

# Connecticut's Coordinated Entry Assessment, VI-SPDAT Retirement, and By-Name-List Version 2



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# Retiring the VI-SPDAT

# Retiring the VI-SPDAT

## How did we get here?

In December 2020 OrgCode Consulting, the developer of the VI-SPDAT, announced the tool would be phased out



A 2019 study looked at the racial disparities within the VI-SPDAT scoring and found that, in general, people who are black, indigenous, and people of color (BIPOC) receive lower prioritization scores than white individuals, even though BIPOC are disproportionately represented in the population of individuals experiencing homelessness. In practice, white people are more likely than BIPOC to confirm they experienced vulnerabilities favored by the subscales.

# Retiring the VI-SPDAT

## From OrgCode.com

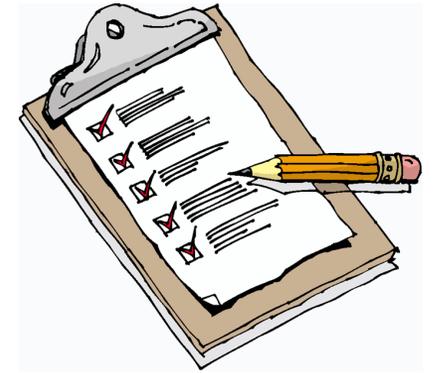
- “In 2013, the VI-SPDAT was created to support communities in engaging people experiencing homelessness, identifying what the next steps might be for each household based on their unique situation, and to assist with identifying the 'most vulnerable' to be served first. We worked with partners to create something that moved us past approaches dedicated to first come - first served, good (or bad) luck, or worse, services and housing as a reward for good behavior. **In its origin, the VI-SPDAT was meant to assist communities in a more equitable distribution and allocation of deeply limited resources.**”
- “Despite our best efforts to communicate and train on recommended practices for who should be administering the survey, when it should be administered, and how the survey should be used, communities were going to use the VI-SPDAT in whatever way that they wanted. After efforts to move communities to the improved version 3 of the tool proved less successful than hoped, the decision to discontinue the VI-SPDAT work was finalized.”
- “Debates over the VI-SPDAT – as a tool and how it was being used in communities – continued to be a distraction to the mission of ending homelessness. We need less debate about tools and more focus on getting people housed and helping them stay housed.”

# Retiring the VI-SPDAT

From OrgCode.com

**Not an Assessment Tool:** the VI-SPDAT was never designed to be an assessment tool.

- “It was designed as a triage tool where it explicitly states that assessment should follow whatever results come from the VI-SPDAT.”
- “That assessment should be comprehensive, empowering, strengths-based, trauma-informed, factor in equity considerations, placed in the context of the local community and composition of the population served, and the intentions of Coordinated Entry.”
- “Unlike the self-reported triage tool, we also believe assessment should capture information using multiple methods: self-report; what is factually observed; with consent, what other professionals have to contribute to understanding the specific needs of the household; and documentation and service data.”
- “Most (all?) communities included in these studies treated the VI-SPDAT as an assessment tool; then the studies fault the VI-SPDAT for various reasons that the tool was never designed to do.”



# Retiring the VI-SPDAT in CT

- Over the years practice of “assessment” and “matching” of housing resources has evolved in CT.
- As Diversion funding expanded, more training and emphasis was placed on “problem solving” and developing a “housing plan” at the front door. Continued efforts of Diversion were encouraged as people moved throughout the system.
- Front line staff were doing the “assessment” all along.
- We noticed people with particularly long lengths of homelessness did not always have high VI-SPDAT scores, which caused them to be skipped over for housing opportunities.

# Efforts to replace the VI-SPDAT in CT

- In 2019 a group met to work on developing a replacement “assessment” tool. We soon realized we did not have the expertise or bandwidth to develop a tool that would not fall to the same issues the VI-SPDAT did.
- In March 2021 DOH released a memo announcing the intent to retire the VI-SPDAT. We have been working since to get HMIS ready for this and updating the policies and procedures accordingly (while navigating a public health emergency).

# But HUD says....

“we need to have an assessment tool”.

