Maricopa Regional
Continuum of Care (CoC)

Annual Coordinated Entry System Evaluation

2017-2018

MARICOPA REGIONAL CONTINUUM OF CARE

ANNUAL COORDINATED ENTRY SYSTEM EVALUATION

2017-2018

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MARICOPA REGIONAL COC'S COMMITMENT TO EVALUATING THE COORDINATED ENTRY SYSTEM

Each Continuum of Care (CoC) receiving CoC Program funding from the Department of Housing and Urban Development (HUD) is required to develop and implement a centralized or coordinated assessment system (also known as "coordinated entry").[1] Coordinated entry is a process for assessing all people experiencing homelessness in the CoC to identify their vulnerability levels and prioritize persons who are most in need of assistance for available housing and services. The goals of coordinated entry are to increase the efficiency of a local crisis response system and improve fairness and ease of access to services, including housing and mainstream benefits.

The Maricopa Regional CoC's coordinated entry is its system for triaging, assessing, and referring individuals and families to appropriate need-based housing interventions.[2] It is intended to serve all geographic areas and all subpopulations in the CoC, including individuals, families and unaccompanied youth. The coordinated entry system was also designed to apply to all housing and homeless services in the Maricopa Regional CoC, including street outreach, programs funded by the Emergency Solutions Grant (ESG), homelessness prevention services, emergency services, mainstream benefits, and HMIS and parallel databases.

While coordinated entry is a requirement to receive CoC Program and ESG funding from HUD, the Maricopa Regional CoC is committed to its core principles as a key method for ensuring that vulnerable persons are able to access the resources that they need to end their homelessness.

ANNUAL EVALUATION OF COORDINATED ENTRY

HUD requires that each CoC conduct an annual evaluation of its coordinated entry system,[3] focusing on the quality and effectiveness of the entire coordinated entry experience—including intake, assessment, and referral processes—for both programs and participants. HUD mandates that this evaluation include soliciting feedback from projects providing services through the system and households that participated in coordinated entry during the evaluation period.

Consistent with HUD requirements, the Maricopa Regional CoC has committed to annually evaluating its coordinated entry system to determine whether it is meeting HUD's standards and the CoC's goals.[4] It strives to do so by employing multiple feedback mechanisms, including individual interviews with service providers and stakeholders, surveys designed to reach a representative sample of participating providers, and focus groups that approximate the diversity of the households participating in the system during the year.

In 2018, the Maricopa Regional CoC commissioned HomeBase to conduct and prepare the annual evaluation of its coordinated entry system. Key community stakeholders and HomeBase developed a primary set of questions to guide the focus of the evaluation and a framework for this evaluation report. These guiding questions, of which the bolded are considered priorities by the CoC, include:

Ensuring Access

- Do the system access points adequately cover the full geographic area of the CoC?
- ***Are vulnerable people able to access the coordinated entry system?***
- ***How can coordinated entry better engage populations that have used the available interventions before but nevertheless remain on the street?***
- ***Does the community have an appropriate number of access points to meet the need of the region?***
- ***What are the specific, concrete barriers which lead agencies face to on-board new providers?***

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[1] HUD's requirements for CoCs to establish and operate a coordinated entry system can be found in the CoC Program Interim Rule, 24 CFR 578.7(a)(8).

[2] Maricopa Regional Continuum of Care Coordinated Entry System Policies and Procedures, Section 1.01

[3] HUD Notice CPD-17-01, *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System*, at II.B.15; *See also* HUD's "*Coordinated Entry Management and Data Guide*," at Chapter 4.

[4] *Maricopa Regional Continuum of Care Coordinated Entry System Policies and Procedures* (Adopted by the Board January 22, 2018), at Section 5.06.

Assessment and Prioritization

- ***Are coordinated entry staff able to effectively determine client needs during assessment?***
- What type of information is missing from the assessment and the centralized waiting list that would help better inform matchers of client needs?
- Are the tools and protocols developed to support assessment and prioritization serving their intended purpose or could they be improved?
- ***Are providers messaging appropriately about expectations when clients interface with the coordinated entry system?***

Referrals and Placements

- ***Are provider agencies able to serve clients who are referred to them?***
- What is the time from assessment to referral? From referral to placement? What can be changed so that this wait time is reduced?
- What is the rate of referral denial? What the underlying reasons? Are there any common patterns among agencies or client subpopulations?
- ***How is the centralized wait list functioning?***
- ***What is the CoC's progressive engagement strategy? How well is it functioning?***

EVALUATION METHODOLOGY

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

- HMIS data in aggregate tables corresponding to evaluation questions.
    - Information was provided by the CoC's HMIS Lead.
    - The client pool for HMIS data is clients with an enrollment into a coordinated entry project between July 1, 2017 and June 30, 2018. This client pool excludes households with an enrollment into their most recent coordinated entry project prior to that time period, but who were still assessed, referred, and/or placed within the time period in question. Any future analysis should ensure that those clients are included.
    - The Family Housing HUB does not use HMIS to collect information about several key parts of coordinated entry, such as referrals and assessment location. Therefore, this report's data analysis related to families with children is limited; it is difficult to identify deficiencies in the system and recommendations for improvement without the comprehensive view provided by HMIS data.
- Online survey targeted to all stakeholders involved in the Maricopa Regional CoC coordinated entry system.
    - The survey was distributed by the CoC Lead to a comprehensive list of stakeholders.
    - It contained questions about perceptions of coordinated entry overall as well as questions targeted only to those involved in distinct phases of the system: assessment, prioritization, matching/case conferencing, and referrals/placements.
    - The survey opened on October 1, 2018 and closed on October 24, 2018.
    - There were 86 total survey responses, 57 from stakeholders of single adult coordinated entry and 29 from those of family coordinated entry. Respondents were not required to answer every survey item, so results presented here are only from those respondents who chose to answer each particular question.
- Four consumer focus groups facilitated on-site by HomeBase staff, as summarized in the table below:

	Single Adults System	Families System
Unhoused Consumers	Unhoused Single Adults Focus Group: o Held 9/5/2018 at Welcome Center o Attendance: 9 consumers	Unhoused Families Focus Group: o Held 9/6/2018 at Family Housing Hub o Attendance: 1 consumer
Consumers Housed Through CE	Housed Single Adults Focus Group o Held 9/5/2018 at PSH site o Attendance: 10 consumers	Housed Families Focus Group: o Held at 9/6/2018 Family Housing Hub o Attendance: 2 consumers

- On-site interviews with leadership at both the Welcome Center at the Human Services Campus and the Family Housing Hub.

- Review of key documents related to the coordinated entry system as provided by the CoC Lead.

COORDINATED ENTRY SYSTEM FRAMEWORK

Coordinated entry in Maricopa County is governed by the Maricopa Regional Continuum of Care Coordinated Entry System Policies and Procedures, adopted by the CoC Board on January 22, 2018. The system is overseen by the Coordinated Entry Subcommittee, which is responsible for providing input and making recommendations to the CoC Board on principles and guidelines for the coordinated entry system.

Currently, coordinated entry in the Maricopa Regional CoC is structured to operate through two distinct, but parallel, systems—one for single adults and on for families with children. Each system has its own Operations Manual that outlines the policies and procedures that govern the day-to-day implementation of coordinated entry for its respective population. While there are some intersections between the systems for single adults and families with children, in many cases they operate as separate systems and the data and information available for each varies. As such, this evaluation report provides separate analyses and recommendations for each.

A brief overview of the structure and general procedures for each of the coordinated entry systems for single adults and families with children is provided below to offer context for the analysis and recommendations contained in this report.

SINGLE ADULTS

The single adult coordinated entry is a system for triaging, diverting, assessing, and referring individuals to appropriate need-based housing interventions. Lodestar Day Resource Center serves as the Lead Operating Agency (LOA) for the single adult coordinated entry system. The system operates under a set of guiding principles, initially created by the Coordinated Assessment Workgroup in 2012, to ensure that the system best meets the needs of the individuals it serves.

To facilitate ease of access for all individuals experiencing homelessness in Maricopa County, single adult coordinated entry provides two primary options for entering the system: through contact with an outreach team or by walking into one of the various access points. The Welcome Center acts as a Hub, or the primary access point, for single adults, with all other access points acting as satellites. To ensure access is standardized across the system, all access points are required to provide the following services: intake and data collection, triage, diversion, assessment, and basic document collection.

The access points utilize the VI-SPDAT to assess single adult clients to determine acuity for prioritization for services. Coordinated entry for single adults prioritizes services first by chronic status, followed by acuity score, then length of time homeless.

The single adult coordinated entry system operates a By Name List (BNL) that includes information used to identify all individuals experiencing homelessness and to prioritize individuals for housing. The system employs two Housing Match Specialists to maintain an accurate inventory of available housing, eligibility requirements for that housing, and the BNL for coordination with community engagement teams. Once an individual has been identified as qualifying for a particular intervention, the Housing Match Specialists facilitate connecting them to programs for which they are eligible. Once an individual agrees to participate in the intervention for which they qualify and are eligible, a referral is made to the housing provider.

FAMILIES WITH CHILDREN

The Maricopa Regional CoC's coordinated entry system for families is operated through the Family Housing Hub (FHH) managed by United Methodist Outreach Ministries (UMOM). The FHH works to match homeless families with minor dependent children to housing and supportive services by assessing the unique needs of each family and connecting them to the appropriate resources to end their homelessness. This system operates under the same guiding principles as outlined for the single adult coordinated entry system.

The FHH operates out of a centralized location in Phoenix, with satellite locations in the East and West Valleys. These satellite locations serve as "one-stop shops" for families who are at risk of or experiencing homelessness

to access targeted and mainstream resources. There are currently four satellite locations for families to enter the coordinated entry system, although some of the remote locations maintain limited hours.

The FHH uses the Family VI-SPDAT to assess clients and determine appropriate housing interventions. The system then uses safety risk and length of time waiting for appropriate intervention to help determine prioritization beyond acuity.

Once the FHH Service Priority Specialist has determined a family qualifies for a particular intervention and meets the eligibility criteria, the FHH refers the family to the selected program for acceptance or denial.

ANALYSIS AND RECOMMENDATIONS

This report provides separate analyses and recommendations for each of the three phases of Maricopa Regional CoC's coordinated entry: Ensuring Access; Assessment and Prioritization; and Referrals and Placements.

