



## Coordinated Entry Assessment and Suggested Action Plan

Prepared for EveryOne Home System Coordination Committee  
By Katharine Gale, Consultant  
February 2020

### Introduction

This report presents findings on both the overall implementation and specific critical issues with Alameda County's Coordinated Entry (CE) process, and a set of recommendations for a phased Action Plan to refine and improve the process, resulting in Coordinated Entry 2.0. The proposed Action Plan is presented first, followed by the detailed findings and analysis that led to the recommended Action Steps as well as greater detail on many of the recommendations.

I developed this assessment through reviewing written information, attending two System Coordination Committee meetings, and holding eight targeted interviews/small group conversations with key stakeholders between November 2019 and January 2020. (See Appendix for a list of participants and documents.) The findings and recommendations are also informed by requirements and guidance from HUD regarding Coordinated Entry, as well as knowledge of other CE systems in California and elsewhere in the U.S.

Many of the issues that Alameda County is facing are similar to what other large communities have experienced, and frequently communities find themselves refining or even relaunching Coordinated Entry within a few years of an initial roll out. Some of the challenges Alameda County now faces are the result of deciding to develop or pilot certain CE pieces separately and to move them forward in a rapidly-changing environment of growing need. The challenges and cracks that have emerged over time are not the fault of any one entity, funding source, or any specific decision or set of decisions that was made. The recommendations here to simplify, clarify, improve, or align practice are possible now because of the work that was done by so many parties to move the implementation forward through significant uncertainty and the lessons learned as a result.

There is a great deal of work already occurring to address aspects of the CE process that this report also touches on, such as increasing and improving Problem Solving; addressing federal requirements for how Coordinated Entry is handled within HMIS; developing a plan for improving domestic violence integration; and a commitment to select a Management Entity, among others. Some recommendations included here are in process already. Other issues identified in this report fall outside of the core scope of work commissioned, and are being addressed through other processes concurrently, such as challenges with governance and improving overall HMIS operations. Such broader system issues are not addressed in the Action Plan; however if they were raised frequently as concerns I have mentioned them in the findings that follow.

Finally, this is not intended to be a comprehensive review of every aspect of the CE process, an assessment of whether it is federally- or locally-compliant, or a summary of what is working well. The evaluation shared at the January SCC meeting highlighted strengths of the current process and included the self-assessment prepared by the SCC in June. Information from that evaluation has influenced these findings, but are generally not repeated as findings here.



**PROPOSED ACTION PLAN**

**Phase 1 (Immediate/ short-term – groundwork for launch of CE 2.0 but within current system design)**

#	Action	Key Players	Timing
1	<p><b>Develop and implement Problem Solving system-wide</b></p> <ul style="list-style-type: none"> <li>• Create basic Policies and Procedures by answering guiding questions (small group and consultant)</li> <li>• Use race equity analysis to inform development of policies and rollout process</li> <li>• Form PS Learning Collaborative</li> <li>• Roll out practice and policies</li> <li>• Create ongoing training approach and trainer cohort and materials</li> <li>• Set performance targets and create data collection strategy, and evaluate quarterly at SCC</li> </ul>	<p>Small planning group, Consultant, SCC, CE system providers, Race Equity office</p>	<p>February – May</p>
2	<p><b>Begin work to refine and phase assessment tool and process</b></p> <ul style="list-style-type: none"> <li>• Convene small tool review group (suggested composition listed in report) and review phasing options and how questions will work in new HMIS flow (building on HMIS Oversight Committee analysis)</li> <li>• If possible, conduct statistical analysis of the impact of questions within the current on distribution to recommend tool revisions/simplifications, including a race/equity analysis</li> <li>• Revise tool questions and pre-screening and test for effectiveness and to ensure revised too does not introduce new race/equity disparities</li> <li>• Establish cut off points for priority group (or groups) and develop new messaging for clients and other stakeholders for what to expect immediately after assessment</li> <li>• Develop clinical review process for specific reconsideration for highly vulnerable people who do not initially score in priority pool</li> </ul>	<p>Ad-hoc Tool Review group, Consultant, SCC</p>	<p>Mar – July</p>

