



Maricopa Regional Continuum of Care Coordinated Entry System Evaluation

May 5, 2023

Abstract

This report analyzes the strengths and challenges of the Maricopa Regional CoC's Coordinated Entry System and the extent to which the system is meeting the goals of coordinated entry to provide efficient access to available housing and services and foster equity and effectiveness in the allocation of resources.

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Executive Summary

Between June 2022 and February 2023, Homebase conducted an evaluation of Maricopa County's Continuum of Care's (CoC) coordinated entry system (CES). This evaluation is intended to set a baseline for future annual evaluations and included the following:

- A review of key policies and procedures
- An analysis of 2018-2021 data from the Homeless Management Information System (HMIS) and 2020 Census
- Focus groups with participating agencies
- Interviews with unhoused and recently housed households
- Interviews with system stakeholders
- Research on national CES best practices and emerging strategies

Overview of System Strengths and Opportunities

The following report analyzes the strengths and challenges of Maricopa County CoC's coordinated entry system. It evaluates the extent to which the system is meeting the goals of coordinated entry to provide efficient access to available housing and services and foster equity and effectiveness in the allocation of resources. No community has determined how to perfectly meet these goals, but Maricopa County's CES has some crucial successes on which it can build.

- **Access.** This section focuses on the system's accessibility for people experiencing homelessness and explores how households enter the system.
 - Key successes:
 - In interviews, most people with lived experience observed that locating a physical access point was relatively easy.
 - Providers noted that the major metro regions within the CoC were well-covered by CES.
 - Providers and people with lived experience mostly agreed that the single adult CES is robust and accessible.
 - Key challenges:
 - Black people are more than four-times overrepresented in the CES relative to the county population.
 - Native American people are more than two-times overrepresented in the CES relative to the county population.
 - Latinx people are underrepresented in the CES relative to the county population.
 - Providers and people with lived experience agreed that access is difficult for families.
 - Providers underscored that there are rural areas that lack sufficient CES coverage.
- **Assessment and Prioritization.** This section evaluates the effectiveness and equitableness of the assessment and prioritization processes in determining client need.
 - Key successes:
 - The Human Services Campus (HSC), the main hub for single adults, assessed 94% of households who enrolled in the CES during the reporting period.
 - United Methodist Outreach Ministries (UMOM), the main hub for families, assessed 82% of families who enrolled in the CES during the reporting period.
 - There are no racial or ethnic disparities in the assessment rate of households enrolled in CES.
 - Providers observed that street outreach teams are effective in building rapport with unhoused persons, so their clients are comfortable self-reporting, taking assessments, and advocating for themselves.
 - People with disabling conditions and those experiencing more than 12 months of homelessness receive assessments at higher rates than average and higher assessment scores than average.
 - Key challenges:
 - People with lived experience perceive the assessment process as dehumanizing, observing that assessment tools fail to account for the breadth of human experience.
 - Staff training is inconsistent and lacks standardization because trainings take place on an agency-by-agency basis.
 - Stakeholders are concerned that the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) is biased and re-traumatizing and that it does not capture vulnerability in an accurate

- manner as fear, stigma, and cultural norms prevent people from responding openly to the invasive and sensitive questions.
- Victim services providers expressed a need for an assessment that considers the needs of survivors of and those fleeing intimate partner violence.
 - Assessors are not collecting information about clients' sexual orientation or gender identity.
- **Referral to Permanent Housing.** This section evaluates the effectiveness and equitableness of the referral process and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.
 - Key successes:
 - For both RRH and PSH, the majority of referrals are accepted, and permanent supportive housing referrals have a particularly high acceptance rate.
 - Providers observed that the referral process for rapid rehousing is smooth.
 - People with disabling conditions and those experiencing more than 12 months of homelessness receive referrals at slightly higher rates than average.
 - Key challenges:
 - Stakeholders noted several subpopulations are underserved: LGBTQIA+ adults, families, people with disabling conditions, and people with substance use histories.
 - People with lived experience observed there is a lack of communication and transparency throughout the referral process.
 - Providers and people with lived experience indicated that housing and assistance available does not adequately reflect the cost of living in the region.
 - People with disabling conditions are much less likely to receive a move-in date. Providers observed that this population needs additional resources, supports, and inventory.
 - Only 6% of assessed families receive a referral. Because women, Black people, and Latinx people disproportionately access CES as families, this is an issue of gender, racial, and ethnic equity.
 - Providers noted that there are racial disparities in negative exits.
 - **System Governance and Management.** This section focuses on system governance, management, communication, and evaluation.
 - Key successes:
 - Some providers are already working to ensure that their staff is demographically representative of the homeless population they serve.
 - Key challenges:
 - Across all focus groups and interviews, individuals described a breakdown in communication and a lack of transparency which makes providers and clients alike feel insecure, unsure of their place, and unable to advocate.
 - Trainings are piecemeal and often provided ad hoc on an agency-by-agency basis.

Recommendations and Next Steps

To address the identified challenges, the report includes recommendations related to access, assessment and prioritization, referral, and system governance and management at the end of each of the corresponding sections. These recommendations are also gathered into an action item list in Appendix A to highlight areas for critical, important, and suggested opportunities for improvement. Maricopa County's CES has some important successes and strong partnerships, both of which can be leveraged to implement the recommendations for system improvement.

Introduction

Each Continuum of Care (CoC) that receives CoC and/or Emergency Solutions Grant (ESG) Program funding from the U.S. Department of Housing and Urban Development (HUD) is required to design and implement a coordinated entry system. Coordinated entry is a process for assessing the vulnerability of all people experiencing homelessness within the CoC to prioritize those most in need of assistance for available housing and services. The goals of coordinated entry are:

1. To increase the efficiency of the local crisis response system,
2. To improve fairness in how housing and services are allocated, and
3. To facilitate rapid access to housing and services.

HUD requires each CoC to conduct an annual evaluation focusing on the quality and effectiveness of the entire coordinated entry experience—including assessment, prioritization, and referral processes—for both programs and participants. Per HUD requirements and for the purposes of continuous improvement, the Maricopa Association of Governments (MAG) commissioned Homebase to conduct an evaluation of the CoC's coordinated entry system. This report analyzes the strengths and challenges of the coordinated entry system, focusing on four key areas:

- **Access.** This section focuses on the system's accessibility for people experiencing homelessness and explores how households enter the system.
- **Assessment and Prioritization.** This section evaluates the effectiveness and equitableness of the assessment and prioritization processes in determining client need.
- **Referral to Permanent Housing.** This section evaluates the effectiveness and equitableness of the referral process and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.
- **System Governance and Management.** This section focuses on system governance, management, communication, and evaluation.

All four sections include recommendations for strengthening the system. These recommendations have been consolidated in Appendix A to highlight areas for critical, important, and suggested opportunities for improvement. The report also includes an overview of evaluation methodology and an analysis of coordinated entry system impact.

Throughout the report, a teal color is used to highlight areas and findings where the system excels, whereas areas for improvement appear in red.

Evaluation Methodology

Homebase collected and analyzed data from the following sources for this evaluation report:

- **An analysis of HMIS data.** Deidentified client-level data corresponding to evaluation questions was provided to Homebase by Solari Crisis and Human Services, the CoC’s HMIS Lead Agency. The client pool consisted of clients who were enrolled in coordinated entry and those who were enrolled in permanent housing projects. Data included clients enrolled from 01/01/2018 to 12/31/2021.
- **An Analysis of 2020 Census data.** Publicly available 2020 Census data for Maricopa County was collected by Homebase. The following variables were excluded from core analyses due to poor data quality: sexual orientation, gender identity.

Analysis section	Data sources	Universe parameters
Access	Coordinated entry enrollment HMIS data (01/01/2018 -12/31/2021)	Deduplicated head of households
	2020 Census data	Individuals
Assessment	Coordinated entry enrollment HMIS data (01/01/2018 -12/31/2021)	First household record
Prioritization and Referral	Coordinated entry enrollment HMIS data (01/01/2018 -12/31/2021)	First household record
System Flow Analysis	Coordinated entry enrollment HMIS data (01/01/2018 -12/31/2021)	First household record
	2020 Census data	Individuals

- **Focus groups with participating agencies.** Homebase conducted three focus groups with 32 coordinated-entry-participating agency staff in January: a focus group for providers who work with youth, families and/or domestic violence survivors; a focus group for entry points, shelter, outreach and other service providers; and a focus group for housing providers who receive referrals. The focus groups were conducted virtually via video and conference call. Feedback from the focus groups was utilized to analyze adherence to coordinated entry system policies and procedures, quality of collaboration, accuracy and consistency of assessment, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these focus groups can be found in Appendix B.
- **Interviews with system stakeholders.** Homebase conducted interviews with 16 system stakeholders, including participating permanent housing providers, housing matchers, shelter staff, local government officials, victim services providers, people with lived experience of homelessness, and coordinated entry staff. Feedback from the interviews was utilized to analyze adherence to coordinated entry system policies and procedures, quality of collaboration, accuracy and consistency of assessment, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these interviews can be found in Appendix B.
- **Focus groups with unhoused and recently housed households.** Homebase conducted five focus groups with a total of 45 people who had direct experience with seeking housing assistance in Maricopa County. Homebase planned these focus groups with MAG leadership by selecting a representative group of providers and asking them to offer the opportunity to their clients, and focus groups were held on-site at these organizations. Focus group participants were provided \$50 gift cards for taking part in the evaluation. Feedback from the focus groups was utilized to analyze ease of system access, efficiency of intake and assessment, adherence to coordinated entry system policies and procedures, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these focus groups can be found in Appendix B.
- **Review of key policies and procedures and past reports** related to the coordinated entry system as provided by MAG to evaluate compliance with HUD requirements. For more information, please refer to Appendix D.
- **Literature review.** Homebase conducted research into the efforts by communities across the country to augment or replace the VI-SPDAT and national best practices related to the four core elements of CES (access, assessment, prioritization, and housing) with an emphasis on race equity. These findings were compiled into a written document outlining best practices and including community examples relevant to the Maricopa Regional CoC. This document is attached hereto as Appendix E, and the findings are incorporated into this report.

Findings and Recommendations

The following sections provide Homebase’s quantitative and qualitative analysis of access, assessment and prioritization, referral to permanent housing, and system governance and management. Within each focus area, Homebase provides an analysis of process and effectiveness, an assessment of equitableness, and recommendations for system improvement.

Access

This section focuses on the system’s accessibility for people experiencing homelessness and explores how households enter the system. Use of the terms “access” and “accessibility” are meant in the broadest sense to indicate whether individuals navigating the system are able to reach the people and resources within it.

Throughout the report, a teal color is used to highlight areas and findings where the system excels, whereas areas for improvement appear in red.

Analysis of Process and Effectiveness

Before the onset of COVID-19, on average 861 households were enrolling in coordinated entry per month. Since COVID-19, on average 589 households are enrolling in coordinated entry per month. HSC and UMOM are the most common access points used, and together they handle about 60% of all households enrolled in the system. The other 32 access points listed in HMIS handle the remaining 40% of households.

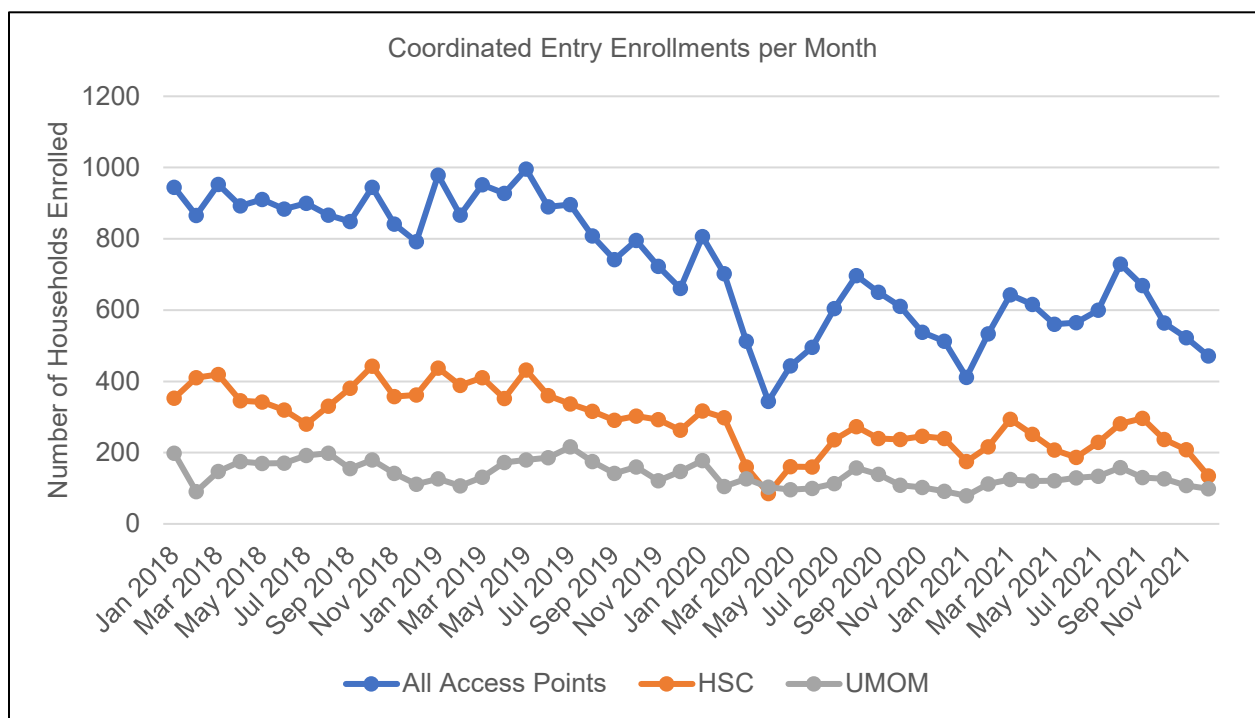


Figure 1. Number of households enrolled in coordinated entry per month. Data source: HMIS.

In focus groups, people with lived experience navigating the CES indicated that it was relatively easy to initially access the system, suggesting that there is a strong network linking people to coordinated entry. Individuals successfully accessed coordinated entry via internet searches, based on information given during discharge from carceral settings, by reaching out to nonprofits, connecting to shelters, and from both formal and informal outreach. In addition, most participants said that locating a physical access point was not difficult, and several individuals received assistance and transportation to get to those entry points. In provider focus groups and interviews, individuals stated that the major metro regions of Phoenix, Mesa, Tempe, and Scottsdale are well covered, though some of that coverage is not permanent. Providers also described the single adult coordinated entry system as robust and accessible, a sentiment that people with lived expertise mostly shared.

Providing effective CES access is a particularly difficult task for CoCs across the country – it requires strong partnership and collaboration between community partners, proactive marketing by CES Lead Agencies, and consistent training. While single adults have relative ease of access to coordinated entry in Maricopa, both people with lived expertise and providers highlighted that access is difficult for families. Additionally, individuals with severe mental or medical health diagnoses, disabling conditions, people who use substances, veterans, and those with criminal records have a particularly challenging time accessing the system. Relatedly, providers observed that additional access points are needed and recommended access points specifically for families, LGBTQIA+ adults, and older adults. People with lived experience observed that connecting with the CES can be difficult for individuals that do not have access to or a working knowledge of a phone or computer. Regarding geographic access, providers overwhelmingly described inequities in the more rural areas outside of the Phoenix metro region, which lack sufficient coverage.

Assessment of Equitableness

Black people are more than four-times overrepresented in the CES population relative to the county population – while they make up 8% of the county population, they make up 37% of the CES population. Native American people are more than two-times overrepresented in the CES population relative to the county population – while they make up 4% of the county population, they make up 9% of the CES population. White people are underrepresented in the CES population relative to the county population. The numbers of Asian or Native Hawaiian people enrolled in CES during the reporting period were too small to draw any conclusions.

