COORDINATED ACCESS WHERE TO START, WHAT TO AVOID, AND HOW TO TAKE IT TO THE NEXT LEVEL









TAKING CA TO THE NEXT LEVEL

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'OLD-SCHOOL' COORDINATED ACCESS

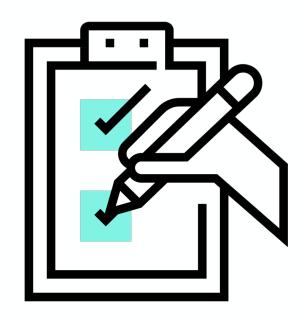
Common processes to ensure appropriate program matching, consistent prioritization, and streamlined flow of clients across homeless-serving system.

Provides information, screening, referral, and intake through one or multiple sites in the homeless-serving-system.

Assessment supports appropriate matching & prioritzation of client to homelessness programs or diversion out from these services.

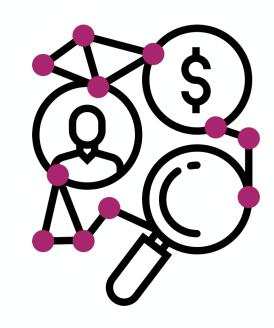
A NARROW VIEW ON CA WILL ULTIMATELY BACKFIRE

- Programs will backlog at some point as the homeless-serving system makes up about 1% of the social safety net ecosystem resources.
- Help seekers will not get access to the diverse services & benefits of the broader safety net they need & have a right to.
- See long-term recidivism as your housing programs can only do so much without broader systems integration.
- Continue to see flow into the homelessserving system, because prevention is an add-on not core mandate of the ecosystem.



CORE BELIEFS GUIDING CA & SYSTEMS PLANNING WORK

- Rights-based: everyone deserves a basic standard of living, including housing, but also supports to thrive.
- Strengths-based: People are more than our definition of 'deficits' or 'problems': everyone has assets and strengths.
- Leveraging: We have tremendous resources in a \$500 billion/yr charity & non-profit safety net we can leverage.
- Prevention: There's no waiting to get to prevention; prevention is the social sector's core work to achieve wellbeing at the individual, community & societal levels.



COORDINATED ACCESS FOR PREVENTION & SYSTEMS INTEGRATION

- Connect the dots across systems and agencies for those looking for help
- Ensure we are leveraging our resources and aligning to common objectives
- CA as practical mechanism for service & benefits coordination and integration across systems.



WHAT'S NEEDED?

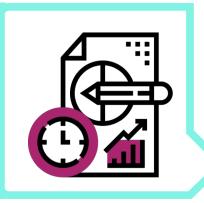
Systems Mapping

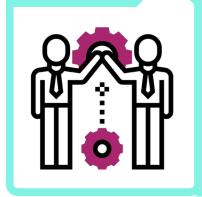




Strategy Alignment

Data/
Information
Sharing





Service &
Benefits
Coordination

WHAT CA ACROSS SYSTEMS LOOK LIKE?

Coordinated process for people looking for help, including housing.



Information

Info on all services & benefits available are transparent and easy to access.



Screening

Eligibility criteria/ prioritization process documentation needs are transparent to help seeker.



Matching

Appropriate referrals to all services that meet help seeker's diverse needs.



Initial Intake

Supporting help seeker w/ initial intake into appropriate supports.



Assessment

Completing necessary assessments before making referrals.



Referral

Supporting helps seeker with appropriate referrals (warm handoff as needed).



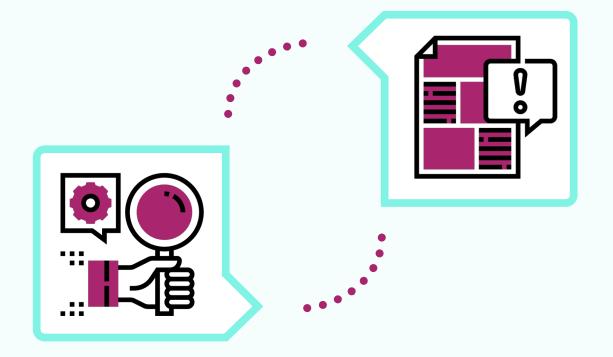
Support Plan

Supporting help seeker with support plan holistic of their needs & strengths.

