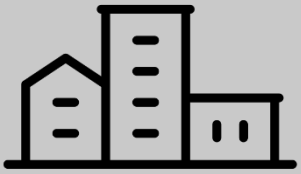

Coordinated Entry for All

2020 Annual Evaluation

King County

King County Department of Community and Human Services
Performance Measurement and Evaluation Unit
401 Fifth Avenue, Seattle, WA 98104
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Prepared for the Seattle/King County Continuum of Care:

King County Regional Homelessness Authority Advisory Board

System Performance Committee

Coordinated Entry Policy Advisory Committee

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Glossary

Case Conferencing: The mechanism for active management of the Priority Pool and for matching households to available housing resources. Hosted weekly by Coordinated Entry for All staff, homeless service providers from the community meet to match households on the Priority Pool to available resources. Households are nominated for resources based on their eligibility and interest, and then tie-breakers are administered as a group in the event that more than one household has been identified for a given resource.

Continuum of Care (CoC): A Continuum of Care (CoC) is a regional or local planning body that coordinates housing and services funding for homeless families and individuals.

COVID Prioritization (COPri): The prioritization method used within Seattle/King County to prioritize households who are most disproportionately impacted by COVID-19 for all housing openings. It incorporates factors which lead to increased risk for mortality from or severity of COVID-19 and relies on cross-systems administrative data.

Homeless Management Information System (HMIS): HMIS is an information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families as well as persons at risk of homelessness.

Housing Triage Tool (HTT): The coordinated entry assessment tool used in the Seattle/King County Continuum of Care. It consists of the VI-SPDAT plus supplemental questions about factors such as foster care involvement, unmet medical needs, and interest in identity-based resources.

Interim Prioritization (IP): Interim Prioritization refers to the process in Seattle/King County of using and assessing new prioritization formulas, in addition to a household's VI-SPDAT score, to address noted racial disparities in who is prioritized for CEA resources while a new assessment tool is found or developed. Interim Prioritization began at the end of 2018.[1]

Mobility Transfer: With a mobility transfer request, households currently enrolled in a housing program are prioritized for transfer to another housing program if they experience an imminent safety issue, require a geographic change, have a change in service need, are aging out of their current program with no other housing options, or if their family size changes.

Priority Pool: The group of households in each population that are prioritized for matches to housing resources. Case conferencing groups will use this pool to match to housing resources. The Priority Pool is sized to match the average number of available resources for each subpopulation within a 60-day period.

Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT): Developed by OrgCode Consulting, an assessment tool administered to individuals and families experiencing homelessness to determine their vulnerability and need of services. Results of the survey can be used to prioritize households for homeless services. It includes questions about a household's history of homelessness, health and wellness, socialization, and daily functioning. There are separate assessments for Adults, Families, and Transition Age Youth.

[1] For more information about the VI-SPDAT and the history of the prioritization process in Seattle/King County, please see Appendix A.

Executive Summary

Coordinated Entry for All (CEA) is the Seattle/King County Continuum of Care's approach to coordinated entry. Coordinated entry is a HUD-mandated process for ensuring that the highest need, most vulnerable households experiencing homelessness are prioritized and placed in housing and that supportive services are used as efficiently and effectively as possible. Maximizing access to essential federal funding for homelessness services requires the region to broadly adopt and utilize CEA. King County's CEA is also committed to ensuring that racial disparities and inequities in the experience of homelessness are eliminated. CEA does not fund, create, or provide housing units to homeless households. Instead it works with providers throughout the community by facilitating referrals and connections to housing services, convening workgroups to improve Seattle/King County's coordinated entry process as a foundation to the homeless response system, and providing trainings and guidance.

Fulfilling HUD's requirement for an annual evaluation of CEA, this evaluation covers regional CEA activities undertaken throughout 2020. The findings of this evaluation will be brought to CEA staff and the CEA governing bodies in order to continuously improve the services that they offer to the community.

Key Findings

'COVID Prioritization' is an exciting and novel development in prioritizing households for housing resources.

CEA made multiple operational changes in response to the COVID-19 pandemic, one of which was to develop a new prioritization method known locally as "COVID Prioritization." COVID Prioritization identifies households experiencing homelessness who are at highest risk for developing serious and life-threatening health complications from COVID-19. These risk factors include advanced age, racial and ethnic identities that are disproportionately represented in the homeless response system and have disparate health outcomes from COVID-19, certain health conditions, and pregnancy status. This new prioritization method makes use of cross-systems administrative data from the Homeless Management Information System (HMIS), Washington State Medicaid Claims Data, and Public Health - Seattle & King County's Healthcare for the Homeless Network. This level of integration and access to cross-systems data was made possible through years of investment in data infrastructure and collaborative data governance by King County DCHS and their partners.

COVID Prioritization has been very successful in addressing equity concerns that have previously beleaguered the prioritization step of the CEA Process, problems not unique to King County, but rather to many of those who've relied on the VI-SPDAT assessment.[2] COVID Prioritization has accordingly received positive feedback from the community in those regards. Some concerns about the transparency of the process that have been voiced could be addressed with targeted communication and outreach to the provider community.

The successes of COVID Prioritization offer a great opportunity for CEA to increase community buy-in to the Coordinated Entry system. Lessons learned from this new method should be used now for CEA to envision and plan for prioritization once the COVID-19 pandemic has been contained.

[2] C4 Innovations, 'Coordinated Entry Systems: Racial Equity Analysis of Assessment Data'

Recommendations:

- Communicate with the homeless response community, nationally and locally, about how COVID Prioritization works and its successes.
- Begin planning now for post-pandemic prioritization by incorporating lessons from the COVID Prioritization experience of using administrative data. This includes anticipating the need for renewed authorization to use these data in this manner, and continued collaboration with subject matter experts in related fields.

Affordable and supportive housing resources are extremely limited relative to the scale of the homelessness crisis in Seattle/King County.

There continue to be too few housing resources to serve all of those in need in the Seattle/King County community. The scarcity is both an issue of overall supply of housing – the number of units – and of the types of units. Permanent supportive units are in short supply for all types of households; resources tailored to seniors, housing that welcomes couples without children, and resources with intensive behavioral health supports for youth and young adults are virtually nonexistent. This limited supply contributes to lengthy episodes of homelessness and a slow Coordinated Entry process. This scarcity also creates an imperative to use existing resources effectively and efficiently, so concerted efforts to decrease the frequency of denials in the Coordinated Entry process should be made. To help in this regard, the system could focus on increasing housing navigation (particularly for Single Adult households) to ensure steady contact and understanding of households needs and preferences, and increasing flexibility in eligibility requirements to make resource matching easier and denials due to ineligibility less likely.

CEA should continue to use their position as a coordinating arm of the homeless response system to inform policy choices and priorities about what types of additional housing resources would meet the unique needs of those currently unserved. Government and philanthropy have the authority and responsibility to increase housing stock, and to do so in a way that supports a regional response to the homelessness crisis. Changes to CEA, whether they be improvements of the existing process or wide-sweeping changes like switching to by-name-lists for all populations, without an increase in resources can have only a minimal impact on households experiencing homelessness.

Recommendations:

- Increase the efficiency of existing resources by focusing on decreasing the number of denied referrals. Increase the availability of quality housing navigation, particularly for Single Adult households, and create flexibility in eligibility requirements wherever possible.
- Continue to use the information about housing needs generated by Coordinated Entry to advocate for new and expanded housing resources.

In order to properly function as a system, CEA needs additional authority and resources.

Coordinated Entry is intended to be a system by which housing resources are distributed efficiently, equitably, and transparently. Without sufficient community buy-in and institutional support, however, it cannot accomplish these goals. As stated by a CEA staff member, *"We call it a system, but it was never*

really implemented as a system, and it's never really been given the resources or the authority to be able to move towards a system."

Participation in CEA is required of providers, but not all of them do so in a committed fashion. Fragmented support for the Coordinated Entry system reduces the system's effectiveness, risking a cycle of decreasing performance and decreasing use. Minimal staffing of CEA, forcing staff to spend all their time and efforts on the essentials of their job, leads to the inability to innovate or to improve the system. This has side-lined the development of alternative approaches to Coordinated Entry such as large scale by-name-lists, which would require far more staff time than is currently available to operate effectively. For a transformational Coordinated Entry system, CEA would need additional authority and resources.

Recommendations:

- Create pathways of accountability for providers participating in the Coordinated Entry system.
- Staff CEA in a sustainable manner that allows for improvement of and innovation in the Coordinated Entry system.

About this Evaluation

The purpose of this evaluation is to improve Coordinated Entry for All's current activities and help plan for its future evolution while maintaining compliance with US Department of Housing and Urban Development and the Washington State Department of Commerce requirements for an annual evaluation of coordinated entry. The lessons from this evaluation will be brought to CEA staff and the CEA governing bodies in order to continuously improve the services that they offer to the community.

Evaluation activities consisted of quantitative analysis of CEA data found in HMIS and interviews with CEA staff. Quotes from those staff interviews are found throughout the report.

Coordinated Entry for All: Background

Coordinated Entry for All (CEA) is the Seattle/King County Continuum of Care's approach to coordinated entry. Coordinated entry is a HUD mandated process for ensuring that the highest need, most vulnerable households experiencing homelessness are prioritized and placed in housing and that supportive services are used as efficiently and effectively as possible. Locally, CEA is also committed to ensuring that disparities and inequities in the experience of homelessness are eliminated. CEA does not fund, create, or provide housing units to homeless households. Instead it works with providers throughout the community by facilitating referrals and connections to housing services, convening workgroups to improve Seattle/King County's Coordinated Entry process as a foundation to the homeless response system, and providing trainings and guidance. Figure 1 is a simplified version of the logic model underpinning CEA's core components.

FIGURE 1: SIMPLIFIED CEA LOGIC MODEL

Inputs	Activities	Outputs	Outcomes
Assessors & Front Door Staff	Attempt Diversion Assess households with Housing Triage Tool	Households diverted Assessments completed	Highest need, most vulnerable households are prioritized and placed in housing
Housing Navigators & Providers	Locate and communicate with households Learn & share household housing preferences	Case conferences attended Clients nominated for resources	Supportive services are used as efficiently and effectively as possible
Referral Specialists & CEA Staff	Organize and facilitate case conferencing Manage referrals Manage priority pool	Housing referrals	Disparities and inequities in the experience of homelessness are eliminated
Housing Resources	Resource availability and eligibility requirements communicated	Program enrollments Housing move-ins	
Data Systems	Routine data entry	Households prioritized	

The CEA Process

Per HUD guidelines, a coordinated entry system consists of four core elements: Access, Assessment, Prioritization, and Referral. 'Access' refers to how those who are experiencing a housing crisis learn that coordinated entry exists and access crisis response services. 'Assessment' is the process of gathering information about a household's barriers to housing and characteristics that might make them more vulnerable while homeless. Ideally this information is collected in phases, collecting information essential to determining immediate needs and connecting to appropriate interventions. 'Prioritization' takes that information and determines to what type of housing and services a household will be referred and who has the highest priority. 'Referral' is the process of offering appropriate housing and supportive services to those people with the highest priority, based on prioritization.

CEA makes use of a 'no-wrong-door' coordinated entry model, in which assessors are spread throughout the community. Diversion services as well as assessments are offered by community-based providers and official Regional Access Point[3] staff. Seattle/King County's assessment is called a *Housing Triage Tool (HTT)* and is based on the *Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)*[4]. When a household completes an assessment, they become eligible to be prioritized for a referral to housing programs via CEA. The highest priority households are identified based on the current method of prioritization. For most of 2020, this was the *Interim Prioritization* method, which was based on the household's HTT score and their answers to certain supplemental questions. Beginning in the fall of 2020, and continuing as of the time of this report, this was the *COVID Prioritization* method, which identifies COVID-19 risk factors as identified in HMIS, Washington State Medicaid claims, and Healthcare for the Homeless Network data.[5] These households are added to the *Priority Pool* the size of which is based on the number of housing resources expected to be made available over the next 60 days.

