Coordinated Access in Houston

*Designing an intentional process for the use of homeless resources*

February 2012
Discussion Items:

1. What is Coordinated Access?
2. Why implement CA?
3. Models of CA
4. Building Blocks of CA
5. Key Questions to Consider
6. Next Steps – Local Discussion
What is coordinated access?

Standardized
• Access, assessment, and referral process for diversion/prevention, shelter, RRH, TH, PSH and/or other related housing and services.

Comprehensive
• Implemented consistently throughout the entire geographic area.

Accessible
• Easy to use and well-publicized to the homeless individuals and families who need it.
# Strategy Shift

## Current System:

**Should we accept this household into our program?**

- Program-Centric
- Unique forms and assessment processes to each organization or small subgroup of programs
- Uneven knowledge about available housing and service interventions in the CoC

## Future System:

**What housing /service assistance quickly ends this household’s homelessness permanently?**

- Client-Centric
- Standard forms and assessment processes used by every program for every client
- Coordinated referral process across the CoC
- Accessible information about available housing and service interventions in the CoC
Guiding Question

Guiding Question: “What housing /service assistance quickly ends this household’s homelessness permanently?”

Core Principles:

- Standardized Access and Assessment
- Coordinated Referral

Steps:
- Access
- Assess
- Assign
- Accountability
Why implement this type of system?

Experience has shown positive outcomes

- Four years of evidence
- Improvements in as little as one year
- Can help end chronic homelessness
- Different models, same core principles
- Improvements for all demographics
- Low rates of returns to homelessness
HEARTH Indicators and Interventions

- Decrease newly homeless
  - Diversion/prevention
- LOS < 30 days
  - “Rapid Exit” approach and philosophy – starts Day One
- Reduce returns to homelessness
  - Eviction prevention
- Increased exits to Permanent Housing
  - Rapid Rehousing, Coordinated Access
- Increase income
  - Benefits assistance and employment services
Why again?

• HUD is requiring all CoCs to develop and implement a coordinated access and assessment system
  • Language is already included in the Emergency Solutions Grant (ESG) Interim Rule and the HEARTH CoC Interim Rule.
  • Applies to all Shelter, Rapid Rehousing, Prevention, Transitional Housing, Permanent Supportive Housing funded by ESG or CoC
• So… since it’s required, the question becomes not “why?” but “when?” and “how?”
Key Lessons Learned

- Tailor to Local Needs and System
- Ensure Access for all in Geographic Area
  - Virtual/physical locations
  - Centralized/decentralized
- Implement in pieces
- Use HMIS
- ID Available Resources in the System
- Quality Assurance
- Test and Adjust
Components of CA

Access
- Centralized, decentralized, Single, multiple
- Virtual, physical
- Government/nonprofit, both?

Assess
- Multi-levels
- Divert first then appropriate intervention

Assign
- Referral process
- Vacancy information

Accountability
- Oversight of Process, QA
- Monitor Program and System Outcomes
# Models – Los Angeles, CA

| Access     | Will use phone-based 211  
<table>
<thead>
<tr>
<th></th>
<th>6 Regional Solutions Centers – walk ins</th>
</tr>
</thead>
</table>
| Assess     | Divert where possible  
|            | Regional Centers Staff will do all assessments |
| Assign     | Diversion, RRH, Maybe set-aside Section 8  
|            | All referrals from Solutions Centers |
| Accountability | City/Cty Agency – LA H’less Svcs Authority  
|            | Monitor Program and System Outcomes |
Models - LA Proposed System

Graphic prepared by The Shelter Partnership

1 FTE Program Coordinator
* Ensures standardized assessment and coordinated services
* Coordinates distribution of Section 8 Vouchers with Family Solutions Centers

Standardized Assessment
Family Solutions Centers

- Antelope Valley
- San Gabriel Valley
- San Fernando Valley
- Downtown
- West
- South LA

Gateway Cities

Coordinated Housing and Services Intervention

- Precariously Housed
  - Prevention (via LAHSA ERT)
- Seeking Shelter
  - Diversion
- Homeless
  - Rapid Rehousing
  - Interim Housing

Housing Stability Services
* Connection to Mainstream Resources
* Referral to Targeted Homeless Programs
* Mediation
* Streamlined Entry to Interim Housing (Motel, Emergency Shelter or Transitional Housing)
* Auxiliary Services (Transportation and Food)
* Housing Search
* Referral to Affordable Housing or PSH
* Access to HACoLA Section 8 Vouchers
* Stabilization Services/Case Management

