Eastern Pennsylvania Continuum of Care Coordinated Entry System Evaluation

March 18, 2022

Abstract

This report analyzes the strengths and challenges of Eastern Pennsylvania CoC's Coordinated Entry System and the extent to which the system is meeting the goals of coordinated entry to provide efficient access to available housing and services and foster equity and effectiveness in the allocation of resources.

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Executive Summary

Between October 2021 and March 2022, Homebase conducted an evaluation of Eastern Pennsylvania Continuum of Care's (CoC) coordinated entry system. This evaluation is intended to set a baseline for future annual evaluations and included the following:

- A review of key policies and procedures
- An analysis of data from the Homeless Management Information System (HMIS), the Point-in-Time (PIT) Count, and the Housing Inventory Count (HIC)
- Focus groups with participating agencies
- Interviews with unhoused and recently housed households
- Interviews with system stakeholders
- A survey targeting participating agencies and system stakeholders
- A directory analysis of system accessibility

Overview of System Compliance, Strengths, and Challenges

The following report analyzes the strengths and challenges of Eastern Pennsylvania CoC's coordinated entry system and the extent to which the system is meeting the goals of coordinated entry to provide efficient access to available housing and services and foster equity and effectiveness in the allocation of resources.

- **Access and Assessment.** This section focuses on the system's accessibility for people experiencing homelessness, explores how households enter the system, and evaluates the effectiveness and equitableness of the assessment process in determining client need.
    - Key successes:
        - Since June 2020, the number of people accessing supportive housing through a side door has decreased significantly.
        - System partners indicate that people fleeing domestic violence and victims of human trafficking have safe and confidential access to coordinated entry.
        - System partners applaud 211 for all they do especially considering the enormous demand and high staff turnover they have endured the past few years.
        - Individuals with lived expertise generally feel respected by assessors.
        - Households with disabilities have strong access to the by-name list.
    - Key challenges:
        - Coordinated entry access points (211 and non-211) are inaccessible to households seeking housing and services in general and especially non-English speakers.
        - CoC partners are concerned that the VI-SPDAT is biased and re-traumatizing and that it does not capture vulnerability in an accurate manner as fear, stigma, and cultural norms prevent people from responding openly to the invasive and sensitive questions.
        - VI-SPDAT score distributions were significantly different when comparing across agencies, regions, and assessors, and assessments administered by 211 agencies had significantly lower scores than those administered by non-211 access points.
        - Coordinated entry policies and procedures do not comply with various HUD requirements related to system access and assessment.
- **Prioritization and Referral.** This section evaluates the effectiveness and equitableness of the prioritization and referral processes and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.
    - Key successes:
        - Housing providers indicate that documenting eligibility for program applicants coming off the by-name list is generally easy.
        - Housing providers indicate that coordinated entry makes it easy to fill vacancies, and vacancies are filled quickly through the by-name list process.
        - System partners indicate that survivors of domestic violence are afforded fair and equal access to rapid rehousing and permanent supportive housing via coordinated entry.

  - Key challenges:
    - Only 17% of households placed on the by-name list wind up enrolling in permanent housing. A significant number of households simply time out from the list per the CoC policy and are removed despite their continued need for assistance.
    - People with higher VI-SPDAT scores are no more likely to access permanent housing through coordinated entry than people with lower scores.
    - Coordinated entry policies and procedures do not comply with various HUD requirements related to prioritization and referral.

- **System Governance and Management.** This section focuses on system governance, management, communication, and evaluation.
  - Key successes:
    - System partners feel that the CoC has appropriate metrics in place to evaluate the performance of coordinated entry on an ongoing basis.
    - The majority of CoC partners know where to provide input and feel comfortable providing input when they have concerns about coordinated entry and feel that their input and concerns are heard and addressed.
    - CoC partners reflected favorably on coordinated entry training and the support that is provided to troubleshoot issues as they arise.
  - Key challenges:
    - Data quality is too poor to conduct an analysis of system equitableness.
    - Coordinated entry governance should be restructured to clarify roles and responsibilities, open lines of communication and collaboration, and empower partners to effectively carry out their duties.
    - CoC Board membership should strive to be reflective of the communities that the CoC serves – both in terms of race and ethnicity but also lived experience of homelessness.

Overview of System Impact

This section focuses on coordinated entry's impact on homelessness across the Eastern Pennsylvania CoC. Overall, 64% of households enrolled in permanent housing programs through coordinated entry eventually move into housing, and move-in rates are equitable by race, ethnicity, and gender. System partners observed that HMIS is helpful in supporting providers to coordinate client care and track homelessness in the community and appreciated the fact that unhoused persons do not need to call every agency in the CoC to access resources. They reflected favorably on the collaboration among providers in the CoC and noted that partner staff are supportive, caring, and respectful. Partners observed that the bottlenecks result primarily from a lack of resources to meet the full need of Eastern Pennsylvania's unhoused population and noted that the distribution of funding is inconsistent, leaving some counties with little to no permanent housing resources.

Recommendations and Next Steps

To address the identified challenges, the report includes recommendations related to access and assessment, prioritization and referral, and system governance and management at the end of each of the corresponding sections. These recommendations are also gathered into an action item list in Appendix A to highlight areas for immediate, medium-term, and long-term improvement.

Introduction

Each Continuum of Care (CoC) that receives CoC and/or Emergency Solutions Grant (ESG) Program funding from the U.S. Department of Housing and Urban Development (HUD) is required to design and implement a coordinated entry system. Coordinated entry is a process for assessing the vulnerability of all people experiencing homelessness within the CoC to prioritize those most in need of assistance for available housing and services. The goals of coordinated entry are:

1. To increase the efficiency of the local crisis response system,
2. To improve fairness in how housing and services are allocated, and
3. To facilitate rapid access to housing and services.

HUD requires each CoC to conduct an annual evaluation focusing on the quality and effectiveness of the entire coordinated entry experience—including assessment, prioritization, and referral processes—for both programs and participants. Per HUD requirements and for the purposes of continuous improvement, the Pennsylvania Department of Community and Economic Development (DCED) and Diana T. Myers & Associates, Inc., (DMA) commissioned Homebase to conduct an evaluation of the CoC's coordinated entry system. This report analyzes the strengths and challenges of the coordinated entry system, focusing on three key areas:

- **Access and Assessment.** This section focuses on the system's accessibility for people experiencing homelessness, explores how households enter the system, and evaluates the effectiveness and equitableness of the assessment process in determining client need.
- **Prioritization and Referral.** This section evaluates the effectiveness and equitableness of the prioritization and referral processes and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.
- **System Governance and Management.** This section focuses on system governance, management, communication, and evaluation.

Each of the first two sections includes a summary analysis of compliance with HUD requirements based on HUD's Coordinated Entry Self-Assessment tool. All three sections include recommendations for strengthening the system. These recommendations have been consolidated in Appendix A to highlight areas for critical, important, and suggested opportunities for improvement and, within those categories, short-term, medium-term, and long-term strategies. The report also includes an overview of evaluation methodology and an analysis of coordinated entry system impact.

