INSTRUCTIONS

This is an interactive PDF that allows you to easily navigate to different sections by clicking on the headings or page numbers in the Tables of Contents, Executive Summary, and Section Summaries. Clicking on a reference to a page number, Appendix, Figure, Table, or Endnote will also take you directly to that location.

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Toward Developing a Regional Coordinated Entry System for Youth and Young Adults Experiencing Homelessness in Greater Boston

Elizabeth Ruth Wilson, PhD

Master in Public Policy Candidate | Harvard Kennedy School

About the Cover

Lauren Leonardis is a 24-year-old advocate, activist, community member, and mother to a three-year old son. She experienced homelessness in Greater Boston as a young adult, traveling and staying in family shelters with her son, and finally obtained permanent housing in December 2015. She is a graduate of the Massachusetts Housing and Shelter Alliance's (MHSA) Leadership Development program and was part of passing the Unaccompanied and Homeless Youth Bill in the Massachusetts Legislature. Leonardis is currently a co-facilitator for the Boston Youth Advisory Board, member of the MHSA Speaker's Bureau, and commissioner on the Massachusetts Unaccompanied and Homeless Youth Commission. She also works as a Youth Homelessness Consultant on other projects.

Leonardis provided the photos on the cover and this page.

Toward Developing a Regional Coordinated Entry System for Youth and Young Adults Experiencing Homelessness in Greater Boston

A Policy Analysis Exercise submitted in partial fulfillment of
the requirements for the degree of Master in Public Policy

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Photo by Laurie Kahn

Acknowledgements

A Note on Terminology

The United States Department of Housing and Urban Development describes individuals and families who lack a fixed, regular, and adequate nighttime residence as homeless.[1] As a result of my research for this PAE, I recognize the use of "homeless" as an adjective defines people by their circumstance and may be offensive. Although it may seem less concise, I have thus chosen to describe people as *experiencing homelessness* rather than "homeless" throughout my PAE, except when referencing proper nouns and direct quotes. I encourage all others to adopt that language in their work and discourse as well.

About Facing Homelessness and the Photos in This PAE

Since 2010, Facing Homelessness has worked to reduce stigma associated with homelessness, encouraging people to *Just Say Hello* to others they encounter who are in need instead of just passing by. The organization believes "we are all the same, all wanting to love and be loved. When we take the time to listen to another person's journey, we begin the process of turning a stranger into a friend and opening our compassion for another human being." To create a community of compassion, Facing Homelessness takes and shares photos and personal stories of people in its community via Facebook, including those who have housing and those who do not. Beginning in Seattle, the organization is working to expand its reach, and 15 other cities have already developed a Facing Homelessness community.[2]
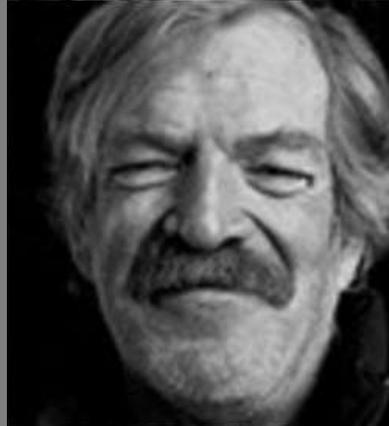
The photos in my PAE are being distributed with permission for nonprofit educational purposes and were provided by Facing Homelessness unless otherwise noted. By sharing the photos, I aim to increase awareness about the organization and inspire readers to start a Facing Homelessness community in Greater Boston. In line with Facing Homelessness's work, I purposefully featured people, particularly youth and young adults, from all walks of life in this report. While many of them have experienced homelessness, several have not. I hope, in viewing the photos, that you will not be able or even try to distinguish those who have and have not experienced homelessness, but rather realize and appreciate how beautiful we all are as human beings. To read more information about the organization and stories of those shown in this PAE, visit facinghomelessness.org and follow Facing Homelessness on Facebook. And, the next time you meet someone in need, at least say hello (and smile).

JUST SAY
HELLO

HOMELESS IN SEATTLE
FACEBOOK IT

Table of Contents

Executive Summary

BACKGROUND

Y2Y Harvard Square (Y2Y) is a student-run shelter in Cambridge, MA, that opened in December 2015 and serves young adults ages 18-24 in Greater Boston. Recognizing it cannot solve youth and young adult homelessness alone, Y2Y would like to understand how it can improve its coordination with other providers in Greater Boston. Currently, providers operate in silos, which has led to inefficient resource use and made it challenging to evaluate the community's progress in ending youth and young adult homelessness.

Y2Y has commissioned this PAE to understand whether developing a *regional coordinated entry system* to disrupt silos would be worthwhile. Unlike a system that coordinates multiple programs within a single organization, a regional coordinated entry system would streamline the data and efforts of multiple programs across providers in different communities (see **Appendix 1** for a glossary).

While Y2Y seeks to improve coordination between providers, it views developing a regional system as a long-term goal. In the short term, the organization is focused on developing its information system and building its capacity. I conducted this PAE to examine the value and feasibility of developing a regional coordinated entry system, identify and evaluate options for developing a system in Greater Boston, and identify strategies that would both help Y2Y improve in the near term and lay the foundation for transitioning to a regional coordinated entry system in the future.

I present the results of a mixed methods investigation involving a literature review, interviews, observations, administrative data, and a survey, which culminated in case studies of five geographic areas (see **Appendix 4-6** for a detailed explanation of my methodology, list of interviewees, and sample interview guide).

KEY FINDINGS

- **Public Value:** Coordinated entry improves efficiency and helps communities better evaluate progress. Practitioners suggest the benefits of developing a system outweigh the costs.

- **Operational Feasibility:** Implementation involves five key decisions—selecting the system's scope, a lead agency, a centralized or decentralized model, an information system, and an evaluation process.

- **Political Feasibility:** Developing a system requires buy-in from clients, providers, and the community.

OPTIONS AND LONG-TERM RECOMMENDATION

I evaluated the value and feasibility of three options for developing a regional coordinated entry system in Greater Boston. Based on an approach in Portland/ Multnomah County, OR, I recommend developing a system, called the *Cambridge-Boston Youth and Young Adult Continuum*. The Continuum would streamline the efforts of the three key youth and young adult providers in Greater Boston: Y2Y, Bridge Over Troubled Waters, and Youth on Fire. I prepared a toolkit for developing the proposed system (see **Appendix 7**).

SHORT- AND MEDIUM-TERM RECOMMENDATIONS

I propose strategies for improving Y2Y's capacity and collaboration with other providers in the near term. I recommend Y2Y hire paid, full-time managers; create an advisory board; and build an analytics dashboard. I also recommend developing standardized procedures for client identification, intake, and referrals and a shared evaluation framework with other providers.

Photo by Jon Chase

1 | Background

Y2Y HARVARD SQUARE

Located in Cambridge, MA, Y2Y Harvard Square (Y2Y) is the nation's first student-run shelter for young adults experiencing homelessness. Its parent organization is Harvard University's Phillips Brooks House Association (PBHA). Managed by young adults and staffed by student volunteers, Y2Y uses a peer-to-peer model to provide shelter and other services for young adults experiencing homelessness (ages 18-24). The organization, which opened in December 2015, is one of only two young adult shelters in Greater Boston and serves guests nightly (7:00 PM-8:00 AM) from October 15-April 15. The facility currently has 22 30-night beds and five 1-night, emergency beds.

Y2Y's Mission Statement

Y2Y's mission is *to provide a safe and affirming environment for young adults experiencing homelessness. Y2Y guests have opportunities to collaborate with service providers, other young adults experiencing homelessness, and student volunteers to create sustainable pathways out of homelessness and develop skills for long-term success.*[3]

PROJECT OVERVIEW

Y2Y recognizes it cannot solve youth and young adult homelessness in Greater Boston alone and would like to improve its collaboration with other service providers. In the long term, Y2Y is specifically interested in creating a *regional coordinated entry system* to improve access to programs and services for youth and young adults experiencing homelessness in Greater Boston. Within a coordinated entry system, different providers generally use the same management information system, share data, and work together to streamline their efforts to improve their efficiency. Unlike a system that coordinates multiple programs within a single organization, a regional coordinated entry system would streamline the data and efforts of multiple programs across providers in different communities.

The United States Department of Housing and Urban Development (HUD) requires agencies receiving federal homeless assistance funding to participate in a coordinated entry system.[4] Some communities in Greater Boston, such as Cambridge, are currently planning and implementing a coordinated entry system, but key providers for youth and young adults, including Y2Y, do not receive federal funding and are not required to participate in those systems. Nevertheless, Y2Y realizes more coordination is needed between providers in Greater Boston to better address youth and young adult homelessness. While communities in Greater Boston have pursued separate coordinated entry systems, Y2Y would like to understand how agencies across different communities could work together to address youth and young adult homelessness on a more regional basis.

While Y2Y would like to improve its coordination with other providers, developing a regional coordinated entry system is a long-term goal. As a student-run organization, Y2Y has limited capacity and experiences high staff turnover. The organization is also planning to become a separate nonprofit from PBHA within the next year and will need to develop its own information system. In the short term, Y2Y is thus focused on improving its capacity and building its information system.

Y2Y has commissioned this PAE to understand whether developing a regional coordinated entry system in the long term would be worthwhile. As Y2Y works to build its capacity and information system, it would also like to understand strategies it can use in the near term to both improve its organization and build the foundation for a regional coordinated entry system.

The purpose of this PAE is threefold:

Purpose of This PAE
1. Assess the value and feasibility of developing a regional coordinated entry system.
2. Identify and evaluate options for developing a regional coordinated entry system for youth and young adults experiencing homelessness in Greater Boston in the long term.
3. Identify strategies to help Y2Y both improve in the near term and build the foundation for a regional coordinated entry system.

Key Definitions

A glossary of key terms is provided in **Appendix 1**. For this PAE, I define *youth experiencing homelessness* as unaccompanied youth under the age of 18 and *young adults experiencing homelessness* as unaccompanied youth ages 18-24 (see the box on **p. 5**). I define *Greater Boston* as the region referred to as the "Inner Core" by the Metropolitan Area Planning Council. Shown in **Appendix 2**, the Inner Core includes the 21 innermost communities within the metropolitan Boston area and has more than 1.6 million residents.[5] I will define a *regional coordinated entry system* as a coordinated entry system that covers multiple Continuums of Care. Given coordinated entry is also referred to as coordinated assessment and coordinated intake by HUD and the National Alliance to End Homelessness (NAEH), I will use those terms synonymously.[6]

UNDERSTANDING THE NEED FOR REGIONAL COORDINATED ENTRY

An estimated 2.1 million youth and young adults under the age of 25 experience homelessness in the US each year.[7] The federal government aims to prevent and end youth homelessness by 2020, but achieving that goal is challenging for two key reasons.[8]

Problem 1: Providers Operate in Silos[9]

Although addressing homelessness involves different-sized nonprofit, private, and government agencies, many organizations that serve youth and young adults experiencing homelessness are small nonprofits. With capacity constraints, such as small staffs and limited funding, providers have operated in silos, focused on meeting their funders' requirements and developing their own programs to better serve clients. They typically do not share data with other agencies, use different methods for prioritizing clients for services, and maintain different information systems.[10] The lack of coordination has led to three key consequences:

Consequence 1: Providers Duplicate Intake Data

When youth or young adults first access services at an agency, they complete an *intake assessment*, through which they report demographic and background information that is used to determine their need and eligibility for programming. Different providers typically have separate intake processes but use similar forms and collect the same data from clients.[11] Given intake can be a lengthy process, however, duplicating that process across providers is not only inefficient but also harmful to clients. Youth and young adults experiencing homelessness have often survived traumatic experiences, and repeating their story may cause psychological harm.[12] To mitigate the potential harm to clients and improve providers' efficiency, HUD has encouraged providers to streamline their intake process with other agencies.[13]

Consequence 2: Providers Use Resources Inefficiently

Providers use different criteria for determining clients' need and prioritizing them for programs and services. Some programs are available on a first-come, first-serve basis, and others use a triage process. Having to meet funding requirements, some providers cherry-pick clients, refusing clients with high barriers that seem less likely to succeed in their program(s). Clients with low barriers may thus be prioritized for and referred to services they may not actually need, while the most vulnerable clients are excluded, resulting in an inefficient use of communities' limited resources.[14]

Consequence 3: Providers Manage Data and Evaluate Performance Using Different Methods

Providers generally focus on evaluating their individual performance, setting targets and tracking their progress to satisfy funding requirements. Given agencies have different funders, providers that offer similar programs and services may measure different outputs and outcomes, such as how many clients access a program or how safe guests feel when staying at a shelter. Providers also use different methods to manage data, with some organizations storing data electronically and others relying on paper forms. Without more uniformity in how providers manage and evaluate data, aggregating data across different agencies and evaluating providers' collective progress in ending homelessness are impractical.

Problem 2: Communities Lack Accurate Estimates of Youth and Young Adults Experiencing Homelessness

In January 2015, communities counted 180,760 youth and young adults experiencing homelessness in the US on a single night, or about one-third of the total

population of people experiencing homelessness (see **Figure 1**).[15] But, HUD and the NAEH suggest current estimates are not accurate.[16] Considered a hidden population, youth and young adults experiencing homelessness are difficult to count because they are more transient than older adults, and counts exclude youth who are "doubled up" or "couch surfing" although they meet the definition of homelessness.[17] As Massachusetts is still refining its count method, it is unclear how many youth and young adults are experiencing homelessness in Greater Boston.[18]

Without accurate population estimates, it is difficult to determine the number of resources needed to prevent and end homelessness. Communities may also use different methods to conduct counts and change methods from year to year, making it challenging to assess changes in the population over time and the longitudinal effect of existing programs and services.[19]

Responses by the Federal Government

The federal government has used three methods to improve coordination between providers and obtain more accurate and reliable population estimates.

Defining Youth and Young Adults Experiencing Homelessness

HUD distinguishes youth in families with children from unaccompanied and parenting youth.

- People **experience homelessness** when they lack a fixed, regular, and adequate nighttime residence.

- **Youth in families with children** are individuals under the age of 18 who experience homelessness while in the custody of a parent or legal guardian.

- **Unaccompanied youth** are individuals under the age of 25 who are not accompanied by a parent or legal guardian or another person over the age of 24 while experiencing homelessness and are also not a parent staying in the same place as their child(ren).

- **Parenting youth** are individuals under the age of 25 who are experiencing homelessness, are not accompanied by someone over the age of 24, and identify as a parent or legal guardian to one or more children, who sleep in the same place as the youth.

Figure 1 shows the 2015 count of youth and young adults experiencing homelessness on one night in the US. For the purposes of this PAE, I focus exclusively on unaccompanied youth, the target population of the youth and young adult shelters in Greater Boston. I define *youth experiencing homelessness* as unaccompanied youth under the age of 18 and *young adults experiencing homelessness* as unaccompanied youth ages 18-24.

Source: 2016 AHAR Report to Congress: Part 1 - PIT Estimates of Homelessness in the U.S.

Response 1: Mandating Continuums of Care

As of 2009, HUD requires communities to form a Continuum of Care (CoC) to be eligible for homeless assistance funding.[20] A CoC is a local or regional planning body that organizes and delivers services for people experiencing homelessness, including outreach, emergency shelter, rapid rehousing, transitional housing, and permanent supportive housing, and submits a single funding application to HUD on behalf of a geographic area. The CoC is responsible for coordinating the efforts of key stakeholders, including government agencies, social service providers, and law enforcement; conducting a biennial count of people experiencing homelessness; and setting priorities for allocating funding to projects within the area.[21] In Massachusetts, there are 16 CoCs, eight of which are in Greater Boston (see **Appendix 3**).[22]

Response 2: Requiring Coordinated Entry

Beginning in 2012, HUD requires CoCs to establish a coordinated entry system to maintain eligibility for federal funding. A coordinated entry system is *a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals* to help individuals and families experiencing homelessness better access housing and services within a geographic area.[23]

Coordinated entry has three key features that help solve the problems associated with silos:

Figure 1. Count of Youth and Young Adults Experiencing Homelessness on One Night in the US, 2015

	Total Youth and Young Adults	Youth in Families with Children	Unaccompanied Youth	Parenting Youth
Under Age 18	127,787	123,120	4,667	126
Ages 18-24	52,973	18,084	32,240	9,775
Total Count	180,760	141,204	36,907	9,901
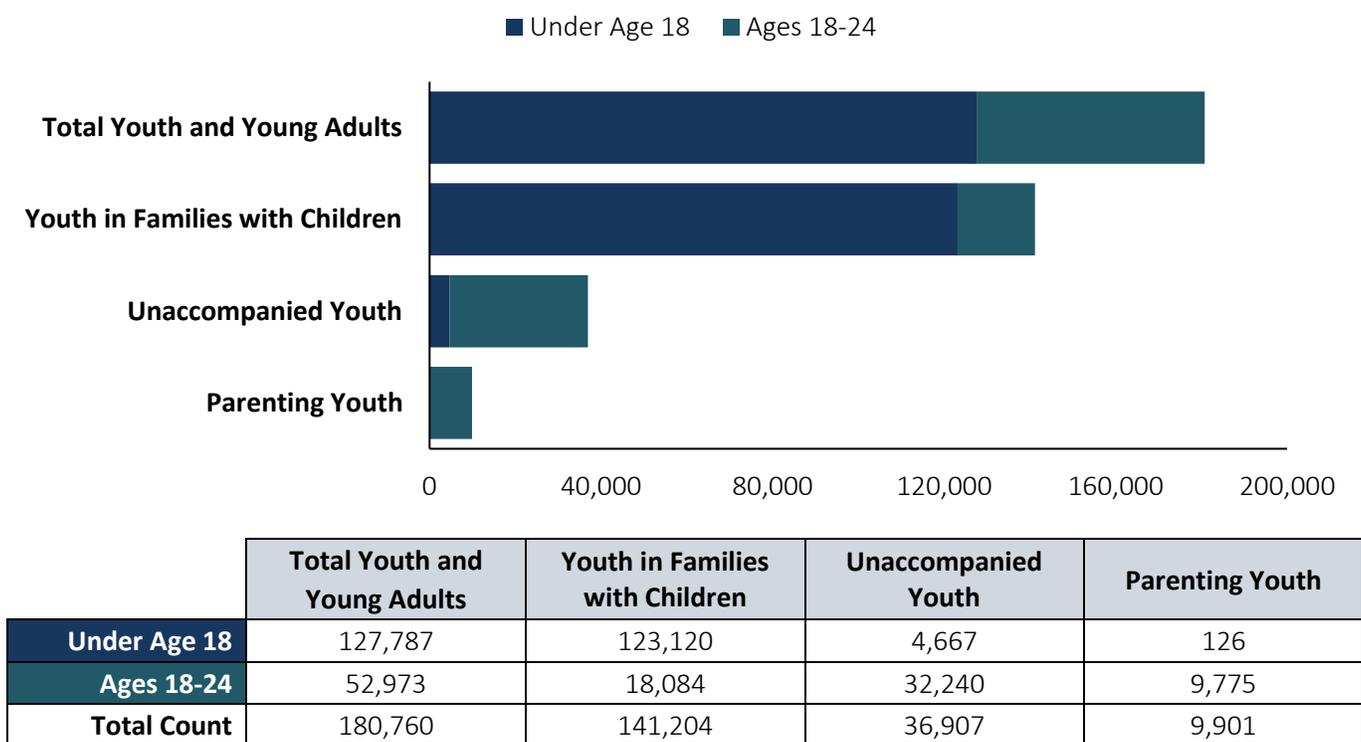
Notes: These figures represent the count of youth and young adults experiencing homelessness on a single night in January 2015. In 2015, parenting youth were included in the count of youth in families with children. HUD also counted 2,649 "accompanied youth" ages 18-24 that were accompanied by someone over the age of 24. As HUD no longer differentiates accompanied youth, I have included the total number of accompanied youth in the "total youth and young adults" estimate in the above table but did not distinguish accompanied youth as a separate category.

Source: 2015 AHAR Report to Congress: Part 1 - PIT Estimates of Homelessness in the U.S.

3 Key Features of Coordinated Entry

(1) Streamlined intake and referrals. To improve efficiency and reduce the frequency clients have to repeat their personal information, providers share intake data. One or multiple providers that participate in the coordinated entry system are designated as "access points," or "points of entry," where clients go to complete intake assessments and receive referrals to programs and services. At intake, clients sign a consent form, so their data can be shared with other agencies they go to for services. All access points use the same method for completing assessments and referrals.

(2) Standardized prioritization. To ensure the most vulnerable clients have access to housing and assistance, clients are prioritized for services based on their vulnerability.

(3) Streamlined data management and performance evaluation. Instead of providers using different methods to manage and evaluate data, they use a centralized management information system to facilitate data sharing and develop a common set of performance measures.[24]

Understanding the Need for a Coordinated Entry System Specifically for Youth and Young Adults

Coordinated entry systems often cover the same geographic area as the CoC and should include all subpopulations, including youth and young adults, single adults, and families. However, CoCs may choose to have separate coordinated intake systems for each subpopulation that, together, cover the entire population of people experiencing homelessness.[25] Within Greater Boston, many CoCs are in the process of planning and implementing a coordinated entry system. Cambridge launched its system in January 2017, and Boston began piloting its system in 2016.[26]

To achieve its goal to end youth homelessness by 2020, HUD has encouraged communities to develop a coordinated entry process that is specifically focused on youth and young adults.[27] In response, some communities have designed and integrated a youth-inclusive process within their existing coordinated entry system, and other communities have established

an entirely separate system for youth and young adults. The coordinated assessment systems being implemented in Greater Boston are designed to serve all subpopulations. Nevertheless, an important consideration is organizations that do not receive HUD funding are not required to participate in a CoC or coordinated entry. Although providers may choose to participate in a coordinated system even if they are not federally funded, they often do not participate if they are not required to. There are three key youth and young adult providers in Greater Boston: Y2Y, Bridge Over Troubled Waters (Bridge), a young adult shelter and service provider in Boston, and Youth on Fire, a drop-in center in Cambridge and program of the AIDS Action Committee that operates out of Y2Y's shelter facility during the day. Given neither of those providers currently participates in a coordinated entry system, the extent the existing systems in Greater Boston actually cater to youth and young adults is limited.

Response 3: Requiring Homeless Management Information Systems

Each CoC must select a Homeless Management Information System (HMIS), a local information technology system that is used to manage client data, track the provision of housing and services to clients, and generate an unduplicated count of people experiencing homelessness.[28]

To standardize data collection across CoCs, HUD requires providers within CoCs to collect specific client information, known as Universal Data Elements, which include name, date of birth, and length of time spent on the street.[29] Data stored within the HMIS is then used to generate more accurate and reliable estimates of the number of people experiencing homelessness who use programs and services. Other federal organizations, such as the Substance Abuse and Mental Health Services Administration and Department of Health and Human Services, have partnered with HUD to require grantees to enter information into an HMIS.[30] Thus, housing and service providers that do not receive HUD funding or participate in a CoC may still be required to enter data into an HMIS.

Although HUD requires CoCs to establish a coordinated entry system and HMIS, they do not require CoCs to

use the HMIS as the management information system for the coordinated entry system.[31] HMISs vary in functionality. Some only allow providers to view the data they entered and may not allow for data sharing between providers. As a result, although many communities have incorporated their HMIS into their coordinated intake system, others use a separate system to manage their assessment and referral data.[32]

Response in Greater Boston: Approaching Homelessness as a Region

Although HUD has promoted and improved coordination between providers by requiring CoCs, the CoC program has unintentionally created new silos. Although providers within CoCs now collaborate more, providers rarely coordinate their efforts with other agencies in different CoCs. The lack of coordination between CoCs is especially problematic in geographic areas that have two or more communities located in close proximity that maintain separate CoCs, such as Minneapolis and St. Paul, MN. Providers may also be located in different communities but serve the same population, such as Y2Y and Bridge. If Y2Y and Bridge participated in a CoC, they would be in two different ones, using separate coordinated assessment systems and different methods to manage and evaluate data. It is thus unrealistic to improve coordination between those providers via existing systems in Greater Boston.

Recognizing the lack of coordination between communities in Greater Boston, key stakeholders are encouraging providers to collaborate across CoCs and approach homelessness on a more regional basis. Beginning in October 2016, Cambridge's mayor and vice mayor have convened meetings with providers, policymakers, and other stakeholders from different communities in Greater Boston to understand how they can improve their coordination.[33,34] At those meetings, to my knowledge, stakeholders have not

yet discussed whether and how they should develop a regional coordinated entry system for youth and young adults.

Understanding the Limitations of Coordinated Entry and the Affordable Housing Crisis

While my PAE will focus on understanding whether Greater Boston should develop a regional coordinated entry system, I recognize coordinated entry is necessary, but not sufficient, to prevent and end youth and young adult homelessness. Although coordinated assessment should improve access to existing housing and services, it does not create more housing or solve the structural factors that have made it difficult for youth and young adults to afford stable housing.

Within Greater Boston, low rental vacancy rates and high rental demand have led to rapid rent increases, which has made it impossible for many individuals and families to afford housing and placed them at risk of homelessness.[35] Someone earning minimum wage in Massachusetts ($10.00) would have to work 104 hours per week to afford a two-bedroom apartment at Fair Market Rent, making the Commonwealth the seventh most expensive place to live in the nation.[36]

Adequately addressing youth and young adult homelessness will require increasing the affordable housing stock. Despite policymakers' efforts, the affordable housing supply is unlikely to meet demand soon. In the short term, communities are relying on coordinated entry systems to disrupt silos and use existing resources more efficiently.

RESEARCH OVERVIEW

Using Moore's Strategic Triangle as a guiding framework, I will examine the public value, operational feasibility, and political feasibility of developing a regional coordinated entry system, identify and evaluate options for developing a system in Greater Boston, and help Y2Y understand the strategies it can use to both improve its organization in the short term and lay the foundation for transitioning to a regional coordinated entry system over time.[37]

Although providers within CoCs collaborate more, **PROVIDERS RARELY COORDINATE THEIR EFFORTS WITH OTHER AGENCIES IN DIFFERENT COCs**, even if they serve the same population.

Methodology

I conducted a mixed methods investigation involving a literature review, interviews, observations, administrative data, and a survey. I interviewed a total of 52 practitioners from 30 organizations and, using the data collected, completed case studies of five geographic areas:

Case Study Areas
1. Cincinnati/Hamilton County, OH, and Northern Kentucky
2. Seattle/King County, WA
3. Portland/Multnomah County, OR
4. Minneapolis/Hennepin County and St. Paul/Ramsey County, MN
5. State of Maine

I completed site visits to three of the case study areas. Within Greater Boston, I interviewed key stakeholders, observed community meetings, and completed site visits to providers that serve youth and young adults. A detailed explanation of my methodology, list of interviewees, and sample interview guide are provided in **Appendix 4-6**.

Limitations

I used a snowball sampling method to identify potential interviewees. That is, many individuals I interviewed suggested other organizations and people to contact. To overcome the bias associated with that sampling method, I searched online databases to uncover additional stakeholders and supplement the list of contacts I received through referrals. Given participation in my interviews and survey was voluntary, my results may also underrepresent some perspectives regarding the value and feasibility of implementing a coordinated entry system that serves youth and young adults and the ways Y2Y can improve.

In the following three sections, I will discuss the results of my research. I will begin by presenting my findings regarding the public value, operational feasibility, and political feasibility of implementing a coordinated assessment system that serves youth and young adults. I will then discuss three options for developing a regional coordinated entry system in Greater Boston and my long-term recommendation. In the third section, I will discuss strategies Y2Y can use in the short to medium term to improve its organization and establish the foundation for a regional coordinated entry system.

2 | Key Findings

SECTION SUMMARY

Public Value: The Benefits and Costs of Developing a Coordinated Entry System

- **Benefits:** Coordinated entry increases efficiency, improves equity, and provides more accurate data.
- **Costs:** Pursuing coordinated entry involves start-up and operating costs, such as software licensing fees, and has unintended negative consequences that place certain clients at a disadvantage for accessing services.
- **Public Value:** Practitioners suggest the benefits of coordinated entry outweigh its costs, and developing a coordinated entry system is worthwhile.

Operational Feasibility: 5 Key Decisions for Developing a Coordinated Entry System

1. Determining the scope of the coordinated entry system
2. Selecting a lead agency to manage the coordinated entry system
3. Selecting a centralized or decentralized coordinated entry model
4. Selecting and developing a management information system
5. Developing an evaluation process to assess performance

Political Feasibility: Key Stakeholder Concerns and Strategies for Addressing Them

- **Clients:** Educating clients helps dispel the myth that a coordinated entry system will create more housing.
- **Providers:** Convening regular meetings with providers throughout the planning process assuages their concerns about relinquishing control over intake and referrals and helps build trust between providers.
- **The Community:** Publicly sharing data about the coordinated entry system's performance may help the community understand why limited resources should be used to support the system.

Few communities have designed or implemented a separate coordinated entry system for youth and young adults experiencing homelessness, and I was unable to identify any areas with a regional system that exclusively serves youth and young adults across multiple CoCs. Considering that limitation, I focused my case studies on areas with a coordinated assessment system that serves youth and young adults within one CoC. I also studied areas with two neighboring CoCs that are considering or in the process of developing a regional coordinated entry system for all subpopulations. The results provided key insights regarding the value and feasibility of implementing a coordinated assessment system more generally and

options for developing a regional coordinated entry system for youth and young adults in Greater Boston.

In what follows, I will discuss my key findings regarding the public value, operational feasibility, and political feasibility of implementing a coordinated entry system. I will specifically describe the benefits and costs associated with development, five key decisions stakeholders must make to operationalize a system, and strategies for overcoming key stakeholder concerns. Throughout my discussion, I will consider the lessons that were consistent across all of the areas I studied and highlight specific examples.

PROFILES OF CASE STUDY AREAS

Each case study area is in a different stage of planning and implementing a coordinated entry system, and those systems vary in scope and target population. As context for understanding the results of my research, I have provided a brief profile of each area below.

Cincinnati/Hamilton County, Ohio, and Northern Kentucky

Separated only by the Ohio River, Cincinnati/Hamilton County and Northern Kentucky have different CoCs and HMISs and are considering how to improve coordination across state lines. Cincinnati/Hamilton County has one coordinated entry system that serves young adults, families, and single adults, which launched in January 2016. Although the coordinated entry system is new, Cincinnati/Hamilton County has had a centralized intake hotline since 2008, which completes all intake assessments and referrals. Since 2004, all providers have also used the same management information system. Cincinnati/Hamilton County is the only community in the nation with 100% of providers using the same information system. Strategies to End Homelessness, the nonprofit that leads Cincinnati/Hamilton County's coordinated assessment system, also helped establish a system in Northern Kentucky in 2016.[38]

Seattle/King County, Washington

Known as "Coordinated Entry for All," Seattle/King County's coordinated assessment system was first launched for families in 2012 and has included young adults since 2013. The countywide system now serves all subpopulations and covers 39 cities. King County is the system's lead agency.[39]

Portland/Multnomah County, Oregon

Unlike other areas I studied, Portland/Multnomah County has an entirely separate coordinated entry system for youth and young adults. Launched in 1999, the "Homeless Youth Continuum" streamlines the data and efforts of four key youth and young adult providers and targets youth and young adults ages 15-

23. The Continuum is designed to serve 1,000 clients each year.[40]

Minneapolis/Hennepin County and St. Paul/Ramsey County, Minnesota

Similar to Cincinnati/Hamilton County and Northern Kentucky, Minneapolis/Hennepin County and St. Paul/Ramsey County are only separated by a river but have two different CoCs. Hennepin County began piloting its coordinated entry system in July 2015 and currently serves single adults, families, and youth.[41] Ramsey County has one system for families that began in 2014 and a separate system for youth (ages 16-24) and single adults that launched in 2016.[42] Both counties are considering how to improve coordination and address homelessness on a more regional basis.

State of Maine

Maine has two CoCs that share the same lead agency, a regional coordinated entry system, and HMIS.[43] The coordinated entry system is currently being piloted in one city, Bangor, and, once fully implemented, will be a statewide system for all subpopulations. MaineHousing (the Maine State Housing Authority) is the lead agency.

PUBLIC VALUE: THE BENEFITS AND COSTS OF DEVELOPING A COORDINATED ENTRY SYSTEM

To inform whether it is worthwhile to build a regional coordinated entry system for youth and young adults in Greater Boston, I examined the benefits and costs of implementing a coordinated entry system in other geographic areas. The results of my research suggest the benefits of coordinated assessment outweigh the costs associated with developing a system.

Assessment of Benefits

Coordinated entry increases efficiency, improves equity, and provides more accurate data, benefiting clients, providers, and the community.

Although the geographic areas I studied have faced different challenges when implementing their coordinated entry system, all of the agencies I interviewed agree the primary benefit of coordinated assessment is the improved collaboration between providers, which yields different benefits for clients, providers, and the community.

Benefits for Clients

Coordinated entry streamlines the intake and referral process, so clients only have to provide their demographic and background information one time. To enter the coordinated entry system, clients first access a designated point of entry, such as a hotline or drop-in center. At intake, clients' information is used to determine their need and eligibility for housing and other services, and intake assessors make referrals accordingly. The streamlined intake and referral process minimizes the potential harm to clients of repeating their background information, particularly youth and young adults who have survived traumatic experiences. Clients also save time because they no longer have to contact providers themselves to check for available programs and services.

Many providers I interviewed suggest the streamlined intake also improves equity. In the absence of coordinated entry, agencies use different methods for screening clients and making referrals; and programs may cherry-pick clients, accepting clients they assume will have a higher chance of success within their program. With coordinated entry, all clients are assessed and referred to programs using the same method, and a triage tool is used to prioritize the most vulnerable clients for housing and other homeless assistance resources. To prevent cherry-picking, many systems also have a rule that providers cannot deny clients a service they are referred to, which improves access to housing and services for clients with the highest need.[44] Clients may, however, refuse services.

The NAEH further suggests coordinated entry reduces clients' length of stay in shelters.[45] If clients are referred to and placed in the right program or intervention the first time, they are less likely to spend time moving from program to program seeking help. And, given access to the right resources, clients will be more likely to transition to permanent housing and remain stably housed over time.[46]

Benefits for Providers

By standardizing the intake process, coordinated entry minimizes duplication across providers. When operating in silos, all providers conduct intake assessments and must spend a lot of time contacting other agencies to see if they have availability prior to making referrals. With coordinated assessment, most providers no longer complete intake or referrals and can focus on other tasks.

Practitioners I interviewed further suggest coordinated entry helps providers use resources more efficiently by ensuring clients receive appropriate matches to programs and services. At intake, clients are prioritized for services based on their vulnerability. If clients have housing at the time they are seeking shelter, many areas, such as **Cincinnati/Hamilton County, OH, and Minneapolis/Hennepin County, MN**, will provide prevention or diversion resources, such as rental assistance, to help those clients keep their housing and avoid entering a shelter. The NAEH suggests such resources prevent clients from entering homeless assistance programs unnecessarily and frees up shelter beds for individuals and families who need them the most.[47] Similarly, because providers are not allowed to cherry-pick clients, their programs and services are more likely to be used to assist clients who actually need them v. clients who seem more likely to succeed.

Using the same management information system and a common set of performance measures also helps providers aggregate their data and better evaluate their collective performance.

Benefits for the Community

From a systems perspective, improved coordination between providers helps the community better utilize existing resources and identify resource gaps. Communities with a coordinated entry system have more accurate and comprehensive data regarding the number of people within the system, the number of people on waitlists for programs and services, and how the needs of those within the system match with resource availability. As a result, stakeholders are

better able to understand the magnitude of homelessness within their community, identify where needs exist, and allocate limited funding to meet those needs. With more reliable population estimates and standardized performance measures, the community is also better able to assess changes in the population over time and its progress in preventing and ending homelessness. As youth and young adults experiencing homelessness are more transient than older adults, having more accurate data about that population is particularly valuable.

