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COORDINATED ENTRY & CARE COORDINATION

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COORDINATED ACCESS

How It Works (and When It Works Best)

Coordinated access (i.e., coordinated entry or CE) is the process mandated by the US Department of Housing and Urban Development (HUD) to avoid multiple intakes, where clients are qualified for housing based on a shared intake process between service providers. Without this process, Continuums of Care (CoCs) are all but guaranteed to experience administrative breakdown, degraded data quality, redundant resource allocation, and, most important, unnecessarily adverse client outcomes.

Eccovia, a leading case management software company, has partnered with many CoCs across the United States to help them achieve their goals in mitigating and preventing homelessness. Three of those partnerships include Coalition for the Homeless of Houston/Harris County, the CoC lead for Houston; Partners for HOME, the CoC lead for Atlanta; and Housing Forward, the CoC lead for Dallas.

In this white paper, we'll explore the way three of the nation's most successful CoCs leveraged data governance and technology to reduce homelessness in their communities by significant margins—all through the coordinated entry framework. In addition, we'll learn how these communities improved their processes with intake, assessment, prioritization, referral, and follow-up, and how case management technology contributed to that improvement.

COORDINATED ACCESS BEYOND COMPLIANCE

Let's be clear: compliance is extremely important! But while meeting HUD and state requirements for data standards, reporting, and so forth is necessary, it is not sufficient to mitigate homelessness. Coordinated access systems are a compliance requirement as well as a guidepost for how to achieve true community care coordination between service providers.

Beyond that, coordinated entry was originally designed to keep clients from being retraumatized, through consolidating the intake efforts of multiple service providers in a community. When intakes are performed over and over again, clients might feel averse to going through "the system" because they're asked invasive questions by strangers, questions that are highly personal in nature and might stir up unpleasant memories.

Coordinated access systems (CAS) are necessary for:

- streamlining access to services for people experiencing homelessness,
- keeping consistent and comprehensive data,
- improving service delivery and allocation,
- enhancing reporting and accountability, and
- better client outcomes.

COORDINATED ACCESS ENABLES ...

STREAMLINED ACCESS TO SERVICES

Efficiency

Depending on the community, there could be various access points (i.e., hotline, outreach, no-wrong-door, single point of entry). But no matter what entry method, the idea is that services should not be duplicated within the community, so as to avoid superutilization.*

* *"Super-utilizers" are defined as clients who receive multiple redundant services, often due to inefficient CAS or chronic illness/homelessness.*

Timeliness

When individuals experiencing homelessness enter a by-name list (BNL), they are then prioritized according to their level of risk/vulnerability. While there are no perfect vulnerability indexes, each community is empowered to choose its own vulnerability assessment tool, be it the VI-SPDAT, the Arizona Self-Sufficiency Matrix, or another.

DATA INTEGRATION AND ACCURACY

Consistency

A CAS ensures that data in the HMIS is consistent across different service providers, especially when it comes to measuring client vulnerability, intake data, and outcomes. This consistency is facilitated by centralized data systems (as opposed to, say, a collection of spreadsheets), where intake forms and case notes can be shared across workgroups.

Data Collection

A CAS with non-HMIS services integrated, such as domestic violence, needs VAWA-compliant data collection where de-identified clients are only accessible to other victim service providers or housing agencies—without demographic information.

IMPROVED SERVICE DELIVERY

Whole Person Care

When HMIS communities work with other non-HMIS providers, it's more likely that clients will be able to have addressed the issues contributing to their experiences. Addressing root issues of homelessness is known as *whole person care,* a concept that has caught on throughout the Housing First–aligned states and municipalities.

Efficient Use of Resources

When communities and service providers share case notes (with client consent, of course!) and overlapping resources, funding is more efficiently used, which leads to the ability to serve more clients experiencing adverse social determinants of health (SDoH).

ENHANCED REPORTING AND ACCOUNTABILITY

Performance Measurement

Reporting tells the story of your community's outcomes, both to funders and to stakeholders. Without an intuitive, efficient way to gather data across the community for data managers, reporting is an unnecessarily onerous task that takes outsized administrative burden.

