



JUNE 2021

## LESSONS IN FAMILY HOMELESSNESS

*Making homeless systems more equitable and effective*



**BUILDING  
CHANGES**



### Topic: **Coordinated Entry**

#### Lessons in Family Homelessness

*Three guiding principles to improve Coordinated Entry for families:*

1. **Identify and eliminate biased Coordinated Entry tools and processes.**
2. **Expand access points to Coordinated Entry to reach as many families as possible.**
3. **Maintain contact with high-priority families after their Coordinated Entry assessment and offer tailored support to assist their transition to housing.**

**Coordinated Entry** is intended to provide equitable access to housing resources for people experiencing homelessness, with distribution of those resources based on an objective assessment of a household's level of vulnerability. Unfortunately, Coordinated Entry has fallen short of those ideals. Homeless systems are wise to **engage in continuous improvement** to make Coordinated Entry more faithful to its original intent.

Through the Family Homelessness Initiative (FHI), Building Changes learned that when homeless systems implement standardized practices and processes—even when done in pursuit of fairness—racial and ethnic inequities often result. That's because **one-size-fits-all approaches to homeless services simply don't work.**

Coordinated Entry is considered the front door of the homeless system. We know that not all families arrive at this front door from the same starting point, or in the same manner. Some families arrive having endured institutionalized racism and the generational traumas associated with it. Others don't feel comfortable approaching the front door at all.

The responsibility lies with homeless systems to create paths to and through Coordinated Entry that every family experiencing homelessness can access equitably. Once in Coordinated Entry, every family needs to feel safe and respected, and given an equitable chance to succeed. Only then will we achieve our vision of all families being stably housed.

**Building Changes** is a nonprofit with extensive experience in testing, evaluating, and advocating for a wide range of strategies to reduce and prevent family homelessness in the state of Washington and across the nation.

With financial support from the Bill & Melinda Gates Foundation, Building Changes led the **Family Homelessness Initiative**, a decade-long intensive effort to create high-performing homeless systems in Washington's three most populous counties: King (Seattle), Pierce (Tacoma), and Snohomish (Everett). From 2011 through 2020, Building Changes assisted in the design and implementation of 79 projects totaling \$29.8 million.

On behalf of the State of Washington, Building Changes administers the **Washington Youth & Families Fund**, a public investment that supports innovative strategies to reduce family and youth homelessness across the entire state.



## Lesson 1: Identify and eliminate biased Coordinated Entry tools and processes.

Federal and state regulators require standardized access points to homeless services. In the quest to achieve consistency, however, some Coordinated Entry tools and processes reveal themselves as overly narrow and rigid, failing to be responsive to all who need to access the system. Over the life of FHI, our government partners in King, Pierce, and Snohomish Counties all recognized the need for **constant iteration to make Coordinated Entry tools and processes more equitable**. Through data analysis, provider experiences, and feedback from people experiencing homelessness, each county learned that some Coordinated Entry tools and processes tended to favor white people over Black, Indigenous, and Other People of Color (BIPOC)—both in terms of who was accessing the system in the first place, and how people were treated during the assessment process.

### Featured Project

- Coordinated Entry Refinements, Snohomish County

With support from FHI, Snohomish County Human Services embarked on a comprehensive overhaul of Coordinated Entry after analyzing data on who was receiving housing referrals in its system. The referrals, it turned out, weighted heavily toward single white men, which was not surprising since the prioritization scales the county was using favored people experiencing chronic homelessness.

The homogeneity of those receiving the county's housing resources was not reflective of the demographics of who actually was experiencing homelessness. The county sought to bring the two factors in line and, in doing so, more equitably serve BIPOC and LGBTQ+ people experiencing homelessness.

Snohomish County had been using a custom-made assessment tool with multiple screening questions that needed a refresh. The county's team of data experts swung into action to develop a better understanding of who was being assessed, and which groups of people were answering certain questions similarly. The team also created sample questions it piloted to further inform the **development of a more equitable assessment tool**.

At the same time, a Coordinated Entry workgroup comprised of county staff and staff from provider agencies identified a wider set of domains of vulnerability, which included financial, physical health, behavioral health, education, and household composition (younger children within a family). Length of time experiencing homelessness would remain a factor in assessing vulnerability, but it would be given less weight.

Since Coordinated Entry prioritization cannot award vulnerability points based on demographics, the county looked at areas of vulnerability that were disproportionately high for BIPOC and LGBTQ+ people, including experience in foster care, contact with law enforcement, and prior incarceration. Questions related to these factors were incorporated into the assessment tool. They also added questions about past incidences of being targeted on the street due to sexual exploitation or sex trafficking because data show that women of color are overrepresented as victims of these crimes.

The county tested the tool as it was in development, with the data team running various scenarios to see who was most likely to rise to the top for prioritization if different questions were weighted differently. The county debuted its new Vulnerability Screening Tool in 2019.

