Michigan Balance of State Coordinated Entry Evaluation

Working with the Balance of State CoC Coordinator and MSHDA to identify and assemble key contacts across each of its 59 counties, OrgCode spent more than 50 hours interviewing Balance of State organizations to identify current processes, service strengths, existing gaps and external environment expectations in their efforts to prevent and end homelessness. Through a series of structured questions (outlined on pages 4-5), staff described each step of how they locate, engage, shelter, document, identify units, and move people experiencing homelessness into permanent housing. Those interviews resulted in several key themes, listed here.

Key Themes

Opportunities for Enhancing Access and Communication:

- Staff across each Balance of State location identified the processes for engaging a Housing Assessment and Resource Agency (HARA) and understood the resources that their community possessed. While organizations knew each other well due to their small staff sizes, they also expressed concern with the lack of well-publicized information on how to access resources with people experiencing a housing crisis as the intended audience. In communities where the HARA is more than 50 miles away from other organizations, mobility and access can be challenging. While staff appreciated that HARAs send staff several times each month to conduct screenings and meet with those who have been surveyed, phone access may provide another helpful method for conducting the common assessment. Finally, particularly for those experiencing first-time homelessness who may not show up at the "right door" to access resources, opportunities for enhanced communication included radio advertisements, newspaper ads, posters, signs and billboards.

Homelessness Prevention and Diversion:

- Multiple staff described how they daily engage individuals and families, including youth and survivors of domestic violence, to prevent their literal homelessness and rapid re-house them. While the majority of those interviewed described diversion as part of their daily tasks, staff also frequently identified wanting to know how to more effectively and consistently provide diversion strategies, with multiple requests for both additional and ongoing technical assistance. Where diversion is happening, staff stated that it was not tracked consistently within the Statewide Homeless Management Information System (HMIS). Refresher trainings and support on broader implementation would be helpful to address strategies for system-wide improvements.

Maximizing Limited Staff Resources:

- Unsurprisingly, interviewees described how the small nature of their organizations and staffing had produced relationships among providers and community-wide expertise on the processes to end homelessness -- often through word of mouth. While HMIS was still not fully utilized, because of limited street outreach

and shelter, communities described a heavy reliance on partnerships with faith-based providers and law enforcement. Significant community involvement and collaboration exists across the Balance of State. Due to the small staffing levels, several people requested a more widely distributed emergency plan for instances when workers are unavailable (due to scheduled leave, holidays or other time off). Some communities have done commendable work already with integrating, marketing and advertising across systems.

Prioritization Enhancement Opportunities:

- Most staff could readily describe their prioritization criteria of highest VI-SPDAT score and longest history of homelessness, including an emphasis on ending chronic homelessness. Balance of State communities overwhelmingly did not describe real-time data and accountability, or easily understanding who the HARA is engaging, who is next, and where opportunities exist to collaborate with those next most likely to be housed through connections. While prioritization is based on vulnerability, it was very clear that subjectivity and strong advocacy continue to play a significant role in decision making.

Additional Transparency:

- While the HARA was frequently described as having the lead on all things from assessment to decision making through a centralized process, staff offered mixed feedback on whether or not there was enough transparency at this time. Responses ranged from "we have literally no idea what is going on" to "our HARA is great," but almost every interviewee could identify opportunities to increase clarity and consistency of expectations. While community providers could point to VI-SPDAT scores and length of time homeless as community priorities, many staff struggled to understand who is getting prioritized and housed, with when and how that occurred. VI-SPDATs continue to be completed at or near first contact, even for people newly experiencing literal homelessness. Because many of the Balance of State communities are small in size, "first come, first served" appears to still be happening quite frequently.

Ensuring Resources and Funding Reflect Needs:

- Across the Balance of State, many locations identified that allocation of funding isn't reflective of their needs. Surprisingly, multiple communities identified having sufficient housing resources to meet the needs of people seeking assistance, including their ability to receive referral to Housing Choice Vouchers and Section 8 subsidies. Others identified having insufficient housing resources or housing stock to end homelessness without requiring the use of sub-optimal housing stock. Several staff identified that MSHDA's separation of homelessness programs and rental assistance programs produced intra-department communication challenges. Others described how the sizable number of subsidized units available across the state made it infuriating to see homelessness continue to exist locally. While the housing subsidies require a Housing First approach, multiple staff described the challenges with finding landlords who also followed that approach, and high quality landlords generally.

Increasing Housing First Implementation:

- Almost every staff described progress with how their community had grown to accept (and often champion) a Housing First approach in ending homelessness, specifically among providers serving people experiencing homelessness and housing insecurity. While several staff expressed their ongoing efforts to build relationships and increase understanding on behalf of their landlords, most staff described holding to a Housing First approach themselves. Housing access and success may still be based too frequently on the "willingness" of program participants to "engage" and "do what they need to do," but the majority of staff used consistent Housing First language when providing feedback.

Expanding HMIS Use and Access:

- HMIS use was consistently described as being a tool primarily used by the HARA but not other service providers. Even among HARA staff, representatives described keeping paper records and separate electronic databases in order to evaluate who they engaged, housed and supported. Across each Balance of State community, staff would greatly benefit from both reminders of existing HMIS reports as well as ongoing technical assistance to ensure comprehensive use of these HUD-required tools. Generally, staff relied on the HARA to generate reports rather than possessing the ability or knowledge on how to run reports themselves. Multiple organizations expressed frustration at the limited HMIS utilization and coverage across various providers, in addition to concerns with data quality and how the information they recorded could inform their understanding of system strengths and gaps.

Interview Questions

Michigan Balance of State organizations were asked the following questions through 30 to 60-minute interviews:

Questions About Coordinated Entry System Access:

1. What are the Access Points or HARA (Housing Assessment and Resource Agency) in your community? Is it a physical location people go to, or is it accessed only over the phone?
2. What does Prevention and/or Diversion look in your community?
3. How do unaccompanied individuals, families, and youth access or find the system? What is the marketing and advertising?
   - Centralized or De-Centralized?
   - Is there one 'right door' that people go to, or are there many?
4. How does your community engage with unsheltered households?
5. For sheltered households: how are new stayers engaged vs. long stayers?
6. When people don't show up at HARA (or the community's access points), how do we know? (Not just system-wide reports of people receiving services, but also system-wide reports of people experiencing homelessness but not currently coming in to receive services)

Questions About Coordinated Entry System Assessment:

7. What is the current training for Access Points administering the VI-SPDAT?
8. What locations in your community complete the VI-SPDAT? Are VI-SPDATs completed on paper or in HMIS directly?
9. At what point in the engagement is the VI-SPDAT completed? Is this different for each access point?
10. Once the VI-SPDAT is complete, what is the next step?

Questions About Coordinated Entry System Referral:

11. When a rapid re-housing opening/slot/vacancy occurs, what's the community process (how are vacancies announced to the system)? Does that look any different for permanent supportive housing openings/slots/vacancies?
12. How are you informed of housing vacancies and/or matches? (both as a front-line services provider who engages the person who is matched to the resource, and as the resource/housing provider whose opening/slot/vacancy is matched to the person engaged by the front-line services provider)
13. How does your community ensure a Housing First model throughout the entire Continuum of Care?

