Pathways to Home

Coordinated Entry System

Ventura County Continuum of Care

What is Pathways to Home?

The *Pathways to Home Program* is the Ventura County Continuum of Care's (VC CoC) Coordinated Entry System (CES) Program. A Coordinated Entry System is a system that allows individuals and families to access services needed to move them away or out of a state of homelessness. A CES Program is a client focused approach to minimizing the complexity and challenges associated with accessing multiple programs to avoid or exit homelessness.

Pathways to Home is built on a **strategic agreement by all homeless services, housing providers and stakeholders** to coordinate services to those clients most in need in the most expedient fashion.

So Why Implement Pathways to Home?

The McKinney Vento Act as amended by HEARTH provides a blueprint for communities as to how different homeless system components can come together at the local level resulting in changes that will result in better outcomes for clients facing a housing crisis.

System level outcomes require system level reporting

Coordinated Entry helps with minimizing the time that people experience a housing crisis

Coordinated Entry helps with moving clients in and out of the homeless system as quickly as possible allowing them to achieve housing stability

Coordinated Entry lets each project contribute to the common effort to decrease homelessness and shorten the length of stay for each client's housing crisis

HUD's formal Definition from the CoC Program Interim Rule:

Centralized or coordinated entry system is defined to mean a centralized or coordinated process designed to coordinate program participant intake, entry, and provision of referrals.

A centralized or coordinated system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised and includes a comprehensive and standardized assessment

HUD's Guiding Principles for Coordinated Entry:

Re-orients service provision to create a client focused environment

Identifies strategies which are best for each household based on the data and knowledge of the full array of services available

Links the household to the most appropriate intervention that will assist the household in to resolve the housing crisis

Who will be IMPACTED?

- Clients
- Service Providers
- Community

Key Decisions

•Click on any key decision to jump to that section.

01 What model of **Access** will we select?

02 What model of **Data Sharing** will we select? This is complete, we chose to share all the data with the exception of Client Notes.

03 Will we use **Progressive Assessment**?

04 Will we use a scale for **Priority Ranking** clients for referral and/or wait-lists?

05 How will we manage **Wait-Lists**?

Planning Process

In designing a Coordinated Entry system it is helpful to consider the basic design of the process. HUD suggests that the primary function of a coordinated entry system is to make rapid, effective, and consistent client-to-housing and service matches – regardless of a client's location within a CoC's geographic area – **by standardizing the access and entry process and by coordinating referrals across the CoC…**

…so how can this be accomplished?

It requires Homeless Systems Change.

In the **current homeless system** the client has the responsibility to find services and housing projects. Sometimes this is done by making multiple calls, or by visiting multiple locations to seek assistance.	With Coordinated entry in place, the client accesses the homeless system through carefully designed protocols.
In the **current homeless system** projects operate with autonomy and make decisions on which clients to accept for project enrollment.	With Coordinated entry, each client is placed into projects for which they are eligible.

It requires Homeless Systems Change.

Current Homeless System		Coordinated entry System
Should we accept this family into our project?	→	What assistance is best for this household?
Project centric	→	Client centric
Unique forms and assessments at each project	→	Standard forms and assessments for every client at each entry point
Project specific decision-making	→	Community agreement on how to triage each client based on their needs
Ad hoc referrals between projects	→	Coordinated referral +similar needs = similar placement

Questions to consider…

How can we make the system easier for the client to navigate?

What strategies will be used for each household type? Will the access look different for adult individuals than for households with children or households with only children?

What do we need to know about the services and projects that each agency has to offer to clients? How will we compile all of the information in a comprehensive listing of what each project has to offer?

Core Operational Components of Coordinated Entry

- Standardized Access
- Standardized Assessment
- Coordinated Referral / Assignment

Standardize Access

The **Access point** is the coordinated entry point into the CoC System of Care. HUD requires that it cover the geographic region of the CoC, be easily accessible by individuals and families seeking homeless or prevention assistance and be well advertised. There are several different models for access and the best fit for each community will depend on a number of factors.

•Standardized Access Models

SINGLE POINT OF ACCESS

This model utilizes a single physical access point. The access site typically conducts assessment and assists with some services like accessing mainstream benefits.

Staff can be permanently assigned to the location or may be staff from local service providers who work to share duties.

MULTI SITE CENTRALIZED ACCESS

This model utilizes multiple physical access points based on geography. The access site typically conducts assessment and may offer the services of a co-located provider.

This type of model may have sites that are targeted to one of several subpopulations.

Staff can be permanently assigned to the location or may be shared staff of the co-located providers.

ASSESSMENT HOTLINES

This model utilizes a single call-in number for clients in need of housing or services. The access site may do some assessment and provide information about accessing mainstream resources.

Staff are typically employees of the local 211 or designated hotline agency.

NO WRONG DOOR

This model utilizes the approach that all existing provider locations are an access point. The access site conducts assessment and may provide services of the co-located provider.

Staff are employees of each provider.