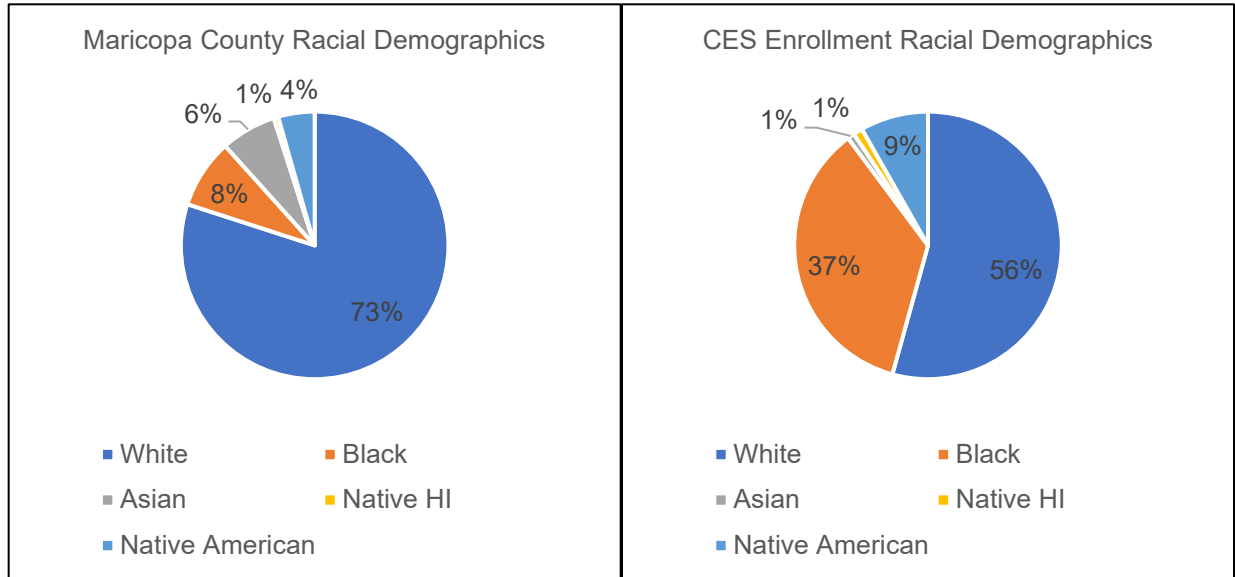


Figure 2. Racial demographics of Maricopa County (left) and the population enrolled in the CES (right). Data sources: 2020 Census and HMIS.

In focus groups, providers agreed that **additional outreach and access is needed specifically for Native American populations**. Several providers recommended access points specifically for Native Americans experiencing homelessness, especially for more vulnerable and underserved individuals like Native American youth and transitional age youth.

Latinx people are underrepresented in the CES population relative to the county population – while they make up 32% of the county population, they make up only 25% of the CES population. Furthermore, Latinx people are overrepresented in the county population below the poverty line, which may suggest that they would be expected to also be overrepresented in the CES population. This could indicate that Latinx populations are facing barriers to accessing the CES, however, the data alone cannot determine if this is true.

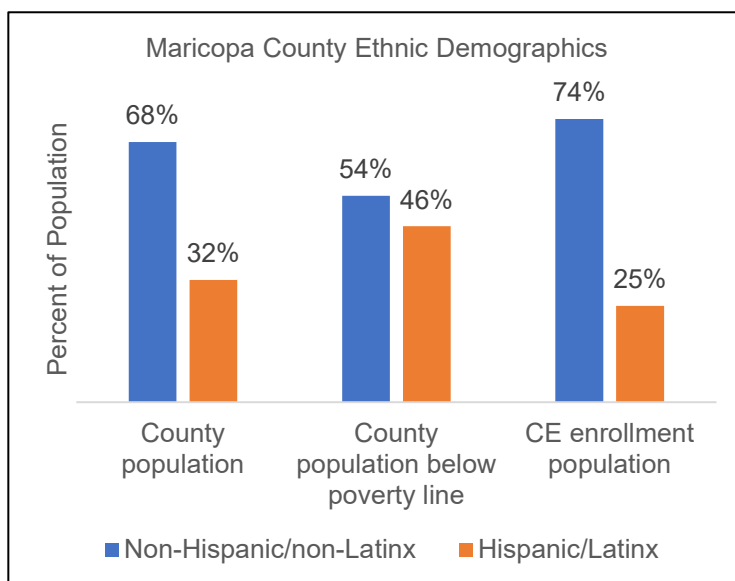


Figure 3. Ethnic demographics of Maricopa County, the County population below the poverty line, and the population enrolled in the CES. Data sources: 2020 Census and HMIS.

In focus groups, providers felt confident that language barriers did not prevent Spanish speakers from accessing the CES because agencies have staff that speak Spanish. System partners observed that the underrepresentation of Latinx residents in the community could be a result of cultural values, namely relying on the help of family and community instead of seeking access to services. Access points and providers should closely evaluate their policies and procedures, staffing, and staff training to ensure that

translation services are available and advertised to the community. If Latinx residents are underrepresented in the CES because of language barriers, these changes could be a solution.

The National Alliance to End Homelessness recently released [an article](#) about Latinx homelessness and solutions to reaching and housing these populations. The article notes that around the country, Latinx underrepresentation in the homeless system of care is not uncommon. It cites research highlighting reasons this may be true, including:

- Latinx people are less likely than other demographic groups to use shelters and other mainstream services, which may prevent them from learning about homeless system resources.
- In 2019, 45% of the US Latinx population was foreign born, so people in this community may have less familiarity with tenants’ rights, legal advocacy organizations, public benefits, and local social service systems.
- Fear that requesting services may have negative consequences for immigration status.

While these are aggregated national trends, they may provide insight into Latinx populations’ access to the CES in Maricopa County.

National Community Examples

The following community examples were selected based on local challenges regarding geographic coordination of access that emerged from feedback received from providers. More information and links to resources can be found in Appendix E.

Seattle/ King County

The Coalition Ending Gender-Based violence will soon be implementing a parallel DV CES. As part of this process, a DV Centralized Helpline comprised of a 12-15-person advocate team will be co-located at Crisis Connections, the community crisis help line. This team will assist with conducting pre-screens for housing assessment referrals, therefore preserving capacity for individual provider agencies to engage in more intensive advocacy work.

Virginia Balance of State (BOS)

Clients presenting for services at provider locations are referred to the nearest access point for triage via phone or in person. The coordinated entry process is spread across 12 local planning groups (LPG’s) that each have at least one centralized physical coordinated access point to ensure that people across the entire BOS geography are able to access the system. Access points do not determine eligibility or conduct program intakes; however, they make referrals based on the information provided by the client and coordinate with prevention, emergency shelter, and housing programs. Households are engaged in a problem-solving conversation while waiting for assessment including alternative resources available to the household, links to mainstream supports, and light assistance. If diversion is not an appropriate option based on the households needs, a shelter referral is made. Although client choice is made a priority, the community is still exploring ways to address racial equity concerns with the process.

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding access to Maricopa Regional CoC’s coordinated entry system.

Finding	Recommendation(s)
<p><i>Latinx people are underrepresented in the population of people enrolling in the CES even though they are overrepresented in the population of people living below the federal poverty line. The current assessment and prioritization process may exacerbate this ethnic disparity.</i></p>	<ul style="list-style-type: none"> • Conduct targeted interviews with Latinx people, advocacy organizations, and providers serving Latinx people to determine barriers this subpopulation faces to accessing the CES. • Recommendations to lower barriers to access for Latinx people can be found in this National Alliance to End Homelessness article, including: <ul style="list-style-type: none"> ○ Hire Latinx staff, especially Spanish speakers, at all levels. ○ Conduct cultural competency training and translation training for staff. ○ Have policies in place to ensure Spanish speaking staff are present and available to translate whenever access points are open. ○ Affirmatively market that translation services are available. ○ Conduct outreach in Latinx communities and community spaces to educate about CE, prevention, and diversion resources. ○ Have policies in place to ensure providers do not require legal documentation from clients

Finding	Recommendation(s)
<p><i>Access points are centered in downtown Phoenix and in-person CES access is limited outside this metro area.</i></p>	<ul style="list-style-type: none"> beyond what is required by the state and federal government. <ul style="list-style-type: none"> ○ Cross-sector training between immigration legal aid organizations and the CoC. ○ Ensure providers understand that rapid rehousing can be accessed regardless of citizenship status. ● Create a map of access points and shelters to determine if more should be established in places Latinx people live, gather, and work.
<p><i>Assessors expressed a need for more training and support related to administering their CES role in a culturally responsive and trauma-informed way to effectively build trust and obtain accurate responses that fully capture vulnerability. Further, turnover in staffing impacts the system’s capacity to build trusting provider relationships.</i></p>	<ul style="list-style-type: none"> ● Leverage Point-in-Time Count and street outreach data to identify regions that would benefit most from localized access points and conduct targeted recruitment to bring on access points in these areas. Some areas may have lower unmet needs that would be met by additional CES outreach — consider expanding existing access point capacity to provide this service on a scheduled or as-needed basis. ● Consider expanding the capacity of outreach teams to complete assessments via CoC and/or ESG funding. ● Consider expanding capacity for remote assessments via CoC and/or ESG funding. For more information, see the Seattle / King County community example in Appendix E. ● Increase collaboration between MAG and local community organizations and government partners to align messaging around homelessness and support in local government/City Council discussions regarding crisis response, supportive housing, and local funding allocations. ● Strengthen coordination between access points through regular community meetings of direct service providers to build relationships, learn about community resources, and create avenues for provider input into systems.
<p><i>Families typically access the CES directly via FHH or via 211 screening and referral to FHH. Coordination challenges and a lack of capacity can lead to slow processing times for clients and referrals to FHH that would be better suited to 211’s services.</i></p>	<ul style="list-style-type: none"> ● Develop a standardized training curriculum for access points. Consider holding regular office hours or other opportunities for assessors to troubleshoot emerging challenges. ● Incorporate racial equity, implicit bias, and cultural responsiveness training in access point onboarding. Prioritize input of those most impacted and grassroots organizations in developing trainings. ● Provide ongoing support to providers, including clinical supervision, to work through emerging challenges related to implementing cultural responsiveness and managing vicarious trauma. ● Consider conducting a study to identify strategies and potential federal, state, local, and private funds to increase provider compensation to meet or exceed living wage, opportunities for professional development and engagement in systems-level conversations, benefits, and ongoing support in their day-to-day work.
	<ul style="list-style-type: none"> ● Organize cross-training and other opportunities for collaboration between 211 and FHH. ● Consider integrating housing problem-solving into coordinated entry to support households in identifying choices and solutions to quickly end their housing crisis and preserve emergency shelter beds and supportive housing resources for households who have no alternative options. Consider the following resources and examples: Innovative Practices in Housing Problem-Solving, Tracking Dynamic Housing Problem

Finding Recommendation(s)

Solving Conversations, Santa Clara County Continuum of Care Housing Problem Solving Guidelines, and Santa Clara County Homelessness Prevention System Operations Manual. Consider also Seattle/ King County's DV Centralized Helpline, consisting of a 12-15 person advocate team co-located at Crisis Connections, the community crisis help line. This team will assist with conducting pre-screens for housing assessment referrals to create capacity for VSPs.

- Train (on an ongoing basis) 211 and non-211 access point staff, shelter staff, and diversion program staff in housing problem solving techniques, including how to apply motivational interviewing to have creative conversations that support participants in identifying and leveraging household strengths, support networks, and other resources in overcoming barriers to housing stability and identifying potential solutions to their housing crisis. Train staff to serve as mediators to assist households in having difficult conversations with individuals in their support network, such as friends and family, employers, debt collectors, and landlords.
- Set up a flex fund accessible by 211, access points, and shelters to provide limited financial assistance for solutions that require monetary support, such as:
 - Move-in costs, including deposit and first month's rent, moving supplies, the cost of a moving truck, and storage
 - Rental application fees and payments for background and credit checks
 - Fees for securing identification documents, birth certificates, and social security cards
 - Transportation, including bus tickets for both local transport and to facilitate relocation to verifiable, safe housing out-of-the-area, car repair for ending homelessness (e.g., for travel from temporary/permanent housing to school/work
 - Previous housing debt/rental arrears if resolving will facilitate an immediate housing placement
 - Utility deposits and arrears needed to secure housing
 - Certifications or license fees related to employment
 - Household expenses such as groceries or cleaning supplies
 - Fees for temporary childcare or other children's activities
- Consider expanding capacity at 211 for diversion and prevention via CoC and/or ESG funding or by identifying and pursuing potential state, local, and/or private funds.

Assessment and Prioritization

This section evaluates the effectiveness and equitableness of the assessment and prioritization processes in determining client need.

Throughout the report, a teal color is used to highlight areas and findings where the system excels, whereas areas for improvement appear in red.

Analysis of Process and Effectiveness

On average, about 672 households are assessed per month. VI-SPDAT assessments consistently make up about 80% of all assessments done. We can use the type of assessment taken as a proxy for a head of household's household type (i.e., that singles take VI-SPDAT, families take VIF-SPDAT, and youth take TAYVI-SPDAT). This indicates that single adults are by far the most prevalent household type accessing the CES. The main CES hub for single adults is HSC and the main CES hub for families is UMOM.

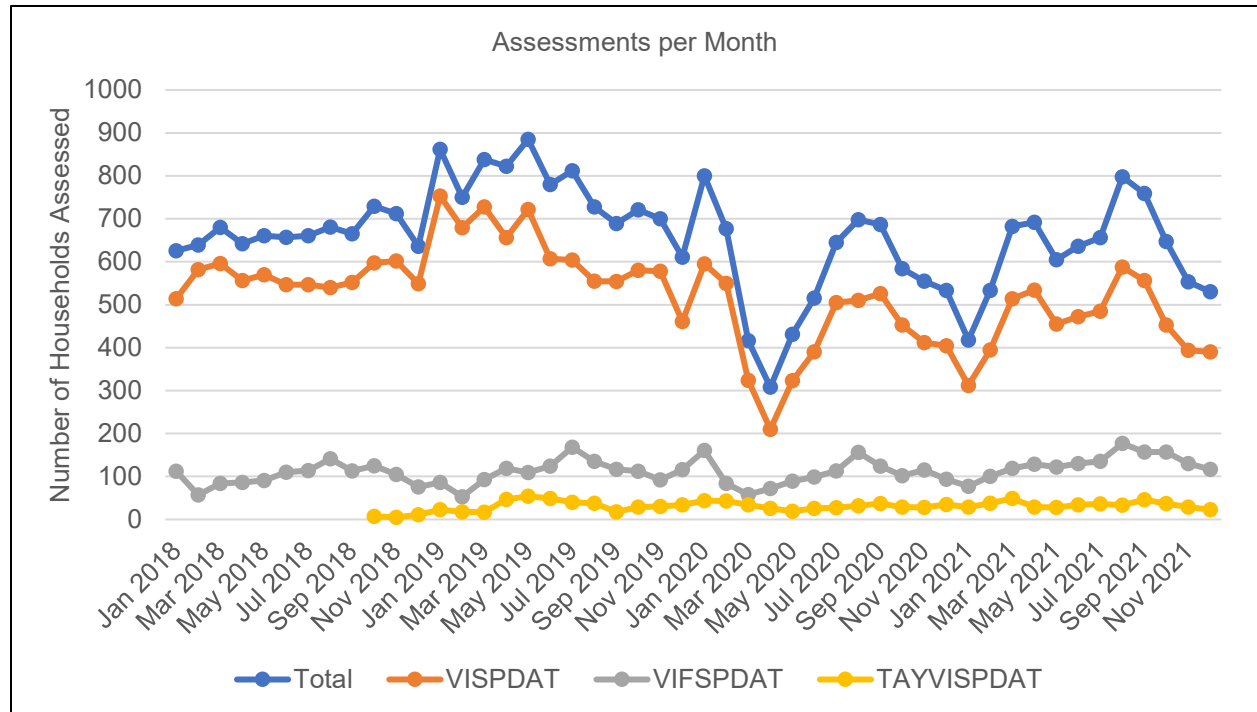


Figure 4. Number of households assessed per month. Data source: HMIS.