Compliance

Securing funding, of course, requires being compliant with HUD, VOCA/VAWA, HOPWA, RHY, HIPAA, and every other legislative act or regulatory body that governs the social services space.

DIFFICULTY OF EXPANSION

Data Quality in Coordinated Entry

As mentioned, many entry methods (i.e., single-door access, no wrong door) are often employed at coordinated access networks, but they all have certain trade-offs that should be taken into account. But no matter what method, they're typically governed by two main observations:

1. *The lower the control of intake data, the lower the data quality. And,*
2. *The lower the data quality, the harder it is to expand access.*

There is no singular "right way" to do access points, but consider how complicated a multi-site or No Wrong Door approach can become.

Without a comprehensive case management system that makes intakes uniform across the community, it's more likely that single-access points and assessment hotlines have to be the main answer.

Consider these access models:

	 SINGLE POINT	 MULTI-SITE CENTRALIZED	 NO WRONG DOOR	 ASSESSMENT HOTLINE
 LOCATION	Centralized	Population centers, high-volume providers, or subpopulation-focused	All existing providers	Telephone or internet-based
 NUMBER OF ACCESS POINTS	1	Depends on geography (2–4)	Many	1 phone number or website
 SERVICES OFFERED	– Access – Assessment – Triage – Emergency – Mainstream	– Access – Assessment – Co-located – Subpopulation	– Access – Limited Assessment – Referrals – Standard	– Access – Mainstream – Limited Assessment
 OPERATING ENTITY, STAFFING	Independent access specialists, single organization	Independent access specialists, co-located providers	Operated by each provider	Local 211 or other hotline agency
 CONTROL	High control with central intake	Moderate control, a "hybrid" approach	Lowest control and most referrals	Initial triage tool

Of course, most communities that succeed at coordinated entry utilize a mix of access-point models. That's where we turn to three top-performing CoCs for guidance.

1. COORDINATED ACCESS POINTS

THE WAY HOME, CoC TX-700

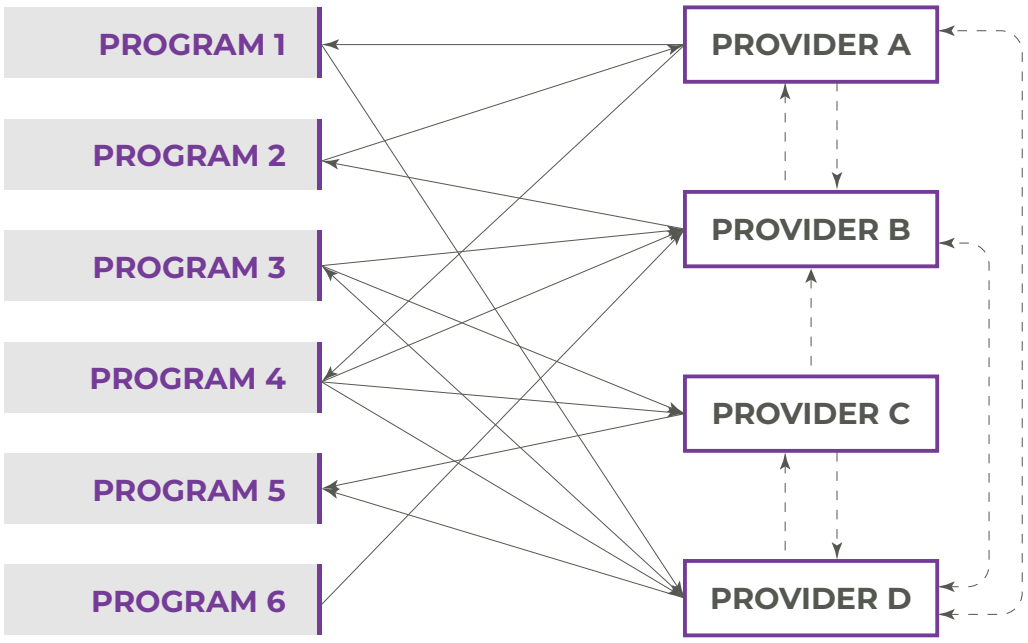
The Continuum of Care TX-700, The Way Home, is composed of 100+ stakeholder organizations (e.g., nonprofit, government, faith-based, philanthropic) from all sectors of the Houston metropolitan area. It's a large sector, covering 665 square miles, with the third-largest number of Fortune 1000 companies. For perspective, Houston's Texas Medical Center is the largest medical center in the world, with more square footage than downtown Dallas.

