

INTRODUCTION

Health center program grantees know the catchphrase, “housing is a social determinant of health,” and many have begun to try to assess and address patients’ housing challenges in order to improve health outcomes. A critical tool available to health centers lies ‘outside the four walls’ of the health center in local homeless coordinated entry systems¹, which provide for a more centralized and coordinated approach to a community’s homeless crisis response system. In short, coordinated entry systems are meant to streamline access to housing options for homeless and at-risk individuals and families in a given geographic region. Health centers serving homeless patients (1,159 health centers served 1,191,772 individuals experiencing homelessness in 2015)² are ideal partners for coordinated entry systems. This brief will provide information for health center program grantees on **what** coordinated entry is meant to be, **how** and **why** to partner with these systems, and will demonstrate both methods and effectiveness of this effort through case examples from the field.

COORDINATED ENTRY: INTERVENTIONS & ASSESSMENTS

The federal Department of Housing and Urban Development (HUD) requires local Continuums of Care (CoCs) to develop a “comprehensive crisis response system in each community [using] new and innovative types of system coordination,” with the goal of “increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources.”³ Coordinated entry processes are intended to help communities prioritize people who are most in need of assistance, e.g. the chronically homeless and/or the most vulnerable in need of housing and supports. Prioritization for housing should take into account a variety of factors, including physical and behavioral health challenges or functional impairments. Of particular relevance to health centers, HUD recently issued a notice for CoCs that included guidance recommending that local CoCs should include mainstream service providers, including providers of physical and behavioral health services – a clear fit for our nation’s network of health centers – in activities related to coordinated entry.

¹ These systems’ names can vary locally, and commonly used terms include coordinated entry/assessment/access. For the purposes of this publication, we refer to coordinated entry systems.

² According to the Uniform Data System (UDS) Of the 1375 Health Center Program Grantees in 2015, 1159 reported serving at least one person experiencing homelessness. The number of homeless individuals served by a health center varies greatly and ranges from 1 to 31,093. Of the remaining health centers, 45 left this value blank in UDS and 171 reported ‘0.’ “Anecdotally, not all health centers reported this information consistently, so the number can potentially be underreported at some health centers.

³ HUD guidance on coordinated entry can be found in the recent CPD-17-01 Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System.

<https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf>

These activities include:

- ✓ identification of people experiencing or at risk of homelessness
- ✓ facilitating referrals to and from the coordinated entry process
- ✓ aligning prioritization criteria where applicable
- ✓ coordinating services and assistance
- ✓ conducting activities related to continual process improvement.⁴

In order to understand why it is important to engage with coordinated entry, health centers need to understand the resources available for homeless individuals. HUD funds CoCs to provide four basic types of homeless assistance:

Permanent Supportive Housing⁵ - Permanent supportive housing, also referred to as PSH or simply supportive housing, pairs non-time limited housing and rental assistance, with supportive services so that people experiencing homelessness with a disability (usually broadly defined) can maintain stability in the community. HUD strongly encourages, and in some cases requires, that HUD-funded PSH prioritize individuals and families who are “chronically homeless” for this type of housing. However, it should be noted that HUD is not the only source of funding for supportive housing, as many states and local governments, alongside foundations, hospitals, and other sources fund this type of intervention as well.

Rapid Re-housing – Rapid re-housing (sometimes referred to as RRH) is a type of permanent housing that emphasizes assistance with housing search and relocation services with short- to medium-term rental assistance. This type of assistance is generally seen as a better fit for families and less vulnerable individuals experiencing shorter terms of homelessness. Rapid re-housing can also be used to serve chronically homeless individuals and families as an alternative to transitional housing or while waiting for a PSH unit to become available.

Transitional Housing – Transitional housing provides up to 24 months of housing with accompanying supportive services. It is meant to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. It should be noted that with a policy emphasis towards permanent housing and various funding incentives from HUD, the total number of transitional housing units available in CoCs decreased by 21% between 2013 and 2016, while the number of slots of permanent supportive housing has trended upwards by 24% over the same period.⁶

Emergency Shelter and Street Outreach Services – Funded through Emergency Solutions Grants, these services are meant to serve as the “front line” for people experiencing homelessness in communities. Shelter should be used as a bridge to

⁴ *Ibid*

⁵ <https://www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/>

⁶ CoC Housing Inventory Count Reports, All States, Territories, Puerto Rico, and DC, 2013-2016. <https://www.hudexchange.info/programs/coc/coc-housing-inventory-count-reports/?filter Year=2013&filter Scope=&filter State=&filter CoC=&program=CoC&group=HIC>

permanency while people are being connected with, for example, apartments for PSH. Shelter is not appropriate as a long term solution to homelessness.

