

# Toward Creating a Coordinated Entry and Assessment System for All Homeless Populations in King County

Prepared by Building Changes, April 2012

This plan was developed by Building Changes for the Committee to End Homelessness in King County (CEHKC). Kari Murphy and Mark Putnam contributed to this report.

# Toward Creating a Coordinated Entry and Assessment System for All Homeless Populations in King County

## Introduction

In Washington State, the Department of Commerce requires all Consolidated Homeless Grant (CHG) Leads and Sub Grantees to have a coordinated entry system in place by December 31, 2014. According to its administrative requirements, each Lead and Sub Grantee must have “a uniform method of client intake which may be customized for families or single adults, etc. There must at the very least be a common tool at intake that consistently screens for eligibility and need for housing and services (including type and intensity).”<sup>1</sup> This requirement is in line with increasing federal and state emphasis on local jurisdictions creating systems coordination. The Federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act requires HUD to measure performance across the homeless system as a whole, including other HUD and federal and state programs whose funds are targeted to prevent and end homelessness.<sup>2</sup> The Act allows HUD to use a community’s performance in determining funding levels. Creating a coordinated entry and assessment system is one way that communities can collect and analyze data to determine their performance at the systems level.

Within this context, King County has been taking significant steps toward reaching its long-term goal of greater systems coordination and integration of all services, such as housing, employment, and mental health. A coordinated entry and assessment system for all homeless populations is a key step to integrating these services. In 2009, the county created “Client Care Coordination,” an intake system for chronically homeless individuals that supports a coordinated service approach. In April 2012, the county launched a coordinated entry and assessment system for homeless families. In mid 2012, as part of a larger, community-wide initiative to more effectively address youth/young adult homelessness, the county began planning a coordinated entry and assessment system for homeless youth/young adults.

Ultimately, the goals of a coordinated entry and assessment system are to simplify access to services by clients, track system outcomes to inform and enhance decision-making, and improve overall system efficiency. The Committee to End Homelessness in King County (CEHKC) wants to ensure that the creation of coordinated entry and assessment systems for different populations

---

1 Administrative Requirements for Consolidated Homeless Grant, Department of Commerce, December 2011. Available online: <http://www.commerce.wa.gov/DesktopModules/CTEDPublications/CTEDPublicationsView.aspx?tabID=0&ItemID=9824&Mid=870&wversion=Staging> (Accessed February 2012).

2 Hearth Academy, NAEH, September 2010. Available online: <http://www.slideshare.net/naehomelessness/implications-of-the-hearth-act> (Accessed March 2012).

---

do not result in a more siloed system with additional barriers for clients to access housing and services. To this end, CEHKC asked Building Changes to research other communities across the country that have a coordinated entry system for two or more populations and create a draft vision for a coordinated entry and assessment system in King County that simplifies access to services and housing by adults, families, and youth. This document summarizes our key research findings and explains how those findings led Building Changes to our recommended vision for an entry system in King County that simplifies access, ensures system performance measurement tracking, and improves efficiency.

## Key Research Findings

Our research focused on communities that are implementing or planning a coordinated entry system for two or more populations.<sup>3</sup> Specifically we looked at the following factors as the key components of a coordinated entry and assessment system in King County: leadership, model, database, assessment process and tools, and evaluation. The decision to focus on these factors was based on the National Alliance to End Homelessness (NAEH) paper on developing and implementing a coordinated assessment process. In addition, the planning process for a coordinated entry and assessment system for families and youth/young adults highlighted these as important components.<sup>4</sup>

## Findings

- Among the communities we researched, it was unanimous that communities implementing coordinated entry assessment systems for multiple populations **are using the same processes and tools for all populations** with some population-specific adjustments or adaptations.
- Most other communities are **not implementing a coordinated entry assessment system for homeless or at-risk youth/young adults.**<sup>5</sup> King County is ahead of other communities in planning for a coordinated entry and assessment system for youth/young adults.
- In most communities we researched, **the county acts as the fiscal agent and a nonprofit provider is the implementing agency.**
- The majority of communities we researched **screen for prevention/diversion activities at the front door.** Examples of outcomes include a 67 percent prevention rate, 26 percent diversion rate for families, and a 16 percent diversion rate for single adults.
- **All communities use HMIS** to support coordinated entry assessment, but in different ways, depending on their system's capabilities and the funding available in the community to make adaptations to HMIS.

Please see Appendix—Research Summary for additional information.

