Building a Coordinated Access Model

Considerations for the Yellowknife Homeless-Serving System

March 2018

TURNER | STRATEGIES

Canada

CITY OF YELLOWKNIFE

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Introduction

Everyone is Home: Yellowknife's 10-Year Plan to End Homelessness (2017, the Plan) recognised the need to review current roles and responsibilities on homelessness support, and resource coordination to ensure an integrated approach is in place when it comes to service delivery.[1] The Plan recommends the creation of an Interagency Council that works closely with the Yellowknife Homelessness Commission to inform decision-making and strategy at the highest levels.

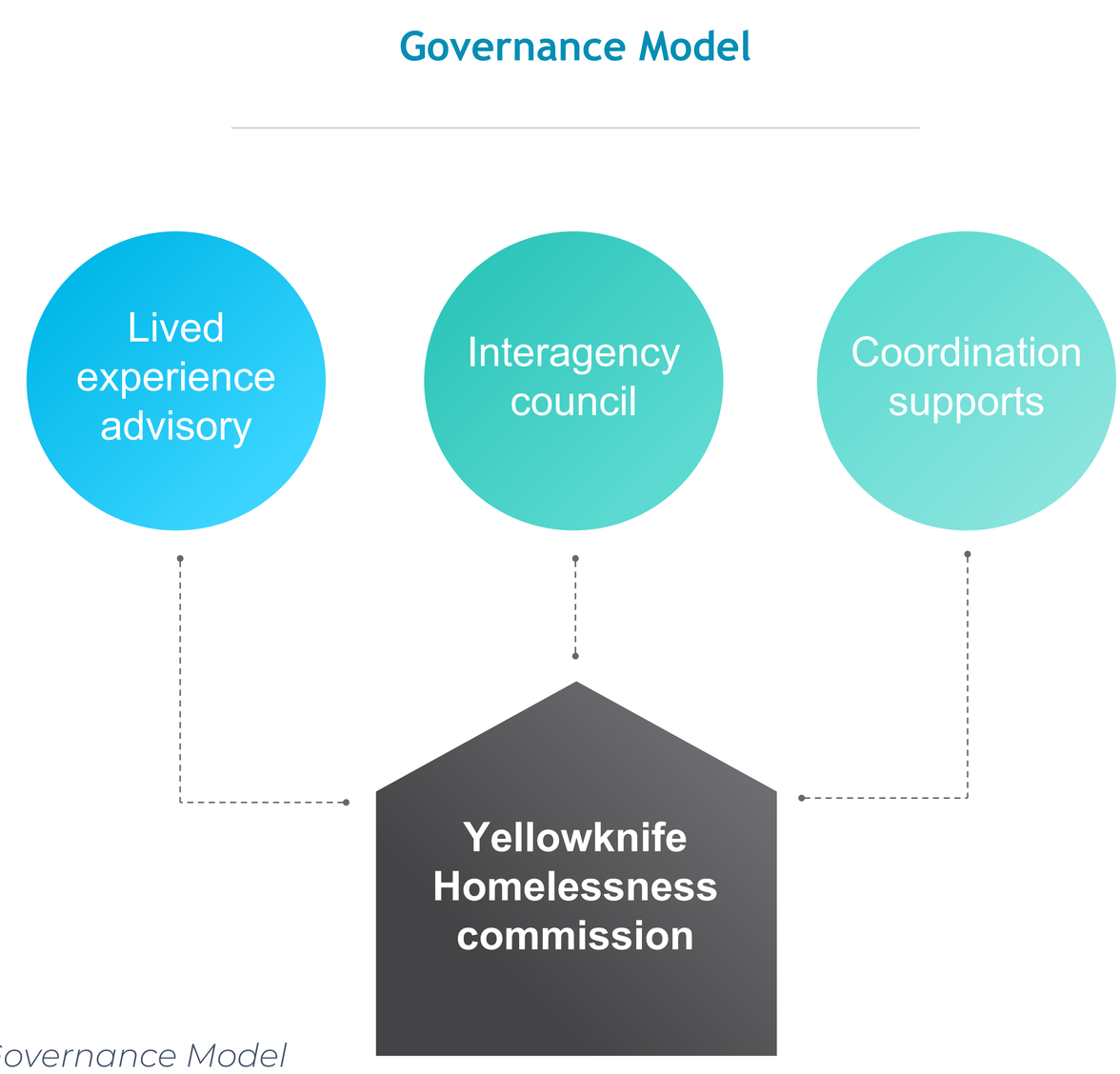

Figure 1 Plan Governance Model

Through this Yellowknife Homelessness Interagency Council (YKHIC), key stakeholders engaged in service delivery would develop a Coordinated Access process to enhance proper triage and referral, common assessment, and manage appropriate program and housing placements.

This would help reduce the 'run around' and frustration service participants experience by having to tell their story multiple times, and being sent from one provider to the next.

To help coordinate the service delivery for individuals and families, the Community Advisory Board engaged Turner Strategies to undertake a preliminary assessment that would inform the development of such an integrated approach. While moving in this direction means coming together and making hard decisions about access to limited supports, it can also provide a better level of coordination for what is available and allow for better tracking of system gaps to feed into planning and advocacy work.

[1] *City of Yellowknife. 2018. Everyone is Home: Yellowknife's 10 Year Plan to End Homelessness. Retrieved from https://www.yellowknife.ca/en/living-here/resources/Homelessness/EVERYONE-IS-HOME---YELLOWKNIFE-10-YEAR-PLAN-TO-END-HOMELESSNESS-FINAL-REPORT-JULY-2017.pdf*

Purpose & Project Overview

The purpose of this report is to assist the CAB in its direction on Coordinated Access with a review of models, and to provide initial community feedback to inform the development of the local Coordinated Access approach for Yellowknife.

Over the course of January to March 2018, the project team undertook a number of activities to inform the process:

- Reviewed of CA models, policies, and procedures from Canadian and US jurisdictions, promising practices, and toolkits;

- Launched a system mapping survey to document programs in place, target groups, services, criteria, etc. as well as interest in CA; of note, only six surveys were completed and thus provide a very limited view of programs in the area. Future expansion of system mapping will therefore be necessary;

- Interviewed key service providers in the Yellowknife region identified to be potential stakeholders in the CA process; a total of 16 individuals were engaged from the following organizations:

    - Centre for Northern Families
    - YK Women's Society
    - Stanton Hospital
    - City of Yellowknife
    - Yellowknife Housing Authority
    - Yellowknife Housing First Program
    - Integrated Case Management, Department of Justice
    - Native Women's Association
    - NWTHC
    - YWCA
    - Salvation Army

    Of note, a further ten individuals either declined or did not respond to requests for interviews; this is a significant limitation of this review and requires further engagement to assess perspectives;

- Met in-person with government and service provider stakeholders to present emerging feedback and discuss potential options moving forward. This was attended by NW Housing Corporation, GNWT Justice – Integrated Case Management, City of Yellowknife, Centre for Northern Families, Service Canada, and YWCA staff.

- Presented the findings and recommendations of the report to the CAB in April; feedback was incorporated in the final report.

Purpose & Project Overview

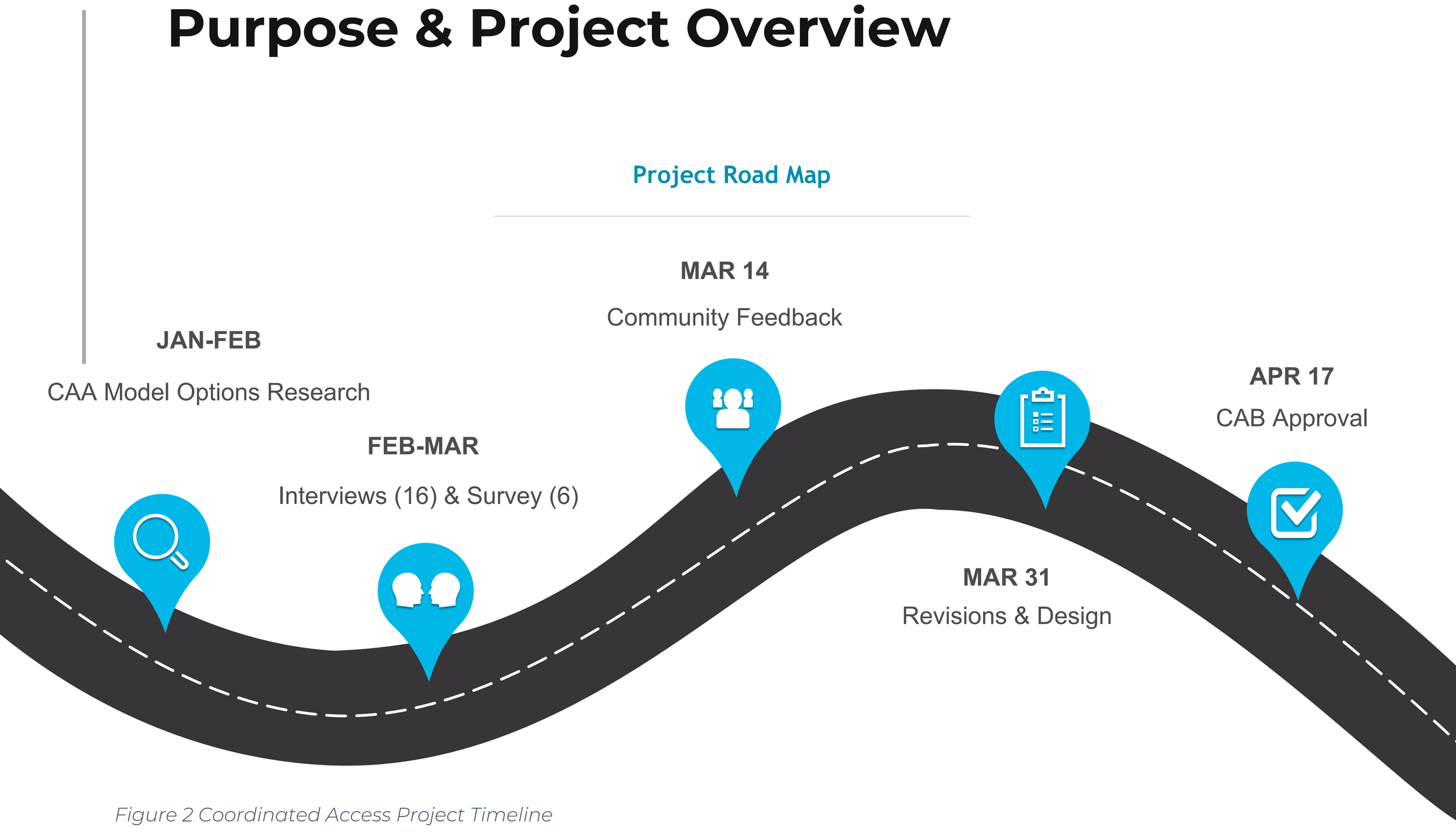

Figure 2 Coordinated Access Project Timeline

Recommendations

The Plan outlined a Coordinated Access model which includes:[2]

- Selecting a common intake and assessment process at key access points in the community;
- Developing an MOU among participating organizations to ensure consistent application of the CA model in practice;
- Dedicated resourcing to coordinate CA rollout and ongoing refinement;
- Establishing an integrated information management committee of the Interagency Council to select a software solution or alternate data sharing approach for the homeless-serving sector;
- Ensuring appropriate linkages into GNWT integration measures to complement such initiatives in community.

The following discussion expands on these in detail and proposes considerations for the community moving forward.

[2] *Ibid.*

Coordinated Access Overview

Coordinated Access is an important component to delivering integrated and focused early interventions for individuals and families at risk of homelessness. Of note, Coordinated Access is also known as Coordinated Access and Assessment, Coordinated Intake, in the UK as Common Assessment, and in the USA as Coordinated Entry.