One of the primary functions of a coordinated entry system is to allocate the above housing resources appropriately and fairly. In the past, homeless consumers often had to sign up on multiple supportive housing program waitlists, and were left to find an available shelter bed on their own. This was ineffective, as it was left to the individual to navigate a myriad of programs. Now, with coordinated entry, HUD mandates that communities use a standardized assessment approach on all presenting individuals and families to determine household vulnerability and eligibility for housing resources, to organize a waitlist, and to provide access to shelter and housing slots via one intake process. The assessment tool (or tools) should be administered to all presenting clients/patients, and may provide a score of some type to help sort the waitlist by “vulnerability.” In other words, those who are the most vulnerable receive prioritized referrals to supportive housing and other resources first as they become available. Individual housing programs or initiatives within coordinated entry may have additional criteria, such as identification as a “high utilizer” or “frequent user” of emergency crisis services as determined through matched administrative data. A strong coordinated entry process will also work to incorporate other housing options for referral for those in need, but possibly lower in vulnerabilities.

While HUD does not mandate or recommend a specific assessment tool, many communities use some version of the Vulnerability Index – Service Prioritization Decision Assistance Tool, or VI-SPDAT.⁷ This is a combination of two tools – the Vulnerability Index created for street outreach that helps to determine the vulnerability of street homeless individuals, and the SPDAT created as an intake and management tool.⁸ Typically this tool involves an initial pre-screening followed by a more in-depth assessment. Another tool in use is the Vulnerability Assessment Tool⁹ (VAT) developed by DESC in Seattle, WA. Finally, some communities, such as Baltimore (see Baltimore example, below) have developed their own tool based on local input and priorities. Detailed specifics of these assessment tools are beyond the scope of this brief, it is however important for health centers to understand that the tools ask questions along a few critical domains such as: mortality risk, medical risk, mental health and substance use needs, social behaviors, organization/orientation, and extent of homelessness. The answers are self-reported from the client and are used to prioritize the household for assistance.

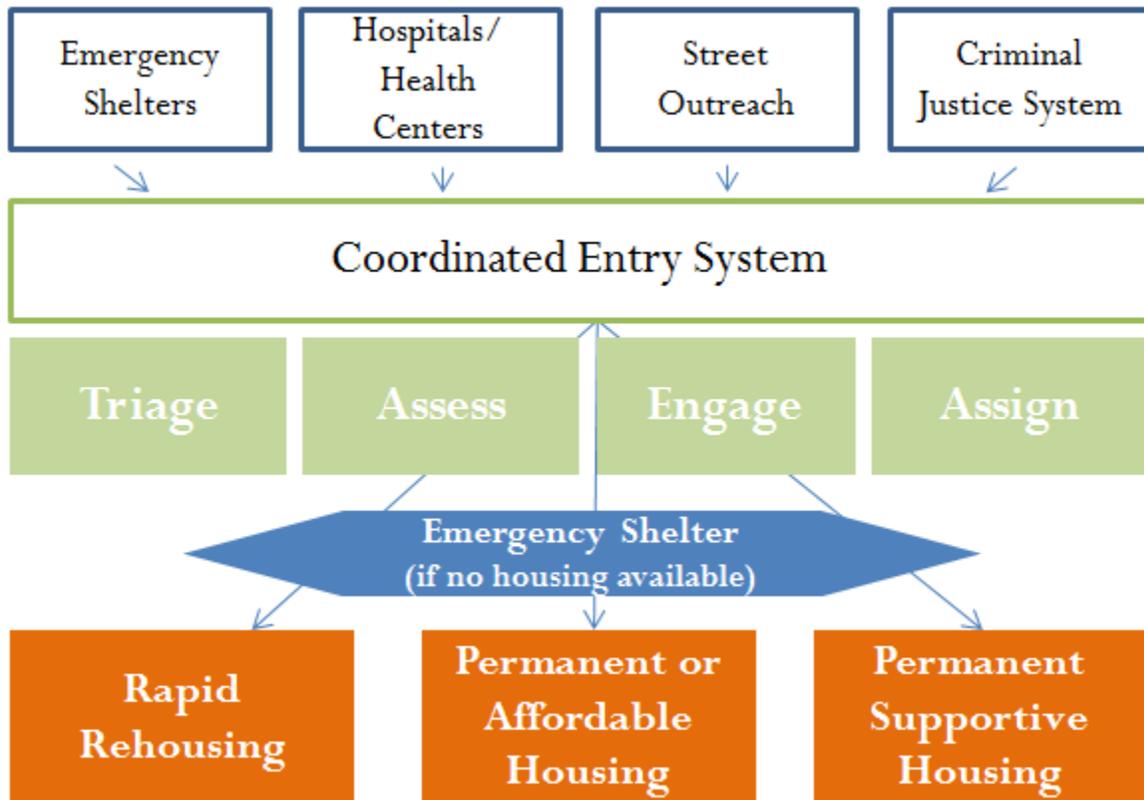
While the effort to build coordinated entry can have significant impact helping a community to prioritize resources and more effectively meet the needs of vulnerable individuals and families, it does not on its own increase the resources – supportive housing units and services. The knowledge gained through a coordinated entry planning and implementation process is valuable and vital in any next step efforts to justify the need to expand the volume of units and resources available for supportive housing.