There are three different Priority Pools, based on household type – Single Adults, Youth and Young Adults, and Families with Children. Prioritized households are connected to housing navigators or are represented by case management staff with whom they have an existing relationship, who advocate for their housing needs and preferences at weekly *case conferencing* sessions. In these case conferencing sessions, available housing resources – for example a unit in a permanent supportive housing project or a spot in a rapid re-housing program – are communicated to the gathered group of providers, who then attempt to match the prioritized households to the resources. Once a household has been nominated for a resource in case conferencing, CEA referral specialists communicate the referral to the housing provider, who then works with the household to enroll them in their program.

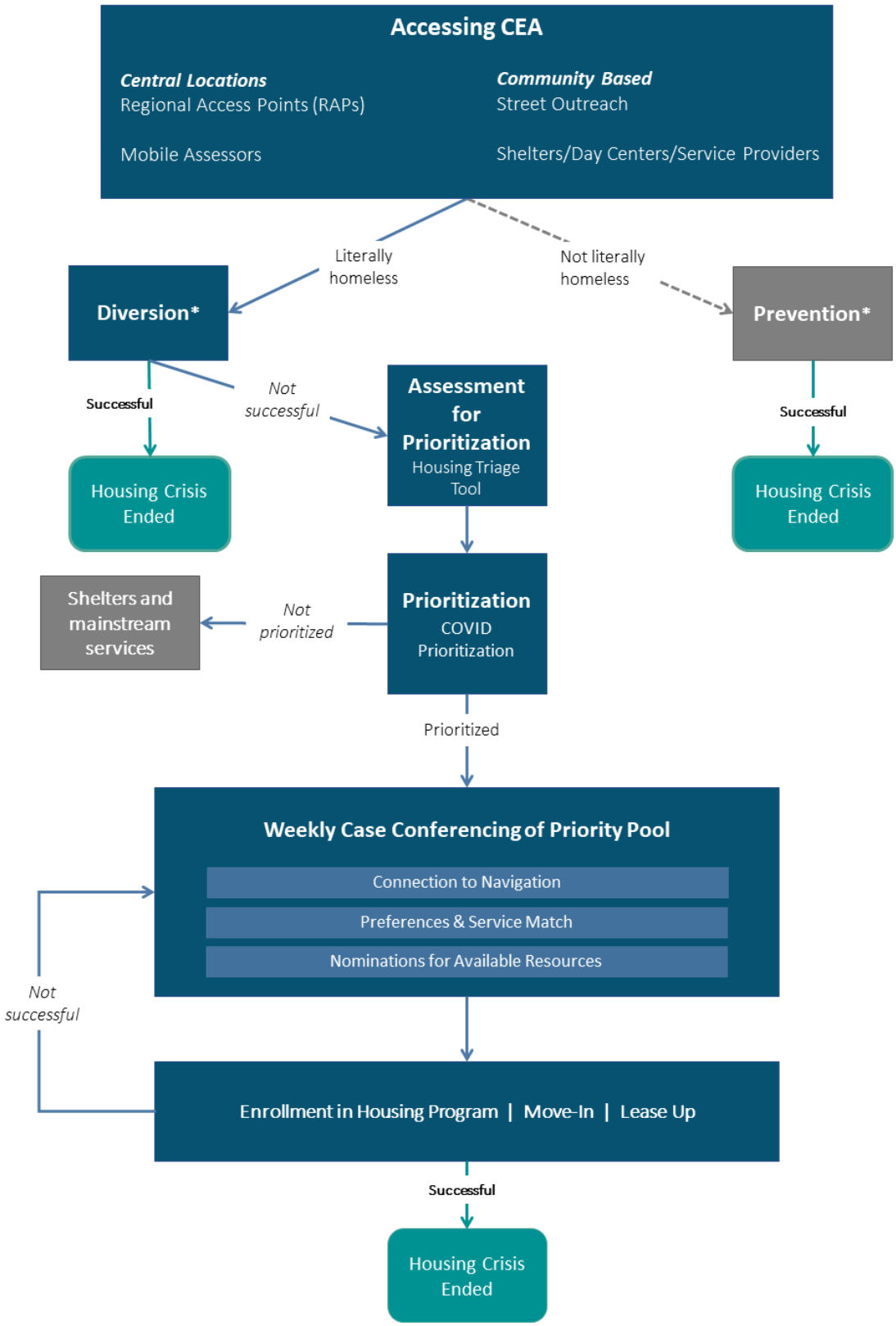
A visual map of this process is found below in Figure 2.

[3] Regional Access Points (RAPs) are an entry point to CEA. These entry points are resource centers where households experiencing homelessness can get help finding housing and other resources. Learn more at https://www.kingcounty.gov/depts/community-human-services/housing/services/homeless-housing/coordinated-entry/access-points.aspx.

[4] For more information about the VI-SPDAT and the history of the prioritization process in Seattle/King County, please see Appendix A.

[5] For more information about COVID Prioritization, see the "Impact of COVID Prioritization" section below.

FIGURE 2: MAP OF CEA PROCESS



*Not staffed by CEA, but supported by and for the CEA Process

CEA's Adaptation to COVID-19

The defining event of 2020 was the global COVID-19 pandemic. As such, the impact of the pandemic will be among the primary focuses of this evaluation. During the COVID-19 pandemic, CEA adapted its practices to account for the unprecedented situation. In most ways, the CEA process remained the same as in previous years. However, there were some significant changes.

COVID Prioritization

Per COVID-19 guidance issued by HUD[6] and Washington State Department of Commerce[7], CEA policies have the potential to protect those most vulnerable to the virus' severe effects by speeding up connections and providing flexibility to lower barriers to permanent housing for people at high risk of COVID-19 complications.

In response, CEA staff worked collaboratively with experts from Public Health - Seattle & King County to identify the characteristics of individuals and households most disproportionately impacted by COVID-19. With these factors, CEA identifies and prioritizes housing people experiencing homelessness who are at high risk for developing serious and life-threatening health complications from COVID-19. These factors include age, race and ethnicity, certain health conditions, and pregnancy status as reported in HMIS, Washington State Medicaid Claims Data, and Public Health - Seattle & King County's Healthcare for the Homeless Network. A more detailed breakdown of these risk factors can be found in Appendix A.

This method of 'COVID Prioritization' was approved by the CEA Policy Advisory Committee on September 24, 2020 and implemented by staff on October 9, 2020. Further discussion of the development and impacts of COVID Prioritization can be found in the 'Impacts of COVID Prioritization' section on page 15.

External Fill Policy Change

To mitigate the health risks of COVID-19 on the population experiencing homelessness, and in an effort to move households into housing faster, the CEA Policy Advisory Committee approved a temporary change to the external fill policy, first for Rapid Re-Housing resources in March 2020, and then for all available resources, effective April 29. After one case conferencing session (instead of two), if a housing resource was not referred to a household, then that resource became immediately available for external fill.[8] Agencies that move to external fills did not need to get formal approval for the external fill, but still needed to complete the HMIS process for tracking. While the policy was in place, agencies were encouraged to keep in mind the community's values and priorities in mind: addressing racial inequities, high vulnerability (VI-SPDAT score), and length of time experiencing homelessness. The implications of the policy change are explored in detail in the 'External Fills' section on page 31.

Virtual Trainings and Case Conferencing

To help prevent the spread of COVID-19, King County employees who could perform their work remotely were under a mandatory telecommute policy for most of 2020. CEA adjusted their activities accordingly, switching case conferencing and trainings from in-person to virtual formats. These were important changes for the wellbeing of the community, although the initial adjustment was challenging. CEA staff reported

[6] https://files.hudexchange.info/resources/documents/Changes-to-Coordinated-Entry-Prioritization-to-Support-and-Respond-to-COVID-19.pdf

[7] https://deptofcommerce.app.box.com/s/mx4yx38vuuhtq3uf2a45uxfmc6dccw8b

[8] In an external fill, the housing provider then gets to make their own choice of who to put in the resource rather than have the decision be made via the communal case conferencing decision structure.

that it has been more difficult to build and maintain relationships with case conferencing attendees due to the virtual format. However, one positive change has been significant improvements in the efficiency and format of online trainings, which are now offered as on-demand learning modules with mandatory knowledge checks and tracking of completion.

Suspension of American Indian/Alaska Native Case Conferencing

Typically, American Indian/Alaska Native (AIAN) identified households are matched to available AIAN specific set-aside resources based on their eligibility and interest in a special AIAN Case Conferencing. However, AIAN case conferencing was on a hiatus for most of 2020 during the pandemic due to the extremely limited staff capacity of Native providers during the early months of the pandemic. AIAN Case Conferencing resumed in March 2021.

Operation of Isolation/Quarantine Facilities

Early in the pandemic, King County acted quickly to set up and begin operations at Isolation and Quarantine sites, designed to provide supervised care to symptomatic, COVID-exposed, or COVID-positive individuals and families who cannot quarantine or recover in their own home, or do not have a home. Given their experience coordinating referrals for individuals experiencing homelessness, staff from the CEA team were redeployed to this work, diminishing the staff capacity of CEA by half for four months between March and July 2020. Despite this, CEA operations continued without disruption due to the hard work and additional hours put in by the remaining staff.

Racial Disproportionality in the Experience of Homelessness

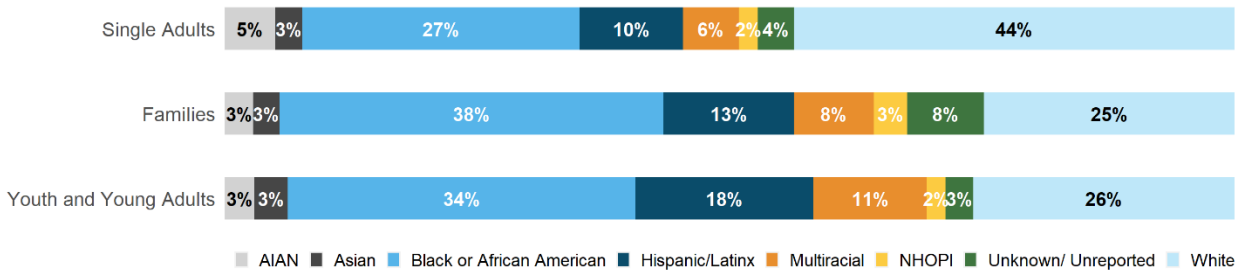
Relative to King County's general population, **homelessness disproportionately affects people of color**. This is especially pronounced for the American Indian/Alaskan Native (AIAN) population and the Black/African American population. While comprising less than 1% and 6% of the general population respectively[9], they represent 4% and 30% of the population experiencing homelessness. By contrast, while the White population represents 60% of King County's population, they represent only 40% of the population experiencing homelessness. The Asian population is also less likely to experience homelessness. However, both Native Hawaiian/Other Pacific Islander (NHOPI) and Hispanic/Latino populations are more likely to experience homelessness relative to their representation in the general population. These numbers are found below in Table 1.

TABLE 1: RACE & ETHNICITY OF KING COUNTY GENERAL POPULATION AND HMIS HOMELESS POPULATION

Race & Ethnicity	King County General Population (2018 ACS)	Households Active in HMIS (Dec 31, 2020)
American Indian/Alaska Native	1%	4%
Asian	17%	3%
Black/African American	6%	30%
Hispanic/Latino	10%	12%
Multiracial	5%	6%
Native Hawaiian/Other Pacific Islander	1%	2%
White	60%	39%
Unknown/Other	<1%	4%

Racial disproportionality of homelessness varies by household composition. Figure 3 shows literally homeless households active in HMIS as of November 2020 by race and ethnicity. The racial and ethnic distribution of Single Adults, Families, and Youth and Young Adults differ significantly. Single Adults have the largest proportion of White households (44%), while Family households are predominantly Black/African American (38%). Youth and Young Adults have a greater proportion of Hispanic/Latino (18%) and Multiracial (11%) households than do the other populations.

FIGURE 3: LITERALLY HOMELESS HOUSEHOLDS ACTIVE IN HMIS BY RACE & ETHNICITY *(KING COUNTY HMIS, DECEMBER 31, 2020)*



[9] 2014-2018 5-Year American Community Survey

Introduction to the Data

Within the CEA System, assessment types, resources, and case conferencing are broken out by household type. The three main household types or populations are: Single Adults (adult-only households)[10], Youth and Young Adults (youth-only households up to 25 years of age), and Families (households with both adults and minors). Additionally, CEA co-facilitates case conferencing for Veteran and American Indian/Alaska Native (AIAN) households of all ages and sizes with leaders from those provider communities. The separate case conferencing sessions are held because of the number of resources available specifically for the Veteran and AIAN populations. Because they make use of separate resources, referrals made to Veterans and AIAN households in those case conferencing spaces are separated out from the household-type breakouts below.

For this evaluation, and for ongoing analysis of the CEA System, the stages of CEA are defined as the following:

- Assessed: Head of household was newly assessed with a Housing Triage Tool during 2020. Households who had previously completed an assessment could remain eligible for prioritization during 2020, meaning that more people were eligible for CEA referrals than just those who were assessed during the calendar year.
- Prioritized: The household was added to the Priority Pool and became eligible for referrals to resources through CEA. The majority of prioritized households were identified using the Interim Prioritization methodology, however beginning in October, the COVID prioritization methodology was used to identify households.
- Referred: The household received a referral to a housing resource through case conferencing in 2020. This does not include referrals made in Veterans or AIAN case conferencing, which do not require the household to be on the priority pool before a referral is made.
- Enrolled: The household was enrolled in the housing program in 2020 to which they were referred by CEA according to the referral data in HMIS. Note, unlike other CEA stages, the quality of this data point is dependent on providers updating the referral history in HMIS. Delayed or missing data may impact the data quality for enrollments.
- Denied: At least one referral to a housing program for a household ended in a denial. A denial may occur due to the household's preference not to accept that housing resource. Alternatively, denials can occur due to the provider's inability to contact the household or a household not meeting the eligibility requirements. A household with a denial may be referred to a different resource.

Reported demographic information is for the head of household. All administrative data is from the King County Homeless Management Information System (HMIS).

[10] 'Single Adult' households overwhelmingly are composed of only one individual, and most resources are designated for only one individual. The group is referred to as "Single Adults" as a result, though some households have more than one member.

Subpopulation Trends in the CEA Process

Impact of COVID Prioritization

COVID Prioritization, which prioritizes housing people experiencing homelessness who are at high risk for developing serious and life-threatening health complications from COVID-19, was a major operational change for CEA in 2020. It makes use of the King County Health and Human Services Integrated Data Hub, a secure database environment which features cross-sector data about clients accessing health and human services within King County, with a backbone of stable master client identities linking across systems. Development of the Integrated Data Hub dates back to 2017 and has taken years to become operational for the purposes of care coordination. Data governance and stewardship are an ongoing process and rely on strong partnerships across multiple departments within King County and agencies across the state of Washington.

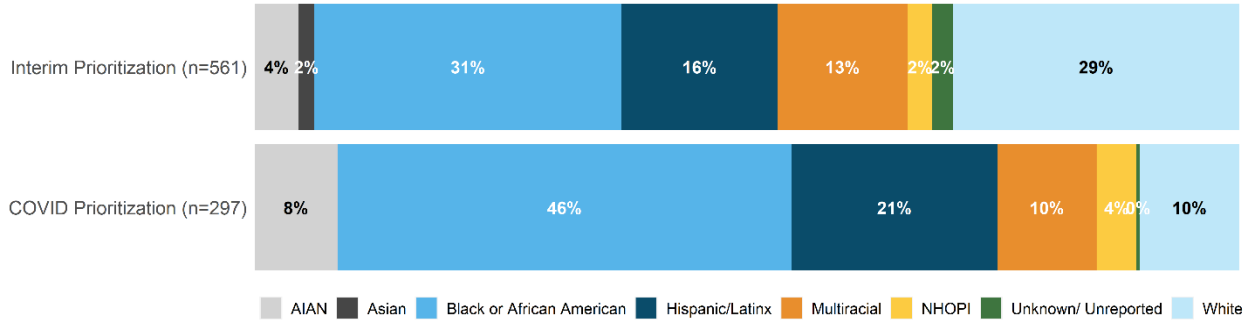
Development of the COVID Prioritization risk factors and risk tiers took intense collaboration between CEA staff, data experts from DCHS' Performance Measurement and Evaluation unit, epidemiologists and data experts from Public Health – Seattle & King County, and HUD technical assistance providers. It was also shaped by community feedback provided by the Coordinated Entry for All Policy Advisory Committee and relied on expedited data use permission from the Washington Health Care Authority. The design of the process and risk factors took care to account for and mitigate the biases present in administrative data due to disproportionate access to social service systems.

The switch to COVID Prioritization in October was among the most significant operational changes to CEA in 2020. Its impact can be seen in the data below and will continue to be seen in reports into the future. Prioritization methodology directly influences one of the earliest stages of the CE process, so impacts on referrals, enrollments, and other long-term outcomes will take time to emerge as those who've been prioritized under this new methodology make their way through the later stages of CE. For now, looking just at the prioritization stage offers some striking findings.

Under the new COVID Prioritization method, a larger share of Black, Indigenous, and People of Color (BIPOC) households were prioritized relative to the previous Interim Prioritization method. This was most pronounced for American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian/Pacific Islander households. A slightly smaller share of multiracial households and no Asian households were prioritized under COVID Prioritization in 2020. These shifts were expected, given that COVID Prioritization explicitly prioritizes households who identify as racial and ethnic groups that have had disproportionately high risk for hospitalization and death from COVID-19.[11] These prioritized identities include American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian/Pacific Islander, as well as multiracial individuals who identify as at least one of those identities.

[11] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

FIGURE 4: RACE AND ETHNICITY OF PRIORITIZED HOUSEHOLDS, BEFORE AND AFTER COVID PRIORITIZATION *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



CEA staff expressed excitement that the new method was finally meeting the equity benchmarks outlined by the community (see Appendix A), and were happy that the system has been able to implement a racially just prioritization system after so many years of working in that direction: *"[COVID Prioritization] seems to be more racially just. From what I've seen, families and households that are being pulled in seem to be representative of the population in King County that's actually experiencing homelessness."* They reported that case conferencing participants were also glad to see the improved equity among the priority pool: *"When I sent it out, the response was mostly positive. People were glad to see that we were getting closer to racial benchmarks. That got a lot of virtual thumbs up from people."*

"People were glad to see that we were getting closer to racial benchmarks. That got a lot of virtual thumbs up from people."

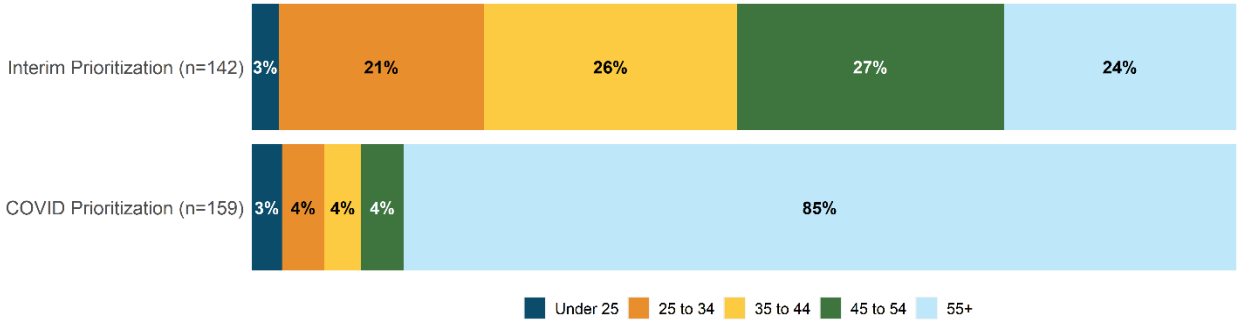
In addition to the increased representation of BIPOC households among those prioritized, CEA staff noticed increased diversity in other areas as well -- *"more diversity every way that you look at it."* Since VI-SPDAT scores no longer influence a household's prioritization beyond their eligibility for CEA referrals,[12] there is greater variance in the scores among Single Adults who've been prioritized, and across household types average scores are lower, falling from an average of 13.3 under Interim Prioritization in 2020 to 9.2 under COVID Prioritization. Despite this fact, CEA staff reported no major changes in being able to successfully match prioritized households to service types in housing resources, adding further support to the consensus that the VI-SPDAT is an insufficient assessment of vulnerability and need among households experiencing homelessness in King County.

The other major shift has been in the age of the prioritized heads of household. While this did not change for Youth and Young Adults, and only slightly increased for Families, the age of prioritized Single Adults has increased dramatically (see Figure 5). CEA staff were pleased that the new method prioritized more elders, given their unarguable vulnerability and the benefits of getting them off the streets. However, available housing resources in our community are not often well aligned with the needs of seniors. *"When you're nearing end of life, you don't want transitional housing, you don't want PSH, you want a nursing home! Truth be told we don't have that type of resource for them."* The Seattle-King County CoC should do what it can to support the needs of unhoused seniors. While this has always been the case, it has become particularly important given the impacts of COVID Prioritization. This may mean adding new services to

[12] As was the case prior to implementing COVID Prioritization, households must still score a 4 or higher in order to be consider for referrals through CEA.

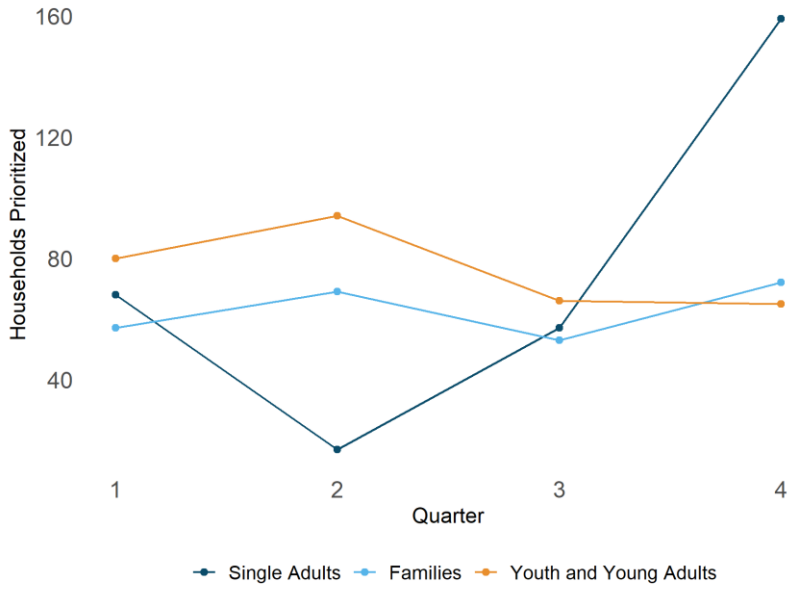
existing housing programs, integrating existing conventional elder care resources with the homeless response system, or developing new resources tailored to their needs.