HUD further suggests resources that cater to youth and young adults are especially limited relative to other subpopulations, and demand far exceeds supply. Developing a coordinated entry system for youth is critical for helping communities use those resources as efficiently as possible.[48]

Assessment of Costs

> **Clients, providers, and the community incur both tangible and intangible costs during the transition from silos to coordinated entry.**

Moore suggests it is important to account for both financial costs and unintended negative consequences when assessing whether a program or service yields public value.[49] Those consequences involve programs' effect on civic and democratic principles, such as equity and liberty. The results of my research suggest planning and implementing a coordinated entry system involves both tangible and intangible costs that are sustained by clients, providers, and the community.

Costs for Clients

Although coordinated entry is designed to improve equity and access to services for all clients, regardless of vulnerability, the system may unintentionally disadvantage certain clients. Depending on their location, access points may be less accessible to clients with transportation or technology challenges. Some communities have virtual access points, such as a 2-1-1 hotline, while others have physical sites complete assessments, such as drop-in centers. Both options

present barriers to accessibility. Clients who lack Internet access will have lower access to virtual points of entry, but clients who are unable to take public transportation may have difficulty reaching a physical access point.[50]

Furthermore, coordinated entry may disadvantage clients with vulnerability scores that approach thresholds. Access points in many areas, including **Cincinnati/Hamilton County, OH, and Seattle/King County, WA**, use the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT automatically generates an index based on clients' background information that is used to determine clients' level of vulnerability and prioritize them for services. In **Seattle/King County, WA**, VI-SPDAT scores range from 0-17 for youth and young adults. Young adults are considered to have low vulnerability with a score of 0-3, medium vulnerability with a score of 4-8, and high vulnerability with a score higher than 8. Specific programs and services are available for clients within each score range, including rapid rehousing, transitional housing, and permanent supportive housing.[51]

Providers suggest having designated programs for each range has disadvantaged clients with a score that approaches thresholds. For example, someone with a score of 8 (at the top end of the medium vulnerability range) may be placed into a program or service faster than someone with a score of 9 (at the bottom end of the high vulnerability range). In **Cincinnati/Hamilton County, OH**, providers have encountered a similar problem and are working to revise their method for prioritizing clients for services. Whereas clients with a medium vulnerability score will qualify for rapid rehousing and those with high vulnerability will qualify for permanent supportive housing, transitional housing will also be available to clients with a score around the medium-high vulnerability threshold.

Costs for Providers

Losing control over intake and referrals is the primary intangible cost to providers. While practitioners I interviewed agree coordination improves efficiency and equity, it also impinges on providers' freedom to tailor the intake and referral process specific to their

needs. Agencies have different funding requirements that may conflict with the requirements to participate in coordinated entry. For example, funders may require providers to report data that are not collected during a standardized intake assessment or housed in a coordinated information system, which is a key challenge for providers.

Additionally, providers that participate in a coordinated entry system generally have to pay a licensing fee to use the management information system. Some software vendors charge a "per-agency" fee, so once agencies pay the fee, any staff member within the organization can use the software; but many companies charge a "per-user" fee, so agencies have to pay for each staff member that uses the software. Interviewees suggest that fee can quickly add up, which makes participating in coordinated assessment less accessible to smaller nonprofits with more limited funding. One practitioner specifically noted their agency has had to divert money from programming to pay the licensing fee—an unintended negative consequence of transitioning to coordinated entry.

Costs for the Community

Practitioners emphasize that developing a coordinated entry system is a community process and requires a significant investment of time from community members to design and implement the system. For communities that receive homeless assistance funding, establishing a coordinated entry system is not an option, but the community may still be reluctant to change and lament the transition to coordination.[52]

Literature suggests communities incur key start-up and operating costs to implement and sustain a coordinated intake system. Start-up costs may include purchasing hardware and software, hiring a consultant to analyze the community's existing resources and help develop policies, developing a referral process, and training staff to use a new management information system. Operating costs include staffing access points and conducting data collection and evaluation.[53] Total costs for a coordinated entry system are difficult to calculate because systems are often connected to and built into the budgets of other programs, such as prevention resources and rapid rehousing programs.

While the federal government may provide funding to allay costs, it may be insufficient, and communities often solicit funding from many sources to support planning and implementation.

Assessment of Public Value: Weighing the Benefits and Costs

Most practitioners I interviewed suggest the benefits of implementing a coordinated entry system outweigh the costs, and it is worthwhile to develop a system. Nevertheless, it is difficult to quantify some of the benefits, and for many communities, it is too early to determine whether the long-term benefits will actually outweigh the short-term costs. Although many practitioners described the benefits of coordinated intake, few areas have reported specific outcomes and costs of their system:

➢ To maintain its HMIS, **Cincinnati/Hamilton County, OH**, had an operating budget of $438,811 in FY 2015. HUD provided $388,611, and user fees contributed $50,200.[54] To use the HMIS, providers pay a $400 annual fee per program. Whereas a small nonprofit may have only one program, larger organizations may have several. In 2015, operating costs totaled $124,940 for the centralized hotline that completes intake assessments and referrals.[55]

➢ In **Seattle/King County, WA**, 638 young adults completed assessments during January-September 2016. Among the young adults waiting for a housing placement between July 1, 2016, and September 30, 2016, 20 received permanent housing and 94 were temporarily housed through the coordinated entry system.[56] In FY 2016, the area had an HMIS operating budget of $948,714, $403,714 of which was provided by HUD. Other funding sources included private organizations and the state and local government.[57]

> Practitioners suggest the benefits of implementing a coordinated entry system outweigh the costs, and it is **WORTHWHILE TO DEVELOP A COORDINATED ASSESSMENT SYSTEM**.

> ➤ The Homeless Youth Continuum in **Portland/ Multnomah County, OR**, served more than 1,220 youth and young adults in FY 2014; 88 percent of the youth served exited services to safe and stable housing. Of those that exited to stable housing, 89 percent were still housed six months following exit, and 84 percent were still housed one year after exit. To support its system, the County received $7.5 million in FY 2014 from a variety of sources, including local government and school districts.[58]

Implications for Greater Boston

Despite the costs of developing a coordinated entry system, practitioners I interviewed appreciate having coordinated entry and suggest it is worthwhile to pursue. Stakeholders I interviewed in Greater Boston anticipate implementing a regional system would have similar benefits for clients, providers, and the community as those realized in other areas. Youth and young adult providers, including Y2Y, Bridge, and Youth on Fire, currently duplicate intake data, use two different information systems, and track different performance measures. A coordinated system would minimize duplication and streamline data management and evaluation, improving providers' efficiency and ability to evaluate progress.

Because communities in the Greater Boston area are so small and youth and young adults frequently seek services in different communities, including Cambridge and Boston, stakeholders anticipate a regional coordinated entry system that collaborates efforts across CoCs would be especially valuable for serving youth and young adults experiencing homelessness. When asked to describe how existing CoCs could better serve the needs of youth and young adults and the benefits of improving coordination between communities in Greater Boston, one stakeholder said the following:

> *Continuing to achieve a better understanding of the specific needs of homeless youth would inform improved service delivery. Reaching and connecting with unaccompanied youth can be quite challenging since many young adults do not wish to be identified for fear of being reported to the State or other authorities.*
>
> *At the agency level, increasing coordination between communities in Greater Boston would reduce the number of different procedures, meetings, and management structures that organizations need to work with. Coordination also helps agencies better serve clients and leads to*

improved efficiency and less redundancy for clients and staff. At the city/community level, increased coordination allows for sharing information related to effective programs and also opportunities to leverage limited funds for greater impact. Additionally, increased coordination would improve our region/state's capacity to accurately measure successes and track performance in serving clients who regularly cross jurisdictions' boundaries.

Despite the potential benefits, stakeholders anticipate implementing a regional coordinated entry system in Greater Boston would involve unique challenges and costs. Unlike the other geographic areas, which are working to implement a system for one CoC or across two CoCs, at most, communities in Greater Boston represent eight different CoCs that have different lead agencies and HMISs and are located in different counties. Streamlining efforts across eight CoCs would be both time-consuming and complex. Moreover, one stakeholder suggested funding is often attached to specific communities. Developing a regional system would thus require exploring the extent communities can pool their financial resources and designing agreements regarding how the different CoCs would work together and allocate funding while ensuring they each meet their separate funding requirements. It also may not be feasible to integrate the different HMISs, but switching to another system may be both costly and challenging for communities.

Nevertheless, key stakeholders in Greater Boston recognize the problems with the status quo and are exploring how to improve coordination across communities. Although it is difficult to assess whether the long-term benefits will outweigh the costs, the results of my research suggest developing a regional coordinated entry system that serves youth and young adults in Greater Boston is a worthwhile consideration.

OPERATIONAL FEASIBILITY: 5 KEY DECISIONS FOR DEVELOPING A COORDINATED ENTRY SYSTEM

Although a coordinated entry system may benefit clients, providers, and the community, streamlining the efforts of multiple providers is challenging. Based on the results of my research, I identified five key decisions stakeholders must make when planning a coordinated assessment system that affect the feasibility of implementing and sustaining the system.

Prior to making these decisions, communities should convene a planning committee with various stakeholders, including service providers, key funders, and government agencies. Planners should assess the local environment to understand the resources available to support the system, including financial and human resources. In some areas, such as **Cincinnati/ Hamilton County, OH, and Seattle/King County, WA**, the CoC's lead agency led planning efforts and convened the committee.

While the types of decisions committees are required to make may vary depending on the local environment, the results of my research suggest the following are key decisions that were consistent across all of the geographic areas I studied. Key stakeholders in Greater Boston would also need to make these five decisions to develop a regional coordinated entry system.

Key Decision 1: Determining the Scope of the Coordinated Entry System

Communities must initially determine the population and geographic area their coordinated entry system will cover. Ideally, a coordinated assessment system will serve all subpopulations, including families with children, youth and young adults, single adults, and domestic violence survivors. While developing a system that covers multiple CoCs and serves all subpopulations may be ideal, it may also be unrealistic. If a system's scope is too large and resource demands exceed resource availability, implementation will fail.

Communities often choose one subpopulation to focus on initially and identify the resources that should be coordinated to serve that target group. Following implementation, communities then work to scale the system over time to serve other subpopulations. Similarly, stakeholders must identify the geographic area their coordinated entry system will cover. Some systems serve clients within one CoC, while others are statewide.

Considerations for Making the Decision

Communities generally determine the initial target population for their coordinated entry system based on the demographics of people experiencing homelessness within their community and the amount of funding and other resources available to support implementation. If a community has a relatively high number of families with children experiencing homelessness, they may focus initially on better serving that population and then scale the system to address the needs of other subpopulations over time. Public pressure may also motivate stakeholders to prioritize a certain population over others, and foundations, nonprofit organizations, and the local or federal government may provide funding to support planning efforts and implementation.

Given HUD's mandate requiring CoCs to establish a coordinated entry system, most systems serve clients within the same geographic area that the CoC covers. Expanding the scope beyond one CoC may be worthwhile to more adequately address the target population's needs but will also be more challenging. When CoCs intend to create a regional system in the long term, they may initially focus on developing separate systems but use standardized methods for conducting assessments and referrals and/or the same management information system. Using the same methods and data system in the short term facilitates the transition to regional coordinated entry over time.

➢ In **Cincinnati/Hamilton County, OH, and Northern Kentucky**, people experiencing homelessness often travel between the two states to seek services. Although providers in those communities have different CoCs and HMISs, providers I interviewed suggest improving coordination across CoCs would be beneficial. One interviewee said, "The goal is to unite the systems. *It does not matter to clients that different CoCs are in different states.* It is beneficial to have common data sharing, so they can better serve clients." Although developing a regional coordinated entry system is not feasible now, it may be plausible in the long term. As preparation, Cincinnati/Hamilton County

and Northern Kentucky already use the same method for identifying clients within their HMISs to facilitate integration of those systems in the future. Some providers in Northern Kentucky also use both HMISs.

➢ **Seattle/King County, WA**, initially focused on serving families with children following a challenge from the Bill and Melinda Gates Foundation in 2008 to better address family homelessness. With funding from the Foundation and United Way of King County (United Way), key stakeholders designed and implemented a coordinated entry system for families, which launched in 2012.[59] With support from the Raikes Foundation, United Way, and Medina Foundation, the County then focused on youth and young adult homelessness and expanded its coordinated assessment system to include youth and young adults in 2013.[60]

➢ **Portland/Multnomah County, OR**, developed its Homeless Youth Continuum in response to public criticism, in 1998, that the existing system to serve youth experiencing homelessness was fragmented and lacked accountability. The County launched the Continuum, a more coordinated system, in 1999; the City and County increased funding from $820,000 in FY 1999 to $2,584,000 in FY 2001 to support implementation.[61]

➢ In the **State of Maine**, key stakeholders wanted to establish a statewide coordinated entry system. Maine has two CoCs, with one covering the City of Portland, ME, and the other covering the rest of the state. To obtain funding for a statewide system that would coordinate the efforts of providers in both CoCs, the Maine State Housing Authority served as a *collaborative applicant* and submitted a grant application on behalf of both CoCs. The system is designed to serve everyone currently experiencing homelessness or at imminent risk of homelessness. Imminent risk of homelessness is used to describe people who believe they will experience homelessness within the next 72 hours. HUD and a private foundation have provided funding to support planning and implementation.[62]

Key Decision 2: Selecting a Lead Agency to Manage the Coordinated Entry System

Practitioners suggest planning and implementing a coordinated entry system is challenging and hectic without a governing body that provides oversight and has final decision-making authority. Communities must select a lead agency that will convene stakeholders, apply for funding, ensure the system complies with HUD and other funding requirements, and manage the system. At times, the agency that manages the system once it is implemented differs from the organization that leads planning efforts.

Considerations for Making the Decision

The lead agency for managing the coordinated entry system is often the same organization as the lead agency for the local CoC. When selecting a lead agency, practitioners suggest it is important to choose an organization with both the time and staff capacity to adequately manage a coordinated intake system. Having a neutral organization that does not provide any programs or services for clients also helps to promote transparency and facilitate decisions that are better for the system as a whole v. individual agencies. However, a service provider may manage a system if they have sufficient capacity and resources to dedicate to planning and implementation.

➢ Strategies to End Homelessness, a nonprofit, led planning and implementation of the coordinated entry system in **Cincinnati/Hamilton County, OH**. That organization also helped plan but does not manage the system in **Northern Kentucky**.

➢ In **Seattle/King County, WA**, All Home King County (All Home) led planning efforts for the Coordinated Entry for All system and serves as the lead agency for the CoC. Once the system was implemented, All Home transitioned management of the system to King County. All Home now provides oversight and evaluates the system's performance.

➢ In **Portland/Multnomah County, OR**, the Joint Office of Homeless Services, a partnership between the City of Portland and Multnomah County, oversees the Homeless Youth Continuum.

➢ The lead agency in the **State of Maine** is the Maine State Housing Authority. That organization not only facilitates the two CoCs within the state and manages implementation of the coordinated entry system but also provides services for individuals and families experiencing homelessness.

Key Decision 3: Selecting a Centralized or Decentralized Coordinated Entry Model

In designing a coordinated entry system, stakeholders must decide whether to use a centralized or decentralized intake process.

− In systems that use a *centralized coordinated entry model*, one location serves as an access point, or point of entry, for clients, which completes intake assessments and provides referrals. The entry point can be a physical building or virtual location, such as a phone hotline.

− In systems with a *decentralized coordinated entry model*, people experiencing homelessness may approach any one of multiple designated access points to enter the system, but all entry points use the same tools and methods for completing intake assessments and referrals. In systems with few providers or many providers spread out over a wide geographic area, all of the providers may serve as an access point but use standardized procedures for intake and referrals, known as a "no wrong door" approach.[63]

Some communities design a hybrid system, using a centralized location as an initial point of entry that may provide information about programs and services and schedule appointments for clients to complete intake at one of multiple access points.[64]

Considerations for Making the Decision

The decision regarding the coordinated entry model is directly related to the scope of the system. The needs of the target population, size of the geographic area the system serves, and resources available to support the system will affect the model the planning committee chooses. Communities that already have a 2-1-1 hotline often incorporate it into the coordinated

entry system, either using it as the sole access point or one of many. Communities serving a large geographic area are less likely to have a single, physical point of entry because it may be inaccessible to clients.

Using a centralized model may ensure the intake and referral process is completed consistently but requires the agency completing assessments and referrals to establish and maintain a high level of trust with providers. A decentralized system may improve access for clients but requires more oversight from the lead agency to ensure the intake and referral process is consistent across all access points.[65]

➢ **Examples of Centralized Models**

In **Cincinnati/Hamilton County, OH**, all individuals and families experiencing homelessness call a hotline to speak with an Intake Specialist, get placed into shelter, or receive referrals to services.

Portland/Multnomah County, OR, also uses a centralized system; there is one Access Center where youth and young adults can go to receive an intake assessment and referrals.[66]

In **Minneapolis/Hennepin County, MN**, all assessments and referrals are completed by the Hennepin County Shelter Team.[67]

➢ **Examples of Decentralized Models**

St. Paul/Ramsey County, MN, has multiple access points, where people can receive an assessment and referrals. One access point specifically serves youth and young adults ages 16-24.[68]

Planning documents suggest the **State of Maine** will have a no wrong door approach because of the diversity and size of the state.[69]

➢ **Example of a Hybrid Model**

Seattle/King County, WA, has multiple access points where anyone experiencing homelessness can receive an assessment and referrals. To obtain general information about resources or schedule an appointment for an assessment, people can call the centralized 2-1-1 line.

Key Decision 4: Selecting and Developing a Management information system

Practitioners I interviewed suggest having a good management information system is paramount for successfully implementing and sustaining a coordinated entry system. The planning committee must select an information system that will meet the needs of the coordinated assessment system and develop practices and procedures for collecting and managing data.

Considerations for Making the Decision

The planning committee should first scan the local environment to identify existing data sources and decide the types of data that should be coordinated. Building Changes, a nonprofit that helps communities in Washington State develop a coordinated entry system, suggests communities should specifically assess where intake and assessment data are stored; information about programs, services, and housing resources; case management data; and client exit data.[70]

If a CoC already has an HMIS in place, it should assess whether the HMIS would support the needs of a coordinated entry system. HMISs vary in functionality, and given they were not originally designed for coordinated intake, they may not permit data sharing between providers. To better accommodate a coordinated entry system, communities may choose to use a parallel system that combines the HMIS with another software platform.[71] To help stakeholders assess the capacity of an HMIS, HUD has developed a capacity assessment tool (see **Appendix 7, p. 107**).[72]

In addition to selecting a management information system, stakeholders must develop uniform methods for collecting and managing data. For data collection, they must create survey forms that will be used for intake, decide the extent providers will share data, and determine the types of data they will share. Written standards should be developed for collecting and entering data in the information system, and providers should devise policies to ensure data quality.

➢ In **Cincinnati/Hamilton County, OH**, a nonprofit, developed and manages the HMIS, known as VESTA, which serves as the sole information system for coordinated entry. That organization and the lead agency for the coordinated entry system both conduct data analyses and generate reports for stakeholders. Providers must have a client's consent to share the client's data with another agency.[73] However, highly sensitive data, such as information about a client's special needs, is never shared between different agencies even if the client has signed a consent form. The Partnership Center, the nonprofit that manages VESTA, works to ensure data quality and provide trainings for providers about collecting, entering, and sharing data.

➢ In **Seattle/King County, WA**, providers also use its HMIS for coordinated entry. During the planning process, the lead agency convened an HMIS Steering Committee that assessed the HMIS's capacity to ensure it would support the needs of the coordinated entry system and developed policies for the HMIS, such as data sharing agreements. The Committee now monitors the daily operations of the HMIS.[74]

➢ **Minneapolis/Hennepin County, MN**, has used a parallel management information system, using its HMIS to store assessment data and another system to manage case management data.[75]

Key Decision 5: Developing an Evaluation Process to Assess Performance

Measuring the performance of a coordinated entry system is important for understanding how well the system is functioning and serving the needs of the target population. Results may be used to satisfy funding requirements, assess resource gaps, and determine where a community's funding should be allocated. When designing a coordinated assessment system, the planning committee should develop policies and standardized measures for evaluating the system's performance, decide who will lead evaluation, and create a schedule for evaluating data and reporting results.[76] The evaluation process should be in place prior to implementation.

Considerations for Making the Decision

When setting performance measures, stakeholders should consider their goals for the system, the outcomes they can measure to examine their progress toward meeting those goals, and the types of data they can collect to assess those outcomes. Providers I interviewed suggest funding requirements often drive their performance measures and schedule for reporting results. For example, HUD requires communities with federally funded systems to report specific outcomes, such as recidivism and the length of time individuals experience homelessness.[77] Results of my interviews and literature review suggest the following indicators are commonly used to assess a coordinated entry system's performance:

Common Performance Measures[78]
– The number of intake assessments completed and referrals made
– New entries into homelessness/the coordinated entry system
– Length of stays in shelters and transitional housing programs
– Vacancy rates of shelter and transitional beds
– The relationship between clients' vulnerability and how quickly they are placed into a program
– The appropriateness of client matches to programs (e.g., the number of clients who refuse services, the reason they refuse services, and clients' satisfaction with services received)
– Rates of return to homelessness (recidivism)

Communities also track client demographics and the relationship between demographic data and outcome measures. An important consideration is there is a key difference between measuring the performance of a coordinated entry system and the performance of programs and services within the system. The former may be evaluated using measures, such as the relationship between a client's vulnerability score and how quickly they are placed into a program. The latter may be assessed using indicators, such as the number of people enrolled in an employment training program or who obtained a GED. Although communities often track the performance of the system and agencies

within the system, stakeholders should take care not to confuse the difference and unrealistically expect coordinated entry to improve outcomes related to the quality of programming.[79]

Likewise, a coordinated assessment system will not create more programs or housing units. While communities will want to track the length of time between a client's entry into the coordinated entry system and placement into housing, that outcome may confound resource availability and the system's effectiveness. Assuming the data are available, communities should compare outcomes, such as the length of stay in shelters, before and after a coordinated intake system is implemented and control for resource availability to help isolate and better assess the system's effect.[80] The NAEH has developed a tool that communities can use to evaluate a coordinated assessment system (see **Appendix 7, p. 122**).[81]

To ensure system performance is regularly monitored, several of the areas I studied, including **Cincinnati/Hamilton County, OH; Seattle/King County, WA; St. Paul/Ramsey County, MN; and the State of Maine**, have a committee or workgroup that evaluates data and reports results to key stakeholders; workgroups often meet on a monthly basis. Some areas have also developed a dashboard that allows them to monitor the performance of their coordinated entry system and agencies within the system in real time.

➢ **Cincinnati/Hamilton County, OH**, has a real-time dashboard built into its management information system. A monthly working group evaluates data and assesses whether any policy changes need to be made. Key stakeholders conduct a more in-depth review of outcomes twice a year and, based on the results, modify programs as needed.

➢ **Seattle/King County, WA**, developed a System Performance Dashboard that uses data from its HMIS and provides a summary of performance for the coordinated entry system and agencies within the system along five metrics: exits to permanent housing, average length of stay, returns to homelessness, entries to homelessness, and

utilization rate.[82] The three key funders of the system, King County, the City of Seattle, and the United Way, agreed to the targets and minimum standards embedded within the dashboard that are used for evaluating the system and individual agencies' performance. The County also maintains interactive dashboards that provide a snapshot of the population experiencing homelessness with demographic data that are sortable by subpopulations, including youth and young adults; track recidivism; and show the County's progress in placing clients into emergency shelter, transitional housing, and permanent supportive housing.[83] Screenshots of those dashboards are provided in **Appendix 7, p. 133**.

Considerations for Sustaining a Coordinated Entry System

Decisions made during the planning process will affect a community's ability to both implement and sustain the system over time. For many of the areas I studied, practitioners suggest it is too early to determine whether their coordinated assessment system was implemented successfully and will be sustainable in the long term.

While it is unclear what has allowed **Portland/Multnomah County, OR**, to sustain its coordinated system for nearly 20 years, the amount of support and buy-in from key stakeholders has likely contributed to the County's success. The County developed its Continuum in response to pressure from the public, and stakeholders were encouraged to improve and maintain coordination to quiet the public's criticism.[84] Interviewees suggest the Continuum's small scope has also made it more sustainable. It may be easier to coordinate the practices of four providers and sustain that coordination than to streamline the efforts of 20 agencies as in **Cincinnati/Hamilton County, OH**. Nevertheless, regardless of the size of the geographic area a coordinated intake system covers or the number of providers within the system, practitioners I interviewed suggest having a good lead agency and management information system are key for sustaining a coordinated assessment system over time.

Implications for Greater Boston

Although Y2Y is interested in developing a regional coordinated entry system for youth and young adults, stakeholders in Greater Boston will need to consider whether that is an appropriate target population to focus on initially and the feasibility of coordinating efforts across CoCs. Given coordinated assessment systems would ideally serve everyone experiencing homelessness, Greater Boston may consider developing a system for all subpopulations instead of focusing only on youth and young adults similar to the **State of Maine**. HUD does permit applications for regional systems that combine multiple CoCs, but the planning committee would need to develop written policies that clarify the relationship of each CoC to the geographic area the system covers. Stakeholders must also consider how they could pool different CoCs' financial resources while complying with CoC-specific funding requirements.[85]

Developing a system across multiple CoCs will pose unique challenges for the planning committee in terms of selecting a lead agency and information system. Planning and Implementing a regional system will require a lead agency that can convene providers across CoCs and serve as a collaborative applicant for funding. That agency would need to have ample time and staff capacity to manage the system and, ideally, would not be a service provider. Given Y2Y is run by student volunteers and focuses on service provision for young adults, it is unlikely the organization could effectively lead the planning efforts or implementation of a coordinated entry system.

To ensure the target population has access to points of entry, stakeholders may consider using a hybrid or decentralized model. It is plausible Boston's 311 line or the statewide Mass 211 line could be integrated into a regional coordinated assessment system. Nearly 30% of the 72,774 requests the Mass 211 line received in 2016 were for housing, shelter, and utilities, which suggests not only that the organization is familiar with existing resources but also that individuals and families in Massachusetts are already familiar with Mass 211.[86]

Moreover, given CoCs in Greater Boston use different HMISs, a planning committee would have to consider whether and how those information systems could be integrated and which software would best meet the needs of the coordinated intake system. In designing an evaluation process, stakeholders should also consider how they can use technology to facilitate data analyses and monitor performance in real time.

POLITICAL FEASIBILITY: KEY STAKEHOLDER CONCERNS AND STRATEGIES FOR ADDRESSING THEM

Even if a system is operationally feasible, successful implementation hinges on the planning committee and lead agency's ability to obtain buy-in from key stakeholders. While some stakeholders will support implementation early on, others may pose stiff resistance. In this section, I describe key concerns of clients, providers, and the community and the strategies practitioners have used to address them.

Clients' Key Concern: Waiting for Housing

The results of my observations and interviews make it clear that clients want stable and permanent housing. Although clients appreciate a more efficient system and not having to repeat their personal story, they are often concerned that coordinated entry only seems to provide a more efficient route to a waiting list than to permanent housing. One interviewee, who formerly experienced homelessness, said, "Provide housing. Bottom line. If you really want to help youth and young adults experiencing homelessness, give them a home." A coordinated entry system can generate unrealistic expectations that clients will be placed into housing more quickly. Although coordinated intake is designed to help people transition more quickly from homelessness to housing, it can only facilitate those transitions if enough housing units and supportive services are available. In many areas, practitioners suggest there is instead a severe shortage of resources.

Communities across the US are facing an affordable housing crisis and lack enough affordable housing units and resources to solve homelessness in the near future.[87] People can wait 10 years to receive a Section 8 voucher, and waiting lists for government housing programs are often closed.[88] Many communities have reported specific data about resource shortages:

➢ In **Cincinnati/Hamilton County, OH**, a total of 11,700 calls were made to the centralized hotline in 2014 for family shelter when shelters were at capacity and no referral could be made.[89]

➢ As of September 30, 2016, 601 young adults were waiting for a housing placement in **Seattle/King County, WA**. Of those waiting, 58 were in shelter; 305 were unsheltered; and 238 were unstably housed.[90]

➢ Transitional and independent living programs for youth and young adults experiencing homelessness typically have a one- to two-month waiting list in **Portland/Multnomah County, OR**.[91]

➢ In **Minneapolis/Hennepin County, MN**, 5,000 families were on the waiting list for a Section 8 voucher in July 2015.[92]

➢ In the **State of Maine**, an estimated 2,000 youth and young adults experience homelessness on a given night, but only three agencies specifically serve that population.[93] Those organizations have a total of 28 shelter beds and 32 transitional beds.[94]

Strategies for Addressing the Concern

Practitioners suggest it is important to educate clients about how the coordinated entry system will work as well as its benefits and limitations to dispel the myth that the system will increase the housing stock. Some communities have developed materials, such as a brochure, to help educate clients. Interviewees also recommend creating a website with information about the system and the community's efforts to create more affordable housing.

➢ In **Cincinnati/Hamilton County, OH**, the lead agency has developed a brochure to help educate clients about the coordinated entry system, how they can complete assessments, and who they can contact with questions. The lead agency also has a website, where it provides information about the community's efforts to end homelessness.[95]

➢ The website for the coordinated entry system in **Seattle/King County, WA**, has an FAQs section, where clients can find out information about the expected wait time for housing and how the coordinated assessment system works.[96] And, the website for the CoC's lead agency outlines how the community is working to create more affordable

housing units and increase access for people at risk of homelessness to existing affordable housing.[97]

➤ **Portland/Multnomah County, OR** developed a brochure that explains the system's goals, where providers are located, and how youth and young adults can access services.[98]

➤ **St. Paul/Ramsey County, MN**, also uses a brochure to help clients understand coordinated entry and that housing is never guaranteed.[99]

Appendix 7, p. 136-141, includes the three brochures.

Providers' Key Concern: Relinquishing Control over Intake and Referrals

Even if providers recognize the potential benefits of coordinating the intake and referral process, they are accustomed to working in silos and will have concerns about transitioning to a coordinated system. Prior to implementation, providers may lack trust with the access point(s) that will complete intakes and referrals. Providers may be concerned about how much data will be shared with other agencies and whether data sharing will place clients' information at risk. Given providers often cannot refuse clients that are referred to them once coordinated entry is implemented, they may also have concerns about how clients will be referred. Although many providers are required to participate in a coordinated entry system, practitioners suggest developing a system proves less challenging if providers support v. resist implementation.

Strategies for Addressing the Concern

To obtain buy-in, promote collaboration, and address providers' concerns, practitioners suggest face-to-face communication is imperative and recommend convening regular meetings with key stakeholders throughout the planning process. Such meetings allow providers to help design the system, establish trust, and understand how and to what extent data will be shared. In many areas, providers have to sign a partnership agreement to participate in a coordinated entry system, which outlines goals for the system, expectations of providers, and how conflicts will be resolved. To address security and privacy concerns,

software vendors typically build security measures into the information system, so providers may only view a client's profile once the client consents and the provider that is gaining access to the client's data signs a data sharing agreement with the agency providing the information.

Once a system is implemented, practitioners suggest the lead agency should hold regular meetings with providers, often called "workgroups," to sustain providers' communication. At meetings, providers can discuss concerns they have, review data, and modify policies, as needed. For areas with a system that serves multiple subpopulations, the lead agency often has separate workgroups for providers serving different subpopulations. Some areas have also developed a process that allows providers to appeal client referrals.

➤ In **Cincinnati/Hamilton County, OH**, the lead agency first met individually with each provider during the planning process to obtain their input and address their concerns. Following implementation, the agency has hosted a monthly workgroup that any provider can attend to develop and modify policies and voice their concerns. To mitigate providers' concerns about the inability to refuse clients, the lead agency also created the Coordinated Entry Review Panel. If any provider has a client that was referred to them they believe does not meet the eligibility criteria, the provider can submit a case to the Review Panel, which will review the client's information and either accept or deny the provider's appeal.[100]

➤ In **Seattle/King County, WA**, separate committees meet quarterly to develop strategies and action steps for better addressing the needs of specific subpopulations, including youth and young adults; single adults and veterans; and families with children. The meetings are open to the public.[101]

➤ In **Portland/Multnomah County, OR**, the four youth and young adult providers sign a statement of collaboration to participate in the system (see **Appendix 7, p. 79**).[102] Directors of all four agencies meet twice each month, at a minimum, in a Continuum Planning Meeting. A Homeless Youth Oversight Committee also meets bimonthly, which

includes the providers and key stakeholders from the community, including law enforcement, youth representatives, the Department of Human Services, local school district, and faith-based organizations. The Committee develops policies, establishes priorities for allocating funding, and evaluates data.

➢ In the **State of Maine**, a Youth Committee meets monthly to consider how they can better address the needs of youth and young adults and has informed the design of the state's coordinated entry system.[103]

The Community's Key Concern: Using Limited Resources for Coordinated Entry

Resources are limited, and practitioners suggest the community may have concerns about the resources that will be allocated [away from other programs] to implement a coordinated intake system. As many of the benefits of coordinated assessment are realized in the long term but costs are incurred in the short term, politicians may be particularly hesitant to support the development of a coordinated system and instead want resources directed to programs and services with more short-term benefits to appease constituents.

Strategies for Addressing the Concern

During the planning process, the planning committee should assess the local environment for existing resources and rely on those resources when possible. For example, a community that already has a 2-1-1 line should consider making the hotline an access point. The planning committee should also develop a communication plan to convey the benefits of coordinated entry and why limited resources should be used to support the system.[104] Developing a system is a community process, and community members should feel included in planning efforts. Once a coordinated entry system is established, community members will also expect to see results (i.e., that programs are meeting their targets and the system is having a positive effect). To maintain the community's support, practitioners favor transparency and recommend making data publicly available, so community members can track the system's progress on demand.

➢ **Cincinnati/Hamilton County, OH**, incorporated its existing hotline into its coordinated entry system as the sole point of entry. The nonprofit that manages the HMIS has also made data available to the public through a website, known as VESTArc, so anyone any generate their own queries and reports to test providers' performance and understand how valuable different projects are to the community.

➢ **Seattle/King County, WA**, has similarly had a hotline for over 40 years and designated it as one of the access points in the coordinated entry system. The CoC lead agency also makes its analytic dashboards publicly available, so anyone can monitor the performance of the coordinated entry system and individual agencies.

Implications for Greater Boston

Similar to the other geographic areas, Greater Boston is facing an affordable housing crisis.[105] Although a regional coordinated entry system could improve providers' efficiency, the system's ability to facilitate people's transition from homelessness to housing would be hampered by Greater Boston's severe housing shortage. Clients may be particularly concerned about wait times for permanent housing or develop the misperception that coordinated entry will help them obtain housing faster. Key stakeholders will need to consider how they would educate clients about the benefits and limitations of coordinated intake and efforts to create more affordable housing.