Questions About Coordinated Entry System Prioritization:

14. What is your community's criteria for prioritization for housing matches? How does the VI-SPDAT score fit into this?
15. Does your community have a Housing Locator/Navigator to assist with housing location supports including landlord liaison, increasing housing stock, developing and coordinating housing solutions beyond CoC funded resources?

Questions About Coordinated Entry System Data Management:

16. Is there a report (or reports) within HMIS that quantify a real-time list of people experiencing homelessness, like a weekly or monthly Point-in-Time count?
17. Is there a report in HMIS that tracks the limited housing resources matched or assigned to people experiencing homelessness, that contains the date of the referral or match, the date of successful enrollment, and the date that the person moved into the unit and had their homelessness ended?
18. When people can't be located, or they're not eligible following the initial referral, what happens when things don't work out?
19. When households return to the system (for whatever reason) after being housed, how does your community identify them? How are they supported?
20. Anything else you think we should know?

De-Identified Interview Responses

Interview 1:

1. Typically I have people come here, 4-5 years ago we were the HARA, there has been a little miscommunication about a new agency being the HARA. I typically give them a flyer about how to access the HARA. If they don't have a phone number, I run a shelter report since April and I call the HARA on their behalf.

We had talked, with our local planning body, about us being able to do a pre-interview over the internet here, since we do have internet access.

The HARA itself is accessed only over the phone. People do try to go to the local Community Action agency, but that has created a huge problem. Same challenge there, where people have to connect with the HARA via the 800 number.

There is a problem where we ask, "what about people who show up at the sites and are told that's not the right place to be, since they're always redirected back to the 800 number as the centralized access point?"

2. If it's someone who I've seen on a daily/weekly basis, I do that more between November and April when the [location name] is running, I work more closely with the local Community Action worker. But during the summer months, I kind of do a little bit, but until Crisis Season begins, there's not a lot. I always divert to having to call the 800 number. I don't know if there's a dedicated financial resource.

3. There are other agencies like [three organization names] and possibly [one organization name] but there are other needs to get housing. When someone presents there, those agencies usually send people here. Because our organization is a bus stop, I've actually seen a lot of people experiencing homelessness who are stuck here now. They arrived at 3am and have nowhere to go. I try to help them as much as I can, I tell them about the 800 number but if they're on their way, they might not call it. A flyer exists at each location. I don't know why [three organization names] continue to send people *here* when they also have the flyer. [One organization name] is entirely volunteer, so uniform training is complicated, same with [one organization name]. They always have representation at each meeting, but that's not always consistently communicated. I don't know if staff are consistently being told to always give out the flyer. Same for [one organization name].

211 station exists right here, they're really good about talking through with people. I've never received referrals *from* there, but they've always been good about handling the caller and knowing about what resources exist. They have a whole set of resources and agencies that access those resources.

211 makes people aware of the 800 number.

4. If we see them at the bus stop. During the Point-in-Time count, because it's run by the people that live here (drop-in Community Centre) but because we don't have the

staffing to be able to go there. But that's their community spot, they shouldn't have to be bothered by anybody. On PIT, I pretty much only

5. In [location name], only one year-round DV, and November-April location. [One organization name] who runs a little bit longer than we do through rotating church sites. This is a huge way to engage volunteers.

Another 24 shelter for families in [location name] that's an hour away.

6. Once a year the local planning body puts on a fair like thing where all the community resources are at one location at the local mall. No outreach. No community engagement.

7. I definitely don't do that. That's something done by [one organization name]. She'll come here when we have the shelter. On a typical day, she does from 4-6 people. It all boils down to if they want to stay and participate and really get ahead in life. I have a good portion of people who don't want to go through the process.

8. One staff. It would be helpful for her to have another person or two to assist. Especially when the crisis season begins, and if there's ever a time when she's out, there's really no backup for her.

Done online. At the end, she shows them the score that they got.

9. She typically does it during the second meeting. In first meeting, depending on how long that takes, there's not enough time.

10. Depending on her score, she puts them on our waiting list. She has a list of clients (typically families who the shelter can't serve) who come to her office. Families often get a lot higher number than most of the singles who stay here.

11. RRH at [organization name]. RRH for veterans is at a different branch of [organization name] with one caseworker for these veteran families.

Announcing vacancies isn't announced. I think they go by VI-SPDAT number. We have a few PSH agencies (at least 2-3 years). [Organization name] has a really good relationship with these PSH agencies and local renters in town who are willing to work with her and the local program. Staff have to put it in the local paper, per state mandate.

12. That would be really, really helpful. But I also think that there needs to be a better understanding from the other organizations too about the amount of time it takes for [organization name] to do.

13. They'd have to refer back to [organization name]. Don't know if there's a form. I can always call the case worker to check if the family expresses concern with exiting homelessness.

14. All of the other [organization name] workers talk about it together as matches occur. That's a meeting that I'm not privy to, which is fine. That's the mechanism.

15. It gets completed by the existing caseworkers. If we had additional staffing dollars, it would go toward other things. Definitely having another staff for [location]. [Organization name] is spread pretty thin in [three location names]. It would be helpful to have a constant person to help out the 24-hour shelter.

16. No. I don't get access to the HMIS. I don't know the reason for that, but I think it's because we're not the HARA anymore. Paperwork from the shelter is inputted into HMIS by a MSHDA or HUD caseworker.

17. Yes; that paperwork is brought to us every CoC meeting.

18. The worker tells them they can come back in 30 days. Or I work with them on a plan B. They're also put on the Homeless Preference List for MSDHA, which is pulled 3-4 times per season.

19. This happens most often when it's a concern with someone's mental state. We try to get them engaged with Pathways. We don't want them to waste resources or keeping trying things that aren't working. I really don't see someone who's experiencing homelessness where it's not a MH issue, so I always try to lean a little further on pathways.

20. Just an overall "what happens if a worker is out?" Is there an emergency plan? When the worker is out, no one has any idea about what's going on. There's no coverage for extreme cases. The public doesn't know what to do.

Interview 2:

1. [Organization name] is the HARA, primarily over the phone. We are considered the central point of access. If someone has a housing crisis, they're pretty much sent here. We're on same complex as our [organization name].

Trying to do a "no wrong door" approach. If people show up at the other organization, they will direct the person to show up at the HARA or call them.

If someone is unsheltered, we have one staff to meet people where they reside.

2. Because our only shelter is DV, we have hotel/motel dollars too. We try to see if there's any friends/family where they can stay, as well as [two organization names] in [neighbouring location] as well as other out-of-county assistance. If people want to stay here, we work to coordinate those services while they're staying out-of-county if they're choosing to be housed in [neighbouring location]. When there are literacy or language barrier, we use both the language line and face-to-face engagements when that's helpful.

3. No radio ads. No known marketing. Pretty much word of mouth. Unless a first-time homeless person goes to [location], another provider or calls 211, they would struggle to know where to go. We're on the HARA list on MSHDA website. Most referrals come from 211, others from DHS.

Five question screener to determine if someone should even access the HARA that asks: is there a concern for DV? If so, automatically referred. They would work with them, do case management, VI-SPDAT and they coordinate with us. If they're category 1 homeless, they go to HARA. If they're at imminent risk, we have a twice a month "Housing Hour" process from [time] with [amount of] people. Serving both singles and families. The screener is only used at one organization currently. We often get referrals with people staying with family indefinitely.