From the HUD Notice on CE Requirements:

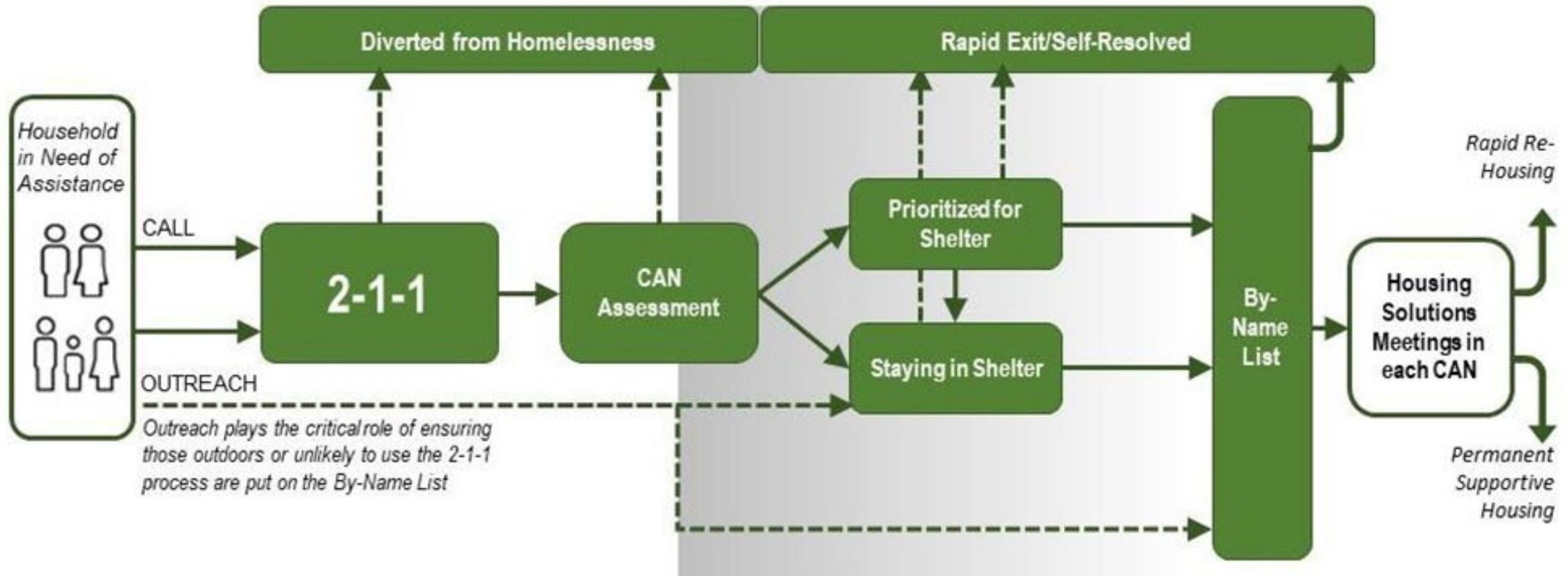
The assessment component of the coordinated entry process may be implemented in phases in order to capture information on an as-needed basis as participants navigate the process, recognizing that trauma-informed approaches are necessary throughout these phases. For example, assessment phases may include the following:

- a) screening for diversion or prevention;
- b) assessing shelter and other emergency needs;
- c) identifying housing resources and barriers; and
- d) evaluating vulnerability to prioritize for assistance.



# CAN System Overview

A high-level diagram of the coordinated access process from entry to exit



# Components of Standard Assessment Process

A look at the new policies

# Community Input

- The CAN Managers received input from the CAN staff responsible for housing matching to learn what was most practical (Housing Solutions Workgroup)
- The new policies closely align with actual practices currently happening



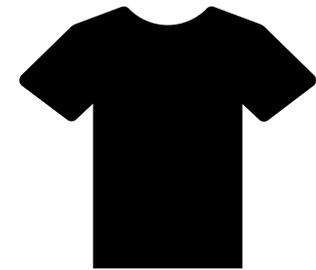
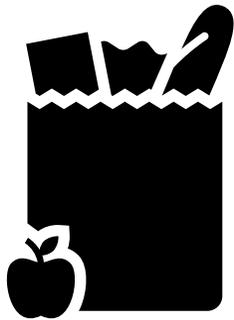
# Components of Standard Assessment Process