Regardless of term used, it is a standardized approach to assessing: a person's current situation; the acuity of their needs; the services they currently receive and may require in the future; and takes into account the background factors that contribute to risk and resilience, changes in acuity, and the role friends, family, caregivers, and community and environmental factors play on a person's development and ability to move forward with their life.[3]

Coordinated Access has two primary objectives:[4]

1. Enhance quality of client screening and assessment
2. Create targeted and efficacious program assistance

Clients	Service Providers	Funders
Simplify & speed up the process to locate and access services Appropriate referrals = less frustration & better service Save time and resources	Appropriate referral stream Begin documentation process – intake paperwork, consents, HMIS Save time and resources allowing staff to focus on housing and case management Interagency collaboration & coordination Decrease the need for marketing at the agency level	Improved speed, accuracy and consistency in screening & referral process Makes it easier to target resources efficiently and accurately Supports system planning, HMIS and enhanced data

Figure 3 CA Benefits

The result of Coordinated Access will be collaborative service networks that efficiently and precisely meet the needs of those who are homeless or at risk for homelessness.

Figure 4 Coordinated Access Steps

[3] *Homeless Hub. 2014. Coordinated Intake. Retrieved from http://homelesshub.ca/solutions/emergency-response/coordinated-intake*

[4] *BitFocus. 2014. Three Steps to Highly Successful Coordinated Assessment. Retrieved from https://bitfocus.com/homeless-management-information-system-hmis/successful-coordinated-assessment-steps/*

CA Models

There are multiple ways of delivering the CA from a physical standpoint as summarised below:

Single Location

- Mix of intake services, drop-in hours, scheduled appointments, outreach.
- Screening, assessment, verification

Multiple Locations

- Access to a standardized intake, assessment and referral process by participating agencies

Hotline

- Hotline number used to request services, receive screening, assessment and referrals

Figure 5 CAA Models

In addition, there are also hybrid aspects such as combining a single point of access with the phone access. Of note, CA models in a community may shift over time – anecdotally from a “no wrong door” or decentralized model towards enhanced centralization.

	Single Point of Access	Multisite Centralized Access	No Wrong Door	Assessment Hotlines
Site Location	Centralized	Located at: • Population centers • High-volume providers • By subpopulation	All existing provider locations	Telephone-based
Number of Access Points	One	Variable, based on geography (2 to 4)	Many	One Telephone number
Services Offered	Primarily access and assessment; may include triage services, emergency services, or other mainstream services	Primarily access and assessment; may include the services of a co-located provider; may be targeted to one of several subpopulations	Access, at least limited assessment, referrals, and the standard services of each provider	Access and often access to an abundance of mainstream services; limited assessment capability

	Single Point of Access	Multisite Centralized Access	No Wrong Door	Assessment Hotlines
Operating Entity	Permanent independent access specialists; may be shared staff of a central shelter or other organization	Mobile or permanent independent access specialists or shared staff of co-located providers	Independently operated by each provider	Local 211 or other designated hotline agency
Hours of Operation	Hours of the central location	Hours of each access site	Hours depend on and vary with each provider	Typically 24-hour operation/ 7 days a week
Consideration	Highest level of control over implementation and compliance for the system; also known as centralized intake	Moderate level of control over implementation and compliance for system; the most adaptable model, sometimes called a hybrid system	Lowest level of control over implementation compliance for the system; still requires standardized forms and coordinated referrals for all	211 is the most popular example; may be combined with any of the other models as a pre-screening tool; often must build a relationship with an outside provider

Figure 6 CA Model Details

Of further note, there are a number of levels of authority options that CA models can bring depending on community negotiation or funding requirements. These range from CA providing information about a programs and referral processes, to giving the CA full admissions authority for program placements.

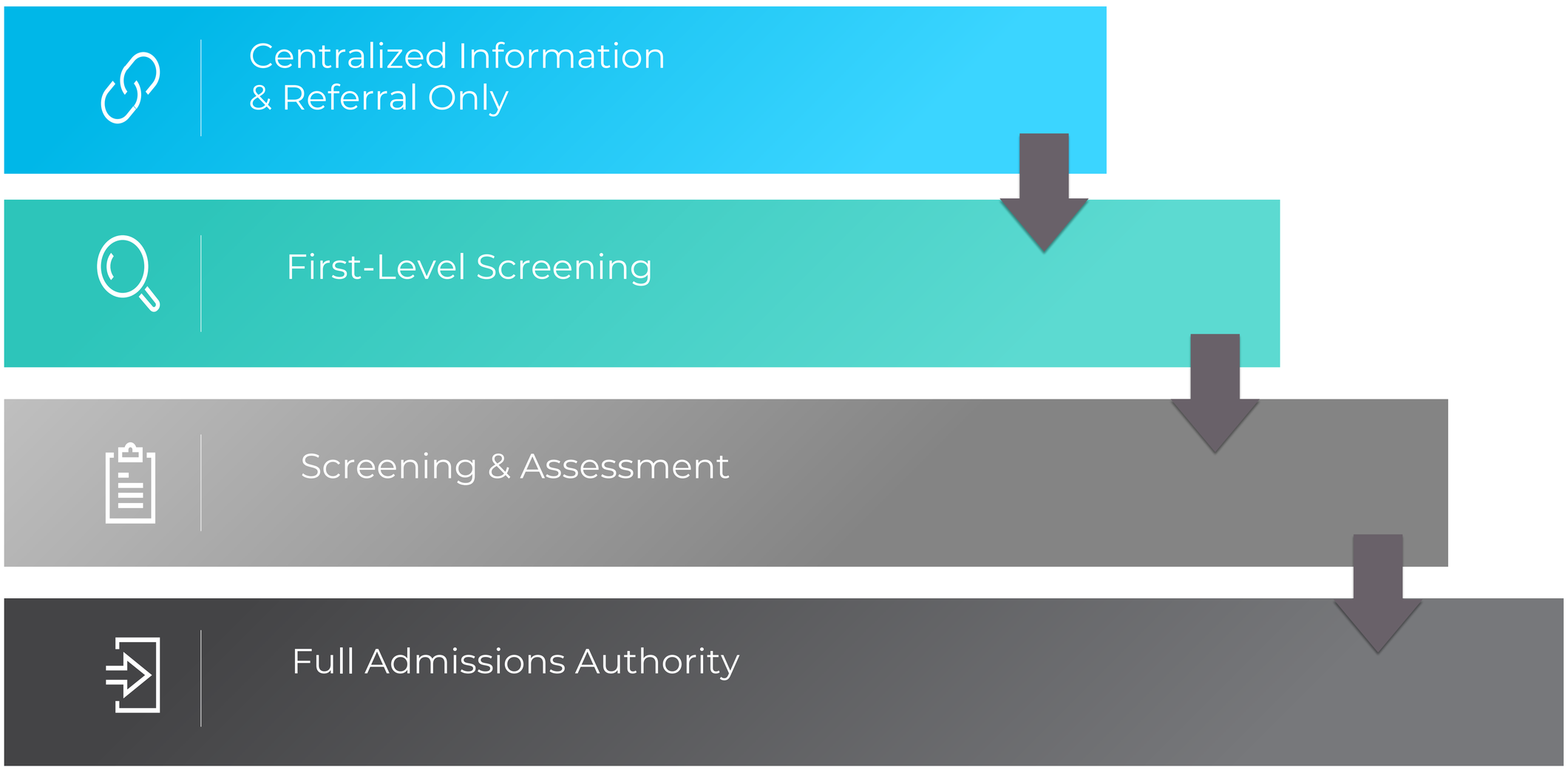

Figure 7 CA Levels of Authority

Depending on the model chosen, community size, and number of providers incorporated, the resource requirements will shift – though these tend to have a number of items in common:

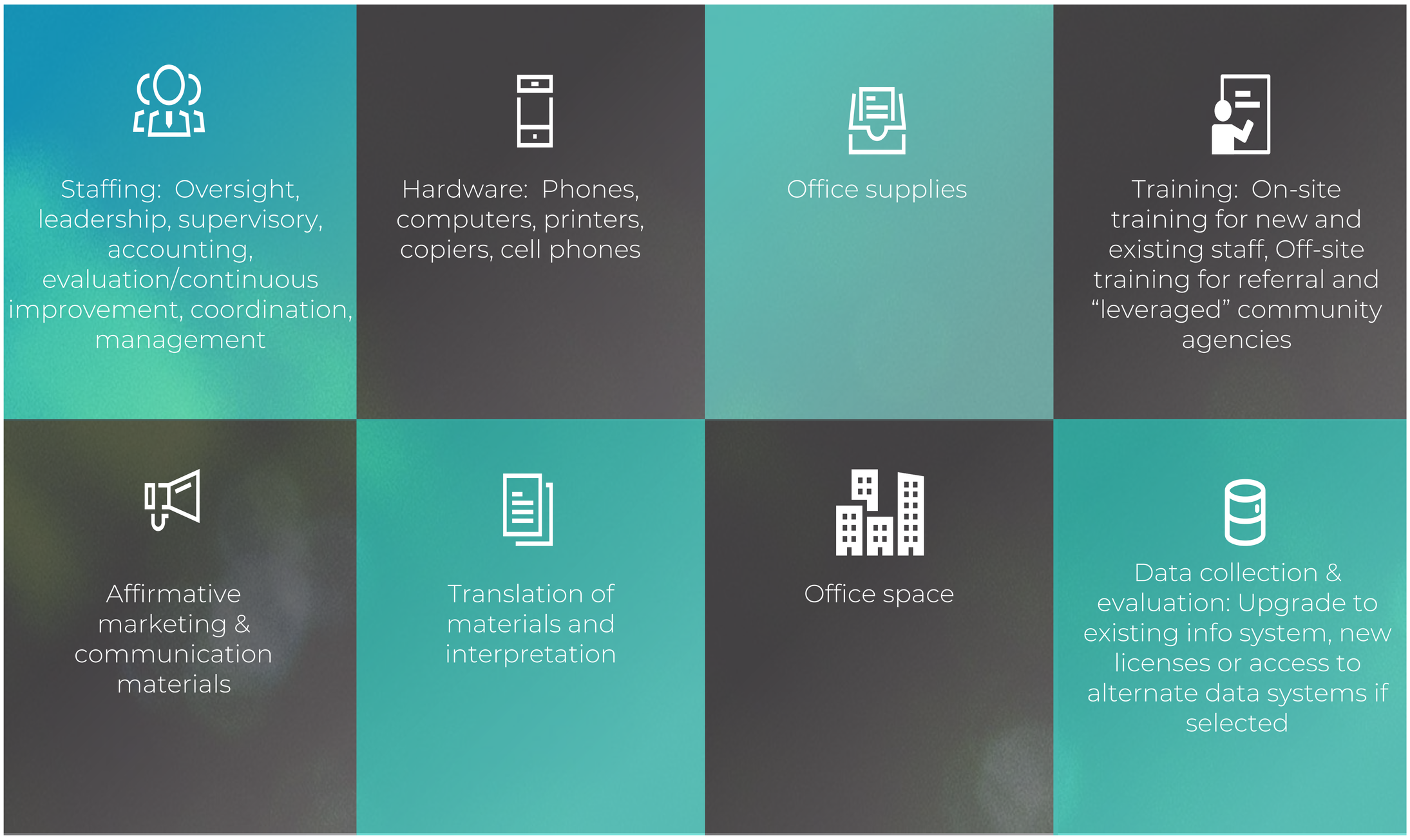

Figure 8 CA Resources

The US Context

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access, and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

Recent shifts in housing and supports practice have challenged the ‘first-come, first-serve’ method or access to those most likely to succeed, by highlighting the need to place the most vulnerable individuals in the same selection pools as individuals with less dire housing needs.