Most single adults enrolled in the CES at HSC, and it assessed 94% of households who enrolled. Most families enrolled in the CES at UMOM, and it assessed 82% of households who enrolled.

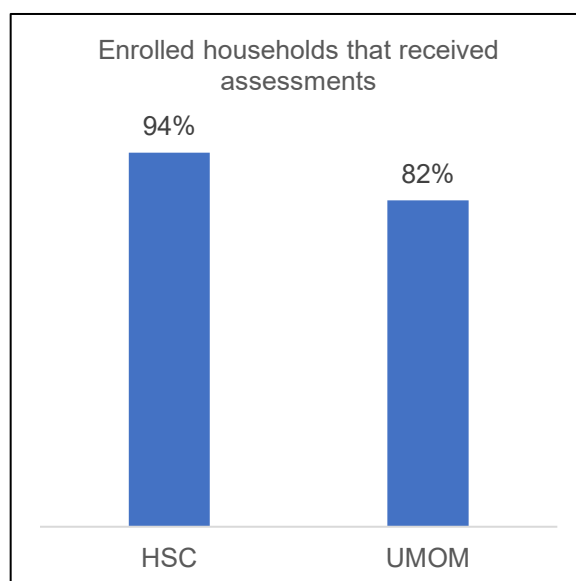


Figure 5. Percent of enrolled households that receive an assessment at each major access point. Data source: HMIS.

Providers commended the work of street outreach teams for the role they play in making clients comfortable self-reporting, taking assessments, and availing themselves of and advocating for

themselves in the system. Providers that participated in the evaluation were **actively engaged in and curious about the assessment and prioritization process**. They were thoughtful about **areas for improvement** and many of them expressed a desire for greater knowledge of and involvement in the system. Along this line, the **current system of assessment seems to allow providers flexibility and space** beyond the VI-SPDAT to advocate for clients based on vulnerability that may not be adequately captured by the assessment. Overall, providers reported that **individuals are comfortable answering sensitive population-specific questions about sexual orientation and criminal legal system involvement** especially if they feel supported by the person and environment in which the assessment is administered.

In focus groups, providers stressed that ongoing system-wide training is necessary, as now **training is taking place on an agency-by-agency basis**. Expanded training should focus on administering the assessment in a trauma-informed way. Indeed, both providers and participants discussed the **need for a trauma-informed assessment and increased sensitivity among staff administering that assessment**. Individuals with lived expertise described being “treated not like humans” and observed that staff did not ask about their housing needs, were unable to answer questions or provide help outside of their limited script, and in many cases were disrespectful. In general, clients described the system as **understaffed**, an issue that is especially difficult during in-between stages in the CES process, when contact with staff is extremely limited and support is hard to come by. Staff stated that **progressive engagement is slow and leads to families entering and exiting frequently**, which has a disproportionate impact on BIPOC individuals and families. These statements were echoed in client focus groups where participants described suddenly being dropped from or having to restart the process, and which several participants described as slow and unresponsive.

As to the assessments themselves, most providers and people with lived expertise observed that there is room to improve the tools, especially the VI-SPDAT. **Individuals who had taken the VI-SPDAT described it as redundant and too narrowly focused on substance use**. These individuals would have preferred an assessment that focused on what could have been done to prevent them from becoming homeless, and which captured the whole breadth of experiences. **Providers felt that VI-SPDAT scores often fail to capture actual vulnerability** especially as to individuals with histories of homelessness, comorbidities, and trauma. Particularly, providers felt that the **VI-SPDAT’s focus on an individual’s most recent experience with homelessness fails to consider historical vulnerabilities**, which mask the actual acuity of specific communities, especially BIPOC individuals and survivors of domestic violence and sexual assault.

Assessment of Equitableness

In alignment with CoC policies aiming to prioritize serving these populations, people with disabling conditions and those experiencing more than 12 months of homelessness receive assessments at slightly higher rates than average. Over 96% of both populations received assessments after they enrolled in CE, whereas 92% of the general population enrolled in the CES received assessments. If there are specific strategies used to ensure these populations receive assessments, those strategies may be useful in increasing assessment rates of other populations.

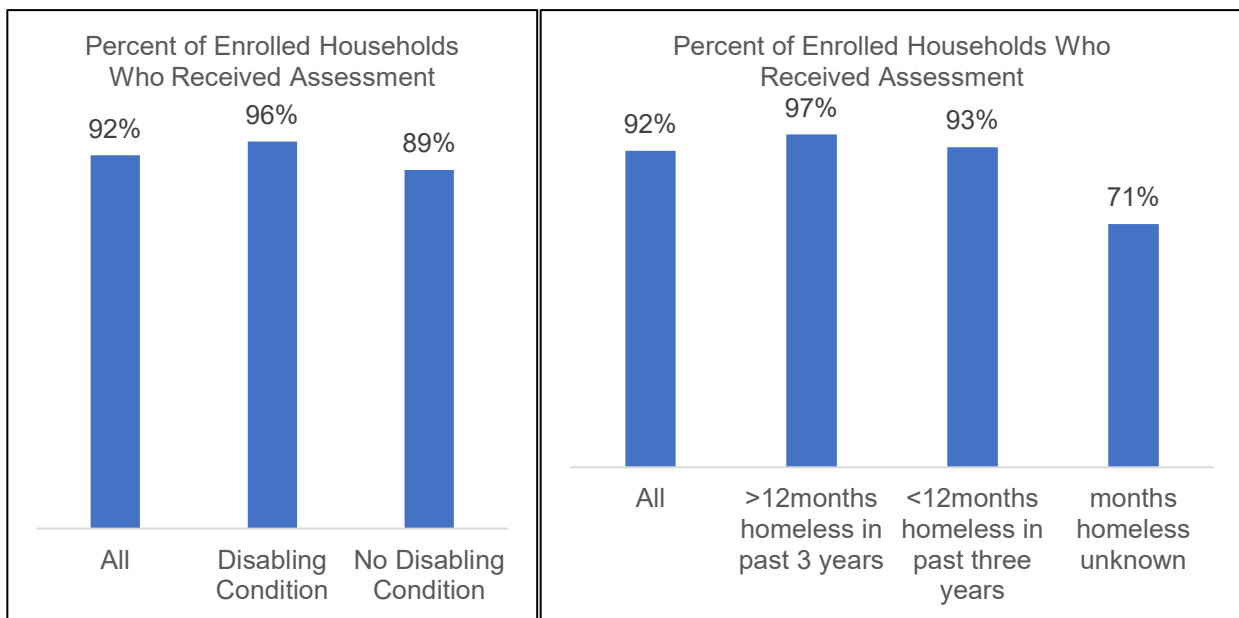


Figure 6. Rate of assessment based on disabling condition (left) and length of time homeless (right). Data source: HMIS.

In accordance with CoC policies aiming to prioritize serving these populations, people with disabling conditions and people spending more than 12 months homeless receive higher VI-SPDAT assessment scores than average. While there are drawbacks to the VI-SPDAT, this data suggests the VI-SPDAT as it is currently used is relatively effective in capturing disabling conditions and length of time homeless as vulnerabilities, which in turn allows for prioritization of people with these vulnerabilities. The same is not true of the VIF-SPDAT, suggesting that if the community wants to prioritize families with disabling conditions or long lengths of time homeless, then changes in assessment questions, wording, or weighting may be necessary.

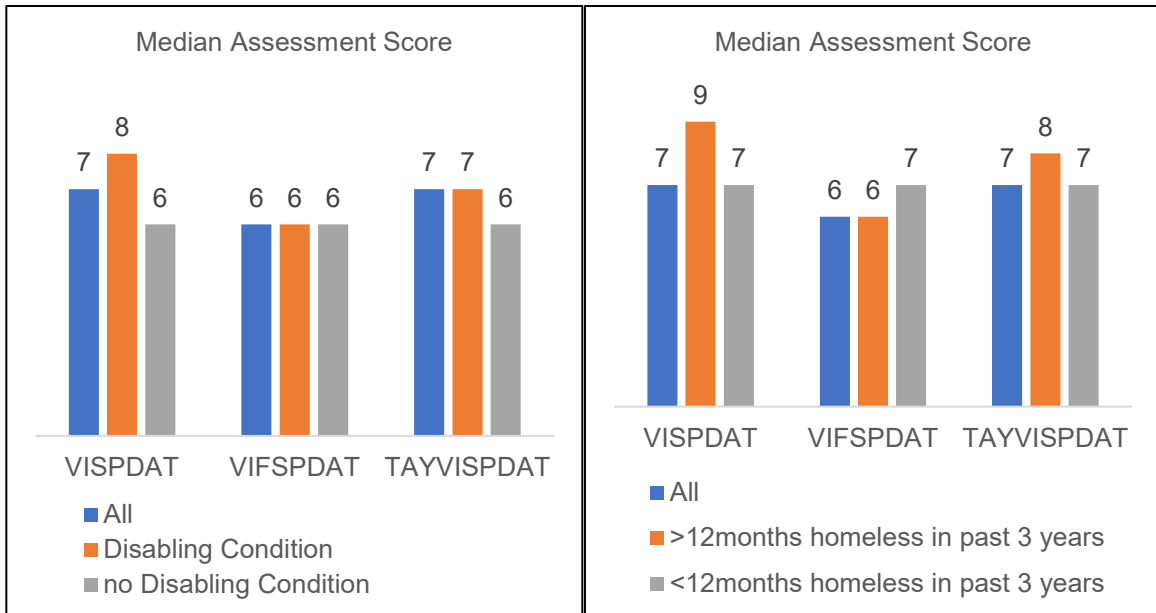


Figure 7. Median assessment score based on disabling condition (left) and length of time homeless (right). Data source: HMIS.

As shown in Figure 8, there are no racial or ethnic disparities in assessment rates of households enrolled in CES.

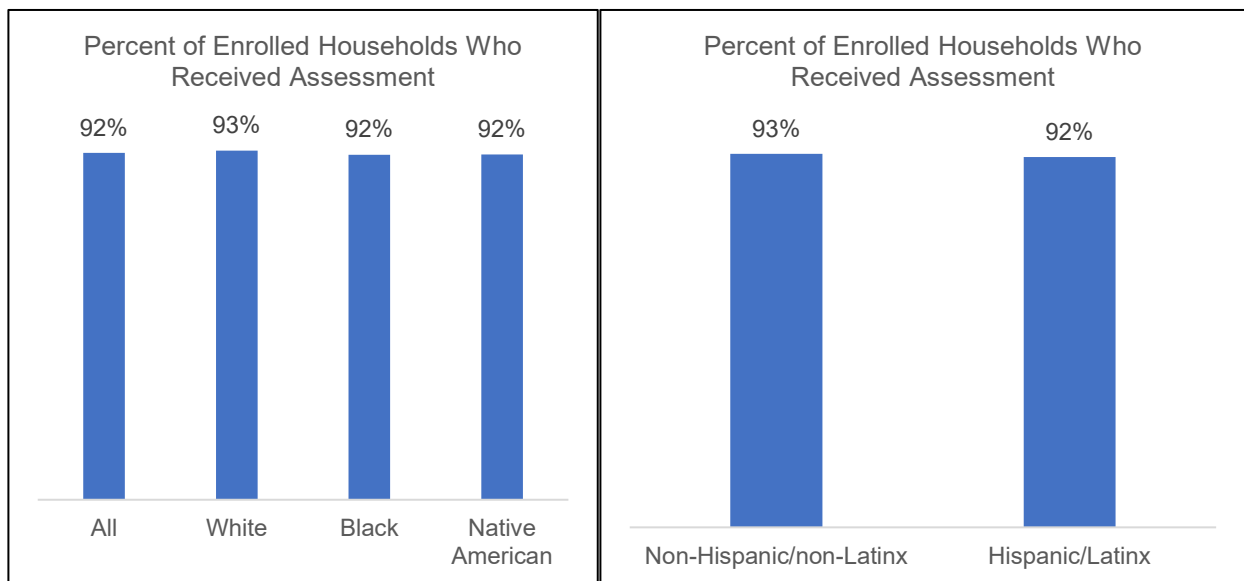


Figure 8. Rate of assessment by race (left) and ethnicity (right). Note: The numbers of Asian or Native Hawaiian people enrolled in the CES during the time period were too small to draw conclusions. Data source: HMIS.

Black and Latinx people take the VIF-SPDAT at higher rates than other groups and take the VI-SPDAT at lower rates. This trend suggests that Black and Latinx people enrolled in the CES are more commonly in families compared other demographic groups.

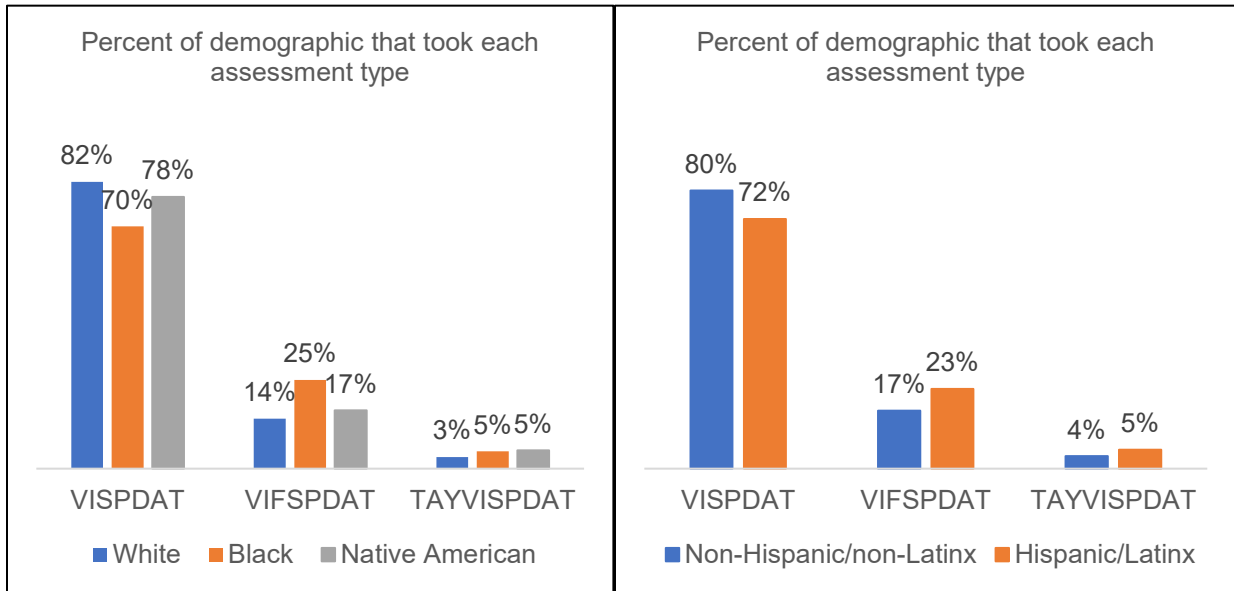


Figure 9. Percentage of each type of assessment for racial demographics (left) and ethnicities (right). Note: The numbers of Asian or Native Hawaiian people enrolled in the CES during the reporting period were too small to draw conclusions. Data source: HMIS.

Across assessment types, Black people have lower median scores than white people. This is also true nationally and suggests that the VI-SPDAT does not capture the full scope of clients' vulnerabilities.

