



Street Outreach (SO) Field Manual

FL-600 Miami-Dade County Continuum of Care

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Purpose

This document outlines guidelines for homeless street outreach (SO) projects throughout Miami-Dade County, Florida. The guidelines align SO efforts across the county to support persons experiencing unsheltered homelessness in achieving permanent housing.

How to Use this Document

This Field Manual combines compliance requirements and essential practices for an effective SO program as part of a larger coordinated County-wide street outreach effort.

For SO staff, these guidelines and the appendices offer a manual of effective SO practice. The guidelines establish a manner of practice, as well as goals and outcomes by which the Miami-Dade County CoC as a whole can gauge progress toward achieving the vision of ending homelessness. The Field Manual describes SO responsibilities and required outreach plans. The document also provides requirements, expectations and/or guidance in the specific areas of SO coverage and coordination; engagement; homeless verification, assessment, Homeless Management Information System (HMIS), permanent housing referral and participation in By-Name List case staffing; and document readiness, income and housing plans.

Appendices offer resources for staff who are fulfilling one or more of the roles described in the guidelines. These resources are designed to support staff working within SO projects with more granular “how to” information to reduce decision fatigue, stress, and burnout, while executing roles more effectively and efficiently. Project administrators, front-line staff, and supervisory staff will find concrete checklists and guides to support the different functions of each role.

Values

- We believe in low barrier housing. Everyone deserves safe and stable housing.
- We act with urgency. No one is homeless one day longer than necessary.
- We respect clients' perspectives, motivations, choices and property.
- We build trusted relationships with clients and partners as the foundation of our work.
- We minimize risk and reduce harm wherever possible with clients and ourselves.
- We create access to housing for underserved people.
- We are transparent with clients and partners about what we can offer.
- We are persistent but kind with all clients.
- We are allies in our clients' journeys toward housing.
- Our work is part of a network of committed service providers; we rely on each other to do what we each do best.
- We practice and support a culture of self-care.
- We meet people where they are and help develop a vision of where they want to be.
- We are flexible and creative problem-solvers.
- We are committed to data and documentation, and we use them to collaborate and continuously improve services.
- We are rigorous outreach planners; it is the backbone of all our work.

Vision, Goals & Outcomes

Vision

The primary goal of SO is to support people experiencing unsheltered homelessness in achieving some form of permanent, sustainable housing.* Teams may use techniques and resources to build trusted relationships and relieve discomfort and risks of living unsheltered, but these efforts are made with permanent housing as the end goal, rather than simply seeking to alleviate the burdens of living on the streets.

Goals

Miami-Dade CoC SO projects focus on achieving goals that support this vision, including:

1. Quickly connecting people experiencing unsheltered homelessness to safe housing, income, and critical health/behavioral healthcare and other supports, using a low barrier housing approach;
2. Identifying people living in unsheltered locations and helping them to maximize safety and reduce harm;
3. Minimizing service gaps or duplication;
4. Using available resources strategically to end unsheltered homelessness for as many people as possible, prioritizing those who are most vulnerable and/or have been homeless the longest;
5. Preparing and supporting people to meet tenancy obligations associated with housing; and
6. Providing a warm handoff and aftercare (as needed and available) to connect people to supports in the community that will assist with housing stability.

Outcomes

SO projects focused on the goals above will produce a number of positive client outcomes, including the following:

- I. Goal: 20% of unsheltered clients who refuse shelter, move into permanent destinations.
 - a. Objective 1: Clients do not experience homelessness one day longer than necessary.
 - b. Objective 2: Clients get supports that help them reduce harm of their current living situation AND prepare them to meet tenancy obligations.
- II. Goal: All clients get support to adjust to their new surroundings through warm-handoffs.
 - a. Objective 1: SO staff follow the client until they are assigned a case manager and they are able to staff the case with the Emergency Shelter or Permanent Housing Program case manager.

SO Principles and Service Orientation

- 1. Housing-Focused:** The goal of SO is to support people experiencing unsheltered homelessness in achieving permanent, sustainable housing:
 - a. Shelter placement does not end a person's homelessness.
 - b. The CoC's objective for SO and for which SO is held accountable will not be met even if the person is placed in shelter as permanent housing is the end goal.
 - c. All SO conversations with unsheltered persons must have a permanent housing focus and not be driven by a motivation to simply place an unsheltered person into a shelter and off the streets.
- 2. Low Barrier Housing:** The CoC has adopted low barrier housing principles and practices based on a philosophy that homelessness can be most efficiently ended by providing someone with access to safe, decent and affordable housing without requiring mental health or substance abuse treatment as a prerequisite to accessing housing or a condition of maintaining it as long as basic tenant obligations are met.

Low barrier practice focuses on simplifying the process of accessing housing through streamlining the application process and removing unnecessary documentation or site visits. It also ensures that supportive housing tenants are not subject to conditions of tenancy that exceed the normal conditions under which any leaseholder would be subject, including participation in treatment or other services.
- 3. Non-Judgmental, Empathetic Engagement:** Empathy and compassion are necessary for effective engagement. SO workers must be non-judgmental in each encounter with an unsheltered person experiencing homelessness. SO should meet the unsheltered person "where they are."
- 4. Trust:** Trust and rapport are necessary for effective engagement, and often are built over time. Rapport in SO is understood to be creating meaningful relationships between SO staff and unsheltered people. SO staff should build connection based on respect, trust and understanding the point of view, values and priorities of the unsheltered person being engaged. In developing trust and rapport, SO staff must be sensitive to professional boundaries.
- 5. Power Imbalance:** SO staff must make efforts to reduce an imbalance of power by presenting as an equal or 'peer-to-peer'. From the point of view of the unsheltered, SO staff have control over resources which are available to the unsheltered and this control can result in a certain degree of power over them. SO staff must be sensitive to this power imbalance in every exchange with an unsheltered person and work to ensure the potential power imbalance does not prevent or stall the effectiveness of the engagement and subsequent services with the unsheltered person.

6. Choice: Choice is necessary for effective engagement, planning and action. SO staff must provide meaningful information to unsheltered persons to allow them to identify a course of action that makes the most sense to them, up to and including the type of housing they seek in order to exit homelessness.

7. Person-Centered and Strength Based Approach: SO staff must use a person-centered and strength-based approach to engagement and offers of assistance. SO workers must work with the unsheltered person to create a plan to resolve their homelessness based upon the specific needs, concerns, goals and strengths of the unsheltered individual.

Strength-based person-centered engagement, case management and housing stability support includes strategies to identify and build on an individual's strengths and goals rather than focusing primarily on their problem areas. Staff, in partnership with the unsheltered person, tap into the unsheltered person's motivation and identify their skills and capacities, existing resources, challenges, and the supports they need to meet their short- and long-term goals. This approach also recognizes the importance of drawing from the strengths of an individual's family and community when developing a plan.

When employed together, participant-centered case management and strength-based approaches aim to reduce stigmatization and marginalization experienced by unsheltered persons by promoting their self-worth and value and targeting the spectrum of challenges causing conflict in their lives rather than focusing exclusively on individual problems.

8. Trauma-Informed: Trauma and its impacts are widespread within the unsheltered homeless population. SO staff must employ a trauma-informed approach to all encounters and their efforts to support the unsheltered person in developing a plan to resolve their homelessness.

Trauma-Informed service provision takes into account knowledge about trauma — its impact, interpersonal dynamic, and paths to recovery — and incorporates this knowledge into all aspects of service delivery:

- Integrates an understanding of trauma, substance abuse and mental illness throughout the program.
- Reviews service policies and procedures to ensure prevention of retraumatization.
- Involves consumers in designing/evaluating services.
- Sees trauma as a defining and organizing experience that can shape survivors' sense of self and others.
- Creates a collaborative relationship between providers and consumers, and place priority on consumer safety, choice and control.
- Focuses on empowerment and emphasize strengths.

9. Traumatic Brain Injury: Traumatic brain injury is frequently found within the homeless population. SO staff must communicate with individuals in ways that use plain language, are clear and concise, and which appropriately articulate housing options and steps that could be taken to resolve their homelessness. SO staff may need to change their approach to engagement and planning when working with unsheltered persons exhibiting behaviors associated with traumatic brain injury. *See Traumatic Brain Injury in Homeless and Marginally Housed Individuals: A Systematic Review and Meta-analysis, Stubbs et al, The Lancet, Public Health*

- 10. Cognitive Abilities and Communication Strategies:** Individuals served through SO will have a broad range of cognitive abilities for a variety of reasons. SO staff must employ different engagement and communication strategies to be responsive to the broad range of cognitive abilities found within among unsheltered persons, including those who have experienced developmental delays, traumatic brain injury or trauma.
- 11. Mental Health Recovery:** A mental health recovery mindset must be practiced by SO staff. In particular, SO staff must act to reduce stigma associated with mental illness and strive to connect individuals to appropriate mental health and community supports.
- 12. Harm Reduction:** Harm reduction practices must be supported by SO staff to help address risks and potential harms related to use of alcohol and other drugs and/or participation in sex work by unsheltered persons. When an outreach staff is prevented from distributing harm reduction supplies (e.g., condoms, clean needles, etc.) by their employer, they must be knowledgeable of where and how to access harm reduction supplies and must share this information with unsheltered persons as appropriate. All SO staff must be able to educate unsheltered person(s) on practices and strategies to reduce harm that do not require access to harm reduction supplies.
- 13. Progressive Engagement and Empowerment:** Progressive engagement customizes the level of support for an unsheltered individual based upon their assets and strengths. The unsheltered person must be provided ample opportunity to demonstrate what they are capable of doing on their own and empowered to do so.

Section 1

Street Outreach Plan

Coordinated Entry System (CES)

The Homeless Trust Coordinated Entry System (CES) provides access to all resources designated for homeless individuals and families in Miami-Dade County. This system ensures that every homeless individual or family is known by name, provides assistance based on the individual or family's unique needs, and matches them to the most appropriate service strategy or housing intervention. CES is driven by homeless verification and assessment. CES ensures the Miami-Dade CoC's limited resources are allocated to achieve the most effective results and that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the Coordinated Entry process.

SO is the main CES entry point to the CoC and is responsible for linking people living unsheltered to these housing resources.

SO projects are responsible for setting up and operating SO efforts that serve as the frontline in the process of rehousing people experiencing homelessness, especially those living unsheltered. Projects must establish outreach plans; align strategically with other outreach services and community referral partners; make housing placements through CoC Coordinated Entry; partner with CoC participating agencies; maintain focus on housing goals; and ensure that appropriate client data and documentation is maintained.

CoCs are responsible for ensuring clarity, transparency, consistency and accountability for clients and service providers throughout the assessment and referral process, as well as facilitating exits from homelessness to stable housing in the most rapid manner possible. The CoC has established Orders of Priority policies for prioritization of housing and service resources to ensure efficient and effective access to appropriate interventions.

Street Outreach Role

The role of SO is to support people experiencing unsheltered homelessness in achieving permanent, sustainable housing. In 2022, Emergency Shelter placement alone resulted in 66% of every unaccompanied person returning to the streets. SO workers must familiarize themselves with resources and connect/assist unsheltered persons to obtain required housing documents (identification, proof of legal status, income and disability verification); get connected to healthcare, inclusive of behavioral health care resources; refer persons who are not prioritized for RRH, PSH or OPH to rent by client or family and friends; provide housing navigation to unsheltered persons referred to RRH, PSH or OPH when a Housing Navigator has not been assigned by the shelter or housing provider (outreach workers should only stop assisting someone with housing navigation when they have met with the assigned Housing Navigator who is familiar with the case and who is assuming housing navigation duties); and/or connect persons capable of work to supportive employment options. When an unsheltered person accepts Emergency Shelter, the SO worker should keep the case open until they are able to staff the case, and share resources identified or in progress with the ES case manager.

