Introduction to the Coordinated Entry System

Erie County Continuum of Care
Before CES
- Limited Resources
- No collaboration between providers
- Long “waitlist”
- Confusing navigation

The Need for…
- Skilled Assessor
- System Navigators
- Collaboration between homeless, housing, and mainstream partners
Why Coordinated Entry?

• Improve communication among community partners, and housing and housing providers.
• Prevent duplication of services.
• Makes it easier to access housing and services
• Prioritize household for limited housing resources based on need and vulnerability.
• Reduce length of homelessness.
What is Coordinated Entry?

• Identification of people experiencing or at risk of homelessness
• Facilitating referrals to and from the coordinated entry process
• Aligning prioritization criteria
• Coordinating services and assistance
Coordinated Assessment for Single/Family/Transition Age Youth should be completed in HMIS; client will then be entered into the Coordinated Entry process.

**Begin here**

- **Homeless 1 year or longer within the last 3 years and with a disability?**
  - Yes: Skyline at Matt Urban
  - No: Without disability?
    - Yes: Homeless 6 months or less with a disability? (VI<4 or F-VI<9 or TAY<8)
      - Yes: with SPOA need to be completed
        - Yes, SPOA
        - With Severe Persistent Mental Illness
          - Tracey from ECD/MH
          - Other PSH (Caz, MU, Spectrum, HOME, Evergreen)
    - No: Have a disability but homeless less than 6 months?
      - Yes, VI<8 or F-VI<9 or TAY<8
        - Hispanic Unidos
        - Matt Urban RRH
        - matt.urban@hopehouseceloled.com
        - Catholic Charities
          - Wneta Miller, wnmiller@brockton.org
          - Matt Urban Hope House, Hscaledothinc.org, outpatient@outpatient.org
          - SPQA: Tracey Johnson, tracey.johnson@bne.org
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**Download VI/SPDAT or PSH Referral documents outside of HMIS:** http://www.homesless.org/continuum-of-care/coordinated-assessment/

*Documentation of homeless history and disability are required or recommended depending on priority.*
Type of Homeless Assistance

- Permanent Supportive Housing
- Rapid Rehousing
- Street Outreach Services
- Emergency Shelter
- Transitional Housing
How does Coordinated Entry Work?

1. Engagement
2. Assessment
3. Triage
4. Navigate
5. Housed!!
Step 1: Engagement

- Housing First Approach
- Trauma-Informed
- Nondiscrimination
- Harm-reduction

- Coordinated Entry Community Training – Asking the Right Questions and Community Questionnaire Sheets
HUD Homeless Def.

Category 1: Homeless □ Such as staying in a shelter, outside, the bus, or a place not meant for human habitation

Category 4: Fleeing DV □ Fleeing or attempting to flee an unsafe setting due to violence or the threat of violence
Unstably Housed

Persons who are unstably housed include people who at program entry or program exit:

▪ Are currently housed and not literally experiencing homelessness or imminently losing their housing,
▪ Are experiencing housing instability, but may have one or more other temporary housing options
▪ Lack the resources or support networks to retain or obtain permanent housing.
What about those who are not “homeless”

Prevention services
Linkages to mainstream resources
Questions?
Step 2: Assessment

- Homeless – VI-SPDAT/TAY-SPDAT/VI-F-SPDAT
- At risk of Homelessness – DIVERSION/SPOA/Prevention
Standardized Assessment Tool

What are they?
• VI-SPDAT
• TAY-SPDAT
• VI-FSPDAT
• SPOA

Why do we use them?
• Details of Current needs
• User-Friendly
• Strengths-Based
• Person-Centered
• Housing-First Orientation
• Transparent
Step 3: Triage

Linkages to Mainstream Resources:

- Domestic Violence Services and Emergency Housing
- Healthcare linkages
- Housing and Supports
- Employment linkages
- Subsidized Housing application
- SOAR Process
- Head Start
Break
Step 4: Match

No BACKDOOR!

• This means people not connected to a housing path must be assessed and entered into HMIS to be matched to a housing intervention as capacity allows

One List!

• HMIS uses data shared by all providers to create a list called, a By Name List of all individuals and households currently experiencing homelessness
• This list includes people considered to be active, meaning enrolled in a homeless project; referred out to a housing provider.
• Priority— not wait list.
Referrals

- The referring agency is responsible for following up with the individuals and families they refer in order to determine whether the individual or family is still in need of permanent or transitional housing.
- Follow-up contact must occur every 30 days at a minimum.
- If the individual or family is still in need of housing, the agency should update contact information if necessary.
- If the individual or family is no longer in need of housing, the agency can inform CE leads to remove the individual or family from the Prioritization List.
# Current Permanent Supportive Housing Order of Priority