While providers may be hesitant to streamline the intake and referral process within one CoC, they may be even more wary of streamlining that process across multiple CoCs. To facilitate trust building between providers, the lead agency should convene regular meetings throughout the planning process and develop a partnership agreement for providers. Stakeholders should also incorporate existing resources, such as Boston's 311 or the Mass 211 hotline, into the system, include community members in planning efforts, and create a website that allows the community to track the progress of the system and individual providers.
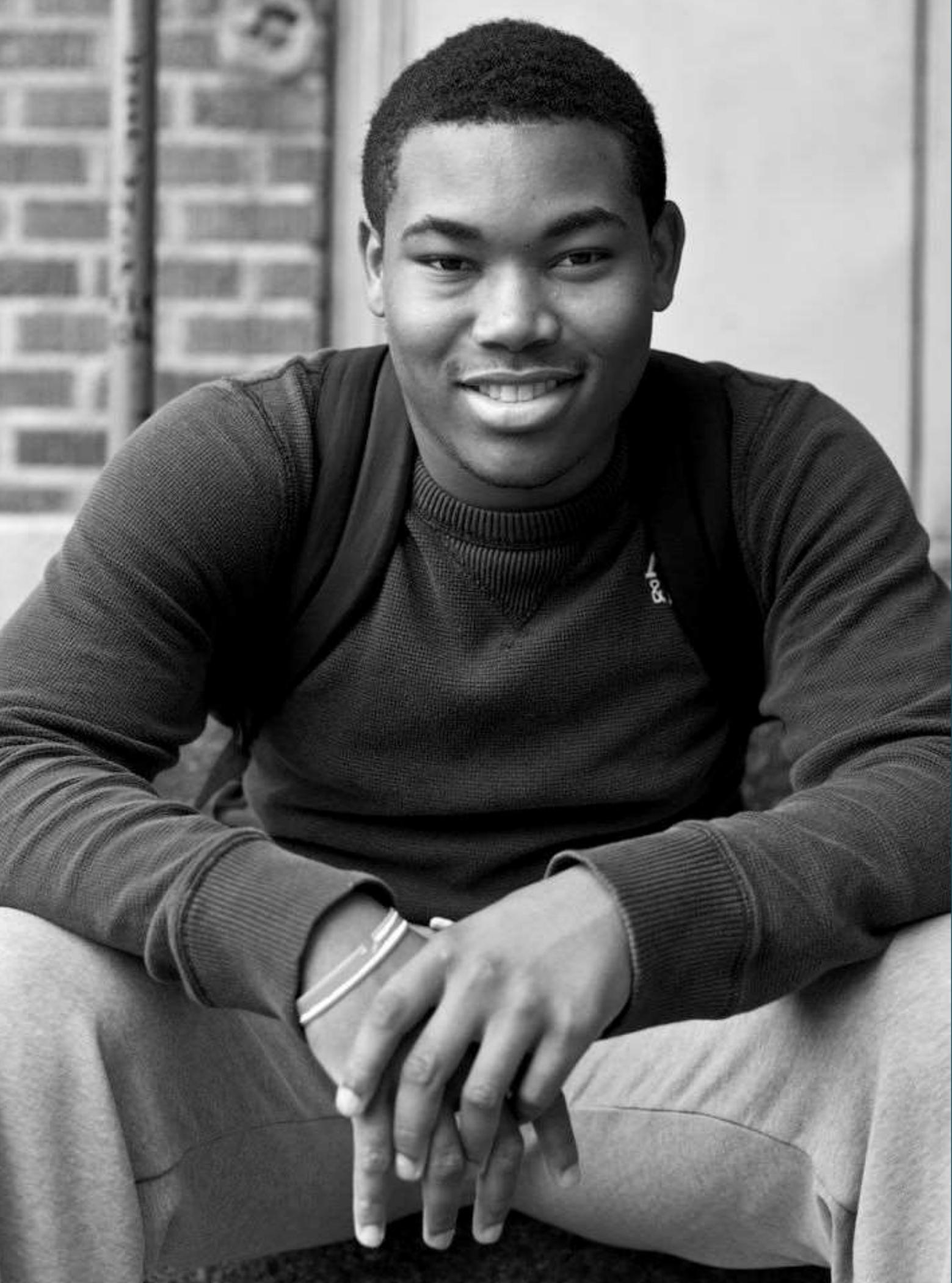
3 | Options and Long-Term Recommendation

SECTION SUMMARY

I identified three options for developing a more regional coordinated entry system in Greater Boston and evaluated the value and feasibility of pursuing each option. Considering the inefficiency of existing systems, maintaining the status quo is not recommended.

Option 1: Develop Greater Boston Coordinated Entry System for All

- **Description:** Regional system that would serve all subpopulations and communities in Greater Boston
- **Evaluation:** Option 1 is ideal but neither operationally nor politically feasible.

Option 2: Develop Cambridge-Boston Coordinated Entry System for All

- **Description:** Regional system that would only coordinate the efforts of the Cambridge and Boston CoCs
- **Evaluation:** Option 2 is less valuable than Option 1 and would not be operationally feasible.

Long-Term Recommendation: Develop Cambridge-Boston Youth and Young Adult Continuum

- **Description:** Coordinates the three key youth providers in Greater Boston, Y2Y, Bridge, and Youth on Fire.
- **Evaluation:** Developing the Cambridge-Boston Youth and Young Adult Continuum is valuable and may be both operationally and politically feasible. Developing the system would be challenging because providers have limited capacity, use two different information systems, and have different funding requirements.

Key features and my evaluation of each option are summarized in **Tables 1 and 2**.

Despite the challenges of implementing a coordinated entry system, the results of my research suggest developing a system is a worthwhile investment of stakeholders' time and communities' resources. Key stakeholders in Greater Boston also recognize more coordination between providers and CoCs is warranted to prevent and end homelessness.

I identified three options for developing a more regional coordinated entry system in Greater Boston. Considering the inefficiency of existing systems, maintaining the status quo is not recommended. In the long term, modeled after the system in **Portland/ Multnomah County, OR**, *I recommend developing a regional coordinated entry system that streamlines the* *data and efforts of the three key youth and young adult providers in Greater Boston and exclusively serves youth and young adults ages 14-24*. In what follows, I will describe the three strategies I considered for reforming the status quo. Based on Moore's Strategic Triangle, I evaluated each option using five criteria:[106]

Evaluation Criteria

- Value for youth and young adults
- Value for providers
- Value for the community
- Operational feasibility
- Political feasibility

In assessing the value for youth and young adults, providers, and the community, I considered both the benefits and costs of pursuing each option. While I focused on how Greater Boston can better address the needs of youth and young adults experiencing homelessness, given the purpose of this PAE, I did not assume a system that exclusively serves youth and young adults would be the best option. Instead, I considered the value and feasibility of creating three systems that vary in scope. **Tables 1 and 2** outline the key features and my evaluation of each option.

Option 1: Develop Greater Boston Coordinated Entry System for All

Drawing on the models used in **Seattle/King County, WA, and Cincinnati/Hamilton County, OH**, one option is to design a regional system for all subpopulations that covers all communities in Greater Boston.

Key Features

This regional coordinated entry system would coordinate the efforts of all eight CoCs and have one lead agency that manages the system and applies for funding. The system would have a hybrid coordinated entry model, using Mass 211 as a centralized access point that clients could call to find out information about existing programs and services and schedule an appointment for an assessment. Multiple access points would also be available throughout the region for individuals and families to receive an assessment and referrals. Access points would use a triage tool, such as the VI-SPDAT, to determine client's need and prioritize the most vulnerable clients for housing.

All CoCs would use the same management information system that would include a comprehensive referral database and provide real-time bed availability, allowing intake agencies to make appropriate referrals

	Table 1. Key Features of Considered Options		
Key Decisions	**Option 1:** **Develop Greater Boston Coordinated Entry System for All**	**Option 2:** **Develop Cambridge-Boston Coordinated Entry System for All**	**Recommendation:** **Develop Cambridge-Boston Youth and Young Adult Continuum**
1. **Scope of the coordinated entry system**	All individuals and families experiencing homelessness in Greater Boston	All individuals and families experiencing homelessness in Cambridge and Boston	Youth and young adults experiencing homelessness in Cambridge and Boston
2. **Potential lead agency**	No clear candidate; an organization may need to be created to lead the system	Massachusetts Housing and Shelter Alliance	Ideally, there would be a joint office between Cambridge and Boston
3. **Coordinated entry model**	Hybrid – uses Mass 211 and multiple, regional access points	Decentralized – access points in both Cambridge and Boston	Decentralized – all providers serve as an access point (no wrong door approach)
4. **Management information system**	Key stakeholders would need to select one HMIS that would serve as the HMIS for the entire system	Integration between the HMISs used in Cambridge (Clarity) and Boston (ETO)	Parallel system between two systems used by Y2Y (Salesforce) and Bridge and Youth on Fire (ETO)
5. **Evaluation process**	Real-time system performance dashboard; monthly workgroup evaluates data	Real-time system performance dashboard; monthly workgroup evaluates data	Workgroup meets twice each month to evaluate data

and easily share client data with other providers. Stakeholders would also develop performance metrics that allow for assessing the system and individual agencies' progress. The lead agency would convene monthly workgroups to design policies to ensure the system caters to each subpopulation's needs, including families with children and youth and young adults; and another workgroup would monitor the information system and evaluate data. A publicly available analytics dashboard would allow the community to monitor the coordinated entry system's progress.

Evaluation

> **Option 1 is valuable but neither operationally nor politically feasible.**

Full coordination is ideal. This strategy would improve access to programs and services for all individuals and families experiencing homelessness in Greater Boston, reduce duplication between providers, and allow the community to better use limited resources. Youth and young adults would benefit from a system that has policies tailored to their specific needs but provides access to a full continuum of services.

While a regional coordinated entry system for all would benefit clients, providers, and the community, implementing such a system in Greater Boston is not feasible. Unlike the systems in **Cincinnati/Hamilton County, OH, and Seattle/King County, WA**, that only coordinate providers within one CoC, developing a regional system in Greater Boston would involve coordinating the efforts of providers in multiple CoCs with different lead agencies. Many of the CoCs use different HMISs, and some have already established a coordinated assessment system. Integrating data between the different HMISs would be impractical, but it would also be challenging and expensive for some CoCs to switch to a different information system. It is also not clear that an existing agency would be able to lead coordination of so many CoCs or manage implementation of a regional system, but developing a new organization and staff to oversee planning and implementation may be costly.

Creating a regional system would also raise concerns from stakeholders regarding how data would be shared, who would fund the system, and how funding would be allocated to support programs and services in different communities. While not impossible, obtaining buy-in from all eight CoCs is improbable. Pursuing this option is thus not recommended.

Option 2: Develop Cambridge-Boston Coordinated Entry System for All

A second option is to create a system that coordinates only two CoCs—Cambridge and Boston. This strategy is similar to the **State of Maine's** approach, in which two CoCs are working together to develop a regional coordinated entry system.[107] I have focused on Cambridge and Boston because the three key youth and young adult providers in Greater Boston, Y2Y, Bridge, and Youth on Fire, are located in those cities.

Key Features

A regional Cambridge-Boston system would serve all subpopulations and use a decentralized coordinated entry model with access points designated in each city. The two CoCs would select one lead agency to apply for funding and manage the coordinated assessment system; design policies for how the two CoCs would work together; and develop measures to evaluate the performance of individual agencies and the system overall. Key stakeholders from both cities would convene in monthly workgroups to design policies for each subpopulation and evaluate data.

The planning committee would have to consider how to integrate the two HMISs that Cambridge and Boston use or whether a different HMIS would better meet the needs of the coordinated entry system. They would also need to select a prioritization tool, such as the VI-SPDAT, for determining clients' eligibility for programs and services. An organization that currently serves both cities and could be impartial in allocating resources would be an appropriate lead agency. The Massachusetts Housing and Shelter Alliance supports coordinated intake and may be considered for that role although it is not clear whether that agency has sufficient staff and time to lead implementation.[108]

Evaluation

> **Some stakeholders may support Option 2, but it is less valuable than Option 1 and would not be operationally feasible.**

Although this strategy does not cover all communities in Greater Boston, it improves coordination between the Cambridge and Boston CoCs and aligns with stakeholders' goal to address homelessness on a more regional v. CoC-wide basis. A streamlined intake process between the Cambridge and Boston CoCs would reduce duplication and improve efficiency, benefiting clients and providers. Using a tool like the VI-SPDAT would help ensure clients have more equitable access to programs and services regardless of their vulnerability. Given youth and young adults tend to be more transient than older adults and the key youth and young adult providers in the Greater Boston area are located in Boston and Cambridge, youth and young adults would particularly benefit from a system that streamlines the efforts of both cities. The community would also gain more comprehensive data about that subpopulation and could better track its progress in preventing and ending homelessness.

This option would have been promising to consider a few years ago; however, it would be both operationally and politically challenging to pursue now because Boston and Cambridge are already in the process of implementing separate coordinated entry systems and use different HMISs. Although some stakeholders that favor coordination may support this strategy, many would resist efforts to coordinate the two systems at this point. While it may be possible to integrate the two HMISs, integration may be costly, challenging, and inconvenient. Moreover, given Y2Y and Bridge do not currently participate in the Cambridge and Boston CoCs, they may also choose not to participate in a regional system that coordinates the efforts of those CoCs, which would limit the extent the system caters to and benefits youth and young adults.

Long-Term Recommendation: Develop Cambridge-Boston Youth and Young Adult Continuum

Modeled after the Homeless Youth Continuum in **Portland/Multnomah County, OR**, I recommend developing a regional coordinated entry system, called the *Cambridge-Boston Youth and Young Adult Continuum*, that would streamline the data and efforts of Y2Y, Bridge, and Youth on Fire and operate separately from existing coordinated intake systems for other subpopulations in Cambridge and Boston.

Key Features

Based on trauma-informed and positive youth development approaches, the proposed system would provide youth and young adults ages 14-24 access to a range of programs and services from street outreach to transitional housing (see **Appendix 1** for a glossary). Providers would also make referrals and facilitate warm handoffs to supports and services outside the Continuum, including mental health care, education, employment, and permanent supportive housing (see **Figure 2**). Because there are so few providers and they are located in two different cities, they would each serve as an access point (i.e., a no wrong door approach). Providers would, however, use the same method for completing intake and referrals, relying on a triage tool to assess clients' vulnerability and provide appropriate matches to programs and services.

Ideally, all providers would use the same information system and develop consent forms and data sharing agreements, so once a youth completes intake at any one of the agencies, their intake data could be shared with the other organizations as needed. The providers would also design a common set of performance

> Modeled after the Continuum in Portland/ Multnomah County, OR, I recommend developing a regional coordinated entry system, called the **CAMBRIDGE-BOSTON YOUTH AND YOUNG ADULT CONTINUUM**.

measures, minimum standards, and targets for assessing their individual and collective performance. A workgroup with representatives from each organization would meet twice per month to design policies, resolve any issues, and evaluate data. Twice each year, the workgroup would generate a report that could be shared with key stakeholders and the public.

Evaluation

> **Developing the Cambridge-Boston Youth and Young Adult Continuum is valuable and may be both operationally and politically feasible.**

Value: Developing the Continuum helps solve the problems associated with the status quo.

At the beginning of this PAE, I suggested addressing youth and young adult homelessness has been challenging for the following reasons:

— **Problem 1:** Providers operate in silos, which leads to duplicate intake data, psychological harm for clients, and an inefficient use of the community's resources. It is also difficult to evaluate progress toward preventing and ending homelessness.[109]

— **Problem 2:** Communities lack accurate population estimates, which makes it challenging to assess resource needs, changes in the population, and the longitudinal effect of programs and services.[110]

Developing the proposed system would help solve those problems. A streamlined intake process would minimize duplication and reduce the potential harm to clients of repeating their personal information. Using a triage tool will ensure the most vulnerable clients are prioritized for services and community resources are used efficiently. Having providers use one information system and standardized performance measures would also help the community better understand the number of youth and young adults accessing programs and services in Greater Boston over time, assess resource needs, and track the community's progress in addressing youth and young adult homelessness.

Feasibility: Developing the Continuum may be feasible but challenging for three key reasons.

Although not nearly as expansive as a system that coordinates the efforts of all CoCs in Greater Boston, the Continuum would improve coordination between youth and young adult providers and is more likely to be achieved in the long term than Options 1 and 2. Y2Y and Bridge are both already interested in sharing data

and have been considering ways to improve their coordination, making this a potentially politically feasible option. Given Youth on Fire operates out of Y2Y's facility, those two providers also have an existing relationship. Nevertheless, developing the Continuum would be challenging for three key reasons:

Challenge 1: Providers have limited capacity.

Although Y2Y is interested in creating a coordinated system, the shelter is only open during October 15-April 15; is run by students, who must balance their commitments to Y2Y with school; and experiences high staff turnover. Youth on Fire has five staff members and is open three days per week.[111] Bridge has existed since 1970 and provides services every day.[112] Of the three providers, Bridge may currently be the best positioned to help develop the Continuum, but given their limited capacity, it is unclear how much time and staff Y2Y and Youth on Fire could devote to planning and implementation in the short term. Given Y2Y is a seasonal organization, the Continuum would also have fewer resources for clients during the summer.

Challenge 2: Providers use two different management information systems.

Although Y2Y and Bridge would like to improve their coordination, they both seem committed to continuing using their current information system, which would make implementing a centralized system unlikely. It is operationally feasible to use both systems in parallel, however, and convenient that Bridge and Youth on Fire already use the same software. Still, integrating the two systems may be challenging and costly.

Challenge 3: Providers have different funding requirements.

Using a common set of performance measures allows providers in a coordinated entry system to aggregate data and evaluate their collective performance. Given Y2Y, Bridge, and Youth on Fire have different programs and funding requirements, they currently track different outputs and outcomes. It may be challenging to create standardized measures that allow providers to both assess their collective progress and satisfy their individual funders.

Considerations for Implementation

Timing and Selecting a Lead Agency

Based on coordinated entry systems that have been implemented in other areas, I estimate it would take approximately 18 months to two years to plan and implement the Continuum. As the City of Cambridge has led efforts in Greater Boston to address homelessness on a more regional basis, it may be a fitting lead agency, but it is not clear the City of Cambridge or Boston would be willing to lead or help fund the system. Ideally, the two cities would partner and establish a joint office to manage the Continuum similar to the Joint Office of Homeless Services in **Portland/Multnomah County, OR**, which is a partnership between Multnomah County and the City of Portland.[113]

Funding the Cambridge-Boston Youth and Young Adult Continuum

In **Portland/Multnomah County, OR**, the Joint Office of Homeless Services pools funding from various sources to support its Continuum, including local government and the Runaway and Homeless Youth Program. Funding totals about $8 million.[114] The four providers that participate in the system are also required to provide funding and/or in-kind resources.[115] The following are potential funding sources for the proposed Cambridge-Boston system:

Potential Funding Sources
– Cities of Cambridge and Boston
– Substance Abuse and Mental Health Services Administration
– Runaway and Homeless Youth Program
– Workforce Innovation and Opportunity Act
– Local school districts
– Private foundations

Note that federal agencies and grant programs, such as the Substance Abuse and Mental Health Services Administration and Runaway and Homeless Youth Program, require grantees to submit data to an HMIS.[116] While Bridge already submits data to Boston's

HMIS, Y2Y does not submit data to the HMIS in Cambridge. When soliciting funding for the Continuum, Y2Y, Bridge, and Youth on Fire should consider the implications of different funding requirements as well as the funding and resources they could individually contribute to support the system.

Addressing Key Stakeholder Concerns

Stakeholders will also need to address potential concerns of clients, providers, and the community. To dispel the false perception that the Continuum will create more housing for youth and young adults, I recommend developing culturally-sensitive materials to educate clients about the benefits and limitations of coordinated assessment. Given the target population, stakeholders should consider disseminating information using mobile technology and social media.

Using a no wrong door approach will allow providers to maintain involvement in completing intake and referrals, allaying their concerns about relinquishing control over the intake and referral process. Nevertheless, a key concern of Youth on Fire will be clients' privacy as sharing data can disclose clients' HIV/AIDS status. I recommend working with both software vendors to build user access levels and other security features into the parallel management information system, so even if another provider is able to view a client's profile, they will only be able to view certain data. In **Cincinnati/Hamilton County, OH**, such highly sensitive data are never shared between providers even if clients consent.[117] Moreover, stakeholders should create a website that informs the community about the system and its performance. The biannual progress reports may be posted to that site.

Even if the Continuum will primarily involve Y2Y, Bridge, and Youth on Fire, planning and implementing the system must be a community process. HUD suggests widespread stakeholder participation is required to successfully develop a coordinated entry system for youth and recommends including child welfare agencies, law enforcement, school districts, health providers, and representatives from the juvenile and adult justice system in planning and implementation.[118] As in **Portland/Multnomah**

County, OR, I recommend forming an Oversight Committee that includes those stakeholders.

Partnering with the Cambridge and Boston CoCs

Although the proposed Continuum will operate separately from the existing coordinated assessment systems in Cambridge and Boston, some of their services and clients will overlap. For example, pregnant and parenting youth will need access to both youth-specific and family resources.[119] A key concern is clients may have to complete a separate intake process if they seek services outside the Continuum, negating the benefits of having a streamlined intake and referral process. Y2Y, Bridge, and Youth on Fire should thus consider how to collaborate with and maintain regular communication with the CoCs to ensure clients have access to the services they need.

To facilitate warm handoffs to providers outside the Continuum in **Portland/Multnomah County, OR**, providers within the Continuum use the local HMIS to manage and evaluate data.[120] At intake, clients have the option to sign two consent forms. One allows their data to be shared with the four youth and young adult providers within the Continuum. Signing the other form allows their data to be shared with any social service agency in the County that uses the HMIS. Given Bridge and Youth on Fire use the same information system as the HMIS for the Boston CoC, I recommend developing a data sharing agreement between providers within and outside the Continuum to prevent clients from having to complete a separate intake if they seek services at other providers in Boston. Stakeholders should also consider how to partner and share data with providers in the Cambridge CoC.

A Toolkit for Developing the Cambridge-Boston Youth and Young Adult Continuum

To plan and implement the Continuum in the long term, stakeholders will have to develop a number of materials and tools, such as client consent forms and partnership agreements. To help stakeholders in Greater Boston, I have prepared a toolkit with sample materials and resources as a companion to this PAE (see **Appendix 7**).

Table 2. Evaluation of Considered Options

Evaluation Criteria	Status Quo	Option 1: Develop Greater Boston Coordinated Entry System for All	Option 2: Develop Cambridge-Boston Coordinated Entry System for All	Recommendation: Develop Cambridge-Boston Youth and Young Adult Continuum
Value for youth and young adults	**Bad** Key youth and young adult providers do not participate in existing coordinated entry systems; harm to clients that must repeat personal data	**Good** Improves access for youth and young adults to all programs and services in the Greater Boston area	**Moderate** Some youth and young adult providers may not participate in the system, which would limit the extent the system caters to youth and young adults' needs.	**Good** Specifically caters to youth and young adults and would provide access to a full continuum of services from street outreach to permanent supportive housing
Value for service providers	**Bad** Providers have control over the intake and referral process but duplicate their data and efforts.	**Moderate** Providers benefit from more efficiency but must relinquish control over the intake and referral process.	**Moderate** Improves providers' efficiency, but switching to a regional system at this point would be inconvenient and costly for providers	**Good** Minimizes duplicate intake data and helps providers better track progress; no wrong door approach, so providers retain control over intake and referrals
Value for the community	**Bad** Community resources are being used inefficiently, and the lack of accurate and reliable data makes it difficult to estimate the population and evaluate the community's progress.	**Good** Provides more accurate data and helps use resources more efficiently; long-term benefits will likely outweigh significant implementation costs related to building the information system and staff capacity	**Good** Allows the community to better track Cambridge and Boston's progress in addressing homelessness; benefits will likely outweigh initial cost of integrating data between both HMISs and operating expenses	**Moderate** Provides more accurate and reliable data about youth and young adults that access programs and services in both cities; costs involved with integrating data systems and building staff to manage system
Operational feasibility	**Good** Maintaining the status quo requires no significant operational changes.	**Bad** Streamlining the efforts of multiple CoCs would require significant changes, and there is no obvious choice for an agency that could lead implementation.	**Bad** Only requires coordinating between two CoCs but would still be challenging because they already developed separate coordinated entry systems and use different HMISs	**Moderate** Only involves integrating efforts of and data between three providers, but they have limited capacity, two different information systems, and separate funding requirements
Political feasibility	**Moderate** While many stakeholders would prefer to maintain separate CoCs, many recognize the need for improved coordination.	**Bad** Obtaining buy-in from all CoCs in Greater Boston would be challenging, if not impractical	**Moderate** Aligns with the goal to improve coordination between CoCs, but the cities are already implementing separate systems	**Moderate** Y2Y and Bridge are already exploring how to improve their coordination, but Youth on Fire would have client privacy and security concerns.

Figure 2. Overview of Cambridge-Boston Youth and Young Adult Continuum

The Cambridge-Boston Youth and Young Adult Continuum creates a unified and coordinated system of programs and services that help youth and young adults experiencing homelessness (ages 14-24) meet their basic needs, connect to critical resources, develop safe and supportive relationships, and obtain self-sufficiency.

Outreach and Safety Services

Coordinated entry and access to shelter and basic services

Street outreach
Daytime drop-in services
Emergency shelter
Food, clothes, toiletries
Showers, lockers, laundry
Internet, computers, phone

Providers: Bridge Over Troubled Waters, Y2Y Harvard Square, and Youth on Fire

Support Services and Development

Access to services and opportunities that help youth find a pathway out of homelessness

Case management
Medical care and behavioral health services
Legal services
Employment training
Life skills workshops
Advocacy training and speaking opportunities

Providers: Bridge Over Troubled Waters, Y2Y Harvard Square, and Youth on Fire

Housing

Access to transitional housing and independent living programs

Short-term transitional residential program
Long-term transitional residential program
Single parent housing for pregnant and parenting women and their children

Provider: Bridge Over Troubled Waters
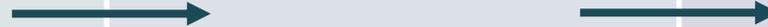
All providers also provide access and referrals to programs outside the Continuum, including:

Mental health care   Addiction recovery   Education   Counseling   Employment   Permanent supportive housing

4 | Short- and Medium-Term Recommendations

SECTION SUMMARY

In the previous section, I suggested developing the Cambridge-Boston Continuum would be challenging because providers have limited capacity, use two different information systems, and have different funding requirements. In this section, I discuss three recommendations for mitigating those challenges.

Recommendation 1: Improve Y2Y's Capacity

Y2Y's staff is insufficient, lacks managerial experience, and completes most data analyses by hand. To improve the organization's capacity, I recommend hiring paid, full-time managers; creating a formal advisory board; and developing a real-time analytics dashboard.

Recommendation 2: Collaborate with Other Providers to Develop Standardized Procedures for Client Identification, Intake, and Referrals

While Y2Y is still in the process of developing its own information system, I recommend collaborating with Bridge and Youth on Fire to create standardized procedures for client identification, intake, and referrals. Adopting standardized procedures now will not only help Y2Y build its information system but also facilitate future integration and data sharing with other providers.

Recommendation 3: Collaborate with Other Providers to Develop a Shared Evaluation Framework

Modeled after an approach in Portland/Multnomah County, OR, I recommend Y2Y collaborate with Bridge and Youth on Fire to create a shared mission, goals, and logic model, which will serve as a basis for developing an evaluation process for the Cambridge-Boston Continuum.

The results of my research suggest developing a regional coordinated entry system for youth and young adults experiencing homelessness in Greater Boston would be beneficial. Based on my analysis of three options, I recommend creating the Cambridge-Boston Youth and Young Adult Continuum. Although Y2Y would like to improve coordination between providers, it views developing a regional system as a long-term goal. Y2Y's current focus is building its capacity and information system as it becomes a separate nonprofit from its parent organization, PBHA. In this section, I will discuss three recommendations that will help Y2Y both improve its organization in the short and medium

term and lay the foundation for developing the Cambridge-Boston Continuum in the future.

In the previous section, I suggested implementing the Continuum may be feasible in the long term but would be challenging for three reasons:

- **Challenge 1:** Providers have limited capacity.
- **Challenge 2:** Providers use two different management information systems.
- **Challenge 3:** Providers have different funding requirements.

To improve its capacity, Y2Y is already working to start a summer season and stay open year-round. I will recommend additional strategies to strengthen the organization's capacity and mitigate the challenges of providers having different information systems and funders.

Recommendation 1: Improve Y2Y's Capacity

Y2Y's staff is insufficient, lacks management experience, and completes most data analyses by hand. To improve the organization's capacity, I recommend hiring paid, full-time managers, creating a formal advisory board, and developing a real-time analytics dashboard.

Hiring Paid, Full-Time Managers

Y2Y has 30 unpaid, student staff members, who manage the shelter. Four paid, full-time employees (all young adults) support the shelter staff and oversee the organization. For student staff, working at Y2Y is often a full-time job. Having to balance their Y2Y and school commitments, many report feeling overwhelmed and suggest the organization needs more staff. One said, "Every staff member is virtually maxed out with commitments." Another added, "Staff capacity is already pretty drained—and I'd like to see Y2Y maybe boost staff capacity by hiring more people." A third similarly proposed "expand[ing] staff to ease the strain on Y2Y's limited staff." The shelter currently has four shifts: dinner, evening, overnight, and breakfast. Each staff member works two shifts per week, and two staff members serve each shift. Although the number of staff working each shift is necessary, it is not sufficient, and staff suggest having a third member on shifts could significantly reduce their workload.

Moreover, while providers I interviewed within Greater Boston and other areas suggest they experience turnover, Y2Y's turnover rate is especially high because students graduate every year. Student staff members typically serve a maximum of three years. Although Y2Y has developed policies to facilitate smooth transitions between graduating and incoming staff members, it is

impossible to retain all staff members' knowledge, which limits the organization's memory.

While Y2Y's current staff structure is admirable, it is not sustainable and will hinder the organization's ability to plan and participate in a regional coordinated entry system. With Y2Y's staff overwhelmed by their existing responsibilities, planning and implementing the Cambridge-Boston Continuum would require time that Y2Y's staff is currently unable to give. Given Y2Y plans to improve its coordination with other providers in the long term, sustaining the organization's current staff structure is not recommended.

I recommend hiring two paid, full-time managers, who are not students and can devote their time and energy to managing the shelter. While current staff only have two shifts each week, managers may be able to work two shifts every day. Adding a third person to shifts will alleviate current staff members' workload. While managers may leave the organization at some point, their position could last longer than three years and would attenuate the effects of Y2Y's high turnover. As the organization plans to stay open during the summer, having managers could also provide some continuity between the summer and fall/spring shelter staff. And, they will generate resource slack, freeing up student staff members' time and improving Y2Y's ability to help develop and participate in a coordinated entry system in the future.

Considerations for Implementation

> **Key implementation steps** include identifying ways to fund the positions, defining the roles and responsibilities for the managers, recruiting and interviewing candidates, and completing the hiring process months before the next fall season to allow adequate training time.

Y2Y's graduating staff members are a key talent pool for filling the management positions, and retaining current members would help preserve institutional knowledge. As Y2Y works to create these two positions, I recommend considering strategies to retain graduating students and transitioning them into a full-

time role. One challenge for hiring full-time staff members is Y2Y is still a seasonal organization, and the shelter is only open during October 15-April 15. If the organization does hire full-time managers, it should consider the types of responsibilities they would have during the off-season.

A potential concern with pursuing this strategy is Y2Y has branded itself as a student-run organization. However, Y2Y already has four full-time employees, who are not students and lead the organization. The new managers will similarly be part of the full-time staff, not the shelter staff, consistent with the existing brand.

Creating a Formal Advisory Board

The young adults leading Y2Y and managing the shelter are industrious and dedicated, but they lack management experience relative to the managers of other agencies I interviewed. Having a parent organization has mitigated that weakness as PBHA and other stakeholders have advised and supported Y2Y, thus far. One of PBHA's adult staff members (a Director of Programs) attends Y2Y staff and policy meetings and is actively involved in the organization. The Director supports students in daily operations and shaping their long-term vision for Y2Y. The role is also designed to help Y2Y build institutional memory in lieu of its high turnover rate.

When Y2Y becomes a separate nonprofit, I assume the PBHA staff member will no longer play an active role at Y2Y. I recommend creating a formal advisory board that, separate from the board of directors, would not have any fiduciary or legal responsibilities but could facilitate Y2Y's transition to a nonprofit and advise the organization as it makes operational and programmatic changes, such as staying open during the summer. Y2Y had a similar board during its founding process to help fundraise, develop its vision, and build the shelter. Although the organization currently has an informal set of advisors, that group does not meet regularly. I propose establishing a formal advisory board that has regular meetings and provides non-binding strategic advice to the organization.

Considerations for Implementation

Key implementation steps include identifying and inviting potential advisory board members and setting a meeting schedule. In its bylaws, Y2Y should clarify the board's role and distinction from the board of directors. To avoid the challenge of terminating someone's membership, Y2Y may also consider having term limits.

Advisors should have complementary expertise and skills to Y2Y's staff and board of directors. Given current plans to begin a summer season, I recommend inviting someone to serve on the advisory board who has experience with expanding a shelter's operating hours. For example, the Harvard Square Homeless Shelter (HSHS), a student-run organization that serves all individuals experiencing homelessness (not only young adults), added a summer program in 2014.[121] A professional that was involved in HSHS's expansion may provide invaluable insight for Y2Y. As Y2Y is still developing an evaluation process and performance measures, I also recommend seeking advisors with experience in performance evaluation and continuous learning. The organization may find mentors through the Service Corps of Retired Executives (SCORE). SCORE mentors volunteer their time to advise start-ups and existing businesses. The Greater Boston area has more than 50 mentors, and Y2Y should consider tapping into that network.[122]

In the long term, as Y2Y works to improve its coordination with other providers, advisors that have experience with implementing a coordinated entry system for youth and young adults will be especially helpful. Y2Y, Bridge, and Youth on Fire should create an advisory board to help develop the Cambridge-Boston Continuum and advise the Continuum's planning committee. For that board, I recommend inviting practitioners who have helped implement coordinated entry systems in other areas, such as **Cincinnati/ Hamilton County, OH; Seattle/King County, WA; and Portland/Multnomah County, OR**.

Creating a Real-Time Analytics Dashboard

Y2Y currently relies on Excel to complete most data analyses for its weekly, monthly, and annual reports. While the information system Y2Y uses has a dashboard feature, staff do not use it. I recommend creating a real-time analytics dashboard that provides a summary of client demographics and allows Y2Y to continuously monitor its performance. Having a dashboard would reduce the data analysis staff members have to complete by hand and allow them to focus on other tasks.

This strategy is modeled after **Seattle/King County, WA**, which uses dashboards to track the progress of its coordinated entry system and agencies within the system (see **Appendix 7, p. 133**).[123] **Cincinnati/ Hamilton County, OH**, also uses analytic dashboards, but they are not publicly available. Although Y2Y is currently focused on evaluating its own performance, it plans to improve coordination with other providers. Y2Y can use Seattle/King County's dashboards as models for designing a real-time dashboard that would allow it to monitor its own performance in the short term and could serve as the basis for building a performance dashboard for the Cambridge-Boston Continuum in the future.

Considerations for Implementation

> **Key implementation steps** include determining the dashboard's purpose, deciding whether Y2Y needs one or multiple dashboards, selecting data to display, building the dashboard(s), and creating a data quality assurance plan.

To create an effective dashboard, Y2Y will first need to determine the dashboard's purpose and the data it should display. **Seattle/King County, WA**, has multiple dashboards that serve different purposes. One monitors the performance of the coordinated entry system and individual agencies, tracking five metrics: exits to permanent housing, average length of stay, returns to homelessness, entries to homelessness, and utilization rate.[124] The system's key funders, the City of Seattle, King County, and United Way, selected those

metrics as well as targets and minimum standards. A separate dashboard summarizes demographic data for people experiencing homelessness.[125] Y2Y may also build multiple dashboards that provide different types of data on demand, such as client demographics and key organizational outputs and outcomes. The dashboard should be easily modified to accommodate change, and data should be easily downloadable for sharing with key stakeholders and including in reports to minimize the work staff members complete manually.

Practitioners I interviewed emphasized the data within an information system is only as good as the data entered into the system. One reason Y2Y has not yet used the dashboard feature is the data within its information system is not always accurate, and staff reported concerns about data completeness and reliability. Exporting raw data into Excel allows staff to manually correct errors before completing analyses. As Y2Y builds a real-time dashboard, I thus recommend also developing policies and procedures for data quality assurance.

To brainstorm solutions for how Y2Y can improve data quality and minimize errors staff members make when entering data into the information system, I conducted a staff survey. One staff member proposed embedding validation checks within the software that prompts staff to complete sections. Another suggested implementing accountability structures, such as having a staff member spot check another member's work. A third person suggested creating policies to standardize data entry. When asked what Y2Y could do to better support them, several staff said they would like more training to understand the types of data they should enter into the system and how to use the backend of the software to double-check data.

Of all the agencies that I interviewed, only one uses the same software as Y2Y to manage and evaluate data. That organization, Rosie's Place, is a women's shelter in Boston and is also in the process of developing a performance dashboard. I recommend meeting with stakeholders at Rosie's Place, who may provide invaluable insight about selecting data to display in the dashboard and the types of policies they have for data quality assurance.

