ST. JOHN'S

HOMELESS-SERVING SYSTEM COORDINATION FRAMEWORK

END HOMELESSNESS ST. JOHN'S

ACKNOWLEDGEMENTS

Prepared by **Dr. Alina Turner** (Turner Research & Strategy) and
Andrew Harvey (Local Coordinator),
for End Homelessness St. John's, June 6, 2016

Developed in partnership with the **Canadian Observatory on Homelessness**
www.homelesshub.ca

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LIST OF ACRONYMS

ABBREVIATION	DESCRIPTION
ACT	Assertive Community Treatment
CA	Coordinated Access
CA Worker	Coordinated Access Worker
CAB	Community Advisory Board
CE	Community Entity
COH	Canadian Observatory on Homelessness
CYFS	Child, Youth and Family Services
EHSJ	End Homelessness St. John's
HIFIS	Homeless Individuals and Families Information System
HMIS	Homeless Management Information System
HPRR Program Model	Homeless Prevention and Rapid Rehousing Program Model
HPS	Homelessness Partnering Strategy
HFSCI	Housing First System Coordination Initiative
HFSCI Advisory Team	Housing First System Coordination Initiative Advisory Team
ICM	Intensive Case Management
MOU	Memorandum of Understanding
NLHHN	Newfoundland and Labrador Housing and Homelessness Network
NL Housing	Newfoundland and Labrador Housing
NLSA	Newfoundland and Labrador Housing Statistics Agency
PIT	Point-in-Time: Homeless Point-in-Time Count

EXECUTIVE SUMMARY

CONTEXT

The Plan to End Homelessness in St. John's (2014-2019), led by End Homelessness St. John's (EHSJ), prioritizes the development of a systems approach grounded in Housing First where diverse services are organized and delivered in a coordinated manner to advance common community priorities. The purposeful, design and management of St. John's homeless-serving system is critical to meeting the community's objective of ending homelessness.

To this end, diverse community engagement processes were undertaken by EHSJ with the technical assistance of Turner Research & Strategy and the Canadian Observatory on Homelessness to develop a System Coordination Framework. These included community forums, stakeholder interviews and focus groups from November 2015 to May 2016.

The resulting System Coordination Framework provides the community with direction on several key elements:

- Common homeless-serving system processes, including Coordinated Access and acuity assessment, program matching, eligibility and prioritization criteria.
- System mapping to discern the homeless-serving system's structure and program components.
- Performance management and quality assurance standards in alignment with data collection, management and reporting through shared information systems.
- Capacity building needs and resources to deliver training and transition support to diverse services for successful Plan implementation.

HOUSING FIRST IN SYSTEM COORDINATION

The guiding philosophy grounding the St. John's System Coordination Framework is that of Housing First, which calls for the recognition of housing as a basic human right. As a recovery-oriented approach, Housing First is focused on quickly moving people from homelessness into housing and then providing supports necessary to maintain it. Rather than requiring homeless people to first resolve the challenges that contributed to their housing instability, including addictions or mental health issues, Housing First approaches propose that recovery should begin from stable housing.

The guiding philosophy grounding the St. John's System Coordination Framework is that of Housing First, which calls for the recognition of housing as a basic human right.

Our approach is to build the Housing First philosophy into our system coordination work across program types. This means that every program type has a role to play in ending homelessness, whether an emergency shelter, transitional housing provider or Intensive Case Management program.

A Housing First System Coordination Initiative (HFSCI) investment plan for the period April 2016-March 2019 to implement the activities outlined in the framework.

The System Planning Framework was approved by the EHSJ Board on May 31, 2016. To date, key efforts have been made to engage the community, particularly those with lived experience of homelessness, in the final deliverables (discussed in later sections).

END HOMELESSNESS ST. JOHN'S ACTIONS SUMMARIZED

This section outlined the main actions and recommendations outlined in the System Coordination Framework at a glance.

1) COORDINATED ACCESS CONCEPTS

a) Implement a **hybrid Coordinated Access (CA)** model with multiple locations throughout the community using the same assessment form, targeting tools, and referral processes with EHSJ playing a key coordinating role supported by the role of the System Planner.

b) Adopt the **Vulnerability Assessment Tool (VAT)** as the coordinated assessment tool for St. John's CA process. Future adaptations to families and youth of the VAT should be implemented as the Canadian Observatory rolls these out.

c) The level of authority for the CA is that of **screening and assessment**, rather than mandatory admissions where CA decisions are binding to the receiving program. Referrals may be made to the appropriate program/agency, but that agency will still have the final decision on admission.

d) Ensure key agencies who are part of the homeless-serving system become **CA Agencies**. These agencies would receive training on coordinated assessment and referral processes and agree to share information using standardized data collection through HIFIS where possible; these roles would be articulated in MOUs.

e) Rollout the CA initiative in a **phased manner**, starting with 3-4 agencies in the next 12 months and expanding pending buy-in and capacity.

f) Explore the addition of a designated phone line accessible 24 hours a day, 7 days per week should facilitate information and referrals using a standard Referral Guide. The expansion of 311 to this end should be investigated with the City of St. John's. This service can be expanded to screen clients for program eligibility to facilitate program matching pending resources and capacity.

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

2) COORDINATED ACCESS OPERATIONS

a) EHSJ will continue to refine the **Systems Map** to document and classify programs in the homeless-serving system, and will require ongoing refinement.

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

c) The System Map will evolve to include real-time vacancies across program types. Ideally, agencies report in to the EHSJ at minimum on a weekly basis any changes in their capacity and occupancy rates (please note that emergency shelter occupancy can be updated daily given that all community-based shelter providers have signed HIFIS data-sharing agreements with the NLSA). Using this information, EHSJ and partners will maintain a **System Capacity Report** to have an up-to-date account of occupancy levels and waitlists updated weekly to support the CA process and appropriate referrals.

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

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

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

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

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

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

3) SYSTEM COORDINATION INFRASTRUCTURE & GOVERNANCE

a) EHSJ will add a **System Planner** position to lead the implementation of the System Planning Framework. The System Planner would provide supports the overall CA process by developing protocols and processes and ensuring effective and efficient operations of the model. The System Planner will represent the CA at a community level and will form relationships with community partners.

b) A **Complex Needs Working Group** will work to address the needs of complex clients with high acuity score (VAT score of 35+) and coordinate care among provides and public systems.

c) As part of its strategic planning process, **NAVNET** is encouraged to consider revisioning itself to play an integral role in the proposed CA process as its Complex Cases Working Group.

d) To enhance integration among homeless-serving agencies and public systems, a **Systems Coordination Table** is will be convened comprising of high-level decision makers that can play key roles in facilitating access to system resources for participants, and support the removal of system barriers for vulnerable populations. MOUs can be developed/adapted to ensure consistent agreements regarding public system participation and accountabilities are in place.

e) EHSJ will work with community and systems partners to review currently active coordination tables with similar mandates as the proposed Systems Table (i.e. advisory/steering committees for Front Step, NAVNET, HFSCI, Frontline Agencies, etc.) to **ensure no duplication** of functions occur with the CA process. The NAVNET Steering Committee in particular has a similar mandate to the proposed Systems Coordination Table.

f) EHSJ and partners will develop and support a formalized **Lived Experience Council**. The Council will provide meaningful input into the measures outlined in the System Coordination Framework.

3) DATA AND PERFORMANCE MANAGEMENT

a) EHSJ will ensure training and technical support is available to build community capacity on an ongoing basis for all aspects of the System Coordination Framework in its training curriculum.

b) NLSA, as the HMIS lead, will support the data management needs of the CA process. NLSA can provide information about HMIS capacity and limitations, assist in the analysis of which data system will best support CA implementation, and provide information about HMIS requirements and regulations.

c) Working with the HMIS Steering Committee, EHSJ will ensure the proposed provincial HMIS is aligned with the direction of the System Coordination Framework. This may include the addition of an HMIS Coordinator staff to provide on-the-ground training, technical assistance, and data management support for St. John's agencies.

d) EHSJ and the City of St. John's will add a Performance Management Planner to support the performance management and service standards implementation in community. This position will also support the HMIS development and operations to ensure its use in performance management at system and program levels.

e) A set of performance measures are proposed as a starting point for discussion moving forward. It recommended that ongoing review of these measures be taken on and that HIFIS data elements are aligned to ensure data collected aligns with the needs of the Framework's directions on performance measurement. Over the next 12 months, EHSJ will work with NLSA and the Systems Coordination Table and HMIS Steering Committee to refine these measures.

f) EHSJ and the City of St. John's will review existing standards of practice in partnership with community agencies and systems to adapt these to the local context. A number of standards were provided as outlined in the HPRR Program Model – Service Standards; these will be reviewed and refined over the course of the next 12 months and supported through capacity building and monitoring long-term.

IMPLEMENTATION BUDGET

EHSJ has prepared an investment budget for the Housing First System Coordination Initiative to advance the System Coordination Framework. The table below summarizes the activities proposed and their total investment; this is broken down by source and year. Further detail in the Housing First System Coordination Investment Plan approved by the EHSJ Board.

ITEM	DESCRIPTION	YEAR 3 2016-17	YEAR 4 2017-18	YEAR 5 2018-19	TOTAL
1	Community Development Worker	$107,211.31	$112,571.88	$115,386.17	$335,169.36
2	Systems Planner	$56,250.00	$76,875.00	$78,796.88	$211,921.88
3	Performance Management Planner Contract	$28,125.00	$75,000.00	$76,875.00	$180,000.00
4	System Coordination Framework Implementation Support	$14,000.00	$50,000.00	$50,000.00	$114,000.00
5	Community Entity Legal, audit, accounting costs, and clerical support	$10,000.00	$10,000.00	$10,000.00	$30,000.00
6	Homelessness Management Information System Support	$30,000.00	$50,000.00	$50,000.00	$130,000.00
7	Research Agenda	$5,000.00	$15,000.00	$15,000.00	$35,000.00
8	Communications & Fund Development	$10,000.00	$25,000.00	$30,000.00	$65,000.00
9	Training & Capacity Building	$37,500.00	$50,000.00	$50,000.00	$137,500.00
10	Community Action Fund	$10,000.00	$10,000.00	$10,000.00	$30,000.00
11	End Homelessness St. John's Meetings	$11,250.00	$15,000.00	$15,000.00	$41,250.00
12	Lived Experience Council Support	$7,500.00	$10,000.00	$10,000.00	$27,500.00
13	Homeless Point-in-Time Count	$67,500.00	–	$67,500.00	$135,000.00
14	Community Plan Strategic Review & Development	–	$50,000.00	$65,000.00	$115,000.00
15	Quality assurance & performance management technical assistance	–	–	$25,000.00	$25,000.00
	Total (All Sources)	**$394,336.31**	**$549,446.88**	**$668,558.05**	**$1,612,341.23**

As shown below, about 63% of total funds have been confirmed at this time from various funding sources.

ITEM	FUNDING SOURCE	YEAR 3 2016-17	YEAR 4 2017-18	YEAR 5 2018-19	TOTAL	STATUS
1	City of St. John's	$60,000.00	$100,000.00	$100,000.00	$260,000.00	Confirmed
2	HPS Community Plan Allocation	$174,356.25	$288,027.50	$288,027.50	$750,411.25	Confirmed
3	HPS Enhancement	$20,000.00	$20,000.00	–	$40,000.00	TBC
4	HPS Homeless Point-in-Time Count Support	$20,000.00	–	$20,000.00	$40,000.00	TBC
5	United Way PIT Count Support	$10,000.00	–	$10,000.00	$20,000.00	Year 3 Confirmed; Year 5 TBC
6	Requested Contribution from NL Government	$109,980.06	$141,419.38	$250,530.55	$501,929.98	TBC
	Total	**$394,336.31**	**$549,446.88**	**$668,558.05**	**$1,612,341.23**	**63% Confirmed**
	Funds Confirmed	*$244,356.25*	*$388,027.50*	*$388,027.50*	**$1,020,411.25**	
	Funds TBC	*$149,980.06*	*$161,419.38*	*$280,530.55*	**$591,929.98**	
	% Funds Confirmed	*62%*	*71%*	*58%*	**63%**	

PLAN TO END HOMELESSNESS IN ST. JOHN'S (2014-2019)

St. John's has a long-standing commitment to collaborative, locally-driven solutions to homelessness. The multi-stakeholder St. John's Community Advisory Committee on Homelessness was established in 2000 to develop and implement previous Homelessness Partnering Strategy (HPS) plans to address homelessness.

The St. John's CACH laid a solid foundation for our future success, investing $18.3 million in HPS funds (levering significant funding from other partners) to address community priorities through a range of initiatives, including the creation of 65 emergency shelter beds, 37 transitional housing beds (22 units), and 237 supportive housing beds (163 units). Other supported projects have included renovations and accessibility improvements to shelters, transitional and supportive housing, non-residential service facilities and new social enterprises, plus a range of initiatives to engage partners, raise awareness, mobilize knowledge, and build capacity. None of this would have been possible without strong partnerships across all sectors.

In 2014, the Community Advisory Committee was renamed and restructured as End Homelessness St. John's (EHSJ) with a new Board of Directors, and committed to developing and leading the implementation of *Ending Homelessness in St. John's: Our 5-Year Plan (2014–2019)* (the Plan). The Plan includes the Homelessness Partnering Strategy (HPS) Community Plan to guide federal investments locally based on Housing First principles.[1]

[1] The full Plan is available online: http://www.nlhhn.org/PDF/YYT-Community-Plan-2014-2019.pdf

The Government of Canada's Homelessness Partnering Strategy (HPS) supports communities to develop local solutions to homelessness. HPS funds local priorities identified by communities through a comprehensive community planning process involving officials from all levels of government, community stakeholders, and the private and voluntary sectors. St. John's is the only HPS-designated community in Newfoundland & Labrador (one of 61 participating communities across Canada). HPS was allocated stable funding over five years (2014-2019) with the goal of supporting communities in developing longer-term solutions to homelessness, in particular moving to a Housing First approach. In the 2016 Federal Budget, HPS received an additional $111 million over two years to be invested in communities.

The City of St. John's acts as the HPS Community Entity (CE) that administers federal homelessness funds for End Homelessness St. John's (through the Non-Profit Housing Division of its Community Services Department) and provides the community development and brokering necessary to move the community forward as a collective.

The Plan outlines the following four priority areas for St. John's:

1) SYSTEM COORDINATION

A coordinated approach to housing and supports following the Housing First philosophy.

- Organize the homeless-serving system.
- Implement Coordinated Access and assessment.
- Develop discharge/transition planning measures.

2) INTEGRATED INFORMATION SYSTEM & RESEARCH

Integrated information system and research to support ending homelessness efforts.

- Implement an integrated information system.
- Build partnerships with the research community.

3) HOUSING & SUPPORTS

Developing a range of housing and supports choices to meet diverse participant needs.

- Support measures to increase housing affordability and reduce homelessness risk.
- Introduce and ramp up a range of Housing First programs.
- Tailor supports to meet the needs of diverse groups.
- Support the enhancement of service quality and impact.

4) LEADERSHIP & RESOURCES

Securing the necessary leadership and resources to support the Plan to End Homelessness.

- Develop the infrastructure necessary to implement the Plan.
- Coordinate funding to maximize impact.
- Champion an end to homelessness.

HOUSING FIRST SYSTEM COORDINATION INITIATIVE (HFSCI)

The St. John's Community Plan to End Homelessness prioritizes the development of a systems approach grounded in Housing First where diverse services are organized and delivered in a coordinated manner to advance common community priorities. The purposeful, design and management of St. John's homeless-serving system is critical to meeting the community's objective of ending homelessness.

This approach aligns with the federal direction, as HPS has defined coordination of resources:

> Planning, developing partnerships and implementing solutions in support of a Housing First approach or a broader systematic approach to addressing homelessness, which includes activities to: identify, integrate and improve services on an ongoing basis; work with the relevant sectors to identify barriers to permanent housing and opportunities to address the barriers; and maximize all investments by coordinating funded activities to avoid duplication and gaps, ensuring that funding is used strategically to maximize results.[2]

As a cornerstone of St. John's Community Plan to End Homelessness, system coordination is about finding ways of better working together to serve those at risk of or experiencing homelessness in our community. To advance these efforts, EHSJ launched the Housing First System Coordination Initiative (HFSCI). Key deliverables over the course of the project (November 2015 to May 2016) include:

1) SYSTEM COORDINATION FRAMEWORK DEVELOPMENT

- System Map/service inventory
- Coordinated Access model design
- Coordinated assessment tool selection
- Development of system program performance indicators
- Identification of implementation resources (Budget, HR, Training)

[2] Available online at http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml

2) POINT-IN-TIME COUNT IMPLEMENTATION PLAN

- Data elements selection
- Methodology
- Implementation plan and resources (Budget, HR, Training)

3) PREVENTION & RAPID REHOUSING PROGRAM DESIGN

- Program model(s) development
- Alignment with System Planning Framework
- Implementation resources (Budget, HR, Training)

EHSJ secured the technical assistance of Dr. Alina Turner (Turner Research & Strategy) to work alongside a Local Coordinator (Andrew Harvey) and an Advisory Team to develop the Framework. The Advisory Team supported this work by making recommendations on key issues pertaining to the development and implementation of the Housing First System Coordination Framework.

The Team provided input and played a key role in the development and implementation of community engagement processes to develop the Framework, such as community forums, stakeholder interviews and focus groups. From November 2015 to May 2016, the Team provided input into the following key elements:

- System mapping to discern the homeless-serving system's structure and program components.
- Common system alignment processes, including consistent acuity assessment, program matching, coordinated intake, eligibility and prioritization criteria.
- Performance management and quality assurance standards in alignment with data collection, management and reporting through HIFIS (Homeless Individuals & Families Information System).
- Capacity building needs and resources to deliver training and transition support to diverse services for successful implementation.
- A Housing First System Coordination Initiative (HFSCI) investment plan for the period April 2016-March 2019.

The System Planning Framework was approved by the EHSJ Board on May 31, 2016. To date, key efforts have been made to engage the community, particularly those with lived experience of homelessness, in the final deliverables (discussed in later sections).

[3] Advisory Team members: Sheldon Pollett (Choices for Youth), Gail Thornhill (Stella's Circle), Madonna Walsh & Annette Breen (NL Housing), Judy Tobin (City of St. John's), Bruce Pearce (End Homelessness St. John's)

COMMUNITY ENGAGEMENT PROCESS

System coordination involves a series of activities to ensure diverse homeless-serving system stakeholders are working in a coordinated fashion to end homelessness. Considerable work was required to land on key decisions for the community to develop its System Coordination Framework. To this end, the role of the HFSCI Advisory Team was essential.

Dr. Turner, the EHSJ Community Development Worker and Local Coordinator developed background materials, including promising practice reviews, to inform the design of the Frameworks. Meetings delved into these components in-depth to determine the course of action moving forward.

A review of existing literature on coordinated intake and assessment models, performance management and general system coordination presented to Advisory Team to discuss proposed course of action for St. John's. Emerging directions were presented to the Advisory Team and to the broader group of community stakeholders at the Provincial Housing First Forum to discuss a proposed course of action for St. John's. During the Forum small group discussion were held on each topic with notes being recorded and synthesized into a "What we heard" report. The feedback from these discussions were used to inform this Framework and the proposed approach to Systems Coordination in St. John's.

