Coordinated Entry: Creating A System of Accessible and Equitable Housing Services
Our mission: Community Council is the catalyst that brings together people, organizations and resources to create a stronger, healthier and more compassionate community.

Community Council is a membership organization that supports health & human services providers in our community. Community Council’s membership includes more 200 nonprofit organizations, businesses, government agencies and individuals focused on health and human service issues. Our primary coverage area of St. Charles, Lincoln and Warren Counties includes three of the four fastest growing counties in Missouri. As our communities grow, the Council provides opportunities for our members to network, collaborate and grow their capacity through community-focused planning. To fulfill our mission, Community Council supports our members in their missions to help struggling people in our communities. We unite all sectors around our community’s social service needs using the following steps: (1) educating people about the issues; (2) creating opportunities for networking and collaboration; (3) collecting and sharing service data; (4) creating organizational partnerships; (5) planning community-based solutions; and, most importantly (6) taking action by creating and leading new initiatives and organizing volunteers. Our services are divided into two program areas: Fragile Family Initiatives and Nonprofit Support Services.

The Fragile Family Initiatives staff works with organizations to address the issues of homelessness, affordable housing and hunger in our three counties and regionally. The Council serves as the lead agency for the Tri-County Continuum of Care, a coalition of more than 50 organizations developing community responses to housing issues and ensuring HUD standards and best practices are in place within our community. As part of this effort, the Council also manages the Community Information Sharing System (CISS), a database through which organizations share client and service information regarding more than 40 housing-related programs. The information collected through CISS is used to establish community benchmarks for service delivery, identify service gaps and duplication within the region and fulfill guidelines for state and federal homeless funding. CISS also serves as the foundation for coordinated entry, a system through which individuals can access all housing and related assistance through a single phone number, creating easier and more equitable access for all people experiencing housing insecurity.

The Nonprofit Support Services staff educates the community about social service issues and provides meeting/event space to assist organizations in their training and outreach programs. Monthly Network Luncheons focus on issues important to the community, as well as the programs and practices in place to help. Other workshops provide training in areas such as human resources, leadership development, marketing and funding. The annual Community Services Summit is a day-long conference providing expert-led workshops, an extensive community services fair and other resource materials for more than 650 professionals serving children and families regionally. The Community Commons offers free/low-cost state-of-the-art meeting space for nonprofit meetings, trainings and events. In 2016, the Commons hosted more than 1,100 meetings and 20,000 attendees.

For more than 60 years, Community Council has gathered leaders from local government, business, education and ministry to discuss the social service needs of their community. The Council has led efforts such as: (1956) established a student loan fund; (1958) helping establish the Association for Retarded Citizens (now ARC); (1966) brought the YMCA to St. Charles County; (1978) loaned funds to form Bridgeway Counseling Services; (1984) coordinated the first Weatherization Program with Union Electric; (1986) established a Housing Task Force to address a lack of affordable housing; (1990) worked with mental health providers to establish a 24-hour information and referral line; (1991) advocated to bring homeless funding to St. Charles County; (1997) implemented a county-wide volunteer clearinghouse; (2004) formed a Hunger Task Force; (2008) secured Neighborhood Stabilization Funding; (2009) launched the Saturday Jubilee Food Drive that now covers 9 counties regionally; (2014) developed a website for the local COAD (Community Organizations Active in Disasters) group; and (2015) helped organize the County’s first Weather Emergency Response to shelter homeless individuals during extreme cold. The Community Council began as a group of leaders volunteering their time to improve their community. Today, with a staff of 5 full-time and 4 part-time professionals, the Council provides leadership to community groups and consulting to local government agencies.
Community Council Member Organizations

Air Comfort Service, Inc.  
Alternative Behavioral Care  
Alzheimer’s Association  
American Cancer Society  
American Heart Association  
Arise Equine Therapy  
Assistance Home Care  
Association of Fundraising Professionals (AFP) - St Louis Chapter  
Athena Leadership Foundation of St. Charles County  
Barnes-Jewish St. Peters Hospital  
Barnes-Jewish St Peters Hospital-Progress West Hospital Auxiliary  
Baue Funeral Homes  
Beck Estate Planning & Elder Law, LLC  
Beyond Housing  
Birthright of St. Charles  
BJC Home Care Services & Hospice  
Boys & Girls Club of St. Charles County  
Bridgeway Behavioral Health  
Brown School - Washington University  
Calvary Church  
Cancer Support Community of Greater St. Louis  
Catholic Family Services Center for Autism Education CenterPointe Hospital  
CHADS Coalition for Mental Health  
Chestnut Health Systems  
Christian Foods II  
City of St. Charles Dept. of Community Development  
City of St. Charles School District  
Commerce Bank St. Peters  
Community Living, Inc.  
Connected LLC  
Connections to Success  
Cottleville Firefighters Outreach  
CPR Solution Saint Louis  
Craven Properties LLC  
Crider Health Center  
Crossroads Clinic Volunteers In Medicine  
Dardenne Presbyterian Church  
Delta Center for Independent Living  
Dependacare Foundation  
Developmental Disabilities Resource Board (DDRB)  
Diversity Committee - St. Charles County Association of Realtors  
Easter Seals Midwest  
EDC Business & Community Partners  
Emmaus Homes, Inc.  
Epworth Children & Family Services  
Faith Covenant Ministries  
Family Advocacy & Community Training (FACT)  
First Bank  
First Step Back Home  
First United Methodist Church - St. Charles  
FISH of St. Charles County  
Fort Zumwalt School District  
Foster & Adoptive Care Coalition  
Foster Adoption Support Team (FAST)  
Foundations Of Love, Inc.  
Francis Howell School District  
Gateway Claybusters  
Gershman Mortgage  
Gifted Support Network  
Girl Scouts of Eastern Missouri  
Good Shepherd Children & Family Services  
Greater St. Charles County Chamber of Commerce  
Habitat for Humanity of St. Charles County  
Happy Stitches  
Harvester Christian Church  
Heat-Up St. Louis, Inc.  
Home Instead Senior Care  
Hope Lutheran Church  
ITN St. Charles - Independent Transportation Network  
Just Cruises & More  
Kids Under Twenty-One (KUTO)  
Learning Momentum LLC  
Legal Services of Eastern Missouri, Inc.  
Lewis and Clark SHRM  
LINC St. Charles County  
Lindenwood University  
Little Hills Quilt Club  
Living Word Christian School  
Loose Threads Quilt Guild  
Lutheran Family & Children’s Services of Missouri  
Lutheran Senior Services  
Major James Morgan Utz Camp 1815  
MC5 - Missouri Coalition Celebrating Care  
Continuum Change  
McCay Senior Care  
Mercy  
MERS Goodwill  
Mid-East Area Agency On Aging  
Mission Matters Group  
Missouri Department of Conservation  
Missouri Job Center of St. Charles County  
Missouri River Quilters  
NAMI of St. Louis  
National Society Daughters of the American Revolution  
Saint Charles Chapter  
Newcomer Funeral Home  
North East Community Action Corporation (NECAC)  
Nurses and Company, Inc.  
O’Fallon Chamber of Commerce & Industries  
OASIS Food Pantry  
Operation Food Search  
Optimists International  
St. Charles #30377  
Our Lady’s Inn  
Phoenix Textile Corporation  
Preferred Family Healthcare  
Pride St. Charles  
Progress West Hospital  
Resources for Human Development- Missouri  
Restore St. Charles  
Rotary Club of St. Charles  
Schneider Asset Management Group  
SCORE Association - Chapter 21  
Send Me St. Louis  
Senior Services Task Force of St. Charles County  
Share Pregnancy & Infant Loss Support, Inc.  
ShowMe Aquatics & Fitness  
Show Me Gems & Minerals Club, Inc.  
Spiritual Assembly of the Bahá’ís of St. Charles County, MO Inc.  
SSM Health St. Joseph Hospital - Lake Saint Louis  
St. Charles City - County Library District  
St. Charles County Ambulance District  
St. Charles County Council of the Blind  
St. Charles County Family YMCA  
St. Charles County Golden Games  
St. Charles County Government  
St. Charles County Treatment Court  
St. Charles County Youth Soccer Association (SCCYS)  
St. Charles Outreach Coalition Against Human Trafficking  
St. Francis Community Services  
St. Louis Chapter of the American Sewing Guild  
St. Louis Crisis Nursery  
St. Louis Life  
St. Louis Society for the Blind and Visually Impaired  
St. Patrick Center  
St. Peters Athletic Association  
Step by Step Counseling, LLC  
Strategic Water Team Corporation  
Streetscape Magazine  
Sts. Joachim & Ann Care Service  
The Aviary Recovery Center  
The Boeing Company  
The Child Center, Inc.  
The Church of Jesus Christ of Latter-day Saints  
The Community and Children’s Resource Board  
The Lead School  
The Rome Group  
The Salvation Army - St. Charles  
The Sparrow’s Nest  
Maternity Home  
Thrivent Financial  
Tri-County Advisory Board  
MO Probation & Parole  
Trinity Episcopal Church  
Trinity Strategic Growth Solutions  
Turning Point  
United Methodist Church of the Shepherd  
United Services for Children  
United Way of Greater St. Louis  
University of Missouri Extension - St. Charles  
University of Missouri - St. Louis Nonprofit Management and Leadership Program  
Visiting Angels of Greater St. Charles  
Visiting Nurse Association of Greater St. Louis  
VITAS Healthcare  
Vitendo 4 Africa Foundation  
Volunteers in Medicine- St. Charles  
VOYCE  
Wellness Research  
We Love Saint Charles  
West Community Credit Union  
Young Choices  
YouthBridge Community Foundation  
Youth In Need  
YWCA Woman’s Place of St. Charles
The Tri-County Continuum of Care was formed in 2004 to enable organizations in St. Charles, Lincoln and Warren Counties to access federal and state homeless funding. Community Council of St. Charles County serves as the lead agency for the Continuum, providing leadership, data management and consulting.

St. Charles, Lincoln and Warren County are three of the four fastest growing counties in Missouri. According to the Missouri Division of Budget and Planning, between 2000 and 2030 Lincoln County is expected to see a 134.4% growth in its population. Warren County follows with 88.5% and St. Charles County with 75.8% population growth. As our communities grow, we must address the systems of care for our vulnerable citizens. The Continuum of Care provides community planning around the issues of homelessness, housing insecurity and affordable housing. Meetings are held monthly and special trainings are provided periodically throughout the year. Continuum committees assist with administration, data management and special projects such as Coordinated Entry.

Organizations participating in Continuum of Care planning include:

- 11th Circuit Family Court
- Agape Ministry of Warren County, Inc.
- Assumption Church St. Vincent De Paul
- Bridgeway Behavioral Health
- City of O’Fallon
- City of St. Charles School District
- Connections to Success
- Crider Health Center
- Crossroads Clinic Volunteers In Medicine
- Fort Zumwalt School District
- Habitat for Humanity of St. Charles County
- Harvester Christian Church
- In His Service
- Labor Ready
- Lincoln County Health Department
- Lincoln County Resource Board
- Lutheran Family & Children’s Services of Missouri
- Megan Meier Foundation
- Mercy
- Mercy Coverage Assistance Program
- Mercy Neighborhood Ministry
- Mid-East Area Agency On Aging
- Missouri Care: Wellcare Health Plans, Inc
- Missouri Department of Elementary and Secondary Education
- Missouri Family Support Division
- Missouri Housing Development Commission
- Missouri Job Center of St. Charles County
- MO National Guard and Reserve Family Assistance Center
- North East Community Action Corporation (NECAC) - Warrenton
- Office of U.S. Senator Roy D. Blunt
- Orchard Farm R-V School District
- Our Lady’s Inn
- Preferred Family Healthcare
- Slex R-1 School District
- Society of St. Vincent de Paul St. Louis
- St. Charles Borromeo St. Vincent DePaul
- St. Charles County Department of Public Health
- St. Charles County Government
- St. Louis Crisis Nursery
- St. Patrick Center
- Sts. Joachim & Ann Care Service
- The Bridge
- The Community and Children’s Resource Board
- The Salvation Army Midland Division
- The Salvation Army-O’Fallon
- Volunteers in Medicine-St. Charles
- Warren County R-III School District
- We Love Saint Charles
- Wentzville R-IV School District
- Wright City R-II School District
- Youth In Need
Community Needs Addressed:
(1) For many people, accessing housing services is a long, difficult process. While they can find information about service providers through United Way’s 2-1-1 system or online through the Community Council’s online resource directory, identifying a provider with program openings to match needs can be challenging. Someone already in distress over their housing situation is forced to make numerous phone calls, undergo multiple assessments and, often, wait long periods for services to become available.
(2) There is no standardized method for determining how applicants should be prioritized for services. Service prioritization decisions are often made at the discretion of case managers. Without standardized evaluation methods, there is potential for biases within the system.
(3) The Tri-Counties (St. Charles, Lincoln and Warren) receives only a fraction (4%) of federal and state homeless funds for the Metro St. Louis region, but serves 26% of the homeless population in the region. This comes to about $274/ homeless person in the Tri-Counties, while St. Louis City receives approximately $6,700/person and St. Louis County receives $3,700/person. With limited resources, nonprofit service providers struggle to keep up with need. Much of case managers’ time is spent answering calls and doing assessments on clients that may not even qualify for the programs they offer.

Coordinated Entry Program Objectives:
(1) Create an easy to use and efficient way for people experiencing housing insecurity to access services. Reduce time spent in homelessness to less than 20 days for all applicants.
(2) Create an unbiased system for placement and prioritization of services using a standardized, research-based assessment tool to determine levels of vulnerability.
(3) Provide a more efficient assessment, referral and waiting list system for nonprofit providers of housing services.

Program Description:
Coordinated Entry is an easily accessible and well-publicized phone number through which people experiencing housing insecurity can access all housing services provided through Tri-County Continuum of Care organizations. Through the phone line, a trained social worker will conduct all triage and vulnerability assessments needed to determine an applicant’s program eligibility and will: (1) provide a qualified referred to an agency with an appropriate program opening for immediate assistance; or (2) place the applicant on a shared waiting list (prioritized by vulnerability assessment scores) for placement when an appropriate opening becomes available.

Coordinated Entry Program Timetable:
2014-15 Database software upgraded to provide foundation for Coordinated Entry.
2015-17 Customized reporting developed. Users trained on data entry protocols, as well as data quality and timeliness.
1/1-7/1/2017 Continuum of Care workgroups develop plan for implementation and operation of Coordinated Entry system for approval in July 2017. The Continuum of Care voted in May 2017 to move forward with Coordinated Entry with Community Council as lead agency. Community Council meets with local government officials, partner agencies and community funders to develop sustainability plan.
7/1-12/31/2017 User agencies trained regarding referral and waiting list processes, protocol changes, data entry and reporting. Initial staff hired to operate Coordinated Entry phone line. Beta testing of system begins. Marketing plan developed to notify public of availability of Coordinated Entry phone line. Council staff continue work on sustainability funding.
1/23/2018 Target date for public release of Coordinated Entry System.
2018 Community Council and Tri-County Continuum of Care develop continuous quality improvement plan based on user and applicant feedback. Additional staff hired as needed based on call volume and assessment times.
Coordinated Entry: Why Is It Needed?

Last year, more than 1,750 households (1,900 adults and 1,300 children) received services because they were homeless or at risk of homelessness in the Tri-Counties (St. Charles, Lincoln and Warren). According to the Australian Housing and Urban Research Institute, “Housing insecurity, in its various dimensions, is linked to insecurities in other areas of life, such as finances, employment, health, insecurity of self and family instability. The consequence of living with this combination of insecurities is that a person’s key focus is on surviving from day to day.”

For many of these people, accessing housing services was a long, difficult process. While they could find information about service providers through United Way’s 2-1-1 system or online through the Community Council’s Online Resource Directory, identifying a provider with available programs and funding to match their needs could be challenging. Someone already in distress over their housing situation was forced to make numerous phone calls, undergo assessments at several agencies and, often, wait for services to become available.

Coordinated Entry is an easily accessible and well-publicized phone number or location where people in crisis can access all housing services provided through Tri-County Continuum of Care organizations. Trained intake staff perform triage to determine if an individual is in imminent danger of homelessness. The triage assessment also identifies veterans, youth and people fleeing domestic violence to direct them to targeted services. Staff may then conduct a standardized VI-SPDAT assessment to determine the needs and vulnerability of the individual or household. Based on the information collected, they provide an online referral to the service provider with programs best suited to the client’s needs. In the past, service providers would ask, “How can I fit this person into my organization’s programs?” They would use their own subjective criteria to place and prioritize those applying for services. With Coordinated Entry, the question asked is now, “What assistance is best for this person?”

**COORDINATED ENTRY FLOWCHART**

1. **Call / Walk-in**
2. **Perform Triage**
   - Did you serve in the military? **YES** → **E-mail referral to SSVF**
   - Are you fleeing domestic violence? **YES** → **E-mail referral to DV shelter**
   - Are you under the age of 13 or 18? **YES** → **E-mail referral to Youth in Need**
3. **Pregnant?** **YES** → **E-mail referral to Our Lady’s Inn**
4. **Homeless or in danger of homelessness?** **YES** → **Perform VI-SPDAT**
   - In crisis? **YES** → **In crisis?**
     - Temporary shelter; crisis averted
     - Complete Coordinated Assessment
5. **E-mail referral to agency on Caseworker referral list that provides needed services identified in Coordinated Assessment: permanent supportive housing, transitional housing, rapid re-housing, and supportive services.**

**IN THE PAST, HELP WAS A CONFUSING MAZE OF PHONE CALLS, APPOINTMENTS AND REFERRALS...**

?? ?? ?? ??
Because all screenings are conducted using the same triage forms and vulnerability screenings, staff do not rely on subjective measures to determine placement. Coordinated Entry is a more equitable system of referrals and placement, since everyone is placed in services or on waiting lists using the same criteria based on their vulnerability and need. In addition, results from triage and assessments can be shared among all agencies in the Coordinated Entry database. This streamlines the eligibility process as clients need only complete one set of intake and assessment forms.

**Standardized Assessment Tools Help Trained Staff...**

- Fairly Provide Placement in Programs Based on Common Screening Questions
- Prioritize Placement in Programs Based on Vulnerability & Need

The Department of Housing & Urban Development (HUD) has mandated that communities accessing federal homeless funds implement a Coordinated Entry program by January 23, 2018. Some state funders are following suit and mandating Coordinated Entry in communities receiving funding.

### TRI-COUNTIES FEDERAL & STATE HOMELESS FUNDING IMPACTED BY COORDINATED ENTRY REQUIREMENT (2016 amounts)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Continuum of Care Funding</td>
<td>$ 272,450</td>
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<tr>
<td>Continuum planning, reporting &amp; performance</td>
<td>5,028</td>
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<tr>
<td>Emergency Solutions Grant (ESG)</td>
<td>297,353</td>
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<tr>
<td>Missouri Housing Trust Fund (MHTF)</td>
<td>350,000</td>
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<tr>
<td>Missouri - Housing First</td>
<td>101,348</td>
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<tr>
<td>VA - St. Patrick SSVF (3 Counties)</td>
<td>531,724</td>
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<td><strong>CURRENT TOTAL</strong></td>
<td><strong>$1,557,903</strong></td>
</tr>
<tr>
<td>HHS - Runaway &amp; Homeless Youth (RHY)</td>
<td><strong>$ 200,000</strong></td>
</tr>
<tr>
<td><em>(Youth In Need seeking to recapture RHY dollars)</em></td>
<td></td>
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<tr>
<td><strong>TOTAL WITH RHY</strong></td>
<td><strong>$1,757,903</strong></td>
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Qualities of Effective Coordinated Entry

The Tri-County Continuum of Care (CoC) is following HUD directives on best practices to design its Coordinated Entry system. According to HUD’s Coordinated Entry Policy Brief, an effective Coordinated Entry program should have the following qualities:

• **Prioritization** - ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC.

• **Low Barrier** - does not screen people out for assistance because of perceived barriers to housing or services, including lack of employment or income, drug or alcohol use, or having a criminal record.

• **Housing First orientation** - people are housed quickly without preconditions or service participation requirements.

• **Person-Centered** - incorporates participant choice, including location and type of housing, level of services, and other options about which households can participate in decisions.

• **Fair and Equal Access** - people can easily access the coordinated entry process, whether in person, by phone, or some other method, and the process for accessing help is marketed and well known.

• **Emergency services** - does not delay access to emergency services such as shelter and includes a manner for people to access emergency services at all hours.

• **Standardized Access and Assessment** - offers the same assessment approach and provides referrals using uniform decision-making processes for all clients.

• **Inclusive** - includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, and survivors of domestic violence.

• **Referral to projects** - makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, rapid rehousing, permanent supportive housing and transitional housing, as well as other housing and homelessness projects.

• **Referral protocols** - programs accept all eligible referrals unless the CoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.

• **Outreach** - process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.

• **Ongoing planning and stakeholder consultation** - CoC engages in ongoing planning with all stakeholders participating in the coordinated entry process. Planning includes evaluating and updating the coordinated entry process at least annually. Feedback from individuals and families is regularly gathered through surveys, focus groups, and other means and is used to improve the process.

• **Informing local planning** - information gathered through the coordinated entry process is used to guide homeless assistance planning and system change efforts in the community.

• **Leverage local attributes and capacity** - physical and political geography, including the capacity of partners in a community, and the opportunities unique to the community, inform local coordinated entry implementation.

• **Safety planning** - protocols are in place to ensure the safety of the individuals seeking assistance.

• **Using HMIS and other systems for coordinated entry** - the CoC may use HMIS or another existing system to collect and manage data associated with assessments and referrals.

• **Full coverage** - covers the CoC’s entire geographic area.
Coordinated-entry-self-assessment

Community Council and the Tri-County Continuum of Care began work toward Coordinated Entry in 2015 when they moved data from the Tri-Counties’ Homeless Management Information System (HMIS)/Community Information Sharing System (CISS) to a CaseWorthy software platform. The new software allowed for greater flexibility in data collection and reporting, included common standardized assessment tools and provided tools for shared eligibility screenings and online referrals. Since 2015, Council staff have worked with partner agencies to train staff on system use, streamline data entry processes and improve data quality.

In January 2017, HUD mandated that all Continuums of Care receiving homeless funding implement a full coordinated entry program by January 23, 2018. The Continuum of Care quickly went to work researching best practices and developing plans appropriate to our community. A vote by Continuum members on an initial plan is expected at the May 2017 meeting. Council plans to hire a Coordinated Entry director and social worker in early fall, so the Continuum can begin Beta testing during the 4th quarter. A “go live” date is scheduled no later than January 23, 2018.

Continuum of Care teams will be meeting throughout the year to ensure progress towards Coordinated Entry implementation. The Continuum and its committees are using HUD’s Coordinated Entry Self-Assessment tool to monitor timelines and progress. Below is a sample page from the self-assessment tool and how the Continuum is using it for project management:

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Phase</td>
<td>Committee</td>
<td>Coordinated Entry Self-Assessment</td>
<td>Questions/Comments</td>
<td>Who is responsible?</td>
</tr>
<tr>
<td>2</td>
<td>A. Planning</td>
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<tr>
<td>2</td>
<td>Executive/CE</td>
<td>1) Deadline for Compliance-January 23, 2018</td>
<td>CoC Program interim rule: 24 CFR 578.7(a)(8) HUD Coordinated Entry Notice: Section 1.B CoC's Coordinated entry process meets the requirements (below) established by the CoC Program Interim Rule CoC Program interim rule: 24 CFR 578.3 &amp; 24 CFR 578.7(a)(8)</td>
<td></td>
<td>CoC Executive Committee</td>
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<tr>
<td>3</td>
<td></td>
<td>2) CES covers the entire geographic area claimed by the CoC. 3) CES is easily accessed by individuals and families seeking housing or services.</td>
<td>St. Charles, Lincoln &amp; Warren Counties to be covered by phone/walk-in in St. Charles; will explore satellite options/outreach next</td>
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<td>CoC Executive Committee</td>
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<td>4</td>
<td></td>
<td>4) CES is well-advertised.</td>
<td>Plan within 2 months of launch</td>
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<td>5</td>
<td>Communications</td>
<td>5) CES includes a comprehensive and standardized assessment tool(s). 6) CES provides an initial, comprehensive assessment of individuals and families for housing and services.</td>
<td>Review current tools &amp; processes; triage, VISPADAT and CE; add additional tools if needed</td>
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<td>6</td>
<td>Performance</td>
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<tr>
<td>6</td>
<td>Policy (also access/outreach)</td>
<td>7) CES includes a specific policy to guide the operation of the centralized or coordinated assessment system to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers. Include waiting lists for publicly funded programs being coordinated by CE. Process document steps 1-5</td>
<td></td>
<td>Dottie will prepare 1st draft</td>
<td>Policy manual 1st draft by 5/15/2017</td>
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<td>8</td>
<td>Access/Outreach &amp; Service access</td>
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<td>9</td>
<td>Policy</td>
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<tr>
<td>10</td>
<td>HMIS</td>
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The Continuum of Care has developed several workgroups to facilitate a smooth implementation of Coordinated Entry and to ensure input and participation from participating agencies. Standing committees overseeing the general work of the Continuum, as well as Coordinated Entry, include:

- **CoC Executive Committee** - monitors overall Coordinated Entry implementation
- **HMIS steering Committee** - oversees database vendor (CaseWorthy), processes and policies
- **Access/Outreach** - works to improve outreach and system access processes and develops criteria for a client referrals.
- **Policy Committee** - reviews policy drafts, recommends changes and presents policies to Continuum for approval.
- **Performance Review** - an ad hoc committee to review Continuum project performance.

Workgroups for the Coordinated Entry project implementation include:

- **Service Access** - public funded agencies (shelters, transitional housing, rapid rehousing, permanent supportive housing) help evaluate and design processes within their organizations to: reduce intake duplication from Coordinated Entry; prioritize waiting lists; receive electronic referrals; increase real-time database access and reporting by staff; and monitor waiting lists. Group may also develop a prioritization process for homeless prevention and/or other emergency assistance.