SO staff must focus on all unsheltered persons, not just those willing to go to shelter or treatment.

SO workers must be able to assist an unsheltered person get document ready, apply for housing, provide housing navigation or connect them to existing navigation resources when available, and assist in moving them into permanent housing.

SO teams may use techniques and resources to build trusted relationships and relieve discomfort and risks of living unsheltered, but these efforts must be made with permanent housing as the end goal, rather than simply seeking to alleviate the burdens of living on the streets.

SO Responsibilities

- Serves as the Miami-Dade **CES primary access point** and operates throughout the full geographic boundaries.
- **Engages** persons and families who are unsheltered.
- Makes **third-party verification of homelessness**. SO is the primary party that provides homeless verification based on observation.
- Collects **Universal Data**, conducts a **VI-SPDAT Assessment** and enters such data and assessment into the **HMIS**.
- Assists unsheltered persons to become **“document ready”** to facilitate their permanent housing placement. SO assists unsheltered persons secure documents such as birth certificates, social security cards, government-issued identification and benefit letters.
- Addresses the unsheltered person or family’s **income** by:
 - Assessing the unsheltered person or families’ **mainstream benefits** utilizing the HMIS Mainstream Benefits Assessment and assist them to apply for benefits for which they may be entitled/eligible.
 - Assisting them in accessing **job-related programs and services**.
- Assists unsheltered persons identify their **housing goals**.
- Makes **shelter, transitional housing, treatment and permanent housing (family or friends or rent by client) referrals and facilitate placements of persons referred to RRH, PSH or OPH**.
- Provides **transportation** following shelter or permanent housing placement and to community resources as necessary to promote engagement efforts or accomplish document readiness.
- Utilizes **HMIS** to:
 - Create a record for the unsheltered person or family to ensure access to the CoC through the CES;
 - Enter Universal Data Elements using the Entry/Exit Assessment;
 - Completes a vulnerability assessment

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- The VI-SPDAT Assessment is completed for disabled persons who report experiencing homelessness for 1 year or longer, or 4 or more episodes;
 - the F-VI-SPDAT Assessment is completed for families with a disabled household member
 - the TAY-VI-SPDAT Assessment is completed for youth ages 18-24
 - Track engagement efforts, contacts and case notes;
 - Documenting the completion of Mainstream Benefits Assessment;
 - Upload client documents (disability verification, birth certificates, social security cards, government-issued identification and benefit letters); and
 - Record emergency shelter, transitional housing or permanent housing referral to HMIS participating agencies.

SO Outreach Plan

Each SO Program must establish an Outreach Plan that covers their entire CoC assigned geographical area. The Homeless Trust will distribute an Outreach Plan Template to be completed by SO Programs. Outreach Plans must be submitted per instructions provided with the Template to the Homeless Trust for review to ensure compliance with SO Standards of Care and this Field Manual.

The Outreach Plan must detail policies, procedures or methods for the following:

Engagement:

- ☐ Use of the most recent PIT Count geo-data to organize SO outreach efforts. There must be no gaps in canvassing efforts for the SO Program's assigned coverage area. While the PIT geo-data will direct SO efforts toward larger encampments or concentrations of unsheltered persons, the Plan must also include regularly scheduled engagement efforts to smaller encampments or concentrations throughout the assigned geographic area.
- ☐ Frequency of engagement of the most vulnerable clients, prioritizing engagement of those who have declined services and seem particularly unwell and/or vulnerable.
- ☐ Strategy to determine if anyone particularly vulnerable was found during the annual PIT count to ensure follow up (e.g., unsheltered families with children, youth, elderly and medically fragile).
- ☐ Detailed schedules, including locations, entities, responsible project/staff, and contact info for each of the "locating" activities (i.e. physical and remote canvassing, office hours), as well as any meetings with CoC, other outreach teams, or other community partners. Schedule must include SO efforts happening during early morning and evening hours, when participants are most likely to be present at their sleeping locations.
- ☐ Outreach team composition, including integration of persons with lived experience of homelessness, and inclusion of or partnership with entities who can provide specific expertise.
- ☐ Expected volume of helpline referrals and outreach response approach and timeframe.

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- ☐ Referrals between SO and Specialized SO teams for participants with behavioral health needs and coordination with crisis teams.
 - ☐ Processes implementing SO Standards of Care for engagement (see Engagement section below).
 - ☐ Engagement techniques that build trust between SO staff and unsheltered persons and motivation for change.
 - ☐ Referral, coordination and regular check-ins with access partners (i.e. Camillus Health Concern, Educate Tomorrow, Pridelines, the Library, needle exchanges, police departments, PATH, DDA funded Lotus SO, and other municipal departments) and timeframe for response.

Universal Data, VISPDAT Assessment and Client Records

- ☐ Approach to Universal Data collection, Assessment, Mainstream Benefits Assessment, case notes and HMIS entry, including timeliness standard and review of data quality.
- ☐ Participation in By-Name case conferencing and housing match communications (meetings, email, calls or other communication) as needed to assist in locating, communicating with, collecting documentation for, and/or offering housing options to clients.

SO Client Services

- ☐ Practices that prioritize resolving the issues that are most likely to prevent participants from quickly obtaining permanent housing.
- ☐ Assisting clients to: (a) become “document ready”; (b) apply for or reinstate benefits; and/or (c) access job programs and employment, including identifying and assisting the client in overcoming barriers to maintaining employment.
- ☐ Providing housing-focused case management services to those who have been prioritized for housing.
- ☐ Assisting unsheltered clients in developing a Housing Plan (identifying personal and housing goals).
- ☐ Referral and coordination with community resources.

Client and Staff Safety

- ☐ Everyday client and staff safety protocols and training, including de-escalation.

Public-Facing Communications

- ☐ Providing information on the CoC and helpline for the public on how to report concerns regarding an unsheltered person
- ☐ Maintaining a process for prioritizing response to public concerns, as resources allow and circumstances warrant, e.g., front line staff following up on calls about a person who appears to be experiencing unsheltered homelessness.

Housing Targets

- ☐ SO Programs are accountable to meet **outreach outcomes**. The Outreach Plan must:
 - Establish monthly or annual performance targets for housing placement and other key outcomes. For example, a SO team with 4 SO FTEs using Critical Time Intervention, where each SO worker maintains a caseload of 20 clients may seek to place 4 clients a month in crisis housing (i.e. ES, TH); and two clients a month directly in permanent destinations.
 - Determine which tasks are most critical to meet specified targets and set timelines for tasks.
 - Track progress on outcomes, using the data to inform ongoing programmatic quality improvements.

Quality Assurance and Improvement

- ☐ Methods by which to assess quality and effectiveness delivery of SO services.
- ☐ Protocols to ensure data quality.
- ☐ Conducting an annual client survey, reviewing client survey results and taking action accordingly.
- ☐ Staff trainings.

Documentation of SO Delivery to Each Unsheltered Person

The Plan must cover the manner in which the SO Project maintains case records in HMIS and uploads other written materials **for each unsheltered person** onto HMIS, that demonstrate SO activities are taking place, including evidence of the following:

- Obtaining a signed Release of Information (ROI)
- Concrete plan for engagement, assessment, placement and other assistance required as quickly as possible.
- Consistent attempts to locate and engage all unsheltered persons in the SO Program's coverage area, including those who have been assessed and those for whom assessment has not yet been made.
- Ongoing efforts to collect Universal Data Elements and VI-SPDAT Assessment.
- SO assistance with document readiness.
- SO assistance with income (mainstream benefits assessment, application or reinstatement and/or job programs).
- Housing referral and communications with Housing Coordinator.
- Outreach service provision is in accordance with SO's plan for an unsheltered individual.
- Connection to services to address health, mental health, addiction, educational, and vocational needs and assisted to use community resources (e.g., schools, libraries, houses

of worship, grocery stores, laundromats, parks, etc.

- Efforts in assisting the unsheltered individual in identifying housing goals and developing housing plan.

Section 2

Coverage And Coordination

Coverage Area:

Miami-Dade CoC SO covers the entirety of Miami-Dade County.

The Homeless Trust contracts with providers who provide general outreach services to unsheltered individuals and families and those who provide specialized outreach targeting certain unsheltered sub-populations or outreach need (i.e. Institutional Discharges).

General and Targeted Street Outreach:

General Street Outreach

General SO providers must focus on all unsheltered persons in their designated coverage area. General SO may refer a homeless person with support service needs, who are not advancing their housing goals, to a specialized outreach team for engagement and assistance.

Specialized Street Outreach

Specialized SO provides case management with enhanced support services specifically focused on an unsheltered sub-population, as follows:

- Persons with a mental health condition in which engagement and treatment may be provided prior to shelter or housing placement.
- Persons engaging in substance abuse, particularly persons with Opioid Use Disorder (OUD).

Discharge MOA Outreach and Placement

The Homeless Trust has entered into a Discharge Memorandum of Agreement with discharging institutions such as jails, hospitals, detox centers and mental health crisis centers to prevent discharges into homelessness. Discharge MOA Outreach is dedicated to providing assessment and placement services to persons identified by MOA partners as at risk of homelessness upon discharge.

Coverage Assignments (as of 10/1/23):

General Outreach Providers	Unsheltered Population	Geographic Area
City of Miami Outreach	Unsheltered individuals and families.	City of Miami and Miami-Dade County (except for the Cities of Miami Beach and Hialeah)
City of Miami HEAT (law enforcement)		City of Miami
City of Miami Beach Outreach and HOT (law enforcement)		City of Miami Beach
City of Hialeah		City of Hialeah
DDA funded Lotus SO		Downtown Miami
SSVF & VA Outreach		Dade, Broward and Monroe
Specialized Outreach	Unsheltered Population	Geographic Area
Camillus House – Lazarus Project and PATH	Persons, predominately chronically homeless, with a mental health condition or substance abuse disorder in which engagement and treatment may be provided on the street prior to shelter or housing placement.	Specialized SO are expected to strategically focus their efforts where the greatest need for their specialized services is found at a given time as well as taking referrals from general outreach teams.
Camillus Health Concern	Unsheltered persons with primary care needs inclusive of behavioral health	
New Hope CORPS	Chronically homeless persons engaging in substance abuse, particularly persons with Opioid Use Disorder (OUD) and/or dually diagnosed.	
Miami Recovery Center	Chronically homeless persons engaging in substance abuse, particularly persons with Opioid Use Disorder (OUD) and/or dually diagnosed.	
Hermanos de la Calle	All unsheltered persons with specialization in serving persons open to shared, sober living.	

Coordinated Referrals for Unsheltered Sub-Populations

Specialized Outreach Teams

Specialized Outreach Teams provide SO services with case management specifically focused on an unsheltered sub-population.

If SO staff encounter an unsheltered person who is refusing all services including shelter and permanent housing and they are suspected to be experiencing serious mental illness AND/OR substance use disorders a referral should be made to a Specialized Outreach team. SO Staff must make a direct referral to the Specialized Outreach Team and make a warm handoff to the team.

Participants determined to be ineligible for SO specialized services due to greater need must be referred to appropriate services, including but not limited to referral to PATH SO team.

Families with Minor Children

In the event that a family with minor children is encountered on the street or other place not meant for human habitation (car, park, abandoned building), referrals should be made immediately to the City of Miami Homeless Assistance Program, which will coordinate diversion assessment and placement efforts, together with other CoC partners.