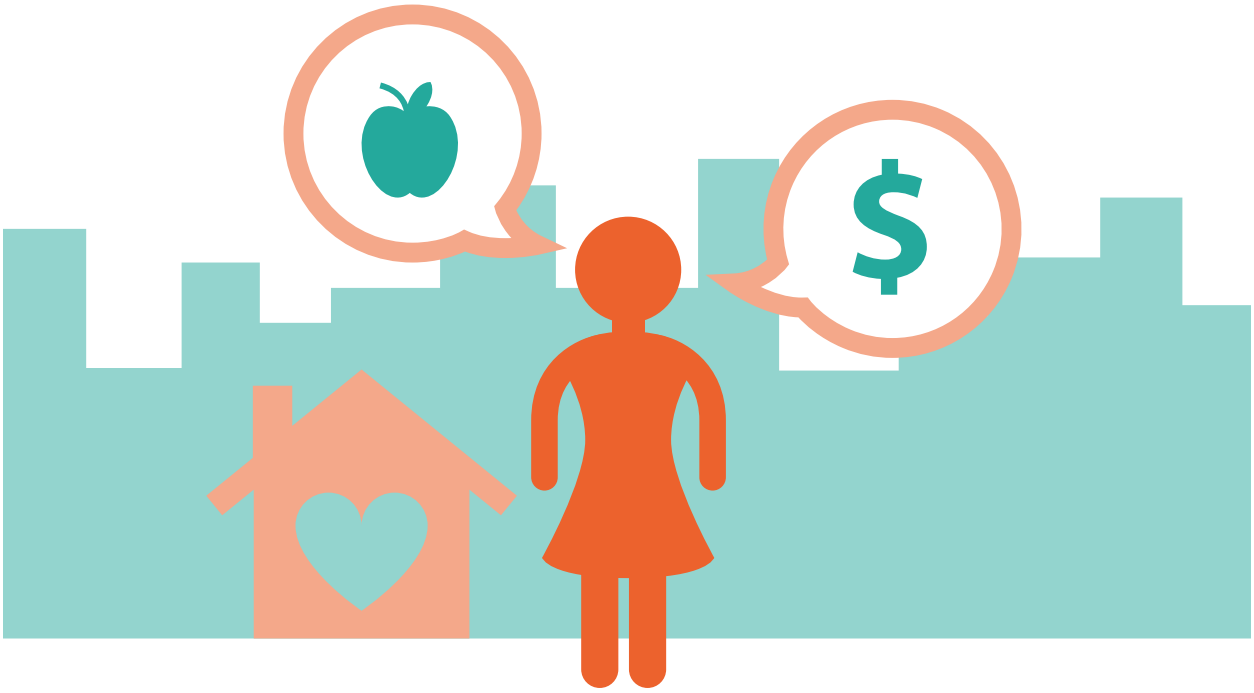
Meetings with stakeholder groups, including service providers (frontline and management), system partners and government were undertaken to test assumptions and findings from the survey, research and Advisory Team meetings on proposed direction. Three focus groups with 30 individuals with lived were also completed leading up to the Forum. Based on input, a draft Framework was developed and presented during a May Community Review Session. The final deliverable incorporates feedback from this Review Session and was approved by EHSJ's Board on May 31, 2016.

Additional detail is provided on the aforementioned engagement components are included herewith.

SYSTEM MAPPING

Without a clear and agreed-upon understanding of the local service delivery landscape, efforts to reduce homelessness may fail to fundamentally shift the community to Housing First. To this end, the development of St. John's System Coordination Framework incorporated an online system mapping survey to:

- Identify the various programs and services currently delivered for homeless and at risk groups;
- Classify these according to program types (transitional housing, emergency shelter, drop-in, health outreach, etc.);
- Assess current capacity (number of beds, number of participants served per year, etc.);
- Identify program funders and their expectations;
- Analyze programs' funded (formal) role versus actual operational functioning (i.e. funded to provide transitional housing, but functions as long-term supportive housing in practice);
- Identify points of articulation between programs and public systems (i.e. hospital, jails, etc.);
- Evaluate current data management processes; and
- Clarify target populations, referral processes, prioritization and eligibility criteria.



The survey was completed by 46 programs in 2016 to develop a preliminary System Map. The System Map was presented at the March 2016 EHSJ Frontline Agencies meeting, and will be discussed at NL Housing's Interdepartmental Advisory Committee (IAC) and EHSJ's System Coordination Table meetings for review and input. EHSJ's Local Coordinator followed up with 15 individual agencies to gain further input on the draft.

This process was designed to support community stakeholders in gaining clarity on program types using common definitions and clearly articulated relationships between components. By articulating the role of programs and how they work together (or where they fail to), the community gained valuable insights into the dynamics of the local response to homelessness and where shifts can occur to meet common goals. The results of the survey were used in discussions with service organization and public systems to develop enhanced clarity on system coordination priorities and lay the groundwork for introducing Coordinated Access and assessment. The systems map is intended to be a "living document", which will grow and evolve with new programs and changes to existing programs. The continued development of the systems map is an important tool for understanding how the system works together and where gaps or barriers exist.

By articulating the role of programs and how they work together (or where they fail to), the community gained valuable insights into the dynamics of the local response to homelessness and where shifts can occur to meet common goals.

PROVINCIAL HOUSING FIRST FORUM

EHSJ collaborated with the Newfoundland and Labrador Housing and Homelessness Network (NLHHN) to identify potential areas of leveraging funding[4] EHSJ had secured for a Housing First Forum to ensure maximum impact from a province-wide and regional perspective. EHSJ and NLHHN were encouraged by provincial partners to develop a Provincial Housing First Forum that would engage key stakeholders in shaping a coordinated homeless-serving system, prevention and rapid re-housing interventions, and foster an enhanced understanding of trauma-informed systems and services.

The Provincial Housing First Forum took place March 1-3, 2016 at St. John's City Hall, and aimed to:

1) Provide participants with comprehensive information regarding promising practices in system coordination, including Coordinated Access, prioritization, and performance management as well as an overview of program implementation options to deliver prevention and rapid rehousing services.

2) Deliver hands-on training to leaders in the sector specific to trauma-informed practices to advance Housing First adoption across Newfoundland and Labrador.

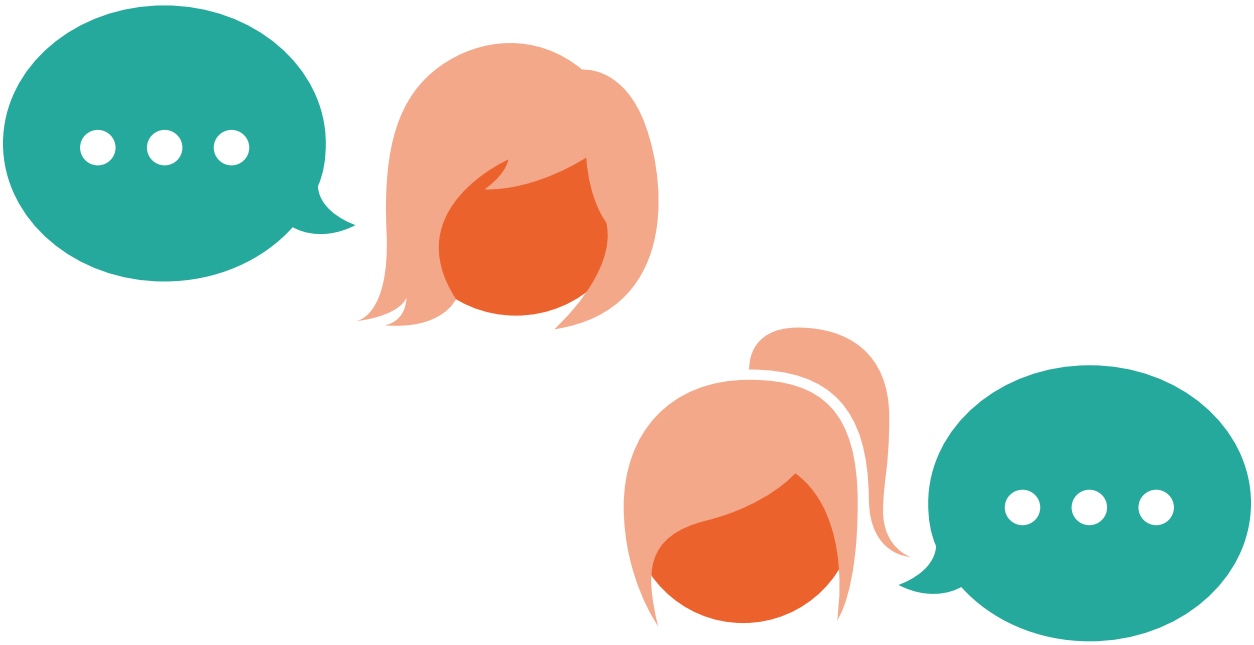
3) Engage in an in-depth discussion regarding key areas of strategic importance to explore potential priority directions moving forward at the local and regional levels.

[4] Funders included HPS, NL's Department of Seniors, Wellness & Social Development, NL Housing, NL's Office of Public Engagement, and the City of St. John's

The Forum responded to needs identified by the community as well as the priorities identified in the Community Plan. Over the three days, 80 individuals from all regions of the province participated in sessions. These individuals came from a wide variety of government and community bodies, listed below.

Leading up to the Forum, Dr. Turner also hosted two webinars in partnership with the Canadian Observatory on Homelessness designed to prime participants with information on Systems Coordination in advance of the Forum. The first webinar, *Systems Planning 101*, was targeted towards St. John's participants. The second webinar was entitled *System Planning and Housing First in Rural Communities* and targeted participants from areas outside of St. John's.[5]

Coming out of the Forum, a *What We Heard*[6] document was produced, drawing together discussion notes taken at each table during the Forum. The document will be shared across the province to ensure that the conversation on ending homelessness continues well beyond the Forum itself. The document was a key source of input into the design of the System Planning Framework.



[5] Webinars are available online at System Planning 101 - https://homelesshub.adobeconnect.com/p8ftzt4kp3k ; System Planning and Housing First in Rural Communities https://homelesshub.adobeconnect.com/p36wf90etax

[6] *What We Heard* document is available here: http://www.nlhhn.org/documents.htm

FORUM PARTICIPANTS

GOVERNMENT DEPARTMENTS

- Department of Advanced Education and Skills
- Department of Justice
- Department of Education and Early Childhood Development
- Department of Seniors, Wellness and Social Development
- Department of Child, Youth and Family Services
- Department of Health and Community Services.
- Service Canada
- Correctional Services Canada

GOVERNMENT AGENCIES

- NL Housing Corporation
- Eastern Health
- Central Health
- Labrador-Grenfell Health

COMMUNITY AGENCIES

- End Homelessness St. John's
- NL Housing & Homelessness Network
- AIDS Committee NL
- Canadian Mental Health Association – NL
- Choices for Youth
- John Howard Society NL
- Salvation Army
- Thrive
- Stella's Circle
- St. John's Native Friendship Centre
- St. John's Status of Women's Council
- Iris Kirby House
- Community Action Committee for Southwestern Newfoundland
- Burin Peninsula Health Care Foundation
- Labrador West Status of Women's Council
- Corner Brook Status of Women's Council
- Mariner Resource Opportunities Network
- The Gathering Place

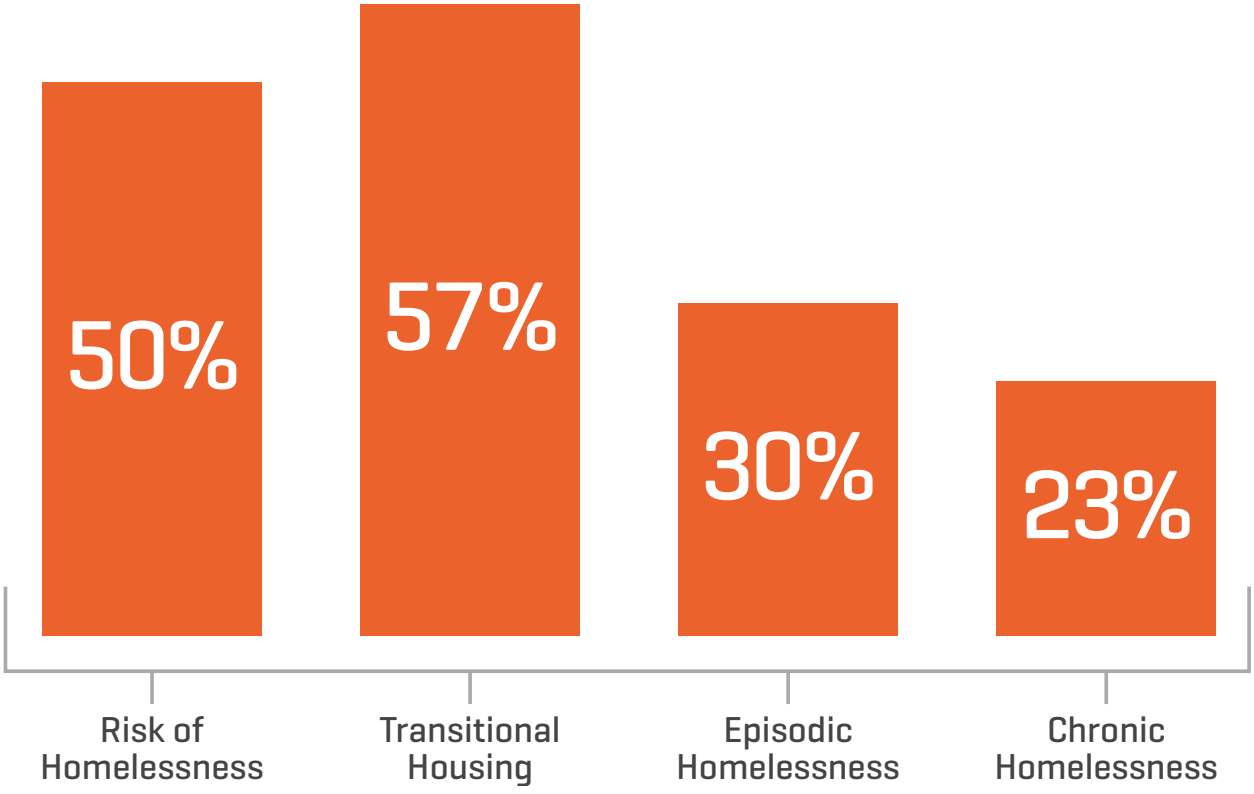
LIVED EXPERIENCE FOCUS GROUPS

As a part of the community consultations for the Housing First Systems Coordination Initiative, three lived experience focus groups were held in February 2016 at Iris Kirby House, Choices for Youth, and The Gathering Place. These locations were selected to ensure representation from known sub-populations including: women fleeing domestic violence, youth, adults and seniors. There were 30 total participants in the three sessions: 6 from Iris Kirby House, 12 from Choices for Youth, and 12 from The Gathering Place.

A wide range of ages were represented among the 30 participants. This includes 10 youth (16-24), 16 adults (25-54), and 4 older adults (55+).

With respect to gender, 50% self-identified as male compared to 37% females. Thirteen per cent did not indicate a gender. Participants' experiences of homelessness are represented in the figure below.

SELF-REPORTED EXPERIENCE OF HOMELESSNESS AMONG FOCUS GROUP PARTCIPANTS (N=30)



Two Social Work students from Memorial University were note takers during the sessions, drafting reports for each session and conducting a thematic analysis to capture key themes. The focus group guide included questions regarding: services available, supports needed for rapid rehousing, gaps and barriers encountered, coordinated access to housing and supports, homelessness prevention, homeless count considerations, and processes for the ongoing engagement of persons with lived experience.

When speaking about their own experiences of homelessness, participants in all of the focus groups identified a wide array of systemic barriers to accessing services. These barriers ranged from practical issues such as transportation or access to a phone, to policies which prevented access to services.

Participants discussed particular challenges faced by individuals who are homeless for the first time, with one individual stating *"No one knows they are going to be homeless until it happens."* They cited a lack of knowledge of services as an important barrier for individuals experiencing homelessness. The practical issues associated with accessing services were also highlighted, in everything from not having a phone to not having bus fare to attend appointments.

Participants discussed particular challenges faced by individuals who are homeless for the first time, with one individual stating "No one knows they are going to be homeless until it happens."

When asked about possible models of Coordinated Access, focus group participants saw merit in both a single site of access and multiple sites, focusing on ease of access (i.e. providing transportation if a single site was chosen). The consensus was that multiple sites would be a good idea, including the suggestion to have services available outside of the downtown. Using telephone-based systems such as 211 to connect individuals experiencing homelessness with services was also discussed at the focus groups.

One topic discussed at length was the importance of public awareness around services. Suggestions were made to use advertising, both online and in areas frequented by individuals experiencing homelessness. The importance of word-of-mouth in awareness of services was also identified, as stated by a focus group participant: *"All homeless are interconnected… word of mouth and reach out to people."* The impact of social stigma affecting homelessness was also discussed during the focus groups: *"People need to speak up about it. Get it out there. It's still a taboo thing which contributes to the hardship of accessing it [housing]."*

The need for continued consultation with individuals with lived experience of homelessness was also identified. One suggestion given was the creation of monthly meeting for those with lived experience. It was also suggested that these meetings could be used as a venue for providing information on services. *"Monthly meetings with people who are experiencing homelessness… awareness of what is available to access."*

The need for continued consultation with individuals with lived experience of homelessness was also identified.

SYSTEM COORDINATION CASE STUDIES

To support a strategic rollout of System Coordination activities in support of the Plan to End Homelessness, EHSJ also documented and analyzed the current state of the homeless-serving system, including its vertical and horizontal integration with public systems.

Case examples were sought from various non-profit service providers and public systems in which system coordination has gone very well - and where it has proved very difficult with less than ideal outcomes for participants. In an effort to document these cases, a sampling of 5-7 examples were collected and analyzed to discern areas of promise and growth moving forward.

These examples were brought forward for discussion at various EHSJ tables (the new Systems Coordination Table, the Housing First System Coordination Advisory Team, Front Step's Advisory Team, and the Frontline Agencies table). Learnings from these case examples also informed EHSJ's System Coordination Framework and resulting initiatives.

REVIEW SESSION & FRAMEWORK APPROVAL

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FUNDAMENTAL CONCEPTS

This section provides an overview and explanation of fundamental system coordination concepts based on existing literature. It draws on key documents including *Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness* and the *Performance Management Guide for Community Entities Working in a Housing First Context* by Dr. Alina Turner.[7]

HOUSING FIRST

The guiding philosophy grounding the St. John's System Coordination Framework is that of Housing First, which calls for the recognition of housing as a basic human right. As a recovery-oriented approach, Housing First is focused on quickly moving people from homelessness into housing and then providing supports necessary to maintain it. Rather than requiring homeless people to first resolve the challenges that contributed to their housing instability, including addictions or mental health issues, Housing First approaches propose that recovery should begin from stable housing.

As a recovery-oriented approach, Housing First is focused on quickly moving people from homelessness into housing and then providing supports necessary to maintain it.

There is an important distinction between Housing First as a philosophy that emphasizes the right to a place of one's own to live, and as a specific program model of housing and wrap-around supports based on consumer choice. We will use the philosophy as a guiding principle for the St. John's Community Plan – but also implement specific new housing and supports to support our vision. Our approach is to build the Housing First philosophy into our system coordination work across program types. This means that every program type has a role to play in ending homelessness, whether an emergency shelter, transitional housing provider or Intensive Case Management program.

[7] Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness
http://www.housingfirsttoolkit.ca/sites/default/files/beyond-housing-turner.pdf

Performance Management Guide for Community Entities Working in a Housing First Context
http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf

HPS has defined the six Housing First principles:

1) RAPID HOUSING PLACEMENT WITH SUPPORTS

This involves helping participants locate and secure accommodation as rapidly as possible and assisting them with moving-in.

2) OFFERING PARTICIPANTS A REASONABLE CHOICE

Participants must be given a reasonable choice in terms of housing options as well as the services they wish to access.

3) SEPARATING HOUSING PROVISION FROM TREATMENT SERVICES

Acceptance of treatment, following treatment, or compliance with services is not a requirement for housing tenure, but participants are willing to monthly visits.

