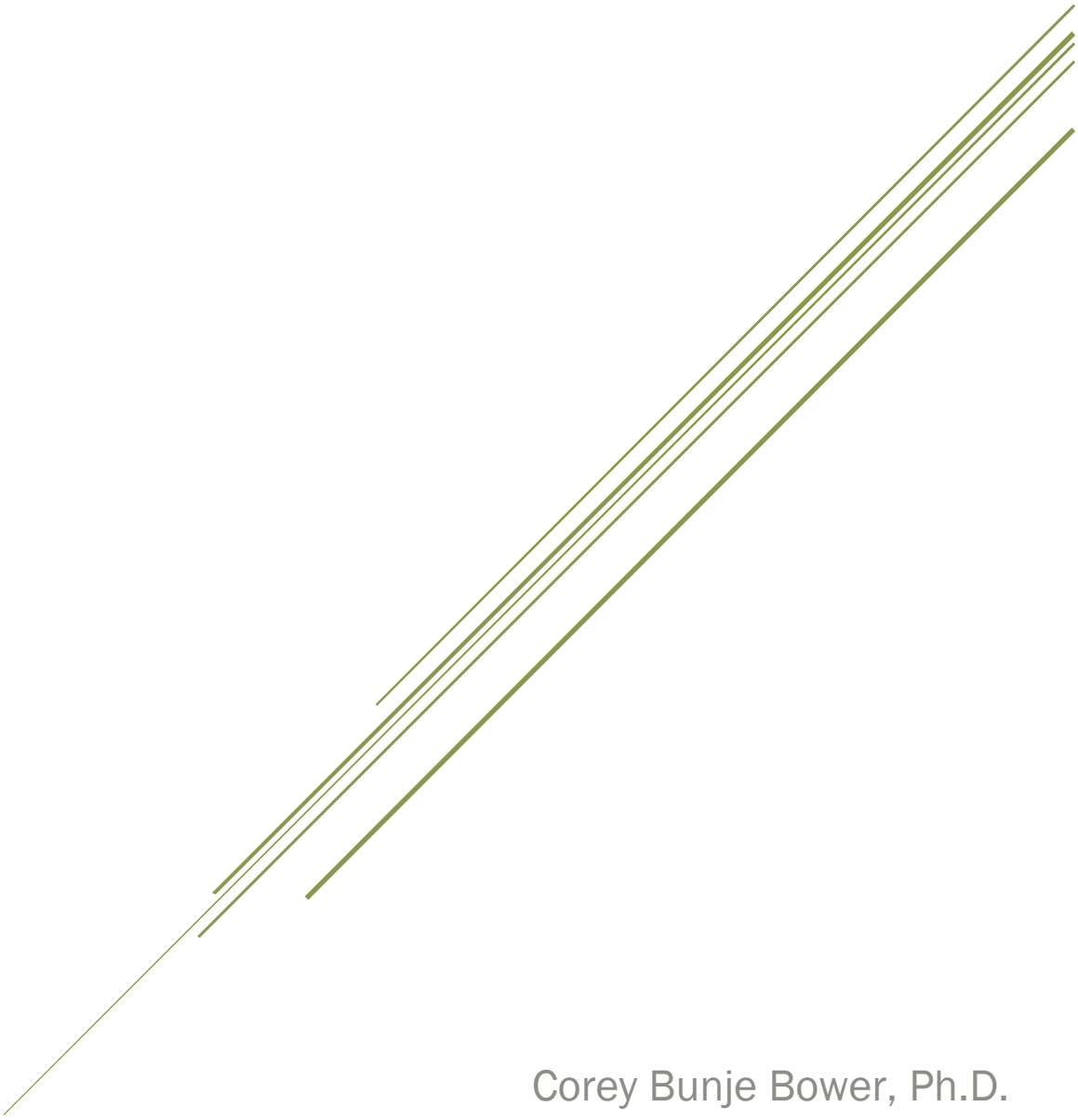
A REVIEW OF THE COORDINATED ENTRY PROCESS IN BUFFALO

PREPARED FOR THE HOMELESS ALLIANCE OF WESTERN NEW YORK

Submitted May 13, 2020



Corey Bunje Bower, Ph.D.
Michelle Wing
Kerri J. Tobin, MSW, Ph.D.
Kubra Say

Takeaways

- Clients with higher VI scores generally *did* receive more intensive services and were housed more quickly

- Though definitive evidence of discrimination is outside the scope of this evaluation, we find evidence suggesting that White families and female transition age-youth experience shorter waits for similar services

- Both service providers and clients generally agree that the process is fair and that they understand it

- Many service providers worried that crucial areas of trauma were not adequately factored in when computing VI scores

- Staff worry that domestic violence is not always weighted enough in the VI – at times, they believe it should override all other concerns

- There are sometimes too many choices/referrals to places given without full explanation – some clients experienced struggled to use the information

- Staff inexperience with trauma/difficult conversations made some of the narrative part of intake difficult

- Many service providers said that HAWNY was hands-off and that they could use more training, with the same materials used by all service providers, and regular refreshers to ensure everyone shares the same understanding

- Frequent staff turnover results in quick promotions of staff who do not fully understand the process

- In the future, service providers need to ensure that clients fill out intake surveys in places where they have enough privacy to keep answers confidential

Purpose

In order to fulfill evaluation requirements mandated by the U.S. Department of Housing and Urban Development, this evaluation examined the effectiveness of the Coordinated Entry (CE) system that has been implemented by the Housing Alliance of Western New York.

Methods

We utilized a mixed-methods analysis of the Coordinated Entry (CE) process. The evaluation was conducted in three parts between April and September of 2019.

We first conducted a quantitative analysis of placement data. We cleaned, sorted, and analyzed the data on client referrals and requests for housing. We broke the data down by vulnerability index score and housing outcome to examine whether those with higher need are, in fact, being served faster and with more intensive interventions. We also examined the process used to create the by-name lists.

Next, we conducted semi-structured qualitative interviews (see Appendix C) with service providers. While we set out to interview 12 service providers, some case managers joined interviews with their directors, totaling 17 interviews with 27 overall participants (pseudonyms and years of service are listed in Appendix B). Service provider participants were asked about their knowledge and comfort level with the CE process as well as their impression of how clients experience the CE process. Service providers also took a short survey (Appendix D) to complement the interviews.

Finally, we conducted semi-structured qualitative interviews (Appendix C) with 49 clients about their experience with the CE process (see Appendix A for pseudonyms, types of housing, race, and gender). Clients also completed a short survey (see Appendix D). While some participants were identified through randomly selected HMIS identification numbers, others were identified when service providers solicited clients with whom they already had meetings or home visits scheduled. Additionally, a research assistant spent time at different service locations to encourage qualifying walk-in clients to participate in the evaluation. By utilizing these three approaches, we were able to survey a wide variety of clients who have experienced the CE process. Clients were asked questions about their experiences, how their needs were evaluated, and whether they felt their needs were assessed and addressed correctly. Each client was compensated with a $15 gift card for taking part in the study. Interviews were recorded, transcribed, and coded by a graduate assistant.

We informed participants before starting that any identifying information about them would be excluded from reports and that they were welcome to stop the interview at any point. Clients were also informed that their participation in this evaluation would in no way impact their services or support.

1.) **Is the process correctly triaging and providing appropriate services?**
2.) **How effective do the various stakeholders perceive the CE process to be?**
3.) **What impact has participating in the process had on the stakeholders?**
4.) **Do stakeholders understand the process?**
5.) **Has HAWNY effectively assisted with the Coordinated Entry process?**

Results and Observations

We focus on the five main questions above to evaluate the Coordinated Entry (CE) intake process. We used data from the interviews, surveys, and placement records to answer the questions.

Is the process correctly triaging and providing appropriate services?

Data Analysis

Tables 1 and 2 below display the results of the client and service provider surveys. By and large, the survey found strong support for the program. For all but one question, at least 50% of respondents agreed that the program was working. And for all but one question, respondents were at least twice as likely to agree that the program was working than disagree and say it was not.

Table 1

Client Survey (n=48)

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Understood questions	72.9%	22.9%	2.1%	0.0%	2.1%
Process clearly explained	60.4%	33.3%	2.1%	2.1%	2.1%
Process emotionally difficult	12.5%	14.6%	22.9%	33.3%	16.7%
Right services offered	47.9%	35.4%	14.6%	2.1%	0.0%
Services offered were fair	47.9%	33.3%	14.6%	4.2%	0.0%
Immediate needs addressed	52.1%	35.4%	10.4%	0.0%	2.1%
Long-term needs met	51.1%	23.4%	19.1%	2.1%	4.3%

Table 2

Service Provider Survey (n=27)

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
Planning is efficient	11.1%	77.8%	3.7%	3.7%	3.7%
Clients find process user-friendly	3.7%	44.4%	37.0%	14.8%	0.0%
Process is emotionally difficult	3.7%	14.8%	22.2%	48.1%	11.1%
Process is efficient	14.8%	63.0%	0.0%	22.2%	0.0%
Assessment process is fair	29.6%	44.4%	11.1%	14.8%	0.0%
Process prioritizes needs effectively	14.8%	55.6%	14.8%	14.8%	0.0%
Process addresses immediate needs	11.1%	55.6%	7.4%	25.9%	0.0%
Process address long-term needs	3.7%	59.3%	11.1%	18.5%	7.4%

We ran numerous analyses using intake data to examine whether the system was working as intended. More specifically, we examined whether people who had higher VI scores were housed quicker and received more intensive services. We also checked to see if these differed by client demographics.

We find that across all three groups (individuals, families, and transition age youth), higher VI scores were generally associated with shorter waiting times. And, using logistic regression, we estimate that the odds of receiving permanent supportive housing are statistically significantly higher for those with higher VI scores among all three groups (see tables in the appendix).

We also ran OLS regressions to predict the waiting time of applicants based on their demographics (Table 3) for each of the three VI surveys (individual adult, family, and transition age youth). Differences by demographic group differ by applicant group. For individual adults, we find no significant differences in receipt of these services by client race, gender, or disability status after controlling for housing type and VI score.

Table 3
OLS Regressions: Waiting Time for Applicants

	Individuals	**Family**	**TA Youth**
Housing intensity (1=Permanent supportive housing)	31.569***	6.256	42.227
VI Score	-0.071	2.376***	-1.5
Disability (1=disabled)	-4.119	-5.407	-1.506
Race (1=White)	-8.858	-12.743***	4.393
Gender (1=female)	-3.595	-4.991	-49.475**
R^2	.036***	.072***	.183**

*p < .05; **p < .01; ***p<.001

For families, we find that White families wait for significantly fewer days than Black families, even after controlling for VI score. White families with low VI scores (0-5) waited an average of eight days versus 23 for Black families. White families with high (10+) VI scores waited an average of 34 days versus 41 for Black families. After controlling for housing intensity, VI score, disability status, and gender, White families wait 12.7 days fewer for services. There are two cautions for interpreting this. One is that we were unable to control for site in the analysis – it may be the case that rural sites with more White families are also able to house families faster (a follow-up analysis should be conducted here). Second, the model explained a low percentage of the variance in wait times (7.2%), indicating other factors that were not observed may be more important.