# Components of Standard Assessment Process

## Needs Assessment

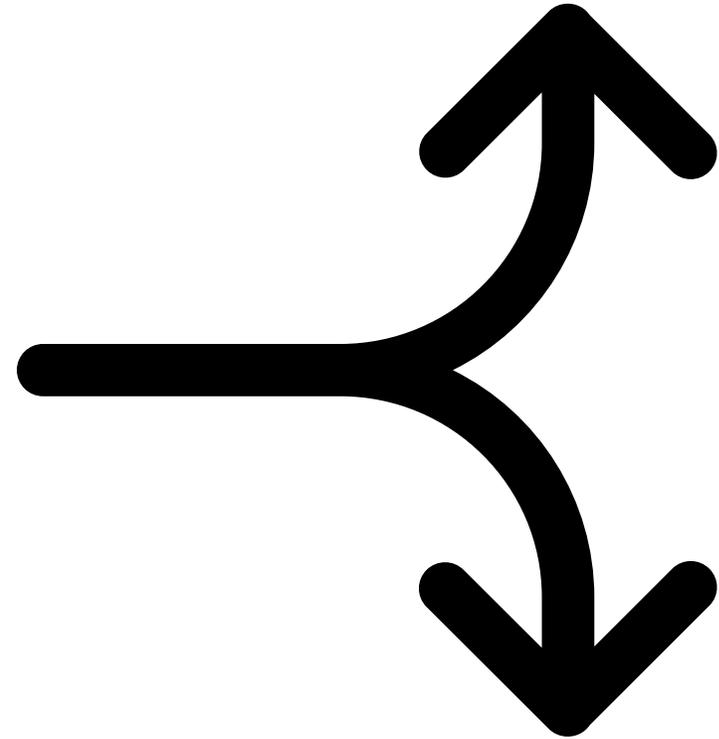
Assessment of needs related to housing and other basic needs (food, clothing, etc.) and referrals as appropriate to other systems of care such as child welfare, income supports and public benefits, workforce development and employment supports, legal aid and mediation, etc.



# Components of Standard Assessment Process

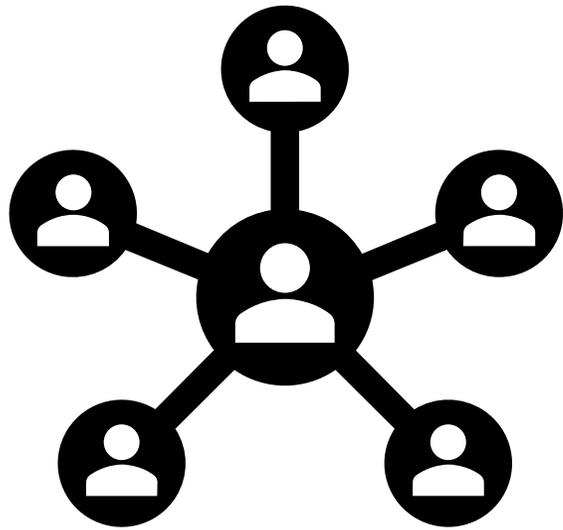
## Diversion

Diversion/problem-solving conversation and referrals to both formal and informal supports where possible. Diversion is not a single step in the process and should be attempted at each phase in case circumstances have changed and the household is able to rely on other supports to resolve their episode of homelessness. The Diversion/problem-solving conversation should include the initial development of a housing plan, based off of the presumed eligibility for CAN resources.



# Components of Standard Assessment Process

## Special Population Identification



Assessors identify if the client could be eligible for resources dedicated to certain populations such as Veterans, youth, persons fleeing or attempting to flee domestic violence, persons living with HIV/AIDS, etc.

# Components of Standard Assessment Process

Release of Information

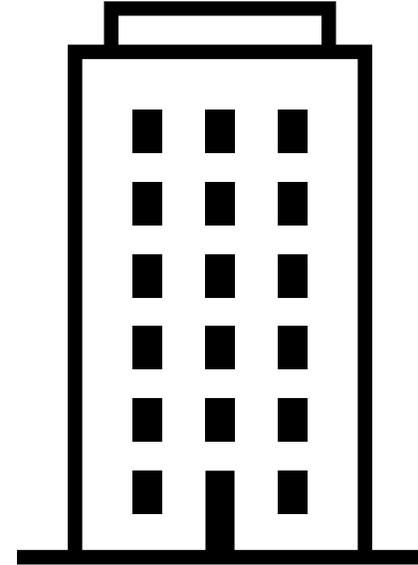
Completion of Releases of Information (ROI) to allow data entry into CT HMIS.



