Coordinated Entry Systems that Work

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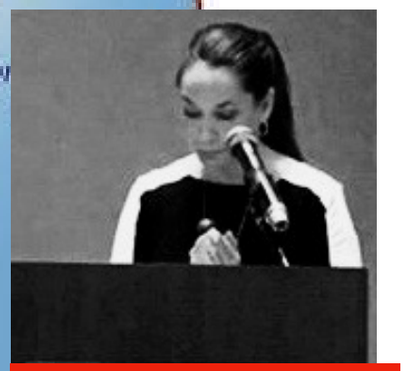
The Merry Misfits of OrgCode

ERIN: Minnesota based youth specialist; SPDAT; coordinated entry

IAIN: Ontario based leader of OrgCode; CEO; do-gooder

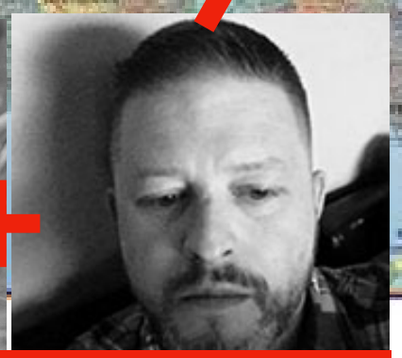
TRACY: Ontario based Associate Director of OrgCode; Master of Everything

KRIS: California based family specialist; shared housing; SPDAT

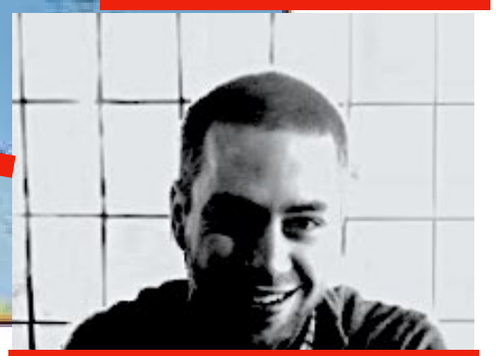


ANN: DC Based Leadership Wonder Woman

MIKE: Arizona based landlord guru



AMANDA & ZACH: West Virginia based rural; HMIS; trainers



DAVID: Florida based data boy wonder; coordinated entry; HMIS

IOWA

61% urban and 39% rural
3 CoC's
2017 PIT
Total Homeless 2,756
Unsheltered 104
Chronic 199
Veterans 171
Youth 140 (73 parenting)

FMR's
Efficiency $417 - $625
1BR $517- $735
2 BR $550 - $927

IOWA

State: Iowa

	Family Units[1]	Family Beds[1]	Adult-Only Beds	Child-Only Beds	Total Yr-Round Beds	Seasonal	Overflow / Voucher	Subset of Total Bed Inventory: Chronic Beds[2]	Veteran Beds[3]	Youth Beds[3]
Emergency, Safe Haven and Transitional Housing	**554**	**1,815**	**1,436**	**15**	**3,266**	**243**	**124**	**n/a**	**115**	**134**
Emergency Shelter	200	638	875	11	1,524	243	124	n/a	29	24
Transitional Housing	354	1,177	561	4	1,742	n/a	n/a	n/a	86	110
Permanent Housing	**297**	**1,011**	**886**	**0**	**1,897**	**n/a**	**n/a**	**n/a**	**527**	**0**
Permanent Supportive Housing*	126	370	699	0	1,069	n/a	n/a	802	430	0
Rapid Re-Housing	135	498	131	0	629	n/a	n/a	n/a	85	0
Other Permanent Housing**	36	143	56	0	199	n/a	n/a	n/a	12	0
Grand Total	**851**	**2,826**	**2,322**	**15**	**5,163**	**243**	**124**	**802**	**642**	**134**

*HUD's point-in-time count does not include persons or beds in Permanent Supportive Housing as currently homeless.
**Other Permanent Housing (OPH) - consists of PH - Housing with Services (no disability required for entry) and PH - Housing Only, as identified in the 2014 HMIS Data Standards.
[1]Family Units and Family Beds categories include units and beds for households with one adult and at least one child under age 18.
[2]Chronic Beds include beds in Permanent Supportive Housing dedicated to serve chronically homeless persons.
[3]Veteran Beds and Youth Beds, respectively, include beds dedicated to serve homeless veterans and their families, and include beds dedicated to housing homeless youth age 24 and younger.

