Coordinated Entry – Yakima County

1/7/2021

YAKIMA COUNTY DEPARTMENT OF HUMAN SERVICES

IN PARTNERSHIP WITH

THE HOMELESS NETWORK OF YAKIMA COUNTY

Contents

Introduction

The Coordinated entry was prompted by funder requirement and community demand. It is not intended to create a single, unified physical access point to services, but a decentralized, standardized process of identifying available resources and allocating them to clients with appropriate service needs. Coordinated entry intake and referral resources can be accessed through any of the participating access points agencies as part of their standard client intake. Essentially, coordinated entry creates a system with no front door – but also **no wrong door**. A client will be assessed in the same format at every access point.

> ***Coordinated entry includes a specific policy to guide the operations of coordinated entry intake and referral to address the needs of all clients affected by domestic violence***

This document only contains policies that defer from those set forth in the Washington State Coordinated Entry Guidelines published by the State of Washington Department of Commerce which can be found at: http://www.commerce.wa.gov/wp-content/uploads/2019/04/hau-coc-coordinated-entry-guidelines-2019.pdf

In 2020, there was a local decision to also use the CE Program enrollment to track all Youth and Young Adults (YYA) that enter our housing and homeless system. This is part of the Anchor Community Initiative to reach functional zero for YYA by 2022.

Scope & Purpose

Coordinated entry is not intended to solve all issues in the homeless service system. Its roles have been carefully defined, and fall into three broad categories:

A. Assessing client needs and eligibility
B. Matching clients with appropriate, available programs and services in a single application
C. Accurately count the number of YYA entering and exiting our system

Coordinated entry does not make any additional housing available and will not replace existing case management systems within participating agencies. There is no guarantee of an appropriate opening for any given household, or that those referred will receive services.

Coordinated entry is not intended to appropriate admissions determinations or documentation requirements from providers. Coordinated Entry provides a single point of access for currently homeless households, displays a unified pool of potential clients when housing openings do arise, and prioritize access to the most vulnerable appropriate households.

Prioritization & Wait List

Coordinated entry will function based around the coordinated entry Active Client List (ACL). While this is not intended to be a wait list, it is conceptually the pool of literally homeless clients (OHY recommendation used for 18-24 TAY) in need of housing in the community at any given moment. The ACL is intended to replace the current 'first come, first served' prioritization model. Clients will be pre-screened so that only literally homeless (OHY recommendation used for 18-24 TAY) households make up the pool and will stay active by confirming their current information at intervals with a coordinated entry provider, outreach team, or call in center. *Clients that identify as victims of domestic violence and have completed the VI-SPDAT will then voluntary sign a Release of Information or provide verbal consent to ensure the confidentiality of that person so that Coordinated Entry may collaborate with local domestic violence services providers' for matching purposes.*

Access to program openings will continue to be at the discretion of providers, who will retain admission authority and the responsibility to document program eligibility requirements, but openings in participating programs must be filled with households pulled from the ACL. Prioritization will be incorporated via the VI-SPDAT tool. This is not intended to be proscriptive (i.e., only the highest rank by SPDAT can be served) but to ensure that low-vulnerability households are not served in place of those with higher levels of need, and to match the most vulnerable clients with the most intensive interventions. *Clients that are victims of domestic violence are scored and prioritized in the same model as ACL.*

Generally, the system will present a selection of potentially eligible households when program openings occur with the most appropriate vulnerability scoring, and the Matching Agent may select from among these options at their discretion. This will vary based on program design, but may include maximum VI-SPDAT scores, maximum within a range, etc. on a per-program basis.

Those with the highest VI-SPDAT scores from each category (Single Adults, Families, Transition Age Youth) will be automatically referred to the Case Conferencing client tracker for assistance. If one client is referred on the basis of their score, all other clients in that score range will be referred as well.

YYA will be enrolled in CE, regardless of the type of service delivered to accurately track the number entering, in, and exited our system. They do not require an assessment to be enrolled in CE.