Throughout the report, **a teal color is used to highlight areas and findings where the system excels**, whereas **areas for improvement appear in red.**

Evaluation Methodology

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

- **An analysis of HMIS, PIT, and HIC data.** Deidentified client-level data corresponding to evaluation questions was provided to Homebase by DCED, the CoC's HMIS Lead Agency. The client pool for HMIS data consisted of clients who were enrolled in coordinated entry, those who were referred to emergency shelter and rental assistance programs, those placed on the by-name list, and those who were enrolled in permanent housing projects. Deidentified, aggregated PIT County and HIC data for 2020 was also provided.

Analysis section	Data sources	Universe parameters
Access	2018-2020 PIT County, coordinated entry enrollment and by-name list HMIS data	Deduplicated households
Assessment	By-name list HMIS data	Most recent household record
Prioritization and Referral	By-name list and permanent housing enrollment HMIS data	Most recent household record
Timeline Analysis	By-name list and permanent housing enrollment HMIS data	Most recent household record

  - Tests of association were chosen depending on the sample, enrollment type (by-name list and permanent housing enrollments), and dependent variable data quality. First, head-to-head associations were tested between outcome variables (dependent variables) and demographics (independent variables). Tests used include ANOVA, t-test, and Chi-Square. Second, multi-variable regression models were developed, whenever possible, based on theory and locally associated variables. Valid logistic and linear regression models were used, and outputs are included in Appendix E.
  - Data limitations included:
    - Prior to June 1, 2020, more people were housed circumventing coordinated entry than through coordinated entry. Since June 1, 2020, marked improvements have been made in the coordinated entry enrollment and by-name list processes, reducing the number of people accessing supportive housing through a side door, thus the majority of our analysis relates to data collected on or after June 1, 2020.
    - Data quality related to coordinated entry enrollment is very poor and only slightly improved after June 1, 2020. The following variables were excluded form core analyses due to poor data quality: race, ethnicity, gender, RHAB, disability status, mental health status, chronically homeless status, domestic violence status, exit destination, prior living situation, and homelessness start date. Only the following variables were included in the analysis of coordinated entry enrollments: household type, veteran status, age, and access point type (211 or non-211).
    - Data quality related to by-name list placements was also lacking. The following variables were excluded form core analyses due to data quality: race, ethnicity, gender, mental health status, domestic violence status, exit destination, prior living situation, and homelessness start date. Only the following variables were included in the analysis of by-name list placements: household type, age, RHAB, disability status, chronically homeless status, veteran status, VI-SPDAT score, and access point type (211 or non-211) and staff.
    - Timeline analysis was incomplete due to poor data quality. While we were able to evaluate the length of time it takes households to access enrollments and move into housing, the interpretation of these data points was limited in three ways. First, we were unable to evaluate whether the length of time to housing is speeding up or slowing down because the sample did not span a long enough time period. Generally, at least 3-5 years of data is needed to properly evaluate coordinated entry timelines as some folks take multiple years to access housing resources. Second, a significant portion of the timeline population enrolled in housing and moved into housing in 0-7 days from coordinated entry enrollment. Third, 40% of the move-in dates were identical to housing project enrollment dates, which is highly improbable, especially in tenant-based rental assistance programs.
    - Whenever missing data was above 10%, findings for association were unreliable and not reported. However, we updated and largely confirmed the previous CoC racial equity analysis. Please see Appendix E for more detail.

- **A survey targeting participating agencies and system stakeholders.** Homebase administered a survey that was completed by 128 staff from emergency shelter, supportive housing, and other service provider agencies with questions tailored to their roles in the coordinated entry system. Feedback from the survey was utilized to analyze adherence to coordinated entry system policies and procedures, quality of collaboration, effectiveness of access and assessment, functioning of the by-name list process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. Aggregated survey responses can be found in Appendix F.

  Respondents represented all five RHABs: 26% of respondents indicated their organization is based in the Central Valley, 26% in the Lehigh Valley, 25% in South Central, 17% in Pocono, and 15% in the Northern Tier (note that respondents were able to select multiple RHABs). The following table summarizes the programmatic affiliation of respondents (note that respondents were able to select multiple roles for their organization):

Programmatic Affiliation	**Responses**	
Emergency Shelter	40%	51
Transitional Housing	26%	33
Permanent Supportive Housing	33%	42
Rapid Rehousing	53%	68
Homelessness Prevention/Diversion	48%	61
Street Outreach	22%	28
Coordinated Entry Call Center (211)	9%	11
Coordinated Entry Access Site (walk-in and/or non-211 call-in)	29%	37
Other	28%	36

- **Focus groups with participating agencies.** Homebase conducted two focus groups with coordinated-entry-participating agency staff in January, a 211 and non-211 access point and shelter staff focus group with five participants and a permanent housing staff focus group with seven participants. Note that due to the COVID-19 pandemic, focus groups were conducted virtually via video and conference call. Feedback from the focus groups was utilized to analyze adherence to coordinated entry system policies and procedures, quality of collaboration, accuracy and consistency of assessment, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these focus groups can be found in Appendix B.
- **Interviews with system stakeholders.** Homebase conducted interviews with 14 system stakeholders, including participating permanent housing providers, Regional Managers, 211 representatives, Victim Service Providers, and coordinated entry consultants and staff. Feedback from the interviews was utilized to analyze adherence to coordinated entry system policies and procedures, quality of collaboration, accuracy and consistency of assessment, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these interviews can be found in Appendix B.
- **Interviews with unhoused and recently housed households.** Homebase conducted Interviews with a total of 30 people who had direct experience with seeking housing assistance in the Eastern Pennsylvania CoC. Participants were provided $100 gift cards.

  Note that due to the COVID-19 pandemic, interviews were conducted virtually via Zoom and over the phone. Feedback from the interviews was utilized to analyze ease of system access, efficiency of intake and assessment, adherence to coordinated entry system policies and procedures, quality of referrals, functioning of the referral process, and compliance with HUD requirements. For purposes of this report, Homebase focused on areas where multiple persons provided similar feedback. A full summary of the feedback from these focus groups can be found in Appendix B.
- **Directory analysis.** Homebase conducted outreach to providers in the Eastern Pennsylvania CoC to identify barriers and assess ease of accessing coordinated entry services. Using the Connect to Home Coordinated Entry Call Center and Access Sites as of August 13, 2021 and a list of Victim Service Providers from the CoC, Homebase attempted to replicate the process someone might undertake if they were looking for housing or supportive services by:

  1. Googling the name of the provider and location, if applicable, and noting how easily or difficultly the correct provider was identified through this search
  2. Locating the provider website, physical address, and phone number listed online and noting how easy or difficult it was to find this information

3. Comparing the website, address, and phone information listed online to that provided in the Connect to Home Coordinated Entry Call Center and Access Sites list and noting differences
4. Calling the number listed on the website, introducing ourselves as Homebase, explaining that we are working on a coordinated entry evaluation for the CoC, and asking:
    a. Whether the number we called is the correct number to access coordinated entry
    b. What languages are spoken or available at the agency
    c. How soon appointments are available for coordinated entry intake
5. If more than one number was listed on the website, or if the number online was different from that provided by Connect to Home, step 3 was repeated for the all the phone numbers

A full chart and summary of the findings from this analysis can be found in Appendix C.