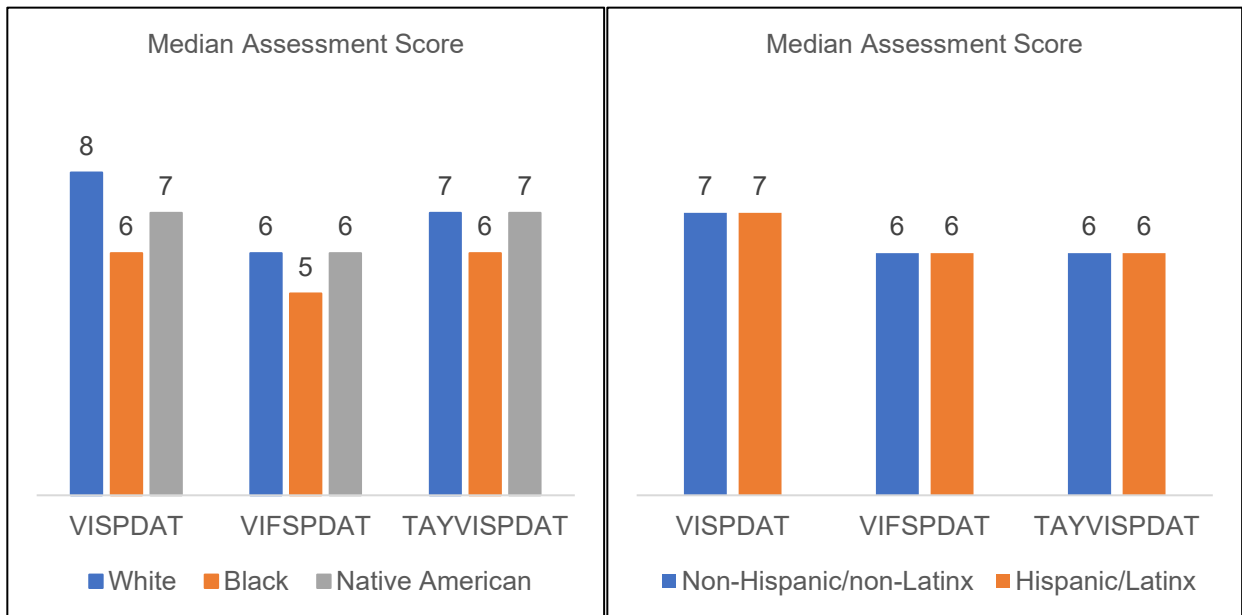


Figure 10. Median assessment score by race (left) and ethnicity (right). The numbers of Asian or Native Hawaiian people enrolled in the CES during the time period were too small to draw conclusions. Data source: HMIS.

A similar inequity exists across genders. Women enrolled in the CES are much more commonly in families compared to men, and **women are assessed at slightly lower rates**. This trend makes the disparity in assessment rate based on household type an issue of gender equity.

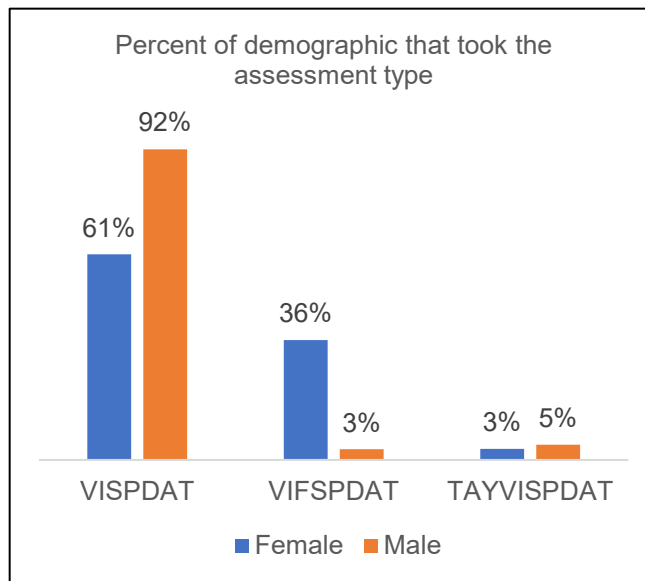


Figure 11: Percentage of each type of assessment by gender. Note: The numbers of people identifying as No Single Gender, Transgender, or Questioning during the reporting period were too small to draw conclusions. Data source: HMIS.

With the available HMIS data, it is not possible to assess whether Maricopa County’s CES serves clients differently depending on their sexual orientation. While the assessment tools do include a question about sexual orientation, of the 32,005 assessments completed from 2018 to 2021, 31,929 (99.8%) have no data about the client’s sexual orientation. Additional context from the community revealed that although these fields exist in the HMIS database, these questions do not appear in the assessment. **Collecting accurate data about sexual orientation during assessments is crucial to understanding if there is inequity in the CES that needs to be addressed.**

In focus groups, many individuals with lived expertise described the **assessment process as dehumanizing, stating that assessment tools failed to account for the breadth of human experience**. These issues were **compounded when an individual had a serious physical or mental health disability**, which became the singular focus of their assessment. Moreover, individuals with severe mental illness diagnoses indicated that some assessment questions were confusing, and staff were not always able to clarify effectively. Staff echoed and elaborated on these complaints, stating that the **lack of a trauma-informed approach and cultural mismatches between those administering and being assessed may lead to lower, inaccurate scoring. Further, requiring clients to self-report experiences like addiction and abuse through an objective lens without any cultural competence or nuance disadvantages non-white clients**, especially when those giving the assessments are mostly white and do not themselves represent a cross-section of individuals experiencing homelessness in Maricopa County. Finally, while some providers noted that the ability to further advocate for clients whose actual acuity was not reflected by the assessment helped to address inequity, others observed that the need to rely on these subjective determinations and outside support were signs of an inequitable system.

Victim services providers expressed a need for a **coordinated entry system that takes into account the needs of survivors of and those fleeing intimate partner violence. Particularly, the need for using an assessment that takes a trauma-informed approach and accurately captures vulnerability and survivor-specific definitions of safety and harm.**

National Community Examples

The following community examples were selected based on local areas of interest including racial equity and building a more equitable assessment tool that accurately assesses vulnerabilities for different populations (e.g., BIPOC, Transitional-Aged Youth). More information and links to resources can be found in Appendix E.

Austin ECHO

The Assessment Prioritization Index (API) contains 21 points total (10 points for health conditions, four points for history of homelessness, seven points for barriers to housing). The CoC developed nine questions that Black and Hispanic/Latinx people answered more frequently than non-black/Latinx people. Additionally, a subset of six questions from the VI-SPDAT that transgender, nonbinary, or gender fluid people answered more frequently than cisgender people was included. The community piloted the new set of questions and evaluated how many people replied “yes” to evaluate the relationship between target demographics and questions asked in comparison to their initial VI-SPDAT assessment. The analysis included more than 15,000 responses to VI-SPDAT questions from October 2016-March 2021 and 2,300 responses to the pilot questions from August 2020-March 2021. All but two of the questions in the API led to statistically significant measures that predicted the new questions will lead to more equitable outcomes. Approximately 1/3 of the assessment tool evaluates barriers to housing using common proxies for race determined by the community (criminal history and gentrified Austin zip code where the individual was raised or last permanently housed). Full analysis of the impact is ongoing; however, Austin ECHO reports seeing higher prioritization scores for Black and Brown people after the pilot implementation.

Austin ECHO's CES written standards outline participant autonomy in the assessment process. Clients must be given active choice and autonomy to select services among all potential options and providers that can meet their needs. Participants who are offered a service based on vulnerability and eligibility are informed of why particular referrals are being offered, as well as steps to request different services if they feel the intervention is not relevant. Participants are informed that they have a right to choose location and type of housing, as well as level and type of services, and voluntarily identify these preferences by completing an Initial Housing Plan or state preferences at the time of program enrollment. Refusing a specific service does not impact a household's prioritization for similar services.

Chicago CoC

Chicago CoC is piloting a six-question assessment to replace the VI designed by a CoC work group and testing various scoring options. The pilot questions tested include questions about history with the criminal legal system, history of housing instability, discrimination with regards to race, sexual orientation or gender identity, and history of domestic violence. The CoC developed scoring ranges for the pilot questions and racial and gender identity questions to identify respondents as high, medium, or low vulnerability. Potential scoring alternatives to using the VI included adopting all 6 pilot questions, scoring by length of time homeless or unsheltered status instead of asking additional questions, and scoring based on if the person completing the assessment is a person of color and/or have been discriminated against based on sexual orientation or gender identity.

Hennepin County

Hennepin CES staff complete an initial CES screening including up to four questions that measure desire to receive culturally specific services for East African and Native American individuals. If the individual identifies as Native American, the assessor inquires about what aspects of Native American culture are important and how important it is that the case manager is familiar with Native American culture.

When Hennepin County evaluated system data, the community found that referrals were inequitable under the VI-SPDAT, with more White people being referred to permanent supportive housing and more Black people being referred to rapid rehousing. The CoC removed the VI-SPDAT from the coordinated entry process to prioritize based on disability, chronic homelessness status, and length of time homeless. The new prioritization tool resulted in more equitable housing distribution for the community and increased housing placement for Black and Indigenous people; however, mockups in other communities have exacerbated disparities for certain populations.

Seattle / King County

For youth and young adults, the community reduced the weight of the VI-SPDAT in the prioritization process: 2/3 of points were distributed towards chronicity, and 1/3 of points were awarded based on the degree to which the respondent spent time in foster care. For example, the scoring formula changed from factoring in VI-SPDAT answers (96%) and length of time homeless (4%) to factoring in VI-SPDAT answers at a reduced proportion of scoring (50%), homeless one or more years (33.33%), and history of foster care (16.67%).

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding assessment and prioritization in Maricopa Regional CoC's coordinated entry system.

Finding	Recommendation(s)
<i>Focus group and interview participants expressed great interest in redesigning the assessment and prioritization process.</i>	<ul style="list-style-type: none"> Form a CES Assessment and Prioritization Redesign Task Group that brings together representatives from the Coordinated Entry Subcommittee, Racial Equity Leadership Team, Lived Experience Subcommittee, Youth Providers Workgroup, and Domestic Violence Workgroup to identify CES prioritization priorities and develop assessment questions. Hold listening sessions with unhoused and

Finding	Recommendation(s)
	<p>recently housed persons to obtain feedback on the proposed questions and incorporate this feedback into the assessment tool. Pilot, evaluate, and continue to fine-tune the questions as needed. Consider for example Austin ECHO's process of creating and testing new questions:</p> <ul style="list-style-type: none"> ○ Austin ECHO established an Equity Task Group made up of service providers, people with lived experience of homelessness, and community advocates to develop a series of pilot questions to be used in conjunction with the VI-SPDAT to address racial inequities. ○ Assessors asked respondents if they would be willing to answer pilot questions after taking the VI-SPDAT. ○ Answers to pilot questions were collected over a period of seven months and analyzed to determine if questions were leading to more accurate assessment and more equitable outcomes. ○ Data analysis was shared back to the Task Group. The community continues to use the pilot questions and discontinued use of the VI-SPDAT. Although analysis of the new questions is ongoing, Austin ECHO's coordinated entry team reports seeing higher scores for BIPOC people experiencing homelessness.
<p><i>Black and Native American people are massively overrepresented in the population of people enrolling in the CES relative to their share of the county population and the county population below the poverty line. The current assessment and prioritization process fails to address these racial disparities.</i></p>	<ul style="list-style-type: none"> ● Prioritize based on vulnerabilities disproportionately experienced by people of color overrepresented in the local homeless population, such as eviction history, involvement with the criminal legal system, poor credit history, and/or geographic area or zip code of an individual's last address. ● Partner with Black and Native American people who have lived experience of homelessness to develop and pilot alternative formulations of assessment questions that more accurately address racial and ethnic disparities. ● Evaluate strategies used to ensure people with disabling conditions and people who have spent more than 12 months homeless receive assessments and apply these strategies to Black and Native American populations.
<p><i>99.8% of assessments have data missing for gender identity and sexual orientation questions. Additional context from the community revealed that although these fields exist in the HMIS database, these questions do not appear in the assessment.</i></p>	<ul style="list-style-type: none"> ● Consider including questions about sexual orientation in the assessment or with program enrollment questions. ● If the community includes these questions, develop educational and training materials for assessors, such as: <ul style="list-style-type: none"> ○ Office hours or an anonymous questions box for individuals to ask questions about sexual orientation and gender identity and expression (SOGIE); ○ A one-page reference guide to SOGIE-related terms;

Finding	Recommendation(s)
<p><i>Some VI-SPDAT questions focus on current or very recent experiences and fail to adequately capture the full breadth of respondents' lived experience. This issue particularly affects survivors of intimate partner violence and human trafficking because they may be in a temporarily safe situation at the point of assessment. Additionally, focusing on current or very recent experiences of homelessness fails to capture the structural causes of homelessness experienced by BIPOC individuals and families.</i></p>	<ul style="list-style-type: none"> ○ A memo regarding the importance and role of SOGIE questions in the prioritization process; and, ○ A full SOGIE training. <ul style="list-style-type: none"> ● Expanding questions to reflect respondents' full (rather than most recent) homelessness experience would enable assessors to identify root causes of housing crises more effectively. <ul style="list-style-type: none"> ○ Consider for example Chicago's assessment pilot, which included questions focused on respondents' full life experience: <ul style="list-style-type: none"> ▪ Growing up, did your family experience housing instability such as frequently moving due to financial reasons, living with other families, relatives, (also known as doubling up), living in a shelter, living in nightly or monthly rentals, or anything like that? ▪ Have you ever in your life, spent any amount of time in a juvenile or adult correctional facility? ▪ Have you experienced violence in a home where you lived or seen others experience violence in a home where you lived? Violence can be physical or emotional (expanding not only the time period to ask about someone's life, but also expanding the definition of violence and vulnerability) ▪ Have you ever been discriminated against due to sexual orientation or gender identity? ● Leverage existing local efforts and partnerships, including work being done by victim services providers, to identify and incorporate trauma-informed assessment questions related to the needs of intimate partner violence and human trafficking survivors and strategies to capture danger, risk, and safety.
<p><i>The VI-SPDAT asks respondents to report on mental and behavioral health conditions, substance use, trauma, and other risk factors. It can be challenging for respondents to report their experiences accurately due to fear of incriminating themselves and losing access to resources or due to conflicting perceptions of one's situation or a mental health condition, among others. Further, cultural norms may impact how respondents identify with and address these risk factors.</i></p>	<ul style="list-style-type: none"> ● In piloting new assessment questions, identify and reframe or eliminate stigmatizing questions. Partner with people with lived experience of homelessness to develop and pilot alternative formulations of assessment questions to minimize re-traumatization and more effectively identify conditions and experiences affecting vulnerability. ● In piloting new assessment questions, <u>evaluate the validity and reliability of questions with an equity lens.</u> <ul style="list-style-type: none"> ○ Do questions and subscales equitably capture the specific vulnerabilities that BIPOC are more likely to experience? ○ Are assessment questions crafted with cultural humility, or conversely, are these questions culturally blind?

Finding	Recommendation(s)
<p><i>There are a variety of barriers that impact service providers' ability to conduct the assessment in a consistent, trauma-informed, and culturally responsive way. Further, the ability to develop trust is impacted by turnover and staff burnout.</i></p>	<ul style="list-style-type: none"> ○ Are assessment questions designed to identify a true vulnerability that indicates housing resource needs? ○ How might a person or family of color respond to the assessment question? Would they be more likely to be subject to greater scrutiny? Would they be less likely to self-report? <ul style="list-style-type: none"> ● It is recommended that the CoC identify and explore partnerships with culturally responsive organizations to provide consistent, ongoing training to build assessor capacity related to trauma-informed care, motivational interviewing, identifying and overcoming implicit bias, and working with survivors of intimate partner violence and human trafficking. Consider leveraging existing committees and work groups to identify and recruit training partners.
<p><i>Providers who work in CES but are not themselves assessors lack a uniform understanding of the assessment and referral processes and their criteria. This issue is amplified when system and process changes take place.</i></p>	<ul style="list-style-type: none"> ● Develop a standard overview training which all individuals working within the CES system undergo as part of the onboarding process. ● As updates and changes occur, provide a written summary, live and/or recorded trainings as needed, and office hours to discuss changes for all impacted providers.