# Components of Standard Assessment Process

## Shelter Referral

Refer to shelter, if unable to divert, and the household is or will be unsheltered that evening.



# Components of Standard Assessment Process

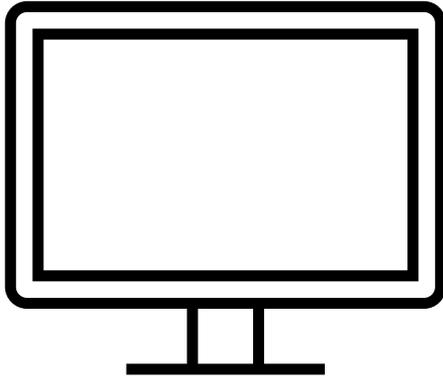
## Initial Assessment

Completion of an initial assessment to make a preliminary determination of likely program eligibility and inform referral strategies for additional housing and services.



# Components of Standard Assessment Process

Create HMIS Record



Record the information from the assessment and result of the appointment in CT HMIS.

# Prioritization for Permanent Supportive Housing (PSH)

# PSH Prioritization

Priority #1: People currently enrolled in Rapid Rehousing (RRH) and were DedicatedPLUS at RRH entry, who have been identified by the CAN as needing a higher level of housing care.

## Details

- a. **Initial Assessment and eligibility review result indicates PSH level of care.**
- b. Cohort is prioritized by the earliest enrollment date in RRH.
- c. If a household is currently unsheltered and also enrolled in RRH, that factor is used as a tie breaker.
- d. Exceptions may be made, based on CAN case conferencing discussion. See policy for details.

# PSH Prioritization

## Priority #2: Verified Chronic Homelessness

### Details

- a) **Cohort is prioritized by cumulative length of time homeless verified by a third party.**
- b) Generally, the initial assessment/eligibility review result (or equivalent tool for population) should indicate the household is presumptively eligible for PSH. If the eligibility assessment result indicates a lower level of care, the CAN will generally offer RRH if available; however, CANs may exercise discretion when case conferencing reveals that the length of time homeless does not accurately reflect a client's need/vulnerability. If RRH is unavailable, the CAN will need to determine if the individual/family will be offered PSH based on several factors, including, but not limited to:
  - i. Anticipated availability of RRH.
  - ii. Timeliness of identifying a PSH referral.
  - iii. Identified service needs.
  - iv. Household primarily experiencing unsheltered homelessness.
- c) **If a household is currently unsheltered, that factor is used as a tie breaker, with priority status provided for the unsheltered household.**
- d) Exceptions may be made based on CAN case conferencing discussion. See policy for details.

# PSH Prioritization

## Priority #3: Verified Dedicated PLUS and not Chronic Homelessness

### Details

- a) Cohort is prioritized by cumulative length of time homeless verified by a third party.
- b) Generally, initial assessment/eligibility review result (or equivalent tool for population) should indicate the household is presumptively eligible for PSH. If the eligibility assessment result or equivalent indicates a lower level of care, the CAN will generally offer RRH if available. If RRH is unavailable, the CAN will need to determine if the individual/family will be offered PSH based on several factors, including, but not limited to:
  - i. Anticipated availability of RRH.
  - ii. Timeliness of identifying a PSH referral.
  - iii. Identified service needs.
  - iv. Household primarily experiencing unsheltered homelessness.
- c) If a household is currently unsheltered, that factor is used as a tie breaker, with priority status provided for the unsheltered household.
- d) Exceptions may be made based on CAN case conferencing discussion. See policy for details.

# PSH Prioritization

## PSH Prioritization Criteria for when there are No Eligible DedicatedPLUS Households

### Details

It is the responsibility of CANs to coordinate with housing and service providers in their covered geographic area to ensure due diligence in conducting outreach and assessment to locate and engage eligible households who meet DedicatedPLUS criteria. However, PSH units should not be kept vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH.