For transition age youth, we find that females experienced significantly shorter waits than males. Overall, males waited an average of 64 days while females waited 13. When controlling for housing intensity, VI score, race, and disability status, we estimate that females wait 49.5 fewer days for similar services. We are not sure what explains this trend, but it again seems likely that unobserved variables (e.g., pregnancy) play a large role here. We recommend HAWNY take a deeper dive here as well.

Service providers
Overall, SPs had a mostly positive response. The majority agreed that the CE process is more efficient, eliminates confusion, overlapping/duplicating services, and creates a fairer system than previous intake processes. Sixty-seven percent of those surveyed agreed or strongly agreed that the process

appropriately addressed the immediate needs of clients, as did 63% that the CE process appropriately addressed the long-term needs of clients. During interviews, SPs said they felt that CE does a good job of matching clients with agencies or programs that specialize in the needs they have. They also felt that CE gave the clients multiple options at times, instead of just one pathway, and mitigated the necessity for clients to travel to or contact multiple agencies or programs before they are appropriately placed.

The number of choices, while good for giving clients options, can sometimes be too much at once, especially for clients who have difficulty making decisions due to their traumatic experiences. Phyllis was skeptical of the system, saying

> *I think that that is really one of the downsides of like giving so much choice to people who still aren't . . . going to be able to make concrete decisions like that . . . where do [we] draw the line, rather than waiting until the last minute and saying oh, I'm sorry you lost your benefit because you've turned down every place that we've offered.*

Domestic violence SPs expressed concerns that their clients often score lower because their homeless history is not long, ultimately leading them to spend more time in a shelter or to return to their abuser while they await housing. Once they are placed, they felt the services provided were appropriate, but that time lag and low score was a major concern for SPs, and something that they felt negatively impacted the overall effectiveness of CE.

Many SPs also felt that the CE process does well connecting clients to services, but that they themselves are not always clear on the roles/specialties of the different agencies and programs, and so would appreciate more training or even a quick reference guide so that they can communicate this information more appropriately to clients to help them through the referral phase. Consistency in training and delivery is important; SPs pointed out that some clients do still receive more services or support because they are more cooperative even though the CE process is designed to prevent that. Adam worried about how client cooperation affected end results:

> *They really don't say much, and they really hesitate to give out information. So I have to be very relaxed with them, and around them, for them to come around and feel comfortable themselves . . . but other than that, they're really reluctant to come out with that information until they do get comfortable with you, and they're not with me long enough, some come for one day and will leave that day and not return. Some will come for a couple days and leave and not return.*

To guarantee that the CE process is connecting clients appropriately, SPs felt that there needs to be more communication and informal relationship building encouraged between intake and outreach personnel. While CE does help and prioritize the most vulnerable, it feels more mechanical to many SPs, which can hinder their ability to guarantee that the client is getting the appropriate support and services. As Sheila put it, "people just need to understand it better, figure out a better way to explain to the clients, and also well, oh, we definitely need a better way and it's not anyone's fault."

Clients

Most clients felt as though they were connected to the appropriate programs. Eighty-eight percent of clients agreed or strongly agreed that their immediate needs were met by the CE process. Seventy-five percent of clients agreed or strongly agreed that the CE process met their long-term needs.

Often, however, the reason or purpose for their connection to a specific program or service was not clearly explained to them, and some clients expressed frustration that they had to figure this out on their own. For individuals whose higher VI scores would connect them to more services and support, this information, as well as the referral follow-up process, could seem overwhelming. The majority of clients, however, mentioned good working relationships with their caseworkers and made particular mention that when confusion arose, they felt comfortable contacting their caseworkers and asking for clarification or assistance. For example, Carl described his comfort by saying:

> *Absolutely. And if there ever was any confusion with them, all I had to do was talk to the man, the man is very straightforward, he's a good dude, he's got a good heart, you know what I'm saying, he loves helping people, so if there ever was any confusion with anything I would just straight up ask.*

Anna echoed similar sentiments, saying "I know if I ever have a question, I can just call, and if there's something that I don't understand, she'll get right back to me and answer all my questions." Bill was particularly grateful, saying, "Oh, no doubt about it. I feel so blessed today."

While there were a number of exceptions, clients overall felt that the system was a fair one that resulted in the correct decisions being made. As Lana put it, "I felt it was as accurate, as far as predictions and the outcome, of course, is very accurate. It helped me get placed in my house."

How effective do the various stakeholders perceive the CE process to be?

Service providers (SPs)

Of those interviewed, 70% agreed or strongly agreed that the CE process prioritizes needs effectively, and 89% felt similarly that the planning process was efficient in addressing the needs of clients, with many comparing the system favorably with past models. In particular, SPs agreed that it helped cut down on concerns like client fatalities and is much more logical than previous systems. As Sadie said,

> *It eliminates the client having to jump from a bunch of different places and having to go all over . . . through coordinated entry they are referred to the correct program that matches them and that will literally house them. So that has really tremendously improved, I think that is the basic.*

SPs cited the streamlining, comprehensiveness, and objectivity as being some of the strongest points of CE. As Aaron put it,

> *It takes away the whole kind of cherry-picking mentality and it really makes it easy on an administrator's level that we can just say ok the next person on the list, like this is the process, so it's a lot more straightforward, easier to follow with those kind of rules.*

As a result of the centralized format, programs and agencies are often able to refer clients that do not fit their model to a more appropriate placement, which many SPs saw as a major positive. Many appreciated the emphasis on serving those with the greatest needs instead of choosing favorites. As Victor put it:

> *In other systems that I've worked with, they would cherry-pick clients, so as of now we prioritize most vulnerable, so yes it's more effective now in addressing the most vulnerable population.*

A number of service providers also appreciated the objectivity of the system. As Jessie put it:

> *It no longer becomes about like somebody's sad story or this person's sad story, or this person showing up like in a worse situation at the moment. It really streamlines it and kind of makes it more fair.*

While CE has helped improve communication and reduce duplication of services, some SPs felt like the personal connections and handoffs still need to be improved. "I think that the whole of homeless services is very convoluted, it can get very confusing very quickly, for people" Anthony said. While many liked the systemization, others did not always like the loss of human touch. Stella worries that

> *now it's literally like a computer, and there is no human interaction with it, and we don't get the human interaction, the client doesn't get the human interaction, and so it just feels like a process and not like a relationship building.*

CE could be more effective if there were more consideration for situations like domestic violence and disabilities. While there is an opportunity for a narrative and context while going through the CE process, the process can also be slightly mechanical, especially if the service providers do not feel confident in their training or are relatively inexperienced with handling trauma. Overall, however, SPs praised the new system.

Clients

Eighty-three percent of clients agreed or strongly agreed that they had been matched to services that they needed and that there were few problems with their experience. Eighty-one percent agreed or strongly agreed that the services they were offered were fair in comparison to those given to other clients. Most clients felt that the services they were provided helped them work toward their established goals of recovery or stability.

The issue of communication was frequently raised, often in relation to timeframe and waiting. While most clients reported good communication with their caseworker, there was often confusion as to what role caseworkers were expected to play in different programs and what the next step was in the process. Clients reported that the Department of Social Services was a source of confusion and hindrance to the process. Many clients felt that they understood the basic concept of services being provided but lacked a detailed understanding of what exactly those services incorporated or entailed (e.g., whether housing support includes utilities or furniture assistance).

The clients who did not view the CE process as effective complained of long waits without explanation, and confusion about what programs or services would provide. One client did not consider the process effective because they felt that disability status was not weighted enough as a contributing factor, and thus resulted in them having a lower VI score than what they expected. Another client took issue more with the feeling that options offered were the only choice, and that clients could not really refuse that assistance because then they would be left with nothing.

Clients also reported different experiences in terms of their overall feelings about the process. Allison was put off, saying, "I think there's definitely room for growth. I feel like a lot of the times when you're in this situation, people treat you as if you have to accept what's given to you because you're in need . . . just because I'm homeless, doesn't mean I shouldn't be privileged, I shouldn't have the same courtesy as anyone else would have in their house."

John, on the other hand, felt more positively, saying "It wasn't hard to understand . . . once I sat down with my caseworker, and they explained what was going on, then it became crystal." Malachi felt even better about the experience, saying

> *They were here to put it all together into one thing for me, it just showed me that there are programs out there that are willing to help me. And I don't feel ashamed of dealing with a program . . . it's like a big family-orientated type thing, and you know you're not discriminated against because of who you are and the rest so yeah I was clear on everything, and it was great.*

While clients encountered many obstacles throughout the process, they generally reported feeling that it was fair and that their needs were addressed.

What impact has participating in the process had on the stakeholders?

Service providers

Only 19% agreed or strongly agreed that participating in the CE process was emotionally difficult for them. They did express frustration with long waits to house clients, pressure to maintain statistics and meet goals, being unable to find clients when they have housing for them, and outside agencies who do not know/understand CE and send clients to the wrong places. Many SPs felt like they would be able to avoid staff burnout/turnover if there was more street outreach to help support the CE process and avoid or mitigate case overload. Alicia said they needed

> *Ongoing training with staff, at least once a year, or twice a year because there's a lot of staff transition and turnover in housing . . . you have to constantly be retraining and keeping up with the regs and things like that, would be really helpful. I mean we've lost a lot of staff to burnout.*

One of the greatest sources of frustration and discouragement was the transfer meeting, which many SPs felt was a dumping ground for difficult clients. SPs also expressed confusion or discomfort because they sometimes feel that they are not completely comfortable with, or knowledgeable about, the new CE system. Despite these feelings, most SPs felt that their work helping clients was effective (as seen in national evaluations as well) and that they were only frustrated with things they felt hindered their ability to help clients.

Some service providers did note that the process was not easy, particularly pointing to the high turnover of staff. As Alicia put it,

> *I mean we've lost a lot of staff to burnout, because it's kind of like how long am I going to hold this person, how long are they going to be in this bridge setting or this motel? Do you know what I mean? You have to be tough and clearly they need to be in the hospital.*

I don't know, this is like a whole systems thing to really do it. I mean like the hospitals don't want to keep these people, we get some of the most dangerous unstable people and everybody just thinks housing is a breeze, and it's not. And like I said, it's for the not faint of heart. And you have to, you love it or you hate it, and I feel that you have to have the passion for it, and you're going to find out if somebody's wants to be in working in this job within 4-6 months. And when I came to work here, I had had staff for 5,6,7,8,9 years. Now, I'm lucky if I can keep people for a year. I mean and that really tells you something, and that puts us in a pickle, because you have to, and it doesn't make people feel good, it doesn't, it's not good for morale.

There were also multiple concerns about correctly handling sensitive questions. For example, Dean complained about the lack of tact:

some of the questions, I get why they are asked, but some of them I feel like I blunder because there's no good way to ask…like one of the questions I have to ask is um about like exchanging like sex for money and that kind of stuff, and I'm like yeah there's really no tact about this question.