To hold itself accountable, Snohomish County Human Services created an oversight Coordinated Entry Advisory Committee made up of people from the community. Members reflect the diversity of those the agency serves, including people with lived experience of homelessness, BIPOC, and people who identify as LGBTQ+. The goal is for this committee to be the driver of continuous improvement of Coordinated Entry in Snohomish County.

## Deep-dive analysis activates change

Building Changes funded and supported a national research study by C4 Innovations that found the use of a prevalent Coordinated Entry tool, the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), and its related processes resulted in system-level racial inequities. On average, BIPOC received statistically significant lower prioritization scores on the VI-SPDAT than their white counterparts, which could affect who receives referrals to housing resources. In December 2020, OrgCode Consulting, the tool’s primary developer, announced it was phasing out the VI-SPDAT to support the goal of transitioning to a future in which Coordinated Entry tools and processes are able to address racial inequities.

**A [news release on the findings and the full report](#) may be downloaded from the Building Changes website.**

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***We are wanting to continuously improve our tool because we recognize it never will be perfect, but it always can be better.***

*—Holly Shelton, Supervisor of Direct Services, Snohomish County Human Services*

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## Lesson 2: Expand access points to Coordinated Entry to reach as many families as possible.

### Featured Project

- 211 and Diversion, Pierce County

Every family experiencing homelessness should be able to access homeless services simply, and in a manner in which they are most comfortable. Homeless systems can work toward this goal by **extending Coordinated Entry to other service sectors**—and even specific physical locations—where families experiencing homelessness tend to seek supports of any kind. Homeless systems also should be as flexible as possible to ensure that individual families can access Coordinated Entry without barriers.

One FHI project introduced Coordinated Entry to Pierce County’s “211” system, a health and human services telephonic support and referral service, the likes of which operate in other jurisdictions in Washington state and across the country. Since some callers to 211 are experiencing a housing crisis, it made sense to tap the 211 agency—in this case, United Way of Pierce County’s South Sound 211—to engage callers in a Diversion conversation as part of the Coordinated Entry assessment, as opposed to passing them off to one of the county’s already established Coordinated Entry providers.

Two of the largest existing providers—Associated Ministries and Catholic Community Services—initially had questions about bringing on an additional Coordinated Entry portal, expressing concerns about coordination and potential confusion among consumers. Both agencies served as supportive partners, however, offering training and shadowing opportunities to 211 staff, and attending the project’s learning circles to offer valuable insight.

There were some challenges related to increasing the access points for Coordinated Entry, however. For example, some families were receiving duplicative screening services by both calling 211 and making Coordinated Entry appointments with one of the other two providers.

Pierce County Human Services took what it learned from the 211 project and applied that knowledge to several Coordinated Entry approaches it hopes to sustain. For example, the county and its provider partners sought to give people flexibility to access Coordinated Entry on demand instead of just by appointment. Prior to the 211 project, people first had to make an appointment and then contact the system a second time for the actual assessment. No-show rates for the assessments were high, so the county and its provider partners wanted to lessen the burden by asking people to show up for Coordinated Entry only once.

Pierce County viewed the 211 phone lines as the logical portal for anyone experiencing homelessness to initially access Coordinated Entry, whether the actual assessment would occur through 211 or with another provider. Associated Ministries agreed to subcontract the entirety of its Coordinated Entry screening work to 211, recognizing 211's expertise in providing information over the phone.

At the same time, the county began working with its provider partners to develop an online resource where people could view actual wait times at the various walk-up Coordinated Entry sites where appointments were not needed. The idea was that when people called 211, the operator either could schedule a Coordinated Entry appointment with 211's navigator or Associated Ministries, or use the online resource to give the caller wait-time information for immediate Coordinated Entry services at one of the walk-up sites.

Some of these innovations had to be put on hold when the COVID-19 pandemic began, as nearly all Coordinated Entry appointments had to occur over the phone or virtually. Experience with the 211 project, however, helped prepare Pierce County Human Services for migrating Coordinated Entry to an all-virtual platform.

A Building Changes evaluation of the 211 project found that by adding a telephonic access point for Coordinated Entry, Pierce County may have increased access for survivors of domestic violence and their families, and Black/African American families. Our data showed disproportionately high user rates for both groups.

An [evaluation report and research brief](#) highlighting the results of the 211 and Diversion project may be downloaded from the Building Changes website.

### **Lesson 3: Maintain contact with high-priority families after their Coordinated Entry assessment and offer tailored support to assist their transition to housing.**

#### **Featured Projects**

- Family Connectors, King County
- Care Coordination, Pierce County

The Coordinated Entry processes of assessment, prioritization, and priority pool placement aren't enough to ensure that families receiving a housing referral will be able to move in successfully. Some families, as a result of the mobility associated with their experience of homelessness, may be difficult to track down when the homeless system attempts to contact them about a referral. If families are not reached quickly, or if their paperwork is not in order, their window of opportunity for housing may close.