# PSH Prioritization

## Priority #4: Currently Literally Homeless AND Formerly but not Currently Chronic and/or DedicatedPLUS

### Details

Households prioritized under this category must:

- a) be currently literally homeless; AND
- b) be formerly but not currently chronic or DedicatedPLUS; AND
- c) have lost chronic or DedicatedPLUS status due to an institutional stay; or
- d) have lost PSH or RRH within the last year.

# PSH Prioritization

Priority #5: Currently enrolled in RRH *and* literally homeless (HUD Category 1 & 4) at RRH entry and have been identified by the CAN as needing a higher level of housing care.

## Details

- a) Generally, initial assessment/eligibility review result (or equivalent tool for population) should indicate the household is presumptively eligible for PSH; however, CANs may exercise discretion when case conferencing reveals that the score does not accurately reflect a client's need/vulnerability.
- b) Cohort is prioritized by the earliest enrollment date in RRH.

# PSH Prioritization

## Priority #6: All Other Currently Literally Homeless (HUD Category 1 & 4), Excluding those in Transitional Housing

### Details

- a) Cohort is first prioritized by cumulative length of time homeless verified by a third party.
- b) Cohort may also be prioritized by eligibility determination as a proxy of severe service need.

# PSH Prioritization

## Priority #7: Homeless Individuals and Families Coming from Transitional Housing.

### Details

- a) Time in transitional housing cannot be applied toward the 12 months of homelessness necessary for chronic and/or DedicatedPLUS eligibility;
- b) Households currently living in transitional housing are literally homeless but not qualified as chronic or DedicatedPLUS;
- c) Such households may only be served in PSH under priority #7.

# Rapid Rehousing Prioritization

RRH contractors must work within their CAN to receive appropriate referrals that coincide with the above described prioritization. **The CAN decides how to prioritize their allocation of RRH funds for financial assistance.** CANs may also establish specific policies regarding short- and longer-term rapid rehousing, or other specific population RRH programs, with regard to targeting these sub-programs to specific populations eligible for RRH.

# Prioritization and Fair Housing

The Fair Housing Act prohibits discrimination in housing on the basis of race, color, religion, sex, family status, national origin or disability. Other than prohibiting the seven bases of discrimination listed above, the Act does not limit the considerations that may be taken into account in making a housing decision or prevent the adoption of preferences as long as those preferences do not violate the rights of one of those seven classes. The Act permits preferences for persons who are disabled.



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# New Prioritization for Young Adults

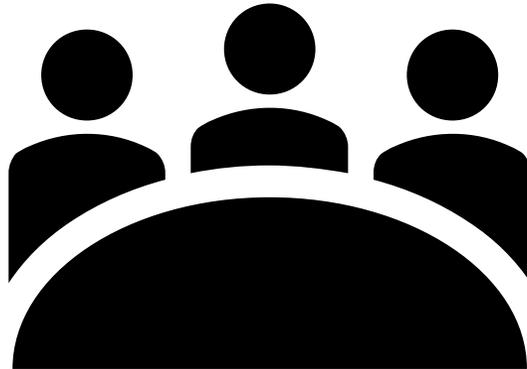
The unmatched Youth By-Name-List should be prioritized in the following way.

- (1) Youth who had at least one previous episode of homelessness
- (2) Most number of days homeless to least, in current homeless episode
- (3) Unsheltered (**YES/NO**)
- (4) If all youth not currently residing in a transitional housing program\* are matched to a resource, then youth currently residing in transitional housing, where they were experiencing Cat 1 and/or 4 homelessness prior to entering transitional housing, can be considered for rapid rehousing resources based on the priority criteria above.

\*YHDP Crisis TH programs should be considered crisis housing programs and not transitional housing programs for prioritization purposes.

# Case Conferencing

- Robust Case Conferencing is critical to ensure all the information obtained from the “assessment” process is factored into the housing matching process.
- Matching is often based on what is available at any given moment. Someone can meet eligibility for PSH and have a long length of homelessness, BUT only RRH has vacancies that week.
- Each CAN has trained staff that facilitate the matching process and will take into account individual circumstances, staff input and projected availability of resources to make the best decision at the time. It’s an art AND a science.



