Appendix G: Matrix of Community Coordinated Entry Models

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
Charlotte, NC (Mecklenburg County) Community Population = 792,862 2013 PIT = 3,993	Decentralized, prioritized access to TH, RRH, PSH	All populations Must be literally homeless or 72 hours from being homeless	Clients can call 211, any provider for brief pre-screen; referred to designated assessment center. Only clients who have been through assessment center can access TH, RRH and PSH.	Five designated assessment centers (shelter and safety net providers with an MOU with CoC) Locally developed Housing Prioritization Tool generates score (letter, color). Highest need also get Vulnerability index to see if eligible for PSH.	Clients who have high needs placed on priority lists for TH, RRH, PSH. Lists are kept very short. Lower barriers clients do not go on any list. Client called when opening available in program for which they meet eligibility criteria.	Clients entered in HMIS at point of contact with Coordinated Assessment but HMIS not used for matching	No information.	Community buy in to serving highest need clients. Tool developed that does prioritization of hardest to house.	Inventory of units available for higher need clients is not right sized. Many who need assistance are not able to get on a list.
Dayton, OH (Montgomery County) Community Population = 141,359 2013 PIT = 1,041	Standardized assessment and referral based in emergency shelters	All populations Clients must be in emergency shelter	Point of entry are the four “gateway” shelters (families, single men, single women, DV).	Initial intake done within 3 days of shelter entry. HMIS data elements collected; diversion screen. Front Door Assessment conducted 7-14 days after entry. Locally developed, comprehensive tool looks at housing barriers. Generates “low, medium or high” score.	Using assessment results, shelter does referral decision work sheet and makes referral to TH, RRH or PSH. Providers must accept 1 out of 4 referrals. Programs not allowed to have non-funder imposed barriers.	Clients entered into HMIS by shelters. Not clear whether matching and referral done in HMIS.	No Information.	Closed side doors; housed many “long stayers”	System does not have sufficient RRH and PSH inventory to ensure all clients receive “best fit” referral.

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
Hennepin County, MN Community Population = 1,185,000 2013 PIT = 3,481	Centralized access to family shelter. "Right to shelter" for families in this community	Families only Must be literally homeless	County service center. Clients can call or make apt. Center staffed by county. Unit also handles WIC, SNAP, other county funded services.	No formal assessment. More problem solving, designed to divert as many as possible. 75% of callers diverted. 25% enter shelter.	Once in shelter, families work with Rapid Exit provider (one nonprofit) that works with them to identify best housing option. Rapid exit assessment done within 72 hours in shelter. Uses modified VI SPDAT. Most clients go to RRH. Manual matching process (paper list of vacancies).	Shelter assessment at County center entered into HMIS. Rapid Exit Assessment not yet in HMIS. Working on fixing this (Abt contract).	County funds the County service center, which has 12 FTEs. This team does more than just shelter access. Looking to add 3 FTEs (housing referral coordinators, HMIS admin)	Shelters like the system. Agencies accepting referrals from shelters are more resistant. Don't like giving up control over who they take; having to take families from rapid exit.	Data disconnect between County service center and rapid exit. Lack of automation of referral process. Hennepin now also trying to figure out how to adapt model to singles, youth

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
Houston, TX Community Population = 2,196,000 2013 PIT = 5,351	Coordinated access into permanent supportive housing (and into RRH starting March 2015)	Only chronically homeless households. Both single adults and families (if CH).	One main "hub" Beacon Day Shelter conducts screening and assessment. Most clients go through this hub. Clients can be assessed at a few other locations. There is a call-in line for frequent users of jail or hospital. Also some outreach programs can do assessment.	Assessment includes HMIS data elements, criminal history (for matching to programs), VI for prioritization. Clients line up at Beacon Day Shelter at 7 and assessments begin at 9. Each assessment takes 15-60 minutes.	Clients who are eligible (chronically homeless) are matched to available vacancies based on results of VI (highest need have priority) and also program screening criteria (criminal record, household type). Once matched, unit may not be available immediately (some programs have waiting lists). Clients call in regularly to stay in touch. Community has little shelter and most clients will not enter shelter anyway while waiting for unit.	Assessment entered into HMIS. Providers enter bed availability into HMIS daily. Matching done through HMIS. But data is not fully shared across whole system.	9 FTEs (4 assessors—staffed at shelter, 2 assessor/navigators, 2 navigators, 1 coalition staff). Beacon Day Shelter has $150,000 CoC grant for assessment work. Other assessment agencies use own funds.	Overall highly successful. Since Feb. 2014, 600 assessments, 175 housed.	Some problems with getting PSH programs to adopt Housing First approach, reduce barriers, but situation improving.