Check-Cutting Entity

* Referrals from HACoLA/HAoLA Homeless Section 8 agencies and/or VASH/ISSF agencies for Security Deposit and Move-In Assistance (families and singles)

At each Community Site, 1 MSW + 2 Housing Stability Specialists provide standardized assessment and coordinated services

3 FTE

Accounting Clerk at Check-Cutting Entity issues checks directly to landlord

1 FTE

Legend

Call 211 / Walk-ins at Site

Pre-screening / Scheduling Assessment Appointments

Referrals from Homeless Service Providers

MSW referral

211
# Models – Dayton

| Access            | - Physical Location – 4 shelters  
|                   | - Men, Women and Families, Youth, DV |
|                   | - Common Intake and Assessment in HMIS  
|                   | - Assess for **ALL** Homeless Services |
|                   | - Refer to Centralized wait lists for RR, TH and PSH – Priorities  
|                   | - Can decline referrals, use case conference |
|                   | - County oversees process  
|                   | - Monthly mtgs of Assessors, NO CH left! |
Models – Columbus, OH

Access
- Single location for Families in downtown
- Run by YWCA

Assess
- Intake and Assessment in HMIS
- Focus on Diversion and RR

Assign
- Referral process for **ALL** Homeless Svces
- All families develop a stabilization plan

Accountability
- CSB oversee process, contracts w/YWCA
- Closed side doors to the homeless system
Models – NYC (PSH)

**Access**
- No wrong door – anyone can fill out application
- Web-based application

**Assess**
- One application form accesses over 10,000 units of permanent supportive housing

**Assign**
- Referral process for **ALL** PSH for Homeless People in NYC
- Providers can decline referrals, must take 1 in 3

**Accountability**
- City oversee process – Multiple govt agencies and funding sources involved
System components: Access

- The entry point for individuals and families facing a housing crisis to determine whether the homeless assistance system is the right place to serve them.
- Access models vary by site location, number of access points, services offered at each access point, and type of organization overseeing each access point.
- Initial efforts are to divert
System components: Access*

Access:
- Single phone number for people facing a housing crisis
- Walk-ins at program sites could call housing info line

* “211” is used in the diagram as a term for a central phone number/hotline staffed by triage/assessment staff who try to divert and if cannot, then emergency placement
System components: Assess

- Goal – understand need and eligibility
- Document homeless and housing history and related barriers
- Identify needs with consistently-used assessment tool
- Capture data to meet program needs and funder requirements
- Obtain consent for sharing with providers
- Result is a housing plan
Assess - multiple levels

Divert
- Assess to divert
- If not, intake for shelter placement

Shelter
- Assess for shelter placement
- HH Size, location, special needs

Next Step – RR, TH, PSH
- If household does not make own plans, assess for Next Step Housing
Assess – housing stability lens

- Homeless and Housing History
- Income and Finances
- Urgent/Special Needs, Disability, Legal Issues
- Community Services and Natural Supports
- Basic demographics, ID, children’s schools etc.
Establish community priorities

- Medical/Vulnerable
- Length of Time Homeless
- Frequent User
System components: Assign

- Match the recommended type of intervention to a program that can provide the right services
- Check availability and make a referral (or direct placement)
- Use HMIS to check availability, transfer client information to the receiving program, and provide enrollment status back to the intake coordinator
- Monitor to ensure successful enrollment
Assign/Refer to Programs

**Sample Criteria**

- Can safely stay where they are or make other temporary arrangements

- Cannot stay where they are

**Divert**

**Shelter**
Assign/Refer to Programs

**Sample Criteria**

- Most Families
  - Singles able to Work

- High Need but not PSH.
  - In transition

- Long term serious disability/condition

**Programs**

- RRH
- TH
- PSH
## Accountability

Ensure consistent procedures across all agencies to ensure fairness for clients, trust from providers, efficiency for the system and compliance with regulations

<table>
<thead>
<tr>
<th>Establish Policies and Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Training and Support to Agencies</td>
</tr>
<tr>
<td>Monitor Process and Outcomes</td>
</tr>
<tr>
<td>Adjust/Evolve Program</td>
</tr>
</tbody>
</table>
How do we implement?