Realities

- There is a difference between WANT and NEED.
- Most people that experience homelessness will do so only once in their life, for a short period of time, and will not experience it ever again.
- Meanwhile, there are a smaller percentage of people that experience episodic homelessness or chronic homelessness.
- We do NOT have an infinite supply of resources, nor do we have more staff and time than we know what to do with.
- Acting like a system requires that we have coordinated access and common assessment.
- All of this occurs within heightened emotional context.

Overcoming History

- Resources are achieved through self-advocacy and persistence, or luck, or first come/served

- The best case managers are the ones that work their way around the system, not through the system – and "side doors" abound

- Experience is used (confused?) as a form of assessment

- Disconnects between emergency side of the homeless service delivery system and the solution side of the service delivery system

- There is no coordinated approach for matching the right person/family to the right resource in the right order

Time is Ticking

CoC establishes or updates its coordinated entry process in full compliance with HUD requirements by January 23, 2018

CoC Program interim rule: 24 CFR 578.7(a)(8) HUD Coordinated Entry Notice: Section I.B

CoC's coordinated entry process meets the requirements (below) established by the CoC Program interim rule.

CoC Program interim rule: 24 CFR 578.3 & 24 CFR 578.7(a)(8)

- CES covers the entire geographic area claimed by the CoC.
- CES is easily accessed by individuals and families seeking housing or services.
- CES is well-advertised.
- CES includes a comprehensive and standardized assessment tool(s).
- CES provides an initial, comprehensive assessment of individuals and families for housing and services.
- CES includes a specific policy to guide the operation of the centralized or coordinated assessment system to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers.

Visual Images of a Coordinated Entry System

System Map and Roles

Outreach, Emergency Shelter, Day Center

By Name List: HMIS data creates prioritized by-name list

Referral: Families are matched with vacancies that meet their needs

Housing programs

You do

Diversion
Prevention
Basic Needs/Shelter
F-VI-SPDAT Assessments
Document Readiness
Enter/Exit HMIS data

You do

Housing Search and Location
Administer Subsidy
Housing Stability Supports
Broker additional services
Enter/Exit HMIS data

Front End / "Need"

Individuals experiencing homelessness assessed and entered into shared universal registry, then prioritized by need, and documentation for housing collected

Back End / "Supply"

Housing supply identified and vacancies filled from shared universal registry

Common Assessment

Coordinated Outreach

Prioritization

Case Conferencing

Housing Navigation

MATCHING!

Inventory of Available Housing Resources

Vacancy Notification

Eligibility Matching

Let’s Begin With A Bathtub

In a metaphorical bathtub where the water represents people experiencing homelessness, our shared commitment to “ending homelessness” looks like draining the tub.