4. The HARA does outreach, as does [organization name], who assists with meals and services. Our Community Mental Health organizations also work with us on campsites. We have an internal form with basic information to help with acuity level and length of time homeless, but we coordinate with case managers to assist with services. The staff with face-to-face contact will call with them, bring people here, give them the information.

5. The CoC has not discussed anything related to DV services. They're part of the CoC, coordinate with HARA, but sometimes we don't even get the referral until they've been staying there two weeks.

6. No.

7. HARA and DV shelter are the only ones trained on VI-SPDAT. Others could get trained.

8. Typically on paper first, then in HMIS. One staff does [number of] hours of HMIS support [days] and admin support. People who are in out-of-county shelters with VI-SPDATs, but they're not done here again, but we were penalized last time for not redoing the survey in order to hit the 94% target.

9. There's not a uniform process. It's a case-by-case basis. Initially, do the five-question survey (fleeing DV, are they homeless, are they in the county, where did they stay last night, do they have resources to resolve on their own). Not everyone who accesses the HARA gets a VI-SPDAT. Almost everybody who is category 1 gets a VI-SPDAT.

10. We look at length of time homeless and VI-SPDAT score because we have both RRH and PSH new projects with lots of openings. We have one case manager who's available if they're interested and they don't already have one. They have a high caseload.

11. VOA is SSVF program, but I don't know how many slots they have.

PSH units dedicated chronic, we have a new PSH dedicated plus project. New RRH unit project from HUD (1, 2, 3 bedrooms). I don't know of the vacancy communication mechanism. I advertise those to the CoC and internally on behalf of the HARA. It also goes out to [name] Council (directors at each of these agencies). Mostly communicated through email. Word of mouth used a lot too. As openings arise, people who engage the HARA are assigned slots as they arise and given 30 days to locate housing (tenant-based), which can be extended as necessary.

We decide as a team who should be prioritized for those slots.

12. All the projects are through the HARA, so we know of openings right as they happen. ESG/ESP, RRH, PSH dollars are all located here. We look with the family to determine what's the best resource for this family? It takes 3-6 months for people to find housing. Three years ago, it was 28 days, now it's more than 58 days.

13. Everything within the HARA is Housing First. The only barriers are what HUD or the state requires. People with criminal or credit histories, which happens frequently and often due to substance use. We are blessed with a lot of housing resources in [location], but they're not as Housing First as they claim. They have the requirement, but still screen people out for credit or criminal histories. That comes from their own internal tenant selection criteria. [Organization name] and [organization name] have developments here and are friendlier to Housing First to screen people in, rather than out, when they're not eligible at first glance. They can identify that we'll need to submit an appeal and work with us to do that. [Organization names] aren't likely to accept you if you have a blip on your history. The CoC hasn't done much Housing First community education

14. VI-SPDAT score and length of time homeless.

15. No right now. We started in 2007 a sub-committee called [name] who did community surveys who came up with 3 goals, of which the housing assessment to evaluation the existing staff is primary. [Organization name] 0.5 FTE through MCAH.

16. I don't know. The APR is run quarterly and contains a PIT. The CoC doesn't actually look at it once it's submitted to do concrete actions. Not a whole lot is done with the reports once the numbers are shared.

17. Not that I'm aware of.

18. We continue to reach out to them for a period of time. If they receive services elsewhere, as soon as they re-engage there, if there is housing available, we re-prioritize them.

19. If they're evicted from RRH or PSH, we re-house them in the same program and help them find another location. Our case manager will do another assessment to see what happened, changed goal setting. If people need help linking to community resources or the landlord, we'll work with them to connect with the person via warm hand-offs.

20. MSHDA has separated homeless programs and rental assistance programs. RDA and MSDHA has over 1600 subsidized units -- that's a lot. Looking at those numbers makes it infuriating to see homeless locally. There needs to be more pressure to change to be more Housing First.

Interview 3:

1. HARA, but also access points that send referrals there. [Organization names] make referrals to the HARA. They do their own intake, plus make a referral to the HARA.

TSA has ESP funds for hotel stays if needed. They do street verification too.

[Organization name] is the HARA. Most appointments are done in-person, not by phone.

2. We always ask clients where they stayed last night, we ask if they family/friends to stay, their long-term plan. Hotels for a few nights if they're street homeless. Prevention eviction assistance and first month's rent (not deposit) through [organization name]. I'm not sure if additional prevention/diversion available other than first/last month's rent through DHS. Other referrals to other local area churches.

3. A lot of the agencies here have resource sheets if someone shows up and everyone knows what each agency does. Local provider working with City to open in the fall/winter for year-round shelter for [amount of] individuals and [amount of] families. DV shelter is year-round, first come, first served and serves primarily families.

More similar to de-centralized, no wrong door access points.

4. Every year we do the PIT count to help with this, after hours in the woods, once a year. The Salvation Army also serves lunch on a daily basis, and we know where the campsites are and learn of new locations. We join Homeless Angels to seek people out at those sites to verify their homelessness.

5. With DV, they don't do a waiting list, it's first come, first served. The site doesn't know when the bed is going to be open. It's flexible for when the beds are available and how long that stay lasts.

6. Every year we do the PIT count to help with this, after hours in the woods, once a year. [Organization name] also serves lunch on a daily basis, so we know where the campsites are, and we (and [organization name]) will seek them out to verify their homelessness.

7. Only three organizations that I know that do the VI-SPDAT. Multiple staff at each organization can do it.

8. Ours are put right into HMIS. [Organization name] also does them that way.

9. [Organization name] does theirs right away as a requirement of funding. [Organization name] also sets up an appointment to do their intake to do the full SPDAT. Unsure of what that looks like at other sites but believed to be at close to first engagement.

10. We put it in to determine the score. If people score below the qualifying number, we still complete a referral, but may not put them in hotel (instead attempting diversion).

11. RRH at HARA, PSH at HARA only. [Organization name] (HARA) sends out emails as soon as the funding is available, or as funds are running out. When there are limited resources, they quantify how many slots are available. Phone calls work for when there

are openings. Openings are relatively constant, but funds run out each year and don't appear to be allocated on a monthly, pro-rated basis.

12. In addition to emails, the HARA sends the alert to the Coordinated Entry access points. The access points find the people who can be served. When someone is matched, we have a [name] monthly meeting covered under the Release of Information to determine how specific people are doing and where challenges arise.

13. We see the research that Housing First works. There are people who get housing even without income, and they receive assistance with utilities. With [organization name] and [organization name], work with the person to find furnishings once the housing is secured. [organization name] program at [organization name] works to help for families find employment. Our community has limited affordable housing, and $1,200 a month doesn't work for the people we serve. Landlords don't always accept PSH or RRH subsidies. We also struggle to find units that pass inspection. We also struggle with people coming from other communities.

14. VI-SPDAT score is the first priority. Also keep communication open so if someone is in a life or death situation, or we've worked with them for a long time and have tried multiple different interventions and have determined what hasn't worked, that can inform the process.

15. No dedicated funding. Existing caseworkers do these tasks.

16. The HARA can do that. Individual organizations can run their own ART reports too.

17. The HARA also has that report. That information can be learned from outside organizations how individual people are doing in the process if they call the HARA. A monthly report goes out to the broader CoC.

18. All those challenges are communicated by the HARA through email or phone. We ask the people that we know that see them regularly, and we also proactively seek them out.