Overall, however, most service providers reported that they felt good about the system.

Clients

The overwhelming response from clients regarding the initial stages (taking the survey and establishing their eligibility) was positive. About 50% of clients did report that the experience was emotionally difficult on the survey (versus 27% who said it was not), but many later clarified in qualitative interviews that that difficulty was the result of experiences that had caused their state of homelessness. As James said

I was a little ashamed, but then I realized that I needed . . . you know, I didn't have no problem answering because you know it was to help me out. At the bottom line, was that I didn't have a problem with it.

Most clients agreed that the intake worker executed the survey with professionalism and kindness. A few clients, however, voiced concern that sometimes the survey was conducted in a public or occupied space, as opposed to a private room, which affected their willingness to be honest. As Diana said, "Well . . . it could have been more private." Clients often cited their own pride or shame as being the only uncomfortable factor, but most stated that they were able to open up to the worker relatively quickly. Anna was more positive, saying, "Yeah, I felt comfortable answering the questions being that I felt like these people were there to help me, so I felt, I didn't feel out of place at all." Ken, meanwhile, had more ups and downs:

I mean, I felt embarrassed I want to say, but I had to swallow my pride and let them know, you know my situation and I really want to get up out of here…I think at first when I took it, I think I wasn't fully honest . . . I felt like I was too scared, too nervous to answer the question…if it was like one on one like me and you, I would be all right.

The process of following up referrals and being connected with services and programs was often where some confusion or difficulty arose. While most clients had a fairly pleasant and efficient experience, with responsive and caring caseworkers, some expressed confusion about their roles and expectations, which

often increased if there was a change in caseworkers or a transfer to a different program or service. Some clients appreciated that they were given the ability to help in the process, while others struggled to handle independent expectations (e.g., looking for available housing on their own). DSS again came up as a difficulty with clients often seeing it as the major obstacle holding them back from obtaining housing and assistance. Most clients did feel that once they were matched, the services and programs they were connected to were appropriate for their circumstances and needs.

Do stakeholders understand the process?

Service providers

Service providers generally reported that they understood the survey, though some reported feeling confused by certain processes (particularly referrals since SPs are not always familiar with every program). Only 48% of SPs, however, agreed or strongly agreed that the CE process is user-friendly for clients (15% disagreed, but none strongly disagreed). Most SPs had the impression that it can be a confusing process for the clients if not explained thoroughly and repeatedly.

DSS was repeatedly cited as a source of confusion, misinformation, and frustration for both clients and SPs. Many SPs reported frequently correcting information or re-explaining to clients how CE works. The concept of priority and how the list is fluid was also cited as a major point that was difficult for SPs to explain. Many SPs also pointed out that clients' mental conditions, diagnoses, or trauma often make it even more difficult for them to understand the information.

Shannon was notably skeptical, saying

> *They don't really know what they're answering most of the time, they don't know what the SPOA is, once they've done all that stuff, they don't know what the priority list is, and how it's formatted and goes forwards and backwards. So they have some staff tell them oh you're #5. Well, you're #5 for today, you might become a 20 tomorrow, because someone else who has a higher VI-SPDAT…I think they're mistaken and confused a lot.*

Anthony was skeptical of the larger context, saying *"*I think that the whole of homeless services is very convoluted, it can get very confusing very quickly, for people especially with all the different terminology, expectations, and referral system, who is eligible for what and why, it can be very confusing and frustrating."

Sheila believes that clients are not the only ones confused:

> *I think a lot of agencies don't have a clear understanding of all the housing programs. They know what PSH is, they know what transitional housing is . . . I think we can do better on, I guess understanding the programs better, maybe having a cheat sheet. Just so we know if a client doesn't qualify for this, they might qualify for this, and who is that contact person for that program.*

SPs recommended making sure that there is consistency among staff and within training programs so that clients are receiving the same explanations and information across agencies and programs. Language barriers are obvious hindrances, but agencies have often managed to accommodate these in informal ways. SPs reported that the language helpline is very expensive, but useful, and could be an

area that needs more support. Additionally, some suggested some consideration/restructuring of how information and process are delivered to acknowledge and factor in how the trauma that clients are going through impacts their capacity to intake and retain knowledge.

Clients

Ninety-six percent agreed or strongly agreed that they understood the CE questions they were asked and 94% of clients agreed or strongly agreed that the CE process was clearly explained to them.

Shawn thought that "The questions made a lot of sense." And Delia was fine asking for help if necessary,

> *I'm a very open person, so if I'm confused, I'll share . . . everything when you go is monitored and recorded, everything is you have to say it a certain way, [then] I can't really let out my feelings and talk about how I feel, and I don't feel like that here.*

Laura, on the other hand, was more unsure, saying "I was a little confused on that because like I knew who I had to deal with there, but I felt like she didn't relay like how this process works, or who these outside contacts were" And Allison was the most unsure, saying "I didn't understand why . . . I still don't understand why . . . I didn't understand if it changed, how come the rules didn't change? I didn't understand that, it didn't make sense to me."

Though there was not universal agreement, most felt comfortable answering honestly (with the previously mentioned exception of more public/populated environments). If there were any questions or confusion, most clients felt comfortable asking for clarification from the service providers.

Has HAWNY effectively assisted with the Coordinated Entry process?

Service providers

SPs overall had a very positive response. The majority stated that HAWNY is always available for questions and support when SPs reached out, and HAWNY's rapid response time was repeatedly cited.

At times, however, they reported that the goals and expectations from HAWNY could be confusing. SPs repeated statements about needing more training or refresher training over periods of time. With a system as complex as CE, many SPs mentioned that training could help them be more confident and feel more comfortable. Some SPs noted that different committee meetings could be overwhelming because the staff feels that they are not as informed as other participants.

Shannon wanted to see more constant engagement, saying

> *I know HAWNY has a job to do, but beyond coordinated entry, they're kind of hands off. Once they get to a housing other than just wanting to get the data and wanting us to get the data in on time, they're very, very hands off . . . if it's not supported on the back end, just like it is on the front end, then the whole process is not going to work.*

Jessie, however, seemed to feel more engaged:

> *Yeah. They're not, they were eager to get this started and they have a lot of follow up, they've provided a lot of training, they've . . . just a lot of support for the whole process,*

> *and they've been really careful about people who were reluctant in the beginning to be part of the process, they've kind of helped ease some of those worries, so they've been very good.*

Ramona echoed this sentiment, praising the responsiveness, "Well, they're always available, I mean I can reach several people at HAWNY just by picking up the phone which I really appreciate. I really appreciate their accessibility, I think they're always accessible." Stella believed HAWNY was constantly learning, saying

> *The Homeless Alliance is amazing, they do ask for that context, they are genuinely curious and they want to know why is it so hard, what makes it hard. Because they know that they don't know what it's like to do what we do. And they're always learning and they're always growing and they've always been really receptive to feedback.*

But Kylie wanted HAWNY to help the service providers learn as well, saying

> *[I'd like HAWNY to provide] recommendations like 'ok you have to do it this way, if you're not doing it this way, then we're coming to talk to you.' And mandatory trainings, or things like that . . . it just baffles me after this many years, that people still don't know the whole process.*

More than any other type of training, service providers discussed the need for more trauma-informed care training. As Sheila put it

> *I think people who are doing the assessment should not only be trained on trauma informed care, but also be trained on how to do the assessments, on how to do the VI. I don't think everyone's trained on that, or maybe they are and they just threw it out the window, like they haven't had experience.*

Clients

Most clients were not familiar with HAWNY specifically but did speak positively about other services besides housing that they were referred to and stated that their caseworkers were usually available for questions, or responsive for any clarification or support needed.

For example, when asked about whether she found the process confusing, Lana said, "Um, no, because the counselor that I have, he says that if I have any questions, just to give him a call. But that pretty much eliminates if I have any confusion."

Recommendations

Overall, the coordinated entry system mostly seems to function the way that it was intended. Clients with higher VI scores *did* tend to receive more intensive services and were usually housed quicker, though there were a couple of discrepancies in speed or type of services based on race and gender. Both service providers and clients generally agree that the process is fair and that they understand it, although not everyone understands every part. We recommend one area for further study and six minor adjustments to improve the functioning of the system in the future.

Differential Services
We find evidence suggesting that White families and female transition age youth experienced significantly shorter waiting times. This merits further exploration. There may be good reasons for these differences since the variables included left much of the variance unexplained, but a deeper dive would more satisfactorily answer this.

Trauma
Many service providers worried that crucial areas of trauma were not considered in VI, which was exacerbated by staff inexperience with trauma. The resulting difficult conversations made some of the narrative part of intake challenging. We recommend more training in trauma-informed care for staff members, something a number of them requested during interviews.

Domestic Violence
Staff worry that domestic violence is not always weighted enough in the VI and, at times, they believe it should override all other concerns. Staff cited multiple examples of clients who arrived with low VI scores but a clear need to escape a volatile home situation. Unless the VI scores can be adapted to account for this, we recommend that service providers create a separate pathway for victims of domestic violence that do not merit immediate intervention based on other criteria. Staff should be trained on how to handle these situations and which local organizations offer appropriate services.

Information Overload
There are sometimes too many choices, and referrals are sometimes made without a full explanation, which meant some clients struggled to use the information. While the VI score streamlines the system, there are still a wide range of outcomes for clients that can happen over a wide range of time. Given the complexity of the overall environment, and especially given the fragile state in which many clients find themselves, we recommend HAWNY and service providers work on a system to communicate the results of the intake process in as clear and concise a method as possible. Much like language around payday loans and other consumer services has been dramatically simplified in recent years, the goal should be to hand clients a piece of paper with as few words as possible explaining what service they should expect and when. The goal should be to consistently communicate a clear and straightforward message throughout the process and follow-ups.

Training
Many service providers said that HAWNY was hands-off and that they could use more training, with the same materials used by all service providers, and regular refreshers to ensure everyone shares the same understanding. We recommend HAWNY take the initiative to schedule trainings at least quarterly.

Turnover
Many service providers cited high staff turnover as an issue. HAWNY should aim to structure trainings, communications, and guidance in ways that accommodate this. In other words, there should not be an assumption that everyone has the same baseline knowledge.

Confidentiality
Some clients expressed concerns about taking the survey out in the open. We recommend that service providers ensure that intake surveys are given in places where clients can keep their answers confidential, which means some visual and aural barriers and/or distancing from other people.

