The Way Home’s
Coordinated Access System

Houston/Harris County
Continuum of Care
Cities that fit into Houston & ETJ Comparison
Homeless in Houston (2015 PIT)

- On January 29, 2015, there were 4,609 people experiencing homeless in Houston/Harris County
  - 1,950 (42%) staying in a place not meant for human habitation
  - 2,659 (58%) staying in emergency shelters, transitional housing, or safe haven.
  - 14% decrease compared to 2014
  - 46% decrease compared to 2011
- Increase in number in PSH
  - 140% since 2011
- Approximately 1 in 7 identified as chronically homeless
- Only 3 chronically homeless families identified
- 2 in 5 had substance abuse problems
- 2 in 5 had mental health issues
- 1 in 8 was a veteran
Access to Housing in the Past

- Street Outreach
- Drop-In Centers
- Meal Programs
- Healthcare & MH Providers
- Faith-Based Programs and Ministries
- 211 United Way
- The VA
- Criminal Justice System
- DV/Sexual Assault Crisis Centers and Shelters
- Emergency Shelter
- Safe Havens
- Transitional Housing
- Affordable/Fair Market Housing
- Permanent Supportive Housing

The Way Home
Access to Housing Today

System Overview

- Targeted Hubs
- Outreach Teams
- Hospitals
- Harris County Jail
- Call Center
- VA CRRC
- Emergency Shelters

Assessment (Housing Triage Tool & VI) → Matching → Referral

- Waitlist

Navigation/Housing

The Way Home
Coordinated Access Key Components

Access
- Easily Accessible (Phone line pilot)
- Multiple Access Points (Assessment Hubs)

Assess
- Standardized Assessment Tool
- HMIS

Assign
- Central Referral System
- Eligibility Matching in HMIS

Accountability
- System (CoC & Coalition) Oversees the Process
- Closes Side Doors
- Monitors referrals and denials
Five Assessment Hubs
Day shelter, VA Drop-In Center, Family Shelter
  - Repurposed staff, dedicated to the system
Easily accessible, all on bus lines
Have frontline staff dedicated to intake and process
Primary Assessment Hub has own dedicated entrance
Intake line being piloted with Harris Health & Harris County Jail
• Housing Assessors document homeless and housing history and related barriers using common assessment tool
• Obtain consent from client for sharing with providers
  – Client signs electronically via mouse or tablet
• Vulnerability Index Assessment (VI) for PSH only
• Next step assessment tools for RRH only
### Housing Assessment

#### Document your housing situations for the past 3 years:

<table>
<thead>
<tr>
<th>Location</th>
<th>Start Date</th>
<th>Departure Date</th>
<th>County towards homelessness</th>
<th>Primary Reason for Leaving</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Star of Hope</td>
<td>02/05/2014</td>
<td>10/01/2014</td>
<td>Yes</td>
<td>SELECT</td>
<td>236</td>
</tr>
<tr>
<td>County Jail</td>
<td>10/14/2014</td>
<td>11/24/2014</td>
<td>Yes</td>
<td>SELECT</td>
<td>34</td>
</tr>
<tr>
<td>Near Beacon</td>
<td>09/19/2015</td>
<td>03/01/2015</td>
<td>Yes</td>
<td>SELECT</td>
<td>54</td>
</tr>
<tr>
<td>-</td>
<td>02/24/2016</td>
<td>-</td>
<td>Yes</td>
<td>SELECT</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Domestic Violence

Are you homeless or do you remain homeless because someone is hurting you? [ ]

- [ ] Yes
- [ ] No

#### Veteran Affairs

- Are you a veteran? [ ] Yes
- How many months were you active duty? [ ]
- What was your discharge status? [ ]
- Are you interested in accessing VA services? [ ]
- [ ] Yes
- [ ] No

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**The Way Home**
Vulnerability Index Assessment (PSH only)

![Image of Vulnerability Index Assessment tool]

### Vulnerability Index Assessment

**Vulnerability Index Assessment Date:**

- **What is the total length of time you have lived on the streets or shelters?**
  - # of Years: 1
  - # of Months: 3
  - # of Times: 30

- **Have you been living in an emergency shelter and/or on the streets for the past year or more?**
  - Yes: No

- **How many times have you had to stay in shelters or on the streets in the past three (3) years?**
  - # of Times: 30

**Where do you sleep most frequently?**

- City: State: Zip Code: 

**What City/State/Zip Code did you live in prior to becoming homeless?**

**Where did you sleep last night?**

### OK, now I'd like to ask you a few questions about your health...

- **Where do you usually go for healthcare or when you're not feeling well?**
  - Specify: 
  - Healthcare for the Homeless Clinic: Hospital: VA: Other: Does not go for care

- **How many times have you been to the emergency room in the past three months?**
  - Times: 3

- **How many times have you been hospitalized as an inpatient in the past year?**
  - Times: 4

- **Do you have an alcohol or drug problem, a serious mental health problem, a developmental disability, or a chronic physical illness or other disability?**
  - Yes: No: Client doesn't know: Client refused: Data not collected

### Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?

