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Coordinated Entry Systems, Assessment of Vulnerability, and Housing Prioritization for People Experiencing Homelessness

WHAT IS A COORDINATED ENTRY SYSTEM?

Organizations that provide services to people experiencing homelessness in the United States know the difficulties involved in coordinating with other agencies and stakeholders in their communities. However, providing an effective, comprehensive community response to homelessness requires cooperation, communication, and coordination. The federal Department of Housing and Urban Development (HUD) requires communities to develop “a comprehensive crisis response system in each community [with] new and innovative types of system coordination” aimed at “increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources.”¹ These crisis responsive systems are known as coordinated entry systems, or CESs, and are intended to identify the most vulnerable community members experiencing homelessness, so that they may be prioritized for housing and other supportive services. Coordinated entry is intended to allow individuals to access all necessary services through a single entry point, to develop clearer and more effective coordination of services across the community, and to more quickly match individuals with the services that they need.

Coordinated entry systems are designed to include input from service providers across the spectrum of homeless services, including physical and mental health service providers, in order to provide a full picture of the vulnerability of community members being considered for prioritization and offer a “centralized and coordinated response” to the housing crisis.² Policies and procedures for individual coordinated entry systems are generally developed by local Continuums of Care (COCs), which, according to HUD, are committees of care providers and stakeholders designed to “promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.”³

CUSTOMIZING A COORDINATED ENTRY SYSTEM

Brian Bickford is the Central Massachusetts Projects for Assistance in Transition from Homelessness (PATH) Team Leader for Eliot Community Human Services' Homeless Services in Worcester, Massachusetts. He has been working with the coordinated entry system in his community since it started and feels that the system is working very well in Worcester. "That's not the sense I get from a lot of people [in other parts of the country]," says Mr. Bickford, conscious of the challenges that many communities face in developing functional coordinated entry systems, but noting that systems can be developed that welcome feedback on what works from providers and continually refine mechanisms for integrating this feedback.

The biggest benefit Mr. Bickford has seen since the implementation of coordinated entry in Worcester is "the creation of housing opportunities that work for each individual... This matching process that we do is very individualized and creates better outcomes because we take the time to figure out what each individual's needs are and what the best available housing option is. So outcomes are pretty good." Mr. Bickford acknowledges that larger communities may have intrinsic difficulties with this level of personalization: "In a larger system, when you have the next person who's most vulnerable and the next available housing subsidy come up, they are matched, and the person is told that is their one option, regardless of whether it works well for them (and if not, they go back on the list). In my experience, not very many people that are homeless will decline an option, even if it is with an organization they have past history with or that doesn't have expertise in that person's issue, leading to the organization possibly being unable to provide the type or level of service that that person needs. This can happen in our system as well, but... [we try to make] deliberate matches based on which organization provides the most compatible services for the needs of that person." For example, a person with mental health issues could be paired with an organization that provides behavioral health services in conjunction with housing: "As a behavioral health clinician and being entrenched in the world of homelessness, I see at times organizations that are housing-focused having a lack of understanding of why there might be issues with an individual in housing that are mental health related. So they may look more at behavioral patterns that can't be tolerated in housing, rather than looking at root causes of mental health conditions," explains Mr. Bickford.

"This matching process that we do is very individualized and creates better outcomes, because we take the time to figure out what each individual's needs are and what the best available housing option is."

- BRIAN BICKFORD, CENTRAL MASSACHUSETTS PATH TEAM LEADER, ELIOT COMMUNITY HUMAN SERVICES' HOMELESS SERVICES, WORCESTER, MA

When asked what strategies have worked in the development of a functional and personalized coordinated entry system in Worcester, Mr. Bickford notes several key elements to the community's success:

1) Community size matters: "We are a midsize city. We don't have the volume of people being referred [that larger cities do]. We have around 5 to 10 people referred every two weeks, so we meet biweekly. I do recognize that our system [benefits from] being smaller and being able to really focus on people as individuals and not just as numbers." Smaller communities may benefit from processing smaller numbers of cases and being able to spend more time personalizing referrals, but may also suffer from a lack of resources in some cases.