Referral to Permanent Housing

This section evaluates the effectiveness and equitableness of the referral process and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.

Throughout the report, a teal color is used to highlight areas and findings where the system excels, whereas areas for improvement appear in red.

Analysis of Process and Effectiveness

Twenty-five percent of people assessed received referrals to permanent housing; the average time from assessment to referral was 106 days. Of the referrals that occurred each year from 2018 to 2021, there were two- to four-times as many referrals to rapid rehousing as there were to permanent supportive housing.

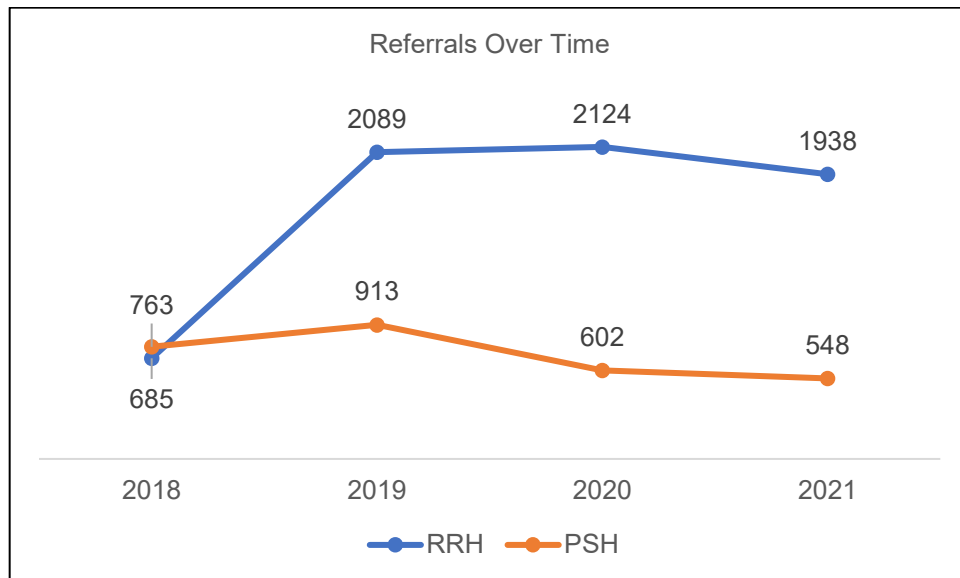


Figure 12. Number of referrals to rapid rehousing and permanent supportive housing by year. Data source: HMIS.

For both RRH and PSH, the majority of referrals were accepted, and permanent supportive housing referrals had a particularly high acceptance rate.

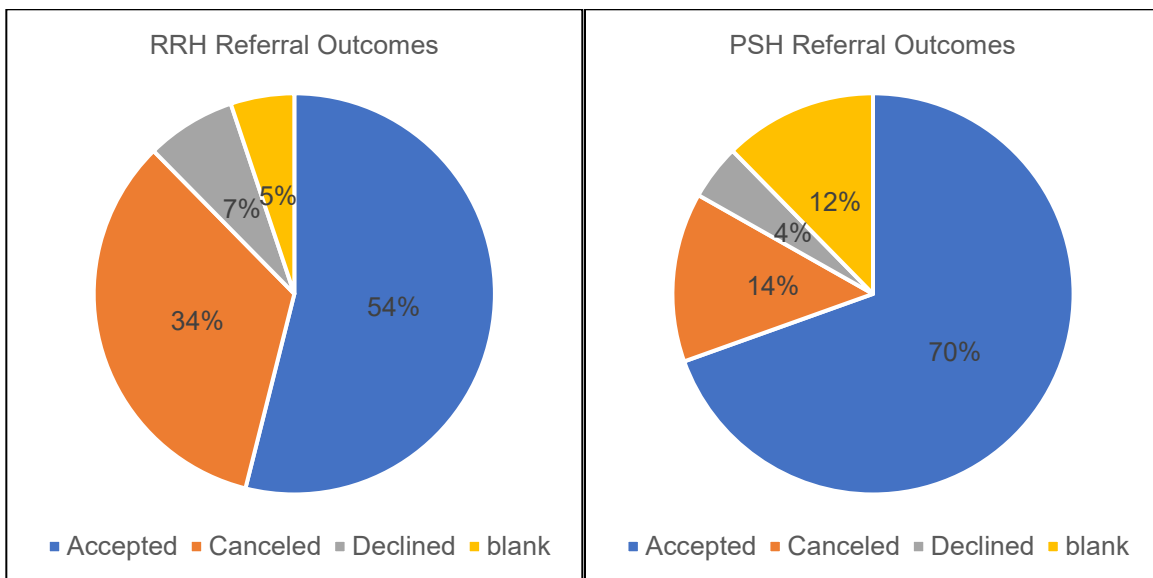


Figure 13. Referral outcomes for rapid rehousing referrals (left) and permanent supportive housing referrals (right). Data source: HMIS.

Providers stated that the referral system for singles relatively streamlined, and households are referred without much incident. Providers also indicated that rapid rehousing referral processes are mostly smooth, though there was some concern that it is difficult for people to maintain their housing once subsidies end. Many providers discussed the success of progressive engagement, which they said helps to keep people on track who do not qualify for or are not able to be placed in permanent supportive housing. In building relationships and being able to gather further information over time, providers were able to identify further needs and offer additional services to individuals. They also had more information when individuals and families were re-assessed. Most providers indicated that the communication around eligibility requirements was adequate and highlighted that additional steps are now being taken like annual eligibility criteria trainings and check-ins with CES staff that should improve this even further.

Both providers and clients described the **difficulties families had in securing housing**. Most providers observed that **assessments failed to accurately score and prioritize individuals**, especially families, and highlighted that they often see families who score in the permanent supportive housing range with the VI-SPDAT knocked down to rapid rehousing after the full SPDAT is administered. In addition to revisiting the ways families are prioritized and referred to housing, providers indicated that **additional resources and inventory are needed for families and youth, as well as BIPOC individuals with disabilities and those who use substances**.

Providers also expressed a desire for an updated resource and provider book, since many organizations closed or reduced service during the COVID-19 pandemic and it can be difficult to ascertain what resources are currently available. Providers discussed common pain points around housing referrals, highlighting document readiness, eligibility requirements, staffing capacity and geographic issues as some of the largest ones. **As a result of eligibility and document requirements, individuals with disabling conditions and high acuity may be passed for housing several times**.

Individuals with lived expertise observed that there was **a lack of communication and transparency** throughout the process. Some individuals relayed that they had waited for four years only to be referred to programs for which they did not qualify. Others reported that they had enrolled in housing programs but were unable to secure units due to a lack of guidance and support. Individuals also identified a **lack of choice** about where they were housed and what housing they received, highlighting the size of the CoC and the differences between its various cities. When provided housing further away from their work and/or community, individuals and families experienced barriers to remaining connected to support systems and maintaining employment. Individuals also discussed that the **housing and assistance available did not adequately reflect the cost of living in the region**, for example, vouchers do not cover nearly enough rent or apartments require 2.5 times rent as a deposit. **Additional mental health supports are needed** at all steps of the process, from street outreach through to permanent housing.

Assessment of Equitableness

There are no major differences in referral rate or days to referral between non-Latinx and Latinx people who receive assessments.

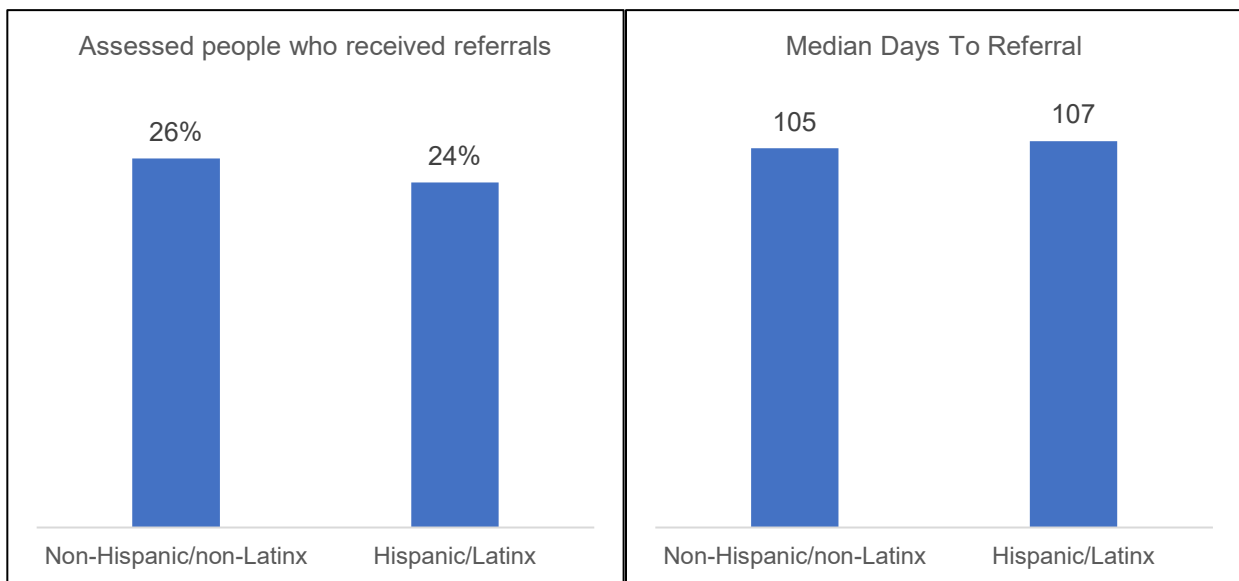


Figure 14. Percent of assessed clients in each group who received a referral (left) and medial days from assessment to referral (right) by ethnicity. Data source: HMIS.

There are no major differences in move-in rate or days to move-in based on ethnicity.

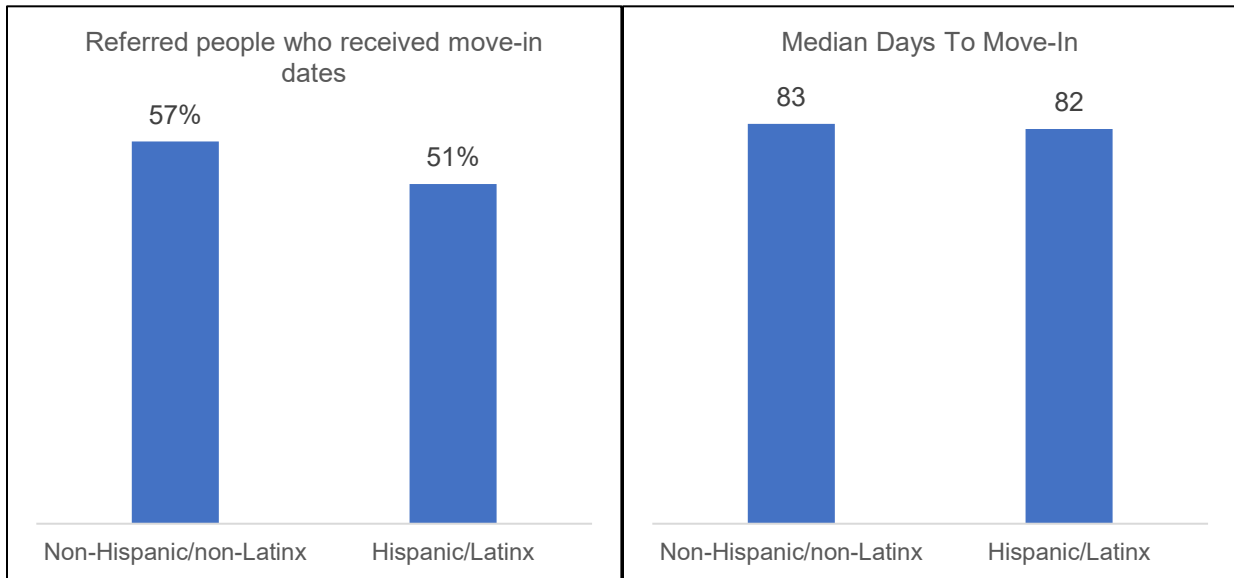


Figure 15. Percent of referred clients in each group who receive move-in dates (left) and median days from referral to move-in (right) by ethnicity. Data source: HMIS.

While it is helpful that the stages of referral and move-in do not contribute to ethnic disparities, they also do nothing to counteract existing disparities in the system: ethnic disparities at the stages of access and assessment persist through the stages of referral and move-in.

While there are no large racial differences in the percentage of assessed clients who receive referrals, **white clients who have referrals have much shorter wait times than Black and Native American clients.**

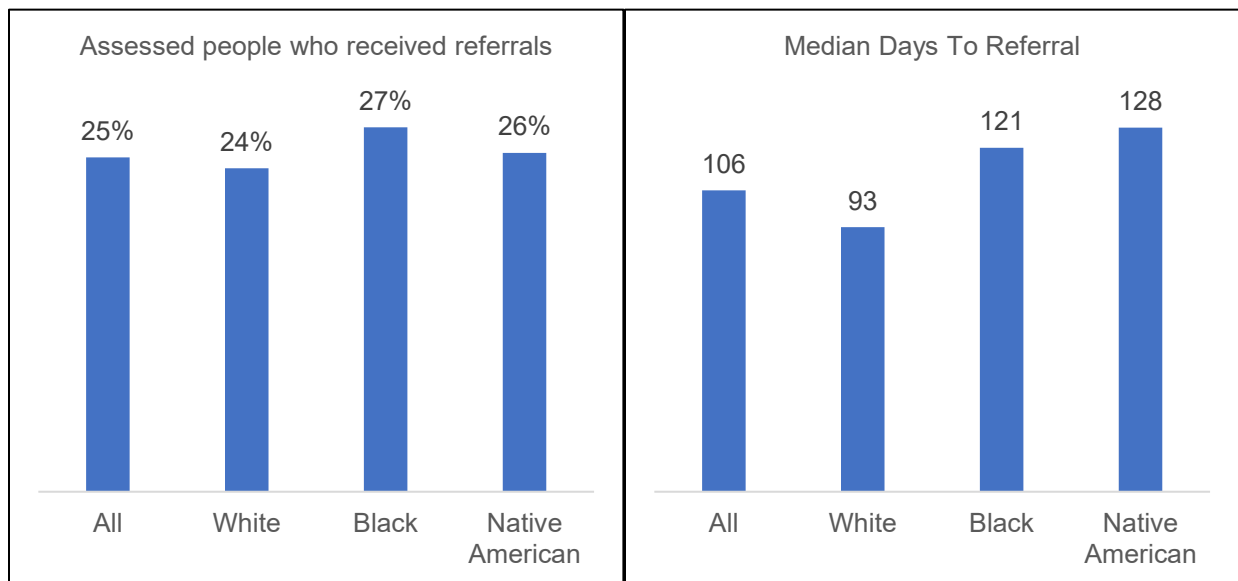


Figure 16. Percent of assessed clients in each group who received a referral (left) and medial days from assessment to referral (right) by race. Note: The numbers of Asian or Native Hawaiian people enrolled in the CES during the time period were too small to draw conclusions. Data source: HMIS.

There are no major differences in move-in rate or days to move-in based on race. While it is helpful that the referral and move-in stages do not contribute to racial disparities, they also do nothing to counteract existing disparities in the system: racial disparities at the stages of access and assessment persist through the stages of referral and move-in.