HYBRID

This model involves combining several of the other models.

Key Decision

What model of Access will we select?

Standardized Access Considerations

- Where are the current entry points? How will this change? Leverage what is already working in the system. Is our 211 active in the CoC? Is there already a youth drop-in center where households with only children access the homeless system?
- Will we have special access points for special populations like Domestic Violence victims or Veterans?
- Will we have mobile staff who can be dispatched for clients that are unable or unwilling to utilize traditional access points? How will we handle data entry for clients served by outreach or mobile staff?
- Will prevention projects be a part of the system? How will you incorporate them?
- What is the projected demand for service? What is the technical capacity of staff to manage the access services?

Key Decision

What model of Data Sharing will you select?

More Standardized Access Considerations

- Consider our plan for non participating providers. How will we address this? We can always proceed without them and hope to convince them to join at a later time once the process is underway.
- Advertising must have an intentional design. How will we address programs that are not actively involved in the CoC? How will clients know how to access the system. How will pastors and other community members know where to send people?
- How will you document the level of demand for Homelessness assistance at the access point? It is important to get an unduplicated count of the people seeking assistance and keep in mind that not all clients will end up with an intervention

Standardize Assessment

HUD requires that this stage of the process include documentation of the needs of individuals and families seeking housing or services; and use of a comprehensive and standardized assessment tool. The purpose of the assessment is to aid in linking clients/households to the most appropriate intervention and then make a referral to that intervention.

Creating the assessment tool is a big part of the design process. This is how each community tailors the process to its specific needs.

Standardized Assessment Considerations

- The purpose of the assessment is to link clients/households to the most appropriate intervention and then make a referral to that intervention.

- When possible attempt to divert the client from the Homeless System using either diversion or homelessness prevention to avoid the necessity for shelter as it is less disruptive for the client.

- What should be documented?
  - Client history
  - Housing barriers
  - Client Needs
  - Difference between the client needs and the available resources
  - Amount of service needed to resolve housing crisis
  - Prescribed intervention
  - Draft of the client's housing plan

- Information gathered during the assessment process should be used to guide decision making in determining the appropriate intervention (Assignment/Referral). The intervention selected should be based on the needs of the client and not simply on which projects have openings at the given time.

Key Decision

Will you use **Progressive Assessment**?

Progressive Assessment

Progressive assessment involves asking only the information that is needed to make the referral at hand. It involves capturing different sets of information about a client during different stages of the process to locate housing and services.

WHY SHOULD WE USE PROGRESSIVE ASSESSMENT?

In an Emergency Shelter the staff often report that 30- 40% of single adults come to shelter for a week or less and need no further intervention and do not appear in the system again. In this example, an in-depth assessment isn’t necessary nor is it a good use of resources.

Key Decision

Will you use **Progressive Assessment**?

Progressive Assessment Considerations

Crisis/Triage Assessment

Does the client have an immediate safety need? If yes, what is the protocol? If no, what is the next step?

Sample questions: Do you have a place to stay tonight? Are you in immediate danger?

Housing Barriers Assessment

What are the barriers the client faces in obtaining permanent housing?

Identify the barriers and figure out next steps.

Sample Questions: What are your current financial resources and debts? Do you have any pending legal issues that might pose an issue in securing a lease?

In-depth Assessment

This assessment contains questions that address the client's ability to maintain housing stability. This could include questions about employment, personal issues and parenting

Sample Questions: What employment skills or training do you have? Do you have any health limitations?

Standardize Assignment Referral

HUD requires that there is a referral provided for housing and/or services for individuals and families experiencing a housing crisis.

Standardized Assignment / Referral Considerations

- Which programs provide which services? Are there providers who are not using HMIS? How will we handle referrals to these providers?
- Place-holder providers can be created and labeled for either the non-HMIS providers or to keep track of clients that are diverted from the system.
- The referral should be made based on the needs of the client and the disposition of the referral should be tracked
- Tracking the disposition of the referral is optional but it will allow for better evaluative reporting in the future.
- What will you do for special referrals like HOPWA and Domestic Violence Providers?
- Consider privacy when making these referrals visible to all providers.
- Consider conducting a “warm hand off” for referrals for Domestic Violence programs where the client is introduced to the staff of the refer-to provider in real time either in person or via phone.

Standardized Assignment / Referral Considerations

- HUD recommends that we make a referral, track the length of time it takes to accept the referral, and document reasons the referral was not accepted.

- Explore the client's eligibility for programs and make an appropriate referral. Eligibility should be based on the rules as set forth in the CoC standards – this can be a complicated process but will be very useful in terms of being able to make good referrals.

- Documenting each program's eligibility requirements may lead to programs relaxing their requirements as part of the discussion.

- What happens when a referral is incompatible? What is the next step that the program/client should take?

- Demand will likely be greater than availability – how do we deal with the wait-list?

- Key Decision

- Will you use a scale for priority ranking clients for referral and/or wait-lists?