19. We communicate that on a regular basis whenever it happens. We ask, "how can we prevent the housing loss" or "how can we re-house them" in order to prevent or reduce their homelessness.

20. Is only one organization allowed to have the rapid re-housing? When there's only two caseworkers, they can get overwhelmed and it takes a long time to get appointments. Can more organizations beyond the HARA help share the load to speed up the housing process? Right now, we have to redetermine eligibility.

Interview 4:

1. [Organization name] office (1 staff) is the HARA. DV shelter but no other shelter. ESP hotel money from the state. We're newly starting to do in-reach at the shelter. About 50/50% in-person vs. over the phone.

2. Somewhat limited. We do a lot of it without really keeping track of it. Many people are doubled up but not literally homeless and we do diversion. We have prevention through ESG. We do SSVF that includes prevention. That seems to be the only funds.

3. I don't think we do a great job of advertising our presence. A lot of it is referrals from other providers ([two organization names]). Some people find from Google to email or call.

4. When we encounter people who are unsheltered, it's usually because they present in-person or because someone calls on their behalf. We engage face-to-face. If we can get them into hotel, we do. We work closely with our local CMH and drop-in centre who encounters people outside and we verify their homelessness.

5. I don't think there's a whole lot of differentiation at the DV shelter. The person is suggested to come into the HARA, but it doesn't seem like it's after a specific amount of time. We're just starting in-reach there to further increase access.

6. I don't think we have that. We're the only HMIS provider in our community, as the HARA ESG and the SSVF provider, so that wouldn't look any different from our current persons served list.

7. Just the one staff at the HARA. Training was done through OrgCode originally.

8. Put live into ServicePoint. Staff have a phone with a hotspot and tablet in the field.

9. Almost always done at soon as the person identifies as experiencing homelessness.

10. The HARA screening assessment is completed, and because we're the only housing provider our process feels a little weak. We can input the VI-SPDAT information into a separate spreadsheet to determine whether they're eligible for the resource.

11. RRH for veterans. ESG RRH also. Balance of State doesn't receive any RRH dollars through statewide application. We do have PSH with about 7 tenant-based units. Openings are communicated at the CoC meeting each month. Internally tracked through coordination with our finance department. Likely to be the same for RRH and PSH openings. We can prioritize more easily by VI-SPDAT score once we screen for PSH.

12. Stable openings for RRH. ESG is a little more limited, and we've struggled to spend those funds by finding people who meet the literal homelessness definition and are under the income limits. We communicate with providers over email or phone calls.

13. Housing First was difficult for people to wrap their heads around – "people without income can't be housed" – since the community is pretty conservative. It's been easier for us as the HARA since we've built that into our internal training. Community-wide it's harder for them to stomach. Landlords are still discriminating based on criminal histories or income sources/levels.

14. It's kind of wish-washy. If we do the VI-SPDAT and they're literally homeless, we work with them on the housing process since we struggle to spend the resources. We're not yet looking at scores or length of time homeless.

15. No.

16. Yes.

17. We can track that through our system performance measures. I don't think we have a report in HMIS that tracks this on an identified way. That would be helpful.

18. Then we fall back into the diversion processes to determine whether we've explored every family/friends option, whether their income has changed. Can we help you apply for other units?

19. I don't think so. Because we're so small, staff often know the person. We have a backup staff who's familiar with the screening process and can give referrals, and we also have staff in Jackson who can come by if our one staff is out for a longer period of time.

20. Not that I can think of off the top of my head. I'm pretty new to the [location] balance of state. Our community is pretty small, so our challenges are more around staffing levels but that's not something that another provider could quickly fix.

Interview 5:

1. If someone experiences homelessness, they are directed to call the HARA, who does the assessment, at which point they're put on a prioritization list. There's a monthly meeting. [Organization name] is the HARA. People can engage the HARA in person or over the phone. [Name] is the HARA staff. [Name] is the one RRH provider. We work quite closely together.

2. Prevention is done at the HARA and also [organization name]. Believed to be ESG. SSVF through VOA in Lansing but they don't often come to the meetings and aren't well-connected. Diversion is largely done at the HARA too, we ask diversion questions to determine whether they can/should go to the HARA. If they're not literally homeless, they can still get on the HCV list.

3. A lot of times they enter by calling 211, who refers people to [organization name] instead of the HARA. The HARA and [organization name] have both informed 211 that [organization name] is not the HARA.

4. DV shelter that's located in [location] and accessible for [location] residences. The HARA can put people in hotels for 3-7 days (no more). For lack of shelter, people who are put into hotel but their time is up often return to their cars or a tent in the woods. Many are afraid to go to the shelters in the city. If [organization name] knows of unsheltered people, they're encouraged to go to the HARA. PATH workers do street outreach who can be contacted day or night to engage people with the HARA. [Organization name] also does street outreach activities. [Organization name] only goes out if someone is contacted about a known location. We're a very small community

5. I don't know.

6. I don't know with the HARA, but if they're in my program, I keep in contact with them constantly via text or phone. Text messaging prevents them from needing to go through the front desk. I'm not supposed to take my cell phone home but I do.

7. [Name/organization name] and I can do them. The HARA is the primary contact. Unknown with whether PATH can/does them. PATH attendance and day-to-day process is a bit unclear.

8. All VI-SPDATs end up in HMIS. I do paper first and then get them into HMIS. I rarely have to do VI-SPDATs. Once on paper, inputted once they leave the office by the end of the day. I do them face-to-face, not over the phone. I get better results the better I know people.

9. I believe they're done at first contact.

10. For myself, the VI-SPDAT score comes with the referral. I open them and begin working with them. I do another 3 months in if circumstances appear to have changed or they appear to need PSH and can't have their needs met through RRH, and if it changes, I'll follow-up with the HARA and bring the information to our prioritization meetings.

11. I get my referrals, but it really depends on how stable the individual/family is, but I keep my list and watch my money very closely. I'm always running balances and I can still expend. Referrals come less than weekly, but [organization name] has the prioritization list and sends referrals at the monthly meeting, but I also get referrals from outside the community from the DV shelter or other faith-based providers in the community.

12. I do get matches when we don't have slots, not often, but occasionally. Otherwise, I get referrals as I have openings. I don't have to wait for the monthly meeting.

13. PSH is just starting this month. We get landlords who deny based on criminal history. We just have to work harder to find landlords who do. Some of the complexes have rigid rules, looking at evictions, credit, criminal history. While they might be nicer to live in, but they're harder to get into.

14. That's a HARA question. I'm just a good worker who does what I'm told.

15. That's just part of my day-to-day job. It would be nice to have that.

16. The CoC report does that and pulls what is true today (for just me) and I run it monthly to ensure no errors.

17. I do it on paper and set it into our main office. The HARA reports on how much money was expended, as well as how many people entered permanent housing at the monthly CoC meetings.

18. We have an appeal process but typically when people are referred, they're eligible. We haven't had a problem with that yet (to date). I do call, email, text message 3-4 times before moving on and documenting in case notes when people disappear.

19. I can recognize their names and cases when they come back. We follow-up 6 and twelve months. Phone numbers change frequently, and emails don't always get returned.

20. DHHS works well with us, but sometimes landlords want 1.5 months for a security deposit while we're limited to 1 month. On a regular basis, DHS denies SERs for housing or deposits.