- **Review of key policies and procedures** related to the coordinated entry system as provided by DCED and DMA to evaluate compliance with HUD requirements. For more information, please refer to Appendix D.

Findings and Recommendations

The following sections provide Homebase's quantitative and qualitative analysis of access and assessment, prioritization and referral, and system governance and management. Within each focus area, Homebase provides an analysis of process and effectiveness, an assessment of equitableness, and recommendations for system improvement. The first two focus areas also include summaries of compliance with HUD requirements.

Access and Assessment

This section focuses on the system's accessibility for people experiencing homelessness, explores how households enter the system, and evaluates the effectiveness and equitableness of the assessment process in determining client need.

Compliance Review

Eastern Pennsylvania CoC's coordinated entry system falls short on various key HUD-required elements related to accessibility of 211 and non-211 (walk-in and non-211 call-in) access points; policies and procedures regarding access by individuals with disabilities, access to emergency services, disclosure of disabilities during the assessment process; fairness and equitability of access to services; and notice to system participants regarding the ability to file nondiscrimination complaints. The requirements for these areas as are as follows[1]:

1. CES access points cover and are accessible throughout the CoC.
2. CoC offers the same assessment approach at all access points and all access points are usable by all people who are experiencing or at risk of homelessness.
3. CES access points are easily accessed by individual and families seeking homeless or homelessness prevention services.
4. CES is easily accessed by households seeking housing or services.
5. CES policies document steps taken to ensure access points are accessible to individuals with disabilities.
6. CES policies document steps taken to ensure effective communication with individuals with disabilities.
7. CES policies document a process to ensure access to emergency services during hours when CES processes are not operating.
8. CoC has established written policies establishing that the assessment process cannot require disclosure of specific disabilities or diagnosis. This information may only be obtained for purposes of determining program eligibility to make referrals.
9. CoC consistently applies one or more standardized assessment tools, applying a consistent process to achieve fair, equitable, and equal access to services.
10. Participants are informed of the ability to file a nondiscrimination complaint.

As described in more detail in the following two subsections, coordinated entry access points are typically difficult to access – neither 211 nor the majority of non-211 access points are staffed adequately to respond to calls in a timely manner, if ever. Hours of operation at 211, the primary access point, are severely limited – calls are only accepted 9 AM to 4 PM on weekdays, and persons experiencing homelessness and CoC partners alike indicate it is extremely difficult to get through during these business hours. While demographic analysis regarding system access and assessment is severely limited by poor HMIS data quality, we observe that the assessment process yields disparate results depending on region, access point type (211 vs non-211), agency, and assessor.

Coordinated entry policies and procedures do not address items 5-8 above or establish a process for filing nondiscrimination complaints.

Analysis of Process and Effectiveness

The quantitative analysis of the effectiveness of system accessibility is hampered by **limited standardization in terms of participant paths through the system**. Specifically, three pathways were identified in the data:

1. Households enter coordinated entry, are placed on the by-name list, and are enrolled in supportive housing projects;
2. Households enter coordinated entry, are not placed on the by-name list, and are enrolled in supportive housing projects; and
3. Households are directly enrolled in supportive housing projects (skipping coordinated entry and the by-name list altogether).

Prior to June 2020, households primarily enrolled in supportive housing projects directly, bypassing the by-name list process altogether. **Since June 1, 2020, marked improvements have been made in the coordinated entry enrollment and by-name list processes, reducing the number of people**

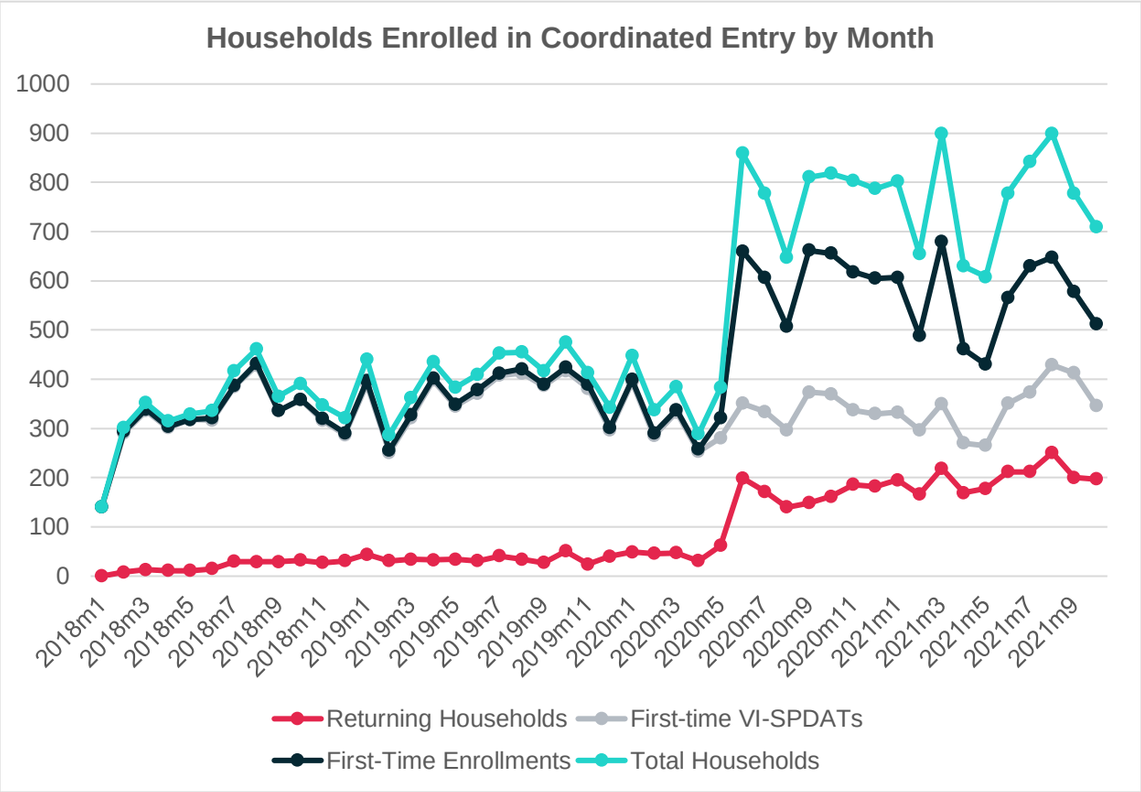
[1] See Appendix C for more details on the compliance review.

accessing supportive housing through a side door, but the issue remains. For more information, see the prioritization and referral section below.

Overall, coordinated entry system access for both first-time and returning households has increased across all regions since the COVID-19 pandemic, however VI-SPDAT assessment rates have remained static, and placement on the by-name list is dependent on the type of access point at which a household presents. Households accessing the system through 211 are less likely to be placed on the by-name list than households presenting at non-211 access points. There is not currently a process in place to audit or review assessments, so it is difficult to opine what may be causing this difference.