---

<sup>3</sup> Building Changes interviewed the following communities, all of which are implementing the same system for all populations: Cincinnati, Hamilton County, OH; Columbus, Franklin County, OH; Dayton, Montgomery County, OH; Tacoma, Pierce County, WA. Hennepin County, MN, is in the early stages of planning for a coordinated entry system for singles. At this time, they are planning to create separate systems for families and singles.

<sup>4</sup> National Alliance to End Homelessness, *One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families*, May 25, 2011. Available online: <http://www.endhomelessness.org/content/article/detail/3974>

<sup>5</sup> Cincinnati is implementing a coordinated entry system for young adults, ages 18–24. Youth under age 18 are not included in this system. Tacoma has a small number of homeless youth/young adults. This population is included in their coordinated entry system, but it is a very small number and not something they had to plan for on a large scale. Lincoln, NE, is in the early stages of planning for a coordinated entry system for youth/young adults.

---

## Vision

We recommend that King County creates one coordinated entry and assessment system for all populations, including youth/young adults, single adults, chronically homeless, and families. We also recommend that the system begin with a focus on coordinating housing and later integrate services. The coordinated entry and assessment system for all populations should include common, consistent processes and tools for assessing and referring individuals and families seeking housing to ensure a seamless, more efficient process that aligns with the Department of Commerce's requirement that all CHG funding grantees use common screening tools. All populations should use HMIS. Prevention and diversion from entering or engaging with the system are central components of the proposed model. The key components of the recommended coordinated entry and assessment system for King County are described in more detail below.

### **Vision for a Coordinated Entry and Assessment System for King County**

**One coordinated entry and assessment system for all populations**, with population-specific adaptations as necessary

#### **Model**

Hybrid of decentralized and centralized phone intake

#### **Fiscal Agent**

King County

#### **Lead Agency**

Strong nonprofit provider

#### **Database**

Same HMIS system as the coordinated entry and assessment system for families is using

#### **Assessment Process**

1. Initial screening for prevention/diversion and eligibility
2. Comprehensive Assessment

## Model

The coordinated entry and assessment system for families in King County is unique among other communities because it is a hybrid of a decentralized (regional centers) and telephone-based centralized intake (2-1-1) model.<sup>6</sup> We recommend that the coordinated entry and assessment system for all populations continue to implement a hybrid model both to account for the large geographic reach of King County and to ensure that all populations are able to access the coordinated system through an engagement strategy that meets their needs. Initial screenings can be conducted for all populations either over the phone through 2-1-1, by population-specific outreach workers, or through regional drop-in centers. Although this increases the number of front doors, it will increase coordination through the fact that each agency conducting the initial screening will use the same screening tools; make referrals using the same criteria; and will access the same database.

## Leadership

The proposed model for King County recommends the county as the fiscal and oversight agent and a strong nonprofit provider as the lead implementer. Although in some communities, the county implements aspects of the screening and assessment process, separating fiscal and implementation activities in King County would allow the government and local nonprofits to utilize their strengths and experience. The government can use their background and expertise in administering contracts and HMIS. Providers can utilize their expertise in working with clients to conduct assessments and referrals. If the county were the fiscal and oversight agent for the coordinated entry and assessment system for all populations, it would be well positioned for the eventual integration of all services, since most of the resources

---

<sup>6</sup> Decentralized intake: Offers multiple locations from which consumers can access services or shelter. Centralized phone intake: Provides one number that consumers can call to access intake and get referrals. National Alliance to End Homelessness, "One Way In: The Advantages of Introducing System-Wide Coordinated Entry for Homeless Families", May 25, 2011. Available online: <http://www.endhomelessness.org/content/article/detail/3974>

---

for housing and services come through the county. In its role as the co-lead of the Continuum of Care with the city that reports to HUD on the community's performance against HEARTH measures, the county is in an ideal position to use the data collected through a coordinated entry and assessment system to evaluate the community's performance.

### **Lead Agency**

The lead agency will be responsible for implementing the unified coordinated entry and assessment system for all populations. This agency should have high cultural competency and a strong background in working with clients whose age, needs, and barriers to housing stability are diverse. In collaboration with funders, providers, and other stakeholders, this agency must be able to design and implement a seamless process for all clients in which there is equal access to the resources that are most appropriate for their needs. It will also be important that this agency is nimble and able to fine-tune the system as needed. This agency must be able to maintain a strong relationship with a variety of different stakeholders, including clients, providers, and funders. It must stay in close communication with providers to ensure up-to-date information on housing stock, inventory, and program eligibility requirements on all programs serving homeless populations in King County.