Recommendation 2: Collaborate with Other Providers to Develop Standardized Procedures for Client Identification, Intake, and Referrals

Y2Y, Bridge, and Youth on Fire use two different information systems. Ideally, they would use the same software to manage and evaluate data once they develop the Continuum, but that is unlikely. Y2Y currently uses PBHA's information system. As Y2Y becomes a nonprofit, it has decided to continue using the same software but will need to create a separate platform from PBHA. While Y2Y is building its own information system, I recommend collaborating with Bridge and Youth on Fire to create standardized procedures for client identification, intake, and referrals. Adopting standardized procedures now will not only help Y2Y build its information system in the short term but also facilitate future coordination and data sharing with other providers.

Developing a Standardized Method for Client Identification

In **Cincinnati/Hamilton County, OH**, outreach staff and shelters issue clients a scan card, known as "VESTA ID," upon initial contact.[126] The ID card is tied to clients' HMIS record, which includes their basic demographic and background information. Clients present their ID when they seek services, which helps providers locate the client's record and minimizes duplicate records within the HMIS. Given most people experiencing homelessness in that area now have a VESTA ID, the ID card also facilitates Point-in-Time Counts. During counts, outreach workers use portable scanners to record the ID number of people they encounter on the street. If someone does not have a VESTA ID, outreach workers will collect their information. **Cincinnati/ Hamilton County, OH, and Northern Kentucky** currently use different HMISs.[127] Because they would like to share data between those systems in the long term, however, providers in both areas use the VESTA ID to collect and manage client data. Other communities have similarly used scan cards to ID clients and help locate a client's HMIS record quickly to reduce intake time.

To facilitate future data sharing, I recommend Y2Y work with Bridge and Youth on Fire to develop a standardized procedure for identifying clients and managing data within their information system. Similar to Cincinnati/Hamilton County and Northern Kentucky, providers in Cambridge and Boston should consider creating an ID card that they issue to youth and young adults experiencing homelessness at initial contact. When clients go to Y2Y, Bridge, or Youth on Fire, they would present that card to ensure the same ID number is used to record information about them. Using the same client ID numbers will help those providers integrate their information systems and match and merge client records when they are ready to develop a coordinated entry system. Using a scan card could also reduce intake time, allowing providers to electronically register clients for shelter beds and other services. As in Cincinnati/Hamilton County, providers in Greater Boston may also use the ID card to conduct Point-in-Time Counts and help obtain an unduplicated, more reliable count of youth and young adults experiencing homelessness.

Considerations for Implementation

> **Key implementation steps** include designing the scan card together with other providers and software vendors, identifying ways to fund the project, and developing a plan for issuing the cards to clients.

Practitioners I interviewed suggest the HMIS vendor helped develop the VESTA ID card in Cincinnati/ Hamilton County, and vendors for other areas have similarly offered an ID card scan system as a software module. Given youth and young adult providers in Cambridge and Boston use different information systems provided by different vendors, it may be challenging to implement a standardized ID system. Y2Y, Bridge, and Youth on Fire must also all be willing to collaborate on this project for it to succeed. I recommend convening a meeting with key stakeholders from Y2Y, Bridge, Youth on Fire, and the two software vendors to explore the possibility of developing an ID system and sharing data between the two information systems.

Developing an ID system will also require funding. Massachusetts has been working to develop a better method to count youth and young adults experiencing homelessness.[128] Given the ID card can help facilitate Point-in-Time Counts, I recommend partnering with stakeholders involved in conducting the annual Massachusetts Youth Count, which may contribute funding to a project that helps identify youth and young adults experiencing homelessness, including the Massachusetts Special Commission on Unaccompanied Homeless Youth, Massachusetts Housing and Shelter Alliance, and MassHealth. Moreover, practitioners suggest youth and young adults are more likely to have cell phones than other subpopulations. In developing an ID system for youth, providers should consider utilizing mobile technology to issue and scan cards. A physical card could be issued to clients that lack access to a mobile phone.

Developing a Standardized Intake Assessment and Referral Database

Y2Y is currently in the process of developing its management information system and needs to create forms within the system that staff and case managers will use to complete intake. Given the organization plans to ultimately move toward a coordinated entry system, I recommend working with Bridge and Youth on Fire now to develop a standardized intake assessment. By building that assessment form into its information system and adopting it as a standard practice in the short term, Y2Y can avoid the cost of changing the form and retraining its staff once the Continuum is developed in the future.

Although Y2Y has a list of resources it uses to make referrals, the list is neither comprehensive nor embedded within the organization's information system. Practitioners I interviewed suggest access points for a coordinated entry system generally have a comprehensive database of available resources in the area with descriptions of programs and services and agencies' contact information. I recommend Y2Y collaborate with Bridge and Youth on Fire to develop one database of available resources for youth and young adults in Greater Boston that they can all use to complete referrals. Given those providers would each serve as an access point in the Continuum and need a common database, developing that database now will help them better understand all of the available resources in the short term and prepare them for the transition to coordinated assessment.

Considerations for Implementation

> **Key implementation steps** include designing the intake assessment, identifying all available resources for youth and young adults experiencing homelessness in Greater Boston, and building the intake assessment and referral database into Y2Y, Bridge, and Youth on Fire's information system.

Most practitioners I interviewed suggest their intake assessment includes questions about client demographics and history and a triage tool. As an alternative to the VI-SPDAT, youth and young adult providers in **Portland/Multnomah County, OR**, use the Transition Age Youth (TAY) Triage Tool, a six-question assessment specifically developed to help identify and prioritize the most vulnerable youth and young adults for supportive housing. Some areas use the TAY-VI-SPDAT, which merges the TAY and VI-SPDAT, although some providers do not think the TAY-VI-SPDAT is as trauma-informed as the TAY (see both tools in **Appendix 7, p. 87-101**).

To develop a comprehensive referral database, practitioners I interviewed suggest partnering with the local 2-1-1 hotline, which should have and may be willing to share information about available resources. Providers in Greater Boston should thus consider working with Mass 211 and Boston 311. Bridge is also the respondent in Greater Boston for the national runaway hotline and likely already has a database of resources for youth that can be supplemented with information about resources for young adults.[129] Once the database is created, Y2Y, Bridge, and Youth on Fire should work with their software vendor to build it into their information system, ensuring it is user-friendly and easily accessible by staff and case managers when working with clients.

> To develop a comprehensive referral database, **PRACTITIONERS I INTERVIEWED SUGGEST PARTNERING WITH THE LOCAL 2-1-1 HOTLINE,** which should have and may be willing to share information about available resources.

Recommendation 3: Collaborate with Other Providers to Develop a Shared Evaluation Framework

Unlike other providers, Y2Y has the unique flexibility to set its own performance measures because funders do not require the organization to report specific outcomes or meet certain targets. While such flexibility is advantageous, Y2Y has found it challenging to select performance measures and targets. None of the other providers I interviewed have that same flexibility, rather they all described tracking and reporting specific outputs and outcomes to satisfy funding requirements.

To set performance measures and targets, Y2Y has, thus far, focused on its own organization and worked internally to develop an evaluation process. However, other providers in Greater Boston that serve the same population or provide similar services can provide invaluable insight for setting appropriate performance goals. In the short term, Y2Y may consider meeting with providers, such as Bridge, which also has a young adult shelter and may help Y2Y understand how they establish performance measures each year.

Once Y2Y has a better idea of its own performance measures and goals, it can focus more on improving coordination with other providers. Developing the Continuum will require overcoming the challenge of providers having different funding requirements. To mitigate that challenge and prepare for the transition to coordinated entry, in the medium term, I recommend collaborating with Bridge and Youth on Fire to create a shared evaluation framework, which will serve as the basis for developing an evaluation process for the Continuum.

Developing a Shared Mission and Goals

The results of my research suggest the first step in developing a shared evaluation framework is for stakeholders to create a shared mission statement and set of goals, which will help unite providers despite their different funding requirements. Providers in other areas typically create a shared mission and goals when developing a coordinated entry system, and the lead agency may facilitate that process.

➢ In **Seattle/King County, WA**, stakeholders have a shared vision "that homelessness is rare in King County, racial disparities are eliminated, and if one becomes homeless, it is brief and only a one-time occurrence" (see **Appendix 7, p. 112**).[130]

➢ The purpose of the Homeless Youth Continuum in **Portland/Multnomah County, OR** is stated as follows: "The strategic investment of community resources—public, private, financial, and human—that creates the unified system of supports and services necessary to: build protective factors, promote developmental outcome attainment, and achieve lasting, long-term impacts in the lives of homeless youth. The goal is to create long-term, sustainable impacts in the lives of youth by strengthening their resilience and fostering positive development through caring relationships, high expectations and meaningful participation."[131]

➢ Stakeholders in **St. Paul/Ramsey County, MN**, have a vision "in which every family and individual has a permanent place to live." They have six goals, including ending homelessness for unaccompanied and parenting youth, building and supporting stability, and expanding housing opportunities.[132]

Considerations for Implementation

> **Key implementation steps** include identifying key stakeholders to include in the development process; convening a meeting with Y2Y, Bridge, Youth on Fire, and other stakeholders; and deciding whether to build the shared mission statement and goals into a broader strategic plan.

As youth and young adult providers in Greater Boston do not yet participate in a coordinated entry system, they do not have a lead agency that could facilitate the process to create a shared mission and goals. One option is for Y2Y, Bridge, and Youth on Fire to meet and develop a shared vision themselves. Alternatively, they may wait until they have identified and selected a lead agency for the Cambridge-Boston Continuum, who would facilitate that process. Although the Continuum will primarily involve those three providers,

it may also be helpful to involve other stakeholders in developing a shared mission and goals for addressing youth and young adult homelessness in Greater Boston, including government agencies, social service providers, health organizations, and law enforcement.

As a start, I drafted the following mission statement, as shown in **Figure 2**: *The Cambridge-Boston Youth and Young Adult Continuum creates a unified and coordinated system of programs and services that help youth and young adults experiencing homelessness (ages 14-24) meet their basic needs, connect to critical resources, develop safe and supportive relationships, and obtain self-sufficiency*. Stakeholders in Greater Boston should use this draft as a basis for identifying their shared purpose and setting goals.

Many geographic areas have published stakeholders' shared mission and goals as part of a broader strategic plan for preventing and ending homelessness. Given neither Cambridge nor Boston has released a plan for ending youth and young adult homelessness, Y2Y and other providers may consider not only developing a shared mission and goals but also devising a strategic or action plan for addressing youth and young adult homelessness in Greater Boston. Having the mayors in Cambridge and Boston adopt a plan to prevent and end youth and young adult homelessness in both cities may help obtain buy-in from key stakeholders for the Continuum. If Y2Y and other providers decide to create such a plan, I recommend partnering with local mayors to develop and publicly launch it.

Developing a Shared Logic Model

After creating a shared mission and goals, stakeholders should develop a shared logic model. A logic model is a tool used to visually show the relationship between stakeholders' resources, activities, the results they expect to achieve in the short to medium term, and the impact they hope to have in the long term.[133] Stakeholders in **Portland/Multnomah County, OR**, created a logic model for their Homeless Youth Continuum (see **Appendix 7, p. 113**), and I recommend stakeholders in Greater Boston also create one for the Cambridge-Boston Continuum. The purpose is to help Y2Y, Bridge, and Youth on Fire thoroughly understand the resources they collectively have and how they use

those resources to achieve their goals. The model will serve as the cornerstone for developing an evaluation process for the Continuum.

5 Key Components of a Logic Model

A logic model has five components: inputs, activities, outputs, outcomes, and impact.[134]

(1) **Inputs** are the key resources available to carry out the Continuum's activities, including the funding available to support the Continuum and Y2Y, Bridge, and Youth on Fire's staff and volunteers.

(2) **Activities** are how the Continuum uses its resources to effect change. In **Figure 2**, I mapped the key programs and services of Y2Y, Bridge, and Youth on Fire, which should be included as activities in the logic model. For example, Y2Y provides shelter, and Bridge provides access for youth and young adults to transitional housing.

(3) **Outputs** are the direct results of the Continuum's activities, such as the number of youth and young adults that use a shelter bed, access drop-in services, or receive referrals to other services.

(4) **Outcomes** are the short- to medium-term changes providers expect because of the Continuum's activities, such as that youth and young adults who receive a shelter bed will feel safe, and clients who receive case management will feel supported.

(5) **Impact** is the long-term effect providers expect their programs and services to have, such as youth and young adults will obtain stable housing and youth and young adult homelessness in Greater Boston will be reduced. Providers' shared goals should directly map onto this section.

Considerations for Implementation

Key implementation steps include identifying key stakeholders that should be included in developing the logic model and creating a timeline and meeting schedule for building the model.

Developing a logic model requires time and will not be completed in one day. Stakeholders should create a realistic timeline and meeting schedule for building the model considering their capacity.[135] Similar to the process for developing a shared mission and goals, it is valuable to include various stakeholders in model development, and having a facilitator may be helpful.

Unlike a logic model for one organization, an important consideration is this model should be developed for the Continuum as a whole. While some outputs and outcomes will focus on individual programs and services (e.g., the number of youth and young adults that receive a shelter bed), Y2Y, Bridge, and Youth on Fire should make sure to consider the collective effect they expect to have by improving coordination, such as reducing the length of shelter stays and prioritizing the most vulnerable youth and young adults for housing. Once the logic model is developed, it should be continuously reviewed. I recommend making review of the logic model one of the responsibilities of the workgroup that will meet twice per month to develop policies and evaluate data for the Continuum.

Moving from a Logic Model to Evaluation

Once stakeholders create the logic model, they should consider their goals/targets for each output and outcome and the measures they can use to evaluate their progress toward achieving those goals.[136] To ensure providers can meet their individual funding requirements, they should take care to develop targets that do not conflict with funders' expectations. To mitigate that conflict, in **Seattle/King County, WA**, key funders worked with other stakeholders to set targets and minimum standards for the coordinated entry system and agencies that participate in the system. As stakeholders plan the Cambridge-Boston Continuum, they should similarly include key funders in meetings to develop performance measures as well as targets and minimum standards for each of those measures.

To help stakeholders in Greater Boston move from a logic model and develop an evaluation process, on **p. 21-22**, I have discussed how other areas evaluate their coordinated entry system, including common performance measures. I also provide many resources and sample materials in the Toolkit (see **Appendix 7**).

Conclusion

Toward achieving the federal government's goal to prevent and end youth homelessness by 2020, HUD has encouraged communities to develop a coordinated entry system that serves youth and young adults. In this PAE, I examined the systems developed in five geographic areas and assessed the value and feasibility of developing a regional coordinated entry system for youth and young adults experiencing homelessness in Greater Boston. Based on an analysis of three options, I recommended creating the Cambridge-Boston Youth and Young Adult Continuum in the long term. The results of my research suggest developing the Continuum would benefit clients, providers, and the community but may be challenging because providers have limited capacity, use two different information systems, and have different funding requirements. To overcome those challenges, I proposed strategies to improve Y2Y's capacity and collaboration with other providers in the near term.

Although creating a regional coordinated entry system is valuable, it will not be sufficient to prevent and end youth and young adult homelessness. At the same time stakeholders work to disrupt silos and improve coordination between providers, they must also work diligently to increase the affordable housing stock and resources to assist and support those at risk of homelessness. By developing the Continuum and improving the supply of affordable housing, stakeholders in Greater Boston will help ensure all youth and young adults in their community have a permanent place to call home.
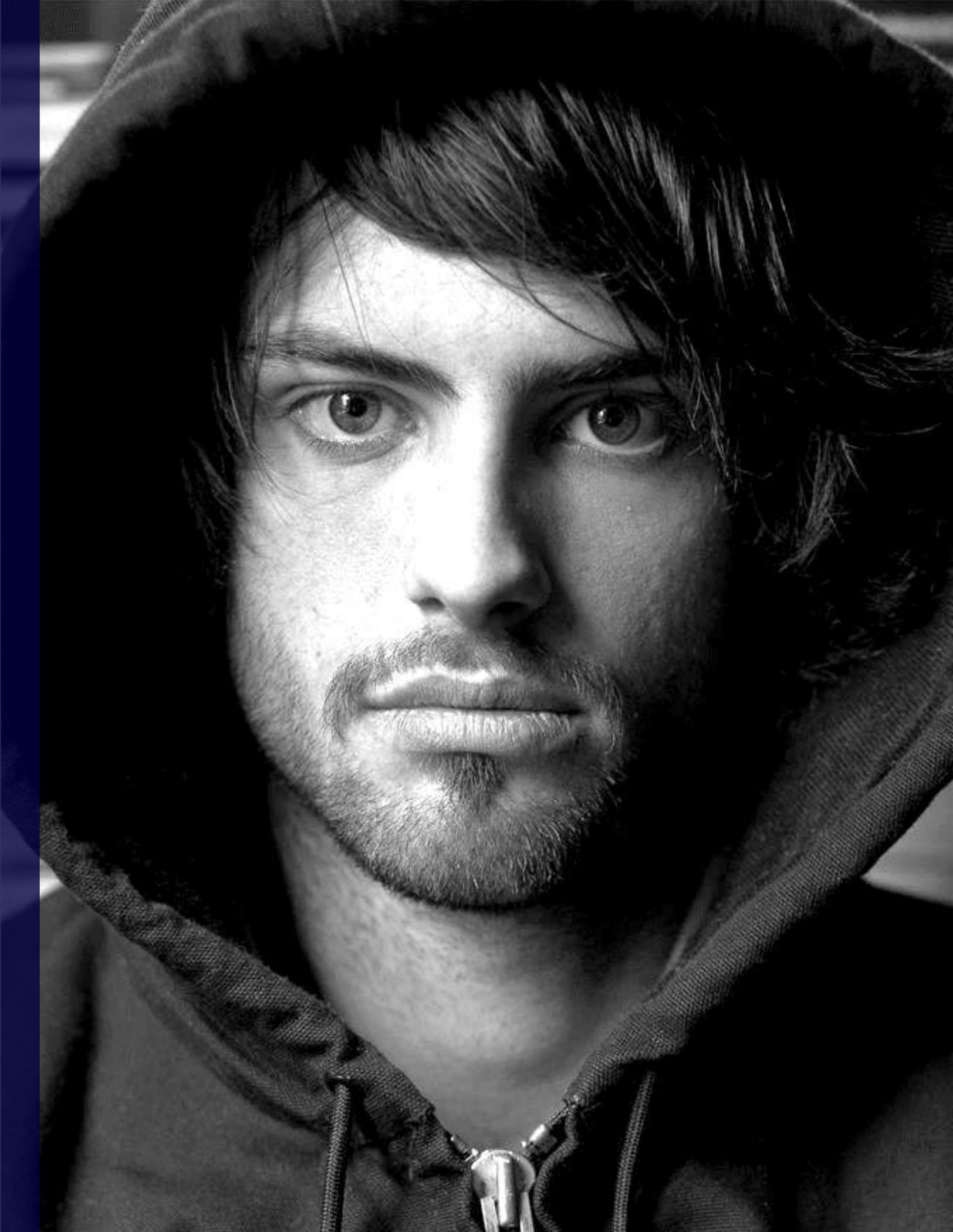
APPENDIX 1: Glossary of Key Terms[137]

A **Continuum of Care (CoC)** is a local planning body responsible for coordinating the full range of homelessness services in a geographic area, which may cover a city, county, metropolitan area, or entire state.

A **coordinated entry system** is a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. It is often developed by and covers the same geographic area as a single CoC.

Couch surfing refers to an individual or family temporarily living with several different people within a short period of time.

Diversion helps individuals and families seeking shelter find alternative housing options, such as staying with friends or family members.

Doubled up refers to an individual or family living with another person without any legal agreement.

Emergency shelter is a facility that provides temporary shelter for people experiencing homelessness.

People **experience homelessness** when they lack a fixed, regular, and adequate nighttime residence.

A **Homeless Management Information System (HMIS)** is a local information technology system that is used to manage client data, track the provision of housing and services to clients, and generate an unduplicated count of people experiencing homelessness.

Parenting youth are individuals under the age of 25 who are experiencing homelessness, are not accompanied by someone over the age of 24, and identify as a parent or legal guardian to one or more children, who sleep in the same place as the youth.

Permanent supportive housing provides housing and supportive services on a long-term basis to people who formerly experienced homelessness.

Point-in-Time Counts are unduplicated one-night estimates of both sheltered and unsheltered people experiencing homelessness.

Positive youth development is the intentional process of providing all youth with the support, relationships, experiences, resources, and opportunities needed to become successful and competent adults.

Prevention resources help individuals and families maintain stable housing, including rental assistance, utility payments, and case management.

Rapid rehousing is a housing model designed to provide temporary housing assistance to people experiencing homelessness, moving them quickly out of homelessness and into permanent housing.

A **regional coordinated entry system** is a coordinated entry system that covers multiple CoCs.

Transitional housing provides people experiencing homelessness a place to stay and supportive services for up to 24 months.

Trauma-informed care is a structure and treatment attitude that emphasizes understanding, compassion, and responding to the effects of all types of trauma.

Young adults experiencing homelessness are unaccompanied youth ages 18-24.

Youth experiencing homelessness are unaccompanied youth under the age of 18.

Youth in families with children are individuals under the age of 18 who experience homelessness while in the custody of a parent or legal guardian.

Unaccompanied youth are individuals under the age of 25 who are not accompanied by a parent or legal guardian or another person over the age of 24 while experiencing homelessness and are also not a parent staying in the same place as their child(ren).

I define Greater Boston as the region referred to as the "Inner Core" by the Metropolitan Area Planning Council. Shown in the orange area below, the Inner Core includes the 21 innermost communities within the metropolitan Boston area and has more than 1.6 million residents.

There are 16 CoCs in Massachusetts. The map below shows the eight CoCs in Greater Boston with each color representing a different CoC. The Balance of State CoC is managed by the Department of Housing and Community Development and covers all communities in the state that are not covered by another CoC. A portion of the Balance of State CoC, shown in yellow, is in Greater Boston.
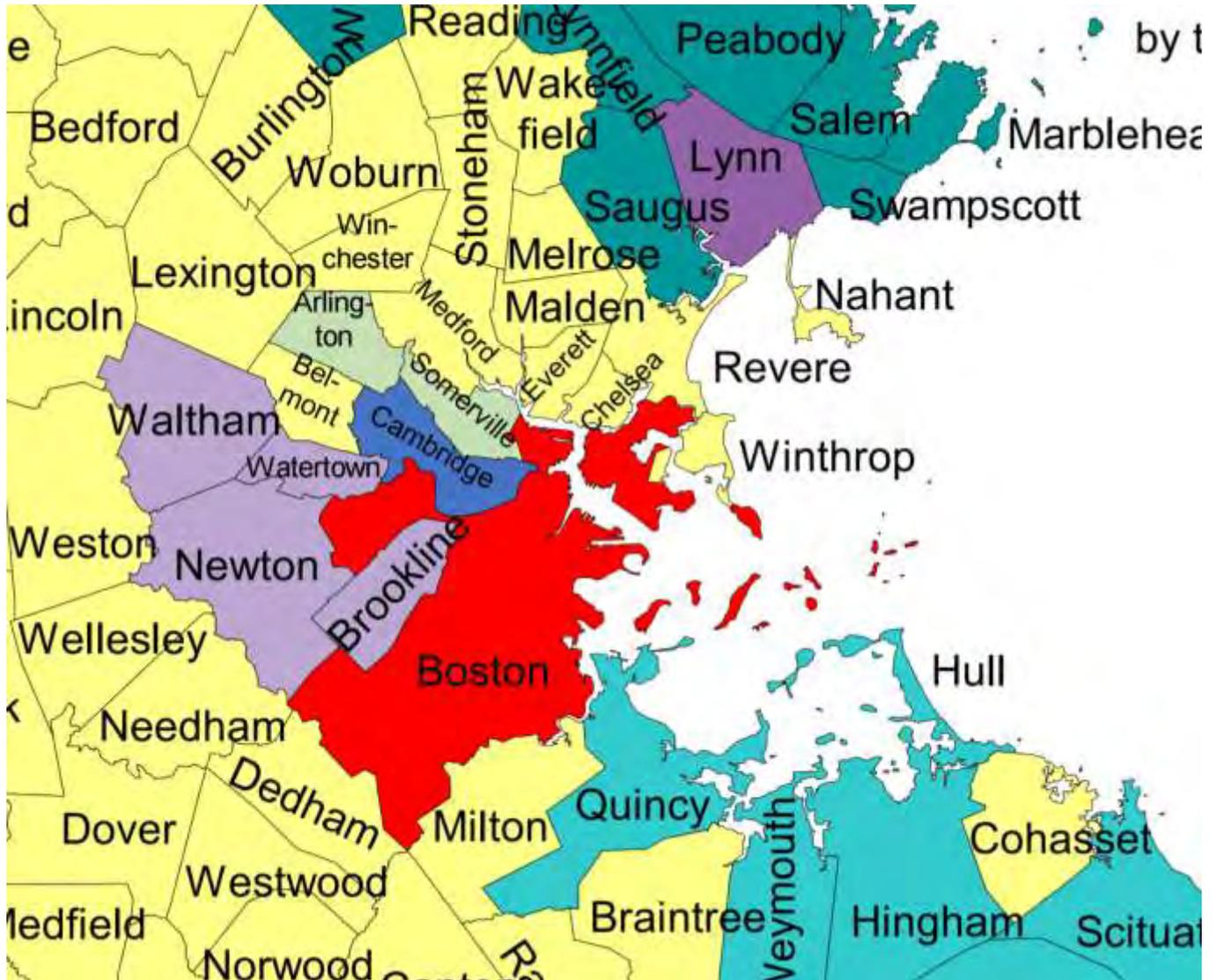
Key (CoC Names)

🟥	Boston	🟦	Quincy/Brockton/Weymouth/Plymouth City and County
🟦	Cambridge	🟪	Lynn
🟪	Brookline/Newton	🟩	Gloucester/Haverhill/Salem/Essex (North Shore)
🟩	Somerville	🟨	Balance of State

APPENDIX 4: Methodology

Literature Review

I reviewed existing literature obtained through online databases and websites for national homelessness organizations, service providers, and communities that have developed a coordinated entry system. I also reviewed materials provided by interviewees.

Interviews

I interviewed practitioners in Greater Boston and five other geographic areas—Cincinnati/Hamilton County, OH, and Northern Kentucky; Seattle/King County, WA; Portland/Multnomah County, OR; Minneapolis/Hennepin County and St. Paul/Ramsey County, MN; and the State of Maine—to understand the value and feasibility of implementing a coordinated entry system that serves youth and young adults experiencing homelessness. I completed site visits to three of those areas.

Within Greater Boston, I completed site visits to and interviewed staff members at Bridge Over Troubled Waters and Rosie's Place, shelters in Boston that serve young adults and women, respectively. I also interviewed key stakeholders involved with addressing youth and young adult homelessness in Greater Boston and implementing the coordinated entry system in Cambridge, including city officials, providers, and other community leaders. At Y2Y, I interviewed full-time and student staff members who are involved with developing the organization's new information system and oversee data collection, management, and evaluation.

I interviewed a total of 52 practitioners from 30 organizations either in person, over the phone, or via email (see **Appendix 5 and 6** for a list of interviewees and sample interview guide).

Observations

As a participant observer, I attended the Metro Boston Regional Homelessness Summit, the meeting convened by Cambridge's mayor and vice mayor to understand how communities in Greater Boston can address homelessness on a more regional basis. I also attended a meeting of the Boston Youth Advisory Board, where young adults who have formerly experienced or are currently experiencing homelessness gathered with city officials, advocates, community leaders, and providers to propose ideas for better addressing youth and young adult homelessness.

At Y2Y, I attended a staff training session to learn how to use the organization's information system and observed one meeting of the Y2Y Policy Group, the organization's key decision-making body that, guided by data, makes most policy decisions.

Administrative Data

I analyzed the results of a staff survey Y2Y conducted in June 2016 (at the end of its first season) to understand staff members' experience working in the shelter and identify areas for improvement. A total of 18 staff members completed the survey. I also analyzed the results of a survey conducted in November 2016 about staff experiences at Y2Y, the level of staff support, and how the organization can better support staff. A total of 16 staff members participated in that survey.

Survey

I conducted an online survey about staff experiences using Y2Y's current information system and how the system may be improved. A total of 14 staff members and case managers completed the survey.

Note: Specific survey questions are not included in this PAE but have been provided to Y2Y for their internal reference.

Case Studies

Using data from my literature review and interviews, I completed case studies of the five geographic areas to assess the value and feasibility of planning and implementing a coordinated entry system for youth and young adults and identify options for developing a regional system in Greater Boston.

APPENDIX 5: List of Interviewees

Greater Boston, Massachusetts

–   Sam Greenberg, Sarah Rosenkrantz, Danielle Goatley, Isabelle Yang, and Tamjid Rahman, Y2Y Harvard Square, Cambridge, MA
–   Peter Ducharme, Regina Benjamin, and Jade Shaughnessy, Bridge Over Troubled Waters, Boston, MA
–   Matan Benyishay, AIDS Action Committee, the parent organization for Youth on Fire
–   Vice Mayor Marc McGovern, Jamila Bradley, Rachel McGovern, City of Cambridge, MA
–   Marianne Colangelo and Shelly Chevalier, Department of Human Service Programs, City of Cambridge, MA
–   Sandy Mariano, Rosie's Place, Boston, MA
–   Denise Jillson, Harvard Square Business Association, Cambridge, MA
–   Lauren Leonardis, Youth Homelessness Consultant, Co-Facilitator of the Boston Youth Advisory Board

Cincinnati/Hamilton County, Ohio, and Northern Kentucky

–   Jamie Hummer, Jennifer Steigerwald, and Tia Alexander, Strategies to End Homelessness, Cincinnati, OH
–   Michelle Budzek, The Partnership Center, Cincinnati, OH
–   Julie Walter, Welcome House, Covington, KY
–   Jarrett Spisak and Kate Arthur, Brighton Center Homeward Bound Shelter, Covington, KY
–   Geoff Hollenbach, Lighthouse Youth Services, Cincinnati, OH
–   Anne Price, Transitions, Inc., Covington, KY

Seattle/King County, Washington

–   Kira Zylstra and Samantha Wiese, All Home King County
–   Susan Gemmel, Alex Williams, Jennifer Onishea, and June Bordas, Crisis Clinic/King County 2-1-1
–   Angie Merrill, New Horizons

Portland/Multnomah County, Oregon

–   Katie Olson, Jill Weir, and Nathaniel Holder, New Avenues for Youth
–   Dennis Lundberg and Neal Sand, Janus Youth Programs
–   Caitlin Campbell, Joint Office of Homeless Services
–   Kanoe Egleston, Native American Youth and Family Center

I also interviewed staff members from the following organizations, which are located in Greater Portland but focus on serving youth and young adults experiencing homelessness in Hillsboro/Washington County, OR:

–   Karen Pomerantz and Andrea Logan Sanders, Boys and Girls Aid Safe Place for Youth
–   Kirsten Carpentier, HomePlate Youth Services

Minneapolis/Hennepin County and St. Paul/Ramsey County, Minnesota

–   D Cadreau and Shennika Sudduth, Ascension Place and St. Anne's Place, Minneapolis, MN
–   Eric Richert, Hope Street, Minneapolis, MN
–   Katelyn Warburton, YouthLink, Minneapolis, MN
–   Kurt Hanson, Ain Dah Yung Center, St. Paul, MN

State of Maine

–   Stacey Spaulding, Preble Street, Portland, ME
–   Rick Smith, New Beginnings, Lewiston, ME
–   Sherrie House, Shaw House, Bangor, ME
–   Scott Tibbitts, MaineHousing, Augusta, ME

Hi, and thank you for allowing me to interview you. I am completing my master's thesis to understand how organizations that serve people experiencing homelessness collect, use, and manage data as well as how cities and regions develop coordinated entry and assessment systems. If I report anything you say in my paper, your statements will be anonymous, so please feel free to say anything you would like during this interview. Do you have any questions before we begin?

Public Value

- What are the benefits of participating in coordinated entry?
- How does developing a coordinated entry system benefit youth and young adults experiencing homelessness? Service providers? The community?
- What are the costs and challenges of participating in coordinated entry?
- What are the key benefits and challenges involved with having a regional v. citywide system?
- Do the benefits of developing a coordinated entry system outweigh the costs to implement and sustain the system?

Operational Feasibility

Resource Requirements
- What resources are necessary to implement a coordinated entry system?
- What funding and tools are available to support the development of a coordinated entry system?

Data Collection, Management, and Evaluation
- What types of data do you all collect? What is the purpose of the data that are collected? How do you all collect that data?
- How many staff members do you all devote to completing data analyses? How do you all manage the limitations of staff capacity and turnover?
- How do you all manage your data? What type of software do you all use to share data?
- Do all providers within a coordinated entry system use the same software to manage and evaluate

data? Can providers integrate data across different software platforms?
- Specifically, what data/how much data are shared between service providers?
- What types of security measures do providers use to manage users' access to data and preserve guests' confidentiality?
- How do you all use the data you collect to evaluate your services and programming?
- How often do you all complete data analyses?
- How does your organization define success?

Other
- What capacity does a lead agency need to oversee planning efforts and implementation?
- What will be necessary to sustain your coordinated entry system?
- If you were starting coordinated entry from scratch, what would you change with how your system is currently run? What advice would you give a community that is just starting?

Political Feasibility

- What sources might support efforts to develop a regional, coordinated assessment system for youth and young adults experiencing homelessness?
- Did you all face any resistance from key stakeholders when implementing a coordinated entry system?
- How did you all address stakeholders' concerns?

Questions for Y2Y Staff Members

- How does Y2Y currently collect and store data?
- How does Y2Y use the data it collects to inform its decision making?
- What are the key ways Y2Y's current information system is not adequately addressing the needs of the organization?
- How would improving the current information system help Y2Y better serve guests and facilitate their access to housing and other services?

APPENDIX 7
A Toolkit for Developing the Cambridge-Boston Youth and Young Adult Continuum

Table of Contents

VESTA

Client Consent Form
Authorization for Release of Information

Client name   SSN   DOB

I understand that this agency, along with many others, participates in VESTA — a community software system. I know that VESTA collects information about many different people who get services and housing in the Greater Cincinnati area in order to understand more about who is in need of assistance or are homeless and to be able to report to the funders who pay for the programs.

With this written consent, I understand and agree that all agencies that use VESTA will be able to see and update basic information about me including: name, social security number, gender, race, ethnicity, birth date, veteran status, and proof of homelessness. I also give consent for the minor children in my household including:

Dependent Children under 18:

_____

_____

_____

_____

_____

_____

_____

_____

I understand that the information about me (and my children) will move electronically between agencies that participate in VESTA and will be available to them as I apply for their services or housing.

I also know that this agency may now have, or may have at a later date, a partnership agreement with other agencies to allow these agencies to share additional information including income, benefits, case plan, goals, progress toward goals, and services provided to me. I understand that I may request a list of which agencies have access to my data at any time from any agency providing me services.

If at any point I have been or become homeless, I understand my homeless certificate will be stored in VESTA and will be available to agencies that may need it to service me. I understand that any homeless agency serving me can provide me with a copy of my homeless certificate, if I ask for it. I also understand that I cannot be denied homeless housing or services because of any information contained in VESTA.

Client Consent Form
Authorization for Release of Information

If at any point I need emergency assistance (food, financial assistance, clothing, etc.) from a community agency I understand that the assistance they provide me may be shared with other emergency assistance agencies. I understand that I have the right to refuse consent to share information in VESTA but that depending on the emergency assistance I need, it may be denied to me based on the agencies' ability to coordinate the services through VESTA with other providers.

Only authorized staff from agencies that have provided me housing and services and who have signed a VESTA confidentiality agreement will be allowed to see, enter, or use information kept in VESTA.

No agency staff or the database administrators will ever give information about me to anyone outside this system without my written consent, except as required by law through a court order or in the event of a public health emergency such as a tuberculosis outbreak. Information in VESTA that does not identify me may be used for research.