2) Case conferencing: In Worcester, the Continuum of Care (COC) coordinated entry committee meets regularly to discuss individual cases that are being assessed for housing prioritization. Mr. Bickford notes that again, community size and resource base affects the capacity for

case conferencing practices: "There's a big difference from a really large COC that has thousands of referrals or housing subsidies, where they can't or don't do case-conferencing to talk about each case, because of the sheer volume. In large systems, some are using [assessment] tools that some [providers] don't find to be helpful. And I assume some people are not honest on these forms so that people receive a higher score..."

In my opinion, case-conferencing still factors in scores, but we can also ask specific questions about individuals and their situation because we actually talk about it [in detail at case conferencing meetings]."

3) The creation of a new assessment tool: "We have created our own assessment tool that meets all of the HUD requirements. It is similar to the Vulnerability Index—Service Prioritization Decision Assistance Tool (VI-SPDAT), which is what most people use, but I feel like [our tool] is very easy to use and has been created in such a way that... it really highlights different populations and the different vulnerabilities that we see in our own community. We've gone through something like 12 iterations in the three years that we've had this tool. Basically, anytime we have seen changes in our community or recognized a greater vulnerability or realized that we need to ask a question in a different way, we have created a different version." Suggestions for changes to the assessment tool can be brought up by any COC members at meetings, and there are sometimes small committees formed to discuss incorporating changes to the instrument.

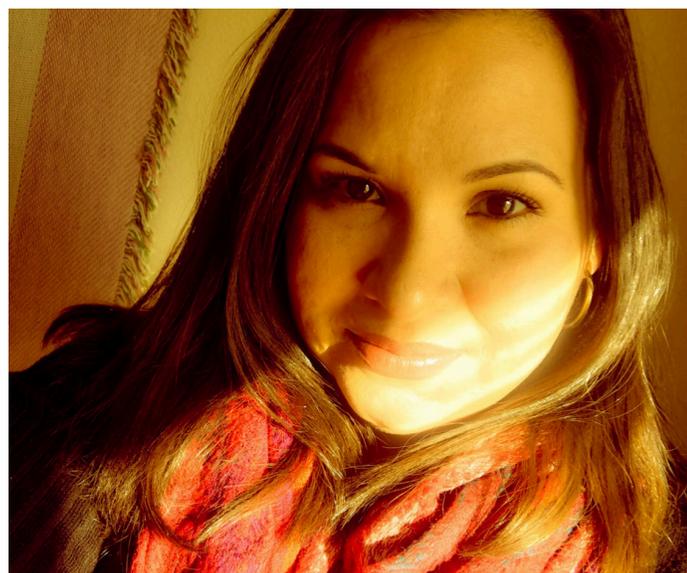
4) Use of unique identifiers to ensure confidentiality of individuals being channeled through coordinated entry:

"We do utilize unique identifiers, and I feel very strongly that confidentiality of individuals in every setting is paramount. "[In Worcester] we do not use names at all, unless we have a release of information, and that doesn't happen until after the person is matched with an organization that has housing. After the match [has been made], I go back to my client, offer the housing opportunity, get a release of information if they are interested, then present the packet to that organization. This is different than a lot of COCs, and some people have voiced that it's too much legwork. But I think people need to know how their information is being shared, and I don't feel comfortable telling my clients to sign a blanket release as a precursor to get housing... I'm always going to give my clients an opportunity to, after the match has been made, do an individual release for that organization specifically."

Successful coordinated entry systems, then, start with conversations about the specific needs of the community, develop personalized tools and procedures, and create systems for hearing and implementing feedback from stakeholders in the interest of continuous improvement.

KEY CHALLENGES OF COORDINATED ENTRY SYSTEMS

Since the implementation of federal rules around the establishment of coordinated entry systems, different communities have had very different experiences. Care providers in some communities report general success in streamlining and customizing prioritization through coordinated entry systems, while others report widespread difficulties and challenges. There is broad geographic variance in the kinds of challenges faced while developing



Christina Garcia, Director of Housing Assistance, Colorado Coalition for the Homeless, Denver, CO

these systems, which are shaped by the size of the community, the amount of available resources, the kinds of organizations and stakeholders operating in the community, and many other factors.