- Identify Population(s)
- Identify Program Types/System Components to Include
- Look at current processes and build from there
- Design structure and assessment tools
- Create referral processes
- Test and Refine in parts
- Community Process

Look at current processes and build from there.
CA Guiding Principles

- Promotes collaboration among providers
- Honors client choice re: geography and services needed
- Incorporates provider choice in enrollment decisions
- Establishes standard, consistent criteria and priorities
- Ensures quality housing and services are provided
- Ensures clear and easy access for consumers
CA Guiding Principles

- Improves efficiency, communication and knowledge of resources
- Streamlines processing
- Uses Systemic “Housing First Approach”
- Accountability - Transparent and Consistent
- Leverages HMIS – use of “real time” data
- Prioritizes Enrollment Based on Need
### Key Considerations

<table>
<thead>
<tr>
<th>ACCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How do people currently access services in a housing crisis?</strong></td>
</tr>
<tr>
<td><strong>What is the volume? How many people/requests?</strong></td>
</tr>
<tr>
<td><strong>What are existing processes to access shelter and Next Step Hsg?</strong></td>
</tr>
<tr>
<td><strong>What is the CA’s geography? Are there transportation or other issues?</strong></td>
</tr>
<tr>
<td><strong>What services exist for diversion and how to incorporate screening?</strong></td>
</tr>
</tbody>
</table>
Annual Homeless Counts
Source: 2012 AHAR

**Single Adults**
- Emergency Shelter: 4,704
- Transitional Hsg: 2,321
- Total: 7,025 People

**Persons in Families**
- Emergency Shelter: 2,643 ≈ 881 HH
- Transitional Hsg: 854 ≈ 285 Households
- Total: 3,497 Persons
  - 1,166 HH
## Prior Living Situation

Source: 2012 AHAR

<table>
<thead>
<tr>
<th>Location</th>
<th>Families in ES</th>
<th>Families in TH</th>
<th>Individuals in ES</th>
<th>Individuals in TH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place not meant for habitation</td>
<td>15%</td>
<td>7%</td>
<td>54%</td>
<td>33%</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>15%</td>
<td>49%</td>
<td>6%</td>
<td>23%</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>1%</td>
<td>3%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Hotel/motel</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Family/friends</td>
<td>60%</td>
<td>26%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Institutional Setting</td>
<td>0</td>
<td>10%</td>
<td>2%</td>
<td>23%</td>
</tr>
<tr>
<td>Other situations</td>
<td>4%</td>
<td>1%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1%</td>
<td>0%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Key Considerations: Access

- Different processes for singles and families?
- How to ensure that the system assessors have the capacity and skills to do diversion screening and make appropriate referrals to shelter?
- How to address the large number of unsheltered people?
- How to get this all in HMIS?
- How to incorporate geographic preferences and patterns?
- How to accommodate emergency placements and next step needs?
## Discussion Questions

### ASSESS

<table>
<thead>
<tr>
<th>How do we gather enough data to make a good match and be useful to the accepting program, but not so much as to waste the client’s and staff’s time?</th>
<th>Can this be integrated into the HMIS? Can data be shared readily with the programs that participate?</th>
<th>Who should be prioritized for each resource? How to decide on priorities?</th>
</tr>
</thead>
</table>

Findings

**Families in Shelter:**
- 52% < 1 mo
- 3% more than 6 mos.

**Families in TH:**
- 46% < 3 mos
- 74% < 6 mos
- 26% > 6 mos

**Singles in Shelter:**
- 54% < 1 week
- 73% < 1 mo
- 10% > 3 mos

**Singles in TH:**
- 22% < 1 mo
- 52% < 3 mos
- About 50% between 3 and 6 mos

### Length of Stay Source: 2012 AHAR

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons in Families in Emergency Shelters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A week or less</td>
<td>30%</td>
<td>5%</td>
<td>54%</td>
<td>6%</td>
</tr>
<tr>
<td>1 wk. to 1 mo.</td>
<td>22%</td>
<td>12%</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>1 - 3 months</td>
<td>34%</td>
<td>29%</td>
<td>16%</td>
<td>30%</td>
</tr>
<tr>
<td>3 - 6 months</td>
<td>11%</td>
<td>28%</td>
<td>7%</td>
<td>22%</td>
</tr>
<tr>
<td>6 - 9 months</td>
<td>2%</td>
<td>15%</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>9 - 12 months</td>
<td>1%</td>
<td>11%</td>
<td>1%</td>
<td>16%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## Long Stayers*

