Coordinated Assessment and an Integrated System of Care
Steering Committee Recommendations

Executive Summary

Due to the high prevalence of homelessness throughout the state, Texas has been identified a “priority state” by the U.S. Interagency Council on Homelessness (USICH) and the U.S. Department of Housing and Urban Development (HUD), increasing Austin’s access to HUD-funded technical assistance (TA) resources. In late 2012, ECHO requested TA on designing a system of coordinated assessment. At the same time, the ECHO Membership Council formed a Steering Committee to lead the development of both coordinated assessment and other improvements to its system for ending homelessness. HUD approved the TA request in early 2013, and the TA commenced in March of 2013.

What is Coordinated Assessment?

HUD defines coordinated assessment as “a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals.” Per the Continuum of Care (CoC) and Emergency Solutions Grants (ESG) regulations, CoCs are required to develop and implement a system for coordinated assessment, and to do so in coordination with any ESG grantees in the CoC’s geography. Once established, all CoC- and ESG-funded programs within the area are required to use that assessment system.

Benefits of Coordinated Assessment

Consistent with HUD expectations, the Steering Committee anticipates that implementation of coordinated assessment will offer Austin/Travis County a number of benefits, including improved client access to services, increased referral appropriateness, reduced administrative burden on clients and providers, improved communication and coordination among providers, and improved data quality—all of which lead to greater system efficiency and effectiveness.

A Framework for Housing Stability that includes Coordinated Assessment

The Steering Committee is recommending the framework shown below, which includes:

• Multiple but limited front doors, with streamlined points of entry for key subpopulations and outlying geographic territories;
• An independent team of experienced staff administering a common assessment tool to determine the appropriate, minimum intervention needed for housing stability; and

• Agency staff working to maximize resources by specializing functions in case management and housing search.

Detailed Recommendations

To implement this framework, the Steering Committee is making the following specific recommendations.

1) **Multiple But Limited Points of Entry.** Given the desire to build on aspects of the system that are already working well, the Steering Committee determined that multiple but limited points of entry would be the most appropriate model in Austin/Travis County. A team of trained Assessment Specialists would be
The Steering Committee envisions an assessment team that works across the community at the designated points of entry. Resources permitting, staff might be hired, trained, and supervised by one agency, but deployed/co-located to other locations to perform this function.

2) **Embrace Diversion.** “Diversion” is a term used for the assistance provided to individuals and families standing at the front door of the system seeking shelter/housing. The tools are very similar to those used in prevention and rapid re-housing programs, including assistance with arrears, short-term rental assistance, landlord mediation, connection to mainstream benefits and services, etc. Individual providers in Austin may be providing some level of diversion assistance, but it is typically not done in a purposeful, consistent manner across the system. However, there are a number of reasons why the Steering Committee feels that a more systematic approach to diversion makes sense, not the least of which is that demand for shelter in Austin/Travis County exceeds local capacity, and consequently, it makes good sense to help households save or recover housing units (when possible) or identify and secure another option if a safe alternative exists.

3) **The Assessment Tool: Self-Sufficiency Outcome Matrix (SSOM).** The Steering Committee proposes a combination of questions that first address the possibility of diversion, and when diversion isn’t an option, then matches the client to the most appropriate permanent housing intervention or “pathway.” Additional questions are also included to capture basic demographic information and make initial assessments regarding program eligibility to help determine a specific referral. For the portion of the tool used to assign clients to a housing intervention, the Steering Committee recommends use of the Self Sufficiency Outcome Matrix (SSOM), an assessment that is already in HMIS and is currently being used locally by some case managers.
4) **Right-Sizing Assistance: Permanent Housing Pathways.** The framework identifies three permanent housing interventions, or “pathways,” and is based on the principle of providing the least intervention necessary to promote housing stability for the client or client family. This strategy, sometimes referred to as “right-sizing” assistance or “just enough” assistance, is important because Austin has more demand for housing assistance than available resources. As such, the assessment tool aims to identify which permanent housing intervention is most effective and cost effective relative to each client’s needs.

- The lowest intervention (minimal housing assistance) is a very light touch. An individual case manager will not be assigned, though the Assessment Specialist may provide referrals to mainstream service providers, and access to group case management or informational workshops may be provided. In addition, one-time financial assistance may be needed.
- The medium intervention is rapid re-housing, which includes between 3 to 24 months of financial assistance and supportive services. The assistance is not one-size-fits-all, but rather titrated based on each client’s unique needs and circumstances.
- The most intensive intervention is permanent supportive housing. PSH is intended to be reserved for those individuals and families who are unable to remain stably housed “but for” a permanent subsidy and ongoing supportive services.

5) **Staff Specialization.** As the TA providers identified during their site visit, staff are often required to wear multiple hats and, consequently, are stretched very thin. To help address this challenge, the Steering Committee recommends specialization across three different roles: 1) Assessment Specialists; 2) Case Management Specialists (three distinct types); and 3) Housing Specialists.

6) **Data Sharing.** To implement the changes discussed in this report and to make full use of coordinated assessment, the Steering Committee recognizes the need to “open” Austin’s Homeless Management Information System (HMIS) and increase data sharing across providers.

**The Path Forward: Key Next Steps**

Many thanks to the agency staff across this community who put in many hours to envision how we can improve our system and make progress on ending homelessness. The Membership Council will share these recommendations with the community at the ECHO annual meeting on November 18 and consider them for adoption at the December Membership Council meeting. Thru the Steering Committee, ECHO workgroups and other especially called stakeholder gatherings, ECHO will continue to
lead towards consensus as we move towards implementation in 2014. Additionally, ECHO will pursue new relationships with community partners and funders to make these recommendations successful.
I. Introduction

Due to the high prevalence of homelessness throughout the state, Texas has been identified as a “priority state” by the U.S. Interagency Council on Homelessness (USICH) and the U.S. Department of Housing and Urban Development (HUD), increasing Austin’s access to HUD-funded technical assistance (TA) resources. In late 2012, ECHO requested TA on designing a system of coordinated assessment. At the same time, the ECHO Membership Council formed a Steering Committee to lead the development of both coordinated assessment and other improvements to our system for ending homelessness. HUD approved the TA request in early 2013, and the TA commenced in March of 2013.

The transition to coordinated assessment represents an important opportunity to rethink how we do things in Austin, why we do them that way, and whether there are more efficient and effective ways of operating. The Steering Committee continues to work through considerations related to implementation, but brings forth the recommendations described in this report to the Membership Council in anticipation of launching a local coordinated assessment process in January 2014.

The remainder of this report is organized as follows:

• Section II provides greater context on what coordinated assessment is, why it is being implemented in Austin/Travis County, and the potential benefits we expect to see;
• Section III presents the framework for the changes being recommended;
• Section IV walks through the detailed recommendations for implementing that framework; and
• Section V outlines key next steps.

