

# One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families

## INTRODUCTION

By centralizing intake and program admissions decisions, a coordinated entry process makes it more likely that families will be served by the right intervention more quickly. In a coordinated system, each system entry point (“front door”) uses the same assessment tool and makes decisions on which programs families are referred to based on a comprehensive understanding of each program’s specific requirements, target population, and available beds and services.

Uncoordinated intake systems cause problems for providers and consumers. Families with housing crises may end up going to multiple agencies that cannot serve them before they get to the one most appropriate for their needs. Each agency may have separate and duplicative intake forms or requirements, slowing down families’ receipt of assistance, and each interaction with an agency opens up a need for data entry into a Homeless Management Information System (HMIS) or a similar system. Extra staff, time, and money are spent doing intake and assessment, taking time away from other, more housing-focused, tasks such as case management, housing location, and landlord negotiation. Research suggests that, in many systems, resources are being conferred on a small subset of families whose needs may primarily be economic, while those with more significant challenges (co-occurring disorders, complete lack of a social support system, etc.) are falling through the cracks.<sup>1</sup> Centralized intake makes it easier for communities to match families to the services they need, no matter how difficult their barriers are to address.

For these reasons and others, homeless assistance systems may wish to consider shifting toward a coordinated entry model. This paper will cover how communities can create a coordinated entry system with a focus on serving homeless families.

## CHOOSING A MODEL

### Different Types of Coordinated Entry

There are two general models for coordinated entry systems – centralized and decentralized. A geographically centralized front door has one distinct location where every family can go to access intake and assessment, while a decentralized coordinated entry system offers multiple sites for intake and assessment. A virtual or telephone-based centralized intake provides one number that consumers can call to access intake and get referrals. Additional

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<sup>1</sup> Culhane, Dennis P. Stephen Metraux, Jung Min Park, Maryanne Schretzman, and Jesse Valente. "Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning" *Departmental Papers (SPP)* (2007).

differences between the models are discussed in the chart below. Regardless of the model, intake staff should be able to help consumers access prevention, diversion, and rapid re-housing resources; use an effective assessment tool; and provide information about local homeless assistance programs, housing resources, and community-based mainstream services. Intake centers and shelters should also be equipped with information about available affordable housing units, rental subsidies, and landlords willing to rent to consumers.

### Centralized vs. Decentralized Coordinated Entry

	<b>Physically/ Geographically Centralized</b>	<b>Centralized Telephone (i.e. “211”)</b>	<b>Decentralized</b>
<b>Physical Requirements</b>	A single location building, room, or space	Space for phones/hotline staff	Multiple coordinated locations throughout the community
<b>Ideal Community</b>	Physically small communities or communities with reliable public transit systems	Any; may be particularly useful in physically large or spread-out communities	Physically large or spread-out communities
<b>Ideal Staffing</b>	Workers who can handle intake and assessment (may or may not be case managers)	Workers who can handle intake and basic assessment	Workers who can handle intake and assessment (may or may not be case managers)
<b>Ideal Services</b>	Intake and assessment; connection to diversion, prevention, and rapid re-housing resources; referrals to other services; other services as decided by the community	Intake and assessment; referrals to other services; other services as decided by the community	Intake and assessment; connection to diversion, prevention, and rapid re-housing resources; referrals to other services; other services as decided by the community
<b>Drawbacks</b>	Center may not be equally accessible to everyone	Need for additional referrals/in-person help may slow down the process of getting services/housing	Less control over consistency of services and data management; potentially more costly (may require more staff, more space than physically centralized model)
<b>Advantages</b>	Fewer sites necessary; no time/training needed to work on coordinating multiple providers	Easier to handle a larger number of clients	More locations available to clients

## **Physically/Geographically Centralized Intake**

Centralized intake offers those seeking services one location – physical or virtual – where they can enter the homeless system. For this reason, the physically centralized intake model is most appropriate for those areas that are small and/or have a reliable and comprehensive mass transit system. The advantages of this model are that the same staff person or people will deliver the assessment to every person requesting services, ensuring consistency in assessment administration and data collection. For centralized intake to work, providers must be confident that they will receive quality referrals as a result of the intake process. Transparency and collaboration go a long way toward creating this kind of trust.

