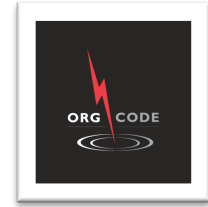


Progressive Engagement and Coordinated Entry: Thoughts from OrgCode



Imagine you have had a heart attack. You are rushed to the hospital. Ideally, you would want to see a cardiologist – the expert in matters of the heart. But let’s say the cardiologist is not available and will not be available for quite some time – weeks or months. Do you want to be put on a waiting list to see the cardiologist, where you do not know when it will happen and you are more likely to die while waiting? Or would you be willing to accept the next best thing – say an Ear, Nose and Throat Specialist – who can do their best to help you with your heart right now? They may be able to save you and provide a treatment pathway that never requires seeing a cardiologist, or at least stabilize you until the cardiologist is available.

Let us take this a step further and try to see this from the emergency room perspective. Again let us imagine you have had a heart attack. You are rushed to the hospital. This time, as it turns out, there are 20 people who have all had heart attacks in the emergency room at the same time. The emergency room staff have to make some important decisions of which heart attack victims to serve in which order based upon some established criteria, not self-advocacy or arbitrary worthiness.

This, in a nutshell, is progressive engagement and coordinated entry, and the individual and system-based framework necessary to make a service pathway focused best on housing in your community.

It Starts with Priority Setting

If everything is a priority, nothing is a priority. The troubling reality for many service providers and communities as a whole is that they have neither stated nor agreed on what their priorities are for which individuals/families will be served in which order based upon which shared values. Too often when it comes to direct service or system-wide functions like coordinated entry we focus on what we will do or how we will do it rather than collectively discussing why we are doing it.

What is most important to your community and why? Are you aiming to serve people that are chronically homeless first? Do you want to serve unsheltered homeless households prior to sheltered ones? Are you trying to serve the sickest people first? How does length of homelessness play into your decision making? Does the age of the program candidate matter to you? What about overall vulnerability and risk to housing stability?

The reality is that if your community has not established shared priorities you have no ability to invest in change and spend on impact. Put another way, without shared priorities one wonders if you are putting your money where your mouth is as a community and ensuring program delivery is aligned to these priorities.

Do not confuse eligibility with a priority. Just because a household is eligible for a particular type of support or housing does not mean they are entitled to it, nor does it mean they should be a priority for it. Your priority setting must transcend eligibility. Your community conversation has to shift from “who can get what?” to “which people are going to get what, in which order, for which reason”.

Where Prevention Fits In

Prediction is impossible in homelessness. Some people think they can tell which people will become homeless and which will not, or which people will return to homelessness and which ones will not. Most prevention programs think they demonstrate cause and effect where they do not; that the provision of rental or utility assistance, for example, has a direct relationship with that household not entering into homelessness. Furthermore, many prevention programs have elements of risk assessment that go into them. While arbitrary at best, these assessments generally reach the conclusion that the lower the risk (for example, having an income, not having experienced homelessness in the past) the better the investment.

But imagine if you re-thought prevention investment so that it aligns with what your community priorities are for shelter or housing programs. For example, maybe your prevention investments are used as an “insurance policy” exclusively for those individuals and families that have moved out of homelessness. Or maybe a household is only eligible for prevention resources if they have similar characteristics to your existing higher need households that are homeless.

When it comes to provision of funds through prevention, in addition to answering the question of who gets the access, one must answer the question of how much will be made available and the intervals of eligibility. Historically, most communities would have a policy something like “a household is eligible for \$1,000 for rent or utility arrears every 18 months”. A progressive engagement approach would look at this differently. First of all, the amount of funding would be dictated by the level of need, starting with the *least* amount of funding to help the household stabilize, and the amount would be customized to the specific circumstance of the household. Second, there would not be a “time-out” period for eligibility. In other words, it would be possible to keep adjusting the level of prevention investment, adding more funds as needed, as often as needed, until a balance has been reached that allows the household to stay housed.

