Fundamentals of Homelessness Response for Managed Care Plans[1]

Homebase
with the support of the California Health Care Foundation

The following pages contain foundational information for managed care plans (MCPs) about how homeless assistance works at the local level, including practical, action-oriented suggestions to help MCPs participate in their community's response to homelessness.

What's included

Succinct and to-the-point information and suggested actions to share with MCPs to empower and encourage them to engage and collaborate with their communities' homelessness response systems, whether in the context of the Housing and Homelessness Incentive Program (HHIP) or otherwise:

- The Basics of Continuum of Care (CoC) Structure, Funding, and Operations
- Coordinated Entry (CE): Fundamentals and Opportunities to Leverage CE for Enhanced Care Management, Community Supports, and HHIP Implementation; and
- Practical strategies for MCPs to partner with their local CoCs.

What's not included

Technical details about homeless assistance programs, systems, and operations that often vary from one community to another.

The Basics of Continuum of Care (CoC) Structure, Funding, and Operations

Although federal and state governments fund homelessness response, the work happens at the local, community level. In California, "community level" most often means the geographic area covered by a single county.

County or city governments provide some homeless assistance, but no single agency or organization administers all resources and services. In almost every community across the country, a network of organizations and agencies provide different types of assistance to individuals and families at risk of or experiencing homelessness.

Due to limited resources, the vast majority of housing assistance is prioritized for people living on the street, sleeping in vehicles or tents, or staying in emergency shelters. Communities often further prioritize housing and intensive supportive services for people experiencing "chronic homelessness," which means those who have a disability and have been homeless for more than a year.

Homeless assistance may include:

- Emergency shelter;
- Financial support (one-time assistance or ongoing rental assistance);
- Temporary or permanent housing;
- Supportive services (e.g., case management, assistance applying for benefits, connections to medical or behavioral health care, help finding or securing housing);
- Transportation assistance; and
- Necessities like food.

[1] This tool was adapted from "Homelessness Response 101 for Health Care Providers and Stakeholders," originally developed in February 2021 by Homebase, in partnership and with the support of the California Health Care Foundation.

5 Key Things to Know About CoCs

What is a CoC? Short for "Continuum of Care," CoC is the umbrella term for the group of organizations and agencies (including community-based organizations and local government agencies) that collectively coordinates homeless assistance activities and resources in a community. **A CoC is not a legal entity.** It is a coalition of organizations and entities that meet regularly to discuss and plan their community's homelessness response. There are currently 44 CoCs in California; most cover a single county's geography, but a few cover a single city or two or more adjacent counties. Though CoCs have certain elements in common, the structures, operations, and resources vary from one to the next.

1. **Each CoC designates an entity to apply for federal funds on its behalf.** The designated entity, often a local government agency or non-profit organization, is referred to as the "Collaborative Applicant" or "CoC Lead Agency." It submits the CoC's application for homeless assistance grant funds from the U.S. Department of Housing and Urban Development (HUD). CoCs also must have a Board comprised of representatives from local homeless assistance organizations and at least one person with lived experience of homelessness. A CoC's Board oversees the requirements associated with HUD funding.

2. **HUD awards homeless assistance grant funds to CoCs through an annual competitive process.** Each CoC runs its own local process based on community priorities to determine which local organizations should receive funding from HUD and for what purposes. The CoC Lead Agency uses those determinations to apply for HUD funds on behalf of the community. CoCs (or their partner counties) may also receive California state funding to address homelessness, also in the form of grants; requirements of those funds vary but many are similar to HUD requirements.

3. **Homeless assistance funding is very limited in both amount (relative to need) and eligible uses.** The primary activity CoCs and CoC-funded organizations use HUD funds for is rental assistance to help people exit homelessness through transitional or permanent housing. Some programs combine rental assistance with services for people who need more than financial support to stabilize and maintain housing. Services funding is extremely limited and often isn't able to cover more than case management. Planning, program operations, project administration, and property acquisition, rehab and construction are the only other eligible uses for HUD CoC grant funds. Nearly all eligible HUD funding must be matched with at least a 25% financial or in-kind match.