Interview 6:

1. [Organization name] is the HARA for [location name] counties. Youth services for people under 18 exist, but otherwise, we have no shelters in [number] of the counties, and the other has a DV shelter and volunteer winter shelter. People with housing needs are generally referred to [organization name]. We get referrals from [organization names]. Contact is primarily face-to-face. They come in via walk-in intake appointments or we setup an intake. If they call, we setup an intake face-to-face. If people can't make it in, we'll meet them in a public place or at another agency where they're currently engaged. The majority of interactions are in-house.

2. ESG prevention, only in [location] we have a private foundation crisis rental assistance. We have SSVF prevention at two different providers referred through the by-name list.

Diversion conversations still occur, sometimes connected through up to 7 days through ESP, and are you sure you want to use ESP now? Diversion is woven into all our conversations because someone may be over income and not qualify, and we have to ask how to help you if you don't qualify for our program. We have a few more resources in [location], but generally we try to make referrals to agencies.

3. If you search online, our [organization name] website leads to emails from all over the county and beyond (multiple a day) seeking assistance. If it's out of the county, I refer them to their community's HARA. We have flyers in-house. We distribute flyers at our community meetings, post offices, laundry mats and libraries. A new round of flyers will include our 800 number instead of our specific county's phone number.

4. We don't have a dedicated street outreach staff. Our one-time tent city was disbanded which we used to intentionally engage. [Location] is expansive and we don't go out there. If law enforcement or CMH provides location and contact information, we'll go see them. Law enforcement and [organization names] can do an after-hours stay in a hotel so that [organization name] contacts them the next day. Otherwise, law enforcement might bring them here. We don't have a dedicated staff doing outreach since there isn't one organized place for people to stay. We volunteer at the winter shelter for in-reach regularly. [Location] has the winter shelter October through April.

5. I wouldn't say that occurs. Our domestic violence shelter is 90 days maximum and tries to work with them that whole time, knowing that they have that time limit. Our winter shelter, our staff goes in about once a month. If they're at shelter and pulled from a program, we engage them a lot more. But it's just one staff doing all those activities (case management, outreach, in-reach, etc.) The housing list gets updated every two weeks and is provided via email with updates.

6. We don't really have that.

7. In [location names], we have one staff in each county who administers VI-SPDAT and SPDAT. In [location name], we have [amount of] staff who conduct VI-SPDAT and SPDAT plus one person who is through [organization name] who serves families in all [number of] counties with both tools.

8. Paper first then HMIS. For the field, we have one that's laminated so we're not killing too many trees. The goal is to have things in HMIS within 5 days, and generally it's done the same day.

9. We do it at first point of contact because we might not get them back. The rest of paperwork/intake might have to occur at a later contact. SPDAT is complete within first two appointments in order to get them onto the prioritization list. If they're going to a hotel, it'll usually be done at the second contact.

10. We have a prioritization list in our agency, among other lists, based on programs (ESG – RRH, ESG – Prevention, RRH – MDHHS, Foundation – Prevention) and VI-SPDAT is put into our prioritization list. We very rarely have an opening in a housing program. We have a case management opening and we prioritize for those slots.

11. [Organization name] has PSH through [organization names], all [number of] counties have RRH through both ESG and MDHHS. Each set of funding is funding specific, so each county has its own prioritization matrix, so we can only place people in those locations. We rarely receive calls for landlords with a housing opening. We prioritize the top scoring people who we have slots for. We don't spend all the money right away. We're constantly prioritizing people as they come in, and it generally comes out where we expend all of our funds each year. We try to spread through the counties but that involves managing all three lists.

12. Email, phone or we meet with the person face-to-face. People in PSH who have been enrolled for years got a "moving up" voucher which created [number of] new openings.

13. Obviously taking people with the highest needs is more challenging than taking people with lower scores. We have constant education and re-education on why (and that) we're intentionally serving people with the highest needs because the person they referred didn't get the help they desired. We have to work with private landlords when people get screened out due to criminal history or other reasons, and if that experience goes poorly for them, they struggle to stay engaged.

14. VI-SPDAT and SPDAT score. We also include a narrative field.

15. That's the ongoing case manager's work.

16. We have our guru who pulls all our reports for our board who publishes that information quarterly.

17. Hand-generated, not from HMIS. Once they're referred, they're put on a person's case management list which is in HMIS.

18. We have two months of attempted contact before sending a 30-day contact. There isn't frequent going out to the place where they last were. If they stop meeting with us, we send them the letter that they have 30 days to contact us before we prioritize a new person. Some move away, some find their own housing.

19. We have a pretty low re-entry rate, but we can tell through HMIS. Hopefully they're pulled for HCV and we offer to assist them with their packet. We do a 3, 6 and 12-month follow-up to identify challenges.

20. We're supposed to be housing the highest acuity people, but they're precluded from MSHDA funded housing because of poor credit or criminal histories. Short of permanent supportive housing, we struggle to find HCV programs that can actually serve our highest acuity folks. Unless we can get them in with a private landlord, we try to work with them on getting disability benefits and increasing them.

Interview 7:

1. If we come in contact with a homeless person, we connect them with HARA for their intake; also use 211

2. Winter shelter gets people off the street; hotel vouchers through HARA; [organization name]; I assume that's what 211 is doing

3. Don't exactly know…I know we advertise 211; probably could be better at this and getting information out to people, and even other organizations if "they come across a homeless person"

4. Don't have street outreach; [neighbouring jurisdiction] does. I guess it would be luck or word of mouth.

5. Skipped

6. Just signed agreement to share information so I think we'll get better at that - shared release. [Organization names] aren't in HMIS but they serve people in need

7-19: Skipped

20: It's hard for me to understand the policies and procedures we're supposed to have in place or "how it works." With HMIS, we only look up clients that are here at [organization name], unless I'm driving down the road and see a homeless person. We get them hooked up with Housing Choice vouchers or VASH, and a Housing Locator on

staff finds units that work. Our HARA does matching but process for prioritization and matching isn't transparent or known to providers.

Interview 8:

1. Accessed in person and over the phone - staff answer phones during operating hours. If unable to come to us, we go to them. Get a lot of referrals from DV. [Organization name] has dollars and they do referrals. Centralized.

2. Diversion is offered through screening; prevention is offered through ESG (20K) until it's gone.

3. Organizations know where to refer to, 'we've developed a system'. Homeless Coalition hasn't been good at marketing.

4. Utilized the system - Sheriff's office has motel vouchers. Really good about it, they are 'really into this'. Next day client needs to go to [organization name] to extend stay and get screened.

5. DV shelter only; utilized motel vouchers for sheltering but ran out of funds; set up warming center within faith community from November through April - meals, sheltering, etc.; [organization name] took over last year; refer to HARA for screening or case management from HARA would go over to screen.

6. Once they are engaged they are engaged; small percentage that stay removed - we try to get and maintain contact - HMIS, case consult, and word of mouth - HMIS only if they tell us (not open). Some unsheltered for 20 years and "are just not interested in housing."

7. All of the trainings on best and promising practices

8. HARA

9. Part of initial phone call/contact

10. Work through paperwork, see where they will fit into program, start doing case management immediately, work on finding housing; have lists of landlords, subsidized units

11. Managed at HARA - VI-SPDAT prioritizes - already thinking about where they will fit into which program. PSH is only [number of] units…if they don't have opening, use RRH first until PSH opens. If RRH and PSH are full, they wait, or we try to get them into some kind of housing. [Organization name] does support services.