- **Crisis Response** - develops process and resources for accessing alternative emergency shelter when clients are triaged and determined to be highly vulnerable, but emergency shelter beds are unavailable,

- **Housing Navigation/Access** - ‘Housing Navigator’ functions may include: working with referral agencies regarding eligibility determination; developing a Housing Stability Plan; completing housing applications; perform housing search and placement; outreach to and negotiations with landlords; assisting with submitting rental applications and understanding leases; addressing barriers to admissions; compiling information on landlords who may be willing to work with a person with housing barriers; and identifying landlord contacts, emails and criteria for receiving referrals.

- **Resource Development** - compiles information on church-based and informal resources for emergency and supportive services.

- **Training** - develops a training schedule and processes for training constituents in Coordinated Entry.
Coordinated Assessment Outcomes & Monitoring

The Tri-County Continuum of Care has developed a set of community-based outcomes based on HUD benchmarks. The Continuum will publish yearly outcomes information and compare current year’s data with Continuum benchmarks. Below is a sample page from the Continuum’s yearly outcomes report:

**Report:** Year 1 and 2-System Performance Report  
**Period:** 10-1-14 to 9-30-15 and 10-1-15 to 9-30-16  
**Program(s):** CoC housing & outreach programs in CaseWorthy

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**Metric 1a - Length of Time Persons Remain Homeless**

<table>
<thead>
<tr>
<th></th>
<th>10-1-14 to 9-30-15 number served</th>
<th>10-1-14 to 9-30-15 Average LOT Homeless</th>
<th>10-1-15 to 9-30-16 number served</th>
<th>10-1-15 to 9-30-16 Average LOT Homeless</th>
<th>CoC Benchmark</th>
<th>Comments/areas for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons in ES</td>
<td>479</td>
<td>39</td>
<td>404</td>
<td>30</td>
<td>&lt;20 days</td>
<td>strengthen linkages between shelter and permanent housing</td>
</tr>
<tr>
<td>Persons in ES, and TH</td>
<td>536</td>
<td>78</td>
<td>457</td>
<td>69</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

**Metric 2a - The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness 2014-2016**

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Persons who Exit to a Permanent Housing Destination (2 Years Prior)</th>
<th>Number Returning to Homelessness in Less than 6 Months (0 - 180 days)</th>
<th>Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)</th>
<th>Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)</th>
<th>Number of Returns in 2 Years</th>
<th>Percentage of Returns in 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit was from ES</td>
<td>207</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>18</td>
<td>9%</td>
</tr>
<tr>
<td>Exit was from TH</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Exit was from PH</td>
<td>32</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Total Returns to Homelessness</td>
<td>249</td>
<td>8</td>
<td>4</td>
<td>9</td>
<td>21</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Metric 3.2 - Number of Homeless Persons in Emergency & Transitional Housing**

<table>
<thead>
<tr>
<th></th>
<th>10-1-14 to 9-30-15 Number served</th>
<th>10-1-15 to 9-30-16 Number served</th>
<th>CoC Benchmark</th>
<th>Comments/areas for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Unduplicated Total sheltered homeless persons</td>
<td>536</td>
<td>457</td>
<td>N/A</td>
<td>Use Coordinated Entry to determine how many people are being turned away for shelter</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>479</td>
<td>404</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>106</td>
<td>82</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

---

Similar reports will be run annually for individual organizations participating in Coordinated Entry and will focus on areas specific to that organization. Community Council staff will review these reports with the organization’s management and staff to determine areas for improvement.

Key focus areas for ongoing monitoring include:

- **Identify individuals NOT being served** - Current data provides a strong picture of services being provided by participating organizations; however, this data does not reflect: individuals who called an organization but did not receive services; referrals to other organizations that did not result in services; individuals identified through street outreach but not accessing services. With Coordinated Entry, the Continuum will better be able to track individuals who have sought assistance, but have not received services.

- **Identify health, mental health and behavioral health issues contributing to homelessness and housing insecurity** - Organizations currently are not required to collect information on disabilities, insurance status, mental health and substance abuse issues that may contribute to homelessness. The standardized intake and vulnerability screenings provided through Coordinated Entry will allow agencies to prioritize individuals with contributing needs, as well as provide data to the community regarding these issues.
Lancaster County, PA, is now in their 8th year of Coordinated Entry. Their program, CHART (Community Homeless Assessment and Referral Team), successfully implemented the Coordinated Entry process among their housing service providers and have expanded to reach other assistance providers in the community. Here is their story:

2009 - 2013
The Lancaster County Coalition to End Homelessness began work on its Coordinated Entry system in 2009. The coalition began as part of county government, but later became a separate nonprofit, allowing it to be nimble as it addressed needs and change.

The coalition hired staff dedicated to the Coordinated Entry initiative and developed workgroups to guide planning and implementation.

