How Progressive Engagement and Diversion Can Help Your Community End Homelessness

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OrgCode Consulting, Inc.
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IAIN: Ontario based leader of OrgCode; CEO; do-gooder

TRACY: Ontario based Associate Director of OrgCode; Master of Everything

ANN: DC Based Leadership Wonder Woman

MIKE: Arizona based landlord guru

AMANDA & ZACH: West Virginia based rural; HMIS; trainers

DAVID: Florida based data boy wonder; coordinated entry; HMIS

KRIS: California based family specialist; shared housing; SPDAT

The Merry Misfits of OrgCode
Homelessness
The Truth about Homelessness

There are three “types” of people who are homeless

• About 80% are “transitionally homeless”
• They are homeless once in their lives, usually for about a week
• They are able to quickly find new housing, and they are never homeless again

• These are the people the emergency shelter system was designed for
The Truth about Homelessness

• What about the other two types?
  • About 10% are “episodically homeless”
    o These people cycle in and out of homelessness
  • About 10% are “chronically homeless”
    o These people are homeless for over a year, some for much longer
The Truth about Homelessness

• For these 20%, the common response to homelessness is clearly not working
  • Or else wouldn’t they be housed by now?
  • Instead, we’ve been seeing an increase, not a decrease, in homelessness
Overcoming History

- Resources are achieved through self-advocacy and persistence, or luck, or first come/served

- The best case managers are the ones that work their way around the system, not through the system – and “side doors” abound

- Experience is used (confused?) as a form of assessment

- Disconnects between emergency side of the homeless service delivery system and the solution side of the service delivery system

- There is no coordinated approach for matching the right person/family to the right resource in the right order
These people are all **homeless**
but they are *not a homogeneous* group
They need to all be assessed using a common tool, which will determine their acuity and the best intervention for them.
These folks have **lower acuity**.
They should receive the lightest touch possible.
These folks have *moderate acuity*. They should usually receive *time-limited* financial and/or case management supports.
These folk(s) have *higher acuity*. They usually need a Housing First intervention and/or Permanent Supportive Housing.
1. Equality: is giving people the same thing/s.
2. Equity: is fairness in every situation.
Ending Homelessness

• A **functional** end to homelessness means no person has to remain homeless longer than 30 days prior to moving directly into **permanent** housing.

• Ending homelessness requires:
  - Shelters working as a process, not a destination
  - Diversion is a service with an outcome
  - Housing-focused conversations
  - Access to permanent housing quickly (less than 60 days)
  - By name registry of all people to be served
End Homelessness by:

- *Closing the front door into homelessness* –
  - Diversion & Prevention/Homelessness Proofing
  - Coordinated Entry
  - Discharge Planning
- *Open the Back Door out of Homelessness* –
  - Housing focused Shelters
  - Housing First
  - Housing Development & Location Services
- *Find the Courage to do things differently* Together
  - Solution Focused Innovation
Visual Images of a Coordinated Entry System
System Map and Roles

Outreach, Emergency Shelter, Day Center

By Name List: HMIS data creates prioritized by-name list

Referral: Families are matched with vacancies that meet their needs

Housing programs

You do
- Diversion
- Prevention
- Basic Needs/Shelter
- F-VI-SPDAT Assessments
- Document Readiness
- Enter/Exit HMIS data

You do
- Housing Search and Location
- Administer Subsidy
- Housing Stability Supports
- Broker additional services
- Enter/Exit HMIS data
Front End / “Need”
Individuals experiencing homelessness assessed and entered into shared universal registry, then prioritized by need, and documentation for housing collected

Back End / “Supply”
Housing supply identified and vacancies filled from shared universal registry

MATCHING!

Common Assessment
Coordinated Outreach
Prioritization
Case Conferencing
Housing Navigation

Inventory of Available Housing Resources
Vacancy Notification
Eligibility Matching
Let’s Begin With A Bathtub

In a metaphorical bathtub where the water represents people experiencing homelessness, our shared commitment to “ending homelessness” looks like draining the tub.