Coordinated Entry Enrollments Over Time

Access to coordinated entry saw a dramatic increase for both first-time and returning households after June 1, 2020 – the monthly average number of households enrolling for the first time increased from 372 to 771 per month and the average number of households returning increased from 30 to 187 per month. Increases were seen both among families and among adults without children. However, the opposite occurred for child-only households. Please see Appendix E for more information on child-only households. Additionally, the number of first-time VI-SPDAT assessments has not significantly changed since 2018. In other words, **while more people are accessing coordinated entry, the number of first-time VI-SPDAT assessments administered is stable**. It is unclear what is happening with people who access coordinated entry but do not receive a VI-SPDAT and/or are not placed on the by-name list as there is no data to show whether or not these persons were experiencing homelessness when they accessed coordinated entry, or whether they were effectively diverted or not.



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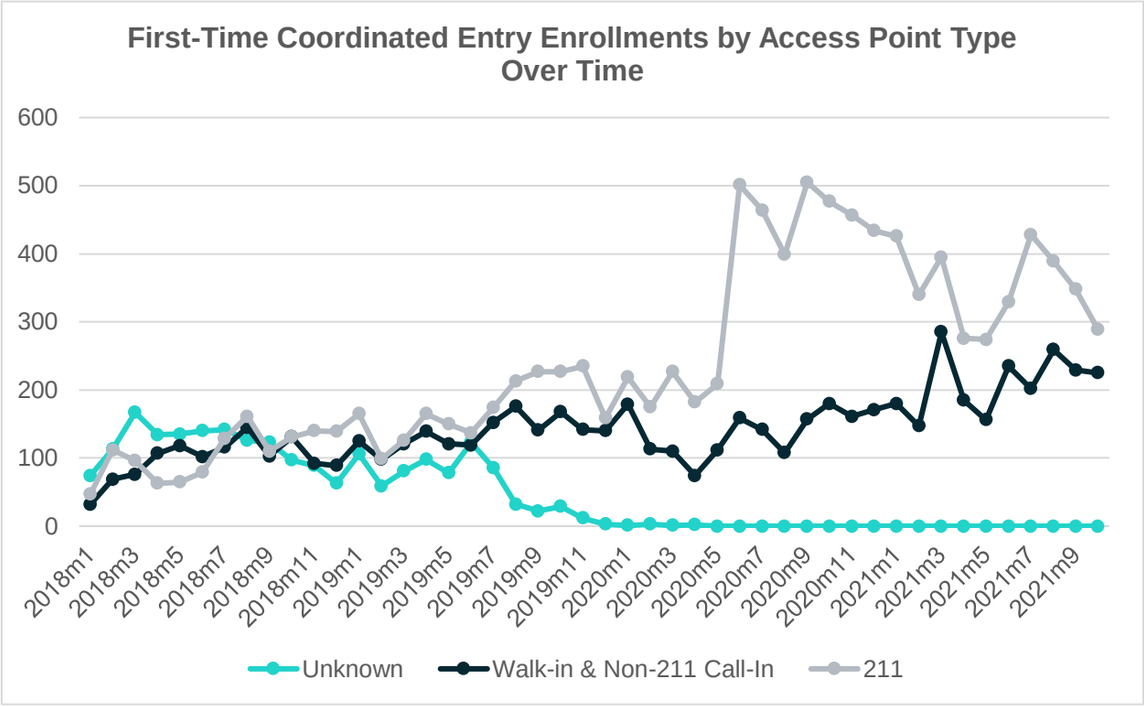
All access points (211 and non-211) saw an increase of coordinated entry enrollments after June 1, 2020. While 211 saw the biggest initial increase, the percentage of households accessing coordinated entry is increasing across the board. The most recent data within the evaluation period indicates that **38% of new coordinated entry enrollments are made via non-211 access points, while 62% are made through 211**. **Data quality around coordinated entry enrollments has improved significantly with enrollments by unknown entities dropping to 0 in May 2020.**



Reflecting on system access, survey respondents indicated that **having one number to call is clear and easy** and appreciated having one centralized list of people in need with the ability to share notes and coordinate resources is beneficial. They especially appreciated how the **system supports collaboration and coordination of client care between providers**. A majority of respondents (66%) agree that **people fleeing domestic violence and victims of human trafficking have safe and confidential access to coordinated entry**. In interviews, providers indicated that they appreciated the single point of entry of the coordinated entry system, which helps to prioritize and maximize limited funding and resources. Providers felt that by limiting access sites rather than using a no wrong door approach the system helped to create a **cohesive access and assessment process with consistent messaging** and fidelity. Providers also applauded 211 for all they do especially considering the enormous demand and high staff turnover they have endured the past few years. The directory analysis indicated that **providers' contact information is easily found through a simple Google search and that such information is mostly accurate.** Some providers did not have information online for specific locations associated with a larger provider network, but in each of these cases the satellite location could be accessed from the main location whose information was available and accurate on Google. Most providers contacted during the directory analysis also indicated that they had **availability for intake appointments within the next day or two**.

Survey respondents had diverging opinions about how well coordinated entry is advertised – 51% thought it is advertised well and 43% disagreed. They were equally split on how easily the system is accessed by households seeking housing or services – 47% considered the system easily accessible and 48% disagreed. In interviews with individuals with lived experience, however, people observed that help was extremely difficult to find and that it was unclear how to ask for assistance. This is especially true for individuals in rural areas and small counties, where even if someone is able to get through to 211 there are virtually no options available. Results from the directory analysis indicate that ease of accessing non-211 access points is quite mixed: fifteen providers were reached successfully on the first day, while five were never reached despite repeated attempts. The remaining 24 organizations were reached with some effort, though it is important to note that the evaluation aspect of the calls made some individuals uncomfortable answering questions and therefore our experience may not reflect the experience of an individual experiencing homelessness.

By far the most common frustration expressed by respondents was that **211 is severely understaffed, resulting in extended wait times for callers**, which is a significant barrier since most persons experiencing homelessness only have a limited number of minutes on their phone plans if they have functioning phones at all. Respondents also added that **211's limited hours of operation (9AM-4PM on weekdays only) make it difficult for persons who are only available to call in the evening to access the system**. More often than not, **people call 211 many times without successfully connecting with a staff person** and, if they do receive a call back, they tend to not answer it because the call originates from a number they do not recognize. In interviews with providers and individuals with lived experience people repeatedly described **the barriers that the system creates for people in crisis**, who must be