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1 ECHO completed a CoC “Check-Up” - a tool designed by HUD to capture community input on strengths and areas for improvement within Austin’s homeless services system. ECHO used the results of the check-up to inform a technical assistance request to HUD. HUD assigned the request to one of its national TA providers, the Corporation for Supportive Housing (CSH). CSH staff Dianna Lewis-Grey (based in Austin) and subcontractor Kristy Greenwalt (based in Washington, DC) were assigned to the project. Ms. Lewis-Grey and Ms. Greenwalt conducted a site visit to tour Austin’s system in March 2013, and subsequently worked with ECHO and the Steering Committee on the design of the coordinated assessment framework as well as other system-level changes aimed at increasing the benefits of coordinated assessment and improving the effectiveness of the system overall. The consultants participated in numerous meetings and conference calls with the Steering Committee and ECHO staff, and prepared ECHO staff for most meetings related to this process.

2 The Steering Committee consists of the following individuals: Jessica Burkemper (Front Steps), Rachel Lawrence (SafePlace), Tim Miles (Foundation Communities), Jo Kathryn Quinn (Caritas), Kathy Ridings, (Salvation Army), Steve Bewsey, (LifeWorks), Stephanie Hayden/Tasha Ponczek (City of Austin HHS), Sandra Eames (Travis County Re-Entry Roundtable), Kim Dear (Seton), Ben King (Seton), Darilynn Cardona-Beiler, (Austin Travis County Integral Care), and Lisa Garcia (Housing Authority of the City of Austin)
II. What is Coordinated Assessment? Why is it Important?

HUD defines Coordinated Assessment as “a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals.” Based on evidence from the 2008 Rapid Re-Housing Demonstration (RRHD) and the 2009 Recovery Act-funded Homelessness Prevention and Rapid Re-Housing Program (HPRP), HUD has concluded that coordinated assessment systems are important in ensuring the success of homeless assistance and homeless prevention programs in communities. Consequently, HUD included a requirement for coordinated assessment in both the Continuum of Care (CoC) Program interim rule and the Emergency Solutions Grant (ESG) Program interim rule.

Per the CoC and ESG rules, CoCs are required to develop and implement a system for coordinated assessment, and to do so in coordination with any ESG grantees in the CoC’s geography. Once established, all CoC- and ESG-funded programs within the area are required to use that assessment system, though HUD notes that such systems are of greatest benefit to a community when all providers—regardless of funding source—participate.

Given that no two communities are the same, HUD’s definition of coordinated assessment allows CoCs to adapt systems to their local context. Factors such as geographic size, microsystems for specific subpopulations, strength of provider relationships, and Homeless Management Information Systems (HMIS) capabilities will impact coordinated assessment design decisions. That notwithstanding, coordinated assessment systems are based on three core principles:

✓ Standardized access to the homeless services system;
✓ Standardized assessment of client needs and circumstances; and
✓ Coordinated referral to the most appropriate program(s) and service(s) available.

Benefits of Coordinated Assessment

In nearly every community, demand for housing assistance far exceeds available resources. A centralized or coordinated process that ensures all providers participate and use the same tools for assessment and referral will lead to greater success in ending homelessness.

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3 The CoC and ESG regulations define coordinated assessment as “a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.”


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resources. Therefore, it is imperative for CoCs to match housing interventions and services to the particular needs of each client and to match system-wide resources to a community’s aggregate demands. As a one-size-fits-all approach to client services is neither practical nor effective, coordinated assessment systems can dramatically improve a CoC’s capacity to align community resources and “right-size” assistance to each household’s unique needs, thereby allowing communities to stretch limited resources to serve more households.

Consistent with HUD expectations, the Steering Committee anticipates that implementation of coordinated assessment offers Austin/Travis County the following opportunities:

- **Increased referral appropriateness.** By standardizing the assessment process, clients can be assessed using consistent standards and matched to projects according to client need, eligibility, and preferences. It also allows communities to prioritize access to the most expensive interventions (including Permanent Supportive Housing and permanent subsidies, such as Section 8 housing choice vouchers) to increase the impact and cost effectiveness of those interventions.

- **Increased fairness.** Consistent assessment protocols and coordinated data systems allow specialists to assess all clients equally and to match them according to need and vulnerability. Clients gain an opportunity to equally access all of the services in the community, regardless of the client’s location or point of entry.

- **Reduced administrative burden on clients and providers.** Coordination reduces total assessment time by quickly capturing the most relevant information and forwarding/sharing it with appropriate community partners, reducing the number and length of interviews and limiting clients’ need to retell often traumatic histories. Likewise, it also reduces the data collection and entry burden on providers, who can focus more on assisting clients than capturing information and documentation that has already been provided.

- **Improved provider coordination.** Implementing standardized processes and coordinated data systems increases provider system awareness, communication and collaboration. Through collaboration, trust between organizations increases and commitments deepen.

- **Improved resource allocation and planning.** Coordinated assessment data can be used to generate aggregate data to support CoC resource allocation and planning. System planners can see where certain types of clients are going, what subgroups are being served most effectively by different programs, which geographies have service gaps, where projects have excess capacity, where duplication of services exists, etc.
• Improved competitiveness for Federal and other resources. Establishing a coordinated assessment system provides communities with the best opportunity to improve performance on HEARTH outcome measures (reducing average length of time homeless, reducing returns to homeless, preventing first time homelessness, etc.), reflecting the community’s progress on ending homelessness and increasing its ability to compete for Federal resources. With improved collaboration and outcomes, local providers and the continuum will be more attractive to local, state and private funders, as well.

III. Transforming Austin’s System: From Managing Homelessness to Ending Homelessness

Developing a framework for coordinated assessment required a critical look at current practices, including processes for intake, assessment, and referral; client needs relative to available services; program eligibility requirements; staffing roles and capacity; and resource levels and uses. The TA providers conducted a site visit to tour Austin’s system in March of 2013, meeting with a variety of providers and other system partners. During the site visit debrief, the TA providers indicated that Austin has strong and dedicated providers, goodwill within the community, use of evidence-based practices, strong city/county support, and good partnerships with mainstream systems. However, they also noted that Austin’s system seemed to be “clogged” with long-term stayers, and that the community could benefit from a more concerted effort to “open the back door” to the system (especially for those long-term stayers). They also found that case managers were often overwhelmed – at least in part the result of duplicating efforts (client assessment, data collection and entry, referrals), having to wear multiple hats, and sometimes lacking expertise/knowledge in certain roles.