GOAL = LESS WATER IN TUB
INCOMING WATER = INFLOW
DRAINING WATER = OUTFLOW
System Performance Measurement

Things to consider:

In what ways can we increase the amount -- sheer quantity -- of people into housing?

In what ways can we reduce bureaucracy, connect supply to demand, and move with an urgency that almost scares others -- but in a good way -- to speed up that process?

In what ways can we provide housing first, not housing only, to support people once they move-in? Can that involve housing options with choice, not placement?

In what ways can we prevent, or rapidly divert, people from experiencing homelessness?
Three Basic Metrics

How long are people spending homeless?

How many are moving into housing?

How many are returning to homelessness?
• There is a difference between WANT and NEED.
  • Most people that experience homelessness will do so only once in their life, for a short period of time, and will not experience it ever again.
  • Meanwhile, there are a smaller percentage of people that experience episodic homelessness or chronic homelessness.
• We do NOT have an infinite supply of resources, nor do we have more staff and time than we know what to do with.
• Acting like a system requires that we have coordinated access and common assessment.
• All of this occurs within heightened emotional context.
Progressive Engagement
What is Progressive Engagement?

Progressive Engagement is an approach to helping households end their homelessness as rapidly as possible, despite barriers, with minimal financial and support resources.

More supports are offered to those households who struggle to stabilize and cannot maintain their housing without assistance.
Is this an outpatient service? Short term stay? Longer term, more involved situation?
If yes, how ill or injured are they compared to everyone else seeking service?
If yes, do they need to be at a hospital?
Are they ill or injured?

The ER knows who each of these 10 people are by name if they are ill or injured and need to be at a hospital. The rest of the hospital does not know them. And, the ER does not know all the people who are ill or injured in the community but ARE NOT at the hospital.
Brief interventions. No ongoing, long-term or permanent support required. Expected to recover.

Diverted or quickly treated and discharged, the rest of the hospital does need to know these people.

Who does what specialties?
Who has space?
What will be the treatment protocol?
Does the patient want it?
Presents for Shelter

Diversion Attempted

Shelter Admission if Diversion Unsuccessful

Minimal Service (housing encouragement) for 14 days

Prioritization Determined

1. Housing First/PSH
2. Rapid Re-Housing
3. No Housing Assistance

Acuity Determined

Housing Triage

Client Notified of Priority Status

Assigned Case Manager

Prep for Housing

Housing Search

Lease Signing

Monitor Results

Goal Setting Linked to Higher Acuity Areas

Case Management Begins in Earnest

Move in

SUCCESS
Returns to Shelter → Diversion Attempted → Shelter Admission if Diversion Unsuccessful → Minimal Service (housing encouragement) for 7 days

Prioritization Determined → 1. Housing First/PSH → Acuity Determined → 2. Rapid Re-Housing → Housing Triage → 3. No Housing Assistance

Client Notified of Priority Status → Assigned Case Manager → Prep for Housing → Lease Signing

Goal Setting Linked to Higher Acuity Areas → Case Management Begins in Earnest → Move in

Monitor Results → Success
Progressive Engagement Practice

• Empower people to demonstrate their resilience and solve their own homelessness through the lightest engagement first.

• Give people an opportunity to demonstrate what they know how to do rather than assuming they know how to do nothing.

• Add more supports when people ask or when it is clearly demonstrated that more support is needed.
Progressive Engagement Practice

• Prevention
• Diversion
• Support consumers with Self-Resolving in shelter
• Shelter is a process, not a destination
• At 14 days, increase services and service planning
• Rapid Re-Housing first, for all
• Assess for intensity of housing stability supports that inform service planning
• More intensive services as needed
The Universe of All Experiencing Homelessness

Those That You Know Exist (Though May Not Know Name)

Provided Consent & Know Name

Engaged in Services (Active)

Imminently House-able (All Paper Work in Order)
Everyone that is homeless

Those you know exist

Coordinated Entry List

Those that consent

Those engaged

Those you have all paperwork done

By Name List

Unknowable

PIT Count
Prevention & Diversion
What is Diversion?

