is training needed? ➢ Does anyone have the capacity to offer this training in the community?

Critical Time Intervention	➢ Host trainings on Critical Time Intervention practices for service agencies providing support for housing retention. ➢ Approach foundations to fund agencies willing to adopt Critical Time Intervention.	➢ What would it look like to truly start the process with housing? ➢ Which agencies might be willing to develop this as a new capacity?
Housing Authority - Special Commitments	➢ Work with your local Housing Authority to create voucher preferences for chronic and veterans. ➢ Work with your local housing authority to establish prioritization policies. ➢ Develop agreements with social service agencies to provide support to clients utilizing these vouchers.	

Collaboration		
Strategy Types	**Change Ideas**	**Key Questions**
VA Partnership	➢ Co-locate VA HUD VASH case managers and PHA, HUD, VASH staff. ➢ Hold weekly Case Conferencing meetings with community, VA and SSVF teams to review and update by-name list. ➢ If applicable, align SSVF Priority 1 Plans with Zero:2016 TDTs, goals, and actions. ➢ Coordinate VA outreach with community outreach. ➢ Streamline VA eligibility	➢ Are decision makers at your local VA Medical Center engaged and at the table in your planning? ➢ Do you have local VASH and SSVF directors at the table? ➢ Is there a clear and shared

	determination. ➢ Determine community's ideal process for referring to appropriate VA funded programs. ➢ Create FLOW with HUD-VASH vouchers by celebrating case management graduates to regular PHA HCV.	understanding of how VASH and SSVF funded housing is being prioritized?
Case Conferencing	➢ Invite all agencies providing navigation services and housing support to meet weekly to assign new clients to navigators and collaborate to provide support. ➢ Host conference calls to make it easier for everyone to participate. ➢ Utilize HMIS during meetings to facilitate shared client view and make real time updates. ➢ Regionalize case conferencing to localize focus and ensure relevance for everyone on the call. ➢ Engage local DMV and Social Security office in streamlining documents for clients in the system.	➢ Do you have a list of all potential to participate in case conferencing? ➢ Is the local housing authority engaged in this process? ➢ Are public services providers (i.e. Mental Health) participating? ➢ How could the process of getting clients document ready and matched to housing be streamlined for maximum speed and efficiency?
Systems Leadership	➢ Host regular meetings of systems leaders to hear about challenges in getting to Zero and problem solve to clear the path. ➢ Engage systems leaders at county agencies to drive participation from front line staff in case conferencing and local collaborative.	➢ Are there systems leader who are willing to call and lead these meetings? ➢ How can the local CAHP/Coordinated Entry system integrate with local public health, housing and other systems in ways that might be mutually beneficial?

Partnerships	➢ Co-Locate staff from different agencies to work in same building to facilitate collaboration and quick communication. ➢ Identify new kinds of partnerships, which are complementary and mutually supportive.	➢ How can you bring the pieces of the housing process closer together to make it faster? ➢ What are examples of successful partnerships in the community that can inspire others and be built upon?
Coordinated Outreach	➢ Map all of the outreach happening and identify gaps. Create a share Google map with this information! ➢ Create a shared Google calendar of outreach schedules. ➢ Host regional outreach coordination meetings or conference calls to respond to outreach needs, eliminate duplication of services and ensure geographic coverage. ➢ Coordinate VA outreach with community outreach. ➢ Inventory all outreach services and main points of contact. ➢ Invite local law enforcement to outreach coordination meetings.	➢ Is there someone who would be a natural fit to lead the effort to coordinate outreach across the CoC? (You need someone in this role!) ➢ Have you met with your local police captain to get buy in on your strategies? (remember to listen to his or her concerns!)
When Possible Consolidate Training and Education	➢ Bring multiple agencies together to conduct shared trainings on the SPDAT, Housing First and Critical Time Intervention. ➢ Host an event for landlords to learn about housing first and working with Section 8. ➢ Host a large multi-agency training with for volunteers on conducting assessments and providing navigation support.	➢ What are the key capacities that need to be built to get to zero? ➢ How can existing meeting structures be used to create opportunities for shared training? ➢ What are the core competencies and strengths that each agency can bring to the table to share?

Bright Spot

United Way of Greater Los Angeles regularly brings systems leaders to the same table to collaborate in breaking down the barriers necessary to get to zero.

Keys to Success

- Identify a lead organization to call meetings and be the leader of systems of leaders
- Make a wish list of all the systems leaders to be a part of the group.
- Listen to systems leaders to learn about the barriers and restraints they face.
- Have front line staff list barriers, which if removed, would help them get to zero.