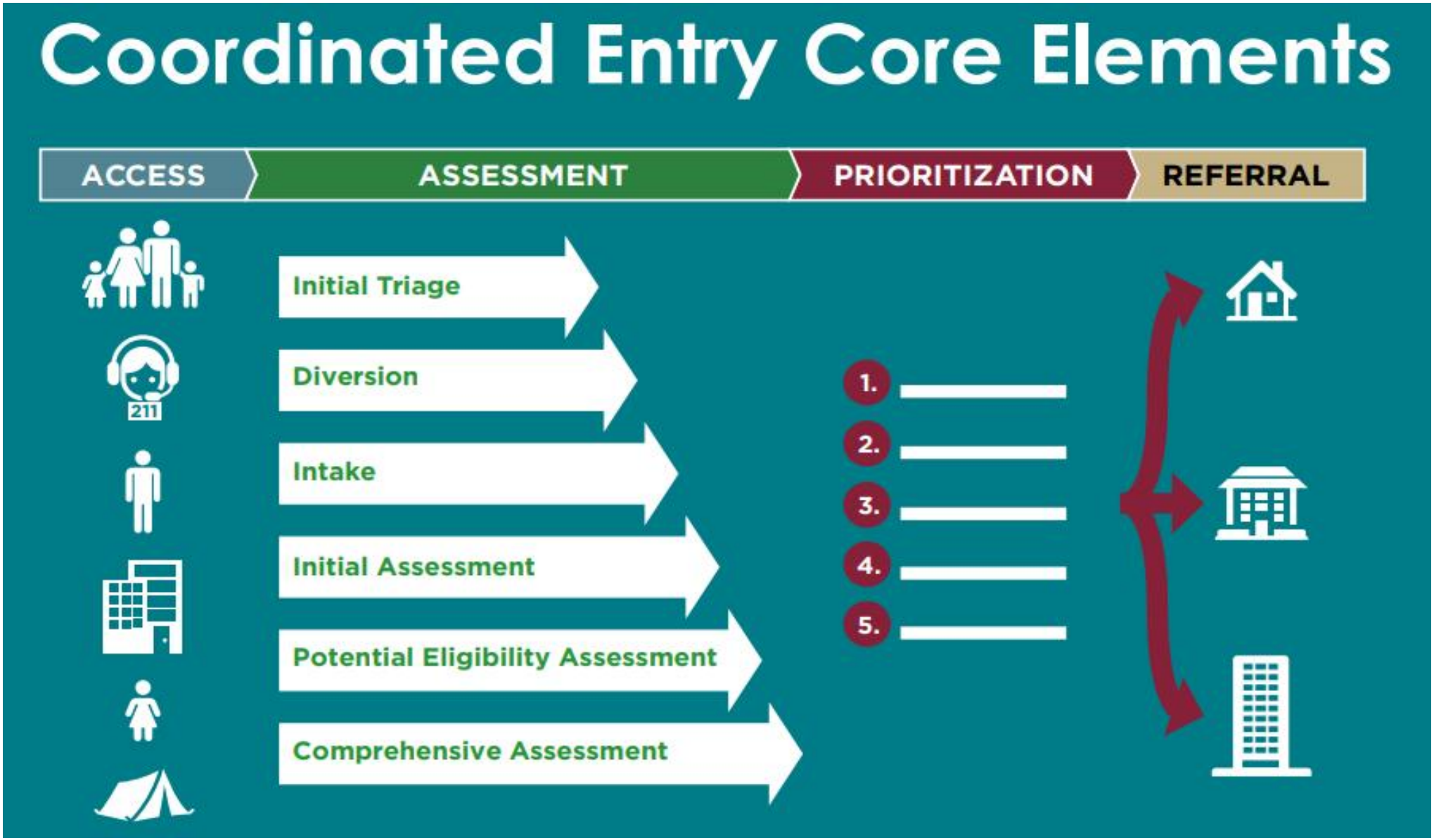
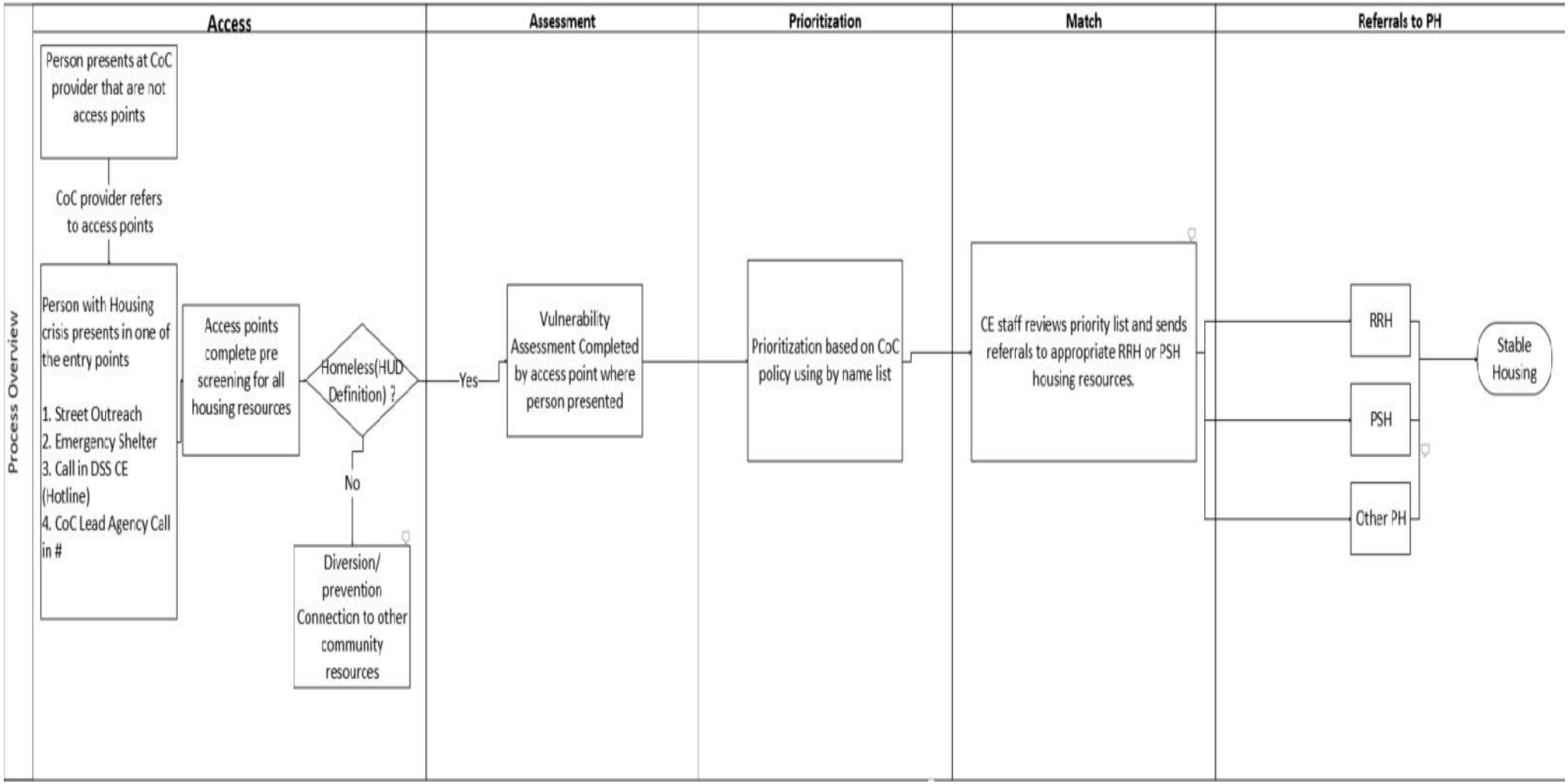
Understanding our system and identifying areas of improvement