#	Action	Key Players	Timing
3	<p><b>Establish rules, practices, inventory, etc. for Zone and central matching</b></p> <ul style="list-style-type: none"> <li>• Determine resources matched at Zone and Central levels</li> <li>• Determine method to keep inventory updated and consistent across Zones (Ideally in HMIS)</li> <li>• Determine role of case conferencing within and across zones and at central level</li> </ul>	Zone Coordination group (with HomeStretch)	March - June
4	<p><b>Develop training plan</b></p> <p>Identify training resources and start working on training planning and delivery</p>	CE Funders or Management Entity if known	March –June to plan, then ongoing
5	<p><b>Evaluate family CE process and access points/address needed family functions</b></p> <ul style="list-style-type: none"> <li>• If resources are available, conduct an evaluation of family process and access points, and use the results to make decisions about the future form of, and funding for, family-specific CE</li> <li>• Evaluate North County Family Front Door (FFD) specifically and develop an interim plan to and improve immediate response to unsheltered families in Oakland/North County, including how to use other outreach and other resources in conjunction with FFD and a plan to improve data collection and reporting</li> <li>• Use the evaluation and/or refined process to inform better definition of desired family functions in Phase 2</li> </ul>	<p>Evaluation: Evaluator, SCC, HMIS Analyst, HCSA, Oakland, Berkeley, FFD.</p> <p>Immediate Plan: HCSA, Oakland, Berkeley, FFD</p>	March- June
6	<p><b>Work with HMIS Oversight to complete development of CE in HMIS and begin using HMIS Reports to evaluate progress</b></p> <ul style="list-style-type: none"> <li>• Complete implementation of new CE HMIS compliance, in conjunction with the above design steps</li> <li>• Use reporting templates from Abt to determine which reports can be developed quickly and run with what’s available</li> <li>• Use staff or consultants to run or assemble reports and begin to review at each SCC meeting</li> </ul>	HMIS Oversight, EOH Analyst and/or HCSA staff or Consultant (if available), SCC, Management Entity when selected. (ICF and BitFocus engaged already)	April – August, ongoing

**Phase 2 - Second half of 2020 and implement by 2021- CE 2.0**

#	Action	Key Players	Timing
7	<p><b>Simplify overall CE design and launch new model and messaging (2.0 model)</b></p> <ul style="list-style-type: none"> <li>• New Management Entity oversee the simplification of the CE design – including potentially retiring and/or reframing HRC and Homestretch language/branding and focusing on defining the functions of Access Points linked to outreach</li> <li>• Implement referral/matching and case conferencing protocols at Zone and System levels (planned for in Phase 1)</li> <li>• Connect new system approach to funding that is anticipated</li> <li>• Ensure the HMIS design supports new model and all key players can perform key functions within HMIS</li> </ul>	<p>Management Entity, ILC/Cross Zone Coordination group, SCC and CoC for approval only</p>	<p>July – December – Timing dependent on ability to also make changes in HMIS</p>
8	<p><b>Address outreach role in the 2.0 design</b></p> <ul style="list-style-type: none"> <li>• Clarify outreach roles and expectations and ensure outreach can be deployed meaningfully to perform all CE-associated functions</li> <li>• Ensure HMIS supports outreach role</li> </ul>	<p>HCSA, Outreach providers, Zone Reps</p>	
9	<p><b>Rethink role of 211 in the 2.0 design</b></p> <ul style="list-style-type: none"> <li>• Assess whether 2-1-1 role continues, expands or shrinks based on new design and especially HMIS capacity and willingness/ability to use HMIS at 2-1-1</li> <li>• Give consideration to potential Shelter Filling and/or inventory tracking role for 2-1-1</li> </ul>	<p>2-1-1, Management Entity, Zone Group/New ILC</p>	
10	<p><b>Integrate DV recommendations and approach in the 2.0 design</b></p> <ul style="list-style-type: none"> <li>• Ensure DV and general violence considerations involved in the overall refinement/simplification process</li> <li>• - Specific changes TBD based on collaborative’s recommendations</li> </ul>	<p>Management Entity, DV collaborative</p>	
11	<p><b>Refine family access and family supporting services in the 2.0 design</b> based on evaluation and/or results of interim plan (see Phase 1 above)</p>		

#	Action	Key Players	Timing
12	<b>Create new policies and procedures and messaging reflecting all of the above and roll out 2.0 design</b>	Management Entity, Zone Group/New ILC	October – December 2020

Consultant(s) can be used to support most of the Phase 1 work. All of the above work in Phase 2 will require staffing and coordination from the Management Entity and/or additional consulting support to facilitate conversations, develop policy recommendations and record them and roll them out.

Decisions about where decision making and approval authority will lie for these actions as well as moving forward will also be needed, and should be as streamlined as possible.

**Plan for 2021**

- Roll out completed 2.0 design
- Address shelter tracking and filling, including adding capacity in HMIS to track and fill openings, if not done in Phase 2
- Work to increase the programs in CE or connected to CE including clear protocols with Prevention programs, non-HUD funded Rapid Rehousing such as AB109 and HSP, certain PSH and other homeless dedicated housing not in system, etc.
- Establish ongoing evaluation process including regular reporting and process for review of CE functions and outcomes

## **Findings and Recommendations**

This portion of the report lays out the findings from the review that inform the recommendations for the Action Plan. They are divided into Big Picture items, many of which are broader than CE alone and fall outside of this scope to address, and recommendations regarding specific aspects/function of CE which are addressed in the Action Plan.

### **A. BIG PICTURE FINDINGS**

These findings are broad, and some are outside of this scope to address recommendations to, but all are critical to the long term improvement of CE functioning. Recommendations for addressing findings in this section come at the end of the section.

#### **1. The CE design and model as implemented is too complex and not aligned**

The current CE process has too many components that operate in distinct ways and have independent identities and even separate branding. Housing Resource Centers (HRCs) were originally to serve as the system hubs (or what many systems call “Access Points”), but in practice many are not operating as true HRCs, as many of the services envisioned to be part of a full service HRC did not materialize or are not being delivered at the sites. HRCs were the core of a hub and spoke model linked to outreach and connected to services in the rest of the system. This model has in part evolved into Resource Zones, many with multiple ‘HRCs’ within them. In some cases Zones cover multiple regions, and some Resource Zones are different for different populations, with a separate Family Front Door (FFD) serving North County and Oakland families.