Ensuring Access focuses on the system's accessibility for people experiencing homelessness. Specifically, this section explores how households throughout the geographic area enter the system, how coordinated entry initially responds to the varied needs of those households, and how the system keeps people engaged.

Assessment and Prioritization evaluates the effectiveness of the assessment in determining client need and explores opportunities to improve the assessment process, including messaging to clients and system expansion.

Referrals and Placements focuses on ensuring an expeditious and effective referral and placement process, including discussions related to equitability of referrals, referral denials, and progressive engagement.

ENSURING ACCESS

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

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

FULL GEOGRAPHIC COVERAGE

Do the system access points adequately cover the full geographic area of the CoC?

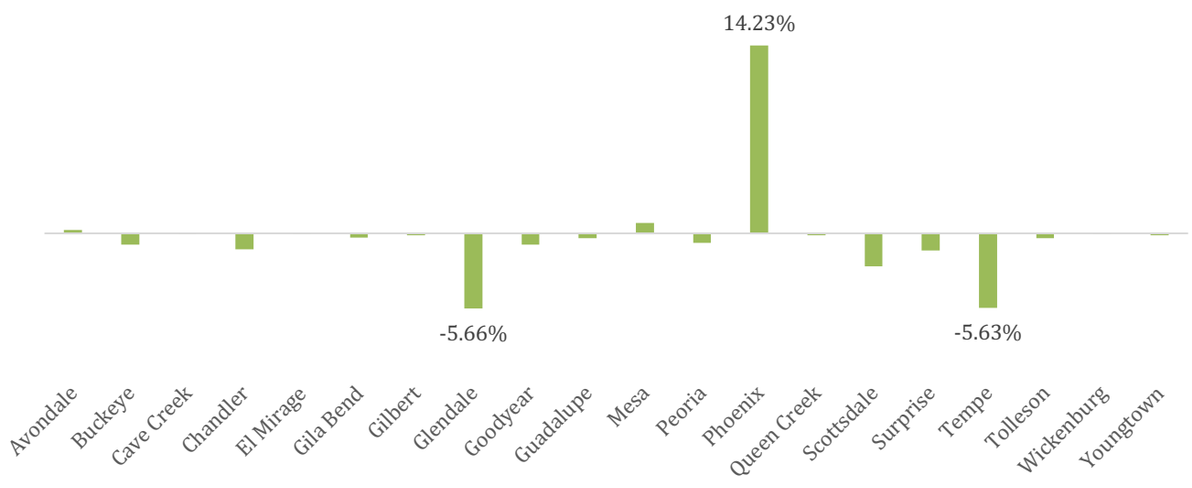
Does the community have an appropriate number of access points to meet the need of the region?

SINGLE ADULTS

Successes

The Welcome Center administers approximately half of all housing assessments for single adults; outreach teams and other access points contribute to the other half of single adult VI-SPDATs completed. A comparison between the 2018 Point-in-Time count of unsheltered persons and the deduplicated count of single adults assessed through coordinated entry indicates that most municipalities are represented proportionally to the size of their surveyed homeless population in terms of access to coordinated entry (see Figure 1).

Figure 1: Under-/Over-Representation in Access to Coordinated Entry



Challenges

Only 30 percent of survey respondents indicated they think coordinated entry adequately covers all geographic areas of Maricopa County. A comparison between the 2018 Point-in-Time count of unsheltered persons and the deduplicated count of single adults assessed through coordinated entry during the measuring period indicates that the municipalities of Glendale and Tempe are underrepresented in terms of access to coordinated entry (see Figure 1).

Survey respondents indicated that additional access points outside of the Phoenix metropolitan area, particularly in the West Valley, would be helpful. While there is an inherent tension between using resources on conducting more assessments when there are not enough resources to actually serve everyone, there are concerns about missing the most vulnerable persons experiencing homelessness by focusing assessments on individuals in the city core. In addition, with limited services and outreach capabilities, individuals experiencing homelessness in suburban areas are at a disadvantage, primarily because they may be automatically taken off of the active list after 30 days without a service transaction.

FAMILIES WITH CHILDREN

Successes

The FHH Operations Manual establishes as guiding principles that the family coordinated entry system should be easy for clients to navigate and should establish multiple points of entry in order to ensure full geographic coverage and access. In accordance with these goals, the FHH provides a "one-stop shop" experience for families with dependent children at risk of or experiencing homelessness four days a week (Monday through Thursday) in Phoenix. Additional satellite offices have been established in the East Valley one and a half days a week and the West Valley one day a week. At the time of the HomeBase site visit, a mobile outreach team was in the process of onboarding as a new mobile access point, the first of its kind in the family coordinated entry system.

Challenges

Only 34 percent of survey respondents indicated that the family coordinated entry system adequately covers all of Maricopa County, and almost half of respondents (48 percent) reported that the system fails to adequately cover the County, with the East and especially West Valley being cited repeatedly as areas of the County with limited coverage. Respondents felt that coordinated entry leadership should carefully consider the strategic placement of any additional physical access point locations, as well as develop strategies for increasing access to the FHH through additional mobile or virtual options. Several survey respondents also indicated that the limited number of access points poses difficulties for families with limited transportation options.

While the centralized location of the FHH is seen as a benefit for those experiencing homelessness in the urban core of the County, survey respondents also noted that the limited hours of the FHH (standard business hours Monday through Thursday) do not give families enough flexibility to access the system.

FAIR AND EQUAL ACCESS

Are vulnerable people able to access the coordinated entry system?

SINGLE ADULTS

Successes

The vast majority of survey respondents indicated that their organizations are equipped to provide the VI-SPDAT in a way that accommodates the diverse needs of Maricopa County residents. Among survey respondents, 79 percent reported being equipped to provide the assessment to persons who do not speak English, 74 percent are equipped to assess persons who are hard of hearing or deaf, and 89 percent are equipped to work with persons who are visually impaired or blind.

A demographic comparison of HMIS data on assessed single individuals versus sheltered and unsheltered persons counted in the 2018 Point-in-Time count indicates equitable access to coordinated entry across ages, genders, races, and ethnicities.

Challenges

In the past, the single adult coordinated entry system included a youth-specific process, but this pathway is no longer available. Providers expressed concerns that youth do not feel safe or comfortable seeking services at the Welcome Center. Survey respondents echoed this concern, observing that additional policies, programs, and services may be necessary to adequately serve youth.

FAMILIES WITH CHILDREN

Successes

FHH staff reported that bilingual English-Spanish staff are available to work with clients during Hub operating hours, and that other translation services are available through existing contracts. The vast majority of survey respondents who answered questions about assessments (73 percent or higher) reported that their organizations are equipped to provide the Family VI-SPDAT to those who are blind, deaf or hard of hearing, and those who do not speak English.

Consumers reported that case managers are friendly and supportive in helping clients address the unique needs of families and are able to provide family-oriented care and services.

Challenges

Interviews with FHH staff, survey results, and consumer focus groups all identified low-barrier shelter as an urgent need to improve outcomes for families experiencing homelessness in Maricopa County. There is specific concern that some family shelters limit access to only women and children. It is important to note that all HUD-funded shelters are required to serve all families and may not limit eligibility to women with children.

While FHH staff provided HomeBase with information on accessibility for non-English speakers, the Operations Manual currently lacks sufficient information regarding system-wide policies and practices to ensure that persons with disabilities and persons with Limited English Proficiency (LEP) are able to effectively access coordinated entry. Marketing and communication of services for the FHH should also reflect the ethnic and linguistic diversity of Maricopa County to ensure that language is not a barrier.

EFFECTIVE ENGAGEMENT

How can coordinated entry better engage populations that have used the available interventions before but nevertheless remain on the street?

SINGLE ADULTS

Successes

Reflecting on previous unsuccessful housing placements, housed consumers observed that client-centered counseling and support services have been crucial to their progress. They spoke highly of the mental health services they received through Community Bridges, Inc. (CBI) and indicated they received excellent care and were treated with respect and without judgment. They also noted that their Permanent Supportive Housing (PSH) case managers provide proactive wrap-around support and care and make them feel welcome and secure. Consumers who have remained housed for an extended period of time indicated that doing the SPDAT every six months might be an inconvenience, but has been helpful in reassessing their needs as their situations change.

Consumers were also appreciative of the guidance and support they received from Central Arizona Shelter Services (CASS). They indicated that CASS provided clear instructions regarding the paperwork they needed, assisted with obtaining the required documents, and made staff available to answer questions.

Challenges

Providers expressed concerns regarding the rate of recidivism, especially as it pertains to chronically homeless individuals. The Welcome Center reported that it was not uncommon for them to encounter over 40 individuals per month who had been placed in housing and had returned to homelessness. Gaps in follow-up and support from providers outside homeless services, including inconsistencies in service delivery at mental health clinics, as well as gentrification and substance abuse, were cited as concerns and factors contributing to recidivism.

CASS operates an estimated 60 percent of Maricopa County's emergency shelter beds, but the CoC is only able to connect a reported half of individuals experiencing unsheltered homelessness to CASS due to perceptions about the provider's barriers to entry, including sobriety requirements. Additionally, 69 percent of survey respondents indicated that narrow eligibility requirements of some housing programs are an impediment to quickly housing clients through coordinated entry.

Consumers expressed concerns that they were not offered all of the program options for which they were eligible and that housing specialists and case managers often seem overwhelmed and are unable to provide proactive assistance and support. Others observed that the units where they were housed were substandard and described living conditions that do not meet Housing Quality Standards.

Consumers expressed interest in job training programs and indicated that life skills training (including orientation to proper hygiene) would be helpful because people lose touch with these habits and with societal norms when they live outside for extended periods.

FAMILIES WITH CHILDREN

Successes

FHH staff described returns to homelessness as somewhat rare among families, occurring with only a portion of high-acuity clients. The family coordinated entry system recently began planning for a case conferencing process where one of the target audiences is families who have interacted with the system but remain homeless.

Challenges

Vulnerable families who have experienced long-term homelessness may be hesitant to access traditional shelter and services. Furthermore, FHH staff identified the limited supply of low-barrier shelter as perhaps the greatest challenge to housing families experiencing homelessness. FHH staff recommend that the CoC invest in additional low-barrier shelter options to help re-engage individuals for whom the traditional shelter system is

overwhelming or presents too many barriers to entry. Perhaps the most important aspect of low-barrier shelters is that they ensure families can stay together and supported throughout the coordinated entry process.