Finally, the TA providers noted that policies limiting shelter stays may have unintended consequences. Some shelters, for example, operate a daily lottery for their beds, while others have 30-day limits. In theory, such policies are intended to incentivize clients to work quickly to resolve their housing crisis and create more equal access for others in the community that need shelter. However, in practice, clients end up bouncing from shelter to shelter, using time and energy simply trying to locate a safe place to sleep and survive from day-to-day. Likewise, case managers use much of their time just managing these processes, conducting client intake, collecting and entering data, and searching for alternate placements as clients near their limit.

During this debrief, the consultants provided an illustration of how clients appear to move through the system. (See Exhibit 1, below.) When presented with this illustration, Steering Committee members nodded heads in agreement and one leader commented, “That’s sure what it seems like.” The slide soon became referred to as our “chaos slide.”
The Steering Committee discussed that while Austin’s system is lean with little duplication of services, there is no clear referral process based on client needs, and no prioritization of clients at the system level. With most programs operating at full capacity, clients are typically referred elsewhere with few specific linkages, warm handoffs, or any expectation that the receiving agency can or will actually serve the client. And, if any prioritization is happening, it is typically within specific programs. Austin has many frequent users moving between shelter, the criminal justice system, and/or the healthcare system, and access to housing is currently determined by funding streams, program requirements, and luck - not critical need or community priorities.
Austin’s Affordable Housing Shortage

In fairness to service providers, the consultants and Steering Committee members all recognize that the Austin housing market is extremely tight. Even in 2010, it was determined that Austin needed 38,000 affordable housing units and nearly 2,000 units of Permanent Supportive Housing. This shortage of available apartments affordable to low- and zero income households makes the work of re-housing people extremely challenging. Thus, the recognition that the system is “clogged” and the backdoor needs to be opened is not made without understanding the reality of a real housing shortage. At the same time, this reality underscores the importance of coordination and prioritization strategies, particularly in the short-term. And, of course, it also highlights the extent to which growth of Austin/Travis County’s affordable housing stock is an essential part of any long-term strategy.

A New Framework

During the debrief, the TA providers also presented a possible framework for including coordinated assessment in Austin/Travis County. In the weeks and months that followed, ECHO and the Steering Committee, continued to refine the framework and work through issues related to implementation. Exhibit 2 below illustrates the recommended framework, which includes:

• Multiple but limited front doors, with streamlined points of entry for key subpopulations and outlying geographic territories;

• An independent team of experienced staff administering a common assessment tool to determine the appropriate, minimum intervention needed for housing stability; and

• Agency staff working to maximize resources by specializing functions in case management and housing search.

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4 The City of Austin Comprehensive Housing Market Study identified that some 38,000 low-income residents could not find affordable housing and the Corporation for Supportive Housing studied the need for Permanent Supportive Housing the same year.

5 Austin Tenants’ Council survey showed that only 8% of apartment units eligible to tenants paying with rent vouchers will actually allow tenants to pay with vouchers. This income discrimination complicates strategies to house clients using rental subsidies.

6 Attachment 1 to this report provides a list of community meetings conducted between March and October 2013 on coordinated assessment and system redesign efforts.
The Steering Committee envisions that every client seeking shelter will be assessed at a point of entry, with the goal of the assessment as follows:

1. Determine if the client’s previous housing arrangement is safe and can be recovered, and if not, if other safe opportunities exist outside of the shelter system (a process known as “diversion”);
Framework for Housing Stability

Screening & Assessment Staff
- Hospitals/MH
  - Inreach
  - Front Steps
  - Sal. Army
  - Caritas
  - Safe Place
  - Life-works
  - VA
  - Other

Housing Navigation & Case Mgmt Staff
- Minimal Intervention
  - (may include at-risk, prevention)
- Rapid Re-Housing
- Admit to Interim Housing (ES/TH)
- Permanent Supportive Housing

*Using progressive engagement, it may be determined that some households need a greater level of assistance to stabilize.

**Subsidized units can be made available for PSH clients who no longer need intensive/ongoing services.

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2. Where diversion is not possible, identify the permanent housing intervention/pathway warranted by the client’s needs and circumstances, as determined by the assessment (i.e., minimal housing assistance, rapid re-housing, or permanent supportive housing);
3. Make an “interim” housing referral (i.e., shelter or transitional housing) if necessary and possible; and
4. Make a case manager assignment (based on a combination of factors, including the interim placement, the permanent housing pathway, and case manager availability) to advance the client along his/her permanent housing pathway.7

Each of these steps is explored in more detail in Section IV, Key Recommendations.

IV. Key Recommendations

This section reflects the Steering Committee’s recommendations regarding implementation of the framework. Necessarily, systems change work must be broken down into components, and the implementation of different components is expected to be phased in over time. While our pilot of the assessment tool (described in Section V) will inform this process, timing will also be driven by resource availability, staff hiring and training, and completion of HMIS upgrades, to name just a few factors. However, the Steering Committee is making recommendations to the Membership Council to move forward with this framework as expeditiously as possible.

Recommendation #1: Multiple But Limited Points of Entry

Early in the process, the Steering Committee considered a variety of different models. For example, the Steering Committee discussed a single, centralized point of entry, but with so many existing strong agencies that see a high volume of traffic, trying to redirect every client to one location did not seem feasible or desirable. Likewise, the Steering Committee considered a “no wrong door” approach, but given the desire to ensure all points of entry are adequately resourced and staffed, concerns about quality, consistency, and cost effectiveness emerged.

Early in the conversation, the Steering Committee referenced the many partners of the BSS+ collaborative as an example of multiple agencies using a common screening tool to determine eligibility for resources. Encouraged by the TA providers to build on aspects of the system that were already working well, the Steering Committee

7 See Attachment 2 for a step-by-step illustration of the framework.

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determined that multiple (but limited) points of entry would be the most appropriate model in Austin/Travis County. As the Steering Committee considered specific points of entry, however, it became clear that access could perhaps be streamlined by subpopulation (i.e., families, singles, veterans, youth, and victims of domestic violence) and geography (particularly for outlying areas of Travis County).

Managing the Front Door

Early agreement around developing a highly trained team responsible for assessment and diversion energized the Steering Committee. This team would have experience working with vulnerable populations, would be knowledgeable about community resources (including eligibility rules associated with major funding streams, such as HUD CoC and ESG resources, as well as County BSS+ funding), and would have the strong problem solving and communication skills needed for assisting individuals and families in crisis. These individuals would be responsible for:

- Providing diversion assistance, if possible and as appropriate based on the household’s needs and circumstances;
- Administering the assessment to determine the type of intervention needed to resolve the household’s homelessness (and ensuring fidelity to the assessment tool ultimately selected by the community);
- Identifying an interim housing placement (as appropriate and available);
- Ensuring a specific staff person is assigned to each household and a warm handoff occurs; and
- Developing capacity to ensure all clients are assessed in an agreed time period.