• Diversion is about saying “YES” to helping households navigate a safe alternative to shelter that is appropriate to their circumstances through an investment in staff time by dedicated staff that have specific problem-solving skills and access to flexible resources to put the solution into action.

• Diversion is NOT a refusal of service.

• Diversion should NEVER use assessment too far upstream.
Prevention vs Diversion

**Prevention** = sustaining an existing safe, appropriate tenancy

**Diversion** = locating safe, appropriate alternatives to shelter once a person/family has become homeless
Backbone Premises

• Homeless and housing services are not always easy to figure out

• Most organizations work really hard to be exceptionally good at its work - but that doesn’t mean everyone that comes to its door is a good fit.

• “Service shopping” is inefficient and ineffective for people in need and for service organizations.

• Helping an individual or family get to the right intervention at the right time to end their homelessness is important.

• If a person can end their own homelessness they should be empowered to do so before intensive services are provided.

  – Often youth diversion happens within a shelter setting
For Diversion to Work...

- Diversion IS a service. NOT the absence of service.
- Diversion should NEVER use assessment too far upstream.
- NO over-rides for diversion attempt.
- NOT assessing for assessment sake...NOT about creating waiting lists.
- Diversion must mean a safe option has been identified.
Characteristics of a Diversion Specialist

• Solution-focused
• Objective
• Maintains confidentiality
• Willingness to find alternatives
• Integrity of process
• Impartial to all parties that may influence current situation unless legal duty to report
• Professional boundaries
• Embraces self-determination
• Honesty
Effective Engagement Strategies

• Think before reacting to what is presented.
• Exercise active listening.
• Focus on the problem, not the emotions.
• Accept responsibility for trying to solve the problem, but do not over-promise or be dismissive from the start.
• Use direct communication. What exactly do they need? Why do they need it? What do you need them to do?
• Focus on the future - not the past.
• Ensure fairness.
Different Scenarios to Consider

1. People homeless for the first time.
2. People that keep coming back to homelessness.
3. People stuck in homelessness and/or not using any of the “usual” homeless services.
4. Diversion for youth has to be grounded in safety and choice
   - Often done while in shelter
Where Is Diversion Happening in Your Community?

Via Coordinated Entry?
Via Agency Referral?
At Your Front Door?
As a Rapid Exit Strategy?
9 Steps to Effective Diversion Practice
STEP ONE: Explain the Process

Explanation of the diversion conversation.

“Our goal is to learn more about your specific housing situation right now and what you need so that together we can identify the best possible way to get you a place to stay tonight and to find safe, permanent housing as quickly as possible. That might mean staying in shelter tonight, but we want to avoid that if at all possible. We will work with you to find a more stable alternative if we can.”
STEP TWO: Today’s Urgency and Untested Options

Why are you seeking emergency shelter today?

What are all the other things you tried before you sought shelter today?

What are all the other things you have thought about trying but have not attempted yet in order to avoid needing shelter today?
STEP THREE: Last Night’s Safety

Where did you stay last night?

a. If staying with someone else, what is the relationship between them and you?
b. How long have you been staying there?
c. Where did you stay before that?
d. Would it be safe for you to stay there again for the next 3-7 days?
e. (If a couple and/or household with children under 18) Would your whole household be able to return and stay there safely for the next 3-7 days?
f. If indicate that the place where they stayed is unsafe, ask why it is unsafe.
g. If cannot stay there safely, or if were staying in a place unfit for human habitation, move to Step Six.
STEP FOUR: Story Behind the Story (At Last Night’s Safe Place)

What is the primary/main reason that you had to leave the place where you stayed last night?

Are there additional reasons why you can’t stay there any longer?
Do you think that you/you and your family could stay there again temporarily if we provide you with some help or referrals to find permanent housing or connect with other services?

If no, why not? What would it take to be able to stay there temporarily?
STEP SIX: New Place to Stay Temporarily

If no, is there somewhere else where you/you and your family could stay temporarily if we provide you with some help or referrals to find permanent housing and access other supports?