An effective coordinated access (CA) process is a critical component to any community’s efforts to meet the goals of “Opening Doors: Federal Strategic Plan to Prevent and End Homelessness”.

In 2014, Housing and Urban Development (HUD) set forth the requirement for coordinated entry in order to secure access to vulnerable individuals from a fragmented service infrastructure. The end result of this implementation will be collaborative service networks that efficiently, and precisely, meet the needs of those who are homeless or at risk for homelessness.

A coordinated assessment system must meet the following criteria:

- Cover the entire continuum of care, regardless of funding source;
- Be easily accessible and well advertised;
- Utilize an assessment tool that is standardized across the whole system;
- Be attuned to local needs and conditions.

Effective Elements

The following key elements of coordinated entry come from HUD's policy brief that provides guidance to homeless serving systems of varying sizes across the US:[5]

PRIORITIZATION

People with the greatest needs receive priority for any type of housing and homeless assistance available in the homeless serving system, including Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), and other interventions.

LOW BARRIER

The CA process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. In addition, housing and homelessness programs lower their screening barriers in partnership with the CA process.

HOUSING FIRST ORIENTATION

The CA process is Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.

PERSON-CENTERED

The CA process incorporates participant choice, which may be facilitated by questions in the assessment tool or through other methods. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions. .

[5] *HUD. 2015. Coordinated Entry Policy Brief. Retrieved from https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf*

FAIR AND EQUAL ACCESS

All people in the local homeless serving system geographic area have fair and equal access to the CA process, regardless of where or how they present for services, whether in person, by phone, or some other method, and that the CA process for accessing help is well known.

Marketing strategies include direct outreach to people on the street and other service sites, informational flyers left at service sites and public locations, announcements meetings, and educating mainstream service providers.

If the entry point includes one or more physical locations, they are accessible to people with disabilities, and easily accessible by public transportation, or there is another method, e.g., toll-free phone number, by which people can easily access them. The entry point is able to serve people who speak languages commonly spoken in the community.

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EMERGENCY SERVICES

The CA process does not delay access to emergency services such as shelter and includes a manner for people to access emergency services at all hours independent of the operating hours of the coordinated entry intake and assessment processes.

For example, people who need emergency shelter at night are able to access shelter, to the extent that shelter is available, and then receive an assessment in the days that follow, even if the shelter is the access point to the CA process.

STANDARDIZED ACCESS AND ASSESSMENT

All locations and methods (phone, in-person, online, etc.) offer the same assessment approach and referrals using uniform decision-making processes. A person presenting at a particular location is not steered towards any particular program or provider simply because they presented at that location.

INCLUSIVE

The CA process includes all subpopulations, including people experiencing chronic homelessness, families, youth, and survivors of domestic violence. However, a homeless serving system may have different access points and assessment tools for the following different populations: (1) adults without children, (2) adults accompanied by children, (3) unaccompanied youth, or (4) households fleeing domestic violence.

These are the only groups for which different access points are used. For example, there is not a separate CA process for people with mental illness or addictions although the systems addressing those disabilities may serve as referral sources into the process. The homeless serving system continuously evaluates and improves the process ensuring that all subpopulations are well served.

REFERRAL TO PROJECTS

The CA process makes referrals to all projects receiving funds, including emergency shelter, RRH, PSH, and transitional housing, as well as other housing and homelessness projects. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals while other housing and services projects determine the extent to which they rely on referrals from the CA process.

REFERRAL PROTOCOLS

Programs that participate in the local CA process accept all eligible referrals unless there is a documented protocol for rejecting referrals that ensures that such rejections are justified and rare, and that participants are able to identify and access another suitable project.

OUTREACH

The CA process is linked to street outreach efforts, so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the process.

ONGOING PLANNING AND STAKEHOLDER CONSULTATION

The homeless serving system engages in ongoing planning with all stakeholders participating in the CA process. This planning includes evaluating and updating the CA process at least annually.

Feedback from individuals and families experiencing homelessness or recently connected to housing through the CA process is regularly gathered through surveys, focus groups, and other means, and is used to improve the process.

INFORMING LOCAL PLANNING

Information gathered through the CA process is used to guide homeless assistance planning and system change efforts in the community.

LEVERAGE LOCAL ATTRIBUTES AND CAPACITY

The physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community's context, inform local coordinated entry implementation.

SAFETY PLANNING

The CA process has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence have safe and confidential access to the process.

USING HMIS AND OTHER SYSTEMS FOR COORDINATED ACCESS

HMIS can be used to collect and manage data associated with assessments and referrals, or they may use another data system or process, particularly in instances where there is an existing system in place into which the process can be easily incorporated.

For example, a CA process that serves households with children may use a system from a state or local department of family services to collect and analyze coordinated entry data.

FULL COVERAGE

A CA process covers entire geographic areas overseen by a local homeless serving system. In cases where it is covering large geographic areas several separate coordinated entry processes might operate over the entire region.

Implementation

HUD provides a tool with a list of both required and recommended Coordinated Entry process elements.

Homeless serving systems can use the self-assessment as a reference: to help identify key aspects of coordinated entry design, implementation, and management; to compare the list of elements in the self-assessment against existing local plans and/or practices to gauge the extent to which the local system currently includes those elements; and as a general outline for a set of policies and procedures a homeless serving system must adopt to support the ongoing management of the Coordinated Entry process and its many functions.

The Coordinated Entry Self-Assessment checklist is extensive and, while out of scope for this brief, a summary is presented with following themes:

- Planning
- Access
- Assessment
- Prioritization
- Referral
- Data Management
- Evaluation

This Self-Assessment identifies elements of CA that HUD has determined are required elements for each local homeless serving system. The Self-Assessment also identifies other elements of functionality, operations, or management that are recommended as good practice, but are not required.

Evaluation

Implementation of the CA has been a challenge in some communities due to capacity and resource issues; however, evaluations of CAs have demonstrated positive service outcomes, including an improvement in multi agency working, information sharing and (a reduction in) referral rates to local authorities:

Hambrick and Rod (2000) present evidence in the form of reviews of a variety of approaches for achieving coordination at the local level, ranging from point-of-service coordination to system-design.

Burt, et al. (2007) advocate for coordinated assessment as key to effective prevention and rapid rehousing programs. Their study of five communities demonstrating key elements of successful strategies including mechanisms for accurate targeting, a high level of jurisdictional commitment, significant mainstream agency involvement, and mechanisms for continuous system improvement.[6]

Levitt (2015) discusses assessment tools for allocating homelessness assistance in coordinated entry systems. A strong tool would be reliable (produce consistent results) and have validity (measure what it claims to measure), so that stakeholders could have faith in the instrument, and it would have predictive value.

[6] *Burt, M.R., Pearson, C. & Montgomery, A.E. J Primary Prevent (2007) 28: 213.*

The Vulnerability Index — Service Prioritization Decision Assistance Tool (VI-SPDAT), the Alliance Comprehensive Assessment tool, and the Hennepin County Eligibility Criteria and Rating Tool and Vulnerability Index were provided to the experts as examples of tools currently being used by communities. The tools are evidence informed, but because they are still relatively new, the evidence base is limited.[7]

Burt (2015) examines new structures for coordinating care for people with complex, co-occurring health conditions. Within that large group, the article focuses on people who are now or recently were homeless, and the importance of including housing as part of coordinating their care.

"Care coordination" is used as shorthand for a continuum of strategies and structures being developed to reach the three goals of better health care experience, better health outcomes, and cost savings.

Six models are described, ranging from simple in structure—a partnership of one permanent supportive housing program and one community health center—to complex, including a limited liability, for-profit care coordination entity serving Cook County, and two county-run programs (in Hennepin County, Minnesota, and Los Angeles County, California). All are works in progress, but show promise of improving care for difficult-to-serve populations.[8]

Coordinated Access in Canada

CAs in Canada remain relatively new in comparison to the US, where they are mandated. Alberta has been experimenting in this areas for about 10 years – we are therefore able to assess some learnings from a Canadian perspective.

The concept of CA is gaining more momentum with communities across the country adapting and testing the model locally.

Federally, the Homelessness Partnering Strategy (HPS) guidance on CA for Designated Communities remains sparse, though future renewals may shift this from the current Directives 2014-2019, outlined below:

- Communities are encouraged to work with shelters and service providers to ensure that the intake of clients prioritizes those with the highest needs;
- Depending on the size of the populations, this may require some communities to develop a more comprehensive and coordinated intake system.[9]

[7] Levitt, Rachelle, Assessment Tools for Allocating Homelessness Assistance: State of the Evidence (February 2015)..

[8] Martha R. Burt (2015) Serving People With Complex Health Needs: Emerging Models, With a Focus on People Experiencing Homelessness or Living in Permanent Supportive Housing, American Journal of Psychiatric Rehabilitation, 18:1, 42-64.

[9] ESDC. 2018. Homelessness Partnering Strategy Directives 2014-2019. Retrieved from https://www.canada.ca/en/employment-social-development/services/funding/homeless/homeless-directives.html

Case Study: Calgary, Alberta

In Calgary, the CA is a single process for people experiencing homelessness to access housing plans and assessments. It is a system-wide process designed to meet the needs of the most vulnerable first (triaging).

The CA aims to create a more efficient homeless serving system by:[10]

- Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);
- Reducing new entries into homelessness (by consistently offering housing plans upfront, reducing the number of people entering the system unnecessarily); and
- Improving data collection and quality, and providing accurate information on what kind of assistance consumers need.

Calgary Homeless Foundation (CHF)

As the System Planner Organization, CHF has the resources, expertise, and robust data base (HMIS) to develop an integrated homeless serving system that meets the needs of those who are homeless, creating greater ease and access to services and supports. CHF uses the CA to determine housing and support needs in the community in order to direct resources effectively.[11]

Distress Centre Calgary

Distress Centre ensures everyone has a place to turn in a time of crisis by providing 24-hour crisis support, counselling, and referrals. The Distress Centre CA team provides services from the fixed location of the SORCe (317 – 7 th Ave. SW) during the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday. Clients can walk-in for appointments or schedule an appointment through a partnering service provider.[12]

Collaborative Service Delivery Group

The following listed agencies are part of a Collaborative Service Delivery Group participating in the CA. They work together and share information to ensure the clients receive the highest quality services towards housing plans and assessments.

- Aboriginal Friendship Centre
- Accessible Housing Society
- Alpha House
- Aspen
- Boys & Girls Club of Calgary
- Calgary John Howard Society
- Children's Cottage Society
- CUPS
- CMHA
- Discovery House
- Dream Centre
- Inn from the Cold
- Keys to Recovery
- McMan Mustard Seed
- The Alex Wood's Homes
- YWCA

[10] CHF. 2016. Coordinated Access & Assessment. Retrieved from http://calgaryhomeless.com/content/uploads/CAA-Manual-Version-7.pdf

[11] CHF. 2018. Calgary Homeless Foundation and Coordinated Access and Assessment. Retrieved from http://calgaryhomeless.com/agencies/coordinated-access-assessment/

[12] CDC. 2018. CAA and SORCe. Retrieved from https://www.distresscentre.com/need-help/caa-and-sorce/

Centralized Location

CA's storefront location at SORCe is located near Calgary's emergency shelters and steps away from a Calgary Transit Light Rail Transit (LRT) station. It is a multi-service site where 14 homeless-serving agencies provide a variety of services that people experiencing homelessness may require, including prevention and diversion from the system of care through information and referral, income support, addiction and mental health services, and outreach services.[13]

Assessment Tool

SPDAT was chosen by Alberta's 7 Cities on Housing and Homelessness, and approved by their largest supporter, the Government of Alberta's Human Services, prior to the implementation of CA in Calgary. It is a detailed assessment measuring an individual's or family's acuity for the purpose of triaging and prioritizing service delivery. It uses 15 measures to calculate a score out of 60 for individuals experiencing homelessness.[14]

Placement Committee Meetings (PCMS)

The primary purpose of PCMs is to collectively review completed SPDATs, and match clients to programs best suited to meet their needs based on the capacity in those programs. Placement Committees occur each week; Families, Youth, Adults.