- Kidney disease: End Stage Renal Disease or Dialysis
- History of strokes, lymphoma, or lung cancer
- History of Heart Strokes or Heart Attack
- Liver disease, Cirrhosis, or End Stage Liver Disease
- Heart disease, Arrhythmia, or Irregular Heartbeat
- HIV/AIDS
- Emphysema
- Diabetes
- Asthma
- Cancer
- Hepatitis C

- **Yes:** No: Refused

*The Way Home*
RRH Singles Next-Step

The Way Home
RRH Family Next-Step

The Way Home
Youth Next-Step

The Way Home
• Match the recommended type of intervention to a program in the CoC that can provide the right services
• Use HMIS to check availability, create a reservation, & make a referral
• Housing Navigators assist clients from referral to lease up
Housing Match (PSH)
Coordinated Access
Triage Workflow

Add or Edit Client

Client Information (includes ROI)

Homeless Services Housing Eligibility

Housing Type Matching (Eligibility Engine)

Interested in DV or VA services

Permanent Supportive Housing

Vulnerability Index

Rapid Re-Housing

Singles Triage Tool

Family Triage Tool

Young Adult Triage Tool

Housing/Program Matching

Units Available (N)

Consolidated Wait List

Units Available (Y)

Electronic Referral

Required Documents List

Coordinated Access HMIS Workflow

The Way Home
Housing Match (RRH)
Waitlist (PSH - CA Staff Only Access)

Below are the referrals or facilities for which the client has been put on a waiting list. When you record a wait here, the provider to whom you want to make the referral will be able to access the list from the Wait List in the Provider Management area.

More than 200 results were found but only the first 20 will be displayed.

<table>
<thead>
<tr>
<th>Client ID</th>
<th>Name</th>
<th>Age</th>
<th>Family Site</th>
<th>Date Placed on List</th>
<th>VH Score</th>
<th>Chronic</th>
<th>Housing/Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td></td>
<td>1</td>
<td>07/20/2015</td>
<td>4</td>
<td>Yes</td>
<td>Northside 1RD</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td></td>
<td>1</td>
<td>07/24/2015</td>
<td>4</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td></td>
<td>1</td>
<td>07/23/2015</td>
<td>3</td>
<td>Yes</td>
<td>SEARCH 1115</td>
<td>(Scattered Site)</td>
</tr>
<tr>
<td>61</td>
<td></td>
<td>1</td>
<td>07/08/2015</td>
<td>3</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
<td>1</td>
<td>02/09/2013</td>
<td>3</td>
<td>Yes</td>
<td>APH - First Responders</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>1</td>
<td>06/02/2014</td>
<td>3</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td></td>
<td>1</td>
<td>08/05/2013</td>
<td>2</td>
<td>Yes</td>
<td>APV - First Responders</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>4</td>
<td>08/04/2013</td>
<td>2</td>
<td>Yes</td>
<td>SEARCH - Pecan Square Village</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>1</td>
<td>08/03/2013</td>
<td>2</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td></td>
<td>1</td>
<td>08/03/2013</td>
<td>2</td>
<td>Yes</td>
<td>Jackson Hicks-Garden</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td></td>
<td>1</td>
<td>07/30/2013</td>
<td>2</td>
<td>Yes</td>
<td>Change Happened - Rescue in Motion</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>1</td>
<td>07/30/2013</td>
<td>2</td>
<td>Yes</td>
<td>MACS - ACE</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>1</td>
<td>07/27/2015</td>
<td>2</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>1</td>
<td>07/07/2015</td>
<td>2</td>
<td>Yes</td>
<td>APH - First Responders</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
<td>1</td>
<td>07/05/2015</td>
<td>2</td>
<td>Yes</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td></td>
<td>1</td>
<td>06/28/2013</td>
<td>2</td>
<td>Yes</td>
<td>APV - First Responders</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td></td>
<td>1</td>
<td>06/18/2013</td>
<td>2</td>
<td>Yes</td>
<td>MACS - ACE</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>1</td>
<td>06/12/2013</td>
<td>2</td>
<td>Yes</td>
<td>HH-HMLES</td>
<td></td>
</tr>
</tbody>
</table>

The Way Home
## Waitlist (RRH)

![Image of a database interface for tracking waitlist clients]

### Screenshot Description:

- **Title:** Rapid Re-Housing Wait List
- **Purpose:** The list displays clients that have been placed on a waitlist for a specific service. It allows users to remove a client from the waitlist, edit client details, and mark clients as turned away or placed.

