Coordinated Entry Protocol

for Suburban Cook County

2016 Edition

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1.   Overview of Coordinated Entry

The Alliance to End Homelessness in Suburban Cook County is developing and launching a new coordinated entry system in 2016. Coordinated entry is a community-wide system that standardizes and expedites the process by which people experiencing homelessness or who are at imminent risk of homelessness access shelter, housing, and homeless resources.

Coordinated entry will help suburban Cook County better target the limited resources provided by the homeless assistance system to people who are experiencing homelessness and need them the most. By standardizing the intake process across the region, by sharing information in real-time, and by adopting uniform prioritization policies, homeless service agencies will be able to refer people to the right program based on their preferences and level of need.

The coordinated entry planning committee adopted the following four goals for the system:
1. The coordinated entry system will match participants to resources based on their preferences and needs within the capacity of the available community resources.
2. The coordinated entry system will improve access to all homeless-specific resources, particularly rapid re-housing, homelessness prevention, and permanent supportive housing.
3. The coordinated entry system will promote low-barrier and Housing First principles in all programs that work with people experiencing homelessness or who are at imminent risk of homelessness.
4. The coordinated entry system will meet HUD's requirements and will be responsive to the needs of the community.

The coordinated entry system in suburban Cook County is designed to be comprehensive and accessible to everyone in the region who experiences a housing crisis. In compliance with HUD's requirements, all programs funded by the Continuum of Care (CoC) and the Emergency Solutions Grant are required to participate in coordinated entry. Over time, other housing programs will be invited to participate in coordinated entry, and the system will be open to all programs regardless of funding source.

A nonprofit partner agency or a consortium of nonprofit partner agencies will administer the coordinated entry system in suburban Cook County. The purpose of this Coordinated Entry Protocol is to outline the components, processes, and expectations of the coordinated entry system, the lead agency/agencies, and all the participating agencies.

2.   Access Points

One of the primary goals of suburban Cook County's coordinated entry system is for the system to be easily accessible and welcoming to the wide range of people who may experience a housing crisis in our region. Therefore, the coordinated entry lead agency will be expected to develop and staff multiple types of access points for people experiencing or at imminent risk of homelessness. The intake and referral process will be consistent across all access points, so that participants receive the same care regardless of which access point they use to enter the system.

Phone
Coordinated entry is a welcome opportunity to improve upon the current Virtual Call Center (VCC), the current system by which participants access homelessness prevention resources. The phone access point in the new coordinated entry system will have expanded hours beyond the current VCC, including nights, with priority given to times when the walk-in centers are closed in order to expand accessibility. Features of the phone access point should include, but are not limited to:
- All calls to be answered live during open hours.
- During closed hours, a recorded message instructing callers to call back later, rather than the option to leave a voice mail which may overload staff capacity.
- A contracted translation service in order to serve people who speak languages other than English.
- A procedure for efficiently handling repeat callers.
- Ideally, the ability to do three-way calling in order to complete a warm hand-off to a referring agency.

The coordinated entry lead agency and oversight committee (described in Section 8) should review call volume data on a regular basis to shift staffing and operating hours to peak call times.

Walk-In
The coordinated entry system will include multiple sites where participants can walk in and meet with an intake professional in person. Maintaining the human touch, especially in times of crisis, is an important part of our community's values. The locations and hours of the walk-in centers will be determined by the coordinated entry lead agency and approved by the oversight committee. Ideally, the walk-in centers will provide some evening hours and weekend availability in order to be fully responsive to the needs of the community. The walk-in centers should also take into account the needs of the entire geographic area and proximity to public transportation, where available. Walk-in centers may be housed within homeless service agencies or other providers of safety net services.

Web

The coordinated entry system will also have a public website that provides information about accessing the in-person and phone access points. In the nascent stages of coordinated entry, it is expected that the website will be static and provide contact information only. As the system matures, it may be possible to have a more interactive public site that conducts assessments and provides referrals electronically. The coordinated entry system will feature an online resource database available to the Alliance, the lead agency, and homeless service providers that shares information about real-time availability of housing resources (see Section 3: Resource Database).

Other Access Points and Resource Availability

In addition to the access points run by the lead agency detailed above, the coordinated entry system will also rely on the services provided by emergency shelters and street outreach providers. Individuals and families who present at emergency shelters or who are found via street outreach will access the coordinated entry system through these access points. These access points will be managed by existing providers, not the coordinated entry lead agency, and will be assessed for services and housing through a parallel path. Please see the coordinated entry diagram (Appendix) and Section 4: Assessment and Referral Processes (page 5) for more detail.