The Steering Committee envisions an assessment team that works across the community at the designated points of entry. Resources permitting, staff might be hired, trained, and supervised by one agency, but deployed/co-located to other locations to perform this function.

In-Reach Into Intersecting Systems

Homeless services systems across the country struggle with the inflow of people from public institutions such as hospitals, prisons/jails, and the foster care system as clients are released without adequate discharge planning. In an effort to stem this flow, the Steering Committee has discussed the importance of “in-reach” into these systems, which may mean part- or full-time co-location of Assessment Specialists in these facilities. The purpose of such in-reach is to help with the early identification of individuals most likely to be homeless at discharge (e.g., because such individuals were homeless at entry into the institution) and to begin making arrangements - including help applying for benefits, establishing connections to community services, reconciling with support networks, and identify housing options - while there is time to plan.

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Schools are another important partner, where in-reach workers can work collaboratively with school staff to identify highly mobile and other tenuously housed families before such families run out of options and reach the shelter door. The specific roles and relationships with each partner system will differ, and staffing these in-reach functions will be dependent largely on funding. However, given the potential benefits and cost savings to all systems involved, the Steering Committee felt it was an important part of the new framework.

Recommendation #2: Embracing Diversion

The Steering Committee sees diversion as a relatively unpracticed strategy in Austin. Individual providers may be providing some level of diversion assistance to some clients, but it is typically not done in a purposeful, consistent manner across the system. The tools and resources required for diversion are similar in nature to those used in prevention and rapid re-housing programs, including (but not limited to):

- Negotiation and/or mediation with landlords, family members, etc. to preserve or save a housing situation.
- Financial assistance for rental or utility arrears, short-term rental assistance, etc.
- Exploration of support networks to consider family members, friends, churches, or other options that may provide an alternative to entering shelter (including negotiation with other housing providers, such as PHA, who may consider extended house guests as a lease violation, placing host families at risk);
- Crisis counseling and referral to mainstream service providers to assist with issues related to domestic violence, health, employment, etc.

The key difference between diversion, prevention, and rapid re-housing relates not as much to the type of assistance provided, but rather when that assistance is provided. Whereas prevention assistance is provided while an individual or family is still housed, and rapid re-housing is provided to households that have lost their housing and entered the homeless services system, diversion is a term used for the assistance provided to those standing at the front door of the system seeking shelter/housing.

There are at least four reasons why a more systematic approach to diversion makes sense:

1. There is a shortage of affordable housing in Austin/Travis County, and as such, it makes sense to help households preserve or recover a housing unit if possible. Further, it is often more expensive to re-house a household in a new unit than it would be to help with any costs and/or services necessary to save the original housing situation.
2. The demand for shelter in Austin/Travis County exceeds local capacity. Therefore, it makes sense to divert households if safe alternatives exist.
3. According to HUD’s Annual Homeless Assessment Report (AHAR), a significant percentage of individuals and families use shelter for only short periods of times, resolving their homeless episode on their own. If these individuals and families can be identified and diverted, it will reduce demands on the system and create space for households that need more intensive support.

4. A growing body of research points to the negative impacts of homelessness on children. No matter how hard providers work to provide safe and supportive environments, emergency shelters are generally not the best place for children. Therefore, if families with children in particular can be placed with a relative or family friend, this may have benefits beyond just reducing demand for shelter.

The Steering Committee discussed the difficulty in knowing which clients could successfully be diverted, what diversion resources would be needed, and how they should be deployed. However, just as “opening the back door” of the system is critical to increasing flow out of the system, so is stemming the flow into the system. Diversion is, of course, not the only solution, but rather one of many changes designed to create a system that uses its limited resources in more strategic and effective ways. By empowering staff situated at the front door to engage with clients in problem-solving, by making it part of their job description, and by tracking and evaluating progress over time, the Steering Committee feels that we will continue to increase our knowledge about what works and for whom.

Recommendation #3: The SSOM Assessment Tool

The Steering Committee spent a significant amount of time considering options related to the assessment tool itself. Given the relative newness of coordinated assessment, there are few assessment tools in existence that have been empirically tested and validated. There is a growing body of data around the Service Prioritization Decision Assistance Tool (SPDAT), a tool developed by an organization in Canada and now in use in over 50 communities across North America. However, many communities are using locally developed tools.

ECHO conducted a call with the creators of the SPDAT, and the Steering Committee spent time reviewing and discussing the SPDAT relative to other options, including two tools currently being used in Austin - the Self Sufficiency Outcome Matrix (SSOM), and the BSS+ screening tool. The Steering Committee found the BSS+ tool, which was originally designed to determine a client’s appropriateness for prevention or rapid re-housing assistance, too limited in nature. However, the Steering Committee found

8 For more information, see the OrgCode website at http://www.orgcode.com/spdat/.

9 See Attachment 3 for a comparison of these tools.
the SSOM tool to be very similar to the SPDAT. It covers many of the same domains, and it automatically calculates a client score, which can then be used to identify the most appropriate intervention. The benefit of the SSOM over the SPDAT is that it is already programmed in HMIS, and a subset of providers in Austin are already using it. For these reasons, the Steering Committee determined the SSOM would be most the sensible choice at this time.

In addition to the SSOM, which is used to assign clients to a particular permanent housing pathway, the initial assessment includes additional questions to assess the appropriateness of diversion (these questions are actually asked before the SSOM is administered). These questions do not provide clients with a score; rather, they are simply intended to help staff explore options related to diversion in a thoughtful and consistent manner.

Finally, the assessment also includes basic questions to collect demographic information and assess initial eligibility for different programs, which could guide the Assessment Specialist in making a specific program referral. The Steering Committee recommends that the receiving agency be responsible for final eligibility determination, including collection of any needed documentation (since those programs will need such documentation for their program files). This will be an area that requires close monitoring and consistent feedback between program partners to ensure that Assessment Specialists are making accurate assessments about client eligibility for programs. To help with program eligibility, ECHO has purchased an eligibility module for use with HMIS that a matches a client profile with program requirements to report what options might be available to assist the client. A high “mismatch” rate would signal problems with the assessment tool or misinformation about program eligibility requirements, which would need to be corrected to ensure the community is realizing the benefits of coordinated assessment.

