November 10, 2014

To: FHI Advisory Committee
CEH Staff

From: Katharine Gale, Consultant, Focus Strategies

Subject: Themes emerging from Community Meeting on Family Coordinated Entry/Assessment

The Community meeting held November 6, 2014 was very well attended with more than 100 people present. The first part of the meeting focused primarily on the findings of the first phase of our assessment, which have been shared with you in the PowerPoint. The final portion of the meeting was devoted to small group work around three key areas of our findings. Every attendee was able to participate in two small group conversations (except for table facilitators who stayed with the same topic for both rounds).

This memo summarizes key themes and ideas that were generated in the small group work, and concludes with a sense of our next steps.

1. Assessment Access and Process

Six groups were asked to brainstorm strategies to make assessment more timely and accessible including who should do the assessment, when and where, and how to keep in touch with families after they have been assessed and are waiting.

Emerging from the discussions was a strong push for decentralization to decrease both the burden on families and the wait time, and to utilize the resources in the community. Ideas floated included:

- Offer assessments at a number of particular locations throughout the community – locations to be data driven by where these is demand/need
    - Make sure assessments are available by drop in rather than appointment
- Do assessments at all locations/every agency with "no wrong door"– have a standard tool and FHC's role be to train all providers and be responsible for quality assurance
- Do assessments within shelters and use FHC to provide mobile capacity to meet with families outside of shelter – especially, use mobile assessment for highest barrier families
- Experiment with remote/camera based assessment from community centers, as can be done by hospitals

Several of these groups also mentioned that there needs to be support for getting families the documents they need, and that documents collected should be scanned and uploaded to HMIS so they are available when a program needs them.

These groups also emphasized the need for a less lengthy and more standard assessment tool that translates more directly to what is needed to access programs. Several also mentioned the need for greater HMIS integration and use of data.

2. Prioritization and Matching

These seven groups were broken up by intervention type and asked what information was needed to make the best matches, what information would increase the rate at which families accept referrals, and whether any families should be prioritized for particular interventions.

Frequent criteria that were mentioned as needed for best matching in nearly all categories included:

- Income and employment status/work history
- "Service needs"
- Health/Medical/mental health/AOD
- Safety planning/DV
- Language need
- Family size/structure/age of kids
- Geographic preferences and connections

Many mentioned that the information from families needed to be accurate and that truthfulness is a concern. Several groups felt a background check was needed for eligibility and/or to be able to work with landlords.

A few noted that an assessment is not a good way to predict success, and a few said that programs needed to remove screening barriers and not use the information to screen families out.

These groups were also asked which criteria would most likely result in families not rejecting the programs offered. On this question, every table said geography was important and some method for matching needs and family preferences to program referred. Some also mentioned language.

Finally, these groups were asked whether any families should be prioritized or 'fast-tracked' for program entry. This table summarizes the suggestions in each intervention type.

Suggestions for Families to Prioritize/Fast Track			
Shelter	Transitional	Rapid rehousing	Permanent Supportive
Medical Large families DV/safety Co-occurring disorders CPS involvement	Pregnant women Higher barriers Medically fragile	Employment history DV *Disabled* *Children receiving services* *CPS involvement* *Teen parents* **Italics: not sure if responses were for this category*	Higher barriers Disability + medical needs/medically fragile CD/MH needs Children with intense needs Hardest to shelter (i.e. family size, barriers above) Pregnant women Domestic violence

3. **Reducing Entry Barriers**

These six groups, focusing specifically on transitional housing and permanent supportive/service-enriched housing were asked to look at how to balance programs' concerns about changing entry criteria with the need to find openings for all families, and what type of support would be most useful for program to reduce and standardize criteria.

For the first question regarding balancing, many of the groups mentioned the concerns of property managers and that they felt they must be able to do some screening to protect other tenants. Specific concerns around sex offenses were noted.

Many tables mentioned that there should be efforts to make a better definition of what a "good fit" is, and perhaps tier the levels of support within different programs so that harder to serve families would be matched with higher services levels. The assessment tool would need to match the tiers. Many said standardization of the screening criteria was very important but also noted there had to be buy-in to what the standards are.

Some tables said that transitional housing should have the lowest barriers, while others though that referrals to transitional housing needed to keep in mind what the real exit potential of the family was going to be after the program.

Frequent suggestions for support to providers to be able to reduce barriers were:

- Greater funding for case management or incentive funding to providers with fewer barriers
- Risk mitigation funds
- Training in clinical services
- Become a learning environment/more sharing of successful strategies
- Flexibility to make a better decision with a family if it is not a good fit/circumstances change – being able to switch programs

Other ideas included mobile clinical supports and flexible funding for supporting family exit strategies.

Next Steps

We will be pulling together and summarizing all we have learned from our King County interviews and meetings, as well as examples of models from other communities that are relevant to the local situation. We will be filling in gaps on a few issues that have been raised or emerged during the last visit and then developing our report and recommendations.

We anticipate that the report will include some recommendations for immediate policy and practice changes that can be made while the system is structured as is and other longer-term suggestions for larger changes. We also plan to include pros and cons when more than one option is offered.

We look forward to working with your committee to shape the final report.