Chicago Coordinated Entry System Outreach Training
May 15, 2017
Welcome and Introductions

- Please share your name and agency
- Coordinated Entry System Case Study
Coordinated Entry System Lead
Entities and Roles

- Coordinated Access Steering Committee (Oversight)
- CSH Project Manager
- Catholic Charities System Administrator & Diversion
- All Chicago HMIS
- Center for Housing & Health Outreach Coordination
- System Navigation for Chronic
- System Navigation for Families
Coordinated Entry System Process

Engage
Assess
Triage
Match
Navigate
House
Coordinated Entry Assessment Through HMIS to Determine Housing Strategy

Transitional Housing

Rapid Re-Housing

Permanent Supportive Housing

Permanent Housing w/ Short Term Support

Diversion

Community Supports

Persons Experiencing Homelessness
Coordinated Entry System Timeline

<table>
<thead>
<tr>
<th>Month</th>
<th>April</th>
<th>May – June</th>
<th>July - August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>Youth Ages 18 – 24 with or without children</td>
<td>Single Adults</td>
<td>Families</td>
</tr>
</tbody>
</table>
Target Population Homelessness

Youth
- Category 1: Literal homelessness
- Category 2: Imminent risk of homelessness
- Category 4: Fleeing Domestic Violence
- Unstably Housed: Moving from one place to the next without the means to secure stable housing

Adults
- Category 1: Literal Homelessness
- Category 4: Fleeing Domestic Violence
Changes to Program Models

- **Chicago CoC Program Models Chart**
  - Approved in December 2014
  - Updated in February 2017
    - Changes in Basic Street Outreach and Specialized Outreach and Engagement Services Models
    - Additional Outreach Model - Housing System Navigator
    - Additional Coordinated Entry Models: Outreach Coordination and System Facilitation Models
<table>
<thead>
<tr>
<th>Program Type</th>
<th>Program Description</th>
<th>Essential Program Type Elements</th>
<th>Expected Outcomes</th>
<th>System Outcomes</th>
</tr>
</thead>
</table>
| Basic Street Outreach | No or low-demand, street-based services providing basic needs assistance and assessments for mental health, substance abuse, or medical services, etc. | Needs assessment with evaluation for at least one of the following:  
- Mental health, Benefit eligibility, Medical care, Substance use, Safety assessment particularly for youth and domestic violence survivors  
- SSI and Medicaid benefits advocacy using SSI Outreach and Access to Recovery (SOAR) model, including pursuing presumptive eligibility  
- Complete the Coordinated Entry System (CES) assessment with participants in geographic area and those assigned through CES.  
- Provide assistance obtaining identification and other needed documentation  
- Assist participants matched through CES in connecting with housing partners including support documentation, appointment follow through, and a warm hand off to the housing provider | - 50% of participants will engage in case management and/or enriched individual services  
- 75% of participants receiving case management and/or enriched individual services will connect to formal and informal support systems at drop-in centers or other community providers  
- 45% of enrolled participants move to more stable housing (family, friends, shelter, housing programs or permanent housing)  
- 90% of enrolled participants complete a CES assessment or have an observed assessment completed on their behalf  
- 75% of people matched to a housing unit through CES will be housed | The expected outcomes for this program type contribute to the following system outcomes:  
- Reduce length of homelessness  
- Reduce recidivism  
- Increase employment & income  
- Reduce overall number of households experiencing homelessness in Chicago |

| Target Population | Persons who are literally homeless  
- Persons who are homeless in public spaces |                                                                 |                                                                 |                                                                 |
<table>
<thead>
<tr>
<th>Program Type</th>
<th>Program Description</th>
<th>Essential Program Type Elements</th>
<th>Expected Outcomes</th>
<th>System Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized Outreach and Engagement Services</td>
<td>Low demand, street-based services providing or assisting participants in accessing the assistance they need.</td>
<td>Based on assessment, provision of or access to the following:</td>
<td>- 50% of participants will engage in case management and/or enriched individual services</td>
<td>The expected outcomes for this program type contribute to the following system outcomes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistance in accessing benefits</td>
<td>- 75% of participants receiving case management and/or enriched individual services will connect to formal and informal support systems at drop-in centers or other community providers</td>
<td>- Reduce length of homelessness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Housing placement</td>
<td>- 45% of enrolled households move to more stable housing (family, friends, longer-term shelter/housing programs or permanent housing)</td>
<td>- Reduce recidivism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medical care</td>
<td></td>
<td>- Increase employment &amp; income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistance in accessing other services</td>
<td></td>
<td>- Reduce overall number of households experiencing homelessness in Chicago</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Substance abuse and/or mental health treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Frame</td>
<td>- None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 90% of enrolled participants complete a CES assessment or have an observed assessment completed on their behalf

- 75% of people matched to a housing unit through CES will be housed
Housing System Navigator

Program Description
Outreach support provided to households matched to housing

Essential Program Type Elements
Assist with documentation, appointment follow through

Expected Outcomes
50% of assigned participants will be enrolled with System Navigators
75% of enrolled participants will be permanently housed
Engage
Engage

**Discussion**

- What techniques do you find useful to engage clients?

