September 2012 Steering Committee Meeting

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Continuum of Care
Steering Committee
September 13, 2012
MHMRA Conference Center
7011 Southwest Freeway

Agenda

3:30 PM Welcome and Introductions Marilyn Brown

3:35 PM Organizational Issues
   • HUD TA Overview Marilyn Brown
   • By-Laws update Thao Costis
   • MOU Process for Lead Agency*** Marilyn Brown

3:45 PM Charrette Process
   • Report on Community Meetings Gary Grier
   • Recommendations from Charrette Marilyn Brown
   • Community Action Plan Development*** Mandy Chapman Semple

4:00 PM CoC NOFA – Overview of the Process Pam Wyatt
   • Recommendation of New Project Priorities*** Whitney Fleming
   • Dispute Resolution Process*** Pam Wyatt

4:20 PM Coordinated Access Update Whitney Fleming/Thuan Huynh

4:30 PM Other Related CoC Activities/Other Business
   • VASH Funding Tom McCasland
   • 100 in 100 Project Jessica Preheim
   • SAMHSA CABHI Grant Whitney Fleming/Thuan Huynh

4:45 PM Public Comment Period

5:00 PM Adjourn

***Action Required

Next Steering Committee Meeting
Thursday, October 11, 2012
3:30 – 5:00 pm
Place TBD
Charrette Recommendations

Although there are many recommendations in this report, all of them fall under one of the five themes outlined below. The relationship of each recommendation to one of these themes has been noted in order to clarify the overall framework for moving forward on the recommendations.

1. **System Mapping and Redesign**: The recommendations under this theme are those that work in support of the effort to understand the resources and housing models that exist within the current system. In order to make effective decisions about how to shift the individual programs toward a comprehensive homeless crisis response system, it is critical to understand what elements currently exist. This includes mapping the existing system and developing system-wide housing models. Analyzing and understanding this data will illuminate the most efficient path for persons experiencing homelessness to reach permanent housing and any other needed services, and provide a framework for rebalancing the allocation of housing and service resources in the system where needed.

2. **Quality Improvement**: A commitment to continuous quality improvement is paramount in any consumer-oriented system. Quality improvement focuses on ensuring that the system, individual providers, and consumers all have adequate tools to evaluate and improve system functionality and performance, especially as it relates to the experience of the homeless consumer. The premise of continuous quality improvement assumes that most challenges in a system are related to process and that when the Continuum of Care has access to quality data, the homeless response system can be designed and organized to meet the needs of all parties: funders, providers, and consumers.

3. **Capacity Building**: For the redesigned system to function effectively there must be a commitment to community-wide capacity building and training at every level – system, agency, consumer, and other key stakeholders. Additionally, integrating cultural competency and language access components at all levels of the system and within every aspect of capacity building and training is critical.
4. **Funder Collaboration**: Building on the work of the existing public/private Funders Together group, including CoC leadership, the funders of homelessness services should come together to discuss their role in system change. Membership could include foundations, business community members, private funders, and government funders, among others. Recommendations that fall under this theme include those that address the role that funders play in redesigning the system by aligning and leveraging homeless and housing funding streams throughout the community.

5. **Change Management**: In order to successfully implement the changes outlined in these recommendations, special attention must be given to stakeholder relationships, the creation of organizational infrastructure to support change, and to clear communication of the process. This includes the development of clear and consistent timelines and messaging at all levels.
1.1 **Map the existing homeless system** of prevention, emergency shelter, rapid re-housing, transitional housing, and PSH resources to determine how much of each resource exists by bed/unit (if applicable) and the funding currently being utilized for each. As part of this mapping process:

   a. Highlight duplication of services and identify gaps in services and housing resources.
   b. Analyze the effectiveness of the interventions within the system in terms of their ability to return people to permanent housing as quickly as possible, using local data where available and national data where such data does not exist. Also examine how this effectiveness varies by subpopulation.
   c. Determine the cost for each successful exit to permanent housing and the cost of each bed/unit using the above data on funding for each housing model in combination with HMIS data.
   d. **Conduct a comprehensive analysis of eligibility criteria for the housing models.** Compare this to demographic and other data available about persons experiencing homelessness to identify where mismatches exist. (An example of this could include determining that while 50% of persons experiencing homelessness report a substance abuse disorder, 90% of available housing models require sobriety.)

1.2 Utilizing existing data and the financial model developed by CSH in 2011, **clearly identify the number of additional PSH units to be developed, establish a community-wide PSH goal with a targeted timeline, measure success in reaching the specific goal, and communicate it to the broader community.** Where necessary:

   a. **Identify unit goal by target population**, such as veterans, youth, domestic violence, chronically homeless, families, driven by local data.
b. Identify the estimate of need for scattered site, single site units and resources/funding opportunities to create and provide adequate services for new units.

c. Integrate housing goals into overall community development goals, specifically local consolidated plans and Public Housing Authority (PHA) administrative plans.

1.3 **Determine and clearly define system Housing Models** (i.e. PSH, Transitional Housing, Rapid Re-housing, Prevention, Emergency Shelter.)

   a. Develop a common profile and set of operating standards for each model, using the work that has already been done on Emergency Solutions Grant (ESG) program prevention as a guide.

   b. Develop a common set of targeting criteria for each housing model in order to streamline consumers' access to the appropriate resource.

   c. Reduce or remove barriers for each program model to better balance the system. Encourage providers to voluntarily shift their programs to align with unmet consumer need as identified in the system mapping process and program model.

1.4 **Rebalance Housing Resources.**

   a. Repurpose existing housing resources such as emergency shelter and transitional housing to permanent housing resources such as rapid re-housing and PSH, as appropriate. This will address bottlenecks that occur at the front door of the system. The portions of each housing model to be repurposed should be identified based on the data analyzed during the system mapping process.

   b. Ensure that service rich housing models are serving those who are truly in need of that level of intensity. Explore opportunities with providers and Public Housing Authorities to preference individuals currently residing in PSH who are no longer in need of high intensity services for Housing Choice Vouchers. Incorporate flexibility within the system to modify the level of service intensity without disrupting housing stability.

   c. Dedicate any new resources to identified gaps in the system.

      i. Create additional units of PSH as outlined in the PSH Implementation Plan, working to make additional resources available for PSH development to drive creation of units.

         1. Continue to work closely with the local Public Housing Authorities to:

            a. Preference and prioritize households experiencing homelessness and individuals exiting PSH who are no longer in need of intense services, such as moving households in PSH to the Housing Choice Voucher program; and

            b. Continue to project base vouchers for PSH projects.

      ii. Address the need for additional short-term housing resources, as appropriate. Work with prevention and rapid re-housing providers to discover creative ways to make interim housing accessible and directly connected to permanent housing options. This could include the use of hotel/motels or bridge subsidies.

2.1 **Create and implement a coordinated intake, assessment, and triage system** to connect people experiencing or at-risk of homelessness to the most appropriate housing model based on the agreed upon definitions and target criteria.

   a. **System Intake—Establish a coordinated intake process** that ensures equal access to resources for homeless and at-risk persons, regardless of point of entry.

   b. **System Intake—Expand coordinated outreach activities** across the system with a focus on moving individuals from the street to housing and supporting individuals and families as they transition from homelessness to housing.

   c. **Assessment—Develop and Implement a common assessment tool** to be used across the system to efficiently and effectively identify the most appropriate housing model.

   d. **Triage—Develop and Implement a tool or protocols to prioritize** placement into available units and/or on a centralized waiting list. Examples include the 100K Homes Campaign Vulnerability Index, DESC Vulnerability Assessment Tool, and/or frequent users triage tools to prioritize placement of the most vulnerable into PSH.
e. **Program Entrance—Develop common entrance criteria** for each housing model that serves to reduce barriers to entrance and supports prioritization of the hardest to serve, especially for permanent supportive housing. This process should be sensitive to programs targeted at specific sub-populations and relative to community need.

3.1 **Draw on the prevention housing model to clearly articulate the target population and activities to be funded under the homeless response system.** Explore the intersection of these activities with other homelessness prevention work to help establish funding priorities and improve the effectiveness of homelessness prevention efforts. Use this new framework to determine the intersection of faith community prevention efforts and how they should be incorporated in the homeless response system, including participation in HMIS.