Though HRCs/Zones theoretically share common policies from the System Manual and common contract requirements, in practice only few shared practices, such as how assessments are done, are followed across Zones. Over time Resource Zones have created their own case conferencing, prioritization and matching policies and practices, which, though not necessarily inconsistent with a decentralized design, are not formally recorded or approved at the system level and cannot be monitored.

Previously, an Implementation and Learning Community (ILC) was used to coordinate around operational issues and make timely decisions and was seen as serving a positive function by most. However, after the primary roll out of CE was done, the ILC was retired; many of its roles either moved to the SCC or no longer exist. As a result there is no formal or regular cross-Zone coordination outside of the SCC, which is too high-level to deal with operational matters. HomeStretch as the coordinator of PSH matching is separately branded and writes its own policies and operates using separate procedures from the overall CE process, though it brings key policy matters to the SCC.

As has been already recognized, the lack of a Management Entity is a significant part of the problem and has contributed to the increasing divergence of policy from practice, and of practice across geographies over time, but appointing a Management Entity alone will not solve this issue unless the CE design is simplified, clarified, and consistently documented. This is not to say that the entire process must be centralized; a geographically-decentralized model is possible with clarity about what is different and what is the same. That determination will also help create greater clarity for future changes/expansion as new funding/resources become available, some with Zone preferences.

#### **2. Complexity in the model results in unclear and conflicting messaging**

Related to the complications of the system, there is a lot of unclear messaging: to clients, to providers – especially front line staff -- and to the public, about what CE is and how it works. A refined system that is

clearer and less complex will need clear and simplified messaging as well as policies and procedures that are consistent and updated. Some of this messaging will need to be related to changes in the assessment and prioritization process, discussed below.

### **3. There are significant issues with CE governance and decision-making**

This assessment was not intended to look at either CE governance or overall system governance. However, during the assessment, stakeholders repeatedly raised concerns regarding governance, decision-making and lack of clarity around accountability. Many said this was the biggest issue from which all other issues stem.

The process to identify a Management Entity is underway which may address many of the concerns raised, though even with a Management Entity the community will still need a well-understood approach to what decisions will be made where and what the role of CE operators and of committees is in making policy decisions. Specific concerns raised include:

- Lack of clarity about where decisions are made and the relationships between different committees;
- Lack of accountability of entities that oversee CE funding and/or HMIS to carry out decisions made by the community;
- Concerns about meeting 'hygiene' including lack of clear documentation of decisions made, items to be decided, and where decisions are recorded; and
- Need for better project management and clear goals for work undertaken. For example high-level work plans reportedly created but not consistently tracked or reported on.

### **4. Data for key CE functions and for measuring performance is not available**

The Alameda County HMIS system does not adequately support CE operations and does not produce information needed to evaluate the process' functioning. Issues with the HMIS system and its governance at a broader level have been assessed and documented in other Technical Assistance work and these are not repeated here. However numerous challenges with HMIS specific to CE were raised by stakeholders repeatedly in this process which bear reporting on, including:

- HMIS not configured to support the work flow or reduce redundancy in the assessment process (this should be being addressed currently at least in part)
- No ability to match resources or assign units/beds within HMIS or to track inventory
- There are not enough Admin or user licenses available so people/agencies that would use this system cannot
- It takes too long to get training and the training is reportedly not high quality
- There is a nearly complete lack of data to assess CE performance on anything other than how the assessment is performing, which means that decisions are being made "based on anecdote" and that reports cannot be brought to system leadership to assess functioning.

### **5. There is lack of clarity around changes in funding and anticipated future resources**

Everyone is aware that the current funding configuration is not going to continue but there is a lot of uncertainty about what the future is going to be. Some of this uncertainty is because it is still playing out at the State and County levels, such as with CalAIM, but some of it appears to be due to a lack of transparency around current funding committed and locally-decided options for the future. In particular, Boomerang funds are potentially very flexible and have been committed to this effort through June 2021, but it is unclear whether they will continue after that time and to what degree. Even the role of the CoC

grant which is expected to continue is not clear. Cities are making funding decisions under the impression that *all* County funding may go away by year's end.

Clear communication about the current funding picture, what is committed, and what options are being explored would be helpful to those involved in operations with staff, those involved in raising funding for agencies, and those making local funding decisions.