Intake & Assessment Procedures

- A coordinated entry assessment and system generated referral from the ACL are required for ALL program entries at participating agencies, except for domestic violence and other victim service providers and some shelter programs that admit on a per-night basis with limited or no entry criteria. Nightly shelters will be encouraged to adopt vulnerability over first come first served access but will not be required to comply in the initial rollout.
- Clients must provide consent before beginning the intake and assessment process using the Client Informed Consent form. If client consent is collected orally via call in, the consent must be collected when the first contact is made with a physical provider.
- Client informed consent documentation should be scanned and uploaded in HMIS whenever possible for all adults in a household. Consent must be uploaded *prior to* generating a referral unless only oral consent is currently available.
- All clients will complete standardized intake information. This may include some of all: a pre-screening form to divert at risk households, an up-to-date HMIS data standards compliant intake form (preferably the coordinated entry HMIS form), and the VI-SPDAT-Single or Family or TAY adaptation adopted for coordinated entry use.
- All VI-SPDAT assessments will use the same script during the assessment.
- Intake information may be recorded directly into HMIS or may be collected on paper forms.
- ALL intake and assessment data should ultimately be entered into HMIS system within 24 hours. If the system is not currently available for some reason, it may be held on paper until the system access is restored.

For youth and young adults, they do not have to have a VI-SPDAT administered to be enrolled in CE.

Client Search

Prior to entering a new client into HMIS, adequate measures need to be taken to ensure the client does not already exist in HMIS. This includes searching by date of birth, names, and variations of names to prevent the entry of duplicate records. Should a duplicate be identified, providers should contact Yakima County for the duplicate record to be merged by the Department of Commerce.

Matching Agent

- The county matching agent will be staff at Yakima County Department of Human Services.
- Matching agent and service providers will maintain a Google document that all service providers will have access too. This document will be a "Live" document that will be update real time with the housing inventory for the County. The matching agent will determine housing vacancies from the ACL.
- The Google document will list the service providers and program names, housing type, housing capacity, and program description and program eligibility requirements.
- Matching agent will prioritize clients using the VI-SPDAT score, placing those with the highest score at the top of the ACL to be the first to be housed once appropriate housing is available.
- One a client is housed, the provider should notify the matching agent for the client to be exited from the CE Program.

Service Access/Referral

- The system will not refer clients to services; clients will remain active within coordinated entry on the ACL, and providers will contact them directly when they are pulled as an appropriate match based on their coordinated entry information and VI-SPDAT score.
    - It is important for clients and case workers to understand that staying on the ACL is essentially the referral for services; sending a client to another participating housing provider will only result in their coordinated entry information being updated.
    - *Victims of domestic violence will remain on the ACL and local DV providers will collaborate with Coordinated Entry the status of the clients housing needs.*
- Clients will stay on the coordinated entry ACL for two months without any action on their part after the initial assessment but should check in if their contact information or housing situation changes.
- Coordinated entry check-ins should be completed at thirty day intervals if the client has a VI-SPDAT score of 15 or higher. This may be done by client households by contacting a coordinated entry provider at the access point which they were assessed.
- If a client fails to check in with the service provider before the 60-day expiration date of their assessment they will be removed without notice from the ACL. Coordinated entry provider or call

center staff should attempt to contact clients at least three times during this period. If there is no response, the client household will be removed from the ACL and exited from coordinated entry.

