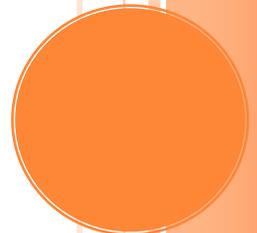


POLICY BRIEF:

“No Wrong Door/Coordination of Services”

The challenge for Los Angeles County and city governments is to move from a collection of independent, loosely connected programs to a coordinated system of care for homeless individuals, families and youth regardless of where they touch the system.

10/21/2015



POLICY BRIEF:

“No Wrong Door/Coordination of Services”

Homeless individuals, families, and youth often touch multiple County/City departments and community-based providers with the potential to receive a wide array of supportive services and gain access to housing. For the most part, services are not well coordinated, and agencies tend to operate under varying definitions of “homelessness,” which may be connected to funding streams, programmatic eligibility requirements, or long-standing bureaucratic practices that create needless barriers and shuffling between programs. Los Angeles County, in collaboration with cities and community partners, has an opportunity to build upon best practices and lessons learned from coordinated entry systems and care coordination for individuals with complex health and social service needs. What strategies can we identify or lessons learned can we strengthen and augment to design a “No Wrong Door” model of access to housing and coordinated service delivery?

Defining Homelessness

The McKinney–Vento Homeless Assistance Act signed into law in 1987 was the nation’s first major legislative response to homelessness. It originally consisted of 15 programs providing a range of services to homeless people including: emergency shelter; transitional housing; job-training; primary health care; education; and some permanent housing. The Act was reauthorized in 2009, when the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act was enacted. The HEARTH Act made numerous changes to the Department of Housing and Urban Development’s (HUD) homeless assistance programs, which expanded upon eligible categories of homelessness. HUD currently defines homelessness as¹:

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary or nighttime residence that is a public or private place not designed for or ordinarily used as regular sleeping

¹ See:

https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

- accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
 - An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
 - An individual or family who will imminently lose their housing [as evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days, having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause]; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing;
 - Unaccompanied youth and homeless families with children and youth defined as homeless under other federal statutes who have experienced a long-term period without living independently in permanent housing, have experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such a status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment; and
 - Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

While the HUD definition applies to Continuums of Care (CoCs), at the federal level there is more than one “official” definition of homelessness. The U.S. Department of Health and Human Services uses a less prescriptive definition than HUD. The variability of what definition of homelessness is used can affect how various programs determine eligibility for homeless populations at the federal, State and local levels.

Move to Coordinated Entry Systems (CES)

The move toward CES culminated with the implementation of the federal “Opening Doors” strategic plan to prevent and end homelessness, the HEARTH Act, and the requirement that CoCs must create a coordinated or centralized assessment and housing placement system that will prioritize access to housing and services based on service need in order to be eligible for federal homeless assistance funding. Coordinated entry is the process through which people experiencing homelessness or at-risk of homelessness can easily access crisis services through multiple, coordinated entry points, have their needs assessed and prioritized consistently, and, based upon those needs, be connected with appropriate housing interventions and supportive services. The central features of a CES encompass having an adequate crisis response system that ensures that individuals, families, and youth have a safe place to stay in the short-term, with access to resources and services that will help them exit homelessness quickly – optimally within 30 days. According to the National Alliance to End Homelessness, critical components of such a system include²:

- *Easily identifiable entry point(s) where fast action can be taken:* Increasingly, communities are developing coordinated entry points where people at imminent risk or currently in the midst of a housing crisis can have their situation assessed and be given immediate assistance. The following assistance should be available at the entry point:
 - Ability to assess needs in a consistent fashion;
 - Ability to help people at imminent risk of homelessness avoid it (for example, prevention resources, i.e. eviction prevention, utility/rental assistance, etc.).
 - Ability to connect individuals, families and youth experiencing a homeless crisis, but without acute health and social service needs, to an appropriate short term housing placement. If possible, diversion resources can be used to find or maintain housing options outside of the traditional shelter system, but when that’s not possible emergency shelter or crisis services housing with some supportive services should be employed to quickly transition to rapid re-housing.
 - Ability to connect people with more acute health or system-based needs (such as those with a mental health crisis or those exiting jail) to another system of care or to permanent supportive housing (PSH).
- *Shelter or crisis services housing:* Individuals, families, and youth should have a decent, dignified place to stay while they resolve their housing

² Based on informational interviews with leadership from the National Alliance to End Homelessness.

