Overview of the Alliance and the Coordinated Entry System

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Background

The Alliance for Housing (Oakland County's Continuum of Care) consists of a network of organizations providing services to those in housing crisis. Through a variety of grants and funding streams, the continuum of care and the organizations that are part of this membership, has an array of programs that provide a comprehensive response to housing crisis which includes immediate emergency shelter, transitional housing, short term financial assistance and housing stabilization services, permanent supportive housing, prevention, diversion and linkage to other long term subsidies such as housing choice vouchers, special needs units and subsidized housing. Operating within a coordinated entry system model, the programs work together to serve the needs of the community.

Funding comes from a variety of resources, including directly from HUD (Housing and Urban Development), as well as from the state housing authority (MSHDA) and local government, as well as linkage to other resources in the community. Additional funds may come into the community through grants and foundations, as well as other funding sources, which may change year to year.

Partnerships

There are multiple providers receiving funding for specific housing programs within the Alliance. There are multiple agencies and organizations working together to meet the needs of the community and to provide a network of support. Below is a list of all the agencies and organizations, which includes entities that are receiving funding directly through the CoC as well as those that are funded differently.

Baldwin Center
Catholic Community Response Team (CCRT)
Common Ground
Community Housing Network (CHN)
Community Network Services (CNS)

Community Sharing Outreach Center
Covenant Community Care
Disability Network of Michigan (DNOM)
Easter Seals Michigan
Gary Bernstein Clinic
HAVEN
Hope Network/New Passages
HOPE, Inc.
Jewish Family Service
John Dingell VA Medical Center
Lakeshore Legal Aid
Lighthouse of Oakland County
Macomb Oakland Regional Center (MORC)
Michigan Department of Health and Human Services (MDHHS)
Michigan State Housing Development Authority (MSHDA)
Oakland County Health Division
Oakland Community Health Network (OCHN)
Oakland County Veteran's Services
Oakland County Schools
Oakland County Sheriff's Office – Program Services Unit
Oakland Family Services
Oakland Integrated Health Network (OIHN)
Oakland Livingston Human Service Agency (OLHSA)
Rochester Neighborhood House
South Oakland Shelter (SOS)
Training and Treatment Innovations (TTI)
Welcome Inn/South Oakland Citizens for the Homeless

Geographic Area

Through the above list of providers it is the intention of the Alliance to provide coverage to all areas of the CoC which encompasses all of Oakland County. The CoC will continue to promote and solicit new membership to ensure that those in housing crisis are able to easily access services through linkage in their local area.

This includes the following cities, townships and villages that are within the borders of the county:

Addison
Auburn Hills
Berkley
Beverly Hills
Bingham Farms
Birmingham
Bloomfield
Brandon
Clarkston
Clawson
Commerce
Farmington
Farmington Hills
Fenton
Ferndale

Franklin	Milford	Royal Oak
Groveland	Milford Township	Royal Oak Township
Hazel Park	Northville	South Lyon
Highland	Novi	South Lyon Township
Holly	Oak Park	Southfield
Holly Township	Orchard Lake	Southfield Township
Huntington Woods	Orion Township	Springfield
Independence	Ortonville	Sylvan Lake
Keego Harbor	Oxford	Troy
Lake Angelus	Oxford Township	Walled Lake
Lake Orion	Pleasant Ridge	Waterford
Lathrup Village	Pontiac	West Bloomfield
Leonard	Rochester Hills	White Lake
Lyon Township	Rochester	Wixom
Madison Heights	Rose Township	Wolverine Lake

Access and Accessibility

This system is intended to be responsive to the various needs and demographics of those in the community in housing crisis. For those that are in outlying areas of the county, there needs to be a way to get quickly linked to the system. The Continuum of Care will continue to solicit new members to build upon the safety network. For those agencies and organizations that do not have the capacity to be formal access points, referral partnerships will be established, allowing them to easily connect the potential program participant that they are working with to the Continuum of Care. This begins with consent and basic demographics to quickly link and triage the presenting individual or household to services.