GOAL = **LESS WATER IN TUB**

INCOMING WATER = **INFLOW**

DRAINING WATER = **OUTFLOW**

System Performance Measurement

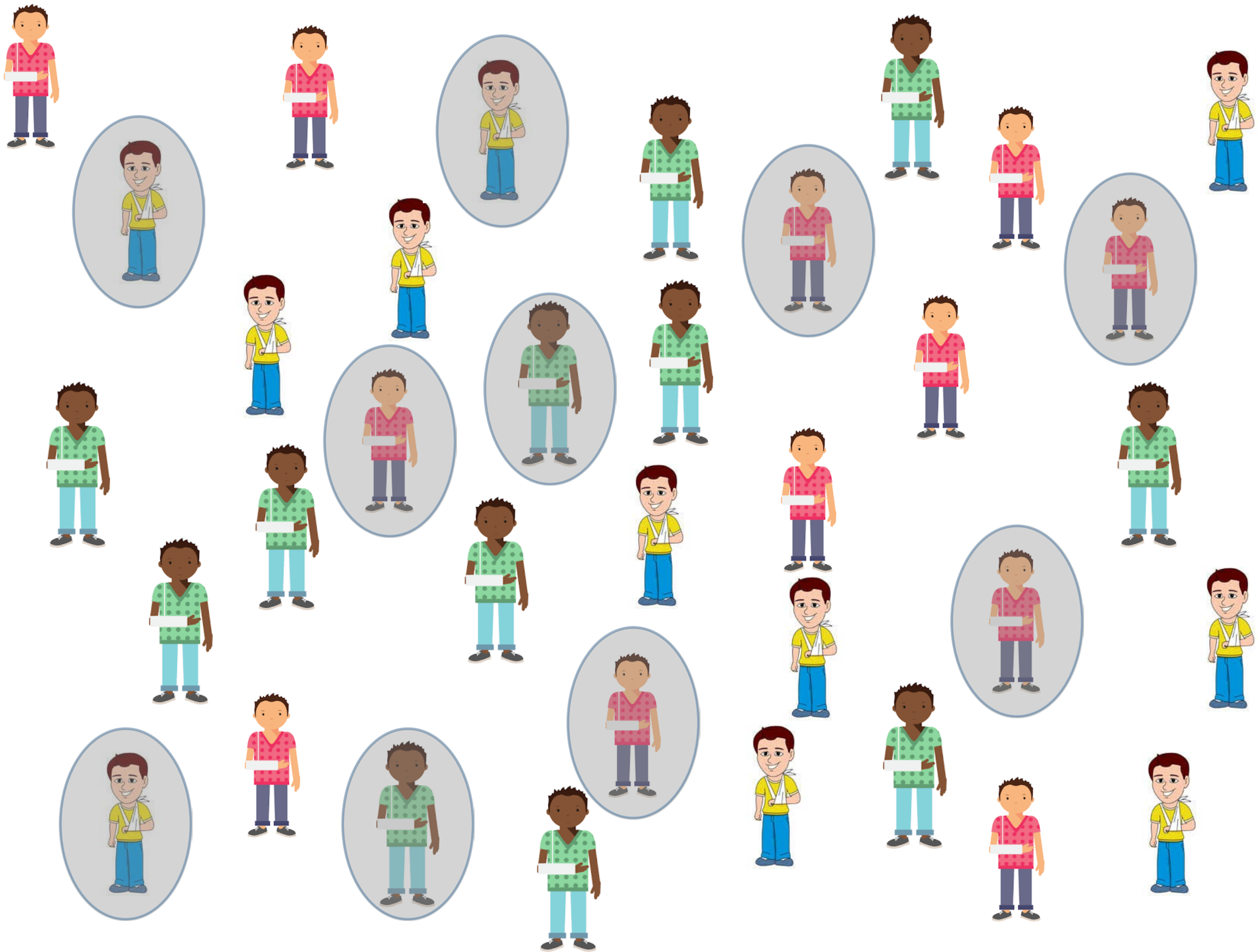
Things to consider:

In what ways can we increase the amount -- sheer quantity -- of people into housing?

In what ways can we reduce bureaucracy, connect supply to demand, and move with an urgency that almost scares others -- but in a good way -- to speed up that process?

In what ways can we provide housing *first*, not housing *only*, to support people once they move-in? Can that involve housing options with choice, not placement?