> We had high rates of recidivism primarily due to the interventions not matching correctly with the individuals being served.

Erol Fetahagic, Director of Analytics and Evaluation, Coalition for the Homeless of Houston/Harris County.

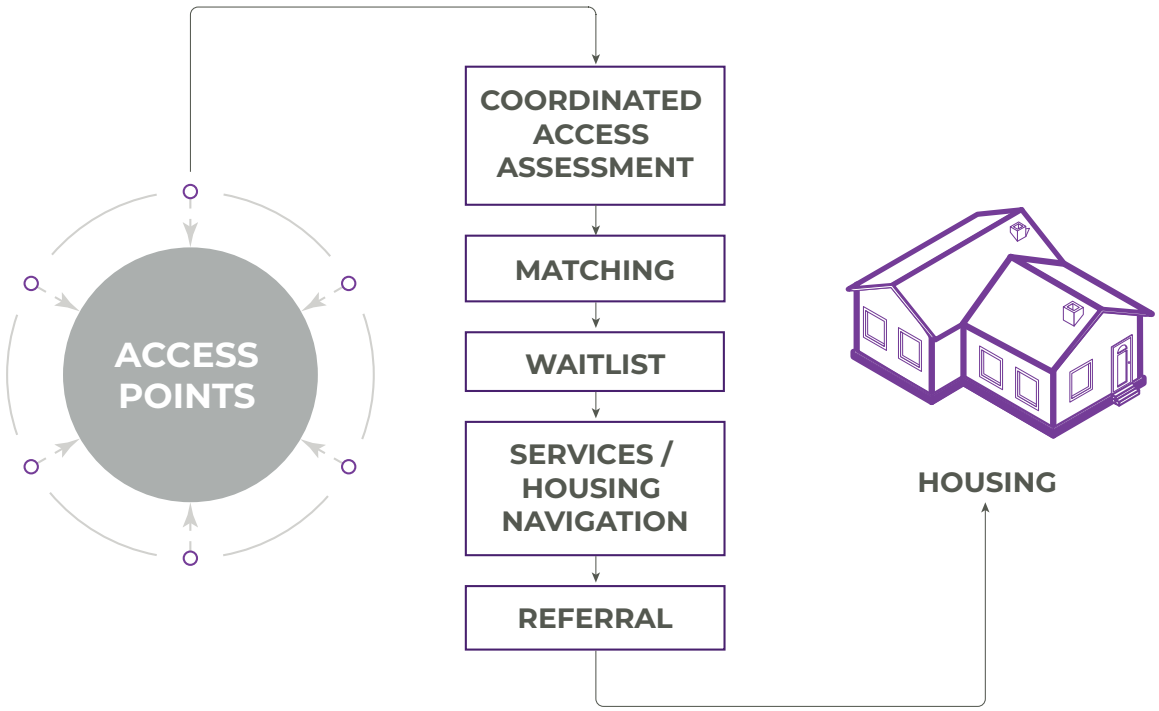
With an annual HUD allocation of about $59 million, Coalition for the Homeless of Houston/Harris County (CFTH) keeps about 8,000 people housed at any given point in the year and has been featured on multiple media outlets for its 63% reduction in homelessness since 2012, a feat rarely achieved.