Prioritizing Shelter Access & The Role of Diversion

Shelters are most effectively used when:

1. Those that you are sheltering resemble the same characteristics of the households you are prioritizing for housing and support programs in your community;
2. Those that you are sheltering desire a housing solution, and programming within the shelter addresses these desires;
3. Only those individuals and families with no safe and appropriate alternatives other than shelter are admitted.

Think for a moment of all the people that used shelter(s) in your community last night. Were those people that needed it the most or those that wanted it the most? Were people experiencing homelessness for the first time yesterday able to navigate their way to the shelter system and figure out how to access to it? Did your priorities for shelter access mirror the priorities you have established for housing and support programs in your community?

Those that you shelter should be the same population you are prioritizing for housing programs. In most instances, this means communities should be trying to shelter those with the deepest needs first, not first come, first served. Furthermore, if you see your shelters as having a direct role in the process of helping households access housing again, then your shelters are a place of first choice for those that want assistance in moving out of homelessness, rather than seeing shelters as a place of last resort or a dumping ground for other systems like health care or corrections within your community. Moreover, the shelters must be explicit that it is their intention to work *with* people to help them achieve housing again. The shelter is NOT the sole answer to someone's housing instability. And, a shelter with a strong housing focus is never used as a free hostel by shelter users. Without alignment of what the shelter is aiming to achieve and what the shelter user sees as the purpose of the engagement with the shelter, progressive engagement is compromised.

So, if a person or family has the characteristics of who you are prioritizing for your housing programs and wants to work on housing, does that mean they should automatically allowed to enter shelter? No. In addition to a housing intention and a resemblance to the population you are prioritizing for housing programs, shelters should only ever be made available to households that have no other safe and appropriate options other than shelter.

You only want to shelter people that have no safe and appropriate alternatives to being sheltered. This is where diversion comes in. Diversion is often misunderstood as turning people away or saying "no". That is the wrong mindset. Diversion is about saying "yes" to helping them navigate a safe alternative to shelter that is appropriate to their specific circumstances through an investment of staff time (often dedicated staff) that have specific problem-solving skills and access to flexible resources to put the solution into action.

There are nine steps to an effective diversion practice, with each step progressing more deeply into resolving the current housing crisis while concurrently determining if shelter access will be required. For obvious operational reasons, it may not be practical to work through all of the steps if your shelter accepts admissions in the middle of the night. But by and large this should be the approach applied to most households presenting for shelter in most instances.

STEP ONE: Explain the Process

Explanation of the diversion conversation.

“Our goal is to learn more about your specific housing situation right now and what you need so that together we can identify the best possible way to get you a place to stay tonight and to find safe, permanent housing as quickly as possible. That might mean staying in shelter tonight, but we want to avoid that if at all possible. We will work with you to find a more stable alternative if we can.”

What is being established in the opening script is a transparent explanation of what is about to happen for the person that is seeking shelter, understanding this may not be what they wanted to hear. First, we are interested in their housing situation *right now* – not the entire housing history. Second, it emphasizes that the work moving forward is something that will happen *together*. In other words, this is not a situation where a household can drop their housing crisis onto someone else’s lap to fix. Third, it focuses on safe, permanent housing, while being clear that if it is possible to avoid a shelter stay to achieve that, then doing so would be most desirable.

STEP TWO: Today’s Urgency and Untested Options

Why are you seeking emergency shelter today?

What are all the other things you tried before you sought shelter today?

What are all the other things you have thought about trying but have not attempted yet in order to avoid needing shelter today?

The key element of the first question is emphasis on *today*. Another way of looking at this, and even probing for more information, is why they were not seeking shelter yesterday, and why they are not here tomorrow. In most instances, the diversion worker will learn of a specific conflict or event that has occurred that has brought them to a place of seeking services today. If it is possible to resolve the conflict or address the event before progressing any further, that should be done.