Recommendation #4: Right-Sizing Assistance - Permanent Housing Pathways

The framework identifies three permanent housing interventions, and is based on the principle of providing the least intervention necessary to promote housing stability for the client or client family. This strategy, sometimes referred to as “right-sizing” assistance or “just enough” assistance, is important because Austin has more demand for housing assistance than available resources. Simply put, the homeless services system is not resourced to provide permanent subsidies to every household in the system, and providing more assistance than a household truly needs to resolve the housing crisis means others in the system do not get assisted at all. As such, the

10 The SSOM calculates a score, but does not associate that score with a particular intervention. However, the SPDAT score is tied to a particular intervention. Because the domains are very similar, ECHO staffed mapped the SSOM scores against the SPDAT scores to enable the SSOM to be used in a similar fashion.
assessment tool aims to identify which permanent housing intervention best meets each client’s need.\textsuperscript{11}

\textbf{Lowest intervention: Minimal Housing Assistance}

This intervention is considered to be a very light touch. The individuals assigned to this pathway are those that could not be diverted but are likely to resolve their homelessness on their own or with very minimal assistance. The Steering Committee envisions that an individual case manager may not be needed, though the Assessment Specialist may provide referrals to mainstream service providers, and access to group case management or informational workshops may be provided (e.g., budgeting/financial literacy, tenant rights and responsibilities). In addition, one-time financial assistance (e.g., assistance with arrears, security deposit and move-in assistance) may be needed.

\textbf{Medium intervention: Rapid Re-Housing}

The next level of intervention is short- to medium-term assistance (i.e., between 3 and 24 months). While financial assistance (e.g., arrears, security deposits, rental assistance, utility assistance) is part of this support, case management and supportive services are equally important. The assistance is not one-size-fits-all, but rather titrated based on each client’s unique needs and circumstances.

A review of the BSS+ program data reveals that clients receive between $2,000 and $3,000 of assistance and have recidivism rates of less than 5 percent. While these are very strong outcomes, the BSS+ program has targeted a relatively narrow group of individuals. The Steering Committee believes that the community could (and should) pursue a wider use of rapid re-housing. In order to do achieve this, however, the Steering Committee recommends reviewing the program model to ensure that among other program components, arbitrary caps on assistance do not prevent targeting of households with more barriers (e.g., those that need more than a few months of assistance but do not need permanent supportive housing). Likewise, the Steering Committee recommends identifying additional funding for RRH efforts (e.g., ESG, CoC, HOME, HOPWA, TANF, LIHEAP), and to the extent possible, streamlining that funding into a single program design to ease the administrative burden. Lastly, greater training on the model is needed to ensure case managers understand

\textsuperscript{11} See Attachment 2 for an illustration of client flow through the system via the three permanent housing pathways.
techniques related to progressive engagement and the importance of individualized case planning and supportive services to help households stabilize.

The UT School of Social Work is assisting ECHO to examine available resources in the community that can be applied towards rapid re-housing strategies. However, assistance will be required from program administrators to consider nuances of different funding streams and to develop a program approach that is both effective and easy to administer.

*Highest intervention: Permanent Supportive Housing*

The most intensive (and most expensive) intervention is permanent supportive housing (PSH). PSH should be reserved for those individuals and families who are unable to remain stably housed “but for” a permanent subsidy and ongoing supportive services.

Austin’s local PSH strategy is based on identifying and prioritizing chronically homeless men and women who are frequent users of public systems and/or vulnerable for death or harm. Both measures are intended to help this community prioritize prospective tenants for PSH with a focus on high-need individuals. This initial strategy emphasizes the frequent users in order to demonstrate reductions in costly uses of public systems and the related reduction in costs once the homeless client is both housed and has access to services and case management.

*Strategic Use of Permanent Housing Subsidies*

In addition to these three interventions, the Steering Committee recognizes that permanent subsidies (such as Section 8 vouchers) are an important resource in efforts to end homelessness. Although the Steering Committee recognizes that all low-income households could benefit from a permanent housing subsidy, not all households require a permanent housing subsidy to remain housed. Because these resources are limited, and because current assessment tools are unable to help us differentiate with any certainty households that can stabilize with a temporary subsidy from those that require an ongoing subsidy, the Steering Committee recommends two strategic uses of such resources: 1) for individuals and families initially assigned to the rapid re-housing pathway but unable to stabilize within the time limits of the program; and/or 2) for individuals and families in PSH programs that no longer need intensive, ongoing services and have demonstrated the ability and desire to “move on” (thereby freeing the PSH unit for someone with high service needs).
**Same Tools, Different Packages**

It is important to note that there is not always a bright line between interventions, especially for clients at the margins. Further, there is overlap among the “tools” used within each intervention (for example, security deposit assistance is a tool that could be provided under each intervention), and the same funding source - for example, HUD’s CoC program - could be used to fund programs within each intervention. Different households will need different packages of financial assistance and services, and the assessment is intended to help us determine the approximate “size” of that package so we can refer them to the appropriate case manager in an appropriate agency, who is then responsible for working with the client on the details of their permanent housing placement.

**Recommendation #5: Staff Specialization**

As the TA providers identified during their site visit, staff are required to wear multiple hats and, consequently, are stretched very thin. To help address this challenge, the Steering Committee recommends some specialization across the different roles.

**Front Door Assessment Specialist**

As described earlier in this report, Assessment Specialists are located at points of entry and are responsible for administration of the assessment, diverting clients (when possible), and otherwise identifying the appropriate housing intervention and making the referral to a specific provider and case manager. The Steering Committee recognizes that clients respond better when they are able to develop trusted relationships with staff, but recognizing that assessment and triage should occur quickly, the Steering Committee trusts the benefits of separating the assessment and case management functions will outweigh any disadvantages, particularly if data sharing is implemented (Recommendation #5, below) and effective referral protocols are established.

**Case Management Specialists**

Case Management Specialists are staff members assigned to work with clients on obtaining and maintaining permanent housing. The framework differentiates among three types of case managers:

- **RRH Case Manager.** This case manager is assigned to a client on the RRH pathway. They may be staff of an interim housing provider (if that agency is also a RRH provider), or they may be staff of another agency co-located at the interim housing facility. The RRH case manager continues additional
assessment to determine the specific type, level, and duration of assistance needed by the client to obtain and maintain housing. In additional to financial assistance, this could include assistance to resolve past evictions/unlawful detainers, intensive housing search assistance due to a criminal history, connection to employment and training providers, etc. The RRH case manager continues to work with clients on stabilization once in housing, particularly on connection to mainstream benefits (if not previously connected during the housing search process). They work closely with Housing Specialists, who are responsible for developing and maintaining relationships with landlords.

- **Pre-PSH Case Manager.** This case manager is assigned to clients on the PSH pathway that cannot be placed directly into PSH (due to a lack of available openings). Pre-PSH case managers are staff of interim housing providers. They are responsible for administering an additional assessment to obtain more detailed information about the client’s barriers and history. This information is needed to identify an appropriate PSH placement as well as to match clients to needed services. The Pre-PSH case manager is responsible for working with the client to prepare for placement (e.g., obtaining needed documentation) as well as helping facilitate access to services. This case manager is responsible for organizing (and participating in) a warm handoff once an appropriate PSH slot becomes available.