PROVIDING TENANCY RIGHTS AND RESPONSIBILITIES

Participants are required to contribute a portion of their income towards rent.

INTEGRATING HOUSING INTO THE COMMUNITY

to encourage participant recovery.

RECOVERY-BASED AND PROMOTING SELF-SUFFICIENCY

The focus is on capabilities of the person, based on self-determined goals, which may include employment, education and participation in the community.

While Housing First, as a philosophy and specific type of program intervention, is a critical part of efforts to address homelessness, it is its strategic application across the homeless-serving system that is essential to making a sustained impact on homelessness.

System coordination, also referred to as system planning, is a method of organizing and delivering services, housing, and programs that systematizes diverse resources to ensure efforts align with ending homelessness goals. Rather than relying on an organization-by-organization, or program-by-program approach, system coordination aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders.[8]

[8] Albanese, Tom. 2010. Performance Measurement of Homeless Systems. Housing and Urban Development.

Mares, Alvin, Greg Greenberg, and Robert Rosenheck. 2008. "Participant-level Measures of Services Integration Among Chronically Homeless Adults." Community Mental Health Journal no. 44:367-376.

National Alliance to End Homelessness, Homelessness Research Institute. 2008. What Gets Measured, Gets Done: A Toolkit on Performance Measurement for Ending Homelessness.

U.S. Department of Housing and Urban Development, Office of Policy Development and Research. 2002. Evaluation of Continuums of Care For Homeless People Final Report.

At its most basic definitional level, a system is the integrated whole comprised of defined components working towards a common end. System coordination requires a way of thinking that recognizes the basic components of a particular system and understands how these relate to one another, as well as their basic function as part of the whole. Processes that ensure alignment across the system are integral to ensure components work together for maximum impact.

Applying this concept to homelessness, a homeless-serving system comprises a diversity of local or regional service delivery components serving those who are homeless or at imminent risk of homelessness.[9]

Reviews[10] of practices in systems approaches have identified several elements that should be considered in operationalizing such approaches to homelessness grounded in Housing First. These practical elements of homeless-serving system planning and coordination should be considered at various organizational levels within a service network, particularly for stakeholders involved in managing coordination functions. In some sites, these roles are located within municipalities, non-profit funders, agency collaborations, or government departments.

ESSENTIAL ELEMENTS	
1	Planning & Strategy Development process follows a systems approach grounded in the Housing First philosophy.
2	Organizational Infrastructure is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.
3	System Mapping to make sense of existing services and create order moving forward.
4	Coordinated Service Delivery to facilitate access and flow-through for best participant and system-level outcomes.
5	Integrated Information Management aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.
6	Performance Management & Quality Assurance at the program and system levels are aligned and monitored along common standards to achieve best outcomes.
7	Systems Integration mechanisms between the homeless-serving system and other key public systems and services, including justice, child, youth and family services, health, immigration/settlement, domestic violence and poverty reduction.

[9] See Albanese (2010),U.S. Department of Housing and Urban Development (2002).

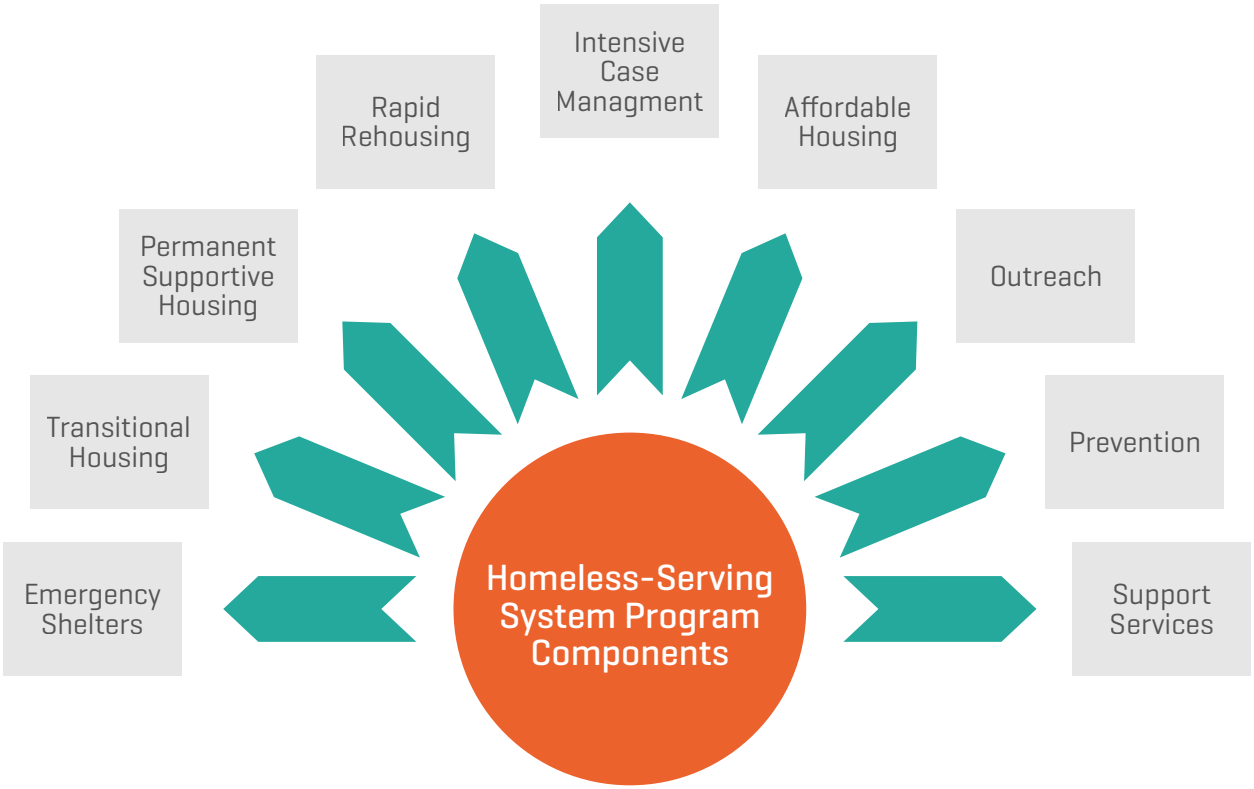
[10] Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness http://www.housingfirsttoolkit.ca/sites/default/files/beyond-housing-turner.pdf

Performance Management Guide for Community Entities Working in a Housing First Context http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf

DEFINING THE HOMELESS-SERVING SYSTEM

Best practices in ending homelessness have increasingly recognized the importance of system planning and coordination as integral to community responses. Such approaches consider the homeless-serving system as an integrated whole comprised of defined program components working towards a common end. This requires that we define the basic components of our local homeless-serving system and understand how these relate to one another and as part of the whole. These components all play a role in ending homelessness following Housing First as a guiding philosophy.

The diagram below presents some of the common program components of successful homeless-serving systems. It is important to note that each of these program components plays a particular role in the homeless-serving system. It is the relationship between these interventions, articulated at the system-level that ultimately drives common community goals. The way these components become interpreted locally depends on local needs, resources and priorities.



Note that part of the work of the community to generate a common system structure is also to define the type of activities appropriately delivered by each program type, their target population, as well as eligibility and prioritization criteria for entry into the programs accounting for participants' level of acuity and homelessness history. Where possible, the length of stay and intensity of supports should also be defined, along with expected outputs and outcomes.

The following program types will be particularly important for St. John's Plan moving forward and are considered essential in our System Coordination Framework moving forward.[11]

INTENSIVE CASE MANAGEMENT (ICM)

longer-term case management and housing support to high acuity homeless participants facing addictions, mental health, and domestic violence and the length of stay generally between 12 and 24 months. Programs are able to assist participants in scattered-site housing (market and non-market) through wrap-around services and the use of financial supports to subsidize rent and living costs and increase self-sufficiency.

PERMANENT SUPPORTIVE HOUSING (PSH)

long-term housing and support to individuals who are homeless and experiencing complex mental health, addiction, and physical health barriers. PSH can be delivered in a place-based or scattered-site model to the highest acuity participants. While support services are offered and made readily available, the programs do not require participation to remain in housing; there is also no limit to the length of stay in the program. Assertive Community Treatment (ACT) programs are an example of PSH using scattered-site housing. Such programs provide longer-term case management and housing support to very high acuity homeless participants facing addictions, mental health, and domestic violence.

RAPID REHOUSING

provides targeted, time-limited financial assistance and support services for those experiencing homelessness, usually episodically or transitionally, in order to help them quickly exit emergency shelters and then retain housing. The program targets participants with lower acuity levels using case management and financial supports to assist with the cost of housing. The length of stay is usually less than one year in the program as it targets those who can live independently after receiving subsidies and support services.

[11] Performance Management Guide for Community Entities Working in a Housing First Context http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf

PREVENTION

programs provide assistance to individuals and families at risk of becoming homeless. Prevention programs couple financial support (rent and utility arrears, damage deposit etc.) with case management to achieve housing stabilization. These programs stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance; programs divert participants at the shelter door and connect participants to financial assistance.

HOMELESSNESS PREVENTION AND RAPID REHOUSING (HPRR)

program elements can be combined to ensure a continuum of supports is in place for those at imminent risk and/or experiencing transitional/episodic homelessness. The aim is to shorten the time homeless as much as possible, where preventing a homelessness episode is not possible. Program participants tend to target low-mid acuity participants with less frequent homelessness lengths of stay and episodes. In some communities, these types of programs are delivered separately and may be specifically focused further on sub-populations (families, youth, singles being discharged from public systems, etc.).

EMERGENCY SHELTERS

provide temporary accommodations and essential services for individuals experiencing homelessness. The length of stay should be short, ideally 7-10 days. Shelters provide essential services to the homeless and can play a key role in reducing homelessness as these services often focus efforts on engaging participants in the rehousing process.

TRANSITIONAL HOUSING

provides place-based time-limited support designed to move individuals to independent living or permanent housing. The length of stay is limited and typically less than two years, though it can be as short as a few weeks. Such facilities often support those with dealing with addictions, mental health and domestic violence that can benefit from more intensive supports for a length of time before moving to permanent housing.

It is important to note that considerable investment in transition housing has been made across Canada - though we know that without permanent housing, participants often cycle through such time-limited facilities. If your community has a considerable stock of such units, consider whether you can transition these to Permanent Supportive Housing.

AFFORDABLE HOUSING
is an appropriate intervention for low income households who cannot afford rents based on market prices. Tenants in affordable housing programs should spend no more than 30 percent of their gross income on shelter. As supports are limited, more complex participants will likely need additional services to maintain housing.

OUTREACH AND DROP-IN CENTRES
provide basic services and referrals to people who are experiencing homelessness or at risk and support engagement into housing. These services aim to move those experiencing homelessness/at risk into permanent housing by facilitating referrals into appropriate programs and providing system navigation support.

ADDITIONAL SUPPORT SERVICES
are involved as well, including furniture banks, food services, education, employment and health supports for vulnerable populations. These may not, however, focus on housing outcomes as a primary objective.

More details about these program components are included in Appendix 4.

ESTABLISHING SYSTEM COORDINATION PROCESSES

While diverse services may exist in the homeless-serving system, it is essential to develop processes to effectively match participant needs to the right service, at the right time so having a Coordinated Access and assessment process in place that uses common acuity measures and prioritization processes to determine program match and eligibility is a key ingredient to a well-functioning system.

Though not an exact science, matching participant need to program type and housing in Housing First systems generally follows the guideline that the higher the participant need, the more intensive the intervention. Generally, we also see that those with longer homelessness histories tend to have higher levels of need (or acuity), thus are likelier to need more intensive supports. Ultimately, participant-choice and tailoring supports are essential.

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Lower Acuity, likelier to be Transitionally Homeless

Rapid Rehousing, Prevention, Affordable Housing

Moderate Acuity, likelier to be Episodically Homeless

Intensive Case Management, Transitional Housing

Higher Acuity, likelier to be Chronically Homeless

Permanent Supportive Housing, including Assertive Community Treatment

The development of common processes to ensure alignment across the homeless-serving system is integral to ensure program components work together for maximum impact. This also ensure participants move through the system effectively and have access to the right resources at the right time.

Common system coordination processes include:

1) COORDINATED ACCESS
processes with clear eligibility and prioritization criteria;

2) COORDINATED ASSESSMENT
to determine the appropriate level, intensity and frequency of supports;

3) PERFORMANCE MANAGEMENT
and quality assurance processes integrated with Homeless Management Information Systems.

We will dive in-depth on implementation options for Coordinated Access, assessment and performance management within the broader context of system coordination.

> A System Planner will be recruited by EHSJ to support the implementation of the System Coordination Framework and support the Coordinated Access process development. The St. John's Homeless-Serving System Design section will describe this in further detail.

COORDINATED ACCESS

Some communities have found success creating Coordinated Access points into their housing and homelessness programs. In Medicine Hat for example, participants seeking housing and supports are assessed using a common acuity assessment tool and then placed into appropriate programs from a central intake point. The aim of this initiative is to create a single entry point into Housing First programs that made entry and right-matching easier from a participant and agency perspective. This also assists to better understand demand for services as applications are centrally managed and analyzed to deduce service demand trends and outcomes.

The aim of this initiative is to create a single entry point into Housing First programs that made entry and right-matching easier from a participant and agency perspective.

Multiple entry points into the homeless-serving system can continue to exist and it is up to local communities to design approaches that are more or less centralized according to local needs and resources.

GOALS & BENEFITS

Developing common acuity assessment and prioritization processes, as well as articulating eligibility and referral processes clearly across the homeless-serving system can go a long way towards enhancing local coordination across multiple entry points as well. Well-articulated system-level policies and processes can facilitate more appropriate participant referrals and reduce frustration and duplication of services. Ultimately, ensuring participants have ready access to the right program at the right time leads to better outcomes for them and the system as a whole.

Coordinated Access has a number of goals regardless of implementation models used:

- Improve speed, accuracy and consistency in screening, targeting and intake;
- Enhance the homeless-serving system's ability to utilize resources efficiently and without duplication;
- Supporting and enhancing the homeless-serving system and advancing systems change;
- Provide information and referral to the right services in a timely fashion;
- Undertake initial screening of participants for programs;
- Collect enough information to make an informed and appropriate referral;
- Assess the level of needs in a consistent manner.

Several benefits were identified from implementing Coordinated Access for participants, service providers and funders.

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

COORDINATED ACCESS PRINCIPLES

A number of key principles for Coordinated Access are outlined below based on the review of promising practices and the local St. John's context.

PRINCIPLE 1: ENSURE SERVICE ACCESSIBILITY

- Allow anyone who needs homeless services to know where to get help and be able to access. services as promptly as possible through an assessment process that is consistent and respectful.
- Ensure staff conducting assessments are trained and competent in assessment.

PRINCIPLE 2: PRIORITIZE SWIFT EXIT FROM HOMELESSNESS

- Facilitate exits from homelessness to permanent housing in the most rapid manner possible given available resources.

PRINCIPLE 3: ALIGN SERVICES TO PARTICIPANT NEED

- Ensure a homeless serving-system that includes a diversity of program types targeted to serve a range of subpopulations driven by an analysis of participant needs.
- Ensure that participants gain access as efficiently and effectively as possible to safe placement. options and the type of intervention most appropriate to their immediate and long-term. housing needs and preferences.
- Ensure that Coordinated Access is sufficiently flexible to enable tailored responses to individual participant needs and circumstances.
- Participation in the Coordinated Access process is voluntary for the participant, who may wish to terminate involvement at any point.

PRINCIPLE 4: PRIORITIZE SERVICES FOR PARTICIPANTS WITH THE GREATEST NEED

- Ensure prevention and diversion from the homeless-serving system are supported as a first choices for participants, where possible.
- Establish uniform, consistent eligibility criteria and prioritization standards.
- Limit eligibility criteria to those required by funding sources or other requirements in order to end homelessness for all people as promptly as possible.
- Ensure that people who have been homeless the longest and/or have the highest levels of need (acuity) have priority access to the project model to which they have been referred.

PRINCIPLE 5: BUILD A SYSTEM THAT WORKS EFFICIENTLY AND EFFECTIVELY FOR PARTICIPANTS, REFERRAL SOURCES, AND RECEIVING PROGRAMS

- Ensure clarity, transparency, consistency and accountability for homeless participants, referral sources and receiving programs throughout the assessment and referral process.
- Incorporate provider and participant choice in enrollment decisions.
- Promote collaboration, communication, and knowledge sharing regarding resources among providers.

PRINCIPLE 6: INVEST IN CONTINUOUSLY STRENGTHENING THE SYSTEM

- Leverage Homeless Management Information System (HMIS) data and infrastructure whenever possible for system evaluation, monitoring, and participant care coordination and ensure data quality.
- Limit data collection to that which is relevant to the Coordinated Access process.
- Continue to make enhancements to Coordinated Access in response to emerging findings and needs and changes in government policy.
- Continuously invest in opportunities to build provider capacity and enable more efficient and effective services.

COORDINATED ACCESS MODELS

There are three main models for implementing a Coordinated Access process. Note that communities may begin with a decentralized approach and shift over time towards enhanced centralization using a hybrid model pending shifting needs. This was the case in both Red Deer and Calgary for instance.

In St. John's we are moving forward with a Coordinated Access approach grounded in Housing First, which can be considered a hybrid model that incorporates aspects of centralized and decentralized approaches. The St. John's Homeless-Serving System Design section will describe this in further detail.

	CENTRALIZED
DESCRIPTION	The centralized intake model uses one entry location where people at risk for or experiencing homelessness are assessed to determine the best resources for their specific needs. This entry location can be by telephone or a physical location. The location may serve all populations or there may be separate locations for each population.
OPTIONS	Single physical point of assessment (i.e., emergency shelter, dedicated assessment centre or other service providers). Centralized phone hotline or (e.g. 2-1-1)
PROS	Opportunity to build on system or structure already in place, such as 2-1-1 or an emergency shelter. Greater likelihood for consistency with only one agency administering assessment tool and making referrals to other agencies as needed. Less space and fewer staff required. Less training time with fewer staff receiving calls and administering assessment tool. One location to refer service seekers. Agencies no longer need to spend time assessing individuals for program entry.
CONS	High volume of calls and assessments for lead agency staff. One physical location may not be easily accessible for all participants if community covers a wide geographic area Partner agencies need to release control of their entry and assessment procedures.
KEY CONSIDERATIONS	Agency conducting assessments and referrals needs to build and maintain a high level of trust among the provider community. Participants with transportation challenges need to be ensured equal access to system through alternatives such as Skype assessments, transportation assistance, mobile assessors, or agencies staying open after regular business hours.

Source: Social Planning, City of Red Deer

	DECENTRALIZED
DESCRIPTION	A decentralized model uses multiple coordinated locations (physical, virtual, or both) throughout the community that offer assessments and referrals. Sites can be operated by one agency or by different agencies. All sites are coordinated because they use the same assessment form, targeting tools, and referral process. Each site has equal access to the same set of resources.
OPTIONS	Phone intake for initial screening, and office location for assessment and referrals along with multiple locations and with multiple phone numbers. One agency does all assessments at different locations throughout community. Different agencies throughout community use same assessment tools.
PROS	Capacity to handle large number of participants. Greater accessibility for communities that cover a large geographic area. Providers may feel more comfortable with this model. Homeless participants are familiar with agencies providing services.
CONS	Requires more coordination and oversight by lead implementing agency to ensure consistency. May be more expensive due to increased rent for space/staff demands.
KEY CONSIDERATIONS	Extensive public outreach to communicate different locations with identical services at all locations.