CA Placement Committees meet weekly to review available program spaces and match clients to appropriate program placements. The goal of these committees is to ensure programs within the homeless serving system maintain appropriate occupancy levels, to facilitate timely and efficient service delivery, and to document learnings.

The committees are designed to seek consensus on all placement decisions. Because each population corresponds to a segment of the homeless serving system (i.e. family programming, permanent supportive housing etc.), the Placement Committees focus on their population and program area of expertise.

CA placements are made based on a combination of criteria, including the acuity of the client, chronicity and vulnerability factors, the number of available placements, and the suitability of program/client match.

This is not a typical chronologically based "wait list" but a triage list based on vulnerability. The triage list is assessed based on best possible match in relation to acuity, client needs and availability of services.

[13] SCORCE. 2018. http://www.scorce.ca/

[14] OrgCode. 2015. Service Prioritization Decision Assistance Tool. Retrieved from (SPDAT)https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/315/attachments/original/1479851561/SPDAT-v4.01-Single-Fillable.pdf?1479851561

The placement process in CA requires the staff of the program in which the client is placed to contact the client within two days to notify them of their placement and coordinate the intake process. Notification of placement into a program does not necessarily equate to immediate housing. For some programs, intake into a program may involve the client beginning the process to find housing utilizing case management and housing location services in a program.

Access to CA services is voluntary and the client can terminate involvement at any point in the continuum.

Benefits

CHF states that without a CA process to determine client acuity, individual agencies have historically independently determined which clients they accepted into their programs through agency-specific eligibility requirements and program entry. This led to multiple system access issues and obstructions.

The CA allows agencies to work together with a common language, assessment tool, processes and policies. This enhances ease of access for clients and more consistent, harmonized processes across the sector, regardless of where or how an individual enters the homeless serving system.

CA also eliminates a common outcome of agency-centric systems of care where by clients could apply for entry into multiple programs at the same time to increase their likelihood of acceptance. This resulted in a system with multiple wait-lists and no way of knowing if the same client waits on numerous lists.

When defining structure in the system of care, it is important to have a thorough understanding of the needs of the population and the programs required to meet those needs. False data related to program wait-lists can skew funding decisions, and lead to a system of care not representative of client needs.

Successful programs identify the needs of the target population thus guiding interventions and funding towards the program types in most demand.[15]

[15] *CHF. 2018. Calgary Homeless Foundation and Coordinated Access and Assessment. Retrieved from http://calgaryhomeless.com/agencies/coordinated-access-assessment/*

Challenges

While CA has improved our knowledge regarding system gaps and program waitlists, it has not impacted the environmental factors that contribute to homelessness in Calgary, such as high rates of migration to the city, limited affordable housing options, and lack of employment opportunities.

Additionally, while we aim to coordinate the system of care through CA, it has not added new spaces, and therefore bottlenecks occur, and lower-acuity clients are not receiving services until more program spaces are funded.

In 2015, Dressler reviewed the CAA program and processes, and noted the following gaps in the System of Care:[16]

- Harm Reduction
- Couples
- Non-English-Speaking Clients
- Transitional Housing
- Clients with a Violent History
- Complex Clients

Finally, consistent and repetitive communication is critical to the success of the program.

Case Study: St John's, Newfoundland and Labrador

In St John's, Coordinated Access is a standardized, system-wide approach to meeting the needs of diverse individuals and families experiencing or at imminent risk of homelessness, where all agencies use the same assessment framework to provide a consistent experience with "no wrong door" for the individuals.

CA matches individuals and families with housing and services based on their current situation, the acuity of their needs, and the support they currently receive.

The following information is pulled directly from the EHSJ's St. John's Coordinated Access Memorandum of Understanding:[17]

[16] Dressler, J. 2015. Coordinated Access and Assessment: Calgary, Alberta. Retrieved from http://homelesshub.ca/sites/default/files/1.1.%20Dressler.pdf

[17] EHSJ. 2017. St. John's Coordinated Access Memorandum of Understanding.

Leadership

CA is an initiative of EHSJ in partnership with community and governmental agencies. The System Planner is responsible for the implementation of CA, and shall act as a resource to members involved in that process.

Membership

Membership in the CA process is composed of EHSJ, Navigators and Networks (NAVNET), and CA Agencies (homeless-serving organizations with a VAT Assessor on staff and/or housing available to the community) that have signed this MOU. Note that no party is an agent of any other party.

The community CA Agencies include, but are not limited to:

- AIDS Committee of Newfoundland and Labrador (ACNL)
- Choices for Youth
- End Homelessness St. John's (EHSJ)
- John Howard Society of Newfoundland and Labrador
- Navigators and Networks (NAVNET)
- Newfoundland and Labrador Housing Corporation (NL Housing)
- St. John's Native Friendship Centre
- St. John's Women's Centre
- Salvation Army – New Hope Community Centre
- Salvation Army – Wiseman Centre
- Stella's Circle – Brian Martin Housing Resource Centre (BMHRC)
- Stella's Circle – Naomi Centre for Women
- Stella's Circle – Other programs
- The Gathering Place
- Thrive – Community Youth Network St. John's

Guiding Principles

Guiding principles for the successful implementation of CA include:

- Adherence to the Housing First philosophy;
- Zero discharge into homelessness;
- Focus on the individual's needs and outcomes;
- Collaboration, cooperation and information sharing between member organizations;
- Confidentiality of individuals involved;
- Compliance with ATIPPA, 2015;
- Commitment and participation of all member organizations, including attendance at all meetings when required; and
- Timely decisions and implementation.

Governance Structure and Reporting

CA is the keystone of EHSJ's St. John's Homeless-Serving System Coordination Framework, approved by EHSJ's Board in 2016. As such, the Intake Table and the Collective Impact Working Group (CIWG) report to EHSJ to ensure alignment with the EHSJ mandate, and compliance with Homelessness Partnership Strategy (HPS) Directives.

The Intake Table and the CIWG

The purpose of the Intake Table and Collective Impact Working Group (CIWG) is to act as referral, planning and service coordination tables for participants experiencing or at imminent risk of homelessness. In the case of the CIWG, participants are experiencing the highest acuity and most complex needs.

The Intake Table aims to make appropriate program/service delivery and housing placements with triage and prioritization decisions based on acuity. The CIWG aims to coordinate a system of care response among community service providers and public systems to ensure that each individual's needs are met using a Housing First philosophy.

NAVNET Approach

The CIWG shall use the NAVNET approach where appropriate (in the case that a participant's VAT score is over 30). The case shall be transferred accordingly for further assessment, following the NAVNET referral process. Before this work can begin, participants shall be asked to sign the NAVNET Consent Form.

The NAVNET approach consist of two options:

1. **Brief Intervention:** For participants with a VAT score of 25+ and therefore considered to have high "complex needs." A brief intervention usually involves identifying what is required for participants with complex needs to have positive outcomes. This may include rental assistance, support hours, etc. NAVNET staff shall work with EHSJ to bring these issues to decision-makers for a response.

2. **NAVNET's Coordinated Systems Response Program:** This approach requires a referral that can be completed by a primary worker who is familiar with the participant being referred and who can get client consent for this response. Once received and eligibility is determined, various government departments, programs within Eastern Health, and some community organizations shall be brought together to commence a longer-term systems response. Participants being referred for this approach need to have a Case Manager/Social Worker who shall continue to work with the person, and who shall join the Multi-System Team that will be set up.

Decisions

Decisions at meetings are made by consensus (i.e. members are satisfied with the decision, even though it may not be their first choice). While some discussion is required, the Chair shall ensure that the discussion does not exceed the allotted time given to each case. If consensus is not reached, the Chair shall make the final decision based on input from all members.

Process

Participants can enter CA through entry points anywhere in the community, including shelters, frontline organizations, systems, and the phone line, in order to conduct the pre-screener. Currently, there are six Assessment Sites:[18]

- AIDS Committee of Newfoundland and Labrador (ACNL)
- The Gathering Place
- Salvation Army Wiseman Centre
- St. John's Native Friendship Centre
- St. John's Women's Centre
- Thrive

1. Entry Point	CA is designed to be accessible for all individuals and families experiencing or at imminent risk of homelessness, with a number of entry points – including streets, shelters, systems, and the phone line. Everyone is treated the same regardless of entry point. If the entry point is not a pre-screener site, it will refer the individual to a frontline organization to conduct the pre-screener.
2. Pre-screening	All individuals fill out a standardized pre-screener with a frontline worker and are either screened into CA, or diverted to existing services or resources (i.e. screened out).
3. Assessment	All participants who screen into CA complete the VAT with a VAT Assessor who then makes a referral to the appropriate program (if available) for review by the appropriate table (see 4 and 5 below), and submits the participant's name to EHSJ for inclusion on the By Name List.

[18] *EHSJ. 2017. St. John's Coordinated Access Info Sheet.*

Process

4. Intake Table	Cases where the participant receives a VAT score of <25 proceed to the Intake Table for review of the case, including the VAT Assessor's referral, and program Matching.
5. Collective Impact Working Group (CIWG)	Cases where the participant receives a VAT score of 25+ proceed to the CIWG for review of the case, including the VAT Assessor's referral, and matching to programs with additional supports as required, along with collective case management. Participants who score 30+ are referred to NAVNET.
6. Program Acceptance	Referrals are assessed on a case-by-case basis, and individuals are matched to programs for follow-up by the appropriate program, or placed on a waiting list if necessary. Individuals are notified, and a transfer to the program is made.

Funding and Resources

Participation in CA does not require a commitment of funds, and members shall not be compensated in any way for participation in the CA process. Members are also not required to provide resources aside from in-kind staff hours and the ability to accept people from the CA process into their programs and housing.

However, the organization that is hosting Intake Table and CIWG meetings shall be required as part of this function is to provide facilities and equipment that are conducive to holding meetings.

Housing Providers

Community housing providers that are CA members have their available units allocated via CA. This means that when units or housing program spaces become available, they are filled with individuals from the By Name List, rather than organizations keeping their own wait-lists.

Review, Evaluation and Performance Management

CA shall facilitate robust, coordinated and well-designed data collection and reporting processes. Using this information, EHSJ shall conduct an annual review with CA Agencies to determine if CA is fulfilling its purpose and abiding by its guiding principles, including fidelity to Housing First.

The CA Agencies agree to being reviewed as needed by EHSJ to ensure ongoing effectiveness and to make required adjustments.

Yellowknife Stakeholder Interview Summaries (n=16)

1. What is working well in terms of coordination between programs?

Commitment to Working Together

Stakeholders report that there has been a lot of effort and time invested in coordination and communication in community over the past year. Overall coordination between programs and services has improved; however, there is still a disconnect in the community with regards to leadership, roles and responsibilities, and how the Plan is to be implemented.

Where good day-to-day coordination of services was noted, it was specific to the frontline workers in organizations and departments. Unfortunately, this was limited to being person dependant, and not yet entrenched in the organizations or systems.

"I hope we can carry this momentum on. This is a direction that we have needed to take for a long time and the public and general – trauma and colonization knowledge has improved drastically."

Communication

Community honed-in on the important role that communication plays in coordinating of services. There were fairly open lines of communication amongst providers – particularly when there are good people in positions.

Those stakeholders who delivery front line services reported the best lines of communication are with other providers; however, again, it is selective and changes if leadership or staffing changes.

Desire for Continuous Improvement – Being Solution Focused

The Integrated Case Management (ICM) team was highlighted as working exceptionally well in community, and has two functions: one is to work with the more difficult clients and help steer them through the obstacles to get housing, and the other to find gaps in policy and practice.