## Recommendations

- 1. Implement better cross-Zone coordination/operational decision-making (Phase 1 and ongoing):** Overall system governance needs to be addressed elsewhere, as do the roles and responsibilities of the Management Entity and the existing EOH Committees. Regardless of how this is decided, I recommend either the relaunching of the ILC or creation of a similar cross-Zone operations group that can address operational issues. This group should be fairly small (9-10 people) and consist of people working at a high *but operational* level – such as staff of the Zone Coordinators, HRC/CBO leads and Home Stretch and should include a rep from the DV collaborative group. This group can start right away to identify where cross-Zone practices can be aligned or defined (see #B3 below) as well as suggest topics for the SCC agenda, and advise the Management Entity when it is selected.
- 2. Address specific HMIS related issues including new CE work flow and outcome report development (Phase 1):** The overall improvement of HMIS and its oversight is being tackled separately. However for this CE Refinement process to be successful two key pieces of HMIS work will need to be integrated in the CE work planning and this Action Plan: 1) Develop new work flow and data collection practices aligned to the new HUD standards but *in the service of the new design*. It is critical to ensure that the HMIS design work happens in conjunction with, and informed by, the development of Problem Solving, phased assessment, and decisions about central and Zone functions. 2) Outcome tracking and reporting from HMIS is critical to evaluate whether the changes proposed here result in more high-priority people actually being housed, shorter waits times, and better overall outcomes. Even as HMIS is being changed and improved, attention to reporting that is possible now should begin immediately and reviewing these reports should be a regular part of the SCC/Zone Coordination group's ongoing oversight work.
- 3. Simplify the overall CE model and refine messaging (Phase 2):** As the Management Entity comes in, and new policies are put in place for Problem Solving, prioritization and Zone coordination (recommended in Action Plan Phase 1), simplify the overall CE model to align more closely with both anticipated resources and more standard functions. Consider redefining HRCs as Access Points with a smaller number of core functions, ensuring these are connected to *dedicated* or collaborating outreach. Refine family access, including determining whether to continue a separate Family Front Door, and/or consider incorporating family specialists into Access Points as needed and as able to be funded, similarly addressing Domestic Violence concerns. Determine what is matched at the Zone level and create policy templates so that Zone matching follows consistent practices. End the separate identity/branding and policy setting for Home Stretch, while preserving centralized matching for PSH and moving Navigation to this matching process as well, if Navigation continues.



## B. RECOMMENDATIONS REGARDING SPECIFIC COORDINATED ENTRY FUNCTIONS

This section reports findings on specific functions or aspects of CE that the Action Plan is intended to address. The phase listed in parenthesis after the recommendation indicates where in the Action Plan I have suggested it should be tackled.

### 1. Expand and Improve Problem Solving (Phase 1)

Wide-spread problem solving support is a key part of the CE design but was only partially implemented and received very little focus in the first two years. CE stakeholders are aligned in the need to build it out and fund a much stronger PS practice. The City of Oakland has arranged for county-wide training to be offered at the end of January which can lay the groundwork for expanding problem solving. HHAP funds may become available soon to fund a system-wide build out of the practice. In addition to training, a series of policy decisions will need to be made, and documents and reports developed to support implementation and evaluation.

- a. **Make Key Policy Decisions:** In a previous document I have laid out a set of key questions that need to be answered. I recommend that a small group (similar to the ILC/cross Zone group mentioned above) be seated for 1-2 meetings to answer the policy questions and bring recommendations to the SCC. Once these are answered, both policy and training policy documents can be developed to support the practice.
- b. **Draft Problem Solving Guidance:** Los Angeles and San Francisco both recently issued a Problem Solving guides which can be looked at as examples. L.A.'s guide is both a training document on best practices and a policy document. I recommend these two purposes be separated and that the policy document cover who is served, where, how funding can be used, and how reporting is done, while best practices and approaches to conducting high-quality Problem Solving be part of a separate training curriculum or materials so that policies can be easily revised without needing to reissue an entire Guide
- c. **Create Reports in HMIS:** In addition, there will need to be work on HMIS to be able to track Problem Solving efforts and impacts. Either a Problem Solving program entry or a separate, but basic, PS assessment may be needed. As soon as the current upgrade is in place this should be looked at. L.A. has an assessment that is already programmed in Clarity that could be adapted.
- d. **Manage Expectations:** Problem Solving is a critical system component and has been successful in many communities as a key component of effectively addressing and reducing homelessness. However, Alameda County must be careful not to expect too much at outset – in this environment and with so many literally homeless people, PS may have a more limited impact, but even a 10-20% reduction would be significant.

### 2. Modify assessment process and develop phased assessment approach (Phases 1 and 2)

There is wide spread agreement that the assessment process is too dominant in the system, takes too much time and focus, and doesn't lead to anything for the majority of people assessed. Reducing the number of questions asked of most people and being able to tell clients in real time if they are likely to be connected to a resource and in what time frame is widely supported, though there are also significant concerns about re-opening the tool-development process.

The assessment process can be somewhat more phased than currently (with both Problem Solving and some key questions that might create a decision tree and reduce the numbers of people assessed) and the assessment tool likely can be shortened and made more compatible with standard HMIS questions

(15 questions are currently customized) but it will take both analysis and discussion among key players to do this work. The process should NOT open up a broad discussion about whether the prioritization criteria need to be changed, but only how roughly the same result can be gotten to more quickly and more efficiently, while ensuring that any race/equity concerns are also addressed and no new disparities are introduced. (See below for recommendation regarding modifying the post assessment process to address specific concerns about highly vulnerable people.)