It is important to note that the coordinated entry system will only be able to offer those resources that are currently available within the homeless service system, and that the current supply of resources does not match demand. Therefore, not all those who present at a coordinated entry access point will be eligible for or will receive assistance. The goal of coordinated entry is to better target the limited resources available to those who need it most.

3.   Resource Database

In addition to the public website, the coordinated entry system will utilize the Homeless Management Information System (HMIS) to provide agencies with information about available community resources. The resource database will initially only be available to HMIS users and should be used to enhance the case management services provided by housing agencies.

The following resources should be included in the database, and updated at least biannually:

- Coordinated entry access points
- Emergency shelter
- Free medical providers
- Food pantries
- Crisis lines
- Resources for specific subpopulations (youth, survivors of domestic violence, Veterans, etc.)

Some online resource databases already exist in the region, so the lead agency will want to coordinate efforts in order not to duplicate work.

4.   Assessment and Referral Processes

The coordinated entry system in suburban Cook County will utilize a phased assessment approach so as to assess individuals and families over time and only as necessary. The goal of the phased assessment process is to gather and share, with appropriate consent, only as much information as necessary to make a successful referral.

Pre-Screen Tool
Participants who present at the walk-in centers or call the hotline will be assessed using a brief pre-screen tool. The pre-screen tool is designed as a decision tree that helps identify the participant's immediate needs: emergency shelter, homelessness prevention resources, diversion and stabilization services (described in Section 5), or referral to specialized services (e.g., Veterans). The coordinated entry intake worker will conduct a brief 5-10 minute conversation with the participant in order to complete the tool and to determine what the appropriate referral should be.

Determining Eligibility for Short-Term Resources
After completing the pre-screen tool, participants will be assigned to a diversion and stabilization services, shelter, or homelessness prevention track. Once a participant is recommended for homelessness prevention resources or emergency shelter, the intake worker will complete a short eligibility questionnaire with the participant. Only if the participant meets the eligibility requirements for the program will he or she be referred. If the participant is deemed ineligible, the intake worker will provide other options to the participant, including offering a stabilization service appointment when appropriate.   If the participant is eligible for homelessness prevention resources but no resources are available at that time, he or she will also be offered a stabilization service appointment.   Whenever

possible, stabilization service appointments will immediately follow the completion of the pre-screen tool.

VI-SPDAT
The VI-SPDAT is an additional assessment tool that will be used by the coordinated entry system to prioritize participants based on vulnerability factors and determine what housing intervention best fits the participant's needs. All persons must sign a VI-SPDAT consent form before the VI-SPDAT is completed. Those who are already in emergency shelter or engaged with street outreach do not also need to complete a pre-screen. They will be directed to the VI-SPDAT when appropriate. For adult-only households, the VI-SPDAT will be completed when the household has been homeless for seven (7) days or more; for families with children and for transition-age youth, the VI-SPDAT will be completed at the point of literal homelessness. The coordinated entry oversight committee will review this policy annually and update if necessary.

Determining Eligibility for Housing Interventions
It is important to remember that the coordinated entry system is striving to be low-barrier and to uphold Housing First principles. Therefore, in gathering eligibility criteria from providers and in determining eligibility for participants, the coordinated entry system will make every effort to screen participants "in" to services, rather than screen participants "out." The community is looking to all participating providers to embrace these same principles.

Housing Intervention Referral Process
A quick and successful referral process will be one of the key measures of success of the new coordinated entry system. The referral process will be guided by a combination of participant preference, project eligibility, and program availability. Referrals to housing providers with vacancies should be as seamless as possible, and supportive of the needs and preferences of participants.

Once eligibility is determined, the participant will be offered the housing interventions that are available at that time, and the referral will be made based on the participant's preference. Generally, the process of receiving programs locating the participant should require not more than a few days. Receiving programs should take no more than two weeks (14 days) to locate the participant and begin the housing placement process. If the receiving program is having trouble locating a participant, the agency will work with regional street outreach teams and housing navigators to assist in their search.

While the coordinated entry system will rely on HMIS, it will also be important for the lead agency to employ a referral coordinator to oversee the referral process. The referral coordinator adds the human element to the process and will be able to troubleshoot any issues that arise. This position will also ensure compliance with the referral process and be able to make key program decisions based on available data.