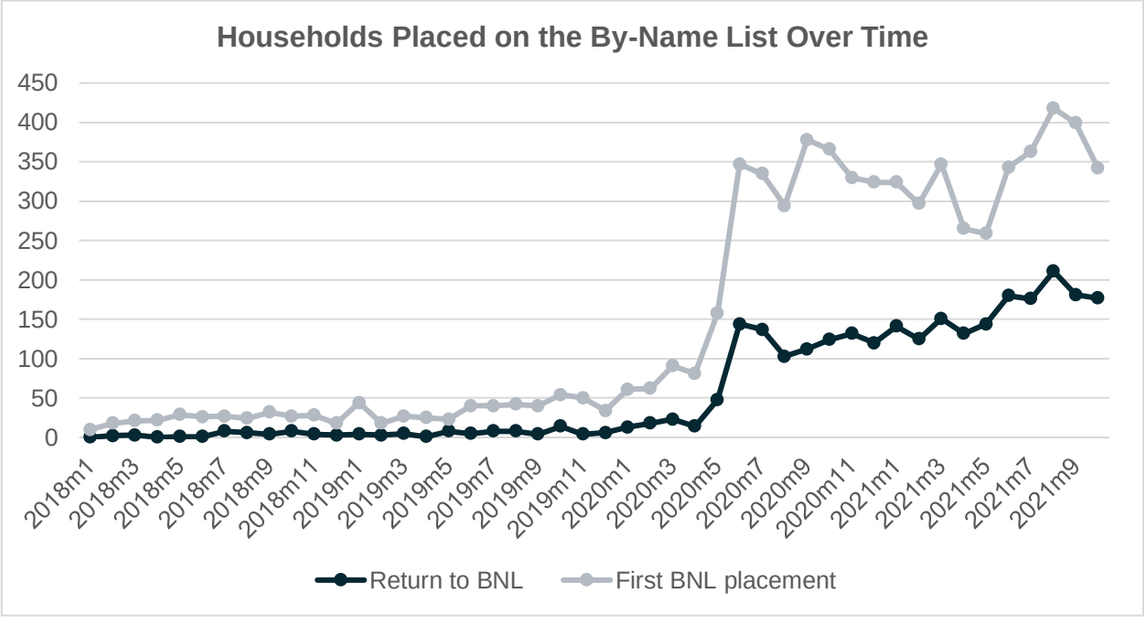
able to endure hours long wait times, call back consistently for weeks, have constant access to a dependable and working phone, and more. People with lived experience navigating the system regularly expressed confusion about what help was available, how to obtain it, and where they are in the process. Even those who received housing through coordinated entry often expressed confusion and disbelief given how difficult it is to navigate the process.

Survey respondents observed that challenges around access are particularly acute for **domestic violence survivors, who are unable to receive immediate access to emergency services and have no choice but to remain in the situations that they are trying to flee**, a fact echoed by the stories of several of the survivors of domestic violence we interviewed. Providers in interviews indicated that **access is difficult for non-English speakers,** and that more bilingual staff are needed at access sites. This is supported by results of the directory analysis, which indicated that most providers are only equipped to use English.

Placements on the By-Name List Over Time

While data improvements and system improvements coincide with the increase in coordinated entry enrollments, qualitative feedback supports the hypothesis that the actual number of people accessing coordinated entry is growing. Similarly, we see that the number of people placed on the by-name list each month is growing as well. Since the coordinated entry policies and procedures require that every person experiencing homelessness that has a VI-SPDAT score be placed on the by-name list, the by-name list serves as an indicator of access to coordinated entry for persons experiencing homelessness.

The following chart demonstrates that by-name list access increased for both first-time and returning households after May 2020 and continues to increase. The trend in returning by-name-list enrollments matches that of first-time by-name list enrollments, and the average time that households spend on the list without a housing match is about 90 days, indicating that **a significant number of households simply time out from the list per the CoC policy and are removed despite their continued need for assistance**. This fact was echoed by interviews with individuals with lived experience, several of whom timed out without knowing that they needed to contact anyone to stay on the list.



Households that access coordinated entry through 211 are 48% less likely to be placed on the by-name list than those who access coordinated entry via non-211 access points ($p<.05$). Survey respondents expressed frustration that sometimes clients have completed an assessment with 211 but do not appear on the by-name list. This finding is important because there are regional differences in terms 211 access. The reasons underlying this trend are unclear because there is no data to show whether 211 callers are more likely to be served with prevention/diversion or to not be experiencing homelessness to begin with.

Prevention and Diversion

Most survey respondents (71%) agreed that it is generally **easy to identify who is eligible for homeless prevention services**. However, they were divided about how well the process for referring people to prevention services works – 51% thought it works well, while 47% disagreed. The majority of survey respondents (66%) agreed with the interviewed stakeholders that **there are not enough homeless prevention resources/services in place to address the local needs**. Despite some relief from the Emergency Rental Assistance Program (ERAP), there are not enough resources to prevent people from losing their housing, and landlords are evicting tenants even after they have applied for ERAP due to the long wait times for receiving financial support. Most respondents (67%) disagreed that people referred to homeless prevention services rarely return to Coordinated Entry for housing assistance.

Survey respondents were divided on how easy it is to identify who is eligible for diversion services – 53% thought it was easy, 38% disagreed, and 9% didn't know. They were equally split on how well the process for referring people to diversion services works – 40% thought it works well and 51% disagreed. The majority of respondents (69%) indicated that **there are not enough diversion resources/services in place to address the local needs**. Most respondents (60%) disagreed that people referred to diversion services rarely return to Coordinated Entry for housing assistance.

The majority of providers in interviews and focus groups stated that there is a large gap in both prevention and diversion services. Further, they discussed that in practice there is confusion about who should be referred to prevention or diversion and how that process works, which creates a bottleneck for such individuals and 211 itself.

Assessment

A majority of survey respondents (67%) agreed that, overall, **the triage, safety planning, and diversion process works effectively in assessing client safety and supporting agencies in making appropriate referrals**. The vast majority (77%) agreed that they have received **sufficient training, materials/tools, and guidance about how to conduct the coordinated entry assessments** for which they are responsible. Individuals with lived expertise mostly stated that they **felt respected by the person giving the VI-SPDAT and many felt comfortable asking for clarification.**

Survey respondents reflected on significant challenges around the VI-SPDAT assessment. A plurality (48%) did not think the assessment process works well. Respondents expressed frustration that **the VI-SPDAT asks very invasive and sensitive questions that have little to do with housing needs and which cause people to fear that their answers will impact their access to current or future services**. Some clients do not want to be seen in a negative light and tend to re-frame situations to emphasize their independence and resilience – stigma and cultural norms prevent them from disclosing their level of need. Clients who do not have this barrier score very differently than those that do. People experiencing homeless in general, and especially particularly marginalized subpopulations such as Black, Indigenous, and People of Color (BIPOC persons), persons identifying as LGBTQI+, and survivors of domestic violence are often already distrustful of systems and **VI-SPDAT questions are re-traumatizing and biased**, rendering the assessment ineffective.

The majority of survey respondents (56%) indicated that **clients' vulnerability is not assessed in an accurate manner (i.e., a person's assessment score does not truly reflect how vulnerable they are)**. They observed that persons with serious mental illness, those with cognitive impairments, and those with lower language skills have a particularly difficult time understanding VI-SPDAT questions, as these are lengthy and convoluted and often ask multiple things in one question, causing confusion and frustration. Respondents also expressed frustration that **the assessment process is lengthy and frequently changes**. Individuals with lived experience also generally found the VI-SPDAT to be unnecessarily long and invasive, with several making remarks about how it was designed to confirm whatever the person administering the assessment thought of them or was looking for.

Assessment of Equitableness

The quantitative analysis of the equitableness of system accessibility is limited by significant amounts of missing data at the points of coordinated entry enrollment and placement on the by-name list. Missing data related to coordinated entry participants' race, ethnicity, gender, chronically homeless status, disabling condition, and prior living situation prevents reliable demographic analysis for system access, as missing data exceeds the 10% threshold required for gauging statistically significant relationships.[2] While coordinated entry enrollment data quality has not improved enough to evaluate equitableness of system accessibility beyond that related to veteran status, disability status, and chronic homelessness status, data collection at the point of a household's placement on the by-name-list has improved since June 1, 2020 and thus we were able to analyze equitableness of access as it relates to veteran status, age, chronically homeless status, disability status, RHAB, and enrollment organization.