- What processes are used at your organization to identify individuals requiring outreach?
  - E.g. Standardized outreach procedures, requests from partner agencies

- Shelter Outreach:
  - What Shelters do you visit?
  - How often do you visit?
Outreach Worker Expectations:

- Assist the participant is accessing the Coordinated Entry System
  - For those who are Skilled Assessors, completion of Coordinated Entry System assessment with participant
  - Assist participant in getting to a drop-in center to complete an assessment
    - **Outcome:** 90% of enrolled participants complete a CES assessment or have an observed assessment completed on their behalf
Assess

- **Observational Assessments**

  - To be completed with individuals who meet the following criteria:
    - Display signs of a severe and persistent mental health condition
    - Sleep in places not meant for human habitation
    - Who are not able to complete a Standardized Housing Assessment due to their mental health condition
Assess

- **Observational Assessments, cont.**
  - Two attempts must be made to complete the Standardized Housing Assessment and can be made by different staff members prior to requesting an Observational Assessment.

- **Observational Assessments will completed by licensed professionals at designated agencies.**
  - Contact the Center for Housing and Health to request an observational assessment.
    - [ChicagoCES@housingforhealth.org](mailto:ChicagoCES@housingforhealth.org)
Assess

- **Discussion**
  - At your organization, what would be helpful to maximize the number of program participants assessed?
    - For ATAs in the room:
      - HMIS reports
        - Lists enrolled participants who have been assessed and those needing assessment.
    - For outreach workers:
      - Case Conferencing (System Integration Team Meetings)
        - Forum to share best practices and resources
• Domestic Violence Services and Emergency Housing
• Healthcare
• HIV/AIDS Housing and Supports
• Employment
• Senior Subsidized Housing
The Shriver Center has an online Help Hub for resources and updates specific to Medicaid enrollment.

- Unless you circle your name on the sign-in sheet we will share your e-mail so that you will be invited to register for this online resource.

More information to follow on how to help people look up their Managed Care Organization to explore healthcare options.
Match

- HMIS uses data shared by providers to create the Chicago One List, a by name registry

- Catholic Charities uses this One List to match people to housing programs based on availability, eligibility, and priorities
  - This process includes notifying providers working with the household via e-mail
  - HMIS entries will be shared including outreach projects the person is enrolled in with housing providers
New Functions of Outreach Professionals

For those connected to an outreach team, the outreach worker will assist with navigation into housing

- Provide assistance obtaining identification and other needed documentation
- Assist participants matched through CES in connecting with housing partners including support documentation, appointment follow through, and a warm hand off to the housing provider
Expected Outcomes:

- 45% of enrolled households move to more stable housing (family, friends, longer-term shelter/housing programs or permanent housing)
- 90% of enrolled participants complete a CES assessment or have an observed assessment completed on their behalf
- 75% of people matched to a housing unit through CES will be housed
Housing System Navigators

- Starting in August, we will have Housing System Navigators for families and people facing chronic homelessness
- Navigators are matched to applicants through HMIS
- Navigators assist with the process of connecting applicants to the housing they are matched to on HMIS
Housing providers will use the newly approved process of verifying chronic homelessness

- The CES Verifying Chronic Homelessness Packet can be found at http://www.csh.org/documents/
- Per HUD regulations, homeless documentation should be obtained within 180 days of the household moving into their unit.
  - Considered best practice to obtain documentation within 45 days of housing the applicant.
- The CES Verifying Chronic Homelessness Packet contains Third-Party Homeless Verification and Disability Verification forms
Shift in documenting homelessness requirements for housing providers:

- 100% of households can use self-certification for 3 months of their 12 months
- 75% of households served need to use 3rd party documentation for 9 months of their 12 months
- 25% of households served can use self-certification as documentation for all 12 months.
- Documents do not expire
• CES Disability Letter can be uploaded in HMIS and shared with the matched housing provider (contingent upon a signed HMIS consent)

• Disability letter does not expire!

• Disability documentation should be collected within 45 days of the participant’s move-in date
Helpful Resources

- **Coordinated Entry System Website**
  - www.csh.org/chicagoces

- **Coordinated Entry System Newsletter**
  - Sign up to stay informed about the latest and greatest related to the Coordinated Entry System in Chicago!
  - We will share a link to sign up for the website via email following the training.
Contact Info

Center for Housing and Health

- **ChicagoCES@housingforhealth.org**
- Brandi Calvert, Director of Housing Special Initiatives and Strategy
  312.334.0962
- Svetlana Zhexembeyeva, Coordinated Entry Specialist
  312.784.9077
- Nicole Goon, Housing Supportive Services Specialist
  312.784.9088

CSH

- **ChicagoCES@csh.org**
- Stephanie Sideman, Senior Program Manager
  312.332.6690 x 2825

[www.csh.org/chicagoces](http://www.csh.org/chicagoces)