FIGURE 5: AGES AMONG PRIORITIZED SINGLE ADULTS *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



While COVID prioritization only influenced prioritizations made in the last quarter of 2020, it had an especially large impact on which Single Adults were prioritized due to the timing of resource availability. 159 Single Adult households were prioritized in the fourth quarter of 2020 using COVID prioritization, compared to only 142 households prioritized using Interim Prioritization from the previous three quarters combined (see Figure 6). A large number of new building lease-ups at the end of 2020 influenced this dynamic, and because of it, COVID prioritization had a particularly strong impact on the demographics of Single Adults prioritized in 2020.

FIGURE 6: NUMBER OF HOUSEHOLDS PRIORITIZED IN 2020 BY QUARTER *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



In general, providers have responded positively to the new prioritization method, and particularly the fact that more households of color were prioritized. The areas of concern have been in the communication and transparency of the method. Because the healthcare data that COVID Prioritization relies upon exists outside of HMIS, it is impossible for providers to see those factors themselves, nor can they be

communicated by CEA staff. While this is necessary due to HIPAA regulations, it causes the process to be more opaque. In addition, while the risk factors themselves are very straightforward and intuitive, the full prioritization schema is quite complicated, and was delayed in being released onto the CEA website. In the future, when the prioritization method changes, CEA should clearly communicate those changes to the public in a timely fashion.

CEA staff reported that they struggled to explain how COVID Prioritization 'works', how being eligible for CEA currently requires the VI-SPDAT but COVID Prioritization does not rely on it except for reports of pregnancy, and how it is distinct from the VI-SPDAT more generally. **Standardized informational materials and a communication plan for providers could have helped minimize confusion in the early days of implementation and increased community buy-in for this new prioritization method.**

The other adjustment for providers has been in their inability to predict whether or not a client they've assessed will be prioritized. Previously, a high score and certain answers on the HTT indicated that a household was likely to be prioritized, and savvy assessors could play to those factors when interpreting questions with their clients, or even (in theory) manipulate responses and scores. This is no longer possible to do given that many of the factors exist outside of HMIS. This also impacts how providers discuss CEA prioritization with their clients, and how they approach working with clients who they expect to be prioritized. CEA staff reported that the pre-existing need for housing navigation for prioritized Single Adult households has been exacerbated due to this fact. They note that the households now being prioritized have been less connected to the major service providers who traditionally have been most involved in the CEA case conferencing process. While it is a good thing that these highly-vulnerable individuals now have an opportunity to obtain housing through the homeless response system, their lack of connection to housing navigation and case management support can create a communication and documentation hurdle when connecting them with housing referrals.

CEA staff identified additional benefits of basing the COVID prioritization in administrative data. The first was that it does not require households to undergo a new potentially traumatizing assessment process or require them to disclose sensitive information to a near stranger in order to be prioritized. While the VI-SPDAT is currently required to be completed for eligibility purposes, in theory it could be done away with in its entirety and replaced with a standalone pregnancy data element. They also appreciated the straightforwardness and credibility of using data about medical conditions, and felt that the households prioritized this way truly were the most vulnerable: *"Health is the only way objectively we can figure out need and who has the likelihood of dying on the street. I like using a medical model because it's not open to bias or interpretation. The facts are the facts – if people have these conditions, it makes them more vulnerable."*

"I like using a medical model because it's not open to bias or interpretation. The facts are the facts – if people have these conditions, it makes them more vulnerable."

They also expressed excitement over the possibilities of integrating data from other systems, such as the behavioral health system and criminal legal system, in order to provide an even more complete profile of vulnerability among those in the homeless response system.

The use of administrative data for prioritization within the coordinated entry system is an exciting new development, made possible by the existence of the King County Health and Human Services Integrated Data Hub. It relies on strong collaboration and partnership across multiple departments within King County

and agencies across the state of Washington, meaning that there is a lot of work required to maintain access and support of the process. Decisions about how the data are used must also be mindful of disproportionate access to social service systems beyond just homelessness response. These biases that are entrenched in the data must be carefully accounted for and mitigated where possible.

COVID Prioritization has had many successes during the time it has been in place. The CEA team should start working with partners now to determine how to prioritize households once the pandemic is under control and incorporate as much of the learning from COVID Prioritization as possible.

Single Adults

Gender

The 2019 evaluation of CEA[13] identified that women in the Single Adult population received disproportionately few referrals and enrollments. This did not persist in 2020; instead, **women comprised greater shares of referrals and enrollments relative to their representation in the Single Adult population**. Conversely, men made up a larger share of prioritizations relative to their representation, but they were less likely to be referred and enrolled. Transgender and gender nonbinary individuals in the Single Adult population received a slightly larger share of assessments and referrals, however, this did not translate to enrollments. Rather, transgender and nonbinary individuals comprised an outsized share of denials relative to their share of referrals.

*Race and E*thnicity

Black or African American households were assessed, prioritized, referred, and enrolled at rates greater than their share of representation in the Single Adults population. This was particularly pronounced at the prioritization stage. As discussed in the previous section, this is due at least in part to the implementation of COVID Prioritization methodology. COVID Prioritization was implemented in October 2020, near the end of the period covered by this evaluation, so its impacts on referrals, enrollments, and other long-term outcomes are not yet visible. This accounts for major differences seen in the prioritization stage that have yet to appear in referrals and enrollments. In particular, Figure 7 shows that Black/African American households in the Single Adults population comprise a much larger share of prioritizations than the following stages. This may change as those who have been prioritized under the new methodology make their way through the later stages of coordinated entry. AIAN and Hispanic/Latinx households also constituted a larger share of prioritizations relative to their share of assessments and their representation in the Single Adults population. White households received fewer prioritizations relative to their representation; though once prioritized they were markedly more likely to be referred and enrolled.

Asian households received slightly smaller shares of services at all stages of the CEA process relative to their representation in the Single Adult population. AIAN households were disproportionately likely to have a referral denied, which was also the case in 2019. Denial rates were generally high across all groups. See the Denials section on page 29 for additional details.

Figures 7 and 8 on the following page display detailed information about the demographic breakdown of Single Adult households in each stage of the CEA process.

[13] King County DCHS, 'Coordinated Entry for All 2019 Evaluation Report'

FIGURE 7: CEA STAGES BY GENDER – SINGLE ADULTS (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020)*

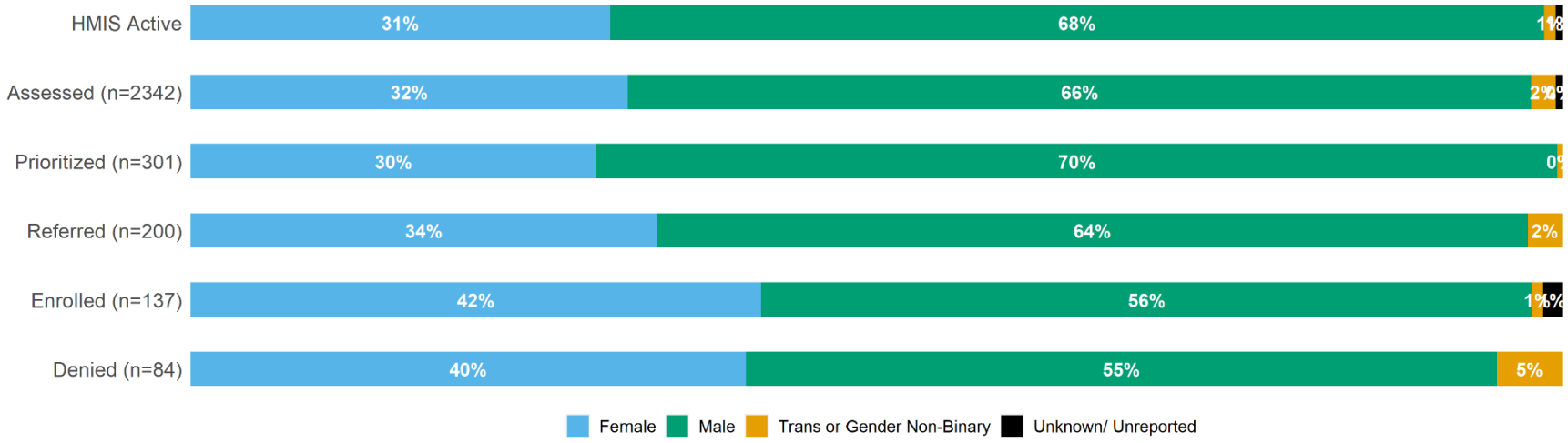
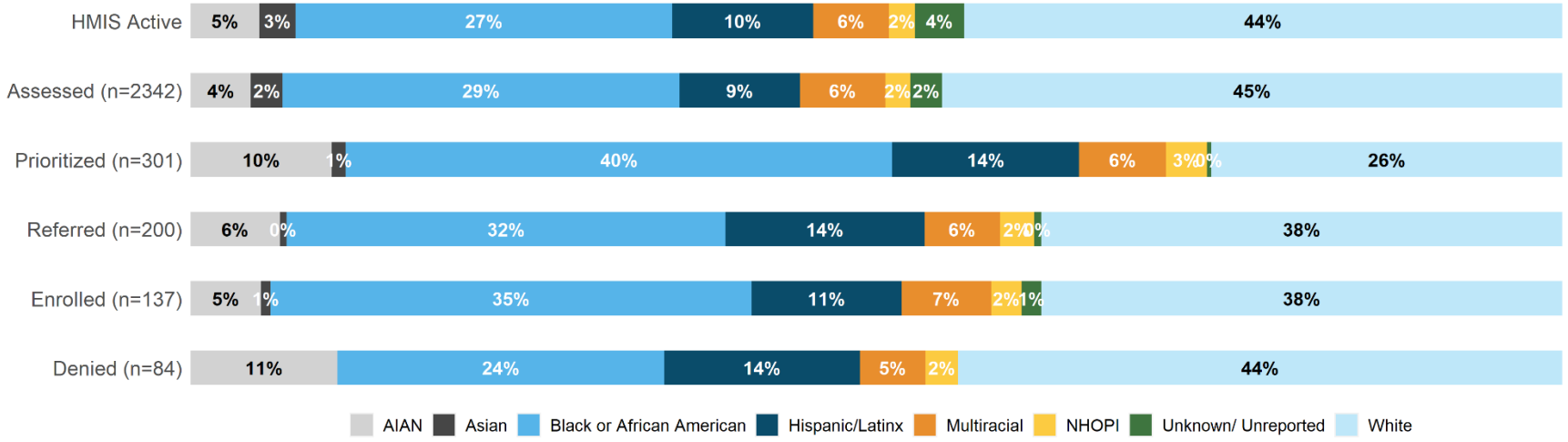


FIGURE 8: CEA STAGES BY RACE AND ETHNICITY – SINGLE ADULTS (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020)*



Families

Gender

Most Family households in HMIS and every step of the CEA process have a female head of household. Several factors may contribute to this including domestic violence as a driver of family homelessness, the impact of the gender wage gap on single mothers, and the possibility that male-headed households may be more likely to have two parents present which decreases economic and social vulnerability.

Families with a male head of household moving through the CEA process receive progressively diminishing shares of assessments, prioritizations, and referrals relative to their representation in HMIS. However, those male-headed families that are referred are less likely to be denied, thus their share of enrollments climbs back to near their share of the family population.

Race and Ethnicity

Families with a Black/African American or NHOPI head of household received proportionally more services at each stage of the process relative to their representation in HMIS, and they also had relatively low denial rates. For families with a Black/African American head of household, this marks a departure from trends in 2019 which saw these households receiving a disproportionately small share of prioritizations and referrals. As referenced previously, this shift may be partially due to the COVID prioritization methodology implemented in October 2020. See 'Impacts of COVID Prioritization' on page 15 for more detail.

Families with a Hispanic/Latinx or multiracial head of household were denied at greater rates relative to their share of referrals. However, due to their outsize representation in prioritizations and referrals, their share of enrollments still outpaced their representation in HMIS. Families with a Hispanic/Latinx head of household also had high denial rates in 2019, indicating a persistent problem.

Families with an Asian or White head of household received disproportionately fewer services in each step of the CEA process relative to their proportion of the HMIS population. No families with an Asian head of household were enrolled in a housing program through CEA in 2020. Renewed attention should be paid to the experience of homelessness among the Asian community and how to best serve those families.

Figures 9 and 10 on the following page display detailed information about the demographic breakdown of Family households in each stage of the CEA process.

FIGURE 9: CEA STAGES BY GENDER – FAMILIES (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020*)

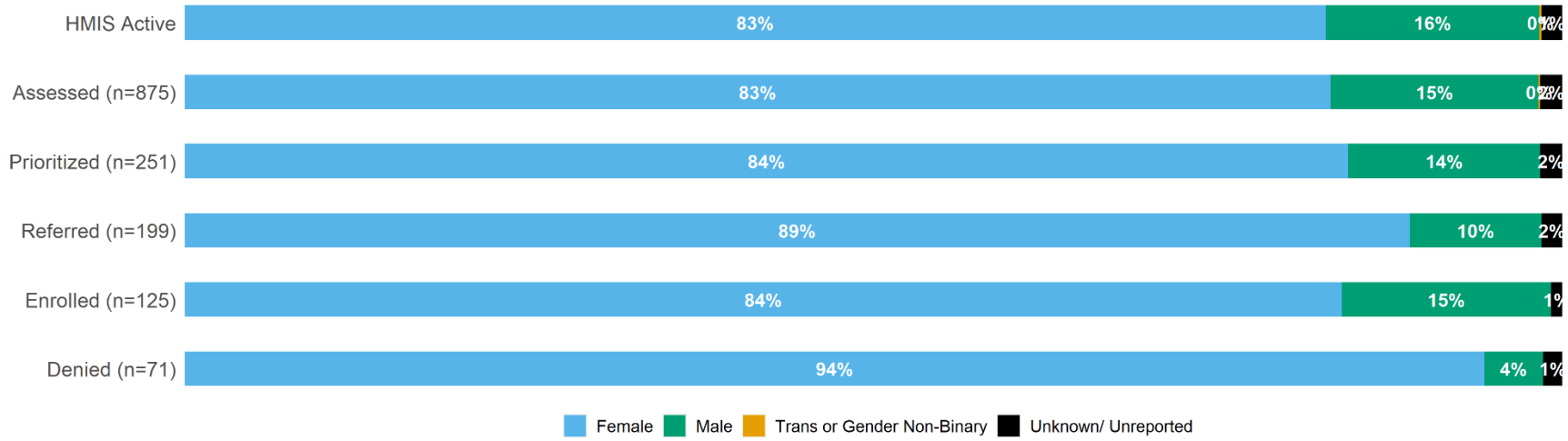
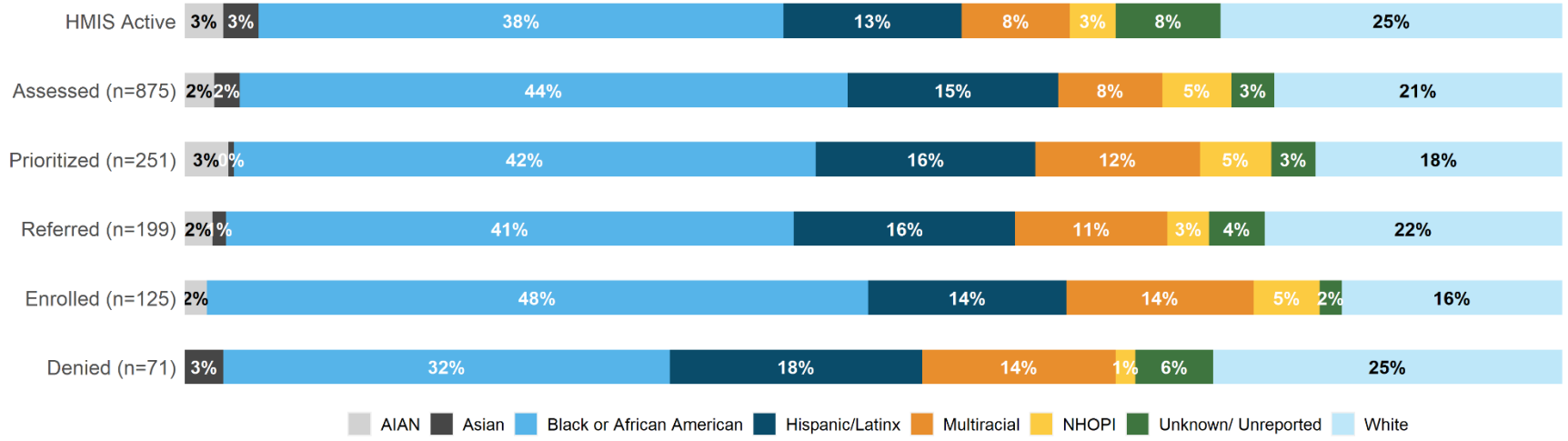


FIGURE 10: CEA STAGES BY RACE AND ETHNICITY – FAMILIES (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020*)



Youth & Young Adults

Gender

Young women comprise a much smaller share of referrals relative to their share of prioritizations. However, those that are referred are more likely to be enrolled than their counterparts; thus, their share of enrollments outpaced their share of referrals and their representation in the Youth and Young Adults population. Conversely, young men received an outsize share of referrals but were more likely to be denied and thus comprised a smaller share of enrollments. Transgender and nonbinary youth and young adults made up a disproportionate share of denials, however this discrepancy may be due in part to their outsize share of referrals.

Race and Ethnicity

Black or African American youth and young adults received a disproportionately small share of services at every stage of the CEA process relative to their representation in the HMIS active population. Once referred, Black or African American youth and young adults comprised a relatively small share of denials and their share of enrollments outpaced their share of referrals and climbed closer to their share of the HMIS active population. COVID prioritization was implemented in October 2020, so effects on referrals, enrollments, and other long-term outcomes will take time to appear as the households prioritized under this new methodology make their way through the later stages of coordinated entry.

Asian youth and young adults received smaller shares of services at all stages of the CEA process relative to their representation among those active in HMIS. This was true for Asian households across all household types – Single Adults, Families, and Youth and Young Adults, in 2020. Asian people were not identified as having a disproportionately high risk for hospitalization and death from COVID-19 and so are not among the prioritized racial and ethnic identities under the COVID Prioritization methodology. While this may account for less representation in the prioritization stage, lack of progress through later stages of CEA for those households that are prioritized is worth continued investigation.

White youth and young adults' shares of services along the stages fluctuated; they received slightly greater shares of assessments and referrals, but fewer prioritizations and enrollments. Their share of denials is notably higher than their share of referrals. Hispanic/Latinx and Multiracial youth and young adults received greater shares of prioritizations, referrals, and enrollments relative to their representation in the population.

Figures 11 and 12 on the following page display detailed information about the demographic breakdown of Youth and Young Adult households in each stage of the CEA process.

FIGURE 11: CEA STAGES BY GENDER – YOUTH & YOUNG ADULTS (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020)*

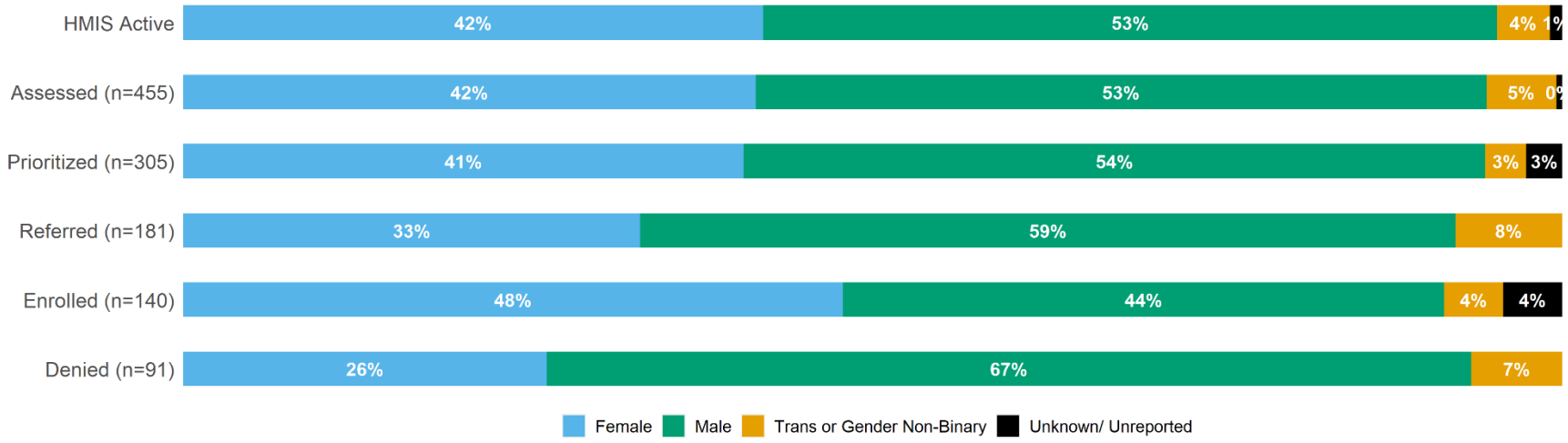
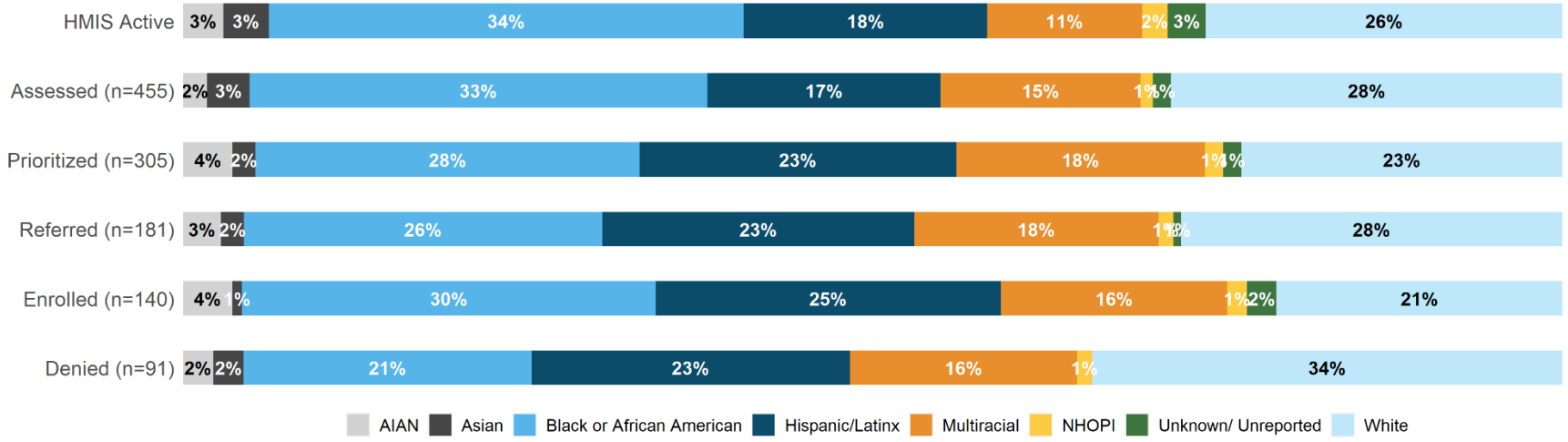


FIGURE 12: CEA STAGES BY RACE AND ETHNICITY – YOUTH & YOUNG ADULTS (*KING COUNTY HMIS, CEA ACTIVITY JANUARY 2020 – DECEMBER 2020)*



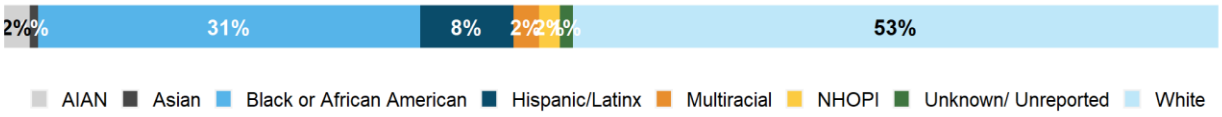
Non-Prioritized Case Conferencing

There are two other "non-prioritized" ways that CEA facilitates housing referrals – Veterans Case Conferencing and American Indian/Alaska Native Case Conferencing. These case conferencing meetings operate in much the same way as the Single Adult, Youth/Young Adult, and Family case conferencing meetings do. The main difference is that rather than only allowing referrals for households on the Priority Pool, any household that includes a United States military veteran or any household expressing interest in AIAN culturally specific resources may be nominated for a resource at their respective case conferencing spaces. Tie-breaking is then done within the case conferencing space, and those providers who are present decide as a group which household receives the referral.