Since coordinated entry is a new process for suburban Cook County, the system will need to remain flexible for the rare circumstances that referrals are unsuccessful. Receiving programs will have the opportunity to return referrals to the coordinated entry lead agency only when the eligibility screening was not accurate, the agency cannot locate the participant, or the participant declines admission to the program. In extremely rare cases, receiving programs can appeal referrals to the coordinated entry oversight committee if the participant does not seem to be a good fit for the program. The receiving program must provide clear evidence on their reason for declining admission. The oversight committee will adjudicate appealed referrals on a case-by-case basis.

Prioritization for Housing Interventions
As stated above, the current supply of homeless assistance resources does not match demand. For several years now, the system of care in suburban Cook County has used a participant's level of vulnerability to target limited resources to those who need them most. The coordinated entry system will continue using this prioritization mechanism to allocate housing interventions.

The Alliance manages a central, by-name vulnerability list for the region, maintained within HMIS. Participants are placed on the by-name list after their VI-SPDAT is completed. The list is prioritized by vulnerability factors, and subpopulations are ranked by different factors as outlined in the table below.

Vulnerability Factors Used to Prioritize for Housing Interventions		
Single Adults	**Families**	**Youth**
• VI-SPDAT score • Chronic Status • Length of time homeless • Age • Tri-morbidity	• Family VI-SPDAT score • Number of previous homeless episodes • Head of household with disabling condition • Dependent with disabling condition that prevents head of household from working	• Transitional Age Youth VI-SPDAT score • Length of time homeless • Lack of access to family and/or community supports

The individual or family who is most vulnerable will be at the top of the list and will be prioritized for housing openings as they become available. Permanent supportive housing

programs will receive up to three referrals at a time per open slot in order to increase the likelihood that an eligible participant will be located and housed quickly. Care will be taken to ensure that no participants are taken off the list until they are housed or deemed "inactive," which means 3-6 months of no contact with an outreach provider.

Housing navigators meet monthly with Alliance staff to oversee progress on housing placements for participants on the by-name list who are the most vulnerable. This process has successfully housed hundreds of vulnerable people over the past few years and will continue under the coordinated entry system.

5.   Diversion and Stabilization Services

Short-term stabilization services are defined as short-term, solutions-focused, non-financial assistance. The goal of the stabilization service is to help participants solve problems, navigate systems of care, and get connected to alternative resources as quickly as possible. Stabilization services are designed to be a short-term intervention and complement existing services in the community.

Diversion—an example of stabilization services—is a strategy being used by high-performing communities to help people seeking shelter avoid homelessness altogether. By helping individuals and families identify alternative housing arrangements and connecting them with mainstream and community resources, some people may be able to maintain their housing and prevent homelessness altogether.

The stabilization service staff will be employed by implementing agencies, and their services will be offered, after the pre-screen tool is completed, to the following populations seeking help:

- **Participants who are not literally homeless, but who are living in an unstable housing situation and need support to stabilize their situation so they do not need to utilize emergency shelters.** For example, if a participant is staying with family and the family is asking him to leave, services could include helping the participant find an alternative living situation or mediating between the participant and host family to find a short-term solution.

- **Participants who are eligible for homelessness prevention financial assistance, but for whom no resources are currently available, or for participants who are ineligible for homelessness prevention.** These

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participants need very light touch services to troubleshoot their crisis so they do not become homeless. One example is a participant who is behind in her rent but who has income. She may need assistance with budgeting and negotiating with her landlord to develop a repayment plan.

- **Participants who score into the "self-resolve" categories of the VI-SPDAT.** These participants are literally homeless, but have scored low enough on the vulnerability assessment not to be eligible for long-term housing assistance. Participants in this category will be offered emergency shelter and short-term stabilization services. These participants may already be engaged in case management services through emergency shelter or other programs; the coordinated entry system can offer a stabilization service appointment in addition to or in the absence of other case management options.

The target is for participants to work with their stabilization service provider by attending 1 to 3 sessions, either in person or on the phone, within a 30 day period. Stabilization services can address a wide variety of issues that best meets the participant's needs. Options include, but are not limited to: budgeting; landlord mediation; family mediation; applying for mainstream benefits; identifying community financial resources to resolve the crisis; and linkage with affordable housing, employment, or health care resources.

This new service option will expand the number of participants who receive at least a light touch from the homeless service system, and will greatly reduce the number of times the system will be forced to turn participants away with no resources whatsoever.