Types of stakeholders who participate in a CoC include

- Nonprofit homeless assistance providers
- Community- and faith-based organizations
- Victim service providers
- Local government
- Public housing agencies
- School districts
- Social service providers
- **Substance use service organizations and mental health agencies/service organizations**
- Local businesses
- Street outreach teams
- **EMT/crisis response teams**
- **Hospitals**
- Affordable housing developers
- Law enforcement and jail(s)
- **Community health centers and clinics**
- People with lived experience of homelessness
- Organizations that serve specific populations (e.g., veterans, youth, LGBTQ+ people, people with disabilities
- Advocates

4. **The primary purpose of a CoC is to promote a community-wide commitment to end homelessness.** CoC members attend meetings, participate in community-wide planning, and coordinate with each other. While many agencies that participate in a CoC receive HUD funding, entities that do not receive HUD funding still participate in the CoC for a variety of reasons: to increase the impact of their own work; to learn more about the different resources available in the community to better serve their clients; to learn strategies and best practices for responding to homelessness; to build relationships with other leaders and organizations with similar missions and values; to better position themselves for future HUD funding; etc.

5. **HUD requires CoCs to develop certain processes.** Because each community has a variety of assistance programs and resources to support people experiencing or at risk of homelessness, HUD requires every CoC to have a process in place to ensure that people who need housing and other supports are connected to local resources in an equitable and coordinated way. That process is called **Coordinated Entry (CE).**

Basics of Homeless Management Information Systems (HMIS)

What is HMIS?

HUD requires each CoC to collect and report certain information about the people they serve. HMIS (short for Homeless Management Information System) are the data systems communities use to collect and analyze client, service, and housing data. HUD does not mandate that CoCs use a particular software; each community may select any system that can collect the required data elements, comply with HUD's data standards, and support reporting requirements.

Information contained in HMIS

HUD requires every community to track specific data points and response options for various data elements. HUD also publishes data standards that CoCs must meet. Types of required data elements include:

- Basic client information, including whether the client has a physical or developmental disability, chronic health condition, HIV/AIDS, mental health issue, or substance use disorder;
- Whether the client receives non-cash benefits or has health insurance, and if so, what kinds; and
- Information about client interactions with the homelessness response system.

Limitations

Having a single system to collect data about those served by a community's homeless assistance programs is extremely helpful to keep track of clients, coordinate the connection to housing and other resources, monitor client outcomes, and track performance metrics at the organizational and system level. However, the information contained in HMIS can be insufficient for various reasons:

- Only programs that receive HUD funding are required to enter information into a community's HMIS. There can be many programs in a community that assist people experiencing homelessness but do not receive HUD funding (e.g., some faith-based organizations, smaller organizations) and therefore are not required to enter information into HMIS;
- Inconsistent data entry and data quality and missing information often occur with so many different individuals and providers entering data;
- Client information contained in HMIS is largely self-reported and clients may refuse to answer questions or provide incomplete or inaccurate information for a variety of reasons. Clients who underreport their health conditions can result in lower prioritization for housing and resources than their actual vulnerability or acuity of need warrants;
- HMIS is only required to comply with HUD data standards, thus may not meet the standards required under HIPAA; and
- HUD does not provide funding for HMIS to all communities. A CoC must annually prioritize and seek specific funding for HMIS alongside their housing and other programs.

Data Sharing

CoCs must get permission from clients to share their information between providers. Most CoCs accomplish this by asking clients to sign a Release of Information (ROI), which explains why, how, and with whom their information will be shared, as well as the measures taken to protect their information. CoCs maintain lists of provider agencies to which their ROIs apply (usually the list of providers who access and use the local HMIS) and either include that list on the form itself or link to it to allow for easier updating. In some CoCs, MCPs and other health providers already have access to HMIS, although some access is read-only. MCPs without HMIS access should discuss with their local CoCs the possibility of entering into an HMIS agency or provider agreement to help facilitate the kind of data matching or exchange needed to coordinate care and services. Additional ROIs or other Data Sharing agreements may be required to share certain client information, depending on how the CoC's HMIS and existing ROIs are structured. See *Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan* in this Toolkit.

Coordinated Entry Basics

What is Coordinated Entry?