To decide how to phase the process and shrink the assessment needs a combination of analysis of the questions versus the new CE work flow in HMIS (some of which HMIS Oversight has already prepared), and potentially an analysis of the weighting and impact of the current questions on how the tool functions. It is possible that a number of questions can be removed and still result in a similar distribution but this needs to be tested. It is also possible that to achieve a distribution with fewer questions, some may need to be added, changed or weighted differently for different populations. For example, to achieve a fair and equitable distribution with fewer questions it may be necessary to ask some things of families or TAY that do not need to be asked of adults, or to weight the same questions differently for different populations. It is also important to determine how this process will overlap with the race equity analysis beings undertaken in the system modeling work.

If the assessment shrinks significantly it will probably be necessary to create a secondary assessment or data collection tool for those prioritized for PSH to ensure that health and other service needs, client preferences, and ADA needs are taken into consideration in the matching process. This may be the place to collect data needed to make matches which are reportedly missing and often out of date in the current process.

1. The assessment refinement process should be started as quickly as possible, in parallel to the Problem Solving process. I recommend a very small group (~6 people) to work on this to include:
  - a. Health Care/Home Stretch rep
  - b. HRC/Zone Reps (2)
  - c. Someone with HMIS expertise
  - d. Consultant support (this will be critical because group will need work in between meetings and staffing)
  - e. Additional input should be brought in at key decisions points including perspectives related to :
    - i. Outreach
    - ii. DV
    - iii. Youth and Family
    - iv. Persons with lived experience

The objective however is to keep the group as small as possible to do most of the work in order to be efficient and keep the conversation focused.

2. If resources are available, conduct a statistical analysis of current tool questions and weighting and how it can be reduced with existing questions.
3. Develop decision tree, revised flow and protocols, working with HMIS Oversight to ensure that the flow is compatible with HMIS functions and results in good data collection and reporting.
4. Building from recent HomeStretch decision to focus on top 5%, establish cut off points for a priority pool or pools and create messaging policies for informing people when they are prioritized or not, and how this relates to PSH versus other resources (note this is related to determining how Zones match – see #3 below)
5. If not planning to migrate data from old to new assessment process, there will need to be a transition or update plan to either conduct new assessments for those still active, grandfather some people in, and/or create a crosswalk of old to new scores.

This work will take some time but can begin right away if there is staffing and resources to support it. A small group should be empowered to do most of the planning work but final decisions should be vetted through a more participatory process that includes a review by line staff who are working in the field.

Two other areas related to assessment that need to be addressed are:

- **Develop special clinical review process (as part of Phase 1):** It is reported by some that there is low representation of certain people with high medical/behavioral issues. This is happening in many places (not just Alameda County) for two reasons: 1) some people with acute disabilities, particularly behavioral health, are not accurate self-reporters in an assessment process of this type, and 2) the tools used typically weight *quantity* of barriers over the acuity of specific issues. Thus, people who may have extremely acute medical or mental health needs may not score highly enough to be prioritized. I recommend this be handled as a policy matter, with an approach that creates a special review and “escalator” process for people who are homeless for a prolonged period and have extremely acute conditions which can be clinically documented but did not score highly in the initial assessment. This process should be managed through a post-assessment process rather than trying to change the tool. (I have a draft policy for this that I can share.)
- **Address concerns re number/location of assessors (Phase 2):** There is a fundamental disagreement about whether there are too many assessors in the system now and if this is introducing quality concerns in the process, versus there are not enough assessors and/or assessors are not in the right places (for example, certain health care settings.) Once the assessment tool and phased process are designed, Problem Solving policies have been determined and are in practice, and HMIS work flow and licensing issues are addressed, this question should be addressed as part of the overall refinement and simplification.

### **3. Refine and Define Regional vs County-wide matching (Phase 1)**

Many people brought up the existence of both regional and county-wide matching approaches for different resources and wondered whether these are compatible and whether they should be consolidated. Zone matching is not a problem in and of itself and occurs in many communities with large geographies for at least some resources, but the lack of a single inventory of resources being matched to, policies for prioritization and matching, practices for case conferencing and other Zone functions is of concern. Likewise, centralized matching to PSH is not in itself problematic even with other matching happening regionally, and has lots of good justifications, but the mismatch between PSH matching centrally and Navigator matching regionally is a significant problem. Finally, the separate branding, policy development and process for the central matching and the Zone matching is overly complex and should be established under one set of overarching policies and coordinated practices, even if some components are conducted differently.

Moving forward several things should happen to clarify these processes, including:

- Create new ILC/cross-Zone coordination group
- Jointly create inventory list for all CE resources and how they are filled (which ones are Zone matched)
- Develop joint policies and practices for prioritizing, matching and documenting for Zone-matched resources
- Move matching to Navigators to the central PSH matching
- Create policies and procedures for matching with similar structures/approaches, including the uses of case conferencing, for both Zone and central matching

- Determine when assessment refinement work is done whether priority scores will be same or different for Zone and Central matching and how this will be communicated

I note that for Zones to be able to have more consistent matching approaches there will also need to be further discussion and decisions about the use of Rapid Rehousing (RRH) within the crisis response system. An analysis of RRH outcomes and a refinement of RRH policies across funding streams is needed but is outside of this scope.