SYSTEM EXPANSION

What are the specific, concrete barriers which lead agencies face to on-board new providers?

SINGLE ADULTS

Successes

Survey respondents provided very favorable feedback regarding how coordinated entry has enabled the community to develop partnerships to wrap services around clients. Communication between providers and a fair and equitable process to prioritize limited housing resources are valued highly by providers, who appreciate the holistic and collaborative approach to ending homelessness that coordinated entry provides. Respondents were also very appreciative of coordinated entry staff and the relationships they have built with providers.

Challenges

Survey respondents unanimously lamented the limited capacity of resources dedicated towards ending homelessness. Some suggestions were to expand coordinated entry to engage providers who are able to serve at risk populations and other non-federally-funded community organizations which are able to provide more flexible support to persons experiencing homelessness.

FAMILIES WITH CHILDREN

Successes

The FHH brings together the 12 agencies and 26 programs that have been operating to prevent and end homelessness in Maricopa County to work collaboratively and effectively to serve all families seeking homeless services. Current contracts for homeless services with the City of Phoenix, HUD CoC, Valley of the Sun United Way (VSUW), and Arizona Department of Economic Security (DES) require participation in the family coordinated entry system.

Challenges

Establishing data sharing agreements continues to be a challenge for the FHH. This aligns with Maricopa County's short-term goal to enhance data partnerships to inform the plan to end homelessness for families and to determine the need for additional housing resources. The FHH continues working to engage partners who are not required to participate in the coordinated entry system, including faith-based providers and behavioral health resources. Strengthening existing partnerships and establishing new ones to expand access to services and resources can help close gaps within the system and bolster client support to prevent recidivism.

RECOMMENDATIONS: ENSURING ACCESS

SINGLE ADULTS

- Support emergency shelter providers in lowering barriers to entry and providing housing-focused case management.
- Provide training on client-centered case management approaches, such as motivational interviewing and harm reduction, to support housing and service providers in serving vulnerable clients. Provide training on Housing Quality Standards to support housing providers in locating appropriate units and advocating for habitable conditions for their clients.
- Strengthen communication and collaboration between homeless housing providers and providers of mental health services to engage and support vulnerable clients.

Engage homelessness prevention providers and other non-federally-funded community organizations to incorporate more flexible support into the system of care.

- Develop program standards indicating the types of services and supports to which housing providers must connect their clients (either through direct provision or through referral), setting a baseline standard of care across the system to address concerns about effective engagement of clients who had previous contact with the system but remain on the streets.
- Develop additional policies, programs, and services to more fully support and serve unaccompanied youth.
- Consider revising requirements for inclusion in the active coordinated entry list to ensure that vulnerable individuals are not excluded due to limited resources and opportunities for services and update policies accordingly. Consider ways to create additional access points outside of the city core, particularly in the West Valley.

FAMILIES WITH CHILDREN

- Increase low-barrier emergency shelter options in the community to meet high demand and allow for families to be united in shelter while working to resolve their homelessness.
- Consider ways to increase family access to coordinated entry to address stakeholder concerns around ease of access. Several ideas include:
  - Creating additional physical, mobile, or virtual access points; and
  - Increasing access to transportation to existing access points for families experiencing homelessness.
- Formalize the services available to non-English speakers in policies and procedures to provide transparency around fair and equal access.

ASSESSMENT AND PRIORITIZATION

HUD requires that each CoC incorporate a standardized assessment practice across its coordinated entry system. While there are a variety of methodologies for collecting information, the assessment process must document sufficient data to make consistent determinations on how to prioritize persons experiencing homelessness for housing and services. CoCs are expected to create prioritization standards based on a household's level of vulnerability or need to determine where households will be referred through coordinated entry.

ACCURATE DETERMINATION OF CLIENT NEEDS

Are coordinated entry staff able to effectively determine client needs during assessment?

Are the tools and protocols developed to support assessment and prioritization serving their intended purpose or could they be improved?

SINGLE ADULTS

Successes

Coordinated entry staff felt the VI-SPDAT is comprehensive and mostly accurate when clients are able to understand the questions.

Challenges

Survey respondents were split on the accuracy and consistency of the assessment process: 29 percent believe that clients' vulnerability is assessed accurately while 54 percent disagree; 36 percent think that vulnerability is

assessed consistently while 46 percent disagree. Respondents noted that the tool may be appropriate for triage but is not suited for housing determinations. Others were concerned that the tool is vulnerable to manipulation since it relies on self-reported information; some clients might answer dishonestly because they are worried about disclosing vulnerability while others might do so to inflate their scores.

Coordinated entry staff expressed concerns about the confusing nature of certain assessment questions, including those focused on HIV/AIDS and access to supports related to activities of daily living. The assessment question about barriers to maintaining shelter or permanent housing is also often misunderstood by clients, who think that the assessor is asking them what challenges will keep them from succeeding rather than vulnerabilities that have affected their housing stability in the past.

FAMILIES WITH CHILDREN

Successes

FHH staff stated that the Family VI-SPDAT, while imperfect, provides an adequate picture of the vulnerability of clients in the coordinated entry system. The number of skilled assessors is intentionally capped to ensure that administration of the assessment tool is consistent. Survey respondents agreed that this was a successful strategy, with a plurality (42 percent) observing that the tool is administered consistently (only 33 percent of respondents disagreed). An overwhelming majority (92 percent) of survey respondents also reported receiving sufficient training and materials to administer the Family VI-SPDAT.

Challenges

Half of survey respondents (50 percent) felt that the assessment tool does not work well, and over half (58 percent) reported that the tool fails to assess vulnerability in an accurate manner. FHH staff related that domestic violence providers believe that the tool fails to properly measure the vulnerability of those fleeing domestic violence. Some stakeholders have concerns about the accuracy and overall usefulness of the Family VI-SPDAT, though, as demonstrated above, they believe that the tool is administered consistently and proper support is offered by coordinated entry staff.

ASSESSMENT INFORMATION

What type of information is missing from the assessment and the centralized waiting list that would help better inform matchers of client needs?

SINGLE ADULTS

Successes

The single adult coordinated entry system utilizes weekly case conference meetings to enable housing navigators and providers to come together to communicate about progress, coordinate referrals, and troubleshoot barriers to housing for clients on the BNL.

Challenges

Survey respondents underscored the need for a more holistic approach to prioritization where the VI-SPDAT remains part of the determination, but other factors are considered as well. Respondents observed that the assessment does not adequately capture medical vulnerability and that it would be helpful to have information from other systems of care, such as hospitals, corrections, and the VA. There was also a concern that the results at times defy common sense—it would be helpful to have documented guidance for such cases.

FAMILIES WITH CHILDREN

Successes

The family coordinated entry system recently instituted a case conferencing process for high-acuity clients to provide more thorough discussion and review of matches before each referral is made. This process is currently limited to families who score very highly on the Family VI-SPDAT, have a history of disconnecting with the system after initial engagement, and/or have severe mental illnesses.

Challenges

The case conferencing process was still in the planning phase in the summer of 2018, so its level of success cannot yet be measured. The family coordinated entry system should develop a plan to track the outcomes of clients that are placed through case conferencing, so it can evaluate the effectiveness of this process.

CONSISTENT MESSAGING

Are providers messaging appropriately about expectations when clients interface with the coordinated entry system?

SINGLE ADULTS

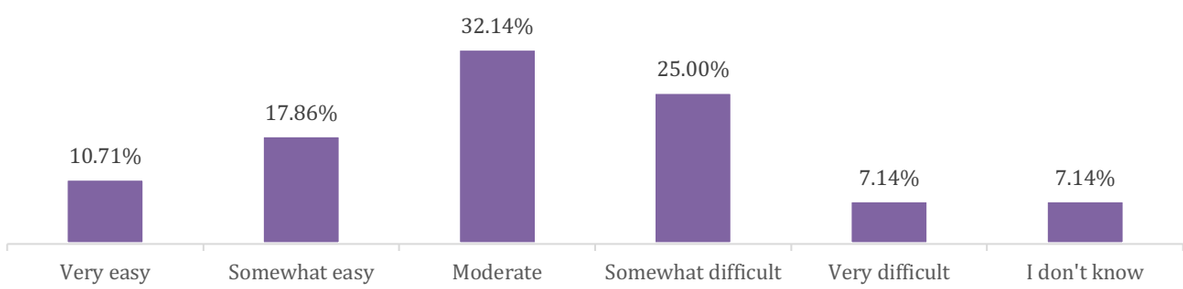
Successes

All assessed individuals receive a guide to available services and a housing plan checklist to support them in addressing their barriers to housing. This guide also encourages them to seek housing on their own.

Challenges

While the housing plan checklist that individuals experiencing homelessness receive includes much information on available supportive services, it provides very limited guidance regarding how to find and apply for housing. It also does not explicitly call out the fact that rental assistance services are limited and that referral rates to supportive housing are low. Thirty-two percent of survey respondents observed that ensuring clients understand coordinated entry is difficult (see Figure 2).

Figure 2: Ensuring Clients Understand Coordinated Entry (Single Adults)



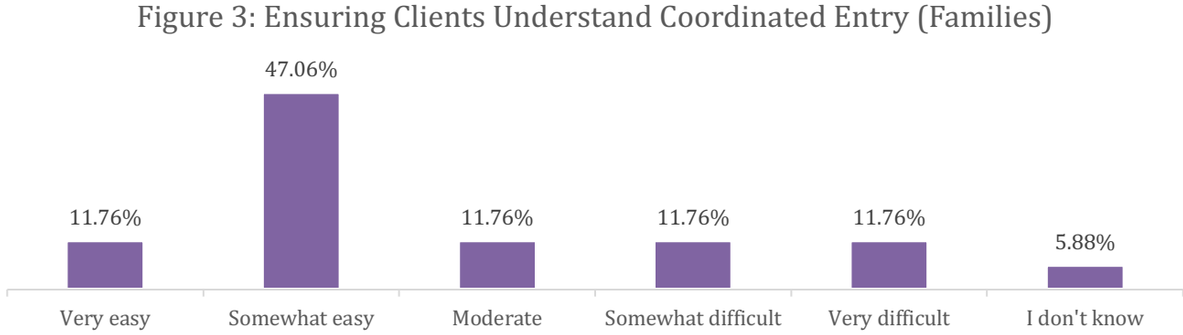
FAMILIES WITH CHILDREN

Successes

Print materials to advertise the FHH provide clear, appropriate messaging regarding the expectations for interacting with the coordinated entry system, including limitations around shelter availability within the County and the construction of each family's housing plan. In consumer focus groups, clients shared that they had received accurate and valuable information regarding housing vouchers and how they work.

In addition, as shown in Figure 3 below, over half (59 percent) of survey respondents reported that it is easy to ensure clients understand the coordinated entry process.

Figure 3: Ensuring Clients Understand Coordinated Entry (Families)



Challenges

During client focus groups, one family reported that they were not given accurate timelines of housing placement and the term of supportive housing assistance that would be provided. Furthermore, 63 percent of survey respondents disagreed with a statement that clients are informed of their place on the Service Priority List and given information about how prioritization works and how they will be informed of changes to their place on the List.

RECOMMENDATIONS: ASSESSMENT AND PRIORITIZATION

SINGLE ADULTS

- Strengthen understanding of the coordinated entry system at each point of contact for clients, including providers who are not participating in the system. In particular, create informational tools to:
  - Ensure providers who are not participating are able to explain the system accurately to their clients and know where to refer clients for an assessment;
  - Facilitate talking points for assessors and access point agencies to directly respond to tough questions and address myths head on; and
  - Support participants who take the VI-SPDAT to remember the information they are given about the coordinated entry system, even when the information is provided as part of a larger intake process.
- Establish a system for monitoring VI-SPDAT administration to ensure consistency and positive client experience, and recommend or require agencies to adopt internal program controls. Consider reinforcement training, especially for agencies that are conducting a very limited number of VI-SPDATs.
- Consider conducting a feedback process with coordinated entry participants who have experienced the VI-SPDAT to strengthen protocols for ensuring the assessment process is as accessible, safe, and trauma-informed as possible and to explore additional prioritization factors and protocols for modifying the assessment as needed to strengthen outcomes.

FAMILIES WITH CHILDREN

- Address provider concerns with shortcomings of the Family VI-SPDAT by:
  - Conducting an analysis of the assessment's effectiveness in matching households to interventions and develop protocols for modifying the assessment as needed to strengthen outcomes; and/or
  - Considering additional prioritization factors (beyond assessment score and length of time homeless) to compensate for areas of vulnerability that the assessment does not take into account.
- Monitor and evaluate the progress and effectiveness of the new case conferencing process to ensure that it is improving the process of prioritization and referral.
- Work with providers to develop more stringent policies around informing clients about prioritization, active list wait times, and how communication about changes to waitlists will occur.

REFERRALS AND PLACEMENTS

The goal of coordinated entry is to create a system that allows for intentional referrals of people to housing and services based on their vulnerability and need. Through these systems, those people with the highest priority, as determined by the CoC's intentional protocol, are referred to the available interventions first.

EFFICIENT TIMELINE

What is the time from assessment to referral? From referral to placement? What can be changed so that this wait time is reduced?

SINGLE ADULTS

Successes

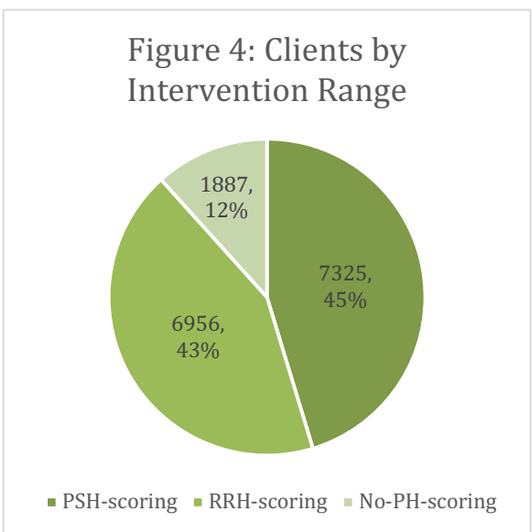
The coordinated entry system timeline is efficient for persons assessed in the rapid rehousing (RRH) intervention range as compared to timelines in other communities who have begun collecting this data. The average time between assessment and housing move-in for someone who was housed through coordinated entry during the reporting period was 119.8 days. For persons referred during the reporting period, an average of 88.65 days had elapsed between assessment and referral. For persons enrolled in a RRH program during the reporting period, an average of 31.79 days had elapsed since referral. For those who were housed during the reporting period, an average of 43.92 days had elapsed between enrollment and move-in.

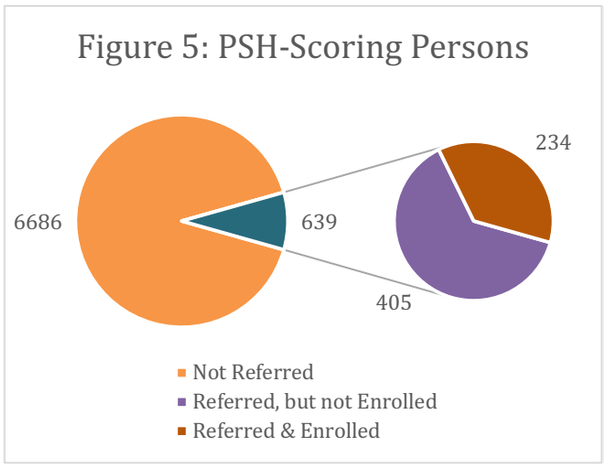
The coordinated entry system timeline is also efficient for persons assessed in the PSH intervention range as compared to timelines in other communities who have begun collecting this data. The average time between assessment and housing move-in for someone who was housed through coordinated entry during the reporting period was 114.88 days (117.42 for those moving into scattered-site units and 111.18 for those moving into project-based units). For persons referred during the reporting period, an average of 69.35 days had elapsed between assessment and referral. For persons enrolled in a PSH program during the reporting period, an average of 34.52 days had elapsed since referral (35.30 for those enrolling into scattered-site PSH and 23.33 for those enrolling into project-based PSH). For persons who were housed during the reporting period, an average of 33.92 days had elapsed between enrollment and move-in (36.23 for those moving into scattered-site units and 3.70 for those moving into project-based units).

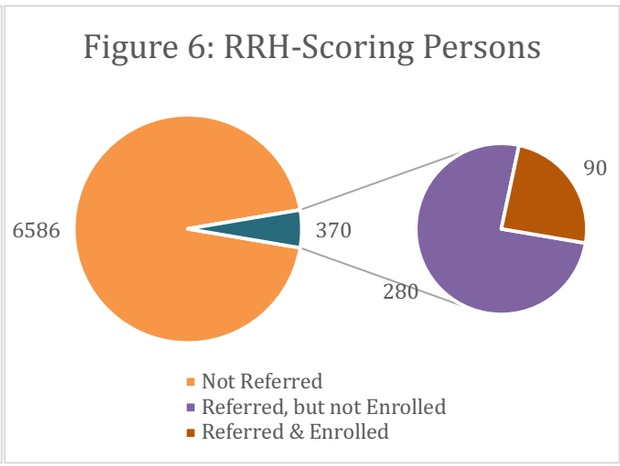
Challenges

Of those persons who had contact with the single adult coordinated entry system over the course of the reporting period, 45 percent scored in the PSH range and 43 percent scored in the RRH range (see Figure 4). Limited system capacity manifests in low referral rates across interventions: nine percent of those who scored in the PSH range and five percent of those who scored in the RRH range received referrals.

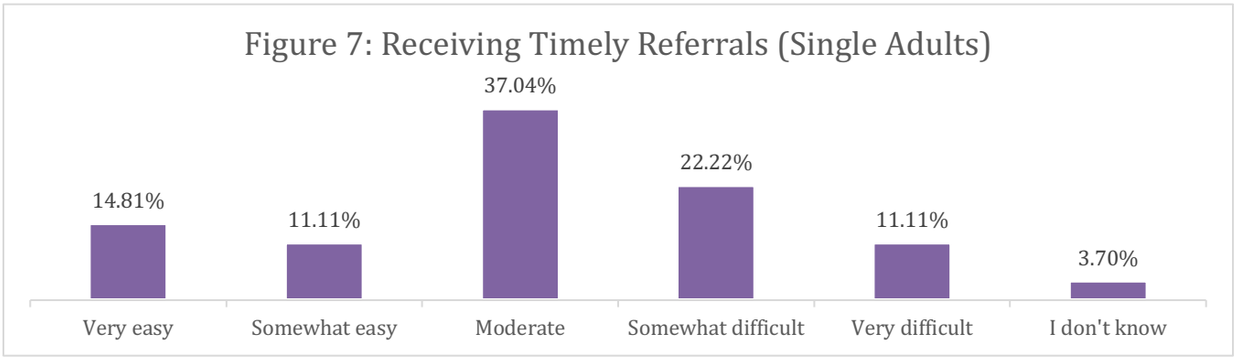
Enrollments were limited as well: 37 percent of PSH-scoring and 24 percent of RRH-scoring referred persons were enrolled (see Figures 5 and 6).

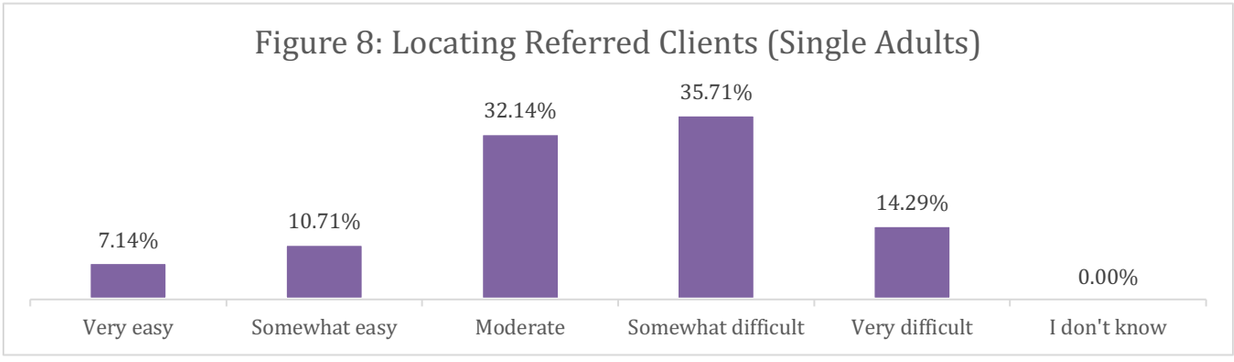


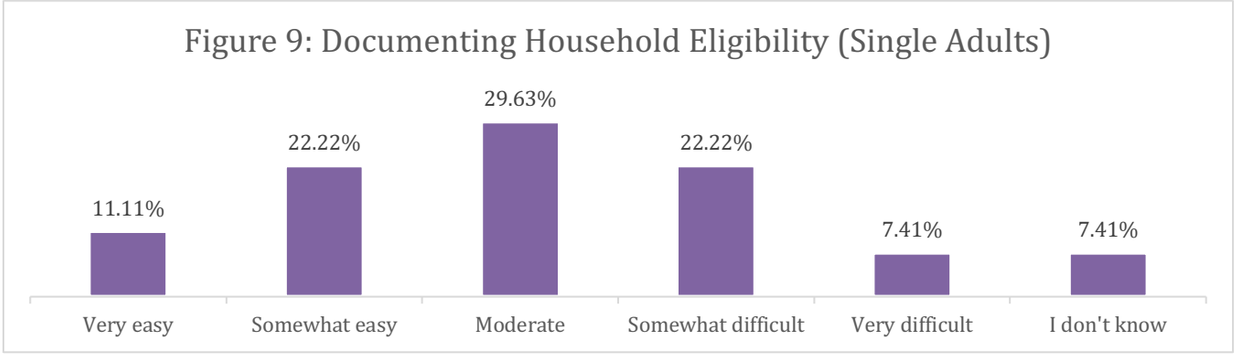




Several aspects of coordinated entry are found to be challenging and are potentially causing bottlenecks: 33 percent of survey respondents find it difficult to receive timely referrals (see Figure 7), 50 percent find it difficult to locate referred clients (see Figure 8), and 30 percent find it difficult to document household eligibility (see Figure 9). Furthermore, survey respondents had varying interpretations regarding the allocation of responsibility for securing eligibility documentation.





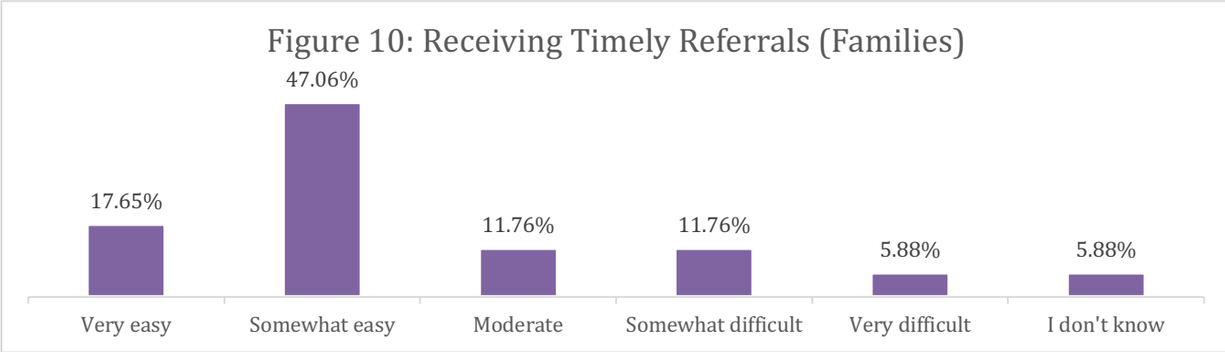


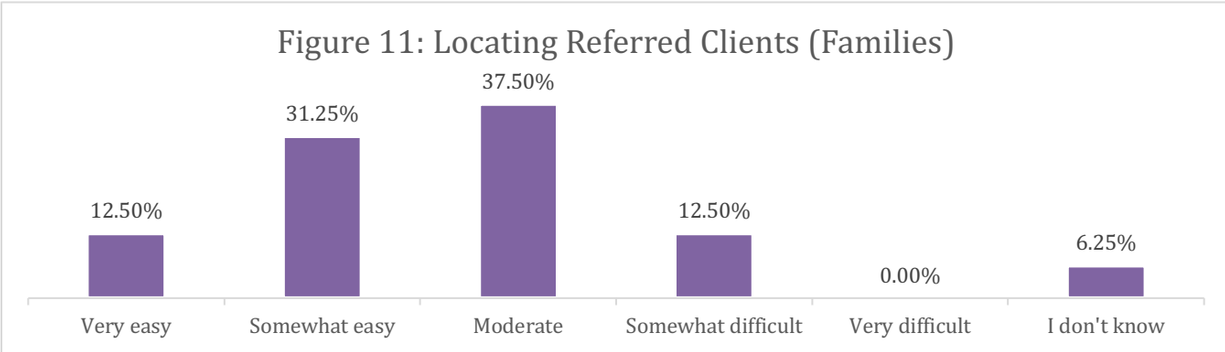
FAMILIES WITH CHILDREN

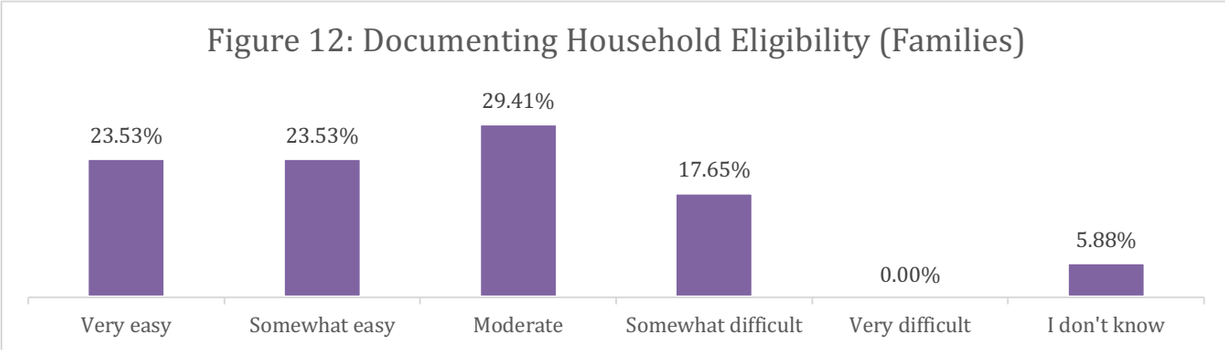
Successes

FHH staff acknowledged long wait times for RRH programs but stated that the system has worked to lower eligibility regulations in an effort to lower barriers to entry. As shown in Figures 10, 11, and 12 below, a

majority of survey respondents described receiving timely referrals as easy, while a plurality found locating referred clients and documenting eligibility to be easy rather than difficult.







Challenges

FHH staff described a lack of PSH options for families that results in extended wait times for placement in PSH programs. Staff also observed that the RRH priority list has over 200 families and an average wait time of four and a half months. Finally, there are bottlenecks for families to simply enter emergency shelters due to limited low-barrier shelter options.

Significant wait time from initial intake and assessment to placement into housing or receipt of a housing voucher was noted as a concern among consumers during focus groups. The reason for the significant amount of time between assessment and referral is in part due to a bottleneck within the system—there is a relatively large number of people entering shelter, but very few exiting to permanent housing options. Evaluating the entire housing portfolio and using creative options like dynamic prioritization may help reduce waiting times for families that require higher level interventions such as PSH.

Finally, perhaps the most difficult aspect of analyzing timelines in the family coordinated entry system is that a lack of HMIS data around referrals makes any analysis largely speculative. If the CoC would like to accurately monitor the timeliness of the family coordinated entry system, it should ensure that HMIS is used to manage all aspects of the system. Furthermore, if the CoC funds any of the family coordinated entry management through the CoC Program, the new APR for the coordinated entry grants requires CoCs to identify the average timeline clients experience between the major phases of coordinate entry, or to "describe how the CoC plans to collect this information in the future, including a timeframe for implementation."

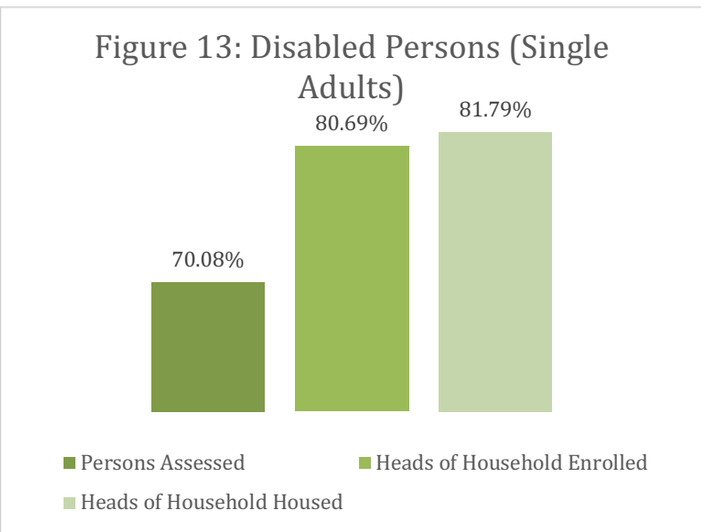
EQUITABLE REFERRAL SCHEME

How is the centralized wait list functioning?

SINGLE ADULTS

Successes

The Welcome Center makes its referrals almost exclusively through HMIS (exceptions are referrals for City of Phoenix, HUD-VASH, and SSVF vouchers), promoting efficiency and accountability. A regular case conferencing meeting is held to discuss program openings and potential referrals, as well as strategies for locating referred individuals. CoC agencies participate actively in these collaborative meetings, which contribute to the efficiency of the coordinated entry process. Fifty-six percent of survey respondents agreed that the BNL is running well (19 percent disagreed).



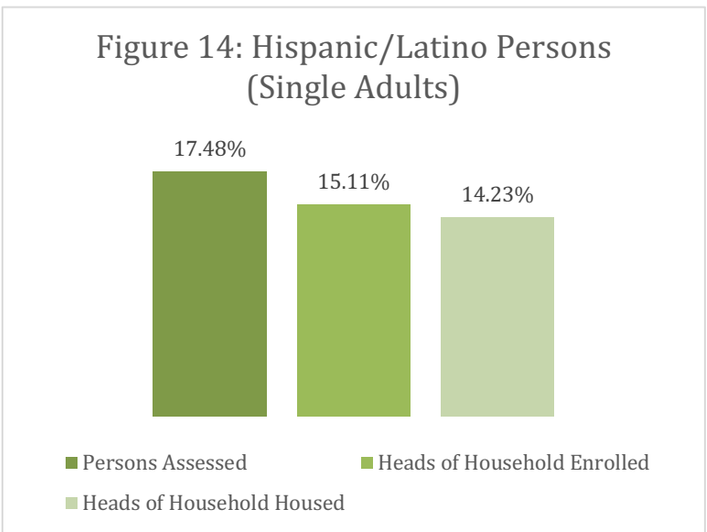
HMIS data demonstrate a consistent age, gender, and race distribution among persons assessed, heads of household enrolled, and heads of household housed.