For example, what about other family members? Friends? Coworkers?

What would it take for you to be able to stay there temporarily?
STEP SEVEN: Identifying Barriers and Assistance Required

What is making it hard for you to find permanent housing for you/you and your family - or connect to other resources that could help you do that?

What do you feel are your barriers?

What assistance do you feel you need?
STEP EIGHT: Current Resources

What resources do you have right now that could help you and your family find a place to stay temporarily or find permanent housing?
STEP NINE: Housing Planning

If admitted to shelter there is still an expectation that you will be attempting to secure permanent housing for you (and your family).

What is your plan at this point for securing housing if you are admitted to shelter?
Progressive Engagement in Housing

Point of Entry

Independently Housed

RRH $  RRH $$  RRH $$$  PSH $$$$$
Progressive Engagement in Case Management

- Understand the context of a client’s situation and concurrent oppressions and traumas
- Support client decision making power
- Set realistic expectations and boundaries
- Use assessments to guide service planning - some clients may need thorough guidance or support, and some very little at all
- Understand that how someone experiences homelessness is not how they experience housing. The past does not predict the future
Progressive Engagement in Case Management

- Housing stability goes beyond financial assistance
- Housing stability services are critical for success in housing

Tools:
- Critical Time Intervention
  - short-term intervention for people adjusting to a “critical time” of transition in their lives.
- SPDAT or other assessment to determine acuity and to inform service planning, and when acuity has stabilized
Progressive Engagement in Practice

- Prevention
- Diversion
- Support consumers with Self-Resolving in shelter
  - Shelter is a process, not a destination
- At 14 days, increase services and service planning
- Rapid Re-Housing first, for all
- Assess for intensity of housing stability supports that inform service planning
- More intensive services as needed
### Administration

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☐ No second parent currently part of the household

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### SPDAT Information

- At/Near Day of Move-In SPDAT Score
- 1 Month in Housing SPDAT Score
- 3 Months in Housing SPDAT Score
- 6 Months in Housing SPDAT Score
- 9 Months in Housing SPDAT Score
- 12 Months in Housing SPDAT Score
- 15 Months in Housing SPDAT Score
- 18 Months in Housing SPDAT Score
- 21 Months in Housing SPDAT Score

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Coordinated Entry for Single Adults - Maricopa County
Objectives

• An Overview of Coordinated Entry
• How does Coordinated Entry benefit our clients?
• How can someone access Coordinated Entry?
• What can we do to make this easier for our clients?
Coordinated Entry is Collaboration of service providers working to streamline services to help connect homeless individuals to available resources and appropriate housing.
With CES

Courtesy of Chris Ko - Home for Good
Who are eligible...

Individuals currently experiencing homelessness in Maricopa County

How to Access?
Coordinated Entry Points

Individuals experiencing homelessness in Maricopa County can gain access to housing resources and services at these locations.

Welcome Center

**Location:** Brian Garcia Welcome Center
**Address:** 206 S 12th Ave
Phoenix, AZ 85007
**Hours:** Monday - Friday 7:30AM-11AM 12:30PM-5PM
**Contact:** 602-229-5155

Community Bridges

*offers access to a number of specialized programs to meet individuals needs.
**Access to care Contact:** 877-931-9142
**Locations:** Across Maricopa County

**PATH - Outreach**

*provides street outreach services to individuals displaying signs and symptoms of mental illness
**24 hour PATH Hotline:** 844-691-5948

**PYRC**

*Ages 18-24 Only
**Location:** Phoenix Youth Resource Center
**Address:** 428 N 24th St
Phoenix, AZ 85009
**Hours:** Monday - Friday 8:30AM-12PM
**Contact:** 602-271-9904

**CRRC**

*US Military Veterans Only
**Location:** Community Resource & Referral Center
**Address:** 1500 E Thomas Rd
Phoenix, AZ 85014
**Hours:** Monday - Friday 7:30AM-4:30PM
**Contact:** 602-248-6040

**Paz de Cristo - Mesa**

**Address:** 424 W Broadway Rd
Mesa, AZ 85210
**Hours:** M-F 12-5
**Phone:** 480-464-2370

**A New Leaf - Mesa**

**Location:** East Valley Men’s Center
**Contact:** 480-610-6722

**Additional Services**

*shelter and Services for Females only may also contact:
**Phoenix:** 602-362-5833
**Mesa:** 480-396-3795
**East Valley:** 480-969-1691

*Please note:* The above services are offered to single adults only. Families interested in these services are encouraged to contact the Family Housing Hub.