I understand I do not have to sign this consent in order to receive services. If I choose not to sign the consent form the agency may enter my information in VESTA but it will not be shared with any other agency.

I understand I can withdraw my consent at any time by informing this agency in writing that I wish to do so. I understand that an electronic copy of this document containing my electronic signature will remain on file and that this consent will expire three years from today.

I understand that I have a right to see my electronic record, ask for changes, and to have a copy of my record printed from any VESTA agency that has served me upon written request.

X _____   _____
Client signature (or other adult household member)   Date

X _____
VESTA User ID of witness

VESTA is administered by The Partnership Center. Ltd.
A full list of agencies using VESTA can be found on http://www.partnershipcenter.net

Northern Kentucky Coordinated Entry VI-SPDAT Client Consent Form

The VI-SPDAT (Vulnerability Index and Service Prioritization Decision Assistance Tool) is a quick survey our community uses to help identify what type of housing services will be most helpful to you. Your answers to this tool will be kept in a secure database managed by Strategies to End Homelessness. Your responses will only be shared with organizations and people named on this signed consent. By signing this form you are consenting to allow _____ (agency name) to share your first name, last four digits of your social security number and your responses on the VI-SPDAT with the following entities (initial appropriate agencies):

__X_ Strategies to End Homelessness   ____Cincinnati Veterans Administration Medical Center
____Housing providers participating in Coordinated Entry in   ____Other_____
Northern Kentucky (listed below)

With this consent you agree that you have been told about and understand the following:
- That the VI-SPDAT will be used to assess your housing needs and will be used to help guide the services available to you.
- That by completing the VI-SPDAT you are not guaranteed housing, nor are you guaranteed a specific timeline for when/if you will receive housing assistance.
- That you agree that Strategies to End Homelessness (STEH) will receive the information in the VI-SPDAT and use that information to assist in connecting you to possible housing services. STEH may contact your shelter/outreach/mental health case manager to obtain the necessary proof of your eligibility and level of assistance, including information held in our community's HMIS.
- You do not have to sign this consent in order to receive services. By not signing this consent, some housing programs may be unavailable to you or your household.
- You can withdraw your consent at any time without penalty by informing the above named agency that you wish to do so, and signing below.
- This consent will be active for 90 days after the signed date.

Client Signature:_____ Date:_____

Staff Witness:_____ Date:_____

I wish to cancel my permission to share identifying information held in the VI-SPDAT form. By signing below I am revoking my consent.

Client Signature:_____ Date:_____

Staff Witness:_____ Date:_____

Agencies Participating in Northern Kentucky CoC's Coordinated Entry Process:
Center for Independent Living Options, Inc | Catholic Charities | Welcome House | Emergency Shelter of Northern Kentucky | Northern Kentucky Area Development District | Women's Crisis Center | Transitions Inc. | Strategies to End Homelessness

Strategies to End Homelessness | 2368 Victory Parkway, Suite 600. Cincinnati, OH 45206 | 513-263-2780

King County Homeless Management Information System (HMIS)
Client Consent for Data Collection and Release of Information

What is the HMIS?

The HMIS is a data system that stores information about homelessness services. Bitfocus, Inc. manages the HMIS for King County. The purpose of the HMIS is to improve services that support people who are homeless to get housing, and to have better access to those services, while meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with Partner Agencies that help King County provide housing and services. A current list of Partner Agencies is at http://kingcounty.hmis.cc/participating-agencies/

BY SIGNING THIS FORM, I AUTHORIZE King County and Bitfocus to share HMIS information with Partner Agencies. The HMIS information shared will be used to help me get housing and services. It will also be used to help evaluate the quality of housing and service programs. I understand that the Partner Agencies may change over time.

The information to be collected and shared includes:
- Name, birthday, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use, and daily living information
- Housing Information
- Use of crisis services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by Partner Agencies
- Results from assessments
- My photograph or other likeness (if included)

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- King County, Bitfocus and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review their privacy policies.

- There is a small risk of a security breach, and someone might obtain my information and use it inappropriately.

- If I have questions about my privacy rights, my HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at (206) 444-4001 x2.

- I can receive a copy of this Consent and the Client Information Sheet

- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.

- This Consent will expire 7 years from my last HMIS recorded activity.

- I may revoke this Consent earlier at any time in writing to:

  Bitfocus, Inc.
  ATTN: King County HMIS
  548 Market St #60866
  San Francisco, CA 94104-5401

- The revocation will take effect upon receipt, except to the extent others have already acted under this Consent.

- My HMIS information may be viewed by auditors or funders who review work of the Partner Agencies, including HUD, The Department of Veteran Affairs, The Department of Health and Human Services, and The Washington State Department of Commerce. I understand that the list of auditors and funders may change over time.

- My HMIS information may be shared to coordinate referral and placement for housing and services.

- My HMIS information may be further shared by the Partner Agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.

- My HMIS information will be combined with other information from the Washington State Department of Social and Health Services (DSHS) to help evaluate the quality of social services.

- My HMIS information may be used for research; however, my identity will remain private.

Important: Personal information is not entered in HMIS for people who are 1) receiving services from domestic violence agencies; 2) fleeing or in danger from domestic violence, dating violence, sexual assault or stalking situation; or 3) have revealed information about being HIV positive or having AIDS. If one of these situations applies to you, **DO NOT** agree to have your personal identifying information collected.

SIGNATURE:

_____   _____

Signature of Patient/Client or Representative: Date

_____

PRINTED NAME

For Agency Use Only:
Client Opted Out (Refused Consent) _____ (Staff/Agency Initials)
Witness Staff & Agency) _____   Date _____

KING COUNTY HMIS - CLIENT CONSENT TO DATA COLLECTION AND ROI   (Version1.3 30Mar2016)
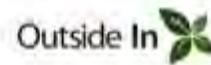
HOMELESS YOUTH CONTINUUM (HYC) CONSENT FORM

In order for you to obtain the best possible services, several agencies are working together to provide a complete continuum of programs and services to runaway, homeless and transitioning young people. The four agencies that partner together to provide these services are called the Homeless Youth Continuum or HYC.

I understand that I am now applying for service to the Homeless Youth Continuum (referred to as HYC below). I also understand that by providing information and completing a screening I may become eligible for the services of the following HYC agencies:

• Janus Youth Programs (JYP)	• New Avenues for Youth (NAFY)
• Native American Youth & Family Center (NAYA)	• Outside In (OI)

I hereby give consent to all agencies of the HYC to provide services to me. I understand that this consent becomes effective on the date below and extends until my 25th birthday, unless otherwise revoked.

My initials and signature below indicate that I have read this consent and the following information and my questions have been answered to my satisfaction.

Initials _____ My rights and responsibilities as a participant have been shared with me and I have reviewed and signed the *Privacy Practices Notice*.

I understand that the information I tell any staff from HYC agencies, or their stated partners, will be held in the strictest confidence under most circumstances as outlined in the *Privacy Practices Notice*.

Initials _____ I understand my responsibility to help maintain safety and respect while I participate in HYC programs and services.

I agree to respect the rules, policies, and expectations of each agency. Consistent expectations at all agencies include:
- Keeping spaces safe and welcoming
- Resolving disagreements non-violently
- Respecting staff requests
- Keeping drugs, drug paraphernalia, alcohol, weapons and stolen goods away from agency spaces
- Respecting our neighbors, including people, public spaces, and private properties.

Initials _____ I also understand that the HYC agencies receive funding for their services from Multnomah County and other public and private sources. I understand that funders may access data and records from the HYC agencies, including demographic information, services provided, and outcomes, to be used by Multnomah County and other funders for the purpose of monitoring and evaluation. I understand that data is required to be shared with NW Social Service Connections for computerized record keeping in ServicePoint and that the NW Social Service Connections privacy notice is available to me. Multnomah County has agreed to use any information about me only for contract monitoring and evaluation purposes and to never publicly release data that would allow an individual client to be identified unless required by law.

Initials _____ During or after my term of receiving services, one of the agencies or a qualified research organization working in conjunction with the project may contact me regarding services. Any such contact would be for either the purpose of follow-up, or conducting research and evaluation on service effectiveness and would be governed by the *Privacy Practices Notice*.

Initials _____ I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

I understand that I may refuse services and revoke this consent at any time. The revocation of this consent is effective upon receipt by the HYC of my written notice of revocation. My signature below indicates that I have read this Consent and that I understand it.

_____   _____
Signature of Participant or Representative   Date

_____   _____   _____
Print Participant Name   Date of Birth   Name of Staff Witness

Revised 05/06/2016
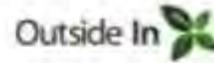
-*HOMELESS YOUTH CONTINUUM (HYC) PRIVACY PRACTICES NOTICE

This describes how information about you and your participation in services at the four Homeless Youth Continuum (referred to as "HYC agency/agencies") partner agencies (Janus Youth Programs, Native American Youth and Family Center, New Avenues for Youth, and Outside In) may be used and shared and how you can get access to this data. Service information includes documentation from your screening and assessment and your participation in shelter, day program, recovery support, housing, education and job training and support, assertive engagement (case management/youth advocate), and Pathways counseling program.

- **How we may use and share information about you:**
  - **Services and Supports** – We may use information about you to provide you with supports, resources, and other services within the Homeless Youth Continuum. Your personal information, including records, may be released between the HYC agencies. For example, information from your screening which documents your eligibility for HYC services will be shared among the HYC partner agencies, and information about you, including information from your assessment, will be shared to refer and maintain access to shelter and to coordinate referrals to housing, employment and education programs operated at the Continuum agencies.

    *Exception: Disclosure of information related to medical, mental health and alcohol and drug treatment provided by Outside In (Clinic and StreetRISE) requires a separate and specific written consent to share this information with other HYC partners.

  - **Checking of current warrant or run report** – HYC agencies must verify warrant and run report status (if applicable) prior to determining and approving eligibility for services at screening as well as entry and access to any of the shelters and housing programs. HYC staff may check warrant status at other times to confirm current warrant status.

  - **Operations** – We may use and share data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc. This includes funders conducting chart reviews.

  - **If there is a medical emergency** – HYC agencies may use and share information to secure treatment for that emergency.

  - **As required by federal, state, or local law**
    - **If abuse or neglect of a child, elder, or disabled person is suspected** – if HYC agencies have reason to believe that you or someone else has been abused or neglected as a minor, disabled individual, or elder.
    - **Lawsuits and disputes in response to a court or administrative order** – if information must be shared due to court order or subpoena.
    - **Law enforcement to help law enforcement officials respond to criminal activities.** Staff of HYC agencies may report crimes they witness. *Exception same as above.*
    - **To avert a threat to individual or public health or safety** – if HYC agencies have reason to believe you are in danger of hurting yourself (self-harm) or someone else.

- **Other Disclosures or Uses of your Personal Information:** Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.
  - **Persons involved as your supports** – With your written consent, we may share agreed upon information with a family member, a close friend, or other person that you have named as being involved as a support.
  - **Other Persons or Agencies that you would like us to share information with** – With your written consent, we may share agreed upon information with an agency or person, such as a health care provider, landlord, attorney, or probation officer.

I acknowledge that I have reviewed the Homeless Youth Continuum Privacy Practices Notice.

I understand that I may revoke this authorization at any time, and if revoked the information described above may no longer be used or disclosed for the purposes described in this written authorization.

I understand that this privacy notice is subject to change.

I understand that I have the right to see my HYC supportive services record if requested.

I state that the screening information I have provided is true and accurate to the best of my knowledge. I authorize the release of any information necessary to coordinate eligibility and access to services within the Homeless Youth Continuum.

Signature of Participant or Representative _____   Date _____

Print Participant Name _____   Date of Birth _____   Name of Staff Witness _____

Updated 09.03.2014

NW Social Service Connections' HMIS/CMIS Client Consent to Release of Information for Data Sharing in Multnomah County

Northwest Social Service Connections' Homeless Management Information System / Client Management Information System (HMIS/CMIS) is a computer system that is used to collect and share information on homelessness and social services in Portland and throughout Multnomah County. The information gathered by HMIS/CMIS, in addition to creating a non-repeated count of people receiving social and/or homeless services and developing combined information that will assist in developing policies to end homelessness, helps agencies plan and deliver services that help people in need. By sharing information with each other, agencies are able to simplify service delivery by tracking services and referrals provided to the persons they serve.

The HMIS/CMIS runs in compliance with all Federal and State laws and codes, including Health Insurance Portability and Accountability Act (HIPAA). All privacy procedures are designed to insure that the broadest range of providers may participate in the project. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights ended and may be subject to further punishments. Any information you provide will not be disclosed to any third party unless authorized by you or required by law. We must still report some information because of our federal, state or funder requirements.

Please read the following statements (or ask to have them read to you), and make sure you have had an opportunity to have your questions answered.

I UNDERSTAND THAT:
• The partner agencies may share basic identifying information about the people they serve with other parties working to end homelessness and provide other social services.
• The release of my information does not guarantee that I will receive assistance.
• I will not be denied services if I refuse to consent to data sharing.
• This authorization will remain in effect 7 years after my latest project exit unless I revoke it in writing. I may revoke authorization at any time by signing a written statement or Revocation form.
• I understand that cancelling my authorization will not change information that has already been given out or actions already taken, but the revocation will be effective as of that date.
• I have the right to see my HMIS/CMIS record, ask for changes, and to have a copy of my record from this agency upon written request.
• I have the right to file a complaint if I feel I have been harmed in some way by the use of HMIS/CMIS.
• I have the right to receive a copy of the HMIS/CMIS Notice to Clients of Uses and Disclosures.

Maintaining the privacy and safety of those using our services is very important to us. Your record will only be shared if you give us permission to do so. There may be risks and/or benefits for you to consider before you decide whether or not to consent to the release of information.

You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share with other, we must still report some information because of our federal and state requirements.

By writing your initials below, I agree to share the following level of information with other Northwest Social Service Connections' HMIS/CMIS partner agencies:

_____ 1) I agree to share Client Record [Name, SSN, and Veteran Status] and Demographics [including DOB, Gender, Race, and Ethnicity] information via the Northwest Social Service Connections' HMIS/CMIS with other Northwest Social Service Connections' HMIS/CMIS partner agencies.

_____ 2) I do not agree to share any information through the Northwest Social Service Connections' HMIS/CMIS with other Northwest Social Service Connections' HMIS/CMIS partner agencies. I understand that this may affect my involvement with the shared Coordinated Entry, shared wait lists, and accessing services at other partner agencies.

Client Name (*please print*)	Client Signature	Date

Client Name (*please print*)	Client Signature	Date

Names and DOB of minor children for whom I am parent or guardian and am sharing

information (as identified above)

Guardian Name, if required (*please print*)	Guardian Signature (if required)	Date

Agency Personnel Name (*please print*)	Agency Personnel Signature	Date

HOMELESS YOUTH CONTINUUM (HYC) CONSENT FORM and CONFIDENTIALITY DISCLAIMER

Name: _____ Date of Birth: _____

In order for you to obtain the best possible services, several agencies are working together to provide a complete continuum of programs and services to runaway, homeless and transitioning young people.

I understand that I am now applying for service to the Homeless Youth Continuum (HYC). I also understand that by providing information and completing a screening I may become eligible for the services of the following HYC agencies:

• Janus Youth Programs (Willamette Bridge Programs, Harry's Mother, and Insights Teen Parent Program) • DePaul Treatment Centers, Inc. (Project Metamorphosis)	• Native American Youth & Family Center (NAYA) • New Avenues for Youth • Outside In

I hereby give consent to all agencies of the HYC to provide services to me. I understand that this consent becomes effective on the date below and extends until my 25th birthday, unless otherwise revoked.

My initials and signature below indicate that I have read this consent and the following and any of my questions have been answered to my satisfaction.

Initials _____   My rights as a participant, including Confidentiality Guidelines, and my responsibilities to respect the rules, policies, and expectations of each agency, have been reviewed with me.

Initials _____   During or after my term of receiving services, one of the agencies or a qualified research organization working in conjunction with the project may contact me regarding services. Any such contact would be for either the purpose of follow-up, or conducting research and evaluation on service effectiveness and would be governed by Confidentiality Guidelines.

Initials _____   NW Social Service Connections or demographic information for computerized record-keeping

Initials _____   *Confidentiality Disclaimer:* The information I tell any staff from HYC agencies, or their stated partners, will be held in the strictest confidence under most circumstances. Exceptions due to Oregon law and to protect my safety include as follows:

- If HYC agencies have reason to believe I am in danger of hurting myself or someone else. In this case HYC agencies need to ensure my safety and that may mean telling someone else or making a referral to another agency.

- If I give the HYC agencies reason to believe that I or someone I know has been abused as a minor child. The HYC agencies will ask me a number of questions concerning abuse against me or other minors by legal guardians close family members, or any other person. Oregon law requires the HYC agencies to report child abuse. The HYC agencies do this to ensure the safety of me and others, to help the abuser involved to receive treatment, and to protect other youth that may now be living or are in contact with this person.

- If there is a medical emergency and the HYC agencies need to provide necessary information about me to secure treatment for that emergency.

- When disclosure is required by court order or subpoena.

- When disclosure includes information pertaining to a current warrant or run report. The HYC must verify warrant or run status prior to entry and access to any of the shelters. It is the HYC agencies' goal to assist me in clearing any outstanding warrants and to support me so that eligibility for services may be authorized and/or maintained.

_____   _____   _____   _____
Signature   Date   Signature of Witness   Date

_____   _____
Signature of Parent, Guardian, or Authorized Representative (if required)   Date

Revised 7/01/12

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Name: _____ Date of Birth: _____

In order for you to obtain the best possible services, several agencies are working together to provide a complete continuum of programs and services to runaway, homeless and transitioning young people.

I authorize the Homeless Youth Continuum (HYC) and each of following HYC agencies:

• Janus Youth Programs (Willamette Bridge Programs, Harry's Mother, and Insights Teen Parent Program)	• Native American Youth & Family Center (NAYA)
	• New Avenues for Youth
• DePaul Treatment Centers, Inc.	• Outside In

to use and share with one another any and all information about me on an as needed basis only and in accordance with Federal Law (CFR 42 Part 2), including but not limited to social, psychological, economic, medical, employment and educational information, and the following information if I place my initials in the applicable space next to the type of information:

Initials _____ Alcohol and other drugs diagnosis, treatment, or referral information

Initials _____ Mental Health diagnosis, treatment, or referral information

Initials _____ NW Social Service Connections or demographic information for computerized record-keeping

(I understand HYC staff will not share information about my HIV/AIDS status, diagnosis, or treatment without my specific written consent.)

This information will be used and shared for the purpose of diagnosis and evaluation, treatment, planning, ongoing coordination, training, interagency referral and computerized demographic information record-keeping.

I also understand that the HYC agencies participate in on-going training coordinated by Multnomah County in which confidential information may be shared and therefore authorize HYC agencies to release data collected through the HYC agencies, including demographic information, services provided and outcomes, to Multnomah County and other data evaluation systems. Multnomah County has agreed to use this information for contract monitoring and evaluation purposes only and to never publicly release data that would allow an individual client to be identified unless: a) an agency or individual contributes funds to the program and the information is to be used for contract monitoring and evaluation purposes only; b) an agency or individual is a HYC member; or c) it is required by law.

I understand that except as otherwise indicated in this authorization, the information obtained or shared after signing this authorization may be redisclosed and no longer be protected under federal law, but that federal or state law may restrict redisclosure of mental health and alcohol and other drug diagnosis, treatment or referral information. The HYC and its participating agencies acknowledge that any information shared among agencies will not be released to other parties without my further written authorization unless permitted or required by law as described in the Confidentiality Guidelines.

I understand that this authorization becomes effective on the date below and extends until my 25th birthday, unless otherwise revoked.

I understand that I may refuse services at any time and that I may revoke this authorization at any time, and if revoked the information described above may no longer be used or disclosed for the purposes described in this written authorization, except to the extent that action has already been taken in reliance on the authorization. The revocation of this consent is effective upon receipt by the HYC of my written or verbal notice of revocation. I understand that I have the right to see my demographic information record if requested.

My signature below indicates that I have read this authorization and I understand it.

_____ _____ _____ _____
Signature   Date   Witness   Date

_____   _____
Signature of Parent, Guardian, or Authorized Representative   Description of Authorized Representative's Authority
             (if required)
                                                                        Revised 07/01/12

Agency Participation Agreement

VESTA® is a *community database application* of The Partnership Center, Ltd. (PCL). With this participation agreement, «Agency_name» ("Agency"), has agreed to use VESTA software as part of the community database effort.

VESTA is used in a variety of ways throughout the Greater Cincinnati Community. With the initialed lines below the Agency agrees that it is using VESTA under the following licenses and in accordance with the license holder's policies and procedures for data collection and data sharing:

_____ As part of the Cincinnati/Hamilton County Continuum of Care for the Homeless' Homeless Management Information System (HMIS). Strategies to End Homelessness (STEH) licenses VESTA for all organizations participating in HMIS. Data entered into any project required or requesting to use VESTA as part of HMIS is subject to the HMIS Policies and Procedures as established by the Cincinnati/Hamilton County Continuum of Care (CoC) via the VESTA Advisory Board which are subject to review and approval by the CoC lead agency, Strategies to End Homelessness and/or the Homeless Clearinghouse.

_____ As part of United Way of Greater Cincinnati's Impact Measurement Initiative, United Way licenses VESTA for organizations funded to provide specific service or with funds administered by United Way. Projects using VESTA under this license are subject to the rules established by the VESTA Advisory Board subject to review and approval by United Way of Greater Cincinnati.

As part of PCL's commitment to a common Community Database, agencies that have projects entering data in VESTA, either through the license held by either United Way or by STEH, may also elect to have any or all of the other projects of the Agency enter data into VESTA. Data entered into these projects are subject to the overall policies and procedures established by the VESTA Advisory Board.

The most current VESTA Policies and Procedures as required for HMIS and/or the United Way are posted on-line at www.partnershipcenter.net.

VESTA System

VESTA is owned and operated by PCL. The Agency acknowledges that it has no rights to ownership of the VESTA software or code. The Agency and its employees are prohibited from, and have no right to sell, distribute, or transfer the original or any copy of the software, VESTA educational materials, or VESTA tools. Further, the Agency is not permitted to allow any unauthorized non-licensed third party access to, or use of the software, without receiving prior permission from PCL.

PCL will maintain the hardware and software required to support VESTA for community wide use, perform regular data backups of all data stored in VESTA, and comply with industry standards for data security. In general, the data and the software will be available for access 24 hours per day. VESTA may be unavailable for short periods once a month to conduct standard maintenance and/or system upgrades. PCL will make every effort to provide advance notice to users, if and when the system will be unavailable, and to make all upgrades in off peak hours. Users will be notified of system upgrades or changes.

VESTA and the local CoC implementation of VESTA are provided to the U.S. Department of Housing and Urban Development under contract by PCL as the National HMIS Data Lab. As the National HMIS Data Lab, VESTA is maintained to the highest possible standards and many of the national HMIS standards and programming methods are developed through VESTA. High quality reporting and leading methods of data collection and analysis are available through VESTA to the community free of charge as part of this arrangement. As the Data Lab, aggregate information from all projects using VESTA as part of the HMIS implementation are used by HUD and the HMIS Federal Partners for research and policy work. No personal

Identifying information on clients is ever provided through the National HMIS Data Lab to any federal partner, program, or person.

Data

All data entered into VESTA is owned by the Agency entering the data. Individual client-level data about all persons served by the Agency may be entered into VESTA. The Agency may view, enter, and edit all information on their clients within VESTA. They may enter an unlimited number of clients and service records into VESTA. Data entry must adhere to data quality, completeness, timeliness, and other policies outlined in the VESTA Policies and Procedures.

The Agency is responsible for supervision of VESTA Users and assuring that security, confidentiality, and data integrity are maintained. The Agency will report any breaches of confidentiality, consent, and actual or suspected misuse of data, or the VESTA software system to PCL immediately. PCL may terminate an individual's User access rights upon violation of confidentiality provisions. If PCL discovers the security breach, the User's account will immediately be suspended and the supervisor and/or agency director will be notified. If the breach involves multiple staff persons, the entire Agency's access may be suspended. Termination of an individual User will not necessarily affect the Agency's overall participation in the system.

As a community database, VESTA enables different agencies to record information about clients and services within a single common software system and to create partnership/data-sharing agreements with other agencies as the Agency determines appropriate. The Agency understands that it is a participant in a community database, and basic demographic information for any client, who has signed a consent form, is shared in common with other VESTA users who are also serving the same client, once the client has entered their project. Project-specific data will not be shared with another agency without the express written consent of this Agency in the form of a signed Partnership Agreement. A VESTA consent form covers the electronic sharing of data through VESTA. The VESTA consent is not a substitute for other Release of Information forms an agency may need or require for workers to share client level information between agencies. It is strongly encouraged that agencies also have a specific policy regarding the storage and electronic sharing of confidential client documents, as these documents can be uploaded, viewed, and downloaded through VESTA.

Client-level identifying information, commonly known as personal identifying information (PII) will not be released by PCL for any reasons other than those required by law. Examples of legally required release may include public health emergency, terrorism/homeland security emergencies, and/or a subpoena by law enforcement officials. PCL may release aggregate data for the purpose of community-wide reporting. PCL will not release any project-specific without the consent of the Agency except as required by law.

Projects and Fields

A standard set of fields is required to be collected on each type of project using VESTA under either the HMIS and/or United Way licenses that enable data collection and reporting based on standards established by funders (United Way, City of Cincinnati – Human Services, Emergency Food & Assistance Program, U.S. Department of Housing and Urban Development, U.S. Department of Health and Human Services, U.S. Department of Veteran Affairs). PCL ensures that all required fields are enabled for each project as funding sources dictate and as Agencies indicate to PCL what funding they are using for projects. PCL will update fields as HMIS Data Standards or United Way specifications change.

Within the framework of VESTA, there is ample room to customize data collection by adding custom forms and fields as required by the Agency or individual projects within the Agency. The Agency may choose to have additional data collection fields created as their project reporting requirements change. The Agency may also authorize multiple projects within the Agency to be set up on VESTA. Project design and set-up work will be provided by PCL under a separate agreement.

Data and Reporting

The Agency may view, enter, and edit all information on their clients within VESTA. They may enter an unlimited number of clients and service records into VESTA.

PCL ensures that all HMIS and United Way reports are written to the standards and methods set by the funders.

The Agency may run an unlimited number of reports in VESTA and export data for other reporting needs. The Agency may choose to utilize standard reports built into VESTA or to have specialized/custom reports designed for their project(s). Reports may be built based on required data fields and/or custom fields that the Agency has specified. Consultation for custom reporting in VESTA is available from PCL.

VESTA Users

A VESTA User is a paid staff person or student intern at an HMIS Agency, or paid or volunteer staff of a United Way licensed Agency, designated by the Executive Director of the Agency to have access to VESTA. The Agency is responsible for identifying users and determining user access levels for VESTA. The Agency maintains full responsibility and liability for their staff and the action of their staff in regard to their use of VESTA. PCL will immediately revoke access privileges or levels for staff pursuant to any request from the Agency. It is the Agencies responsibility to notify PCL when a user leaves employment at the organization or the organization has other reason to terminate an employee's access or access level to VESTA. PCL strongly encourages agencies to educate HR staff regarding employee access to VESTA and to include reviewing and revoking VESTA access, as needed, as part of the agency's exit/termination policies and procedures.

All VESTA Users are required to sign a User agreement at least once per year which outlines their responsibility for the privacy and security of the system and the information contained therein. User agreements expire annually and require renewal. Users will be deactivated if they do not have an active user agreement on file at PCL or are dormant per the VESTA policy.

Each VESTA User has a unique username, password, and PIN (Personal Identification Number) that governs the security level for that VESTA User. VESTA Users may not share their account, username, password, or PIN with any other person. Any person found sharing any of these security items with any other person will be immediately terminated as a VESTA User and will not be eligible for reinstatement.

Prior to receiving their username and password all VESTA Users are required to be trained by PCL. PCL will provide either group or one-on-one training depending on the number of Users the agency has becoming operational at one time. Training is included in the license and annual fee the organization pays to participate in VESTA and therefore is provided free of charge. If PCL schedules one-on-one training on-site at the Agency location and the trainee fails to attend, and does not call, or have their Agency call to cancel the training, a $25.00 fee will be assessed to the Agency for each scheduled User failing to be present.

System Hardware, Software, and Connectivity

Agencies are responsible for purchasing and maintaining computer hardware, operating software, networking, and internet access systems that enable VESTA operation. All computers that access VESTA must have up-to-date anti-virus software installed and running on the system at all times it is in operation. Because of the confidential nature of data stored within VESTA and its use as a community database application, PCL, in accordance with the policies of the VESTA Advisory Committee, requires that the system must be accessed from a private or semi-private location.

Volunteers, students, and staff levels are identified by the Agency. Volunteers and students using VESTA will only be allowed to access VESTA on a secure computer at the Agency's location which has a digital certificate installed on the computer. If the Agency has volunteers, students, or other staff that require such security levels, it is the responsibility of the Agency, and Agency's Information Technology staff, to allow and support administrative access by the PCL user support team to the individual computer that will need the certification placed on it.

VESTA has a variety of tools that may be used by the Agency, based on specific needs. These include: VESTACard (a scan card system); VESTADocup (a document storage system built into VESTA); VESTAe-sign (an e-signature system enabling electronic consent and other document signing), VESTAClient (a secure way for clients to access their records in VESTA to facilitate messaging, chores, etc.); a Bed Finder (facilitating placement in the organizations beds through the Central Access Point); Red Folder module (a method to link client records stored on the agency's server to the client's record on VESTA), and a Back Office system (enabling financial payments to be made for client level activities). Each of these features is available to the Agency based on need. PCL will provide the functionality within VESTA to make these features operational, and depending on the nature of use and funding, may also be able to provide initial hardware. Initial setup may require the

support from Agency's Information Technology associates. The on-going operation, support, maintenance, and replacement of all hardware associated with any of these features is the responsibility of the Agency.

Eligibility and Termination

This agreement will automatically renew annually unless PCL or the Agency elect to terminate the agreement. PCL will renew all agreements in accordance with the HMIS and United Way licenses unless the Agency has been found in serious breach of security issue(s) and/or the licensing agency no longer includes the Agency or their project under its umbrella.

The Agency may terminate their participation in VESTA at any time. Upon request, PCL will provide the Agency one copy of all data entered by the Agency into VESTA, up to the date of termination, in the form of a Microsoft Access database or .CSV file, whichever is the most reasonable considering data volume and complexity. The original data already in the system will remain in the system; will continue to be used in aggregate reporting and for client searches (based on consent and limited to basic client information); and cannot be removed. Fees paid will not be refunded. The Agency understands that if they are operating a project under the HMIS and/or United Way licenses, and elect to terminate, participation projects which require participation for funding may be jeopardized by their termination.

PCL maintains the right to temporarily shut off access to any Agency, project, or individual who has breached any confidentiality provisions of this Agreement or of the Policies and Procedures associated with their User Agreement and/or License. PCL will seek advice and ruling of the VESTA Advisory Board regarding the appropriate sanctions and processes for continued use or disconnection, including but not limited to termination of participation.

Fees

Annual licensing fees for VESTA are provided by Strategies to End Homelessness, under a grant from the U.S. Department of Housing and Urban Development specifically for HMIS, and from United Way of Greater Cincinnati for projects required to use VESTA as part of the funding agreement with United Way (including other funds administered by United Way, such as City of Cincinnati Human Services funding). The licensing fee provides the Agency with:

a. VESTA Software, fully compliant with all HMIS Data and Technical standards and United Way requirements.
b. Software updates – no less than three times per year.
c. Report functionality for Funder Reports including: HMIS Reports for HUD, HHS, and VA programs; United Way Reports for EA, Emergency Food and Shelter Board, City of Cincinnati General Fund, and Basic Demographic.
d. Report functionality for Universal reports including: Active Client List, Bed night list, Export via Access, and CSV.
e. VESTA Advisory Board oversight of Emergency Assistance and HMIS implementation.

A contract with PCL, by Strategies to End Homelessness, funded under a grant from the U.S. Department of Housing and Urban Development, and matched with Agency fees and other community resources, enables Lead Agency and User Support services. These include:

a. HELP Desk - User Support via telephone and email, Monday - Friday 9-5.
b. New user training for all HMIS and United Way projects
c. Free classroom training on basic and advanced database use skills.
d. Troubleshooting and basic research into database support for project specific needs.
e. Annual monitoring of all HMIS and EA projects. Under the HMIS contract, PCL's role in HMIS may be broader than the role PCL plays in the Agency's non-HMIS projects. PCL is under contract with Strategies to End Homelessness, Inc. as the HMIS system administrator. As such, PCL will perform data quality assurance and security checks; utilize the data for system administration; provide technical support, auditing, and research; and maintain system compliance with legal and regulatory requirements for HMIS systems.

There are some fees associated with VESTA that are the agencies responsibility. All Agency fee schedules are posted on the PCL website at: www.partnershipcenter.net. PCL provides the VESTA Advisory Board its fee schedule annually for review and comment.

a. Each project of the Agency using VESTA is charged a fixed annual per-project fee. If PCL determines that splitting a project into separate projects for data entry/data maintenance purposes (e.g. quick services) it will waive the fee for the additional project. PCL does not charge a fee for the Agency's Front End Project.

b.   A one-time set up fee is charged for all new standard projects beginning to use VESTA. Standard projects are those that use the basic HMIS and/or United Way required fields, other standard VESTA forms, standard reporting, and require very minor customization.

c.   Customization of an existing project (adding forms, fields, or functionality), extensive design and/or development work for a new project, or reconfiguration of an entire Agency in VESTA are available and will be individually quoted by PCL based on the Agencies needs and scope of services required.

d.   Custom report design and/or development will be charged to the Agency based on the actual amount of time spent to develop and code the report. If a custom report required by an agency was developed for another agency, it will be provided to the Agency free of charge as a benefit to sharing in a community software system.

e.   Agencies may elect to have additional training on VESTA or training customized to its specific needs. PCL will work with the Agency to establish a fee, if necessary, prior to training.

An Agency who does not pay their VESTA Fees within three months of billing and who have not contacted the PCL President to make other financial arrangements will be terminated from VESTA and the appropriate licensing organization will be advised.

Signatures
The above named Agency agrees to all terms associated with this Agreement.

Signature _____   Signature _____

Printed name _____   Michelle Budzell
                                     Printed name

Title _____   President, The Partnership Center, Ltd.
                             Title

Date _____   Date _____

MEMORANDUM OF UNDERSTANDING

Implementation of Revised System Wide Performance Targets and Minimum Standards

The City of Seattle Human Services Department, the City of Seattle Office of Housing, the King County Department of Community and Health Services, and the United Way of King County (the Funders) enter into this Memorandum of Understanding ("MOU") as collaborative partners to implement System Wide Minimum and Target Standards for Homeless Investments and Funding Processes.

I.   Description of Partner Funders

Homelessness Services Funders:
The Seattle Human Services Department (HSD) is one of the largest contributors to Seattle's safety net as it provides $89 million in funding through 450 contracts to nearly 200 agencies that support Seattle's most vulnerable residents each year. The city of Seattle is committed to addressing the homelessness crisis in Seattle and HSD invests nearly $50 million dollars in services to address homelessness. The Human Services Departments investments include contracts for Emergency Shelter, Transitional and Rapid Re-Housing, Permanent Supportive Housing, Prevention and Diversion Services, Case-Management and Food Programs.

The mission of the King County Department of Community and Human Services (DCHS) is to enhance the quality of life, protect rights and promote the self-sufficiency of our region's diverse individuals, families and communities. The Homeless Housing Program within DCHS administers and oversees funding for housing stability and services programs for families and individuals in King County. The program invests $37 million dollars annually to address homelessness in our community.

The United Way of King County's mission is to bring caring people together to give, volunteer, and take action to help people in need and solve our community's toughest challenges. The United Way is committed to addressing homelessness and has established a goal to reduce the number of unsheltered people by 50%. The United Way invested $8.8M to support efforts to address homelessness over the last fiscal year.

Housing Capital Funders:
The Seattle Office of Housing provides capital and operating funding for development and preservation of affordable housing in Seattle. The Seattle Housing Levy, the Office of Housing's largest fund source, dedicates at least 60% of rental program funds to housing serving extremely low-income residents below 30% AMI, including homeless households. The Office of Housing anticipates investing $34 million in capital funds in 2016.

The Housing Finance Program within the King County DCHS provides capital funding for affordable housing, including housing for homeless households, throughout King County. The Housing Finance Program anticipates investing nearly $10 million in capital funding towards homeless housing in 2016.

II.   Background

The federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act requires that each Continuum of Care (CoC) establish targets and show annual progress in achieving those targets and reducing homelessness.

In 2013, the Seattle/King County CoC established CoC System Wide Performance Metrics for: 1) Exits to Permanent Housing, 2) Length of Stay, and 3) Returns to Homelessness that each program aspires to accomplish. The current CoC targets were developed based on a review of existing project type data taking sub-population distinctions into consideration. The Seattle Human Services Department, King County, and United Way funding contracts all include the current CoC targets language detailing the quarterly monitoring of targets and the consequences of projects failing to meet projected targets. Programs were provided with performance data in both 2013 and 2014 as an initial step toward measuring progress quarterly.

All Home (lead for the Seattle/King County CoC) launched a new Strategic Plan in June 2015 which calls for a continuation and improvement of efforts to measure our progress and adapt practices based on data. As part of the action steps of the Strategic Plan, All Home stakeholders committed to using the System-Wide Analytics and Projection (SWAP) suite of tools to better understand our systems planning and change efforts. King County, the City of Seattle, and United Way of King County jointly funded a consulting contract with Focus Strategies that includes a full system analysis using the SWAP tools. Using our local data, Focus Strategies has made recommendations to realign funding and programming, and to improve investment alignment between King County funders to better support our shared goals to make homelessness rare, brief, and a one-time occurrence.

Focus Strategies recommends that the Seattle / King County CoC revise the current CoC System Wide Targets as follows: move away from an approach grounded in local data to one based on national practices; adopt utilization rate and entries from homelessness as additional standards; eliminate the distinction between overnight and case managed emergency shelters for single adults; adopt standards for transitional housing that reflect a 'bridge' model; and alter the distinctions between sub-populations. Based on the Focus Strategies recommended targets, the proposed System Wide Targets are:

REVISED System Wide Targets					
	Core Outcomes			Entries from Homelessness	Utilization Rate
Project Type	Exit Rate to Permanent Housing	Length of Stay	Return Rate to Homelessness		
Emergency Shelter	50% (S & YYA) 80% (F)	30 days (S/F) 20 days (YYA)	8% (S/F) 5% (YYA)	90%	95%
Transitional Housing	85%	90 days (S/F) 180 (YYA)	8% (S/F) 5% (YYA)	95%	95%
Rapid Rehousing	85%	120 days	3% (S/F) 5% (YYA)	95%	NA
Permanent Supportive Housing	90*	N/A	3% (S/F) 5% (YYA)	95%	95%

*Following HEARTH, the PSH performance standard for Exits to Permanent Housing will be exits to and retention of permanent housing.

In addition, Focus Strategies recommends that for the first time the Seattle / King County CoC adopts minimum standards under which programs who do not meet the minimum standards would not be eligible to receive funding.

	Core Outcomes			Entries from Homelessness	Utilization Rate
Project Type					
	Exit Rate to Permanent Housing	**Length of Stay (days)**	**Return Rate to Homelessness**		
Emergency Shelter	40%(S) 65%(F) 35% (YYA)	90 days (S/F) 30 days (YYA)	10% (S/F) 20% (YYA)	90%	85% (S/F) 90% (YYA)
Transitional Housing	80%	150 days (S/F) 270 days (YYA)	10% (S/F) 20% (YYA)	90%	85%
Rapid Rehousing	80%	180 days	5% (S/F) 20% (YYA)	90%	NA
Permanent Supportive Housing	90%*	NA	5% (S/F) 20% (YYA)	90%	85%

Table title: **NEW System Wide Minimum Standards**

*Following HEARTH, the PSH performance standard for Exits to Permanent Housing will be exits to and retention of permanent housing.

III.   Commitment

Improving system-wide performance increases our ability to make homelessness rare, brief, and one-time in King County. The implementation of minimum standards and revision of current target performance standards provides an opportunity to support this improvement by identifying and rewarding high-performing projects and providing targeted assistance to low-performing projects.

Towards this end, the homelessness services funders -- Seattle Human Services Department, the King County Department of Community and Human Services Homeless Housing Program, and the United Way of King County-- hereby agree to phase in a shift from our current CoC targets to the revised System Wide Targets in the chart above over the next two years, fully implementing by 2018 based on each funder's schedule of funding processes. See Attachment 1.

Effective immediately, new and renewed services contracts will include language reflecting the new system wide targets and minimum standards, and begin to evaluate and provide technical assistance to providers.

In order to implement the new system-wide targets and minimum standards, shifts in project models for transitional housing projects and emergency shelters without case management are needed. Shifts in relevant targets for those project types will be made in accordance with shifts in project models, with a goal to fully implement the recommendations by 2018.

RFI/RFP funding decisions will be based on a model consistent with our **Continuum of Care Notice of Funding Availability (CoC NOFA) ranking system**, adopted by the All Home Funder Alignment Committee. Under this model, for each RFI/RFP:

- o For all funding processes, the CoC evaluation team, acting on behalf of All Home, will create a consolidated ranking of all projects based on performance on the new system-wide targets and minimum standards identified above. The performance ranking will be used by funders for scoring in the RFI/RFP process. The ranking and the process used to create it will be shared on the All Home website. For processes led by a single funder, funder evaluation staff will follow a parallel process.
- o In addition, as part of the application process, agencies will report on their project performance and provide a plan and timeline for improvement where needed.
- o Projects meeting the System Wide Targets in effect at the time of the RFI/RFP will be awarded bonus points.

The Office of Housing and the King County DCHS Housing Finance Program, as housing capital funders, agree to support effective implementation of system wide targets and standards by coordinating with homelessness service funders when awarding capital funding for homeless housing. This coordination will include evaluating provider performance on targets and standards when reviewing applications for capital funding for new homeless housing. Support for implementation of targets and standards will also include activities to revise existing programs to improve performance, such as working with funders and providers to convert to alternative homeless program models, and working with owners to make physical changes to buildings, as necessary and feasible.

The homelessness services funders agree to support funding decisions made by each other and not provide supplemental services funding to a program whose funding has been reduced or eliminated by another funder due to failure to meet minimum standards. The Funders acknowledge that should it be necessary to convert a homeless housing project to serve another extremely low-income population, operating and services funding from sources other than the homeless services system may be required.

V.   Approval

We, the undersigned have read and agree with this MOU. Further, we have reviewed and approve the collaborative effort described here.

Catherine Lester, Director
Human Services Department
City of Seattle
Date: 9 - 6 - 16

Sara Levin, Vice President,
Community Services
United Way of King County
Date: 9/6/16

Adrienne Quinn, Director
King County Department of Community &
Human Services
Date: 9/6/16

Steve Walker, Director
Seattle Office of Housing
Date: 9/6/16

Implementation Timeline

Below is an outline of how each of the Funders will align to our shared 2018 goal that all housing programs will meet at least one of the CORE new system wide targets to be eligible for funding and that 50% of RFP scoring will be based on performance metrics.

Year 1 - 2016			
	County	City	UWKC
Data Review			
	- Project-level performance will be posted quarterly on the All Home website with a one-quarter delay. - As always, providers may review their performance on all metrics other than returns to homelessness at any time.		
RFP's			
	- Include language in all RFPs prioritizing the NEW system wide targets and minimum standards. - 30% of RFP points are dedicated to performance metrics. - Apply CoC Funding Ranking Order process to determine applicants points awarded for performance metrics.	No RFP process in 2016	- Include language in all RFPs prioritizing the NEW system wide targets and minimum standards. - Apply CoC Funding Ranking Order process to determine applicants points awarded for performance metrics.
Continuation Contracts			
	- At contract renewal, projects that do not meet or demonstrate progress on the project – level targets and minimums during 2016 will receive a notification of low performance.		

Year 2 – 2017
Changes from year 1 are underlined

Data Review

- Project-level performance will be posted quarterly on the All Home website with a one-quarter delay.
- As always, providers may review their performance on all metrics other than returns to homelessness at any time.

RFP's

- 40% of RFP points are dedicated to performance metrics.
- Apply CoC Funding Ranking Order process to determine applicants points awarded for performance metrics.
- Projects must meet one of the NEW system wide minimum standards.

Continuation Contracts

- Projects that do not meet or demonstrate progress on the project – level targets and minimums during 2017 will not receive continuation funding in 2018.
- At contract renewal projects must meet at least one of the Core NEW system minimum standards.

Year 3 – 2018
Changes from year 2 are underlined

Data Review

- Project-level performance will be posted quarterly on the All Home website with a one-quarter delay.
- As always, providers may review their performance on all metrics other than returns to homelessness at any time.

RFP's

- 50% of RFP points are dedicated to performance metrics.
- Apply CoC Funding Ranking Order process to determine applicants points awarded for performance metrics.
- Projects must meet one of the core NEW system wide targets.

Continuation Contracts

- Projects that do not meet or demonstrate progress on the project-level targets and minimum standards may not receive continuation funding.
- At contract renewal projects must meet at least one of the Core NEW system minimum standards.

HOMELESS YOUTH CONTINUUM
MEMORANDUM OF UNDERSTANDING – STATEMENT OF COLLABORATION
JUNE 2016

The current Homeless Youth Continuum (HYC) agencies are Janus Youth Programs, Native American Youth and Family Center, New Avenues for Youth and Outside In.

This document solidifies the agreements between the HYC agencies and Multnomah County, while acknowledging that this is a dynamic system that undergoes change to respond to youth need on an on-going basis.

Commitment to the HYC Service Delivery Model

New partners to the collaboration will commit to implement the HYC model as it has been articulated in the provided documents. System services will be delivered in an assertive engagement practice that is rooted in knowledge of positive youth development and adolescent brain development research.

Staff will be expected to engage in cross agency collaboration at both an individual youth and system's level, and will provide culturally competent services to all homeless youth, particularly those in underserved populations. Staff will receive the support and training necessary to be successful in meeting all System expectations in order to fully practice the model.

All partners are committed to on-going evaluation, analysis, and learning in our work together to meet the needs of homeless youth in Multnomah County. Included in this learning is a commitment to continual meaningful input on the part of staff and youth regarding their experience in the system. We agree to work together, ideally with outside funding and an outside evaluator, to continually document and report on the evolution of and progress of the system. We also agree to work cooperatively to evaluate the impact of system changes, including annual reviews and an in-depth evaluation that is presented to the Homeless Youth Oversight Committee.

Commitment to the HYS Procurement Process

Agency's support and fully participate in the procurement process as articulated in the *Notice of Intent*. At a minimum, this means that agency's share with all partners in the System both ownership and decision making responsibilities.

Agency's will participate in good faith during any required negotiations in order to reach consensus among all Continuum providers and will commit to representing a balance between the interests of individual agencies and the interests of the System, where those interests may be oppositional.

Agencies entering into the partnership agree to accept a Human Services Partnership Agreement contract, and all of the resulting expectations and responsibilities that accompany this, with the County.

Commitment to Provide Resources

Agencies will provide at a minimum, 25% cash match and/or in-kind resources match to the total amount of County contracted services awarded to the agency.

As is feasible, the system will participate in collaborative resource development with all other Continuum providers.

Goals of the Partnership

A Human Services Partnership Agreement is a non-traditional contracting relationship between Multnomah County and service providers where the parties participate in a relatively equal manner through shared decision-making processes, contribute significant resources towards mutual goals, share responsibilities for achieving those goals, and accept risk and benefits according to mutually agreed upon arrangements.

Partner Agencies share the following in pursuit of the ultimate goal of providing youth with safety off the streets and assisting them in their transition towards independence:

- Promote community connections & have long term impacts on youth lives;
- Reach underserved youth populations, including youth of color and youth outside of the downtown core;
- Individualize services to youth;
- Allow for the development of population-specific services;
- Use the practices of assertive engagement as a service delivery model;
- Strengthen collaborations amongst homeless youth provider agencies
- Place a large emphasis on staff training and support.

Collaboration and Conflict Resolution

The Continuum Partners have been and continue to be highly collaborative. Joint decision-making and planning occur on an on-going basis at all levels among Continuum staff regarding staffing, program hour coverage, representation at meetings, response to crisis, etc.

Conflicts are resolved at the lowest level possible between partner agencies. With assistance from the Multnomah County HYC Coordinator, many issues are worked out and resolved through the bi-monthly Continuum Planning Meetings. If agreement is not reached at this level, or at the Executive Director level, the issue would be brought before the Homeless Youth Oversight Committee for resolution. If agreement between HYOC members is not reached, the issue would come back to the Department, and/or the Chair for final resolution.

Accountability

Agencies will share full responsibility with all Continuum providers for all aspects of service delivery including but not limited to: staff training and development; staff core competencies; performance expectations and compensation packages; achievement of individual youth and system outcomes; data collection and reporting; comprehensive evaluation administration; communication practices; and, conflict resolution.

The Homeless Youth Oversight Committee (HYOC) is the accountability body for the Continuum, developing policy and providing oversight, advising on long-term system planning, evaluating data, establishing funding priorities, and ensuring system coordination and collaboration.

Statement of Commitment to the Homeless Youth Continuum Partnership/Collaboration

I, _____ have legal authority to commit my agency,
            Name

_____, to the collaboration requirements in order to be considered in partnership with the Homeless Youth Continuum (HYC). On behalf of my agency, I understand that this statement is binding and once made, constitutes an expected commitment by the County. If for any reason the County determines that my agency is unable to fulfill its stated commitment, I understand that my agency's continued partnership with the Homeless Youth Continuum will be jeopardized and may be ended.

_____   _____
Signature of Agency Representative   Date

National Alliance to
END HOMELESSNESS

www.endhomelessness.org
IMPROVING POLICY | BUILDING CAPACITY | EDUCATING OPINION LEADERS
1518 K Street, NW, Suite 410 | Washington, DC 20005
Tel 202.638.1526 | Fax 202.638.4664

<div style="background:cyan">

SAMPLE PREVENTION & DIVERSION ASSESSMENT TOOL

*Includes questions adapted from Hennepin County and Columbus YWCA assessment tools

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This assessment tool, based on Minneapolis/Hennepin County, Minnesota's and Columbus, Ohio's assessment forms, will be of use to communities attempting to determine if a household needs prevention or diversion assistance. This should be administered as soon as a household enters an assessment center to determine if they will need shelter or if they can be assisted and housed without having to enter the homeless assistance system. The prevention segment of this tool should be tweaked based on the community's data on its sheltered population. Prevention assistance should be targeted to those households that most closely resemble the households already in shelter. For more information on prevention targeting, please see the Alliance's paper, Prevention Targeting 101. For more on what shelter diversion is and what the benefits of it are, please read Closing the Front Door: Creating a Successful Diversion Program for Homeless Families.

Instructions for the person administering the tool are in red.

Start by gathering required data to begin HMIS entry and creating an identifier for the household/household members.

Introductory Questions

1. **Are you homeless (living on the street, staying in an emergency shelter or transitional housing program, fleeing domestic violence) or at-risk of homelessness?**

   ☐ Yes ☐ No
   If the household is not homeless or at-risk, refer to other mainstream resources.

2. **Where did you stay last night?**

   ☐ With a friend/family member/other doubled up situation
   Skip to Diversion Questions.

   ☐ A hospital

   ☐ Jail/prison

   ☐ Juvenile detention facility

   ☐ In a hotel/motel

   ☐ In a foster care/group home

   ☐ In a substance abuse treatment facility

   ☐ In my own housing – rental
   Skip to Prevention Questions.

☐ In my own housing – owned
Refer household to foreclosure prevention resources if necessary.

☐ In a car, on the street, or in another place not meant for human habitation

☐ In other housing _____
Ask household to define "other housing."

3. **What brought on your housing crisis?**

☐ Problems with landlord
If yes, ask what specific issues are. Interpersonal? Disputes about the unit? Problems being caused by the tenant? Not paying rent? Make a note of the answer. Use this answer to determine what kind of mediation or conflict resolution is necessary.

☐ Have rental or utility arrears (circle which)
If yes, list amount owed: $_____

☐ Evicted or in the process of being evicted from a private dwelling or housing provided by family or friends

☐ Victim of foreclosure on rental property
If yes, skip to Diversion Questions.

☐ Living in housing that has been condemned
If yes, skip to Diversion Questions.

☐ Unable to pay rent

☐ Experiencing high overcrowding
If yes, determine extent of overcrowding in the unit. If situation seems untenable, skip to Diversion Questions.

☐ Violence or abuse occurring in the family's household
If the household is in immediate danger, refer them to law enforcement and/or the appropriate domestic violence provider.

☐ Other _____
Ask household describe "other."

Diversion Questions

4. **Are you safe in your current living situation?**

☐ Yes ☐ No
If no, but household is otherwise eligible for diversion, divert them to a location other than where they are currently staying and make sure that it is somewhere where the household feels safe.

5. **Is there anyone else you and your family could stay with for at least the next three (3) to seven (7) days if you were able to receive case management services/transportation assistance/limited financial support?**

☐ Yes   ☐ No
Help family think through potential places – with family, friends, co-workers. Have them identify what barriers they think exist to staying in a certain location and how they might be overcome.

If answer to this question is yes, household qualifies for diversion assistance. Skip to Concluding Questions.
If answer to this question is no and shelter diversion has therefore been ruled out, go to Prevention Questions.

Prevention Questions

6. **Are you safe in your current living situation?**

   ☐   Yes   ☐ No

   If no, admit or refer to emergency shelter.

7. **Do you believe you will become homeless within the next seven (7) days?**

   ☐ Yes   ☐ No

   At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

8. **Have you ever been to a shelter or another homeless assistance program before?**

   ☐ Yes   ☐ No

   At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

9. **If you answered yes to the previous question, what was the name of the program?**

   _____

   When were you last there?   _____/_____/_____

10. **Household income is at or below 30 percent of AMI**

    ☐ Yes   ☐ No

    If the community has data on sheltered households, they should adjust the percentage accordingly. At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

11. **Has household experienced homelessness in the last 12 months?**

    ☐ Yes   ☐ No

    At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

***If community has data on sheltered households available, it should use this data to shape the development of this assessment tool and add more questions as more information on sheltered households becomes available. In every case that the household being assessed matches a sheltered household, one point should be added (e.g., if most households entering shelter are exiting jail or prison, and the household being assessed is exiting jail or prison, they should receive one additional point). The total points needed to be eligible for prevention should be adjusted accordingly as additional questions are added to this tool. Some examples of questions to be added:

- Prior living situation matches most common prior living situation of sheltered households (look at response to question two)
- Trigger of housing crisis matches most common housing crisis for sheltered households (look at response to question three)
- Household composition matches that of sheltered households (singles vs. families, age of head of household, number of children, etc.)

Total Prevention Points: _____

Provide prevention assistance if household has at least three points (remember to adjust the number of points necessary if adding additional questions).

Concluding Questions – Case Manager Only

1. **Does client qualify for diversion assistance?**

   ☐ Yes ☐ No
   If no, attempt to make appropriate referrals to other available community/mainstream resources.

2. **If so, what kind of assistance do they need initially to be successfully diverted?**

   ☐ Landlord mediation

   ☐ Conflict resolution with potential roommate

   ☐ Rental assistance (Amount _____)

   ☐ Utility assistance (Amount _____)

   ☐ Other financial assistance (Amount _____)

   ☐ Other assistance (Define: _____)

3. **Does client qualify for prevention assistance?**

   ☐ Yes ☐ No
   If no, attempt to make appropriate referrals to other available community/mainstream resources.

4. **If so, what kind of assistance do they need initially to be successfully diverted?**

   ☐ Landlord mediation

   ☐ Conflict resolution with potential roommate

   ☐ Rental assistance (Amount _____)

   ☐ Utility assistance (Amount _____)

   ☐ Other financial assistance (Amount _____)

   ☐ Other assistance (Define: _____)

This concludes the assessment.
See next page for the follow-up form.

Follow-Up Form (Case Manager/Assessment Staff Only)

1. **Was the household diverted from entering shelter? (If no, skip to question two).**

   ☐ Yes ☐ No

   If yes, to where:

   ☐ Friend's house

   ☐ Family member's housing

   ☐ Previous housing

   ☐ Other (please describe): _____

   How long were they in this housing? Number of days: _____

2. **Did the household receive prevention assistance?**

   ☐ Yes ☐ No

   What type?

   ☐ Utility assistance in the amount of $_____

   ☐ Rental assistance in the amount of $_____

   ☐ Security deposit in the amount of $_____

   ☐ Moving costs in the amount of $_____

   ☐ Other $_____

   After 30 Days…

   1. **Did they find permanent housing?**

   ☐ Yes ☐ No

   After 90 Days…

   1. **Have they come back to shelter/the homeless assistance system since being diverted?**

   ☐ Yes ☐ No

   2. **Are there whereabouts known?**

   ☐ Yes ☐ No

3. If they are known, where do they live currently?

☐ Remained in initial housing

☐ Relocated to different permanent housing unit

☐ In homeless assistance system

4. **If they "remained in initial housing" or "relocated to different permanent housing unit," how long have they been there? Number of Days: _____**

With support from the Conrad N. Hilton Foundation and the W.M. Keck Foundation, CSH commissioned Dr. Eric Rice to develop a **TAY Triage Tool** for prioritizing homeless transition age youth (TAY) age 18-24 for supportive housing. The tool was developed in consultation with providers of housing and services to homeless youth, consultation with stakeholders from youth systems of care, and site visits with six providers of permanent supportive housing to youth. Data from Rice's NIMH-funded survey of 646 homeless youth, recruited from drop-in centers in Los Angeles from 2011 to 2012 was used to conduct the subsequent analyses. The results of the analysis were then vetted with both sets of stake holders. The resulting tool consists of six items.

The six items are:

1. Have you ever become homeless because: I ran away from my family home, group home, or foster home;
2. Have you ever become homeless because: There was violence at home between family members;
3. Have you ever become homeless because: I had differences in religious beliefs with parents/guardians/caregivers;
4. How old were you when you tried marijuana for the first time?;
5. Before your 18th birthday, did you spend any time in jail or detention?;
6. Have you ever been pregnant or got someone else pregnant?

One of the great benefits of the **TAY Triage Tool** is its ability to quickly and easily identify the most vulnerable youth. With only these 6 items, which are relatively non-invasive, the tool identifies youth who are vulnerable to many problems and suffering from a great many issues.

There were several background characteristics that differed among those youth identified as highest risk (endorsing 4, 5 or 6 of the items) and not identified by the tool. 50% of the highest risk youth reported being a part of the foster care system, compared to 36% of those not. Among those identified as highest risk, 43% do not have a high school diploma or GED relative to 34% not identified. While equal numbers of those identified and those not had legal employment, more of the youth identified as highest risk reported having a job that was "under the table". And perhaps most striking, 87.7% of youth identified as highest risk reported having biological children compared to only 39.5% of those who were not identified.

Some current substance use was significantly higher among those who were identified as highest risk. In particular, any use of methamphetamine in the prior 30 days was reported by 40.9% of youth identified as highest risk, relative to only 23.7% among those unidentified. Using marijuana more than 40 times in the past month was reported by 66.7% of youth identified as highest risk whereas 45.9% of unidentified youth reported this same level of use.

Mental health problems and traumatic experiences were also more common among those youth identified as highest risk. 66.7% of highest risk youth can be considered depressed whereas 51.2% of those unidentified were depressed. Likewise, posttraumatic stress was reported by 46.7% of those youth identified as highest risk, relative to 30.4% of those who were unidentified. Among those youth identified as highest risk, 64.6% reported physical abuse, 46.7% reported being sexually molested, and 42.6% reported being forced to have sex against their will, compared to 39.5% reporting abuse, 23.3% molestation, and 19% reporting sexual assault, respectively among those youth not identified.

In practical application, we recommend prioritizing homeless youth who score 4 or higher for supportive housing. A guide for utilizing the **TAY Triage Tool** is in development.

Transition Age Youth -

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(TAY-VI-SPDAT)

"Next Step Tool for Homeless Youth"

AMERICAN VERSION 1.0

Eric Rice, PhD

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0
- Family VI-SPDAT V 2.0
- Next Step Tool for Homeless Youth V 1.0

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- F-SPDAT V 2.0 for Families
- Y-SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT assessment product, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

The TAY-VI-SPDAT – The Next Step Tool for Homeless Youth

OrgCode Consulting, Inc. and Community Solutions joined forces with the Corporation for Supportive Housing (CSH) to combine the best parts of products and expertise to create one streamlined triage tool designed specifically for youth aged 24 or younger.

Administration

Interviewer's Name	Agency
Survey Date	
DD/MM/YYYY ____/____/_____	

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname

In what language do you feel best able to express yourself? _____

	LAST 4 DIGITS OF Social Security Number	Consent to participate
		☐ Yes ☐ No

	SCORE:
IF THE PERSON IS 17 YEARS OF AGE OR LESS, THEN SCORE 1.	

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

☐ Shelters   ☐ **Couch surfing**   ☐ **Other (specify):**
☐ Transitional Housing ☐ **Outdoors**
☐ Safe Haven   ☐ **Refused**   _____

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING",   **SCORE:**
OR "SAFE HAVEN", THEN SCORE 1.

2. How long has it been since you lived in permanent stable   _____   ☐ Refused
   housing?

3. In the last three years, how many times have you been   _____   ☐ Refused
   homeless?

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS,   **SCORE:**
AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

B. Risks

4. In the past six months, how many times have you...

   a) Received health care at an emergency department/room?   ____ ☐ Refused

   b) Taken an ambulance to the hospital?   ____ ☐ Refused

   c) Been hospitalized as an inpatient?   ____ ☐ Refused

   d) Used a crisis service, including sexual assault crisis, mental ____ ☐ Refused
      health crisis, family/intimate violence, distress centers and
      suicide prevention hotlines?

   e) Talked to police because you witnessed a crime, were the victim ____ ☐ Refused
      of a crime, or the alleged perpetrator of a crime or because the
      police told you that you must move along?

   f) Stayed one or more nights in a holding cell, jail, prison or juvenile ____ ☐ Refused
      detention, whether it was a short-term stay like the drunk tank, a
      longer stay for a more serious offence, or anything in between?

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR   **SCORE:**
EMERGENCY SERVICE USE.

5. Have you been attacked or beaten up since you've become   ☐ Y   ☐ N   ☐ Refused
   homeless?

6. Have you threatened to or tried to harm yourself or anyone ☐ Y   ☐ N   ☐ Refused
   else in the last year?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM.   **SCORE:**

7. Do you have any legal stuff going on right now that may result   ☐ Y   ☐ N   ☐ Refused
in you being locked up, having to pay fines, or that make it
more difficult to rent a place to live?

8. Were you ever incarcerated when younger than age 18?   ☐ Y   ☐ N   ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR LEGAL ISSUES.   SCORE:

9. Does anybody force or trick you to do things that you do not   ☐ Y   ☐ N   ☐ Refused
want to do?

10. Do you ever do things that may be considered to be risky like   ☐ Y   ☐ N   ☐ Refused
exchange sex for money, food, drugs, or a place to stay, run
drugs for someone, have unprotected sex with someone you
don't know, share a needle, or anything like that?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION.   SCORE:

C. Socialization & Daily Functioning

11. Is there any person, past landlord, business, bookie, dealer,   ☐ Y   ☐ N   ☐ Refused
or government group like the IRS that thinks you owe them
money?

12. Do you get any money from the government, an inheritance,   ☐ Y   ☐ N   ☐ Refused
an allowance, working under the table, a regular job, or
anything like that?

IF "YES" TO QUESTION 11 OR "NO" TO QUESTION 12, THEN SCORE 1 FOR MONEY MANAGEMENT.   SCORE:

13. Do you have planned activities, other than just surviving, that   ☐ Y   ☐ N   ☐ Refused
make you feel happy and fulfilled?

IF "NO," THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.   SCORE:

14. Are you currently able to take care of basic needs like bathing,   ☐ Y   ☐ N   ☐ Refused
changing clothes, using a restroom, getting food and clean
water and other things like that?

IF "NO," THEN SCORE 1 FOR SELF-CARE.   SCORE:

15. Is your current lack of stable housing...

    a) Because you ran away from your family home, a group   ☐ Y   ☐ N   ☐ Refused
       home or a foster home?

    b) Because of a difference in religious or cultural beliefs from   ☐ Y   ☐ N   ☐ Refused
       your parents, guardians or caregivers?

    c) Because your family or friends caused you to become   ☐ Y   ☐ N   ☐ Refused
       homeless?

    d) Because of conflicts around gender identity or sexual   ☐ Y   ☐ N   ☐ Refused
       orientation?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.   **SCORE:**

    e) Because of violence at home between family members?   ☐ Y   ☐ N   ☐ Refused

    f) Because of an unhealthy or abusive relationship, either at   ☐ Y   ☐ N   ☐ Refused
       home or elsewhere?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR ABUSE/TRAUMA.   **SCORE:**

D. Wellness

16. Have you ever had to leave an apartment, shelter program, or   ☐ Y   ☐ N   ☐ Refused
    other place you were staying because of your physical health?

17. Do you have any chronic health issues with your liver, kidneys,   ☐ Y   ☐ N   ☐ Refused
    stomach, lungs or heart?

18. If there was space available in a program that specifically   ☐ Y   ☐ N   ☐ Refused
    assists people that live with HIV or AIDS, would that be of
    interest to you?

19. Do you have any physical disabilities that would limit the type   ☐ Y   ☐ N   ☐ Refused
    of housing you could access, or would make it hard to live
    independently because you'd need help?

20. When you are sick or not feeling well, do you avoid getting   ☐ Y   ☐ N   ☐ Refused
    medical help?

21. Are you currently pregnant, have you ever been pregnant, or   ☐ Y   ☐ N   ☐ Refused
    have you ever gotten someone pregnant?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.   **SCORE:**

22. Has your drinking or drug use led you to being kicked out of   ☐ Y   ☐ N   ☐ Refused
    an apartment or program where you were staying in the past?

23. Will drinking or drug use make it difficult for you to stay   ☐ Y   ☐ N   ☐ Refused
    housed or afford your housing?

24. If you've ever used marijuana, did you ever try it at age 12 or   ☐ Y   ☐ N   ☐ Refused
    younger?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.   **SCORE:**

25. Have you ever had trouble maintaining your housing, or been kicked out of an
    apartment, shelter program or other place you were staying, because of:

    a) A mental health issue or concern?   ☐ Y   ☐ N   ☐ Refused

    b) A past head injury?   ☐ Y   ☐ N   ☐ Refused

    c) A learning disability, developmental disability, or other   ☐ Y   ☐ N   ☐ Refused
       impairment?

26. Do you have any mental health or brain issues that would   ☐ Y   ☐ N   ☐ Refused
    make it hard for you to live independently because you'd need
    help?

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.   **SCORE:**

IF THE RESPONENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1   SCORE:
FOR MENTAL HEALTH, SCORE 1 FOR TRI-MORBIDITY.

27. Are there any medications that a doctor said you should be   ☐ Y   ☐ N   ☐ Refused
    taking that, for whatever reason, you are not taking?

28. Are there any medications like painkillers that you don't   ☐ Y   ☐ N   ☐ Refused
    take the way the doctor prescribed or where you sell the
    medication?

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.   **SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	/1	**Score: Recommendation:**
A. HISTORY OF HOUSING & HOMELESSNESS	/2	0-3: no moderate or high intensity services be provided at this time
B. RISKS	/4	
C. SOCIALIZATION & DAILY FUNCTIONS	/5	4-7: assessment for time-limited supports with moderate intensity
D. WELLNESS	/5	
GRAND TOTAL:	/17	8+: assessment for long-term housing with high service intensity

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ _____ or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the youth at some point in the future
- safety planning

Appendix A: About the TAY-VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT – almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order – or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

The Youth – Transition Age Youth Tool from CSH

Released in May 2013, the Corporation for Supportive Housing (CSH) partnered with Dr. Eric Rice, Assistant Professor at the University of Southern California (USC) School of Social Work, to develop a triage tool that targets homeless Transition Age Youth (TAY) for permanent supportive housing. It consists of six items associated with long-term homelessness (five or more years) among transition-aged youth (age 18-24).

Version 2 of the VI-SPDAT

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool.

Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The TAY-VI-SPDAT – The Next Step Tool for Homeless Youth

One piece of feedback was the growing concern that youth tended to score lower on the VI-SPDAT, since the Vulnerability Index assesses risk of mortality which is less prevalent among younger populations. So, in version 2 of the VI-SPDAT, OrgCode Consulting, Inc. and Community Solutions joined forces with CSH to combine the best parts of the TAY, the VI, and the SPDAT to create one streamlined triage tool designed specifically for youth aged 24 or younger.

