

Potential Barriers to Success

Currently, this sector is significantly underfunded and understaffed. Several church-based programs exist to facilitate prisoner re-entry. Ongoing work and coordination between groups will be critical for increasing sector resources.

Meeting HUD Priorities

The prison re-entry sector specifically supports the following HUD Priorities.

HUD Priority	
B7	Make communities more livable.
F3	Establish substance abuse treatment programs targeted to the homeless population.
F4	Establish job training programs that will provide opportunities for economic self-sufficiency.
F5	Establish counseling programs that assist homeless persons in finding housing, managing finances, managing anger, and building interpersonal relationships.
F6	Provide supportive services, such as health care assistance that will permit homeless individuals to become productive members of society.
F7	Provide service coordinators or one-stop assistance centers that ensure chronically homeless persons have access to a variety of social services

SECTOR 7: ACCESS TO SERVICES

Overarching Goal

Individuals and families who are homeless or imminently at risk of becoming homeless can find and access services easily.

Sector Description

Ensuring that people can find and access services easily can be viewed from three perspectives: clients, providers, and continuum of care (which represents the community).

- Clients: Individuals and families should be able to easily determine if services are available to meet their specific needs. They should be directed to the providers, programs, and/or services that best match their most critical concerns. Ideally, clients should be able to receive most if not all of their needed services through a minimum number of site visits. Where it is necessary to access multiple providers, it is beneficial to have coordination between the providers so that conflicting demands do not burden the client. It is also helpful to minimize the number of times clients must provide the same information to different organizations. Any system of sharing data must provide for approval/consent by the client.
- Providers: Providers need to know where there are gaps, both in their own services as well as across the entire continuum. Providers can better coordinate services and expectations/requirements if they can view (have access to) the entire client picture. Shared data serves individual clients more effectively while also ensuring better distribution of services to all clients reducing overlaps and redundancy. Finally, access to high quality comprehensive data assists providers with grant writing and reporting which, in turn, expands funding sources.
- Continuum of Care: To ensure clients have access to services, the Continuum of Care needs to have a broad picture of what is available and where there are gaps (both missing services and inadequate availability). The Continuum of Care also benefits from unduplicated population data from which create a community-wide perspective of services. The Continuum of Care must be able to measure the effectiveness of programs and services in order to effectively allocate resources and measure progress.

Progress in the Last Five Years

Five years ago, access to care focused on how homeless individuals received services when they found their way to social service agencies – a process which was complicated and full of obstacles. One of the long time barriers to access was the lack of a coordinated information and referral process. Every organization had its own resource list or “sticky note system” which rapidly became outdated and required duplicative effort to maintain. The outcome for clients

was that information given with the best of intentions often caused inconvenience for both clients and providers. A second barrier was the lack of coordinated data collection and reporting. This barrier hampered even the best efforts to coordinate care, made it difficult for providers to report on clients served and services provided (both for internal management and for fund development and reporting), and precluded any data-driven focus on performance outcomes or determination of gaps and needs.

Today, access to care has evolved into a systemic approach to data collection/reporting and improved service coordination. Progress has been made on several key fronts.

- **2-1-1:** 2-1-1 is the national abbreviated dialing code for free access to health and human services information and referral. 2-1-1 is an easy-to-remember and universally recognizable number that makes a critical connection, via referrals, between individuals and families in need and the appropriate community-based organizations and government agencies. In 2001, Pikes Peak United Way joined the effort to bring a coordinated Information & Referral system to the Pikes Peak Region by joining the Colorado 2-1-1 Collaborative in the kick-off stage.

The local center was launched in June 2004, making 2-1-1 available to El Paso, Teller, Park, Chaffee, Lincoln, and Cheyenne counties (5 other centers provide the service to 37 additional counties). Since that time, the database of resources in El Paso County has expanded to cover nearly 400 providers and 2,000 services (statewide it includes 3,600 providers and 13,000 services). The data is maintained regularly to ensure a high degree of accuracy, and it encompasses not only name, address, phone number, and hours of operation, but also includes such information as eligibility, intake procedures and requirements/limitations, need for appointment, accessibility to bus routes, and much more. The database greatly improved matching client need to provider thus reducing the frustration for both. Since 2004, local call volume has tripled from under 8,000 to 24,373 in 2008 (statewide call volume was 220,000 for 2008).

- **Homeless Management Information System (HMIS):** In 2003, Homeward Pikes Peak contracted with Pikes Peak United Way to be the System Administrator for the local HMIS. This met both the community and provider need for a data system and HUD's requirement that every Continuum of Care create an HMIS. Tapestry software was chosen primarily because it was already in use for the statewide 2-1-1 system thus offering coordination with the Metro Denver and Balance of State Continuums of Care. The objective was to have a fully integrated and statewide 2-1-1 and HMIS system (one of only a few in the country). Local Continuum of Care agencies were an integral part of the software design, working with the vendor to develop and implement software that would meet both HUD and community requirements. Since the pilot implementation in December 2005, the following has been accomplished.

- 10 providers are actively using HMIS and over 9,000 client records have been created.
- Data drawn from the HIMS was an integral part of the 2008 SuperNOFA application charts.
- The community has achieved or exceeded required bed coverage in four of six categories (three of the four required categories and one of the two optional), and have total bed coverage of 59% (goal is 75%).
- During 2008, the Continuum of Care voluntarily participated in the Annual Homeless Assessment Report in 3 of 4 categories.
- Colorado Springs used the HMIS for the January 2009 Point-In-Time survey.
- The Continuum of Care has worked with the vendor to implement many system improvements and expansions.