3.2 **Designate the coordinated intake and assessment system as the primary referral source** for prevention and rapid re-housing programs.

3.3 **Embrace diversion as an essential part of the coordinated assessment process** and explore the use of nontraditional prevention tools like long-term service provision in existing housing settings for people with severe mental illness, including those living with family members and in personal care homes. Connect this analysis with the broader housing service delivery model discussion.

4.1 **Utilize a system mapping process to analyze the supportive services needed to maintain housing both within the mainstream system and homeless system; identify gaps and duplication; explore reallocation strategies; and identify and cultivate new service resources, models, and partnership opportunities to fill the gap for services tied to housing.**

4.2 **Define a new service delivery model that allows services to be provided in-home or in close proximity to housing.**

   a. Create a comprehensive set of core services available to all housing models at varying intensity and duration and incorporating best practices such as harm reduction, trauma informed care, motivational interviewing, etc.

   b. Leverage this new service delivery model to attract and coordinate with mainstream service systems like primary and behavioral healthcare, substance abuse services, employment services, etc.

      ii. **Seize the opportunity of the Medicaid 1115 Waiver process** to develop and demonstrate the efficacy of health-based wraparound services for homeless individuals with chronic conditions.

      iii. **Capitalize on the capacity of local community health centers** as healthcare homes for homeless individuals, fully leveraging the funding streams available through Medicaid, and create a thoughtful funding strategy for filling remaining gaps.

   c. Define opportunities to leverage non-traditional, informal service partnerships that complement core services linked to housing such as:

      iv. **Implement a peer support system** to assist households transitioning from homelessness to housing.

      v. **Identify specific opportunities to partner with the faith community to leverage additional social support networks** for households transitioning from homelessness to housing.

   d. **Enhance service provider coordination and collaboration with** property managers and landlords

4.3 **Embrace the coordinated assessment process as the mechanism** through which to refer the most appropriate and prioritized households to service connected housing.
Quality Improvement

2.2 Establish clear performance metrics to evaluate the efficacy of coordinated access across the system. Collect data to determine the effectiveness of common entrance criteria and its impact on bed utilization and program performance.

3.4 Continue to use data to drive targeting of prevention resources, funding allocation, and refinement of the assessment tool. Elevate this decision making to the system level.

3.4 Explore the use of HMIS to share, in real time, availability of prevention resources.

3.5 In conjunction with coordinated assessment, explore regionalization of prevention and rapid re-housing activities to preserve efficiencies, ensure service quality, and establish the local connections with property owners necessary to improve success rates.

3.6 Expand the use of specialized housing case managers to administer prevention and rapid re-housing activities.

4.4 Explore the use of a wide array of service performance and quality indicators, including housing stability, health and wellness, morbidity and mortality, quality of life indicators, etc., to support the continuous quality improvement of services connected to housing.

5.2 The CoC should drive a community process to set performance measures and indicators and finalize all performance measurement instruments and protocols. Coordinate ongoing forums for stakeholders at every level to ensure comprehension, manage expectations, and facilitate open dialogue, looking specifically to existing local performance measurement efforts as a model. Align with such efforts to ensure all facets of the system are represented and participating regardless of their use of HMIS.

5.3 Utilize housing models to establish unique performance goals and articulate operating standards by housing model type (Prevention, Rapid Re-housing, Shelter, Transitional Housing, PSH.)

5.4 Promote data driven decision making at the system and individual program level.
   a. Establish data collection and data sharing protocols across the system.
b. **Integrate the use of data into homeless system planning and evaluation practices**, creating a culture of continuous quality improvement and mutual accountability, specifically **embracing peer accountability practices** by hosting regular quality improvement forums in which individual and system level data is presented in combination with technical assistance and peer education.

c. **Use data to establish a case for prioritization** of resources, retooling of programs, and the rightsizing of the homeless response system.

d. **Integrate individual program and system level performance into the funding matrix.** This could be achieved using a joint RFP process that would allow seemingly unrelated investments, like capital funding, to be linked to system performance standards.