Some communities may have separate intake centers for different populations (e.g., singles and families). This kind of set-up would still be an example of a centralized approach.

### **Centralized Model Example: Hennepin County, MN**

In Hennepin County, Minnesota, all families must meet with a member of the Shelter Team at the Hennepin County Social Services building, the only entry point for families to the homeless assistance system, before they can access one of the County's two family shelters. Shelter workers use a triage tool with each family that captures information about where they last stayed, the benefits they currently receive, and their financial resources. Shelter Team members also begin assessing families on their employability and their eligibility for programs like Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF) cash assistance, Head Start, Legal Aid, etc. and ask families about other potential housing options outside of shelter. Shelter entry is viewed as a "last resort" option to be used when no other resources (like alternative housing or prevention) are available or appropriate. A Rapid Exit Coordinator (REC), who assesses each family for rapid re-housing eligibility, meets with the family within 72 hours of their entry into shelter. Shelter stays for a family can only be extended after this meeting if the REC determines there are no better housing options available for them at the time. Using this centralized intake strategy, Hennepin guarantees all families are assessed using the same tool and begins linking families to the appropriate services and a rapid re-housing plan immediately.

### **Centralized Telephone Example: Memphis/Shelby County, TN**

Memphis and Shelby County, Tennessee put their Homelessness Prevention and Rapid Re-housing Program (HPRP) funds to good use by creating a telephone-based centralized intake for homeless families in October 2009. Several different agencies, including providers, share responsibility for staffing the 24-hour hotline, which received 18,000 calls in one year's time. Staffers were able to connect families to HPRP benefits as well as resources and programs like eviction prevention, rental assistance, food stamps, and cash assistance. Only 6 percent of the families requiring face-to-face assessments ended up going to a shelter or transitional housing. Memphis saw a 6 percent decrease in family homelessness and a 14 percent decrease in length of stay in emergency shelter and transitional housing between fiscal year (FY) 2009 and FY 2010.

## **Decentralized Intake**

The decentralized intake model offers families multiple locations from which they can access services or shelter. The coordinated aspect of this model comes from the fact that each agency doing intake uses the same set of agreed-upon assessment and targeting tools; makes referrals using the same criteria; and has access to the same set of resources. Larger communities, or communities without a transit system to support everyone coming to one centralized location, may find the decentralized approach easier to implement. However, an increase in the number of organizations a community has participating in the system entry process may increase the likelihood of variation in terms of how assessments and referrals are handled. This particular issue may make the decentralized model less desirable for some communities than a centralized model that uses staff from only one organization.

### **Decentralized Model Example: Alameda County, CA**

Consumers in Alameda County with a housing crisis go to one of eight Housing Resource Centers (HRC) in the region (six geographically spread-out centers and two population specific centers) to access intake. Consumers can also access the HRCs through a 211 line. At the HRCs, staff members conduct in-depth assessments of consumer needs. Using the information obtained from a common assessment, each household is given a score and referred to financial assistance and/or case management and provided with prevention, rapid re-housing, and/or housing location services, as well as any other resources they might need.

Despite the fact that HRCs are spread throughout the region, each Center remains coordinated with the others. All eight HRCs use the same assessment tool, data collection methods, and targeting strategy, and each is co-located with different services that homeless assistance users may need. Staff members at each Center include a mix of program assistants, case managers, housing specialists, Center coordinators, and finance personnel. Communication among staff at different HRCs happens at monthly in-person meetings and online. The data collected at each Housing Resource Center is used in an ongoing effort to improve targeting and service efforts over time.