Appendix A: Client list

#	Pseudonym	Housing Type	Race/Gender
1	Laura	PSH	White Female
2	Allison	PSH	Black Female
3	Carol	PSH	Black Female
4	Ciara	PSH	Black Female
5	Craig	PSH	White Male
6	Ethan	PSH	White Male
7	Shawn	PSH	Black Male
8	Cecilia	PSH	White Female
9	Anna	RRH	Black Female
10	Lana	RRH	Black Female
11	Javier	RRH	Latinx Male
12	Michael	RRH	Black Male
13	Josue	RRH	Latinx Male
14	Callie	RRH	Latinx Female
15	Aleta	RRH	Black Female
16	Donte	RRH	Black Male
17	Delia	RRH	Black Female
18	Carl	RRH	White Male
19	Katie	RRH	White Female
20	Garth	RRH	White Male
21	Frank	PSH	White Male
22	Roy	PSH	White Male
23	Leslie	RRH	Black Female
24	Charlie	PSH	White Male

25	Matt	PSH	Black Male
26	John	PSH	White Male
27	Martin	ES	White Male
28	William	ES	Black Male
29	Daniel	ES	Black Male
30	Arthur	ES	Black Male
31	Malachi	ES	Black Male
32	Ken	ES	Black Male
33	Walt	ES	Black Male
34	Bill	TH	White Male
35	Wesley	TH	Black Male
36	Joshua	ES	White Male
37	James	ES	Black Male
38	Marcus	ES	Black Male
39	Mauricio	ES	Latinx Male
40	Kyle	ES	White Male
41	Devonte	ES	Black Male
42	Lyle	TH	White Male
43	Malik	TS	Black Male
44	Mariah	PSH	White Female
45	Michelle	PSH	White Female
46	Sharon	PSH	White Female
47	Diana	PSH	Black Female
48	Aaliyah	PSH	Black Female
49	Shannon	RRH	Black Female

Appendix B: Service Providers

Pseudonym	Years of Experience (>/< 5 years)
Leslie	>5
Aaron	>5
Victor	>5
Sheila	<5
Shannon	>5
Alicia	>5
Sophia	<5
Ray	>5
Dale	>5
Jessie	>5
Garrett	>5
Stella	>5
Julia	<5
Sadie	>5
Dan	<5
Dean	>5
Ramona	>5
Penelope	<5
Sylvia	<5
Anthony	<5
Josie	<5
Kylie	>5
Faith	>5
Phyllis	>5
Teresa	>5
Leah	<5
Adam	<5

Appendix C: Interview Protocols (Client and Service Provider)

Qualitative interview- clients

Opening script: (after giving a little bit of my background to make the client a little more comfortable with who I am, what my role is) A couple years ago, local organizations started using the "coordinated entry" process to prioritize housing for people who are most in need. You went through that process when you were connected to [location]. We want to know how the process is working and would like to hear how it went for you and what was good and bad about it. Everything that we talk about will be kept confidential, your information will be de-identified, and this conversation in no way will impact your services or assistance.

[If they indicate they don't understand what CE is]

When we talk about Coordinated Entry, we are specifically referring to the process during which you were taken through an assessment called VI-SPDAT or vulnerability index to determine your needs, and then potentially provided information, support, or referrals to the resources and programs you qualify for.

1. Do you remember taking an assessment about your needs at [location], called VI-SPDAT or Vulnerability Index (give examples of some questions from the VI assessment e.g.: "In the last 3 years, how many times have you/your family been homeless?" Or "Is everyone in your family able to take care of basic needs, like bathing, changing clothes, getting food and clean water, etc.?")
    a. How did you feel about the assessment?
    b. Did you understand the questions?
    c. Did you understand why you were taking it?
    d. How long were you at [location] before you took this/these assessment(s)?
2. Did you feel comfortable answering questions honestly and working with the [location] workers to assess your needs?
    a. What would have made you feel more comfortable?
3. Were you given clear reason and understanding for what services you could be immediately offered?
    a. if applicable: Were you provided clear information and access to the services you were offered?
4. Would you say you're satisfied with how the coordinated entry process and having your needs assessed was conducted?*
5. Was there any part of the coordinated entry process that you thought could be clearer?
6. Was there a part of the coordinated entry process you felt worked particularly well?

*For clients already receiving housing support, replace #4 with:

    a. Was your provider clear and prompt in providing services?
    b. Can you give more detail about the services you were provided or connected to?

Qualitative interview- service providers

1. How many years of homeless service experience do you have?
2. Would you say the coordinated entry process is more or less effective in addressing the needs of clients than the previous system? Can you specify in what ways?
3. Is the coordinated entry process confusing? Do you feel like clients are receiving services in the way you think is best?
4. Has the Homeless Alliance/Coordinated Entry Lead agency provided the assistance you need with the process?
5. If you had to recommend any changes, what would they be?
6. Can you think of any questions or topics we should make sure to discuss with clients?

Appendix D: Service Provider Survey and Client Survey

All questions were answered using a Likert scale of strongly agree, agree, neither, disagree, strongly disagree

Client Survey:

1. I understood the questions asked in the coordinated entry assessment.
2. The coordinated entry process was clearly explained to me.
3. The Coordinated Entry process was emotionally difficult for me.
4. I was offered the right services as a result of the coordinated entry process.
5. The services I was offered were fair in comparison to other clients.
6. The referral process addressed my immediate needs.
7. The referral process addressed my long-term needs.

Service Provider Survey:

1. The planning is efficient in addressing the needs of the clients.
2. Clients find the coordinated entry process user-friendly.
3. The Coordinated Entry process is emotionally difficult for me.
4. The Coordinated Entry process used to provide clients access to housing and services is efficient.
5. The assessment process is able to provide clients fair, equitable and equal services.
6. I feel the Coordinated Entry process prioritizes needs effectively.
7. The referral process addresses the immediate needs of the clients.
8. The referral process addresses the long-term needs of the clients.

Questions	Please choose one:				
1. I understood the questions asked in the coordinated entry assessment.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
2. The coordinated entry process was clearly explained to me.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
3. The Coordinated Entry process was emotionally difficult for me.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
4. I was offered the right services as a result of the coordinated entry process.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
5. The services I was offered were fair in comparison to other clients.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
6. The referral process addressed my immediate needs.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
7. The referral process addressed my long-term needs.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree

Questions	Please choose one:				
1. The planning is efficient in addressing needs of clients.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
2. Clients find the coordinated entry process user-friendly.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
3. The Coordinated Entry process is emotionally difficult for me.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
4. The Coordinated Entry process used to provide clients access to housing and services is efficient.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
5. The assessment process is able to provide clients fair, equitable and equal services.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
6. I feel the Coordinated Entry process prioritizes needs effectively.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
7. The referral process addresses the immediate needs of the clients.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree
8. The referral process addresses the long-term needs of the clients.	(1) Strongly Agree	(2) Agree	(3) Neither	(4) Disagree	(5) Strongly Disagree

Appendix E: Data Tables

Client Survey Questions	Strongly Agree		Agree		Neither		Disagree		Strongly Disagree	
I understood the questions asked in the coordinated entry assessment	35	72.9%	11	22.9%	1	2.1%		0.0%	1	2.1%
The coordinated entry process was clearly explained to me	29	60.4%	16	33.3%	1	2.1%	1	2.1%	1	2.1%
The coordinated entry process was emotionally difficult for me	6	12.5%	7	14.6%	11	22.9%	16	33.3%	8	16.7%
I was offered the right services as a result of the coordinated entry process	23	47.9%	17	35.4%	7	14.6%	1	2.1%		0.0%
The services I was offered were fair in comparison to other clients	23	47.9%	16	33.3%	7	14.6%	2	4.2%		0.0%
The referral process addressed my immediate needs.	25	52.1%	17	35.4%	5	10.4%		0.0%	1	2.1%
The application process addressed my long-term needs	24	51.1%	11	23.4%	9	19.1%	1	2.1%	2	4.3%

Service Provider Questions	Strongly Agree		Agree		Neither		Disagree		Strongly Disagree	
The planning is efficient in addressing needs of clients.	3	11.1%	21	77.8%	1	3.7%	1	3.7%	1	3.7%
Clients find the coordinated entry process user-friendly.	1	3.7%	12	44.4%	10	37.0%	4	14.8%		0.0%
The CE process is emotionally difficult for me.	1	3.7%	4	14.8%	6	22.2%	13	48.1%	3	11.1%
The CE process used to provide clients access to housing and services is efficient.	4	14.8%	17	63.0%		0.0%	6	22.2%		0.0%
The assessment process is able to provide clients fair, equitable and equal services.	8	29.6%	12	44.4%	3	11.1%	4	14.8%		0.0%
I feel the CE process prioritizes needs effectively.	4	14.8%	15	55.6%	4	14.8%	4	14.8%		0.0%
The referral process addresses the immediate needs of the clients.	3	11.1%	15	55.6%	2	7.4%	7	25.9%		0.0%
The referral process addresses the long-term needs of the clients.	1	3.7%	16	59.3%	3	11.1%	5	18.5%	2	7.4%

Individual Descriptive Statistics

	Clients	Avg Waiting Time (Days)
Race/Ethnicity		
Black-Hispanic	21	68.76
Black-Non-Hispanic	343	57.21
Black Total	364	57.88
White-Hispanic	44	55.82
White-Non-Hispanic	306	52.25
White Total	350	52.69
Gender		
Female	265	49.28
Male	449	58.91
Disability Status		
No	64	46.56
Yes	648	56.36
Provider Type		
Permanent Supportive Housing	342	71.17
Rapid Re-Housing	372	40.78
VI Score		
0-5	113	41.26
6-10	363	56.64
Above 10	238	60.03
Total	**714**	**55.34**

VI SCORES VS. PROVIDER TYPE

VI Score	Permanent Supportive Housing		Rapid Re-Housing	
	# of Clients	Avg. Waiting Time (Days)	# of Clients	Avg. Waiting Time (Days)
0-5	13	76.85	100	36.63
6-10	131	80.50	232	43.17
Above 10	198	64.62	40	37.30
Grand Total	**342**	**71.17**	**372**	**40.78**

VI SCORES VS. DISABILITY STATUS

VI Score	No		Yes	
	# Of Clients	Avg. Waiting Time (Days)	# Of Clients	Avg. Waiting Time (Days)
0-5	27	61.67	85	35.26
6-10	33	34.97	329	58.97
Above 10	4	40.25	234	60.36
Grand Total	**64**	**46.56**	**648**	**56.36**

VI SCORES VS. GENDER

VI Score	Female		Male	
	# Of Clients	Avg. Waiting Time (Days)	# Of Clients	Avg. Waiting Time (Days)
0-5	57	42.65	56	39.84
6-10	130	45.83	233	62.68
Above 10	78	59.86	160	60.11
Grand Total	**265**	**49.28**	**449**	**58.91**

VI SCORES VS. RACE/ETHNICITY

VI Score	Black (Hispanic)		Black (Non-Hispanic)		Black (Total)		White (Hispanic)		White (Non-Hispanic)		White (Total)	
	#	Avg Time	#	Avg Time	#	Avg Time	#	Avg Days	#	Avg Time	#	Avg Time
0-5	2	139	63	46.9	65	49.8	1	77	47	28.7	48	29.8
6-10	14	58.4	184	56.8	198	56.9	27	53.5	138	56.9	165	56.3
Above 10	5	69.6	96	64.7	101	65	16	58.4	121	56.1	137	56.4
Total	**21**	**68.8**	**343**	**57.2**	**364**	**57.9**	**44**	**55.8**	**306**	**52.3**	**350**	**52.7**