5.5 **Involve consumers in program evaluation** by establishing an annual consumer report card process.

5.6 Building on the current quarterly HMIS data sharing practices, **explore the use of HMIS to establish a performance measurement dashboard**, including the availability of real time data, trends, and progress toward goals.

5.7 **Explore partnerships with academics and consultants** to dive deeper into the system data and promote such partnerships to enhance individual program evaluation whenever possible, but especially in pilot and/or demonstration projects.

5.8 **Identify pertinent data sources within other systems**, especially related to subpopulations like youth, veterans, and victims of domestic violence, and develop protocols for inclusion and/or system integration. This should be driven at the system level through the Continuum of Care and/or an interagency council on homelessness.
1.5 **Proactively build the capacity of stakeholder groups to support the system redesign effort and work within the new system.**

a. **Develop a capacity building and technical assistance strategy for housing and service providers** that emphasizes understanding the CoC housing models and associated operating standards and targeting criteria. Additional capacity building topics could include but are not limited to: Implementing and working within a Harm Reduction Model; Working effectively with chronically homeless and otherwise vulnerable homeless individuals; Understanding and working within a Housing First model; and Managing the organizational change process required to shift or repurpose current models.

b. **Cultivate PSH developers by working with public partners**; also explore opportunities to use an integrated housing approach to incorporate permanent supportive housing into affordable and market rate apartment complexes

c. **Outreach to landlords** to explore the use of existing units in the community for a scattered site or clustered approach.

2.3 **Offer training and ongoing technical assistance** to support implementation of the common assessment tool and coordinated assessment and triage protocols. Targeted training should be made available to frontline staff on an ongoing basis.

3.8 Develop a housing case manager **training program and certification process** for prevention and diversion.

4.4 **Cultivate and train housing developers** to move PSH creation forward.

6.4 **Prepare existing leaders to shift from provider to systems advocacy.** Utilize existing provider leadership to advocate at the system level. Groom organizational executive directors and board members for broader policy advocacy through a formal education and training process. Embed opportunities in the CoC planning infrastructure to drive policy analysis and organize and mobilize advocacy efforts.
Funder Collaboration

1.6 **Coordinate the right-sizing work across funders**, including Funders Together and the CoC leadership, to discuss their role in the system shift. This will include reallocating funds to support the right-sizing effort as well as requiring grantees to remove barriers to entry and adhere to the standards for each housing model.

2.4 **Coordinate across funding sources** based on agreed upon community-wide metrics, performance measurements, outcomes, reporting requirements, and data requirements to ensure full and robust use of the coordinated intake, access, and triage system.

4.6 Based on the identified local PSH goal, the Funder Collaborative should **identify opportunities to coordinate, align, and braid housing, operations, and service resources** and reduce barriers to moving permanent supportive housing creation forward, while also promoting quality housing and services. Additionally, the Funder Collaborative should **identify ongoing opportunities to cultivate additional housing and service resources** to fill gaps within the system.
Change Management

1.7 Clearly message and manage the right-sizing process.
   a. Develop and disseminate a right-sizing plan that describes the goals of the process, the timeline for its implementation and the opportunity for technical assistance and training to agencies and case managers to prepare them for the newly right sized system.
   b. Identify a body to manage the right-sizing process, whether through the existing CoC structure or a newly-designated entity.

2.5 Develop and distribute clear and consistent messaging on how to access housing and services for households that are at-risk or experiencing homelessness. Specifically work with non-traditional partners such as the police, the faith-based community, health systems, school systems, etc. to ensure access to system-wide coordinated intake, assessment and triage.

3.9 Develop a messaging and marketing plan for homelessness prevention services utilizing both traditional (advertising on buses) and non-traditional (working with faith community, police, schools, etc) marketing strategies.