Source: Social Planning, City of Red Deer

	HYBRID
DESCRIPTION	A combination of some elements of both centralized and decentralized model.
OPTIONS	Hybrid models are unique to each community as they are created with the needs of the participant in mind. This can include a centralized coordinated intake that uses mobile outreach for shelters, systems, and assertive street outreach.
PROS	Greater likelihood for consistency with only one agency administering the assessment tool and making referrals. One location/agency to refer individuals who are experiencing homelessness. Agencies no longer need to spend time assessing individuals for program entry. This means more resources can go to housing and supports. Mobile outreach means participants can access services where they are at – shelter, street, hospital, etc. There are no side doors to accessing housing programs to ensure participants with the highest acuity are housed first.
CONS	Partner agencies need to release control of their entry and assessment procedures. As this is a change to what has been done in the past, providers may not feel comfortable with this model. Participants may not initially be comfortable accessing services at an agency they are not used to.
KEY CONSIDERATIONS	Agency conducting assessments and referrals needs to build and maintain a high level of trust among the provider community. Intake staff must be aware of other community resources for effective diversion to occur. As this is a change to what has been done in the past, communication about the new process needs to occur with everyone in the community. Allow time for the community to transition to this new model.

Source: Social Planning, City of Red Deer

COORDINATED ASSESSMENT

It is important to have a consistent process in place to match participants with appropriate programs. Acuity assessment tools, such as the Vulnerability Assessment Tool (VAT), Service Prioritization Decision Assistance Tool (SPDAT), or Calgary Acuity Scale can be used to understand the level of need among those experiencing homelessness.

The Canadian Observatory on Homelessness has reviewed such acuity assessment tools specifically for the Canadian context and has recommended the VAT (Vulnerability Assessment Tool) as a useful evidence-based tool for consideration in collaboration with research and clinical experts.[12]

Assessment tools measure a variety of aspects (health, mental health, addictions, system interactions, etc.) and should be strategically assessed and selected to meet community needs as some modifications of these tools may be necessary. Note that different tools may be used for different objectives: communities may choose a screening tool to collectively assess level of needs at intake and assist in program matching as part of Coordinated Access; at the program level, agencies may choose a different tool that is best suited for the services provided and target participant group that assists in ongoing case management, for instance.

Assessment tools measure a variety of aspects (health, mental health, addictions, system interactions, etc.) and should be strategically assessed and selected to meet community needs as some modifications of these tools may be necessary.

[12] The COH report is available online at http://www.homelesshub.ca/sites/default/files/ScreeningforHF-Dec8 pdf

Whichever tool is chosen as part of Coordinated Access, it is important that it is used consistently across services to ensure a common understanding of need is in place and enable system-level assessments of program success and accurate matching of participant needs. Using this information, a coordinated assessment process can be applied to help match participants to interventions and track progress across programs.

It is important to highlight that coordinated assessment tools are not perfect and have some key limitations:

- It does not deliver perfect information and cannot predict who will be successful.
- It will not change system gaps and misalignment on its own.
- It is not necessarily the most important part of your process.
- Assessment tools are only one source of information to guide decision making.
- It does not replace the sound judgement of professionals.

EHSJ will implement the Vulnerability Assessment Tool (VAT) as its Coordinated Assessment tool, with the support of the Canadian Observatory on Homelessness. The St. John's Homeless-Serving System Design section describes this in further detail.

PERFORMANCE MANAGEMENT

Performance management is essential to understand the effectiveness of interventions, as well as a community's overall progress towards reducing homelessness.

> Performance measurement is a process that systematically evaluates whether your efforts are making an impact on the participants you are serving or the problem you are targeting (Albanese, 2010).

Performance management:

- Articulates what the homeless-serving system, as a whole, is trying to achieve;
- Illustrates whether progress is being made towards preventing and reducing homelessness in a particular community;
- Keeps programs accountable to funders;
- Quantifies achievements towards the goals of the Community Plan and HPS targets;
- Uses information gathered for continuous improvement;
- Aligns program-level results to participant outcomes at the individual and system-levels; and
- Informs the next round of strategy review and investment planning.

Once system structure and service coordination processes are clarified, performance management can also be developed for the program and system-levels leveraging integrated information management. A systems-focused performance management process can develop a clear understanding of impact on priority populations against targets, but also illustrate levels of performance at the service level.

This requires stakeholders to agree on common indicators and targets at the system and program levels which align with Housing First (i.e. immediate access to permanent housing, participant-choice, etc.). Sample indicators address issues such as occupancy, length of stay, destinations at exit, recidivism, rehousing rates, income, self-sufficiency, acuity, interaction with public systems.[13]

A distinction should be made between program and system-level performance indicators here:

- *Program Performance Indicators* vary depending on the target population, program purpose, services design, etc. They are useful for measuring program performance of individual programs and to compare performance across similar programs.
- *System Performance Indicators* reflect aggregate system performance and impact. They are used to measure achievement across the homeless-serving system towards high-level goals and can be used compare various communities.[14]

Under Housing First, the system should work to reduce length of stay in emergency shelters and demonstrate stability in longer term options, positive housing exits from programs, along with decreased recidivism among rehoused groups, increased self-sufficiency and income. Overall, if operating efficiently with adequate resources, homeless-serving systems can assess overall reductions in homelessness using a range of information sources, including point-in-time counts and information system data.[15]

Program-level indicators align to their system-level counterparts to demonstrate how a particular program contributes to a homeless-serving system's progress towards reducing homelessness. No one program can reduce homelessness on its own; an intentional systems approach is critical to ensure interventions are aligned and working towards broader community goals without unnecessary duplication or gaps.

EHSJ has approved key performance measures and targets for the St. John's Homeless Serving System, which will be implemented and refined with the support of a new EHSJ Performance Management Planner. The St. John's Homeless-Serving System Design section describes this in further detail.

[13] For a full discussion on program and system indicators and targets, please see Performance Management Guide for Community Entities Working in a Housing First Context http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf

[14] See Albanese (2010).

[15] Performance Management Guide for Community Entities Working in a Housing First Context http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf

SERVICE STANDARDS

Similarly, quality assurance standards for services are needed to ensure best results. Transparent and agreed-upon service standards across the homeless-serving system need to be developed, implemented, and monitored consistently. Quality assurance not only covers areas like case management practice, but also issues of staff, participant and community safety, grievances and serious incidents.

Once system structure and service coordination processes are clarified, performance management can also be developed for the program and system-levels leveraging integrated information management. A systems-focused performance management process can develop a clear understanding of impact on priority populations against targets, but also illustrate levels of performance at the service level.

BENEFITS OF SERVICE STANDARDS

- Provide assurance for participant, community, funders, agencies services are meeting/ exceeding expectations;
- Ensure alignment with local Plan, Housing First, HPS targets;
- Empower participants through participation in performance management at program and system-level;
- Promotes service integration across sector and with mainstream systems; and
- Reveal program gaps and priorities for investment.

To support service quality and performance, capacity building and technical assistance is required as well, particularly for frontline staff who will be leading implementation. In this manner, service monitoring, investigations of serious incidents and grievances, and remediation focuses on continuous improvement through technical assistance and capacity building. Without adequate resources in place to support uptake, buy-in from frontline staff is limited. This not only includes the development of resources (toolkits, tip sheets, webinars, conferences, etc.) and technical assistance, but also ensuring adequate time to manage changing expectations and workloads.

> Standards of practice for the St. John's Homeless Serving System have been approved by EHSJ, which will be implemented and refined with the support of the Performance Management Planner. The St. John's Homeless-Serving System Design section describes this in further detail.

LIVED EXPERIENCE

Participant choice is fundamental to Housing First. Participant input should be incorporated in strategic planning at the macro-level as well as via quality assurance processes, wherever possible and appropriate. A participant advisory group can provide input on elements of system coordination, priorities to address service gaps, emerging trends, program performance and service quality.

Such advisory groups can act as an opportunity for peers to interact, reducing isolation and enhancing social skills, and promoting community integration.[16] Suggestions from the At Home/Chez Soi experience with participant involvement includes: early involvement, purposeful selection of members, clear communication of roles and responsibilities, a consumer coordinating group, space for critical dialogue throughout the process and provision of honoraria.[17]

A Lived Experience Council will be convened and supported to guide the implementation of the Plan to End Homelessness and the System Coordination Framework. The St. John's Homeless-Serving System Design section describes this in further detail.

[16] Employment and Social Development Canada. Homelessness Partnering Strategy Directives 2014-2019. Directive 13: Persons with Lived Experience (PWLE) of Homelessness. Available from http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml

[17] At Home/Chez Soi Project: Toronto Site Final Report. Available from: http://www.homelesshub.ca/resource/homechez-soi-project-toronto-site-final-report

The comprehensive MHCC Toronto Site Caucus Protocol (October 2010) http://www.housingfirsttoolkit.ca/sites/default/files/Caucus Protocol.pdf

INFORMATION MANAGEMENT

An efficient information system is essential to implementing performance management processes and system planning. An integrated information system is a locally administered, electronic data collection system that stores longitudinal person-level information about those accessing the homeless-serving system. The shared information system aligns data collection, reporting, coordinated intake, assessment, referrals and service coordination in the homeless-serving system.

An integrated information system can assist communities to:

- Develop unduplicated counts of participants served at the local level;
- Analyze patterns of use of people entering and exiting the homeless-serving system; and
- Evaluate the effectiveness of these systems.

Regardless of which software system is used (Homeless Individuals and Families Information System [HIFIS] or another Homeless Management Information System [HMIS], etc.), implementing a common tool will create a more coordinated and effective housing and service delivery system and will act as the backbone of the homeless-serving system.

These information systems are absolutely essential to the effective implementation of plans to end homelessness. They are also important for government and other funders to track their investments and progress against objectives. Rather than simply providing a means of tracking participants in a particular funded program, these information systems act like the nerve-center of a homeless-serving system. This can capture all the points of contact between a person experiencing homelessness and the homeless-serving system.

The learning from 20 years of US experience in over 300 US communities that implemented information systems is that they work when tailored to local needs. A comprehensive community engagement process is essential for local stakeholders to come together to determine collective needs and processes, and choose a software solution. Although implementing a single software solution is the ideal option, it may not be possible in all communities. However, there are steps that can be taken to improve data collection and management:

- Develop consistent definitions and data sets to ensure that all programs are collecting the same data using the same definitions (a good place to start would be the data required in the Community Plan);
- Develop and sign agreements to share data;
- Develop tools and technology to allow the system coordination leads to gather data from the programs and analyze it.

One of the barriers noted to introducing such systems in the Canadian context is that of privacy legislation, particularly when multiple legislation is involved. Privacy may be a challenge, but it is not insurmountable. Learning from the experience of communities with operating systems, we can develop the necessary information sharing, storage and security measures that satisfy all applicable legislation. Implementing an information system is integral to developing a homeless-serving system. The implementation process requires local stakeholders to collaborate.

In St. John's, the decision to use HIFIS as the community's HMIS has been made, and an HMIS Steering Committee[18] is developing the rollout of the web-based HIFIS 4.0 software regionally. This includes working through the privacy legislation considerations to ensure information sharing supports system coordination.

[18] The HMIS Steering Committee includes: EHSJ, the City of St. John's (CE), NL Housing, Service Canada, the NL Housing & Homelessness Network, the Transition House Association of NL, and the Town of Grand Falls-Windsor (NL's Rural HPS Community Entity).

INTEGRATING ACROSS SYSTEMS

Once the structure and alignment of the homeless-serving system are defined, the points of intersection with other systems become clearer. In order to integrate the homeless-serving system with key public systems and services, including justice, child, youth and family services, health, and poverty reduction is also evident in partnerships and shared protocols and policies.

Discharge Planning Committees, for example, work to ensure participants do not cycle in and out of public systems like jails and hospitals and homeless shelters by developing referral networks and programs specifically targeting those at imminent risk for discharge into homelessness.

Processes can also be developed to integrate Housing First programs with public systems. For example, an ICM program focused on reducing discharging into homelessness of high acuity participants with long term homelessness and justice interaction histories can be introduced. The eligibility, prioritization and referral processes of the program would be fully aligned with the system planning approach.

The notion of integration is about working together to improve results, which can take the form of a collaborative arrangement. System-level integration can entail centralized management and funding, while at the service level, it can involve the coordinated delivery of services both within (vertical integration) and/or between (horizontal integration) sectors and agencies.[19]

Housing and Urban Development's evaluation of homeless-serving systems in the US found that successful integration was achieved when particular strategies were applied between systems, such as common policies and protocols, shared information, coordinated service delivery and training. In addition, the following were also recommended:

- Having staff with the responsibility to promote systems/service integration,
- Creating a local interagency coordinating body,
- Having a centralized authority for the homeless-serving system,
- Co-locating mainstream services within homeless-specific agencies and programs, and
- Adopting and using an interagency management information system.

Integration strategies can be applied in a range of contexts to improve outcomes. For instance, programs within the same agency, between different agencies, and between sectors of agencies. The scale at which integration efforts are implemented will determine which strategies are best suited to achieve intended outcomes; further, the types of services that require integration will further impact the tailored approach moving forward. Several U.S. studies suggest that service coordination closest to the participant is more effective than broader top-down structural integration measures in terms of individual housing and health outcomes.[20] Ultimately we need to ensure participant and structural strategies are aligned first and foremost with impacting participant-level results.[21]

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[19] Browne, Gina, Dawn Kingston, Valerie Grdisa, and Maureen Markle-Reid. 2007. "Conceptualization and measurement of integrated human service networks for evaluation." International Journal of Integrated Care no. Oct.-Dec.: e51.

[20] U.S. Department of Housing and Urban Development, Office of Policy Development and Research. 2002. Evaluation of Continuums of Care For Homeless People Final Report.

Hambrick, Ralph, and Debra Rog. 2000. "The Pursuit of Coordination: The Organizational Dimension in the Response to Homelessness." Policy Studies Journal no. 28 (2):353-364.

[21] Evans, T., Neale, K., Buultjens, J., & Davies, T. (2011). Service integration in a regional homelessness service system. Lismore, New South Wales, Australia: Northern Rivers Social Development Council. p. 30.

A System Coordination Table and Complex Needs Working Group are being convened by EHSJ to move these integration actions into practice in support of the System Coordination Framework. The St. John's Homeless-Serving System Design section describes this in further detail.

The chart below summarizes the essentials of system planning and integration.

FOCUS ON INTEGRATION WITHIN HOMELESS-SERVING SYSTEM	FOCUS ON INTEGRATION BETWEEN HOMELESS-SERVING SYSTEM & OTHER SYSTEMS
Planning & Strategy Development	
Local strategy follows shared vision and principles grounded in evidence-based practice to end homelessness.	Development of shared planning approaches across systems targeting common target population.
Organizational Infrastructure	
Organizational infrastructure is in place to implement homelessness plan and coordinate the homeless-serving system to meet common goals.	Coordinating infrastructure to lead integration efforts across systems is established.
System Mapping	
Making sense of existing services serving and creating order moving forward.	Extending service mapping to document populations experiencing homelessness and housing instability touch points across systems.
Coordinated Service Delivery	
Ensuring key system alignment processes including Coordinated Access, assessment and prioritization, are in place to facilitate access and flow through services for best individual and system-level outcomes.	Development of Coordinated Access, assessment and prioritization to determine service matching for participants across systems using shared processes & facilitate integrated service delivery.
Integrated Information Management	
Shared information system aligns data collection, reporting, Coordinated Access, assessment, referrals and service coordination in the homeless-serving system.	Extending the use of a shared information system, or developing data bridges among existing systems to enable information sharing for service coordination and planning purposes.
Performance Management & Quality Assurance	
Performance expectations at the program and system levels are articulated; these are aligned and monitored along set service standards to achieve best outcomes. Resources are in place to support uptake across organizational levels.	Common indicators are developed across similar service types and at system levels to articulate how components fit as part of broader whole. Service quality standards are in place across systems providing similar function, reinforced through monitoring and capacity building.

COORDINATED ACCESS MODEL

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

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

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

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

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

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

COORDINATED ACCESS AGENCIES

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

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

The proposed rollout would be phased, starting with 3-4 sites in the next 12 months and expanding pending buy-in and capacity. The addition of a hotline access call-in number and capacity for CA staff to engage in outreach at key 'high traffic' sites that may not be CA Agencies can enhance the accessibility to the process even further.

A designated phone line accessible 24 hours a day, 7 days per week should facilitate information and referrals using a standard Referral Guide is recommended. Pending capacity and resources, this can include initial screening to facilitate eligibility assessment and program matching. The expansion of 311 or Mental Health Crisis line to this end should be investigated before commencing the creation of a new service. The hotline access number should be advertised through diverse media, including social media, posters, pamphlets, training materials for staff, etc.

COORDINATED ACCESS WORKERS

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

To enhance our response from the prevention lens, we have developed the Homelessness Prevention and Rapid Rehousing program as a targeted diversion and eviction prevention support within our homeless-serving system. These services are particularly targeted at those at high risk of becoming homeless, and require concerted targeting and assessment to ensure effective use of resources.

However, the homeless-serving system's role in prevention varies according to the type of prevention service in question. Key providers can work to prevent evictions and stabilize those at imminent risk for homelessness using existing supports and connecting program participants to assistance. Diversion services can help people who approach the shelter system to get back into housing rather than enter shelter. Moving forward, we cannot rely solely on the HPRR program – we all need to continue to do our part with existing resources, both formal and informal (social networks, family reconnection, etc.) to stabilize clients and reduce entry into the homeless serving system where possible and appropriate.

A key role for the CA Workers is to provide general information and referrals at the key CA Agency sites, but also to work on an outreach basis across other common touch points for the population, such as key public systems, emergency shelters, drop-in centres, community centres, etc. CA Workers may complete coordinated assessment using the VAT in designated public system locations such as hospitals, jails, treatment facilities, etc., as well. In this manner, the community will have assigned sites for CA to occur, but also regular outreach services in other sites to facilitate access.

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

CA Workers will work with EHSJ and NLSA to assist in maintaining a current System Map, Referral Guide and weekly System Capacity Reports for the homeless-serving system. These elements will be described in more detail

REFERRAL PROCESS

Based on the EHSJ System Mapping Survey and community consultations to date, a draft Systems Map was developed. It is important that this marks the first iteration of a systematic effort to document and classify program in the homeless-serving system and will require ongoing refinement.

Key points of articulation with public systems need to be further refined as well; this aligns with the Plan's implementation priority for Year 3 (2016-2017) regarding system integration. The EHSJ Systems Table marks an initial effort to this end that will require additional development in implementation. See Appendix 4 and 6 for an overview of the current Homeless-Serving System.

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

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

Based on a refined Systems Map, it is recommended that a Referral Guide[22] be developed to ensure consistent referrals are being made across the homeless-serving system and from public systems. At minimum, the Referral Guide will include the program name, agency, key contact person(s), main phone number, eligibility criteria, target population, services provided, and program type.

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

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

SYSTEM PLANNER

The addition of a System Planner position as part of EHSJ is proposed to lead the implementation of the System Planning Framework (please see Appendix 4 for the System Planner job description). The System Planner would support the overall CA process by developing protocols and processes and ensuring effective and efficient operations of the model. The System Planner will represent the CA at a community level and will form relationships with community partners. This person must be responsive to changes in the homeless sector and general management of the initiative.

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

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

A key role for the position is also to maintain a current System Map, Referral Guide and communicate a System Capacity Report outlining occupancy and waiting lists to CA agencies on a weekly basis. Appendix 4 provides the Position Description.