NGOs currently hold quarterly information sharing sessions and provide updates on program changes. There are opportunities for feedback from front line about how the ICM is being operated. There is a desire from stakeholders to build upon the success of the ICM and development of a front-line working group in community that would meet one to two times per month and discuss communication, process, and policy challenges experienced at the front-line level.

2. What opportunities for improvements do you see to enhance coordination?

(see also #1 – Communication and Continuous Improvement)

Stakeholders agreed that there are always opportunities for improved coordination amongst NGOs, the GNWT & City. There are recognized attempts for change, however “not much has changed” at the service coordination level.

Philosophical Alignment

There was an overwhelming want to create layers of opportunity to get everyone at the table again to have the important discussions. Most felt that the conversations are not currently aligned and bringing everyone into the same room and creating a mechanism for all stakeholders to be engaged and to hear the dialogue would be an improvement.

A re-examination of the policies currently in place that are prohibiting enhanced coordination and services was identified as being a priority.

Many felt that NGOs, GNWT, and the City were coming at the work from different philosophies, and reaffirming the commitment to housing first, and the Plan would be a positive move. NGOs identified that principles of harm reduction must continue to be a foundation of the work on a go-forward basis.

In the absence of appropriate, person based-responses, it is difficult to change systems.

Timely Service Coordination

The need for timely and appropriate services for the “hard to house” was identified as a priority to avoid the “spiral down effect” that many vulnerable individuals face.

While departments and NGOs are responsive, and there is an understanding across the departments about prioritizing need, situations arise that require quick access. Having the ability to be person centered and creating flexibility in the response system would improve the timely access of services for people who are in emergency situations.

Another perspective to timely service coordination was shared from a housing provider, who identified that they could be doing a better job at referring people earlier when their rent is not paid. The challenge with the referral process was that even when referrals were made, people had to wait months to be seen, thereby exacerbating the situation.

3. What specific measures do you see that can improve coordination among providers?

Building on What is Working

The Integrated Case Management (ICM) team was identified by all stakeholders as a resource from which to learn, or on which to expand in order to increase coordination. The frequency of the meetings was identified as being inadequate to meet the current needs; however, opportunities for growth and additional meetings were presented as options to overcome this.

Stakeholders provided a range of measures; however, they were short to expand in this section (comments were repetitive and covered in other areas):

- Development of a communications plan
- Evaluation of the programs and services to determine service level of impact and accountability to community/the Plan;
- Front-line workers to have an opportunity to attend meetings;
- Being person centered and not program centric.

4. What would success look like if we implemented these coordination measures?

"Ultimately, it would look like fewer systemic barriers for our clients (e.g. medical access and overall wellness). For service providers, communication and an ease of referrals, and who belongs where. Success looks like people feeling comfortable accessing services that are available to them."

Effective use of Available Services

Determining the most impactful use of available resources and programming space for those in greatest need was a prominent theme when talking about what success would look like.

"Success is being able to serve people efficiently and not have them bounce from agency to agency."

"Success would be everyone on the same page. Have conversations about what your programs and policies are."

Effective use of Available Services

In order to achieve a higher degree of coordination, it was recognized that improved communication and understanding about what programs and services are currently being offered in the community is important.

Almost all stakeholders identified the need for more effective case conferencing between programs and services. Suggestions about how to achieve improved coordination of services revolved around the desire to have NGOs move towards a CA model.

> “If NGOs moved to a CA model, a better assessment of their (homeless) needs would happen. They are not just a person with an addiction….The assessment would look at what is the best approach to support them. For example, a modified home care approach, or an ACT team approach.”

Improvements to Overall Health & Wellbeing

Success in coordinating measures would result in, “a reduction is substance abuse, violence, sexual abuse, emotional abuse; people would generally be living healthier lives.”

Implementation of coordinated measures would also result in a reduction of inappropriate use of emergency services, and a reduction in acute mental illness [in that people would be able to access services, not rely on emergency responders].

When people are able to access the right services, education can be improved, and their employment (traditional or non-traditional) can be enhanced.

Impact on the Family

The impact on families, and specifically the children, in community was also discussed at length and the recognition that success would mean “… fewer children being taken away from families, more being returned to families. Children supported, graduating high school, people will be starting to say ‘I’m healed from residential schools, not I’m a victim’.”

Impact on the City

The economic and visual impact of addressing the issues of homelessness were also noted as part of defining success. Housing and providing supports to homeless people would have a direct impact on the downtown core – “not an eyesore” – and helping to minimize public drunkenness.

It was shared that downtown businesses would flourish more and that the economic development of the City and Territory would improve.

5. The Plan identifies the idea of coordinated access – what would make sense on the ground based on your knowledge?

Who Leads?: System Oversight

There appears to be a disconnect in community about leadership (backbone organization role) in community versus shared responsibility to ensure the Plan is successful.

This is not an uncommon struggle for communities that are developing and implementing plans to end homelessness.

A revisiting of roles and responsibilities, as well as reexamination of services under the homeless serving system of care, requires fulsome conversation as communities make progress; new partners come/leave the table, and leadership changes within organizations, thereby potentially impacting level and type of commitment.

The hardest part is keeping up with the programs and services under which NGOs operate. The unique thing in Yellowknife is to exhaust services. There is a finite number of services, and that can be used as a strength to have a mechanism to really understand where there is overlap.

Structure & Environment - NGOs, GNWT & City

The type of environment was important to stakeholders; the majority envisioned it as a one-stop shop, a physical location that was a warm and inviting place that people could walk into and be assessed for their housing needs. The need for “front end” people to be “people people” who were trained exceptionally well to meet people where they were at ranked high on the list.

There was acknowledgement about the strong work of NGOs in the community and how well they worked with the population. This was in contrast to the degree of paperwork and statistical reporting that would be required ongoing, and the potential role for coordinated access. NGOs are “great working with people. There is so much paperwork involved, and that’s a different skillset.

People are often asked to do both. Let the people people be the people people.” This separation of skillset lead to the suggestion that coordinated access, wherever it was situated, could be the “…one place could do the data, evaluation, standardize data and information statistical piece, and the administration – let them do that. If one window could do the lead with that, that would be helpful.”

Options for how coordinated access could be implemented on the ground were suggested and are presented below. It was clear from all stakeholders that coordinated access should not fall solely under an NGO, and that it must be a shared model: NGOs/ GNWT/City.

"Does not matter who leads it. Leadership needs to happen at a high level, not at the program level. If there is a true desire to do it – then it doesn't matter where it sits."

Option: Have a City building with NGO representation = shared leadership at the building. One stakeholder noted that it was confusing that the Plan (initiative) was coming from the City, and they felt that is was a "foreign" idea for the coordinated access to be coming from a level of government that does not provide services.

Option: Tha Plan should be coordinated through an integrated department with GNWT. Based on resources, this was felt to be the best place to situate based on who receives funding.

Option: "It might be a nice pilot between government and NGOs. It might be a headache, but I see strengths in both. Need the soft people component and the government infrastructure at the table."

6. How would our organization be able to participate in such an initiative?

Stakeholders shared many insights about how their organizations would be able to participate and contribute to achieve success, recognized the need to come together differently, and were open to the idea that "we can learn a lot from each other."

The strongest element for participation was the **willingness to come to the table and re-engage in conversation** to move the initiative forward. The impact of not coming together was captured concisely by one stakeholder: "Our program participants suffer daily because we are not coordinated."

- If there was coordinated access, we would be at the table to assist, and receive people who needed assistance;
- Being able to be part of the conversations, and being present at the location (for coordinated access);
- Definitely want to sit at the table;
- However, we can help facilitate the conversations;
- "We have a long-standing history in the NWT, so we can bring some insight to that and help create a structure that will work for Aboriginal people."
- There is a role for a hospital in discharge planning. Also, the hospital can assist, especially in the area of in/out flow systems (of clients).

In the areas of accountability for NGOs, and prioritizing who is in greatest need in community, the concept of **disrupting the system** was introduced by some stakeholders.

Stakeholders suggested that there is an opportunity to get all NGOs in the same room, and to move towards outcomes-based results and funding, with the expectation that if outcomes are not met, funding is reallocated. To achieve greater coordination, it was suggested that attendance at meetings would be mandated, and that collaborative work models be implemented as being part of the collective.

In essence, creating a mechanism for accountability both to the needs of the system and the community to address homelessness.

Due to the current system and how it is operating, there is a sense that the homeless serving programs are taking “lower-risk population”, and the “higher-risk” is not being served.

“It’s not complicated, although lots of attempts have been made. Some individuals are disruptive towards the good work, and this needs to stop.”

7. What supports would you need to be successful?

Healthy Collaboration

The need for more collaborative working partnerships in community and the need to be able to advocate for one another – “the work is difficult enough as it is.” The definition of success with the population and community needs to be explored.

In order to really understand something and create something new, you need to consult with people on multiple levels and then bring together other big picture thinkers at the table. Having Aboriginal and lived experience people at the table in a consultative role continues to be imperative as this work goes forward.

Stakeholders acknowledged that “we have come a long way,” and there is always room for improvement in how community works together. While one stakeholder commented that a “burn it down and restart” approach may be required, others felt the community had come far enough to resolve and work through the issues.

To that end, the call for an accountability process, when individuals/departments do not work in a certain way, was mentioned as well as the support from the higher levels to support this accountability framework. A suggestion was the creation of formalized **Memorandum of Understandings** (MOUs) amongst all partners involved in the work of addressing homelessness in Yellowknife (NGOs, GNWT, City, Landlords, Business).

Increased Funding & Service Options

An increase in funding for homeless serving initiatives was identified. If more funding was available, the community could provide more wrap around services, and perhaps create more options for similar type services.

It was noted that a lot of people (homeless) have burned bridges and are not allowed back into certain programs. Talk about duplication of services was present, with the clear distinction that having choice in programming does not equate to duplication of services per se.

The need for innovative ways to be involved in community and creating those opportunities for homeless people, be it through language or cultural programs, was part of the discussion around service options/duplication.

Additional Housing Units

The addition of more low-end housing units was identified as a barrier to achieving success. Suggestions to look at major builds and to focus on what the target population is wanting in terms of housing size is necessary. Bachelor and one bedroom unit were on the list of most desired unit sizes.

Training & Staff

Improved access to training specific to trauma-informed care, and change management training through the transition would help create success. Some people have been in their jobs for decades, and have not evolved with the initiatives, such as harm reduction or housing first; they have effectively worked in silos for decades.

On the flip side, there are some organizations that have “rotating doors in some leadership roles” which means that “you never know what you’re dealing with” in terms of their perspective on the Plan, and how they see their organization’s role in the system.

Key Considerations

A coordinated assessment system is about people. It provides an entire system that is dedicated to enabling the client to interact with service providers to choose interventions that meet their unique needs and achieve their goals. It paves that way for even those who are most in need to reach self-sufficiency and holistic well-being.

Yellowknife stakeholders recognise this and are advancing the 2017 Plan with CA implementation. Based on the interview summaries presented above, the following broad recommendations for developing a Coordinated Assessment Model for Yellowknife include:

1. **Develop a hybrid CA model with multiple sites complemented by mobile outreach.** This would enable CA staff to connect with diverse populations in environments they are comfortable in:
    - Adult
    - Youth
    - Families

In addition, complementing the three sites with Mobile Outreach CA would ensure broad reach to where people are at – rather than only expecting them to come into CA sites.