CoC Motel/Hotel Provider:

City of Miami Homeless Services
Assistance 1(877) 994-4357, option 5

Unaccompanied Youth (under age 25)

- **Unaccompanied Minors: Unaccompanied individuals** under age 18 can be referred to the Miami Bridge (305) 635-8953
- **Unaccompanied Youth:** Former foster care youth, ages 18-24, can be referred to dedicated shelter beds, and must be referred to Citrus Family Care Network for housing assistance services (305) 455-6000
- **Non-foster care youth:** Youth ages 18-24, who have not been in foster care, must be referred to Educate Tomorrow for housing assistance services. A youth helpline will be established on October 1, 2023.

Veterans

Unsheltered persons who identify as a veteran must be referred to the VA or its partners for outreach, case management and housing placement assistance by calling 1(877)994-4357, option 3. VA services include outreach, shelter, short-term rental assistance, transitional housing and permanent supportive housing.

Domestic Violence or Human Trafficking

Persons actively fleeing Domestic Violence or Human Trafficking can call 1-877-994-4357, and after selecting a language, press #2 to talk to an advocate, develop a safety plan, and for housing placement assistance.

Clients can also visit the Coordinated Victims Assistance Center at 2400 South Dixie Highway or one of five Domestic Violence Outreach Units (Lawson E. Thomas Hialeah District Court, Joseph Caleb Community Center, North Dade Justice Center and South Dade Government Center).

Camillus Health Concern

Camillus Health Concern provides primary care and behavioral health services to unsheltered persons on the streets, and can uniquely address primary care issues such as wound care, infections, obesity, pain, heart concerns, diabetes...

Miami-Dade Public Library System

The Southeast Florida Library Information Network (SEFLIN) has worked cooperatively with the Miami-Dade Public Library System to staff select libraries with social worker trained in engaging persons experiencing homelessness. Visit <https://mdpls.org/social-services>, or call 786-988-6816 or email socialservicesmail@mdpls.org for current information. Community resources are available at the following library locations (view link for location address):

Main Library on Mondays, Tuesdays, Wednesdays & Fridays

Northeast-Dade Aventura Branch on alternating Wednesdays

Hispanic Branch on alternating Wednesdays

Miami Beach Regional on Fridays

Sessions are available from 11 a.m. - 4 p.m. Sign in begins at 9:30 a.m.

Walk-in patrons are welcome and will be seen on a first come, first served basis.

Project IDEA

The IDEA Syringe Service Program (Project IDEA) is an HIV/AIDS intervention effort focused on persons with Opioid Use Disorders (OUD) who inject. The IDEA Program: (a) operates a Syringe Service Program (SSP); (b) conducts engagement to promote voluntary participation in residential substance abuse treatment and medication-assisted substance abuse treatment (MAT) as well as to address complex health needs; and (c) maintains ongoing connection to persons in recovery.

SO staff should engage an unsheltered person “where they are” and without judgment. Unsheltered persons with a substance abuse may not be open to help offered by SO, however, they may be willing to seek help from Project IDEA. SO should provide information about Project IDEA and encourage connection to the program.

Coordination with Access Points and Other Community Partners

SO must coordinate efforts with and receive referrals from access partners like Camillus Health Concern, Educate Tomorrow, Pridelines, the Miami-Dade Public Library System, IDEA Exchange, Downtown Development Authority Ambassadors, police departments, and other municipal departments.

Hours of Services and Office Access:

Hours of Service

- SO services, including specialized outreach, are to be generally provided from early morning to evening hours Monday through Friday with staff on-call during after hours and weekends.
- Outreach programs charged with meeting the unique needs of clients are encouraged to utilize flexible scheduling to allow for improved and intensified engagement in an effort to move clients toward permanent housing.
- Targeted outreach events with local law enforcement and other partners may also require flexible scheduling.

Office Access

- At the option of the SO Program, general SO Programs may offer services through a walk-in center or office.

Transportation

- All SO providers must provide transportation to shelters or housing programs.
- SO providers must ensure availability of transportation for persons with physical disabilities to include persons who use a wheelchair either through accessible vehicles or by paying for a third party to transport persons with handicaps preventing them from boarding a regular vehicle.
- Specialized SO teams must transport to appointments needed to facilitate permanent housing, this may include but not limited to appointment needed to obtain or maintain entitlements or identification assistance, and meetings with landlords or property owners/managers.

Responding to Encampments and Building Condemnations

- When there is planned clean up, closure of an encampment or response to building condemnations within their coverage area, SO providers must provide advanced intensive outreach and referral efforts upon notice of the planned closure as well as during closure. In the event of law enforcement involvement, SO staff are present to assist the homeless individual(s) only and cannot engage in any enforcement activities themselves.

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- Each team should develop a protocol for
 - placing notices of clean up operations
 - process for securing storage, labelling of personal property and how to reclaim items
 - handling items that are contaminated or otherwise pose a health or safety concern

Interface with Law Enforcement

- Whenever possible, SO providers must assist unsheltered homeless individuals in the event individual(s) are directed to move from where they are staying by law enforcement. Effort must be made by SO staff to make referrals and help the individuals experiencing homelessness connect to resources.
- SO staff are only present to assist the homeless individual(s) and cannot engage in any enforcement activities themselves.
- In event that local law enforcement agencies have established their own homeless outreach teams (e.g. City of Miami and City of Miami Beach), the law enforcement agency may request that the SO Providers operating within the agency's jurisdiction participate in the law enforcement agency's outreach and engagement activities. SO staff will participate when operationally available, and/or their participation will not jeopardize the relationship between the SO staff and the unsheltered person.
- In some circumstances, SO staff may witness behavior or actions on the part of an unsheltered person that triggers a legal mandate to report the incident or information to law enforcement (e.g., human trafficking). SO staff must do so promptly and thoroughly in these instances, in accordance with training on Mandated Reporting.

Cold or Inclement Weather

- Pursuant to the Homeless Trust Cold Weather and Disaster Plan protocol, the Homeless Trust's Emergency Coordinator and the Miami-Dade County Office of Emergency Management will alert the Homeless Trust to impending inclement weather or other emergencies and the Homeless Trust will direct SO providers to suspend their structured engagement activities to focus on notifying unsheltered individuals of the impending weather event or other emergency.
- In the event of an impending inclement weather situation or other emergency, SO staff must work with unsheltered persons to help them prepare for the event and/or access available emergency resources, including overflow beds made available at Emergency Shelters or shelters designated by the Office of Emergency Management.
- SO providers must **submit their** emergency/disaster preparedness and response procedures to Mike.Pimentel@miamidade.gov on or before April 1st every year.

Section 3

ENGAGEMENT

Making contact with someone living on the street is the first step in beginning the rehousing process with that person. Within each CoC, the outreach program working within their assigned geography must figure out how to plan and execute a comprehensive outreach approach to make sure that all people living unsheltered within the CoC have been identified and engaged. This approach must include a subset of the activities below, understanding that within a limited number of hours, outreach teams will determine how to be most effective and efficient at balancing the time spent on each type of activity. Focusing on only one type of outreach activity reduces the likelihood that outreach teams will identify all people living unsheltered in the CoC.

* WAYS TO FIND & ENGAGE PEOPLE LIVING UNSHELTERED *



Physical Canvassing

- *Informed by unsheltered PIT Count*
- *Useful for encampments; less useful to locate people living by themselves*
- *Efforts can be reduced if outreach team invests in robust remote canvassing*



Helpline Referrals

- *Teams receive information from the public about where people are living unsheltered*
- *Teams get direct calls from people seeking housing stability*



Remote Canvassing

- *Invest in partnerships with entities who interact with people living unsheltered — these entities serve as “eyes and ears” for outreach teams*
- *Outreach team communicates regularly with entities to get information about where people are living unsheltered*



Office Hours

- *Use sparingly, keep it brief*
- *Must be regular to be useful*
- *Set days/times that allow greatest participation from stakeholders*
- *Meet virtually to allow for greater participation*

Engagement Standards

The following engagement standards must be incorporated into the Outreach Plan.

1. The Outreach Plan must be Housing-Focused and incorporate Low barrier practices. The goal of SO is to support people experiencing unsheltered homelessness in achieving permanent, sustainable housing. The foundation of Outreach Plans must be based on the following principles:
 - a. Shelter placement does not end a person's homelessness. Placement in permanent housing ends their homelessness.
 - b. All SO conversations with unsheltered persons must have a permanent housing focus and not be driven by a motivation to simply place an unsheltered person into a shelter and off the streets.
 - c. Permanent housing is the end goal of SO. SO must remain connected to persons placed in shelter until they have the opportunity to staff their case with the shelter case manager and discuss progress with housing specific goals. SO must provide the adequate level of services to persons refusing shelter to obtain permanent housing directly through SO efforts.
 - d. Low barrier housing principles and practices are based on a philosophy that homelessness can be most efficiently ended by providing someone with access to safe, decent and affordable housing without requiring mental health or substance abuse treatment as a prerequisite to accessing housing or a condition of maintaining it as long as basic tenant obligations are met.
 - e. Low barrier housing includes simplifying the process of accessing housing through streamlining the application process and removing unnecessary documentation or site visits.
2. SO contacts predominantly occur in the unsheltered persons environment or places not meant for human habitation. Some exceptions apply such as referrals from institutions for persons being discharged without safe housing.
3. SO staff are required to use the HMIS to record each contact under the Current Living Situation. This record will record a date, and current living situation.
4. If a referral is made during the contact, SO teams may use the Coordinated Entry Event to record the date of event, event type and disposition.
5. SO must stay connected to existing unsheltered persons as follows:
 - i. SO workers must re-contact unsheltered persons who previously declined engagement within 7 days unless the person cannot be located. Whenever possible, follow up outreach attempts should be made by the same staff involved in the last encounter with

the unsheltered person if at all possible.

- ii. Each week, 75% or more of field SO workers time should be spent contacting, engaging and serving unsheltered individuals/families with at least 50% or more of that time allotted to re-engaging previously encountered persons, preferably already enrolled in HMIS.
 - iii. Re-engagement activities must be designed and implemented to assist the unsheltered person take steps from being unhoused to housed.
 - iv. As part of the outreach contact activities with unsheltered persons, SO staff must take any and all actions to ensure that the person is “document ready” to move into housing.
- 6. SO staff must maintain regular contact and coordination with informal access partners like Camillus Health Concern, Educate Tomorrow, Pridelines, the Library, needle exchanges, police departments, and other municipal departments to identify and engage with unsheltered persons.
- 7. SO staff are expected to use mobile devices in the field to utilize HMIS to enter Universal Data Elements, utilize the VI-SPDAT assessment tool, make referrals, record contacts and the date of engagement, and enter client notes into the HMIS.
- 8. SO Teams must preferably work in groups of two, but should avoid having four or more outreach staff approach an unsheltered person at the same time.
- 9. SO staff must exit their vehicles to engage with unsheltered persons except in limited circumstances.
- 10. SO staff must verbally identify themselves, the organization they work for, and the intention of their engagement in every encounter with an unsheltered person they have not previously engaged with during SO.
 - a. During a SO encounter, SO staff must respect an unsheltered person’s wish to not engage with the SO staff. The SO provider must not use any punitive measures to individuals who either refuse offers of services or decide at a later date that they would like to receive services.
 - i. Whenever the SO staff are transferring contact with an unsheltered person to another SO staff within the same or different SO provider, all reasonable efforts shall be made to ensure that there is a warm hand-off, which occurs best when all relevant parties, including the unsheltered person, are in the same location and are sharing information transparently.