Christina Garcia is the Director of Housing Assistance for the Colorado Coalition for the Homeless in Denver, Colorado. Her organization is a Health Care for the Homeless (HCH) agency that also provides housing assistance and supportive services. In her role coordinating housing assistance, Ms. Garcia is involved with Denver's coordinated entry system, One Home. Since 2013, One Home has been working to develop a CES that works for all stakeholders. "In theory," says Ms. Garcia, "coordinated entry is an equitable approach to resource allocation... this would be a system that is no longer subjective about who gets housing based on who shows up to our doors, but instead identifies those who have the most need, regardless of which service provider they access first."

"Unfortunately," says Ms. Garcia, "these benefits have been obscured by many implementation challenges that have led to unnecessary barriers to services, which has resulted in insufficient numbers of people being enrolled in the program and funds going unused."

Some of the barriers to services that Ms. Garcia identifies include:

- Administrators of assessment tools are predominantly white and may not be asking questions in a culturally responsive manner.
- People are required to access a service provider or outreach worker (who may be avoiding certain areas out of implicit bias) in order to get in the queue.
- There are bureaucratic holdups in the system that do not allow for timely processing of referrals.
- Agencies with available resources for permanent supportive housing have been prevented from transferring folks seamlessly.
- Continuity of care is often frustrated by difficulties in obtaining privacy releases and sharing information between agencies, making warm hand-offs more difficult.

Ms. Garcia notes that some of these barriers to services are bureaucratic in nature, with some decision-makers "not being close to the front lines to understand the challenges and how agencies operate. We have clinical teams assessing families and individuals based on their needs, but their assessments are being overridden by policymakers not connected to the work." Ms. Garcia also explains that an important challenge in her community has been the reliance on an assessment tool called the VI-SPDAT.

ASSESSMENT AND THE VI-SPDAT

A key part of coordinated entry systems is the use of screening tools to evaluate the vulnerability of individuals. Screening tools may look at indicators like physical and behavioral health, trauma, socioeconomic status, and housing barriers. Scores on the screening tools are used to assess each person's vulnerability, and to prioritize housing for the most vulnerable people.

The Vulnerability Index—Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed by OrgCode and Community Solutions and is the most widely-used index in coordinated entry systems across the country. Researchers Catriona Wilkey, Rosie Donegan, Svetlana Yampolskaya, and Regina Cannon describe the VI-SPDAT process like this:

"The VI-SPDAT merged two existing tools—the VI as a pre-screening tool and the SPDAT as an in-depth assessment—to provide a less intensive and more accessible approach for frontline agencies. Following its administration with an individual or family, wherein the client is asked to self-report a number of risk factors, including length of homelessness, various medical conditions, substance use and mental health, and 'daily functioning,' the tool scores vulnerability on a scale of 0-17. A score of 0-3 will result in a recommendation for "no housing intervention," a score of 4-7 will result in a recommendation for Rapid Re-Housing, and a score of 8 or more will result in a recommendation for Permanent Supportive Housing/ Housing First, according to the single adult VI-SPDAT scoring summary recommendations."⁴

Ben King is a neurology epidemiologist at the University of Texas in Austin, Texas. He is a researcher who has studied the VI-SPDAT and its implications and serves on the National Health Care for the Homeless Council (NHCHC)'s Research Committee. According to Dr. King's research on assessment protocols used in coordinated entry systems, there are several main concerns with the VI-SPDAT: "It is the most popular and widely-used prioritization scheme," he explains, "but it was never intended to be the sole one. It was developed as a pre-screening triage tool, but most communities are using it on its own." Dr. King also notes that methodologically, the VI-SPDAT was never validated to be used as many communities are using it and that, in general the measure is under-evaluated.