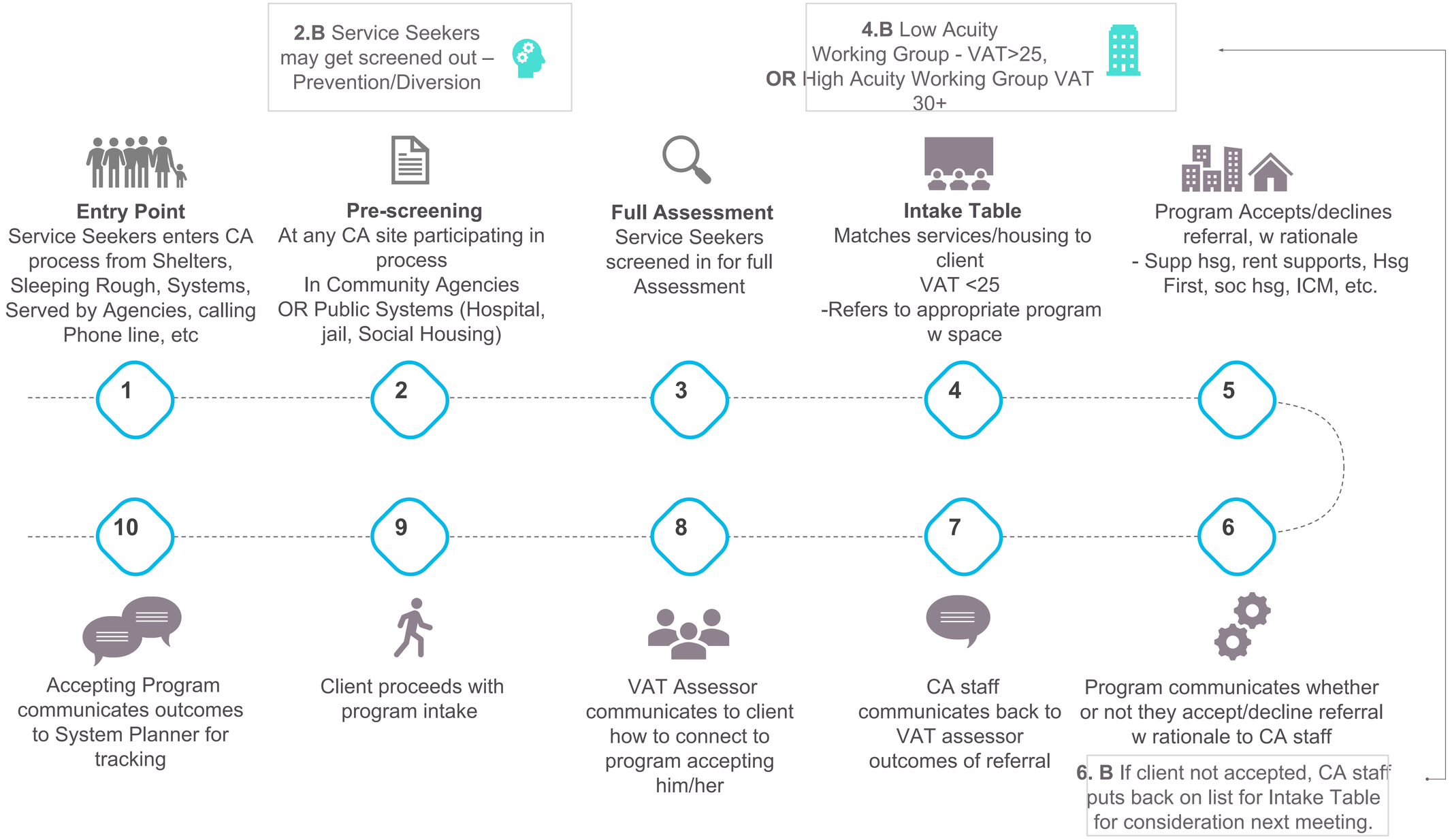

Figure 9 Client Path in potential CA Model for YK

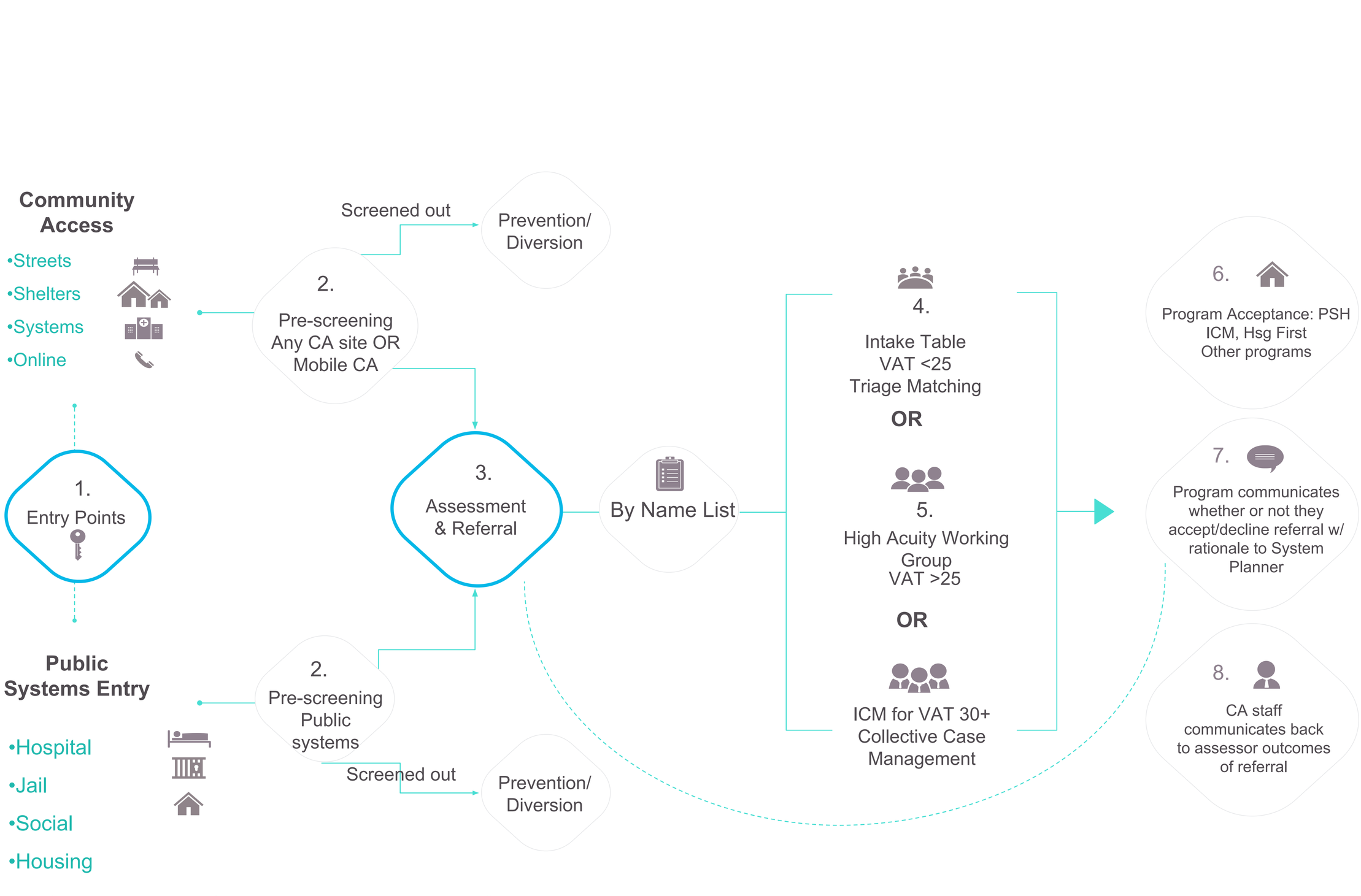

Figure 10 Potential CA Model Component for YK

Some notes from the meeting brought forward a number of additional considerations including:

2. Creation of an Interagency Council focused on homelessness bringing together NGO and government stakeholders. ICM is bringing together frontline NGOs on a quarterly basis and key GNWT departments monthly to enhance coordination around wellbeing in general. Is there a potential to look at aligning the Plan's call for an Interagency Council with these already occurring meetings to address service coordination goals for NGOs and government departments working on homelessness-related issues?

3. Launching a client-level case coordination table particularly focused on homelessness comprising of NGO and government frontline service providers. Despite the meetings already occurring, there is no dedicated table including government and NGOs working on homelessness at the client level.

4. Development of a Funders Table to better leverage funding towards common homelessness goals. The Plan identified the need to coordinate funding, but currently funders working on homelessness are not meeting and sharing basic information about their funding stream or considering how best to collaborate toward common goals.

CAB Action Steps

Amalgamating the interviews, meetings and discussions, the following system-focused action items emerged for the CAB's consideration.

1. ESTABLISH CA LEADERSHIP

In many cases, an existing organization with experience in building networks and tracking data can be designated to serve as the lead agency for CA. The CAB will need to consider who is best positioned to lead the CA rollout in community in partnership with the GNWT.

2.FINALISE THE CA FRAMEWORK: GOVERNANCE AND MODEL TYPE – HYBRID

An appropriate governance model and staffing will need to be finalised. A lead CA organization will be responsible for providing the common infrastructure and other resources needed by community stakeholders to more effectively serve at-risk populations. A point-person (CA Coordinator) will be needed to coordinate CA operations.

3.COMPLETE A SYSTEM MAP: PROGRAMS, SERVICES AND FLOW

Based on a System Mapping Survey and community consultations, a draft Systems Map was being developed but not completed due to time restraints. A map would illustrate the steps in the supportive and supported housing system, and identify the gaps, inefficiencies, and bottlenecks within that system.

4. SECURE FUNDING FOR SUSTAINABLE CA PRACTICES

A careful consideration to long-term secure funding will be needed to start and maintain CA. Often, multiple sources of funding may be available, however, a case will need to be made. It is important to consider that funding for CA agencies is not necessarily secure, and it would be beneficial to have this in place so CA development is not thwarted with short-term funding cycles.

5.CREATE DOCUMENTS, POLICIES, PROCESS AND RESOURCES

Additional required documentation tools to implement the CA need to be developed:, likely led by the CA Coordinator

- Consent Form/Notice of Privacy Practices/Release-of-Information Forms
- Intake/Referral Forms
- Assessment Forms
- Case Plans

6.IMPLEMENT DATA COLLECTION PLATFORM

A shared measurement platform, such as HIFIS, captures client-level, system-wide information over time on the characteristics and services needs of men, women, and children experiencing homelessness. A community database can provide the following benefits:

- better data;
- progress tracking towards shared goal;
- enabling coordination and collaboration;
- learning and course correction;

Where this is not possible, workarounds such as Google Docs/Sheets can be used to ensure data is being shared appropriately to support integrated case planning.

7.DECIDE ON A CONSISTENT ASSESSMENT TOOLS

The VAT is a triage assessment tool to screen participant acuity and key issues related to housing. The CA model should review the VAT and determine whether this should be implemented as the CA assessment tool. Iterations of the VAT for families and youth should be implemented as available.

8. EXPLORE HELPSEEKER AS A TOOL TO CONNECT CLIENTS TO SERVICES

HelpSeeker is an online app avaialble for free to map resources and match clients to them. The CA model could leverage HelpSeeker as an online resource tool for clients and providers.

9.DEVELOP PROCESSES TO TRACK AND EVALUATE PERFORMANCE

CA should have a system to:

- Register “new” clients through a centralized database to minimize duplication;
- Monitor progress of individual clients
- Evaluate and report performance to stimulate quality improvement.

Likely, the CA Coordinator would collate information to develop and communicate performance trends to participating organizations.

10. TRAIN AND ORGANISE STAFF

Significant training of relevant agencies and individuals to use the model is required to ensure proper implementation and data collection. A training schedule will be needed to ensure CA staff and community/government organizations or onboard and know the CA protocols involved in the new model.

11. CONDUCT A COMMUNITY AWARENESS CAMPAIGN

The CA workers and their represented organizations play a substantial role in providing community awareness of CA and its development. The participation of the CA leadership in other health, social service, and justice meetings and activities within the community is also critical in achieving community awareness.