5.9 Use accurate data to dispel myths, articulate the story, and influence public dialogue.
   a. Translate political will into action.
      a. Capitalize on current political will by defining specific goals, including achievable short term wins. Move quickly or risk losing the political will that has already been built.
      b. Deploy strategies to sustain political will beyond election cycles or charismatic leaders. Ensure a broad array of political support among city council, county commissioners, and state legislators, and hold elected officials accountable for their commitments to this issue. Ensure there are community leaders with long tenure to reinforce the message when there is turnover in elected official representation. Foster relationships with retired elected officials.
c. **Concentrate on building relationships with policy-makers over the long term**, not just in moments of crisis.
d. **Mobilize local political will to impact state policy** and resource allocation.
e. **Tie the issue of homelessness to other critical policy areas**, instead of treating it as a stand-alone issue. Related issues often have advocates or government affairs personnel that may be interested in the mutual benefit of coordination and collaboration on policy issues. Use these connections to foster deeper linkages between systems, including, for example health care transformation efforts and criminal justice reform.

### 6.2 Message the community goal of preventing and ending homelessness consistently.

a. **Invest in a professionally developed strategic communication plan**, which narrows the many relevant messages down to one or two, with resources dedicated to communicating these messages, including press placement.
b. **Create a branded campaign** focused on consensus goals to create explicit commitment and a shared identity on the part of stakeholders and to serve as a rallying point. Examples could include the Los Angeles Home for Good campaign or Albuquerque’s the Smart Way to Do the Right Thing.
c. **Tailor messages to target audiences.** Use fiscal impact arguments at the state level, for example.

### 6.3 Nurture the advocacy infrastructure, allowing for diversity of viewpoints.

a. **Create meaningful opportunities for faith and business leadership, civic groups and community leaders, and neighborhoods and superneighborhoods within the CoC structure.** Options include replicating the Los Angeles Home for Good model or creating a CoC led policy body. Reach out to volunteer groups and identify opportunities for their specific interests and skill sets to be utilized to outreach homeless individuals and contribute to policy discussions.
b. Acknowledge the point of view of **community-based organizations functioning outside the Continuum of Care structure**, embracing diverse perspectives. Identify areas of consensus for common advocacy efforts, and stimulate ongoing dialogue in areas of disagreement.
c. **Keep consumers involved** to humanize the issue and provide education and training opportunities to them on effectively communicating their experience and advocating at a system level.
Additional Recommendations:  
Infrastructure and Change Management

The recommendations outlined in this report will require an infrastructure with the necessary leadership and staff support to create effective change. The CoC should review the recommendations outlined in this report and craft an action plan that includes the specific steps, roles, resources, and responsibilities to drive implementation. See Appendix D for a sample action plan.

7.1 **Maintain and build upon the momentum and sense of urgency** generated by the HUD technical assistance engagement and local government prioritization of ending homelessness.

7.2 Use the Continuum of Care and Coalition for the Homeless staff, as CoC Lead Agency, to **drive implementation of the recommendations included in this plan**. Use/repurpose existing CoC committees where relevant and create new ones where needed to develop detailed implementation plans. Turn recommendations into clear action items that include timelines for completion and identify persons who are responsible.

7.3 When prioritizing which recommendations to work on first, look for a few that can **create early wins** and success for the community. This will keep people engaged and interested in this effort.

7.4 Use this report as a **framework for CoC visioning, long-term strategic planning and the development of annual action plans**.

7.5 Utilize the long-term strategic planning and annual action planning process to **identify specific initiatives or campaigns that the business, faith, and civic communities can cultivate**. Ask government partners to convene and staff a local interagency council on homelessness. Bring these partners to the table to work in concert with the CoC to lead system change efforts. Use these partnerships as a vehicle to communicate the new vision and strategies.

7.6 **Use increased accountability to change systems, structures, and policies that do not support the vision.** Promote and develop stakeholders that can help implement the vision and reinvigorate the change process with a steady infusion of new efforts, themes, and change agents.

7.7 **Continue to articulate the connections between the new business models and performance success at the system and program level.** Success should be shared and celebrated. Consider holding periodic events to engage the community and celebrate the completion of steps in this process and the new behaviors that have contributed to success.