<table>
<thead>
<tr>
<th>Rank</th>
<th>Priority</th>
<th>Tie Breakers</th>
<th>Tie Breakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Chronic</strong> (homeless continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, totaling 12 months or more with disability)</td>
<td>1. VI Score 2. Length of time homeless</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
</tr>
<tr>
<td>2</td>
<td><strong>Non-Chronic</strong>: homeless <strong>MORE</strong> than 12 Months in 3 years with DISABILITY</td>
<td>1. VI Score 2. Length of time homeless</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
</tr>
<tr>
<td>3</td>
<td><strong>Non-Chronic</strong>: Homeless between <strong>9-12 months</strong> with DISABILITY &amp; VI score <strong>10 or more</strong></td>
<td>1. VI Score 2. Length of time homeless</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
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</tbody>
</table>
## Current Rapid Rehousing Order of Priority

<table>
<thead>
<tr>
<th>Rank</th>
<th>Subpopulation</th>
<th>Secondary Prioritization</th>
<th>Tie Breaker</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Homeless 6+ Months (within 12 months) &amp; VI score 4-9</td>
<td>1. Length Time Homeless 2. VI score</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
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<tr>
<td>2</td>
<td>Homeless 3-6 months (within 12 months) &amp; VI score 4-9</td>
<td>1. Length Time Homeless 2. VI score</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
</tr>
<tr>
<td>3</td>
<td>Homeless less than 3 Months (within 12 months) &amp;</td>
<td>1. Length Time Homeless 2. VI score</td>
<td>1. Household with children/unaccompanied youth under 25 2. Unsheltered</td>
</tr>
</tbody>
</table>
# The List

- **HMIS ID**
- **Chronic Homeless Status**
- **Vulnerability Index (VI) Score**
- **Housing Status**
- **Current Project Enrollment(s)**
- **Additional Factors to help match to appropriate projects**

<table>
<thead>
<tr>
<th>Client</th>
<th>Single Score</th>
<th>VI Date</th>
<th>Family Score</th>
<th>TAY</th>
<th>VI date</th>
<th>Detail status</th>
<th>Referral Date</th>
<th>Referred Agency</th>
<th>PSH NOTE</th>
<th>Veteran</th>
<th>DV</th>
<th>Disability</th>
<th># of Childr</th>
<th>Homeless HMA</th>
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<tr>
<td>1111</td>
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<td>1/10/2018</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
<td></td>
<td></td>
<td></td>
<td>No (HUD)</td>
<td>Yes (HUD)</td>
<td>Yes (HUD)</td>
<td>0</td>
<td></td>
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<tr>
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<td>1/17/2018</td>
<td>12</td>
<td></td>
<td></td>
<td>Referred</td>
<td>1/30/2018</td>
<td>RSH-RBH</td>
<td></td>
<td>No (HUD)</td>
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<tr>
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<td></td>
<td></td>
<td>Referred</td>
<td>3/3/2018</td>
<td>RSH-RBH</td>
<td></td>
<td>Yes (HUD)</td>
<td>No (HUD)</td>
<td>Yes (HUD)</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>No (HUD)</td>
<td>No (HUD)</td>
<td>Yes (HUD)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Step 4: Navigate

- Shelters and Drop-in Centers - Case managers listed on the Standardized Housing Assessment will be visible to the housing provider for follow up along with HMIS entries and exits Outreach Professionals
- For those connected to an outreach team, the outreach worker will assist with navigation into housing
- System Navigators for families and people facing chronic homelessness Navigators assist with the process of connecting applicants to the housing they are matched to on HMIS
- Refer to other supports/services that are available to them (e.g., shelter case management, connection to mainstream resources, help connecting with family or friends).
Step 5: Housed

Bi-weekly meeting to discuss on who is being housed.

- An increase in exits from the homeless system to permanent housing
- The rate at which we are able to house people experiencing homelessness
Where to access Coordinated Entry

- Harbor House Resource Center: CE HUB
- NFTA Bus Station Outreach Satellite Office
- Outreach Team – Matt Urban Outreach and Best Self Outreach
- Department of Social Services
- Emergency Shelters
- Compass House Resource Center
- Buffalo And Erie County Public Library Central Library - (Opening in July 2018)
Take Away -

• Not one agency’s responsibility
• **Not** about putting YOUR CLIENTS into YOUR PROGRAM
• Does not solve the issue of quality housing – but rather prioritizing scarce resources to stabilize and address the needs of the most vulnerable
• “Match.com” for homelessness services
Questions:
Links:

- **SPOA**  https://familyfirst.secure.force.com/spoa/apex/spoa2_home
- **VI-SPDAT Family:** for households with children  
- **VI-SPDAT Single:** For single Head of Household with no children  
- **TAY-VI-SPDAT:** For households with only children/ Transition Age Youth 18-24)  
- **HAWNY:**  https://wnyhomeless.org/continuum-of-care/coordinated-entry/
CE Leads Contact Information

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Skylar Diamond
Matt Urban Outreach

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716-893-7222 x305