Further implementation considerations:

- **Who will manage the day to day operations of the system?**
- **How will clients and providers participating in the system give feedback?**
- **How will Coordinated Access be resourced?**
- **Will the Coordinated Access process be implemented in phases? For specific populations first? Which subpopulations may need to be considered based on local need?**
- **How will prevention functions be incorporated into the process, if at all? Are there mainstream providers in the area that could be engaged in the process?**

Yellowknife’s CA Model

This section outlined the main actions and recommendations proposed for community consideration. We were able to adapt these recommendations on the hybrid CA model in use in the St. John’s community thanks to End Homelessness St. John’s commitment to supporting the broader national community of practice on system planning.

Coordinated Access Overview

- Implement a **hybrid Coordinated Access** with multiple locations throughout the community using the same assessment form, targeting tools, and referral processes.
- The **Vulnerability Assessment Tool (VAT)** is the proposed assessment tool for Yellowknife’s CA process. Future adaptations to families and youth of the VAT should be implemented as the Canadian Observatory rolls these out.
- The recommended level of authority for the CA is that of **screening and assessment**, rather than mandatory admissions where CA decisions are binding to the receiving program. Referrals may be made to the appropriate program/agency, but that agency will still have the final decision on admission.
- Ensure key agencies who are part of the homeless-serving system become **CA Agencies**. These agencies would receive training on coordinated assessment and referral processes and agree to share information using standardized data collection through HIFIS where possible; these roles would be articulated in MOUs.

- Rollout the CA initiative in a **phased manner**, starting with three to four agencies in the next 12 months and expanding pending buy-in and capacity.

- Explore the addition of a **designated online resource** accessible 24 hours a day, seven days per week should facilitate information and referrals using a standard Referral Guide. HelpSeeker as an open source app can be explored to this end.

- CA Agencies will identify key staff who act as **CA Workers** that work to actively refer the individual or family to community services and assist them with accessing those services.

Coordinated Access Key Elements

- A **Systems Map** should be in place to document and classify program in the homeless-serving system.

- Based on the Systems Map, it is recommended that the CAB and partners develop a **Referral Guide** to ensure consistent referrals are being made across the homeless-serving system and from public systems. At minimum, the Referral Guide will include the program name, agency, key contact person(s), main phone number, eligibility criteria, target population, services provided, and program type.

- The System Map should evolve to also include real-time vacancies across program types. Ideally, agencies would report in to the CAB at minimum on a weekly basis any changes in their capacity and occupancy rates. Using this information, a **System Capacity Report** should be developed to have an up-to-date account of occupancy levels and waitlists updated weekly to support the CA process and appropriate referrals.

- CA partners should continue to refine **program matching** processes to ensure VAT scores correspond to referral options. As a start, a rough division of VAT scores is proposed to guide referrals; these will need to be reviewed and updated, particularly as learnings emerge in implementation.

- CA partners should work to ensure **prioritization and eligibility criteria** are reviewed with agency partners and updated in the Referral Guide on a go-forward basis.

- CA partners should use the Referral Guide to develop **communications materials** for those experiencing homelessness or at risk, and market it effectively. The Guide should be available as a print and online resource, updated on an ongoing basis as needed, and formally reviewed yearly at minimum.

Coordinated Access Process

- Throughout the CA process, participants will be empowered to independently resolve their housing issues. **Prevention and diversion strategies** will be explored, leveraging natural or existing resources where possible.

- If the participant requires additional supports, particularly if they are at imminent risk as defined by HPS or already homeless, the CA Worker would administer the **VAT assessment** to determine appropriate referrals.

- Once the VAT is completed, the provider will make a referral to the appropriate program(s) as per the **Referral Guide**.

System Coordination Infrastructure & Governance

- A dedicated **CA Coordinator** position should be in place to lead the implementation of the CA model. The CA Coordinator would support the overall CA process by developing protocols and processes and ensuring effective and efficient operations of the model. The CA Coordinator will represent the CA at a community level, and will form relationships with community partners.

- A **Complex Needs Working Group** could be developed to work to address the needs of complex clients with high acuity score (VAT score of 35+ or other cut-off level pending population - ie. youth)) and coordinate care among providers and public systems. As part of its strategic planning process, the **Department of Justice's ICM team** is encouraged to play an integral role in the proposed CA process as its Complex Cases Working Group.

- To enhance integration among homeless-serving agencies and public systems, a **clear line of sight to** high-level decision makers that can play key roles in facilitating access to system resources for participants is needed. This would support the removal of system barriers for vulnerable populations. MOUs may be developed/adapted to ensure consistent agreements regarding public system participation and accountabilities are in place.

- The CAB should work with community and systems partners to review currently active coordination tables with similar mandates as the proposed CA committee to **ensure no duplication** of functions occur with the CA process..

- CAB partners should help develop and support a formalized **Lived Experience Circle** to provide meaningful input into the measures outlined in the Plan to End Homelessness and the proposed CA Model.

Coordinated Access Operations

To advance system coordination for those at risk of or experiencing homelessness to diverse community and mainstream system services and housing, a Coordinated Access approach is recommended for Yellowknife with multiple locations throughout the community to offer assessments and referrals. All sites will use the same assessment form, targeting tools, and referral processes. Each site has equal access to the same set of resources.

Providers who participate in Yellowknife's CA will use a single, standardized assessment tool for all participants. The Vulnerability Assessment Tool (VAT) is recommended as the community's CA assessment.

The proposed model for Yellowknife was developed based on adaptations of the Coordinated Access models in Calgary, St John's, and Hennepin County. Best practices documented by the National Alliance to End Homelessness in the U.S. were used to ensure models aligned with recommended standards.

The model recognizes that Yellowknife has a limited number of providers working with the target population, thus already acting as access points to housing and support services. What is needed is enhanced coordination and alignment across these providers, and methods of analyzing trends system-wide, rather than on a case-by-case basis. This also aligns with priority participants being consulted and placed on their preference to access resources tailored to their unique needs (i.e. youth, women, etc.) across different areas of the city.

The approach ensures that there is 'no "wrong door" for participants to access coordinated services in the community, irrespective of whether they access the system through agencies where they have existing relationships with providers. In all cases, the same protocols will be used.

This model further allows the community to explore future centralization options, if needed. Many communities begin with decentralized models and, enhance these through additional measures over time.

Coordinated Access Agencies Roles

In the proposed Coordinated Access model, all key agencies who are part of the homeless-serving system would become CA Agencies using consistent protocols, pending capacity and willingness to participate in the process. These agencies would receive training on coordinated assessment and referral processes, and would agree to share information using standardized data collection through HIFIS where possible.

MOUs will be developed among CA Agencies outlining their role in accepting participants referred through the process, agreeing to participate in the proposed access assessment processes, and making best efforts to share information to advance CA goals within applicable legal bounds.

To date, the following agencies have emerged as potential key CA Agencies in this model, though the list remains preliminary at this point:

1.Centre for Northern Families
2. Side Door Youth Ministries
3. The Salvation Army
4. Yellowknife YWCA
5. Yellowknife Health and Social Services Authority (YHSSA)
6. Department of Justice ICM
7. *Future* Indigenous Healing Centre

The proposed rollout would be phased, starting with three to four sites in the next 12 months and expanding (pending buy-in and capacity). The addition of a hotline access call-in number, and capacity for CA staff to engage in outreach at key 'high traffic' sites that may not be CA Agencies, can enhance the accessibility to the process even further.

It is recommended that a designated phone line – accessible 24 hours a day, seven days per week – to facilitate information and referrals using a standard Referral Guide be implemented. The expansion of 311 or Mental Health Crisis line to this end should be investigated before commencing the creation of a new service. The hotline access number should be advertised through diverse media, including social media, posters, pamphlets, training materials for staff, etc.

Coordinated Access Workers

Each CA Agency will identify key staff who act as CA Workers, and who work to actively refer the individual or family to community services, and assist them with accessing those services. If prevention is not possible or effective, or the individual/family is experiencing homelessness, the CA Worker will consider the participant for further assessment and referral.

A key role for the CA Workers is to provide general information and referrals at the key CA Agency sites, but also to work on an outreach basis across other common touch points for the population, such as key public systems, emergency shelters, drop-in centres, community centres, etc. CA Workers may complete coordinated assessments using the VAT in designated public system locations such as hospitals, jails, treatment facilities, etc., as well. In this manner, the community will not only have assigned sites for CA to occur, but also regular outreach services in other sites to facilitate access.

CA workers will place priority on preventative and diversionary services to ensure those in need are served outside the homeless-serving system, if possible and appropriate. Any referrals into Housing First programs, such as ICM and supportive housing, as well as complex cases, would need to meet eligibility and prioritization criteria for the referral to be considered. Referrals would be made accounting for a number of factors, including: participant assessment score; homelessness history; and suitability of participant and program match; participant preferences; and agency final decision.

Referral Process

Based on a System Mapping Survey and community consultations , a draft Systems Map will be developed. It is important that this marks the first iteration of a systematic effort to document and classify program in the homeless-serving system, and will require ongoing refinement. This can be facilitated through an online resource, such as HelpSeeker.

It is recommended that the CA partners work to ensure accuracy in the preliminary System Map, and update it on a go-forward basis. The System Map should evolve to also include real-time vacancies across program types. Ideally, agencies would report in to the CA Coordinator, at minimum, on a weekly basis any changes in their capacity and occupancy rates.

Based on this information, the CA Coordinator will develop communiqués to CA agencies regarding availability on a weekly basis. In this manner, agencies making referrals will be aware of available space on a real-time basis.

Based on a refined Systems Map, it is recommended that a Referral Guide be developed to ensure consistent referrals are being made across the homeless-serving system and from public systems. At minimum, the Referral Guide will include the program name, agency, key contact person(s), main phone number, eligibility criteria, target population, services provided, and program type. Again, an online app can be used to this end.

The Referral Guide should be used to streamline referrals across the system, including public systems. It should further be developed into communications materials for those experiencing homelessness or at risk and marketed effectively. The Guide should be available as a print and online resource, updated on an ongoing basis as needed, and formally reviewed yearly at minimum.

CA Coordinator Role

The addition of a CA Coordinator position a is proposed to provide supports for the overall CA process by developing protocols and processes and ensuring effective and efficient operations of the model. The CA Coordinator will represent the CA at a community level, and will form relationships with community partners. This person must be responsive to changes in the homeless sector and general management of the initiative.

The role aligns well with the current approach taken by the City of Yellowknife and the Yellowknife Homelessness Commission grounded in community development principles, collaborative decision-making and collective impact. It also ensures that an organization is dedicated to system coordination without playing a role in direct client service provision.

The CA Coordinator will also be responsible for quality assurance, evaluation, and continuous improvement of the CA program including, but not limited to: reviewing VATs for quality; providing feedback on VATs; providing shadowing services to new VAT users; and coordinating training on the VAT.

A key role for the position is also to maintain a current System Map, Referral Guide, and to communicate a System Capacity Report outlining occupancy and waiting lists to CA agencies on a weekly basis.

[19] *Example of a referral guide from Calgary: http://calgaryhomeless.com/wp-content/uploads/2014/07/CHF-Agency-Referral-List-rev-July-2014.pdf*

Complex Cases Working Group

The consultation process surfaced a number of challenges among providers in responding to the needs of complex cases: clients with high levels of needs, involved with multiple systems of care with long term housing instability histories.

The Government of the Northwest Territories' Integrated Case Management (ICM) Pilot Project is led by the Department of Justice in partnership with the departments of Education, Culture and Employment, Health and Social Services, as well as the Yellowknife Health and Social Services Authority, and the NWT Housing Corporation. This project is for existing GNWT clients with two or more complex needs who reside in Yellowknife, Dettah or N'dilo and who require supports that do not duplicate existing services. The goal of the ICM pilot is to develop and establish a more coordinated, streamlined approach to service delivery for clients with complex needs in the GNWT.