In 2020, 286 households received referrals via Veterans Case Conferencing. They were overwhelmingly male (90%) and from Single Adult households (93%). Slightly less than half (47%) were households of color, a slightly lower percentage than the number of Veteran households of color active in HMIS in a given month (48%, as of December 2020). Figure 13 below shows the racial and ethnic distribution of referrals received through Veterans Case Conferencing.

FIGURE 13: VETERAN CASE CONFERENCING REFERRALS BY RACE AND ETHNICITY (N=286)

King County HMIS, CEA Activity January 2020 – December 2020



WHAT IS THE VETERAN BY-NAME-LIST?

The Veteran By-Name-List or 'VBNL' is a list of all veterans experiencing homelessness in King County, as identified in HMIS and by the local Department of Veterans Affairs. It is used to facilitate Veterans Case Conferencing and is a tool with which to assess progress against the goal of ending veteran homelessness.

The VBNL has been successful in improving collaboration between Veteran housing service providers, Coordinated Entry for All staff, funders, and other partners. It is actively maintained by these local partners and updated twice monthly to ensure that information is correct. Active management and continuous collaboration in the community has contributed to increased transparency and understanding of veteran homelessness within the community

These successes are underpinned by the wide availability of resources for Veterans experiencing homelessness. HUD-Veterans Affairs Supportive Housing (HUD-VASH) vouchers are available to eligible Veterans while Supportive Services for Veteran Families (SSVF) RRH resources are accessible to all households on the VBNL. Additionally, robust housing navigation services for Veterans support connections to these resources.

From American Indian/Alaska Native Case Conferencing, ten households received referrals, less than one-third of the number in 2019. This decline is a result of AIAN Case Conferencing being put on hold for most of 2020 due to diminished staff capacity of AIAN providers as a result of the pandemic. Of the ten referrals, four were ultimately enrolled in a housing program; the remaining six were pending at the time data was pulled for this report. The majority (80%) of referrals went to men, a reversal from 2019 when more than half went to women. Most (80%) of referred households were Single Adults. Nine out of the ten households referred through AIAN Case Conferencing were identified in HMIS data as being AIAN, with the remaining household identified as White.[14]

Efficiency of the CEA Process

Length of Time in CEA

Being housed through CEA can be a very lengthy process, and length varies widely by household composition. The process tends to be longest for Single Adult households, for whom housing resources tend to be scarcest. For single adults, the median length of time between assessment and prioritization was 350 days, compared to 38 days for Family households and 31 days for Young Adult households. The mean length of time was much higher for all populations, meaning that while most households are prioritized within that number of days, there are some who end up waiting more than 4 years before being prioritized. The length of time between prioritization and referral was much shorter across the board, but longest again for Single Adult households.

TABLE 2: AVERAGE LENGTHS OF TIME IN CEA *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*

	Assessment to Prioritization (in days)		Prioritization to Referral (in days)	
	Median	Mean	Median	Mean
Single Adult	350	539.2	36	59.7
Family	38	244.5	16	29.7
Young Adult	31	221.7	23.5	39.7

Several factors contribute to the long length of time between assessment and prioritization. The first is the limited amount of housing resources that are available in the community. This significantly slows throughput in the priority pools. Without significant throughput, new households cannot be prioritized. Additionally, any time a new prioritization method is introduced, households who were assessed some time ago yet were unlikely to have been prioritized under the previous method can be brought to the top of the list, increasing average length of time measures. So long as there is a scarcity of resources, it will be impossible to house all the households requesting assistance, and there will be households who have extremely long waits for housing (if they are housed at all). It is likely that switching to COVID Prioritization increased the average length of time between assessment and prioritization for the year 2020.

[14] Resources available in AIAN Case Conferencing often have a preference, not a strict eligibility requirement, that they be given to AIAN identified households.

FIGURE 14: DAYS BETWEEN ASSESSMENT AND PRIORITIZATION (DOTTED LINE REPRESENTS MEAN) *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*

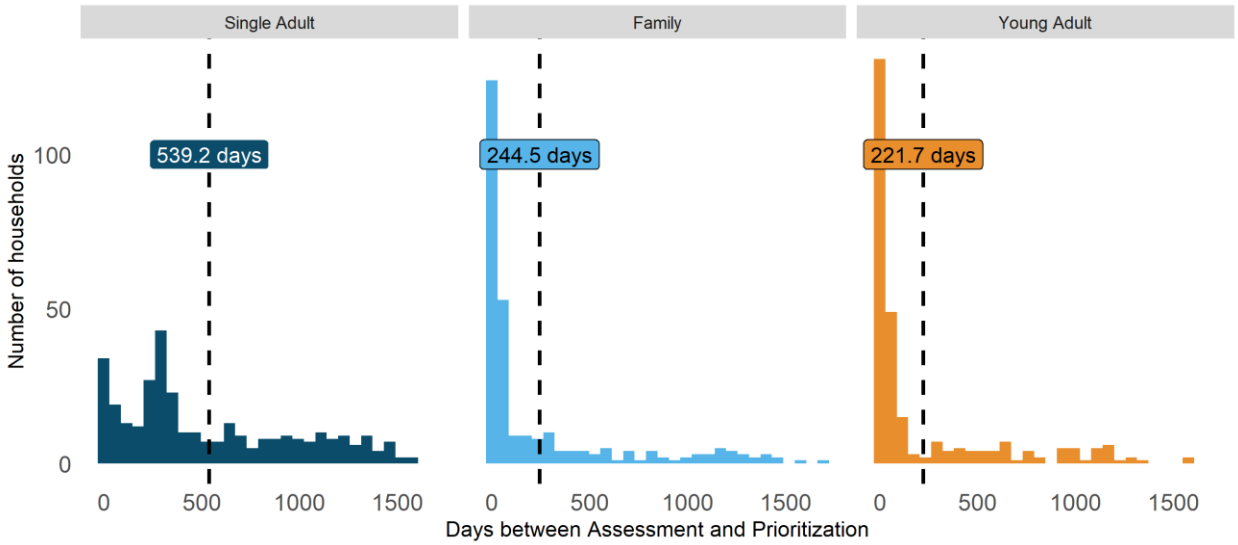
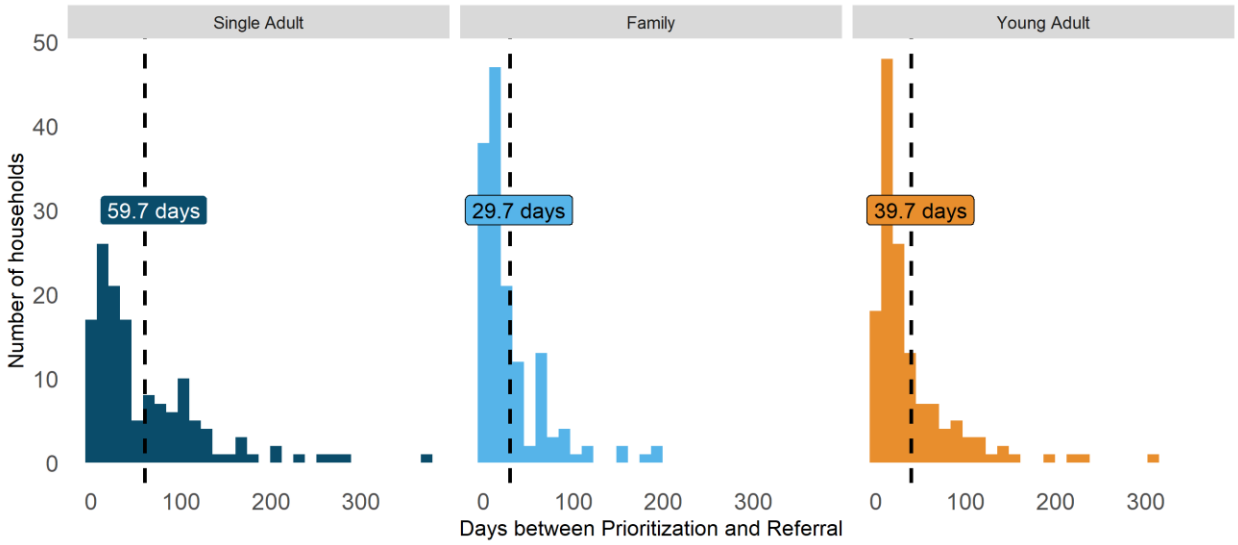


FIGURE 15: DAYS BETWEEN PRIORITIZATION AND REFERRAL (DOTTED LINE REPRESENTS MEAN) *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



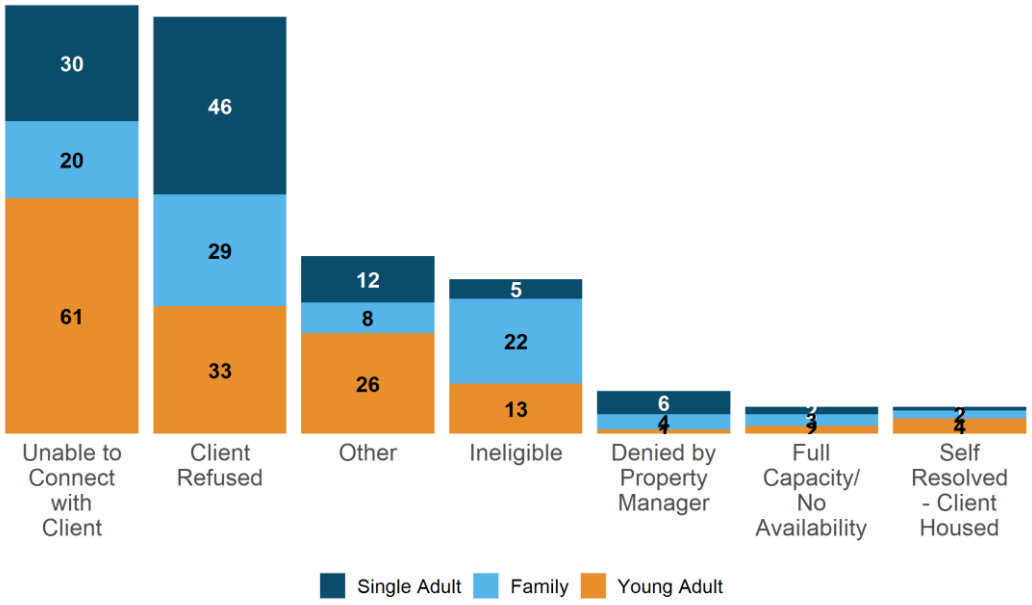
Without a significant overhaul of the CEA process, or a significant increase in housing stock, it is unlikely that the length of time between stages will change soon. With that in mind, the provider community needs to understand and communicate that households should expect a long amount of time after they have been assessed to become eligible for referrals through CEA. Informational materials for households being assessed should make this point clear as well.