More specifically, the lead agency should have strengths in these areas:

### **Knowledge**

- Crisis intervention
- Existing homeless housing service providers in King County
- Strength-based assessments and services

### **Experience**

- Working with diverse populations (cultural, socio-economic, and persons with cognitive, language, and behavioral health challenges)
- Serving individuals, youth/young adults, and families experiencing and/or at risk of homelessness, including awareness of the impacts of trauma

### **Ability**

- Create a system for documenting and evaluating program effectiveness
- Partner with a variety of local housing and human service organizations, including mainstream services
- Coordinate communications with various stakeholders, including funders, housing and service agencies serving families, database staff, and 2-1-1 staff

### **Database**

We recommend that the HMIS system be adapted to include the capability to support a coordinated entry and assessment system for all populations. Currently, the families system is set up so that all demographic information from the initial screening process and the comprehensive assessments is entered directly into Safe Harbors. The assessment tools and the inventory are part of an addition called an HMIS flow-through, which is compatible with Safe Harbors. Safe Harbors could be adapted in a similar way to include assessments and inventory for all populations.

The benefits of a common and shared database are many. From a client-level perspective, it would ensure a more seamless process of matching individuals and families with the right resources, particularly those who fit into two or more homeless populations.

With a shared database, regardless of where or how an individual or family enters/engages with the system, the resources that best meet their unique needs can be identified without a lot of phone calls, and they can easily be referred to the provider with that resource, whether that provider is in the singles, youth/young adult, chronically homeless, or families system. See *Table 1* below for client profiles that could enter into and be served by multiple systems—either the singles, youth/young adult, Client Care Coordination, or families homeless systems.

A shared database would make information sharing among providers easier and more efficient. In addition, it would make a comprehensive analysis of the entire homeless system in King County possible. The system could be evaluated on several shared outcomes, including:

- Prevention and diversion efforts
- Reductions in length of stay of homeless clients in services
- Reductions in episodes of return to homelessness
- Increased employment, education, health, and wellbeing outcomes while in services/housing

**Table 1: Client Profile Examples**

Client Profile Description	Homeless Systems			
	Youth/Young Adult	Families	Client Care Coordination	Single
Former foster youth, who are pregnant and/or already a parent				
Young parents (18 – 22)				
Young parents (18 – 22), whose children are in the Child Welfare system temporarily				
Adult parents, whose children are in the Child Welfare system temporarily				
Single parents, whose children are in the Child Welfare system temporarily				
Older young adult with youth (<18) sibling				
Young adults, who meet the definition of chronically homeless				
Over 18, single male/female – connection to adult services				
Veterans, ages 18 – 22 (individuals or in families)				

---

## Assessment Process

We recommend a two-tiered screening process that involves an initial screening to identify immediate needs and to screen for prevention/diversion and general eligibility. Later, if the individual or client still needs services, a comprehensive assessment is conducted to identify needs and strengths.

### Screening

In this model, if an individual or family identifies as needing housing, a short, web-based screening is conducted. The tool screens for prevention/diversion, determines basic eligibility for housing and services, and identifies immediate needs. Eligibility for diversion or prevention activities is a key component of the initial screening process. By positioning these activities at the front door, more individuals would be diverted or prevented from entering the system without making additional phone calls and participating in additional assessments. Clients whose needs could best be served with these resources would then be referred to agencies with diversion or prevention resources. The screening tool would be the same for homeless or at-risk youth/young adults; single adults; and families, with the addition of a few population-specific questions if necessary. The Client Care Coordination system would continue to administer its assessment tools, but would upload these into the shared database.

Population-specific providers would conduct initial screenings at multiple points throughout the county where individuals seek or are engaged in services. These assessment points could include drop-in/resource centers, 2-1-1, and street outreach workers. Maintaining separate screening locations by trained personnel at these locations would allow the system to best meet the unique and distinct needs of individuals, youth/young adults, and families. Families would continue to be screened

by 2-1-1. Youth/young adults and single adults could screen into the system through 2-1-1, shelters, outreach staff, or at drop-in centers.<sup>7</sup>

### Comprehensive Assessment

If, after an initial intervention, individuals and families seek further support or cannot be diverted from the homeless system, a comprehensive assessment is conducted within a specified and agreed-upon number of days. Population-specific distinctions to the tool and the way it is administered may need to be made. For example, the Client Care Coordination assessment tools and processes would look slightly different because they identify high-utilizers through the Integrated Database and use a vulnerability assessment tool to match clients with the right resources.