- crises. Every facility should be open 24 hours per day, seven days per week, and provide access to nutritious meals. The programs should not discriminate on any basis, including sexual orientation or gender identification. All services should be voluntary. Special accommodation should be made for families and/or individuals who are: fleeing domestic violence; under the age of 24; exiting sexual or labor trafficking; and/or identify as lesbian, gay, bi-sexual, transgender, and questioning (LGBTQ). While not necessarily required in every facility, the following capacities should be available in the community:
- Accessible to people under the influence of substances, experiencing a mental health crisis, or with other issues that may present barriers to entry at some facilities;
 - Available to partners and pets;
 - Storage for belongings; and
 - Confidentiality for those fleeing domestic violence and others who require it.
- Assistance to “Self-resolve:” For homeless populations without acute health or social service needs, or multiple previous homeless episodes, these individuals, families, and youth should be assisted and encouraged to self-resolve quickly and safely. Such assistance might include family intervention and conflict resolution, housing search, facilitating roommate situations, transportation support, practical employment assistance, access to legal services, referrals to community service providers, etc.
 - Rapid re-housing: If it becomes clear at any point that people cannot or will not be able to self-resolve, more intensive assistance should be provided via rapid re-housing, which includes the following four elements: housing identification; rent support and financial move-in assistance; supportive service provision; and case management.
 - Intensive service provision and case management. For those with acute health, mental health, substance use disorder (SUD), and/or complex social service needs, intensive case management/care coordination will be required along with PSH to secure housing stability.

HUD’s primary goals for CES are³:

- Assistance should be easily accessible no matter where or how people present;
- Implement standardized intake/assessment tools and practices;

³ See: <https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>

- Access to emergency services, such as shelter-based care should be available at all hours, to the extent possible, and be independent of the operating hours of coordinated intake and assessment processes;
- Incorporate a system-wide housing first approach to all types of programs;
- Use the Homeless Management Information Systems (HMIS) or other systems to track and evaluate progress; and
- Prioritize homeless assistance for those with the most severe service needs.

CES also has the benefits of creating shared goals and uniform decision-making practices, thereby creating system flow in that there is a unified focus on serving priority populations. At the same time, the flow of individuals and families into homelessness is reduced by incorporating prevention and diversion resources at initial contact through the standardized assessment/intake process to help prevent or divert individuals and families from entering homelessness before the crisis occurs. Resources are maximized most effectively when the most intensive services are matched to those with the most severe needs in tandem with ongoing case management or care coordination to achieve housing stability and wellness. In managing housing and service resources in this manner, additional information is provided about service needs and gaps, and where additional resources or the re-prioritization of resources are most needed across the service delivery spectrum.

Bringing an effective, coordinated system to scale in a county as large and geographically complex as Los Angeles will take political will, resources, additional program planning and prioritization of resources, enhanced data technology infrastructure to collect and share real-time information, buy-in, and time to educate and train agencies on a new model of service delivery. This will require the use of pooled and flexible resources, moving beyond the limitations of individual programs to stitch together an intricate regional service delivery network to connect homeless individuals, families and youth to the most appropriate and tailored housing interventions and service supports.

Current Efforts

Los Angeles County has already developed several innovative programs that integrate housing interventions with supportive services, and Los Angeles has been cited as a leader in CES implementation by the U.S Interagency Council on Homelessness and other national organizations.