6.   Special Populations

As stated above, the coordinated entry system will be comprehensive and accessible to all. However, special populations may have unique needs that the coordinated entry system will need to be designed to address.

Youth
Youth experiencing homelessness require developmentally appropriate outreach and services in order to successfully interact with the coordinated entry system. The lead agency should consider how access points will be youth-friendly to both minors (under 18 years of age) and transition-age youth (18 to 24 years old). Youth are more likely to take

advantage of access points that are open in the evenings and on weekends, and they may also be more comfortable accessing services via text, phone apps, or social media.

Survivors of Domestic Violence

Confidentiality and safety are of utmost concern to survivors of domestic violence. Before the pre-screen tool is completed, all participants who come to walk-in centers or call the phone line will be asked if they are attempting to flee domestic violence or experiencing intimate partner violence. If yes, none of the participant's information will be entered into HMIS, and referrals will immediately be made to domestic violence-specific resources. Participants in domestic violence programs will be able to complete the VI-SPDAT and become eligible to receive RRH and/or PSH through the coordinated entry system. Whether participants choose to access domestic violence-specific or general homeless assistance resources, they must be able to choose whether their personal information is locked down. In addition, the by-name list should use a different identification number than the HMIS identification number for survivors of domestic violence.

Veterans

The pre-screen tool will identify if a participant seeking assistance is a Veteran. Veterans will be offered Veteran-specific resources or general homeless assistance. If a Veteran chooses to be connected to Veteran-specific resources, he or she will be quickly referred to the Hines VA or a Supportive Services for Veteran Families (SSVF) provider. The VA is a long-time and effective partner of the Continuum of Care and has a wide variety of housing and health care resources available to Veterans experiencing homelessness. If a Veteran chooses not to be referred to the VA or a SSVF provider, he or she will be served by CoC resources. Veteran participants in Veteran-specific transitional housing programs will be able to complete the VI-SPDAT and become eligible to receive housing assistance through the coordinated entry system.

7. Staffing

The coordinated entry system will require a talented and dedicated staff of direct service and program management professionals in order to be successful. While the exact staffing pattern and division of responsibilities will be designed by the coordinated entry lead agency, the following staff responsibilities should be included:

Direct Service Staff Responsibilities

- **Intake (Phone):** First point of contact at the call center. Responsible for entering all data into HMIS, conducting pre-screen assessments, and making referrals to homelessness prevention, housing interventions, stabilization services, or other mainstream and community resources.
- **Intake (Walk-In):** First point of contact at the coordinated entry walk-in center. Responsible for entering all data into HMIS, conducting pre-screen assessments, and making referrals to homelessness prevention, housing interventions, stabilization services, or other mainstream and community resources.
- **Stabilization Services:** Responsible for providing short-term, solutions-focused crisis intervention and resource advocacy to participants who are not eligible for homeless system resources or for whom no resources are currently available.
- **Street Outreach:** Responsible for outreaching to locations where people experiencing homelessness spend their nights (overpasses, parks, bus stations, etc.) Outreach staff will serve as an additional access point to coordinated entry for those who may not call the phone line or visit a walk-in center.

Program Management Staff Responsibilities
- **Project Management:** Responsible for the successful implementation of coordinated entry, including all access points and the referral process. Provides leadership to staff, operational support, and appropriately engages with community stakeholders. Actively participates in the coordinated entry governance structure.
- **Due Process:** Responsible for developing and maintaining a process to receive and respond to grievances of participants and providers. Grievances that cannot be resolved by the coordinated entry lead agency and all provider appealed referrals will be forwarded to the oversight committee for resolution.
- **Outcome Measurement:** Oversees data entry, tracks system progress as defined by the coordinated entry performance metrics, and runs performance reports and shares them with community stakeholders.
- **Partner Coordination:** Responsible for facilitating homeless service providers' participation in coordinated entry to ensure full participation, communication, and coordination. Identifies additional organizations that can receive referrals from coordinated entry for non-homeless assistance services and works with them to ensure quality and appropriate referrals from the coordinated entry system.
- **Referral Coordination:** Facilitates the housing referral process and ensures that the referral process is smooth and successful for both participants and receiving agencies.

8.   Oversight and Governance

The coordinated entry lead agency will be responsible for day-to-day implementation and evaluation of the coordinated entry system. In addition, a coordinated entry oversight committee made up of Alliance staff, representatives from nonprofit partner agencies, and community representatives will provide governance and oversight of the system. Participation in the oversight committee is open to all interested community partners. The oversight committee will have two co-chairs elected annually by the committee; co-chairs may not work for or be affiliated with the coordinated entry lead agency.