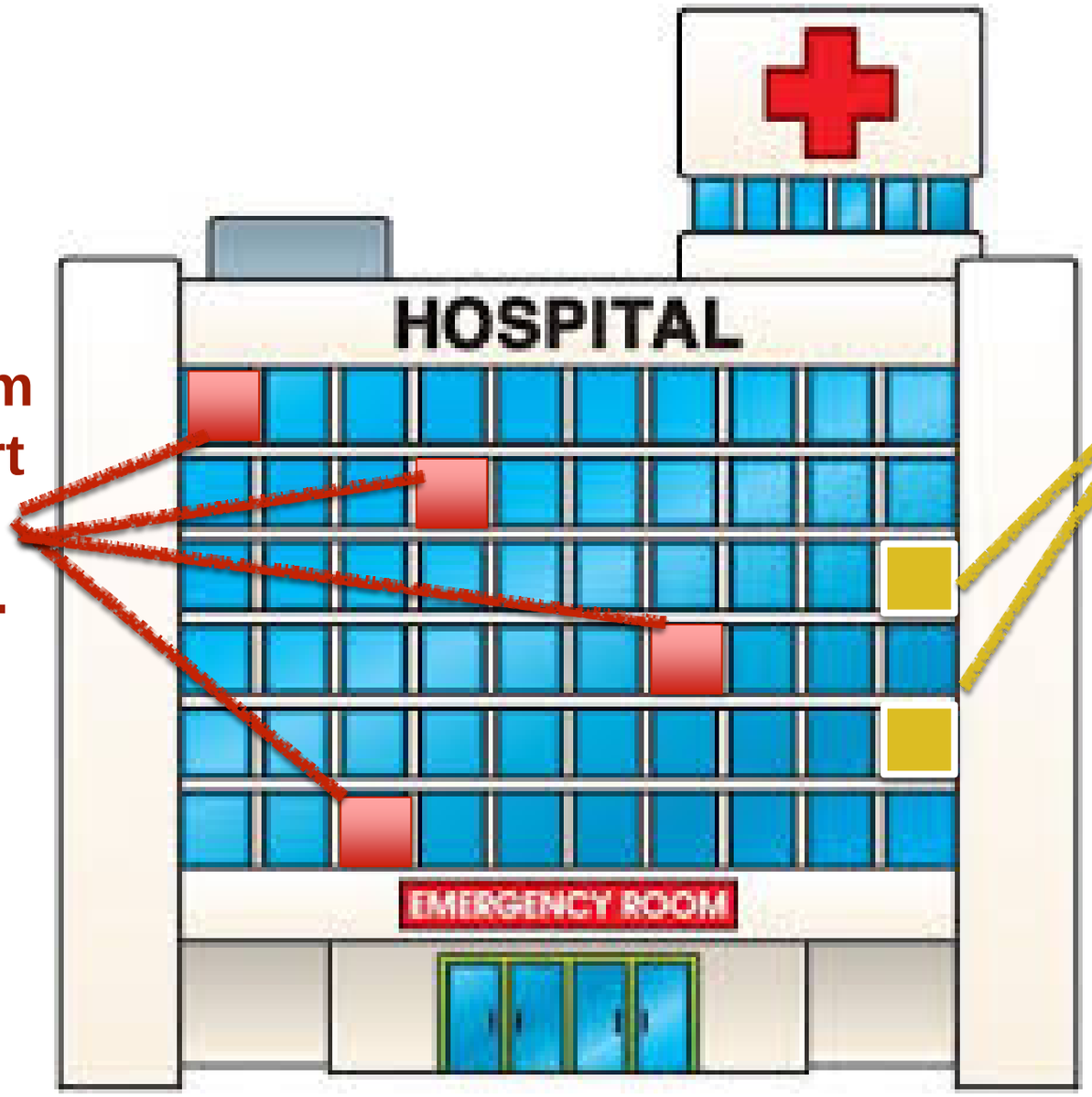
In what ways can we prevent, or rapidly divert, people from experiencing homelessness?



Is this an outpatient service? Short term stay?
Longer term, more involved situation?
If yes, how ill or injured are they compared to everyone else seeking service?
If yes, do they need to be at a hospital?
Are they ill or injured?

The ER knows who each of these 10 people are by-name if they are ill or injured and need to be at a hospital. The rest of the hospital does not know them. And, the ER does not know all the people who are ill or injured in the community but ARE NOT at the hospital.

Brief interventions.
No ongoing, long-term or permanent support required.
Expected to recover.



Who does what specialties?
Who has space?
What will be the treatment protocol?
Does the patient want it?

Diverted or quickly treated and discharged, the rest of the hospital does need to know these people.

Presents to Shelter

Returns to Shelter for Diversion

Diversion Attempted

Shelter Admission if Diversion Unsuccessful

Minimal Service (housing encouragement) for 14 days

Housing Triage

Activity Determined

1. Housing First/RRH
2. Assisted Housing
3. No Housing Assistance

Prioritization Determined

Client Notified of Priority Status

Assigned Case Manager

Prep for Housing

Housing Search

Lease Signing

Move in

Case Management Begins in Earnest

Goal Setting Linked to Higher Acuity Areas

Monitor Results

WHAT ABOUT LONG-TERM SHELTER STAYERS OR PEOPLE RETURNING TO OUTDOORS?

So…who’s doing what?!

Prevention vs Diversion

Prevention = sustaining an existing safe, appropriate tenancy

Diversion = locating safe, appropriate alternatives to shelter once a person/family has become homeless

Prevention

- Challenge assumption – the lower the risk, the better the investment
- Align prevention with community priorities for shelter or housing
- Insurance policy for those moved out of homelessness
- Higher needs = eligible
- Challenged ‘fixed’ amounts, start with least amount, increase as needed

Outreach

- Housing first/Housing focused
- Is necessary everywhere and should be an integral part of your system
- Outdoor homelessness does not happen by accident:
  - Rejection of shelter
  - Rejected by shelter
  - Lack of space in shelter
  - Reputation of shelter
  - Proximity to shelter