In the immediate implementation phases, the System Planner works to:

- Facilitate engagement of homeless-serving system partners in developing Policies and Procedures for the CA
- Working with EHSJ to secure funds to resource CA implementation
- Providing training on VAT and other CA processes
- Leading quality assurance processes for the CA initiative
- Supporting the CA Agencies in this transition
- Continue to refine Systems Map and Referral Guide on an ongoing basis
- Developing a Referral Form and step-by-step process for CA agencies
- Keep up to date inventory of programs and fill rate on a weekly basis and share this with providers in a weekly System Capacity Report
- Develop a database to keep track of CA referrals and their outcomes
- Follow up on outcomes from referrals made with providers to ensure database is up-to-date
- Develop monthly reports on CA process outcomes, output, and learnings to the Systems coordination table
- Co-Chair Systems Coordination Table and prepare materials for review
- Document system barriers and represent these at Systems Coordination Table
- Liaise with partner agencies on an ongoing basis

COMPLEX CASES WORKING GROUP

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

Navigators and Networks (NAVNET) comprises a network of senior government and community representatives whose aim is to work collaboratively to explore innovative solutions to address the gaps in services and barriers faced by clients with multiple and complex needs. The role of NAVNET, operated by Eastern Health, has been to coordinate community and public system responses for complex cases. It is important to clarify that NAVNET itself does not offer services per se; rather, it works with other providers to coordinate care.

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

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

NAVNET is undertaking a strategic planning process over the coming months and its Steering Committee can consider taking on this role in community, its risks and impacts. If moving in this direction is appropriate, NAVNET will work with EHSJ to develop revised protocols and processes to align with the System Coordination Framework. These should be revisited a year into implementation to consider further refinement as well as the potential expansion of NAVNET into lower acuity groups or the creation of a second group for such populations.

SYSTEMS COORDINATION TABLE

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

To enhance integration among homeless-serving agencies and public systems, an EHSJ Systems Coordination Table is proposed. It is important to note that the Systems Coordination Table is about more than the homeless-serving system: like the community goal of ending homelessness, the CA initiative calls for the coordination of diverse services within public systems as well. To this end, the Systems Coordination Table should advance systems integration.

In fact, public systems can be engaged at various levels in the CA:

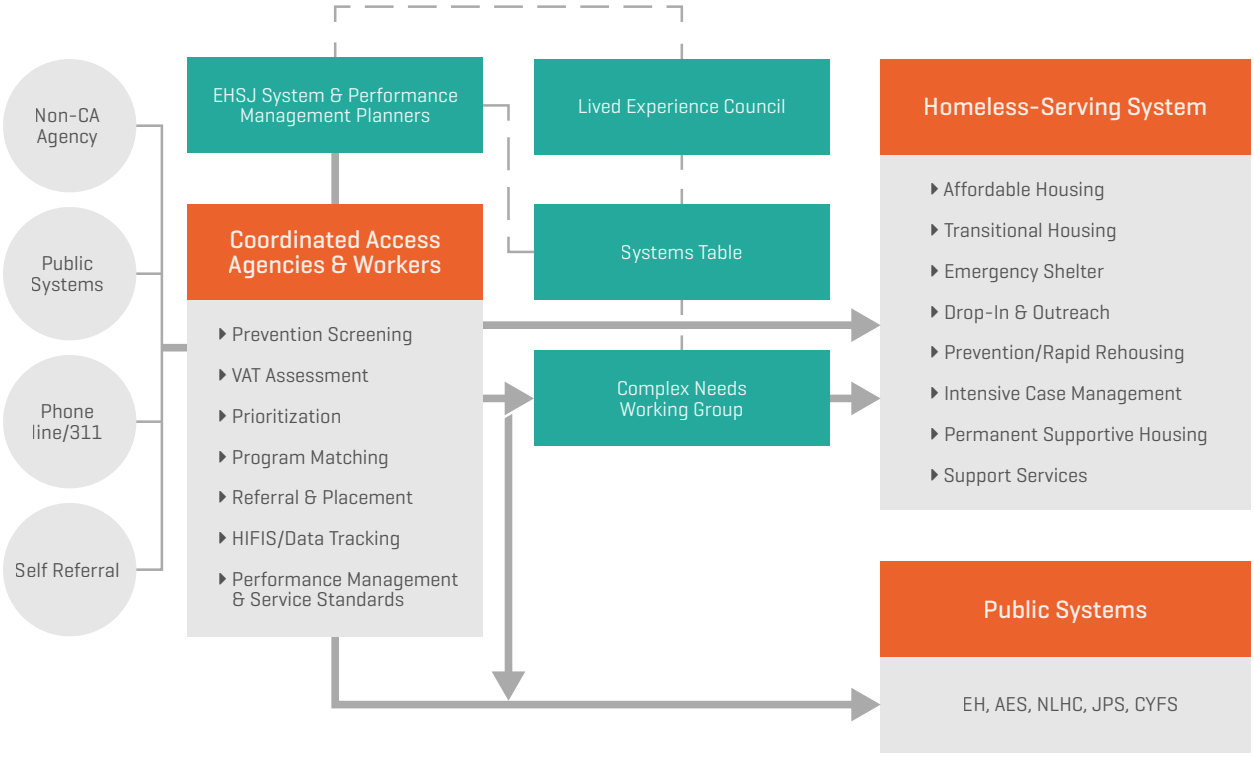
- Co-locating mainstream resources at CA sites.
- Utilizing a common assessment tool or incorporating key evaluative criteria required of public system services into the CA process can help prioritize homeless people for multiple benefits and match them to the right services to meet their needs.
- Establishing priority status for housing projects or services for which homeless people may qualify. Establishing a priority can increase the movement of people out of the homeless system and into permanent housing.
- Establishing a procedure for referring those experiencing homelessness or at risk, reducing or consolidating some of the documentation requirements associated with completing a referral, and sharing information in streamlined ways can help obtain resources quickly.

Key public system partners can become CA Agencies and receive training to complete the VAT with participants or refer them to CA agencies etc., and would in turn receive referrals where appropriate. At a minimum, written policy and procedures should articulate how the referral process with key mainstream services will be made and received. The Systems Coordination Table has a role in developing these by supporting the System Planner.

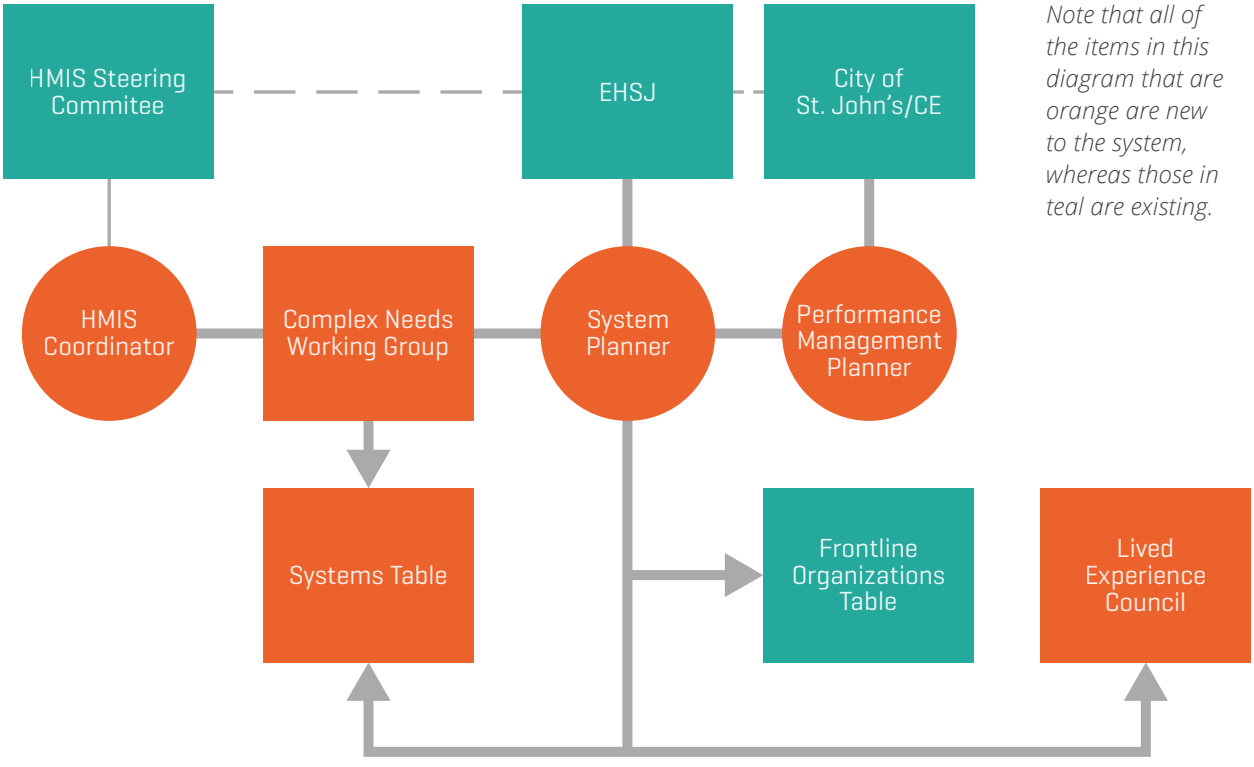
The Systems Coordination Table will meet on a monthly basis at minimum to discuss CA progress, emerging trends and barriers. System partners can play key roles in facilitating access to system resources for participants, and support the removal of system barriers for vulnerable populations. MOUs can be developed/adapted to ensure consistent agreements regarding public system participation and accountabilities are in place.

It is recommended that EHSJ work with community and systems partners to review currently active coordination tables with similar mandates as the proposed Systems Table (i.e. advisory/steering committees for Front Step, NAVNET, HFSCI, Frontline Agencies, etc.) to ensure no duplication of functions occur with the CA process. The NAVNET Steering Committee in particular has a similar mandate to the proposed Systems Coordination Table. Where an appropriate table already exists that can be enhanced to take on this work, it should be considered. The recent reorganization of NAVNET's Steering Committee with a focus on resolving system barriers can be considered as a refocused Systems Table.

COORDINATED ACCESS MODEL OVERVIEW



INFRASTRUCTURE & GOVERNANCE MODEL DIAGRAM



Note that all of the items in this diagram that are orange are new to the system, whereas those in teal are existing.

Please refer to the Executive Summary for a list of key actions to move the System Coordination Framework into implementation, alongside a budget overview to support these actions.

LIVED EXPERIENCE VOICE

Those with lived experience can and should play a key role in the implementation of the Plan to End Homelessness; they should have a seat as partners and champions and be provided with meaningful leadership opportunities. Many with lived experience wish to give back as means of acknowledging the support they had access to in times of need, but also as a means of further self-development and empowerment.

Supporting meaningful lived experience engagement in CA development and implementation is a foundational principle for the initiative. Those with lived experience need authentic opportunities to shape the implementation of the CA at the operational and system levels. More than providing feedback, they can be active forces co-developing the processes and interventions and provide support to others in peer-based approaches.

Conversations around formally engaging those with lived experience in Plan implementation have already emerged and are supported from the perspectives of those consulted in this process. It is recommended that a formalized Lived Experience Council be developed and supported. Part of its role will also be to help shape the CA process and provide ongoing feedback on implementation progress and learnings. The Council can provide meaningful input into the performance and quality assurance processes outlined in the System Coordination Framework as well, along with guidance on best strategies to communicate with the target population and emerging trends.

CA OPERATIONS

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

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

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

- **Document participant's homelessness history and housing barriers**. Gather sufficient information to allow for appropriate placement and for the creation of an accurate housing and service plan to address a participant's needs.
- **Identify appropriate services**. Link participant information and the local system's resources. Characterize or score the participant's profile against a number of intervention options.
- **Document discrepancy between participant needs and available resources to meet need**. The specific resource a participant need may not be available at the time of referral. Communities should document if there is a demand for housing or services beyond what is currently available.
- **Respect participant preferences**. Ask direct questions about needs and preferences of the participant in order to ensure the best assessment.
- **Capture just enough data to meet project needs and funder requirements**. Design assessment forms to represent the intake data needs for the full continuum of services that may be offered at the access point.
- **Obtain consent for sharing data with providers**. Comply with local, provincial, and federal requirements.
- **Draft, or at least initiate, a housing plan**. Work with participants to begin development of a housing plan that can be transferred to the next stage of service.
- **Standardized practice**. Apply standard practices at every point of entry for every participant in order to ensure consistent assessments.
- **Training**. All staff participating in the CA process receive training and certification prior to conducting these assessments.

SCREENING WITH A FOCUS ON PREVENTION

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

Prevention is not about turning people away; it is about helping them find solutions to their housing situation and leveraging resources in community. Prevention utilizes the lightest touch possible leveraging natural resources with minimal use of community resources. Prevention is a service in itself. The goal is to find housing solutions while avoiding the homeless-serving system including emergency shelters and supportive housing programs. It is critical that all agencies incorporate this approach as part of their practice, rather than relying on EHSJ's Homelessness Prevention and Rapid Rehousing Program, because this resource is limited and has its own eligibility criteria.

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

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

PREVENTION EXPLORATORY QUESTIONS

The following exploratory questions should guide CA staff interviews with participants to ensure a prevention focus is consistently applied. The information that is gathered will indicate how to proceed. These questions are used in Calgary Homeless Foundation's Coordinated Access and Assessment process.

1) Why are you seeking help with housing? What brought you here today?
2) What have you tried already or in the past? How did that work for you?
3) What other things have you considered doing?
4) What barriers are there preventing you from using the above to address your housing situation, even for the short term while other options can be explored?
5) Where did you stay last night (if a family, did they all stay in one place)?
6) Is this a safe situation for you to return to and if so could you stay there for a few days or a week while other options are explored and resources accessed?
7) What would it take for you to be able to stay there a few more days? If the barrier is, for example, food scarcity, then explore supports such as Food banks or referrals to relevant community resources.
8) What other options do you have – family, friends or coworkers, again even if just for a week or so? Explore – what would it take for you to stay there - consider possible ways to remove barriers.
9) What is making it difficult for you to be in stable housing at this time? -I.e. being new to the area, recent immigrants, financial barriers such as damage deposit or unemployment, age, health or mobility issues.
10) What resources does the participant already have available or is utilizing that would be of benefit in helping to formulate a prevention strategy – are they employed, already receiving financial assistance or using other community resources or services.
11) If need provide information for emergency shelter – this may be the only or safest option. You still need to convey there is an expectation they will continue to actively seek permanent housing for themselves/family. Explore what their plans are to accomplish this.

If the participant requires additional supports, particularly if they are at imminent risk as defined by HPS or already homeless, the CA Worker would administer the VAT assessment to determine appropriate referrals. Note that all clients admitted into the Homelessness Prevention and Rapid Rehousing program (HPRR) will be required to have a VAT completed, however, a referral for a client at risk of homelessness to HPRR can be made without a full VAT once screening for prevention is completed.

THE VULNERABILITY ASSESSMENT TOOL (VAT)

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

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

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

The VAT includes 10 domains:

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

Each VAT domain serves as one question for a total of 10 questions. Domains 1 to 9 are measured on a 1-5 scale, with a score of 1 indicating no evidence of vulnerability and a score of 5 indicating severe vulnerability. Items are summed to find total score. Those with highest scores are considered to be at highest risk and can be prioritized for services. The tool also allows for interviewer to add comments and observations.

The tool is free but requires training, though the COH is developing these tools and will be supporting communities in adapting them. Training and technical support will be low cost with goal of building community capacity to support training on an ongoing basis. A train-the-trainer approach is recommended, where key individuals in St. John's receive training nationally and then take on ongoing provision for the local community, especially given turnover in the non-profit sector.[23] The COH is also working with national HIFIS team to ensure the VAT is available on the system.

[23] The VAT is available online at http://www.desc.org/vulnerability.html

PROGRAM MATCHING

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

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

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

INFORMATION IN REFERRAL GUIDE – (311, PUBLIC, POSTERS, SOCIAL MEDIA, WEBSITES, ETC.)									
Program Name	Agency	Program Type	Target Population	Services Provided	Key Contact	Phone Number	Address	Referral Process	Eligibility Criteria

SYSTEM CAPACITY REPORT (CA AGENCIES)				
VAT Score Range	Prioritization Criteria	Capacity (Beds/Units/ Caseload)	Occupancy (Date)	Waitlist (Date)

The System Capacity Report would be updated weekly regarding occupancy and available online (Google Drive, etc.) for CA Agencies to access and update until HIFIS is fully adapted to accommodate the process (please note that emergency shelter occupancy can be updated daily given that all community-based shelter providers have signed HIFIS data-sharing agreements with the NLSA).

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

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

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

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

KEY DEFINITIONS

Based on HPS and research done by other Housing First implementing communities[24] and the Canadian Observatory on Homelessness, the Plan to End Homelessness in St. John's uses the following the definitions to breakdown our homeless population.

- Populations at **imminent risk of homelessness** are defined as individuals or families whose current housing situation end in the near future (i.e. **within 2 months**) and for whom no subsequent residence has been identified. These individuals are unable to secure permanent housing because they do not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or a public or private place not meant for human habitation (HPS).[25]

[24] See pages 10-11 from Calgary Plan to End Homelessness, Calgary Homeless Foundation, online at: http://calgaryhomeless.com/wp-content/uploads/Calgarys_10_Year_Plan_2008.pdf

See the Government of Alberta definitions of chronic and episodic homelessness online at: http://humanservices.alberta.ca/homelessness/14630.html

Also see the Canadian Homelessness Research Network's review of chronic, episodic, and transitional definitions internationally online at: http://www.homelesshub.ca/sites/default/files/BackgroundCHRNhomelessdefinition.pdf Canadian Definition of Homelessness: What's being done in Canada & elsewhere? (2012)

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

- **Transitionally homeless** persons may be homeless for the first time (usually for less than three months) or has had less than three episodes in the past three years. Most people experience homelessness for a short time and infrequently in their lifetime. Usually, this is a result of lack on income or housing affordability challenges.
- **Episodically homeless** people experience recurring episodes of homelessness throughout their lifetime. This group is likelier to face more complex challenges involving health, addictions, mental health or violence. According to HPS, an **episodic** homeless person is currently homeless and has experienced **3 or more episodes of homelessness in the past year** (of note, episodes are defined as periods when a person would be in a shelter or place not fit for human habitation, and after at least 30 days, would be back in the shelter or inhabitable location (HPS). For the Plan's purposes, once we address the needs of 90% of the estimated episodic group using the HPS definition, we would then move to a broader group which is defined using the Alberta government's episodic homeless definitions of someone who is homeless for less than a year and has fewer than 4 episodes of homelessness in the past 3 years.
- **Chronically homeless** refers to individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems) who experience long-term and ongoing homelessness as result of complex barriers, particularly related to mental health and addictions. According to HPS, they are currently homeless and have been homeless for six months or more in the past year (i.e., have spent more than **180 cumulative nights** in a shelter or place not fit for human habitation) (HPS).[26] For the Plan's purposes, once we address the needs of 90% of the estimated episodic group using the HPS definition, we would then move to a broader group which is defined using the Alberta government's chronic homeless definitions of someone who is homeless who has either been continuously homeless for a year or more, or have had at least 4 episodes of homelessness in the past 3 years.

Notably, the episodically and chronically homeless are the highest users of the system and are the most vulnerable as result of poor health. As a result, communities who aim to end homelessness often prioritize tailored interventions for these groups, then move upstream to address transitional homelessness and the at risk population. In St. John's, our approach is to strategically focus on the chronic and episodic homelessness using HPS definitions where appropriate and then shift resources to address broader groups as the immediate priority populations are rehoused and stabilized.