Note that some SO teams operate follow-up HMIS projects for clients who may have a case manager assigned at a shelter for the purposes of following the client until they are housed. ***These projects are not considered SO. The existence of follow-up projects augment CoC efforts and are not a substitute for SO teams’ responsibility to make warm-off handoffs or provide Pre-CTI assistance.***

Safety Protocols

SO Programs must develop and maintain safety protocols for frontline staff that include guidelines to maximize client and staff safety in all outreach-related interactions, including at a minimum:

- Required notice (to whom) of where/when canvassing will occur and how often staff will check in.
- Required trainings, e.g., in de-escalation techniques and other necessary personal safety skills.
- Under what conditions staff are paired or solo while canvassing.
- Under what conditions clients may/may not be transported while staff are canvassing.
- Incident debriefing, reporting, management, and follow-up.

Coordination with Community Resources

Each unsheltered individual or family may have specific and/or immediate needs that can be met through coordination with and referral to other SO specialized teams, Hotel/Motel Program, crisis teams, health/behavioral healthcare, needle exchange programming, benefits or employment, food, showering options, mail services and other community programs.

SO staff are required to assess whether an unsheltered person that they engage requires additional services or assistance.

Community Services and Resources

SO teams are expected to develop a list of community services and resources with established referral contacts that unsheltered persons can be referred to and directly brought to.

Regardless to whether the unsheltered person is willing to go to shelter or housing, SO Teams should assist them in accessing community services or resources. Such services or resources must include:

- Basic needs such as clothing, shoes, food, bathroom facilities and showering.
- Employment and job training programs.
- Family services

Provision of Information and Goods

- SO teams must provide information regarding shelter and housing options available as well as social and health-related services, shower, mail, and food assistance available in the community.
- SO teams may provide hygiene kits, food, clothing, blankets or other resources as may become available as part of engagement but always with the intent of moving a person toward permanent housing.

Emergency Services or Assistance

Mental Health or Substance Abuse Mobile Crisis

- **Mental Health & Baker Act Protocol** for persons who pose a threat to themselves or someone else due to Severe Mental Illness (SMI). A Mobile Crisis Team 1(800) 435-7968, funded through Thriving Mind, the managing entity for substance abuse and mental health, can evaluate the individual or you can call 911 and request a Crisis Intervention Team (CIT) trained officer.
- **Substance Abuse & Marchman Act** protocol is a two-step process, one for assessment and the other for treatment. The person's spouse or guardian, any relative of the person, any three (3) responsible adults who have personal knowledge of the person's substance abuse impairment, and in the case of a minor, the minor's parent, legal guardian, legal custodian or licensed service provider can petition an involuntary exam. Adult Petitions take place at the Clerk of Court, Probate Section, Miami-Dade County Courthouse on 73 West Flagler Street Room 234 Miami, FL 33130. Their informational package visit: <https://www.miami-dadeclerk.com/library/family/1- marchman-act-adult.pdf>.

Child or Vulnerable Adult Abuse Mandatory Reporting

- **Immediate Danger:**

Call 911, if SO staff suspects or knows of a child or vulnerable adult is in immediate danger.

- **Child or Vulnerable Adult Abuse Mandatory Reporting Requirement:**

SO staff who knows, or has reasonable cause to suspect, that:

- a) a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare.
- b) a vulnerable adult has been or is being abused, neglected, or exploited. must make a report to the DCF Child Abuse Hotline by phone or online.

Abuse Hotline:

1-800-962-2873 (Hotline is 24 hours a day and 7 days a week.)

To report an allegation in Spanish or Creole, call 1-800-962-2873 or 1-800-955-8771.

Online Reporting:

- [Report Child Abuse Online](#)
- [Report Adult Abuse Online](#)

Section 4:

Homeless Verification, Assessment, HMIS, Permanent Housing Referral And BY-NAME LIST

CoC Eligibility and Priority for Assistance

- To be **eligible** for CoC homeless services, shelter or housing programs, a person must meet the HUD **definition of homelessness**:

HUD Definition for Homeless:

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Has a primary nighttime residence that is a public or private place not meant for human habitation;
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements; **or**
- Is exiting an institution where (s)he has resided for 90 days or less and who resided in an ES or place not meant for human habitation immediately before entering that institution.

- The CoC **prioritizes chronically homeless persons** in its Orders of Priorities for Housing Placement:

HUD Definition for Chronically Homeless:

A chronically homeless individual or head of household is **disabled** and:

- Coming directly from a place not meant for human habitation, an emergency shelter, or a safe haven; **and**
- has been residing in a place not meant for human habitation, an emergency shelter, or a safe haven for a period of: at least twelve (12) months either continuously **or** cumulatively over a period of at least four (4) occasions over the last three (3) years* where each separate occasion of homelessness adds up to 12 months.

* In the case of four occasions or more with breaks:

- Stays of less than seven nights in one of these places is not considered a break and instead counted toward the total time residing in a place not meant for human habitation, an emergency shelter, or a safe haven.
- Stays in institutions of fewer than 90 days are not considered a break and instead the time spent in the institution is counted towards the total time residing in a place not meant for human habitation, an emergency shelter, or safe haven.”

SO Responsibilities for Documenting Homelessness and Chronicity

Verification of Homelessness: SO staff has the primary role in documenting an individual or family's homeless status based on observation.

- **Determining Chronicity:** Entering every contact in the HMIS is **critical** to documenting episodes of homelessness for the purposes of determining homeless chronicity and permanent housing placement under the CoC's Orders of Priorities.
- **HMIS Utilization Critical for Verification and Chronicity:** SO staff are required to use the HMIS to record each contact, date, location and outcome of the contact and other relevant information that will assist SO staff to successfully engage and house the unsheltered individual or family.

Stay Connected: SO must stay connected to existing unsheltered persons. SO workers must re-contact unsheltered persons who previously declined engagement within 7 days unless the person cannot be located. Whenever possible, follow up outreach attempts should be made by the same staff involved in the last encounter with the unsheltered person if at all possible.

- **Homeless Verification for Persons who Refuse Shelter:** An unsheltered client who refuses to enter shelter may still be entered into HMIS and referred for services, including rental assistance, focused on shortening a homeless episode.
- **Third Party Verification:** Note regarding 3rd party verification that SO may encounter. HUD allows homeless verification by law enforcement or community members. Please see documentation requirements for these 3rd party verifications in the CoC Orders of Priorities for Housing Placement.
- **Orders of Priorities Documentation Requirements:** HUD has established homeless verification and chronicity documentation requirements. The *CoC Orders of Priorities for Referrals to Permanent Housing* incorporates these HUD requirements. SO Programs should be knowledgeable of these HUD documentation requirements. SO staff must comply with policies and procedures governing documentation of homeless verification found in the Trust's Orders of Priorities Policies.

Universal Data Elements and VI-SPDAT Assessment

- In order to place a homeless person or family into shelter or housing, Universal Data Elements must be collected and an assessment using the VI-SPDAT assessment tool must be conducted (together “Assessment”).
- The purpose of the Assessment is to make an informed and objective decision regarding the level of need, recommended housing intervention of each family, and streamline eligibility determinations.
- SO staff must enter Assessment data and all contacts documenting episodes of homelessness into HMIS. *Failure to do so leaves homeless persons on the street.*
- The individual or family may not provide Universal Data Element information or agree to VI-SPDAT assessment at initial or subsequent contacts. SO staff must continually engage the person or family. During contacts, SO staff should attempt to encourage voluntary sharing of Universal Data Elements and VI-SPDAT information (to be entered into HMIS when such information is provided) until all required Universal Data Elements and VI-SPDAT data are entered into HMIS.

Pro tips for maximizing pre-enrollment contacts:

- *Ask questions and build the assessment and service plan over time at a pace that works for the client.*
- *Fill out what is known, as a worker learns it through normal conversations, rather than attempting to gather information in a single session.*
- *Jot down or record notes on a phone or pocket-sized pad rather than bringing forms into the field.*
- *Scan or take photos of documents using a phone.*
- *Maintain schedule of document due dates or use HMIS follow up feature.*

Homeless Management Information System (HMIS)

HMIS Guidelines

Projects are responsible for collecting and entering into HMIS all required client-level data elements. Projects should follow the guidelines below to ensure a robust, accurate data environment:

- Enter all clients using the Entry/Exit Assessment regardless of their desire to engage or provide a release of information.
- Document all contacts. The initial contact can be recorded in the Entry/Exit Assessment as part of a project entry. Follow up contacts are documented in the Entry/Exit Assessment as part of Interims. Interims opens the Entry/Exit Assessment and allows the outreach worker to view the initial Entry/Exit Assessment responses, update any data element(s) and/or add a new contact.
- To refer a client to another service, a release of information (ROI) must be entered. Release of information should be set to expire after seven (7) years.
- Once a client engages, meaning they ask or agree to a referral to out-patient health, shelter,

treatment or rental assistance, the outreach worker must complete all the Universal Data Elements in the Entry/Exit Assessment and add the Date of Engagement. This may occur in the first contact as part of the project entry, or it can be done in Interims. Data quality does not count against your project until the Date of Engagement is entered. Clients can provide a partial or refuse to provide any part of their Social Security Number (SSN) and still meet data quality as long as the SO completes the question on SSN data quality. All universal data elements must be entered in HMIS ahead of a referral to other CoC programs (ES, TH, and PH).

- Enter data in HMIS within 24 hours after contact. When a client is enrolled in Street Outreach and no contact is made in 90 days, the system will automatically close the case back to the date of entry (or last contact) with a destination of “Place not meant for human habitation.”
- Whenever possible complete the appropriate VI-SPDAT vulnerability assessment. The VI-SPDAT is designed for unaccompanied adults and couples without children age 25 and older. The VI-F-SPDAT is intended for families. The TAY-VI-SPDAT is designed for unaccompanied and parting youth ages 18-24. Many of the prioritization factors for rental assistance are determined by the vulnerability tool.
- Outreach workers should use the Coordinated Entry and Local Questions assessment to record client phone number, emergency contact and to upload essential documents for housing (identification [for children as well when applicable], proof of disability, proof of income and proof of their legal status in the US.
- Outreach workers may use the Coordinated Entry Event to document access and referral events and the client or resource disposition. For example an event can be created for referral to shelter with the following dispositions:
 - Client accepted
 - Client rejected
 - Provider rejected
 - Resource unavailable
- Maintain documentation in HMIS using case notes of consistent attempts to locate and engage all participants, including those who are eligible AND those for whom eligibility determinations have not yet been made.
- Employ a data quality review process to ensure data completeness and accuracy.
 - This must include running a project APR and EVA report, and looking for and correcting data quality issues.
 - It must also include a monthly and annual retrospective check of clients whose exit destination is “place not meant for human habitation.” By doing this SO teams will find end user errors and clients who were erroneously discharged to place not meant for human habitation after no contact for 90 days. When clients were connected to ES, TH or PH, as evidenced by the HMIS record, even if the connection was done by another SO provider, teams should correct their discharge destination to reflect the correct

- placement.
 - SO end users should be trained to thoroughly search for clients before adding a new record or entering into a SO project to
 - avoid duplicating client HMIS IDs, and
 - avoid entering someone onto SO whose already connected to ES, TH or PH.
- SO teams should upload any assessment or other tools used to screen, assess or document progress or preferences outside of HMIS, including those provided in the appendix, onto HMIS using the File Attachments feature in the Client Profile.
- Supervisors should hold case staffing meetings weekly, assign clients to outreach workers or case managers in HMIS and maintain manageable caseloads for their teams using Critical Time Intervention.
- Refer suggestions to the HMIS Administrators or Asst. Executive Director of the Homeless Trust to improve HMIS data collection and entry efficiency, availability and usefulness in informing service delivery.