- **PSH Case Manager.** This case manager is assigned to clients on the PSH pathway once placed into PSH. This case manager is responsible for confirming/documenting program eligibility. (With the help of the Pre-PSH case manager, this should largely be in place by the time a slot becomes available, but the PSH provider will need to review the information and maintain the appropriate documentation for their files.) The PSH case manager is responsible for coordinating the care of the client while in PSH. This case manager is also responsible for helping identify clients that may be ready and interested in moving on (graduating) from PSH.

**Housing Specialists**

Housing Specialists would be responsible for recruiting landlords to partner with the homeless services system and identifying units as they become available. The Housing Specialist could also play a role in conducting habitability inspections, lead-based...
paint inspections, and determining compliance with Fair Market Rent and Rent Reasonableness guidelines.\textsuperscript{12}

Recommendation #6: Data Sharing to Support Coordination

To implement the changes discussed in this report and to make full use of the coordinated assessment, the Steering Committee recognizes the need to “open” our HMIS and increase data sharing. Our current system requires individuals seeking homeless services to provide much of the same information at each stop, and requires each homeless service provider to input this same data into our HMIS. There are few safeguards against duplication of services or client records, or against faulty data. HMIS reports may include wide margins for error due to these duplications and data-quality concerns. It is the Steering Committee’s expectation that by working together and sharing data, we can provide more effective services to our customers.

Benefits of Data Sharing

In regions that have opened up their HMIS for data sharing, providers have seen more effective services for the people in their programs and reduced duplication in their reporting. For example, Alameda County, CA saw time savings and more effective services once they started sharing data. They initially started sharing limited data, but later opened their entire system. The State of Michigan also saw time savings from the decreased data entry, as people only had to complete admissions once for a variety of programs. This helps people to receive the right services more quickly.

A recent Bowman System presentation demonstrated that, with data sharing, HMIS can be used as a case management tool. The State of Michigan feels strongly that sharing data has helped with the coordination of care by allowing organizations to simultaneously build a better coordinated plan for individuals. Providers have indicated that it is helpful to see a person’s story in their service history, including program entry/exits and history of changes for various data elements.

Sharing data has also led to more consistent and accurate information about clients in those communities with open systems. Alameda County, for example, started seeing more relevant and accurate reports, which have helped them with planning and funding decisions. They attribute the improved quality to providers being able to see data inconsistencies and digging for the real information. Incidentally, they feel that this has also led to improved communication amongst partners.

\textsuperscript{12} ECHO conducted a survey of staff in the community providing housing search assistance to clients (regardless of their specific title) to obtain greater insight into the challenges and opportunities related to landlord recruitment and housing market navigation. A summary of findings is included in Attachment 2 of this report.

October 14, 2013
Opening Austin’s HMIS

The current Release of Information (ROI) implemented in October 2012 allows sharing of client demographic data only. Consistent with findings from other communities, ECHO reports that sharing has resulted in better data quality on these data elements and has reduced the amount of data entry across providers. To support the work of coordinated assessment, the Steering Committee recommends the following:

1. Change HMIS to an open system. Clients will need to opt-out of sharing instead of the current opt-in.

2. Limit the opt-out of sharing to only the additionally protected data around detailed medical information, specific disabilities as defined by the data standards, domestic violence, and case management notes.

3. The open sharing of services would identify the provider agency that may serve the protected classes around mental health, substance abuse and HIV/AIDS. The vast majority of clients and providers do not now open the sharing of services but in the future, the providers serving these protected classes would have the ability to close the sharing for their clients, based on the ROI.

In response to local efforts to improve coordination of services and in order to comply with anticipated HUD measurements, ECHO proposes that all CoC providers/HMIS users collect the following data elements:

1. Date became Homeless - to determine the length of homelessness

2. First time homeless (Y/N) - to capture the number of first time homeless

3. Employed (Y/N) - to capture at Entry and Exit employment data

4. Employment Tenure - Permanent, Temporary, Seasonal (Entry/Exit)

5. Employment Level - Full time, Full time temp, Part time, Part time temp, etc. (Entry/Exit)

6. Employment Readiness Status - Job Ready, Getting Ready, Not Ready (Entry/Exit)

7. Category of Employment

8. Education Level - last completed

9. Education Degrees - level of degree or training

For coordinated assessment we also want to capture:

10. Frequent User Data - for prioritization of clients in a housing track. This data or a subset of this data, will come from data agreements with entities across
the community and it will need to be determined how to best capture this information in HMIS, or simply give case managers access to this information.

a. Criminal background (Y/N)
b. Felony convictions (Y/N)
   i. Date of last conviction
c. Jail bookings
d. Number of active Downtown Austin Community Court cases
e. Number of Emergency Medical Service calls in last year
f. Number of Clinic visits in last year
g. Number of Emergency Department visits in last year
h. Number of Hospital visits in last year
i. Number of nights inpatient in last year

V. Summary and Next Steps

An enormous amount of work has gone into researching and studying new requirements, identifying and analyzing options, and discussing and debating the recommendations in this report. ECHO thanks all of the members of the Steering Committee, as well as the many other community members that have participated in conversations and meetings along the way. The Steering Committee feels that implementation of the recommendations in this report can transform the homeless services system in Austin/Travis County from a system that manages homelessness to one that effectively ends it.

However, moving from design to implementation is where the real work begins. Change does not happen overnight, nor does it happen with the flip of a switch. It will require an openness among community partners to taking risks and considering new ways of operating. It will require continuous evaluation of our efforts and a willingness to give and accept feedback to learn and improve as we go. And it will require the unceasing commitment and cooperation of all partners in the system - not just HUD-funded partners.

As a first step, the Steering Committee proposed piloting the assessment tool with a subset of providers over a 30-day period, and this has begun. The purpose of the pilot
is to better understand issues related to administering the assessment (e.g., how long
does it take to administer, how much experience/training is needed to effectively
administer it, how consistent are results when administered by different agencies) as
well as to begin to understand more about the consumers in our system (e.g., how
many are candidates for diversion, what percentage are “assigned” to each
permanent housing pathway). This will allow us to think about how to use resources
most effective to support a full rollout. Further, the pilot phase will likely alert us to
policy and procedural questions that are difficult to predict in the abstract.
Consequently, this will allow us to have conversations about how to handle those
situations and establish better written policies and procedures to guide the full
rollout.