- Should the client make contact again, manual re-enrollment will be required. This can be accomplished by re-opening the record, removing the exit date and re-saving the record.
- If a client completes a check-in in a housing situation that is not literally homeless, their coordinated entry information should be immediately updated and an exit completed if they have been (or will not be) literally homeless for a period of 7 days or more.
- If a client is selected off the ACL for placement, the provider must flag the coordinated entry enrollment as claimed, since many households will be a high priority for multiple programs.
- If a client is pulled for referral and is unable to document the information as reported in coordinated entry and is ineligible for services thus, the coordinated entry data should be updated to reflect current knowledge gained during program verifications, the client released back to the ACL (or exited as housed if appropriate), and another client selected for placement.
- If a client fails to respond to a housing placement, they may be returned to the ACL.
    - If a client is repeatedly pulled for services and fails to respond, they may be exited from coordinated entry.
    - Attempts to contact clients must be made three times before a coordinated entry exit occurs.
    - NO CLIENT IS TO BE EXITED FROM coordinated entry FOR ACTIVELY REFUSING A HOUSING PLACEMENT!
- If a high priority client (i.e., chronically homeless, high VI_SPDAT) client is pulled for a placement in a temporary housing service, they may remain active in the ACL to be placed in a more intensive permanent placement but their coordinated entry information should be updated with to reflect their new housing situation.
- For youth and young adults - If a Youth/Young Adult who is unsheltered has had no contact with any system/provider (i.e. CES access point, system navigators and/or community outreach) for 60 days, they will be moved to Inactive (Unknown)
    - Within the current capacity of the outreach teams and/or shelter staff and partner agencies, reasonable attempts will be made to locate young adults that are known to be homeless but haven't been seen to re-engage them before moving to 'inactive'.
- If a YYA on the inactive list contacts the homeless system including outreach workers, drop-in centers, shelters, meal lines, etc., they will be moved from the inactive list to the active list and can be referred with the date of status change.

- Young Adults who are active without a current housing plan or housing approval will be moved to Inactive (Over 24) the month following their twenty-fifth birthday.
- If a youth/young adult will be residing in an institution for 90 days or less, they will remain active in CE
    - If it is unknown how long they will be in an institution, they will remain enrolled in CE until they surpass 60 days, at which time they will be moved to inactive status.

Reasons for denial

All programs participating in coordinated entry must follow their written policies regarding denial into their programs. Policies must be designed to screen in rather than screen out participants into programs. All receiving programs must have an appeal process. Some of the reasons for denial into a program could be but not limited to:

- No actual vacancy available
- Client does not meet program requirements
- Missed intake appointments without good cause
- Criminal behaviors
- Program cannot safely accommodate or meet the needs with the supports provided by the program
- Client has been sanctioned from program or services in the past
- Client Refusal to participation in this program
- No program funding

The receiving Program must enter the reason for any decisions to reject a client in HMIS and contact the matching agent for timely notification to ensure quick matching to another program for client.

IRIS-CE Case Management

This section outlines the process to identify individuals for the Interdisciplinary Team. Local priorities include:

- Youth and Young Adults
- Chronically Homeless
- Medically Fragile
- Families with Children

Provider Team Case Conferencing

The Coordinated Entry Provider team consists of only individuals who are current HMIS users who have the following in place:

- A current Interagency Partnership Agreement with the Washington State Department of Commerce
- A current Interagency Data Sharing Agreement with the Yakima Valley HMIS Collaborative
- A current User Agreement signed in HMIS

Individuals of high concern should be first case conferenced at the Provider meeting – this would include the following individuals:

- Individuals with chronic needs who we have been supporting rather than expecting to change.
- Individuals who cause upheaval in the social service system, are seen and treated by multiple service providers
- Individuals who use a LOT of resources, repeatedly and potentially cost the system unnecessarily.

Process

1. Standing conference is the Provider Coordinated Entry Meeting.
2. Any member of the Provider Coordinated Entry Team identifies a client who would benefit from a case conference.
3. The Client is Case Conferenced at the Provider Coordinated Entry Meeting – ideally, a permanent housing solution is identified. If not, the Lead Case Manager is identified to refer them to an Interdisciplinary Team:
    - The client is asked for permission to consult with other others –including agencies the client may not be involved with, but a referral is being considered.
    - Along with the consent forms, the Inter-Disciplinary Team Case Conference Form is sent, and all agencies serving the client complete as much information as possible in the first sections to bring to the case conference. This form is Form B: Inter-Disciplinary Team Case Conference Form in the Forms section of this document[1].
    - An Interagency plan is developed (not necessarily in this order) to address.
        - Housing
        - Health care
        - Drug / alcohol
        - Mental health
        - Spiritual support

[1] Note – this form should not be transmitted over email as it will contain personally identifying information; this is only a tool for Case Managers.