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

REFERRAL CONSIDERATIONS	EMERGENCY SHELTER	TRANSITIONAL HOUSING	AFFORDABLE HOUSING
VAT SCORE	Any	Moderate - High	Any
PRIORITIZATION	First come, first served	First come, first served	First come, first served
HPS ELIGIBILITY CRITERIA			
COMMUNITY PLAN CRITERIA			
ADDITIONAL CONSIDERATIONS	Available spaces/ capacity Additional program/funder eligibility criteria. Agency experience with participant/willingness to accept referral		

REFERRAL CONSIDERATIONS	PERMANENT SUPPORTIVE HOUSING	INTENSIVE CASE MANAGEMENT	PREVENTION/ RAPID REHOUSING	OUTREACH/ DROP IN CENTERS
VAT SCORE	High	High	Low - Moderate	Any
PRIORITIZATION	VAT Score + Length of Homelessness	VAT Score + Length of Homelessness	VAT Score + Length of Homelessness/ Imminent Risk of Homelessness	First come, first served
HPS ELIGIBILITY CRITERIA	Chronic (currently homeless & have been homeless for six months or more in past year) Episodic (3 or more episodes of homelessness in past year) Chronic/Episodic		Episodic / Transitional or At Imminent Risk	
COMMUNITY PLAN CRITERIA	Move to these definitions once needs of 90% of those who meet HPS criteria for chronic and episodic are met: Chronic (homeless for less than a year and has fewer than 4 episodes of homelessness in the past 3 years) Episodic (either been continuously homeless for a year or more, or have had at least 4 episodes of homelessness in the past 3 years)		Episodic / Transitional or At Imminent Risk	
ADDITIONAL CONSIDERATIONS	Available spaces/ capacity Additional program/funder eligibility criteria. Agency experience with participant/willingness to accept referral			

PRIORITIZATION

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

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

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

Eligibility criteria should be:

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

Once the referral is made, the provider receiving referrals should make every effort to connect with the participant within 5 days of receipt. They should also communicate the outcome of the referral to the referring provider and the EHSJ System Planner within 5 days of receipt and again within 5 days of connecting with the participant. If connection with the participant is not realized after 3 documented attempts and 30 days from original receipt, the participant can be reported as MIA to EHSJ and to the referring agency.

INFORMATION MANAGEMENT

An efficient information system is essential to system coordination. An integrated information system is a locally administered, electronic data collection system that stores longitudinal person-level information about those accessing the homeless-serving system. The shared information system aligns data collection, reporting, coordinated intake, assessment, referrals and service coordination in the homeless-serving system.

In St. John's, the NL Statistics Agency and EHSJ have an agreement in place to work on ensuring HIFIS implementation supports the Plan objectives moving forward. Thus, part of this work is ensuring alignment between the community's information system processes and system coordination activities, including the CA initiative.

Working with the HMIS Steering Committee, EHSJ should ensure the proposed provincial HMIS is aligned with the direction of the System Coordination Framework. This may include the addition of an HMIS Coordinator staff to provide on-the-ground training, technical assistance, and data management support for St. John's agencies.

Consents to release information for participants, as well as integration of data collection for CA with HIFIS will be required to enable this process to function appropriately. To this end, the HMIS implementation process should be closely entwined with CA implementation.

NLSA, as the HMIS lead, will be included in the planning for data management in the CA process. NLSA can provide information about HMIS capacity and limitations, assist in the analysis of which data system will best support Coordinated Access implementation, and provide information about HMIS requirements and regulations.

DETERMINING FUNCTIONALITY[27]

Information management systems can support a wide range of Coordinated Access activities. The following list includes functionality that can make Coordinated Access easier for the front-line staff and administrators and result in better service delivery to the participant.

ACCESS, ASSESSMENT, AND REFERRAL

- *Standardized assessment workflow* with prompts for additional information if needed and warning for missing information.
- *Occupancy tracking* in real-time so referrals can be made to available units/beds/caseloads.
- *Assessment results in real-time*. Assessors need to rely in part on their own experience and potential history with the person they are assessing. However, assessment tools that are programmed into Coordinated Access software can offer a systematic process for assessing people to support continuity of the process and remove as much bias as possible. Some software will score the assessment automatically indicating level of vulnerability or chronicity; currently, COH is working with HIFIS to integrate the VAT in this manner.
- *Automated eligibility determination*. This feature produces a list of housing and service resources that match the person's eligibility and needs.
- *Documentation repository*. Electronic scanning and/or upload feature that allows documents to be attached to a particular participant for both eligibility and security purposes.
- *Referral tracking with real-time status updates*. Some systems will allow front-line staff to document a referral to an agency and with proper participant consent, the receiving agency can see the referral and can document acceptance, pending or denial status and why.

[27] This section of information management was adapted from the Coordinated Entry Guidebook developed by Matt White, Abt Associates for Housing and Urban Development.

COORDINATED ACCESS MANAGEMENT

- *Systematic workflow*. All users of the system have access to the same workflow, from entering the person into the software through follow-up process post housing placement. This can result in easier front-line staff support and training.
- *Homeless and mainstream referral guide*. A searchable database of housing and service resources that can be maintained by the community. This feature allows a structured and systematic way to keep critical information including eligibility and exclusionary criteria, resources availability, and contact information.
- *Generation and real-time updates of prioritization list*. This may be a single, master list or it may be several lists based on subpopulations or sub-regions within the Coordinated Access implementing jurisdiction.
- *System-wide occupancy tracking*. Real-time reports to view current occupancy and upcoming vacancies by program type and location.
- *Administrative report*. Reports can be built into some software that allows system planners to see front-end staff work load, outstanding referrals, process roadblocks, etc.
- *Referral results*. Reports showing the number of referrals that were not accepted, remain outstanding or resulted in a successful entry into a project.
- *Performance Management*. The System Planner can determine if a particular project conducting assessments or referrals in the Coordinated Access process is performing as expected in order to fine-tune Coordinated Access. Reports can be pulled to evaluate the access, assessment, prioritization and referral phases of Coordinated Access to determine what is working and what needs adjustment.

It is recommended that the Homeless Management Information System (HMIS) Steering Committee work with national HIFIS to explore what capabilities the software has in relation to these functionalities. Once this is determined, community consultation on selecting preferred available functions should be made.

DATA ELEMENTS

In considering necessary data collection from people being evaluated by the Coordinated Access process, the HMIS Steering Committee should decide how much of the information collected at each of the following assessment points should be entered into HIFIS:

- Screening for diversion or prevention,
- Assessing shelter and other emergency needs,
- Identifying housing resources and barriers,
- Evaluating vulnerability to prioritize for assistance;
- Screening for project eligibility, and
- Facilitating connections to mainstream resources

Assessments conducted in such a phased manner should build on each other and limit the frequency with which a person must repeat a personal story so as to reduce trauma and improve system efficiency. The minimum amount of information should be passed from one phase to the next that will still allow for the appropriate level of service to be delivered.

In considering necessary data collection for evaluation of the Coordinated Access process itself, the HMIS Committee should determine what information should be collected and what to do with information collected in order to facilitate the following system-level activities:

- Referral Management: What information will be necessary to collect in order to support the CA referral, prioritization policies and procedures? Will prioritization lists be automated through software or manually managed using data pulled from the data collection system? How will prioritization information be shared with the appropriate stakeholders?
- Progress Tracking: Will HIFIS allow key stakeholders to track the progress of individual people throughout the Coordinated Access process? What information will be necessary to facilitate such tracking?
- System Monitoring: What information does the System Planner need in order to monitor daily operation? Will HIFIS allow participating projects to provide feedback regarding referrals and placement?
- Performance Measurement: How will performance of Coordinated Access be measured? What data will be necessary to conduct those measures?
- Reporting: What reports will the System Planner need from HIFIS?

DATA QUALITY

Once decisions are made about what data to collect, the HMIS Steering Committee should develop processes to promote data collection efficiency and quality. If paper-based forms are to be used for data collection, computer-based data entry forms should very closely mirror the paper data collection forms.

No matter the method of data collection and entry, rigorous and standardized training of all staff involved with data collection or entry will reduce errors and foster high quality data. Furthermore, a robust data quality plan for the entire CA process should be implemented that includes the following components:

- Concrete benchmarks for timeliness, completeness, and accuracy
- Monitoring procedures specifying how and when monitoring occurs and who is responsible
- Clear incentives for compliance
- Contractual buy-in and agreement mechanism

DATA SHARING PROTOCOLS

Data sharing benefits can include:

- Reduced burden on people who do not have to repeatedly provide the same information, especially in regard to recounting traumatic experiences
- Increased data quality
- Reduction in duplicate entries
- Increased accuracy of referrals
- Increased data quality, particularly around project entry and exits
- Reduced data collection burden for intake workers and case managers

As St. John's providers discuss data sharing within the context of CA, they should recognize that sharing data can occur at each phase of the CA process. Participant information should only be shared when needed to access housing and support services and not shared when the information is not necessary for the delivery of these services. Shared data should be on a "need to know" basis in the context of the participant's needs and broader privacy policies.

All information management must adhere to the collection of information and its use which are aligned to federal and provincial legislations and regulations and professional guidelines about privacy. Legislation includes the Privacy Act (federal), the provincial Access to Information and Protection of Privacy Act, 2015 (ATIPPA, 2015) and the Personal Health Information Act (PHIA) and any other professional regulatory bodies to which the employee has membership. Additional privacy requirements may need to be applied when collaborating with mainstream service providers.

When sharing information from one organization to another, the participant's written consent must be obtained. Written consent is not required for data collection and entry into HMIS or other Coordinated Access data system however, it is for sharing this information. Options for the person to opt-out of the data being entered into the HMIS should be available.

PERFORMANCE MANAGEMENT

Based on input from the consultations and reviews of promising approaches, a number of performance measures are proposed as a starting point for discussion moving forward. It recommended that ongoing review of these measures be taken on and that HIFIS data elements are aligned to ensure data collected aligns with the needs of the Framework's directions on performance measurement.

Over the next 12 months, it is recommended that the City of St. John's and EHSJ explore the creation of a Performance Management Planner position to lead the development of these measures and their implementation in practice (see Appendix 4 for this job description). Working with the Performance Management Planner, the HMIS Steering Committee, NLSA and the Systems Coordination Table, the position would engage agencies to refine these measures. Additional consultation with frontline agencies should be undertaken. Meetings with key funders, including AES, NL Housing and Eastern Health should be pursued to develop consistency in performance expectations across program types. These metrics should apply to system providers, such as Eastern Health, who provide services as part of the homeless-serving system.

The Performance Management Planner will play a key role in moving the HMIS development process further working with the HMIS Steering Committee. They will be integral to HMIS operations given their focus on reporting, evaluation and performance management. Appendix 4 provides the Position Description.

Training on implementing these measures is critical to their adoption in practice. Working with NLSA, EHSJ should develop a training curriculum for providers on these measures. How these measures are entered and pulled from HIFIS will need to be addressed as well. The training will need to be delivered on a go-forward basis at regular intervals to accommodated staff turnover in the sector.

Appendix 6 provides an overview of the performance measures proposed for St. John's Homeless-Serving System, while Appendix 4 provides the Performance Management Planner job description.

SERVICE STANDARDS

Service standards should also be adopted across the system and tailored to specific program types where applicable. A number of models are already in place which can be adapted once the system design is completed. This can support participants, funders, and service providers to hold each other accountable to agreed-upon quality expectations to ensure best possible outcomes. Capacity building and technical assistance will be required to support programs in meeting set service standards, which are reinforced through monitoring and remediation processes.

It is recommended that rather than starting from scratch, EHSJ and the City of St. John's review existing standards of practice in partnership with community agencies and systems to adapt these to the local context. A number of program and system standards are considered essential to well-functioning homeless-serving systems, though these will need to still be carefully reviewed over the course of the next 12 months and supported through capacity building and monitoring long-term.

As in the case of performance measures, it is recommended that the Performance Management Planner, System Planner work with the Systems Coordination Table to refine these standards. Additional consultation with frontline non-profit and public system providers should be undertaken. Meetings with key funders, including AES, Eastern Health, and United Way are needed to develop consistency. Again, these standards need to apply regardless of whether the service is being delivered by non-profit or public system providers in the homeless-serving system.

Capacity building to facilitate the implementation of these standards will be essential. To this end, EHSJ should develop a training curriculum for providers on these standards and deliver on a go-forward basis at regular intervals to accommodated staff turnover.

The standards outlined below are considered to be excellent standards of practice in the field. They are drawn from three main resources listed below.

1) Calgary Homeless Foundation's *Standards of Practice - Accreditation Process and Standards Manual*

2) Homeward Trust Edmonton's *Service Manual*

3) Mental Health Commission of Canada's *Follow-up Implementation and Fidelity Evaluation of At Home/Chez Soi Project– Appendix 5*[28]

As part of the HFSCI, program standards aligned with these documents were developed for rapid rehousing and prevention using the aforementioned sources. These standards can be adapted to other program types moving forward.

KEY STANDARDS OF PRACTICE FOR HOMELESS-SERVING SYSTEMS

STRATEGIC ALIGNMENT

Programs demonstrate:

- alignment with the broader homeless-serving system;
- alignment with Housing First philosophy;
- strategic fit with the Community Plan, federal and provincial ending homelessness goals;
- clearly articulated eligibility criteria appropriate for program type and target population;
- clear and consistent process of screening and intake of participants to ensure appropriate fit in the program;
- appropriate prioritization process for participants to access the program;
- well-articulated referral network into the program, and from the program.

[28] Calgary Homeless Foundation.2011. Standards of Practice - Accreditation Process and Standards Manual (2011) - available from http://calgaryhomeless.com/wp-content/uploads/2014/05/CHF-Case-Management-Accreditation-Manual.pdf

Homeward Trust Edmonton. Service Manual. Available from http://www.homelesshub.ca/sites/default/files/EHT Housing First Service Manual.pdf
Mental Health Commission of Canada. 2013. Project. Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-Site Report. Available from http://www.mentalhealthcommission.ca/sites/default/files/Housing_At_Home_Qualitative_Report_Follow-up_Implementation_Fidelity_Evaluation_Cross_Site_ENG_0.pdf

COMPLIANCE

Programs demonstrate:

- grievance processes are in place for participants and communicated to them;
- serious incidents review processes are in place and appropriately reported to appropraite channels;
- program is being operated in compliance with government privacy and information security requirements;
- reporting and evaluation activities meet contractual requirements and used in ongoing quality assurance efforts;
- appropriate staffing levels and qualifications are in place to operate the program effectively;
- training and capacity building activities are in place to support improved participant outcomes.

SERVICE DESIGN

Programs demonstrate:

- operations align with principles of Housing First;
- activities contribute to the goal of permanent housing and are appropriate for the program type and target population;
- program is serving target population it was designed for;
- length of time and service intensity are appropriate for the target population and program type;
- clear and consistent graduation criteria are in place to move participants to self-sufficiency, while ensuring they are supported to reduce returns into homelessness.

CASE MANAGEMENT

- acuity changes over time using an evidence-based tool demonstrating increasing stability;
- participant visits of appropriate frequency;
- appropriate staff to participant ratios;
- crisis plans are in place;
- discharge plan with aftercare and follow-up assessments to ensure no discharging into homelessness.

HOUSING PLACEMENT

- placement process aligned with principle of Housing First (participant choice, housing permanency) in scattered-site or place-based housing;
- placements in housing that is affordable for participant incomes;
- housing meets relevant safety and habitability standards;
- transparent and fair process to determine financial subsidies for participants (rent, utility supports);
- appropriate leases, third party agreements, insurance, etc. are in place;
- process to resolve tenancy issues (arrears, safety, landlord/neighbour disputes) is articulated.

TRAINING AND CAPACITY BUILDING

The development and coordination of training and capacity building activities for the Homeless-Serving sector will be critical to enhancing capacity for service delivery under Housing First, implementing the System Coordination Framework, adopting enhanced service standards and safety protocols, as well as using data in decision making, etc.

A slate of training opportunities for the sector will need to be delivered in a coordinated fashion, leveraging local expertise or bringing in technical experts as needed. The EHSJ Community Development Worker, System Planner and Performance Management Planner will develop a training agenda and coordinate sessions and trainers based on community needs. Diverse training opportunities will be organized using the Training & Capacity Building budget to fund meeting costs, trainer fees, etc.

A jurisdictional review and research identified core skills and/or training critical to Housing First and system coordination work. The list below would need to be tailored based on resources, interests, and emerging priorities. It is recommended that regular training opportunities be offered to frontline, management, and leadership staff in the sector on a monthly basis to support practice change. This will help in the creation of a professional learning community (sharing of resources, debriefing, etc.). Funds are set aside to bring in experts for training, but also to incent sharing of learning within the community among agencies, thereby recognizing and promoting local expertise.

The budget proposed $50,000 per year for 3 years (2016-2018) to support this training schedule. This would enable us to develop regular training days offered for core areas, as well as a yearly conference for frontline and management in the sector to share best practices, reflect on progress, and share learnings.

List of potential training topics for next 3 years are listed below, with core training bolded as a 2016 priority system-wide (note that some of these trainings may be combined in delivery):

1) **Crisis De-Escalation Training**
2) **First Aid/CPR**
3) **Suicide Intervention**
4) **HIV for Service Providers**
5) **Case Management – Complex Clients**
6) **Suicide Intervention**
7) **First Aid/CPR**
8) **Aboriginal Awareness**
9) **System Coordination Basics**
10) **Coordinated Access and Assessment**
11) **Vulnerability Assessment Tool training**
12) **Evaluation and Performance Management**
13) **Housing First Fidelity and Case Management Standards**
14) **Freedom of Information/Privacy legislation**
15) **Safety Planning in a Housing First Context**
16) **Trauma-Informed Practice for Frontline workers**
17) **Working with Youth and Natural Supports**
18) Inclusion/multicultural sensitivity
19) LGBTQ2s* awareness
20) HIFIS Training for frontline and agency leads
21) Homelessness and its layers
22) Working with Landlords/ Landlord-Tenant Relations

23) Understanding public benefits
24) FASD, global cognitive functioning, and other neurological issues
25) Understanding the impacts of trauma on children
26) Training for frontline workers in effective techniques (i.e. MI, DBT)
27) Case notes and record keeping
28) Individual Service Plans
29) Client engagement techniques
30) Disease education and prevention e.g., HIV/AIDS
31) Domestic violence
32) Ethics/boundaries
33) Family dynamics
34) Harm reduction approaches
35) Hoarding
36) Home visit 101
37) Mental Health First Aid, Mental health/addictions, in particular as it relates to sub-populations
38) Motivational interviewing
39) Non-violent crisis intervention
40) Psycho-social rehabilitation
41) Stages of change
42) Strength-based approaches
43) Universal precautions
44) WHIMIS/Assessing the environment
45) Work-life balance and stress management including burnout avoidance

EHSJ is concretely planning for and investing in training and capacity building activities to support the homeless-serving system through its Housing First System Coordination Initiative to ensure to our sector has support for the necessary transitions that lie ahead.

As aforementioned, we will be leveraging the training materials and opportunities offered at a national level through the Canadian Observatory on Homelessness, particularly on the VAT and are already working with their team to support our implementation of St. John's Homeless Point-in-Time Count (a separate document outlined our proposed approach for the 2016 Count). The Canadianized VAT Manual is complete and has received sign-off from DESC (the group that created the original tool). Dr. Tim Aubry is the interim Chair of the VAT Training Sub-Committee of the Housing First Toolkit Task Force.

In addition, we will be looking to access Housing First training being offered by the Canadian Alliance to End Homelessness. Training will be led by CAEH's Director of Training, Wally Czech, with a slate of offerings for communities to facilitate and accelerate the shift to Housing First and ending homelessness in Canada by providing high quality, accessible, affordable, evidence based training and technical assistance.

Services offered by the CAEH will include:

1) **Initial core community training** to introduce communities and organizations to Housing First

2) **Customized Housing First training and technical assistance** providing tailored onsite and remote training and advisory support

3) **Developmental evaluation and fidelity assessment** to assess a program's progress toward Housing First fidelity and provide quality improvement advice

4) **Professional development** on technical skills relating to Housing First (for example harm reduction and motivational interviewing)

5) **Brokered consulting services** connecting communities to Canadian and international experts on a range of needs from client prioritization and assessment to system planning for communities working to end homelessness

APPENDIX 1

HOUSING FIRST SYSTEM COORDINATION FRAMEWORK ADVISORY TEAM TERMS OF REFERENCE

PURPOSE

The St. John's Plan to End Homelessness prioritizes the development of a systems approach grounded in Housing First where diverse services are organized and delivered in a coordinated manner to advance common community priorities.