A single implementing agency will be responsible for conducting comprehensive assessments and referrals for all clients. The assessors should have staff with extensive knowledge and expertise in working with all populations, including communities of color; chronic homeless individuals; immigrants and refugees; and lesbian, gay, bisexual, transgender, and queer (LGBTQ).

We recommend using a uniform assessment that focuses on individuals' and families' strengths and housing barriers. This assessment seeks to identify an individual and family's history and key needs that, if met, will help the individual or family obtain and retain permanent housing. The information from this assessment is then uploaded into the shared database to begin the process of matching individuals and families quickly to housing programs (and services, if needed) that have demonstrated success with clients who have similar presenting issues and needs. A filter and drop-down menu ensure that only those resources for which individuals and families are eligible and that meet their needs are available for referrals. Using this list, the

---

<sup>7</sup> For more information on the proposed youth/young adult coordinated engagement strategy, please see the implementation plan entitled, "Priority Action Steps to Prevent and End Youth/Young Adult Homelessness" written by Building Changes in April 2012.

case manager and the client can discuss which option would best help the client reach identified goals. Once this decision is made, the client would then be referred to the program.

### Evaluation

We recommend that King County conduct regular evaluations of the system’s performance according to both HMIS data and client surveys. This information should be used to make system improvements and to inform model and strategy development. Below are performance measures that should be tracked and evaluated:

#### Client-Level Satisfaction

- Client needs are met—clients report being matched with the right resources at the right time

- Clients (especially those who fit into multiple systems) report a seamless process of getting matched with resources