HMIS data also indicate that there are a higher proportion of disabled heads of household housed than disabled persons assessed (see Figure 13), reflecting the system's effective prioritization of vulnerable persons.

Challenges

Twenty-four percent of survey respondents agreed that the prioritization process accurately reflects the vulnerability of clients, while 41 percent disagreed. Fifty percent of survey respondents indicated that it is difficult to tell where a client is on the BNL.

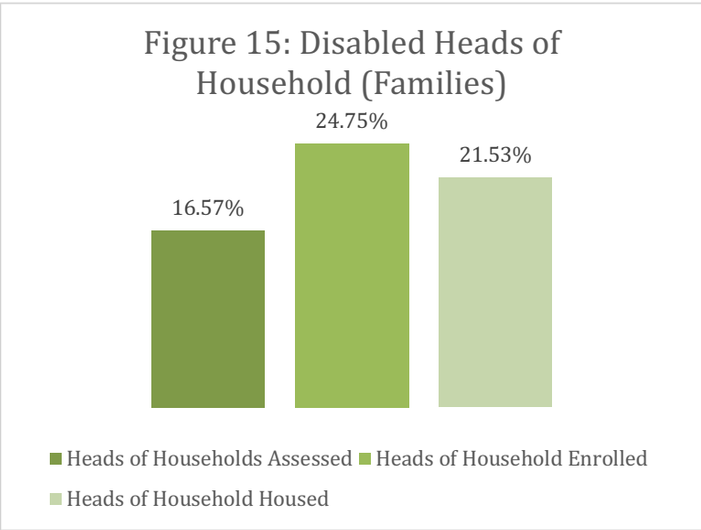
HMIS data demonstrate a higher proportion of Hispanic/Latino persons assessed than Hispanic/Latino heads of household housed: while 17.48 percent of persons assessed identify as Hispanic/Latino, only 14.23 percent of housed heads of household identify as such (see Figure 14).



FAMILIES WITH CHILDREN

Successes

The family coordinated entry system uses assessment data and established eligibility criteria to add families to Service Priority Lists for appropriate interventions, which may include transitional housing (TH), RRH, or PSH. Additionally, FHH staff report that clients who decline services or temporarily lose contact with the system will be candidates for case conferencing to ensure they do not return to homelessness.



HMIS data demonstrate consistent age, gender, race, and ethnicity distributions among heads of household assessed, heads of household enrolled, and heads of household housed.

HMIS data also indicate that there is a slightly higher proportion of disabled heads of households housed than disabled heads of household assessed, demonstrating that the system provides some prioritization of vulnerable families (see Figure 15).

Challenges

As there appears to be a significant wait time for RRH and PSH options for clients who are eligible for these interventions, the FHH should evaluate its current RHH and PSH programs to identify strategies to lower barriers and make access less restrictive, as well as to help clients move on from PSH into other subsidized/affordable housing in order to decrease the length of the Service Priority List.

APPROPRIATE REFERRALS

What is the rate of referral denial? What the underlying reasons? Are there any common patterns among agencies or client subpopulations?

Are provider agencies able to serve clients who are referred to them?

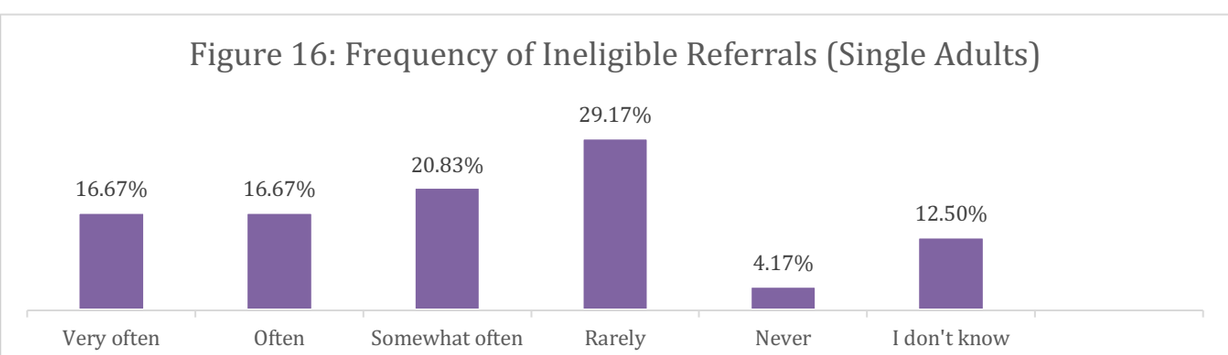
SINGLE ADULTS

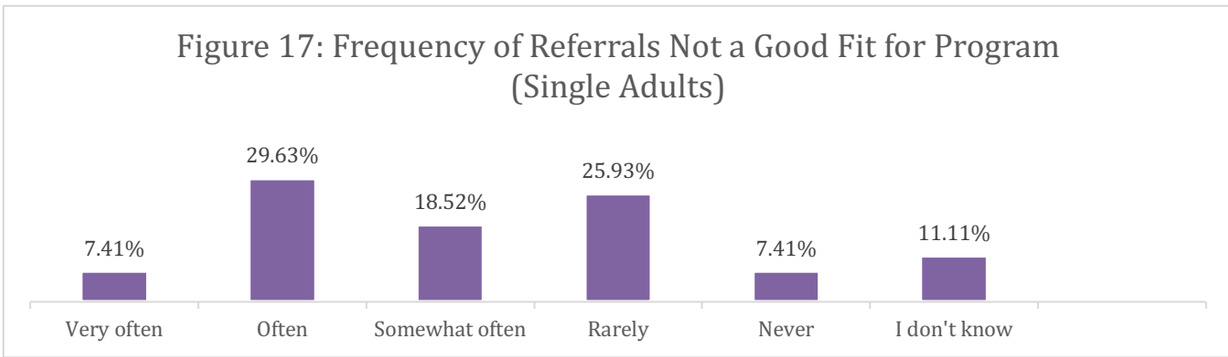
Successes

Thirty-three percent of survey respondents indicated that they rarely or never receive ineligible referrals or referrals that are not a good fit for the program (see Figures 16 and 17). Respondents noted that coordinated entry works well with providers to find appropriate housing and observed that prior to the launch of the system clients were not placed accurately.

Challenges

Thirty-three percent of survey respondents indicated that they often or very often receive ineligible referrals and 37 percent reported often or very often receiving referrals that are not a good fit for the program (see Figures 16 and 17). Respondents noted difficulties with correcting assessments in cases where vulnerability turned out to be higher than previously thought.





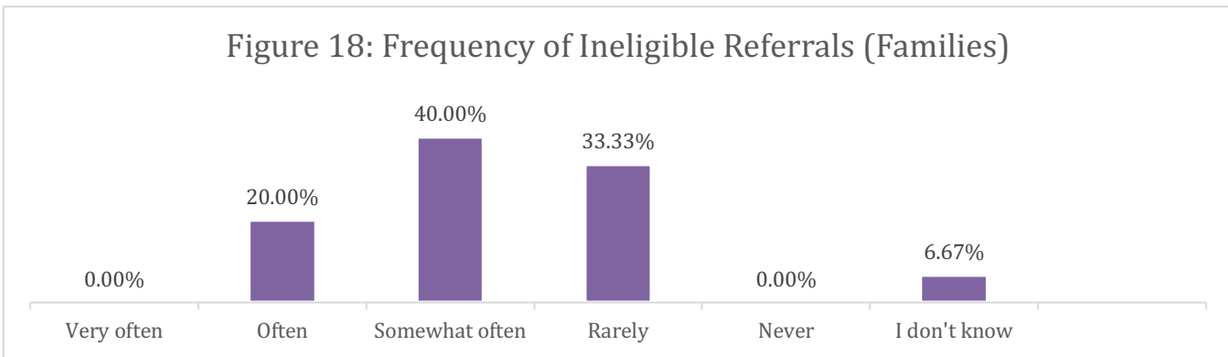
FAMILIES WITH CHILDREN

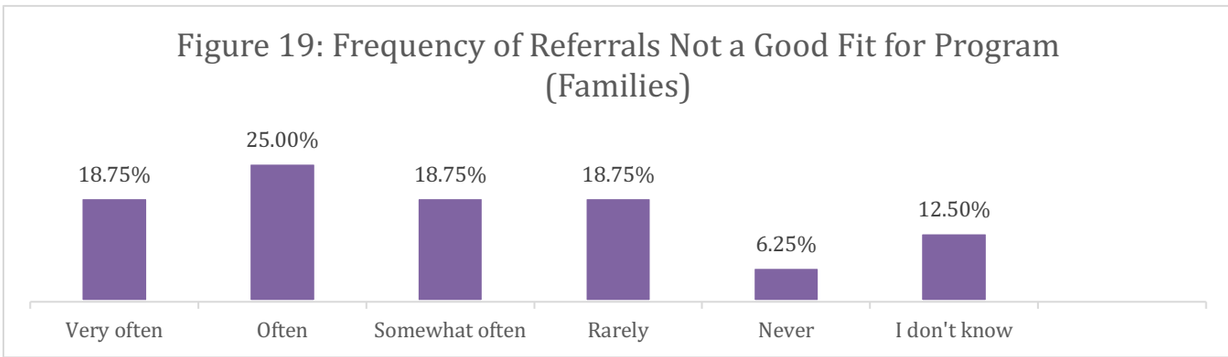
Successes

Programs have the option to decline services to 15 percent of the eligible families referred to them by the FHH, but FHH staff reported low levels of ineligible and rejected referrals. Clients who have been declined services are redirected by the FHH Service Priority Specialist to an alternate program.

Challenges

While staff reported low levels of rejected referrals, it is impossible to confirm due to lack of HMIS data on referrals in the family coordinated entry system. In addition, survey responses about ineligible and inappropriate referrals were mixed, as shown Figures 18 and 19 below. Survey respondents specifically observed that complex and high eligibility criteria in TH projects are a leading cause of referral rejections.