Access

Coordinated Entry Core Elements




Process Overview
Access
Assessment
Prioritization
Match
Referrals to PH
Person presents at CoC provider that are not access points
CoC provider refers to access points
Person with Housing crisis presents in one of the entry points
1. Street Outreach
2. Emergency Shelter
3. Call in DSS CE (Hotline)
4. CoC Lead Agency Call in #
Access points complete pre screening for all housing resources
Homeless(HUD Definition) ?
Yes
No
Diversion/ prevention Connection to other community resources
Vulnerability Assessment Completed by access point where person presented
Prioritization based on CoC policy using by name list
CE staff reviews priority list and sends referrals to appropriate RRH or PSH housing resources.
RRH
PSH
Other PH
Stable Housing

The engagement point for persons experiencing a housing crisis, could look and function differently depending on the specific community. Persons (families, single adults, youth) might initially access the crisis response system by calling a crisis hotline or other information and referral resource, walking into an access point facility, or being engaged through outreach efforts.

How should Access to our Coordinated Entry System be defined?

- Define Model
- Identify High Impact Strategies for Improving Access
- Breakout Groups to Develop Action Items for High Impact Strategies

Review of Current System vs Possible Changes

- Current system access points:
  - Rescue Mission, Trust House, Family Promise, HAT
- HMIS enrollment:
  - Central Intake or Access Points?
  - Coordinated Entry referral to Central Intake in HMIS?
  - Centralized?
- HUBs vs. refining current process?
- DV access needed
- Targeted prevention model:
  - Centralized vs HUBs

How should our Coordinated Entry System be defined?

Coordinated Entry Access Models:

	SINGLE POINT OF ACCESS	MULTIPLE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Site Location	Centralized	Located at population centers, high-volume providers, and possibly separated by subpopulation	All existing provider locations	Telephone based or internet
Number of Access Points	1	Variable, based on geography	Many	1 telephone number of website access
Services Offered	Primarily access and assessment; may include triage services, emergency services, or other mainstream services	Primarily access and assessment; may include the services of a co-located provider; may be targeted to one of several subpopulations	Access, at least limited assessment, referrals, and the standard services of each provider	Access to the homeless system, often includes access to mainstream services, limited assessment capability
Operating Entity, Staffing	Permanent independent access specialists; may be shared staff of a central shelter or other organization	Mobile or permanent independent access specialists or shared staff of co-located providers	Independently operated by each provider	Local 211 or other designated hotline agency
Hours of Operation	Hours of the central location	Hours of each access site	Hours depend on and vary with each provider	Typically 24-hour operation, 7 days a week

How should our Coordinated Entry System be defined?

Considerations:

SINGLE POINT OF ACCESS	MULTIPLE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Highest level of control over implementation and compliance for the CoC; also known as "centralized" intake or assessment.	Moderate level of control over implementation and compliance for the CoC's the most adaptable model, sometimes called a "hybrid" system.	Lowest level of control over implementation and compliance for the CoC; however, still requires standardized forms and coordinated referrals for all.	211 is the most popular example; sometimes combined as an initial triage tool with any of the other models; often must build a relationship with an outside provider.

How should our Coordinated Entry System be defined?

Considerations for Separate Access Points:

- The CoC might want to have different access points for those HUD-designated subpopulations, with staff conducting assessment in a culturally sensitive and informed manner but making referrals according to the standards established by the CoC.
- If the community has pre-existing networks for subpopulation groups, the CoC might want to choose to have a partially separated coordinated entry process with a separate access point. CoC policies and standards would still apply. Examples might be a youth drop-in center or a domestic violence hotline.
- Multiple access points or methods (e.g. crisis line) can be safer for domestic violence survivors, as a single, well-known location can put them at risk.
- The Coc might want to offer mobile access to people in subpopulations who might resist going to a centralized access point. This mobile access might be through trained outreach staff who are prepared to assess people in phases.