Unfortunately, poor data quality around race ethnicity, gender, prior living situation, exit destination, mental health status, domestic violence history, and history of homelessness precluded us from analyzing with confidence. With that said – we did conduct some general assessments of race, ethnicity, and gender to update the coordinated entry racial equity analysis conducted in 2021.

[2] Dong, Y., & Peng, C. Y. (2013). Principled missing data methods for researchers. *SpringerPlus*, *2*(1), 222. https://doi.org/10.1186/2193-1801-2-222. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3701793/

The following table contains a breakdown of missing data:

Rates of Missing Data by Variable

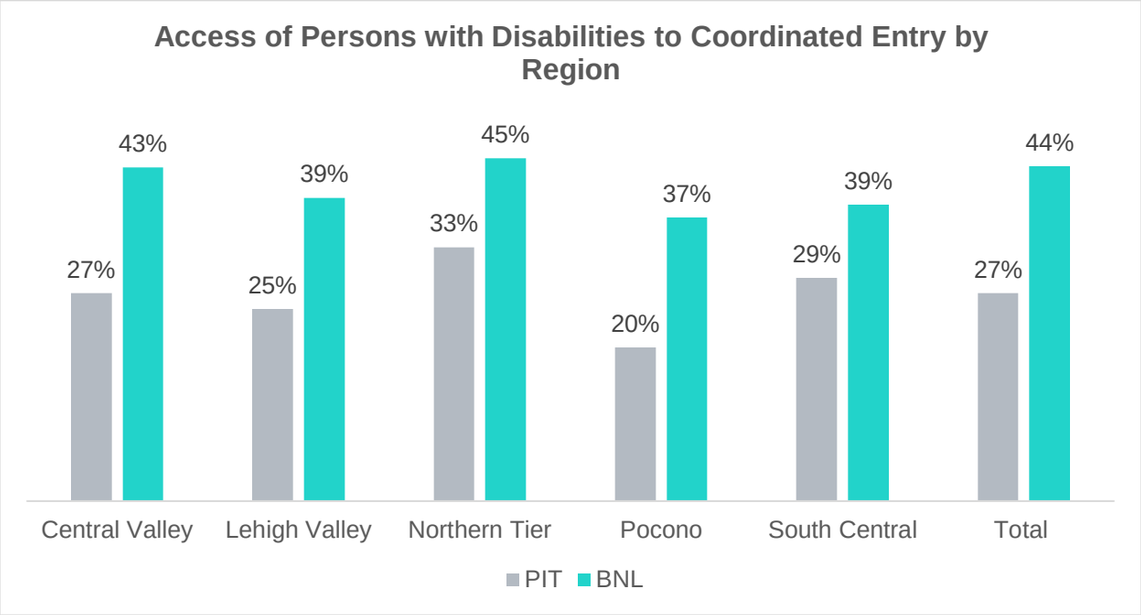
	Coordinated Entry Enrollments 1/1/18-10/30/21	Households on the By-Name-List 1/1/18-10/30/21	Households on the By-Name-List 6/1/20-10/30/21	Households on the By-Name-List on 10/30/21
Household Type	2%	1%	1%	0%
Race	17%	19%	20%	19%
Ethnicity	14%	17%	18%	16%
*BIPOC**	15%	17%	19%	17%
Domestic Violence Status	70%	51%	50%	91%
Exit Destination	75%	65%	62%	
Prior Living Situation	87%	66%	71%	55%
Veteran Status	6%	4%	5%	4%
Gender	12%	16%	18%	15%
Age	7%	5%	5%	1%
Chronically Homeless Status	46%	9%	8%	3%
Disability Status	44%	5%	4%	2%
Mental Health Status	78%	57%	56%	13%
VI-SPDAT Score	21%	1%	1%	0%
Region / County / Zone	46%	4%	4%	4%
History of Homelessness	78%	43%	49%	31%
Enrollment Organization	11%	3%	1%	<1%

* BIPOC is defined as all non-white races and all Latinx persons.

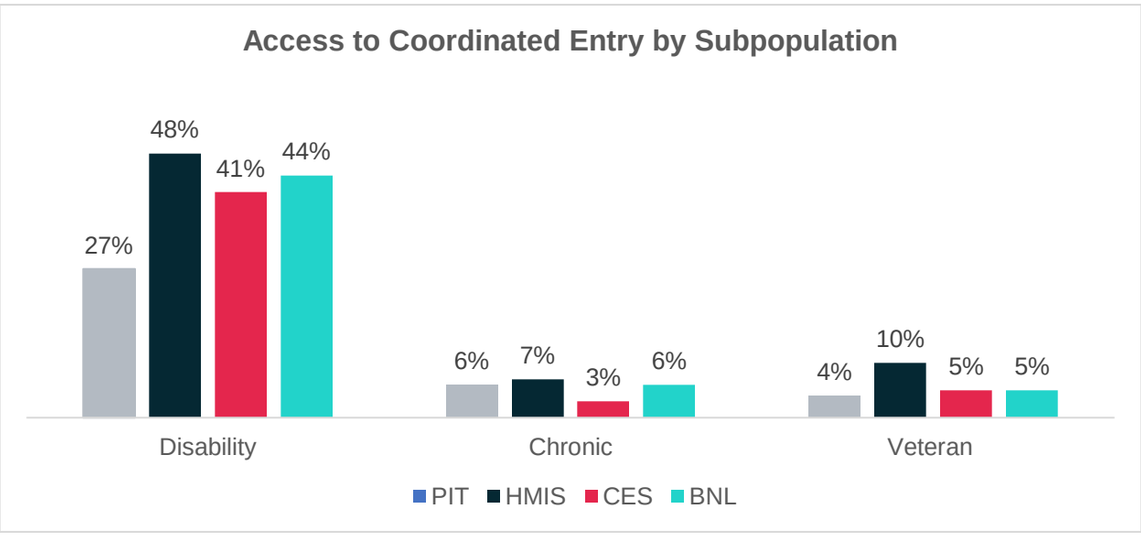
Access by Persons with Disabilities

In the time spanning June 2020 to October 30, 2021, **persons with disabilities and those experiencing chronic homelessness were more likely to access non-211 access points than they were to access 211**. Specifically, 43% of households enrolled in coordinated entry via non-211 access points had a disabled head of household vs 41% for 211 ($p<.05$). Similarly, 5% of households enrolled in coordinated entry via non-211 access points had a chronically homeless head of household vs 3% for 211 ($p<.05$).

Households with disabilities have strong access to the by-name list. Across every RHAB the proportion of people accessing the by-name list who have disabilities is higher than the proportion of persons with disabilities represented on the 2019-2020 PIT Counts.



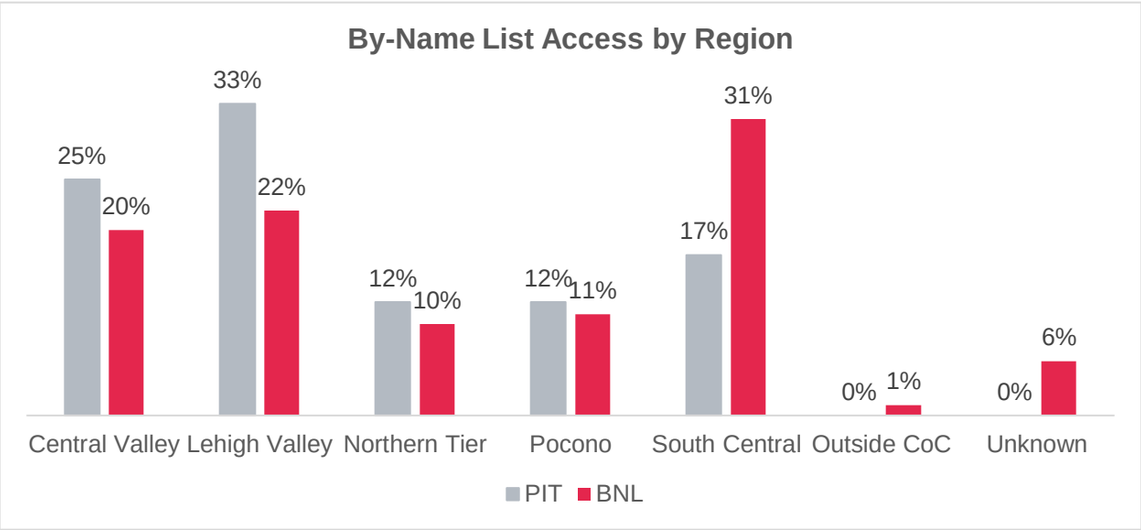
The proportion of persons with disabilities represented on the by-name list is also close to the proportion of persons with disabilities represented across all shelter, safe haven, transitional housing, rapid rehousing, and permanent supportive housing programs in HMIS. The proportion of households experiencing chronic homelessness is slightly below that on the PIT count and across HMIS programs, indicating that people may be becoming chronically homeless after being placed on the by-name list.



Heads of households with disabilities or with a veteran status were just as likely to be placed on the by-name list whether they accessed coordinated entry through 211 or through a non-211 access point. However, households experiencing chronic homelessness on the by-name list were slightly more likely to have accessed coordinated entry via a non-211 access point. These households make up 7% of non-211 coordinated entry enrollments and only 5% of 211 enrollments; this difference, while small, is statistically significant ($p<.05$).

Access by Region

The Central Valley and Lehigh Valley RHABs appear underrepresented on the by-name list while the South Central RHAB appears overrepresented. After careful review of available data, it is still unclear why households in South Central have stronger access to the by-name list than households in other regions. While persons experiencing homelessness in South Central make up 17% of the CoC's PIT Count, they account for over 41% of households accessing coordinated entry though non-211 access points and 28% of households accessing through 211. Furthermore, this higher proportion is seen for all household types and all demographics for which data was available.



The relatively higher dependence of some regions on 211 as the primary access point may be impacting households' access to the by-name list and, as a result, to supportive housing. For example, in Lehigh Valley, where 81% of coordinated entry enrollments are made by 211, households are less likely to be placed on the by-name list than those in other regions where more people access coordinated entry through non-211 access points.

Assessment

VI-SPDAT score distributions (for every version of the tool) were significantly different when comparing across agencies, regions, and assessors, and assessments administered by 211 agencies had significantly lower scores than those administered by non-211 access points.[3] This quantitative finding was echoed by survey respondents, who observed that people who are assessed in person consistently score higher than those assessed over the phone, as the process is more accurate when sitting face to face with someone, gaining their trust, and being able to read their body language and identify if they are not understanding a question due to a mental health condition or cognitive impairment.

Race, ethnicity, and gender were excluded from the VI-SPDAT score analyses due to high rates of missing data with one exception – there was enough data on young adult households to allow for an analysis of score differences based on ethnicity and gender. Latinx young adults received higher VI-SPDAT scores and were more likely to score an 8 or above.

Households without Children

VI-SPDAT score distributions differed when independently comparing eight variables: region, disability, age, veteran status, chronically homeless status, access point type (211 or non-211), agency completing the coordinated entry enrollment, and staff person completing the coordinated entry enrollment. Some of these differences were expected (e.g., people with disabilities and those experiencing chronic homelessness scored higher) while other relationships were not (e.g., people scored statistically differently based on region, agency, access point type, and assessor). The following set of tables summarize the analysis.

[3] This report focuses primarily on VI-SPDAT score differences across access point types and regions. Please see Appendix E for comparisons across agencies and assessors.

The first table outlines expected associations compared to associations found in conducting 16 independent head-to-head regression analyses. "Yes" indicates an expected or found association and "No" indicates that there was no expectation or no found association. For example, it is expected that disability and chronically homeless status are associated with higher VI-SPDAT scores, and this is confirmed by bivariate analysis. Conversely, it is expected that access point type, (211 or non-211) is not associated with VI-SPDAT score, but a relationship was found.

	Region	*Disability Status*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type*	*Agency*	*Staff*
Expectations	No	Yes	-	-	Yes	No	*No*	No
Bivariate Analysis/ Raw Score	**Yes**	**Yes**	Yes	Yes	**Yes**	**Yes**	**Yes**	**Yes**
Bivariate Analysis/ Likelihood of 8+ Score	**Yes**	**Yes**	Yes	Yes	**Yes**	**Yes**	**Yes**	**Yes**

The second table is a summary of multi-variable regression models. Eight multi-variable regression models were run accounting for all demographics and for all household types. Models reported are only those where R-squared (R2) was above 0.10. Having an R2 above 0.10 means that a significant enough sample variance can be explained by the model to warrant interpretation. The full valid regression tables meeting this threshold are provided in Appendix E. While younger adults without children and non-veterans tended to receive higher scores, the relationship between access point type (211 or non-211) and VI-SPDAT score was the most notable finding. Additionally, these findings reflect a theme throughout the report.

	Region	*Disability Status*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type*	*Agency*	*Staff*	*R2*
Raw Scores Controlling for Agency	**Yes**	**Yes**	Yes	Yes	N/A	N/A	**Yes**	N/A	.15
Raw Scores Controlling for Staff	**Yes**	**Yes**	Yes	Yes	N/A	N/A	N/A	**Yes**	.19
Likelihood of 8+ Score Controlling for Staff	**No**	**Yes**	Yes	No	N/A	N/A	N/A	**Yes**	.11

Note: Due to significant missing data, chronically homeless status was dropped from multi-variable regression models

An ANOVA test of VI-SPDAT scores by region identified that the Central Valley has the highest scores while the Northern Tier and Pocono have the lowest scores. Put another way, Central Valley, Lehigh Valley, and South Central have significantly higher scores than Pocono and Northern Tier. Some of these differences may be attributed to access point type as Pocono and Northern Tier see higher rates of system access via 211 than do Central Valley and South Central, however Lehigh Valley has high rates of system access via 211 as well so other factors are at play in addition to access point type.