Coordinated Entry (CE) is the process each CoC sets up to ensure people experiencing or at risk of homelessness are prioritized for a community's limited resources based on severity of need. CE also ensures that people are matched to available resources most suitable to meet their needs. **CE's primary purpose is to allocate housing resources fairly and appropriately.** It can also be used to refer and connect people with health care and other mainstream resources. It is critical for MCPs to understand how CE works, both generally and in their local CoCs.

The idea behind Coordinated Entry is **similar to emergency room triage**, which ensures that someone having a heart attack is served before someone with a broken arm, even if the person with the broken arm arrived at the emergency room first and has been waiting for hours. Under Coordinated Entry, higher acuity people are served before lower acuity people. Unlike emergency room care, due to limited available resources, CE does not guarantee that every person who needs housing assistance will receive it.

Benefits of CE

Without CE, people experiencing homelessness have to seek out multiple individual organizations that might be able to help them. In addition to being extremely burdensome for people already in crisis, individuals able to manage the burden often end up on numerous separate waitlists for housing.

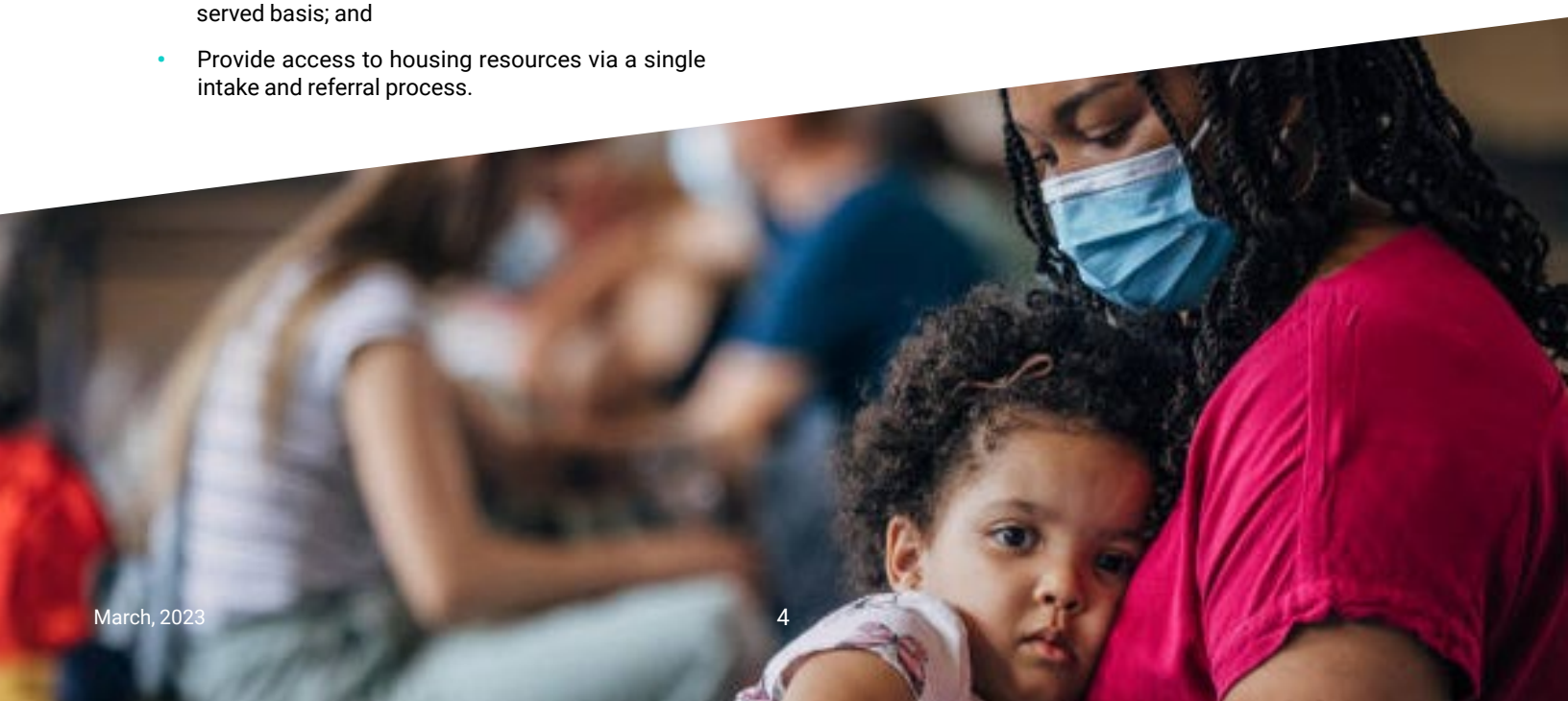
CE removes reliance on individual program waitlists organized on a first-come, first-served basis that do not take acuity of need into account. Instead, CE focuses on acuity of need so the individuals and families in the most dire of circumstances can be housed before those in less need. It also helps people more quickly learn about and get connected to different types of assistance beyond housing (e.g., public benefits, health coverage, or employment help). With CE, a person's access to resources does not depend on the individual case manager assigned (if any) or a person or family's own ability to navigate complicated systems.