Additional accessibility considerations include:

- Language: Accommodations will be provided to those that may have English as a second language or are unable to read materials that are provided. Participating agencies will ensure that interpreter services are made available either through internal resources or by contracting with another agency for these services. Depending on the situation this may require assistance via phone, or face to face, based on the forum on the circumstance. Best practices suggest that an "I Speak" poster or written materials be provided to all potential clients on walk in at any participating agency with ability to simply point at the language that the person speaks so appropriate interpreter services can be provided.

  It should be noted that in all cases an interpreter must be offered to the individual. It should never be assumed that a family member can

interpret on behalf of the program participant. This resource must be offered to allow the individual an opportunity to communicate freely and without bias.

- Visual/Hearing: To ensure equal access to individuals and households that present with a disability, accommodations will also be made. For those with visual impairments, an agency representative will read all written materials, or provide audio copies or alternative forms of written materials (i.e. large sans-serif font like Arial or Tahoma) to the potential program participant or existing program participant. For those with hearing impairments, the use of sign language interpreters or alternative modes of communication such as text to relay systems will be utilized.

- Physical: Participating agencies within the Continuum of Care will work to ensure that physical locations are accessible to all from a facility's structural standpoint. While there are instances where buildings may not be accessible in all features, accommodations will be made as soon as possible. This may mean locating a person temporarily to an office on the ground level of a building for shelter although typical services are on a different floor, meeting with a potential program participant in an alternative/community location for assessment, etc.

- Transportation: it is recognized that transportation is often a barrier to those needing access to this crisis response system. This may be due to limited public transportation or due to the cost of transportation resources. Participating agencies within the Continuum of Care will work closely with individuals and households by either providing transportation resources (i.e. bus tickets or connection with transportation services that are low cost/free) or by arranging for meetings to take place within community locations more accessible to the individual or household.

Affirmative Marketing and Outreach

To ensure that anyone in a housing crisis in Oakland County is aware of the resources available to them, and can access these services easily, the Alliance for Housing implements a marketing plan that includes promotion of the services provided by the network of agencies. The Continuum of Care provides these services to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, and disability.

It is recognized that often those with the most need and the most vulnerable may not reach out to this network of their own initiative. Those least likely to apply will remain an important component to reach these groups, including

outreach directly to potential program participants in housing crisis, but also to partnering agencies across the Continuum of Care's geographic area so that those in need that come in contact with those agencies or faith based organizations can quickly link these households to services.

The CoC put together a Help Card. The Help Card is a small portable card that has emergency/crisis numbers that are answered 24/7. The Help Card also has general, non-emergency services information listed. These include housing, shelters, food pantries, soup kitchens and Latino services. These cards have been given out to the police department as well as agencies, shelters, and volunteers. They are used as an immediate resource to provide information to those in need.

The Alliance arranges a yearly Community Resource Day (CRD). This event is a one-day community oriented event to offer help. The CoC draws in all the resources in the community that can support people and families in times of crisis to one area. These can range from housing assistance, veteran services, and employment services to hair-cuts. The purpose of the event is to promote services made available to clients and help explain how people can apply for them. CRD is also an opportunity to raise awareness in the community. It creates the ability to inform about the need as well as offer an opportunity to address it.

The CoC also coordinates an annual Point in Time Count (PIT) in January of each year, to not only meet the HUD requirements for funding but in addition to reach out to those with the most need, often unsheltered in the coldest time of year. The coordinating body utilizes feedback from community members, both service providers and those who are or have previously been homeless, to target efforts and outreach to the places where those on the street would seek shelter from the elements. This allows the community teams to provide direct outreach and engagement to those who would not seek out assistance without these efforts.