HMIS Terminology & Entries:

Engagement Status	HMIS Records
❖ Opening HMIS Household Record	HMIS Entry/Exit Assessment: Entry
❖ Engaging with client, but client not accepting shelter or permanent housing.	HMIS Entry/Exit Assessment: Interims
❖ Engaging client and collecting universal data and VI-SPDAT information.	HMIS Entry/Exit Assessment: Interims
❖ Client accepts shelter placement.	HMIS Date of Engagement
❖ Client accepts permanent housing placement, but refusing shelter pending placement	HMIS Date of Engagement
❖ Exit from SO	HMIS Entry/Exit Assessment: Exit

Participants are discharged from the project only for the following permitted reasons:

- Outreach staff have been unable to make contact with the participant in the past 90 days (automated HMIS discharges after 90 days of no contact recorded in HMIS).
- Participant was placed in emergency shelter (ES), safe haven (SH) or transitional housing (TH) by ab SO team or a third party. The team who places client in ES/TH/SH should not close the case until a warm handoff is made, meaning ES/TH/SH has assigned a case manager and the SO worker has talked to the case manager about client strengths and other referrals made or possible referral options. Clients should be able to connect with their assigned outreach worker until the case manager is assigned. The outreach worker should follow up with the shelter if a case manager has not been assigned or contacted them after 5 working days.

However, some SO teams operate Follow-Up Projects. These projects are not considered SO. The Follow-Up Projects will keep clients open in HMIS who may

have a case manager assigned at a shelter for the purposes of following the client until they are housed.

- Participant has been institutionalized (including hospitalization, jail, prison, and residential treatment).
- Participant is deceased.
- Participant has been transferred to a different project to receive case management and housing placement services.
- Participant has requested to be discharged.

HMIS Training and Monitoring

The Homeless Trust will monitor SO Providers' use of HMIS and accuracy of data

- entered into HMIS to determine compliance with CoC Standards, Policies and Procedures applicable to HMIS use and the SO Field Manual.
- SO staff must be trained on conducting a VI-SPDAT and the use of HMIS to:
 - Search for the household to avoid creating duplicate records OR opening someone in SO whose already in shelter, Transitional Housing or Permanent Housing
 - Create household record, including adding multiple members if a family;
 - Correctly document data elements that result in errors or poor data efficacy such as personally identifying information, universal data elements, income and housing data, and chronic homeless data;
 - Document each contact;
 - Document the engagement date;
 - Use Coordinated Entry Event to document referrals and referral dispositions;
 - Use notes to document where to find the client, engagement attempts and other critical milestones leading to the housing referral;
 - Enter all Universal Data Elements in the Entry/Exit Assessment
 - Enter the correct VI-SPDAT Assessment for unaccompanied persons who are disabled and meet the Chronic Homeless definition, families with a disabled member or youth led households;
 - Utilize HMIS Mainstream Benefits Assessment to report benefits being received by the household, application and date of application for benefits and application status;
 - Upload "Document Ready" documents;
 - Reporting placement or exit for other reason (i.e. institution, friends or family reunification, absence for 90 days).

Permanent Housing Referrals and By-Name List (BNL)

Permanent Housing Referral:

- SO must NOT refer unsheltered clients to the Homeless Trust Housing Coordinator unless their client is open in an HMIS SO, ES, SH or TH project. BNL's are reviewed at least twice a month in case staffing meetings led by the Homeless Trust Housing Coordinator. Anyone wishing to obtain a copy of the BNL may email Carlos.Laso@miamidade.gov. Case staffing meetings are conducted to review status of existing referrals and make new referrals for permanent housing, which includes, but is not limited to, Rapid Rehousing, Permanent Supportive Housing, mainstream housing voucher programs and privately owned units set aside for homeless households under Trust referral agreements.
- Such permanent housing providers, programs or owners may only take referrals from the Trust Housing Coordinator and are prohibited from taking direct referrals from SO, shelters or other permanent housing programs.
- The Trust Housing Coordinator is responsible for matching the unsheltered person to the appropriate housing based on review of HMIS Universal Data Elements (UDE), the CoC Coordinated Entry and Local Questions Assessment, Homeless Prevention Assessment and vulnerability tools such as Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT); Family (F-VI-SPDAT).
- Placement into a shelter beds can be used to stabilize a client on their way to permanent, sustainable housing, but shelter is not the end goal of SO housing placement.
- SO teams must have the appropriate level of support services to be able to walk who is refusing all services but permanent housing, from unsheltered to housed. These support services include but are not limited to Case Management, Behavioral Health services or connection to a FQHC with a homeless grant, Supportive Employment or connection to Career Source and Housing Navigation.

By-Name List (BNL) and Case Conferencing

- The Homeless Trust maintains a by-name list (BNL), a comprehensive list of every unsheltered person in Miami-Dade County who have been entered into the HMIS. The BNL is generated by Homeless Trust staff with Administrative access to the HMIS.
- The BNL is used as a tool to prioritize homeless persons for permanent housing most appropriate based on their HMIS record.
- SO staff must participate in BNL Case Conferencing and Housing Matching meetings as necessary to ensure all eligible persons have an opportunity for referrals to housing.

SO Services Pending Placement and SO Exit

SO staff must continue to provide ongoing assistance as described in this Manual to clients following referral until the client is approved for permanent housing and as warm hand-off between SO, the client and the permanent supportive housing program has occurred.

Section 5:

Document-Readiness, Income & Housing Plan

SO Client Services

SO Programs must:

- Assists unsheltered persons to become **“document ready”** to facilitate their permanent housing placement. SO assists unsheltered persons secure documents such as birth certificates, social security cards, government-issued identification and benefit letters.
- Addresses the unsheltered person or family’s **income** by:
 - Assessing the unsheltered person or families’ mainstream benefits utilizing the HMIS Mainstream Benefits Assessment and assist them to apply for benefits for which they may be entitled/eligible.
 - Assisting them in accessing job-related programs and services.
- Assists unsheltered persons identify their **housing goals**.

“Document Ready”

To facilitate rapid permanent housing placement, SO staff must actively assist unsheltered persons in becoming “document ready”. This requires SO staff’s direct assistance with acquiring birth certificates, photo identification, benefit letters and employment verification and income documents. Direct assistance includes assisting the unsheltered person with filling out forms, applying online and being transported to an agency office.

To facilitate housing placements and maintain a document record for the benefit of the unsheltered person, collected documents must be scanned into HMIS.

Document Resources/Information:

- **Birth Certificate**

SO providers must assist unsheltered persons in securing their birth certificate.

- **Government Photo Identification**

SO staff must assist an unsheltered person to gather documents required for a County ID, Florida Driver’s License or Florida ID Card.

Florida Driver's License or ID required documents found here: <https://www.flhsmv.gov/driver-licenses-id-cards/what-to-bring/>

State policy for verification of residence for homeless:

“Customers applying for a Class E driver license or ID card, who are homeless and reside in an agency where housing services are provided (homeless shelter, probation home, etc.) may provide a letter from the housing agency with the residential address and statement that the customer resides at the location and a Certification of Address document with Section A completed self-certifying their residential address. The Certification of Address will serve as the 2nd proof of residential address document.

Homeless Certification Letters may come from:

- Homeless Shelter or Public Assistance Agency
- Local School District Homeless Education Liaison
- Foster Parent/Department of Children and Families

Customers who are homeless and do not reside in an agency where housing services are provided (homeless shelter, probation home, etc.), may provide a Certification of Address document with Section A completed self-certifying their residential address as General Delivery.”

- **Benefits Letter (TPQY)**

The Social Security Administration (SSA) only issues Benefits Letters (known as TPQY) via its online portal. To verify all sources of income or lack thereof, housing providers require a TPQY even if the unsheltered person is not receiving benefits,

Unsheltered persons must be assisted in setting up a SSA portal account, which may require assistance with establishing a personal email. Once the account is set up, the unsheltered person may request their TPQY. SSA does not allow third parties to request a TPQY except under very limited circumstances.

- **Employment Verification and Income Documentation**

To assist the unsheltered person's employer with providing employment verification, SO staff may provide the employer with the Trust's Employment Income Verification Form found online at <https://www.homelesstrust.org/homeless-trust/providers/home.page>.

SO staff must assist unsheltered in printing off income verification if needed (i.e. direct deposits recorded in bank statements or online banking apps such as Chime).

Income

Securing Benefits

- SO staff must identify whether unsheltered person is receiving benefits and assist them with applying for benefits, including reinstatement of benefits.
- SO staff must use the HMIS Mainstream Benefits Assessment to record benefits that the unsheltered person is receiving or has applied for and the status of an application. The purpose of the HMIS Mainstream Benefits Assessment is to ensure that all providers serving the client are aware of benefits being received and benefits for which the unsheltered person has applied and the status of the application to avoid disruption to benefits or lack of follow-through with applications.
- SSA Benefits – SOAR Application: The SOAR effort in Florida is an initiative designed to increase access to SSI/SSDI for eligible adults who are experiencing or at risk of homelessness and have mental illnesses, medical impairments, and/or co-occurring substance use disorders. The SOAR process is intended to expedite review of applications and reduce risk of rejection for failure to properly document disability.
 - Unsheltered persons with disability, legal status in the US, who are not already receiving or pending an active application for disability must be assisted with a SOAR application. The SOAR Online Course: Adult and Child Curriculums are free and are located on the SOAR Works website (<https://soarworks.prainc.com/content/soar-online-course-catalog>).

Employment

- SO must determine if an unsheltered person is seeking employment and assist them in connecting with job programs or services.
- SO must also determine if the client will or is experiencing barriers to securing and/or maintaining employment (identification, transportation, clothes and showering) and assist the client in overcoming such barrier(s).
- SO should connect clients to employment training and placement opportunities offered by:
 - **CareerSource** operates one-stop employment centers co-located at or near ES facilities as well as mobile employment units that visit ES facilities.
 - **Workforce Development, Inc.** an enhanced Miami employment program, hires formerly homeless, connection to city vendors' on-the-job training/apprenticeship program and hiring homeless in projects that receive city funding.

Housing Planning

- SO staff are expected to utilize client-focused motivational interviewing to assist engaged persons to assess and/or identify their motivations, housing goals, strengths and supports, barriers to housing sustainability and how to overcome them.
- ***Tip:*** *Service planning begins by asking people what they want, helps them define their desires and interests, establishes a vision for what they want out of life, and builds hope that those things are possible. Outreach staff then design services to help clients achieve their goals.*
- Participants must be connected to appropriate on-going services in advance of planned placement. SO staff is expected to assist them in accessing resources they need to maintain their motivation and achieve their housing goals.

HMIS Housing Plan Assessment and HMIS Case Plan

- When clients refuse shelter, SO Programs should use the Housing Plan Assessment in HMIS to explore the client's goals, identify their strengths and identify barriers related to housing and health to explore direct placement into housing.

Outreach Staff Practice **Guidelines**

Outreach Staff Practice Guidelines

CoC funded Outreach projects are monitored on the guidelines in this section. Other outreach teams are encouraged to adopt the guidelines in their operation.

Key Responsibilities of Outreach Workers.