The Membership Council will share these recommendations with the community at the
ECHO annual meeting on November 18 and consider them for adoption at the
December Membership Council meeting. Thru the Steering Committee, ECHO
workgroups and other especially called stakeholder gatherings, ECHO will continue to
lead towards consensus as we move towards implementation in 2014. Additionally,
ECHO will pursue new relationships with community partners and funders to make
these recommendations successful.
## Attachment 1: Work Group Meetings

<table>
<thead>
<tr>
<th>Topic</th>
<th>Meeting Date</th>
<th>Meeting Purpose</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Coordinated Assessment (CA) Planning</strong></td>
</tr>
<tr>
<td></td>
<td>March 18</td>
<td>Overview &amp; orientation for ECHO Membership Committee</td>
</tr>
<tr>
<td></td>
<td>March 21</td>
<td>Site visit debrief with Steering Committee and presentation/discussion of draft CA framework</td>
</tr>
<tr>
<td></td>
<td>April 19</td>
<td>Steering Committee meeting to focus on guiding principles, assessment &amp; triage, and system entry issues</td>
</tr>
<tr>
<td></td>
<td>June 12</td>
<td>Steering Committee meeting to discuss refinements to the framework and review/discuss possible assessment tools</td>
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<tr>
<td></td>
<td>June 18</td>
<td>Community meeting with Bowman on HMIS options for Coordinated Assessment</td>
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<tr>
<td></td>
<td>June 28</td>
<td>Steering Committee meeting #2 on assessment tool/questions</td>
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<tr>
<td></td>
<td>July 12</td>
<td>Steering Committee meeting #3 on assessment tool/questions</td>
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<tr>
<td></td>
<td>July 15</td>
<td>ECHO Membership Council discussion of recommendations; idea to request input at Annual Meeting in November</td>
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<tr>
<td></td>
<td>July 18</td>
<td>Steering Committee meeting #4 on assessment tool/questions</td>
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<tr>
<td></td>
<td>Sept. 8</td>
<td>Steering committee to further refine assessment questions and discuss language in draft report</td>
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<tr>
<td></td>
<td>October 7</td>
<td>Meeting with COC Executive Directors to discuss recommended framework and HACA draft homeless preference</td>
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<td></td>
<td>April 17</td>
<td>Introductory meeting with consultant and community partners to establish common understanding and set stage for work ahead</td>
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<tr>
<td></td>
<td>May 9</td>
<td>Data gathering for PSH frequent users prioritization and evaluation</td>
</tr>
<tr>
<td>Topic</td>
<td>Meeting Date</td>
<td>Meeting Purpose</td>
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<td>-------------------------------------------</td>
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</tr>
<tr>
<td>Access to Permanent Supportive Housing (PSH)</td>
<td>May 15</td>
<td>Teleconference with Salt Lake City and Philadelphia experts to learn about PSH best practices &amp; lessons learned in other communities</td>
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<td></td>
<td>July 2</td>
<td>PSH policy and definitions discussion</td>
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<td></td>
<td>July 12</td>
<td>Data gathering and discussion with PSH Leadership Finance Committee</td>
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<td></td>
<td>July 18</td>
<td>Meeting with Travis County Criminal Justice Planning Dept. about sharing data related to criminal justice system involved clients who need PSH</td>
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<tr>
<td></td>
<td>July 19</td>
<td>Meeting with ICC to discuss healthcare data sharing about clients who need PSH</td>
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<tr>
<td></td>
<td>August 6</td>
<td>Facilitated discussion on PSH prioritization and standards for case management</td>
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<tr>
<td></td>
<td>August 20</td>
<td>Continued conversation about prioritizing PSH clients using systematic collection of data</td>
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<tr>
<td></td>
<td>Sept. 9</td>
<td>Follow up conversation with Travis County CJP re data the before housing and the year after housing</td>
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<td></td>
<td>October 16</td>
<td>Continued conversation on data for Prioritization</td>
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<tr>
<td>Streamlining &amp; Expanding Rapid Re-Housing (RRH)</td>
<td>April 19</td>
<td>Introductory meeting with consultant and community partners to establish common understanding and set stage for work ahead.</td>
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<tr>
<td></td>
<td>May 17</td>
<td>Web-based meeting to compile a list of resources and examine program eligibility requirements, eligible activities, and program limitations to begin discussion on braiding resources to fund diversion and RRH assistance.</td>
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<tr>
<td></td>
<td>May 20</td>
<td>Teleconference with Minneapolis and Salt Lake City experts to learn about RRH best practices &amp; lessons learned</td>
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<td></td>
<td>June 5</td>
<td>Kick-off of UT School of Social Work project to help align RRH funding sources</td>
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<tr>
<td></td>
<td>June 28</td>
<td>Housing Specialists Project: Debrief on survey findings and recommendations</td>
</tr>
<tr>
<td>Topic</td>
<td>Meeting Date</td>
<td>Meeting Purpose</td>
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<tr>
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<tr>
<td>July 19</td>
<td></td>
<td>Housing Specialists Meeting to learn about each other</td>
</tr>
<tr>
<td>July 29</td>
<td></td>
<td>UT School of Social Work Project debrief on RRH resources</td>
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<tr>
<td>Sept. 8</td>
<td></td>
<td>UT School of Social Work Fall project kick-off to continue work on RRH Funding recommendations</td>
</tr>
<tr>
<td>Sept. 13</td>
<td></td>
<td>Housing Specialists Meeting to explore staffing tough cases, share strategies, etc.</td>
</tr>
<tr>
<td>October 18</td>
<td></td>
<td>Housing Specialists decide to meeting monthly</td>
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</table>

**Funders Coordination**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Meeting Date</th>
<th>Meeting Purpose</th>
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</thead>
<tbody>
<tr>
<td>April 18</td>
<td></td>
<td>City of Austin &amp; Travis County</td>
</tr>
<tr>
<td>August 22</td>
<td></td>
<td>Discussion about LOI to DSHS for Healthy Communities Collaborative Grant</td>
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</table>

October 14, 2013
The Steering Committee reviewed a number of possible assessment tools. The final two tools under consideration included the Self Sufficiency Outcome Matrix (SSOM) and the Service Prioritization Decision Assistance Tool (SPDAT). As illustrated in the table below, the SSOM covers most of the domains covered in the SPDAT. Further, because the SSOM assessment is already programmed in Austin’s HMIS and being used locally by some case managers, the Steering Committee recommends use of the SSOM.