### Table Preview:

<table>
<thead>
<tr>
<th>Date Placed on List</th>
<th>Triage Type</th>
<th>Score</th>
<th>Service Type</th>
<th>Provider Name</th>
<th>Referred By</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/22/2015</td>
<td>Family</td>
<td>10</td>
<td>RRH Waitlist Placement</td>
<td>Salvation Army Social Services (RRH)</td>
<td>Michael Chiotel</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>03/01/2015</td>
<td>Single RRH</td>
<td>9</td>
<td>RRH Waitlist Placement</td>
<td>SEARCH Homeless Services (RRH)</td>
<td>Michael Chiotel</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>06/22/2015</td>
<td>Single RRH</td>
<td>8</td>
<td>RRH Waitlist Placement</td>
<td>Memorial Assistance Ministries (RRH)</td>
<td>Michael Chiotel</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>06/18/2015</td>
<td>Family</td>
<td>8</td>
<td>RRH Waitlist Placement</td>
<td>Harris County Social Services (RRH)</td>
<td>Joanna Ruiz</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>06/14/2015</td>
<td>Family</td>
<td>7</td>
<td>RRH Waitlist Placement</td>
<td>Memorial Assistance Ministries (RRH)</td>
<td>Loretta Randolph</td>
<td>713.310.5120</td>
<td>New</td>
</tr>
</tbody>
</table>

### Additional Information:

- **Focus:** The image emphasizes the importance of tracking clients on waitlists, ensuring that their status can be updated accurately and efficiently.

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**The Way Home**
Client Dashboard

Shows if client has been assessed, waitlisted, housed, if they are chronic, & what the VI score is
CA Staff Dashboard

Future check-outs
Accountability

• Determine if Coordinated Access is working
• Monitor the Coordinated Access System; dashboards
• Refine the system based on data
• Provide updates to the CoC
• Monitor referrals & denials; facilitate case consultations if needed
• Develop policies & procedures & revise as necessary
• Provide scoring for the NOFA
CA Fact Sheet

The Way Home

Coordinated Access is a centralized or collaborative process designed to coordinate program participant intake, assessments, and referrals to housing.

The Department of Housing and Urban Development (HUD)’s new regulations require that all Continuums of Care (CoC) develop and implement a coordinated access and assessment system for all HUD-funded programs.

Assessment:
- A common screening tool that collects a participant’s homeless history, disability history, criminal background history, etc. to determine the best housing intervention (Permanent Supportive Housing (PSH) or Rapid Re-housing (RRH)) for that participant.
- The only way to access PSH or RRH in our CoC is through Coordinated Access.

PSH has been prioritized for participants who are chronically homeless. If a participant does not meet the HUD definition of chronic homelessness, they will not be eligible for any PSH program.

 RRH has been prioritized for families with minor children who are not chronically homeless. Only participants residing in emergency shelters or places not meant for human habitation will be eligible.

Locations:

At a drop in center:
- The Beacon, 1212 Fairlawn St.
  M-F: 9:30 am - noon
  M, T, Th, F: 1:30 - 4:00 pm
  Phone: 713-259-9737
- VA Drop-In Center, 1418 Preston
  M, 8 am - 2:30 pm, T-F, 8 am - 5 pm
  S, 8 am - 4 pm, Su, 9 am - 4 pm
  Phone: 713-797-2913

At a shelter (clients must be a resident):
- Salvation Army Red Shield Lodge, 2407 N. Main
  Intake: M-F, 4:30 - 7:30 pm
  Phone: 713-224-2975
- Star of Hope Men’s Development Center, 1811 Rusk
  M-Sa, 8-11 am, 1-3 pm, Su, 9 am - noon, 2-3 pm
  Phone: 713-227-8900

What Coordinated Access ISN’T:
- It is not a program...
- It does not increase housing inventory...
- It does not eliminate program eligibility...

...it is an entry point to determine an individual’s housing eligibility.
...it helps us access the existing inventory more efficiently.
...clients still need to meet programs’ and landlords’ eligibility criteria.