12. Skipped

13. Consultations all the time: "the girls" are always in communication all of the time. I think out community has a good housing first orientation but it's hard without the housing base. Have Housing Choice Voucher (almost filled) and people come all the

way over from [neighbouring location] to find people to get them going. Landlords won't take HCV, so they are hard to 'use' and the other ones don't pass HQS.

14. VI-SPDAT only; first come first served is tie-breaker

15. Yes - Navigators help people navigate all of the resources and different systems

16. Not in HMIS but we do have a handwritten log (case management/screeners)

17. Yes, that is in the HMIS reports

18. If they are not eligible, "the girls" talk to them and work with them to find alternatives. This doesn't happen that often. Usually go over income guidelines.

19. Tracked through HMIS.

20. Always had a system but CES forced us to write it down; really think that what is written is what we are doing - increasing the ability to identify and serve - all of the organizations, churches, and other systems.

Interview 9:

1. HARA is [amount of] miles away so screening is done over the phone; people locally are calling a completely different community; don't get someone have to leave a message, often don't have a phone number so people aren't served, getting missed, etc.

2. Don't know - have no idea how they can be aware of what is going on locally

3. Not marketed well. No fliers, no press release, usually dumb luck.

4. No shelter, at campgrounds. In winter - hang out in library and then into Walmart. No outreach.

5. No shelter at all - might leave community to seek shelter elsewhere; double up a lot

6-9. I don't know

10. Haven't been communicated with to know that - communicating with client only. Limited services available. Lots of people willing to help but no one knows what is going on. Did PIT but no one knows what's going on.

11-19. I don't know

20. Limited communication, HARA is so far away, clients get communication but people working with them keep saying they haven't heard anything, no one knows prioritization, referral, or matching. Major issues with distance and location. No local resources. 'you call a number and hope for help.' A local presence even once a week would help. Regional issues: are we supposed to apply for it or is the HARA applying on our behalf? Roles and process are unclear. We have no idea what we are supposed

to be doing. (HARA is in [location] and we are representing [three county locations] would feel the same). Two monthly calls/committees but not helpful or clear what is the point; region-specific call isn't even happening.

Interview 10:

1. In person or over the phone - office hours or call and make appointments

2. Screening does Diversion and Prevention - coming up with a resource guide so no matter where they come in they get the same information (i.e. shelter – [amount of] shelters serving different populations); HARA goes to shelters for assessments 1x week

3. Word of mouth, 211, everybody knows who we are

4. No outreach, just got a grant. HARA specialists do go out if there is someone sleeping outside/car/etc. if they become aware of it.

5. I don't know

6. Not sure; probably just one list

7. Catch up on training - inherited HARA; HMIS training, VI-SPDAT, some best practices

8. One location with mobile options; directly into HMIS

9. Try to do a VI-SPDAT on almost everybody but we do ask if they do qualify for services

10. Get all paperwork together, submitted, case consultation does discuss who qualifies for what, or prioritize them by VI-SPDAT

11. We don't announce vacancies, only have a couple of programs, based on eligibility, haven't had a big problem with a huge waiting list yet, finances determine when there is 'vacancy'.

12. Skipped

13. Centralized - low barrier - no prerequisites

14. We are using the VI-SPDAT alone now but looking to make changes to improve - mostly for ESG, other programs have openings so "no need to prioritize/rank yet" (?!) and "no need for tie-breakers yet" (?!).

15-19: I don't know

20. People can stay in shelter up to 90 days and are full "but no waitlist for housing." We don't have a waitlist for housing, but we do have a waitlist for program - have vouchers but challenge is finding landlords/housing. Engage with landlord association but this is the biggest challenge.

Interview 11:

1. Three HARA locations - physical building in those three locations. Does intake for homeless, but many agencies refer to us. Most everyone knows we are HARA.

2. Growing into it – we really need help with methods/procedure for diversion - people come to us in crisis and we try but it's so hard.

3. 211 and people are beginning to know that, [organization name] is starting point for many people, law enforcement; local planning body has planned a lot which has helped - many parties involved across system.

4. No shelter; no outreach - active DV shelter; people are hidden or doubled up mostly

5. Not applicable

6. Don't have this

7. Do both VI-SPDAT and full SPDAT. Three have done trainings, but no best practices or training standardized. VI-SPDAT is done immediately at intake/first point of contact; after 6 months do full SPDAT

8. HARA only

9. No VI-SPDAT over phone, only meet in person. Every single person does intake HMIS (paper first), and [organization name] database, screening for all services not just homeless

10. Don't have to worry about prioritization because everyone that has come to us has been able to be served either through mainstream resources or public housing (?!)…this may change

11. Not applicable

12. Not applicable

13. Not applicable; we need help with prioritization

14. Using VI-SPDAT and length of time in shelter as tie-breaker; shelter length of stay (ESG) allows for one week in motel and create housing plan, and then can ask for another week in shelter - housed within those two weeks. Sometimes takes longer and sometimes other agencies (DHHS) can assist, private [organization names] can help. Getting harder and harder because housing that is available is "awful."

15. Through agency and planning body staff, nothing formal - housing resource guide

16. No - need a lot of HMIS support - put everything in but don't use reports

17. No

18. Doesn't happen

19. Yes

20. Nothing to add

Interview 12:

1. HARA is phone only, no mobility or in person, part of 10 counties - used to be a local face but lost that

2. Don't have shelter, doubled up/couch surfing; don't get past initial hurdle because it looks like they are already diverted until it becomes chronic and mental health folks are burning bridges, etc.

3. During winter there is [organization name] - area churches for bedding down overnight. During summer [organization name] provides tents (but [organization name] chases them down), and other encampments

4. No shelter other than DV and winter shelter

5. Not applicable

6. Don't know

7. Done over the phone at call center…not sure - might add Housing Navigator and/or Street Outreach which could help…major barriers because of regional considerations and eligibility/access

8. HARA phone

9. All calls

10. Put on by-name list, have monthly meeting, case conferencing

11. Not a strong engagement or follow up so people sometimes fall off the list. Not a lot of resources, some vouchers.

12. Not applicable

13. Not applicable

14. Not positive - heavily relies on VI-SPDAT score

15. Not yet - this would help a lot

16. We don't have a lot to do with HMIS but I'm sure there is a lot in there: looking at areas that have shelter vs. those that don't - allocate resources appropriately for each community

17-20. Skipped

Interview 13:

1. Youth call HARA and then are directed to [organization name] or youth can call directly - multiple access points

2. Yes; some. Have Transitional Living Program where we use Host Homes - connect them there and then do Case Management. Doing TAY-VI-SPDAT now. Family reunification.

3. Big word of mouth component but not much marketing beyond that. Prevention workers are in schools, so they do rotations to identify and prevent homeless youth (RHY).