VI INDIVIDUAL – CORRELATIONS

	Gender (Female)	Race (White)	Disability	Housing Intensity	Waiting Time (Days)	VI Score (Categorical)	VI Score (Cont.)
Gender (Female)	1	.094*	-.074*	-.168**	-.055	-.106**	-.099**
Race (White)	.094*	1	.122**	.101**	-.033	.112**	.127**
Disability	-.074*	.122**	1	.282**	.034	.248**	.270**
Housing Intensity	-.168**	.101**	.282**	1	.181**	.516**	.586**
Waiting Time (Days)	-.055	-.033	.034	.181**	1	.065	.101**
VI Score (Cat.)	-.106**	.112**	.248**	.516**	.065	1	.901**
VI Score (Cont.)	-.099**	.127**	.270**	.586**	.101**	.901**	1

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

a. Assessment Type = VI

d. Listwise N=712

OLS Regressions: Waiting Time for Individual Applicants

	Model 1	Model 2	Model 3	Model 4	Model 5
Housing intensity (1=Permanent supportive housing)	30.183***	30.937***	31.521***	32.155***	31.569***
VI Score		-0.211	-0.131	-0.071	-0.071
Disability (1=disabled)			-5.377	-3.882	-4.119
Race (1=White)				-9.225	-8.858
Gender (1=female)					-3.595
R^2	.033***	.033***	.033***	.036***	.036***

*p < .05; **p < .01; ***p<.001

VI INDIVIDUAL – REGRESSION MODELS FOR INTENSE HOUSING (DISCRETE)

	β	$\chi^2\chi^2$ (Wald)	*p*	e^Be^B (Odds)	$Model\ \chi^2$	R^2
VI Score	.512	151.424	.000	1.668	283.902***	.439
Disability (1=disabled)	2.824	13.843	.000	16.842	311.189***	.472
Race (1=White)	.174	.803	.370	1.191	311.386***	.473
Gender (1=female)	-.786	14.810	.000	.456	326.568***	.491

Families (VI-F) Descriptive Statistics

	# of Clients	Avg Wait (Days)
Race/Ethnicity		
Black-Hispanic	14	26.00
Black-Non-Hispanic	226	33.69
Black Total	240	33.24
White-Hispanic	60	28.22
White-Non-Hispanic	148	16.76
White Total	208	20.07
Gender		
Female	382	26.78
Male	66	29.11
Disability Status		
No	220	29.30
Yes	228	25.03
Provider Type		
Permanent Supportive Housing	27	41.93
Rapid Re-Housing	421	26.18
VI Score		
0-5	79	15.86
6-10	289	27.34
Above 10	80	37.48
Total	**448**	**27.13**

VI SCORES VS. PROVIDER TYPE

VI Score	Permanent Supportive Housing		Rapid Re-Housing	
	# of Clients	Avg. Wait (Days)	# of Clients	Avg. Wait (Days)
0-5	1	63.00	78	15.26
6-10	4	25.50	285	27.36
Above 10	22	43.95	58	35.02
Total	**27**	**41.93**	**421**	**26.18**

VI SCORES VS. DISABILITY STATUS

VI Score	No		Yes	
	# Of Clients	Avg. Wait (Days)	# Of Clients	Avg. Wait (Days)
0-5	50	19.88	29	8.93
6-10	147	32.41	142	22.09
Above 10	23	29.91	57	40.53
Total	**220**	**29.30**	**228**	**25.03**

VI SCORES VS. GENDER

VI Score	Female		Male	
	# Of Clients	Avg. Wait (Days)	# Of Clients	Avg. Wait (Days)
0-5	64	16.84	15	11.67
6-10	250	26.07	39	35.46
Above 10	68	38.75	12	30.25
Total	**382**	**26.78**	**66**	**29.11**

VI SCORES VS. RACE/ETHNICITY

VI Score	Black (Hispanic)		Black (Non-Hispanic)		Black (Total)		White (Hispanic)		White (Non-Hispanic)		White (Total)	
	#	Avg Time	#	Avg Time	#	Avg Time	#	Avg Days	#	Avg Time	#	Avg Time
0-5	1	25.00	39	23.23	40	23.28	2	0.00	37	8.70	39	8.26
6-10	8	15.88	151	34.76	159	33.81	41	27.54	89	15.69	130	19.42
Above 10	5	42.40	36	40.53	41	40.76	17	33.18	22	34.68	39	34.03
Total	**14**	**26.00**	**226**	**33.69**	**240**	**33.24**	**60**	**28.22**	**148**	**16.76**	**208**	**20.07**

VI FAMILY - CORRELATIONS

	Gender (Female)	Race (White)	Disability	Housing Intensity	Waiting Time (Days)	VI Score (Categorical)	VI Score (Cont.)
Gender (Female)	1	-.068	-.043	.026	-.021	.033	.076
Race (White)	-.068	1	.207**	-.010	-.169**	-.003	.007
Disability	-.043	.207**	1	.230**	-.055	.206**	.229**
Housing Intensity	.026	-.010	.230**	1	.096*	.330**	.400**
Waiting Time (Days)	-.021	-.169**	-.055	.096*	1	.165**	.192**
VI Score (Cat)	.033	-.003	.206**	.330**	.165**	1	.866**
VI Score (Cont.)	.076	.007	.229**	.400**	.192**	.866**	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

a. Assessment Type = VI-F

d. Listwise N=448

OLS Regressions: Waiting Time for Family Applicants

	Model 1	Model 2	Model 3	Model 4	Model 5
Housing intensity (1=Permanent supportive housing)	15.750*	3.825	6.795	6.221	6.256
VI Score		2.394***	2.630***	2.325***	2.376***
Disability (1=disabled)			-8.580*	-5.199	-5.407
Race (1=White)				-12.667***	-12.743***
Gender (1=female)					-4.991
R^2	.009*	.037***	.048***	.070***	.072***

*p < .05; **p < .01; ***p<.001

VI FAMILY – REGRESSION MODELS FOR INTENSE HOUSING (DISCRETE)

	β	$\chi^2\chi^2$ (Wald)	*p*	$e^B e^B$ (Odds)	$Model\ \chi^2$	R^2
VI Score	.469	34.905	.000	1.598	58.639***	.335
Disability (1=disabled)	3.235	9.166	.002	25.408	77.251***	.433
Race (1=White)	-.640	1.740	.187	.527	79.059***	.442
Gender (1=female)	.203	.080	.777	1.225	79.142***	.443

TRANSITION AGE YOUTH (TAY) DESCRIPTIVES

	# of Clients	Average of Waiting Time (Days)
Race/Ethnicity		
Black	41	36.93
White	26	34.31
Hispanic	13	31.46
Gender		
Female	45	12.58
Male	35	64.26
Disability Status		
No	30	27.67
Yes	50	39.70
Provider Type		
Permanent Supportive Housing	10	79.00
Rapid Re-Housing	70	28.93
VI Score		
0-5	9	25.00
6-10	44	27.82
Above 10	27	50.59
Grand Total	**80**	**35.19**

VI SCORES VS. PROVIDER TYPE

VI Score	Permanent Supportive Housing		Rapid Re-Housing	
	# of Clients	Avg. Waiting Time (Days)	# of Clients	Avg. Waiting Time (Days)
0-5	-	-	9	25.00
6-10	1	67.00	43	26.91
Above 10	9	80.33	18	35.72
Grand Total	**10**	**79.00**	**70**	**28.93**

VI SCORES VS. DISABILITY STATUS

VI Score	No		Yes	
	# of Clients	Avg. Waiting Time (Days)	# of Clients	Avg. Waiting Time (Days)
0-5	4	8.25	5	38.40
6-10	20	37.40	24	19.83
Above 10	6	8.17	21	62.71
Grand Total	**30**	**27.67**	**50**	**39.70**

VI SCORES VS. GENDER

VI Score	Female		Male	
	# of Clients	Avg. Waiting Time (Days)	# of Clients	Avg. Waiting Time (Days)
0-5	6	8.17	3	58.67
6-10	29	9.76	15	62.73
Above 10	10	23.40	17	66.59
Grand Total	**45**	**12.58**	**35**	**64.26**

VI SCORES VS. RACE/ETHNICITY

VI Score	Hispanic		Black		White	
	# of Clients	Waiting Time	# of Clients	Waiting Time	# of Clients	Waiting Time
0-5	-	-	5	6.60	4	48.00
6-10	8	22.88	24	37.00	12	12.75
Above 10	5	45.20	12	49.42	10	54.70
Grand Total	**13**	**31.46**	**41**	**36.93**	**26**	**34.31**

TAY CORRELATIONS

	Gender (Female)	Race (White)	Disability	Housing Intensity	Waiting Time (Days)	VI Score (Cat.)	VI Score (Cont.)
Gender (Female)	1	.117	-.111	-.200	-.385**	-.244*	-.305**
Race (White)	.117	1	.215	.124	.019	.005	.067
Disability	-.111	.215	1	.293**	.088	.194	.202
Housing Intensity	-.200	.124	.293**	1	.249*	.404**	.500**
Waiting Time (Days)	-.385**	.019	.088	.249*	1	.151	.149
VI Score (Categorical)	-.244*	.005	.194	.404**	.151	1	.897**
VI Score (Cont.)	-.305**	.067	.202	.500**	.149	.897**	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

a. Assessment Type = TAY

d. Listwise N=80

OLS Regressions: Waiting Time for Transition Age Youth Applicants

	Model 1	Model 2	Model 3	Model 4	Model 5
Housing intensity (1=Permanent supportive housing)	50.071*	46.74	46.015	45.854	42.227
VI Score		0.743	0.719	0.704	-1.5
Disability (1=disabled)			1.939	3.374	-1.506
Race (1=White)				-4.515	4.393
Gender (1=female)					-49.475**
R^2	.062*	0.063	0.063	0.064	.183**

*p < .05; **p < .01

TAY – REGRESSION MODELS FOR INTENSE HOUSING (DISCRETE)

	β	$\chi^2\chi^2$ (Wald)	*p*	$e^B e^B$ (Odds)	$Model\ \chi^2$	R^2
VI Score	.816	8.821	.003	2.261	23.382***	.479
Disability (1=disabled)	19.718	.000	.997	365863870.162	30.279***	.595
Race (1=White)	.978	.993	.319	2.658	31.035***	.607
Gender (1=female)	-1.382	1.642	.200	.251	32.862***	.636

Coordinated Entry Process Self-Assessment

The U.S. Department of Housing and Urban Development (HUD) requires that Continuums of Care (CoC) establish and operate a coordinated entry (CE) process—and that recipients of CoC Program and Emergency Solutions Grants (ESG) program funding within the CoC's area must use that CE process. The requirement was established in the 2012 CoC Program interim rule (24 CFR 578) and the 2011 Emergency Solutions Grants (ESG) interim rule (24 CFR 576). Details of the requirement, as well as additional policy considerations, are provided there and in several documents issued by HUD since:

- **HUD Coordinated Entry Notice CPD-17-01 – Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System** (2017)
- **HUD Prioritization Notice CPD-16-11 – Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing** (2016)
- **Coordinated Entry Policy Brief** (2015)
- **CoC Program interim rule: 24 CFR 578.7(a)(8)**
- **ESG interim rule: 24 CFR 576.400(d)**
- **HUD Equal Access rule: 24 CFR 5.105(a)(2) and 5.106(b)**

Based on these documents, this tool identifies aspects of coordinated entry that HUD has determined are **Required**, as well as other aspects of CE functionality, operations, or management that it has **Recommended** as good practice but not required. Some unique design features of CE may be appropriate for some subpopulations or geographic areas but are not universally applicable across all CoCs; these are identified as **Optional.** The source document(s) for each Required item is noted in **bold**, and for each Recommended item if appropriate.