- **Identifying who is living unsheltered within a defined geographic area.** Outreach workers physically canvass the full geography of Miami-Dade County, the City of Miami's team maintains active relationships with partners that discharge persons into homelessness (i.e. Public Hospital, jail...), and connect with people experiencing homelessness via the helpline or Camillus' Day Center walk-in referrals.
- **Making contact and establishing credibility with people living unsheltered.** Outreach workers forge primary relationships with people living unsheltered, earning their trust through consistent and reliable interactions where workers can demonstrate kindness and helpfulness.
- **Collecting and entering data into the Homeless Management Information System (HMIS).** Outreach workers use HMIS every day to record information about clients they have been in contact with, services that have been provided, complete universal data vulnerability assessments, make referrals, write progress notes and upload housing documents.

***Note:** Getting a client's information into a single system means that the client doesn't have to repeat the same information multiple times. It also reduces the information gathering burden that staff within the homeless service system collectively bear. Further, this information is the only way that projects can consistently and accurately report progress toward the outcomes. Entering complete, accurate and timely information is the most important way to make sure the project gets credit for the work you're doing.*

- **Assessing client needs and developing housing and service plans.** Staff begin assessing client needs with clients who refuse shelter and direct placement into housing is an option.

- **Providing housing-focused case management.** Street Outreach projects are most successful at achieving positive client housing outcomes when they operate with adequate client to staff ratios. Much of an outreach worker's time may be spent providing housing-focused case management. Staff are expected to stay involved with enrolled clients even if they utilize stabilization beds (shelter) while enrolled, until they are housed.

***Note:** Focus on quality over quantity. The level of intensity to be successful limits the number of clients a case manager can serve successfully. For instance, vulnerable clients may need hands-on assistance to access services and supports. Someone may need some coaching on meeting with SSI, a potential landlord or even gaining access to needed psychiatric and or medical services.*

- **Collaborating with CoC Housing Coordinator to move clients into housing.** Outreach workers participate in weekly case staffing meetings and complete Universal Data Elements (UDE) and vulnerability assessments to make sure that their clients are prioritized for housing opportunities.

Some examples include:

An outreach worker makes contact with someone living unsheltered and preliminarily determines that the person is eligible for Permanent Supportive Housing (PSH). The outreach worker completes the HMIS UDE and vulnerability tool and emails the CoC Housing Coordinator to make an effort to have the client prioritized for referral to PSH.

An outreach worker attends a regular case staffing meeting (aka. By Name List [BNL] meeting) to match clients to available housing units, using the meeting to make sure all of the client's information, needs and housing preferences are available to the CoC Housing Coordinator.

An outreach worker attends a regular BNL meeting to hold each other accountable for agreed-upon commitments, and when necessary, work out new relationships between staff and a particular client to advance their client's housing plans.

An outreach worker receives referrals from helpline operators for someone living unsheltered. The worker gets location details from the operator and makes every attempt to find the person, complete UDEs and vulnerability tool and add the client onto their HMIS project.

Develop a Relationship with Clients from Day One

- Begin developing relationships with clients from the first time they encounter someone living unsheltered and continue with that relationship until after the client has moved into housing or been engaged by a new case manager.
- Begin by building trust, gradually engaging, and working toward acceptance of services and housing offers.
- Talk about opportunities, resources, service possibilities, your role and the team(s) you work with, successes others have had as a result of working with you or outreach colleagues, etc. Keep in mind that your outreach team may or may not be the primary team working with this individual, so take care to include other outreach teams in your description of who can help.
- Keep it simple so you don't overwhelm with information.
- Don't lose sight of the immediate goal: getting someone to talk to you and tell you some of their story.
- The length of this process varies widely, given the individual circumstances of people living unsheltered.
- Your relationship does not end until after the client moves into permanent housing. Shelter is a step along the path, not the end goal.

On Day One, your goal is to create a “why” for the person to engage with you. Identify yourself and your organization and get the person to talk to you.

Ask open-ended questions and get to know the person without pushing any agenda. Actively listen to what the person is telling you they need and want. Figure out which basic needs you can help the person meet and what you can do to relieve discomfort. Ask what they want or need. Work on small tasks so that people get something out of the interaction — this could be a blanket, coffee, or information. Make sure you have hygiene packets and other supplies whenever you go out in the field. Check HMIS as soon as you can, and read all client case notes available to you.

Q: How do I know if I was successful at Day One engagement?

A: The individual wants to speak with me again.

Keep up momentum with these tips:

Engage again within 48 hours

If you are handing off further engagement with the client, consider bringing the outreach worker who will continue engagements with you on your follow-up visit. Follow through on the commitments you made to the individual during your first contact.

If you have just received a referral and have not yet met the client, try to accompany the outreach worker who first engaged the client when they go back a second time.

Regardless of whether you can go with the other outreach worker, make every attempt to engage your new client within 24 hours of receiving their name/information and location.

When meeting someone new, some behaviors make you feel comfortable and more receptive to talking and others make you feel less receptive:

More receptive...

- Is open to your opinions
- Listen to you
- Makes eye contact
- Sits at your level
- Responds to you
- Focuses on your needs

Less receptive..

- *Pushes a point of view*
- *Gives one opinion after another*
- *Displays body language of disinterest*
- *Answer phone during a meeting*
- *Has own agenda in forefront*

First Contact Practices:

Closing the Loop During & After First Contact

Before Leaving the Engagement:

- ☐ Did I offer something that would reduce the person's risk, harm or discomfort?
- ☐ Did I do a 360 scan for **emergency needs** (acute physical or mental health problems, e.g., imminent risk of suicide, homicide or other harm)?

***Note:** If you believe there is imminent risk to the person or others, call 911 and request a CTI officer OR call mobile crisis (305) 774-3616. If they are hospitalized, check on them and continue the relationship.*

- ☐ Did I get the person to talk to me?
- ☐ Did I ask about whether they need an ID, Social Security Number or SSN card?
- ☐ Did I ask the person about income?
- ☐ Did I ask about military service?
- ☐ Did I reinforce a strength or positive behavior the person demonstrated? What about the progress we made today? e.g. "We completed a release so we can get you healthcare." or "We found a place you can do laundry."
- ☐ Did I talk to this person about their plan to end their homelessness and what help they need?
 - ☐ If they indicated they have family or friends who could be a source of safe housing, did I ask if they need help to get in contact with them?
- ☐ Did I commit to coming back and give the person a general sense of when that will be?
- ☐ Did I ask "If I can't find you here, where are the places I can find you?" and "Is there a way to contact you if I can't find you?"
- ☐ Did I look for signs that this person has mental illness or substance use disorder?

Continued...

Within 24 Hours of the Engagement:

- ☐ Record **the person and their location in HMIS.** (for all contacts)

Note: Enter something into HMIS, even if it's simply a detailed note with the location and circumstances for persons refusing all services. **YOU DO NOT NEED TO COLLECT A FULL CLIENT RECORD TO ENTER INTO HMIS until an engagement date is entered.**

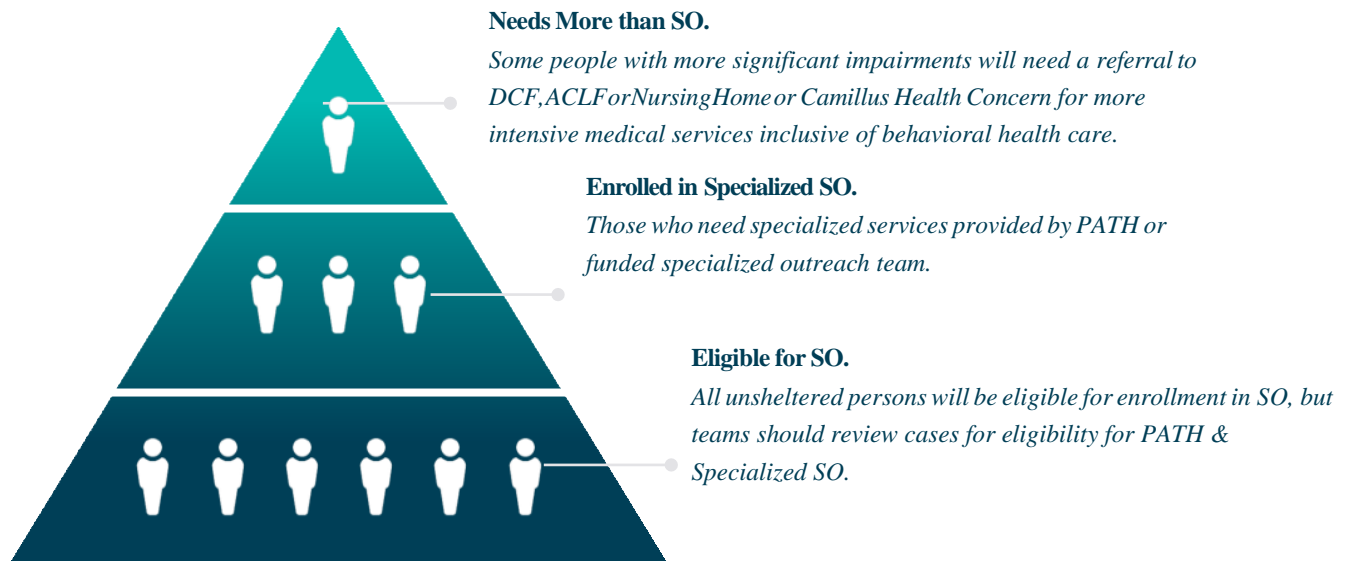
- ☐ Did I follow the standard for adding anonymous clients?

View guidance here:

<https://www.homelesstrust.org/resources-homeless/library/providers/policies-and-procedures/hmis-anonymous-client.pdf>

- ☐ Write down the commitments I made to this person so I won't forget, e.g. when I will come back, what I will bring or do for this person?
- ☐ Record in case notes where I can find the person and how to contact them if I can't find them?
- ☐ Record in case notes any family or friends who could be a source of safe housing. Have I followed up already? If not, what's my plan to follow up in the next 24 hours?
- ☐ Does this person appear to meet the criteria for Specialized SO, i.e. behaviors that indicate mental illness and/or substance use disorder, or someone who does not have legal status?

Outreach Service Options for People Living Unsheltered



Next steps for each individual will depend on an assessment of whether the individual needs more than the outreach teams can offer. The VA Outreach services are an option if the client has served in the military.

Respect Client's Rights

Outreach workers must operate in ways that respect each clients' rights to confidentiality, to make grievances, and to decide how and when their personal information is disclosed. Specifically, staff must do the following for all clients:

- Adhere to confidentiality requirements in all discussions with participants, colleagues, and collateral contacts regarding participant information, as well as in handling participant records.
- Obtain and file a signed release of information for disclosures of confidential information
- Inform outreach participants early and often about how they can use the grievance process to grieve eligibility and termination decisions and other issues.
- Outreach workers must operate in ways that respect each clients' rights to confidentiality, to make grievances, and to decide how and when their personal information is disclosed.

Provide Housing-Focused Case Management

It's the end of Week 2. How do you know if you're on track?

- ☐ *I have gotten my client a State ID if needed.*
- ☐ *I have started benefits applications with or for my client (referring someone to an application is not an appropriate level of support).*
- ☐ *I have a clear sense of what my client's housing plan, goals and preferences are and have gotten specific information on different housing options from my supervisor, CAN staff, and/or colleagues.*
- ☐ *I followed through on commitments to my client and have a plan and timeline to meet with them again.*

Housing focused case management begins early in the process of engaging an individual living unsheltered. Case management time must be spent on activities primarily aimed at quickly connecting unsheltered homeless individuals and families to safe available housing, as well as income, health/behavioral healthcare and other supports, including:

- Screening enrolled clients for public benefits eligibility and assist in applying for benefits, including SSI/SSDI, Medicaid/Medicare, SNAP, TANF, and other non-cash or cash benefits. **Assistance could be helping someone fill out an application or filling it out for them.**

Note: *Referrals alone do not meet this standard.*

- Screening enrolled clients' **SSI status** and connecting them to a **SOAR trained case manager**.