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
Los Angeles County, CA Community Population = 10,017,068 2013 PIT = 53,798	Decentralized, regionally based access to all shelter and housing programs through 8 Family Solutions Centers (FSC).	Families only Homeless by HUD definition (includes Category 2, imminently homeless).	211 is initial point of entry. Initial screening for DV, homelessness, need for housing. 211 schedules appt. at FSC. FSCs are regionally based and each has a unique service planning area (SPA).	FSCs use one or more standardized assessment tools, F-SPDAT, or locally created tool. Family Crisis Team member does the assessment. Attempt diversion using mainstream resources. If not diverted, develop housing plan, including placement into "next step" or permanent housing. Plan also addresses benefits, income, employment, behavioral health	Matching is done at the FSC level, not a system wide approach. Each FSC has RRH resources. They also are responsible for maintaining an inventory of housing referrals (e.g. shelter, TH, PSH, etc.) in their region.	FSCs enter clients into HMIS, including universal data elements. Currently matching and referral is not done using HMIS but plan is to do so.	System is funded through a variety of City and County including TANF, ESG and general funds. $10 million for all functions including rapid rehousing. @15 FTE's on Family Crisis Team which includes assessment function.	Diversion rates as high as 85%. Focusing deeper resources such as permanent subsidies on highest need families.	Working differently in different parts of the County depending on the relationships between providers and the range of services available.

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
Montgomery County, PA Community Population = 812,376 2013 PIT = 438	Decentralized, regionally based access to rapid rehousing through three Housing Resource Centers	All populations Currently for literally homeless by HUD definition, Category 1. Will add imminently homeless next year, as add diversion component.	"Your Way Home" call center, operated by 211 organization, is initial point of entry. Pre-screen for DV, homelessness, mainstream resources. Call Center schedules appointments at HRC. How soon appointment is set based on pre-screen score.	Call center uses SPDAT pre-screen tool, and HRCs use full SPDAT. Assessment appointment includes full SPDAT and development of Housing Assistance Plan. "Coaches" do assessment, housing planning, manage subsidy and exit clients.	Each HRC has RRH resources; operate on a progressive engagement model. They can also make referrals to shelter and keep a central list of openings. Also link to career and financial counseling, legal services, etc.	Call Center starts HMIS record. HRCs complete record. Use "Smartsheet" software for SPDAT scores and openings. HMIS system is open to all providers; exploring opening it to other organizations that serve the clients	System is county and privately funded. Call Center about $125K a year. Three HRCS about $2 million including seven FTE "coaches", housing specialists, rapid rehousing funds	Community agreement to prioritize based on highest need. Standardized method for delivering rapid rehousing. Very low no show rates for appointments.	Concerns that pre-screen information not accurate, self-reported. Shelters uncomfortable at first at not being assessors but now working. Doesn't currently include diversion or PSH.
Pierce County, WA Community Population = 819,743 2013 PIT = 1,997	Centralized intake system for access to all system components	All populations Literally homeless (or within 72 hours)	Access Point for Housing (AP4H) operates a call in line and also conducts in person assessments. (211 and other providers refer to AP4H, with some minimal pre-screening.) Callers to AP4H who are literally homeless receive appt. for assessment within a week.	90 minute "strengths" assessment. Includes eligibility criteria for programs. Locally developed tool. Clients are put on Placement Roster in order in which they were assessed. Currently the roster has over 700 households.	As vacancies are available at participating ES, TH, RRH, and PSH, AP4H will search Roster for household that meets eligibility criteria, try to contact, make referral.	AP4H enters results of assessment into HMIS and also into Access database. Database used for semi-automated matching process	System is funded by Pierce County and Gates Foundation. Call center has 10 FTE staff who handle initial calls, diversion screen, and conduct assessments.	More transparent and streamlined method of accessing programs for clients.	Long waiting list. Lack of prioritization or removal of barriers means more difficult clients may never be referred. Many providers would prefer to take referrals from their own referral networks.

Community	Type of System	Population	Entry Points/Initial Contact	Assessment Tools/Process	Matching, Referral, Prioritization	Use of HMIS	Staffing and Funding Sources	Successes	Challenges
San Francisco, CA Community Population = 837,442 2013 PIT = 7,350	Centralized access to family shelter	Families only Literally homeless, must receive benefits in SF or be willing to transfer to SF.	Families call Connecting Point for initial 10-15 min. screening. Based on initial screening get on list and wait for appointment. Some get appointment right away, depending on work volume. Those with active DV referred to DV system.	Use locally developed tools for phone screen and for in person assessment. Lengthy in person meeting for assessment, gather information, explain shelter rules. Once on list, clients must call or come in once per week to stay on list. Those who don't are made inactive and ultimately removed from list.	Main purpose of Connecting Point is to get families into longer-term shelter. Shelter priority for families with medical or mental health needs and those on list > 5 months. Provide case management while family waiting for shelter referral. Also help get people on waiting lists for permanent housing, do some diversion work. Connecting Point does not refer into TH or PSH.	Not using HMIS. Provider has own database.	12 FTEs total (6 CM, 3 Housing Specialists, 3 Admin). City/County funded (SF is both a City and a County).	More standardized and fair way of using shelter resources. Households can get access to case management and sometimes rental assistance while on list.	Only provides access to some longer-term shelters, not to crisis beds, rapid rehousing or permanent housing options. Not integrated into HMIS. Fairly long wait times to access shelter.