# By Name List v2

# What is By Name List v2?

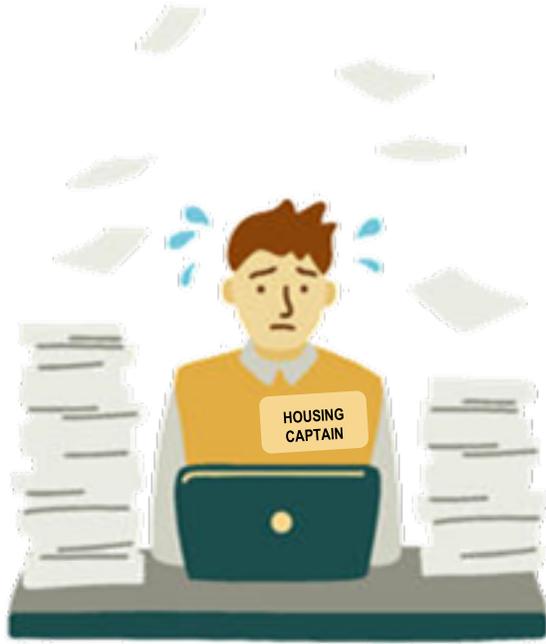
A new, more comprehensive list of everyone currently experiencing homelessness in our system



**BNL v2** uses the actual enrollment data in CT HMIS to compile an active list that includes everyone experiencing homelessness in Connecticut who has current or recent activity in the system.

The current BNL requires each client to have a VI-SPDAT (or Family VI-SPDAT or Next Steps Tool) assessment and they must be manually marked as Active to be included on the list.

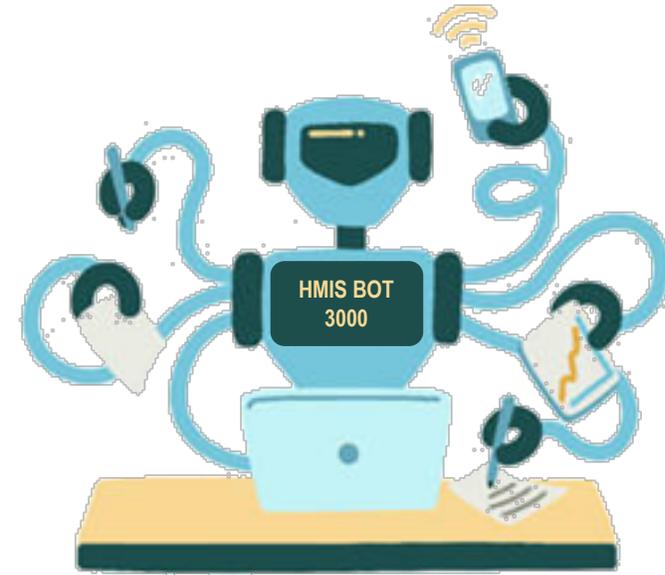
# Criteria for Inclusion on BNL Active Lists



## MANUAL PROCESS

### Current BNL Active List:

- Must be literally homeless
- Must have VI-SPDAT
- Must be marked as “Active” by a housing captain or BNL manager



## AUTOMATED PROCESS

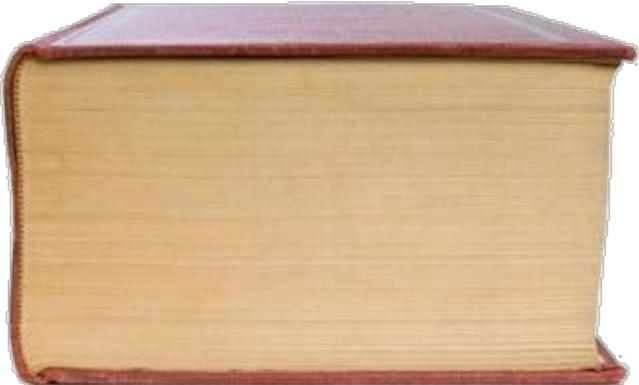
### BNL v2 Active List:

- Must be literally homeless
- Current/recent enrollment in outreach, emergency shelter, or other literal homeless projects