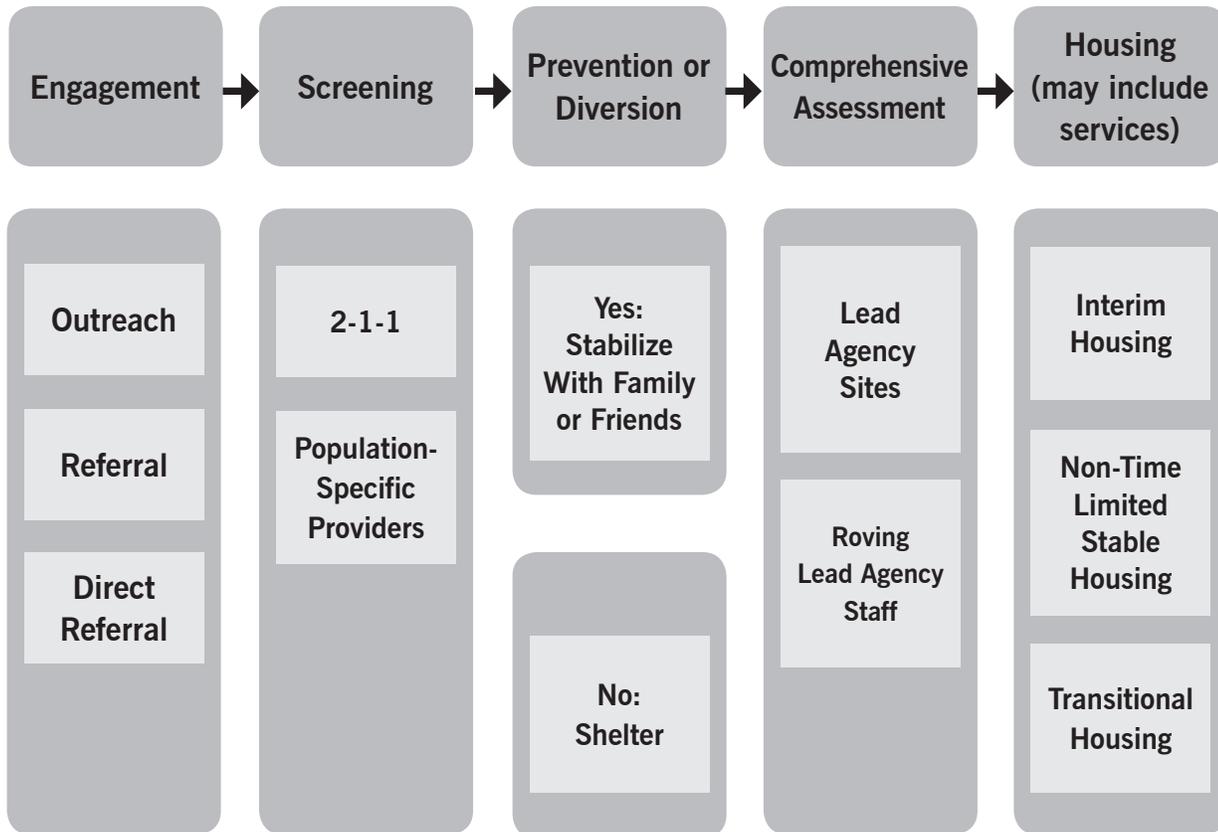
#### HEARTH Performance Measures

- Average length of stay in homelessness
- New entries into homelessness
- Repeat entries into homelessness

#### Measures Important to Improving Homeless System<sup>8</sup>

- Type of assistance consumers need
- Rate of exits into permanent housing
- Rate at which people are moving through the homeless assistance system
- People prevented/diverted from entering homelessness

### Coordinated Entry System for All Homeless Populations



<sup>8</sup> National Alliance to End Homelessness, Coordinated Entry: The Basics. Available online: <http://www.endhomelessness.org/content/article/detail/4511> (Accessed March 2012).



# Appendix—Research Summary

## List of Communities Researched and Interviewed

1. Cincinnati, Hamilton County, OH
2. Columbus, Franklin County, OH
3. Dayton, Montgomery County, OH
4. Tacoma, Pierce County, WA
5. Minneapolis, Hennepin County, MN<sup>9</sup>
6. Seattle, King County, WA

## Leadership

### Separate Fiscal Agent & Lead Agency

- Minneapolis, Hennepin County, MN
- Seattle, King County, WA
- Tacoma, Pierce County, WA

### Same Fiscal Agent, Population-Specific Lead Agencies

- Columbus, Franklin County, OH
- Dayton, Montgomery County, OH

### Same Fiscal Agent, Same Lead Agency

- Cincinnati, Hamilton County, OH

## Database

All the communities listed above use HMIS, with differences in which information is included in the database (i.e., inventory, screenings and assessments, referrals, wait list) depending on their vendor and whether or not their system is closed or open.

## Assessment Process

- All communities listed above gather multiple levels of information from clients through at least two different assessments.
- Most communities interviewed who are implementing the same coordinated entry system for multiple populations reported that their prevention and diversion activities are at the front door.

## Evaluation

All communities listed above are tracking their outcomes and measuring their performance. Early reports indicate positive outcomes. Please see the following Coordinated Entry Research Summary (pp 10–11) for a list of each community's reported outcomes.

---

<sup>9</sup> Currently in the process of designing a coordinated entry system for single adults.

