Housing Opportunities Action Council (HOAC)
Ten Year Plan to Address Homelessness
DRAFT Work Plan, 17-19

Intervention Area 2: Comprehensive Care Coordination	**Overarching Goal:** Inform a new system of care coordination, in which residents have universal access to case management services, and are supported in maintaining or accessing permanent affordable housing and other community resources.

Impact Indicators:

Strategy:

- 2.1. By July 2019, increase the capacity of the service provider system to provide comprehensive, well-coordinated case management services.

Problem:

Persons experiencing homelessness and housing instability often have complicated needs requiring involvement of multiple service providers; fragmented, inconsistently coordinated service delivery system; no single point of coordinated entry/universal assessment system to access services; clients often interface with multiple care coordinators as they navigate a complex, confusing service system; provision of population specific housing supports (i.e. vets, single women with children, persons with disabilities, etc.), without addressing gaps in the whole system. Fragmented data systems make it difficult to understand the need and complexity of the affordable housing crisis; annual point in time count does not adequately capture size and scope of the homeless population; current demographic and population level data are not centralized for easy access by the public; limited capacity to maintain and update data.

Milestones:	Dates:
Convened planning team of agencies providing care coordination and case management (HOAC Care Coordination Action Team).	September 2017
Inventoried agencies providing care coordination and case management in the region and completed gaps analysis of current referral pathway system.	September 2017
Recommended shared/common definition of care coordination/case management.	December 2017

Housing Opportunities Action Council (HOAC)
Ten Year Plan to Address Homelessness
DRAFT Work Plan, 17-19

• Common coordinated intake/entry form drafted, including common data standards and definitions, with specialty questions as addendum (Developed a coordinated entry, assessment, and application process [2.3.]).	• January 2018
• Completed pilot project of common coordinated entry form with summary of lessons learned and recommendations for future implementation. (Implemented a coordinated entry, assessment, and application process [2.3.])	• October 2018
• Evaluated common coordinated entry form and pilot project with a subset of 3-4 agencies (Evaluated a coordinated entry, assessment, and application process [2.3.]).	• October 2018
• Established coordinated, comprehensive data system to better determine size, scope, and needs of populations experiencing homelessness and housing instability (2.4.)	• 2019

Activities	Performance Indicator	Target Date	Owner
ACTION TEAM FORMATION			
1. Convene planning team of agencies providing care coordination and case management (HOAC Care Coordination Action Team).	Planning team minutes and names of participants.	July – September 2017	HOAC Care Coordination Action Team (CCAT) and Community Service Consortium (CSC)
2. Review, edit and approve draft work plan to guide implementation efforts and track progress, aligned with Community Service Consortium's (CSC) Coordinated Intake and Data Sharing Systems efforts.	Approved Final Work Plan.		
3. Solicit consultation and technical assistance from other communities/resources (e.g. CSC; Columbia Health Council, Hood River; US HUD CoC TA Center, etc.).	# of technical assistance contacts.	Ongoing	

PARTNER INVENTORY & ASSESSMENT			
4. Inventory all agencies providing care coordination/case management services in the region and document gaps in current referral pathway system (coordinated with Community Health Worker Training Hub, Early Learning Hub, and IHN-CCO's Universal Case Management Work Group).	Final Inventory.	September 2017	HOAC CCAT, CSC, Benton County Healthy Communities Team and Epidemiologist, CHW Training Hub, IHN-CCO's Universal Case Management Work Group
a. Develop survey/assessment tool and distribute to agencies.	Final survey and results.	October-November 2017	
b. Gather, review and cross walk current intake/entry forms from partner agencies.	# of intake/entry forms and names of agencies.		
5. Based on survey results, recommend a shared/common definition of care coordination/case management for coordinated intake/entry pilot project.	Approved shared definition of care coordination/case management.	December 2017	
COORDINATED INTAKE/ENTRY PILOT PROJECT			
6. Draft a common coordinated intake/entry form, including common data standards and definitions, with specialty questions as addendum.	Final draft common coordinated intake/entry form.	January 2018	HOAC CCAT, CSC, Pilot Project Agencies, BCHD HC Team and Epidemiologist
7. Develop implementation and evaluation plan for pilot project, aligned with work plan metrics and performance indicators.	Approved Implementation and Evaluation Plan.	March 2018	
8. Pilot and evaluate common coordinated entry form and pilot project with a subset of 3-4 agencies.	Final evaluation results report.	April – October 2018	
PROJECT IMPLEMENTION AND EVALUATION			
9. Disseminate pilot project results and recommendations for implementation across the service delivery system.	# of shares (presentations, meetings, agencies, etc.).	November-December 2018	HOAC CCAT, CSC
10. Assess capacity for full implementation across the service delivery system or expansion to include additional agencies. Include analysis of funding and	Final analysis of funding and sustainability	2019	HOAC

sustainability opportunities available through OHP and other private/public sources.	opportunities.		
11. Establish shared, comprehensive data system to better determine size, scope, and needs of populations experiencing homelessness and housing instability (2.4.)	Shared, comprehensive data system.	2019	BCHD HC Team and Epidemiologist, League of Women Voters, COG

Sector Alignment Opportunities:

- Linn-Benton-Lincoln Community Health Worker Training Hub; Community Health Centers (CHC) of Linn and Benton Counties' SDH Screening Project; Benton County's 2017 CHA and 2018 CHIP and Public Health Nursing Maternity Case Management+ Program; InterCommunity Health Network Coordinated Care Organization (IHN-CCO)'s Universal Case Management Committee; Linn-Benton-Lincoln Early Learning Hub; 211 Info.

Recommended HAOC Infrastructure Changes: