COORDINATED ENTRY

SOUTHERN NEVADA CONTINUUM OF CARE
ANNUAL COORDINATED ENTRY SYSTEM EVALUATION REPORT

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SOUTHERN NEVADA HOMELESSNESS CONTINUUM OF CARE

ANNUAL COORDINATED ENTRY SYSTEM EVALUATION

2018

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SOUTHERN NEVADA HOMELESSNESS CONTINUUM OF CARE'S COMMITMENT TO EVALUATING THE COORDINATED ENTRY SYSTEM

Each Continuum of Care (CoC) that receives CoC and/or ESG Program funding from the US Department of Housing and Urban Development (HUD) is required to develop and implement a centralized or coordinated assessment system, commonly known as "coordinated entry". Coordinated entry is a process for assessing the vulnerability of all people experiencing homelessness within the CoC to prioritize those most in need of assistance for available housing and services. The goals of coordinated entry are: (1) to increase the efficiency of the local crisis response system, (2) improve fairness in how housing and services are allocated, and (3) facilitate rapid access to services, including housing and mainstream benefits.

Southern Nevada is committed to these core principles as a key method for ensuring that the most vulnerable persons can access the resources that they need to end their homelessness.

ANNUAL EVALUATION OF COORDINATED ENTRY

HUD requires each CoC to conduct an annual evaluation of its coordinated entry system, focusing on the quality and effectiveness of the entire coordinated entry experience—including intake, assessment, prioritization, and referral processes—for both programs and participants. While HUD does not specify the scope or methods of the annual coordinated entry evaluation, HUD recommends that the annual assessment include, at a minimum, review of the effectiveness and efficiency of the overall process, feedback regarding the ease of use from those who experienced a housing crisis, and an analysis of referral outcomes.

Consistent with HUD requirements, Southern Nevada has committed to conducting an annual evaluation of its coordinated entry system to determine whether it is meeting HUD's standards and the CoC's goals. To do so, it employs multiple feedback mechanisms, including individual interviews with service providers and other stakeholders, surveys designed to reach a representative sample of participating providers, and focus groups that approximate the diversity of the households participating in the system during the year.

In 2018, the CoC commissioned HomeBase to conduct and prepare the annual evaluation of its coordinated entry system. This evaluation is designed to focus on the system and its functioning, as well as the extent to which it has streamlined access, assessment, and referral processes for housing and other services. To determine whether the coordinated entry model is functioning as it was designed, and how responsive the system is to client and provider needs, the evaluation considered a range of issues including:

Evaluation of Access, Assessment, and Prioritization

- Do the system entry points adequately cover the full geographic area of the CoC? Are people able to access the coordinated entry system?
- Are coordinated entry staff able to effectively determine client needs during assessment?
- What is the distribution of client assessment scores for each of the assessment types (single adults, families, youth/TAY, and survivors of domestic violence)?
- What type of information is missing from the assessment and/or the centralized waiting list that would help better inform matchers of client needs?
- Are the tools and protocols developed to support assessment and prioritization serving their intended purpose, or could they be improved?
- To what extent is the prioritization process effectively ensuring that clients are able to access all resources for which they are eligible, regardless of the type of assessment received (e.g., are clients receiving the TAY VI-SPDAT accurately prioritized for housing programs intended for single adults, if appropriate)?
- What is the time from assessment to referral?

Evaluation of Referrals, Placements, and Outcomes

- Are provider agencies able to serve clients who are referred to them?
- What is the time from referral to placement? Is the community able to efficiently locate clients in the event that a housing placement becomes available? What can be changed so that this wait time is reduced?
- What is the rate of denial and the reasons for denial? Are there any common patterns among agencies or client subpopulations?

- How is the centralized wait list functioning?
- Are certain client subpopulations more successful in their placements than other subpopulations?
- Is the average length of stay in homelessness decreasing?
- Have rates of exit into permanent housing for every intervention increased?
- Have rates of returns to homelessness decreased?
- Does the community have appropriate metrics in place to evaluate the performance of the coordinated entry system on an ongoing basis?

This evaluation report seeks to answer the above questions and provide recommendations for how the Southern Nevada CoC can improve the efficiency and effectiveness of its coordinated entry system.

EVALUATION METHODOLOGY

HomeBase collected and analyzed data from the following sources for this evaluation report:

- *HMIS data* in aggregate tables corresponding to evaluation questions.
    - Information was provided by the CoC's HMIS Lead.
    - The client pool for HMIS data is clients with HMIS system interaction between October 1, 2017 and September 30, 2018.
- An *online survey* targeted to all stakeholder organizations involved in the Southern Nevada Homelessness CoC coordinated entry system.
    - The survey was distributed by the CoC Lead to a comprehensive list of stakeholders.
    - It contained questions regarding overall perceptions of coordinated entry, as well as questions targeted only to those involved in distinct phases of the system: assessment, prioritization, matching/case conferencing, and referrals/placements.
    - The survey opened on January 18, 2019, and closed on January 30, 2019.
    - There were 30 total survey responses from representatives of a range of organizations. The types of stakeholders included providers of emergency shelter, transitional housing (TH), permanent supportive housing (PSH), rapid rehousing (RRH), street outreach, and other services. A slight majority of respondents (16) came from organizations that act as assessment sites for coordinated entry. Two-thirds of respondents (20) serve in management or as executive director of an organization, with only one-third (10) serving in front-line positions.
    - Respondents were not required to answer every survey item, and as described above, only answered questions about different phases of the system if they indicated participation in that phase. Thus, the survey responses presented here are only from those respondents who chose to answer a given question.
- Eight *consumer focus groups* facilitated on-site by HomeBase staff[1]:
    - Consumers housed through coordinated:
        - Youth & TAY – 1/15/19
        - Domestic violence – 1/16/19
        - Single Adults – 1/17/19
        - Families – 1/17/19
    - Unhoused consumers:
        - Youth & TAY – 1/18/19
        - Domestic violence – 1/16/19
        - Single adults – 1/16/19
        - Families – 1/16/19
    - Due to timing constraints, attendance at the focus groups was not ideal. In planning focus groups for future evaluations, attention should be paid to client work/school schedules, and resources for and time to organize transportation for clients.
- Four system-level on-site focus groups for *providers* facilitated by HomeBase staff (invites sent to all providers in these groups):
    - Matchers focus group – 1/8/19[2]

[1] Focus groups were used to gather feedback and inform this report, but were not conducted in a scientific manner.
[2] This focus group included matchers who recently stopped performing this role due to a reorganization of matching duties in the CoC.

  - Coordinated Entry Task Force focus group – 1/8/19
  - Coordinated Entry Working Group focus group – 1/15/19
  - Domestic Violence provider focus group – 1/17/19
- One interview with Head Matcher conducted remotely by HomeBase – 1/24/19
- Review of key documents related to the coordinated entry system as provided by the CoC Lead, including coordinated entry policies and procedures.

COORDINATED ENTRY SYSTEM FRAMEWORK

Coordinated entry in Southern Nevada is governed by the Coordinated Entry System Policies and Procedures, effective January 2, 2018. The system is overseen by the Coordinated Entry Working Group, which is responsible for providing input and making recommendations to the CoC Board on principles and guidelines for the coordinated entry system. The Southern Nevada Coordinated Entry system was designed according certain guiding principles, which include: easily accessible for clients; ease of use for agencies; housing focused; prioritize based on need; Housing First; sustainable; client centered; coordinated services; use of real-time data; accountable; leverage existing partnerships and resources; quality assurance; access; interdependency; and streamlined process.

The Southern Nevada Coordinated Entry system assesses severity and type of need by first using the Short Assessment Triage Tool (SATT) for all clients, which identifies the best sub-population assessment tool to use. Tools specific to sub-populations are: Community Housing Assessment Took (CHAT) for single adults; Family Community Housing Assessment Tool (FCHAT) for families; TAY VI-SPDAT for youth; and the DV Assessment for individuals or families who were initially assessed through a DV crisis assessment and are now residing in a DV shelter.

Once assessed, all clients are prioritized within a single Community Queue based on their individualized vulnerability. A client's placement on the Queue is made by comparing the raw assessment score to the scores of other clients that have received the same assessment type. Clients are then prioritized based on this comparative assessment (i.e., clients at the top of the Queue are those that have been deemed most vulnerable compared to the full range of clients receiving the same assessment). In this manner, clients can be prioritized for and placed into any program type for which they are eligible, without regard to the type of assessment received. Providers inform the matching team of programmatic vacancies and matchers make referrals from the top of the Queue, considering differing program eligibility requirements wherever possible. It is then incumbent on the provider to physically locate the client, confirm eligibility, and either enroll the individual or family into the program or reject the referral, in which case the client is returned to the Queue for additional referrals.

ANALYSIS AND RECOMMENDATIONS

This report analyzes the strengths and challenges of the Southern Nevada's Coordinated Entry system, and makes recommendations in four key areas: Access; Assessment and Prioritization; Referral and Placement; and Outcomes. Note that comprehensive recommendations from all sections are available in Appendix A.

Access focuses on the system's accessibility for people experiencing homelessness. Specifically, this section explores how households throughout the geographic area enter the system, how coordinated entry initially responds to the varied needs of those households, and how the system keeps people engaged. Specific areas reviewed were: full geographic coverage; fair and equal access; and effective engagement.

Assessment and Prioritization evaluates the effectiveness of the assessment in determining client need and explores opportunities to improve the assessment process, including messaging to clients and system expansion. Specific areas reviewed were: accurate determination of client needs; consistent messaging; and prioritization.

Referral and Placement focuses on ensuring an expeditious and effective referral and placement process, including discussions related to equitability of referrals, referral denials, and progressive engagement. Specific areas reviewed were: efficient timeline; effective referral scheme; and appropriate referral.

Outcomes focuses on the available indicators that might show whether coordinated entry is achieving its goals. This section has just one subsection reviewing these outcome metrics.

ACCESS

A coordinated entry system can only be successful if those people experiencing housing crises or homelessness know about the system and have a way to gain access to it. As such, HUD requires that coordinated entry cover the entire geographic area of a CoC with access points that are accessible and well-advertised to the people living there. CoCs must be mindful of local need, geography, capacity, and available services when designing a coordinated entry system that facilitates fair and equal access to all. HUD also required CoCs to engage with affected populations to make them aware of coordinated entry.

HUD requires CoCs to use standardized access points in a coordinated entry system; however, it does allow for separate access points to the extent necessary to meet the needs of certain populations, including individuals, families, youth, survivors of domestic violence, and persons at risk of homelessness.

As noted by HUD, the purpose of designating access points is to ensure that all people in a community have equal access to all crisis response system resources in the CoC. Equal access is an important part of the overall strategy of coordinated entry, which shifts the system from a project-centric focus to a person-centric focus.

FULL GEOGRAPHIC COVERAGE

Successes

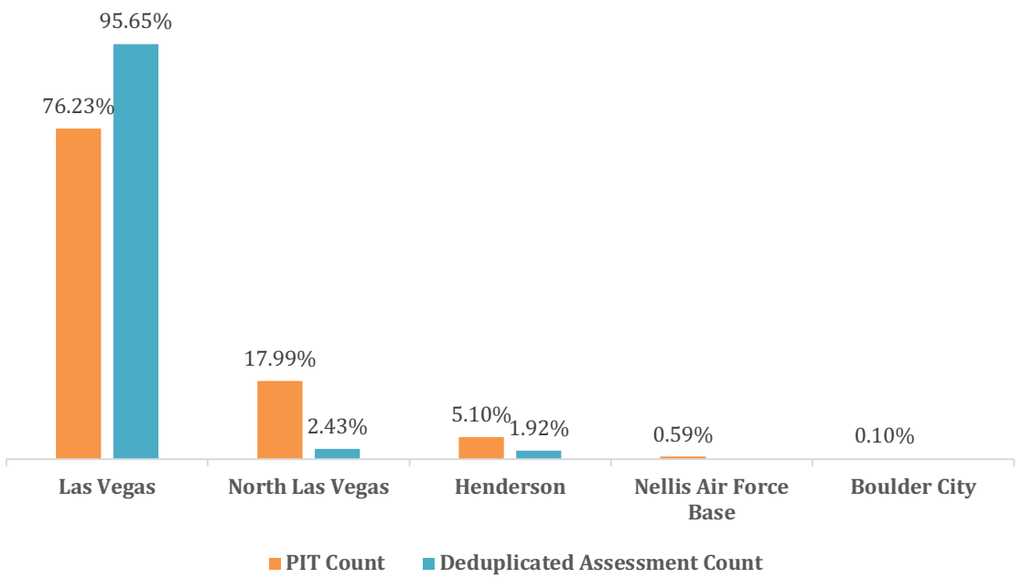
Stakeholders and consumers reported overall general satisfaction with the geographic coverage of Southern Nevada's Coordinated Entry system. Of the 30 responses to the stakeholder survey, 19 consumers (63.33 percent) indicated that the Coordinated Entry system adequately covered all geographic areas of the CoC. In addition, nearly every consumer focus group participant indicated that while they were experiencing homelessness, they were aware of shelters, outreach teams, or other service providers that are (or could be) access points to coordinated entry.

Challenges

Despite the general satisfaction with geographic coverage, data collected for this report shows that there are possible improvements. For example, based on a review of HMIS data, it appears that North Las Vegas and Henderson are underrepresented in coordinated entry assessments as compared to the percentage of the

sheltered and unsheltered homeless population counted in these cities during the PIT count. *See Figure 1 below.* This suggests a gap in adequate coverage for these areas, possibly preventing some clients from accessing coordinated entry or forcing them to travel into Las Vegas to do so.

Figure 1: PIT vs Assessments by City



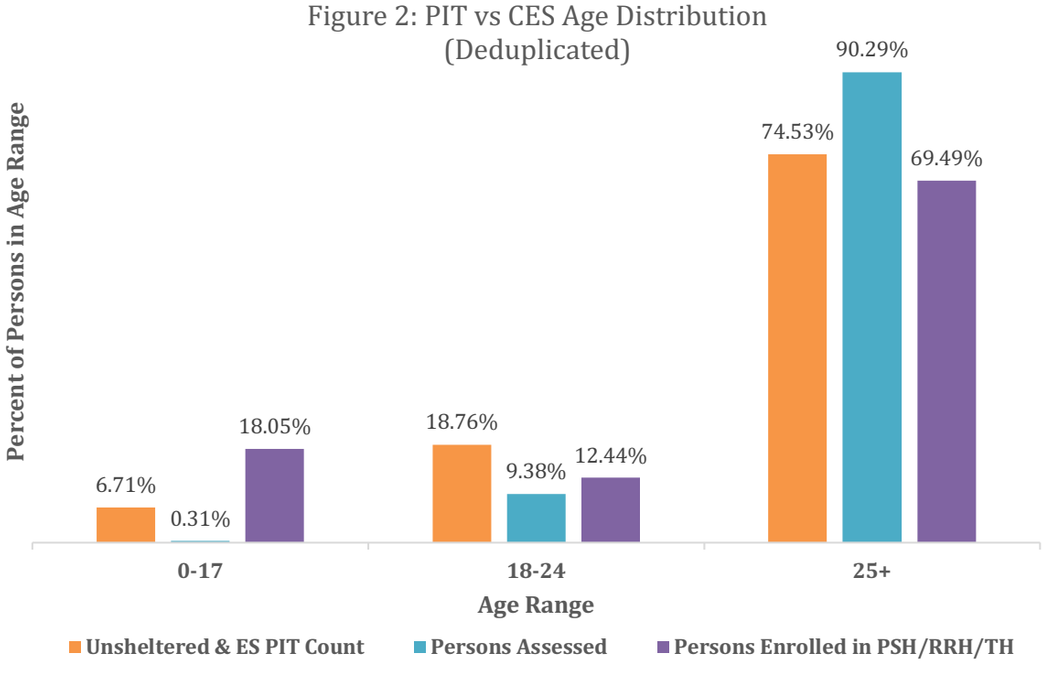
In addition, while only 2 survey respondents (7 percent) indicated they do not think coordinated entry adequately covers all geographic areas of the Southern Nevada Homelessness CoC, another 9 survey respondents (30 percent) responded that they did not know whether there was adequate geographic coverage. This could indicate a greater need for explanation and marketing of the coordinated entry's purpose and requirements.

FAIR AND EQUAL ACCESS

Successes

Figure 2 below compares the age distribution of persons counted during the 2018 Point-in-Time (PIT) count with the age distribution of persons assessed during the reporting period and the age distribution of persons enrolled in PSH, RRH, or TH during the reporting period.

Figure 2: PIT vs CES Age Distribution (Deduplicated)



HMIS data analysis shows that most vulnerable and protected classes are equitably served by coordinated entry. Minors (children under 18) were overrepresented in the population of persons enrolled into PSH, RRH, or TH during the reporting period as compared to the PIT count. *See Figure 2 above.* In addition, there is equity in access to coordinated entry among genders and among HUD's prescribed race and ethnicity categories. *See Appendix B.*

Furthermore, most stakeholder survey respondents whose agencies performed coordinated entry assessments indicated that their organizations are equipped to provide assessments accommodating the diverse needs of Southern Nevada residents. Among survey respondents, 85 percent reported being equipped to provide the assessment to persons who do not speak English and 60 percent reported being equipped to work with persons who are visually impaired or blind.

Challenges

While minors were overrepresented in the population of persons enrolled into PSH, RRH, or TH, they were severely underrepresented among persons assessed during the reporting period. *See Figure 2 above.* This trend is surprising because over half (55.10 percent) of minors counted in the PIT count were unaccompanied by adults. In addition, youth 18- to 24-years-old were underrepresented in the population of persons assessed and in the population of persons enrolled in PSH, RRH, and TH as compared to the PIT count. *See Figure 2 above.* This data suggests that youth might be inconsistently referred to and aware of the coordinated entry process.

While providers generally believed that access was fair and equal, they also offer some ideas on improving access for specific populations. Feedback from the survey and focus groups indicates a lack of capacity for assessing those who are hard of hearing or deaf, as well as those who require Tagalong translation service, which is not used on a widespread basis. In addition, agency staff serving survivors of domestic violence indicated that further CoC-wide training on identifying signs of domestic violence and other abuse could help more rapidly identify clients needing specialized services.

EFFECTIVE ENGAGEMENT

Successes

Many participants in consumer focus groups reported experiences with effective messengers of coordinated entry, with outreach teams receiving particular praise ("They were pretty informative and let you know what you were doing and why"). In the youth-specific focus groups, many participants said they had been referred to coordinated entry by a school counselor. Throughout the consumer focus groups, participants consistently mentioned a robust word-of-mouth information sharing network among their peers experiencing homelessness which referred them to access points. This suggests both that the CoC has had success in marketing coordinated entry, in general, and that this word-of-mouth network is an asset that may be leveraged in improving engagement.

Challenges

Despite the general successes outlined above, some specific populations in the focus groups shared experiences that suggest a need for improved engagement. The youth consumer focus groups reported mixed awareness of coordinated entry, with one participant stating he lived "out in the washes," where there was no discussion of coordinated entry. Some youth reported that they accessed coordinated entry through Safe Place sites, but that staff at the sites (grocery stores or gas stations) were not aware of their roles in the Safe Place program. Some youth disagreed with their peers as cited above (in "Successes") about school counselors, contending that counselors did not know how to refer them to help. Youth awareness of coordinated entry, therefore, seems mixed, and the population may be better served through more training and awareness campaigns for school counselors, Safe Place sites, and other youth-serving organizations.

The consumer focus group for unhoused single adults was conducted exclusively with clients in a shelter-based, employment-centered program. These clients were all literally homeless before entering shelter, but none were aware of coordinated entry, and only one thought that he had received an assessment. Their feedback highlights the need for all providers to be aware that everyone in need of housing should have access to

coordinated entry, regardless of whether there is a non-coordinated entry resource they can utilize in the meantime.

Other issues raised during the focus groups included: participants lacked internet access or a charged cell phone to learn about resource; information on the internet was too difficult for participants to interpret; the printed resource lists were sometimes out of date; and difficulties in transportation to coordinated entry access points and other service providers.

RECOMMENDATIONS: ACCESS

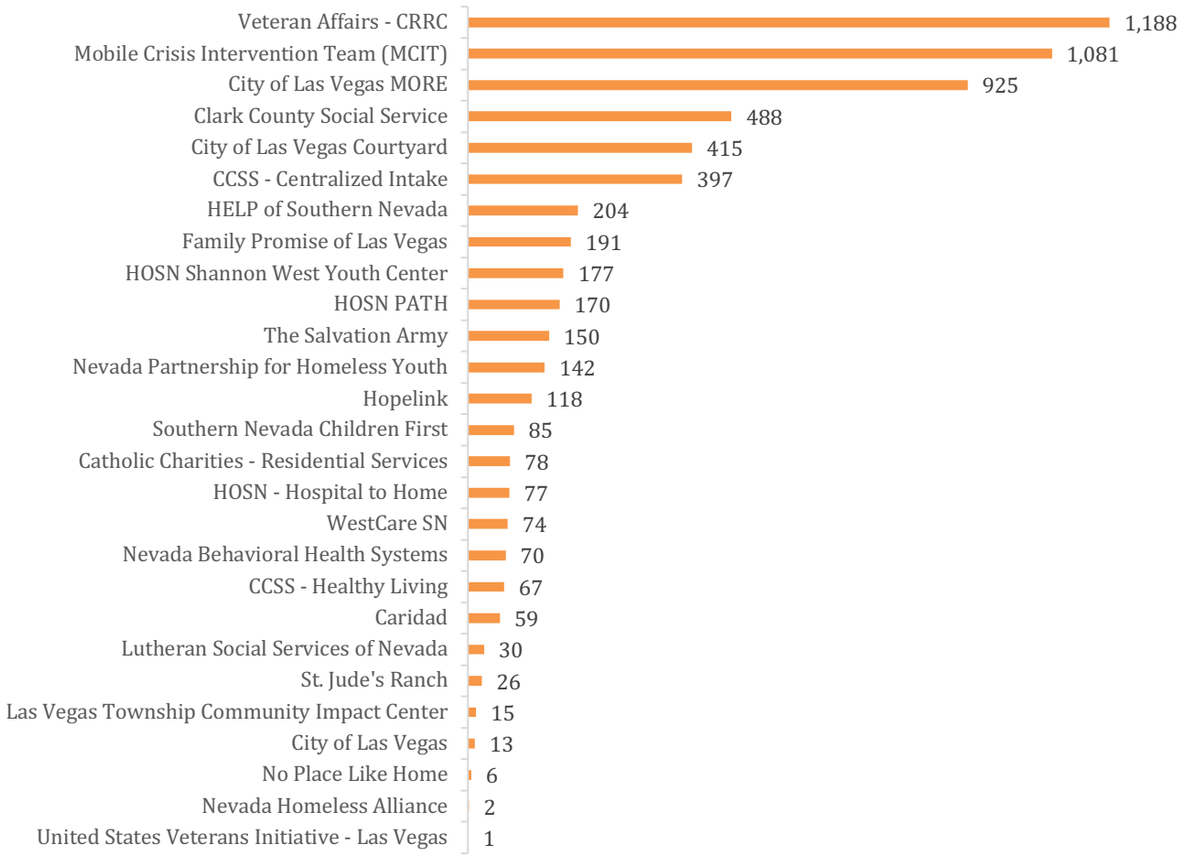
1. Develop strategies to better inform and promote access for clients in remote areas and other populations that utilize coordinated entry at lower rates, including:
    a. Conduct regular comparisons of completed assessments and homeless populations data (PIT, etc.) to determine if any populations are disproportionately disconnected from coordinated entry;
    b. Develop and distribute targeted marketing tools, such as small cards that clients can keep and share with others, to better inform clients about coordinated entry;
    c. Ensure that all coordinated entry resources are available to any large local populations of non-English speakers; and
    d. Utilize communication networks among those experiencing homelessness, including utilizing the resources outlined above.
2. Address access issues specific to coordinated entry for youth, including:
    a. Conduct deep analysis of coordinated entry accessibility for unaccompanied minors; and
    b. Ensure that Safe Place sites and school counselors receive consistent training on coordinated entry.
3. Ensure staff at all access points are regularly trained on identifying the signs of domestic violence so they can more quickly refer survivors to DV-specific providers.

ASSESSMENT AND PRIORITIZATION

HUD requires that each CoC incorporate a standardized assessment practice across its coordinated entry system. While there are a variety of methodologies for collecting information, the assessment process must document sufficient data to make consistent determinations on how to prioritize persons experiencing homelessness for housing and services. CoCs are expected to create prioritization standards based on a household's level of vulnerability and need to determine where households will be referred through coordinated entry. In addition, providers should provide clients with consistent and accurate information about the assessment and prioritization processes and outline what is expected from clients in these processes.

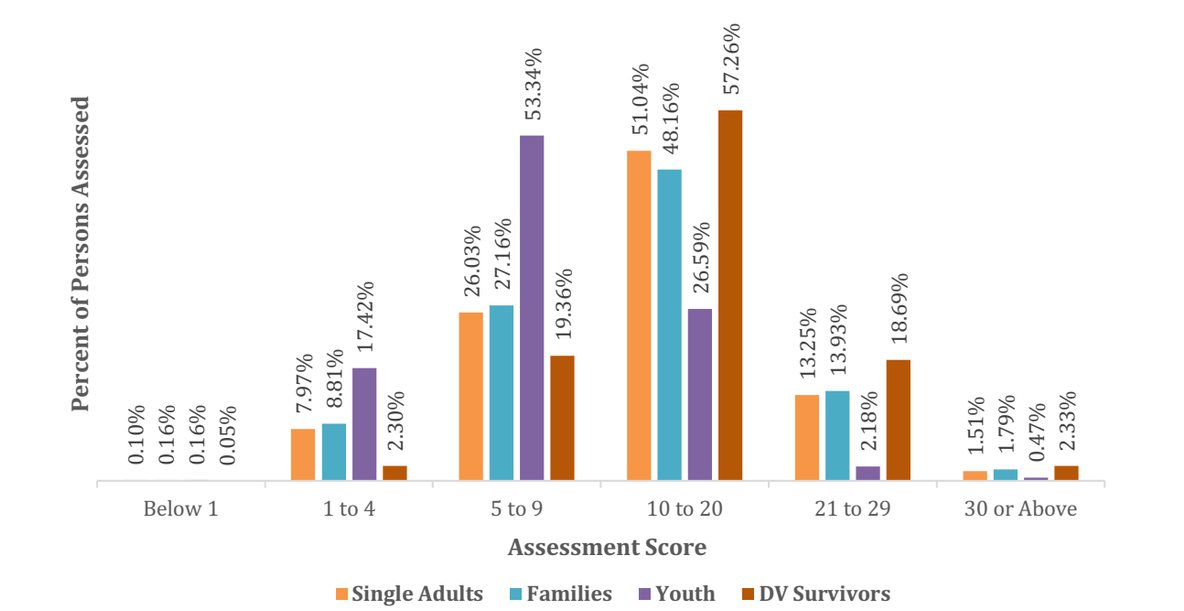
The clear majority of assessments administered in the Southern Nevada Homelessness CoC during the reporting period were performed by Veterans Affairs (19.01 percent), the Mobile Crisis Intervention Team (17.30 percent), and City of Las Vegas – MORE (14.80 percent). *See Figure 3 below.*

Figure 3: Total Assessments per Agency
(Duplicate)



As described previously, the Southern Nevada Homelessness CoC employs distinct assessment tools for single adults, families, youth, and survivors of domestic violence. The distribution of scores is roughly bell-shaped (normal) for each population. *See Figure 4 below.*

Figure 4: Assessment Scores
(Deduplicated by Latest Assessment)



ACCURATE DETERMINATION OF CLIENT NEEDS

Successes

Overall, stakeholders reported confidence in the accuracy of the assessment tools. Of survey respondents whose agencies performed coordinated entry assessments, the majority (73 percent) agreed that, overall, the assessment tools worked well. Similarly, the majority of respondents agreed that the tools accurately (59 percent) and consistently (64 percent) assess client vulnerability. In addition, providers reported in focus groups that the CHAT provides a more accurate assessment of client vulnerability among families and single adults than the VI-SPDAT, which was used for those populations in the past. An overwhelming majority (95 percent) of survey respondents who work on assessments also felt that training, materials and guidance about assessment tools was sufficient.

Challenges

While they had overall confidence in the assessment tool, some survey respondents doubted the accuracy of assessments when a there is a delay between assessment and placement, suggesting there should be a set of short follow-up questions to identify any major changes in vulnerability. One survey respondent who disagreed that the assessment was accurate suggested: "Vulnerability should also include their current homeless situation and priority given to youth in our respective programs whose situations changed to desperate." Furthermore, some commenters suggested that a three-year data look-back period for assessments was not comprehensive enough to capture vulnerability, stating: "Someone who has been sober for three years, but a lifetime of substance abuse has left them with little to no options does not have that vulnerability captured."

More urgently, some providers who had confidence in the tools themselves expressed concern about the administration of assessments. In focus groups, providers shared anecdotal evidence of reassessments within days or weeks of the previous assessment, sometimes with drastically higher scores. Some providers shared concern about the large number of assessors, though others expressed a desire to add emergency shelter staff as assessors. When asked about how assessments are administered, most providers mentioned a need for previously-trained assessors to be regularly retrained or certified, and some suggested remedial measures for staff or organizations that consistently ignore the established policies around assessments. The level of concern in this area was high among providers, suggesting it may be a priority area for the CoC to address in the future.

CONSISTENT MESSAGING

Successes

The data collected for this evaluation suggest that clients are receiving consistent messaging about coordinated entry when undergoing assessment. Feedback from most of the consumer focus groups suggests that those who have gone through the coordinated entry process generally have an accurate understanding of the purpose of coordinated entry and its general operations. When asked about their understanding of the need for coordinated entry, clients across multiple focus groups responded: "It's what needs to happen to get housing." Consumer focus group participants also understood that the assessment, while necessary, was not a guarantee of housing, either in the short or long-term. Many, though not all, understood that they would have to check back with their case worker to know if a housing placement became available for them.

In addition, stakeholder survey results show that most respondents (75 percent) believe that clients are clearly informed of follow-up requirements related to the Community Queue post-assessment.

Challenges

While consumers understand most general concepts around coordinated entry, they generally did not understand prioritization, its purpose, and what it means for those who are not on the top of the list. Some consumers expressed a desire to receive updates on their place on the list, and suggested an in-between contact person to provide these updates. One stakeholder survey respondent suggested that assessors should give a clear explanation to participants that completing an Assessment for Services does not guarantee entry into shelter or housing, and that while waiting to see if any resources are available, participants should continue to seek employment (if not employed or able to work) and other housing options.

PRIORITIZATION

Successes

A majority (70 percent) of survey respondents involved with the prioritization process agreed that the coordinated entry process works well. Almost 59 percent agreed that the prioritization process accurately reflects client vulnerability. This sentiment was echoed in the provider focus groups, where a success consistently cited across all groups was that coordinated entry is prioritizing the most vulnerable for housing and services.

Challenges

While the general feedback from stakeholders about prioritization was positive, there are several specific areas related to prioritization where the CoC could take concrete actions to improve the performance of coordinated entry.

One possible area where the CoC can continue to improve is in its prioritization of those with disabilities. Per an analysis of HMIS data, while 43.78 percent of persons assessed during the reporting period had a disabling condition, 50.23 percent of those enrolled in PSH, RRH, and TH had one. We would expect an optimal system that prioritizes the most vulnerable persons for housing to have a greater proportion of disabled persons enrolled in PSH, RRH, and TH. (This is especially the case with HUD-funded PSH programs, where a disabling condition is an eligibility requirement.)

Another specific area of attention that was discussed during the provider focus group was the need to develop a policy on how to prioritize clients who were evaluated using the VI-SPDAT and remain on the list. Focus group participants commented that there are still clients on the list who had been evaluated using the VI-SPDAT, and that there is no set policy on how to prioritize their scores.

RECOMMENDATIONS: ASSESSMENT AND PRIORITIZATION

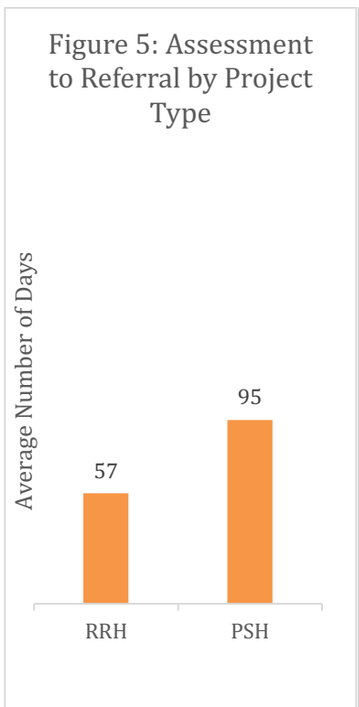
1. Implement strategies to improve the consistency and validity of assessments, including:
    a. Establish a process for the review of re-assessments that occur soon after an original assessment and/or produce an assessment score much different than the original assessment, including establishing a threshold above which a significant score change would trigger case conferencing to understand and address the situation;
    b. Require all assessors at an organization to complete an annual recertification to continue administering assessments. Recertification might include a review of the organization's previous year assessments to pinpoint any areas requiring discussion or clarity; and
    c. Consider sanctions for organizations that do not follow established policies and procedures around administering assessments, including temporary loss of assessment privileges.
2. Develop an orientation packet for clients that contains information about what to expect and what is expected after the assessment is complete.
3. Set policy on how to prioritize clients who were assessed using previous assessment tools (i.e., VI-SPDAT).
4. Consider extending the period of time that is considered by assessment tools (beyond the current three-year period).

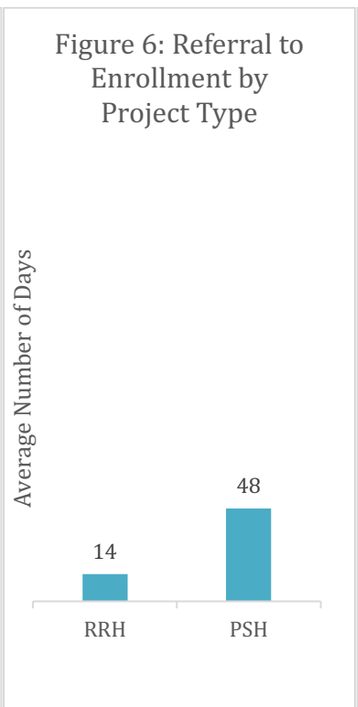
REFERRAL AND PLACEMENT

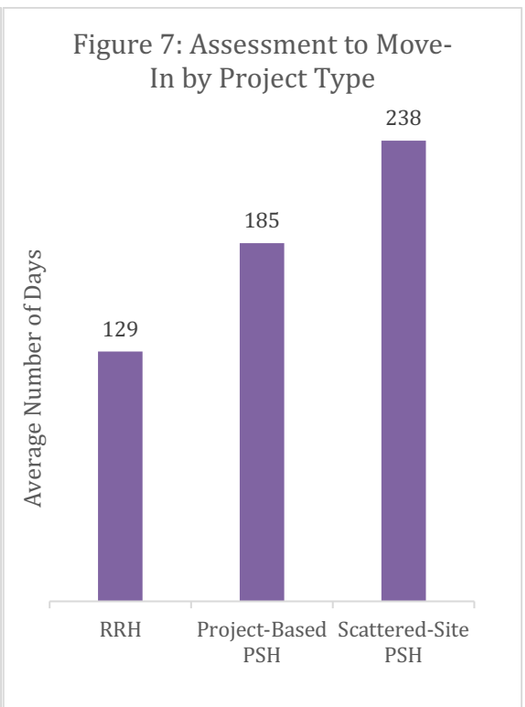
The goal of coordinated entry is to create a system that allows for intentional referrals of people to housing and services based on their vulnerability and need. Through these systems, those people with the highest priority, as determined by the CoC's intentional protocol, are referred to the available interventions first. Whenever possible, referrals should be appropriate for the receiving agency and should house the most vulnerable clients as efficiently as possible.

EFFICIENT TIMELINE

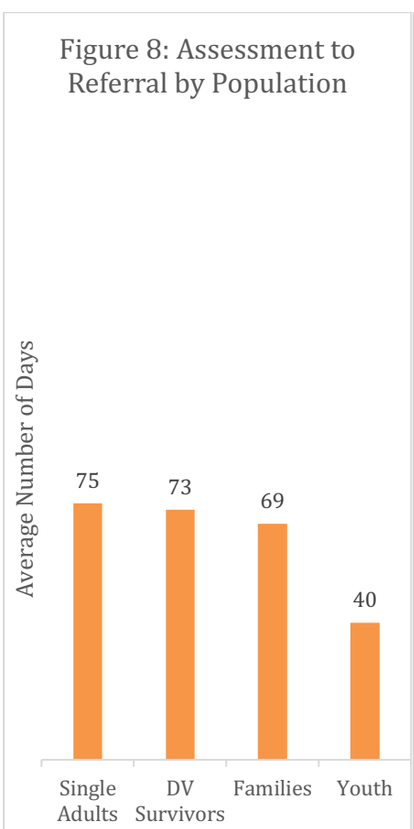
Figures 5, 6, and 7 below demonstrate the coordinated entry system timeline by project type.

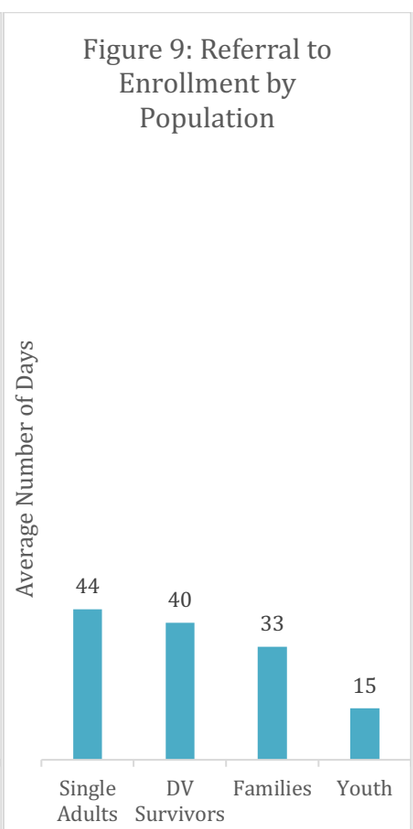






Figures 8, 9, and 10 below demonstrate the coordinated entry timeline by client population.





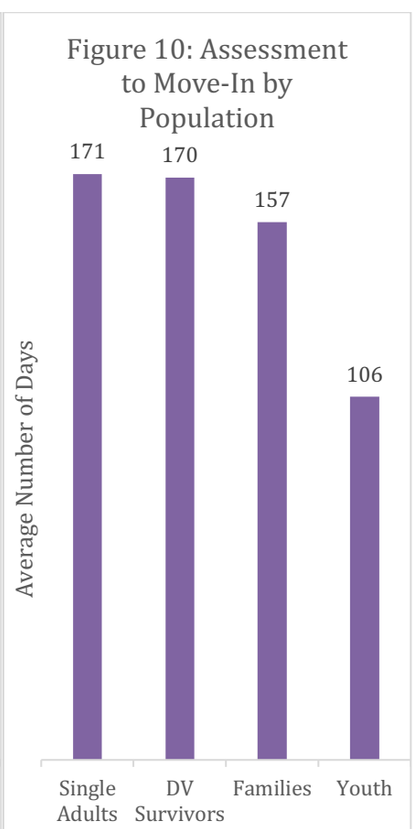
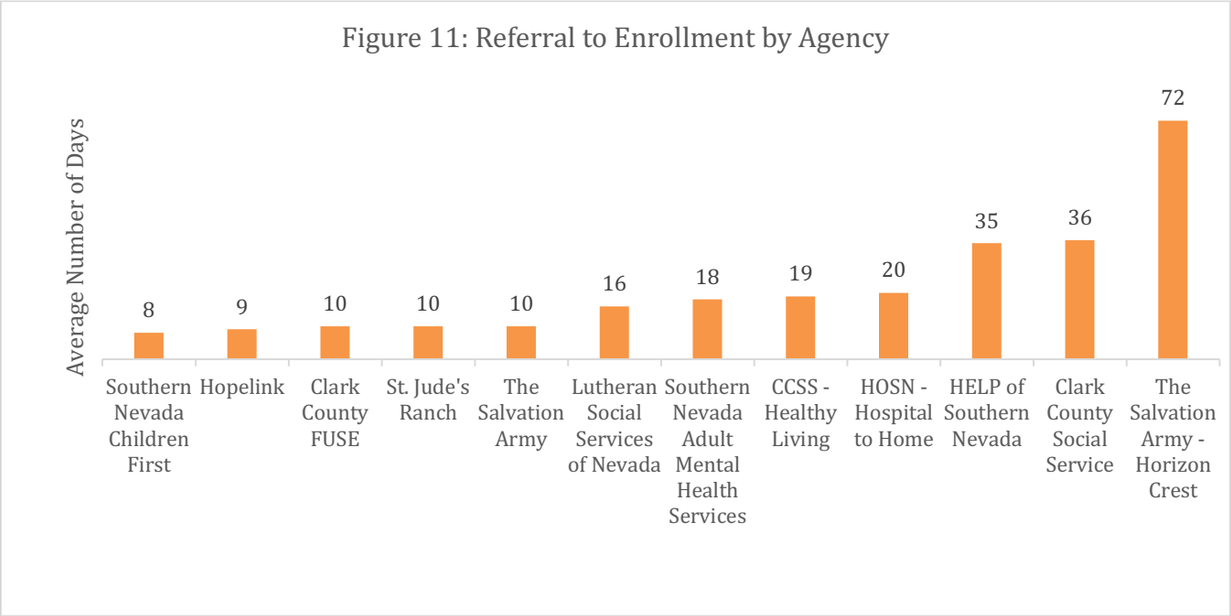


Figure 11 below demonstrates the average time each agency took to enroll referred persons.



Successes

Analysis of HMIS data shows some successes related to timeliness of referral and placement. On average, less than two months elapsed between first assessment and referral to RRH for persons referred during the reporting period. *See Figure 5 above.* Just two weeks elapsed between first referral and program enrollment for those who were enrolled in RRH during the reporting period. *See Figure 6 above.* Nevada Children First, Hopelink, Clark County FUSE, St. Jude's Ranch, and the Salvation Army were particularly efficient in enrolling referred persons within ten days of referral. *See Figure 11 above.* The CES timeline was particularly efficient for youth, who were referred within 40 days of first assessment and enrolled within 15 days of referral. *See Figures 8 and 9 above.* Overall, youth were housed three and a half months from first assessment. *See Figure 10 above.*

In addition, one consumer focus group participant reported that she was housed within two weeks, which greatly exceeded her expectations. Others in focus groups indicated time from referral to housing generally ranged from one to six months.

Challenges

While we highlighted some successful program types and providers above, the HMIS data show that other programs struggled with timely referral and placement. For example, over four months elapsed between first assessment and housing move-in for persons in RRH, which is somewhat long for that program type. *See Figure 7 above.* However, timelines related to PSH were even longer than RRH. On average, persons referred to PSH during the reporting period had waited over three months after their first assessment. *See Figure 5 above.* Almost two months elapsed between first referral and program enrollment for those who were enrolled in PSH during the reporting period. *See Figure 6 above.* Overall, between first assessment and housing move-in, over six months elapsed for persons in project-based PSH and almost eight months went by for persons in scattered-site PSH. *See Figure 7 above.* PSH programs often have longer timelines because they serve higher-need (and thus sometimes harder to house) clients. However, participants in provider focus groups described one possible reason for extended timelines for PSH referrals and placements in Southern Nevada: the closing of some existing PSH projects required programs to accept those project's existing clients, elongating wait times for clients captured in the reporting period.

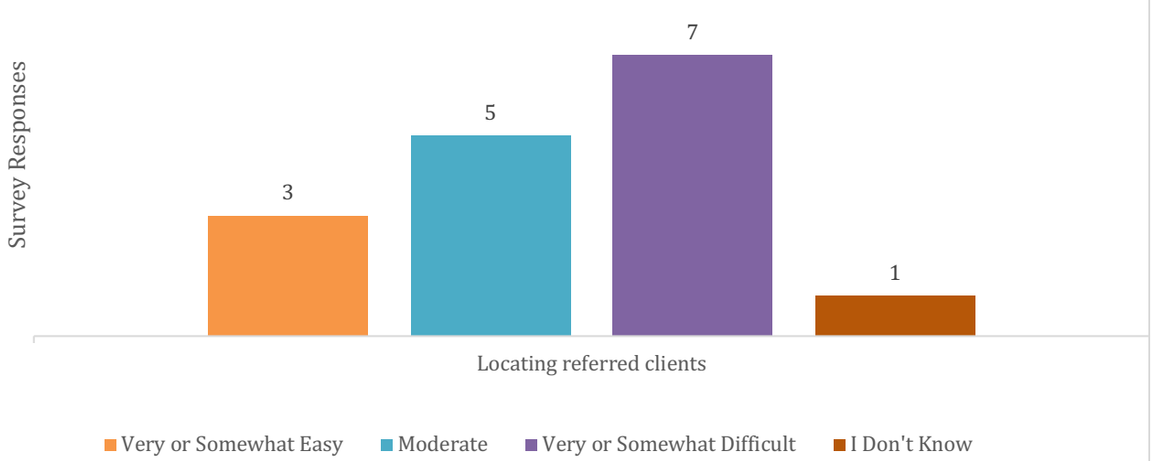
Among providers, HELP of Southern Nevada, Clark County Social Service, and the Salvation Army - Horizon Crest averaged particularly extended wait times between referral and enrollment. *See Figure 11 above.* This could be related to the types of programs these providers administer (i.e., programs for harder to serve clients). If not, the CoC should investigate how to address issues related to timeliness.

The waiting time was comparable and extended throughout the phases of coordinated entry among single adults, families, and survivors of domestic violence. This fact is especially concerning for the survivor population whose safety needs are particularly acute. *See Figures 8, 9, and 10 above.*

In focus groups, some providers commented on the pattern of having the same clients referred to them multiple times, but being unable to house them because after referral, they are unable to locate them. The stakeholder survey revealed an area of difficulty in the referral process was locating clients who had been referred to a program. *See Figure 12 below.*

While the issues outlined here are not unique to the Southern Nevada Homelessness Continuum of Care, they are important areas for continued analysis and problem-solving.

Figure 12: Ease of Receiving Referrals from Coordinated Entry



EQUITABLE REFERRAL SCHEME

Overall, 17.42 percent of households first assessed during the reporting period have received referrals to permanent housing: 22.78 percent of survivors of domestic violence, 21.07 percent of youth, 13.72 percent of single adults, and 10.83 percent of families.

Successes

Results from the stakeholder survey show that 75 percent of those responding (of just eight respondents) agreed that, overall, the Community Queue was running well. Of those same respondents, 63 percent indicated that it was not difficult for their organization to tell where a client was on the Community Queue. Some comments on the survey conveyed that the centralized wait list has improved over time. Similarly, providers in focus groups praised the recent change from a decentralized, multi-provider matching process to a centralized matching team housed within one provider.

Challenges

Some survey respondents stated that a challenge of the Queue is keeping the list up-to-date by removing people who have resolved their housing situation in another way or have not been in contact with any providers for an extended period. One focus group participant described one of the challenges of the Queue this way: "Some clients are on the queue for years. They talk to someone often enough to remain on the list, but they don't want to accept referrals that are given for whatever reason (they won't take my dog, etc.)."

APPROPRIATE REFERRALS

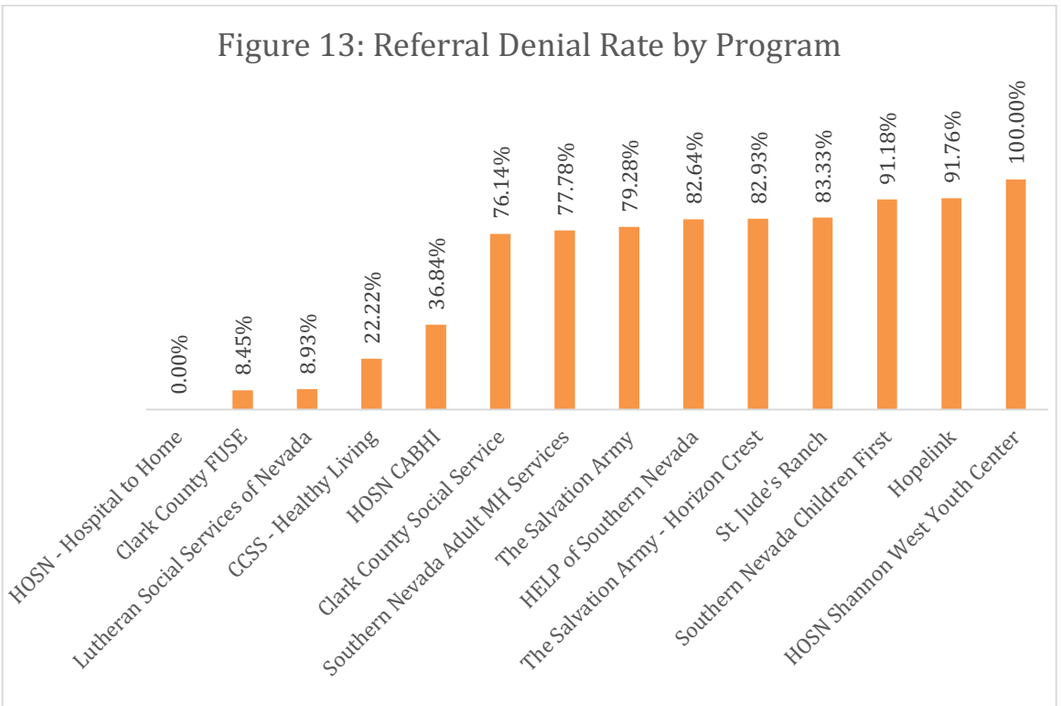
Successes

HMIS data shows that the family referral process seems to be functioning well, with 82 percent of families' referrals accepted during the reporting period.

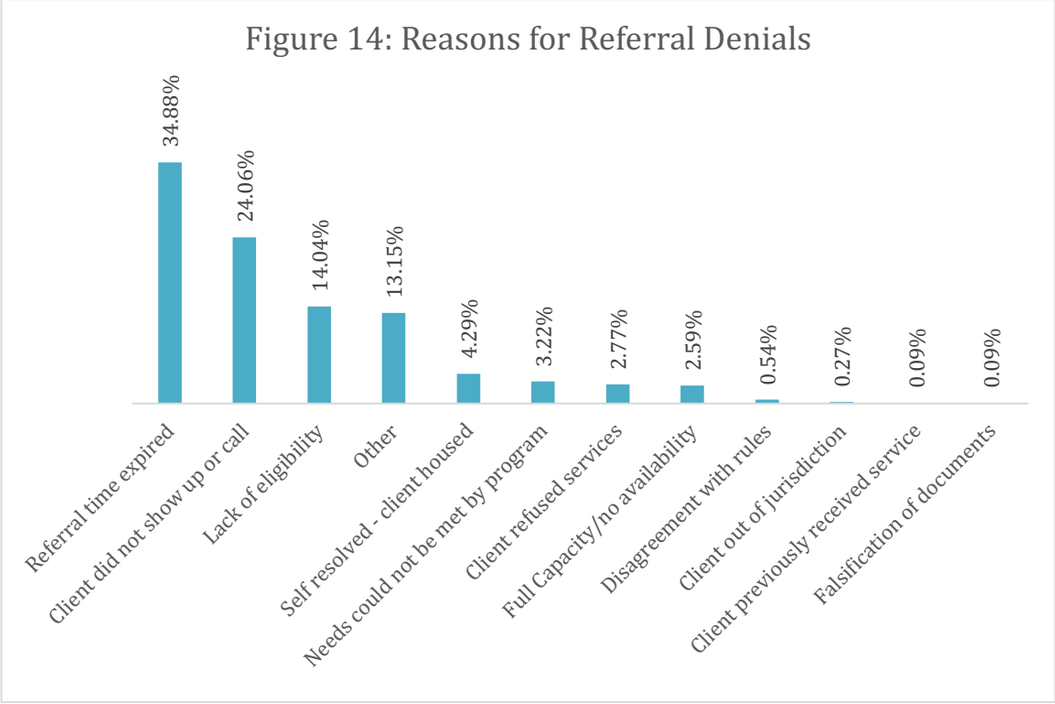
Respondents to the stakeholder survey highlighted other successes related to appropriate referrals. Most respondents who accept referrals indicated that ineligible referrals were rare (53 percent), that the referral process works well (82 percent), and that coordinated entry makes it easy to fill program vacancies (59 percent). In addition, almost all (seven of eight) respondents familiar with the matching process reported that matchers have the necessary information to match clients with the appropriate service and housing intervention. This last data point was supported by providers in focus groups who praised the new dedicated matching team, saying that it has increased consistency and allows for observation and analysis of patterns across the system.

Challenges

While providers clearly believe that referrals are generally appropriate, some HMIS data suggest the opposite. During the reporting period, only 34.36 percent of all referrals were accepted. Unlike the high acceptance rate for families shown above, the numbers were low for single adults (33.07 percent), youth (27.78 percent), and survivors of domestic violence (34.56 percent). While a few programs accepted most of their referrals, the clear majority had very high referral denial rates. *See Figure 13 below.* There was no relationship between time spent on the community queue waiting for a referral and the likelihood of referral rejection. *See Appendix B.*



About one third of referrals expired back to the queue after pending for 30 days. The other most common reasons cited for denied referrals were client did not show up or call, lack of eligibility, and "other" reasons. *See Figure 14 below.*



While 14 percent is a large proportion of denied referrals to be caused by lack of client eligibility, it is unclear whether the eligibility issues would have been detectable to matchers before the referral.

In provider focus groups, many participants did cite an inability to locate clients after referral as a major problem. However, some providers shared concerns that programs may sit on referrals until they expire, as suggested by the HMIS data. Whatever the case, there is frustration around the lack of information about reasons for expired and denied referrals. Sometimes, a lack of information leads matchers to re-refer clients to the same program. These incidents are frustrating for the housing providers and matchers, but even more so for clients who remain homeless.

Denial or expiration of referrals and an inability to locate referred clients are common issues in all coordinated entry systems, but they seem particularly acute in Southern Nevada. Our recommendations to address this issue are provided below.

RECOMMENDATIONS: REFERRAL AND PLACEMENT

1. Address the very high proportion of referrals that are denied for cause or let expire through a variety of measures, including:
    a. Consider removing referral expiration and requiring that programs check in with a matchmaker before denying referrals;
    b. Consider updating the referral denial reasons and providing guidance to agencies receiving referrals regarding when it is appropriate to select a reason. If guidance already exists, failure to comply should be addressed;
    c. Encourage providers to add notes that will help the matchmaker for future referrals (for the client or for the program); and
    d. Consider adding auto-generated HMIS notices that pop up when referrals are denied and include next steps that users should take if they are still in contact with the client, or if the client returns in the future for services (e.g., making sure contact and assessment information is up-to-date).

2. Experiment with methods to increase provider ability to locate clients after referral, including:
    a. Consider leveraging outreach teams to contact persons near the top of the community queue before enrollments are made to begin working on documenting eligibility for PSH;
    b. Ask additional questions about how to locate client and collect client contact information (i.e., email address, family member or friend who can get a message to client about housing opportunity);
    c. To decrease the time between referral and enrollment, consider developing a standard referral location checklist to support providers in finding referred persons; and,
    d. Follow written policies about removing clients form queue if they have not checked in within a certain time and update system accordingly.
3. Consider conducting a deeper analysis of the factors affecting the PSH CES timeline to answer the following questions:
    a. Is the recent closure of other PSH projects responsible for the extended timelines from assessment to housing move-in?
    b. Are referrals held up due to a lack of communication around program openings?
    c. Are PSH providers appropriately moving on participants who have stabilized to free up capacity to serve more vulnerable clients?
    d. What is causing delays between enrollment and move-in for project-based PSH participants?
4. Support RRH and PSH providers in building capacity around landlord engagement and housing-focused case management.
5. Create and implement a strategy for regular review (i.e., quarterly) of referral outcomes to respond to any system challenges and trends.
6. Ensure that policies and procedures around matching have been updated to reflect recent centralization of matching into one agency, and that all stakeholders understand the new matching process.

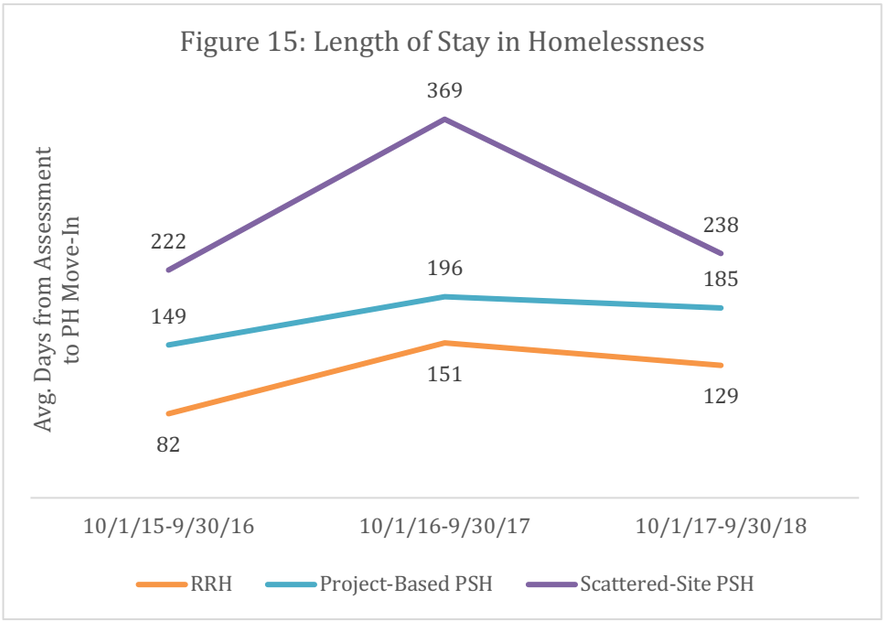
OUTCOMES

While the purpose of coordinated entry is to identify and prioritize the most vulnerable clients experiencing homelessness and place them in housing and services, it should also improve the outcomes for the clients who are served. This section explores HMIS data and some qualitative information around outcomes to offer insight into how coordinated entry might be affecting outcomes.

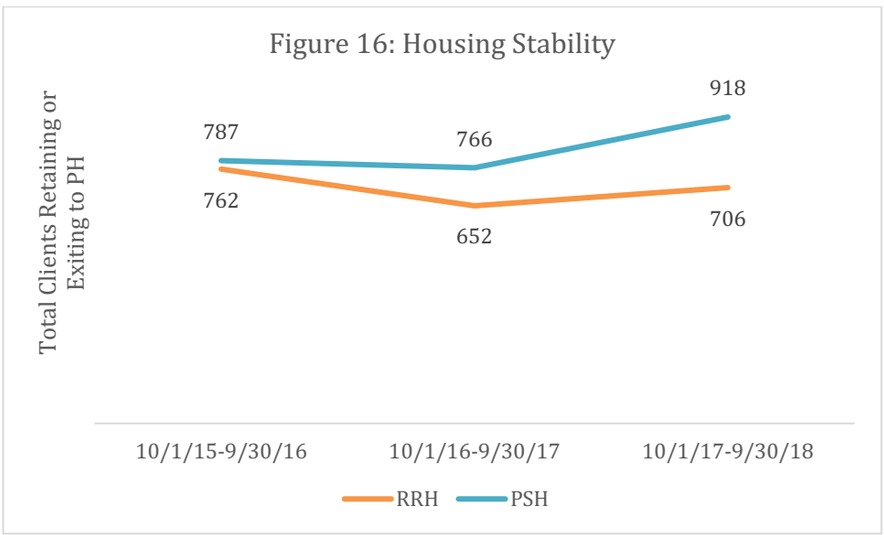
Successes

Race and disability status do not appear to affect housing placement for persons enrolled in PSH and RRH. HMIS data demonstrate a consistent race distribution among persons enrolled and persons housed. *See Appendix B.* In fact, more people among those housed (71.24 percent) than those enrolled (50.23 percent) had a disabling condition, indicating that programs are advocating effectively for the most vulnerable persons.

Coordinated entry is becoming more efficient in moving people out of homelessness. The average time from a client's first assessment to permanent housing move-in decreased for all project types during the reporting period. *See Figure 15 below.*

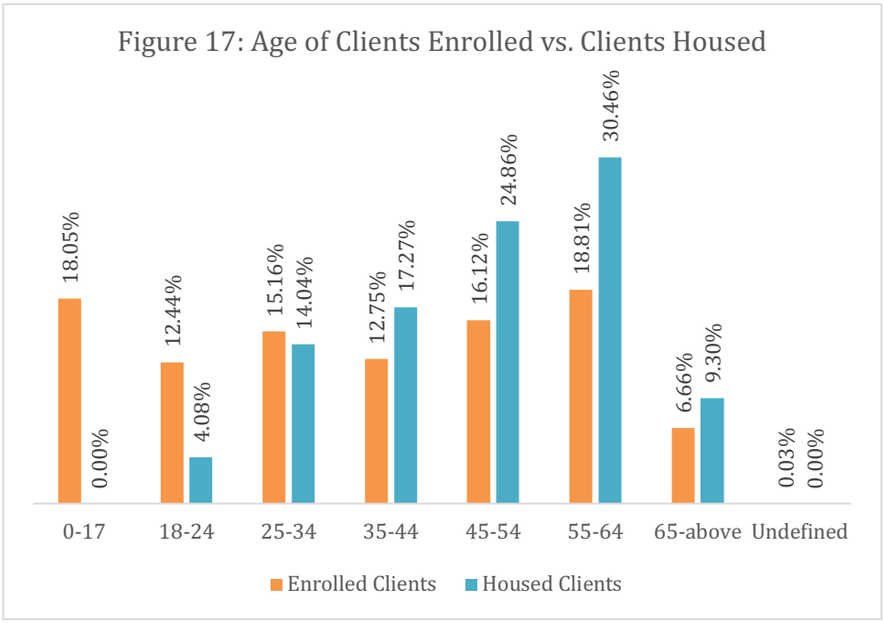


Coordinated entry is helping more households achieve housing stability. The total number of clients retaining or exiting to permanent housing increased during the reporting period and represented increased housing stability achieved in both PSH and RRH. *See Figure 16 below.*

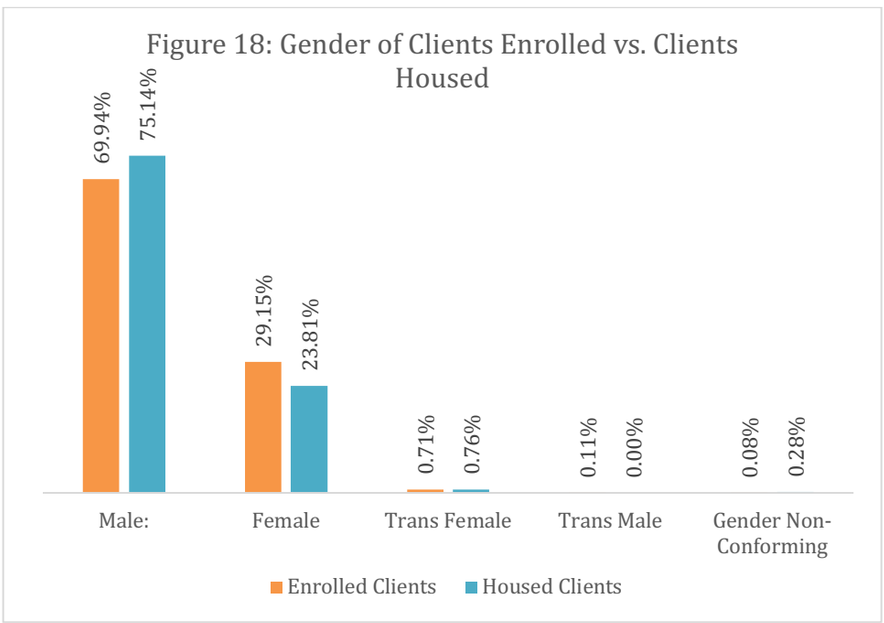


Challenges

Hispanic/Latinx persons, youth, and females enrolled in permanent housing programs are experiencing challenges securing units. While there are 12.83 percent Hispanic/Latinx among clients enrolled in permanent housing programs in the reporting period, there were only 8.25 percent Hispanic/Latinx clients housed. *See Appendix B.* Youth enrolled in permanent housing programs are also experiencing challenges securing units. While the distribution is relatively flat among the age ranges of persons enrolled into permanent housing, youth are severely underrepresented among the housed client population, which skews towards older adults. *See Figure 17.*



Females are also underrepresented among housed clients as compared to those enrolled into permanent housing. *See Figure 18.*



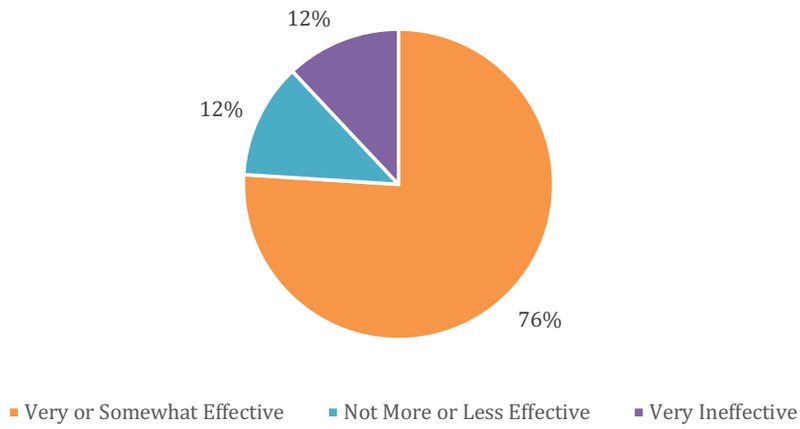
RECOMMENDATIONS: OUTCOMES

1. Consider conducting a deeper analysis of the challenges Hispanic/Latinx persons, youth, and females are experiencing in securing units once enrolled in permanent housing programs.
2. Continue tracking data around housing stability and length of stay homeless to ensure continued success in these areas.

CONCLUSION

This evaluation shows that the Southern Nevada Homelessness Continuum of Care has implemented a coordinated entry system that is successful in many core areas. The community believes this is the case as well; results from the survey show that, overall, system stakeholders feel that coordinated entry is effective: 76 percent of those responding to this question on the survey indicated that coordinated entry is either somewhat or very effective, with only 12 percent answering very ineffective (and none somewhat ineffective). *See Figure 19 below.*

Figure 19: Overall Effectiveness of Coordinated Entry



While those achievements should be celebrated and built upon, the CoC should also work to address some key areas of concern. Perhaps most important among these areas of concern are: inconsistent administration of assessments, lack of clarity around denied and expired referrals, inability to located referred clients, and extended wait times from assessment to housing move-in. We have provided the CoC with recommendations on how to address these challenges throughout the report, which are also compiled in *Appendix A* below.

APPENDIX A

COMPREHENSIVE LIST OF RECOMMENDATIONS

ENSURING ACCESS

1. Develop strategies to better inform and promote access for clients in remote areas and other populations that utilize coordinated entry at lower rates, including:
    a. Conduct regular comparisons of completed assessments and homeless populations data (PIT, etc.) to determine if any populations are disproportionately disconnected from coordinated entry;
    b. Develop and distribute targeted marketing tools, such as small cards that clients can keep and share with others, to better inform clients about coordinated entry;
    c. Ensure that all coordinated entry resources are available to any large local populations of non-English speakers; and
    d. Utilize communication networks among those experiencing homelessness, including utilizing the resources outlined above.
2. Address access issues specific to coordinated entry for youth, including:
    a. Conduct deep analysis of coordinated entry accessibility for unaccompanied minors; and
    b. Ensure that Safe Place sites and school counselors receive consistent training on coordinated entry.
3. Ensure staff at all access points are regularly trained on identifying the signs of domestic violence so they can more quickly refer survivors to DV-specific providers.

ASSESSMENT AND PRIORITIZATION

1. Implement strategies to improve the consistency and validity of assessments, including:
    a. Establish a process for the review of re-assessments that occur soon after an original assessment and/or produce an assessment score much different than the original assessment, including establishing a threshold above which a significant score change would trigger case conferencing to understand and address the situation;
    b. Require all assessors at an organization to complete an annual recertification to continue administering assessments. Recertification might include a review of the organization's previous year assessments to pinpoint any areas requiring discussion or clarity; and
    c. Consider sanctions for organizations that do not follow established policies and procedures around administering assessments, including temporary loss of assessment privileges.
2. Develop an orientation packet for clients that contains information about what to expect and what is expected after the assessment is complete.
3. Set policy on how to prioritize clients who were assessed using previous assessment tools (i.e., VI-SPDAT).
4. Consider extending the period of time that is considered by assessment tools (beyond the current three-year period).

REFERRAL AND PLACEMENT

1. Address the very high proportion of referrals that are denied for cause or let expire through a variety of measures, including:
    a. Consider removing referral expiration and requiring that programs check in with a matchmaker before denying referrals;

   b. Consider updating the referral denial reasons and providing guidance to agencies receiving referrals regarding when it is appropriate to select a reason. If guidance already exists, failure to comply should be addressed;
   c. Encourage providers to add notes that will help the matchmaker for future referrals (for the client or for the program); and
   d. Consider adding auto-generated HMIS notices that pop up when referrals are denied and include next steps that users should take if they are still in contact with the client, or if the client returns in the future for services (e.g., making sure contact and assessment information is up-to-date).
2. Experiment with methods to increase provider ability to locate clients after referral, including:
   a. Consider leveraging outreach teams to contact persons near the top of the community queue before enrollments are made to begin working on documenting eligibility for PSH;
   b. Ask additional questions about how to locate client and collect client contact information (i.e., email address, family member or friend who can get a message to client about housing opportunity);
   c. To decrease the time between referral and enrollment, consider developing a standard referral location checklist to support providers in finding referred persons; and,
   d. Follow written policies about removing clients form queue if they have not checked in within a certain time and update system accordingly.
3. Consider conducting a deeper analysis of the factors affecting the PSH CES timeline to answer the following questions:
   a. Is the recent closure of other PSH projects responsible for the extended timelines from assessment to housing move-in?
   b. Are referrals held up due to a lack of communication around program openings?
   c. Are PSH providers appropriately moving on participants who have stabilized to free up capacity to serve more vulnerable clients?
   d. What is causing delays between enrollment and move-in for project-based PSH participants?
4. Support RRH and PSH providers in building capacity around landlord engagement and housing-focused case management.
5. Create and implement a strategy for regular review (i.e., quarterly) of referral outcomes to respond to any system challenges and trends.
6. Ensure that policies and procedures around matching have been updated to reflect recent centralization of matching into one agency, and that all stakeholders understand the new matching process.

OUTCOMES

1. Consider conducting a deeper analysis of the challenges Hispanic/Latinx persons, youth, and females are experiencing in securing units once enrolled in permanent housing programs.
2. Continue tracking data around housing stability and length of stay homeless to ensure continued success in these areas.

APPENDIX B

DATA TABLES

ENSURING ACCESS

FAIR AND EQUAL ACCESS

Gender	*Unsheltered & ES PIT Count*	*Persons Assessed*	*Persons Enrolled in PSH/RRH/TH*
Male	69.02%	62.19%	69.94%
Female	30.40%	37.03%	29.15%
Trans Female or Trans Male	0.51%	0.61%	0.82%
Gender Non-Conforming (i.e., not exclusively male or female)	0.07%	0.12%	0.08%
Left Blank (null)/Data Not Collected/Client Refused/Client doesn't Know	N/A	0.05%	0.00%

Race	*Unsheltered & ES PIT Count*	*Persons Assessed*	*Persons Enrolled in PSH/RRH/TH*
White	54.21%	49.19%	46.69%
Black or African American	34.57%	41.44%	45.55%
Asian	2.60%	1.27%	0.88%
Native Hawaiian or Other Pacific Islander	1.53%	0.98%	1.22%
American Indian or Alaska Native	2.07%	1.54%	1.42%
Multi-racial	5.02%	2.88%	3.54%
Left Blank/Data Not Collected/Client Refused/Client doesn't Know	N/A	2.68%	0.71%

Ethnicity	Unsheltered & ES PIT Count	Persons Assessed	Persons Enrolled in PSH/RRH/TH
Non-Hispanic/Non-Latino	88.90%	87.19%	86.88%
Hispanic/Latino	11.10%	11.57%	12.83%
Left Blank/Data Not Collected/Client Refused/Client doesn't Know	N/A	1.24%	0.28%

REFERRAL AND PLACEMENT

APPROPRIATE REFERRALS

Time Spent on Community Queue	Referrals Made	Referrals Denied	Percent Referrals Denied
Less than a week:	633	460	72.67%
1 Week - 3 Months:	686	526	76.68%
3 - 6 Months:	145	95	65.52%
6 Months to 1 Year:	54	33	61.11%
1-2 years:	11	4	36.36%
2 years or more:	0	0	N/A

OUTCOMES

SUCCESS IN PLACEMENTS

Race	Clients Enrolled	Clients Housed
White	46.69%	49.81%
Black or African American	45.55%	44.21%
Asian	0.88%	0.85%
Native Hawaiian or Other Pacific Islander	1.22%	1.14%
American Indian or Alaska Native	1.42%	1.71%
Multi-racial	3.54%	2.18%
Left Blank/Data Not Collected/Client Refused/Client Doesn't Know	0.71%	9.00%

Ethnicity	*Clients Enrolled*	*Clients Housed*
Non-Hispanic/Non-Latinx	86.88%	91.75%
Hispanic/Latinx	12.83%	8.25%
Left Blank	0.00%	0.00%
Data Not Collected	0.20%	0.00%
Client Refused	0.08%	0.00%
Client Doesn't Know	0.00%	0.00%