Denials

Overall, denials are a major efficiency problem in the CEA process. They occur very frequently: **42% of clients who received a referral experienced at least one denial.** Denials can be demoralizing and even traumatizing for households, and they cause delays that decrease the utilization of resources. Decreasing the number of denials should be a top priority for the Coordinated Entry System.

The most commonly reported reason for denials was the inability to connect with or contact the client, representing 34% of all denials. The next highest reason for denials was refusal by the client, accounting for 33% of denials. Details on denials can be found in Figure 16 below.

FIGURE 16: PROVIDER REPORTED REASONS FOR DENIAL *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



Households refuse housing resources for many different types of reasons. Among the most common are the location of the program relative to their job or support system, the type of accommodations provided by the program, and the type of services offered by the program. Many refusals do not list any explanatory information. Table 3 below lists the most common refusal types and typical examples.

TABLE 3: TYPICAL EXAMPLES OF PROVIDER REPORTED 'CLIENT REFUSED' REASONS *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*

Typical Examples of Refusal Reasons	
Accommodation	Client expressed a need for a larger unit.
	Refuses to stay in shared living space
Location	Client has turn down the opening stating the area is not a good fit for her and her child.
	Client said this program is too far from his support system in Seattle.
Service type	Client [respectfully] denied RRH. She expressed her income is back at 0.
	Client seeking PSH resources.
No clear info	Declined unit
	Client said they were not interested

Denials due to ineligibility accounted for 12% of denials. Ineligibility was most commonly related to the household's income (either being too high or too low for a resource), family size and child custody issues, homelessness status, and age (most often related to upper age limits for youth and adult resources).

One way to decrease the number and frequency of denials is to increase the availability and quality of housing navigation for households in the priority pools. This could be done through expanding existing capacity at provider agencies or shifting to a model that resources the Coordinated Entry System to conduct navigation. Having strong navigation support can increase the levels and success of communication between the referred households and the housing providers. It can also help to guarantee households' preferences and eligibility profile are taken into consideration when a referral is made. Navigation resources are particularly sparse for Single Adult households, but all populations could benefit from improved support.

Another way to decrease the number of denials is to change the CEA 'no contact' policy. CEA guidelines state that providers must, at a minimum, attempt to contact a household at least two times within 48 hours before denying a referral.[15] Given how common these denials are, CEA should consider adjusting the denial guidelines, either increasing the number of required attempts or how long a household is given to respond. Additional guidance around how much time households have to provide required documentation, when it's appropriate to deny a client due to missing documentation, and how to handle appointment 'no-shows' should be formalized as well. Such changes could be accompanied by incentives for providers who make strong efforts to contact households who are particularly hard to reach, and disincentives for those who do not make reasonable accommodations for such households.

[15] Coordinated Entry Policy and Procedures Manual v6.2, p. 36

While the general trends in denial data above can be trusted, based on review of the notes entered in HMIS, many denials are miscategorized[16]. For example, among denials categorized as 'Client Refused', notes included:

- "Client never showed up for his appointments."
- "They refused after they were housed with a project-based section 8 voucher."
- "Client disclosed income significantly above the income limit of […]. When informed of the income limit of […], the client chose not to complete application paperwork."

All of these are more accurately classified under other denial reasons.

Denial information is important for system planning and for appropriate contract management. Trainings about the CEA referral process in HMIS should emphasize the importance of this information and provide clear examples about when to use which categories and appropriate notes to include. Depending on staff capacity, there should also be monitoring and follow-up with providers to ensure compliance and high data quality.

CEA staff already work with the denial data on a daily basis and are able to identify housing providers who consistently deny clients for frivolous reasons and fail to uphold housing-first principles. Despite this knowledge, they don't have the authority to ensure compliance with the CE system and often do not have a clear path of recourse. Creating these pathways of accountability are vital for proper functioning of the CE system.

External Fills

Not all resources that become available for placement through CEA are actually filled during the case conferencing process. For example, a resource may have a very particular eligibility requirement based on household composition (e.g. "single woman under 30 who is fleeing domestic violence") that is not aligned with the households currently on the priority list. Or the resource may not be desirable to the households in the priority pool, due to its location, offered services, or rules for residents. In such a case when the resource does not receive any referrals during case conferencing, it becomes eligible for an External Fill. The housing provider then gets to make their own choice of who to put in the resource rather than have the decision be made via the communal case conferencing decision structure. In this way, **External Fills represent a misalignment between the composition of the priority pool (e.g. due to household composition, preferences, or service need) and the resources available in the community**.

While External Fills create a pathway to housing for households who would not otherwise be prioritized, agencies gain subjective decision-making power that may disadvantage case workers or providers with whom they do not have a strong relationship. Agencies also gain the power to choose a household that is "easier to work with" over one that is more vulnerable. They also advantage clients who have already formed

"It creates an issue of access to the External Fill when all folks are not welcome to have those units."

[16] No clear trends emerged around which types of denials were the most likely to be miscategorized, and errors were roughly equally distributed among the different reasons.

connections with the area's largest providers. In discussing External Fills and the major agencies in the region, CEA staff said:

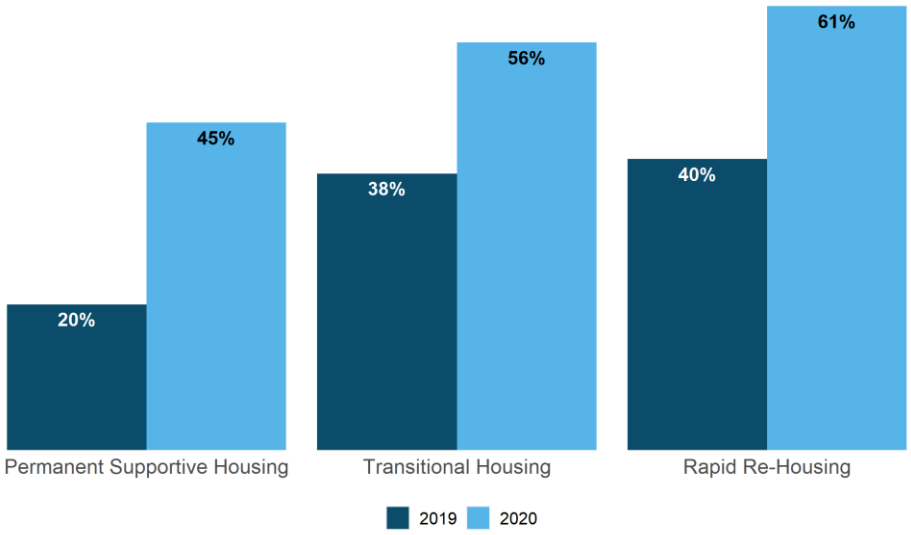
> *"They're huge. It means that they are serving the community, they are having a large number of folks coming through their centers and their shelters, so it's highly encouraging. However, when it comes to how far reaching… There are certain areas of King County that are excluded, like South King County, or maybe the Eastside, where they're not predominately there. So it creates an issue of access to the External Fill when all folks are not welcome to have those units."*

In response to the COVID-19 pandemic and in an attempt to move households into housing faster, the CEA PAC made efforts to decrease the amount of time between a unit becoming available and being filled. On March 26th, 2020 the CEA PAC approved a temporary change to the External Fill policy for Rapid Re-Housing resources limiting the number of case conferencing meetings a housing resource could be open for a CEA prioritized referral from two meetings to one. On April 23, 2020 the CEA PAC extended that interim External Fill policy for all available resources (Rapid Re-Housing, Transitional Housing, Permanent Supportive Housing and Other Permanent Housing). At the time of their decision, the PAC recommended that providers consider the following when choosing who to enroll in External Fill resources:

> *During the [length of the policy], any external fills can be made at the discretion of the provider, keeping our community's values and priorities in mind:*
>
> - *Addressing racial inequities*
> - *High vulnerability (VI-SPDAT score)*
> - *Length of time experiencing homeless*

This policy change led to a significantly increased number of resources being placed via External Fill. The numbers below look at the total number of enrollments that were the result of External Fill and those that were the result of Prioritized CEA Referrals. Between 2019 and 2020, a much higher percentage of those enrollments came via the External Fill process. This was especially pronounced for Permanent Supportive Housing resources, which more than doubled the frequency with which External Fills occurred, from 20% to 45% of the time (see Figure 17).

FIGURE 17: PERCENT OF ENROLLMENTS THROUGH EXTERNAL FILL *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*

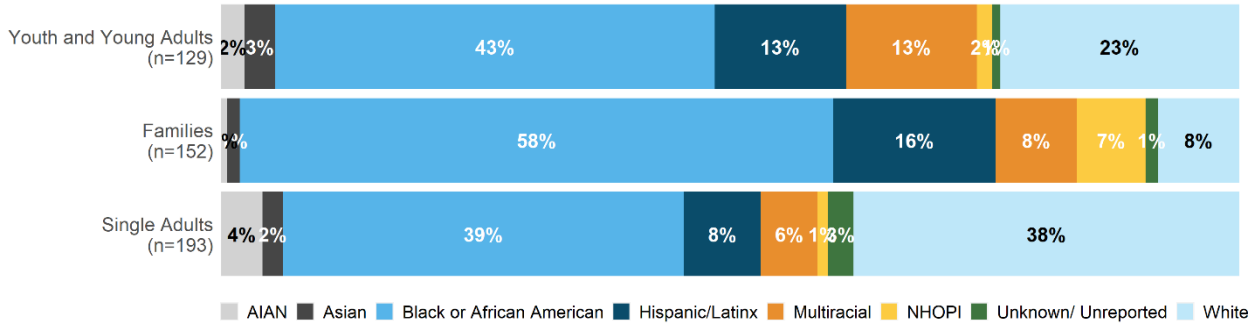


Single Adults received the greatest number of External Fills (193) followed by Families (152) and Youth/Young Adults (129). CEA Staff noted that the policy change led to behavior change by providers in case conferencing:

> *"More people were less likely to refer. A lot of units went to External Fill. It was always that they had folks that were off the priority pool that would have been better... either a better service match or a better quote-unquote 'fit' for the resource rather than the folks that were on the priority pool."*

One strength of External Fills is that households of color have tended to receive a greater proportion of External Fill enrollments as compared to CEA enrollments. However, this trend shifted after the COVID Prioritization methodology was put in place. As a result of these trends, the CEA PAC ended the temporary External Fill policy change and as of March 25, 2021 housing resources must once again be available for prioritized referrals for two case conferencing sessions.

FIGURE 18: RACE & ETHNICITY OF EXTERNAL FILL ENROLLMENTS *(KING COUNTY HMIS, CEA ACTIVITY JANUARY – DECEMBER 2020)*



External Fills remain popular among much of the provider community due to the level of control they offer over a program's enrollees, meaning that each provider's values and concerns are considered as they fill the resources. However, External Fills represent a significant failure of the Coordinated Entry System and harm the regional response to the homelessness crisis:

> *"[There is a] sentiment that is getting bigger and bigger – that agencies, service providers, are so focused on only wanting to use their resources to address their clients, their people, the issue that they see, and not really seeing the response to homelessness as a regional response."*

> *"A few of the agencies have banded together and don't release their External Fills to the community. They refer within themselves, to the point where they have a full-on case conference."*

CEA should work to communicate the system-level importance of adherence to the CEA process and solidify their position as uniquely placed to identify the most vulnerable households systems-wide. At the same time, CEA must work to improve the alignment between the priority pool and available resources. Expanding the size of the priority pool may lead to higher levels of success finding households that are an appropriate service match for programs, but such an endeavor would require additional staff support in the form of housing navigation for prioritized households. To decrease the occurrence of External Fills, as CEA plans for prioritizations after COVID Prioritization, it should focus on developing a prioritization method that is racially equitable, identifies households that are an appropriate service match for the resources in the community, and is trusted by the provider community to identify the most vulnerable households.