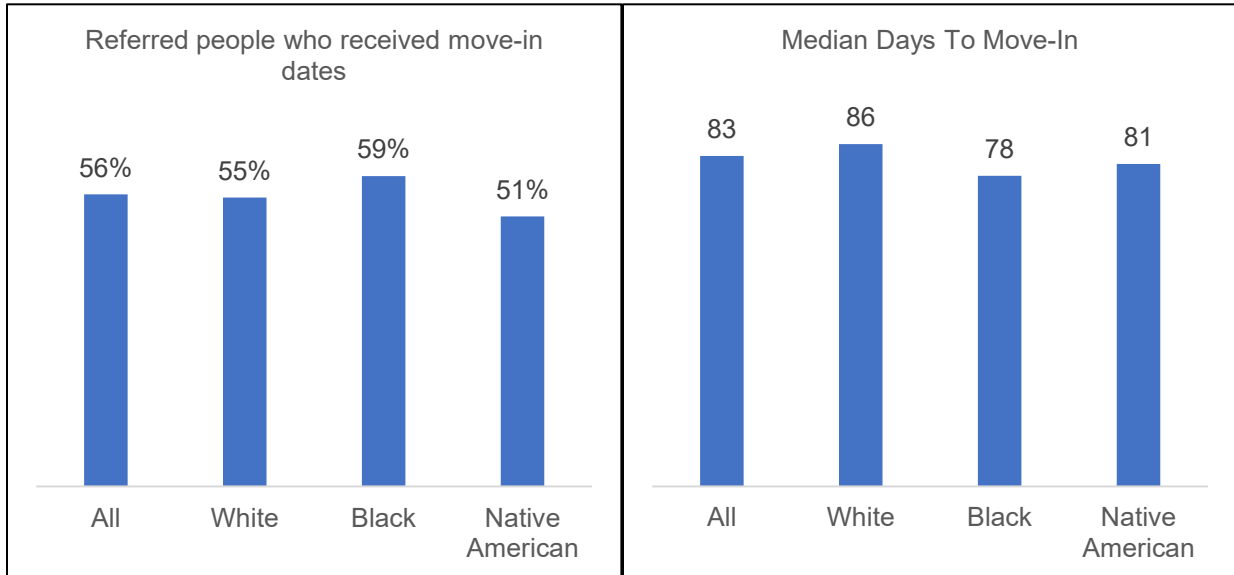


Figure 17. Percent of referred clients in each group who receive move-in dates (left) and median days from referral to move-in (right) by race. Note: The numbers of Asian or Native Hawaiian people enrolled in the CES during the time period were too small to draw conclusions. Data source: HMIS.

Overall, male and female clients who are assessed receive referrals to housing and about the same rate. They also wait about the same length of time in order to receive a referral. While there are gender disparities in assessment rate (see Assessment section), **for people who receive assessments, there are no major gender disparities in referral rates or timelines.**

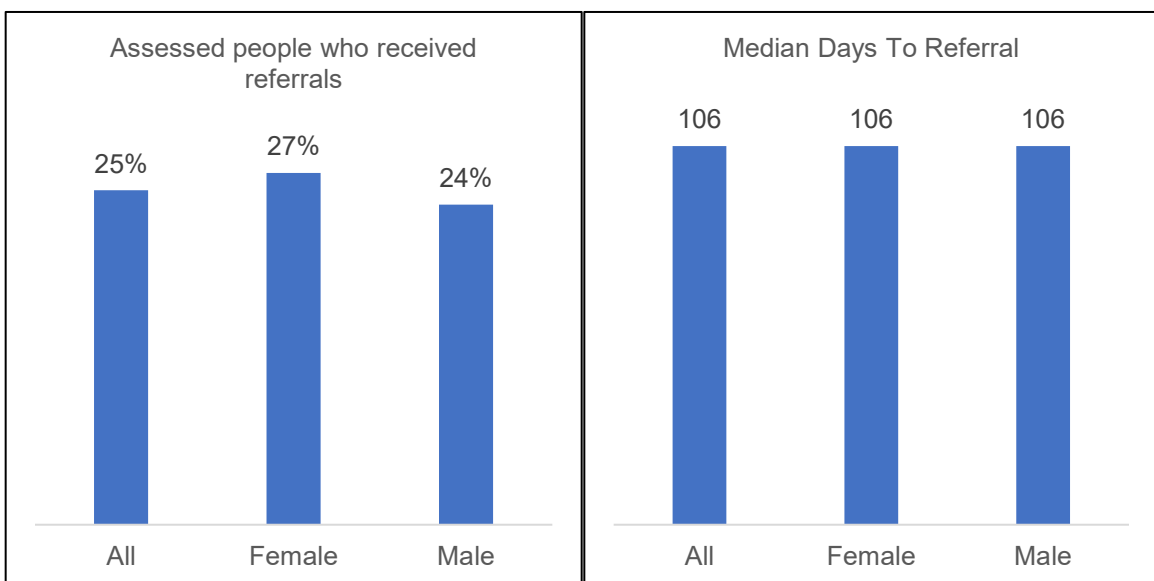


Figure 18. Percent of assessed clients in each group who received a referral (left) and median days from assessment to referral (right) by gender. Note: The numbers of people identifying as No Single Gender, Transgender, or Questioning during the time period were too small to draw conclusions. Data source: HMIS.

In accordance with CoC policies to prioritize serving people with disabling conditions and people who have been homeless for a long time, these populations receive referrals at slightly higher rates.

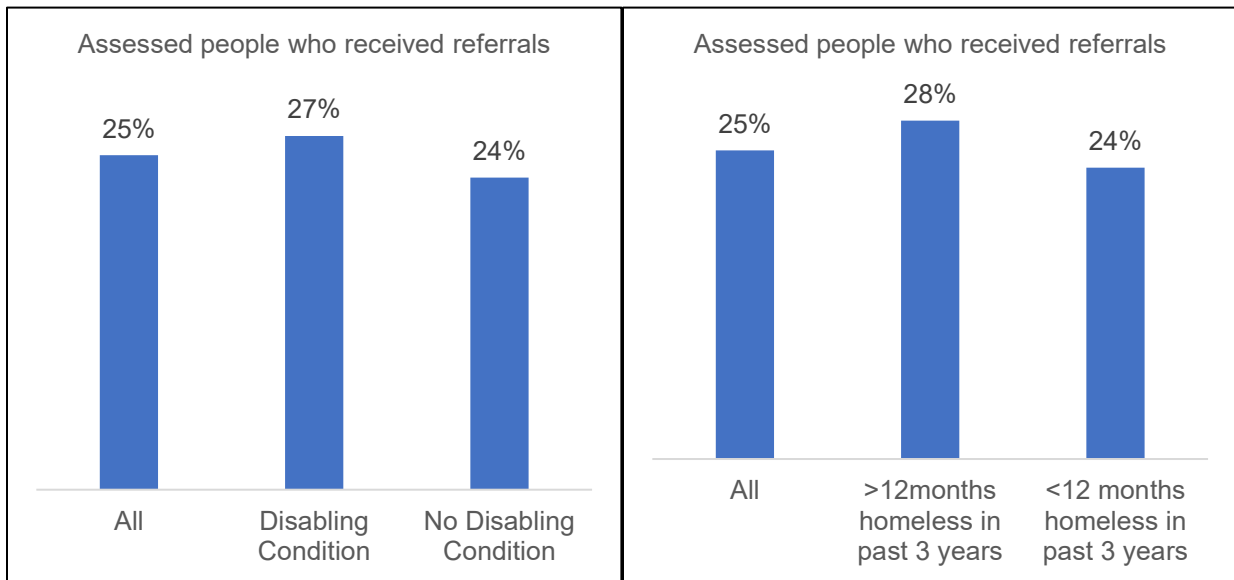


Figure 19. Percent of assessed clients in each group who received a referral by disabling condition (left) and length of time homeless (right). Data source: HMIS.

People with disabling conditions are much less likely to receive a move-in date. CoC policy is to prioritize serving this population, but providers are struggling to house them. Potential reasons for this include the difficulty of having a fixed income, accessibility of units, and a need for more intensive case management. Targeted interviews with clients with disabling conditions, housing providers, and disability advocacy and service organizations can help determine the causes and solutions. People who have experienced homelessness for more than 12 months receive move-in dates at about the same rate as people with shorter histories of homelessness.

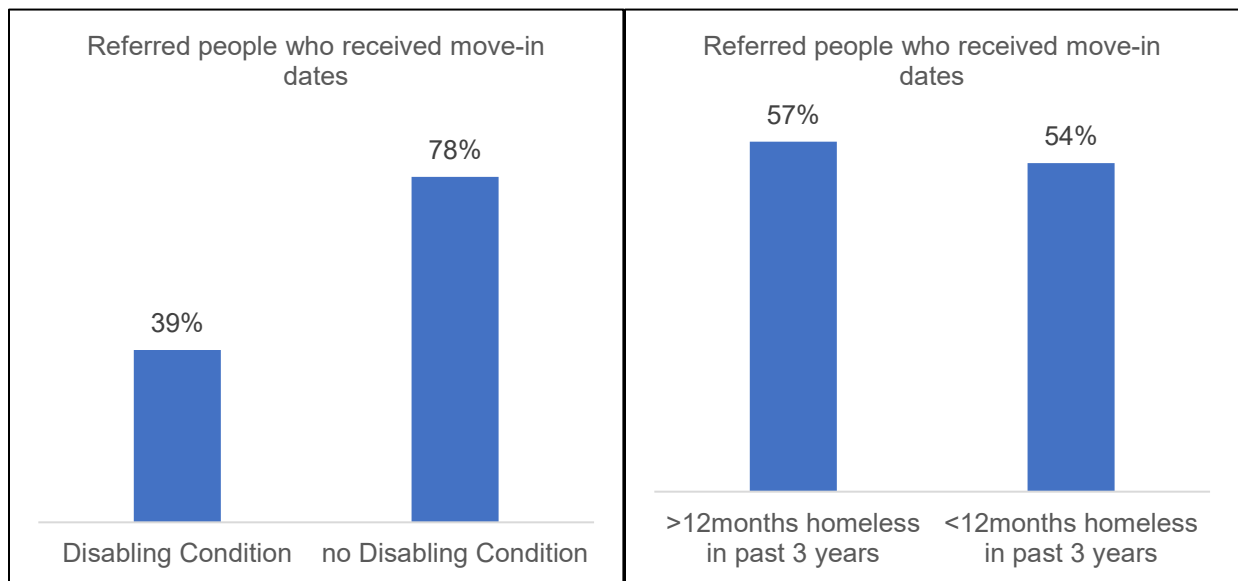


Figure 20. Percent of referred clients in each group who receive move-in dates by disabling condition (left) and length of time homeless (right). Data source: HMIS.

When people with disabling conditions do receive move-in dates, they have a shorter wait time than people who do not. People who have experienced homelessness for more than 12 months have a longer wait time than people who have not.

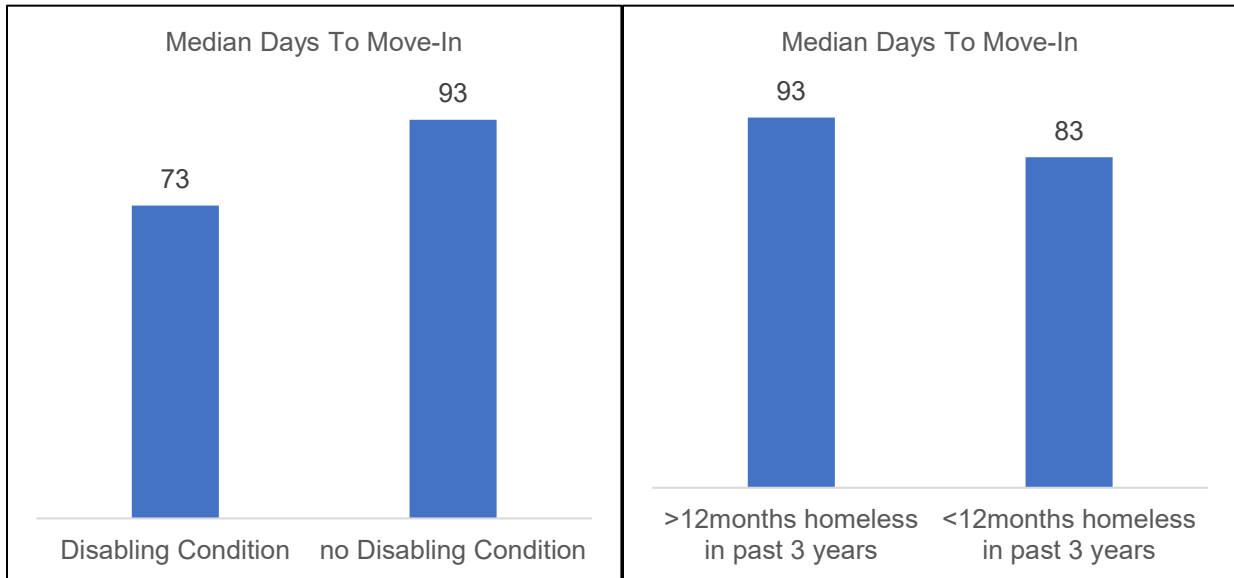


Figure 21. Median days from referral to move-in by disabling condition (left) and length of time homeless (right). Data source: HMIS.

Across all assessment types, clients who accessed permanent supportive housing have higher assessment scores than clients who accessed rapid rehousing. This suggests that in general, **clients are sorted into the housing type that matches their assessment score.**

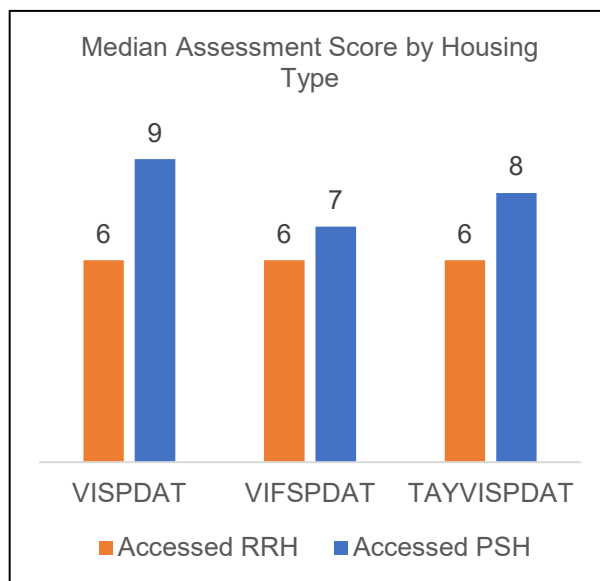


Figure 22. Median assessment scores of clients accessing rapid rehousing and permanent supportive housing. Data source: HMIS.

Clients who accessing permanent housing (rapid rehousing or permanent supportive housing) had median assessment scores that were identical to clients who did not access housing. **If the goal of assessing vulnerability is to determine prioritization for housing, then this goal is not being met.**

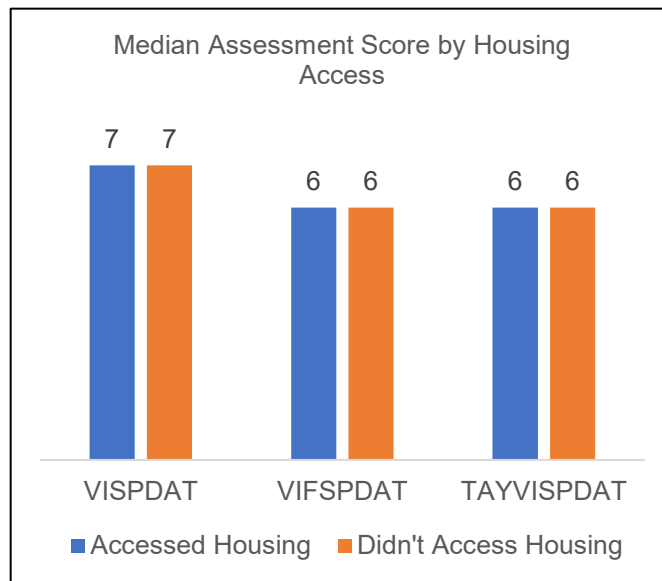


Figure 23. Median assessment scores of clients who did and did not access housing. Data source: HMIS.

Large disparities in referral exist depending on household type: single adults receive referrals at much higher rates than families or youth and young adults, but they wait much longer to receive a referral. **The very small percentage of assessed families receiving referrals is particularly concerning because women, Black people, and Latinx people disproportionately access the CES as families (as discussed in the Assessment section).** This means that a failure to refer families to housing is an issue of racial, ethnic, and gender equity – the system assesses these populations at lower rates, and even if these populations receive an assessment they are less likely to receive a referral. Major steps must be taken at multiple points in the system to rectify racial, ethnic, and gender disparities.