CE Requirements

With CE, HUD mandates that each CoC:

- Use a standardized assessment approach with every individual or household that needs housing assistance to determine vulnerability, needs, and eligibility for resources;
- Organize a community-wide waitlist for housing resources that prioritizes individuals and families based on vulnerability/severity of need rather than on a first-come, first-served basis; and
- Provide access to housing resources via a single intake and referral process.

A well-functioning CE process ensures: (1) limited housing resources are prioritized to those most in need because of health issues, vulnerability to death or victimization, or the circumstances of their homelessness; and (2) people seeking housing are more likely to be matched with resources that meet their specific needs, regardless of where, when, or how they "show up" seeking assistance.



5 Key Things to Know about CE

1. **CE is required.** Every CoC must operate a CE system as a condition of receiving HUD funding. Every organization that receives HUD's homeless assistance grant funding must participate in CE. All housing vacancies and rental assistance vouchers funded with HUD's homeless assistance grant funding must be filled through the CE process.

2. **Key Components of CE** (1) Intake: entry by each person into the CE system; (2) Assessment of each person; (3) Prioritization of every assessed person based on vulnerability/severity of need; (4) A process to match resources to individuals or families as they become available, based on the established prioritization; (5) Referrals to housing programs that provide the matched resources; and (6) Placement of people into the housing programs to which they've been referred.

3. **CoCs have flexibility in designing their CE processes.** Every CoC's CE process must meet certain requirements, but CoCs have flexibility to customize their process. Based on local capacity, needs, and resources, each CoC must plan and design (1) how and where to identify people in need of homeless assistance; (2) what tool(s) to use to assess each person or family; (3) what factors to include when determining relative vulnerability of those assessed (i.e., the information on which to base prioritization); (4) the process and people involved to match available resources to prioritized people and connect those people to the agencies who hold the resources; and (5) how to evaluate whether the process is working well.

4. **CE is open to all organizations that serve people experiencing homelessness.** Only HUD-funded programs are required to participate, but the goal is for all local organizations with resources for people experiencing homelessness to participate, regardless of funding source. CE can be used to refer individuals and households to health care and other mainstream services and resources in addition to housing assistance.

5. **CoCs must evaluate and refine their CE processes to center equity, address disparities, and improve outcomes**. Although HUD has mandated CE for multiple years, CoCs are at different points in implementation. CoCs should regularly make adjustments to ensure the process is working effectively and equitably. Even in communities with an established CE system, there is always room for discussions, planning, and changes to improve implementation. Partners with diverse perspectives and expertise - including MCPs and other health system partners - are critical to identify issues, offer new insights, and inform changes.

Key Components of Coordinated Entry

System Entry
People seeking housing or services make contact with the community's homelessness response system, usually by interacting with an outreach worker, calling 211, or showing up at a service provider site.

Assessment
All individuals and families who enter the system are assessed in a consistent manner, using a uniform decision-making process and standardized assessment tools.

Prioritization
People are prioritized for housing and community resources based on factors agreed upon by the CoC, ensuring limited resources are used in the most effective manner and households most in need of assistance are prioritized for housing and services.

Matching
As housing resources become available, people at the top of the community's priority list are given a choice to accept those resources for which they are eligible and which appear to meet their needs.

Referral
People matched with a resource are referred to the program holding that resource, which requires communication between those who made the match decision, the person being referred, and the program providing the resource.