MAKING COORDINATED ACCESS WORK

By-Names-List (BNL) tells you what you need.

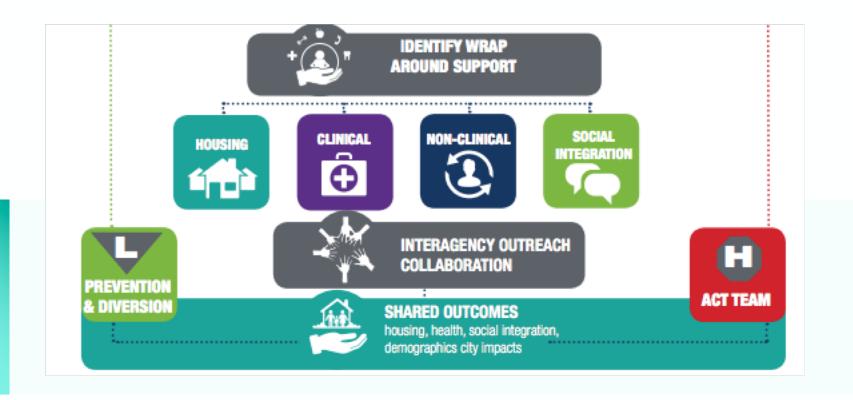
You need to match people to resources based on needs.



Live Systems
Map (like
HelpSeeker)
tells you what
you have.

Allows you to leverage what your community has, not just what you fund/operate.

ABBOTSFORD PREVENTION & RESPONSE SYSTEM





- Affordable housing and supportive housing
- Housing with Abbotsford Rental Connect (HARC)
- Market Housing

CLINICAL



- Fraser Health Authority
- Access clinic
- Addictions/Mental Health
- Abbotsford Primary Health Services

NON-CLINICAL



- Housing retention
- Support workers
- Income
- Other supports as required by participants

SOCIAL INTEGRATION



- Work, volunteer and civic engagment opportunities
- Service provider connections

FUNCTION OF

Anchor agencies work together to designate appropriate community support. Their role is vital and includes VAT administration referral to the Outreach Team and liaison to ACT, as well as updated service/housing availability.