Diversion

- Often misunderstood as saying ‘no’
- Actually saying ‘yes’ to a solution to their housing crisis that doesn’t involve shelter
- 9 Steps to Effective Diversion
  - Client centered and solution focused; doesn’t assume we are the solution but part of the solution
  - Requires dedicated staff with specialized skills
  - Must be actionable; financial resources needed

Sheltering

1. Those that you are sheltering resemble the samecharacteristics of the households you are prioritizing for housing and supportprograms in your community;

2. Those that you are sheltering desire a housing solution, and programming within the shelter addresses these desires;

3. Only those individuals and familieswith nosafe and appropriate alternatives other than shelter are admitted.

Emergency Shelter

- **Emergency shelters** are a vital part of the process of ending homelessness

- **Emergency shelters** play an **important role** in a homelessness crisis response system

- The effectiveness of emergency shelter greatly impacts your system's performance

Key Components of Emergency Shelters in an Effective Crisis Response System

- ✓ Housing First approach
- ✓ Immediate and easy access
- ✓ Housing-focused services
- ✓ Rapid exits to permanent housing
- ✓ Measure outcomes to improve performance

Assessment/Survey

1. Be grounded in evidence and be rigorously tested.
2. Be easy to administer.
3. Assist with identifying different levels and types of housing supports.
4. Include the voice of persons with lived experience in its creation.
5. Be sensitive to culture, race, gender, and various types of homelessness.
6. Reinforce a trauma-informed approach to service delivery.
7. Transcend different population groups.
8. Work for YOUR community, YOUR principles, and YOUR prioritization process.

So…

- WHO is administering it and what measures or processes are put in place to train people on it?
- WHAT tool are you using?
- HOW are you using it?
- WHEN are you administering it?

Prioritization

- Process by which all persons in need of assistance who use coordinated entry are ranked in order of priority
- Established by the CoC with input from all community stakeholders
- To the maximum extent feasible, ensure that people with more severe service needs and levels of vulnerability are prioritized for housing and homeless assistance before those with less severe service needs and lower levels of vulnerability

Prioritization

The prioritization process may use any combination of the following factors:

A. physical, mental, developmental or behavioral health disabilities;

B. high utilization of crisis or emergency services to meet basic needs;

C. the extent to which people are unsheltered;

D. vulnerability to illness or death;

E. risk of continued homelessness;

F. vulnerability to victimization

G. other factors determined by community based on severity of needs

Principles Inform Priorities

Communities must establish the priorities for their resources. For example:

- Chronic homeless ahead of non-chronic
- Outdoor homeless over sheltered
- Frequent service users over "ordinary" service users
- Medically frail over healthy
- Households with higher acuity ahead of households with moderate or lower acuity

How NOT to Prioritize

Communities should not violate the Fair Housing Act by including any of the following seven federally protected classes within local prioritization:
race, color, religion, national origin, sex, disability, and familial status

This requirement is made explicit on page 11 of HUD's Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, stating "CoCs and recipients of CoC Program-funded PSH must continue to comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II or III of the Americans with Disabilities Act, as applicable."

What about lists?!

To Be On a List…

- The person has to go through the coordinated access process. No side door additions.

- The person has to provide informed consent to be on a list or stored in a database of any sort.

- The person has to be in a position where they can be imminently house-able. For example, people that pass away or end up serving a prison sentence are removed from a list.

- Outreach, shelter or other service providers have to be able to demonstrate contact with the person. You cannot hold service providers accountable for persons that disappear.

Organize Process by Supply & Demand

- Outreach, Drop-ins, Day Services and Emergency Shelters put clients **ON** the Priority List
- Housing Providers take clients **OFF** the Priority List