# The BNL v2 Active List is Bigger!

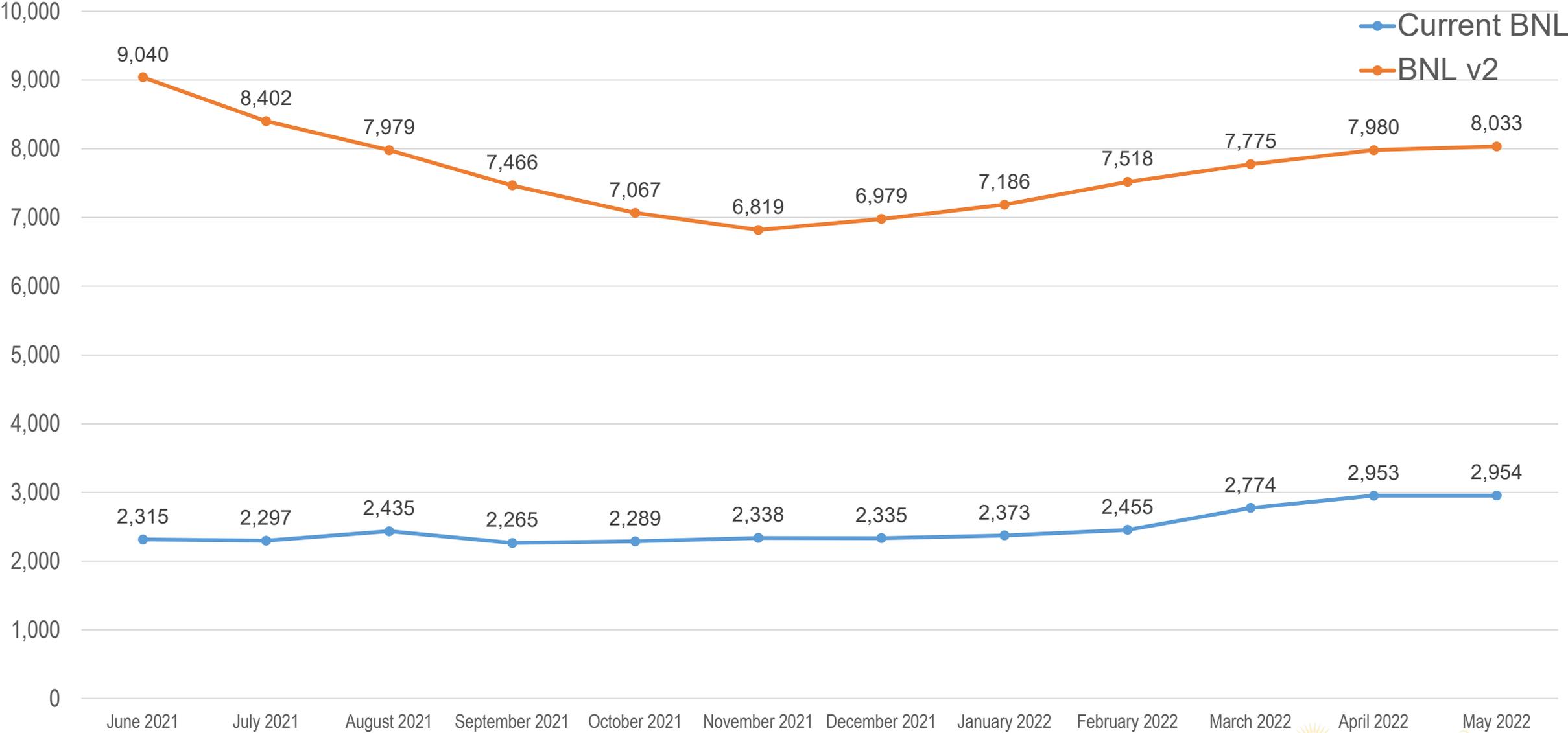


**Current BNL**  
2,954 Active  
on May 1, 2022



**BNL v2**  
8,033 Active  
on May 1, 2022

# The BNL v2 Active List is Bigger!



# Adding People to the BNL Active List

**SCENARIO 1:** In spring 2022, a client who was housed by our system last year returns to homelessness and enrolls at Claus House Emergency Shelter. How do we ensure the client is included on the Active list for housing matching?

## Current BNL process

A staff member at Claus House contacts a BNL manager for the CAN to update the client's status to "Active" on the BNL.

## BNL v2 process

The client is automatically included on the active list because they have an open enrollment in a literally homeless project.



# Adding People to the BNL Active List

**SCENARIO 2:** A new client attends their CAN appointment today. Unfortunately, there are no viable options for diversion from homelessness and the client will be sleeping at Claus House Emergency Shelter tonight. How do we ensure that this client is included on the Active list for housing matching?