Placement
People are placed into the program and ultimately into housing. This usually entails ensuring the person is "document-ready" and often requires the person, program, and other partners to work together to address various barriers to housing placement and stability.

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Assessments

Relevant assessment factors include information about each person's needs, strengths, preferences, barriers they face to secure housing, length and duration of past and current episodes of homelessness, and characteristics that make them more vulnerable while experiencing homelessness. Most assessment information is self-reported and people may under-report certain conditions for various reasons.

Prioritization

Prioritization schemes are decided by each community and usually take into account the severity of service needs, considering factors such as risk of illness, death, and/or victimization; history of high utilization of crisis services; and significant physical or mental health challenges, substance use disorders, or functional impairments.

Opportunities to Leverage CE to support ECM, CS, and HHIP Implementation

Coordinated Entry (CE) offers practical and meaningful opportunities for cross-system coordination. By plugging into a community's CE process, MCPs can (1) ensure members with housing needs connect to the homelessness response system in the way most likely to get them assessed, prioritized, and connected to available resources; (2) ensure members are made aware of and referred to benefits and services like Enhanced Care Management (ECM) and Community Supports (CS); and (3) contribute valuable expertise to improve the overall CE process over time so both housing and Medi-Cal resources get to those who need them most in an efficient and equitable way.

Each improvement to the CE process and each member connection to housing resources or Medi-Cal benefits contributes to improved member outcomes and decreased burdens on the health system. **The following are examples of ways MCPs (or their contracted providers) can participate in CE and contribute to its improved functioning.**

System Entry

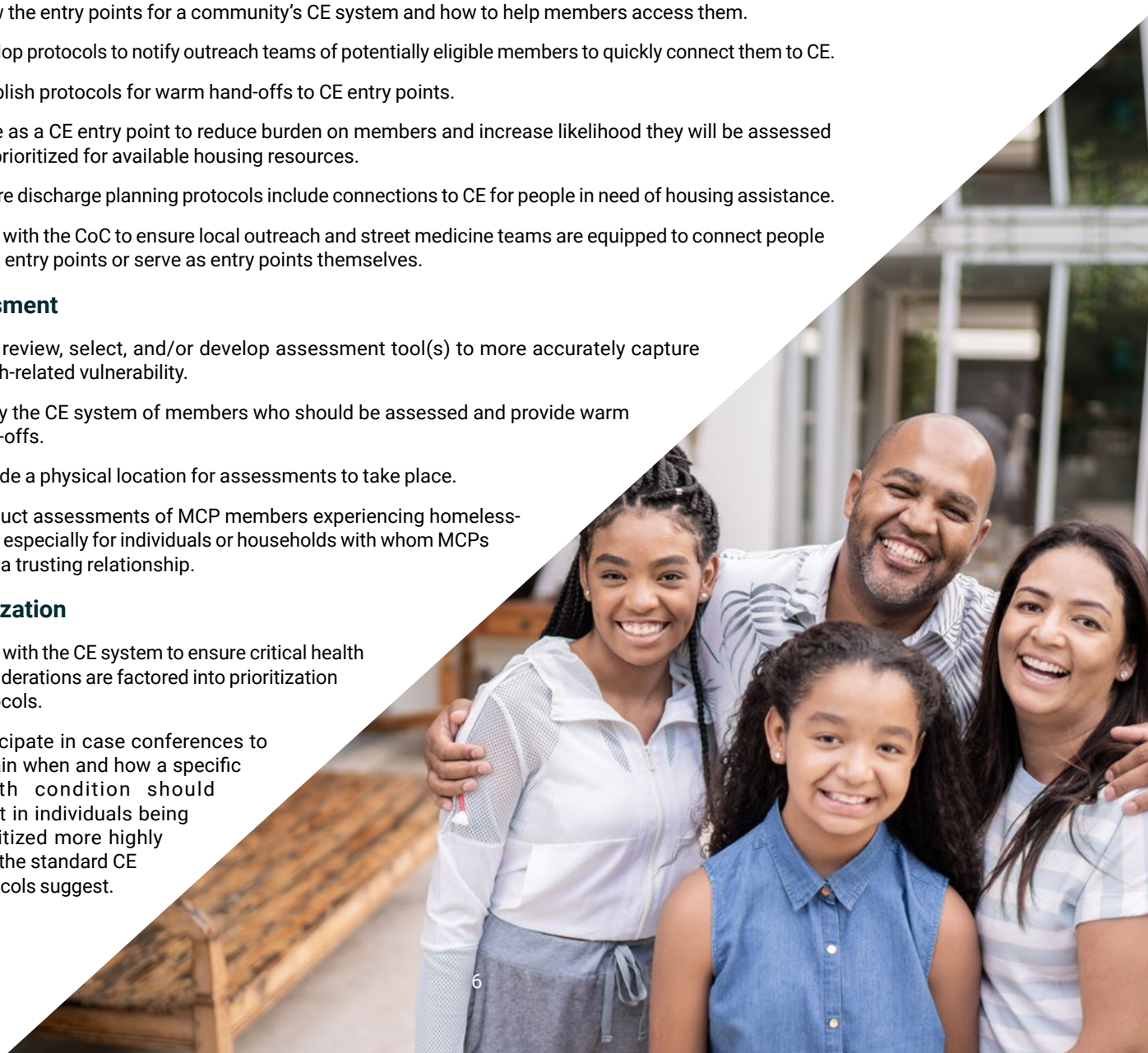
- Learn to identify members experiencing or at risk of homelessness to connect to the CE system.
- Know the entry points for a community's CE system and how to help members access them.
- Develop protocols to notify outreach teams of potentially eligible members to quickly connect them to CE.
- Establish protocols for warm hand-offs to CE entry points.
- Serve as a CE entry point to reduce burden on members and increase likelihood they will be assessed and prioritized for available housing resources.
- Ensure discharge planning protocols include connections to CE for people in need of housing assistance.
- Work with the CoC to ensure local outreach and street medicine teams are equipped to connect people to CE entry points or serve as entry points themselves.