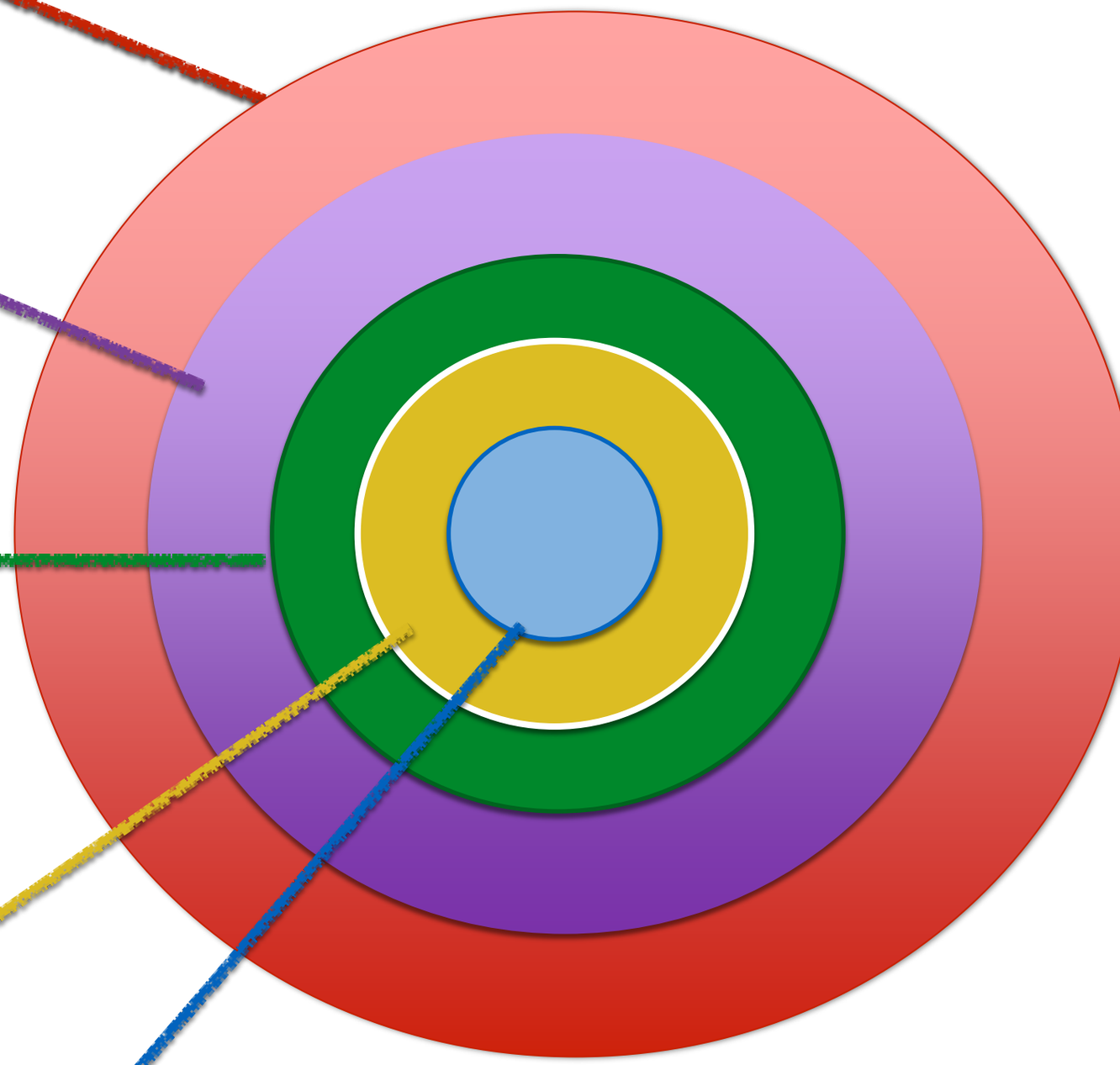
The Universe of All Experiencing Homelessness

Those That You Know Exist (Though May Not Know Name)

Provided Consent & Know Name

Engaged in Services (Active)

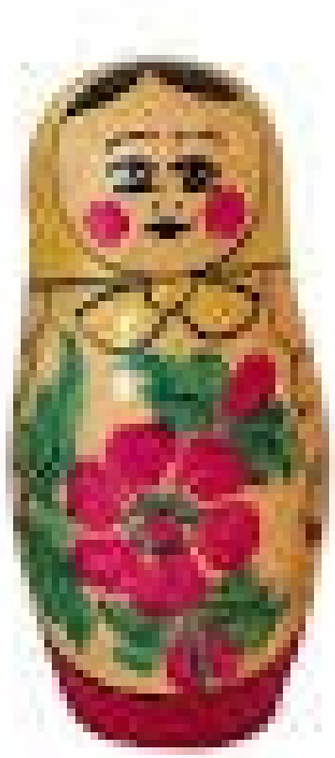
Imminently House-able (All Paper Work in Order)