Justice's ICM can play an integral role in the proposed CA process as its Complex Cases Working Group. ICM can build on success to date by coordinating care among diverse systems and providers, and expanding its role to high acuity cases identified through the CA process. ICM has the consent processes in place to enable information sharing, which presents an important opportunity to kick-start the CA initiative.

Within the proposed CA process, clients with VAT assessment scores in the highest range (35+) would be referred to the Complex Cases Working Group for case planning and service coordination. If they fit criteria and there is capacity available, ICM would convene a coordinated response on a client-by-client basis using current protocols. Where barriers arise or policy change is needed, the Complex Cases Working Group will bring these to higher levels and various government departments to become part of the larger policy change work that the Commission is undertaking.

CA Screening & Assessment

The recommended level of authority for the CA is that of screening and assessment, rather than mandatory admissions where CA decisions are binding to the receiving program. Information gathering, screening, and a standardized assessment using the VAT would be completed. Referrals may be made to the appropriate program/agency, but that agency will still have the final decision on admission.

Assessment is an iterative process that may take place over a period of several days and involves several points of contact. Assessment will only involve the collection of information essential to ascertain the immediate crisis, and match the participant to the appropriate interventions.

The assessment process for CA participating agencies will include the following:

- **Document participant's homelessness history and housing barriers.** Gather sufficient information to allow for appropriate placement, and for the creation of an accurate housing and service plan to address a participant's needs.

- **Identify appropriate services.** Link participant information and the local system's resources. Characterize or score the participant's profile against a number of intervention options.

- **Document discrepancy between participant needs and available resources to meet need.** The specific resource a participant needs may not be available at the time of referral. Communities should document if there is a demand for housing or services beyond what is currently available.

- **Respect participant preferences.** Ask direct questions about needs and preferences of the participant in order to ensure the best assessment.

- **Capture just enough data to meet project needs and funder requirements.** Design assessment forms to represent the intake data needs for the full continuum of services that may be offered at the access point.

- **Obtain consent for sharing data with providers.** Comply with local, provincial, and federal requirements.

- **Draft, or at least initiate, a housing plan.** Work with participants to begin development of a housing plan that can be transferred to the next stage of service.

- **Standardized practice.** Apply standard practices at every point of entry for every participant in order to ensure consistent assessments.

- **Training.** All staff participating in the CA process receive training and certification prior to conducting these assessments.

Screening with a Focus on Prevention

Throughout the CA process, participants will be empowered to independently resolve their housing issues. Prevention and diversion strategies will be explored, leveraging natural or existing resources where possible. Through prevention activities, the participant is empowered to resolve their situation sooner, which maintains dignity, encourages resilience, and is more cost efficient on the strained resources of the homeless sector.

Prevention is not about turning people away; it is about helping them find solutions to their housing situation. Prevention utilizes the lightest touch possible leveraging natural resources with minimal use of community resources. Prevention is a service in itself. The goal is to find housing solutions while avoiding the homeless-serving system, including emergency shelters and supportive housing programs.

Providers who participate in CA will assist participants by engaging in an exploratory discussion and providing referrals to other resources. Participants should not move beyond the prevention stage until all options have been exhausted. Providers would not discuss supportive housing programs until chronicity and acuity have been established, and preventative measures have been exhausted.

Examples of prevention supports participants may be offered include family reunification, landlord mediation, and referrals to financial assistance for damage deposits, rent, and/or food. To this end the Referral Guide must have a listing of prevention resources, and means of accessing these for staff and participants.

The Vulnerability Assessment Tool

The VAT was developed by the Downtown Emergency Service Center in Seattle (U.S.). It is recommended by the COH as an evidence-based screening tool, and will be adapted for youth and families in the near future. Choices for Youth are already slated to be a pilot site for the COH to test the youth VAT adaptation in the coming year. Once the VAT is adjusted for youth and families, it should be used as appropriate at program intake, follow up, and exit to assess changes across acuity domains.

The VAT is a triage assessment tool to screen participant acuity and key issues related to housing. The purpose is to help ensure fairness in placements with the focus on serving those with the most acute needs first, and to accurately match the participant to resources; however, completing it does not guarantee housing or placement in a program.

The participant should be encouraged to be honest and accurate, so that the score and information gathered in the VAT accurately reflects their needs. It is not always in their best interest to just get a high score as different programs take participants that fall into different ranges of acuity.

The Vulnerability Assessment Tool

The VAT includes ten domains:

1. Survival Skills
2. Basic Needs
3. Indicated Mortality Risks
4. Medical Risks
5. Organization/Orientation
6. Mental Health
7. Substance Use
8. Communication
9. Social Behaviours
10. Homelessness

Each VAT domain serves as one question for a total of ten questions. Domains 1 to 9 are measured on a one-to-five scale, with a score of “1” indicating no evidence of vulnerability, and a score of “5” indicating severe vulnerability. Items are summed to find total score. Those with highest scores are considered to be at highest risk, and can be prioritized for services. The tool also allows for interviewer to add comments and observations.

The tool is free, but requires training though the COH is developing these tools, and will be supporting communities in adapting them. Training and technical support will be low-cost with the goal of building community capacity to support training on an ongoing basis. A train-the-trainer approach is recommended where key individuals in Yellowknife will receive training nationally, and then take ongoing provision for the local community, especially given turnover in the non-profit sector[20]. The COH is also working with national HIFIS team to ensure the VAT is available on the system.

Program Matching

During the VAT assessment, the CA provider should discuss all possibilities of how the participant can be reached in the future – phone, email, messages, other professional in community, etc. If a program match is made, the provider will have to locate the participant to inform them. It is important that the VAT is only one source of information used.

The referring provider should discuss the participant's preferences once options are explained. Professional opinion should also be documented to provide context to the VAT assessment. At this point, intake of basic data elements should also be entered into HIFIS and the referral should be documented if HIFIS, is available. To this end, a CA Referral Form should be developed to capture essential information consistently.

Once the VAT is completed, the provider will make a referral to appropriate program(s) as per the Referral Guide. The referring staff should check the System Capacity Report from the CA Coordinator to have an up-to-date account of occupancy levels and waitlists. The referrals will be made electronically via email with attachments of the VAT assessment and the CA Referral Form.

Information in Referral Guide – online app, public, posters, social media, websites, etc.									
Program Name	Agency	Program Type	Target Population	Services Provided	Key Contact	Phone Number	Address	Referral Process	Eligibility Criteria

System Capacity Report (CA Agencies)				
VAT Score Range	Prioritization Criteria	Capacity (beds/units/ caseload)	Occupancy (Date)	Waitlist (Date)

[20] *The VAT is available online at http://desc.org/documents/06.30.2015.DESC.Intro_to_Vulnerability_Assessment_Tool.incl%20VAT%20&%201-page%20validity.pdf*

The System Capacity Report would be updated weekly regarding occupancy, and will available online (Google Drive, etc.) for CA Agencies to access and update until HIFIS is fully adapted to accommodate the process. If HelpSeeker was used, the app can be used to generate occupancy trends in real time pending agency use and buy-in.

Determining program matching must be done by referring providers in a consistent manner to ensure VAT scores correspond to referral options. As a start, a rough division of VAT scores is proposed to guide referrals; these will need to be reviewed and updated, particularly as learnings emerge in implementation.

- Low: 1-15
- Moderate: 16-35
- High: 35+

As the priority on ending chronic and episodic homelessness, as defined by HPS, is set forth as a community goal in the Plan, it is recommended that question 10 on the VAT be scored in a tailored manner. Rather than assigning a score, the total length of time homeless will be recorded in number of years (i.e. 3 years, 0.5 years, etc.). If two participants have the same score, the one with a higher number of years homeless should be prioritized.

In addition, the referring provider should indicate what category of homelessness the participant fits to, as per HPS definitions. Note that HPS programs are expected to screen according to these definitions and program have additional eligibility criteria, which should be outlined in the Referral Guide used by referring providers at the time of the VAT assessment.

Key Definitions (HPS)

- Populations **at imminent risk of homelessness** are defined as individuals or families whose current housing situation end in the near future (i.e. **within two months**) and for whom no subsequent residence has been identified. These individuals are unable to secure permanent housing because they do not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter, or a public or private place not meant for human habitation (HPS).[21]

- **Transitionally homeless** persons may be homeless for the first time (usually for less than three months) or have had less than two episodes in the past three years.

- **Episodically homeless** refers to individuals, often with disabling conditions, who are currently homeless and have experienced **three or more episodes of homelessness in the past year** (of note, episodes are defined as periods when a person would be in a shelter or place not fit for human habitation, and after at least 30 days, would be back in the shelter or inhabitable location (HPS).

- **Chronically homeless** refers to individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems), who are currently homeless and have been homeless for six months or more in the past year (i.e., have spent more than **180 cumulative nights** in a shelter or place not fit for human habitation) (HPS).[22]

Prioritization

In reality, providers will receive more referrals than they can accommodate. To this end, some program types will need to adhere to prioritization criteria. Where this is not possible, rationale should be provided (i.e. participant did not want particular housing type, etc.).

Once the referral is made, the receiving agency will examine their waitlist against capacity and make a decision based on highest VAT score within their assigned ranges, additional eligibility criteria, and professional judgement on a case-by-case basis. Note that the VAT does not replace professional judgment, but rather it introduces consistency and common language to community referral processes.

Referral Considerations	**Emergency Shelter**	**Transitional Housing**	**Affordable Housing**	**Permanent Supportive Housing**	**Intensive Case Management**	**Prevention/ Rapid Rehousing**	**Outreach/ Drop In-Centres**
VAT Score	Any	Moderate-High	Any	High	High	Low-Moderate	Any
Prioritization	First-come, first-served	First-come, first-served	First-come, first-served	VAT Score + Length of Homelessness	VAT Score + Length of Homelessness	VAT Score + Length of Homelessness/ Imminent Risk of Homelessness	First-come, first-served
HPS Eligibility Criteria			Chronic/ Episodic	Chronic /Episodic	Chronic /Episodic	Episodic /Transitional or At Imminent Risk	
Additional Considerations	Available spaces/ capacity Additional program/funder eligibility criteria. Agency experience with participant/willingness to accept referral						

[22] HPS definitions are available online at http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml#fn3

Even if a participant has the highest score, if the only available program space is restricted to youth or women, and he is neither, a placement would not be possible or appropriate. Eligibility is impacted by program type, funder requirements, agency philosophy, and, in some cases, may not be explicit to participants/internal or external agency staff. Clarity on these criteria will, however, reduce improper referrals, assist in development of referral network, establish a resource directory in HIFIS, and determine gaps/duplication in the system.

Eligibility criteria should be:

- Specific, clear and transparent
- Impacts access to program
- Aligned with funder requirements

Once the referral is made, the provider receiving referrals should make every effort to connect with the participant within five days of receipt. They should also communicate the outcome of the referral to the referring provider and the CA Coordinator within five days of receipt and again within five days of connecting with the participant. If connection with the participant is not realized after three documented attemptsm and 30 days from original receipt, the participant can be reported as MIA to the CA Coordinator and to the referring agency.

Further Information: Toolkits and Guides

- Housing and Urban Development (HUD) developed Coordinated Entry Core Elements: a guidebook outlining what HUD requires, and how to plan and implement a Coordinated Entry process appropriate to their needs and resources, and the vision of the CoC's membership; and consider implementing additional elements beyond basic requirements.

- The National Alliance to End Homelessness's Center for Capacity Building developed a toolkit on coordinated access: Coordinated Entry Toolkit

- 20KHomes is spearheading the adaption and creation of byname lists (BNL) and co-ordinated access systems. Their Coordinated Access and Prioritization Resources provide a number of examples, tools and guides.