Dr. King's qualitative interviews revealed that providers are concerned that the VI-SPDAT does not account for the severity of difficulties people are experiencing. "Index is a term used for something that sums up a number of issues or totals a score based off of counts (as opposed to scales, rankings, etc.)," explains Dr. King, "so it is based on the number of problems someone has: you have 17 problems I'm worried about, you have 15 problems, you have eight

problems. So it counts the number of problems but doesn't acknowledge the severity of any of those issues." As an example, Dr. King recounts an experience with a clinician who told him about a client that had stage IV cancer but only scored a seven on the VI-SPDAT, which would not qualify her for housing prioritization in the coordinated entry system: "The clinician thought this was the most medically vulnerable person she had seen in months, but they scored low on items that asked about mental health and substance abuse and there was no social victimization, etc."

Moreover, research suggests that social inequities may be reinforced in the usage of the VI-SPDAT. In 2019, a study was published to provide a data-driven look at racial disparities in coordinated entry systems and their relationship to use of the VI-SPDAT as an assessment tool. The study found that:

- "On average, Black, Indigenous, and People of Color (BIPOC) clients receive statistically significantly lower prioritization scores on the VI-SPDAT than their White counterparts;
- "According to VI-SPDAT data White individuals are prioritized for Permanent Supportive Housing (PSH) intervention at a higher rate than BIPOC individuals, though this is not true for families;
- "Race is a predictor of receiving a high score (i.e.,



Dr. Ben King, University of Texas, Austin, TX

an assessment for Permanent Supportive Housing/ Housing First), where being white was a protective factor for single adults;

- "VI-SPDAT subscales do not equitably capture vulnerabilities for BIPOC compared to Whites: race is a predictor of 11 [out of the] 16 subscales, and most subscales are tilted towards capturing vulnerabilities that Whites are more likely to endorse."⁵

There are several running theories, according to Dr. King, to explain why these racial disparities are so pronounced in VI-SPDAT assessment and referral practices. One possibility is that the survey is not cross-culturally competent, representing a psychometric problem with the index. Another possibility is that interviewer bias (both conscious and unconscious) leads to data collection problems and misrepresentation of people belonging to groups that face broader social discrimination. There may also be problems with the usage of self-report in assessments, possibly related to health literacy, where individuals under-report medical problems due to shame, lack of knowledge, or social desirability.

Ms. Garcia echoes these concerns with the VI-SPDAT from a provider's perspective, describing clients with acute conditions that have low VI scores and do not qualify for services. "I'm also not seeing certain marginalized populations coming through with this system," she says, "and there is a lack of training around how to engage people and ask the questions in a way that gets accurate responses." She also notes that the VI-SPDAT is a rigid assessment tool that "doesn't have the flexibility to allocate resources to targeted populations (like camp populations)," decreasing the team's ability to look at other factors that might influence placement. One population that can be impacted by reliance on the VI-SPDAT is families, since the assessment does not factor in issues like the age of the youngest child or other factors that are important for developing a holistic view of the family's needs.

As Dr. King notes, "it's problematic when you have a scale that is so complex that the model can differ between demographics. The model of vulnerability looks different for men and women, whites and non-whites, Hispanics, and non-Hispanics. There are different models and patterns of vulnerability, and it's alarming to see the between-group differences in models that shouldn't be comparing scores between those groups at all. We have to fix that." Still, he emphasizes that although the VI-SPDAT is a psychometrically-imperfect tool, it is currently part of "an incredibly important process... Instead of throwing the baby out with the bathwater, we can work on fixing the process... work on responses to address these issues and re-define some of the more dynamic elements that we can include in coordinated entry."

Tips for Developing Customized Vulnerability Assessment Tools (from Ben King):

- » Take plenty of time and get it right.
- » Stakeholder and larger community meetings should be used to gather wide input in what constructs the community wishes to prioritize. Opinions will differ, and this will be a difficult conversation, but if consensus can be reached, it will eventually lead to greater buy-in from the community.
- » The prioritization method should probably be kept as simple as possible. Going with broadly-defined or inclusive constructs like "vulnerability" and prioritizing everything has been shown to create issues.
- » If an objective measure related to your prioritization method of interest can be identified, this would alleviate the influence of self-report biases (in either direction).
- » If possible, use an already-existing measure that has been previously tested and validated, with peer-reviewed evidence behind it, to capture the construct your community wants to prioritize.
- » Regardless of whether you use a new or old measure, these should be tested extensively with pilot studies of reliability, validity, and cross-cultural sensitivity in your own community to confirm performance. There are researchers and survey developers who can be enlisted to help with this type of work.
- » Watch for forthcoming resources at NHCHC conferences about the steps involved in developing new, community-specific prioritization tools.