County

- Housing for Health (HFH): The County Department of Health Services (DHS) launched HFH in November 2012 to provide services and housing assistance for homeless individuals who have complex health, mental health, and/or substance use needs and are high-users of DHS hospital services. DHS utilizes a variety of community-based supportive housing options, including

single family homes, individual apartments, blocks of apartment units, or entire buildings. DHS administers a rental housing component of HFH through the Flexible Housing Subsidy Pool (FHSP). The FHSP locates housing and provides move-in assistance and rental subsidies. HFH also uses other housing resources, such as Housing Choice Vouchers provided by the Housing Authority of the City of Los Angeles, Shelter + Care through the Los Angeles Housing Services Authority (LAHSA), and units of affordable or supportive housing created through other funding sources and made available to people receiving services funded through HFH. HFH is linked to a flexible array of services, including: intensive case management; crisis intervention; linkages to health, mental health, and SUD treatment; assistance with benefits; housing search assistance for those who use tenant-based rent subsidies; life skills; and job skills training. HFH also funds interim housing options, including recuperative (respite) care to provide short-term stability for some homeless people experiencing chronic illness or recovering from hospitalization, until they can move into permanent housing. Since the inception of the program in 2012, HFH has housed 1,035 County patients, 92% of whom have retained housing after 12 months.

- Single Adult Model (SAM): Beginning in the 2014-2015 fiscal year, the Board of Supervisors reallocated ongoing Homelessness Prevention Initiative (HPI) funding to implement SAM, which includes several components that seek to align more effectively outreach and engagement; health/mental health/SUD treatment; and housing assistance for single adults experiencing homelessness who are high users of health and mental health services. New or re-structured programs include: Multi-disciplinary Integrated Teams (MITs) to provide street and shelter-based intensive engagement and support; integrated mental health, health, and SUD services; ongoing case management; and connections to housing assistance for homeless persons with serious mental illness.
- Homeless Families Solutions System (HFSS): LAHSA launched HFSS in 2013 with County and Los Angeles City financial support. HFSS provides a regional system to address family homelessness by re-housing families quickly and efficiently and connecting families to supportive services within their communities. The 211 hotline, the emergency shelter system, MITs or other outreach and engagement teams, and the Department of Public Social Services (DPSS) connect homeless families to a family solutions center (FSC) within one of the eight geographic service areas. FSCs assess and triage families for an array of supportive services, including: health and mental health services; SUD; disability benefits advocacy; crisis housing; diversion services; rapid-rehousing; employment development; legal services; child care; and PSH.

- C3 – County+City+Community: A robust street outreach and engagement strategy that operates under HFH and focuses on the 50 square blocks of Skid Row by breaking it up into four quadrants with a 5-member, multi-disciplinary team for each quadrant consisting of: health; mental health; substance abuse; LAHSA Emergency Response Team; and peers with lived homelessness experience. The strategy also involves collaboration with the business community; community health providers; and the human service and housing provider community. The strategy plans to include day-time welcoming centers that provide food, showers, bathrooms, and access to services, sobering centers, and connections to interim and permanent supportive housing. In addition, connecting Skid Row residents from street encampments to PSH promotes neighborhood beautification and revitalization, plus the ability to install additional amenities, such as: pocket parks/planting of trees and more community greenery, bike racks, benches, trashcans, and restrooms.
- Board-adopted Diversion Plan: The District Attorney, in collaboration with the Mental Health Advisory Board, developed a recommended plan to safely divert non-violent mentally-ill offenders from jail, and the plan was adopted by the Board of Supervisors on September 1, 2015. The Mental Health Advisory Board used lessons learned from Miami-Dade County, Florida – a leader in jail/mental health diversion efforts. The “Sequential Intercept Model” (SIM) of mental health diversion planning occurs along the criminal justice continuum, as a series of points where interventions can be applied to prevent an individual from further entry and escalation into the criminal justice system. This is particularly important for mentally ill and homeless individuals who are significantly more likely to become involved in the criminal justice system and remain incarcerated than their counterparts with stable housing. The five intercepts consist of: 1) law enforcement/emergency services first contact; 2) post-arrest/arraignment; 3) courts/post-arraignment/alternatives to incarceration; 4) community re-entry; and community support. The plan incorporates mental health, health, and SUD resources along with recommendations to increase investments in housing resources to DHS’ FHSP and to DMH’s specialized housing programs to increase PSH for diverted, mentally ill and potentially homeless offenders.