If you are familiar with the VI-SPDAT, you will notice some differences in the TAY-VI-SPDAT compared to VI-SPDAT version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.
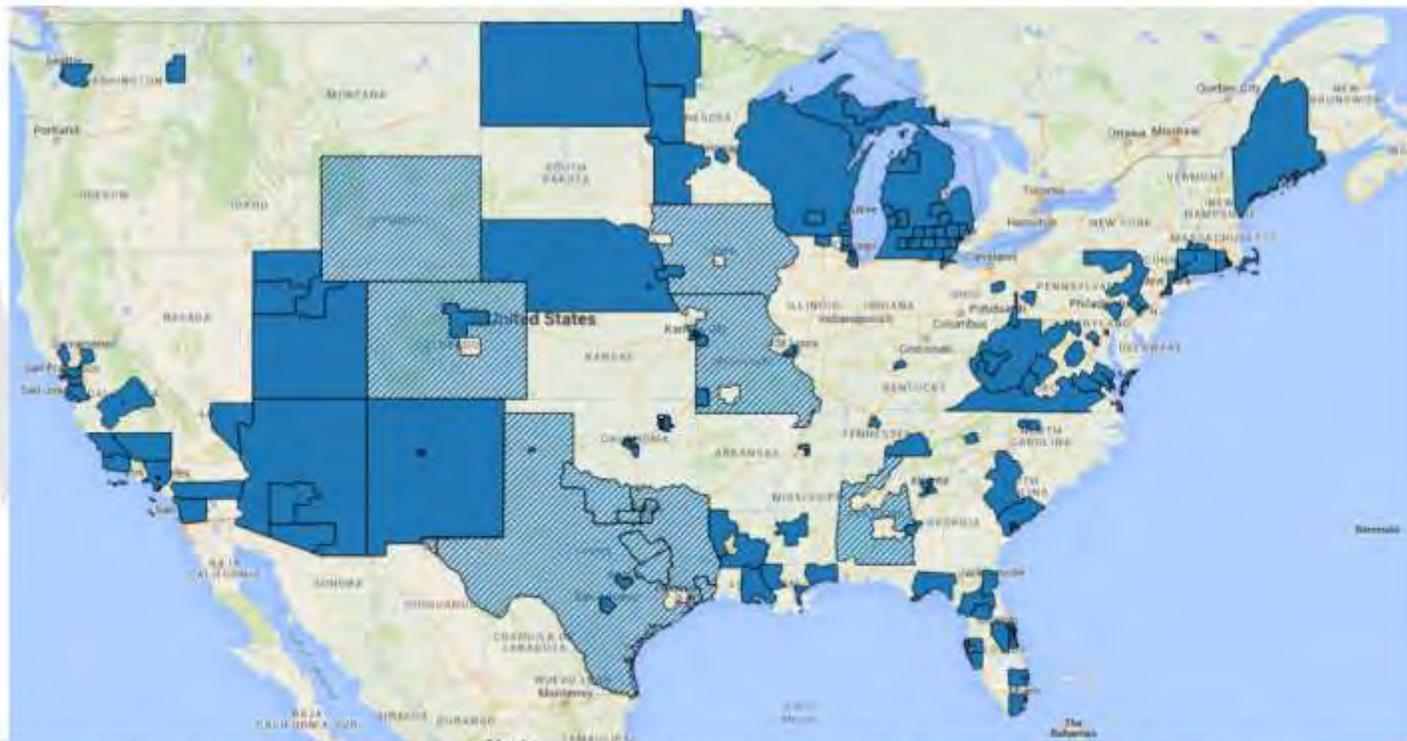
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A partial list of continua of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

California
- San Jose/Santa Clara City & County
- San Francisco
- Oakland/Alameda County
- Sacramento City & County
- Richmond/Contra Costa County
- Watsonville/Santa Cruz City & County
- Fresno/Madera County
- Napa City & County
- Los Angeles City & County
- San Diego
- Santa Maria/Santa Barbara County
- Bakersfield/Kern County
- Pasadena
- Riverside City & County
- Glendale
- San Luis Obispo County

Colorado
- Metropolitan Denver Homeless Initiative
- Parts of Colorado Balance of State

Connecticut
- Hartford
- Bridgeport/Stratford/Fairfield
- Connecticut Balance of State
- Norwalk/Fairfield County
- Stamford/Greenwich
- City of Waterbury

District of Columbia
- District of Columbia

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties
- Tampa/Hillsborough County
- St. Petersburg/Clearwater/Largo/Pinellas County
- Tallahassee/Leon County
- Orlando/Orange, Osceola, Seminole Counties
- Gainesville/Alachua, Putnam Counties
- Jacksonville-Duval, Clay Counties
- Palm Bay/Melbourne/Brevard County
- Ocala/Marion County
- Miami/Dade County
- West Palm Beach/Palm Beach County

Georgia
- Atlanta County
- Fulton County
- Columbus-Muscogee/Russell County
- Marietta/Cobb County
- DeKalb County

Hawaii
- Honolulu

Illinois
- Rockford/Winnebago, Boone Counties
- Waukegan/North Chicago/Lake County
- Chicago
- Cook County

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

Louisiana
- Lafayette/Acadiana
- Shreveport/Bossier/Northwest
- New Orleans/Jefferson Parish
- Baton Rouge
- Alexandria/Central Louisiana CoC

Massachusetts
- Cape Cod Islands
- Springfield/Holyoke/Chicopee/Westfield/Hampden County

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

Missouri
- St. Louis County
- St. Louis City
- Joplin/Jasper, Newton Counties
- Kansas City/Independence/Lee's Summit/Jackson County
- Parts of Missouri Balance of State

Mississippi
- Jackson/Rankin, Madison Counties
- Gulf Port/Gulf Coast Regional

North Carolina
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

New York
- New York City
- Yonkers/Mount Vernon/New Rochelle/Westchester County

Ohio
- Toledo/Lucas County
- Canton/Massillon/Alliance/Stark County

Oklahoma
- Tulsa City & County/Broken Arrow
- Oklahoma City
- Norman/Cleveland County

Pennsylvania
- Philadelphia
- Lower Marion/Norristown/Abington/Montgomery County
- Allentown/Northeast Pennsylvania
- Lancaster City & County
- Bristol/Bensalem/Bucks County
- Pittsburgh/McKeesport/Penn Hills/Allegheny County

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

Tennessee
- Chattanooga/Southeast Tennessee
- Memphis/Shelby County
- Nashville/Davidson County

Texas
- San Antonio/Bexar County
- Austin/Travis County
- Dallas City & County/Irving
- Fort Worth/Arlington/Tarrant County
- El Paso City and County
- Waco/McLennan County
- Texas Balance of State
- Amarillo
- Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties
- Bryan/College Station/Brazos Valley
- Beaumont/Port Arthur/South East Texas

Utah
- Statewide

Virginia
- Richmond/Henrico, Chesterfield, Hanover Counties
- Roanoke City & County/Salem
- Virginia Beach
- Portsmouth
- Virginia Balance of State
- Arlington County

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

Multnomah County Homeless Youth Services Screening

Date of Screening: _____	Time of Screening: _____am/pm	Staff Member: _____	□ - Returning Youth
Location of Screening: □-AC/Shelter □-NAFY □-OI □-NAYA □-Other: _____			Last Exit Date: _____

DEMOGRAPHIC INFORMATION

Participant Name: _____ DOB: ____ / ____ / ____ Age: _____
First Name   Middle Initial   Last Name

Alias: _____ Gender: □ Female □ Male □ Transgender □ Other: _____

Address: _____ **ZIP CODE**
Street Address or P.O. Box   City   State

Phone/Cell Contact: (____) _____ Email: _____

Make a copy of

Age Verification: □ Yes   □ No   If Yes, Identifier Type: _____ # _____ the ID for file.

Social Security Number: ____ - ____ - _____   Primary Language: _____

MULTNOMAH COUNTY (DCHS) Race Identity *(Please mark as many as apply)*:
- □ African
- □ Asian
- □ Black or African American
- □ Latino or Hispanic
- □ Middle Eastern
- □ Native American or Alaska Native
- □ Native Hawaiian or Pacific Islander
- □ Slavic
- □ White   □ Declined to Answer

FEDERAL Race/Ethnicity Questions for HOUSING RELATED PROGRAMS: *(You may choose up to two)*:
- □ Asian
- □ Black/African American
- □ Native American or Alaska Native
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Don't Know
- □ Declined to Answer

What is your ethnicity?
- □ Hispanic/Latino
- □ Non-Hispanic/Latino

Description of Participant: Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Identifying Marks (tattoos, scars, piercings): _____

Referral Source: _____

Have you had past involvement with DHS/SCF/CSD?   □ Yes   □ No   If yes, when? _____

Are you currently involved with DHS/SCF/CSD?   □ Yes   □ No   Case Worker: _____

Have you been arrested, picked up by the police, or spent time in jail or detention before your 18th birthday?   □ Yes = 1   □ No = 0

TAY SCORE

ELIGIBILITY

Do you have a safe, viable place to stay?   □ Yes □ No   If yes, where or with whom? _____

Primary Sleeping Place (in past week): _____   How long have you been on the streets? _____

What was the reason you left your last living situation? _____

YOUTH primary area of residence in the past 6 months: | **Parents'** primary area of residence at the time you left home:
- □ Within Portland Metro area
- □ Outside Portland Metro area, in Oregon
- □ Outside Portland Metro area, not in Oregon

- □ Within Portland Metro area
- □ Outside Portland Metro area, in Oregon
- □ Outside Portland Metro area, not in Oregon

HOMELESS HISTORY

Are you entering from the streets, emergency shelter, or Safe Haven?   □ Yes   □ No

→ *If Yes, indicate approximate start date:* _____

NOTE: OR-501: Portland / Gresham / Multnomah County

Regardless of where you stayed last night, how many times have you been on the streets, in emergency shelter, or in Safe Haven within in the past 3 years (including today)? _____   Total # of months homeless, on streets, or in shelter? _____

Length of time homeless – Status documented?   □ Yes   □ No

Modified October 2016

EMERGENCY CONTACT INFORMATION

Name of Contact: _____ Phone: (____) _____

Address: _____ Relationship: _____

EMPLOYMENT / EDUCATION / MEDICAL HISTORY

Current Employment Status: _____ Are you interested in getting a job?   ☐ Yes ☐ No

Current School Status: _____ Highest Grade Level Completed: _____

Are you interested in continuing/pursuing your education? ☐ Yes ☐ No

When you were attending school, did you have an IEP? ☐ Yes ☐ No   Any special needs? _____

What other agencies have you worked with for services in the past? _____

Health Insurance: ☐ None   ☐ State Children's Insurance   ☐ COBRA
                       ☐ Medicaid (OHP) ☐ Veteran's Administration   ☐ Private Pay
                       ☐ Medicare   ☐ Employer Provided   ☐ State Health Insurance for Adults

DV Survivor: _____   Are you currently fleeing a DV situation? _____ Yes _____ No
* If yes, how long ago did DV episode occur? __1-3 mon __3-6 mon __6-12 mon __12 mon or longer
U.S. Veteran Status: _____ Household/ Family Type: _____

Have you ever become homeless because: TAY SCORE

Was there violence at home between your family members?	☐ Yes = 1 ☐ No = 0	
Did you have differences in religious beliefs with parents/guardians/caregivers?	☐ Yes = 1 ☐ No = 0	
Did you run away from your family home (or foster home)?	☐ Yes = 1 ☐ No = 0	
If you have used marijuana, how old were you when you tried it for the first time? (If 12 or younger, Yes = 1)		

Ongoing Income: _____ $ _____   SNAP/Food Stamps: ☐ Yes ☐ No

                                                   Medication   Not Taking

Prescribed Medications: ☐ Yes ☐ No If Yes, list medications: _____   ☐

On-going health problems: _____ High Risk Diagnosis ☐ Yes ☐ No   TAY SCORE

Have you ever been pregnant or did you get someone pregnant? **(See screening manual.)**   ☐ Yes = 1   ☐ No = 0

YOUTH'S SELF IDENTIFIED NEEDS/GOALS AT TIME OF SCREENING

Check all that apply:

☐ Safety Services (food, clothing, hygiene)   ☐ Employment/Job Readiness Training
☐ Shelter (Immediate/Crisis)   ☐ Housing (Long Term, Transitional, Independent)
☐ Health Care/Medical Attention/Prescription Assistance ☐ Mental Health Support
☐ Education (GED, HS Diploma)   ☐ Travel/Relocating
☐ A/D Treatment   ☐ Other_____

PRIMARY REFERRAL DESTINATION

Is the youth eligible for Homeless Youth Services?

☐ **NO**	**If youth is NOT ELIGIBLE for HYS, why?** (Check all that apply) ☐ Safety ☐ Sex Offender ☐ Developmental Issues ☐ Age ☐ Legal Status (Warrants, etc.) ☐ Other Resources Available **What is the primary referral destination?** (Check only ONE box) ☐ Adult Homeless Services ☐ Family/Friend ☐ Court / Law Enforcement ☐ Alcohol and Drug Program ☐ Harry's Mother ☐ Mental Health Program ☐ Domestic Violence Shelter ☐ Education / Employment ☐ YBR/Outreach ☐ Transitional Living for Homeless ☐ Hospital / Medical ☐ SCF / DHS / CSD ☐ Other: _____	Total the six TAY questions (1 point for each "Yes" answer). **TOTAL TAY SCORE**
☐ **YES**	**If youth IS ELIGIBLE for HYS, please indicate PRIMARY REFERRAL DESTINATION.** (Check only ONE box) Primary Service Coordination Agency: ☐-Janus ☐-NAYA ☐-New Avenues ☐-OI ☐-Other Youth Escorted to Continuum Agency? ☐ Yes ☐ No ☐ Refused Signed HYC Agreement, Consent & Confidentiality Disclaimer? ☐ Yes ☐ No	

Staff are required to verify run report and warrant status by contacting (503) 988-3489

Run Report: ☐ Yes   ☐ No   ☐ Unable to Verify   Misdemeanor Warrant: ☐ Yes   ☐ No ☐ Unable to Verify
Probation Status: ☐ Yes   ☐ No   ☐ Unable to Verify   Felony Warrant: ☐ Yes   ☐ No ☐ Unable to Verify
If this number is temporarily out of service, you may try the main office number: (503) 988-3475. Please only use this secondary number if absolutely necessary.

Modified October 2016

Homeless Youth System Screening Narrative

Name:		DOB:		Age:		Gender:	
Last Name, First Name, Middle Initial		Month / Day / Year					
Primary Race:		Secondary Race:				Ethnicity:	
Screener:		Screening Location:		Date of Screening:			

Description of Youth	
Immediate Crisis	
Vulnerability	If vulnerability is present and selected, please provide further explanation in the next column.
	Primary:
	Secondary:
	Tertiary:
Housing Status	
Family, Relatives, and Friends	
Mental, Physical Health Issues	
Community Resources	
Engagement and Advocacy	**TRACK** ☐ General ☐ Motivated ☐ Vulnerable

Eligibility Decision & Referral Information

Is the youth eligible for HYS Services:	If YES, where was youth referred:	If NO, where was you referred:

Legal and Identity Information

Does youth have a warrant? If YES, why was the warrant issued?	Is youth an identified Sex Offender? If YES, explain:	Youth identity verified? How was identity verified?

Revised 02.08.12

Screening Narrative Standards

Overall Goal: For all staff involved in screening to gather accurate and consistent information to determine eligibility for HYS Services.

Screening/Eligibility Interview: Generally, Janus Youth Programs (JYP) Access Center Staff and the Native American Youth and Family Center (NAYA) Assertive Engagement Staff are the primary Homeless Youth System (HYS) staff to conduct a screening to determine eligibility.

Purpose of the Interview:
- Determine if youth is elibible for services (age, vulnerability, housing situation, and access to other resources)
- Determine most appropriate (and available) services for youth. This could be the HYS or another rsocial service agency outside of the HYS.

Interview Format: Generally, all written narratives summarizing the screening interview should follow the format outlined below:

1. **Basic demographic information**
   a. age, gender, (and/or gender identity), race, location of screening and staff member conducting screening

2. **Brief description of how the youth presented at screening**
   a. Appearance, hygiene, cognitive functioning, any apparent communication issues (other primarily language than English, etc.), was the youth high/intoxicated, in crisis or experiencing trauma

3. **What is the immediate crisis or issue? What led them to seek out services from the HYS?**

4. **Vulnerability** (The screener will only address the applicable vulnerability issues identified below.)
   a. Age (<15 – High Risk, 16 to 17 – Medium Risk, >18 – Low Risk)
   b. Mental/Emotional Health/Developmental Delays
   c. Medical Issues (e.g. pregnancy, high risk diagnosis, etc.)
   d. Physical Disability
   e. Pregnant and/or Parenting
   f. Suicidiation / History of Severe Self Harm
   g. A/D Abuse
   h. Sexual Abuse/Exploitation
   i. Victimization (factors that may cause youth to be targeted for violence/abuse)
   j. Street Acculturation (Is the youth street savvy?)
   k. Other Community/External Resources Available

5. **Housing Status**
   a. Where have they been staying and for how long (street, camping, friends, couch surfing, etc.)
   b. What has been their history of housing (housing instability)
   c. Describe current housing situation (if unsafe, describe conditions that make their housing situation unsafe)

6. **Family/Relatives/Friends**
   a. What is their history with family (family could include relatives other than immediate family members, close friends, foster care providers, etc.). When did they have contact last?
   b. When did they live with family members, what is their current relationship, do they have the ability to return to family?

7. **Mental and Physical Health Issues, Abuse History, Criminal Justice Involvement**
   a. Brief assessment of their mental and physical health
   b. Abuse history (including physical, emotional and sexual abuse, involvement in sexual exploitation activities)
   c. Substance use/abuse history, current use patterns, drug of choice, when did they last use
   d. Criminal justice involvement (warrants will be verified)

8. **Community Resources** (mental health, alcohol and drug, development disability, DHS, schools, etc.)
   a. What other people/agencies has the youth had contact with in the past? (Include staff names and phone numbers if known.)

9. **Engagement and Advocacy**
   a. What is the youth's stated readiness/interest in working on the common goal areas: employment, education, housing, mental health and alcohol and drug treatment?

10. **Eligibility Decision and Referral Information**
    a. Initial Eligibility Determination: Is youth eligible for services? (Yes/No)
    b. Referral Information:
       - **If eligible for HYS services,** where was youth referred, how was the connection made to the referral agency, priority for AE services (vulnerability issues), etc.
       - **If NOT eligible for HYS services,** where was youth referred, assistance provided, contact made with the other referral source to transition youth to other program and/or service.

Revised 02.08.12

VULNERABILITY CRITERIA

Eligibility does not equal access to AE Team services. Access Center screeners use the screening process/paperwork to determine eligibility and willingness to engage according to three distinct tracts of service delivery:

1) **General Eligibility:** Youth who meet the HYC homelessness eligibility criteria and are willing to make a time commitment to engage in services. These are youth who meet the baseline vulnerability of homelessness and who lack stable/viable community resources. Services include shelter, day program access for meals & hygiene, leverage services, etc. These youth may be pre-contemplative, however as they become more motivated toward contemplation and an action plan to meet specific goals they may request AE Team services at their primary referral agency.

2) **Vulnerable Eligibility:** Youth who meet the HYC homelessness eligibility criteria and are willing to make a time commitment to engage in services AND present with factors that increase their vulnerability beyond baseline homeless vulnerability. Services include shelter, day program access for meals & hygiene, leverage services and AE case management as soon as it is available. The following factors are considered when determining level of vulnerability:

- Age

- Level of A/D abuse

- Developmental Delays and/or Mental Health Needs

- Lack of Resources

- Medical Issues (pregnancy, high risk diagnoses, disabilities, etc.)

- Mental/Emotional Health

- Risk of Sexual Exploitation/Abuse/CSEC

- Level of Street Acculturation

- Suicidation

- Other Factors That May Increase Trauma/Victimization

3) **Motivated Eligibility:** Youth who meet the HYC homelessness eligibility criteria, are willing to make a time commitment to engage in services, AND present as highly motivated to move through the continuum of care as quickly as possible with minimal support. This is typically for youth who present with a well-developed action plan, such as waiting for verified imminent housing and/or employment, Job Corps placement, military deployment, family reconciliation, etc. but who may benefit from temporary support in the interim. Services include shelter, day program access for meals & hygiene, leverage services and AE case management as soon as it is available.

Revised March 2014

HMIS Capacity Assessment Tool

This tool is designed to help CoC and HMIS staff assess if a HMIS
meets the community's data collection and usage needs.

	Description	Yes	No	Notes
	Client Data Collection			
1	Client intake			
2	Needs assessments			
3	History of services provided			
4	Resources directory to provide information and make referral, an I&R application			
5	Client financial worksheets			
6	Case management (needs assessment)			
7	Program entry and exit history			
8	Referral management (referral type, follow up, status)			
9	Client follow-up			
10	Capacity to record family and household relationships			
11	Collection of socio-demographic information			
12	Assessments for determining client self-sufficiency			
13	Does the software collect all of the HUD Program Descriptor Data Elements (see worksheet labeled PDDE Assessment)?			
14	Does the software collect all of the HUD Universal Data Elements (see worksheet labeled UDE Assessment)?			
15	Does the software collect all of the HUD Program-Specific Data Elements (see worksheet labeled PDE			
	Functionality to Support Case Management			
16	User friendly interface			
17	data			
18	Reminder capability ("tickler")			
19	Print capabilities			
20	Process for flagging incomplete records			
	Data Sharing			
21	Capability to share client level data across programs or agencies.			
22	Flexible data sharing capability so that clients and agencies can identify which part or parts of client files can be shared.			
23	Flexible data sharing capability so that clients and agencies can identify the agencies with which information can be shared.			
24	Capacity to set time limits on the sharing of client level data or agency information.			

	Description	Yes	No	Notes
	Reporting Capacity and Import/Export Capacity			
25	Built-in standard reports and forms for the U. S. Department of Housing and Urban Development such as the Annual Progress Report/Annual Performance Report (APR), including a report on missing data.			
26	Built-in standard reports and forms for the U. S. Department of Housing and Urban Development such as the Homeless Prevention and Rapid-Rehousing Program (HPRP) Quarterly Performance Reports (QPR), including a report on missing data.			
27	Built-in standard reports and forms for the U. S. Department of Housing and Urban Development such as the Annual Homeless Assessment Report (AHAR), including a report on missing data.			
28	Built-in standard reports and forms for other federal reports and forms, such as the PATH Annual Report or RHYMIS.			
29	Has canned program-level demographic report with numbers and characteristics of clients served.			
30	Has canned program-level data quality assessment reports for analysis and correction.			
31	Has canned Continuum-level data quality assessment and HMIS usage reports for monitoring and compliance.			
32	Ability to generate and save customized reports and forms from within the application **without programmer's assistance** on multiple levels:			
	a. Client and program level reports and forms that permit individual users to build their own reports and forms by choosing fields, sort orders, data ranges, etc.			
	b. Agency level reports that permit reports and forms to be built reflecting data collected by multiple users in multiple programs within a given agency.			
	c. System-wide reports that demonstrate the usage of services based on data collected by multiple users and multiple agencies within the Continuum of Care.			
	d. Communal reports that can be generated by the Continuum of Care, including the HUD Outcome Measures and CoC defined Outcome Measures.			
	e. Reports and forms must be viewable onscreen in a print preview and exportable to PDF, Excel and			
	user-friendly format. Print screen capability is also desirable.			
	g. Flexibility in generating queries to extract information based on specific data elements or configurations of data elements to use with industry standard applications including common databases, spreadsheets, and report writing tools such as Access, Excel, or Crystal Reports.			
	h. Statistical analytic tools.			

	Description	Yes	No	Notes
	Information and Referral, Housing Information			
33	I & R application must adhere to the AIRS Data Transfer Protocols.			
34	I & R application must incorporate the AIRS XML file protocols.			
35	Experience in importing and exporting I&R data from other database systems.			
36	Referral tracking and reporting capacities specific to services referred from I&R application and allowing for tracking from within the client data collection module.			
37	Real-time capability to handle residential logs of bed availability, a bed reservation system, and waiting list capacity.			
38	Capability of handling vacancy and rental information for transitional and permanent housing.			
	Security			
39	Technical safeguards to ensure a high level of client confidentiality, specifically to the:			
	a. Back end server(s) including data encryption and transmission			
	b. User name and password access			
	c. Automatic timeout/logoff			
	d. Read, write, edit and delete capabilities			
	e. Module and sub-module access			
	f. Group level access			
	g. Automated audit trail			
	h. 128-bit encryption and SSL certifications			
40	Compliant with HIPAA and any and all applicable federal, state and local laws and regulations regarding privacy and confidentiality.			
41	Must have capacity to securely manage data stripped of identifiers that is transferred from each agency to an aggregate level database.			
42	Ability to define and redefine levels of access to client information within each agency and the CoC.			
	Systems Integration			
43	Programming: Willingness and experience in customizing automated and manual import/export utilities, with date specification and a transaction			
44	Open programming language that would permit integration and transfer of data between diverse database systems.			
45	Project management: Capability and experience to manage migration of data from legacy systems.			
46	Capability to integrate from multiple databases for communal reporting.			
47	Capacity for import/export data transfer through Comma Separated Values (.CSV).			
48	Capacity for import/export data transfer through Extensive Markup Language (.XML).			

	Description	Yes	No	Notes
	Training & Documentation			
49	Training to ensure successful implementation and continuing operation of the software.			
50	On-line help available and easily comprehended.			
51	Help desk (24 hour or Local Standard Time compatibility 800 toll free number).			
52	Software problem/issue submission and resolution tracking capacity with follow up protocols.			
53	Demo database available for training and testing use. Must be able to be refreshed for sequential training sessions.			
54	Understandable user and system administrator manuals updated to the current version of the software.			
	Software Development			
55	Provisions for receiving and responding to software client feedback on future development.			
56	Provisions for receiving, evaluating, and responding to software fixes.			
	Support & Maintenance			
57	Provisions for ongoing system maintenance.			
58	Technical support and maintenance for web based system hardware and software.			
59	Technical support and assistance for system administrators.			
60	Technical support for system users.			
61	Ability to have on-site technical support for initial implementation of the system.			
62	Unobtrusive maintenance: frequency and nature of upgrades timing of implementation with notification.			
	User-Friendliness			
63	**Rate ease of use of screens for: (1= very easy 2=somewhat easy 3=somewhat difficult 4= very difficult)**			
	a. client intake			
	b. assessment of need			
	c. history of services provided			
	d. identification of resources through Information and Referral (I&R)			
	e. program exit/discharge			
	f. client follow-up (i.e. long term outcomes of			
64	**Rate overall: (1=very satisfied 2=somewhat satisfied 3=somewhat dissatisfied 4=dissatisfied)**			
	a. ease of navigation			
	b. look of HMIS screens			

	Description	Yes	No	Notes
	Vendor History and HMIS Services			
65	Demonstrated successful implementation in HMIS in at least 3 CoCs.			
66	Has sufficient, dedicated support staff knowledgeable of HMIS application.			
67	Help desk availability during shelter operating hours with demonstrated, satisfactory response times.			
68	Technical support for system administrators.			
69	Technical support for system users. (any additional cost?)			
70	Ability to have onsite technical support for initial implementation.			
71	Provisions for ongoing system maintenance. (any additional costs?)			
72	Has understandable user and system administrators manuals updated to the current version of the software.			
73	Has demo database available for training and testing use. Demo DB must be updated with latest version of software upgrades.			
74	Has demonstrated ability to make ongoing product enhancements to comply with industry standards. (any additional costs?)			
75	Has demonstrated, satisfactory response times for fix and patch releases.			
	Costs			
76	Licensing			
77	Support and/or help desk			
78	Training			
79	Add-ons to general HMIS product (PATH reporting, call center management, etc.)			
80	Fees for custom software necessary for reporting			
81	Fees for correction of data (consolidation of duplicate records)			
82	Fees for data imports/exports			
83	Fees for software updates and/or upgrades (new versions, fixes, and/or patches)			

ALL HOME KING COUNTY VISION AND GOALS

Our vision is that homelessness is rare in King County, racial disparities are eliminated, and if one becomes homeless, it is brief and only a one-time occurrence.

On July 1, 2015, All Home will launch a new four-year Community Strategic Plan, A Regional, Aligned, Community Plan to End the Experience of Homelessness among Residents of Seattle/King County to achieve this vision. The plan is a recommitment to our vision of ending homelessness, and to the steps needed to make this vision a reality.

What are Our Goals, Strategies and Outcomes?

The plan has three core goals, strategies to address them, and outcomes to measure progress:

Make Homelessness Rare	Make Homelessness Brief and One-Time	A Community to End Homelessness

Advocacy and action to address the true causes of homelessness, **resulting in**:

- Fewer people unsheltered or temporarily housed
- More people housed and sheltered
- Reduced racial disparities among people experiencing homelessness
- Fewer people exiting institutions directly into homelessness
- Fewer low-income households spending >50% income for housing

Address crisis quickly, and align resources to meet the needs and strengths of people, **resulting in**:

- People experiencing fewer days homeless
- Fewer people losing housing stability once housed
- Increased income
- Reduced racial disparities among people experiencing homelessness

Engage and activate the community, **resulting in**:

- Increased engagement of residents
- Increased leadership of business and faith leaders
- Effective and efficient governance and system infrastructure

Multnomah County Homeless Youth Continuum Logic Model, 2014

Major Program Components	Program Activities	Process Outputs	Exit Client Outcomes (SP)
SAFETY SERVICES	*Services are designed to engage youth and provide safety off the streets*	■ 1,000 youth receive safety services	60% of youth who participate in safety services will enter Assertive Engagement services (SP)
○ Flexible and geographically diverse system access ○ Shelters (Street Light and Porch Light), and day services ○ Other system referrals and linkages ○ Opportunities for engagement	○ Screen youth in a variety of community settings ○ Support youth connections to medical, mental health and/or ATOD treatment ○ Provide overnight shelter ○ Provide day services	○ 250 youth will access short-term shelter ○ 500 youth will access the crisis shelter ○ Daily participation in day programs will average above 40 youth at each location	
RECOVERY-ORIENTED SUPPORT SERVICES	*Recovery Support Services are designed to help youth engage in recovery, connect to treatment services, and provide aftercare support*	■ 800 youth served annually	○ Referrals to Treatment ○ Treatment Connections

○ Provide community-based, culturally responsive, and individualized recovery-oriented supports integrated into HYC
  ➤ A/D, MH, and Co-Occurring Specialists
  ➤ Peer Recovery Supports
○ Maximize community treatment options
	○ Provide recovery engagement, treatment connection & support, and aftercare supports
	○ Offer pro-social recreation (clean & sober activities) and other group recovery support options
	○ Collaborate with community treatment resources
		○ Screening & Assessments
		○ 200 Recovery-Oriented Groups/Activities
		○ A/D & MH Specialist support hours
		  ➤ Treatment engagement, support and aftercare	

ASSERTIVE ENGAGEMENT SERVICES	*Activities use Positive Youth Development and Motivational Interviewing principles*	■ 400 youth receive assertive engagement services (caseload ranges between 15 and 20)	○ 80% of youth have established at least one relationship with a positive adult outside the HYC system (SP) ○ 85% of youth completed at least half of their AE goals (SP) ○ 75% of youth exit to safe stable housing (SP) *To be included in annual report:* ○ % of youth graduated or finished their GED (SP) ○ % of youth enrolled in post-secondary education (SP) ○ % of youth who completed a job training program (SP) ○ % of youth in job training (SP) ○ % of youth employed (SP)

○ Provide opportunities for meaningful community participation
  ○ Individual support provided in or by the community (coaching/mentoring)
  ○ Getting youth's needs met in the community (e.g., accompany to court hearing)
  ○ Prosocial and experiential activities that are community-based
	○ Support and advocate with education, job training and employment opportunities
	○ Support youth connection to experiential learning and leadership projects
	○ Support youth connection to community organizations/resources
	○ Support youth to connect to shelter and other housing options
		○ 80% of youth report multiple opportunities to participate in meaningful community activities & leadership opportunities offered by the Continuum
		○ 60% of AE youth report participating in meaningful community events, activities, experiential learning projects & other meaningful community participation (YS, OR)
		○ 50% of AE youth report participation in leadership opportunities (youth forums, tribal councils, focus groups, mentoring)	

○ Build and strengthen caring relationships	○ Identify social capital in the lives of each individual youth using eco-maps or another approved tool ○ Support youth connection with long-term community relationships ○ AE staff work with youth to establish a supportive relationship using the practice of MI	○ 85% of youth have eco-maps or other social network tool updated every 3 months (OR) ○ 85% of youth will have established a caring relationship within AE team or Continuum Staff (YS)	
○ Have high expectations for what youth can accomplish	○ Use Motivational Interviewing (MI) skills ○ Focus on strengths	○ 100% of AE staff receive annual training in Motivational Interviewing (SS) ○ 85% of youth report AE team has high expectations (YS)	
HOUSING SERVICES	*Youth have access to transitional and permanent supportive housing*	■ 130 are served in the housing program	○ 75% exit Transitional Housing to safe, stable housing (SP) ○ 85% exit Transitional Housing to permanent housing (SP) ○ 70% in permanent housing at 6 month follow-up (SP) ○ 85% in permanent housing at 1 year follow-up (SP)
○ Transitional housing ○ Short-term housing ○ Permanent support housing	○ Support youth connections to safe/stable housing ○ Provide transitional housing and rent assistance ○ Provide permanent supported housing	○ 70 funded by City of Portland ○ 40 funded by HUD ○ 20 targeted by Plan to End Homelessness	

Multnomah County Homeless Youth Continuum Evaluation Tool
FY15-16

System Inputs
- Youth characteristics
- Number of youth served
- System conditions
- Contextual factors

Process Measures
- AE principles
- Core techniques
- High expectations
- Youth directed services
- Flexible services
- Responsive services
- Trauma-informed services
- Integrated system
- System connection
- Continuity of staffing
- Employee support
- Employee satisfaction
- Small AE caseload
- AE frequency of contact

Interim Benchmarks
- Drop-in accessibility
- Shelter accessibility
- Safety services connections
- Recovery-oriented support
- Recovery-oriented participation
- Opportunities
- Community participation
- Leadership participation
- Relationships in the community
- Relationships with HYC staff
- Housing options
- Housing services

Outcomes
- AE engagement
- Treatment referrals
- Completion of goals
- Community connections
- Resilience
- Youth development
- Safe, stable housing
- Permanent housing
- Housing stability
- Secondary education
- Workforce development

CRITERION		MEASUREMENT
SYSTEM INPUTS		
Service Point	YOUTH CHARACTERISTICS[1]	• Age • Gender • Race/ethnicity • Predictive factors
Service Point	NUMBER OF YOUTH SERVED	• Total youth served in HYC • Number of youth served by program area
Sup Survey HYC Focus Group	SYSTEM CONDITIONS	• Changes in HYC resources, providers, ancillary programs, etc. • Changes in state or federal resources or requirements • Changes in local policy landscape (A Home for Everyone, etc.) • Changes in characteristics of youth served • New challenges or opportunities
Sup Survey HYC Focus Group Stakeholder Survey[2] School District Data[3]	CONTEXTUAL FACTORS	• Economic factors, job market, housing market, etc. • Youth not served by HYC

[1] Include an analysis of the youth characteristics by service type (e.g. which youth are screened in, which are deemed ineligible, which youth exit out of safety services, which youth access other program areas, which youth engage in AE, etc.) to see if there are patterns in which youth are being served.

[2] Annual survey of key stakeholders outside of the HYC such as school district homeless liaisons, service providers serving at risk and homeless youth, DHS, etc.

[3] Data on unaccompanied youth comparing: number who are doubled up vs. those who meet HYC criteria, age and demographics compared with HYC youth.

CRITERION		RATINGS / ANCHORS				
PROCESS MEASURES		(1)	(2)	(3)	(4)	(5)
Sup Survey Staff Survey	**AE PRINCIPLES:** All HYC staff demonstrate a clear understanding of AE principles	< 40% of staff demonstrate clear understanding of AE principles	40-55%	56-70%	71-85%	>85% of staff demonstrate clear understanding of AE principles
Staff Survey	**CORE TECHNIQUES:** All HYC staff employed longer than 6 months are familiar with or have received training in the AE model's core techniques such as Motivational Interviewing, Strengths-Based Practice, Positive Youth Development, and Trauma-Informed Care	< 40% of staff receive training in the AE model's core techniques	40-55%	56-70%	71-85%	>85% of staff receive training in the AE model's core techniques
All Youth Survey	**HIGH EXPECTATIONS:** Youth report that staff have high expectations for their future success	< 20% of youth report that staff have high expectations	20-40%	41-60%	61-80%	>80% of youth report that staff have high expectations
AE Youth Survey	**YOUTH DIRECTED SERVICES:** AE youth report that they participate in setting their own goals	< 20% of AE youth report that they participate in setting their own goals	20-40%	41-60%	61-80%	>80% of AE youth report that they participate in setting their own goals
All Youth Survey Staff Survey	**FLEXIBLE SERVICES:** HYC services are flexible to meet youth where they are, and youth get the services that best fit their developmental needs	< 20% of youth and staff report that services are flexible	20-40%	41-60%	61-80%	>80% of youth and staff report that services are flexible
All Youth Survey Staff Survey	**RESPONSIVE SERVICES:** HYC services and supports are responsive to youth's cultural diversity, gender identity, and sexual orientation	< 20% of youth and staff report that services and supports are responsive	20-40%	41-60%	61-80%	>80% of youth and staff report that services and supports are responsive

Staff Survey PSU Assessment	**TRAUMA-INFORMED SERVICES:** HYC services are guided by trauma-informed approaches	< 40% of staff report that services are trauma-informed	40-55%	56-70%	71-85%	>85% of staff report that services are trauma-informed
Sup Survey	**INTEGRATED SYSTEM:** The HYC operates as an integrated network, sharing investment, risk, outcomes, opportunity, and accountability	< 40% of supervisors report the HYC operates as an integrated system	40-55%	56-70%	71-85%	>85% of supervisors report the HYC operates as an integrated system
All Youth Survey	**SYSTEM CONNECTION:** Youth report they know who to talk to in the HYC to get support	< 20% of youth report they know who to talk to in the HYC to get support	20-40%	41-60%	61-80%	>80% of youth report they know who to talk to in the HYC to get support
HYOC Data Report	**CONTINUITY OF STAFFING:** Staffing continuity supports ongoing relationship-building between staff and youth	> 80% turnover in 1 year	60-80%	40-59%	20-39%	< 20% turnover in 1 year
Staff Survey	**EMPLOYEE SUPPORT:** Staff report that they receive the support and supervision they need in order to do their jobs well	< 40% of staff receive the support and supervision they need	40-55%	56-70%	71-85%	>85% of staff receive the support and supervision they need
Staff Survey	**EMPLOYEE SATISFACTION:** Staff feel the work they do is a meaningful and valued part of the HYC	< 40% of staff feel the work they do is meaningful and valued	40-55%	56-70%	71-85%	>85% of staff feel the work they do is meaningful and valued
Sup Survey	**SMALL AE CASELOAD:** AE staff maintain small caseloads of 15-20 youth per AE team member	> 30 youth per AE staff	27-29 youth per AE staff	24-26 youth per AE staff	21-23 youth per AE staff	15-20 youth per AE staff
Chart Review	**AE FREQUENCY OF CONTACT:** AE staff maintain frequent contact with AE youth through face-to-face interactions and/or substantive interactions via phone, e-mail, or text	Average of less than 1 substantive interaction/ month or fewer per youth	1 – 2 / month	3 - 4 / month	5 - 6 / month	Average of 6 or more substantive interactions / month per youth

CRITERION		RATINGS / ANCHORS				
INTERIM BENCHMARKS		(1)	(2)	(3)	(4)	(5)
Safety Services Youth Survey	**DROP-IN ACCESSIBILITY:** Youth in safety services report that drop-in services are easily accessible	< 20% of safety services youth report that drop-in services are easily accessible	20-40%	41-60%	61-80%	>80% of safety services youth report that drop-in services are easily accessible
Safety Services Youth Survey	**SHELTER ACCESSIBILITY:** Youth in safety services report that they know how to access shelter	< 20% of safety services youth report that they know how to access shelter	20-40%	41-60%	61-80%	>80% of safety services youth report that they know how to access shelter
Safety Services Youth Survey	**SAFETY SERVICES CONNECTIONS:** Youth in safety services report they know how to connect to medical, mental health and/or drug and alcohol services and treatment when needed	< 20% of safety services youth report they know how to connect to services and treatment when needed	20-40%	41-60%	61-80%	>80% of safety services youth report they know how to connect to services and treatment when needed
Recovery-Oriented Services Youth Survey	**RECOVERY-ORIENTED SUPPORT:** Youth in recovery-oriented services receive the engagement, treatment connection, and support that they need	< 20% of youth in recovery-oriented services receive the engagement, connection, and support they need	20-40%	41-60%	61-80%	>80% of youth in recovery-oriented services receive the engagement, connection, and support they need
Recovery-Oriented Services Youth Survey	**RECOVERY-ORIENTED PARTICIPATION:** Youth in recovery-oriented services report multiple opportunities to participate in pro-social recreation and other group recovery support options	< 20% of youth in recovery-oriented services report having multiple opportunities to participate	20-40%	41-60%	61-80%	>80% of youth in recovery-oriented services report having multiple opportunities to participate
Youth Survey Staff Survey	**OPPORTUNITIES:** Youth are offered opportunities to participate in community activities	< 20% of youth are offered opportunities to participate in community activities	20-40%	41-60%	61-80%	>80% of youth are offered opportunities to participate in community activities

		< 20% of youth participate in community activities	20-30%	31-40%	41-50%	>50% of youth participate in community activities
Youth Survey	**COMMUNITY PARTICIPATION:** Youth participate in community activities	< 20% of youth participate in community activities	20-30%	31-40%	41-50%	>50% of youth participate in community activities
Youth Survey	**LEADERSHIP PARTICIPATION:** Youth participate in leadership experiences	< 20% of youth participate in leadership experiences	20-27%	28-33%	34-40%	>40% of youth participate in leadership experiences
Youth Survey	**RELATIONSHIPS IN THE COMMUNITY:** Youth report that they have developed relationships with at least one positive and supportive adult outside of the HYC	<20% of youth have developed positive relationships outside of the HYC	20-40%	41-60%	61-80%	>80% of youth have developed positive relationships outside of the HYC
Youth Survey	**RELATIONSHIPS WITH HYC STAFF:** Youth report that they have developed relationships with at least one positive and supportive adult who works in the HYC	<20% of youth have developed positive relationships within the HYC	20-40%	41-60%	61-80%	>80% of youth have developed positive relationships within the HYC
All Youth Survey	**HOUSING OPTIONS:** HYC youth report that they know about the safe and stable housing options that are available to them	<20% of youth report that they know what housing options are available to them	20-40%	41-60%	61-80%	>80% of youth report that they know what housing options are available to them
AE Youth Survey	**HOUSING SERVICES:** AE youth report that they receive the services and supports they need to support their transition to safe and stable housing	<20% of AE youth report that they receive the services and supports they need to support their transition to housing	20-40%	41-60%	61-80%	>80% of AE youth report that they receive the services and supports they need to support their transition to housing

CRITERION		RATINGS / ANCHORS				
OUTCOMES		(1)	(2)	(3)	(4)	(5)
Service Point	**AE ENGAGEMENT:** 40% of youth who participate in safety services enter AE services	< 20% of youth who participate in safety services enter AE services	20-27%	28-33%	34-40%	>40% of youth who participate in safety services enter AE services
ROSE Report	**TREATMENT REFERRALS:** 75% of youth who are referred to treatment services connect to treatment	< 45% of youth who are referred to treatment services connect to treatment	45-55%	56-65%	66-75%	>75% of youth who are referred to treatment services connect to treatment
Service Point	**COMPLETION OF GOALS:** 85% of youth who exit AE complete at least half of their AE goals	< 40% of youth who exit AE complete at least half of action plan goals	40-55%	56-70%	71-85%	>85% of youth who exit AE complete at least half of action plan goals
AE Youth Survey at Exit	**COMMUNITY CONNECTIONS:** 85% of youth who exit AE have positive support people in the community that they can rely on and go to for help and support	< 40% of youth who exit AE have positive support people in the community	40-55%	56-70%	71-85%	>85% of youth who exit AE have positive support people in the community
AE Youth Survey at Exit	**RESILIENCE:** 85% of youth who exit AE have developed resilience factors such as an understanding of their own strengths, hope for the future, and connections to community resources for meeting their needs	< 40% of youth who exit AE have developed resilience factors	40-55%	56-70%	71-85%	>85% of youth who exit AE have developed resilience factors
AE Youth Survey at Exit	**YOUTH DEVELOPMENT:** 85% of youth who exit AE have gained knowledge, skills, and tools that will help them in their transition to adulthood	< 40% of youth who exit AE have knowledge, skills, and tools that will help in their transition to adulthood	40-55%	56-70%	71-85%	>85% of youth who exit AE have knowledge, skills, and tools that will help in their transition to adulthood

Service Point	**SAFE, STABLE HOUSING:** 75% of youth in short term shelter and housing programs exit transitional housing to safe, stable housing	< 45% of youth exit transitional housing to safe, stable housing	45-55%	56-65%	66-75%	>75% of youth exit transitional housing to safe, stable housing
Service Point	**PERMANENT HOUSING:** 65% of youth in short term shelter and housing programs exit transitional housing to permanent housing	< 35% of youth exit transitional housing to permanent housing	35-45%	46-55%	56-65%	>65% of youth exit transitional housing to permanent housing
Service Point	**HOUSING STABILITY:** 70% of youth in short term shelter and housing programs who exit to permanent housing are still in permanent housing at 6 month follow up	< 40% of youth are still in permanent housing at 6 month follow up	40-50%	51-60%	61-70%	>70% of youth are still in permanent housing at 6 month follow up
Service Point	**HOUSING STABILITY:** 65% of youth in short term shelter and housing programs who exit to permanent housing are still in permanent housing at 12 month follow up	< 35% of youth are still in permanent housing at 12 month follow up	35-45%	46-55%	56-65%	>65% of youth are still in permanent housing at 12 month follow up
Service Point	**SECONDARY EDUCATION:** 75% of youth who exit AE services have a GED or high school diploma*	< 45% of youth who exit AE have a GED or high school diploma	45-55%	56-65%	66-75%	>75% of youth of youth who exit AE have a GED or high school diploma
Service Point	**WORKFORCE DEVELOPMENT:** 50% of youth who exit AE services have received or are enrolled in post-secondary education and/or job training and/or are employed*	< 10% of youth who exit AE services have received or are enrolled in post-secondary education and/or job training and/or are employed	10-25%	26-40%	41-50%	>50% of youth of youth who exit AE services have received or are enrolled in post-secondary education and/or job training and/or are employed

*New data will need to be collected in Service Point at exit for these measures

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National Alliance to END HOMELESSNESS

Coordinated Assessment Evaluation Tool

Communities can use this tool as a quick way to assess how well their coordinated assessment system is functioning. The tool has two parts: one part should be completed before a coordinated assessment process has been implemented, and one part should be completed six months to a year after implementation. Embedded in the tool are instructions explaining how communities can gather the information needed for the evaluation. As with the other tools, communities should feel free to modify this tool as they see fit.

More detailed instructions on how to use this evaluation tool are in red.

Part I: Before Implementing Coordinated Assessment

Choose a six month reporting period to answer the following questions. Fill in as much information as you can.

1. Number of organizations currently doing assessments and referrals: _____

   Any organization doing assessments of consumer need, including individual programs and designated assessment centers, and making referrals or admitting households to other homeless or housing programs should be included.

2. Program Table

Type of Organization	Number of Organizations in Each Program Type	Total Number of Entries into Each Program Type	Rate of Exits to Permanent Housing*
Prevention/Diversion			
Emergency Shelter			
Transitional Housing			
Rapid Re-housing			N/A
Permanent Supportive Housing			N/A
Other Types of Housing/Programs			

*Rate of Exits to Permanent Housing equals the number of people that exit each program type in the given six month period for permanent housing divided by the total number of people that exited each program type within that six month period.

3. System Outcomes

Average Length of Stay in Emergency Shelter Programs

Singles: _____ Families*: _____ Youth: _____

Average Length of Stay in Transitional Housing Programs

Singles: _____ Families: _____ Youth: _____

New Entries into Homelessness

Singles: _____ Families: _____ Youth: _____

* Communities should define 'family' in a way that makes sense to them.

4. Coordinated Assessment Questionnaire

List the most popular response to each question from the Coordinated Assessment Questionnaire, which is part of the Coordinated Assessment Toolkit.

Question 2. Where did you go to get help when you became homeless?

Question 3. When you became homeless, was someone able to place you into emergency shelter, permanent housing, or another housing program immediately?

Question 4. After intake, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

Question 6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

5. Longer Qualitative Assessment Tool Responses
  Survey for Consumers
  Survey for Community Leaders/Executive Directors
  Survey for Direct Service Provider/Front Line Staff
  Analyze using the **Survey Analysis Sheet.**

Document any general trends present in the surveys, especially areas of concern.

6. Does the community have a system-wide wait list for services?

☐ Yes ☐ No

7. Size of the wait list for homeless assistance (system-wide; if no system numbers available, use program type   numbers)

_____ waiting for shelter

_____ waiting for transitional housing

_____ waiting for rapid re-housing

_____ waiting for permanent supportive housing

_____ waiting for other interventions

_____ total

We recommend adding a space on your assessment tool to document where the person was ultimately sent (their "secondary referral") and where they would've ideally been sent based on the results of your assessment ("primary referral") had that resource been available. For example, if the assessment indicated that a person should receive prevention assistance but no funds were available and they had to go to shelter, you would write 'prevention' as the primary referral and 'shelter', along with the name of the shelter, as the secondary referral. If they were eligible for rapid re-housing and were referred to the appropriate rapid re-housing program, that program would be listed as both the primary and secondary referral. Both the program type and name of the program the person was referred to should be noted.

Part II: After Coordinated Assessment (six months – one year after implementation and every six months thereafter)

1. Number of organizations currently doing assessment and intake: _____

   Any organization doing assessments of consumer need, including individual programs and designated assessment centers, and making referrals or admitting households to other homeless or housing programs should be included.

   How many "side doors" does your community have (organizations that participate in the coordinated assessment model but admit clients coming from places other than the coordinated assessment centers into their programs)? _____

   How many organizations are there that do not participate in the coordinated assessment process and do their own intake and assessment? _____

2. Program Table

Type of Organization	Number of Organizations in Each Program Type	Number of Primary Referrals Made to Program Type*	Number of Secondary Referrals Made to Program Type**	Rate of Exits to Permanent Housing
Prevention/Diversion				
Emergency Shelter				
Transitional Housing				
Rapid Re-housing				N/A
Permanent Supportive Housing				N/A
Other Types of Housing/Programs				

*Number of Referrals (Primary): Number of referrals made because this housing option was determined to be the best choice for the client.

**Number of Referrals (Secondary): Number of referrals made because this housing option had bed availability at the time of intake (secondary referrals would only be made if first choice option wasn't available). If a community does not separate primary and secondary referrals, communities should insert the number of referrals made to this program type in this column.

3. System Outcomes

   Average Length of Stay in Emergency Shelter Programs

   Singles: _____ Families: _____ Youth: _____

   Average Length of Stay in Transitional Housing Programs

   Singles: _____ Families: _____ Youth: _____

   New Entries into Homelessness:

   Singles: _____ Families: _____ Youth: _____

4. Coordinated Assessment Questionnaire

List the most popular response to each question from the Coordinated Assessment Questionnaire, which is part of the Coordinated Assessment Toolkit.

Question 2. Where did you go to get help when you became homeless?

Question 3. When you became homeless, was someone able to offer you prevention assistance or place you into emergency shelter, permanent housing, or another housing program immediately?

Question 4. After intake, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

Question 6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

5. Qualitative Assessment Tool Responses
   Survey for Consumers
   Survey for Community Leaders/Executive Directors
   Survey for Direct Service Provider/Front Line Staff
   Analyze using the **Survey Analysis Sheet.**

Document any changes since the first survey administration.

6. Does the community have a system-wide wait list for services?

☐ Yes ☐ No

7. Size of Wait List (system-wide; if no system numbers available, average among programs)

_____ waiting for shelter

_____ waiting for transitional housing

_____ waiting for rapid re-housing

_____ waiting for permanent supportive housing

_____ waiting for other interventions

_____ total

To determine success:

The following factors might indicate success with coordinated assessment:

- The number of organizations doing individual intake and assessment decreased
- There are no "side doors" in the community
- Average length of stay in homelessness is decreasing
- Rate of exits into permanent housing for every intervention has increased
- New entries into homelessness have decreased
- Consumers are most often naming the designated intake point(s) as a response to question number two on the Coordinated Assessment Questionnaire
- There is a centralized wait list now (if there wasn't before) or no wait list at all
- The number of organizations consumers had to work with before getting into permanent housing has decreased (Coordinated Assessment Questionnaire question number six)
- Most referrals are being made under the "primary" category

Consider making adjustments to your system (such as modifying program types or changing who receives Continuum of Care funding if):

- Primary and secondary referrals are not matching up
- The same consumer concerns are coming up in the surveys pre- and post-implementation of a coordinated assessment

Coordinated Entry Assessment Questionnaire

For Survey Administrators:

This survey of consumers (people experiencing homelessness or that formerly experienced homelessness) can be used as an evaluation tool to determine if coordinated assessment is creating a shorter path for consumers between homelessness and a return to permanent housing. The questionnaire ties into the **Coordinated Assessment Evaluation Tool**, but can be used independently.

It is crucial that as communities move forward they include consumers in the evaluation process; after all, coordinated assessment systems are meant to serve them more efficiently. The questionnaire should be administered at consistent intervals before and after a coordinated assessment has been implemented; suggestions and responses should be taken seriously and used to aid in the process of making adjustments or changes to the assessment system. Consumers should never be pressured or mandated to take the survey. Communities should feel free to develop their own system for how the survey is administered, change the questions in the survey, and make decisions about how the consumers to be surveyed are selected.

For Consumers:

Thank you for taking this survey about your experiences. Everything you say here will be anonymous. We will use these surveys to improve the way we serve people experiencing homelessness in our community.

There may be some terms in the survey that you are unfamiliar with. To help, here is how we define the following words in the survey:

Permanent Housing: Housing that you live in and can stay in or leave whenever you want. It may be an apartment with your name on the lease or a house. It may also be a place where you are staying with somebody else, but are allowed to stay or leave whenever you want. An emergency shelter or other program bed (described below) would **not** be considered permanent housing.

Program Bed: A bed or apartment-like unit in an emergency shelter, transitional housing, recovery program, or other program where you can only live temporarily (NOT permanent housing).

Homeless Assistance Organization or Program: Any program or organization that offers services or housing to someone who is about to lose their housing or has already become homeless.

1. What category below would best have described the last time you were homeless (or describes you now if you are currently homeless)?

☐ Single Adult

☐ Unaccompanied Youth (18 to 24 years old)

☐ Adult in a homeless family (that includes children)

☐ Child in a homeless family (that is 18 years old or younger)

☐ Adult in a homeless couple

☐ Other _____

2. Where did you go to get help when you became homeless?

Write name of organization here: _____

3. When you became homeless, was someone able to place you into emergency shelter, permanent housing, or another housing program immediately?

☐ Yes ☐ No

4. After you were assessed for your needs related to your homeless episode, were you able to move directly to permanent housing (like your own apartment), or did you have to stay somewhere else first?

☐ Directly to permanent housing

☐ Sent somewhere else first

☐ I was not assessed/asked questions about what I needed when I asked for help with my homeless episode

5. Are you currently housed in permanent housing?

☐ Yes ☐ No

6. (If you are currently housed in permanent housing): How many homeless assistance organizations or programs did you have to work with before you got into permanent housing?

☐ One

☐ Two

☐ Three

☐ Four

☐ More than four

7. (If you are currently housed in permanent housing): How much time passed between the first time you went to get homeless assistance and the day you got into permanent housing?

☐ Less than a month

☐ One to three months

☐ Four to six months

☐ Seven to nine months

☐ Ten to twelve months

☐ More than a year

☐ Between a year and two years

☐ Between two years and three years

☐ Other _____

8. (If you are NOT currently housed in permanent housing): How much time has passed since the first time you went to get assistance at the organization you listed in question two?

    ☐ Less than a month

    ☐ One to three months

    ☐ Four to six months

    ☐ Seven to nine months

    ☐ Ten to twelve months

    ☐ More than a year

    ☐ Between a year and two years

    ☐ Between two years and three years

    ☐ Other _____

9. (If you are NOT currently housed in permanent housing): When do you expect to be permanently housed?

    ☐ Within one month

    ☐ Within two months

    ☐ Within three to six months

    ☐ More than six months from now

    ☐ I don't know

10. (If you are currently housed in permanent housing): Do you think that you may become homeless again in the future?

    ☐ Yes   ☐ No

11. (If you answered yes to question 10): When do you think that will happen?

□ Within three months

□ Three to six months from now

□ Six to twelve months from now

□ Over a year from now

12. (If you think that you will become homeless again in the future): Why do you think that might happen?

13. (If you are in permanent housing now): Are you satisfied with your housing?

□ Yes □ No

14. (If you answered 'No' to question 13): If you are not satisfied with your current permanent housing, how can your housing needs be better met?

15. Did you feel any pressure to complete this survey or did anyone force you to take this survey?

□ Yes □ No

System Performance Dashboard
1/1/2016 to 12/31/2016

Hover for instructions

How is our system performing?

Exits to Permanent Housing	Average Length of Stay	Returns to Homelessness	Homeless Entries	Utilization Rate
45.0%	100.7	7.5%	64.7%	83.3%

Select View
- ⦿ Targets
- ◯ Minimum Standards

Project Type
All

Are projects meeting their performance metrics?

Select a project to view individual performance details above.
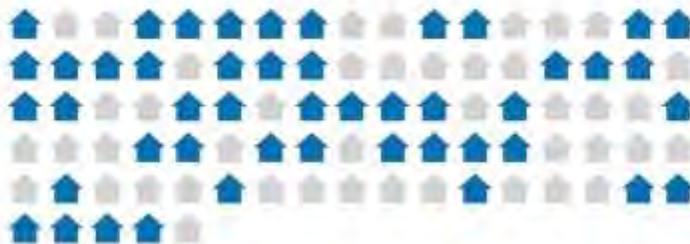
Number of Metrics Met
- ⦿ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Emergency Shelter

Rapid Re-Housing

Transitional Housing
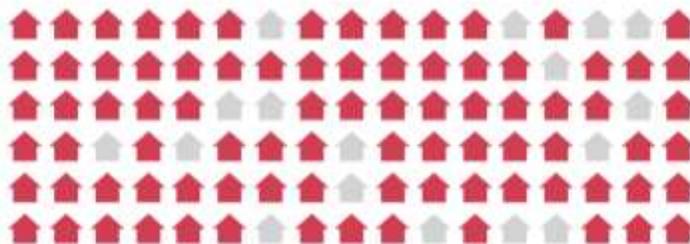
Permanent Supportive Housing
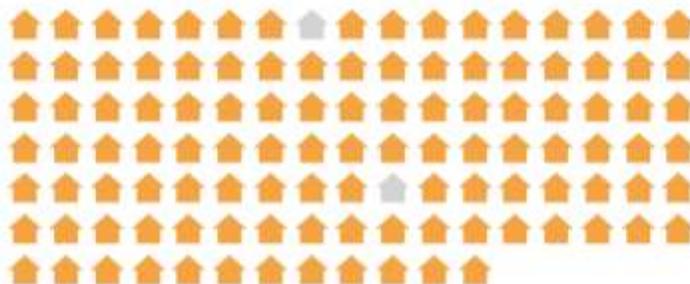
King County Homeless Housing System Performance

Youth and Young Adults

Homeless Households Housed Against Goal

RARE

	2013	2014	2015
	370	411	321

Quarterly Target

	Q1 2016	Q2 2016	Q3 2016
Target	200	237	214
Housed	79	42	65

Days Spent in Emergency Shelter and Transitional Housing

BRIEF

Year	Days
2013	116
2014	99
2015	134

Quarter	Days
Q1 2016	147
Q2 2016	114
Q3 2016	76

2016 Target

Percent Returning after Exiting to Permanent Housing

ONE TIME

	2013	2014	2015
	20.3%	16.9%	12.5%

	Q1 2016	Q2 2016	Q3 2016
	7.7%	7.6%	3.1%

2016 Target
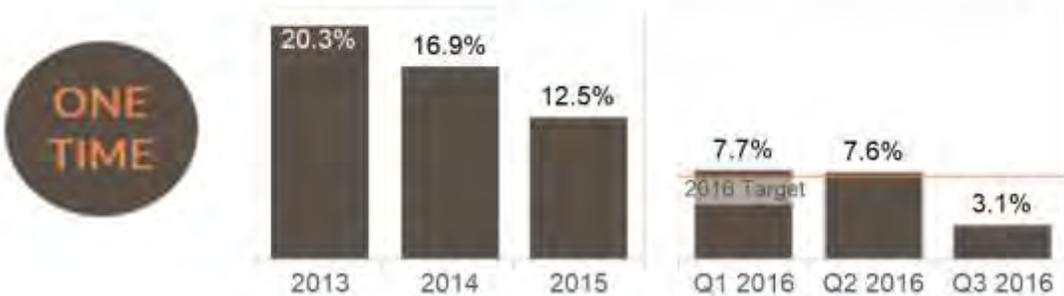
Last Permanent Zip Code of unaccompanied minors experiencing homelessness in 2015

Select a Population
Unaccompanied Minor

Select a Region

East Rural
East Urban
North Urban
Seattle Proper
South Rural
South Urban
Vashon

Number of unaccompanied minors

274

Hover over circle for instructions
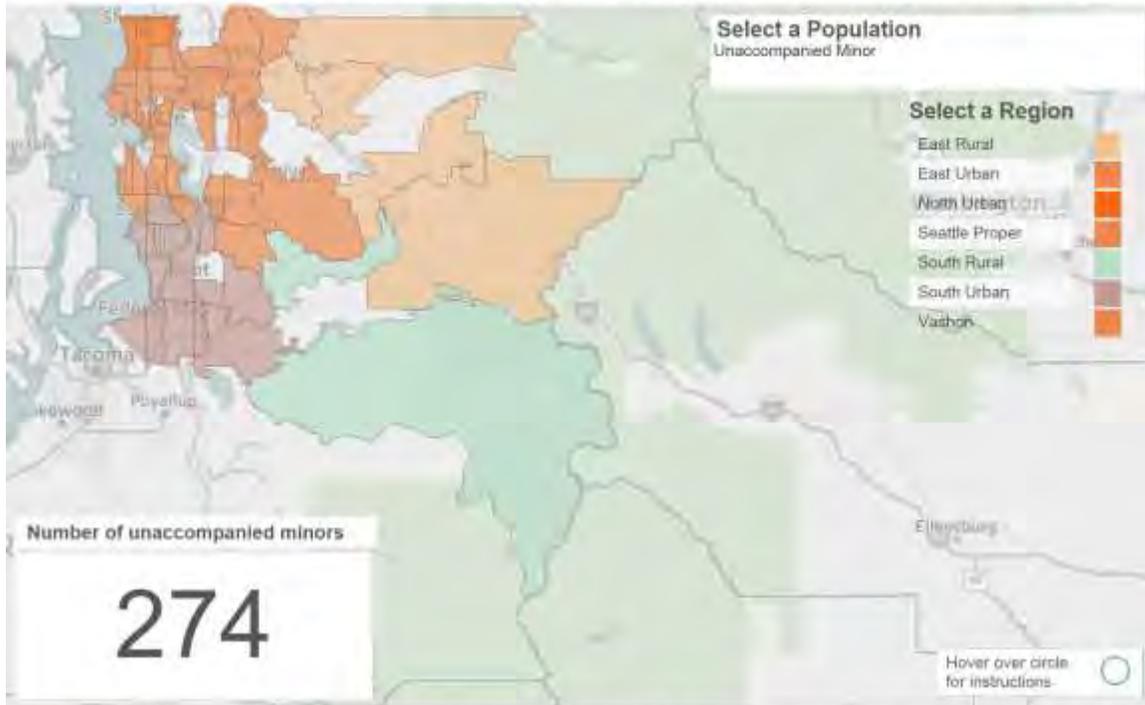
Characteristics of unaccompanied minors experiencing homelessness

Age

Under 18
100%

Reported Race

American Indian or Alaska Native	6%
Asian	4%
Black or African American	31%
Multi-Racial	15%
Native Hawaiian or Other Pacific Islander	5%
White	38%

Gender

Male 126 47%

Female 144 53%

Average Income at Enrollment Entry

East Rural	
East Urban	$135
North Urban	$88
Seattle Proper	$23
South Rural	
South Urban	$31

What is Coordinated Entry?

All housing agencies in Cincinnati's homeless services system participate in the Coordinated Entry system. This system allows our community to provide a coordinated response to homelessness that is person-centered, fair, and preserves choice and dignity. Coordinated Entry is designed to prioritize people with the most severe service needs and connect them to housing that will best meet their needs.

Coordinated Entry does:

- Match people to housing that best meets their needs.
- Place all continuum wide housing openings in one spot, increasing the potential housing matches for everyone.
- Ensure our community is prioritizing people who have the highest need.
- Screen people for eligibility for housing programs.

Coordinated Entry does not:

- Create more housing inventory.
- Limit a client's housing options based on what agency or case manager the client has.
- Screen people OUT of housing programs based on the person's barriers.

If you have additional questions about Coordinated Entry, please ask your case manager or other staff member that completed the VI-SPDAT with you.

The Coordinated Entry point person at this location is:

_____

If you still have further questions, please direct them to the above person, and they will try to assist you.

If you have comments or feedback about the process, please call the Coordinated Entry Manager at

513-354-6682

or fill out a form on Strategies to End Homelessness' website at

www.strategiestoendhomelessness.org/coordinated-entry-feedback

Coordinated Entry and You

A short guide to Cincinnati and Hamilton County's new housing prioritization process

STRATEGIES TO END HOMELESSNESS
prevent. assist. solve.

Coordinated Entry has three steps:

Step One: Assess

Our community uses a standardized assessment tool called the VI-SPDAT (Vulnerability Index - Service Prioritization Decision Assistance Tool) to get a good picture of your current situation and what services may be available to you.

Q Does completing the VI-SPDAT guarantee housing?

A Unfortunately no. There simply isn't enough funding in our homeless services system to help everyone. You and your case manager should also be working on a housing plan outside of Coordinated Entry. This may include looking for other affordable housing options, as well as obtaining helpful documentation like identification, utility bill status, etc.

Step Two: Plan

Based on the VI-SPDAT and other tools your case manager may use, you will work with your case manager on a housing plan that is built on your strengths and current resources.

Q Can my case manager determine where I am in line for housing?

A No. The prioritization list is always changing and is based on a number of factors including but not limited to: the VI-SPDAT, past housing and homelessness history, special needs, etc.

Step Three: Refer

Along the way, housing opportunities may become available for you. Your case manager will be notified if that happens, and s/he will provide you with additional information at that time.

Q Who manages the Prioritization list?

A Strategies to End Homelessness manages the Coordinated Entry process as an impartial agency that does not directly provide any housing or shelter services.

Overview

In 1998, the homeless youth service agencies in Multnomah County were organized into a collaborative Continuum to ensure maximum coordination, effectiveness, and accountability. In 2008, a new partner joined the Homeless Youth System - Native American Youth & Family Center – to expand services beyond the downtown core and to further meet the needs of diverse communities of youth in Multnomah County.

The Continuum is designed to serve youth in Multnomah County who have no viable home options.

These services are provided to our community because the Continuum believes:

- *All youth have great value and potential.*
- *That youth deserve an opportunity to succeed in school, work and life*
- *Stable housing gives youth an opportunity to build better lives.*
- *All youth have the right to a safe, decent place to live*

Funding: Multnomah County DCHS – Community Services, City of Portland, Portland Public Schools, Housing & Urban Development, Portland Children's Levy, Federal Department of Health and Human Services, Meyer Memorial Trust, Oregon Community Foundation and Private Donations.

Place Stamp Here

Multnomah County Human Services
Community Services Division
421 SW Oak Street, Suite 200
Portland, OR 97204

Homeless Youth Continuum

Serving the homeless youth population in Multnomah County, Oregon

System Description

The Homeless Youth System focuses services and supports for youth ages 15-23 years. Services are intended to be a late stage intervention and are available to those most affected by continued homelessness. The four agencies making up the Continuum include Janus Youth Programs, Native American Youth and Family Center, New Avenues for Youth & Outside In.

The primary goals of the Continuum are to meet the basic safety and developmental needs of homeless youth in Multnomah County. This is accomplished through a coordinated system of supports and services that seek to connect youth to the larger community. Success is measured using the evidence based practices of Positive Youth Development.

The system is designed to serve approximately 1000 youth annually.

County-Funded Services

- **Safety Services:** 24 hour immediate access, crisis services, basic needs services, shelter, and engagement opportunities.

- **Assertive Engagement:** Providing access, eligibility, assessment, transition planning and support. Teams are multi-disciplinary, multi-agency, relationship focused, mobile and operate throughout Multnomah County. Linkage to education, employment, health services, mental health, and alcohol/drug services is provided through the AE teams.

- **Housing:** Site based and scattered site options focus on moving youth to independence.

Service Locations

Janus Youth Programs   (503) 432-3986
1635 SW Alder Street

- *Safety Services:* shelter, screening, basic services, link to Assertive Engagement teams
- *Street Outreach:* Yellow Brick Road and Outreach and Engagement (O&E)
- *Bridgehouse:* Transitional housing for 7 youth

Native American Youth & Family Center
5135 NE Columbia Blvd.,   (503) 288-8177

- *Access to Safety Services, basic resources, screening*
- *Assertive Engagement, outreach*
- *Education Program & Learning Center*
Cultural Arts & Recreation Program

New Avenues for Youth   (503) 224-4339
820 SW Oak Street & 1220 SW Columbia

- *Safety Services and basic resources, screening*
- *Assertive Engagement, outreach*
- *Alternative School*
- *Late night Drop In:* meals, activities, and outreach to hard to reach youth
- *Transitional Housing and Independent Living*
- *Permanent Supported Housing*
- *Alcohol/Drug & Mental Health Services*
- *PAVE:* Career Training and Employment

Outside In   (503) 223-4121
1132 SW 13th Avenue

- *Safety Services and basic resources, screening*
- *Assertive Engagement, outreach*
- *Employment Resource Center*
- *Healthy activities*
- *Transitional Housing and Independent Living*
- *Alcohol/Drug & Mental Health Services*
- *Medical Clinic & Trans Resource Center*
- *Educational services*
- *Permanent Supported Housing*
- *Project Erase – Tatoo removal*

Accessing the System

Eligibility is determined through a screening process provided by mobile staff and at all agency locations. Screenings are coordinated through Janus Youth Programs (503) 432-3986. Following the screening, youth begin working with an assertive engagement team member who provides support and linkage to identify and meet the youth's needs.

Services Linked to the Continuum

Harry's Mother: Offers services to runaway youth up to age 17 including crisis intervention, emergency shelter, case management & family reunification services. 24 Hotline for Runaways – (503) 233-8111

Juvenile Reception Center – Receives youth up to age 18 brought in by police for minor/status offenses as a detention alternative.

DePaul Treatment Centers: Alcohol and drug treatment offering assessment, in-patient, out-patient, and after-care support services to youth and their families.

Insights Teen Parent Program: Case management, parent education, support groups, and housing assistance for pregnant and parenting teens.

Continuum Agency Website Addresses

www.janusyouth.org
www.nayapdx.org
www.newavenues.org
www.outsidein.org

Diversion Services

Prior to entering shelter, CAHS staff helps Ramsey County families experiencing homelessness in identifying any alternative options to shelter. Occasionally diversion services is able to provide limited financial assistance to eligible families when funds are available and prevention resources have been exhausted in order to resolve a family's housing crisis.

Diversion funds are available only for families seeking shelter that could avoid shelter with some financial assistance. With the limited number of shelter beds available, diversion services maximizes the use of shelter for those families with no other housing option.

CATHOLIC CHARITIES
of St. Paul and Minneapolis

RAMSEY COUNTY

HeadingHome
RAMSEY
A regional initiative to end homelessness in Saint Paul and Ramsey County

Located at:

Woodland Hills Church (Entrance B)

1740 Van Dyke Street

Maplewood, MN 55109

Metro Transit Bus Route Information:

Route 64 (Larpenteur Ave & Van Dyke St.)

Route 80 (White Bear Ave & Larpenteur

RAMSEY COUNTY COORDINATED ACCESS TO HOUSING AND SHELTER (CAHS)

If you are seeking shelter for your family, please call United Way 211 at 651-291-0211.

If you are experiencing domestic violence Day One services may also be of assistance in finding a safe place for your family while fleeing abuse. Day One can be reached at 1-866-223-1111

What is CAHS?

Since 2014 CAHS has been helping Ramsey County families with minor children experiencing homelessness access emergency shelter. Once in shelter, CAHS connects these families with supportive housing programs as openings are available.

With the creation of CAHS, families experiencing homelessness no longer have to contact each shelter and housing provider individually to check for openings.

Contact Us

Located Inside the Woodland Hills Church
1740 Van Dyke Street
Maplewood, MN 55109

(651)-215-2262
CHS.FAS.Shelterteam@co.ramsey.mn.us
CAHS@cctwincities.org

Visit us on the web:
www.ramseycountyCAHS.com

Ramsey County Emergency Shelter for Homeless Families

CAHS fills the openings of the Ramsey County emergency shelters for homeless families.

Please note shelter space is limited and no beds are immediately available. Completing an intake with Ramsey County shelter staff is the only way to be placed on the waitlist for the Ramsey County emergency shelters for homeless families.

To see if you qualify for an intake please call United Way 211 at 651-291-0211 for a prescreen. If eligible, United Way 211 will advise you on the next appropriate steps.

Supportive Housing Programs for Homeless Families

CAHS works with several dozen Ramsey County supportive housing programs for families including Rapid Re-Housing, Transitional Housing, and Permanent Supportive Housing.

Once a family is in shelter, a housing assessor will work with the family to help determine the types of housing programs they may be eligible for.

Ramsey County families with minor children staying in a shelter that CAHS does not fill, for example, Mary's Place, Domestic Violence Shelters, Naomi Family Residence Housing Plus Program, should contact CAHS to determine if they are eligible for a housing assessment.

Please note housing is never guaranteed and families are always encouraged to continue seeking housing on their own.

ENDNOTES

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2 | Key Findings

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