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Implementation Team

CA Implementation Project Manager

CA Program Manager

CA Workgroup
Permanent Supportive Housing Workgroup
Rapid Re-Housing Workgroup
CA Transition Team
Special Population Workgroups
Roles and Responsibilities

CA Implementation Project Manager
- COC Lead or neutral party
- Manage and support all participating partners through implementation
- Develop Project Management Workbook and Action Plans
- Facilitate Workgroups
- Trouble shoot
- Hold on to the VISION

CA Program Manager
- COC Lead agency staff person
- Manage and support all participating partners
- Maintain oversight of all manual processes during implementation
- Facilitate case conferences
- Oversee CA data and performance
- Develop CA MOU’s
- Manage ongoing CA operations
Roles and Responsibilities

CA Workgroup
- Senior leaders from provider agencies, city and county leadership, Housing Authorities and COC Lead, VA, etc.
- Higher level decision making and community planning
- Develop CA Business Rules
- Develop Housing Models

PSH Workgroup
- PSH providers throughout the community, Housing Authorities, and COC Lead
- Standardize eligibility criteria
- Standardize documentation requirements
- Standardize enrollment and referral processes
- Eliminate individual waitlists

RRH Workgroup
- RRH providers throughout the community and COC Lead
- Standardize eligibility criteria
- Standardize documentation requirements
- Standardize enrollment and referral processes
Roles and Responsibilities

CA Transition Team

- Staff (mid-level and senior staff) from any agency directly impacted by CA
- Operationalize all CA plans

Special Population Workgroups

- Staff (mid-level and senior staff) from any provider agency that has potential for CA integration
- Develop alternative strategies for integration into CA system
Action Planning

• Project Manager develops a Project Management Workbook
  – Driving work for each workgroup
• CA Transition Team develops a phased roll out Action Plan
  – Driving specific logistical tasks that need to completed in specific timelines
    • Staffing
    • Community-wide Communications
    • CA Staff Training
    • Each phase of roll out has specific targets/goals
    • Tie targets/goals to resources
    • Develop client flows for each CA location that do not disrupt existing operations
Phased Roll Out

• Phase I- 1/6/14-4/1/14
  – Build out the basic CA workflow in HMIS
  – Get 2 CA locations staffed and functioning
  – House 25 individuals and 5 families
• Phase II- 4/1/14-7/1/14
  – Continue HMIS build out, resolve Phase I issues, build out waitlist, and identify performance needs for HMIS
  – Get 1 more CA location staffed and functioning, begin testing CA Call Center, and add 1 Mobile Outreach CA Assessor
  – House 75 households
• Phase III- 7/1/14-11/1/14
  – Continue HMIS build out, resolve Phase II issues, incorporate performance measures and reporting abilities
  – House 100 households
  – Clear existing provider waitlists
  – Close the side doors
Progress to Date

- Phase 1 HMIS Build Out Complete (January 2014)
- Phase 2 HMIS Build Out Complete (June 2014)
- Referrals through HMIS can display outcomes
- RRH Pilot rolled out (January 2015)
- Complete collaboration between agencies and housing authorities

- 5 Hubs Are Up and Running
  - Beacon, Star of Hope Women & Family & Men’s Shelter, Salvation Army, & VA Drop-In Center
  - 13 Housing Assessors and 4 Housing Navigators, including an Outreach Assessor/Navigator

- Call-In option being piloted with jail diversion project & county hospitals
- Real-time unit availability in HMIS; 1500 PSH beds
- 489 PSH & over 700 RRH units online through the end of 2015
- 3160 clients assessed (500-600 have left the system), 531 PSH (avg 100 days), 496 RRH (avg 104 days)
Challenges

- Locating clients that are next to be housed
- Length of time in locating clients and/or units (CBC issues, documenting homelessness)
- Providers not updating bed data promptly
- Providers enrolling clients outside of CA (monthly reports)
- Intake line needs expanded hours
- Providers not accepting referrals (has gotten better)
Things to Consider

• Workgroups meet when there is WORK!

• Special population groups can be challenging, start ASAP
  – ROI’s
  – Use of HMIS or other data management systems

• Electronic build outs take longer than expected

• Technology and staffing require repurposing and/or finding new funds

• The shift in THINKING is much more challenging than the shift in OPERATIONS
  – Community Data, not Agency Data
  – Repurposed CA staff are not “helping out” a new system, they are the new system
  – A Good Fit, not Eligibility
  – There is a housing option for everyone
  – The clock starts the day CA staff say, “Hello, nice to meet you”!
  – This is not a pilot or a demonstration project, this is our HOMELESS RESPONSE SYSTEM
Thank You!

The Way Home is a coordinated system to end chronic and veteran homelessness by 2015, to end family and youth homelessness by 2020, and to build a system in which nobody has to be without permanent housing for more than 30 days.

For more information visit: www.thewayhomehouston.org

Or email: info@thewayhomehouston.org

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