**Family Housing Hub:** 602-595-8700 or fhhub.org

For additional assistance with rent, utilities or other issues, please dial 211 or visit 211arizona.org
4 Different Parts to Coordinated Entry

1. Entry
2. Prioritization
3. Engagement
4. Housing
The 3 parts to ENTRY

Diversion: Explore and connect to alternative resources

Assessment: Complete the VI-SPDAT housing assessment for prioritization

Resources: General services outside of shelter or housing prioritization
## Diversion: Safe & Appropriate

<table>
<thead>
<tr>
<th>Philosophy Shift</th>
<th>Practice Shift</th>
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<tr>
<td>• Call for shelter doesn’t mean there is no other option</td>
<td>• Use a strength based assessment vs. a needs based assessment</td>
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<tr>
<td>• Belief in a strength based approach – individuals/households are the best resource for problem solving</td>
<td>• Before conducting intake, engage individual/household in conversations, identifying safe alternatives to shelter</td>
</tr>
<tr>
<td>• Shifting from the idea that the shelter is a household’s only resources</td>
<td>• Assist in connecting to community resources to avoid shelter stay</td>
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Why is Diversion so important?

- Inflow of new individuals experiencing homelessness and utilizing services is greater than housing resources available.
  - Roughly 1 in 10 receive assistance through a housing program through Coordinated Entry.
  - Connection to resources outside the homeless system is one of the most important services we can offer individuals in various housing crises.
July Inflow/Housed snapshot

Inflow\textsuperscript{(new)} 280  \rightarrow  Active 1788  \rightarrow  Housed 335

(Shelters, outreach, assessed)

*Data for Chronic, Veterans, youth only provided in collaboration with Crisis Response Network and Community Solutions Built for Zero community Change Package.
Assessment (VI-SPDAT)

Assessment does not ensure housing placement
<table>
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<tr>
<td>Permanent Supportive Housing</td>
<td>8+</td>
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By-Name-List

• Community Prioritized Housing List.
• How to get on the List?
  – Completing an assessment at an Entry Point.
  – Having a shelter stay within the last 14 days.
  – Having an engagement with Outreach staff within the last 30 days.
• The list is produced weekly by HMIS.
• Coordinated Entry Housing Match department on the Humans Services Campus utilizes list to refer individuals for navigation and housing services.
  – Navigators are amazing client engagement staff who participate in CE by getting folks identified on the BNL document ready for housing.
July BNL (wk.1)

- 2183 Homeless individuals actively using services and on BNL
  - Shelters, outreach, assessed
- 667 Chronically Homeless
- PSH – 48%
- RRH – 40%
- General Supports – 12%
Prioritization
Who is most Vulnerable?

We don’t have enough Resources

- Chronic Status
- Length of time homeless
- VI-SPDAT Score

So we prioritize our resources
What does this list look like:

<table>
<thead>
<tr>
<th>Prioritized List Number</th>
<th>Client ID</th>
<th>Full Name</th>
<th>VI-SPDAT Score</th>
<th>Months Homeless</th>
<th>Chronically Homeless</th>
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<td>Lord Voldemort</td>
<td>13</td>
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</table>

This list includes the people who score for Permanent Supportive Housing that are chronic.
Engagement
## 2 Primary Functions:

1. **Connecting with the client (may be easy but may also be hard)**
   - Contact Shelter CM
   - Leverage Outreach teams – PATH, HSC, etc.