HMIS now has the ability to provide the information necessary to quantitatively examine how homeless services are provided in the community and justify appropriate action steps. Data elements to inform these indicators have been incorporated into each sector's action plans. Aggregated, they will convey a point-in-time snapshot of homelessness in the Pikes Peak region. Over time, the data elements will delineate progress and remaining gaps. Both will be used to update annually the 10-year plan as part of the region's Conference on Homelessness. The HMIS Advisory Committee meets monthly, and establishes policies and procedures as well as provides oversight for HMIS usage in the Continuum of Care.

- **Point-In-Time Surveys:** In 2002, Catholic Charities of Colorado Springs undertook the region's first point-in-time count of homeless persons. Since then, Homeware Pikes Peak and Pikes Peak United Way have facilitated 7 subsequent counts: March 2004, January and August 2005, January and August 2006, January 2007, and January 2009. The semi-annual counts in 2005 and 2006 allowed the community to examine seasonal differences. The August 2006 and January 2007 counts were part of a coordinated statewide effort to measure homelessness, the first in 17 years. All survey results are an integral part of HUD SuperNOFA application and reporting, and are one of the components of the needs assessment process. Results are provided on demand and are used regularly in grant applications and reports.
- **Housing/Bed Inventory:** As part of the point-in-time process, Pikes Peak United Way annually updates the Housing/Bed Inventory and HMIS Participation chart. The chart encompasses Emergency Shelter, Transitional Housing, and Permanent Supportive Housing, and includes individual and family beds, special populations, HMIS participation, and bed utilization rates. This, too, is an integral part of the HUD SuperNOFA application and reporting, and is another major component of the needs assessment process.

- **Needs Assessment:** Housing and service needs are assessed annually by CHAP participants, HMIS Advisory Committee, Homeward Pikes Peak, and the city's Housing and Community Development Division. This year, El Paso County is conducting a comprehensive, county-wide housing needs assessment which will add additional comprehensive data to the 2009 assessment process. One of the Access Sector's action steps (see page 78) is to improve this process through service gaps/needs data.
- **Annual Homeless Assessment Report (AHAR):** The AHAR is HUD's annual report to Congress on the state of homelessness in the United States. Data must be drawn from the HMIS and covers four categories: Emergency Shelter Individuals and Families, and Transitional Housing Individuals and Families. The data includes year-long data as well as quarterly snapshots of duplicated and unduplicated number of people (in several demographic breakdowns), length of homelessness, frequency of use and cross-category use, and bed utilization rates. Colorado Springs became a voluntary, contributing Continuum of Care for the October 2007 – September 2008 reporting period in 3 of the 4 categories. It is currently expected that AHAR participation will be mandatory in 2010.
- **Rapid Reader Card System:** In July of 2007, Colorado Springs began working with the HMIS vendor and a sub-vendor to develop a card printer/reader system to facilitate data collection and service delivery. The system consists of a camera to capture a picture of the client, a printer to produce a card with the client's picture and bar code of a Personal Identification Number (PIN), and a scanner to record services delivered to clients. In the short term, the system will assist clients and providers of high-volume services such as shelters, soup kitchens, and emergency services by facilitating service enumeration. In the long run, it will facilitate client access to services through a streamlined intake process and data sharing if/when allowed by clients. The Continuum of Care is currently completing testing of the pilot implementation at the New Hope Center and will complete at least two more pilot sites in 2009.
- **Rapid Re-Entry pilot:** Homelessness, particularly for families, is often situational. Loss of employment, catastrophic illness, or divorce can plunge adults and children alike into crisis. The 2008 SuperNOFA application provided funds for pilot Rapid Re-Entry programs. These programs rely on early identification and resolution of a family's or individual's housing barriers and provide the supportive service assistance necessary to facilitate their speedy return to permanent housing. Interfaith Hospitality Network has outlined a Rapid Re-entry pilot program for this community. Upon approval from HUD, the pilot will be initiated with clients in Interfaith Hospitality Network programs.

Current Gaps and Barriers

Access to care continues to be confounded by the lack of centralized intake tools and coordinated case management. Client data is inherently difficult with the homeless population as individuals move between service providers, friends, and relatives. Client data sharing, particularly related to healthcare, is governed by HIPAA regulations. Currently, the HMIS system does not generate unduplicated counts or Continuum of Care-wide reports automatically. Data must be manipulated manually - a time and labor-intensive process. HMIS staff are working with a volunteer to build a more responsive reporting mechanism and working with the vendor to build more serviceable reporting tools.

As this 10-Year Blueprint evolved, data specificity became more critical. Not all agencies, even within a sector, quantify process outputs or measure outcomes using the same data elements. During 2009, HMIS staff will meet with each sector to delineate the specific measurement tools and data most relevant to outcome measurement. These outcome indicators will also be important for evaluation of program effectiveness. Examples of outcome indicators to be examined include:

- Percentage or rate of people seeking serves able to access those services.
- Measurable improvement in one or more key areas such as housing stability, income, employment, education.
- Point in time decrease in homelessness as a proportion of the population.
- Reduction in time individuals and families are homeless.
- Reduction in services sought over time in the continuum of care.

Ensuring sector data reflects sector priorities will hone HMIS requirements and help refine the next iteration of the 10-Year document.