*Emergency Shelter Stay of More Than 180 Days

Source: 2012 AHAR

<table>
<thead>
<tr>
<th>Population</th>
<th>Number of homeless persons</th>
<th>Number of Long-stayers</th>
<th>Percentage that are long-stayers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>4704</td>
<td>130</td>
<td>2.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(35% of Homeless Vets are Long-Stayers)</td>
</tr>
<tr>
<td>Persons in Families</td>
<td>2643</td>
<td>64</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

(35% of Homeless Vets are Long-Stayers)
Key Considerations: Assessment

• How do we gather enough data to make a good match and be useful to the accepting program, but not so much as to waste the client’s and staff’s time?
• How to create standard forms that meet agency’s needs and allow for program-specific information?
• How to incorporate consumer choice?
• What should priorities be?
### ASSIGN

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the inventory and how is availability of beds and services maintained and reported?</td>
<td>How can all programs be engaged in Coordinated Access?</td>
</tr>
<tr>
<td>How to share information about programs to level the playing field?</td>
<td>What should the process be to make and respond to referrals? Decline policy?</td>
</tr>
</tbody>
</table>
Houston System Inventory – 2012 HIC

- PSH 3090
- ES 1273
- RR 177
- SH 25
- TH 3102

- Emergency Shelter
- Rapid Rehousing
- Safe Haven
- Transitional Housing
- PSH
Occupancy – 2012 PIT Count

• ES - 1063 of 1273 beds = 84%

• RR – 177 of 177 = 100%

• Safe Haven – 20 of 25 beds = 80%

• TH – 2280 of 3102 beds = 74%

• PSH – 2902 of 3090 beds = 94%
Key Considerations: Assign/Refer

- How to make the process work - Need to collect eligibility criteria for all programs in the system.
  - Should there be community-wide standards for some program types/components?
- How to create an inventory with the key information needed?
- How to maintain vacancy availability?
- How to incorporate provider choice and a process for declining referrals?
Key Considerations: Assign/Refer

- How to assign the “next step” after emergency shelter?
  - What is the process post shelter to determine next step: RR, TH, PSH, other etc.?
- What about closing the side doors to the system?
- How to integrate this process with SNAP, TANF, Medicaid and other existing access processes for systems of care?
## Discussion Questions

<table>
<thead>
<tr>
<th><strong>ACCOUNTABILITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How should the process be managed and overseen?</strong></td>
</tr>
<tr>
<td><strong>What can we do to ensure that all organizations and programs participate?</strong></td>
</tr>
<tr>
<td><strong>Who will compile and analyze the data?</strong></td>
</tr>
<tr>
<td><strong>Who needs to be involved in policy making?</strong></td>
</tr>
<tr>
<td><strong>How is feedback from assessors and receiving agencies gathered and learned from?</strong></td>
</tr>
</tbody>
</table>
Costs Per Exit - SAMPLE

Average Cost Per Exit

- Singles in Shelters
- Singles in TH
- Singles in RRH
- Families in Shelters
- Families in TH
- Families in RRH

<table>
<thead>
<tr>
<th>Cost per exit</th>
<th>Cost per exit to PH</th>
</tr>
</thead>
<tbody>
<tr>
<td>$244</td>
<td>$216</td>
</tr>
<tr>
<td>$425</td>
<td>$481</td>
</tr>
<tr>
<td>$449</td>
<td>$1,645</td>
</tr>
<tr>
<td>$5,310</td>
<td></td>
</tr>
<tr>
<td>$11,623</td>
<td></td>
</tr>
</tbody>
</table>

- $2,000
- $4,000
- $6,000
- $8,000
- $10,000
- $12,000
- $14,000
Performance Purchased - EXAMPLE

- Single Adults

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Average LOS</th>
<th>Cost Per Exit to PH</th>
<th>Rate of Exit to PH</th>
<th>Rate of Returns to Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY SHELTER</td>
<td>15 days</td>
<td>$5,366</td>
<td>4%</td>
<td>46%</td>
</tr>
<tr>
<td>TRANSITIONAL HOUSING</td>
<td>84 days</td>
<td>$14,031</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>RAPID RE-HOUSING</td>
<td>N/A</td>
<td>$1,879</td>
<td>90%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Key Considerations: Accountability

• What entity will oversee the CA system?
  • Who has authority and needs to be involved to make it work for the homeless system, not just HUD funded programs?
• What funding is required? What are possible sources?
• What is the feedback mechanism for providers and consumers?
• What should be the indicators/outcomes for each component of the system and the coordinated access process?
Thank You

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