⁷ <http://www.orgcode.com/product/vi-spdatt/>

⁸ <http://www.orgcode.com/wordpress/wp-content/uploads/2014/08/VI-SPDAT-Manual-2014-v1.pdf>

⁹ <http://desc.org/research.html>

Figure 1: Coordinated Entry



ROLES FOR HEALTH CENTERS

Many health centers – especially Health Care for the Homeless (HCH) grantees – are aware of coordinated entry processes locally, yet not involved actively in their operation or governance. There are many ways in which becoming involved can not only benefit the health center operations and patients, but can also help the homeless system organizations. Some HCH grantees operate supportive housing and other programs funded by HUD, and therefore are required to participate in local coordinated entry processes. They've reported that doing so has had some real benefits:

- *Easier referrals to housing:* Health center staff is able to refer patients to the homeless system with less effort. Instead of making calls to multiple housing providers, the staff simply makes one call to an intake/assessment site where the person can be assessed and connected to the appropriate resource.
- *Reduce the “black box” quality of homeless systems:* Some health centers report feeling “out of the loop” from homeless systems, even though they are working with the same people. Working with the CoC entities the health center can be better connected and coordinate efforts with other organizations working with the same patients/clients, and the health center can be part of a community's efforts to end homelessness.
- *Providing a medical perspective on need:* Health centers may have a different perspective on what makes a patient “medically vulnerable.” Health centers with a seat at the table of the Continuum of Care's coordinated entry governing committees can have say in how consumers are targeted and prioritized locally.
- *Opportunities for patient engagement:* Health centers are a place where clients can not only be assessed for housing eligibility, but a place where they may be seeking other services, such as primary and behavioral health services. This introduction presents an opportunity for engagement of clients/patients who may be resisting efforts by street outreach workers, resulting in quicker connections to housing resources. Health centers can execute MOUs with CoC organizations to make this coordination easier to discuss across systems.

Health centers can link into coordinated entry in a variety of ways. Some were detailed above from the recent HUD Notice. Beyond assistance with identification, referrals, service coordination and governance activities, it is important to recognize that health centers have unique resources and relationships with clients/patients that can greatly benefit coordinated entry. These include:

- Health centers can serve as an intake hub where pre-screenings and assessments take place. Coordinated entry intake workers can be placed inside health centers for a streamlined engagement and screening process.
- Health center workers and homeless service providers can collaborate to locate vulnerable people, and vice versa (see example from Richmond). This collaboration is mutually beneficial, helping understaffed homeless outreach teams locate and health center staff engage clients in care, potentially resulting in quicker placement into housing.

- Health center data systems may have information to help document a patient’s disability and length of homelessness, which needs to be established in order to qualify for HUD-funded supportive housing.
- Health centers can be part of care coordination teams once people are housed to help ensure fewer returns to homelessness and a continuation of health improvements brought on by stable housing.

EXAMPLES FROM THE FIELD

Health Care for the Homeless (HCH), Baltimore, MD

In Baltimore, coordinated entry launched in 2013 and the Health Care for the Homeless program had a seat at the table right away. HCH participated as a provider of Permanent Supportive Housing and a ‘navigator’ entity, which trained key staff to assist individuals through the coordinated entry process. The Baltimore CoC began using a locally-created tool, the Baltimore Decision Assessment Tool, based on the Vulnerability Index. The Baltimore HCH assisted in building and testing the tool as well as training navigators to use the tool, to reinforce the need for consumer-appropriate language. HCH staff served on coordinated entry work groups and participated as a testing site for a new system within the Homeless Management Information System (HMIS.) The integration of coordinated entry into the HMIS, occurring later in 2017, will improve coordination and access to housing resources for individuals experiencing homelessness. Baltimore HCH staff is uniquely positioned to participate in coordinated entry, feeling the knowledge they possess on health and experience asking sensitive questions make them an ideal solution to measuring vulnerability and housing needs for the homeless system. Staff also play a role in engaging hard to reach consumers over time, as they have an ability to follow up with clients using case management and outreach services. Health center staff use the Electronic Health Record to document homeless status and complete ‘housing plans’ with client consent. This documentation is used for homeless verification and follow-up steps for the individuals.