CoCs can use this **Coordinated Entry Self-Assessment** as a reference to help them identify key aspects of CE design, implementation, and management; compare this list against their existing CoC plans and/or practices to gauge the extent to which the CoC currently includes these elements; and as a general outline for a set of policies and procedures a CoC must adopt to support the ongoing management of CE processes and functions.

Contents

Version 1.1

This document is Version 1.1, which replaces the original version posted on the HUD Exchange on January 23, 2017. This Version 1.1 reflects the following changes:

1. **Section A. Planning.** Item #1 has been updated to correct the date that CoCs are expected to achieve full compliance with Coordinated Entry requirements established by the Notice. The correct date is January 23, 2018.

2. **Section C. Assessment.** Item #9 has been updated to correct an earlier error in citation. The privacy protections noted in the requirement are from HUD's Coordinated Entry Notice: Section II.B.12.f.

3. **Section E. Referral.** Item #2, in ***"Referrals to Participating Projects,"*** has been moved from Required to Recommended. The CoC's Coordinated Entry policies and procedures used to prioritize homeless persons within the CoC's geographic area for referral to housing and services must be made publicly available and must be applied consistently throughout the CoC's area for all subpopulations. HUD *recommends* that each CoC homeless assistance project also make its prioritization policies and procedures publicly available. That is, the requirement is at the CoC level, not the individual project level.

A. PLANNING

	☑	ASSESSMENT NOTES
** Required **		
Deadline for Compliance.		
1. 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**	☑	
Core Requirements since 2012.		
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)**		
2. CES covers the entire geographic area claimed by the CoC.	☑	
3. CES is easily accessed by individuals and families seeking housing or services.	☑	
4. CES is well-advertised.	☑	
5. CES includes a comprehensive and standardized assessment tool(s).	☑	
6. CES provides an initial, comprehensive assessment of individuals and families for housing and services.	☑	
7. 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.	☑	

A. PLANNING

	☑	ASSESSMENT NOTES
** Required **		
Core Requirements.		
8. CoC, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, has established and consistently follows written standards for providing Continuum of Care assistance which can guide the development of formalized policies and procedures for the coordinated entry process: • Written standards provide guidance for evaluating individuals' and families' eligibility for assistance under 24 CFR Part 578. • Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive transitional housing assistance. • Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance. • Written standards provide guidance for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance. • Written standards provide guidance for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance. **CoC Program interim rule: 24 CFR 578.7(a)(8)**	☑	
9. CoC and each ESG recipient operating within the CoC's geographic area must work together to ensure the CoC's coordinated entry process allows for coordinated screening, assessment and referrals for ESG projects consistent with the written standards for administering ESG assistance. **CoC Program interim rule: 24 CFR 578.7(a)(8)** **ESG interim rule: 24 CFR 576.400(d) and (e)**	☑	Rural sites are more limited in coordination due to geography.
Full Coverage.		
10. If multiple CoCs have joined together to use the same regional coordinated entry process, written policies and procedures describe the following: • The relationship of the CoC(s) geographic area(s) to the geographic area(s) covered by the coordinated entry process(es); and • How the requirements of ensuring access, standardizing assessments, and implementing uniform referral processes occur in situations where the CoC's geographic boundaries and the geographic boundaries of the coordinated entry process are different. **HUD Coordinated Entry Notice: Section II.B.1**	☑	

A. PLANNING

	☑	ASSESSMENT NOTES
** Required **		
Marketing.		
11. CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or who are least likely to apply in the absence of special outreach. **CoC Program interim rule: 24 CFR 578.93(c)** **ESG Program interim rule: 24 CFR 576.407(a) and (b)**	☑	
12. Coordinated entry written policies and procedures include a strategy to ensure the coordinated entry process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status. **HUD Coordinated Entry Notice: Section II.B.5** **HUD Equal Access rule: 24 CFR 5.105(a)(2) and 5.106(b)**	☑	
13. Coordinated entry written policies and procedures ensure all people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process. **HUD Coordinated Entry Notice: Section II.B.5**	☑	

	☑	ASSESSMENT NOTES
** Required **		

Nondiscrimination.

14. CoC has developed and operates a coordinated entry that permits recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. Recipients and subrecipients of CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws, including the following:

    - Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
    - Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
    - Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
    - Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.
    - Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

    HUD Coordinated Entry Notice: Section I.D

B. ACCESS

** Required **

	☑	ASSESSMENT NOTES
Access Models.		
1. CoC offers the same assessment approach at all access points and all access points are usable by all people who may be experiencing homelessness or at risk of homelessness. If separate access points are identified to meet the needs of one of the five populations allowable by HUD's Coordinated Entry Notice, initial screening at each access point allows for immediate linkage to the appropriate subpopulation access point (e.g. unaccompanied youth who access CES at the access point defined for adults without children are immediately connected to the youth-specific access point). **HUD Coordinated Entry Notice: Section II.B.2.a**	✔	
Accessibility.		
2. CoC ensures that households who are included in more than one of the populations for which an access point is dedicated (for example, a parenting unaccompanied youth who is fleeing domestic violence) can be served at all of the access points for which they qualify as a target population. **HUD Coordinated Entry Notice: Section II.B.2.f**	✔	
3. CoC provides the same assessment approach, including standardized decision-making, at all access points. **HUD Coordinated Entry Notice: Section II.B.2.a**	✔	
4. CoC ensures participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking. **HUD Coordinated Entry Notice: Section II.B.12.e**	✔	
5. CoC's access point(s) must be easily accessed by individual and families seeking homeless or homelessness prevention services. **HUD Coordinated Entry Notice: Section II.B.8**	✔	

B. ACCESS

	☑	ASSESSMENT NOTES
Emergency Services.		
6. CoC's CE process allows emergency services, including all domestic violence and emergency services hotlines, drop-in service programs, and emergency shelters, including domestic violence shelters and other short-term crisis residential programs, to operate with as few barriers to entry as possible. People are able to access emergency services, such as emergency shelter, independent of the operating hours of the system's intake and assessment processes. **HUD Coordinated Entry Notice: Section II.B.7**	✔	
7. CoC's written CE policies and procedures document a process by which persons are ensured access to emergency services during hours when the coordinated entry's intake and assessment processes are not operating. CE written policies and procedures document how CE participants are connected, as necessary, to coordinated entry as soon as the intake and assessment processes are operating. **HUD Coordinated Entry Notice: Section II.B.7.b**	✔	All sites have someone available 24/7
Prevention Services.		
8. CoC's written CE policies and procedures document a process for persons seeking access to homelessness prevention services funded with ESG program funds through the coordinated entry process . If the CoC defines separate access points for homelessness prevention services, written policies and procedures must describe the process by which persons are prioritized for referrals to homelessness prevention services. To the extent to which other (i.e.., non ESG -funded) homelessness prevention services participate in coordinated entry processes, the policies and procedures must also describe the process by which persons will be prioritized for referrals to these programs. **HUD Coordinated Entry Notice: Section II.B.8**	✔	Some coordinators were confused by these procedures and requested streamlined guidance.
Full Coverage.		
9. CoC's access points cover and are accessible throughout the entirety of the geographic area of the CoC. **HUD Coordinated Entry Notice: Section II.B.1**	✔	Adequate, but some rural areas are quite far from the nearest site
Marketing.		
10. CoC's written coordinated entry policies and procedures document steps taken to ensure access points, if physical locations, are accessible to individuals with disabilities, including accessible physical locations for individuals who use wheelchairs, as well as people in the CoC who are least likely to access homeless assistance. **HUD Coordinated Entry Notice: Section II.B.5.c**	✔	

** Required **

B. ACCESS

	☑	ASSESSMENT NOTES
** Required **		
11. CoC's written CE policies and procedures document steps taken to ensure effective communication with individuals with disabilities. Recipients of Federal funds and CoCs must provide appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters. **HUD Coordinated Entry Notice: Section II.B.5.c**	✔	
12. CoC's access point(s) take reasonable steps to offer CE process materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency (LEP). **HUD Coordinated Entry Notice: Section II.B.5.d**	✔	While widely-spoken languages like Spanish are covered, less frequently-spoken languages of newer arrivals (e.g., Burmese) are lacking.
Safety Planning. 13. CoC has a specific written CE policy and procedure 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 service providers. At a minimum, people fleeing or attempting to flee domestic violence and victims of trafficking have safe and confidential access to the coordinated entry process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelter. **HUD Coordinated Entry Notice: Section II.B.10**	✔	
Street Outreach. 14. Street outreach efforts funded under ESG or the CoC program are linked to the coordinated entry process. Written policies and procedures describe the process by which all participating street outreach staff, regardless of funding source, ensure that persons encountered by street outreach workers are offered the same standardized process as persons who access coordinated entry through site-based access points. **HUD Coordinated Entry Notice: Section II.B.6**	✔	Multiple people felt there could be even more people doing street outreach.