Some families also need high levels of tailored support to buoy their chances of successfully obtaining and maintaining stable housing. That **tailored support should begin at Coordinated Entry**—before they receive a housing referral or enroll in a housing program.

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*I think of it analogous to how there were many employers who were really resistant to teleworking, then got thrown into it 100%, and now may never go back. Something similar is happening with our Coordinated Entry engagement. So much more of it is happening in forms other than in person. There was a lot of resistance to that from staff initially, and now they are learning that it can be just as successful.*

—Anne Marie Edmunds,  
Homeless Programs  
Specialist, Pierce County  
Human Services

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Two FHI projects tested strategies to keep contact with—and offer support to—families that receive high prioritization scores at Coordinated Entry.

In King County’s Family Connectors project, operated through Catholic Community Services, navigators served as advocates for families not already formally engaged with the homeless system through a provider. The navigator would consistently reach out to a family and, if successful, offer an array of resources to address immediate barriers that could get in the way of a successful move-in. Those services included housing search assistance and preparation of required paperwork. When a program referral was made, the case manager connected the family quickly and seamlessly to the housing provider. Flex funds were available to help the family with upfront costs associated with move-in.

A similar approach was taken in Pierce County with the Care Coordination project, operated through Inside Passages Pierce County. A care coordination navigator was assigned to a project-eligible family at Coordinated Entry. (In this project, any family eligible for Foundational Community Supports [FCS] under Washington State’s Apple Health Medicaid health plan was eligible for care coordination.)

The Care Coordination project operated around building a relationship between the navigator and the family, with the navigator serving as a single point of contact and someone on whom the family can depend. Navigators offered families a variety of support, tailored to their specific needs, with the goal to address any barrier and help mitigate any crisis that could stand in the way of a family being able to respond quickly and successfully to a referral from a Rapid Re-Housing or Permanent Supportive Housing program. In some cases, care coordination provided enough support to assist families in securing housing on their own, without a housing program referral.

The array of care coordination services to families also included behavioral health support, assistance in social service benefits planning, legal aid, and job finding. Navigators also assisted families in obtaining birth certificates, Social Security cards, and other forms of identification, which housing programs and landlords may require prior to move-in.

Families served through care coordination typically face myriad challenges in their lives that can prevent or delay their successful exit from homelessness. In one family, for example, the mother was working on maintaining her sobriety, establishing regular outpatient mental health counseling, reunifying with her older children through the state, preparing for the birth of her new baby, ensuring her full-time job would be returned to her after maternity leave, mending fences with estranged family members, and addressing outstanding bench warrants in a different county than where she lived. Her care coordination navigator partnered with her through the various circumstances while assisting in connecting her to various social service benefits through the state. The mother eventually received a referral to a Rapid Re-Housing program, and, after receiving additional assistance from her navigator to assemble the appropriate identifications and documents, her family successfully moved into housing.

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***It’s really key for families to have a consistent person who is familiar with their unique circumstances and can assist them in accessing appropriate long-term resources. If we do lose contact with families, which can happen for a variety of reasons, they know they can reach back out to their specific person, receive a quick response, and get assistance to link back to the services and supports they desire.***

—Heather Knudsen,  
Executive Director, Inside  
Passages Pierce County

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Care coordination services may continue after a family has moved into housing, working in step with the housing program. Care coordination navigators will step away, however, if a family prefers working exclusively with their housing program case manager.

Care coordination in Pierce County was provided under the evidence-based practice **Critical Time Intervention** (CTI), which utilizes motivational interviewing and family-centered planning to support people going through periods of transition in their lives. CTI helps build and buttress support systems for families within their own communities—support that outlives whatever time-limited support they may receive through a housing program.

## Explore options where other systems can pay for homeless services

Some homeless services, including care coordination, can be billed to sources outside the homeless system, such as through targeted Medicaid benefits under the State of Washington’s Medicaid Transformation agreement with the federal government. Medicaid recognizes housing as a medical necessity, and therefore treats some evidence-based housing supports as a covered benefit. By billing certain homeless services to Medicaid, either directly or through a waiver program like FCS, a homeless system can shift those resources elsewhere. This is helpful because homeless systems are notoriously underfunded in comparison to the demand for services.

While billing homeless services to Medicaid presents an intriguing option to preserve more resources for people experiencing homelessness, we learned through FHI that challenges exist in doing so. For a provider to bill homeless services under Medicaid, families receiving the services must be enrolled in the health plan, and not all are. Inside Passages Pierce County assisted families not currently covered through Medicaid by connecting them to an enrollment specialist who could support them through the process. FCS eligibility thresholds can be quite restrictive, and rules tend to be complex. Meeting enrollment and eligibility requirements to ensure coverage and authorization can involve hours of advocacy work, putting excessive administrative burden on providers and disincentivizing them from leveraging Medicaid funding.

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