BEST PRACTICES FOR CLINICIANS

Brooks Ann McKinney is the Director of Vulnerable Populations for the Cone Health System in Greensboro, North Carolina, a hospital system with five hospitals and a number of clinics and outpatient services. She is currently working on medical respite care and supporting development of a new permanent supportive housing project. Her community is implementing a FUSE model (Frequent User System Engagement) and setting up meetings once a month to discuss cases. The FUSE model targets individuals who are high utilizers of existing services, including emergency rooms, for housing prioritization. FUSE "can be combined with coordinated

entry," explains Ms. McKinney, "because advocacy for housing can save costs for the community... It closes the revolving door to institutional care like the hospital and jail."

One of the risks of targeting high utilizers for prioritization, as many providers are aware, is the risk of simplifying people into dollar signs, overemphasizing communities' economic interests, and underemphasizing the human cost of homelessness. Ms. McKinney is conscious of these risks, explaining, "I don't discuss costs when I'm trying to convince somebody, because it's important that every individual gets housing. But it's the same with the VI-SPDAT; it's like putting a number on people and only helping with housing if they have a high enough number. So the humanity can sort of get lost in the process. This has to be resolved by community engagement and conversations, rather than by the systems themselves. If you had adequate housing on the front end, then you wouldn't have to prioritize people. But since you do, coordinated entry is a way of grappling with that."

As is the case in many other communities, Ms. McKinney's community experiences difficulty with chronic funding issues and unrealistic expectations; she explains: "Every community I know seems to be having some tense issues with coordinated entry because there are too many agencies, and when you have private dollar agencies and COC agencies trying to work together, it's difficult... Agencies not receiving [federal] dollars feel they don't have to do all the recommendations of the COC. Also, faith-based organizations may not believe in harm reduction and low-barrier shelter, so this creates another layer of problems when there are different rules and criteria at different shelters. I try to mediate these discussions as an employee

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- BROOKS ANN MCKINNEY, DIRECTOR OF VULNERABLE POPULATIONS, CONE HEALTH SYSTEM, GREENSBORO, NC

of the hospital system... I try to bring people together to advocate for the most vulnerable (including medically fragile people who need low barrier entry into shelters)."

A nuanced understanding of the community-level challenges of coordinated entry—including funding, inter-agency communication and coordination, caseload, etc.—is an important starting point for clinicians who want to more effectively engage with and help reform their own coordinated entry systems. Clinicians can begin by listening and paying close attention to the community-level factors that shape the coordinated entry landscape in which they are operating.

Erin Willis is the Coordinator for the coordinated entry system All Doors Open, through 2-1-1 of Eastern Oklahoma, which was started in 2017 when HUD began providing funding, and fully launched by April 2018. The system uses a referral system called Unite Us, designed to "provide holistic referrals to support other needs in addition to housing, and to connect people for all their needs." Ms. Willis explains that after coming from direct services into her current coordinating role, "we are still

transitioning from the old way to a new coordinated entry model, and it has been challenging. We are working to find policies and procedures that flow well and don't overlook too many populations, but we are having a hard time finding things that work well for everyone. There are hard conversations to be had about prioritization and access."

But these conversations, asserts Ms. Willis, are integral to the continued development of coordinated entry systems that fulfill the promise of the model, and are made stronger by the participation of care providers across the homeless services community.