As an early participant in coordinated entry, the Baltimore HCH learned some valuable lessons to impart to other health center program grantees. They advise obtaining access to the CoC’s Homeless Management Information System (HMIS); executing MOUs with participating agencies to ensure ease of service coordination for those individuals in PSH who are utilizing health center services; and obtaining trainings relevant to the coordinated entry process, including documentation of chronic homelessness and identification assistance, HMIS system procedures, and Housing First methodology. Finally, health center EHRs contain valuable information and notes on homelessness status and disability. If client consent is obtained, leveraging this information can help to document chronic homelessness and assist in the housing process.

Equipped with the right tools and community partnerships, health center staff are great advocates to prioritize vulnerable health center clients for supportive housing through coordinated entry, resulting in a faster path to stability and improved health outcomes.

Daily Planet in Richmond, VA

The Daily Planet is a HCH grantee in Richmond, and offers medical respite and a Safe Haven program that provides a temporary stay for clients targeted for supportive housing, in addition to comprehensive and integrated healthcare to those who are homeless, or at risk of homelessness. Daily Planet's foray into supportive housing began in 2010 when a partnership with Virginia Supportive Housing led to a 3-year Cooperative Agreement to Benefit Homeless (CABHI) grant from SAMHSA to continue the work of the 100,000 Homes initiative¹⁰. This continued partnership with the CoC led to Daily Planet's active participation in the community's coordinated entry process. They are part of the Housing Team that meets regularly to identify, prioritize and place individuals into housing. A Daily Planet outreach coordinator is tasked with leading the outreach efforts of the process. Supportive housing staff and Daily Planet case managers work together to ensure smooth access to Daily Planet's medical, behavioral health services and psychiatric services.

Daily Planet's experience has shown the importance of strong collaboration among stakeholders across the community provides the key to making coordinated entry work. In Richmond, the police department, behavioral health entities, the local housing authority, hospitals and emergency departments, and the local Veterans Administration, Social Security Administration, and Department of Social Services are all active parties in coordinated entry. Participation from across Richmond's stakeholders has made funding from various sources more available for supportive housing focused outreach, though case management funding remains a challenge. Other challenges Daily Planet and partners have worked through are common ones in many communities – finding landlords willing to rent to this vulnerable population, sustaining and maintaining housing, and providing connections to the community so residents don't feel isolated. In summary, Helena DeLigt, COO for Programs at Daily Planet recommends health centers get involved with coordinated assessment in order to move towards a common understanding of prioritization of housing resources in the community and to ensure the health center perspective is heard and improve accessibility to your services

¹⁰ <http://100khomes.org>

SOME FINAL TIPS FOR GETTING STARTED

So, where to begin? First, determine where your community is on coordinated entry implementation. Jurisdictions are at varying stages of coordinated entry in terms geographic, population, and intervention implementation. HUD requires all communities to be in compliance by February 2018, so most are in various stages of planning and implementation in order to be on board by that time. Some items to put on your list to get started are below.

Engage the governing leadership: As a health center, you will want to engage coordinated entry leadership in order to discuss your regular involvement and role. Coordinated entry processes should have regular governance meetings, which you can attend.

Data: If your health center eventually becomes an intake site where housing screenings and assessments are done, you will want to explore becoming a user of the CoC's Homeless Management Information System (HMIS) to be able to enter data and perform look ups. Ask about the process for becoming a user, and take a look at the CoC's Release of Information form signed by clients.

MOUs: In order to discuss the needs of specific patients, you will likely need an MOU with participating service providers.

Consider carefully your role(s): As stated in the HUD guidance¹¹ and repeated below, there are many ways to participate in a community's coordinated entry. You can do one or more – attending regular meetings will help you discover where the gaps are in the system and where your health center can help.

- ✓ identification of people experiencing or at risk of homelessness
- ✓ facilitating referrals to and from the coordinated entry process
- ✓ aligning prioritization criteria where applicable
- ✓ coordinating services and assistance
- ✓ conducting activities related to continual process improvement.

Perseverance: A coordinated entry system does not solve the issue of supply of quality supportive housing, but rather prioritizing scarce resources to stabilize and address the needs of the most vulnerable. Health Center participation in the development and implementation process of coordinated entry can be messy as multiple priorities are discussed and incorporated, but the end result can be a comprehensive system that connects a broad range of resources.

¹¹ <https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf>

ABOUT CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

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