Staff Perspectives on CEA

In interviews with the CEA staff, they repeatedly voiced their belief in the fundamentals of Coordinated Entry systems, their appreciation for the work that the provider community does under challenging circumstances, and their deep care for the individuals and families experiencing homelessness in our community. They also voiced concerns about how the CEA system has been supported by DCHS and the community, the structures of accountability for housing providers, and the resources that exist to serve those experiencing homelessness.

Compared to other CoCs in the United States, CEA feel that they have a very limited staff: *"Seven of us just really isn't enough to respond to the community's needs."* Being consistently under-staffed means that CEA has been unable to focus on innovation, development, or improvement of the Coordinated Entry system. *"You don't have time to be creative or do things a different way. You're just always trying to get the basic work done."*

Their jobs extend far beyond simply processing referrals to housing, though traditionally that is how their success has been measured. *"At the very least I process referrals at case conferencing. I also hold navigation calls. I provide tech support. I also am the middle person between housing providers and direct service staff that work directly with the homeless folks that we serve… Whatever's needed."*

Staff reported that their position working in the community helped connect otherwise disparate service providers to the entire homeless response system, and that this isn't something that's easily captured in quantitative data:

> *"Coordinated Entry is not just about prioritizing the most vulnerable households and getting them into housing and having high utilization rates and referral rates and all that. There's a lot more to Coordinated Entry than just that. It's about access to the system. It's about helping providers. Especially since providers have so much turnover in the community – you hire new folks and they have no idea what's going on. So me being able to the community like that, and being able to help them navigate it, I think went a long way."*

Despite their vital position as system navigators, CEA staff reported not always feeling supported by leadership as evidenced by the ways they've been resourced:

"We call it a system, but it was never really implemented as a system, and it's never really been given the resources or the authority to be able to move towards a system."

Lack of authority to hold community providers accountable for their compliance with Coordinated Entry was frequently cited as a major concern among CEA staff. Despite being first-hand witnesses to housing providers failing to meet the requirements of their contracts, failing to be client-centered, and failing to uphold housing-first principles, CEA staff have no authority themselves to ensure providers face repercussions. CEA staff reported that it is often challenging for them to identify a contract manager or funder who is responsible for enforcement, and even when they were able to identify those entities, they did not receive support in implementing operational changes:

> *"Even to this day there are programs that are to the best of my knowledge supposed to be coming through Coordinated Entry, via prioritization, and they still aren't. That's despite pointing out that they're not, despite pointing out that this is an issue, that we could solve it with other folks that are internal to the department and our colleagues at the City, and that doesn't occur."*

This frustration at lack of internal support is combined with frustration over a lack of external support for the Coordinated Entry System. The principles of Coordinated Entry, articulated by a staff member, should be agreeable to everyone: *"Resources should be distributed efficiently and equitably, and that process should be transparent."* However staff feel that there is significant pushback against the entire concept, leading to an undermined system. *"It becomes this self-fulfilling prophecy, where if folks don't believe in the system, they don't participate in the system, they start putting their time and energy elsewhere, and therefore they undermine the system to where it's less likely to be something that they support."*

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CEA staff reported that agencies bring up things that happened many years ago in the Coordinated Entry System as their reasons for lack of buy-in, despite significant changes being made in the meantime. CEA staff acknowledge the vital importance of relationships with the community in a well-functioning Coordinated Entry System, and would like to focus additional efforts on encouraging those relationships:

> *"Before the pandemic, I was going around, trying to reestablish some of those relationships in the community with the housing providers, and I was in the community a lot. We need to continue that work. We need to be in the community, educating…. Being able to develop the relationship to the point where folks are buying-in, versus debating at a lease-up table where we're trying to develop strategic response and people are talking about data pulls."*

Staff felt that the driving factor of distrust with the provider community is the act of prioritization, as it takes agency and power away from individual providers and places them in the system. Staff believe that this is the only logical approach given the crisis state of homelessness and the operation of a systems-level approach to solutions: *"If you go to a hospital, an ER, you get triaged. It's not first-come-first-served, it's not a bakery! You need system processes; it's not rocket science."* Still, CEA staff understand and empathize about how, on a human level, it is difficult to manage bifurcated caseloads and constantly have challenging conversations with clients about the unlikelihood of their being housed through the standard channels of the homeless response system due to the scarcity of resources. Staff expressed hope that Seattle-King County will continue to move toward a regional, systems-level approach to the homelessness crisis, that it will be consistent and easily navigated by those experiencing homelessness, and that the community's trust in the Coordinated Entry System will improve.

Among recommended changes to the homeless response system were suggestions to increase the quantity and availability of housing resources and to make sure that those resources are client-centered, housing-first models. Staff specifically highlighted the need for certain types of resources: additional permanent supportive housing, housing that accepts couples without children, housing that allows pets, and housing

with intensive behavioral health supports for youth and young adults. They also noted the importance of housing providers (and their funders) allowing flexibility while working with households on issues such as eligibility and documentation requirements. One of their hopes for the future is for funders and the CoC to be: *"working with providers on the eligibility requirements, whether that's chronic homelessness, or verifying someone's income, verifying if someone's a veteran. That really is a challenge for most people because it's hard to provide those documents when you don't have access to even get those types of documents."*

Overall, CEA staff want the CoC and Regional Homelessness Authority to focus on designing the system around the experiences and needs of people experiencing homelessness, rather than those of the providers and funders. They highlighted the ongoing need for a new coordinated entry assessment to take the place of the unpopular and problematic VI-SPDAT. The new assessment will ideally be offered in phases, take a holistic view of a households vulnerability, and *"[m]ore inclusion of their voice into what they think they need to resolve their homelessness."* This inclusive, client-centered approach should be integrated throughout the entire homelessness response and coordinated entry systems:

> *"The folks that hold the contracts are not the people we serve. The people that are laying on the streets, the people that don't have food to eat – those are who we serve, and that is who we need to keep in mind when we are building this system that is supposed to be a response to what they need."*

Conclusion

Coordinated Entry for All is an incredibly complex system that works to facilitate collaboration across dozens of agencies for thousands of households. Through its workgroups, case conferencing sessions, and trainings, CEA is tasked with forming connections across the Seattle/King County Homeless Response System. At the same time, CEA has limited authority and agency when it comes to how much housing there is, who is ultimately enrolled in housing programs, and what households' eventual housing outcomes are. Funders and providers are ultimately responsible for the structure and resource environment in which CEA operates and have a major impact on the outcomes that it can achieve. For those areas that it does influence, it is important that CEA operate as well as possible.

CEA has made great strides in improving the prioritization process through its implementation of COVID Prioritization. Initial results have been positive, and it is important for CEA to communicate those achievements throughout the community and to continue their work in this direction. It remains unclear what prioritization will look like after the COVID-19 pandemic, and it is important for CEA not to lose ground. Additionally, the process still requires households to undergo the VI-SPDAT assessment despite the numerous issues that have been identified with it as an assessment tool. CEA should begin work now to envision what the next phase of prioritization will look like in the Seattle/King County community.

The frequency of denials, large number of external fills, and length of the CEA process are challenges in terms of the efficiency of the coordinated entry system. Progress in these areas is significantly constrained by the availability of housing resources and the activities of funders and providers. Still, CEA should consider new policies and guidance for when an agency may deny a referral for no contact and be given authority to hold programs accountable for their participation in coordinated entry.

Future work on developing CEA and evaluating it should strive to focus on the experience of homeless families and individuals within the coordinated entry system.

Appendix A: CEA Prioritization History

CEA Prioritization History

SUMMER 2016	Coordinated Entry for All launches.
SUMMER 2017 – FALL 2017	Homeless service providers raise concerns regarding racial equity of the VI-SPDAT. Providers noted that clients being referred to them skewed white, male, and young.
WINTER 2017	Race & ethnicity data analysis for Single Adult VI-SPDAT scores performed by King County DCHS demonstrates disparities for Black/African American individuals.
SPRING 2018	CEA Policy Advisory Committee establishes CEA Racial benchmarks – goals for who should be prioritized and referred to housing – based on the demographics of those experiencing homelessness in the community.
SUMMER 2018	CEA Team begins development meetings for new prioritization tool. It becomes evident that additional resources are required, in particular subject matter experts on tool development who could validate its use as a prioritization tool.
FALL 2018	In lieu of new prioritization tool, Interim Prioritization (IP) is developed, approved, and launched. IP refers to the process of using and assessing new prioritization formulas based off of existing data, in addition to a household's VI-SPDAT score, to address noted racial disparities in who is prioritized for CEA resources while a new assessment tool is found or developed.
	IP Single Adult formula proposed.
WINTER 2018	IP Single Adult formula implemented.
	IP Young Adult and Family formulas proposed and implemented.
SUMMER 2019	Analysis showed that IP Single Adult formula was not achieving progress toward racial benchmarks. Reverted to original formula.
WINTER 2019	Seattle Foundation Communities of Opportunity grant application submitted to fund assessment tool development, but application was not selected for award.
SUMMER 2020	HUD/Washington Department of Commerce disseminated guidance on adapting CES prioritization for COVID-19
FALL 2020	CEA COVID Prioritization implemented

CEA Racial Benchmarks for Prioritization

	SINGLE ADULTS	FAMILIES	YOUTH & YOUNG ADULTS
AMERICAN INDIAN/ ALASKA NATIVE	8%	7%	5%
ASIAN	3%	3%	3%
BLACK/ AFRICAN AMERICAN	31%	49%	36%
HISPANIC/ LATINX	10%	12%	17%
MULTIRACIAL	5%	8%	12%
NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER	1%	4%	2%
WHITE	42%	17%	26%

Interim Prioritization Formulas

POPULATION	PRIORITIZATION FACTORS	WEIGHT
SINGLE ADULT	VI-SPDAT Score	50%
	Homeless 2+ years	25%
	Homeless 5+ times	25%
YOUTH/YOUNG ADULT	VI-Y-SPDAT Score	50%
	Homeless 1+ year(s)	33.33%
	History of Foster Care	16.67%
FAMILY	VI-F-SPDAT Score	50%
	Older child helps with childcare	12.5%
	Unsupervised children aged 12 or under	12.5%
	History of foster care	12.5%
	Pregnant household member	12.5%

COVID Prioritization Risk Factors

INCREASED RISK FOR MORTALITY FROM OR SEVERITY OF COVID-19:	
AGE	Over the age of 75
	Between the ages of 65 to 74
RACE AND ETHNICITY	Black or African American
	American Indian or Alaska Native
	Native Hawaiian or Other Pacific Islander
	Hispanic/Latinx
HEALTH CONDITIONS	Diabetes
	Heart disease
	Kidney disease
	Lung disease
	Sickle cell disease
	Weakened immune system
	Or the absence of any medical record
PREGNANCY	Household member who is pregnant

Additional information about Interim Prioritization and COVID Prioritization can be found by accessing the 'Prioritization' tab at: https://www.kingcounty.gov/depts/community-human-services/housing/services/homeless-housing/coordinated-entry/ABOUT.aspx