This issue of *Healing Hands* has looked at elements of coordinated entry that are key to a system's success, including the development of sound assessment tools, case conferencing mechanisms,



"A Bed to Myself" by Mike, PhotoVoice Digital Exhibit, Heritage Health, Coeur d'Alene, ID

and systems for confidentiality. A few other lessons learned by participants in coordinated entry systems include:

- **Consider the need for flexibility in coordinated entry systems.** Ms. Garcia explains that the rigidity of her community's system has made it difficult to make the system work for everybody. She would like to see the system change toward "allowing some flexibility—[for example], if there's a delay, opening up and serving other families who would score within that range and qualify for assistance otherwise. Allowing for the system to fit the needs of people rather than requiring people to fit the needs of the system."
- **Prioritize inter-agency communication across differences.** "We need organizations to come together," says Ms. McKinney, "and all understand that they have different funding streams and different restrictions, but that it is important to collaborate through these differences in order to accommodate all the needs." This includes communication between agencies providing health care and agencies providing other services. She notes: "COCs should be working with federally-qualified health centers (FQHCs) and health services in communities, since so many people are medically fragile... [This collaboration between health and housing] is essential if we want to really take care of people."
- **Develop a sense of shared ownership by being open to feedback.** "What's been really helpful for our community," says Ms. Willis, "is using partners to inform the system design. That way, it's making sure that the community has shared ownership over the improvements... Often, the work is landing on frontline staff at partner organizations. So it's really important that they are central to the system design." She also notes that her community is working on developing more robust feedback mechanisms by building out satisfaction surveys to collect information from providers and clients about how the system is working for them.
- **Don't be afraid to get creative.** Ms. Willis's coordinated entry system is interested in developing a number of new initiatives to enhance their "no wrong door" model, including the establishment of "a community hub—a central, easily-accessed walk-in or dial-in location where people can come, get assessed, and get triaged." They are also exploring ways to work more effectively with domestic violence service providers, seeking to make sure people leaving dangerous situations have seamless and confidential access to services. Creative thinking is key, she says, as well as collaboration with partners who have the clearest understanding of the challenges faced by the specific populations they serve.

CONCLUSION

It is important to know that coordinated entry is "a living thing," says Ms. Willis. "There is always room to improve and



modify and make adjustments where needed. But to do that and have data that supports that, we have to dive in, give it a shot, be flexible, and learn and grow. The intention behind coordinated entry is completely necessary in all communities, but it takes a while to find the flow or process that works best. Don't give up, don't walk away, provide feedback." By continuously integrating feedback, communities can work toward developing robust, coordinated entry systems that are able to meet their aim of better responding to the complex needs of vulnerable people experiencing homelessness.

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Appendix: Example of a Vulnerability Assessment Formula (from Catherine Crosland):

OPH Main: Composite score is the first prioritization and is made up of the following items:

[SCORE Age]

- i. 1 point for clients age 50-59
- ii. 2 points for clients age 60+

[SCORE Children]

- i. 2 points if any number of children under 5
- OR
- ii. 1 point if any number of minor children

[SCORE LoT] *LoT is a sum of months on list and the most recent answer to total number of months experiencing homelessness (FYI: this may be duplicating months homeless if that question is being updated at interim review)

- i. 1 point for each month homeless rounded to two decimal places for partial months
- OR
- ii. 12 points if LoT homeless greater than 12 months
- AND
- iii. Total LoT divided by 12 with a max of 10 additional points

[SCORE DV]

- i. 2 points if Hoh is a DV victim/survivor and is currently fleeing

[SCORE Service FUSE]

- i. 1 point if family total of emergency services accessed in last 6 months is 5+

[SCORE Police FUSE]

- i. 1 point if family total number of arrests/incarcerations/police run-ins is 3+

[SCORE QOL Aggregate] The QOL score is based on the scoring criteria attached.

- i. 4 points if QOL score is 1 or more standard deviations below the mean
- ii. 2 points if QOL score is less than the mean, but not 1 standard deviation below
- iii. 1 point if the QOL is less than 1 standard deviation above the mean

Cumulative LoT is the second prioritization after the composite score

LoT is a sum of months on list and the most recent answer to total number of months experiencing homelessness (FYI: this may be duplicating months homeless if that question is being updated at interim review)

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