The CoC utilizes social media to connect with other agencies, as well as individuals seeking services. Anyone who has access to social media can go to our page to find out information about upcoming events, services and resources they may be interested in. The Alliance for Housing website also offers an array of information pertaining to each agency as well as documents and information relating to the CoC.

Screening and Assessment

Screening:

Access/ Referral Points: As noted previously in this document there are agencies and organizations that are formal partners that share information within HMIS to allow for a coordinated system, utilizing a QSOBAA (Qualified Service Organization Business Associate Agreement) as well as consents from potential program participants to share the information within the network and HMIS. These partners are able to utilize a community wide assessment in HMIS to assess and refer those presenting as homeless or at risk of homelessness. This assessment was tailored to include the essentials (including HUD standard questions related to homeless history and other factors, as well as the VI SPDAT[1] for those who present as literally homeless) to determine potential eligibility for variety of programs and resources, and to streamline the system without duplication. Each partner agency, with the exception of the DV Shelter, has the ability to make a referral to quickly link the potential program participant with appropriate services. If a potential program participant qualifies for services offered within the CoC based on the assessment, a referral is made in HMIS to the appropriate program or agency.

These access/referral points will be strategically placed in the community and will routinely be evaluated to ensure accessibility across the Continuum of Care. The Continuum of Care will also utilize referral partners, not formally in the HMIS system, but community partners that can provide quick standardized information in case a family in crisis, in need of RRH or Prevention funds, presents at their location.

Households that present at any access/referral point, regardless of whether it is an access/referral point dedicated to the population to which the household belongs, can easily access an appropriate assessment process that provides the Continuum of Care with enough information to make prioritization decisions about this household. The household will then be linked to appropriate resources. To ensure that this information is collected in a consistent manner, all access/referral points will use a standardized screening tool for basic information needed to determine eligibility and prioritization.

This process assures that households who are included in more than one population (for example unaccompanied youth also fleeing DV) can be served at all access/referral points. This also allows for standardized decision

[1] SPDAT stands for **Service Prioritization Decision Assistance Tool (SPDAT) and is a full assessment. The VI – SPDAT is the Vulnerability Index which provides a screening to determine need. Both assessments are used to assess need and risk factors for persons that present as homeless.**

making. Additionally no access/referral point can deny a person who has or is a victim of domestic violence, dating violence, sexual assault and stalking. Rather, the assessment will be completed, linkage occur and services will be provided with safety considerations for the individual or household in mind.

There may be situations where transportation or other challenges prevent the person from meeting with a screener face to face. The program participant can complete a screening to begin the process via phone to eliminate such barriers and this is often a standard process across the Continuum of Care, especially at the HARA. Additionally agency staff at access/referral points will work with potential program participants to meet at a location that is easily accessible for the program participant. This may include issues with transportation, being already temporarily housed at a community partner's location, or utilization of street outreach services. Additionally those with disabilities may have a need for the staff to come to them for additional reasons.

All providers that are HMIS licensed users in the Coordinated System will be considered ACCESS points for potential program participants presenting in housing crisis to link with services. The agencies utilize a CoC level QSOBAA[2] (Qualified Services Organization Business Associates Agreement) that provides the ability to coordinate services and share data entered in to the Service-Point HMIS data system, between the listed partner agencies for Oakland County. The QSOBAA only includes sharing data captured within HMIS. The agreement is signed by each agency, local Lead HMIS Agency, MCAH, and MSHDA that governs the privacy standards for all those that can see multiple organization data.