From document review, it was unclear whether the family coordinated entry system follows the approach outlined in the overall coordinated entry policies and procedures manual for documenting and justifying provider denial of referrals. Policies and procedures for the family coordinated entry system should make clear the reasons for which a program can deny a referral and ensure that the program's rationale for any denials is clearly documented in case a client would choose to file a grievance. For programs that approach the 15 percent denial rate, the FHH should investigate why referrals are denied: Is the program unwilling to serve certain clients? Is the program being referred clients who it is not able to appropriately serve? The answer to the reason for a program's high denial rate can help guide the FHH in either developing a corrective action plan for the program or for making improvements to the referral process to better align with program eligibility requirements and populations served. Furthermore, if providers are not approaching the 15 percent denial

rate, as stated by FHH staff, the CoC should consider lowering the percentage of denials to align with the average denial rate seen in practice.

PROGRESSIVE ENGAGEMENT

What is the CoC's progressive engagement strategy? How well is it functioning?

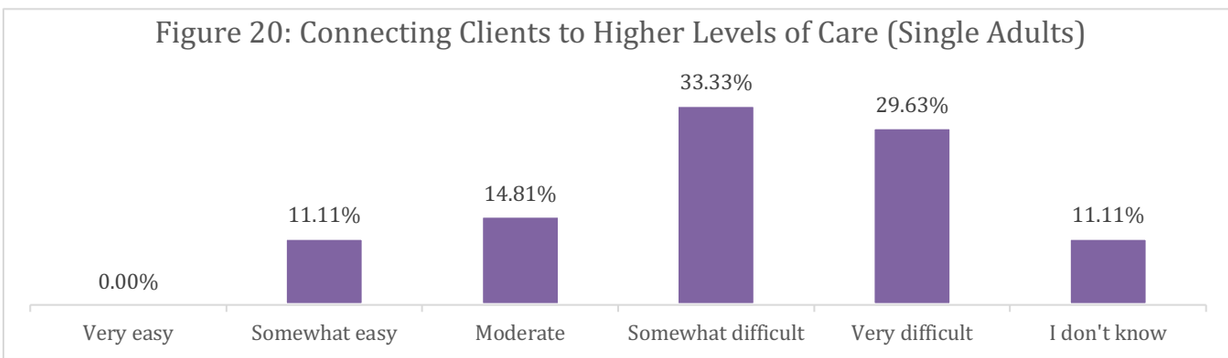
SINGLE ADULTS

Successes

The Human Services Campus is a one-stop-shop which houses the Welcome Center and provides a host of other wrap-around services including shelter, identifications, showers and restrooms, clothing, meals, employment and income services, connection to food stamps and health insurance, medical care, mail, and bag storage. Individuals seeking assistance here receive a guide that includes a housing plan checklist and provides instructions on where, when, and how to access the robust supportive services available at the Campus.

Challenges

The majority (63 percent) of survey respondents find it difficult or very difficult to connect clients who need more intensive services to a higher level of care (see Figure 20). Housing providers observed receiving referred clients who present with severe barriers to housing that may not have been captured in the VI-SPDAT and noted that it would be helpful to incorporate a more sensitive assessment tool. Respondents also indicated that availability of resources to provide intensive care is limited. Finally, hands-on training in diversion strategies was requested.



FAMILIES WITH CHILDREN

Successes

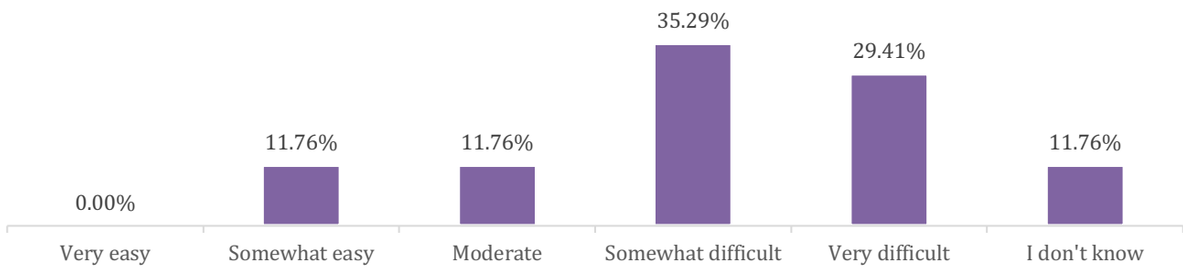
The family coordinated entry system's work with progressive engagement begins with its diversion program. FHH staff as well as stakeholder survey respondents expressed particular pride in the diversion program, which they see as one of the more successful outcomes of coordinated entry implementation in Maricopa County.

If diversion is unsuccessful, the family is served through the modified progressive engagement strategy: the Family VI-SPDAT score determined by the staff at the FHH governs the initial intervention for the family. In the event that the intervention is not successful and the family, still experiencing homelessness, returns to the FHH with a full assessment score from an F-SPDAT-trained provider agency that substantiates the need for a higher level of suppor, the family will be routed through the established procedures for accessing that intervention.

Challenges

A majority (65 percent) of survey respondents indicated that it is difficult to connect a client who needs more intensive services to a higher level of care, as shown in Figure 21 below. In addition, FHH staff reported that a lack of shelter, specifically low-barrier shelter, leads to high -need families falling out of touch with the system and remaining literally homeless.

Figure 21: Connecting Clients to Higher Levels of Care (Families)



RECOMMENDATIONS: REFERRALS AND PLACEMENTS

SINGLE ADULTS

- Deepen provider capacity and consistency in implementing best practices for locating referred households, including through regular trainings, especially for new staff. Consider establishing mandatory practices or a checklist of strategies to more fully enumerate expectations regarding reasonable attempts to locate referrals.
- Develop standardized procedures to track, analyze, and follow up on referral rejections to minimize the occurrence of denials, identify unnecessary barriers to program entry, and more effectively match individuals to appropriate programs.
- Strengthen providers' understanding regarding eligibility requirements through regular trainings, especially for new staff. Consider developing standard eligibility documentation checklists and form letters to streamline the process for CoC-funded programs.
- Develop baseline standards as well as goals related to Housing First and support shelter and housing providers in lowering barriers to program entry and retention and eliminating unnecessary requirements through training and technical assistance.
- Strengthen ongoing coordinated entry participant engagement and availability of up-to-date contact information, including approaches such as:
    - Encouraging participants to sign up for and regularly check email addresses;
    - Training providers to input detailed contact information in HMIS and update information regularly;
    - Considering a modification to the HMIS interface to encourage updating contact and location information (e.g., by showing contact information first or creating a flag or red highlight reminder for providers if information has not been updated for a certain period of time); and
    - Encouraging providers to regularly discuss coordinated entry with clients, even after they have been assessed, to strengthen engagement.
- Analyze differences in proportions of Hispanic/Latino persons at each phase of coordinated entry to determine factors underlying this trend. Consider analyzing the coordinated entry timeline by age, gender, race, and ethnicity to determine whether different populations flow through the system at different rates.

FAMILIES WITH CHILDREN

- Use HMIS to manage the referral process for coordinated entry to allow for easy monitoring and analysis of timelines from assessment to referral to placement.
- Evaluate the current housing portfolio and identify necessary changes to meet client needs via a progressive engagement strategy. Such changes could include:
    - Lowering restrictive eligibility barriers in transitional housing projects dedicated to families;
    - Increasing the variety of lengths of rental assistance offered in the CoC's RRH portfolio to better serve a wide range of client needs; and

  - Increasing the supply of non-restrictive PSH projects dedicated to families in the community.
- Define standards around referral rejections, including:
  - Clarify uniform procedures and criteria for programs to deny referred clients, and create a system to ensure adherence;
  - Conduct an analysis of program eligibility rules and referral denial rates to determine the extent to which provider-created rules lead to denials;
  - Investigate programs with high denial rates to understand underlying causes and take corrective action; and
  - Consider lowering the permitted rate of referral rejection below 15 percent.

CONCLUSION

Coordinated entry in the Maricopa Regional CoC operates with two distinct systems for single adults and for families with children. At this point it is recommended that the CoC invest effort or resources into unifying the two pathways, as the two populations have different needs and are largely served by separate providers. While it may make sense to combine the two systems in the future, at this juncture it is recommended that the Maricopa Regional CoC invest energy into the other sugestions throughout the report to strengthen the effectiveness of the current system and improve client experience. Continuing diligent oversight by the Coordinated Entry Subcommittee and encouraging open communication between the coordinated entry lead agencies should help maintain consistency across the two systems.

One area that is complicated by the current structure of serving single adults and families with children separately is how unaccompanied youth fit into the system. As the CoC works on strengthening its coordinated entry system, it is recommended to place an intentional focus on youth and how this population can be more fully supported and effectively served within the existing bifurcated system.

Overall, the majority of participants in the evaluation process reported that the coordinated entry system benefits the community by making access to housing more equitable. They reported being encouraged by progress being made in the community and expressed looking forward to continuing to strengthen the system to enhance outcomes for households experiencing homelessness in Maricopa County.

APPENDIX A

COMPREHENSIVE LIST OF RECOMMENDATIONS

ENSURING ACCESS

SINGLE ADULTS

- Support emergency shelter providers in lowering barriers to entry and providing housing-focused case management.
- Provide training on client-centered case management approaches, such as motivational interviewing and harm reduction, to support housing and service providers in serving vulnerable clients. Provide training on Housing Quality Standards to support housing providers in locating appropriate units and advocating for habitable conditions for their clients.
- Strengthen communication and collaboration between homeless housing providers and providers of mental health services to engage and support vulnerable clients. Engage homelessness prevention providers and other non-federally-funded community organizations to incorporate more flexible support into the system of care.
- Develop program standards indicating the types of services and supports to which housing providers must connect their clients (either through direct provision or through referral), setting a baseline standard of care across the system to address concerns about effective engagement of clients who had previous contact with the system but remain on the streets.
- Develop additional policies, programs, and services to more fully support and serve unaccompanied youth.
- Consider revising requirements for inclusion in the active coordinated entry list to ensure that vulnerable individuals are not excluded due to limited resources and opportunities for services and update policies accordingly. Consider ways to create additional access points outside of the city core, particularly in the West Valley.