A large healthcare system provided in-kind space as a contribution to the project, building on the connection between housing and health outcomes.

2013 - 2017
CHART staff joined with United Way’s 2-1-1 system as an entry point for Coordinated Entry. 2-1-1 is available 24/7 to provide prescreening. 2-1-1 then refers clients who are homeless to CHART social workers who respond within 24 hours of the referral and complete vulnerability assessments. Their aim is to divert individuals from shelter to other housing supports.

Coordinated Entry is fully funded through county service funding, homeless assistance grants and some ESG funds.

Present
Lancaster County serves a population of 600,000. In 2015, 1,872 referrals were made to CHART and 1,220 assessments were completed.

Today, CHART has 160 partners including housing providers, churches, nonprofits, educators and hospital teams.

Coalition staff work with hospital quality assurance to divert homeless individuals from the ER to housing services. Hospital teams have access to the Coordinated Entry database, and there are discussions about bridging medical records to the system. Hospital staff like the ability to make electronic referrals when they are doing discharge planning.

CHART also created a faith-based networking group and now links to 800 area churches. Most church benevolent funds are now managed through regional groups (ministeriums) using the CHART system.

Tomorrow
The dream is to create a county-wide social services network based on the CHART system!
What Do the Tri-Counties Need to Be Successful?

The Tri-County Continuum of Care is at a financial disadvantage when it comes to funding for homeless programs, including Coordinated Entry. In the St. Louis region, there are large gaps in homeless funding from one community to another:

### ST. LOUIS REGION HOMELESS FUNDING BY COUNTY

<table>
<thead>
<tr>
<th>County</th>
<th>Continuum of Care Funding</th>
<th>Funding per Homeless Person Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Louis City</td>
<td>$12,531,638 (85%)</td>
<td>$6,721</td>
</tr>
<tr>
<td>St. Louis County</td>
<td>$1,684,596 (11%)</td>
<td>$3,704</td>
</tr>
<tr>
<td>Tri-Counties</td>
<td>$517,262 (4%)</td>
<td>$274</td>
</tr>
</tbody>
</table>

(St. Charles, Lincoln, Warren)

To ensure homeless individuals in our community receive the services they need, the Continuum of Care organizations have diligently worked to create system efficiencies based on community planning and collaboration.

Although mandated to implement Coordinated Entry, the Tri-County Continuum of Care will receive no additional funds from HUD for the program. Therefore, we are seeking investment from Continuum organizations, county government, local municipalities and other funders for start-up costs and, in some cases, sustainability of the program.

Our estimated budget for 2017 and the first three full years of Coordinated Entry includes the following:

<table>
<thead>
<tr>
<th></th>
<th>2017 (Q4)</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff salaries:</td>
<td>$50,000</td>
<td>$210,000</td>
<td>$260,000</td>
<td>$265,000</td>
</tr>
<tr>
<td>Database expansion:</td>
<td>$4,500</td>
<td>$18,000</td>
<td>$18,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>Office Space:</td>
<td>$1,500</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Utilities:</td>
<td>$6,000</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$0</td>
</tr>
<tr>
<td>Computers/Equipment</td>
<td>$5,600</td>
<td>$28,400</td>
<td>$41,900</td>
<td>$42,400</td>
</tr>
<tr>
<td>Marketing &amp; Administration</td>
<td>$67,600</td>
<td>$315,400</td>
<td>$463,900</td>
<td>$466,400</td>
</tr>
</tbody>
</table>

To sustain the program, we are asking each of the organizations participating in Coordinated Entry to provide a level of funding based on their usage of the system. In addition, we have received commitments from the St. Charles County Government, as well as several municipal governments, to help fund the system. Community Council is currently negotiating funding amounts with our government partners. In addition, we are seeking funding from community organizations with a vested interest in the success of Coordinated Entry (hospital systems, the Economic Development Commission, etc.). We are looking to several grant funders to assist with start-up costs for Coordinated Entry to allow our community partners the opportunity to gradually add the expense for Coordinated Entry into their respective budgets. Our expectation for investments is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Grant Funds</td>
<td>37%</td>
<td>40%</td>
<td>27%</td>
<td>21%</td>
<td>0%</td>
</tr>
<tr>
<td>Continuum of Care Partners</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>County &amp; Local Govts.</td>
<td>63%</td>
<td>39%</td>
<td>48%</td>
<td>51%</td>
<td>65%</td>
</tr>
<tr>
<td>Community Partners</td>
<td>15%</td>
<td>18%</td>
<td>20%</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>