The agencies participating in this agreement include:

Participating Agency	**Subpopulation/Specialty**
Common Ground	Youth
Community Housing Network	HARA for OC, Housing Provider
HOPE	Low barrier shelter
Lighthouse	Emergency Services, Housing Provider
Oakland Integrated Health Network	FQHC
South Oakland Shelter	Shelter and Housing Provider
Training and Treatment Innovations	Housing Provider, Veteran Services

** Please note that HAVEN is a shelter and one stop for individuals and households that are experiencing domestic violence. Based on regulations they do not enter information into HMIS but connect potential program participants with the CoC.*

[2] Oakland County-Alliance for Housing, Qualified Service Organization Business Associate Agreement (QSOBAA) 2017

Referral:
The CoC is developing a referral system for all non HMIS agencies to use with individuals that are trying to connect with the coordinated system. A one page community wide referral sheet will be available for agencies that do not use HMIS. This will be implemented by January 28th, 2018

Eligibility and Prioritization:
Any individual or household in housing crisis is able to access the CoC for housing resources and referral. Due to the high need and capacity to serve, prioritization is used to insure that those with the most need receive limited resources first. The community utilizes established thresholds to meet the needs while balancing capacity and available resources. These thresholds are community established and routinely reviewed to ensure that they are appropriate.

Thresholds have been established, along with a prioritization policy, that provides guidance and structure for determine eligibility and prioritization for prevention, rapid rehousing, permanent supportive housing and transitional housing. These policies both honor HUD guidelines and regulations, as well as unique funding requirements based on the program and grantor guidelines.[3]

Rapid Rehousing:

- Individuals and families that present who are literally homeless, who are under 30% AMI are potentially eligible for rapid rehousing from one of the Continuum of Care partners. Based on specific grant parameters, programs have some differences in assistance that can be provided in specific line items. The Continuum of Care develops an annual grid that spells out the allowable items and parameters of each program funding. This includes nuances with percentage or amount of rent that a program will assist.

- To ensure that those with the most need are served, the community established thresholds with a minimum vulnerability score to be eligible for RRH. Over time this changes, with community input and feedback. This is based on capacity and level of funding. When there are less resources to serve everyone that presents as eligible, the community raises threshold to ideally be in line with VI SPDAT guidelines (6+ for individuals and families) but when more funding is available will relax this requirement as long as the presenting

[3] Alliance policies and supplements: Oakland County Centralized Housing Registry Policies and Procedures, Prevention Program Overview Grid, Community Established Thresholds

household would remain homeless "if not for this assistance" has increased the threshold when those with higher scores cannot access more intensive programs due to availability to ensure rapid rehousing.

Permanent Supportive Housing:

- Individuals and families that present who are literally homeless, who are under 30% AMI are potentially eligible for permanent supportive housing from one of the Continuum of Care partners. The community has established a prioritization registry to ensure that those with the most need are served first as part of the CE

Transitional Housing:

- Common Ground and Lighthouse are agencies under the CoC that provide transitional housing.
- Common Ground Graduated Apartment Program: This consists of providing housing subsidies and supportive services to homeless adult for up to two years. This program helps people develop a greater level of self-sufficiency, interpersonal skills, and housing readiness. During this time residents must maintain employment and an education plan.
- Lighthouse PATH: PATH is a two year transitional housing and empowerment program for homeless women and their children. The program offers comprehensive case management, including parenting, life skills, help with personal finance, job training and workforce development.
- Both transitional housing programs have representation at the Prioritized Housing workgroup and utilize this forum to access referrals.

Assessment:

The CoC uses a phased approach to assessment that includes multiple stages. This process has integrated housing first principles focusing on rapidly housing program participants without preconditions to services. This process strives to be person centered focusing on a participant's individual strengths, goals, risks and other factors. Questions are asked in a way that are easily understood by the participant and are sensitive to the diverse experiences that program participants have. When applicable, individuals and households are offered choice in decisions about location and type of housing within specific available grant parameters. When educating program participants about the program options, staff explains expectations for both program staff and program participants.

Initial Triage- As noted earlier an initial screen provides the initial triage, working with potential program participants to resolve the immediate housing crisis and linking with the appropriate systems to address the immediate needs. For those that are literally homeless this will include a VI-SPDAT when working with a participating access point.