B. ACCESS

		☑	ASSESSMENT NOTES
Recommended	**Accessibility.**		
	15. CoC's access points, if physical locations, are sited in proximity to public transportation and other services to facilitate participant access. A CoC or recipient of Federal funds may be required to offer some variation to the process, e.g., a different access point, as a reasonable accommodation for a person with disabilities. For example, a person with a mobility impairment may request a reasonable accommodation in order to complete the coordinated entry process at a different location.	☑	Transit was provided if the site wasn't accessible by public transit
	16. CoC's access points provide connections to mainstream and community-based emergency assistance services such as supplemental food assistance programs and applications for income assistance.	☑	multiple people complained that paperwork was smooth at site but then had long delays at DSS
Optional	**Access Models.**		
	17. CoC's access points provide virtual entry where individuals and families experiencing a housing crisis may present for initial assessment screening (e.g. a 211 or other hotline systems that screens and directly connects callers to appropriate crisis housing and service providers in the area).	☑	
	18. CoC has multiple access points, each assigned to a specific sub-region within the CoC.	☐	Question was not part of this evaluation.
	19. CoC has partnered with neighboring CoCs to create a single access point covering the multi-CoC region.	☑	
	20. The CoC has multiple access points to facilitate access, coordinate entry processes, and improve the quality of information gathered for the following subpopulations: • Adults without children; • Adults accompanied by children; • Unaccompanied youth; • Households fleeing or attempting to flee domestic violence; or • Persons at risk of homelessness.	☑	
	21. CoC has a "no wrong door" approach in which a homeless family or individual can present at any homeless housing and service provider in the geographic area.	☑	

		☑	ASSESSMENT NOTES
Optional	**Prevention Services.** 22. CoC's CE process includes separate access point(s) for homelessness prevention so that people at risk of homelessness can receive urgent services when and where they are needed. If separate access points for homelessness prevention services exist in the CoC, written CE policies and procedures describe the process by which persons will be prioritized for referrals to homelessness prevention services. **HUD Coordinated Entry Notice: Section II.B.8**	☑	
Optional	**Safety Planning.** 23. Victim service providers funded by CoC and ESG program funds are not required to use the CoC's coordinated entry process, but CoC- and ESG-funded victim service providers are allowed to do so. Or, victim service providers may use an alternative coordinated entry process for victims of domestic violence, dating violence, sexual assault, and stalking. **Note – if an alternative CE process is used for victims of domestic violence, dating violence, sexual assault and stalking, that alternative process must meet HUD's minimum coordinated entry requirements.*	☑	

C. ASSESSMENT

	☑	ASSESSMENT NOTES
** Required **		
Assessment Process.		
1. CoC consistently applies one or more standardized assessment tool(s), applying a consistent process throughout the CoC in order to achieve fair, equitable, and equal access to services within the community. **HUD Coordinated Entry Notice: Section II.B.2.a**	✔	
2. CoC's written policies and procedures describe the standardized assessment process, including assessment information, factors, and documentation of the criteria used for uniform decision-making across access points and staff. **HUD Coordinated Entry Notice: Sections II.B.2.g.1 and II.B.3**	✔	
3. CoC maintains written policies and procedures that prohibit the coordinated entry process from screening people out of the coordinated entry process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record. **HUD Coordinated Entry Notice: Section II.B.4**	✔	
Assessor Training.		
4. CoC provides training opportunities at least once annually to organizations and or staff persons at organizations that serve as access points or administer assessments. CoC updates and distributes training protocols at least annually. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's coordinated entry written policies and procedures. **HUD Coordinated Entry Notice: Section II.B.14**	✔	Many people said HAWNY was responsive when more training was requested but still felt that more regular training was needed.

C. ASSESSMENT

	☑	ASSESSMENT NOTES
** Required **		
5. CoC's coordinated entry process training curricula includes the following topics for staff conducting assessments: • Review of CoC's written CE policies and procedures, including any adopted variations for specific subpopulations; • Requirements for use of assessment information to determine prioritization; and • Criteria for uniform decision-making and referrals. **HUD Coordinated Entry Notice: Section II.B.14**	☑	
Client-Centered. 6. Participants must be informed of the ability to file a nondiscrimination complaint. **HUD Coordinated Entry Notice: Section II.B.12.g**	☐	This question was not asked, but nobody expressed concerns.
Participant Autonomy. 7. CoC coordinated assessment participants are freely allowed to decide what information they provide during the assessment process, to refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to other forms of assistance. Written policies and procedures specify the conditions for participants to maintain their place in coordinated entry prioritization lists when the participant rejects options. **Note – Programs may require participants to provide certain pieces of information to determine program eligibility only when the applicable program regulation requires the information to establish or document eligibility.* **HUD Coordinated Entry Notice: Section II.B.11**	☑	
Privacy Protections. 8. CoC has established written policies and procedures concerning protection of all data collected through the CE assessment process. **HUD Coordinated Entry Notice: Section II.B.12**	☑	
9. CoC has established written policies and procedures establishing that the assessment process cannot require disclosure of specific disabilities or diagnosis. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals. **HUD Coordinated Entry Notice: Section II.B.12.f**	☑	

C. ASSESSMENT

	☑	ASSESSMENT NOTES
Recommended		

Assessment Process.

10. CoC uses locally specific assessment approaches and tools that reflect the characteristics and attributes of the CoC and CoC participants. ☑

11. CoC uses a valid, tested, and reliable assessment process which gathers only enough participant information to determine the severity of need and eligibility for housing and related services. ☑

12. CoC uses a phased approach to assessment which progressively collects only enough participant information to prioritize and refer participants to available CoC housing and support services. ☑

13. CoC employs a phased approach to assessment which segments the collection of participant information into the following stages: ☑
    - Initial Triage – resolving the immediate housing crisis; identification of the CoC crisis response system as the appropriate system to address the potential participant's immediate needs.
    - Diversion and/or Prevention Screening – examination of existing CoC and participant resources and options that could be used to avoid entering the homeless system of care.
    - Crisis Services Intake – information necessary to enroll the participant in a crisis response project such as emergency shelter or other homeless assistance project.
    - Initial Assessment – information to identify a participant's housing and service needs with the intent to resolve participant's immediate housing crisis.
    - Comprehensive Assessment – information necessary to refine, clarify, and verify a participant's housing and homeless history, barriers, goals, and preferences. Assessment information supports the evaluation of participant's vulnerability and prioritization for assistance.
    - Next Step/Move On Assessment – information revealed or known after an Initial Assessment is conducted when that new information may suggest a revised referral strategy. Or, re-evaluating participants who have been stably housed for some time and who may be ready for less intensive housing and service strategies.

14. CoC employs a Housing First oriented assessment process which is focused on rapidly housing participants without preconditions. ☑

C. ASSESSMENT

	☑	ASSESSMENT NOTES
Recommended		
Assessor Training.		
15. All staff administering assessments use culturally and linguistically competent practices, including the following: • CoC incorporates cultural and linguistic competency training into the required annual training protocols for participating projects and staff members; and • Assessments use culturally and linguistically competent questions for all persons that reduce cultural or linguistic barriers to housing and services for special populations.	✔	
16. All assessment staff are trained on how to conduct a trauma-informed assessment of participants. Special consideration and application of trauma-informed assessment techniques are afforded victims of domestic violence or sexual assault to help reduce the chance of re-traumatization.	✔	Trauma-informed training isn't always evenly distributed across programs (many wanted more).
17. All Assessment staff are trained on safety planning and other next step procedures if safety issues are identified in the process of participant assessment.	✔	
Client-Centered.		
18. Physical assessment areas are made safe and confidential to allow for individuals to identify sensitive information or safety issues in a private and secure setting.	✔	At some sites there were concerns that intake interviews were in open locations.
19. Assessment questions are adjusted according to specific subpopulations (i.e. Youth, Individuals, Families, and Chronically Homeless) and responses to questions. For example, if a participant is under the age of 18 questions related to Veteran status and experience with the armed services can be skipped.	✔	
20. Assessment questions and instructions reflect the developmental capacity of participants being assessed.	✔	
21. CoC's assessment process incorporates a person-centered approach, including the following: • Assessments are based in part on participant's strengths, goals, risks, and protective factors. • Tools and assessment processes are easily understood by participants. • Assessments are sensitive to participants' lived experience. • Participants are offered choice in decisions about location and type of housing. • Participants are able to easily understand to which program they are being referred, what the program expects of them, what they can expect of the program, and evidence of the program's rate of success.	✔	A number of clients mentioned that more repetition of instructions would be helpful. Amidst intense trauma, they often felt confused about what to do with, for example, the phone number they were handed.

C. ASSESSMENT

		☑	ASSESSMENT NOTES
Recommended	**Incorporating Mainstream Services.** 22. CoC includes relevant mainstream service providers in the following activities: • Identifying people at risk of homelessness; • Facilitating referrals to and from the coordinated entry process; • Aligning prioritization criteria where applicable; • Coordinating services and assistance; and • Conducting activities related to continual process improvement. 23. CoC has established written CE policies and procedures describing how each participating mainstream housing and service provider will participate, including the process by which referrals will be made and received.	✔ ✔	
Optional	**Assessment Process.** 24. CoC uses a publicly available, rather than locally specific, standardized assessment tool(s) to facilitate their assessment process (e.g. VI-SPDAT or vulnerability index-service prioritization decision assistance tool). 25. CoC allows Veteran Affairs (VA) partners to conduct assessments and make direct placements into any homeless assistance program, with the method for doing so included in the CoC's coordinated entry policies and procedures and written standards for affected programs.	✔ ✔	
	Street Outreach. 26. Street outreach activities incorporate the assessment process, in part or whole, into street outreach activities or separate the assessment process so that it is only conducted by assessment workers who are not part of street outreach efforts.	✔	Do as much as possible, but multiple sites felt they could use more street outreach and that there was sometimes disconnect between street outreach and assessment.

D. PRIORITIZATION

	☑	ASSESSMENT NOTES
** Required **		

Core Requirements.

1. CoC uses the coordinated entry process to prioritize homeless persons within the CoC's geographic area:
   - Prioritization is based on a specific and definable set of criteria that are documented, made publicly available and applied consistently throughout the CoC for all populations.
   - CoC's written policies and procedures include the factors and assessment information with which prioritization decisions are made.
   - CoC's prioritization policies and procedures are consistent with CoC and ESG written standards under 24 CFR 578(a)(9) and 24 CFR 576.4.

   **Note – Refer to HUD Prioritization Notice: CPD-16-11 for detailed guidance on prioritizing persons experiencing chronic homelessness and other vulnerable homeless populations in permanent supportive housing.*

   HUD Coordinated Entry Notice: Section II.B.3

   ☑

2. CoC's written CE policies and procedures include the factors and assessment information with which prioritization decisions are made for all homeless assistance.

   HUD Coordinated Entry Notice: Section II.B.3

   ☑

Emergency Services.

3. CoC's written CE policies and procedures clearly distinguish between the interventions that <u>will not</u> be prioritized based on severity of service need or vulnerability, such as entry to emergency shelter, allowing for an immediate crisis response, and those that <u>will</u> be prioritized, such as permanent supportive housing (PSH).