7.8 **Develop a plan to cultivate new leadership and ensure leadership succession.** The commitment to capacity building and change management can create a new generation of leaders eager to carry the torch. With a bit of planning, these practices can be embedded and a steady flow of leaders secured to ensure the vision of preventing and ending homelessness is made a reality.
Dispute Resolution Process

A grievance may be filed by any applicant organization that claims it has been adversely affected by in the application process:

- Improper application of rules, regulations and procedures
- Improper interpretation of rules, regulation and procedures
- Disparity in the application of rules, regulation and procedures
- Violation of rules, regulation and procedures
- The score assigned by the Applicant Review Team

Action Item

1. Create a dispute resolution process committee
   a. Review current dispute resolution process
   b. Draft any changes to the dispute resolution process
   c. Present to CoC Steering Committee for approval at October 2012 meeting.
MOU and Priorities for Houston/Harris County Continuum of Care Grant FY2012 New Projects

I. Requirements for Client Targeting
New applicants are required to target 100% of project clients from one or a combination of the following populations in order to be considered eligible:
   A. People who are Chronically Homeless (At least 80% documented as chronically homeless, and up to 20% self-declaration of chronic homelessness)
   B. People with Disabling Conditions of Severe Mental Illness
   C. People with Disabling Conditions of Co-Occurring Substance Abuse and Mental Health Disorders

New applicants may not provide housing for only one gender. For example, there may not be programs for only men or for only women.

II. Bonus Points for Client Targeting
Bonus points will be awarded if new projects serve the eligible required client populations listed in paragraph I a, b, c who also have the characteristics of one of these targeted groups:
   A. People who have criminal convictions that make accessing housing difficult
   B. Households with children
   C. People who are victims of domestic violence

III. Client Eligibility
   A. New projects must move clients into permanent housing directly from streets and shelters without preconditions of treatment acceptance or compliance.
   B. Upon implementation of the Coordinated Intake process for the Continuum of Care’s homeless residential system, funded programs must comply with business rules developed, and the sole means of accepting clients into the SHP program will be through the Coordinated Intake system. Based on HUD’s final Continuum of Care Program rule and the local plan, domestic violence providers, domestic violence providers may be exempt from participation.
   C. Programs are required to accept tenants with zero income, and may have the goal of helping clients obtain income through benefits or employment to contribute to rent once admitted but may not un-enroll tenants from the program if income is not gained.
   D. Clients may not be un-enrolled from the program for reasons other than non-compliance with the basic lease agreement. For example, clients are allowed to have alcohol in their homes and may not be un-enrolled unless their behavior would cause eviction by the landlord.
   E. New applicants must be in compliance with HUD’s Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity rule published in January, 2012 requiring all HUD-funded housing programs to:
      • Make housing available without regard to actual or perceived sexual orientation, gender identity, or marital status
      • Include in “families” and “households” persons regardless of actual or perceived sexual orientation, gender identity, or marital status
      • Refrain from inquiring about an applicant’s or occupant’s sexual orientation or gender identity for the purpose of determining eligibility or otherwise making housing available
IV. Services

A. The provider is obligated to have in place on-site supportive services (provided directly or sub-contracted) or provide transportation and access to supportive services that will:
   • Help program participants obtain or remain in permanent housing;
   • Help participants increase skills and/or income;
   • Provide intensive case management at least while the person is initially transitioning out of homelessness

B. A combination of one or more Evidence Based Practices (EBP) or promising practices for the target client group will be implemented in case management and other supportive services provided by the grantee or sub-contracted

C. Services must be provided in a culturally competent and inclusive context. The people the permanent supportive housing program is designed to serve are almost by definition marginalized and excluded from their communities and mainstream society. Bringing them into housing and offering meaningful services requires providers to bridge cultural, language, and other barriers.

D. To be able to engage and help stabilize people who have a history of trauma, permanent supportive housing programs need to be trauma-informed. This means training all staff who will be working with SSH participants to understand the nature and manifestations of trauma in human life and to ensure that both housing and services are offered in safe, nonthreatening environments.

E. Separation of housing and services underpins the supportive housing model. Property management functions and support services are handled by separate staff, and often even by different organizations. They coordinate with one another but clearly differentiate the roles of property manager and service provider.

F. Eligibility and continued tenancy is not dependent on participation in services provided, rather on the requirements of tenancy.