Diversion and/or Prevention Screening- All presenting households and individuals in housing crisis will be assisted with identifying diversion and prevention resources. Every effort will be made to avoid entering the homeless services system by exploring options that may include linkage with natural supports, more affordable housing options or mainstream community resources.

Crisis Services Intake- For those in housing crisis, intake includes identification of individuals housing and service needs in an effort to resolve the program participants' immediate situation.

Comprehensive Assessment- After potential program participants are screened as potentially eligible for a program a full face to face assessment occurs. In a face to face assessment accommodations are made to meet the person in a location that will not present barriers and will also allow for safety and confidentially as the presenting individual or household will be relaying sensitive information. At this time more information is collected to continue to build on the information already collected in the previous phases. This includes more detailed information about housing and homeless history, barriers, goals and preferences. The assessment supports the evaluation of the participant's vulnerability and prioritization of assistance utilizing the full SPDAT in this process.

In this process the individual or household is informed of the ability to file a non-discrimination complaint as well as an overview of the assessment process. During this assessment potential program participants are freely allowed to decide what information they provide during the assessment process. This includes the ability to refuse to answer questions on the assessment, and refused housing and service options, without limiting their access to other resources and programs. Rejection of a form of assistance will lead to the potential program participants being removed from prioritization for that specific resource but will allow them to access any other eligible resources without any additional consequence.[4]

Next Step Move On Assessment- Opportunities to reassess potential program participants often occur throughout routine interaction with the

[4]CoC Anti-Discrimination Policies & Equal Access Rule

individual or household. This may include an updated VI-SPDAT after six months or in situations where a significant life event had been reported. Additionally, full SPDATs occur on a regular and consistent basis at scheduled intervals to insure continued tracking towards progress and goals and to evaluate reduction of intensive services and assistance. Additional tools like the moving up assessment are utilized in specific programs to gauge transition from cost and service intense programs such as PSH.

Privacy and Protection

The CoC only shares program participants information and documents when the program participants provides written consent with either an ROI or coordinated services agreement. It should be noted that initial screening with HMIS entry may be limited to a verbal consent as the interaction may not be face to face. The CoC partners comply with privacy and protection for all HMIS entries in accordance per MCAH under the operational rule HIPAA[5]. Similar precautions are taken with all hard copy documentation; program participants chart files and any other electronic data storage requiring all participating agencies to securely maintain information. This includes locking of filing cabinets and doors as well as restrictions places on electronic files. Additionally, when utilizing e-mail between agencies only non-identifying information is used or e-mail is protected with encrypted software.

As mentioned earlier in this document, the assessment process is a phased approach which includes an initial screening and triage with a follow up assessment as applicable. Through the assessment process program participants are not required to disclose information regarding specific disabilities or diagnoses. Rather broad categories are utilized in accordance with universal data elements established by HUD/HMIS however a specific diagnosis for disability may be required to determine specific program eligibility in order to make an appropriate referral. For instance, a PSH program may require a disability of severe and persistent mental illness in order to qualify due to the specific grant parameters. Additionally all PSH program require a disability of all deration.

As referenced in 'Access/Referral Points' on page 5, a QSOBAA was put in place to allow for sharing of information for those that share data in HMIS as well as PSH partners that work with those experiencing domestic violence. However, because of the need to share information beyond the partners covered in the QSOBAA, a community MOU has been put in place that allows for the partners to share coordinating services. Additionally, changes will be made to the Alliance's HMIS Release of Information to allow for continued coordinated assessment and services.

[5] 2016 MSHMIS Operating Policies and Procedures, Part III. Privacy, p 8-14

Assessor Training

Oakland County HMIS System administrators provide training for new users in Oakland County. Updated workflows are provided via Alliance's website. Required as a part of the MSHMIS User Requirement & Documentation[6] HMIS Users are informed and understand the privacy rules associated with collection, management and reporting of client data. Users of HMIS are trained to complete the coordinated entry assessments, enter data into HMIS, and obtain signed required confidentiality agreements. Training for HMIS users and agency staff serving as access points will be held at minimum annually and more frequently as needed.