Of course, this success was hard won. In 2011, Houston had the fifth-largest homeless population in the country, and a homeless individual might not receive the right services if they didn't walk into the right access point. On top of that, the access models were hard to navigate, like in this previous model prior to Houston's CE innovation:



Fast-forward to today: Houston's CAS is far more navigable and takes into account several social-service-adjacent systems, such as criminal justice, healthcare, and more. Hospitals, phone intakes, VA departments, outreach teams, and more organizations now participate in the CAS for Houston. But how did they support and build this new workflow? One key part was to add By-Name Lists (BNLs) under one roof, rather than having multiple waitlists, enabled by ClientTrack:

A simplified model:



With multiple access points that allow for various subpopulations, Houston established workgroups, including outreach teams, within its ClientTrack environment to help assessors and navigators (CAS team members) do the day-to-day monitoring of the "action on the ground," as well as help data managers create system forms and BNLs for permanent supportive housing and rapid rehousing.

Of course, Houston isn't the only community to have great success evolving its coordinated entry. Atlanta's Partners for HOME has something to teach us too.

2. COORDINATED ACCESS ROLES

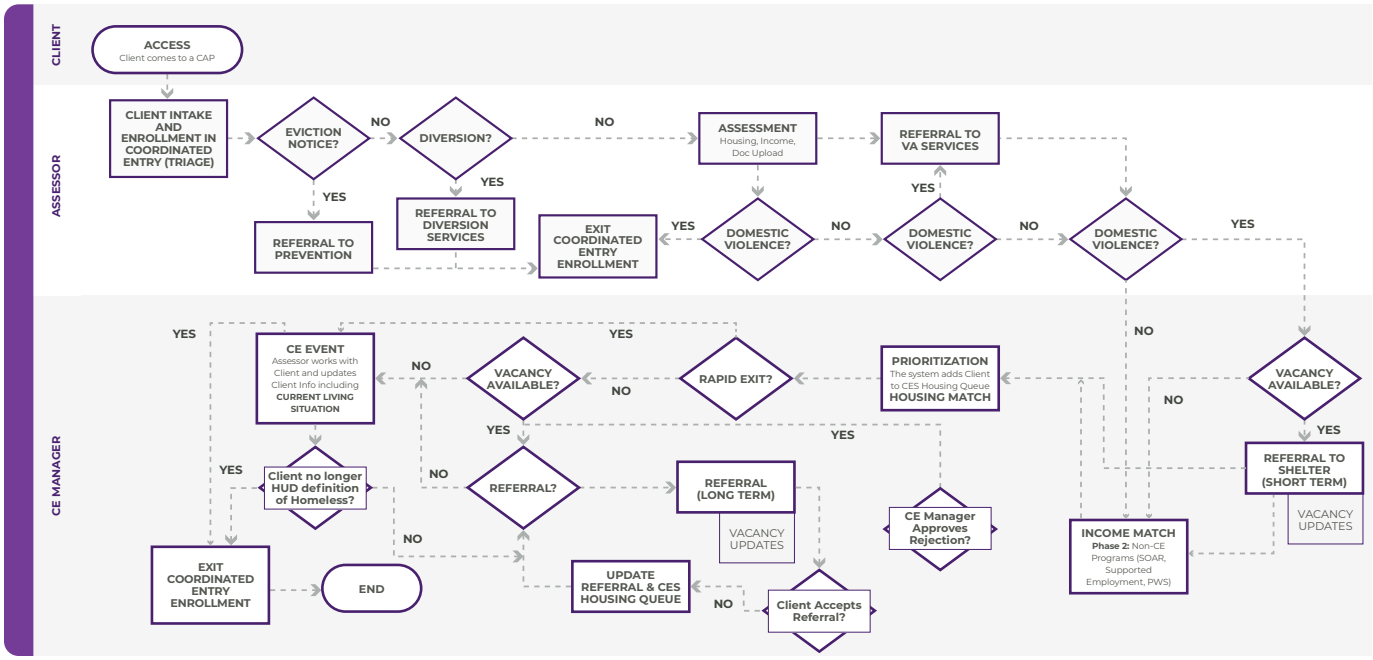
PARTNERS FOR HOME, CoC GA-500

Together with the Institute for Community Alliances (ICA), Atlanta's ClientTrack implementation for CAS started in 2016 with the following timeline:

2016–17	Atlanta defines Coordinated Entry with Eccovia Atlanta and Fulton County shared visions for common Coordinated Entry
2018	Coordinated Entry is live **SYSTEM DESIGN INCLUDES:** - *Provider workflow to create vacancies and eligibility* - *CE Assessor enrollment workflow* - *CE Manager Matchmaker: HQ and referral* - *CE Provider enrollment*
2019–20	2022 Data Standards released Eccovia's Product team designed a Coordinated Entry framework Georgia HMISD retrofits new Data Standards into their custom framework
2021–22	CE role-based training Leaning Management System for training Moved to Informed Consent Privacy policy Published Performance Dashboard QAT Dashboard built out
2023–24	CE Manager Transition HQ clean-up Additional refinements proposal (HP & Diversion) Queue Analysis Tool refinements

Before working with Eccovia's team to implement ClientTrack, PFH's initial CAS workflow was too restrictive. For example, metadata were often missing from reports due to status-change dates.

One key to making this workflow less restrictive was to allow more options for the CAS team.



Workgroups were created with assessors and navigators, who had specific documentation to follow.

Meticulous documentation was made for these assessors' workflows to ensure continuity of data and positive client outcomes.

Processes in ClientTrack include:

- » enrolling a client into coordinated entry
- » enrolling a client into short-term intervention (i.e., emergency shelter)
- » conducting referrals for clients not on the agency's housing queue
- » accepting a referral
- » updating a client's living situation
- » completing a re-assessment
- » exiting a client from CE before housing
- » updating financials, barriers to entry, and insurance

For example, **housing assessors** became broadly responsible for:

Crisis Assessment

Prevention and Diversion Referrals

Accepting Referrals

Exiting Clients from the CAS

Updating Client Records

3. PRIORITIZATION & ASSESSMENTS

THE WAY HOME, CoC TX-700

In addition to the HUD-required prioritization data elements, CFTH's locally-developed housing prioritization tool has been revised to include 16 more questions, pictured below.

FY2024 HOUSING PRIORITIZATION TOOL (ABRIDGED)

- Where did you sleep last night?
- Have you been homeless in the past?
- How many times have you been homeless in the past 3 years?
- (Frequent service user?) Calculation
- Do you or anyone in your household have a disabling condition?
- How many times in the past 6 months have you accessed medical services in the ER?
- Do you have a serious physical health diagnosis that requires palliative care, hospice, or terminal illness treatment? (Examples: symptomatic AIDS, cancer, colostomy, ALS, etc.)
- Have you ever been involuntarily hospitalized for a mental health condition?
- In the past year, have your drugs or alcohol usage had a negative impact on your life?
- Have you ever been involved in the foster care system?
- Have you ever been involved in the juvenile justice system?
- How many times in the past year have you been arrested or in jail/prison/juvenile detention?
- Are you homeless or remaining homeless because someone is hurting you?
- Has someone asked (or forced) you to have sex or sell anything in exchange for something?
- Is someone threatening to harm you or your family if you don't do what they ask?
- Do you have income?

For criminal-justice access points, CFTH had a jail diversion supportive housing project that worked with the area's largest mental health provider. This provider would train its staff to do assessments in the jails and then call the CoC intake line to do assessments.

Primarily, it was for people who were homeless prior to jail and would be homeless again after, and who were working with the mental health provider.

PARTNERS FOR HOME, CoC GA-500

For Partners for HOME, prioritization for housing is based on the client's VI-SPDAT score (while PFH updates its version of the VI-SPDAT every 6 months or so) and the length of time they experienced homelessness. However, in order to receive a referral, the client must be "document-ready," which is where navigators and assessors come in to assist.