The two other questions are exploratory in nature. In learning what they have already tried, there is an opportunity for the diversion worker to learn what worked and did not work. There is also an opportunity to not suggest things that have already been

attempted. The more important of the questions by way of diverting people from shelter is that which they have thought about doing but have not tried yet. In most instances this results in concrete actions that can be attempted at that moment, though taking those actions may require assistance with accessing a phone, counselling/briefing on what they are thinking of attempting, accessing transportation, etc.

STEP THREE: Last Night's Safety

Where did you stay last night?

- a. If staying with someone else, what is the relationship between them and you?
- b. How long have you been staying there?
- c. Where did you stay before that?
- d. Would it be safe for you to stay there again for the next 3-7 days?
- e. (If a couple and/or household with children under 18) Would your whole household be able to return and stay there safely for the next 3-7 days?
- f. If indicate that the place where they stayed is unsafe, ask why it is unsafe.
- g. If cannot stay there safely, or if were staying in a place unfit for human habitation, move to Step Six.

You are trying to ascertain whether the place they are coming from is safe to return to while the household works on a more permanent housing solution. There are discernible differences in the diversion process when the person seeking shelter services has been in a safe, appropriate place for some time versus the person that is bouncing around from one location to another without safety and security.

STEP FOUR: Story Behind the Story (At Last Night's Safe Place)

What is the primary/main reason that you had to leave the place where you stayed last night?

Are there additional reasons why you can't stay there any longer?

Another way of looking at this step is "what is the story behind the story?", which is intended to enrich the contextual understanding for the diversion worker to figure out a pathway forward.

STEP FIVE: What Would it Take to Stay (At Last Night's Safe Place)

Do you think that you/you and your family could stay there again temporarily if we provide you with some help or referrals to find permanent housing or connect with other services?

If no, why not? What would it take to be able to stay there temporarily?

This is an entry into progressive engagement with diversion. Instead of going “all in” with a solution or even a range of resources, the fundamental question is “What would it take to be able to stay there temporarily?” In other words, the diversion worker is asking the service-seeker what they feel the solution would be rather than, perhaps, providing more resources than are actually required or more intervention than what would be necessary. Importantly, the diversion worker has to be able to take action on the types of “asks” the service-seeker may have, in order to divert them from shelter. For example, if the person identifies that helping out with groceries would make it possible to go back temporarily, the diversion worker has to have the immediate ability to support that, as opposed to having many layers of approval or passage of time to reach accessing the resource.

STEP SIX: New Place to Stay Temporarily

If no, is there somewhere else where you/you and your family could stay temporarily if we provide you with some help or referrals to find permanent housing and access other supports? For example, what about other family members? Friends? Co-workers?

What would it take for you to be able to stay there temporarily?

Again step six is progressive engagement in action. It empowers the service-seeker to identify both other people and the resources that would be necessary to achieve the outcome rather than having finite resource options to suggest or trying to solve the problem for the service-seeker.

STEP SEVEN: Identifying Barriers and Assistance Required

What is making it hard for you to find permanent housing for you/you and your family - or connect to other resources that could help you do that? What do you feel are your barriers? What assistance do you feel you need?

The fact that this step comes later in the diversion process is also progressive engagement in action. Rather than leading with barriers or history in the diversion engagement, we are focused first on action. It is entirely likely that many of the people seeking shelter services can be diverted before ever reaching this step. Rather than trying to prescribe a program or service response, the ball is put into the court of the service-seeker to name the barriers and assistance required.

STEP EIGHT: Current Resources

What resources do you have right now that could help you and your family find a place to stay temporarily or find permanent housing?

The intention of this step is to focus on what the individual or family has rather than what they do not have, in order to progress further into finding a solution that does not rely on the service provider or system of care to solely be the solution to their housing instability. While additional questions can be added to probe for information, this step intentionally does not rely on a series of forms or a particular decision-making matrix in order to dictate how to proceed.