Marketing

In accordance with several civil rights and fair housing laws[7], The Alliance for Housing affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or least likely to apply in the absence of special outreach. This includes ensuring that all people, various populations and subpopulations in the geographic area, are served. While this is not an exhaustive list, the CoC has addressed the needs of those experiencing chronic homelessness, veterans, families with children, youth and those fleeing domestic violence[8].

24 Access with the Help Card as mentioned on page 5. Additionally the local 211 offered through United Way contains information about housing and other crisis resources. The Continuum of Care will maintain an up to date listing to provide a global entry for all housing resources with access points available.

Access

Please see information about screening and assessment located on page 3 for information about access models and accessibility.

Emergency Services

A potential program participant that presents in housing crisis, in need of emergency services, is not limited by the business hours of an access or referral partner. All after hours lines will provide information about who to call when the person is presenting after hours for services. Additionally, a Help Card with emergency information has been printed with resources that provide 24/7 access to a low barrier shelter, see page

[6] 2016 MSHMIS Operating Policies and Procedures, Part II. B & Appendix A.

[7] Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II and III of the American with Disabilities Act.

[8] CoC Anti-Discrimination Policies and Equal Access Rule

5. If the potential program participant is seeking emergency shelter after hours we have a designated shelter that is able to take them 24/7 and connect them to the appropriate service/agency during regular business hours.

Prevention Services

The same process is utilized for all RRH and Prevention Services. The same intake and screening are used consistently across the Continuum of Care with the exception being the VI which is only used for those who present as literally homeless. As noted in other sections of this document prevention services are also included in prioritization and community established thresholds.

Street Outreach Teams

Any street outreach services working with the Continuum of Care will be integrated into the standardize screening and assessment tools. Outreach workers will at minimum provide an agreed upon screening as a referral partner with a consent filled out to share information. Those who are also access/referral points will complete the coordinated assessment and prioritization tools as appropriate.

Mainstream Resources

Screening and Intake routinely discusses and links with any available resources in the mainstream. This includes assistance with income and food assistance.

Virtual Entry

24 Access with the Help Card provides virtual access to providers that can assist with linkage and access/referral points. Additionally the local 211 offered through United Way contains information about housing and other crisis resources. The Continuum of Care will maintain an up to date listing to provide a global entry for all housing resources with access points available.

Training

The CoC will be offering LGBTQ+ sensitivity training for all agencies. This training will take place annually with updated trainings as needed. Every year at the annual retreat policies and procedures are sent out on the list serve for review and asked for feedback for any updates as well as discussion at the meeting. The CoC also takes part in webinars provided by the HUD Exchange whenever applicable to stay up to date with HUD policies.

Evaluation

The CoC evaluates all state and federal grants yearly with the sub grantees. Agencies receive a set of requirements, federal and state guidelines and community specific goals. The CoC evaluates the agencies' paperwork and documents so making sure that program participants are eligible, rents are being collected as well as the processes the agencies use throughout the program. Agencies are also evaluated on their participation within the CoC events and meetings. The CoC also uses HUD and MSHDA documents to assure they are operating at an efficient level as HUD and MSHDA guidelines require. Every agency receives a follow up letter with evaluation results so they can see what is effective and what needs improvement.

The Alliance for Housing also has an Operation Committee which consists of a minimum of one Board Member and other members of the Alliance at large. This committee focuses on reviewing other operations within the CoC, coordinates the CoC process as well other consolidated and/or collaborative applications throughout the year. The Operation Committee assesses the current projects the CoC is working on and determines what is effective and what needs to be improved upon.

The Alliance for Housing is developing a plan to conduct CoC evaluations with current and past program participants through CoC funded agencies to get feedback regarding their experience with the programs.