#### **4. Develop, fund and deliver key training (Phase 1 and ongoing)**

According to stakeholders, there was limited training provided on CE policies and functions during the time of the launch and this has all but stopped. There needs to be consistent training available on a variety of topics including not only HMIS and how to conduct assessments but also:

- Understanding the rest of the crisis response system
- Messaging for clients and other community partners
- Making sure front line staff have the same information related to referral resources
- Implementing Problem Solving
- Safety planning and Trauma-Informed Care

Regular training on CE policies is required by HUD; training on other topics and practices is not required but it's a critical piece where many people reporting seeing a gap. This gap in training not only leads to different practices across the system but also continues a lack of connection across components which shared training can help bridge. For front line staff in particular there is a need to understand how CE connects to the rest of the system. Specific learning communities for different roles or program types are one method to deliver ongoing training as well as support relationship building and should be considered as part of the training framework.

Ensuring there is regularly available training will require ongoing funding and perhaps dedicated staffing. While most delivery cannot begin until the Management Entity is selected and underway, planning for training needs, including a regular curriculum/set of CE-related topics to be covered and delivery methods can and should begin to be planned for right away so that the Management Entity can pick it up quickly once it starts its work. In 2018 EveryOne Home and Aspire Consulting LLC developed recommendations for system wide training. This can be starting point for this work, though the plan proposed is broad and covers a wide array of potential training beyond CE needs.

#### **5. Evaluate family CE process and access and consider restructuring family approach (Phases 1 and/or 2)**

Homeless families are addressed differently in different parts of the county and the approach to CE for families should be evaluated and potentially restructured; there is a particular need for immediate attention to this issue in North County. In North County, a separate Family Front Door functions as an almost entirely separate system from that for adults, while in the rest of the county families are integrated into overall CE. Many concerns were raised about the Family Front Door including chronically-insufficient staffing, unclear practices and lack of accountability. Stakeholders had a difficult time describing what the FFD does and were skeptical about its effectiveness, reporting receiving numerous complaints from families or family-serving entities. There is wide-spread recognition that families need family-appropriate responses and services, as well as a desire to have an immediate response to unsheltered families, but no stakeholders other than those connected to FFD felt that the right direction to go is further separation of the family system throughout the county.

As stated above regarding the lack of data, it is important to acknowledge that no data is available to support the claims/concerns reflected. Making immediate changes could be an example of being anecdotally-driven. Thus, if possible an evaluation of the current approach to families in CE should be done prior to determining the long-run plan for how to address family needs.

However, in the short-run there is a need to address the gap in meeting the immediate needs of unsheltered families in North County. Oakland, Berkeley, HCSA and FFD should convene to develop a short-term response plan, including better reporting/tracking on what happens when families are identified by other partners in the system and referred to FFD, and how resources can be deployed immediately to meet the needs of unsheltered families, including other non-FFD outreach.

#### **6. Define outreach role more clearly and develop shared outreach expectations (Phase 2)**

Most stakeholders agreed that outreach is a critical part of the CE process and should be where more attention is paid. While each Zone has outreach attached, it is not clear that the expectations of outreach are clear both as it relates to conducting assessments (and now Problem Solving) and for locating people who are matched. HCSA is supporting some outreach coordination but not all outreach that is connected to CE is covered by CE funding (for example, Berkeley's HOTT team or Family Front Door) and it is not clear how this outreach coordination relates to overall CE oversight and rules or policy making and evaluation. If there is specific outreach guidance related to CE it may be in contracts but is not reflected in policies and not reported on in the SCC work.

Addressing the role of outreach and how to support it moving forward is a key element of refining and simplifying the system as recommended above. I suggest that a focus on refining, standardizing and supporting outreach be part of phase 2. This should also be considered in relationship to the future role of 2-1-1 and whether 2-1-1 can send outreach out to meet someone, as well as how outreach relates to shelter placement.

#### **7. Address 2-1-1 issues and refine role (Phase 2)**

There are a number of concerns about the role of 2-1-1 and whether it is functioning well. The initial proposal was for 2-1-1 to do initial screening, problem solving and referrals to HRCs with warm handoffs whenever possible. I believe the model for using 2-1-1 came from the HPRP-era in which 2-1-1 also put the information they collected into HMIS, which was one of the big advantages of the initial 2-1-1 step.

The warm handoff is infrequently successful (25% in latest report), and since data is not collected in the same format it is not clear whether the extra work of walking through the screening is more effective than what they would otherwise do in making referrals to prevention, shelter and to HRCs/an access point. 2-1-1 reports they are pulling together weekly lists of referrals and sending them via email to the Zones – however, it sounds like this is ad-hoc and the practice is not reflected in the system manual. 2-1-1 is supposed to do some over-the-phone problem solving but it is reportedly variable as to whether it happens, based on staff person, their training, and the amount of time they have. In addition, 2-1-1 is intended to fulfill the requirement for 24/7 access but this likely does not result in increased access, as callers have to wait for a call back from an HRC during business hours.

