COORDINATED ENTRY APPEALS

- Coordinated Entry referral decisions are made by a consensus of the case conferencing group. Any agency that disagrees with the decision of the group would need a way to appeal these decisions to a neutral body.
- The Coordinated Entry Advisory Committee (CEA) directed HomeFirst and CDC staff to draft a proposal for this committee.

COORDINATED ENTRY APPEAL COMMITTEE PROPOSAL

- Two (2) housing providers
- Two Coordinated Entry Access points
- 1-2 Other representatives. These could be a provider that doesn't receive referrals but is involved in addressing homelessness. This could be a FQHC, or staff who works for an agency that address homelessness but is not involved in service delivery.

All of the representatives would ideally be from a higher level than the staff that attends the case conferencing meeting. The appeals committee would only need to meet on an as-needs basis rather than having a regular standing meeting.

SHELTER MONITORING COMMITTEE

- Shelters are required to set aside 25% of their beds for referrals from hospitals, outreach teams and other emergency service providers.
- A community group tasked with implementing this policy recommended to the CEA the creation of a Shelter Monitoring Committee to monitor compliance with this policy and to address other issues at shelters.
- CEA considered this proposal at the June 15th meeting but there was concern that the committee lacked any formal oversight power, and was not clear on what the scope of this group would be.

SHELTER MONITORING COMMITTEE

- Staff feels that this group could be helpful with monitoring the bed set aside policy.
- This committee could also hear concerns about shelters and report these to the CEA or CoC board.
- Staff recommends limiting the scope of this group to monitoring the set aside policy and hearing general concerns.
- Staff does not recommend having this body hear client-level grievances as agencies already have processes in place to address these concerns.

EMERGENCY HOUSING VOUCHERS

- There is a large gap in supportive services for many of the EHV voucher holders. This is partially caused by the recently approved policy amendment to Rapid Rehousing (RRH) prioritization and partly caused by a lack of capacity among RRH providers. Staff estimates that there are roughly 150 voucher holders who will not be able to access supportive services. A working group has met to discuss this gap. The group is looking to engage with RRH providers to see their capacity and to determine the amount of funding needed to serve the clients and to try to identify possible funding sources and agencies that have capacity.

EMERGENCY HOUSING VOUCHERS (EHV)

- Santa Rosa Housing Authority has requested 30 EHV referrals.
- Previously, there was a working group that disbursed these referrals.
- Now that the new CE operator is holding case conferencing meetings for all referrals, there is no need for a parallel process.

EMERGENCY HOUSING VOUCHERS (EHV)

- Recommendations
  - Provide direction on what subpopulation the EHV vouchers should be directed.
  - Direct that these referrals be made through the new case conferencing meeting and not through a parallel process.
  - Consider revising the populations served by EHV. Below are 2 proposals
  - Pair ESG and EHVs as intended originally, but use RRH scoring range. Would not require any CE policy changes, as it would still fit in the "other housing prioritization" policy. Con: Would require an amendment to the EHV MOU. Would require heavy lift in terms of coordination with RRH providers, contracted numbers to serve, etc, to ensure that the total number of individuals served is not reduced.
  - Direct referrals at the Move-On population. This would include creating a “step down" policy from higher service-intensive interventions to lower, and use it for these vouchers with PSH move ons. Pro: Smart resource distribution, would open up several PSH slots in the community. The clients would presumably not need any supportive services as the intention of Move on is to serve individuals who are no longer in need of supportive services. Con: would require a policy amendment, there is the potential that there will not be 30 clients in PSH programs ready to move on.