   HUD Coordinated Entry Notice: Section II.B.7

   ☑

D. PRIORITIZATION

	☑	ASSESSMENT NOTES
** Required **		
Nondiscrimination.		
4. CoC does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex age, familial status, disability, actual or perceived sexual orientation, gender identify or marital status. CoC's written policies and procedures for CE document how determining eligibility is a different process than prioritization. **Note – In certain circumstances some projects may use disability status or other protected class information to limit enrollment, but only if Federal or State statute explicitly allows the limitation (e.g. HOPWA-funded projects may only serve participants who are HIV+/AIDS).* **HUD Coordinated Entry Notice: Sections I.D and II.B.2.g(2)**	✔	
5. CoC's written CE policies and procedures document process for participants to file a nondiscrimination complaint. **HUD Coordinated Entry Notice: Section II.B.12.g**	✔	Clients were not necessarily aware of where they would file these complaints even if staff had procedures in place.
7. CoC's written policies and procedures document conditions under which participants maintain their place in coordinated entry prioritization lists when the participant rejects referral options. **HUD Coordinated Entry Notice: Section II.B.9**	✔	
Prioritization List.		
8. If the CoC manages prioritization order using a "Prioritization List," CoC extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards. **HUD Coordinated Entry Notice: Section II.B.3**	✔	
Prevention Services.		
9. If separate access point(s) for homelessness prevention services exist in the CoC, written CE policies and procedures describe the process by which persons will be prioritized for referrals to homelessness prevention services. **HUD Coordinated Entry Notice: Section II.B.8**	✔	

D. PRIORITIZATION

Recommended

	☑	ASSESSMENT NOTES
Prioritization List. 10. CoC has established a community-wide list of all known homeless persons who are seeking or may need CoC housing and services to resolve their housing crisis. The community-wide list generated during the prioritization process, variously referred to as a "By Name List," "Active List," or "Master List," provides an effective way to manage an accountable and transparent prioritization process.	✔	Many service providers expressed uncertainty about part of the list and expressed a need for more regular communication.
Prioritization Factors. 11. CoC uses any combination of the following factors to prioritize homeless persons: • Significant challenges or functional impairments, including physical, mental, developmental, or behavioral health challenges, which require a significant level of support in order to maintain permanent housing. • High utilization of crisis or emergency services to meet basic needs. • Extent to which persons, especially youth and children, are unsheltered. • Vulnerability to illness or death. • Risk of continued homelessness. • Vulnerability to victimization, including physical assault, trafficking, or sex work. **HUD Coordinated Entry Notice: Section II.B.3**	✔	
Prioritization Process. 12. CoC identifies a prioritization entity, agency, or other decision-making entity empowered by the CoC to manage the process of determining and updating participant prioritization for available CoC housing and supportive services.	✔	
13. In cases where the assessment tool does not produce the entire body of information necessary to determine a household's prioritization, either because of the nature of self-reporting, withheld information, or circumstances outside the scope of assessment questions, the CoC allows case workers and others working with households to provide additional information through case conferencing or another method of case worker input.	✔	
14. CoC maintains a prioritization list such that participants wait no longer than 60 days for a referral to housing or services. If the CoC cannot offer a housing resource to every prioritized household experiencing homelessness within 60 days or less, then the CoC adjusts prioritization standards in order to more precisely differentiate and identify resources for those households with the most needs and highest vulnerabilities.	✔	In a couple of cases, clients had to wait longer than 60 days. There should be regular communication when this happens.

D. PRIORITIZATION

		☑	ASSESSMENT NOTES
Recommended	15. In the event that two or more homeless households within the same geographic area are identically prioritized for the next available unit, and each household is also eligible for that unit, the CoC selects the household that first presented for assistance in the determination of which household receives a referral to the next available unit.	✔	
Optional	**Prioritization Process.** 16. CoC establishes scoring criteria that translate the participant's current living situation and barriers impacting participant's ability to obtain and/or maintain housing into a numerical score that can also be used to inform the referral process.	✔	Some felt that situations of immediate distress (e.g., domestic abuse) weren't adequately prioritized by the score.

E. REFERRAL

** Required **

	☑	ASSESSMENT NOTES
Referrals to Participating Projects.		
1. CoC's CE process includes uniform and coordinated referral process for all beds, units, and services available at participating projects within the CoC's geographic area for referral to housing and services. **HUD Coordinated Entry Notice: Section II.B.3**	☑	
2. CoC and projects participating in the coordinated entry process do not screen potential project participants out for assistance based on perceived barriers related to housing or services. **HUD Coordinated Entry Notice: Section II.B.3**	☑	
3. CoC- and ESG-program recipients and subrecipients use the coordinated entry process established by the CoC as the only referral source from which to consider filling vacancies in housing and/or services funded by CoC and ESG programs. **HUD Coordinated Entry Notice: Section I.B**	☑	
Nondiscrimination.		
4. CoC and all agencies participating in the coordinated entry process comply with the equal access and nondiscrimination provisions of Federal civil rights laws. **HUD Coordinated Entry Notice: Sections I.D and II.B.3**	☑	
5. CoC's referral process is informed by Federal, State, and local Fair Housing laws and regulations and ensures participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children. **HUD Coordinated Entry Notice: Sections I.D and II.B.3**	☑	

E. REFERRAL

Recommended

Referrals to Participating Projects.

	☑	ASSESSMENT NOTES
6. CoC maintains and annually updates a list of all resources that may be accessed through referrals from the coordinated entry process.	✔	List was updated annually, but quarterly updates would be better due to frequent personnel changes.
7. Each CoC project establishes and makes publicly available the specific eligibility criteria the project uses to make enrollment determinations.	✔	
8. Non HUD-funded CoC agencies participating in the coordinated entry process fill project vacancies only through referrals from the referring agency/entity.	✔	
9. CoC's written CE policies and procedures include standardized criteria by which a participating project may justify rejecting a referral.	✔	
10. CoC's written CE policies and procedures document uniform process for managing rare instances of referral rejection, as well as the protocol the coordinated entry process must follow to connect the rejected household with a new project.	✔	
11. Upon referral, CoC participants receive clear information about the project they are referred to, what participants can expect from the project, and expectations of the project.	✔	Presenting this more often and in more different ways would help.
12. CoC identifies a referral entity, agency, CoC-subcommittee, or other decision-making entity empowered by the CoC to manage the process of referring participants to available CoC housing and supportive services.	✔	
13. If a CoC participant is prioritized for permanent supportive housing (PSH) but no PSH resources are available, that participant is offered any other CoC resource available in the CoC's geographic area.	✔	
14. CoC establishes a minimum set of participant information associated with a referral and which will be shared by a referring agency/entity with the project receiving the referral.	✔	
15. CoC establishes alternate processes to identify suitable options when projects reject a participant and when participants reject a project.	✔	

E. REFERRAL

		☑	ASSESSMENT NOTES
Recommended	16. CoC employs a 'Housing Navigator' function to ensure efficient and effective enrollment, and subsequent movement from one CoC project to another. While specific 'Housing Navigator' functions will vary from CoC to CoC, typical duties include the following: • Work closely with referral agencies regarding eligibility determination. • Develop a Housing Stability Plan. • Complete housing applications. • Perform housing search and placement. • Outreach to and negotiations with landlords. • Assisting with submitting rental applications and understanding leases. • Addressing barriers to project admissions.	✔	
	Participant Autonomy. 17. CoCs incorporate a person-centered approach into the referral process. That approach is documented in CoC's written policies and procedures for coordinated entry management. A person-centered approach includes: • Participant choice in decisions such as location and type of housing, level and type of services, and other project characteristics, including assessment processes that provide options and recommendations that guide and inform participant choice, as opposed to rigid decisions about what individuals and families need. • Clear expectations concerning where participants are being referred, entry requirements, and services provided.	✔	
Optional	**Referrals to Participating Projects.** 18. CoC establishes referral zones or referral regions within the geographic area of the CoC. These referral zones are designed to avoid forcing persons to travel or move long distances to be assessed or served. 19. CoC transmits participant referral information electronically, via the CoC's HMIS or other data management system.	✔ ✔	

F. DATA MANAGEMENT

		☑	ASSESSMENT NOTES
** Required **	**Core Requirements.** 1. When using an HMIS or any other data system to manage coordinated entry data, CoC ensures adequate privacy protections of all participant information per the HMIS Data and Technical Standards at (CoC Program interim rule) 24 CFR 578.7(a)(8). **HUD Coordinated Entry Notice: Sections II.B.3 and II.B.13**	☑	
** Required **	**Privacy Protections.** 2. CoC's written CE policies and procedures include protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. **HUD Coordinated Entry Notice: Section II.B.12**	☑	
** Required **	3. CoC prohibits denying services to participants if the participant refuses to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation. **HUD Coordinated Entry Notice: Sections II.B.12.c and II.B.13**	☑	
** Required **	4. If using HMIS to manage coordinated entry functions, CoC ensures all users of HMIS are informed and understand the privacy rules associated with collection, management, and reporting of client data. **HUD Coordinated Entry Notice: Section II.B.12**	☑	
Recommended	**HMIS Use.** 5. CoC uses HMIS as part of its coordinated entry process, collecting, using, storing, sharing, and reporting participant data associated with the coordinated entry process.	☑	
Recommended	**Privacy Protections.** 6. CoC only shares participant information and documents when the participant has provided written consent.	☑	

F. DATA MANAGEMENT

		☑	ASSESSMENT NOTES
Optional	**Data Systems Management.** 7. CoC imports and exports data to support collaboration between homeless service providers and mainstream resource providers (Medicaid, criminal justice re-entry programs, healthcare services, etc.). 8. CoC integrates data between multiple data systems to reduce duplicative efforts and increase case coordination across providers and funding streams. 9. CoC manages and maintain a list of referral resources in a systematic way that encourages high data quality and utilizes the AIRS Taxonomy to ensure uniformity in naming and describing resources.	☑ ☑ ☑	
	HMIS Functionality. 10. CoC automates coordinated entry processes including resource prioritization, prioritization list management, and eligibility determination.	☑	

G. EVALUATION

		☑	ASSESSMENT NOTES
** Required **	**Core Requirements.** 1. CoC consults with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with coordinated entry. Solicitations for feedback must address the quality and effectiveness of the entire coordinated entry experience for both participating projects and households. **HUD Coordinated Entry Notice: Section II.B.15**	✔	Annual meetings took place, but many expressed a need for more frequent meetings so that feedback could be more routinely incorporated into procedures.
	Evaluation Methods. 2. CoC ensures through written CE policies and procedures the frequency and method by which the CE evaluation will be conducted, including how project participants will be selected to provide feedback, and must describe a process by which the evaluation is used to implement updates to existing policies and procedures. **HUD Coordinated Entry Notice: Section II.B.15**	✔	
	Privacy Protections. 3. CoC ensures adequate privacy protections of all participant information collected in the course of the annual coordinated entry evaluation. **HUD Coordinated Entry Notice: Section II.B.12**	✔	
Recommended	**Evaluation Methods.** 4. CoC incorporates system performance measures or other evaluation criteria into their required annual coordinated entry evaluation plan.	✔	

G. EVALUATION

		☑	ASSESSMENT NOTES
Recommended	5. CoC ensures that evaluation is part of the implementation planning process from the inception of CE: • Determine which aspects of the effectiveness of the system will be measured. • Determine which aspects of the process will be evaluated for fidelity to the policies and procedures. • Determine how to gather data to track the selected measures. • Determine whether and how to use the evaluation results to inform other aspects of the system planning and monitoring.	☑	
	Stakeholder Consultation. 6. CoCs employ multiple feedback methodologies to ensure participating projects and households have frequent and meaningful opportunities for feedback. Feedback methodologies include the following: • Surveys designed to reach either the entire population or a representative sample of participating providers and households; • Focus groups of five or more participants that approximate the diversity of the participating providers and households; and • Individual interviews with participating providers and enough participants to approximate the diversity of participating households.	☑	