STEP NINE: Housing Planning

If admitted to shelter there is still an expectation that you will be attempting to secure permanent housing for you (and your family). What is your plan at this point for securing housing if you are admitted to shelter?

If the household has a plan in place, terrific. If not, there is an opportunity to engage in solution creation without provision of a one-size fits all solution. It is better that, from the front door of the shelter, there is a focus on having people plan their own exit prior to entry rather than having people come into service and then find the way out. This also is critical for setting up opportunities for self-resolution within shelter.

Creating Opportunities for Self-Resolving in Shelter

Three things are true (perhaps inconveniently so). The first truth is that analysis of shelter data in community after community demonstrates that the majority of shelter users only use shelter once in their life and generally for shorter periods of time (two weeks or less). The second truth is that for a long part of the history of sheltering there were not programs like Rapid ReHousing, and people by and large were still assisted and able to get out of shelter and into housing. The final truth is that analysis of data in your own community would demonstrate the truths found in every other community: if you are economically poor (including on assistance), live with a mental illness or substance use disorder, or have barriers like being a registered sex offender, having poor credit, or less than ideal tenancy history – you are more likely to be housed than homeless. You are also more likely to be in the private market without any sort of subsidy. You are likely to live in housing that would pass inspection. You are not very likely to be in a situation of overcrowding.

While all of these are true, they are often unknown or discounted, which interferes with the application of progressive engagement. We need to learn more about how most people are self-resolving within a short period of time and frame that as normal operating procedure for all shelter users. We need to realize that programs like Rapid ReHousing are *one* tool in our toolbox, not the only tool in the toolbox. We need to stop pathologizing the experience of homelessness, or thinking that we can predict who can get out quickly, and who is going to need a longer period of time or greater assistance to get out of homelessness.

Shelters need to remove any programming or messaging that interferes with the ability of people to focus exclusively on getting out of the shelter, and doing so as quickly as possible. There is no reason why any person during the first two weeks of their shelter stay should be enrolled in any programming or assigned to a case manager to navigate a broad range of life issues. Instead, to best engage, there should be intentional housing conversations with each person in their first two weeks of shelter stay that is driven by tasks, not goals. The shelter should also make available passive resources to assist in this endeavor. For example, overnight staff at a shelter can research and print off every online listing of an apartment for rent within 50 miles of the shelter every single night so that people searching for housing do not have to do their own online research.

If the individual or family is still present in the shelter 15 days later, then the conversation and approach needs to shift, going deeper into engagement. Why 15 days? Because if most people can achieve self-resolving within two weeks it makes logical sense to become more involved only after a two week period. You may, however, want to consider 15 days as a rule of thumb as opposed to hard and fast rule. You may want to look at the mean or median length of time it takes people within shelters in your community to achieve a self-resolving solution and use that as a benchmark.

Whether 15 days or your own community's benchmark, this would be the most appropriate time to complete an assessment like the VI-SPDAT as a way of understanding which strengths the household has, so as to create an individualized housing plan for each person. Every individualized housing plan must have two or more approaches to helping the household achieve housing, one of which will always continue to be self-resolution, and the other one(s) would include opportunities like Rapid ReHousing. To be clear, any provider that puts all of the proverbial eggs into the basket of a housing program while giving up on self-resolving is not practising an appropriate response to helping the person get housed.

For those individuals and families that extend their shelter stay for 15 or more days (or community benchmark), the level of engagement changes. Whereas those there two weeks or less had daily, quicker meetings with staff about housing tasks, those households with identified higher acuity should now be having more intensive, likely longer discussions about activating their housing plan and the tasks associated with it, about two times per week.