The oversight committee is responsible for:
- Providing general oversight and support to the coordinated entry system.
- Receiving, investigating, and resolving grievances from participants and providers that cannot be resolved by the coordinated entry lead agency.
- Adjudicating appealed referrals from housing programs.
- Evaluating the efficiency and effectiveness of the coordinated entry process by reviewing performance data on a regular basis.
- Conducting an annual review of the Coordinated Entry Protocol.
- Recommending policy changes or protocol improvements to the Continuum of Care Board of Directors for final approval.
- Regularly providing updates to the Continuum of Care and community partners to ensure the transparency of the coordinated entry system.

9.   Evaluation

In order to ensure that the system is meeting the community's goals and operating at maximum efficiency, coordinated entry will be regularly evaluated according to the following performance metrics, adopted by the oversight committee in February 2016:

- **System Capacity**: These outcomes will measure participant entries and exits, program occupancy rates, and system outputs in order to capture how efficiently the coordinated entry system is running and to compare system capacity to level of system demand.

- **System Performance**: These outcomes will measure how well the coordinated entry system is meeting the CoC's expectations as outlined in this protocol, as well as HUD system performance measures such as decreasing overall homelessness,

length of homelessness, and repeats of homelessness. Where possible, performance data will be used to compare system performance pre-coordinated entry and post-coordinated entry—and over the time of implementation—in order to document system improvements. For example, one metric might be to measure the length of time from a participant requesting help to being housed.

- **Characteristics of Persons Seeking Services:** These metrics will keep a careful watch on the types of persons seeking services, which entry point they use and when, and how long they receive services. The system will regularly evaluate this data to ensure that participant needs are being served to the best of the community's ability, the system is as responsive as it can be, and bottlenecks are resolved as quickly as possible.

Evaluation mechanisms will be built into system operations and will include:
- Monthly review of performance metrics prepared by the lead agency and reviewed by the oversight committee.
- Quarterly performance reports, prepared by the lead agency, reviewed by the oversight committee, and provided to the Continuum of Care Board of Directors.
- Regular participant satisfaction feedback, either through surveys, focus groups, or other best practices.

The coordinated entry lead agency, oversight committee, and CoC Board will use the opportunity of regular system evaluation to change procedures as necessary and better meet the needs of participants and the community.

10. Glossary of Terms

Continuum of Care (CoC): a community planning body, as required by the U.S. Department of Housing and Urban Development, to organize and deliver housing and services for a specific geographic region; develop a long-term strategic plan for preventing and ending homelessness; and to apply for federal resources.

Emergency Solutions Grant (ESG): a program of the U.S. Department of Housing and Urban Development to provide emergency shelter to homeless individuals and families living on the street; rapidly re-house homeless individuals and families; and prevent individuals and families from becoming homeless.

Homeless Management Information System (HMIS): Computerized data collection system designed to capture client-level information on characteristics and services needs; and help communities identify service gaps, improve performance, and plan for emerging needs.

Homelessness Prevention (HP): Short-term financial assistance and stabilization services to prevent shelter entrance and promote housing retention.

Housing First: Rather than moving homeless individuals and families through different "levels" of housing until they are "housing ready," this evidence-based best practice moves households immediately from the streets or emergency shelter into their own housing with wraparound services.

Rapid Re-Housing (RRH): Short-term housing subsidy and strategic case management provided to persons who are homeless in order to reduce the length of time households spend homeless and increase the rate at which households are placed into permanent housing.

Permanent Supportive Housing (PSH): Long-term rental assistance with supportive services. Majority of programs serve people with disabilities or people experiencing chronic homelessness, but requirements vary by subsidy source.

Supportive Services for Veteran Families (SSVF): a program of the U.S. Department of Veterans Affairs to provide supportive services to very low-income Veteran families living in or transitioning to permanent housing.

Virtual Call Center (VCC): A rotating, volunteer-run call center with limited hours serving as the current access point for homelessness prevention resources in suburban Cook County.

VI-SPDAT: An evidence-based assessment tool that combines the Vulnerability Index (VI) to determine the chronicity and medical vulnerability of homeless individuals, and the Service Prioritization Decision Assistance Tool (SPDAT) to help service providers allocate resources in a logical, targeted way.

11. Appendix: Coordinated Entry Diagram

Suburban Cook County Coordinated Intake Diagram

Edited 02/22/2016