4. Nothing - there is someone on-call 24-7 for youth

5. Runaway youth use licensed foster homes and 18+ use host homes in any of [number of] counties

6. Not applicable

7. No formalized training

8. Over phone, have mobility, or can do TAY-VI-SPDAT at [organization name]. Want to get a better feel for what's going on before doing the TAY-VI-SPDAT completed; working on consistencies at access points - can serve up to 21 but don't always get referred 18+ youth

9. HARA will do it right away and [organization name] might wait

10. Put in "stupid" HMIS and "then help the kid engage in finding a host home;" if in immediate need of shelter, we'll connect them to emergency shelter, diversion is attempted, document readiness, etc. youth over 18 who are not willing to do Host Homes. Youth HAVE to go through HARA to get on by-name list

11. Interagency service teams do matching - meet weekly/bi-weekly - to review list based on openings and vulnerability; feel okay about it; could improve; youth can be missed. The TAY is supposed to level the playing field youth are still harder to get housed because scores aren't high enough and no one wants to rent to youth.

12. Skipped

13. I think we're doing pretty well with this

14. Generally the VI-SPDAT score is used but client advocacy is still a very significant factor

15. [Half] of our counties have them - helps with landlords

16. Started using HMIS because of HUD funding but now state is making us too. RHY programs also require. Do a lot of data entry, Michigan DHS questions too, a lot of time is on clean up - inconsistent data entry. Not sure outcomes are reflective of what's happening (HUD definitions are limited to what defines 'success'). Hard to clean up and interpret data.

17-19. Skipped

20. "In theory, Coordinated Entry is a good idea, but need to make sure there is a strong youth voice - until there is we are discouraging people from calling the HARA."

Challenge with BoS is that everyone is in a different place, setting guidelines and then comparing that with what works for each community, specifically. Allocation of funding isn't always in the best interest of the client/community.

Interview 14:

1. HARA covers [amount of] counties in rural [location of] MI. The only way they will receive services is by phone. We are first come first served shelter vs. come right to shelter - don't just show up at 5…want to force people to register with HARA. If they come after hours, they call HARA to leave a message, but admit them. "HARA is very good."

2. Diversion happens within any intake either at shelter or via HARA - several times during intake where Diversion is attempted at both shelter and HARA.

3. Brochures throughout community, law enforcement, hospital and ER staff, all social service agencies, jail - central intake HARA number; getting connected with 211

4. Rural community isn't comfortable with unsheltered persons - law enforcement and other social service agencies know to refer to [organization name].

5. Average length of stay is 28 days but struggle to serve very high acuity persons – interviewee mentioned 'readiness' and that people 'don't do anything to help themselves' - employ lots of peers who motivate others with their stories

6. Not sure

7. VI-SPDAT's happen at HARA

8. HARA

9. Does it immediately at first point of contact - hardest part for us is Spring after people are getting kicked out of summer cottage rentals

10. Case management review with clients every 8-10 days…do other programming, strengths and weaknesses programming, etc. to help them map out a plan and do journaling…They are also on a by-name list.

11. Limited vouchers but landlords have very high barriers; vouchers are handled through the HARA

12. Not applicable

13. Not applicable

14. Local planning board and agencies use VI-SPDAT for prioritization

15. Yes - Housing Navigators find places they can get it, let us know what the barriers are

16. Use HMIS for data entry, length of stay, sit down quarterly to review data, follow/engage people for up to two years

17. Skipped

18. Skipped

19. Usually client would contact us unless they are in the continuance program then we would know as their name would come up in our meetings to know in advance…if they come back into shelter and start at square one.

20. See a lot of really cool things happening out there and bring them back. A lot of large communities have resources that rural [location] Michigan will never see…don't have the critical mass to do what larger cities are doing. Really want to become more efficient and shorten the length of time people are with us.

Interview 15:

1. The HARA - have a physical location as well as go to the three shelters weekly. All other organizations refer to HARA. Increasing mobility but most of it happens on site.

2. Diversion is attempted as part of initial pre-screen, if unsuccessful they are referred to shelter (people will just go directly to shelter as well)

3. 211, word of mouth, Health and Human Services team, social media

4. Depends, no street outreach, policy has been that they need to call us because we have found that people 'want to live in their car', especially if they have kids because then we are mandated to report. Shelters are never really full.

5. Not applicable
6. We have a team that meets - talk about households experiencing homelessness but aren't totally - system isn't open enough to see that (only organization using HMIS currently) have mechanisms to track things but not in HMIS

7. Training on VI-SPDAT by OrgCode, no other formal training but are Social Workers, Intake Coordinator

8. Just started doing live entry into HMIS

9. Skipped

10. 14 days in shelter, if they qualify for programming do VISPDAT, if not refer to mainstream resources

11. Meet with Housing Resource Specialist.

12. Very little PSH (only [amount of] units, DV has a few). Word of mouth, small community.

13. 75% believe in it and 25% don't at all. One is a church and another program - doing some housing with tons of conditions, another one maybe going to do family shelter. Housing program doesn't take referrals through CES.

14. Not good at prioritization. Subjective, squeaky wheel gets the grease. Don't prioritize based on acuity.

15. Yes - Housing Resource Specialists help with housing plans, locating units, addressing barriers, document readiness.

16. No - more word of mouth, is updated but it's not live.

17. Not applicable

18. Depends. Would refer to other programs. Exited. Do follow ups regularly to make sure they are still stably housed.

19. If they return to shelter, we get a shelter bed report. If they are housed and get an eviction notice, typically landlords will call HARA first to support prevention/mediation.

20. Biggest thing is if we could get people to use HMIS.

Interview 16:

1. Most come to our office and then they call the HARA while they are here. HARA is in [location name] about [amount] miles away. If after-hours, they will try calling sheriff's department or calls from churches or the City.

2. Yes. HARA does Diversion during screening. We will put them up in a hotel. No shelters.

3. Most people know they can come to [organization name] - main player in Social Work field. For [two organization names] and churches…word of mouth.

4. If we know about them we try to get them into the office to call the HARA. Hidden homeless - stay unnoticed in the woods. No outreach.

5. Not applicable

6. Not applicable

7. All through the HARA

8. Not applicable

9. Not applicable

10. If they qualify for services, HARA will fax documents to fill out. Leave it in the hands of the HARA and the client to directly talk to each other. Can do one night at a time in hotel to ensure engagement and HARA also provides motel vouchers. HARA allows sheltering in home community for a week.

11. Housing commission, landlord list, we provide front end assistance, encourage people to seek out resources. If they qualify through DHS they take care of it. Don't know if anyone is getting housed through CES, but HARA case management comes on site to use space and meet with staff. For the most part we know who the HARA is working with.

12. Not applicable

13. Not applicable

14. Prioritized based on VI-SPDAT, work with highest acuity first, lower scores tend to languish, but we have a group that meet to target those people and help - former debt to landlords, etc.

15. No

16. No data; no HMIS

17-19. Skipped

20. Communication between HARA and community was terrible but now it's much better - we still don't know everything that goes on. Low paying jobs - not enough to pay rent. Single women with children are biggest demographic and more seniors.

Interview 17:

1. [Organization name] in-person or phone for both counties; 24-hour hotline would be a point of entry to make initial contact and refer to HARA

2. No shelter - HARA does prevention and diversion, HARA comes out and does initial intake and do housing plan

3. Working on this now; have brochure now, had a workshop to introduce CES, word of mouth, social media, law enforcement has vouchers

4. Law enforcement, some street outreach

5. Not applicable

6. Not applicable

7. Some local providers do VI-SPDAT but also refer to HARA…

8. Don't know

9. Don't know

10. Have no idea what happens when they call the HARA, we do sign a release but not always sure what happens, some organizations don't have very good communication

11. We definitely know when someone is housed, and we provide follow through but don't know how that process happens or decisions are made.