<table>
<thead>
<tr>
<th>Domains</th>
<th>BSS+</th>
<th>Alamed a Co. Tool</th>
<th>SSOM</th>
<th>SPDAT</th>
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<tr>
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<td></td>
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</tr>
<tr>
<td>Emergency services frequency of use</td>
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<tr>
<td>Vulnerable to harm on the street</td>
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<td>Yes</td>
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<td>Hygiene/daily living skills</td>
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<td>Home/neighborhood skills (for those housed)</td>
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<td><strong>Employment situation</strong></td>
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<tr>
<td><strong>Food Stability</strong></td>
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<td><strong>Childcare availability</strong></td>
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<td><strong>Children’s Education</strong></td>
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<td><strong>Parenting Skills</strong></td>
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<td><strong>Adult education level (relating to employability)</strong></td>
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<td><strong>Transportation Access</strong></td>
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<td><strong>Involvement with the community</strong></td>
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<td><strong>Housing Safety</strong></td>
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<td><strong>Credit history</strong></td>
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<td><strong>Current Housing Crisis description</strong></td>
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</table>
As discussed in the body of this report, Austin’s system is currently “clogged” with long-term stayers. Thus, not only is matching clients to the most appropriate intervention important, but so is prioritizing clients within those interventions. Given the costs involved, this is particularly true for permanent supportive housing (PSH). Several studies have confirmed the effectiveness of the PSH model, but it is most cost effective when targeted to those individuals and families with the most severe barriers to housing stability, many of whom happen to be “frequent users” of other public systems.  

In Austin, each agency or collaborative participating in the development and operation of PSH has defined “frequent user” from its own lens and has determined its own method of prioritization. In relation to the community’s work on coordinated assessment, it became increasingly clear that a more coordinated strategy was needed for prioritizing access to PHS. A meeting of key stakeholders in April 2013 set into motion a community process to determine a more cohesive and effective strategy for targeting our limited PSH resources.

The emerging PSH strategy focuses on client usage of the following public systems:

- Hospital emergency departments and hospitalization
- EMS
- Downtown Community Court, Jails & Prisons
- Shelters

A “frequent user,” or “fuser,” of each system has a relative definition. Based on local practices, and best practices, we propose to use the following:

- Frequent hospital emergency department visits/hospitalization - 5 hospital contacts in any three month period
- Frequent EMS user - 3 contacts in last 30 days before housing
- Frequent DACC - 25 cases or more pending before housing
- Frequent Jail - 3 or more trips in the past 3 years
- Recent Prison History - person has been incarcerated in the past 5 years
- Frequent Shelter user - 50% of nights slept in shelter in previous 6 months

In addition to these fuser categories, the strategy targets certain subpopulations known to benefit from PSH:

13 See the United States Interagency Council on Homelessness research database for information on PSH cost studies.
• Chronically Homeless Veterans with mental illness (including PTSD) and substance use issues
• Men, women and unaccompanied youth diagnosed with severe mental illness
• Men, women and unaccompanied youth diagnosed with substance abuse issue
• Men and women diagnosed with both mental illness and co-occurring substance abuse issues
• Men and women diagnosed with a physical or development disability that impacts his/her ability to work and live independently.

Each of these subpopulations is known for vulnerability on the streets - vulnerability for death, for harming themselves or others, or for being victimized or injured. Assessment questions will determine some aspects of vulnerability, but additional tools like the Vulnerability Index are still under consideration for use in developing a single, prioritized list to determine placement into PSH units.

In determining who gets into PSH and how PSH improves their lives, we will need to use the fuser data twice: (1) After a homeless client has been assessed for the appropriate housing intervention and initial eligibility for PSH has been determined, we need frequency of use data from each of the above systems to determine this client’s relative priority for PSH; and (2) After the client has been chosen for PSH, we will need the data to set a baseline for comparing frequency of use and relative known community costs while homeless and then, afterwards while housed with PSH.

Some PSH stakeholders are in agreement to develop a list of all clients needing PSH and use it to fill some open units through “community staffing”, similar to a centralized list for PSH. Further, stakeholders recognize that a variety of additional changes will be required to improve our local administration of PSH programs, including maximizing the use of our current PSH inventory to meet needs of priority populations by better targeting turnover units (including considering “move on” strategies where units were not originally targeted effectively); investing new resources into PSH and ensuring that tenant selection from a centralized list is incorporated as part of the original funding proposal; accessing opportunities available under the Affordable Care Act to help cover health and supportive service costs for individuals living in PSH; and increasing training and support for widespread implementation of evidence-based practices, particularly with regard to supportive service models.
Attachment 5: Housing Specialist Survey - Key Findings

In spring of 2013, ECHO conducted a survey of staff throughout the community providing housing search and placement services (regardless of their specific title) in order to identify how “housing specialists” are currently being utilized as it relates to doing outreach to landlords/property owners to develop, maintain and sustain relationships that help to expand housing opportunities for persons with housing barriers including search for affordable housing. From this, ECHO would make recommendations to enhance what we are currently doing around landlord outreach and expanding housing opportunities for persons looking for housing. Following were the key findings from the survey:

- Agencies in Austin/Travis County use different titles for a “housing specialist,” and their roles/functions vary across organizations.
- Existing “housing specialists” as well as case managers are being very creative in developing strategies to work with landlords and getting clients housed.
- Current market conditions are making it increasingly difficult to find housing options for clients.
- There are a number of ways to build credibility and strengthen relationships with landlords to help increase housing opportunities.
- There appears to be limited formal, proactive marketing and landlord outreach occurring within organizations, and even less occurring across organizations in a system-wide context.
- Some terms commonly used may have negative stigma attached to them that impacts relationship building with landlords, and consequently, some organizations are changing the language they use.
- There are limited formal training opportunities for dedicated housing specialists and/or case managers performing the function of housing search and landlord outreach.
- Few organizations are collecting measures to track how effective they are in recruiting landlords and expanding the number of housing units available to vulnerable populations.

ECHO and the Housing Workgroup have been discussing these findings and have begun work on a strategy in response to the findings. There is widespread agreement that stronger coordination across agencies is needed, ensuring that housing specialists are equipped with materials to share that accurately describe how supported housing works (whether it be RRH or PSH), and ensuring they are fully versed on the strategies and resources available. ECHO is working on messaging materials with the City of Austin and on outreach with the Austin Apartment Association and Austin Board of Realtors.

With the exception of the BSS+ housing specialists, the majority of housing specialists are currently employed by individual agencies and look for housing opportunities for
clients of their respective agencies.\textsuperscript{14} In some instances, this leads to a competitive environment more than a collaborative one. Given the coordinated assessment framework, the Housing Workgroup has been exploring the feasibility of bringing housing specialists under a central entity, or alternatively an agreement that they will work across agency lines viewing housing specialists as one team operating according to a common set of rules and protocols. For example, housing specialists could serve as the main point of contact for a portfolio of landlords and case managers, and in the event that an issue or concern is raised by a landlord about a specific tenant, it would be the responsibility of the housing specialist to contact and coordinate resolution with the case manager assigned to the client/tenant. This may aid in landlord recruitment if landlords know there is a neutral third party who will assist if and when conflicts arise.

\textsuperscript{14} BSS+ housing specialists identify units for clients served by the broader collaborative of BSS+ agencies.