Pros and Cons of Multisite and No Wrong Door

	Multisite Centralized Access	No Wrong Door
Pros	• Ability to identify entry points in rural areas • Starting point to offer more wide-spread access (no wrong door) • Assessment – can market assessment sites to general public	• More access in rural areas • Many points of access • Increase opportunities to catch harder to reach clients
Cons	• Limited in rural areas	• Lack of control • Turnover/training • Service providers may not understand “system” • Multiple trips to enroll into system • Limited assessment?

Vote on BRCoC Coordinated Entry Model

Poll results:

Multisite Centralized Access – 92%

No Wrong Door – 8%

Identification of High Impact Strategies for Improving Access

At the last meeting, several areas for access improvement were identified:

- Emergency Services/After Hours
- DV Access
- Geographical Coverage
- Accessibility
- Outreach

Ranking and Breakout Groups

Poll Results (top 3):

- **Emergency Services/After Hours**
- **DV Access**
- **Geographical Coverage**

Breakout Groups:

Identify strategies/actions to improve access in the focus area of your choice

Prioritize based on feasibility

Breakout Group Review

Review identified strategies/actions for the identified areas of improvement & prioritize based on urgency feasibility

Emergency Services/After Hours Group (Alison, Amanda, Tanyia, Courtney, Hannah, Sandy, Ben)

- Need hospital social work and law enforcement at the table
- Need to understand availability of ACCESS at sites (hours, populations, etc.)
- 211 to take after-hours/weekend calls, as well as rural calls; refer to shelter (if available), and "pre-triage" and send basic info to Central Intake
- (Lockers needed for people to store belongings after hours)
- TRUST – dedicated beds that aren't being used – can be used for overnight/emergency shelter?
- Vouchers for crisis rooms, especially in rural areas; agreement with rural law enforcement for transportation?

DV Access Group (Brian, Hope, Lana, Amy)

1 .Awareness of DV program eligibility and services – transparency of processes, current status of program, eligibility, etc.
2. Equity – transgender & male client access
3. Decreased barriers to access
4. Confidentiality issues
5. Getting people into the shelter and safe
6. Speed of shelter enrollment
7. Access for clients who are further along in the fleeing process (Transitional housing specific to DV exists – TAP)
8. Non-DV provider training & trauma-informed processes
9. Adding DV processes to initial intake for all agencies & referral process
10. Creating partnerships with a group of hotels so DV clients can be spread among multiple sites. Training for hotel staff of the safety & privacy concerns – Network of hotels already exists (TAP & DV providers)

Geographical Coverage Group (Matt, Jo, Miriam, Phillip)

- TAP agrees to act as access and/or referral point for clients in Alleghany County/Covington
- SafeHomes discussed as potential access point for DV population in Alleghany/Covington
- Craig County DSS discussed ass potential referral/access point for clients in Craig County. Jo Nelson has relationship with DSS Director in Craig County (Pat Franklin) and will reach out to her to begin conversations around integrating Craig DSS into CES
- Discussion around potentially using hotline/2-1-1 as referral/access point for rural area
- Botetourt Resource Center discussed as potential access point for individuals in rural areas of Botetourt County
- Jo Nelson stated an organization is beginning work to implement an emergency shelter in Alleghany County. Group discussed ensuring this organization is connected to the CoC/CES. Jo Nelson has connection to this group and will facilitate.
- Discussion around individuals having access to housing and other supportive services in rural communities. TAP staff currently offer transports to the Rescue Mission for individuals in Alleghany/Covington who need emergency shelter.
- Discussion around HAT and/or Central Intake offering on-site and/or remote assessment services through rural access points

Upon initial access, CoC providers associated with coordinated entry likely will begin assessing the person's housing needs, preferences, and vulnerability. This coordinated entry element is referred to as Assessment. It is progressive; that is, potentially multiple layers of sequential information gathering occurring at various phases in the coordinated entry process, for different purposes, by one or more staff.

Coordinated entry process must collect sufficient information to make prioritization decisions consistently and facilitate access to housing and supportive services across the CoC's coverage area.

Next Meeting

Thursday, August 4th at 10:00AM.

In-person at the Council of Community Services and virtually via Zoom (link provided in meeting invitation to follow).