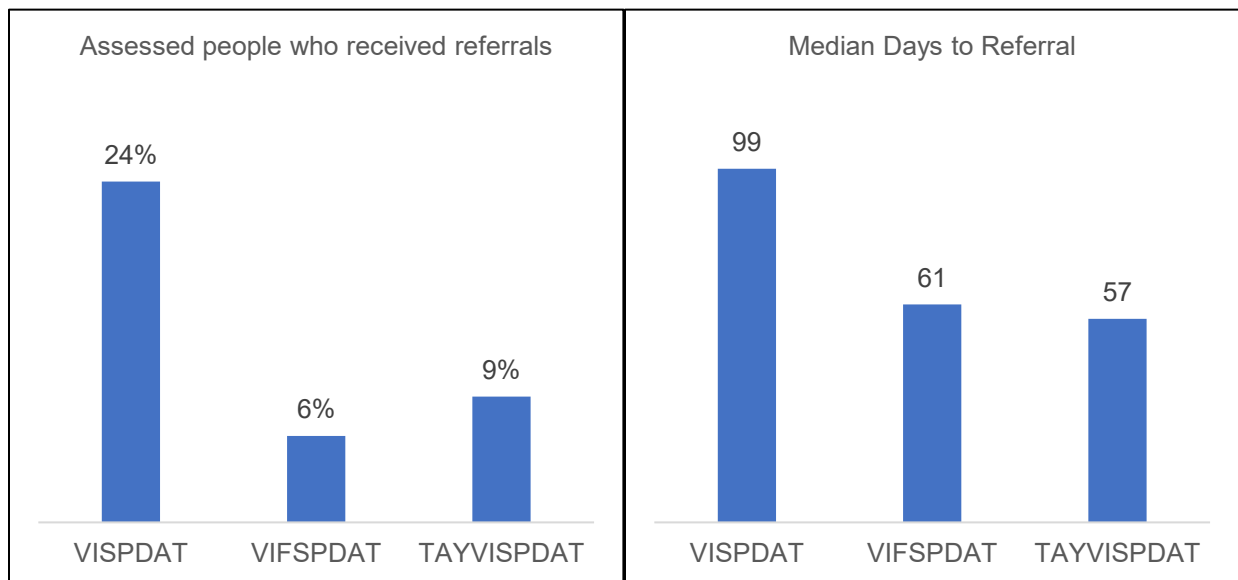


Figure 24. Percent of assessed clients in each group who received a referral (left) and median days from assessment to referral (right) by household type. Data source: HMIS.

While there are no large differences in the percent of referred single adults, families, or youth who receive move-in dates, single adults have longer wait times to move-in. **Added to the longer wait time to receive a referral, this means single adults move more slowly through the system.**

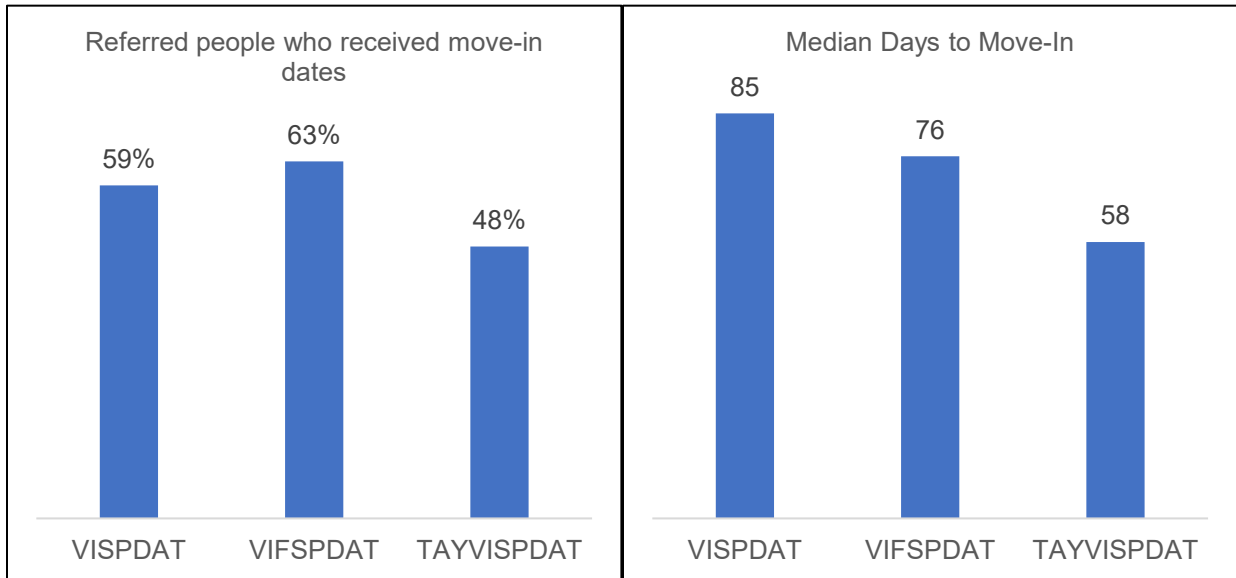


Figure 25. Percent of referred clients in each group who receive move-in dates (left) and median days from referral to move-in (right) by household type. Data source: HMIS.

The most discussed issue around prioritization from stakeholder engagement was that **specific groups are not being adequately served, including LGBTQIA+ adults, families and individuals with disabling conditions or substance use histories.** Further, providers highlighted the racial disparities and inequities in the prioritization process and related challenges with private landlords. To combat this trend, individuals advocated for explicitly including equity in prioritization or having navigation services advocate for BIPOC clients with private landlords. Providers also noted a **disparity in negative exits for BIPOC people and higher exits to shelter, hospitals and jails among black people.** Further, **eviction rates are higher in the zip codes that tend to have the largest BIPOC populations in the area, and black people are more likely to experience lease non-renewals.**

National Community Examples

The following community examples were selected based on issue areas of referrals, namely client choice and reengaging clients who have fallen out of contact with the system once they get to the point of referral. More information and links to resources can be found in Appendix E.

Austin ECHO

CES standards reference “Service Descriptions and Participant Choice” in initial assessment. The standards also reinforce participant autonomy, meaning that clients must be given and informed of their active choice in selecting among services and providers that can potentially meet their needs. Participants are given reasons as to why they are being referred to certain services, as well as explanation of potential impacts if they choose a level of services other than that which is recommended by their initial assessment. Additionally, DV survivors may choose to participate in mainstream CES or access services through DV providers only.

Hennepin County

Housing referrals denied by clients are discussed at family and youth case conferencing meetings where the preferences of the household are reviewed. The Hennepin CES transfer policy applies to units filled by CES and to households that have moved through assessment, prioritization, and referrals to housing in the system. Vacancies in rapid rehousing and transitional housing programs are filled based on prioritization and client preference with regard to program type. To request a transfer from rapid rehousing to permanent supportive housing, a transfer request form is submitted to CES staff detailing efforts to help the household stabilize in rapid rehousing and describing the need for permanent supportive housing services. If the transfer request is approved, the current program provides eligibility paperwork to the program accepting the transfer and is responsible for requesting a new referral after the transfer takes place.

Seattle/ King County

Households continue to be prioritized based on their assessed level of need even if the housing referral is unsuccessful. Households may also refuse available housing or services referred to them without any repercussions to their status on the prioritized list. If a household is unable to be contacted by the CES, they are moved to a Disengaged List and are immediately returned to the Priority Pool for housing resources referral once they re-engage.

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding referral to permanent housing in Maricopa Regional CoC's coordinated entry system.

Finding	Recommendation(s)
<p><i>Individuals who have disabling conditions are referred to housing at rates higher than their coordinated entry population, but the percentage who move into housing is low.</i></p>	<ul style="list-style-type: none"> • Expand case conferencing between access points, outreach teams, and housing providers (beyond matching households to program openings) to develop strategies to address client supportive service needs during the referral and housing search process. • Analyze existing rapid rehousing and permanent supportive housing providers, features and assistance models, identify any changes or additional capacity necessary to achieve successful outcomes with vulnerable participants, and support agencies in seeking additional funding to meet these needs (see, e.g., HUD's <i>Long-Term Financing of Permanent Supportive Housing Projects</i> and USICH's <i>Federal Programs that Support Individuals Experiencing Homelessness</i>). • Build partnerships with providers of long-term services and supports to connect persons who are unable to live independently to nursing homes, long term care facilities, and home-based services.
<p><i>Many programs have restrictive eligibility requirements that lead to individuals higher on the By Name List being skipped for eligible clients below. This results in higher-acuity clients waiting on the By Name List longer or exiting it before receiving housing. Moreover, providers reported feeling distrust and confusion about how the By Name List functions because it does not appear that people are pulled from it sequentially.</i></p>	<ul style="list-style-type: none"> • Enact a policy to monitor referral denials to ensure that housing programs are screening in vulnerable households, and referral denial rates and reasons are considered in evaluating funding applications. • Provide targeted technical assistance to permanent housing programs to build capacity and support them in lowering barriers and implementing Housing First, as needed.
<p><i>Documentation requirements and processes vary by agency. There is not a centralized document or uniform understanding of what these requirements are, which leads many clients to be referred to programs before they are document-ready. This creates confusion for clients, many of whom are navigating these systems without staff support and is cumbersome for staff.</i></p>	<ul style="list-style-type: none"> • Create a handbook of the documentation requirements and processes for all CES agencies and have copies on hand for all staff to refer to during intake, assessment, and case management meetings. • Focus staff efforts by prioritizing documenting chronic homelessness and gathering other eligibility documentation for the top 30% of households on the By Name List. • Encourage agencies to review policies and procedures to ensure that the documentation being requested is no more than necessary to meet funding requirements and does not present a barrier to securing housing. Provide targeted technical assistance as needed.
<p><i>Clients are matched to programs outside the cities and areas where they live (and where they prefer to continue to reside) and are distanced from their support networks, jobs, schools, and communities.</i></p>	<ul style="list-style-type: none"> • Ask clients about their preferred geographic locations and those which will not work for them. Include a map of the CoC and a list of the cities and subregions therein as part of the assessment process to support clients in identifying their geographic preferences. • Transportation barriers may present a significant obstacle to individuals moving into new regions, especially those that are remote from jobs and schools. Inquire about transportation needs and limitations, provide assistance to address these needs whenever possible (bus pass, help planning and navigating travel routes and schedules, etc.).

System Governance and Management

While a coordinated entry system requires the involvement of all the community's homeless service providers, HUD requires certain organizations to provide governance and management of the system. According to HUD's [Coordinated Entry Management and Data Guide](#), a community must designate a "policy oversight entity" to make policy decisions about coordinated entry and a "management entity" to provide day-to-day operational management of the system. This brief section summarizes findings around the management of Maricopa Regional CoC's coordinated entry.

Complete and accurate data and information are crucial to evidence-based decision-making and effective system management, and accessible information and system buy-in among implementing partners are key to the overall success of coordinated entry systems

Throughout the report, **a teal color is used to highlight areas and findings where the system excels**, whereas **areas for improvement appear in red**.

Analysis of Process and Effectiveness

Across all focus groups and interviews, individuals described a **breakdown in communication and a lack of transparency** which makes providers and clients alike feel insecure, unsure of their place, and unable to advocate. **Providers expressed a desire for a consistent way to communicate with one another, share resources, and streamline processes across agencies**. Similarly, the **relationship between MAG and CES providers suffers from infrequent communication, lack of accountability and confusion about roles and responsibilities**. **Trainings are piecemeal and often given ad hoc on an agency-by-agency basis**. Further, there is **no central system to share and monitor data** across the CoC.

Assessment of Equitableness

Some providers are already working to ensure that their staff is representative of the homeless population they serve in terms of gender, ethnicity, and race, in addition to lived experiences of homelessness. Furthering equity requires creating work environments that support the specific needs of staff who are connected to the issue in more personal ways. More training and support are needed so staff can perform their roles in CES in a culturally responsive and trauma-informed way. This will help effectively build trust and obtain accurate responses that fully capture vulnerability. Hiring and supporting staff who reflect the experiences and identities of those they work with is an area of growth for the CoC as a whole, in addition to ensuring staff in leadership positions also reflect the demographics of those being served by the CoC.

Providers and clients alike stressed the **lack of standardized and meaningful training around implicit bias, racial equity, system inequities and cultural competency, which affects the daily operations of CES**. This can show up in different levels of trust and inequitable engagement, which can lead to racial disparities and lack of access to services. For example, supporting individuals and families in **accessing a higher level of service can require advocacy on the provider's part**, which leads to inequity in access. Additionally, **individuals with lived expertise did not know how to file a discrimination complaint and indicated that they would be afraid to file grievances**.

National Community Examples

The following community examples were selected based on needs expressed by providers and system partners with regards to training and capacity building. More information and links to resources can be found in Appendix E.

Austin ECHO

Austin ECHO released a Racial Disparities Report that assesses racial and ethnic disparities amongst staff in the Homelessness Response System to ensure that the community is moving towards a more equitable system not just in service provision, but also in employment and staffing. The report recognizes that currently, the service provider community and ECHO staff continue to be overwhelmingly white especially in leadership positions, even though the system disproportionately serves BIPOC clients. The report encourages a system in which staff more closely reflect the composition of people currently experiencing homelessness to be more representative of the community.

Clark County

After developing a community specific assessment tool, Help Hope Home in Clark County, Nevada utilized SafeNest, a DV housing and service provider as a partner in providing training. All of Clark County's assessors must complete training for population-based tools and a DV awareness training unit provided by SafeNest to complete assessments.

Hennepin County

The Domestic Violence subcommittee works to build coordination and communication within the coordinated entry system through ongoing annual training and cross training for providers and CES staff. The subcommittee also monitors and analyzes CES data specific to survivors on a continual basis to assess unmet needs for housing and services.

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding system governance and management in Maricopa Regional CoC's coordinated entry system.

Finding	Recommendation(s)
<p><i>There is variability in the degree to which CES partner agency staff and CoC leadership reflect the communities that the CoC serves – both in terms of race and ethnicity but also lived experience of homelessness.</i></p>	<ul style="list-style-type: none"> • Prioritize leadership development of direct services staff – provide opportunities to participate on committees and work groups and developing other avenues to uplift the perspectives of direct services staff, particularly those with lived experience, in CES decision-making. • As a CoC, work to define the identities and experiences that should be represented and update governance policies to include a diversity mechanism to meet these goals. Ensure that decision-makers during this process include BIPOC and people with lived experience of homelessness. <ul style="list-style-type: none"> ○ Some principles to help start this process include: <ul style="list-style-type: none"> ▪ Develop a membership profile chart that defines and tracks what special skills and qualities the Board will require of its members (see here for an example on pp. 7-8) ▪ Ensure readability and accessibility of materials and communications ▪ Determine who is making decisions about recruitment and standardize this process. ○ Homebase has also identified and recommends the following resources: <ul style="list-style-type: none"> ▪ “Equity, Diversity and Inclusion in Recruitment, Hiring and Retention,” Desiree Williams-Rajee, Kapwa Consulting (2018). Prepared for Urban Sustainability Directors Network (USDN). ▪ “Equity in Recruiting, Selecting and Retaining New Members.” (n.d.). Homebase. ▪ “Toolkit for Employing Individuals with Lived Experience Within the Public Mental Health Workforce.” (2014). Working Well Together. ▪ “Using Outreach to Increase Access.” (n.d.) Community Toolbox.
<p><i>There is a desire among CoC partners for more open conversations about system performance.</i></p>	<ul style="list-style-type: none"> • Provide regular updates on data related to the functioning of coordinated entry through committee and case conferencing meetings, public dashboards, and/or other channels. <ul style="list-style-type: none"> ○ Highlight success in areas such as number of referrals and housing stability of persons connected to housing programs via coordinated entry. • Provide clarity on the By Name List by either making the list itself accessible for CES staff to review, or by providing updates on it with summary explanations for individuals who are pulled non-sequentially. • Provide data regarding referral rates and timelines to access point agencies to support them in setting clear expectations with clients.