G. In the case of programs that provide housing or services to families with children, project sponsor will designate a staff person to be responsible for ensuring that children being served in the program are enrolled in school and connected to appropriate services in the community, including early childhood programs such as Head Start, part C of the Individuals with Disabilities Education Act, and programs authorized under subtitle B of the title VII of the HEARTH Act (42 U.S.C. 11431 et seq.).

V. HMIS

The Homeless Management Information System (HMIS) is a critical tool used for tracking program participation, and the data collected therein can be analyzed to report on program, agency, and community-level outcomes—requirements now mandated by most public and private funders of homeless services.

In addition, HMIS data is used to produce the Annual Progress Report (APR) and the Houston/Harris County Continuum of Care’s submission for the Annual Homeless Assessment Report to Congress (AHAR) and quarterly PULSE reports.

It is also used for reconciliation of the annual Point-in-Time Count in January.

Finally, it is anticipated that the Coordinated Intake system will be dependent on the housing utilization tools within HMIS.

Therefore, due to the importance of data collection as outlined above, all Continuum of Care funded projects (with the exception of domestic violence providers, who are required to use a comparable database) are required
to participate in HMIS in accordance with the data entry guidelines set by the HMIS Lead Agency ("the Coalition for the Homeless"). These guidelines include, but are not limited to,

A. The timely and accurate entry of data;
B. A complete exit assessment with exit destination and updated housing status; and
C. The maintenance of client information confidentiality.

In addition to providing all HUD mandatory data, agencies should strive to collect the maximum data elements for all clients.
Coordinated Access System

Houston/Harris County/Fort Bend County CoC

CALL CENTER - SCREENING

DIVERSION

OUTREACH

WALK-INS

ACCESS CENTERS

ASSESSMENT / HOUSING PLAN

EMERGENCY SHELTER

INTERIM PLACEMENT

HOUSING PLACEMENT

TRANSITIONAL, RAPID RE-HOUSING, PERMANENT SUPPORTIVE HOUSING
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Relationship</th>
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<tr>
<td>Anderson, Bruce</td>
<td>Consumer Advisory Council</td>
<td>Current or Formerly Homeless Person in Recovery from Substance Abuse or Mental Illness</td>
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<tr>
<td>Brown, Marilyn</td>
<td>Texas Department of Assistive and Rehabilitative Services Division for Rehabilitative Services</td>
<td>State Employment and Education Agency for People with Disabilities</td>
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<td>Local Lead Agency for grant; CoC Lead Agency</td>
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<td>Dawson, Barbara</td>
<td>SEARCH</td>
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<td>Fuentes, Joe</td>
<td>MHMRA of Harris County</td>
<td>Mental Health and Substance Abuse Treatment Provider</td>
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<td>Grace, Robert</td>
<td>Houston Area Community Services</td>
<td>Mental Health/ SubSTANCE Abuse Treatment; Case Management Provider; FQHC</td>
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<td>Gunsolley, Tony</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>Isbell, Francis</td>
<td>Houston Housing Authority</td>
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<td>Kincaid, Leonard</td>
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<td>Lacefield Lewis, Lauren</td>
<td>Texas Department of State Health Services</td>
<td>Substance Abuse Treatment Advisor</td>
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<td>Lemelle, Daphne</td>
<td>Harris County, Community Services Department</td>
<td>State Mental Health and Substance Abuse Authority</td>
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<td>Savannah, Sheila</td>
<td>City of Houston, Neighborhood Services Division HDHHS</td>
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<td>Texas Department of Housing and Community Affairs</td>
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SAMHSA Grant Program Model

Program Serving 165 Chronically Homeless Clients

Initial Target Population:
- MHMRA
- SEARCH
- Healthcare for the Homeless
- VA
- Houston
- Homeless Service Providers
- Other Programs
- Substance Abuse Providers
- FQHC’s

Intake System:
- HMIS
- PHA Personnel

Case Managers (4):
- SEARCH
- HACS

- Medical – HHH, HACS
- Housing – 165 Units
- Mental Health/Substance Abuse
- Mainstream Benefits

Evidence Based Practices in Use

End Goals:
1) Coordinated point of entry for 165 chronically homeless
2) Maintain target population in housing
3) Increase income and mainstream benefits
4) Decrease homeless recidivism