Diversion Fund

A part of the IRIS grant from Yakima Valley Community Foundation is a diversion fund to assist individuals in obtaining permanent housing. Yakima Neighborhood Health Services is the administrator of this fund.

Requirements for Accessing the fund

A household must meet one of the priority populations identified by the Coordinated Entry Policy Team:

- Chronically Homeless or Medically Fragile
- Families with children
- Veterans
- Youth or Young Adults

The household must be enrolled in both HMIS and into Coordinated Entry. If an individual is not yet ready to participate in Coordinated Entry, then an alternative funding stream should be identified.

Process by Agency Type

Funds can be accessed by organization with or without HMIS access

- Agencies with HMIS Access – Access Points and all other current HMIS users:
    1. Lead Case Manager will send Yakima Neighborhood Health Services and the Homeless Network of Yakima County[2] a request for funds using the form in Form A: Coordinated Entry/IRIS Financial Request Form.
    2. Yakima Neighborhood Health Services will log-into HMIS and confirm the client is enrolled into **Yakima Coordinated Entry NBN0** Program.
    3. Yakima Neighborhood Health Services will disburse funds including the staff of the Network in any communications.
- Agencies with No HMIS Access:
    1. Lead Case Manager will send Yakima Neighborhood Health Services and the Homeless Network of Yakima County a request for funds using the form in Form A: Coordinated Entry/IRIS Financial Request Form.
    2. The Lead Case Manager will coordinate with the Homeless Network of Yakima County to conduct an intake into HMIS via Telephonic Informed Consent.
    3. Staff from the Homeless Network of Yakima County will enroll the household into the **Yakima Coordinated Entry NBN0** Program[3].
    4. Staff from the Homeless Network of Yakima County will inform Yakima Neighborhood Health Services the household is enrolled.
    5. Yakima Neighborhood Health Services will log-into HMIS and confirm the client is enrolled into **Yakima Coordinated Entry NBN0** Program.
    6. Yakima Neighborhood Health Services will disburse funds including the staff of the Network in any communications.

[2] annette.rodriguez@ynhs.org and Lee@HomelessNetworkYC.org

[3] Both Yakima County and Yakima Neighborhood Health Service will be backup in case staff is unavailable.

Forms

This section contains forms referenced in the above section.

A – Coordinated Entry/IRIS Financial Request Form

To request assistance from the IRIS Fund, complete the form below and send to:

- Annette Rodriguez: annette.rodriguez@ynhs.org
- Lee Murdock: Lee@HomelessNetworkYC.org

Agency			
Agency_____ _____	Lead_____		Date: / /
Client Type			
□ First level Case Conferenced	□ IT Conferenced		□ Independently identified
Priority Population			
□ Chronically Homeless	□ Medically Fragile	□ Families	□ Youth or Young Adult
HMIS			
Client Unique ID _____	□ Confirmation they are enrolled in CE		□ All other funding exhausted?
Request			
Amount_$_____ □ Application Fees □ Housing Deposit □ Utility Deposit/Payment □ Rental Assistance/Arrears □ Moving Expenses □ Storage □ Transportation	□ Emergent Needs □ ID and Documents □ Employment needs □ Legal Services and Fees □ Interpreter/Translation Services □ Other (Specify)		Confirm financial assistance will result in permanent housing. □ Yes □ No □ Unsure
Notes			
Additional Information:			

B – Inter-Disciplinary Team Case Conference Form

Agency	_____	Lead Case Manager	_____
Client Name		Current Living Situation	
Assessment/Concerns			
Presenting Problem:			
1.			
2.			
3.			
Identified Needs:			
1.			
2.			
3.			
Actual/Potential Barriers:			
1.			
2.			
3.			
Client Strengths and Resources			
Case Conference Notes			
Tentative Goals:			
1.			
2.			
3.			

Plan of Care To be completed during the IT Meeting			
Who	**Activity**	**Date**	**Outcome**
Notes/Summary			
Represented Agencies			
Date for Re-evaluation (if needed)			
Agencies missing from the Table (To include in next meeting)			