### **Sample Program Structure**

Though program set-ups can vary greatly, here are two examples taken from Alameda County of what the staffing of a coordinated entry intake center might look like:

#### **Center Serving Approximately 400 Households per Year**

- 1 full-time (FT) Program Compliance Manager
- 1 FT Intake Specialist
- 2 FT Case Managers

#### **Center Serving Approximately 120 Households per Year**

- 2 FT Case Managers
- 1 Housing Specialist
- .4 Clinical Supervisor
- .3 Supervision/Program Coordination

- .35 Intake and Data Entry Specialist
- .05 Housing Inspector (purchased hours of a city-employed housing inspector who inspects units for housing quality and the presence of lead)

## **ASSESSMENT AND TARGETING**

A well-developed assessment tool helps communities determine the best program match for each homeless family coming to the front door. Assessments at the intake center do not need to delve into consumer's histories very deeply; they simply need to gather enough information to determine which intervention and program are the best fit. When developing an assessment form, communities should take cues from other communities' forms, examine required data elements from HMIS and funders' data collection requirements, and gather information on:

- Where the family slept last night;
- The family's reason for coming to the center;
- The last time/place the family was in permanent housing; and
- The family's income.

### **First Step: Assessment for Prevention/Diversion**

Everyone coming in the door of an intake center should be assessed immediately to determine if they are eligible for prevention or diversion assistance. Prevention resources can help those families that are not yet homeless, while diversion resources can be used to assist those seeking shelter to find or maintain housing options outside of the traditional shelter system. Those families eligible for prevention and diversion may need access to financial assistance for rental and utility payments, rental arrears, etc. They may also need access to a case manager to help with conflict resolution or housing stabilization.

### **Referral to Shelter**

Those families that do not qualify for prevention and diversion assistance may need to be referred to emergency shelter until they can be rapidly re-housed or enrolled in another more appropriate program. Shelters should:

- Work to minimize the amount of time families need to spend there by beginning the development of a permanent housing plan as soon as possible;
- Have services focused on providing permanent housing as quickly as possible; and
- Link families to community-based supports.

Shelter beds should be viewed as a resource to be used only when absolutely necessary.

## **Second Step: Assessment for Rapid Re-Housing Eligibility**

Once in shelter, families should receive a comprehensive rapid re-housing assessment within the first week. This more comprehensive assessment or triage tool should be used to determine what barriers this particular household may have to entering and retaining permanent housing and how serious these barriers are.

Effective rapid re-housing requires case management and financial assistance, as well as housing search and location services. Though available units may at times seem scarce, oftentimes this problem can be overcome by good relationships with landlords, being flexible on lease terms, or offering landlords more money up front.

## **Third Step: Assessment and Referral to More Intensive Interventions**

The small percentage of consumers unable to be served by prevention, diversion, or rapid re-housing programs will most likely need more intensive housing and service interventions, such as substance abuse treatment, transitional housing, or permanent supportive housing. Domestic violence survivors who are not eligible or appropriate for prevention and rapid re-housing services may also fall into this category, and might best be served by a referral to a domestic violence shelter. To find out more about serving domestic violence survivors who are eligible to be served with prevention and rapid re-housing services, please see the Alliance's paper on the topic:  
<http://www.endhomelessness.org/content/article/detail/3822>.

## **MAKING THE TRANSITION TO COORDINATED INTAKE**

### **System Considerations**

1. Preparing for coordinated entry provides an excellent opportunity for communities to assess what services they have available and what services are lacking. This “system mapping” is one way that communities can see who their stakeholders are, what services they provide, and how they fit into the larger system. If there are a number of providers that are all providing the same type of services to the same population (for example, five different families-only transitional housing providers), the community should evaluate what unique services each one can provide and what opportunities exist for collaboration and consolidation.
2. Effective coordinated entry requires that the staff performing intake and assessment functions have a thorough understanding of the services available in the community. Communities might consider having a database or some other information source that can be easily updated and contains provider names, locations, hours of operation, services provided, etc. Intake staff should circulate this list on a regular basis to the rest of the homeless assistance provider community to ensure all the information listed is accurate.