Permanent supportive housing (PSH) is referred to chronically homeless households with a score of 11 or higher, while rapid rehousing (RRH) is referred to individuals or families with a score of 4 or higher.

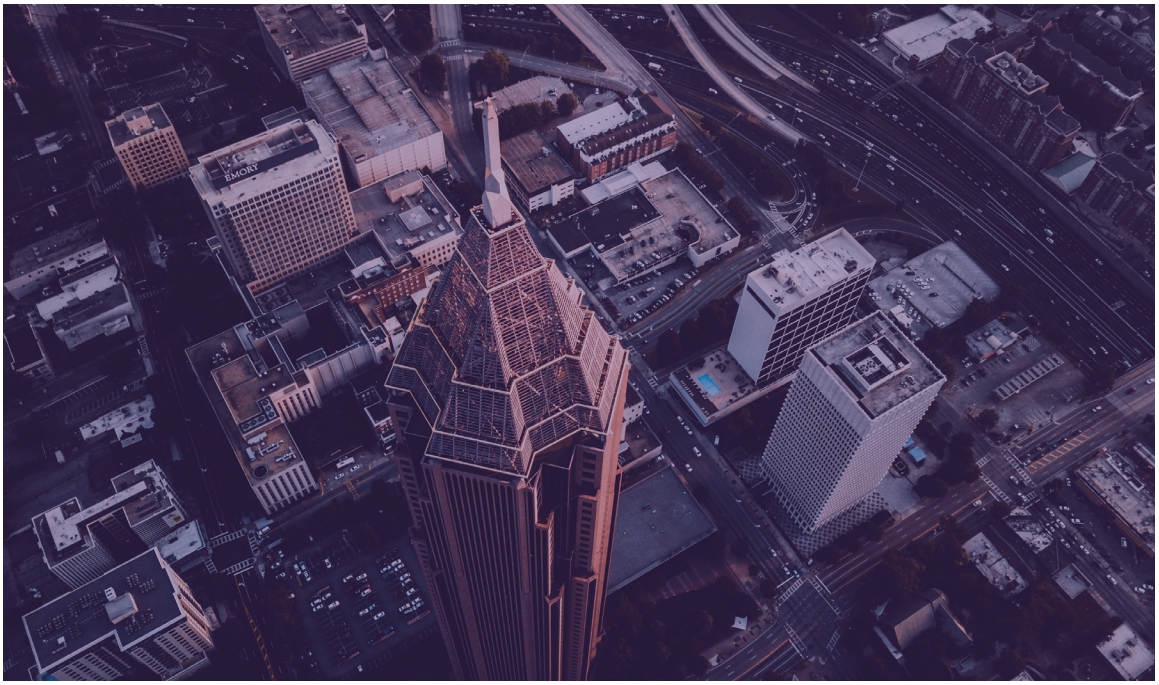
With the assistance of ICA and PowerBI, Atlanta's CoC developed a queue analysis tool to find big-picture and granular data stories in its coordinated entry referrals.

Referral Process for Atlanta's CoC

1. Assessors can make emergency shelter (ES) and diversion referrals for clients on housing queue.
2. Only the CE manager can make RRS and PSH referrals in HMIS.
3. Once a referral is made, CE manager will notify assessor or case manager and connect them with the provider.
4. Assessors must contact client and offer, accept, or reject the referral within 72 hours.
5. Assessors or case managers ensure client contact info is listed in the HMIS for the provider, assisting with coordination as needed.
6. Provider will "reject" referral if client is not reachable, or if the assessor doesn't complete intake within 72 hours.

ClientTrack Custom Coordinated Entry Features

- Custom HMIS report for referrals
- CE auto-exit at time of enrollment to PSH
- Referral status shows in housing queue and Queue Analysis Tool
- Placement rejection report/dashboard for CE managers to approve and review, ensuring Housing First compliance
- Offline units
- Client checkout



4. DATA SHARING AND GOVERNANCE

PARTNERS FOR HOME, CoC GA-500

In PFH's data dictionary, they connect the HUD data elements to the common field names and outline the use cases for each field, as well as whether the data element is connected to domestic violence services, as their local DV providers refer their survivor clients to housing services in the HMIS via deidentified client data.