There will undoubtedly be some shelter users with a plethora of co-occurring complex needs, long histories of trauma, and both personal and institutional realities that interfere with quick passage into housing. It is easiest, in these instances, to focus on those with fewer issues or to resign oneself that people with such circumstances will have to be in shelter until a permanent supportive housing opportunity becomes available. That is demeaning and nonsense. Communities need to learn what non-homeless individuals and families with the same needs, histories and realities do to find and stay housed and replicate those strategies. That means boots on the ground intelligence. That means going to lower-income neighborhoods and speaking with tenants about how they figured out their housing needs without being homeless. That means seeing the strengths of the dozens, hundreds or even thousands of people in your community as

local community experts that can teach you how to overcome the obstacles that you saw in the people you are sheltering.

Housing-Focused Sheltering

Progressive engagement is possible in shelters that are hyper-focused on housing. As previously discussed, diversion and the first two weeks of shelter stay and engagement are important. But there are other changes also necessary to allow for better housing outcomes out of shelter.

The first is changing the orientation of staff. No longer should we think of shelter staff referring shelter users to housing workers. Instead, every shelter staff should see themselves as being some form of housing worker. Does that mean all shelter staff should do assessments or engage with landlords or prepare materials for housing access? Of course not. In its simplest form if staff within the shelter are not talking about housing with everyone using the shelter they are having the wrong conversation. And that can transcend positions like intake, admission, overnight, dietary and specialized housing staff.

Changing the orientation of staff can be reinforced through setting program performance target measures and making sure that all staff are aware of them and can apply them. If the shelter has set goals related to average lengths of stay or movement from shelter to permanent housing per month, each shelter staff needs to know what these are and how to turn these into action on a daily basis regardless of their position. We need to move away from shelter staff seeing their primary job as policing behavior and transform that into engagement, support, service and housing resolution.

This leads to the second important: establishing and supporting expectations. We need to reframe the experience of being sheltered from one of rules (which lead to social control and policing of shelter users) to one of expectations (which is aligned to social service and supporting shelter users). One of the clearest expectations to be shared with shelter users is the expectation of getting housed quickly and not returning to homelessness. This expectation is independent of any program offerings like permanent supportive housing. Regardless of what resources are available, the expectations are the same.

The third important change is messaging. Active dialogue between staff and program users is the most obvious way to change messaging. However, shelters need to also look at passive communication that occurs within the shelter. Is every message on bulletin boards and message boards related to housing? Or is the core purpose of the shelter being confused by messaging things like free food, access to employment, health services or employment? If you dilute the message of the importance of housing, you struggle to progress towards housing. An important message for shelter users to hear is how many people have self-resolved their homelessness without needing to wait for any type of program assistance.

Transforming from Waiting Lists to Priority Lists

More than semantics, for a system to work well and progressively engage in solutions, waiting lists need to be replaced by priority lists. When a name is added to a waiting list, the expected outcome is to wait until a solution comes along. When a name is added to a priority list, the expected outcome is action.

A priority list is an extension of living your community's shared values. It also requires a very clear articulation of what you are trying to achieve in what order in your community.

For example, if your community were to say that your top priority is to help chronically homeless persons who are tri-morbid and living outside with a VI-SPDAT score of 13 or above access housing, then it is easier to put that into action than putting people on a list for Rapid ReHousing just because they are eligible for it.

A priority list forces your community to match your resources to your priorities rather than looking at which individuals and families are eligible for which resources. For example, let us say you have a person that would seemingly benefit from Permanent Supportive Housing as they are of higher acuity, chronically homeless, and meet other eligibility criteria that may in place in your community for Permanent Supportive Housing. Let us also say that the same person has other characteristics that meet what your community's priorities are – say, that they are tri-morbid, homeless on the street most of the time, have been homeless for five or more years, and are 60 years of age or older. But, let us assume, there have been no vacancies in Permanent Supportive Housing for 30 days, and they remain homeless. If they are your top priority, it makes sense to use the resources that you do have, rather than the ones you do not. Sure, you could put them on a waiting list for Permanent Supportive Housing, but that will really go nowhere fast. Or you could apply Rapid ReHousing. In choosing the Rapid ReHousing option, remember that you are trying to make the Rapid ReHousing work, not just using it as a stopgap measure waiting for a Permanent Supportive Housing spot to become available. Think back to the Ear, Nose and Throat Specialist helping the heart attack victim. They are not *just* trying to keep the person alive (though that is a really good start); they are trying to actually cure the ailment.