FAMILIES WITH CHILDREN

- Increase low-barrier emergency shelter options in the community to meet high demand and allow for families to be united in shelter while working to resolve their homelessness.
- Consider ways to increase family access to coordinated entry to address stakeholder concerns around ease of access. Several ideas include:
    - Creating additional physical, mobile, or virtual access points; and
    - Increasing access to transportation to existing access points for families experiencing homelessness.
- Formalize the services available to non-English speakers in policies and procedures to provide transparency around fair and equal access.

ASSESSMENT AND PRIORITIZATION

SINGLE ADULTS

- Strengthen understanding of the coordinated entry system at each point of contact for clients, including providers who are not participating in the system. In particular, create informational tools to:
    - Ensure providers who are not participating are able to explain the system accurately to their clients and know where to refer clients for an assessment;
    - Facilitate talking points for assessors and access point agencies to directly respond to tough questions and address myths head on; and
    - Support participants who take the VI-SPDAT to remember the information they are given about the coordinated entry system, even when the information is provided as part of a larger intake process.

- Establish a system for monitoring VI-SPDAT administration to ensure consistency and positive client experience, and recommend or require agencies to adopt internal program controls. Consider reinforcement training, especially for agencies that are conducting a very limited number of VI-SPDATs.
- Consider conducting a feedback process with coordinated entry participants who have experienced the VI-SPDAT to strengthen protocols for ensuring the assessment process is as accessible, safe, and trauma-informed as possible and to explore additional prioritization factors and protocols for modifying the assessment as needed to strengthen outcomes.

FAMILIES WITH CHILDREN

- Address provider concerns with shortcomings of the Family VI-SPDAT by:
    - Conducting an analysis of the assessment's effectiveness in matching households to interventions and develop protocols for modifying the assessment as needed to strengthen outcomes; and/or
    - Considering additional prioritization factors (beyond assessment score and length of time homeless) to compensate for areas of vulnerability that the assessment does not take into account.
- Monitor and evaluate the progress and effectiveness of the new case conferencing process to ensure that it is improving the process of prioritization and referral.
- Work with providers to develop more stringent policies around informing clients about prioritization, active list wait times, and how communication about changes to waitlists will occur.

REFERRALS AND PLACEMENTS

SINGLE ADULTS

- Deepen provider capacity and consistency in implementing best practices for locating referred households, including through regular trainings, especially for new staff. Consider establishing mandatory practices or a checklist of strategies to more fully enumerate expectations regarding reasonable attempts to locate referrals.
- Develop standardized procedures to track, analyze, and follow up on referral rejections to minimize the occurrence of denials, identify unnecessary barriers to program entry, and more effectively match individuals to appropriate programs.
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- Strengthen ongoing coordinated entry participant engagement and availability of up-to-date contact information, including approaches such as:
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    - Considering a modification to the HMIS interface to encourage updating contact and location information (e.g., by showing contact information first or creating a flag or red highlight reminder for providers if information has not been updated for a certain period of time); and
    - Encouraging providers to regularly discuss coordinated entry with clients, even after they have been assessed, to strengthen engagement.
- Analyze differences in proportions of Hispanic/Latino persons at each phase of coordinated entry to determine factors underlying this trend. Consider analyzing the coordinated entry timeline by age, gender, race, and ethnicity to determine whether different populations flow through the system at different rates.

FAMILIES WITH CHILDREN

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    - Conduct an analysis of program eligibility rules and referral denial rates to determine the extent to which provider-created rules lead to denials;
    - Investigate programs with high denial rates to understand underlying causes and take corrective action; and
    - Consider lowering the permitted rate of referral rejection below 15 percent.

APPENDIX B

DATA TABLES[5]

ENSURING ACCESS

SINGLE ADULTS

FULL GEOGRAPHIC COVERAGE

City	*Deduplicated Single Adults Assessed*	*Percent of Total Single Adults*	*2018 Unsheltered PIT Count (All Persons)*	*Percent of Total 2018 Unsheltered PIT Count*	*Percent Under-/Over-Representation in VI-SPDATs*
NULL	375	5.02%	0	0	
Avondale	57	0.76%	13	0.50%	0.27%
Buckeye	0	0	22	0.84%	-0.84%
Cave Creek	0	0	1	0.04%	-0.04%
Chandler	65	0.87%	54	2.06%	-1.19%
El Mirage	0	0	2	0.08%	-0.08%
Gila Bend	0	0	8	0.31%	-0.31%
Gilbert	1	0.01%	4	0.15%	-0.14%
Glendale	45	0.60%	164	6.26%	-5.66%
Goodyear	0	0	22	0.84%	-0.84%
Guadalupe	0	0	9	0.34%	-0.34%
Mesa	469	6.28%	144	5.50%	0.78%
Peoria	54	0.72%	38	1.45%	-0.73%
Phoenix	6016	80.50%	1735	66.27%	14.23%
Queen Creek	2	0.03%	5	0.19%	-0.16%
Scottsdale	5	0.07%	67	2.56%	-2.49%
Surprise	16	0.21%	39	1.49%	-1.28%
Tempe	367	4.91%	276	10.54%	-5.63%
Tolleson	0	0	9	0.34%	-0.34%
Wickenburg	1	0.01%	2	0.08%	-0.06%
Youngtown	0	0	4	0.15%	-0.15%

[5] Note: Comparisons were only performed for single adults due to data mismatch in families between PIT data (all households) and HMIS data (information collected only for heads of household).

City	Deduplicated Single Adults Assessed	Percent of Total Single Adults	2018 Unsheltered PIT Count (All Persons)	Percent of Total 2018 Unsheltered PIT Count	Percent Under-/Over-Representation in VI-SPDATs
TOTAL	7473	100%	2618	100%	

FAIR AND EQUAL ACCESS

SINGLE ADULTS

Age	Persons Assessed	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
NULL	0.07%	N/A
0-17	0.12%	0.84%
18-24	7.36%	8.83%
25-64	86.50%	90.33%
65+	5.95%	

Gender	Persons Assessed	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
NULL	0.03%	N/A
Data not collected	0.04%	N/A
Female	32.66%	26.66%
Gender Non-Conforming (i.e. not exclusively male or female)	0.08%	0.02%
Male	66.68%	72.90%
Trans Female (MTF or Male to Female)	0.33%	0.42%
Trans Male (FTM or Female to Male)	0.17%	

Race	Persons Assessed	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
NULL	0.07%	N/A
American Indian or Alaska Native	6.52%	5.99%
Asian	0.71%	0.81%
Black or African American	29.47%	20.94%
Client doesn't know	0.11%	N/A
Client refused	0.07%	

Race	Persons Assessed	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
Data not collected	0.12%	N/A
Native Hawaiian or Other Pacific Islander	0.99%	0.46%
White	61.96%	69.26%
Multiple Races	N/A	2.53%

Ethnicity	Persons Assessed	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
NULL	0.04%	N/A
Client doesn't know	0.05%	N/A
Client refused	0.04%	N/A
Data not collected	0.20%	N/A
Hispanic/Latino	17.48%	20.37%
Non-Hispanic/Non-Latino	82.19%	79.63%

FAMILIES WITH CHILDREN

Age	Person Assessed (Family Head of Household)	2018 PIT Count (Sheltered and Unsheltered Households with Children Only and Households Without Children)
NULL	0.06%	N/A
0-17	0.52%	0.84%
18-24	14.82%	8.83%
25-64	84.40%	90.33%
65+	0.19%	

REFERRALS AND PLACEMENTS

EFFICIENT TIMELINE

SINGLE ADULTS

Length of time (days)	Persons Scoring in RRH Range	Persons Scoring in PSH Range	Persons in Scattered-Site PSH	Persons in Project-Based PSH	Persons Scoring Below PH Intervention Range	All Persons in Coordinated Entry
Assessment to Referral	88.65	69.35			197.63	118.54
Referral to Enrollment	31.79	34.52	35.30	23.33	43.33	36.55

Length of time (days)	Persons Scoring in RRH Range	Persons Scoring in PSH Range	Persons in Scattered-Site PSH	Persons in Project-Based PSH	Persons Scoring Below PH Intervention Range	All Persons in Coordinated Entry
Enrollment to Housed	43.92	33.92	36.23	3.70	18.00	31.95

Intervention Range	Persons Assessed	Persons Referred	Referral Rate	Persons Enrolled	Enrollment Rate
PSH	7325	639	9%	234	37%
RRH	6956	370	5%	90	24%
No PH Intervention	1887	19	1%	5	26%

EQUITABLE REFERRAL SCHEME

SINGLE ADULTS

Age	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
NULL	0.07%	0.00%	0.00%
0-17	0.12%	0.08%	0.12%
18-24	7.36%	7.56%	6.15%
25-64	86.50%	85.98%	87.21%
65+	5.95%	6.38%	6.51%

Gender	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
NULL	0.03%	0.00%	0.00%
Data not collected	0.04%	0.00%	0.00%
Female	32.66%	32.33%	30.28%
Gender Non-Conforming (i.e. not exclusively male or female)	0.08%	0.08%	0.00%
Male	66.68%	66.83%	68.76%
Trans Female (MTF or Male to Female)	0.33%	0.50%	0.60%
Trans Male (FTM or Female to Male)	0.17%	0.25%	0.36%

Race	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
NULL	0.07%	0.08%	0.12%

Race	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
American Indian or Alaska Native	6.52%	4.37%	4.70%
Asian	0.71%	0.50%	0.60%
Black or African American	29.47%	34.51%	34.50%
Client doesn't know	0.11%	0.00%	0.00%
Client refused	0.07%	0.00%	0.00%
Data not collected	0.12%	0.00%	0.00%
Native Hawaiian or Other Pacific Islander	0.99%	0.67%	0.97%
White	61.96%	59.87%	59.11%

Ethnicity	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
NULL	0.04%	0.00%	0.00%
Client doesn't know	0.05%	0.00%	0.00%
Client refused	0.04%	0.08%	0.12%
Data not collected	0.20%	0.00%	0.00%
Hispanic/Latino	17.48%	15.11%	14.23%
Non-Hispanic/Non-Latino	82.19%	84.80%	85.65%

Disability Status	Persons Assessed	Heads of Household Enrolled	Heads of Household Housed
NULL	0.05%	0.08%	0.12%
Client doesn't know	0.17%	0.08%	0.00%
Data not collected	0.60%	0.00%	0.00%
No	29.09%	19.14%	18.09%
Yes	70.08%	80.69%	81.79%