To make sure all providers, assessors, navigators, and other case workers had the maximum-allowable access necessary for their roles, workgroups were created in PFH's ClientTrack environment, which allowed for them to create data-sharing agreements throughout the community. These agreements entailed:

- Monthly, mandatory CE workgroup meetings to ensure compliance and case conferencing
- Management by CE managers for active lists
- Step-by-step guides
- Allowing end-user access into HMIS training modules
- Monthly meetings for CE Refinement Committee

Data Sharing Agreements (DSAs)
Implied consent was achieved through tracking client consent in the ClientTrack case notes
Clients who restricted data sharing began a process of manual referrals
CE assessors were given read-only access

DALLAS CoC: CLIENT CONSENT AND DOMESTIC VIOLENCE

Dallas's Housing Forward implemented a data-sharing structure for DV providers that classified organizations as sensitive and non-sensitive.

For example, organizations funded by HOPWA (Housing Opportunities for Persons with AIDS) and RHY (Runaway Homeless Youth) grants were classified as sensitive organizations, which were only required to get signed client consent when the client opted to share their data in HMIS. If consent was given, enrollment data was only shared with other sensitive organizations from which the client was receiving services.

If the client did not consent to share their data, the data was still entered, but the sharing setting was set to "restricted" in ClientTrack, so enrollment data was only seen by organization serving the client.

All other HMIS organizations—those not funded by HOPWA or RHY grants—are considered non-sensitive, so no consent form was needed for these organizations. This is because Housing Forward's privacy policy covers sharing for these organizations under informed implied consent. Enrollment data, then, is shared and visible by all organizations within the ClientTrack environment.

Now, why is this useful? Three words: **compliance**, **reporting**, and **protection**, all of which wouldn't be made possible without a comparable database.

COMPLIANCE

VOCA (Victims of Crime Act) and VAWA (Violence Against Women Act) require that grantees not disclose any PII (personally identifying information) regardless of whether the information has been encoded, encrypted, hashed, or otherwise protected, meaning that in order for victim service providers to participate in housing referral and other HMIS activities, they need a comparable database that's separate from the HMIS.

REPORTING

HUD typically requires VSPs to run the APR and CAPER reports for participating CoCs, Emergency Solutions Grantees (ESGs), at minimum. VOCA requires grantees to report on the Victim Assistance Formula Grant, if applicable.

PROTECTION

VAWA requires grantees to make "reasonable efforts" to prevent inadvertent disclosure of PII, which means the comparable database needs protection beyond minimal compliance. Some solid examples include: Audit trail logging, Azure safeguards, and Single Sign-On (SSO).

LOOKING FORWARD TO TRUE CARE COORDINATION

Smart processes were essential to all three of these communities' success at reducing homelessness in their areas via coordinated access and entry, but none of those processes would've been possible without robust data technology that allowed for custom assessment workflows, consent-driven workgroups based on role types, uniform intake forms, and everything else addressed in this piece.

There are many different needs and approaches. Whatever the solution, it's clear that coordinated care via the coordinated access system model is not possible without sharing data between providers.

To facilitate data sharing, everyone needs to be on the same page. Without a data sharing platform used by all partners, agencies, and providers, coordination of any sort will be severely hampered.

And because no two CoCs are going to look exactly alike, or have identical programs and needs, it's important that your platform can handle your organization's unique circumstances. You need a data sharing platform that will assist rather than hamper you.

A common thread in all the examples cited is ClientTrack, Eccovia's case management platform. ClientTrack powers coordinated entry programs across the country and can adapt to the needs of organizations of all sizes, and provide for a wide variety of services and tracking needs.

ClientTrack® by eccovia

To learn more about ClientTrack and how it can enable coordinated entry in your community, reach out to us at info@eccovia.com

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