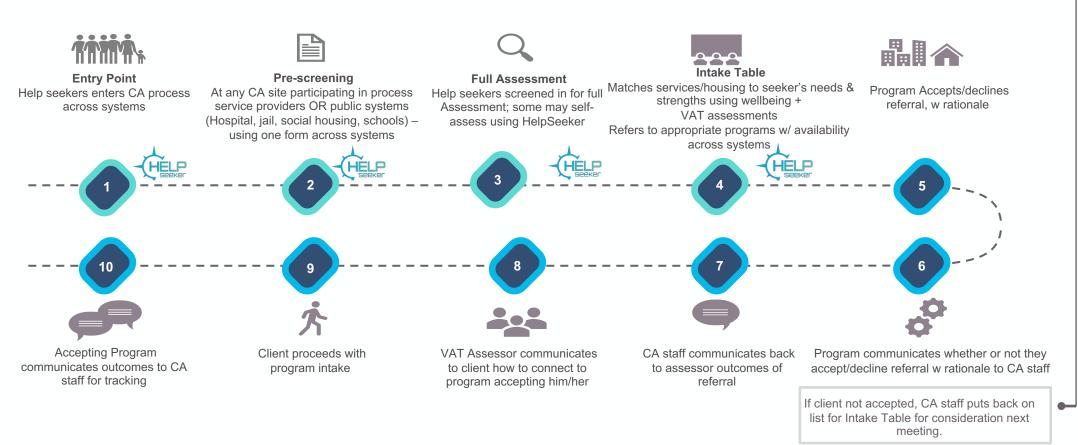
ACT TEAM



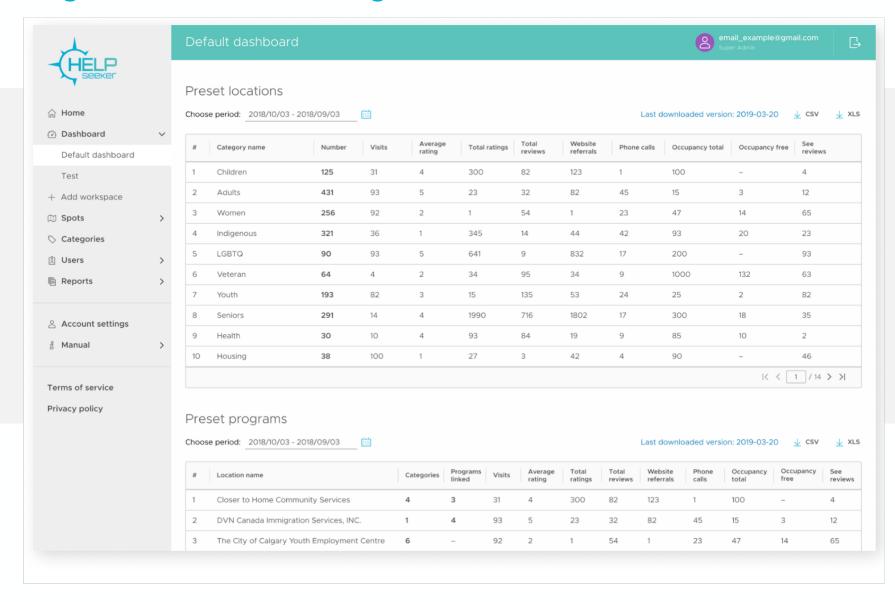
ACT Team stands for Assertive Community Team and provides flexible community based supports for adults with serious and persistent mental illness.

ABBOTSFORD'S PROPOSED CAUSER JOURNEY

CA across systems to prevent vulnerabilities
Assesses holistic individual and community wellbeing & supports alignment •



Using HelpSeeker Occupancy/Eligibility Reports to Right-Match Clients through Coordinated Access with Realtime Data



A HOLISTIC, PERSON-CENTERED LENS

There are various interrelated domains impacting wellbeing, including basic needs like housing and income, and beyond - such as education and recreation. These domains are impacted by relationships, community, and societal contexts.

An integrated safety net ecosystem will need to work across these domains to achieve desired impact and overcome the current siloed approach.



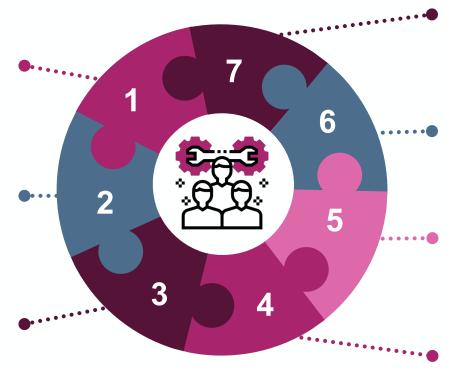
INTEGRATION STRATEGIES

Successful integration achieved when particular strategies applied across systems.

Common policies and protocols, shared information

Coordinated service delivery and training

Having staff with the responsibility to promote systems/service integration



Adopting and using an interagency management information system

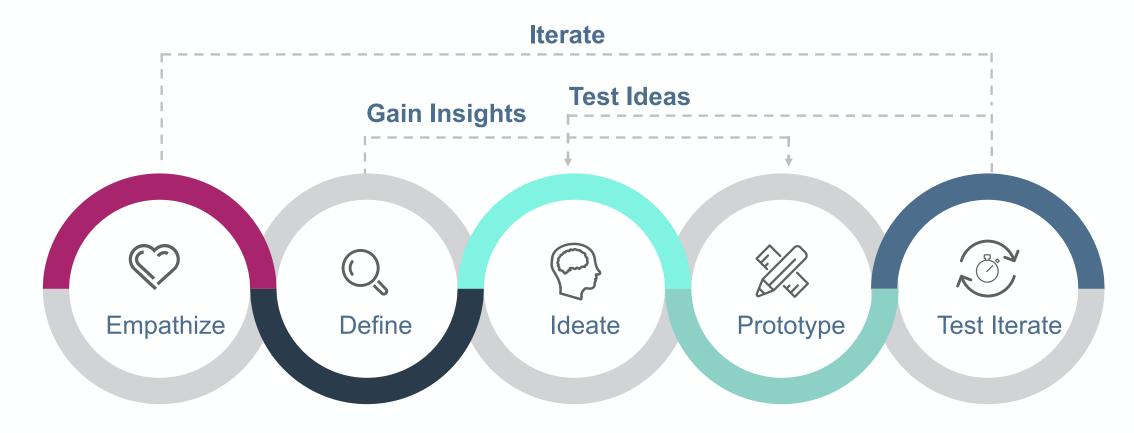
Co-locating mainstream services within homeless-serving agencies and programs