The purposeful, design and management of St. John's homeless-serving system is critical to meeting the community's objective of ending homelessness. One of the key steps to successful community-based system coordination efforts is the inclusion of thoughts, ideas, and expertise from a diverse range of community stakeholders in the development of a System Coordination Framework.

To this end, the End Homelessness St. John's (EHSJ) has secured the technical assistance of Dr. Alina Turner (Turner Research & Strategy) to work alongside this Advisory Team to develop the Framework. The Advisory Team will support this work by making recommendations on key issues pertaining to the development and implementation of the Housing First System Coordination Framework.

The Team will provide input and play a key role in the development and implementation of community engagement processes to develop the Framework, such as community forums, stakeholder interviews and focus groups.

Over the course of November 2015 to May 2016, the Team will provide input into the following key elements:

- System mapping to discern the homeless-serving system's structure and program components.
- Common system alignment processes, including consistent acuity assessment, program matching, coordinated intake, eligibility and prioritization criteria.
- Performance management and quality assurance standards in alignment with data collection, management and reporting through HIFIS.
- Capacity building needs and resources to deliver training and transition support to diverse services for successful implementation.
- A Housing First System Coordination Initiative (HFSCI) investment plan for the period April 2016-March 2019 for EHSJ approval.

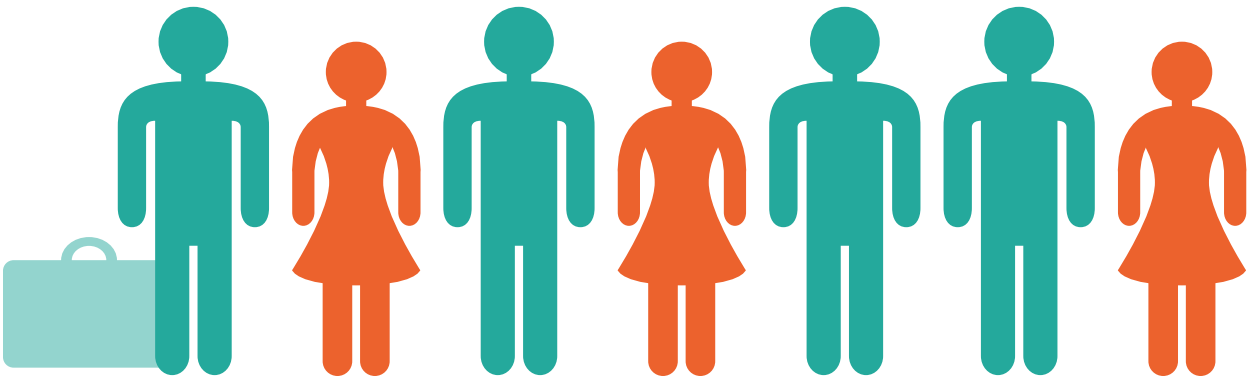
COMPOSITION OF THE ADVISORY TEAM

The Housing First System Coordination Framework Advisory Team comprises of approximately 6-8 stakeholders representing a variety of disciplines: service providers, policy makers, funders, universities, and service participants.

Current members include: Gail Thornhill (Stella's Circle), Madonna Walsh (NL Housing), Sheldon Pollett (Choices for Youth), Judy Tobin (City of St. John's), Bruce Pearce (End Homelessness St. John's), Andrew Harvey (Local Coordinator) and Dr. Alina Turner (Turner Research & Strategy).

MEETINGS & DECISION MAKING

The Advisory Team will meet and make decisions both in person and online. In person meetings will occur monthly for 1-2 hours from Nov. 2015 to May 2016.



APPENDIX 2

RESOURCES PROVIDED TO EHSJ TO ADVANCE THE SYSTEM COORDINATION FRAMEWORK

COORDINATED ACCESS POLICIES & PROCEDURES

- Calgary – provided to EHSJ
- Hennepin County – provided to EHSJ
- Coordinated Assessment Toolkit - http://www.endhomelessness.org/library/entry/coordinated-assessment-toolkit

ASSESSMENT TOOLS

- COH Report on Coordinated Assessment Tools - http://www.homelesshub.ca/sites/default/files/ScreeningforHF-Dec8.pdf
- VAT Toolkit - http://www.desc.org/vulnerability.html

SYSTEMS MAP

- Excel version
- Online Survey Tool

IMPLEMENTATION

- Excel sheet for three-year budgets for System Coordination Framework implementation, and provincial HMIS provided to EHSJ.
- Job descriptions for CA program and HFSCI expansion for EHSJ provided.

SYSTEM PLANNING

- Key Elements of System Planning - http://www.housingfirsttoolkit.ca/sites/default/files/beyond-housing-turner.pdf
- Calgary Homeless Foundation System Planning Framework: http://www.homelesshub.ca/sites/default/files/CHSS-System-Planning-Framework-online-jan2012_1.pdf
- Red Deer System Planning Framework: http://www.reddeer.ca/media/reddeerca/about-red-deer/social-well-being-and-community-initiatives/housing-and-homelessness/Red-Deers-System-Framework-for-Housing-and-Supports---Final-Report-Jan-2016.pdf

PERFORMANCE MANAGEMENT

- Performance Management Guide for Community Entities Working in a Housing First Context - http://www.homelesshub.ca/sites/default/files/CEGuide-final.pdf
- Program performance report examples using HMIS: http://calgaryhomeless.com/hmis/data-analysis

QUALITY ASSURANCE STANDARDS

- Calgary Homeless Foundation. Standards of Practice - Accreditation Process and Standards Manual (2011) - http://calgaryhomeless.com/wp-content/uploads/2014/05/CHF-Case-Management-Accreditation-Manual.pdf
- Homeward Trust Edmonton. Service Manual: http://www.homelesshub.ca/sites/default/files/EHT Housing First Service Manual.pdf
- Mental Health Commission of Canada. 2013. Project. Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Cross-Site Report.
- http://www.mentalhealthcommission.ca/sites/default/files/Housing_At_Home_Qualitative_Report_Follow-up_Implementation_Fidelity_Evaluation_Cross_Site_ENG_0.pdf

APPENDIX 3
VULNERABILITY ASSESSMENT TOOL

Participant: _____

Date: _____

Completed By: _____

VAT SUMMARY

Offered a copy, if declined (please check) ☐

Initial, Housed, 3, 6, 9, 12, Final (please circle)

See VAT Guide: http://www.uwcnvi.ca/web_documents/cfp_hps_hf_appendix_b_-_sample_assessment_tool.pdf

ITEM	DIMENSION	SCORE	DESCRIPTION
1	Survival Skills		Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment
1.1	No evidence of vulnerability	1	Strong survival skills; capable of networking and self-advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior
1.2	Evidence of mild vulnerability	2	Has some survival skills; is occasionally taken advantage of (e.g. friends only present on paydays); needs some assistance in recognizing unsafe behaviors and willing to talk about them.
1.3	Evidence of moderate vulnerability	3	Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave $ to someone for an errand and person never returned or short changed)
1.4	Evidence of high vulnerability	4	Is a loner and lacks "street smarts"; possessions often stolen; may be "befriended" by predators; lacks social protection; presents with fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors; is or was recently a DV victim; may trade sex for money or drugs
1.5	Evidence of severe vulnerability	5	Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed, sexual assault); often opts for the street to shelters; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs); clear disregard for personal safety (e.g. walks into traffic)
	Additional Comments		

2	Basic Needs		Ability to obtain/maintain food, clothing, hygiene, etc.
2.1	No Trouble Meeting Needs	1	Generally able to use services to get food, clothing, takes care of hygiene, etc.
2.2	Mild Difficulty Meeting Needs	2	Some trouble staying on top of basic needs, but usually can do for self (e.g. hygiene/clothing are usually clear/good)
2.3	Moderate Difficulty Meeting Needs	3	Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance (e.g. prompting and I&R (Information and Referral)
2.4	High Difficulty Meeting Needs	4	Doesn't wash regularly; uninterested in I&R or help, but will access services in emergent situations; low insight re. needs
2.5	Severe Difficulty Meeting Needs	5	Unable to access food on own; very poor hygiene/clothing (e.g. clothes very soiled, body very dirty, goes through garbage & eats rotten food) resistant to offers of help on things; no insight
	Additional Comments		
3	**Indicated Mortality Risks**		**Mortality Risks**
	Has none of the 8 identified risk factors	1	Mortality Risks: 1) More than three hospitalizations in 12 months; 2) More than three ER visits in previous three months; 3) Aged 60 or older; 4) Cirrhosis of the liver; 5) Renal disease; 6) Diabetes; 7) Heart disease; 8) Tri-morbidity, co-occurring psychiatric, substance abuse and chronic medical condition.
	Has 1 of the identified risk factors	2	
	Has 2 of the identified risk factors	3	
	Has 3 of the identified risk factors	4	
	Has 4+ of the identified risk factors	5	
	Additional Comments		

4	Medical Risk		Medical conditions that impact person's ability to function.
4.1	No Impairment	1	No health complaints; appears well; would likely access medical care if needed
4.2	Minor or temporary health problem(s)	2	Cast or splint but able to take care of daily activities; recovering from minor surgery and doing well with self-care; acute medical problem such as a respiratory or skin infection but takes medications; follows up with medical provider
4.3	Stable significant medical or physical issue(s), or chronic medical condition(s) that is being managed	3	Chronic but stable medical problems such as diabetes, emphysema, high blood pressure, heart disease, seizure disorder, Hepatitis C or B, HIV disease; cancer in remission; has clinic or doctor and takes meds more often than not; smaller or larger stature/size making person vulnerable; sight or hearing impaired; has not been in hospital for overnight stay in last 3 months; OR over 60 years old w/o reported conditions but does not access care even for routine checkups
4.4	Chronic medical condition(s) that is not well-managed or significant physical impairment(s)	4	Poorly managed diabetes or hyper-tension, undergoing treatment for Hep C; needs home oxygen; liver failure; kidney failure requiring dialysis, sleep apnea requiring C-PAP; HIV disease not adequately treated; dementia; severe arthritis affecting several joints, pregnancy, frequent asthma flares, recurrent skin infections, cancer. Symptoms without known explanation: swelling, untreated open wounds, shortness of breath, recurrent chest pain, unexplained weight loss, chronic cough, cognitive impairment, incontinent of urine or stool. Not taking meds as prescribed or frequently loses them; can't name doctor or last time seen; hospitalized in last 3 months; illiterate or non-English speaking.
4.5	Totally neglectful of physical health, extremely impaired by condition, serious health condition(s)	5	Untreated AIDS, terminal illness that is worsening; missing limb(s) with significant mobility or life activity issues; obvious physical problem that is not being cared for such as large sores or severe swelling. Blind, deaf and/or mute, severe dementia, uncontrolled diabetes, refuses to seek care; breathing appears difficult with activity; can't name or doesn't seek regular medical care; more than one hospitalization in past year.
	Additional Comments		

5	Organization/ Orientation		Thinking, developmental disability, memory, awareness, cognitive abilities – how these present and affect functioning.
5.1	No impairment	1	Good attention span; adequate self-care; able to keep track of appointments
5.2	Mild impairment	2	Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmental disability; dementia or other organic brain disorder; some mild memory problems
5.3	Moderate impairment	3	Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or developmental disability problems
5.4	High impairment	4	Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult
5.5	Severe impairment	5	Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to manage; memory fully or almost or absent / impaired
	Additional Comments		
6	**Mental Health**		**Issues related to mental health status, MH services, spectrum of MH symptoms & how these impair functioning.**
6.1	No MH issues	1	
6.2	Mild MH Issues	2	Reports feeling down about situation, circumstances; (e.g. situation depression)
6.3	Moderate MH issues	3	Reports having MH issues, but does not talk about them; reports having service connection already in place; may be taking prescribed medications
6.4	High MH issues	4	Tenuous service engagement; possibly not taking medications that are needed for MH; not interested in services due to mental illness / low insight
6.5	Severe MH needs	5	No connection to services (but clearly needed), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/ paranoia, fearful/phobic, extreme depressed or manic mood); no insight regarding mental illness
	Additional Comments		

7	Substance Use		Issues related to substance use, services, spectrum of substance use & how use impairs functioning
7.1	No or Non-Problematic Substance Use	1	No substance use or strictly social – having no negative impact on level of functioning.
7.2	Mild Substance Use	2	Sporadic use of substances not obviously affecting level of functioning; is aware of substance use, still able to meet basic needs most of the time
7.3	Moderate Substance Use	3	Ninety (90)-180 days into addiction recovery; COD w/o any follow-up care; relapse risk still present. OR Substance use affecting ability to follow through on basic needs; has some support available for substance use issues but may not be actively involved; some trouble making progress in goals (e.g. could be a binge user.)
7.4	High Substance Use	4	In first 90 days of CD treatment or addiction recovery; still enmeshed in alcohol/drug using social group; high relapse potential. OR Use obviously impacting ability to gain/ maintain functioning in many areas, (e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs); not interested in support for substance use issues but this may be due to low insight or other reasons (e.g. mental illness)
7.5	Severe Substance Use	5	Active addiction with little or no interest in CD treatment involvement. Obvious deterioration in functioning (e.g. MH, due to Sub Use); severe symptoms of both substance use & mental illness; low or no insight into substance use issues; clear cognitive damage due to substances; no engagement with substance use support services (and clearly needed)
	Additional Comments		
8			
8.1	No communication barrier		Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs
8.2	Mild communication barrier		Has occasional trouble communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed
8.3	Moderate communication barrier		Poor attention span; withdrawn but will interact with staff/ service providers when approached; pressured speech; very limited English
8.4	High level communication barrier		Physical impairment making communication very difficult (e.g. hearing impaired & unable to use ASL); unwilling/ unable to communicate w/ staff (e.g. shy, poor or no eye contact); doesn't speak English at all
8.5	Severe communication barrier		Significant difficulty communicating with others (e.g. mute, fragmented speech); draws attention to self (e.g. angry talk to self/others); refuses to talk to staff when approached; may leave to avoid talking to provider
	Additional Comments		

9	Social Behaviors		Ability to tolerate people & conversations, ability to advocate for self, cooperation, etc.
9.1	Predatory behaviors, and/or no problems advocating for self	1	Has a hx of predatory behavior; is observed to be targeting vulnerable clients to "befriend"; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so
9.2	Mildly problematic social behaviors	2	Mostly "gets along" in general; if staff need to approach person, s/he can tolerate input & respond with minimal problems; may need repeated approaches about same issue even though it seems s/he "gets it"
9.3	Moderately problematic social behaviors	3	Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some noncooperation problems at times
9.4	Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some noncooperation problems at times	4	Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self
9.5	Severely problematic social behaviors	5	Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and off-putting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network
	Additional Comments		
10	**Homelessness**		**Length of Time Homeless**
10.1	At imminent risk of homelessness	1	Populations at imminent risk of homelessness are defined as individuals or families whose current housing situation end in the near future (i.e. within 2 months) and for whom no subsequent residence has been identified. These individuals are unable to secure permanent housing because they do not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or a public or private place not meant for human habitation (HPS definition).
10.2	Transitionally homeless	2	Transitionally homeless persons may be homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years.
10.3	Episodically homeless	3	Episodically homeless refers to individuals, often with disabling conditions, who are currently homeless and have experienced 3 or more episodes of homelessness in the past year (of note, episodes are defined as periods when a person would be in a shelter or place not fit for human habitation, and after at least 30 days, would be back in the shelter or inhabitable location (HPS definition)
10.4	Chronically homeless	4	Chronically homeless refers to individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems), who are currently homeless and have been homeless for six months or more in the past year (i.e., have spent more than 180 cumulative nights in a shelter or place not fit for human habitation) (HPS definition)
10.5*	Length of time homeless (#years)	5	Total number of years homeless; * Addition for St. John's only.
	Additional Comments		

END HOMELESSNESS ST. JOHN'S SYSTEM PLANNER CONTRACT

The System Planner will provide consulting services to support the implementation of End Homelessness St. John's (EHSJ's) System Coordination Framework. This contract position will report to EHSJ's Community Development Worker through a contract with the Homelessness Partnering Strategy Community Entity (CE) which is the City of St. John's Community Services Department (Non-Profit Housing Division), and will be accountable to EHSJ's Board of Directors.

The contract is for a maximum of $56,250.00 consisting of consulting fees inclusive of all other taxes and expenses unless otherwise agreed upon, for a minimum of 640 hours from July 15, 2016 to March 31, 2016. Monthly hour logs and invoices will be submitted for reimbursement.

Based on yearly reviews, EHSJ needs and funding, the contract will be reviewed with possibility for renewal in 2017/18 and 2018/19 (at $76,875 in 2017 and $78,796 in 2018, based on 12 months' service annually for a minimum of 1,280 hours/yearly).

The System Planner will provide supports the overall Coordinated Access (CA) implementation process by developing protocols and processes and ensuring effective and efficient operations of the model. The System Planner will represent the Coordinated Access initiative at a community level and will form relationships with community partners. This person must be responsive to changes in the homeless sector and general management of the initiative.

The role aligns with the current approach taken by EHSJ grounded in community development principles, collaborative decision-making and collective impact. It also ensures that an organization is dedicated to system coordination without playing a role in direct client service provision. This is an exciting opportunity for those who are interested in community stakeholder engagement, enjoy interacting with a wide and diverse range of individuals and agencies, and who wish to have a major role to play in St. John's 2014-2019 Community Plan to End Homelessness.

The System Planner will have experience providing leadership at the community level, understand St. John's community processes, budgeting and arising issues. They are able to facilitate building local capacity in the non-profit sector and support the implementation of system coordination and Homeless PIT Counts on an ongoing basis.

ACCOUNTABILITIES AND DELIVERABLES

- Facilitate engagement of homeless-serving system partners in developing Policies and Procedures for the CA initiative
- Works with EHSJ to secure funds to resource CA implementation
- Provides training on VAT and other CA processes
- Leads quality assurance processes for the CA initiative
- Supports the CA Agencies in this transition
- Continues to refine Systems Map and Referral Guide on an ongoing basis
- Develops a Referral Form and step-by-step process for CA agencies
- Keeps up to date inventory of programs and fill rate on a weekly basis and share this with providers in a weekly System Capacity Report
- Works with the Performance Management Planner to develop a database to keep track of CA referrals and their outcomes
- Develops reports on CA outcomes and learnings to the Systems coordination table
- Works with the EHSJ Community Development Worker to deliver schedule of training and events to improve coordination and service quality in the homeless serving sector.
- Supports the Systems Coordination Table and prepares materials for review
- Supports the Lived Experience Council Table and prepares materials for review
- Documents system barriers and represent these at Systems Coordination Table
- Liaises with partner agencies on an ongoing basis
- Identifies community skills, assets, issues and needs
- Ensures the homeless serving sector is included in planning and implementation
- Identifies new resources in dialogue with the community and assessing existing approaches
- Builds links with other groups and agencies
- Helps to raise public awareness on issues relevant to the community
- Prepares reports and policies
- Develops and implements strategies that advance the Plan and System Planning Framework
- Liaises with interested groups and individuals to set up new services

EDUCATION & EXPERIENCE

- Master's degree preferred, with at least two years' experience in non-profit environment; or, will consider candidate with Bachelor's degree and at least five years' experience in the non-profit environment;
- Leadership experience with ability to mentor, coach and inspire staff is strongly preferred;
- Experience negotiating with a variety of community stakeholders;
- Experience with a variety of software systems, including Microsoft Office;
- Knowledge and experience with complex database structures.