From 2-1-1's perspective they are seen by clients and other agencies as being a key part of the system and because they can be reached when others cannot, clients are reportedly calling them to find out about their situation. However, 2-1-1 can only send them back to their HRC. 2-1-1 cannot send out outreach to meet someone and frequently does not get the circle closed to them to know what is happening afterwards. Some 2-1-1-staff now have read-only HMIS access (though not all) and can look up

the status of a caller, but it's difficult as they have to leave their own data system to look in HMIS. 2-1-1 collects useful data about the calls they field and the connections made which is shared monthly and quarterly with HCSA but it is not clear that this information feeds into other analysis of the system.

I recommend once the first phase of work is completed, including new work flow in HMIS, revised assessment tool and phasing, and design of problem solving is completed that the role of 2-1-1 be evaluated and reconsidered. 2-1-1's role could be expanded to do tracking of shelter openings and placement (see below), as well as to implement more robust and consistent phone-based problem solving, which would be an expansion and likely require additional funding, policies and trainings, as well as HMIS adoption, but could improve the overall system function. Alternatively, 2-1-1's role could be reduced to a more traditional I & R role.

## **8. Improve Domestic Violence coordination and integration (Phase 2)**

There is not a clear policy or practice for coordinating with the DV system other than at the outset of the assessment process when a determination to refer over is supposed to be made (though inclusion of DV providers in Zone conversations may be happening in some places). Domestic Violence providers feel that there needs to be more attention to issues of violence and associated needs throughout the entire system's interactions with people, and want a better way for people within their system of care to interact with the crisis response system, particularly to get access to housing resources that the DV system does not have.

DV providers have been frustrated with feeling excluded from the planning process until recently, and feel that DV is still viewed as a "special population" and not that violence is both a significant factor leading to homelessness and a feature of the homeless experience for many people, particularly homeless women. They want responding to the impact of violence to be a core element of the system's practice and reflected in policy and training.

The HUD grant for DV and coordinated entry is currently being used to assess needs and develop training and approaches to address the need for more DV-responsive approaches in the system. However, it likely could be used in future years to fund DV specific services within CE such as a DV coordinator or specialists within Zones as they have in L.A. The providers working on this effort report they have not determined whether they think there should be an integrated CE system or a parallel system with key connecting points and coordination. Both are allowable under HUD guidance.

Once the initial work has been done on the assessment refinement (with DV participation) and the Management Entity has been selected there will need to be work done with this grant and the planning to decide key design questions and determine how future year funding (assuming this grant will be renewable) is to be used. Some of this planning work could be connected to refining the role of family access and family-focused services, especially since some of the providers involved overlap, though it is important to note that not all survivors are members of family households.

## **9. Simplify Zone model including potentially redefining HRCs as Access Points (Phase 2)**

As described in the Big Picture findings above, the overall system design is too complex and has morphed significantly over time. Resource Zones have become the locus of much matching work. It is unclear whether HRCs are really functioning in the way they were envisioned and it is clear that at least in the leadership of the south/mid/east zone there not a strong interest in using the HRC model. One purpose

of establishing HRCs was to have places that could have other services on site (i.e. like Family Solution Centers in L.A. at public agencies such as Health, Human Services , etc. outstation their staff, or to be placed within more comprehensive program locations such as Family Resource Centers.) Even CE-linked services that were originally to be delivered in HRCs, such as legal clinics and Housing Education workshops, have not actually been held within most of the HRC sites, and it is likely that these programs and services may go away in the future due to funding constraints.

Given all this, HRCs function now as more limited system Access Points. Either true HRCs should be created and supported, or consideration given to redefining these locations and their connected outreach partners as Access Points. Access Points could be numerous within some Zones as long as they are well coordinated at the Zone level. This approach may also be more consistent with available resources in the future and would allow for a new messaging of CES 2.0. This will also allow the potential for adding additional Access Points in the future for specific populations or at mainstream entities, based on a clear set of criteria for what constitutes an Access Point and what functions are required. (Note: this decision should not be made until the assessment tool/process and phasing are refined and HMIS is functioning well for CE.)

#### **10. Centralize or define and clarify shelter-filling function (Phase 2 and/or Phase 3)**

Matching to shelter is not consistent across the county. SSA includes the requirement to go through CE in its shelter standards attached to all contracts, but this has not been enforced. Abode is doing shelter matching in mid, south and east county to at least some beds. They have found this useful for creating flow because prioritized people can be supported in shelter prior to housing. Berkeley was doing this but has recently stopped the practice reportedly because shelter stays had gotten too long. Oakland is not doing this for most beds, using outreach to fill a variety of temporary beds (though EOCP and 211 are working together on filling shelter.) The FFD makes shelter referrals for families in Oakland and North County.

At this time most stakeholders do not want to use CE, at least not under the current process, to fill shelter beds. There is interest in connecting shelter more directly to outreach and this is being done in some cases but, again, it is not clear what the practice is or how it is tracked.