City

- Housing Opportunities for Persons with AIDs (HOPWA): The program was designed to provide states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing and supportive service needs of persons living with AIDS or other related diseases, and their families. The HOPWA program authorizes entitlement grants and competitively awarded grants for housing assistance and services. The City of Los Angeles serves as the administrator of the HOPWA program for all of Los

Angeles County. The Los Angeles Housing Department (LAHD) is the entity within the city designated to carry out the program. HOPWA leverages and coordinates resources with the following:

- The program works with four public housing authorities throughout Los Angeles County. HOPWA pays for the first 12 months of rental assistance at the conclusion of services, after which clients transition to the regular Housing Choice Voucher program (provided they have remained eligible), so they can maintain permanent housing.
- The Housing and Community Investment Department's HOPWA program and the County Department of Public Health, Division of HIV and STD Programs (DHSP) work together to better coordinate programs and funding. DHSP assumes the costs of the HOPWA funding for other programs/agencies including: Residential care facilities for the chronically ill; treatment beds for persons with substance abuse; mental health counseling; food and nutrition services. This allows HOPWA funds to be available for more permanent and interim housing options, housing specialist costs, and other related housing costs.
- HOPWA works closely with HFH, funding a pilot program in collaboration with the County to place a Housing Specialist at the USC Rand-Schrader HIV/AIDS Clinic to work with homeless HIV/AIDS clients to more quickly access HFH, connect them to HOPWA services including interim housing while waiting for permanent housing, and provide follow-up and links to other supportive services.
- HOPWA utilizes the Coordinated Entry System (CES), which operates throughout the County to identify and assess homeless persons for housing and service needs and match them to permanent housing resources.

Community/Philanthropy/Government:

- CES: Stitches together over 100 programs and agencies across the eight service planning areas of Los Angeles County into a no-wrong door system, connecting homeless adults to the permanent housing opportunities best suited for them. Originally sponsored by the United Way of Greater Los Angeles and the Home for Good Funders Collaborative, it is now supported and advanced by a broad base of County, LA City, and community partners. It is a platform that facilitates coordination through the following means:
 - Universal Assessment: A common multi-part survey is used by all participating agencies, collecting data on demographics, eligibility, personal preferences, and level of service need (VI-SPDAT).

- *No Wrong Door*: CES entry points are wherever this survey is administered - on the street, in a shelter, in a clinic, at a business or place of worship. While there are designated walk-in sites for assessment in each region, those are not the exclusive points of entry.
- *Shared Data*: This survey is entered into a common database (LAHSA's HMIS) with a release of information that allows sharing of these data elements across participating agencies to allow for seamless connections between programs, care coordination, and resource matching.
- *Resource/Service Matching*: Just as client information is pooled into CES, PSH providers also submit information on housing vacancies into the database. The specific eligibility requirements for and relative intensity of the resource are then matched against the client information to make resource matches. Primarily used for PSH resources thus far, CES is now also being used to match to rapid rehousing resources, health care supports and benefits.

From July 2014 to June 2015, Countywide CES operations assessed 9,721 people and 1,738 people were permanently housed, over 90% of whom were chronically homeless.

Comparative Perspectives/Best Practices

Los Angeles is recognized as a leader on a national front for creating coordinated entry models, such as CES and innovative, targeted interventions along the homeless population continuum for families (HFSS), single adults (SAM), and for those individuals with complex health, mental health, SUD needs that are frequent users of DHS' hospital/emergency services (HFH). These coordinated entry/integrated service models all: (1) utilize various outreach/engagement teams to identify homeless clients; (2) employ standardized assessments and protocols to determine clients' needs; and (3) link clients with the most appropriate interim and/or permanent housing and tailored service supports.