Coordinated access across systems

Creating a local interagency coordinating body

DESIGN THINKING MINDSET:

A Non-Linear Process for Breakthrough



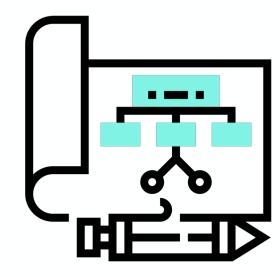
ENDING HOMELESSNESS IN ST. JOHN'S & CA

Julia von Rhedey System Planner, End Homelessness St. John's



END HOMELESSNESS IN ST. JOHN'S (EHSJ)

- Government, Non-Profit and Private sectors to maximize and leverage capacity to develop and implement system integration, advanced data collection and coordinated access to services
- The City of St. John's currently serves as the designated community based organization (Community Entity – CE) in St. John's for Reaching Home



COORDINATED ACCESS (CA)

 Coordinated Access (CA) is a standardized, system-wide approach, designed to match individuals experiencing or at imminent risk of homelessness, with programs and services that will be best suited to serve their needs and ensure their long-term housing stability.



EHSJ GUIDING PRINCIPLES









Zero discharge into Homelessness



6 Compliance with ATIPPA, 2015



Focus on the individual's needs & outcomes



Commitment & participation of member organizations. (meetings / tables / etc.)



Collaboration, cooperation & info sharing between member organizations



CA GUIDING PRINCIPLES



COLLABORATION

We believe we are stronger when we work together.
Our relationships are built on a shared vision that we can end homelessness in our community.



CONFIDENTIALITY

Through informed consent, we honour the privacy of the people we serve. We only share information when it will help achieve housing stability.



INTEGRITY

We engage ethically and transparently in our words and actions. We seek to create trust, respect for all viewpoints and we give space for everyone to participate.



HOUSING FIRST

The belief that everyone deserves a home is ingrained in everything we do. Housing is the first step, with supports and services based on choice and need.



SOLUTION FOCUS

We look forward to solutions, not backward at problems. While the perfect solution may not exist, we commit to do our best with what we have.

WHAT DOES ACCESS MEAN?

 Refers to the engagement point for an individual or family experiencing or at risk of homelessness.



ACCESS: PRE-SCREENER

OMELES SNESS						
ST. JOH PRE-SCREE		NATED ACCESS				
		personal info must be signed befo	re this form is complete			
		h the CA Pre-Screener Information ion measures must be exhausted p				
1. Individua	l (or head of household)	name:				
2. Please in	dicate the individual or fa	amily's current homelessness state	us:			
home		inually homeless for a year or more C rs, due to complex and persistent bar se				
	Episodic homelessness – Homeless for less than a year AND <4 episodes of homelessness in the past 3 years, due to complex issues such as addictions or family violence					
the pa	Transitional homelessness – Homeless for the first time OR <2 episodes of homelessness in the past 3 years, generally due to economic or housing challenges, requiring minimal and one-time assistance					
least		ss – Housed, but do not have safe and we the resources or support networks				
☐ None	of the above, please spe	ecify:				
B. What is t	ne individual or family's	current housing situation?				
add	itution – health (including iction treatment) itution – corrections	Housed Couch surfing (i.e. staying with friends/family/others)	Shelter Rough sleeping (i.e. outside, car)			
go то	QUESTION 4	GO TO QUESTION 5	GO TO QUESTION 6			
4. Do vou h	ave a safe and stable ho	using situation to return to?				
∏ Yes						
П№	EILL OUT BELOW	W, THEN GO TO QUESTION 6				
Flease	писае, апи ехріані, ітті	nent safety and/or stability concerns:				
1						