## **Current BNL process**

Wait 14 days. Meet with client to complete the appropriate VI-SPDAT assessment.

## **BNL v2 process**

The client is automatically included on the active list because they have an open enrollment in a literally homeless project.



# Adding People to the BNL Active List

**SCENARIO 3:** An outreach worker has been engaging with a person who consented to enrollment in the Omni Outreach program. They do not want to answer more questions than necessary. How do we ensure that this client is included on the Active list for housing matching?

## Current BNL process

Continue periodic engagement until the VI-SPDAT assessment is complete, which may take piecemeal questioning over multiple visits.

## BNL v2 process

The client is automatically included on the active list because they have an open enrollment in a literally homeless project.

# Removing People from the BNL Active List

**SCENARIO 4:** A client at Claus House Emergency Shelter is leaving today, and staff records the exit destination as “Staying or living with family, permanent tenure”. The client has no other enrollments in the system. How do we ensure that the client is not included on the active list?

## **Current BNL process**

Shelter staff contacts the CAN BNL manager to have the client marked as Inactive and Housed on the BNL.

## **BNL v2 process**

The client is automatically excluded from the active list because they do not have any currently open literally homeless enrollments and their exit destination was to housing.



# Removing People from the BNL Active List

**SCENARIO 5:** At the housing matching meeting today, one of the clients on the active list is known to be housed. After confirming that the person is housed, how do we ensure that the client is not on the active list tomorrow?

## **Current BNL process**

A BNL manager updates the client's status to Inactive and Housed on the BNL.

## **BNL v2 process**

Check the client's enrollment history. If any literally homeless enrollments are still open, contact the providers to close the enrollments with the appropriate exit destination. If all enrollments are closed, ensure that the exit destinations are recorded correctly.

# Removing People from the BNL Active List

**SCENARIO 6:** Staff at Claus House Emergency Shelter close the enrollment of a person who has not been at the shelter for a period of time, marking their exit destination as unknown. This was the client's only homeless enrollment in CT HMIS. How do we exclude this client from the active list?

## **Current BNL process**

If the client was on the BNL, a BNL manager for the CAN updates the client's status to "Inactive" on the BNL after all due diligence attempts are exhausted.

## **BNL v2 process**

Since the client's exit was not to a housed destination, the client will remain on the active list for 90 days after their last date of homelessness activity in the system, unless an exit to housing is recorded.

# By Name List v2 - Preview

# BNL 2.0 Location – In CT HMIS

The screenshot displays the CaseWorthy™ user interface. At the top, a dark blue navigation bar contains the CaseWorthy logo, a hamburger menu icon, and three tabs: 'CASE MANAGEMENT' (active), 'ADMINISTRATION', and 'MY CASES'. Below this, a breadcrumb trail shows 'Dashboard'. The left sidebar identifies the user as 'Empowered Solutions Group' and features a 'Reporting' section with a dropdown arrow and a 'Custom BNL Exports' option. The main content area is titled 'CT HMIS - General Reports' and features a large blue circular icon with a white person silhouette and three dots. Below the icon, the text 'By Name List (BNL) v2' is displayed.

# BNL 2.0 Report Parameters

Save Report  
Parameters

## Documentation Link

## Select report criteria.

Period End Date  
(Defaults to  
Today)

CAN Filter ★  
(Enrollment)

All  None  Some

Organization(s) ★

All  None  Some

Program Type ★

All  None  Some

Project(s) ★

All  None  Some

Sort By ★

## General Filters

Household Types ★

VI/Next Steps ★  
Assessment

# BNL 2.0 Key Columns

HMIS ID	Age	Gender	Household Type (From Qualifying Enrollment)	Coordinated Access Network*	Preferred Community	# Days Homeless (All Time)	# Days Homeless (Last Three Years)	# Months Homeless (All Time)	# Months Homeless (Last Three Years)
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- Demographic Information

- Client ID
- Name
- DOB
- Family ID
- Household Type (Family or Individual)
- Relationship to Head of Household

- Location Information

- Coordinated Access Network
- Preferred area/town where client wants to live
- Current Living Situation

- Prioritization Information

- Days and Months Homeless

- Eligibility Information

- Chronic Status
- Disability Status

# THANK YOU!