Two other jurisdictions cited for their coordinated entry models include Richmond, Virginia and Columbus, Ohio:

- *Homeward – Richmond, VA*: Homeward serves as the organizational model for the Greater Richmond Continuum of Care (GRCoC), which covers the City of Richmond and a seven-county area, and is the lead for GRCoC's coordinated entry system. Homeward combines annual federal, State and local funding including HUD, state planning dollars, local government non-departmental funding, United Way funding, and other philanthropic dollars. A new statewide effort to end homelessness launched in September 2014 has produced the momentum to create a coordinated entry system, as an essential part of a larger holistic strategy for ending veteran homelessness. In 2014, the State developed its Plan to End Veteran Homelessness and to implement a coordinated system for veterans to access HUD-Veterans Affairs

Supportive Housing, Supportive Services for Veteran Families assistance, and other resources. GRCoC is working in partnership with the local VA Medical Center to implement a coordinated entry system that will:

- Provide greater outreach to identify veterans experiencing homelessness;
- Create multiple points of entry into the system;
- Implement standardized assessments that can be performed in the field by trained staff; and
- Coordinate the alignment of housing and service interventions based upon assessments.

Although this effort is initially focused on veterans, the community sees this as an opportunity to test this model, in order to refine the development of a more comprehensive system that will eventually serve the continuum of all homeless populations. While the focus has been to target resources specifically devoted to veterans, Homeward and GRCoC see opportunity to achieve greater integration with mainstream systems and resources. Future plans include a focus on:

- Greater coordination with the criminal justice system to connect people experiencing homelessness and cycling through jail to housing and supportive services;
 - Engaging mainstream systems, such as the Department of Social Services, in both referring people to the coordinated entry system, and potentially performing the VI-SPDAT screenings;
 - Strengthening connections with Child Protective Services and Adult Protective Services to better address the needs of vulnerable households; and
 - Developing connections with the mainstream workforce system to improve employment outcomes and financial stability for people exiting homelessness⁴.
- Community Shelter Board/Coordinated Intake Assessment – Columbus, OH: This jurisdiction is a recognized leader in combatting family and single adult homelessness through a “Prevention/diversion housing first model” and through coordinated investments and oversight to create a transparent data-driven system and continuous learning opportunities to refine strategies. Although the scale is much smaller than Los Angeles County, the significant reduction in homelessness rates for both families and single adults in Columbus’ CoC has made it a model to emulate. In 1997, just before the height of the recession, 1,217 families entered homelessness in Columbus

⁴ See: <http://usich.gov/blog/richmond-and-la>

before declining to 746 in 2009. From 2007 to 2009, the community continued to reduce homelessness in the midst of a nationwide recession with 7 percent, 6 percent, and 4 percent reductions in overall, family, and single adult homelessness respectively during that two-year time frame. Columbus has achieved these outcomes through a homeless assistance system that quickly connects homeless people to housing, provides appropriate case management, and connections to mainstream service supports to help them achieve stability.

For example, the family coordinated entry model utilizes the local YWCA as a centralized intake point for all homeless families. Families that are currently homeless are immediately triaged and linked to interim or permanent housing with supportive services. Families with places to stay in the community for at least two days are eligible for referral to the Stable Families Prevention Program, which offers diversion assistance. Within 48 hours of this referral, while remaining in their current housing situation, families are given a more intensive screen to guarantee program eligibility. If eligible, they are assigned a Stable Families case worker, who helps them with budgeting and crisis planning and connects them to community resources. Many families in the program also receive financial assistance to help them maintain their current housing situation. Columbus was able to divert more than one out of four families seeking shelter in calendar year 2010, and the rate at which families enter shelter after participating in the Stable Families Prevention Program is less than 5 percent.