2. **Working with the client to get them document ready (different programs require different items)**
   - 2 Valid forms of ID
   - Verification of Chronic Homeless Status
   - Documentation of Disability
   - SMI Evaluation
   - Applications
   - And More
Coordination of Care

• The Housing Match Department hosts weekly Case Conferencing meetings where navigators and providers come together to communicate progress, coordinate referrals, and troubleshoot any barriers to housing.
  – Additionally Housing Match and providers are openly communicating throughout the week to ensure timely placement.
Referral to Housing

Once the client has all documentation for housing, CE Housing Match will refer them when...

- They are next on the priority list
- An appropriate vacancy comes available
Basic Overview

Entry Point (gets a housing assessment)

Gets prioritized based on chronic status, Length of time homeless and assessment score

Once, document ready- client is referred to a vacant unit

Works with clinic, shelter or outreach to get document ready
How can this benefit our vulnerable neighbors?
What is the benefit?

Opens up so many options for housing and care coordination
What can we all do to make the process smoother for vulnerable individuals in the community?
How to Help?

- Clarity of message
- Realistic expectations
- Communication with Coordinated Entry – contact a site and learn more
- Work the Plan
  - Obtain ID’s
  - Engage and follow-up
● **Do** explain Coordinated Entry as a collaboration of service providers working to streamline services to help connect homeless individuals to available resources and appropriate housing.

● **Do** explain the VI-SPDAT is an assessment that enables our network of service providers to understand their needs, program eligibility, and assist in matching them to the best resources available.
• **Don’t** guarantee housing or a voucher to a client or give them a timeframe in which they will be housed.

• **Don’t** tell a client that the most vulnerable are being prioritized for housing. Please remember that we are using the VI-SPDAT to match people to appropriate housing.
What to expect at an Entry Point?

1. Information Gathering
   The goal is to learn more about your current housing situation and offer appropriate resources so we may assist you in creating a housing action plan.

2. Resources
   Based on the information you provide, we will offer you resources that match your specific needs to help you better end your homelessness. For example, medical care, support in obtaining employment, and even identification services are just a few of many resources staff can offer to you.

3. Housing Plan
   Once we have helped you explore potential resources to address any current housing barriers, we’ll work together to create a short term housing plan like where you can stay for the next week or so. Next, we’ll help you create a long term housing plan that focuses on safe and stable permanent housing.

   Completing the process above DOES NOT guarantee housing or a voucher.

What happens Next?

Work the Housing Plan!

Use the short and long term housing plan along with the resources you obtained to meet your goal! Some key items we have identified that are helpful for housing are:

1. Increase Income—connect to many organizations that provide employment services OR apply for Social Security income Benefits
2. Get at least 2 Valid forms of Identification (State ID, Birth Certificate, Social Security card, etc.)
3. Get connected to government benefits like SNAP and AHCCCS
4. Look at apartment/housing lists and find a place that you would want to live in that you can afford.

How will I know if I get referred to a housing program?

If a referral is made to housing, the housing provider will contact you! Be sure to provide all contact information upfront such as phone number, email, current mailing address, and any contact info for a case manager you may be working with.
Thank you!
Family Coordinated Entry
Family Housing Hub
One Door, One Process

12 agencies were operating 26 programs for families experiencing homelessness in Maricopa county.

For years there have not been enough resources to serve all families seeking homeless services.

In order to use our resources more effectively & efficiently, we DECIDED to work together differently.
Fair & Equitable Access

All families experiencing homelessness - regardless of their connections - receive the same fair & equitable opportunity to access services.

• No priority access for funders, board members, VIPS, elected officials, or outreach teams.

• veteran families needing emergency shelter have to wait, too.

• With a regional approach, the residents of all cities & towns are treated equally – none are prioritized or discriminated against.
Step 1: Safety Screening

DOMESTIC VIOLENCE
Imminent danger due to DV?
Fleeing DV?
Desire for DV services?
Referrals to Centralized Screening Line

Families will still be assessed through FHH if desired

CRISIS
Is there a danger to self or others?
Referrals made to the Crisis Hotline

Families will be assessed when appropriate
Step 2: Veteran Screening

Refer to Veteran Service Priority Specialist

- Additional veteran documentation required?
- Refer to VA Community Resource & Referral Center

- Veteran status and eligibility confirmed?
- Continue with FHH process
- Refer to VA Community Resource & Referral Center for additional services and support
Step 3: Attempted diversion

• We agree to commonly fund and support services to families seeking shelter, with a strong focus on resolving and diverting as many families as possible whenever it is safe and appropriate to do so.