# Coordinated Entry Research Summary

(A) Multiple Homeless Populations				
Coordinated Entry Components	Cincinnati, Hamilton County, OH	Columbus, Franklin County, OH	Dayton, Montgomery County, OH	Tacoma, Pierce County, WA
<b>Model: Geographically Centralized; Telephone-based Centralized Intake; Decentralized</b>	Decentralized: Telephone-based centralized intake (shelters & prevention only) and young adult outreach workers	Geographically centralized by population (YWCA Family Center for families; Hand On Central OH for single adults)	Decentralized: Enter through shelters or street outreach team	Telephone-based centralized intake
<b>Prevention/Diversion</b>	Prevention at front door during initial assessment. Plan to include diversion soon	Occurs at the front door during initial assessment	Intake goal is diversion, completed within 1st 3 days	Diversion is included in centralized intake
<b>Target Population</b>	Families, single adults, veterans, and young adults	Families and single adults	All homeless populations (DV, single adults, youth and young adults, families)	All homeless populations
<b>Initial Screening Tool</b>	Intake tool (tweaked for subpopulations)	<u>Families &amp; Singles:</u> Intake Assessment <u>Families:</u> YWCA Family Advocate confirms track & completes family goal plan	Front Door Intake: 1–3 days after entry into shelter	Yes—administered over the phone by trained assessors
<b>Entity responsible for administering screening tool</b>	Central Access Point (CAP) Staff (county staff); youth intake workers	<u>Families:</u> YWCA <u>Single Adults:</u> Hands On Central Ohio	Trained assessors—Shelter staff & street outreach staff	Associated Ministries
<b>Comprehensive Assessment Tool</b>	Each provider uses own assessment tool	Provider-level Intake Assessment Tool	<u>Front Door Comprehensive Assessment:</u> 7–14 days after entry into shelter. Housing barriers scoring tool included.	In person
<b>Entity responsible for administering comprehensive assessment</b>	Providers	Individual housing providers	Shelter staff (trained assessors)	Associated Ministries
<b>Database</b>	HMIS (Vesta)	HMIS (Bowman Service Point)—open system	HMIS—includes HEARTH outcomes. Used HMIS to create an excel spreadsheet that the County manages. Providers email her as spots open up.	HMIS (ServicePoint)
<b>Information included in database</b>	Electronic intakes; referrals & reservations; placements; inventory	Assessments; contacts tracked; resolution of the crisis; reservation process; waitlist	Open system—entry/exit; assessment; shelter transactions	Assessment; bedlists
<b>Fiscal &amp; Oversight Agency</b>	County Continuum of Care (Strategies to End Homelessness)	Community Shelter Board (CSB)	County (Montgomery County)	County (Pierce County)
<b>Lead Implementing Agency</b>	County Continuum of Care (Strategies to End Homelessness)	YWCA for families and Hands On Central Ohio for single adults	County-funded providers	Associated Ministries
<b>Evaluation Method (questionnaires)</b>	HMIS data and reports	HMIS reports	Consultant created a report that analyzed their system outcomes	HMIS reports; 3rd party evaluation
<b>Outcomes (length of stay, new entries into homelessness, repeat episodes)</b>	68% prevention & 97% do not enter shelter 12 months post exit; 35 days in shelter for families; Streamlined access to emergency shelter; higher shelter occupancy rates; cost and time savings for shelter	<u>Families:</u> Repeat stays in shelters < 10%; 21 days is average length of stay; 68% with successful housing outcomes; 26% diversion rate; using data to change system <u>Singles:</u> 25% repeat contacts; 16% diversion rate	Equal access for all populations & agencies; housed hardest to serve; housed more people than ever; system shifted to a housing focus; moved people out of shelter more quickly	Decreased vacancy rate

# Coordinated Entry Research Summary

	(B) Homeless Families	
Coordinated Entry Components	Minneapolis, Hennepin County, MN	Seattle, King County, WA
<b>Model: Geographically Centralized; Telephone-based Centralized Intake; Decentralized</b>	Geographically centralized (Hennepin County Social Services building)	Geographically centralized; telephone-based centralized intake; decentralized
<b>Prevention/Diversion</b>	Included in initial triage assessment. Use assessment info to connect to other benefits (TANF, etc.) as needed. Shelter entry is "last resort". At shelter, Rapid Exit Coordinator (REC) meets w/ family within 72 hours of entry. Assesses each family for rapid re-housing eligibility.	Not currently at the front door. Plans to include at a later date.
<b>Target Population</b>	Homeless Families	Families
<b>Initial Screening Tool</b>	Triage tool at County Social Services Building (where they last stayed, benefits, financial resources). Rapid Exit Assessment Tool at shelter.	2-1-1 Screening
<b>Entity responsible for administering <u>screening tool</u></b>	Triage tool = Shelter Team (County staff); Assessment tool (County Staff); Rapid exit tool (nonprofit provider, not shelter or county staff)	2-1-1 Staff
<b>Comprehensive Assessment Tool</b>	Assessment tool (employability, eligibility for benefits, & housing options)	In-person assessment at CCS
<b>Entity responsible for administering <u>comprehensive assessment</u></b>	County	Catholic Community Services (CCS)
<b>Database</b>	HMIS (ServicePoint) & MAXIS (Minnesota case management system)	HMIS with the addition of HMIS flow throughs
<b>Information included in database</b>	<u>HMIS</u> : Assessment information <u>MAXIS</u> : Case management information	Screening; assessment; inventory; matching; housing placement roster; eligibility requirements
<b>Fiscal &amp; Oversight Agency</b>	County (Hennepin County)	County (King)
<b>Lead Implementing Agency</b>	County & Rapid Exit Coordination agency	Catholic Community Services (CCS)
<b>Evaluation Method (questionnaires)</b>	Aren't able to pull reports and track outcomes with HMIS system. Use a different data analysis tool and method.	HMIS data and reports
<b>Outcomes (length of stay, new entries into homelessness, repeat episodes)</b>	Avg. length of stay in shelter = 35 days; 95% don't return to shelter within 12 months	To be determined (system is launching in April)