GENERAL COMPETENCY REQUIREMENTS

CULTURALLY CONGRUENT

A passion for, belief in and communication of the EHSJ vision, mission and values. Will promote a transparent, ambitious, goal and achievement oriented culture. Demonstrates a strong service ethic and customer service approach.

BUILDING EFFECTIVE TEAMS

Creates strong morale and spirit in her/his team; shares wins and successes; fosters open dialogue; delegates appropriately to team; defines success in terms of the whole team; creates a feeling of belonging in the team.

COLLABORATIVE AND COLLEGIAL

Works well with others, whether at the most senior levels, with direct reports or with others across the organization. Understands how to work with the community in a collaborative manner.

MANAGING CHANGE

Ability to adapt and thrive in a changing environment; capable of maintaining high levels of performance under pressure.

RESULTS ORIENTED

Sets high standards of performance including setting goals and priorities that maximize available resources to deliver results against the EHSJ direction, objectives and public expectations. Will monitor progress and make adjustments as necessary on an ongoing basis.

PROJECT MANAGEMENT SKILLS

Proven strong project management skills with ability to multi-task and set priorities within tight timelines.

CREDIBILITY

Demonstrated ability to build organizational trust in his or her professionalism, expertise and ability to create solutions and deliver desired outcomes.

Application Deadline: _____

Apply To: _____

END HOMELESSNESS ST. JOHN'S PERFORMANCE MANAGEMENT PLANNER CONTRACT

The Performance Management Planner will provide consulting services to support the implementation of End Homelessness St. John's (EHSJ's) System Coordination Framework. This contract position will report to the City of St. John's Manager of Non-Profit Housing, Community Services Department which serves as the Homelessness Partnering Strategy Community Entity (CE), and will be accountable to EHSJ's Board of Directors.

The contract is for a maximum of $37,500.00 consisting of consulting fees inclusive of all other taxes and expenses unless otherwise agreed upon with for a minimum of 430 hours from September 1, 2015 to March 31, 2016. Monthly hour logs and invoices will be submitted for reimbursement.

Based on yearly reviews, City of St. John's needs and funding, the contract will be reviewed with possibility for renewal in 2017/18 and 2018/19 (at $$75,000 in 2017 and $76,875 in 2018, based on 12 months' service annually for a minimum of 1,280 hours/year).

The Performance Management Planner will lead community consultation process on developing performance measures and service quality standards and support their implementation in practice advancing the System Coordination Framework. They will support the evaluation and monitoring needs of the City with respect to its role as the Community Entity (CE) for Homelessness Partnering Strategy vis-à-vis funded sub-projects.

The Planner plays a key role in the implementation of the strategic direction and system coordination priorities focusing on program investments and liaison with partner agencies. This is an exciting opportunity for those who are interested in community stakeholder engagement, enjoy interacting with a wide and diverse range of individuals and agencies, and who wish to have a major role to play in St. John's 2014-2019 Community Plan to End Homelessness.

The Planner will actively engage the community in collaborative projects and assume leadership positions as identified by the community. The duties of the role are split between community development and contract management work. The Planner must be able to demonstrate strong communication and group facilitation skills.

ACCOUNTABILITIES AND DELIVERABLES

- Supports the CE in managing funding investment portfolio in homelessness by related to contract management requirements;
- Implements investment performance management, competitive acquisition and contracting, compliance monitoring, and evaluation processes to support ongoing quality improvement, accountability, strategy implementation and reporting;
- Ensures ongoing system and program level performance management processes are in place and recommend ongoing improvements and changes to ensure Plan milestones are met;
- Leads the development and implementation of service quality standards throughout the homeless-serving system;
- The Performance Management Planner will play a key role in moving the HMIS development process further working with the HMIS Steering Committee. They will be integral to HMIS operations given their focus on reporting, evaluation and performance management. Appendix 4 provides the Position Description.
- Supports reporting projects for the CE, including relevant analysis of the Homeless Management Information System (HMIS) to performance management purposes;
- Evaluates program and system performance against Plan goals and report as appropriate to diverse stakeholders;
- Engages in contract management and negotiations;
- Implements key capacity building and training initiatives to increase homeless serving system's capacity to deliver Plan goals resulting in enhanced standards of practice in service delivery.

EDUCATION & EXPERIENCE

The ideal candidate will possess the minimum of a Bachelor's degree in a research, planning, business, leadership/management, or social services related program. Preference will be given to those candidates in possession of a Master's degree or pursuing a Master's degree.

Ideally the candidate will have experience in the not-for-profit social services sector with a minimum of 3 years' experience in:

- program oversight including financial monitoring and demonstrated experience in the cycle of Continuous Quality Improvement;
- program audit; and analysis;
- working with external stakeholder groups, such as community agencies;
- ability to mentor, negotiate with, coach and inspire stakeholders;
- using variety of software systems and complex database structures, particularly HIFIS.

GENERAL COMPETENCY REQUIREMENTS

CULTURALLY CONGRUENT

A passion for, belief in and communication of the EHSJ vision, mission and values. Will promote a transparent, ambitious, goal and achievement oriented culture. Demonstrates a strong service ethic and customer service approach.

BUILDING EFFECTIVE TEAMS

Creates strong morale and spirit in her/his team; shares wins and successes; fosters open dialogue; delegates appropriately to team; defines success in terms of the whole team; creates a feeling of belonging in the team.

PROJECT MANAGEMENT SKILLS

Proven strong project management skills with ability to multi-task and set priorities within tight timelines.

ANALYTICAL & FINANCIAL MANAGEMENT SKILLS

Ability to analyze data to arrive and effective conclusions and understanding of financial implications of data

COLLABORATIVE AND COLLEGIAL

Works well with others, whether at the most senior levels, with direct reports or with others across the organization. Understands how to work with the community in a collaborative manner.

MANAGING CHANGE

Ability to adapt and thrive in a changing environment; capable of maintaining high levels of performance under pressure.

RESULTS ORIENTED

Sets high standards of performance including setting goals and priorities that maximize available resources to deliver results against the EHSJ direction, objectives and public expectations. Will monitor progress and make adjustments as necessary on an ongoing basis.

PROJECT MANAGEMENT SKILLS

Proven strong project management skills with ability to multi-task and set priorities within tight timelines.

CREDIBILITY

Demonstrated ability to build organizational trust in his or her professionalism, expertise and ability to create solutions and deliver desired outcomes.

Application Deadline: _____

Apply To: _____

APPENDIX 5
ST. JOHN'S HOMELESS-SERVING SYSTEM COMPONENTS

Component definitions provide detailed descriptions of each program type available in the St. John's Homeless-Serving System and current classification based on available information. This document should be updated yearly at a minimum by the EHSJ System Planner.

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Outreach & Drop In Centres			
Engagement intended to link individuals and families who are homeless and in need of shelter, housing and support services.	Low-demand, accessible services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into housing and engaging them in services over time. Multi-disciplinary staff provide or link persons with: case manager, assistance to develop a person-centered case management plan, housing placement, on-site psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services.	Homeless/at risk individuals and families.	Choices for Youth – Outreach Program Stella's Circle – Brian Martin Housing Resource Centre Salvation Army – New Hope Community Centre The Gathering Place AIDS Committee NL – SWAP THRIVE – Learning Programs Community Sector Council NL – Vibrant Communities Empower NL – Advocacy Skills Stella's Circle – Just Us Women's Centre Key Assets – Child and Family Services Eastern Health – Psychiatric Assessment Unit Department of Advanced Education and Skills – Income Support

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Emergency Shelter			
Emergency Shelter programs provide stabilization and assessment, focusing on quickly moving all persons to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.	Entry point shelter with: • showers, • laundry, • meals, • other basic services, Linkage to case manager and housing counselor (co-located on-site), with the goal of helping households move into stable housing as quickly as possible. Shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct VAT assessment of repeat clients or clients requesting such assessment within 14 days of entry to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed. First time homeless clients will receive a VAT assessment upon or after the 7th day of a continuous shelter stay.	Homeless individuals, youth and families.	Stella's Circle – Naomi Centre Choices for Youth – Young Men's Shelter Salvation Army – Wiseman Centre St. John's Native Friendship Centre – Shanawdithit Shelter The AIDS Committee NL – Tommy Sexton Centre Iris Kirby House

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Emergency Shelter			
Emergency Shelter programs provide stabilization and assessment, focusing on quickly moving all persons to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.	Entry point shelter with: • showers, • laundry, • meals, • other basic services, Linkage to case manager and housing counselor (co-located on-site), with the goal of helping households move into stable housing as quickly as possible. Shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on client needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct VAT assessment of repeat clients or clients requesting such assessment within 14 days of entry to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the client will need to remain stably housed. First time homeless clients will receive a VAT assessment upon or after the 7th day of a continuous shelter stay.	Homeless individuals, youth and families.	Stella's Circle – Naomi Centre Choices for Youth – Young Men's Shelter Salvation Army – Wiseman Centre St. John's Native Friendship Centre – Shanawdithit Shelter The AIDS Committee NL – Tommy Sexton Centre Iris Kirby House

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Prevention & Rapid Re-housing			
Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. Prevention programs provide assistance to individuals and families at risk of becoming homeless. Prevention programs couple financial support (rent and utility arrears, damage deposit etc.) with case management to achieve housing stabilization. These programs stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance; programs divert clients at the shelter door and connect clients to financial assistance. Prevention and Rapid Rehousing programs tend to target lower acuity clients with less frequent homelessness lengths of stay and episodes (transitionally/episodically homeless). The elements of these program types can be combined to ensure a continuum of supports is in place for those at imminent risk and/or transitionally homelessness. The aim is to shorten the time homeless as much as possible, where preventing a homelessness episode is not possible.	Housing Identification • Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness/at risk. • Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. • Assist households to find and secure appropriate rental housing. Rent and Move-In Assistance (Financial) • Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing. • Provide financial assistance to prevent evictions and housing loss (utility and rent arrears, etc.) Case Management and Services • Help individuals and families experiencing homelessness/ at risk identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. • Help individuals and families experiencing homelessness/ at risk address issues that may impede access to housing (such as credit history, arrears, and legal issues). • Help individuals and families negotiate manageable and appropriate lease agreements with landlords. • Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing. • Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided. • Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.	Individuals and families at experiencing transitional/ episodic homelessness or at imminent risk of homelessness with moderate levels of acuity, who are able to live independently once intervention ends (<12 months)	Stella's Circle Brian Martin Housing Resource Centre – HPRR Program Enhancement Choices for Youth Outreach and Youth Engagement Program – HPRR Program Enhancement Salvation Army (multiple programs) Key Assets – Residential and Family Based Care

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Intensive Case Management			
Intensive Case Management (ICM): longer-term case management and housing support to high acuity homeless participants facing addictions, mental health, and domestic violence and the length of stay generally between 12 and 24 months. Programs are able to assist participants in scattered-site housing (market and non-market) through wrap-around services and the use of financial supports to subsidize rent and living costs and increase self-sufficiency.	Housing Identification • Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness. • Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. • Assist households to find and secure appropriate rental housing. Rent and Move-In Assistance (Financial) • Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing. ICM Case Management and Services • Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. • Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues). • Help individuals and families negotiate manageable and appropriate lease agreements with landlords. • Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing. • Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided. • Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.	Individuals and families at experiencing episodic/ chronic homelessness with moderate levels of acuity, who are able to live independently once intervention ends (<24 months)	Eastern Health – ACT Team, NAVNET, Tuckamore Centre, Connect Team Department of Advanced Education and Skills Choices for Youth – Moving Forward Stella's Circle/Choices – Front Step Correctional Services Canada – Community Mental Health Services Canadian Mental Health Association NL – Justice Program THRIVE – Street Reach Dept. of Child, Youth & Family Services – Youth Services Program

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Transitional Housing			
Safe, temporary apartments located in project-based or scatter-site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency.	Safe units located in site-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency. Recognizing that a zero tolerance approach does not work for all clients, some transitional housing programs would employ a harm reduction, or tolerant, approach to engage clients and help them maintain housing stability assuming that the project-based environment allows for appropriate observation of the family environment and care of children. Housing assistance may be provided for up to 2 years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services. Housing plan within 2 weeks. Average stay is 6 months – but up to 2 years. All programs provide follow up case management post exit. Expectation of 6 months of post placement tracking to assess success.	Homeless single adults and families contemplating recovery or newly in recovery, youth, ex-offenders, single-parent females younger with children	Stella's Circle – Emmanuel House Iris Kirby House John Howard Society NL – Howard House Pleasant Manor Stella's Circle – Jess' Place

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Permanent Supportive Housing			
Project-based, clustered and scattered-site permanent housing linked with supportive services that help residents maintain housing.	Permanent housing with supports that help clients maintain housing and address barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; 24/7 tenant support services; and property management services. Recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while clients are in treatment or in other institutions. If a client returns to a program after 30 days and their unit was given to someone else, staff should work with that client to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage clients with serious substance abuse issues. While in PSH, clients should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.	Targeted to persons experiencing long-term homelessness, disabilities, and significant barriers to self-sufficiency.	Stella's Circle – Supportive Housing, Carew Lodge Choices for Youth – Rally Haven, The Lilly The AIDS Committee NL – HIV Supportive Housing

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Permanent Supportive Housing			
Project-based, clustered and scattered-site permanent housing linked with supportive services that help residents maintain housing.	Permanent housing with supports that help clients maintain housing and address barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; 24/7 tenant support services; and property management services. Recognizing that relapse is part of the recovery process, PSH programs should hold units open for 30 days while clients are in treatment or in other institutions. If a client returns to a program after 30 days and their unit was given to someone else, staff should work with that client to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage clients with serious substance abuse issues. While in PSH, clients should receive supportive services appropriate to their needs from their case manager and/or the ACT multidisciplinary team.	Targeted to persons experiencing long-term homelessness, disabilities, and significant barriers to self-sufficiency.	Stella's Circle – Supportive Housing, Carew Lodge Choices for Youth – Rally Haven, The Lilly The AIDS Committee NL – HIV Supportive Housing

COMPONENT TYPE	ESSENTIAL ELEMENTS	TARGET POPULATION	ST. JOHN'S PROGRAMS
Affordable Housing			
Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive services.	Broad range of clustered or scattered-site permanent housing options for individuals with temporary barriers to self-sufficiency, including group living arrangements, shared apartments, or scattered-site apartments. Clients can receive rental subsidies (transitional or permanent, deep or shallow) and supportive services. Both length and intensity of housing subsidy and services are defined on a case-by-case basis depending on client's needs.	Persons who were formerly homeless/at risk	NL Housing City of St. John's Stella's Circle John Howard Society NL – Garrison Place
Support Services			
Support Services are involved in the homeless-serving system, including furniture banks, food services, education, employment and health supports for vulnerable populations. These may not however responsible for housing outcomes as a primary objective.	Essential elements differ depending on program focus.	Target population may not be strictly homeless/at risk – broader definitions of vulnerability may be used.	Home Again Furniture bank ACCESS Women's Clinic Key Assets – Residential and Family Based Care Stella's Circle – Brian Martin Housing Resource Centre Service NL – Residential Tenancies Division Dept. of Justice and Public Safety – Victim Services Senior's Resource Centre NL – Information and Referral Services Dept. of Advances Education and Skills – Income Support Eastern Health – Housing Division John Howard Society NL – Learning Resources/ C-STEP program

APPENDIX 6

ST. JOHN'S HOMELESS-SERVING SYSTEM PERFORMANCE MEASURES

**Support Services will have program-specific measures.*

	OUTREACH & DROP-IN CENTRES	EMERGENCY SHELTER	TRANSITIONAL HOUSING
CAPACITY	annual # of clients served	# of beds/units	# of beds/units
OCCUPANCY	N/A	90%	95%
LENGTH OF STAY/ STABILIZATION		21 days	90% households are stably housed at 6 months. 75% households remain stably housed at 12 months post exit. 50% households remain stably housed at 24 months post exit.
DESTINATIONS AT EXIT	70% of clients engaged in program leave program to go to positive housing destinations	50% of those engaged with shelter service providers leave program to go to positive housing destinations	85% go to positive housing destinations
RETURN TO HOMELESSNESS	N/A	Less than 20% of clients return to shelter/rough sleeping within the next 2 years. For individuals and families in similar circumstances in the preceding year, incidence was at least 10% less than in the year before.	Less than 5% of clients return to shelter/rough sleeping within the next 2 years
INCOME	20% of those engaged with shelter service providers report an increase in income from employment and/ benefits	30% of those engaged with shelter service providers report an increase in income from employment and/ benefits	85% of clients leaving program report an increase in income from employment and/ benefits Where clients are unable to increase income, 95% maintain stable source of income
INTERACTION WITH PUBLIC INSTITUTIONS	Program defined, if applicable	Program defined, if applicable	Program defined, if applicable
PROGRAM-SPECIFIC	30 days from initial contact to engagement. 30 days from engagement to VAT assessment. VAT assessment completed on all clients within 60 days of initial contact.	Initial shelter intake within 24 hours. All emergency shelter clients residing in shelter for more than 7 days receive VAT assessment, placement score, and successful linkage to the most appropriate housing stability program type. Emergency shelter clients are placed in housing stability program within an average of 21 days. Housing placements include: Rapid Re-housing Transitional Housing Affordable Housing Permanent Supportive Housing	90% households provide improved family environment for children (e.g., improved school attendance).

	AFFORDABLE HOUSING	PERMANENT SUPPORTIVE HOUSING	INTENSIVE CASE MANAGEMENT	PREVENTION/ RAPID REHOUSING
CAPACITY	# of beds/units	# of beds/units	# of point-in-time case load capacity; annual # of clients served	# of point-in-time case load capacity; annual # of clients served
OCCUPANCY	95%	95%	95%	90%
LENGTH OF STAY/ STABILIZATION	At any given reporting period, 85% of the people housed will still be permanently housed. Households maintain housing (no exits to non-permanent housing destination).	90% of households maintain permanent housing (no exits to non-permanent housing destinations 90% of households who leave the program, obtain more autonomous or independent living arrangements	95% maintain housing for at least 6 months; at least 85% maintain housing for at least 12 months	90% households are stably housed at 6 months. 75% households remain stably housed at 12 months. 50% households remain stably housed at 24 months.
DESTINATIONS AT EXIT	Less than 5% return to shelter within 6 months., within 12 months.	85% of clients leaving program go to positive housing destinations	85% of clients leaving program go to positive housing destinations *Homeless individuals are considered to have successfully exited the program when they demonstrate the ability to maintain stable housing and require less intensive supports and services, and as a result, leave an organization's Housing First client caseload.	85% of clients leaving program go to positive housing destinations # of clients referred are diverted from shelter (i.e., they would have become homeless otherwise) due to prevention assistance.
RETURN TO HOMELESSNESS	Less than 5% of clients return to shelter/rough sleeping within the next 2 years	Less than 5% of clients return to shelter/rough sleeping within the next 2 years	Less than 5% of clients return to shelter/rough sleeping within the next 2 years	Less than 5% of clients return to shelter/ rough sleeping Clients do not enter shelter system within 180 days (6 months) following the provision of prevention assistance.
INCOME	Program defined, if applicable	50% Households increase income (earned and/or benefit).	85% of clients leaving program report an increase in income from employment and/ benefits Where clients are unable to increase income, 95% maintain stable source of income	85% of clients have an increase in income at program exit
INTERACTION WITH PUBLIC INSTITUTIONS	Program defined, if applicable	Intake and Exit comparison of: EMS interactions, Hospital days, days in jail/ prison etc.	Intake and Exit comparison of: EMS interactions, Hospital days, days in jail/prison etc.	Intake and Exit comparison of: EMS interactions, Hospital days, days in jail/prison etc.
PROGRAM-SPECIFIC				90% households provide improved family environment for children (e.g., improved school attendance).