• Diversion includes looking at the current circumstance of the family – from wherever they are connecting from across the County – and professionally, sensitively, and patiently attempting to solve their housing instability without ever requiring shelter admission.
In 2017, the FHH has worked with **3468** adults and **5657** children experiencing homelessness.

### In Person Family Visits

- **Resource Only**: 11%
- **Assessed**: 34%
- **Diverted**: 55%
  
  **N = 832**

### Returns After Diversion

- **No Return to FHH**: 92%
- **Return to FHH**: 8%
  
  **N = 327**
Step 4: Formal Assessment

Family VI-SPDAT

- 15-20 minutes
- Provides a starting point for a progressive engagement model
- 9+ are later assessed with full F-SPDATs

Initial Acuity Score Sample for Homeless, non-diverted families (n = 414)
Step 5: Beginning Intervention Assigned

- Family VI-SPDAT score
  - Eviction Prevention
  - Emergency Shelter (0-3)
  - Rapid Rehousing (4-6)
  - Transitional Housing (7-8)
  - Permanent Supportive (9+)
  - Subsidized/Section 8
  - Permanent Affordable Housing
Step 6: Referrals & Service Priority List

- 1 page referral sent from FHH to Program
- Program accepts/denies within 24(ish) hours
- Goal: 85% acceptance rate
- If accepted, either placed on SPL or sent to agency if unit is available.
- If denied, FHH works toward alternative referral.
Step 7: Is shelter needed?

- Families scoring 0-3 are only eligible for ES.

- Families scoring 4-8 need ES as a 30-day bridge during housing search.

- Families scoring more than 7 may need ES until a TH or PSH unit is available.
Step 8: Document & Data Collection

- Documentation of homeless status
- Proof of identity
- Proof of relationship with child(ren)

- HMIS Entry created
  - Informed consent
  - DV victim files are closed
- UDEs collected
- F-SPDAT score attached
- Documents uploaded
- Electronic file prepared to be manually opened to receiving program.
Step 9: Vacancies filled from Service Priority Lists

- The chart below illustrates the number of families waiting to access each intervention for 4 consecutive weeks.
- Families must wait a few days to a month *even for emergency shelter*. No intervention is immediately available.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>7/13</th>
<th>7/20</th>
<th>7/27</th>
<th>8/3</th>
<th>Estimated wait time</th>
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<tbody>
<tr>
<td>Emergency shelter (ES)</td>
<td>81</td>
<td>106</td>
<td>109</td>
<td>97</td>
<td>6 weeks</td>
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<tr>
<td>Rental subsidy &amp; services (RRH)</td>
<td>185</td>
<td>197</td>
<td>208</td>
<td>200</td>
<td>4 months</td>
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<tr>
<td>Temporary Housing &amp; support (TH)</td>
<td>53</td>
<td>52</td>
<td>53</td>
<td>55</td>
<td>4 months</td>
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<tr>
<td>Veteran temporary housing (GPD)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1-2 weeks</td>
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<tr>
<td>Permanent Supportive Housing (PSH)</td>
<td>17</td>
<td>17</td>
<td>20</td>
<td>19</td>
<td>Unable to estimate*</td>
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</tbody>
</table>

*The chart above illustrates the number of families waiting to access each intervention for 4 consecutive weeks.*

*Families must wait a few days to a month *even for emergency shelter*. No intervention is immediately available.*
What do we do when we encounter a homeless family?

- Contact the Family Housing Hub.
- Help with transportation, if needed.
- Attempt diversion. Help them with problem solving, identifying options, etc.
Questions

Contact

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cschuster@umom.org