Ī	Yes DIVERT		
	No FILL OUT BELOW, THEN GO TO Please indicate, and explain, safety and/or stability		
6. V	What has been tried already? Specify at least 3 at	ttempts. Please indicate the outcome. Outcomes:	
_	lousing search support		_
_	andlord mediation inancial mediation (budgeting, credit counselling)		_
_	emporary stay with family or friends until housing		_
_	emporary emergency shelter until housing is found		_
=	dome care supports		_
=	ncome resources (Income Support, CPP, OAS etc.) food bank, clothing, furniture support referrals		_
=	Employment support referrals		_
=	access to community agency support services		_
=	Referrals for mental health, trauma, substance use Referrals to address family/relationship breakdown		_
_	Referrals to address family/relationship breakdown		_
		Outcome:	_
_			_
		Date:	_ I
	rral Agency:		_
Refe	rral Agency:	Phone:Email:	-

ASSESSMENT

 Assessment refers to the gathering of information about an individual or family accessing the system.



VULNERABILITY ASSESSMENT TOOL (VAT)



Survival Skills



Basic Needs



Indicated Mortality Risks



Medical Risks



Organization/ Orientation



Mental Health



Substance Abuse



Communication



Social Behaviours



Homelessness

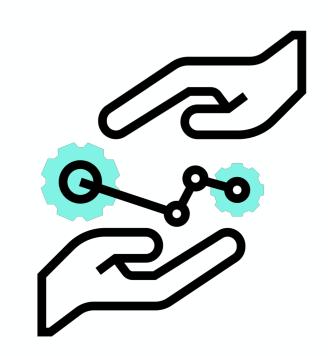
PRIORITIZATION

 The process of determining an individual or family's priority for housing based on information gathering through the assessment.

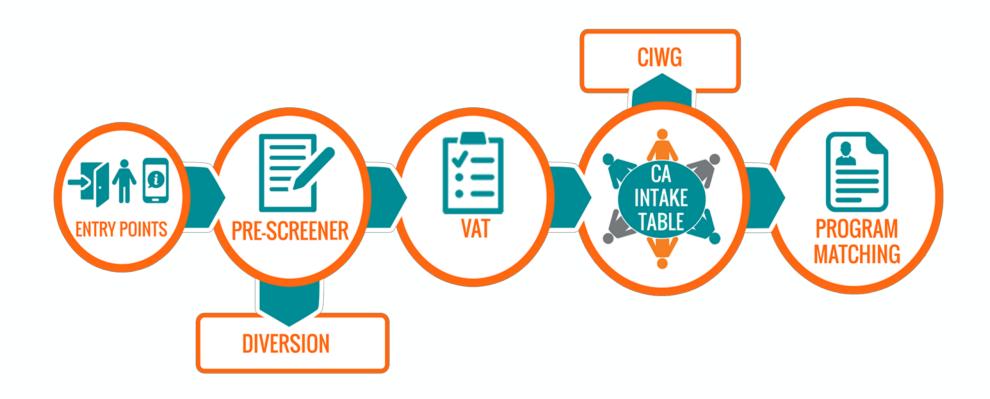


PROGRAM MATCHING

 The process whereby the individual or family is matched to and offered housing based on project specific eligibility, needs and preferences.



COORDINATED ACCESS INTAKE TABLE



PROGRAM MATCHING

Program	Currently homeless	Needs not being met by existing system	Not able to self-resolve, i.e. insufficient resources or support networks	Type of homelessness			Vulnerability			Previous history of successfully maintaining housing	Estimated length of program intervention required for individuals to successfully maintain housing				
				Chronic	Episodic	Transitional	At imminent risk	<15	15-25	25-35	35+	Previous hist mainta	<12 months	12-24 months	>24 months or not at all
Intensive Case Management (ICM)	✓	✓	√	√	√	×	×	×	√	√	√	√or×	x	√	×
Homelessness Prevention and Rapid Rehousing (HPRR)	√or ×	✓	√ 	x	√	√	✓	✓	√	×	×	✓	✓	×	×
Supported Referrals (SR)	√ or x ⁵	✓	✓	×	×	√	✓	✓	✓	×	×	✓	✓	x	x

GETTING STARTED: HAMILTON'S JOURNEY

Amanda DiFalco Manager, Homelessness Policy and Programs Housing Services, City of Hamilton



VISION: EVERYONE IN HAMILTON HAS A HOME

Our journey began with an end goal in mind...