Note: All frontline staff need training in how to conduct a functional assessment on the impact of someone's disability on daily functioning.

Pro tips:

- *Get records from anywhere the person has been treated.*
- *Find out if the client ever had SSI. If so, SOAR is unnecessary — update their application to reinstate benefits.*
- *If you observe an obvious disability, physically go with the person to the SSI office to apply for presumptive SSI. This includes visible physical disabilities, clear signs of mental illness, etc. Presumptive SSI can be obtained in two weeks and lasts six months while official SSI is obtained, without the threat of paying those six months back.*

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- Screening for a history of military services and connecting them to Veterans Affairs (VA) Outreach and services.
 - Accompanying enrolled clients to their initial appointments for other services, benefits, outreach assessments, and housing appointments whenever possible, including offering transportation, assisting with applications and interviews, providing client documentation, and acting as an advocate for your client.
 - On an “as needed” basis, assisting clients to access a stabilization bed temporarily on the path toward permanent housing.
 - Using “**warm hand-offs**” to help clients establish a relationship with staff providing on- going services.

Note:** Well-handled referrals are essential to helping clients successfully access homeless services and resources. **Referral Pro Tips:

- *Referrals should be made as a “warm hand-off,” in which outreach workers personally introduce clients to their new providers, benefits staff, or outside community agencies/providers.*
- *Outreach workers should communicate with colleagues about referrals in person, on the phone, via HMIS, or other direct communication options. Email should be a method of last resort.*
- *For referrals that aren’t straightforward and may need more people to weigh in, outreach workers may need to conduct case conferences with multidisciplinary teams to coordinate referrals.*
- *Remember that clients also have to exercise personal initiative, upholding the equal, collaborative relationship between staff and clients.*

Maintain a Client Centered Approach

- Work persistently, e.g., offering services multiple times in different ways, talking over coffee, etc., to assist clients in locating safe temporary accommodations and permanent housing that can accommodate their entire family, including any pets.
- Assist clients with a low housing barrier approach, making sure they can access permanent housing without unnecessary prerequisites such as abstinence, treatment, service participation requirements, or other determinants of “housing readiness”.
- Try to understand clients’ perspectives, including any reasons why they are not using shelter and/or other services, and accept choices as a matter of fact without judgment. Know that people bring different experiences and priorities to this process —

Continued...

the outreach worker's role is to listen and discuss with clients on how best to meet their needs.

- Build trust by helping clients solve problems that are most important to them, which could be focused on safety, medical care, transportation, protection from the weather, access to food, water, clothing, sunscreen and toiletries, and companionship.
- Offer flexibility in how, where, and when services are provided, e.g. if someone wants shelter immediately, help them get into shelter and continue working with them.
- Provide case advocacy on behalf of clients to make sure they receive needed services.
- Help clients understand risks and reduce harm caused to themselves and others by risky behavior.
- Notify supervisor or colleagues of where you will be, for how long and when you will check in.
- Complete all required trainings, e.g. de-escalation, harm reduction, and other safety skills.
- Follow all safety protocols established by the project.
- Follow incident reporting, management, and follow-up protocols.
- Clients may not make progress on your timeline. Keep helping and understand that there are limits to what you as an individual can do. Give grace to the client and yourself.

Maximize Safety and Reduce Harm for Outreach Workers and Clients

- Act in a trustworthy and transparent way, following through on commitments and being honest about what you can and cannot do.
- Recognize signs and symptoms of trauma, avoiding known triggers for clients, and responding to reactions effectively, including being predictable and reliable regardless of client response.
- Learn clients' histories of risky or dangerous behavior. Always check HMIS case notes.
- Intervene as necessary when someone presents an imminent risk of danger to self or others.

Conduct Needs Assessment and Create Housing Plans

Service planning begins by asking people what they want, helps them define their desires and interests, establishes a vision for what they want out of life, and builds hope that those things are possible. Outreach staff then design services to help clients achieve their goals.

- Generally, when a client refused shelter and may be eligible for housing options, outreach workers need to begin asking about the individual's housing plan, goals, and preferences.
- Active listening is beneficial, checking to make sure your understanding is right by reflecting back to the client what you think you heard.
- If you're able, talk through the positives and negatives of different housing options, starting from what the client has in their mind.
- Avoid giving "reality checks" to clients, e.g. "You'll never be able to afford that."
- Start to bring the client's longer-term goals into focus by describing different paths to reach those goals.
- If the client is behaving in ways or engaging in activities that aren't in service of those longer-term goals, ask how important it is to keep doing those activities or behaviors, and negotiate with them on how to minimize the impact on their longer-term goals. This part of the engagement is about getting people to think through other ways they might achieve short-term gains or at least get them thinking about how it impacts other things they need or want. Do not use guilt, blame or direct confrontation to prompt behavior changes.

Being Proactive Pays Off: *Over the next week, assess for which needs are most time-consuming or require the longest lead time, and get started on these first. Outreach workers need to proactively tackle the tasks that will be critical to obtaining and sustaining housing. Waiting to begin these tasks can have major negative impacts on both obtaining and sustaining housing later in the rehousing process, especially income. Outreach workers can roughly follow the order of priority below, making tweaks as the situation demands:*

- *State ID*
- *SSI application, noting that most people do not require a full SOAR application. Only those with complicated SSI claims such as severe psychosis, SUDs, or other complex disabilities will need SOAR. For everyone else, the usual process is sufficient if started early enough. Get some tips from the SOAR team about how you can support a non-SOAR application*
- *SSDI application, including verification of disability, only if work history seems to indicate that SSDI is a possibility (see <https://www.ncoa.org/article/ssi-vs-ssdi-what-are-these-benefits-how-they-differ>)*

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- *Employment*
 - *SNAP/Food Stamps application*
 - *Social Security Number and/or SSN Card application*
 - *Medicaid/Medicare application*
 - *Connecting/reconnecting with natural support network (family, friends).*

Support Clients Through the Housing Application and Move-in Process

- Participate in BNL Case Conferencing and Housing Matching meetings as necessary to ensure all eligible persons have an opportunity for referrals to housing.
- Make at least monthly attempts to visit or contact clients after move-in to assess on-going service needs and connect clients to appropriate services as necessary for at least three months after move-in.
- Prepare clients for success by thinking through contingencies in advance of housing and mitigating risks to housing stability. Consider the impact of how a client structures their days, roles they play in their social networks, habits and patterns of behavior that could lead to housing solutions like:
 - *Housing multiple unsheltered persons who make up a social network either on the same lease or with separate leases, in nearby units, within the same time frame, and other ideas to successfully stabilize a group of people who are close.*
 - *Anticipating hoarding patterns by purchasing clear storage bins, negotiating limits on how much stuff is allowable in the unit, visiting more frequently to assess the amount of stuff and assisting with removal of excess stuff.*
 - *Anticipating the need to help the client maintain their relationship with the outreach staff, as well as form trusting relationships with other service provider staff by accompanying them to appointments and staying temporarily engaged with clients after they are housed to increase feelings of stability, companionship and trust.*

Plan Ahead for Successful Transitions

- Incorporate the expectation of an eventual transition to another provider early in the engagement process. Taking this early step helps to ease transitions later in the process.
- Actively involve the client in the referral process and attend to the client's emotional concerns about the transition.
- Inform the staff of the linkage site about the client's needs and characteristics and provide them with technical assistance and emotional support for their concerns.
- Provide follow-up support on a gradually declining basis to both new staff and the client to prevent abandonment issues.

Consistent Practice:

Doing Your Homework Between Contacts

Before Leaving the Engagement:

- ☐ Did I offer something that would reduce the person's risk, harm or discomfort?
- ☐ Did I revisit their plan to end their homelessness and what help they need?
 - ☐ *If circumstances have changed with family or friends who could be a source of safe housing, did I ask if they need help to get in contact with them?*
- ☐ Did I commit to coming back and give the person a general sense of when that will be?
- ☐ Did I revisit benefits and income with the client and get their consent and availability to set up necessary appointments?

Within 72 Hours of the Engagement:

- ☐ Write down the commitments I made to this person so I won't forget, e.g. when I will come back, what I will bring or do for this person.
- ☐ Record in case notes any family or friends who could be a source of safe housing. Have I followed up already? If not, what's my plan to follow up in the next 24 hours?
- ☐ Using a basic sense of the client's housing plan, goals, and wishes, work with supervisor to determine which housing options seem like they might work for the client. Get specifics of eligibility, waitlists, and other relevant information from your supervisor to prepare for your next discussion with the client.
- ☐ Set up appointments for your client and make sure your schedule allows you to accompany them.
- ☐ Fill out benefits applications as needed.
- ☐ Enter additional client information into HMIS and update case notes.

Checklist¹:

Maintaining Safety for Clients and Staff

*****Frontline staff must complete required safety trainings before conducting outreach*****

General Ways To Create Safe Spaces:

- ☐ Listen
- ☐ Be reliable and supportive
- ☐ Explain your role
- ☐ Work together on something
- ☐ Provide some comfort and/or relief
- ☐ Provide support for whatever feelings someone is having

Before Going Out in the Field:

- ☐ Am I following the coordinated outreach plan? (*Ok to not follow only if responding to an emergency*)
- ☐ Is my cell phone charged?
- ☐ Do I have business/contact cards and my ID?
- ☐ Did I tell my supervisor or another staff person where I'll be and when?
- ☐ What is my plan for checking in? *Agree on how often to text your supervisor or colleague to verify that you are ok. Consider setting an alarm on your phone to remind you.*
- ☐ Did I remind [agency/partner] that I will be canvassing in this area today?
- ☐ Did I remove any valuables from my pockets or bag?
- ☐ Am I carrying incentives? Can I put them somewhere safe other than on my person?
- ☐ Am I wearing comfortable clothing and shoes I can move easily and walk/jog in?
- ☐ Do I remember my agency's contingency plan for worst-case scenarios or dangerous situations? *If not, review.*
- ☐ Know your backup. If it is a partner, know where they will be. If it is the police or ambulance, how long will it take to get there. If it is a crisis team, how long will it take. Plan any interventions accordingly.

¹ Adapted from one originally developed by outreach workers in Skid Row, Los Angeles, found in NCHCH's Workplace Violence: Prevention & Intervention: Guidelines for Homeless Service Providers (2011)

While You Are in the Field:

- ☐ Introduce yourself and inform people of what you are doing and why. It is best if you are introduced by someone who knows the person — a librarian, soup kitchen worker, another homeless person you know.
- ☐ If working with a partner, always present yourselves as a team.
- ☐ If someone does not agree with what you are doing, avoid engaging in argument and try to put physical distance between you and them.
- ☐ Identify an emergency exit route each time you enter a new situation. If none, do not enter the area.
- ☐ Never enter clients' cars, homes, or any enclosed areas that don't have a clear emergency exit route.
- ☐ Never approach those who are giving "signs" that they do not want to be bothered.
- ☐ If you see that sale of sex or drugs for money is in progress or being set up, leave the area immediately without drawing attention to yourself or others.
- ☐ If you know someone is holding illicit drugs, wrap up the interaction as quickly as possible. Do not accept or hold any type of controlled substance.
- ☐ Stick to your plan to text your supervisor or colleague at the agreed-upon time. Inform them of any unusual developments.
- ☐ In an emergency, call 911. Do not separate from partner unless staying would increase your danger.
- ☐ Do not accept gifts or food or buy any merchandise from clients; however, you might bring a coffee or a snack so that you can have it together.
- ☐ Do not give or lend money to clients — clients may avoid you if they cannot repay it. Money becomes the focus and does not help the client move toward longer-term goals.
- ☐ Maintain confidentiality of all clients you meet.
- ☐ Tell clients approximately when you will be back and how to reach you. Give clients your card. Ask them where you can contact them if they are not in the same spot.