3. Getting providers to buy in to the idea of releasing control over the intake process may be difficult at first; however, it is necessary for a coordinated entry system to be successful. Communities wishing to adopt a coordinated approach should discuss the following benefits with providers:

- A more coordinated intake process will take the pressure off of their staff to assess eligibility, since everyone needing assistance will be assessed at the front door.
- Under a coordinated system, providers will know that the people coming to their programs are already eligible for their services.
- Developing a coordinated entry process is one of the many ways a community can incorporate the systems-focused approach encouraged by the HEARTH Act.

Though coordinated entry typically means that providers accept whoever is referred into their program, some communities may allow providers to refuse services to a small percentage of referred households. Dayton/Montgomery County, Ohio, for example allows providers to reject some referrals, but often requires a “case conference” at which the intake worker, program staff, and client all meet to discuss an alternative housing strategy for the consumer. Case conferencing allows providers to have some say in the admissions process, but also fosters a sense of system-wide accountability for meeting the needs of each homeless family.

4. Coordinated entry requires trained intake staff at a minimum. Communities may need to re-assign staff from other organizations to take on this duty or train and hire new staff to perform it.

### **Program Considerations**

1. Programs should carefully assess how their own program resources can best be used to end homelessness. Information gained from HMIS data, staff observations, available funding streams, and a community-wide needs assessment of the need for and availability of interventions needed to serve families experiencing homelessness should inform these assessment efforts. Some programs may end up having to change their service strategies dramatically based on their findings.

2. Providers should prepare staff for changes to their intake process and eliminate “side doors,” access points to services that exist outside of the centralized system. This means programs will have to learn to reject requests for admission for a client from individuals or organizations with which they may have a personal relationship, and refuse to accept new clients unless they have been referred from the intake center.

### **EVALUATION**

To ensure that the coordinated entry system is meeting the needs of homeless families and allocating a community’s resources properly, there must be an on-going evaluation of how efficiently the homeless assistance system is functioning. This will involve taking a close look at changes in HEARTH Act outcomes and the paths consumers are taking through the



system to reach permanent housing. It will also involve adjusting the system, if necessary, to improve performance.

Evaluation of a coordinated intake system can be accomplished in several ways. Recently housed consumers can be given brief questionnaires to gather information about their experience with the system. Responses should be analyzed based on when the consumer first made contact with the homeless assistance system and when they were placed into permanent housing. Communities will want to see if, since the implementation of a coordinated entry model, the time from system entry to permanent housing has gotten shorter and involved fewer interactions with different agencies. These surveys can also ask consumers how they accessed services; if they did not access them through the intake center, the community will know that some side doors in the community still exist.

While coordinated intake is certainly not only the factor that influences outcomes on these measures, systems will still want to check in for the following trends in HEARTH outcomes after the coordinated entry system has been a place for a set period of time:

- Length of stay, particularly in shelter: If consumers are referred to the right interventions, and those interventions have the necessary capacity, fewer families should be staying in shelter waiting to move elsewhere. Also, if families are referred to the right place right away, over time, they will likely be spending less time jumping from program to program looking for help, which would reduce their overall length of stay in homelessness.
- New entries into homelessness: If everyone seeking assistance is coming through the front door to receive it and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If families are sent to the intervention that is the best fit the first time, they should have a better chance at remaining stably housed.

As part of the evaluation process, communities should establish a feedback loop that involves using the information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but that program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be time to make system-wide shifts in the types of programs and services offered. Communities with a coordinated entry system tracking all their data have a centralized source of information on who is entering their system, who is on a wait list, what their needs are, and how those needs match with what's currently available. Disseminating this information to everyone in the service provider community will create an opportunity to improve the system as a whole. Tools to help communities conduct these evaluations will be available on the Alliance website soon.

## **CONCLUSION**

Coordinated entry offers a more organized, efficient approach to providing homeless families with services and housing by creating quicker linkages to programs and matching



families' needs to providers' strengths. When implemented effectively, it simplifies the roles of providers, shortens the path back to permanent housing for homeless families, and fosters a sense of system-wide responsibility to place every homeless family, regardless of the complexity of their problems, into permanent housing as quickly as possible.