12. Not applicable

13. Not applicable

14. HARA determines what program would be the best fit, use VI-SPDAT, clients don't always understand process - fine how it is but transparency could be improved

15. No

16-19. Skipped

20. Marketing and outreach for rural communities, has a couple of tent cities throughout the county but outreach can't 'find' them. Faith based community plays a big role both providing services and financial assistance. Lots of politics - rebuilding trust. [Organization name] hasn't been known to do a lot of work.

Interview 18:

1. [Two organization names], 211 or 800 number - first thing they do when they come to shelter - not in HMIS

2. Have some dollars available to help with rent

3. Have a 211 system for anyone in need that people know about, very connected to faith community - small towns people go to churches, word of mouth, fliers, community connect event

4. We know a lot of people are camping in the summer, churches may provide short term lodging, totally community funded organization, work with DNR and law enforcement, word of mouth

5. Can sleep [number of] beds, can stay 90 days longer if they are making serious progress. Progress/success/length of stay is based on client's ability to do the work and 'willingness' to 'embrace changes'

6. Not applicable

7. [Organization name] does VI-SPDAT and full so we just refer to them and they send case managers to shelter to do them

8. Skipped

9. Refer people to HARA at the first point of contact

10. Case management from HARA and also shelter - ROI and close partnership, also broker additional services

11. Collaboration with HARA - hard to get city approval for new affordable units, have no PSH (and we need it!) but have vouchers, yes, we have RRH

12. Skipped

13. Not applicable

14. VI-SPDAT score, CH, 'number of incidents' - attempt to house CH without leaving other people behind

15. Internal, landlord lunches and support - all falls under the umbrella of the CoC, ESG is going to up Prevention to support placements already made

16. Recidivism: we know

17-19. Skipped

20. No HMIS entry or participation at all. Great relationship with our HARA - but very high turnover in Case Management (terrible pay). From our standpoint we are in good shape but HARAs need to pay people better and professionalize these positions

Interview 19:

1. Combination of site based and mobile - initial screenings are done over the phone. If eligible/homeless, they are routed to Housing Resource Specialists

2. I wish we did Diversion better. Was doing the 9 Steps but has fallen away from that - hard for consistency. Some providers might be doing Diversion but HARA is not really. We were asking questions without purpose but want to get back to it.

3. Word of mouth. By and large there is a single access point, side doors closing. Don't know if all the counties have the same perspective on prioritization so that makes it challenging. People may still be 'doing their own thing' but people get housed through HARA.

4. No outreach

5. Not applicable

6. I think that information might be in the system. Only HARA enters information into HMIS. Too much reliance on referral to HARA for communication about service delivery and where people experiencing homelessness are. Increase utilization of HMIS

7. VI-SPDAT online, other trainings that arise

8. Just the HARA and HARA sub-contracts, shelters in [location name] (funded through DHHS - enter into HMIS)

9. Inconsistent

10. Depends. Skype call every week to look at priority list, what housing specialists' caseloads look like.

11. Gets communicated by email

12. Skipped

13. Skipped

14. First thing is CH, then VI-SPDAT, then first come first served

15. Not really

16. No

17. No

18. Don't have a process - draw from priority list, match them, if they can't be found through channels we have we will reach out to providers they have crossed paths with, and then just close it.

19. I know there are recidivism reports you can run but we don't really or use that data in a useful way. If we see someone come through that we know we've helped before just word of mouth or in meetings.

20. Skipped

Interview 20:

1. Three HARAs represented - physical locations and phone number along with after-hours support

2. For [location name], Diversion is large because there is no shelter so more intentional, if we have to shelter we have to bus people to [neighbouring location],

done after or during VI-SPDAT…identify someone in their network. Prevention funds as well…if they are forward thinking (going to be at risk) then we can provide Prevention and landlord mediation and court support.

3. Manistee we are everywhere - outreach is really good. Partner agencies have fliers, biz cards, community postings, liquor and tobacco stores, community clerks, law enforcement, hospitals, road sergeant…

4. Outreach. Our community would refer them to the phone number or site for screening - no mobile screeners…may be some mobile screening but depends on agency. Safe harbor winter shelters they would get referred too.

5. Not applicable

6. If they have gone to HARA and have a VI-SPDAT, yes - otherwise no, would be in Google doc. and in HMIS file - offer and accept. Don't do Diversion tracking well.

7. Baseline is OrgCode, recert annually. Other best and promising practices ad hoc.

8. Skipped

9. Sheltered in place - done within 24 hours; Outreach - not necessarily done at first contact - eligibility and referral; HARA phone - if you aren't diverted, VI-SPDAT immediately. Using VI-SPDAT score for eligibility to program but will stay on Google doc and will stay on radar.

10. Depending on where you were enrolled at, a Case Manager would be identified - transferred to case manager and client for ongoing communication; coordinated case management as some agencies have different services to offer based on acuity. Case managers work on document readiness and housing/units based on what they qualified. If they are screened and aren't eligible they would be told and referred to mainstream resources.

11. Based on qualifying room size and eligibility and acuity…if client finds housing they can jump the line but if Housing Locator finds it then it goes to next prioritized person - average of 7 on caseload. System seems to absorb 100% responsibility for ALL households who get screened but EVERYONE is screened…screening everybody but not everybody gets the referral - ending homelessness vs. ending poverty

12. Skipped

13. 90% housing first; exception is Safe Harbor shelter that pops up in winter - wouldn't fit Housing First due to stipulations (sobriety, sex offender status, etc.)

14. CH, VI-SPDAT, DV, Youth, single mom that's pregnant…what gets you on the board is the VI-SPDAT and the 'discussion' makes the decision - still based on advocacy/subjectivity in some ways.

15. Yes

16. Use Google doc in every two-week meeting and HMIS report to validate/verify - homelessness or VI-SPDAT report

17. Yes - program enrollment, leased up, etc.

18. If they had been in HMIS we would continue to seek them for 90 days until we close them; otherwise Google doc - 'parked' after 60 days. - HMIS isn't statewide but has CoC-specific boundaries for visibility. MICAH working on generating 'new group' which would allow transparencies over those new boundaries.

19. Can't see across regions - so yes if they return to our system but no if they don't unless I put in a help ticket.

20. Skipped

Interview 21:

1. [Organization name] is the HARA for the county. Access can be done in person or over phone. During the week but can do on-call 24-7 by hotel without contacting HARA first - crisis intervention - and then [organization name] follows up with them.

2. [Organization name] is go to for housing resources - they do some Prevention and Diversion is part of screening - no shelter but access to hotels in emergency.

3. Word of mouth - everyone knows [organization name]. Also 211.

4. Informal outreach

5. No shelter but use hotels or shelters in other communities

6. Not applicable

7. Multiple doors - not just VI-SPDAT at HARA

8. Don't know

9. More quickly at HARA vs. mental health - pick clients as well as getting names off prioritization list

10. Not housing first; mental health units have to be eligible for case management billing

11. When we have a vacancy we let [organization name] know but also house people we have been working with

12. Skipped

13. Case Management is required

14. CH first and then VI-SPDAT

15. Don't know - specific programs/staff might do this

16. No HMIS - contract with [organization name]

17-20. Skipped