De-Escalation Methods

To learn more, check out these resources:

Crisis Prevention Institute | www.crisisprevention.com

Assertive Communication: De-Escalation | <https://thousandwaves.org/self-defense/resources/>

The Center for Nonviolent Communication (website) | www.cnvc.org

QBS, Inc. | Quality Behavioral Solutions (website) | www.qbscompanies.org

Behaviors Indicating Agitation and Potential Physical Aggression:

- Change in pitch of voice (either screaming or very soft) or quickening rate of speech.
- Verbal threats, abuse, profanity or argumentative behavior.
- Increasing signs of tension, including clenched jaw or fist, rigid posture, fixed or tense facial expression, frowning, tears, eyes widening, shaking or trembling.
- Intense eye contact or avoidance of eye contact.
- Increased psychomotor restlessness (i.e., a feeling of restlessness associated with increased motor activity such as pacing, wringing hands, picking at skin, twisting hair, etc. This may occur as a manifestation of nervous system drug toxicity or other conditions); or
- Catastrophic or over-reaction to a minor stress; escalating behaviors or explosive loss of control.

The goal is always to protect potential victims, yourself, and others, de-escalate the situation, and help the individual regain control. Behavioral strategies to reduce agitation:

- ☐ Speak in a soft, quiet, even-toned voice.
- ☐ Exhibit a calm manner.
- ☐ Repeatedly call the person by name (if known).
- ☐ Maintain appropriate eye contact.
- ☐ Do not argue, point finger, fold arms, or take a "John Wayne" stance. Standing sideways is best.
- ☐ Calmly ask what the person needs. Allow time and space for a response. The goal is to help the person regain control of their situation.
- ☐ Offer to leave and come back another time.
- ☐ Encourage the person to sit down by sitting down yourself.

Behavioral Strategies To Reduce Potential of Assault:

***Note:** Sometimes people are lashing out because they are scared. Acknowledge that the person may not feel safe and ask what would make them feel safer. If a delusion is causing the behavior, do not argue with the delusion (e.g., no one is following you). Focus on what would help them feel safer.*

- ☐ Scan the area for other people, potential weapons and obstacles.
- ☐ Stand sideways and when you change place or position, do so calmly.
- ☐ Do not crowd the person or touch them. Give them space and be sure that the person has a way to exit the situation if they choose.
- ☐ If others are around, ask the person "Is there somewhere we could go to talk?"
An audience can feed escalation behaviors.
- ☐ If the person you are seeing is engaged in a conflict with another person, do not get in the middle.
- ☐ Maintain appropriate eye contact; continue calling the person by name.
- ☐ Keep the person talking; use "please".
- ☐ Help the person save face. Make it look more engaging to calm down than to assault.
- ☐ Do not mistake anger for aggression.
- ☐ If someone is paranoid, do not argue or confront. Give the person as much control as possible.
- ☐ If others are with you who can help, use methods of talking "to and through" the individual to let others know your plan.
- ☐ If there is a crowd gathering, try to move others away.
- ☐ Be aware of the usual progression of aggression and have a plan if physical assault occurs.
- ☐ If things are escalating and de-escalation techniques are not working, move away and get help. Pay attention to your instincts.

Outreach Supervisory **Guidelines**

Outreach Supervisory Guidelines

Projects should have supervisory capacity to ensure their long-term sustainability, decrease staff turnover, and facilitate clients exiting homelessness to permanent housing. Projects are encouraged to establish and maintain a supervisory role to:

- Provide a minimum of one hour of 1:1 supervision with staff every other week; and
- If project has more than one outreach staff, host team meetings every other week and/or regular “huddles” (brief review of the client list and planning for short-term interventions and immediate needs)

Supervisory Guidelines.

Supervisors are responsible for supporting outreach staff in the process of rehousing people experiencing unsheltered homelessness. Supervisors are encouraged to use 1:1 supervision, team meetings, and daily/regular huddles to support staff in the following ways:

- Examine progress on housing targets with outreach staff, troubleshoot barriers, identify fixes and refocus staff on critical tasks through establishment of daily, weekly and monthly priorities (Minimum 1x/month).
- Support staff effectiveness by reinforcing low barrier and assertive engagement skills and how to build participant motivation (as needed).
- Assist outreach staff to strategically plan concrete daily objectives that are aligned with the project’s outreach plan (Minimum 2x/month).
- Model collaborative service planning and case reviews with outreach teams (Daily/as needed).
- Revisit the outreach plan regularly, including adjusting canvassing and eligibility documentation strategies as necessary (Minimum 1x/month).
- Reinforce the importance of client documentation and development of meaningful service plans, including helping staff to carve out time for these activities if necessary (Minimum 1x/month).

Continued...

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- Practice workload management. Clients may require more time at different points in the process. Ensure that staff have adequate time to carry out the most time-consuming activities such as accompanying people on treatment visits, benefits meetings and landlord interviews (Weekly).
 - Ensure that the outreach team is following safety protocols, including establishing an easy way for front line staff to give advance notice of where/when they will be, practicing check-ins while staff are in the field, pairing staff for less visible visits, and reinforcing safe behaviors in the field (Daily/as needed).
 - Provide information on resources that staff need in order to effectively do their jobs. Develop organizational relationships/memorandum of understanding (MOU) with community-based services and supports that staff will regularly be accessing. Advocate for resources for clients (as needed).
 - Support staff self-care by recognizing emotional and psychological needs of staff, acknowledging successes, reinforcing boundaries, managing vicarious trauma and burn-out, and prioritizing support to staff involved in critical incidents with clients (as needed).
 - Support professional development by connecting staff to training opportunities offered by partner agencies, CoC, or other PATH grantees, and track staff training participation to ensure at least 12 hours of training annually on relevant topics (Minimum 1x/month).
 - Maintain up-to-date knowledge on CoC and non-CoC participating housing options and advise front line staff on eligibility, rules, and availability (as needed).
 - Reinforce the importance of timely, accurate, and complete HMIS data entry. Lead staff through data quality review (quarterly) and make sure they receive all available training on HMIS (as needed).

Supervisory Checklist

Semi-Annual Supervisor Self-Check-Ins (Also Use for New Hires):

- ☐ Have staff gone through necessary trainings in the past year?
 - ☐ *Assertive Engagement*
 - ☐ *Motivating for Change*
 - ☐ *Safety Protocols*
 - ☐ *Trauma Informed Practice*
 - ☐ *Housing-Focused Service Plans*
- ☐ Do staff have professional development goals that I can support?
- ☐ Does the staff member have a talent I can call out? Are they good at negotiating with landlords, are they good at SSI, are they good with making a clinical connection, are they a master engager, or other skills that help clients achieve their goals?
- ☐ Have I reviewed staff performance and provided them with concrete and objective feedback, including strengths to continue, growth areas to focus on, and key deficiencies that require immediate remedy?
- ☐ What skills/experience do we need to hire to make the team more effective?

Monthly Check-Ins:

- ☐ Did the project reach our internal housing targets for the month? What worked well and what didn't work well? *Discuss barriers and identify solutions. Keep staff focused on critical tasks for housing outcomes.*
- ☐ Did staff across the projects meet their canvassing commitments? If no, why? Can the deficiency be corrected or does it indicate a need to decrease the commitment?
- ☐ What adjustments need to be made to the outreach plan?
- ☐ What adjustments need to be made to caseloads?
- ☐ Are we meeting our commitments to the CoC, including:
 - ☐ *Prompt responses to helpline referrals.*
 - ☐ *Collecting and sharing all eligibility documentation.*
 - ☐ *Collecting and entering CoC required data elements into HMIS.*

Continued...

- ☐ Is the CoC meeting its commitments to outreach projects, including:
 - ☐ *Communication and training on any changes to the assessment process, shelter waitlist protocols, or BNL protocols.*
 - ☐ *Unsheltered clients on the BNL are being referred to permanent housing.*
 - ☐ *Unsheltered clients are moving into housing.*

Weekly/Bi-Weekly Check-Ins (1:1 and Team Meetings):

- ☐ How are each of my staff doing emotionally?
- ☐ Are any staff displaying behaviors or communicating in ways that indicate a need to reinforce boundary setting skills and encourage self-care? What about a need for training in certain areas?
- ☐ Are any staff communicating about clients in ways that indicate a need to reinforce assertive engagement techniques, motivational interviewing, or low barrier principles?
- ☐ Are staff having problems with one or more clients that rise to the level of shifting the client to another person's caseload? Are staff adequately trained and skilled to meet the needs of each of their clients?
- ☐ Are caseloads manageable? Look at acuity, tasks and frequency of contact, e.g. how many clients need a lot of assistance in connecting to resources? Is this manageable?
- ☐ What is the biggest burden on staff this week?
 - ☐ *Is there immediate relief that I or a team member can provide?*
 - ☐ *Is there long-term relief I can seek out through strengthening or establishing a partnership, better coordinating on tasks, or identifying a person or entity who can assist?*
 - ☐ *Is this burden something that I need to bring to our next meeting with the funders to seek an alternative standard?*
- ☐ Are staff allocating appropriate amounts of time to each of their major tasks: canvassing, case management, documentation, data entry, coordinating with CoC and other partners?
- ☐ Canvassing: Who goes where this week and are there any barriers to meeting that commitment?
- ☐ Are staff meeting their milestones with clients?
- ☐ Which client(s) is high priority for our team this week?
- ☐ Are staff setting aside adequate time to enter data into HMIS, including case notes?

Continued...

- ☐ What meetings are staff attending? Any we can remove?
- ☐ Any outstanding helpline referrals? What is the plan for responding to those?

Daily/Regular Check-Ins (Huddles):

- ☐ **Canvassing:** Follow the outreach plan. Who goes where today? If anyone is physically canvassing, reinforce use of safety checklist by using it yourself, e.g., ask where staff will be, is their cell charged, confirm when they will check in and with whom, etc.
- ☐ **Case Management:** Do any staff need information on specific housing options? Commit to doing the legwork on getting that information, e.g. eligibility, rules, availability, etc.
- ☐ **Data Entry:** Check in on HMIS entry and case notes for contacts made in the previous 24 to 72 hours — what's current status and plan for entering in a timely manner into HMIS? Reinforce the need to carve out time for doing needs assessments and developing service plans and entering both into HMIS. Assist staff as needed to shift workloads.
- ☐ **Documentation:** What do staff need help collecting? Are they keeping up with documentation collection?
- ☐ **Coordinating with Partners:** Are there any tasks that require connecting with other partners? If so, reinforce the importance and preferred method of communicating with the appropriate partner(s).

When Critical Incidents Occur:

- Follow safety protocols during and after the incident.
- Help staff members debrief after a critical incident, including documenting the encounter, filing notations in the client's case notes, making recommendations regarding the client's status in the project, identifying what might have been done differently to improve the outcome, and planning for follow up.
- Review staff adherence to safety protocols during the critical incident and ensure that staff receive additional or re-trainings as necessary.
- Provide long-term support to staff involved in the incident. Staff may experience short- or long-term psychological trauma, fear of returning to work, changes in relationships to coworkers and clients, feelings of incompetence, guilt or powerlessness, or fear of criticism by supervisors².