A Progression of Housing & Support Options

This table is intended to provide a high-level overview of the housing and support options and how it relates to progressive engagement.

Option	When Used	Commentary
Diversion	With all people presenting for shelter	<p>Sheltering should be reserved for those people that: a) most closely resemble the community's priorities for housing programs; b) have no safe and appropriate options other than shelter.</p> <p>Diversion should be attempted for every individual and family, without any subjective over-rides (thinking that a person or family CANNOT be diverted and therefore not even attempting to divert them).</p>
<i>Diversion progresses to Self Resolve when the individual or family cannot be diverted from shelter.</i>		
Self Resolving	With all people that have entered shelter, as well as all people that are unsheltered and highly organized ⁱ	Self Resolving will always be one of at least two options for all people that experience homelessness. There has to be an intentional approach to supporting households to Self Resolve, with staff in shelters not thinking they can predict outcomes.
<i>Self Resolving progresses to Light Touch when the individual or family cannot seem to get themselves out of homelessness without some financial or other support resources, but does not require the full Rapid ReHousing suite of supports and resources.</i>		
Light Touch	For those people able to self-resolve if only for one or two, but not all three elements of Rapid ReHousing ⁱⁱ	Not all communities have flexible funding or staffing that can be used in this way, but those that do find they have considerably more options than putting an individual or family into the "Rapid ReHousing Bucket". The use of the Light Touch approach may or may not be a tool within Coordinated Entry itself.
<i>Light Touch progresses to Rapid ReHousing when an individual or family requires short term financial assistance, assistance locating and securing housing, and support assistance.</i>		
Rapid ReHousing	Three possibilities: 1. First option for all people whether they score for Rapid ReHousing or Permanent Supportive Housing;	"Rapid ReHousing until proven otherwise" is an acceptable operating approach wherein this housing intervention is tried for any person or family rather than direct access to Permanent Supportive Housing. It is critical in this scenario that Rapid ReHousing is attempting to make the housing permanent stable, not functioning as a placeholder until a Permanent Supportive Housing unit is available.

	<p>2. First option for all people scoring for Permanent Supportive Housing but unable to access Permanent Supportive Housing within 30 days;</p> <p>3. Exclusively for those of moderate acuity.</p>	<p>In delivering Rapid ReHousing to more acute households it is possible that the Rapid ReHousing does not resemble this housing intervention in the classic model. You are more likely to see smaller staff to client ratios and greater flexibility in length of time for the supports in community. Much can be learned from the experience of more rural communities that do not have Permanent Supportive Housing and have made operational adjustments to Rapid ReHousing to well serve higher need households.</p>
<p><i>Rapid ReHousing progresses to Permanent Supportive Housing when the individual or family cannot permanently stabilize in housing without ongoing social and financial assistance.</i></p>		
Permanent Supportive Housing	<p>Two possibilities:</p> <ol style="list-style-type: none"> 1. Option for those who have had two or more unsuccessful Rapid ReHousing attempts; 2. Directly for those that have higher acuity. 	<p>No community has the perfect amount of Permanent Supportive Housing, even those that have been steadily increasing stock for many years. Because it is so scarce, many communities find it important to ensure the priority setting process for Permanent Supportive Housing is more restrictive than widely inclusive (narrows the pool of potential people that could move into Permanent Supportive Housing) and/or require proof that Rapid ReHousing has been attempted (perhaps multiple times) prior to making it possible to enter into Permanent Supportive Housing. Because Rapid ReHousing does not negatively impact homeless status, this is an option worthy of careful consideration when demand for Permanent Supportive Housing grossly outweigh supply.</p>
<p><i>Any housing intervention – but especially Rapid ReHousing and Permanent Supportive Housing – progresses to Prevention when it is necessary to “double down” to help any individual or family that was prioritized for a housing and support program to be able to remain within the housing and support program.</i></p>		
Prevention	<p>For those individuals and families housed through light touch, Rapid ReHousing or Permanent Supportive Housing.</p>	<p>Think of prevention not as a general tool to keep individuals or families out of homelessness, but rather a resource that is progressed to in order to save a tenancy once that individual or family becomes housed through a housing program.</p>