Priority Ranking ***or*** Wait-Lists?

HUD has indicated that referrals should not be done on a first come, first served basis. The expectation is that clients are prioritized for service when limited resources are available.

The first step is to determine which scale will be used for Priority Ranking, if applicable.

Examples: Vulnerability Index, VI-SPDAT, SSOM, SPDAT, or community created tools.

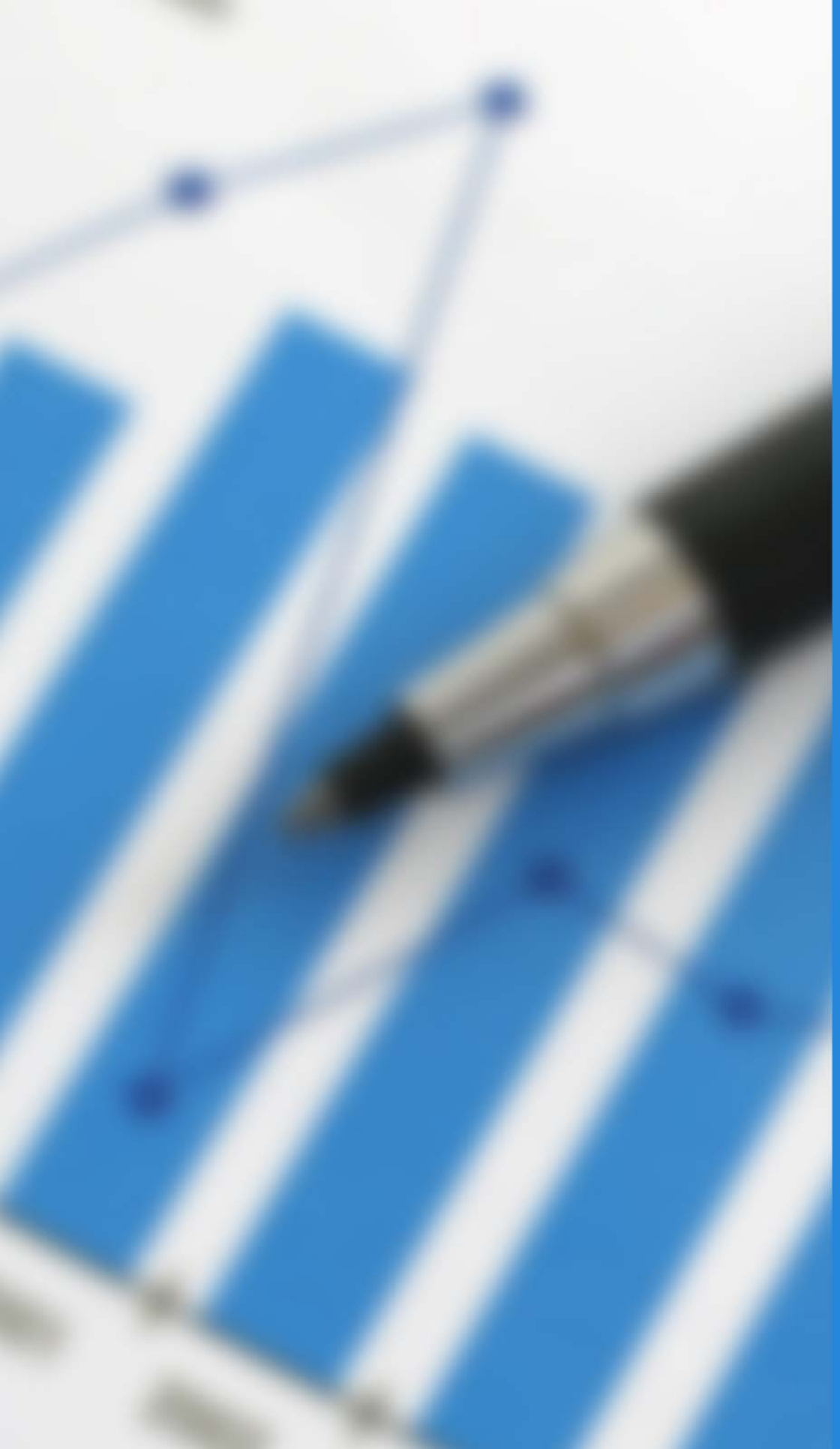
How Will We Manage Wait-Lists?

HUD recognizes that implementation of Coordinated Entry does not increase resource availability. Wait-lists should use some sort of priority protocol. What will our community do to help with prioritizing clients on the wait-list?

Will the wait list be CoC-wide or provider specific?

•Key Decision

•How will you manage wait-lists?



Reporting

We should be able to easily run reports to help gauge the effectiveness of our Coordinated Assessment System.

How many referrals are made and how many are accepted/denied?
How many referrals are outstanding?
Is the system growing as a result of implementation of Coordinated Assessment?
What about average length of stay, is it increasing or decreasing over time?
How quickly are services being delivered?
How quickly is data updated in the HMIS?