Working back from this vision we had to determine:

- What tools were needed to gain buy-in from the community?
- What strategies were required to support implementation?
- O Who could support our work?
- Or How we would communicate the new process?
- How will we measure our progress towards success?

Answering these questions signified the shift from doing well intentioned work to becoming a results driven community

VISION: PLANTING THE SEED OF INSPIRATION

Every vision starts with inspiration...

20K Homes/Built for Zero Campaigns Lessons Learned

- Number of housing placements in communities increase when you introduce data driven goals
- National coalition accelerates progress
- Coordinated Assessment and Housing Placement System emerged as the way forward in ending homelessness

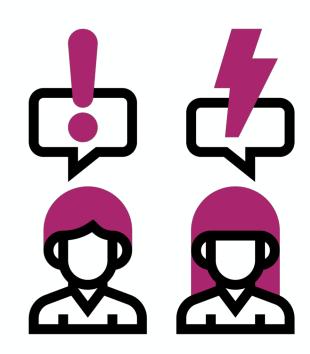
What we Learned for our Community:

- Organizing the Homeless Serving System
- Case conferencing vs. automatic referral list to housing with supports
- Prioritization for limited housing with support resources

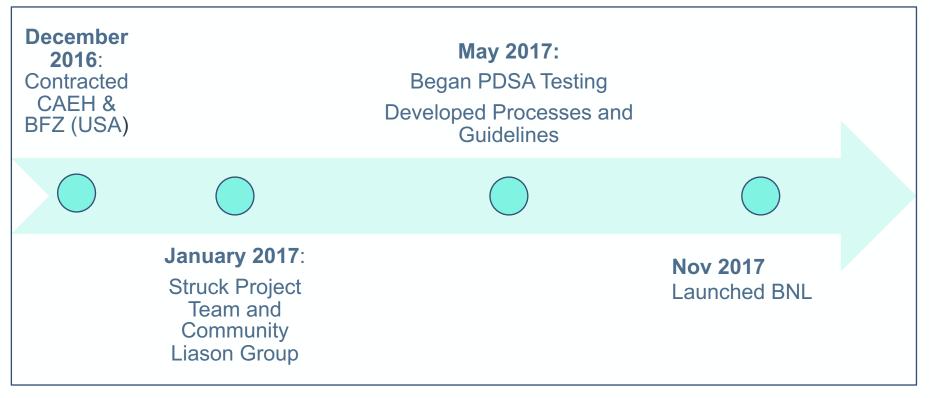
IMPLEMENTATION

Hamilton forges ahead in 2017...!

- Building the will
- Community Liaison Team + City staff working group
- The Action Plan
- Standardization and coordination (intake, VI-SPDAT)
- Technology and guidelines
- Implementation November 1, 2017



IMPLEMENTATION: THE TIMELINE



Present Day:
Continuous
Improvement and
Quality Assurance

System Planning I Coordinated Access I Real Time Data

IMPLEMENTATION: KEY LEARNINGS

- Know your "Why"
- Governance and Resources
- Imperfect action beats perfect planning every time
- Celebrate successes
- The Power of PDSA
- Strategic planning and advocacy
- Move from focusing our efforts on our inflow to focusing on outflow
- Technology as a tool
- Train and repeat....again and again
- It's a journey not a destination
- Start reporting something
- Making the shift from helping people to being accountable to the people we serve

CHALLENGES & LEARNINGS

Challenges	Learnings
Coordinated Entry and Exits to Housing	 Commitment from Housing Providers is hard; you need to know what's in it for them. Be relentless in your pursuit of housing resources
Communication with agency staff	Community buy-in is paramount
Managing on-going change	When to communicate informationHow to manage the release of information
Emotions (self-preservation)	 Strategically identifying naysayers Acknowledging and accepting negative feedback
Data quality and Quality Assurance	Establish annual indicatorsIntegrate data reporting requirementsFail Forward

QUESTIONS?

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