Finding	Recommendation(s)
<p><i>Creating a cohesive coordinated entry structure is complicated because of the variety of municipalities and local governments that make up the CoC. Differences in local political will, public perception, staff capacity and budgets lead to disparate services, messaging, and treatment. This is especially difficult when municipalities and cities act as the direct service providers in their area.</i></p>	<ul style="list-style-type: none"> • Engage cities within the CoC to meet regularly with CoC leadership to discuss and coordinate on messaging, vision, and strategy for ending homelessness throughout Maricopa County. • Develop language to describe the role and goals of CES and to highlight its successes. This language should be distributed throughout to all CES organizations, and providers should be encouraged to use it or modifications of it with clients and the public. • Work with people with lived expertise to develop messaging and materials to address and combat the anti-homeless sentiment described by people with lived expertise during focus groups. CoC successes and impact should be more widely publicized.

System Flow

To better understand how different demographic groups move through the coordinated entry process, HMIS data can be analyzed to determine the percentage a given demographic group makes up of each stage of the CES. This analysis uses the same HMIS data as all the analyses above but, displayed this way, it more clearly demonstrates a system-wide view of demographic disparities as people move through the CES. As with all HMIS analysis, this cannot explain *why* any demographic disparities exist.

The most extreme disparities in race and ethnicity occur at the time of CES enrollment. These disparities persist as people move through the system. The system prioritizes assessing and referring people with disabling conditions, but this population still has a lower rate of move-in to housing. At all stages, the system prioritizes serving people who have spent more than 12 months homeless at rates above their share of the population enrolled in the CES.

Throughout the report, a teal color is used to highlight areas and findings where the system excels, whereas areas for improvement appear in red.

System Flow by Race

Black people are massively overrepresented in the population of people enrolling in the CES relative to their share of the county population and the county population below the poverty line. The assessment, referral, and move-in processes do not alleviate this racial disparity, so it persists as people move through the system.

Native American people are overrepresented in the population of people enrolling in the CES relative to their share of the county population and the county population below the poverty line. The assessment, referral, and move-in processes do not alleviate this racial disparity, so it persists as people move through the system.

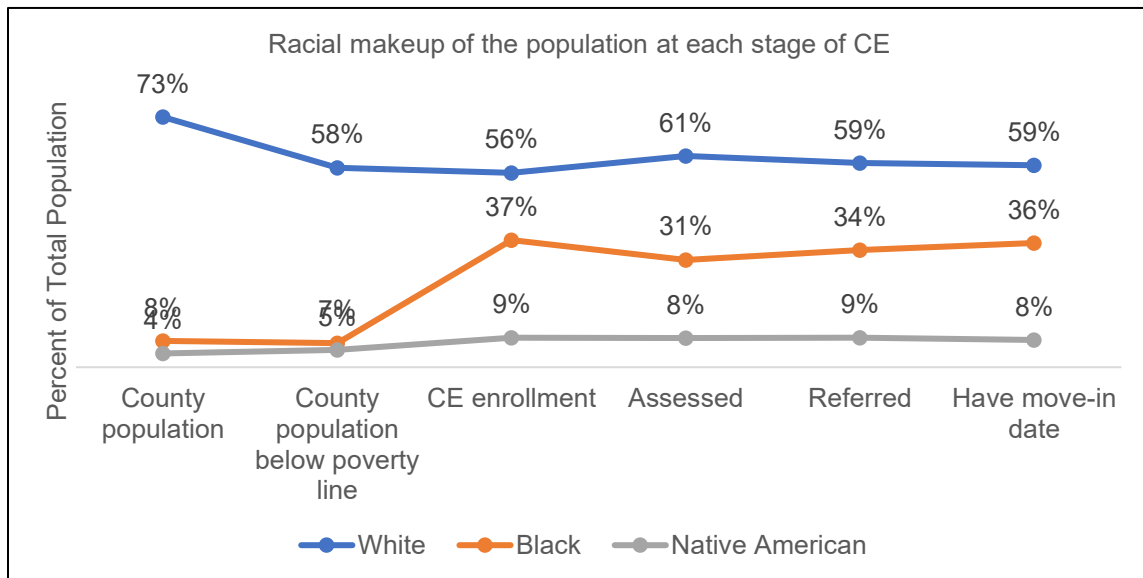


Figure 26. Percent of the population at each stage of the CES that is made up of a given race. Data sources: HMIS and 2020 Census. Note: Too few people in the CES identify as Asian or Native Hawaiian to analyze.

System Flow by Ethnicity

Latinx people are underrepresented in the population of people enrolling in the CES relative to their share of the county population and the county population below the poverty line. As described in the Access section, there are several potential reasons for this underrepresentation, but further qualitative research is needed to determine if any of these reasons are true. The assessment, referral, and move-in processes may exacerbate this underrepresentation, suggesting Latinx people may be served at lower rates than non-Latinx people as they move further through the system.

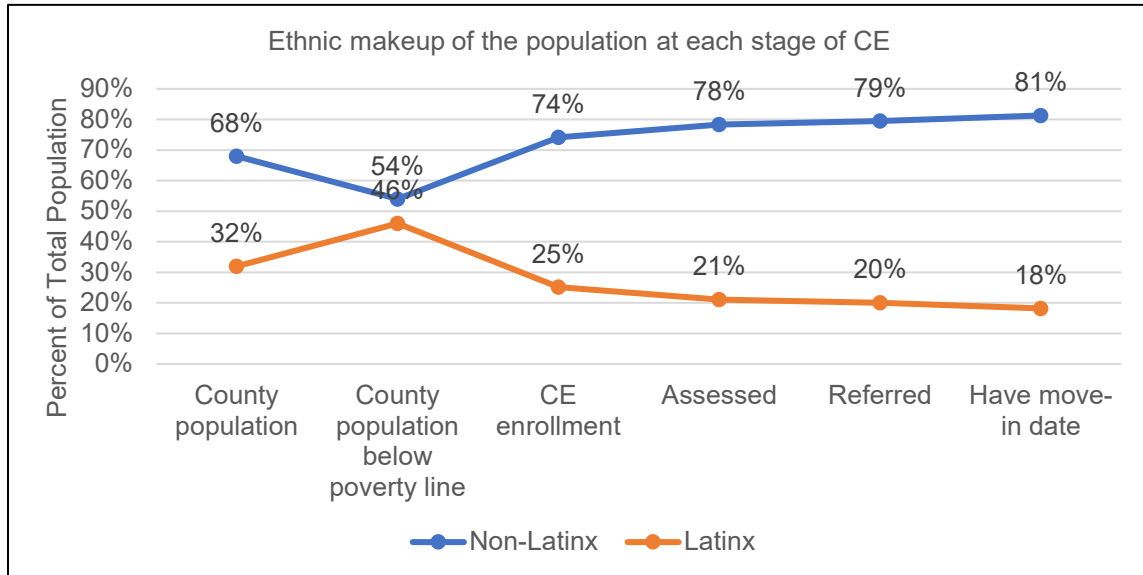


Figure 27. Percent of the population at each stage of the CES that is made up of a given ethnicity. Data sources: HMIS and 2020 Census.

System Flow by Gender

Women are slightly underrepresented in the populations of people who are assessed, referred, and receive a move-in date.

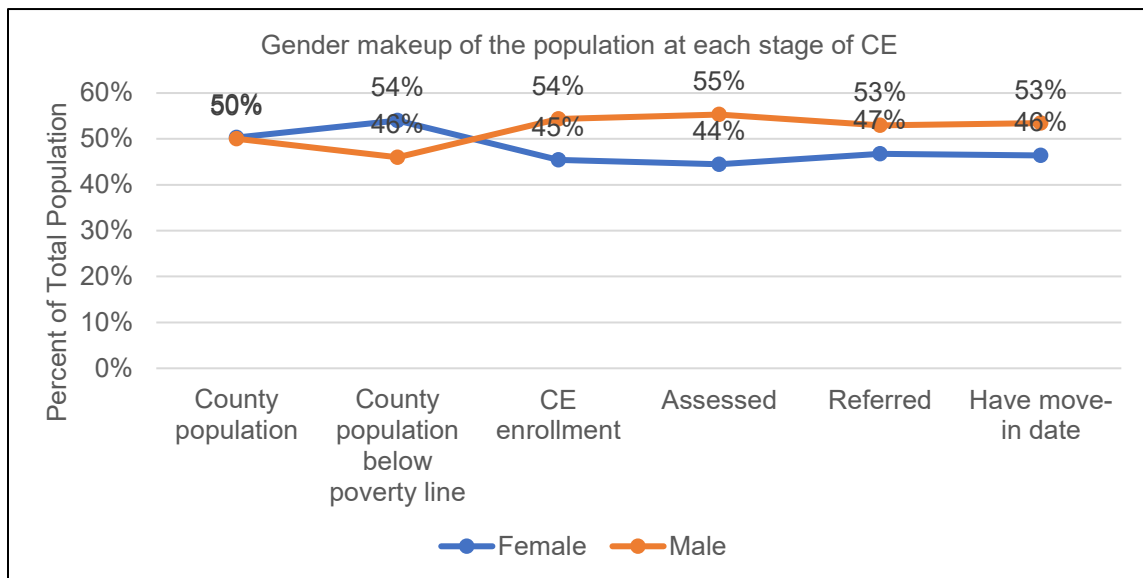


Figure 28. Percent of the population at each stage of the CES that is made up of a given gender. Data sources: HMIS and 2020 Census. Note: too few people in the CES identify as No Single Gender, Transgender, or Questioning to analyze.

System Flow by Disabling Condition

CoC policy is to prioritize people with disabling conditions. **This is successful at the stages of assessment and referral, where people with disabling conditions make up a larger share of those populations than they do the population at CES enrollment. However, people with disabling conditions still receive move-in dates at a lower rate.** As shown in the Referral section, people with disabling conditions also wait longer for a referral and for a move-in date, suggesting this population may need more resources and/or support at later stages of the CES.

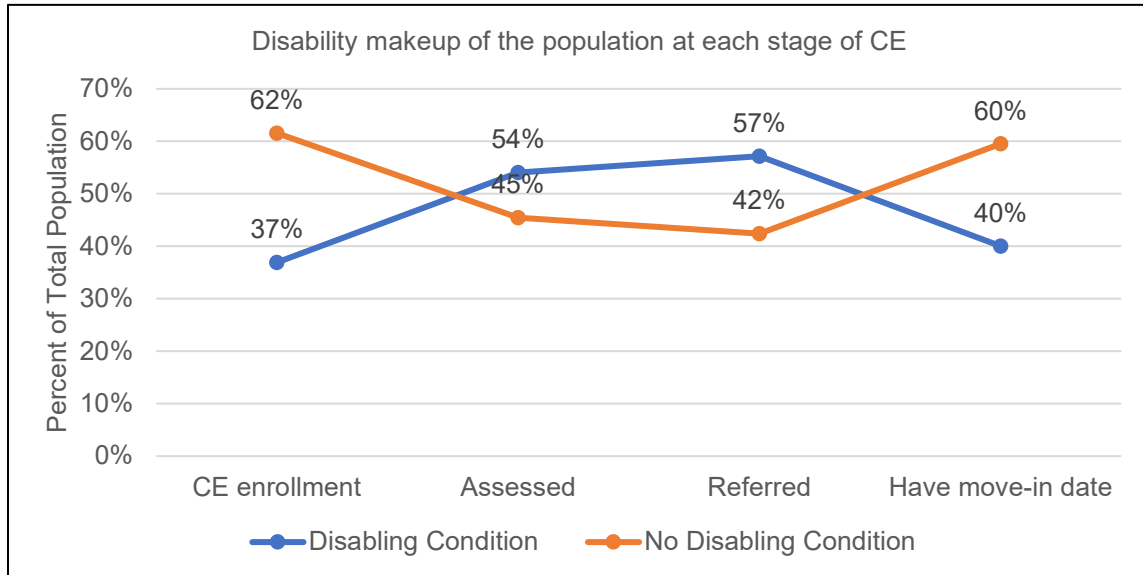


Figure 29. Percent of the population at each stage of the CES that has a disabling condition. Data sources: HMIS.

System Flow by Length of Time Homeless

CoC policy is to prioritize people who have been homeless for a long time. **This is successful throughout the system, where at every stage of the CES people who have spent more than 12 months homeless make up a larger share of the population than they do the population at CES enrollment.** As shown in the Referral section, people who have spent more than 12 months homeless wait much longer for a referral and for a move-in date, suggesting this population may need more resources and/or support at later stages of the CES.

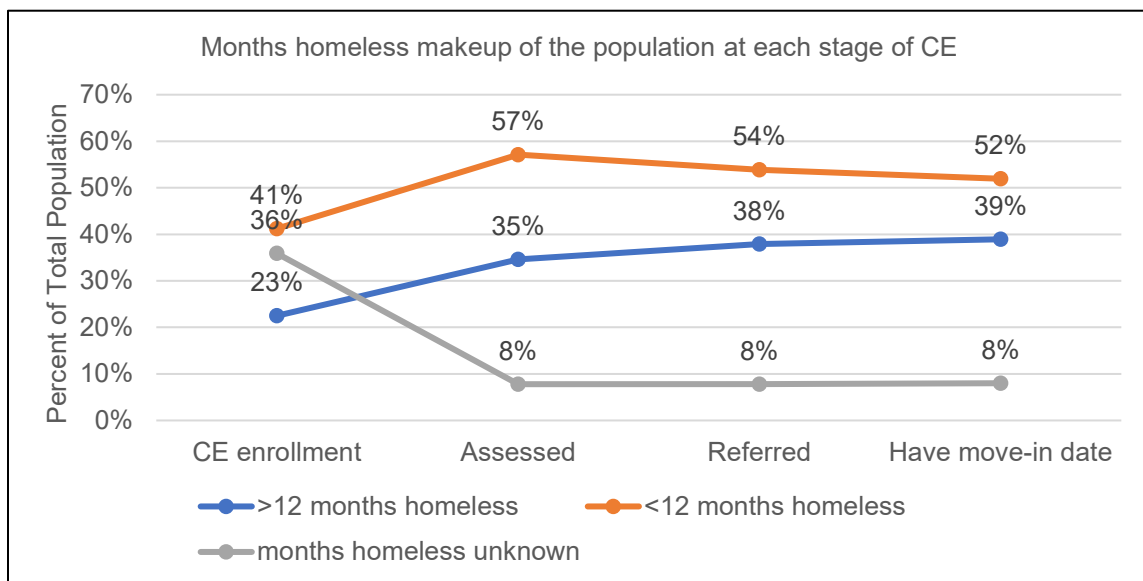


Figure 30. Percent of the population at each stage of the CES that has been homeless for more than 12 months. Data sources: HMIS.

Conclusion

Coordinated entry comes with a myriad of challenges for system partners, direct service providers, and participants alike. Finding a solution that effectively advances equity and holistic system capacity is no small task and requires extra work and input on top of already demanding workloads of day-to-day service delivery.

However, there are many successes and system elements where the Maricopa CES is functioning effectively. Providers and people with lived experience agreed that the single adult CES is robust and that the major metro regions within the CoC are well-covered by the CES. People experiencing chronic homelessness and living with disabilities are referred to housing programs at higher rates than average, highlighting the effectiveness of the current prioritization process in connecting people with these vulnerabilities to permanent housing solutions. Additionally, providers are already making efforts to foster equity within their organizations and strive to ensure staff is reflective of the community being served.

Maricopa can build upon these achievements by implementing the recommendations laid out in this report, also available in Appendix A. We advise the CoC to continue to assess coordinated entry on an ongoing basis and refine policies and practices to progress towards a more equitable and impactful system.