It is fine to have filling shelters operate under different rules, however, the current result is that there is no clear process for ensuring beds are filled, tracking openings, or making shelter available to people who are prioritized for Navigation. 2-1-1 continues to give out phone numbers to people who call for at least some shelters and to track some openings, but not all. The burden on people experiencing homelessness to seek and secure shelter has not been lifted and it is very confusing as the messaging is unclear. HMIS is not set up to track or fill openings, something which worked well in Berkeley in the previous HMIS configuration.

One option is to work with 211 to fill shelter beds at all times. Another option is to use outreach and Zones to track openings and fill through HMIS, with 2-1-1, or an assigned on-call Access Point to play this role on weekends and evenings. Whatever method is chosen, the decision needs to reduce disparate pathways and side doors to shelter and make clear what beds are accessed how, as well as determine whether some beds can be designated for those prioritized through CE (the way that San Francisco Navigation Centers provide places for people who are in *Housing Referral Status* and expected to get a resource from CE.)

This work will take focus and time. I am uncertain whether it should be tackled in Phase 2 as part of the simplification and change in the 2-1-1 role or afterwards. Some of this will depend on planned changes and capacity of HMIS. Developing a plan to address this topic needs more information than was available in preparing this report.

### **11. Integrate and connect CE to homelessness prevention programs (Phase 3)**

The CE system needs to include coordinated access to prevention programs even if this is through different access pathways. 2-1-1 currently makes referrals and HRCs are supposed to refer to during the assessment process; However these needs to be a way to connect these programs into the system more comprehensively. Unless there are specific resources committed to this effort sooner, this should be undertaken in 2021.

### **12. Inventory other homeless programs not using CE (Phase 3)**

A number of programs that serve homeless people continue outside of CE. This includes some PSH units, some RRH programs, and other program types that serve large numbers of homeless people. Not all these programs can or should come into the CE process (though certain programs such as some population specific State-funded RRH can and should.) For those not incorporated, better information about how to access them, and support for clients to gain access to those program and thus be removed from CE when they are enrolled is needed. Unless there are specific resources committed to this effort sooner, this should be undertaken in 2021.

### **Additional Issues**

Finally two additional issues were raised as concerns in interviews or documents that are not covered here:

- Lack of grievance process and need for ombudsperson. (Creating this function could be tackled in Phase 2 system simplification work but may be part of what is already expected of the Management Entity.)
- Increasing the focus on how to support and retain staff and address high turnover rates which is an enormous issue locally and across the state and is impacting CE quality and alignment.



## Appendix: Sources of Information Used

### 1. Interviews/Meetings Held

Organization/Group	Person/People Spoken with
Abode	Vivian Wan
Alameda County Community Development Agency	Suzanne Warner
Alameda County Health Care Services Agency	Kerry Abbott (alone and with group), Robert Ratner (alone and with group), Lucy Kasdin, Marta Lutsky, Kathleen Clanon
BACS	Jamie Almanza
City of Berkeley	Kelly Wallace, Jennifer Vasquez, Kristen Lee
Domestic Violence collaborative	Kate Hart, SAVE; Helen Ayala, Ruby's Place; Liz Varela, BFWC; J'Nai Aubry, Tunisia Owens, Erin Scott, Family Violence Law Center
Eden I&R 2-1-1	Alison DeJung
Everyone Home	Julie Leadbetter, Jessie Shimmin (second conversation with Jessie alone)
Oakland Zone Meeting	Lara Tannenbaum, Nic Young, City of Oakland; Daniel Cooperman, BACS; Sabrina Thomas, BFWC

### 2. Documents Reviewed:

- 2-1-1 data report for November 2019, Eden I&R, December 2019
- Alameda County Coordinated Entry 2.0 Concepts for Discussion– (no date, *HMIS Oversight Committee*)
- Alameda County Housing and Community Development Homeless Management Information System Assessment – ICF, June 2019
- Alameda County Housing Crisis Response System Manual – December 9, 2019
- Alameda County's ICF HMIS Assessment Overview – June 2019
- CE Management Entity Progress Report, Everyone Home, August 8, 2019
- Coordinated Entry Access Packet, June 26, 2019
- Coordinated Entry Evaluation – First Annual, Everyone Home, Jan 1 2020
- Coordinated Entry Evaluation Plan, Everyone Home, August 2019
- Coordinated Entry Process Self-Assessment, SCC, June 2019
- Coordinated Entry Restructure (no date, *Everyone Home Author?*)
- Coordinated Entry System – Health Care Team Issues Feedback – September 2019
- Coordinated Entry/HRC Flyer, Everyone Home, no date
- Core Operational Functions for Coordinated Entry Management Entities, (no date, *ICF Author?*)
- Key Themes from Providers Process Evaluation of Coordinated Entry, Aspire Consulting LLC, October 2019
- Prioritization Analysis, October 2017 through June 30, 2019 (*no date, J. Shimmin Author?*)
- Prioritization Options – Response Questions- and Weighted Scores, August 23, 2019
- Recommendation to HUD COC on Designating a Coordinated Entry Management Entity, SCC work group, November 13, 2019
- Recommendations for Development a Standardized, Countywide Training Program for Alameda County's Housing Crisis Response system, March 2018, EveryOne Home