Program success can be attributed to Columbus' approach to comprehensive data tracking and management that emphasizes consistency, transparency, and almost complete participation in the HMIS. In 2010, one hundred percent of CoC Columbus service providers participated in the community's HMIS, and has coverage of 98 percent of shelters, 91 percent of transitional housing, and 95 percent of permanent supportive housing providers. The HMIS operates as an open system, which makes most of the client information available to all providers in the system including emergency shelter history and receipt of financial assistance. However, HIPPA-protected health information and domestic violence related information cannot be viewed. Columbus is a solid example of an effective homeless coordinated entry system⁵.

⁵See: http://usich.gov/usich_resources/solutions/explore/columbus_coordinated_entry_system_ywca_family_center_and_coordinated_point/; and <http://www.endhomelessness.org/library/entry/the-columbus-model-becoming-a-data-driven-system>

Discussion Questions

- As there is more than one definition for homelessness at the federal, State, and local levels, how should the various definitions interact in a coordinated system? For example, should all agencies identify those families/individuals who meet the HUD definition, separate from those people who meet a given agency's broader definition?
- Does there need to be a basic definition/understanding of homelessness for identification purposes across County/city Departments that are not core health and human service agencies, but come into contact with homeless individuals/families/or youth? What should be their response?
- What would "No Wrong Door" mean?
- How can County, city and community providers that serve homeless populations within their programs, but are constrained by program eligibility or funding requirements, coordinate more effectively to serve the multi-faceted needs of homeless individuals in terms of health; mental health; SUD; housing; public benefits; vocational/educational services; legal needs; and life skills/money management?
- What have the complications been in having separate coordinating systems for families (HFSS) and single adults (CES)? Should these separate systems be consolidated into one system? If yes, what factors need to be considered?
- Could/should a coordinated system be built around Medi-Cal, since: (1) almost all homeless individuals and families now have Medi-Cal; (2) Medi-Cal is a federal and State-funded entitlement program; and (3) many homeless people need significant health, mental health, and/or SUD treatment?
- Could Medi-Cal fund the cost of a comprehensive health/mental health/SUD assessment for homeless families and individuals? If so, how would such an assessment compare to the VI-SPDAT currently in use in CES?
- Based on which criteria should homeless individuals, families and youth be sorted for service coordination?
 - Health service needs: one or a combination of health, mental health, and/or SUD.
 - Population focus: single adult, chronic, veteran, family, transition-age youth.
 - Income potential: work, disability benefits (SSI/SSDI/veterans).
- Which services should be coordinated and who determines?
- What is the role of a case manager or service navigator?
- How can case managers/service navigators ensure appropriate linkage to services and ongoing coordination?
- What factors determine when to employ service coordination?

Resources

- Are there dollars that Los Angeles County and/or cities are currently spending on homeless services/housing that could be leveraged or pooled to enhance effectiveness?
- Are there more creative ways to braid federal, state, and local funding to support coordinated and integrated models of homeless service delivery?
- What funding sources could help defray the costs of implementing CES, including staffing and infrastructure, particularly data systems, required to manage the process?

Legislative Advocacy

Are there any changes in State and/or federal law which should be pursued?

- What specific guidance/and or regulatory flexibility could federal agencies provide that would make it easier to manage multiple funding streams necessary to provide seamless access to housing and services for homeless populations?

Potential Policy Options

- Strengthen County/city/community participation and investments in CES to continue to build the infrastructure and support required to streamline service access, assessment, matching and prioritization to appropriate housing interventions and service supports for homeless individuals, families, and youth.
- Enhance the emergency shelter system to be available 24 hours a-day/7-days a week to address the needs of homeless individuals, families and youth, and utilize the shelter system as a point of assessment and entry into the homeless services system.
- Expand/consolidate investments into innovative housing programs, such as the Flexible Housing Subsidy Pool.
- Conduct a comprehensive, Medi-Cal-funded, health assessment (including mental health and SUD) for all homeless families and individuals, and use the results of that assessment as a primary determinant of the appropriate service path for an individual, family, or youth.
- Create an integrated, countywide system of rapid rehousing.