Progressing Through Different Types of Housing

There is a tendency to look at independent living in the private market as the dominant housing solution. Depending on local conditions this may not be practical when one examines the amount of income people have relative to the cost of housing. It is also one of the reasons why Diversion, Self Resolving and Light Touch – and even in some instances Rapid ReHousing – are not in a position to thrive. When these options are cut off, a system of care quickly bottlenecks with long waiting lists (even with more restrictive local priorities) and impossibly unwieldy by-name lists. To increase flow-through into housing, individuals and families experiencing homelessness should be coached to progress through a range of housing options, not just focusing on independent living in the private market. In addition, service providers that are trying to help individuals and families realize housing solutions need to examine a range of residential solutions across different systems, not just within the homeless service delivery system.

Housing Option	Commentary
Family	While often considered for youth and to some extent families (especially single parent families) there is an advantage to supporting single adults to consider reuniting with their ageing parents, siblings, or adult children.
Hospice Care	Helping people die with dignity in secure housing is important, independent from the homelessness and housing services sector.
Adult Development Services/ Adult Mental Health Supportive Housing	These are often group home situations or smaller congregate opportunities where adults with development delays (and in some instances pronounced cognitive deficits) live with others with comparable circumstances with supports catered to their specific needs.
Roommates	Matching for roommates can happen by encouraging people that are homeless to find one or more person that they feel they could be compatible with in housing, or through more intentional matching approaches.
Shared Housing	Like the roommate approach, but with separate agreements (leases) between each of the inhabitants and the landlord.
Room-letting	Some communities have taken intentional approaches to match people that are homeless and in need of housing with people that are “over-housed” (usually seniors, especially widow(er)s that have more bedrooms than required for the housing occupants).
Independent Living	It is possible to think of independent living as the housing opportunity that a person or family progresses to only after all other less costly options have been considered (or even attempted), rather than as the starting point for considering housing options.

Implications for Coordinated Entry

What does this all mean for coordinated entry? In a word, everything.

An individual or family should only enter the Coordinated Entry system once Diversion and Self-Resolving have been thoroughly attempted. One might also say that Light Touch, if available, is also attempted prior to considering a household for Coordinated Entry. And, as previously noted, Self Resolving remains on the table for everyone, always even if they are progressing into the Coordinated Entry system.

There are several different approaches for structuring a coordinated entry system (for example, descending acuity, frequent service users, universal system management) and the approach chosen by a community should be related to their values and priorities. Regardless of which approach is selected, the goal of a community is not to see how many different individuals and families can be added to a waiting list. The goal is how many individuals and families can move into permanent housing. The fewer the households that progress to needing resources dedicated to coordinated entry, the better the flow through to housing by way of coordinated entry.

Again, no longer are we examining what people are eligible for, we are looking at how we match resources to community priorities.

Coordinating residential solutions has to include the broadest possible range of housing options (not just private market, independent living) and a higher functioning coordinated entry system that is progressively engaging, also looks at all residential solutions, not just those within the homelessness and housing service delivery system.

ⁱ There is an established process for evaluating the degree of organization of an encampment that allows an outreach provider to determine if someone is organized sufficiently and resourced sufficiently to allow a person to move directly from living outdoors to permanent housing without requiring Coordinated Entry.

ⁱⁱ The three elements of Rapid ReHousing are the availability of financial assistance, support assistance, and assistance with locating and securing housing. An example of light touch may be a household that needs financial assistance for a security deposit, but requires no help finding the place to live and requires to supports to stay housed.