Everyone that is homeless

Unknowable

Those you know exist



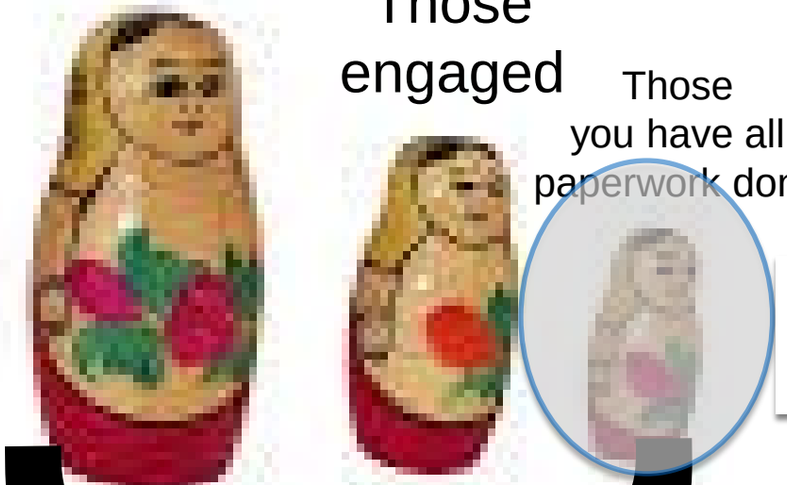
PIT Count

Coordinated Access List

Those that consent

Those engaged

Those you have all paperwork done



Priority List

By Name List

This sounds like a lot…

CoC Leadership

Staffing the CoC-Good

At the bare minimum, a CoC should accomplish:

- Monitoring of every CoC project annually (could be a combination of desk/in-person monitoring).
- Frequent look at performance measurement.
- Writing of the annual Collaborative App, and assistance with project applications.
- Implementation of the Coordinated Entry Project.

Staffing the CoC-Best

- Monitoring of every CoC project annually (could be a combination of desk/in-person monitoring).
- Frequent look at performance measurement.
- Writing of the annual Collaborative App, and assistance with project applications.
- Implementation of the Coordinated Entry Project.
- Specific staff allocated to building relationships with VA, PHAs, Faith-Based Shelters, Health Clinics, and other partners.
- Data Quality.
- Frequent Training.
- Collaborative App.
- PIT/HIC
- Planning for the Future.
- Budgeting and Need Assessment (by geography/acuity).

Strong Programs

If you aren't talking about HOUSING, you're having the wrong conversation.

All program components can be Housing First and Housing Focused:

- Outreach
- Shelter
- Housing

Social Service, not Social Control

NEVER shall there be:

- Attempts to heal or fix people;
- Requirements for sobriety;
- Mandatory medication compliance;
- Mental or physical health treatment requirements;
- Mandatory participation in programming
- Expectations of “graduating” into housing including any program requirements to become “housing ready”.

Service Requirements

- Trained, professional staff with knowledge of intervention, application of ethics, perform to standards, and professional boundaries
- Flexible hours & intensity
- Vast system knowledge
- Personalized case management; needs are identified through assessment then matched to resources
- Home visits/supports in vivo
- Impeccable time management skills
- Ability to manage larger caseloads (25-35 per case worker) for Rapid Re-Housing; and moderate caseloads for PSH (15-20 per case worker)
- Structured, documented, strategic approach to service delivery
- Fidelity to proven case management

Housing First means INTENTIONALLY

- Working with youth with felony convictions
- Working with youth that are registered sex offenders
- Working with youth that have poor/no credit
- Working with youth with a history of evictions and poor rental history
- Working with youth that may choose to continue using drugs and alcohol
- Working with youth that may continue to engage in higher risk behaviours
- Working with youth who don't want to work with you

Best and Promising Practices

- Housing First
- Harm Reduction
- Services and staff are Trauma Informed
- Understanding of the Stages of Change
- Culturally Competent
- Positive Youth Development
- Family Stability and Early Childhood supports
- Intensive, objective-based service planning
- Proactive vs. Reactive

HMIS

Three Basic Metrics

How long are people spending homeless?

How many are moving into housing?

How many are returning to homelessness?

HMIS and the CoC

- If you're the Lead and the CoC, hold yourself accountable for good data.
- If you're the CoC and have designated an HMIS Lead, you must hold them accountable for good data.
- Transparency
- Beyond minimum standards.

HMIS and the CoC

- At a minimum, an HMIS must be (in this order):
  1. Easy for clients to move through and receive assistance.
  2. Easy for agencies to use.
  3. Come with appropriate training and follow-up for users and agencies.
  4. Be easy to pull data from into reports.

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