Assessment

- Help review, select, and/or develop assessment tool(s) to more accurately capture health-related vulnerability.
- Notify the CE system of members who should be assessed and provide warm hand-offs.
- Provide a physical location for assessments to take place.
- Conduct assessments of MCP members experiencing homelessness, especially for individuals or households with whom MCPs have a trusting relationship.

Prioritization

- Work with the CE system to ensure critical health considerations are factored into prioritization protocols.
- Participate in case conferences to explain when and how a specific health condition should result in individuals being prioritized more highly than the standard CE protocols suggest.



Matching

- Participate in matching case conferences to provide additional facts about members that might increase the likelihood of appropriate and successful housing resource matches.
- Help members understand their options and how each might impact health care access and outcomes.
- Educate CE system operators on Medi-Cal benefits and services available to people experiencing or at risk of homelessness, including eligibility criteria.

Referral

- Offer support to housing providers and their clients (e.g., provide health care or other services to clients) to increase the likelihood that referred members are accepted and successful in housing placements.
- Help members procure necessary eligibility documentation (e.g., disability verification) so they can more quickly access housing.
- Educate CE system partners/providers on Medi-Cal enrollments and work with them to facilitate Medi-Cal enrollments so that more people experiencing homelessness have health coverage.
- Educate CoC/CE system operator and providers on the referral processes for Medi-Cal benefits and services and work with them to streamline those referrals through CE.

Placement

- Provide transportation help to get clients to appointments.
- Follow up with housed members to ensure continued connections to health care needed to support long-term housing stability.

Connecting with your Local CoC

There's no one way to collaborate with a CoC or participate in a Coordinated Entry system that applies across the board. Each CoC has different things to offer and needs different things from potential health care partners. Specific opportunities to partner with CoCs (whether in the context of HHIP implementation or otherwise) vary across CoCs as well.

The best way to engage with your local CoC(s) in a mutually beneficial way is to connect with and begin to build a relationship with representatives from key CoC stakeholders such as the Lead Agency, CoC Chair, or Coordinated Entry operator. Remember that while a county agency might serve as one or more of those roles, that's not always the case. Speaking with CoC and CE leaders is a great way to learn about the health needs of people who engage with your local homelessness response system, share insights about your and your members' needs, and discuss opportunities for cross-system collaboration and partnership to address those needs.

A list of all California CoCs and their websites is available here.