	Mean Score	*Notes*
Central Valley	**7.6**	Higher than all other regions (p<.05)
Lehigh Valley	7.1	Higher than Northern Tier and Pocono (p<.05)
South Central	7.0	Higher than Northern Tier and Pocono (p<.05)
Outside CoC	6.6	
Northern Tier	**6.5**	
Pocono	**6.4**	
Total	7.0	

A t-test on VI-SPDAT scores by access point type identified that adults without children accessing 211 scored .7 points lower on average and were less likely to score an 8 or higher than those accessing non-

211 access points. While 211 clients were less likely to be experiencing chronic homelessness, they were just as likely to have a disability.

	Mean VI-SPDAT Score
211 Access Points	6.7
Non-211 Access Points	7.4
Difference	**.7 (p<.05)**
Total	7.0

Households with Children

When analyzing VI-SPDAT scores of households comprised of adults with children, veteran status and age were excluded due to data quality issues. Chronically homeless status was excluded due to insufficient sample size. The difference between scores at 211 and non-211 access points was greater than that among adults without children – households with children accessing through non-211 access points scored on average 1.1 points higher than those accessing via 211. The distribution of scores by region had Pocono at the bottom and Central Valley at the top (same as for households without children).

The following tables mirror those in the adult-only section in style and format.

	Region	*Disability Status*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type 211*	*Agency*	*Staff*
Expectations	No	Yes	-	-	Yes	No	*No*	No
Bivariate Analysis/ Raw score	**Yes**	**Yes**	Yes	N/A	N/A	**Yes**	**Yes**	**Yes**
Bivariate Analysis/ Likelihood of 8+ Score	**Yes**	**Yes**	Yes	N/A	N/A	**Yes**	**Yes**	**Yes**

Again, only three of the multi-variable regression models met the R2 0.10 threshold.

	Region	*Disability*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type 211*	*Agency*	*Staff*	*R2*
Raw Scores Controlling for Agency	**Yes**	**Yes**	N/A	N/A	N/A	N/A	**Yes**	N/A	.14
Raw Scores Controlling for Staff	**Yes**	**Yes**	N/A	N/A	N/A	N/A	N/A	**Yes**	.20
Likelihood of 9+ Score Controlling for Staff	**Yes**	**Yes**	N/A	N/A	N/A	N/A	N/A	**Yes**	.12

*** denotes evidence of a relationship but R2 falls below .10 threshold*

‡ denotes significant relationship found in bivariate analysis

Note: Due to significant missing data, age and veteran status were dropped from multi-variable regression models. Chronically homeless status was dropped because the sample size of families was too small to analyze.

Households with children from outside the CoC had higher VI-SPDAT scores than all but Central Valley households. Central Valley households received significantly higher scores than all other regions. Families from Pocono saw significantly lower scores than other regions.

	Mean VI-SPDAT Score	*Notes*

Outside CoC	**10.7**	Higher than all regions except Central Valley (p.<.05)
Central Valley	**9.9**	Higher than all other region except Outside (p<.05)
South Central	9.1	Higher than Pocono (p<.05)
Lehigh Valley	9.0	Higher than Pocono (p<.05)
Northern Tier	9.0	Higher than Pocono (p<.05)
Pocono	**8.0**	Lowest and significantly lower than average (p<.05)
Total	9.1	

Households with children that accessed 211 scored on average 1.1 points lower than those accessing non-211 access points.

	Mean VI-SPDAT Score
211 Access Points	8.7
Non-211 Access Points	9.8
Difference	**1.1 (p<.05)**
Total	9.1

Young Adults (18-24)

Unlike VI-SPDAT scores among other household types, scores among young adults only differed by regions in one way – Pocono scores were significantly lower than scores in other regions. However, please note that the sample size was small in this analysis with only 39 young adults assessed in Pocono.

	Mean VI-SPDAT Score	*Notes*
Lehigh Valley	7.9	
Central Valley	7.9	
Northern Tier	7.6	
South Central	7.3	
Outside CoC	7.0	
Pocono	**6.5**	Lowest but small sample size (n = 39)
Total	7.6	

As with other household types, differences in scores across access point type were significant – 211 scores were 1.0 point lower on average and 1.2 points lower when controlling for all other variables in the multi-variable regression analyses.

The following tables mirror those in the sections related to households with and without children in style and format.

	Region	*Disability Status*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type 211*	*Agency*	*Staff*
Expectations	No	Yes	-	-	Yes	No	*No*	No
Bivariate Analysis/ Raw score	Yes	Yes	Yes	N/A	N/A	Yes	Yes	Yes
Bivariate Analysis/ Likelihood of 8+ Score	Yes	Yes	No	N/A	N/A	Yes	Yes	Yes

Four of the eight multi-variable regression models met the R2 0.10 threshold.

	Region	*Disability*	*Age*	*Veteran Status*	*Chronically Homeless Status*	*Access Point Type 211*	*Agency*	*Staff*	*R2*
Raw Scores Controlling for Agency	**Yes**	Yes	Yes	N/A	N/A	N/A	**Yes**	N/A	**.12**
Raw Scores Controlling for 211	**Yes**	Yes	Yes	N/A	N/A	**Yes**	N/A	N/A	**.10**
Raw Scores Controlling for Staff	**Yes**	Yes	Yes	N/A	N/A	N/A	N/A	**Yes**	**.15**
Likelihood of 8+ Controlling for Staff	**No**	Yes	Yes	N/A	N/A	N/A	N/A	**Yes**	.10

*** denotes evidence of a relationship but R2 falls below .10 threshold*

‡ denotes significant relationship found in bivariate analysis

Young adults that accessed 211 scored 1 point lower on average than those accessing non-211 access points and 1.2 points lower when controlling for region, disability status, and age.

	Mean VI-SPDAT Score
211 Access Points	7.2
Non-211 Access Points	8.2
Difference	**1.0 (p<.05), multiple regression difference is 1.2**
Total	7.6

Since data quality was better for young adults, gender and ethnicity were analyzed individually. Latinx young adults scored on average 1 point higher than non-Latinx individuals. No differences in scores were found with regards to gender.

Ethnicity	*Mean VI-SPDAT Score*
Non-Latinx	7.3
Latinx	8.3
Difference	1.0 (p<.05)
Total	7.4

Note: 9% of ethnicity data is missing

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding access to and assessment in Eastern Pennsylvania CoC's coordinated entry system.

Finding	**Recommendation(s)**
CES access points are inaccessible to households seeking housing and services in general and especially non-English speakers; the Central Valley and Lehigh Valley RHABs appear underrepresented on the by-name list.	• Expand the CoC coordinated entry grant to hire more 211 staff and compensate non-211 access points. Prioritize bilingual staff for open positions. • Consider exploring the option of an online client portal to complete or revise assessments, upload documents, receive housing match notifications, and communicate and coordinate appointments with case managers. • While expansions in system access are recommended across all regions, the CoC might consider making targeted future investment in Central Valley and Lehigh Valley access points to address inequities between RHABs.
CES policies and procedures do not comply with HUD requirements related to system access and assessment.	• Develop and implement procedures documenting steps taken to ensure access points are accessible to individuals with disabilities. • Develop and implement procedures documenting steps taken to ensure effective communication with individuals with disabilities. • Develop and implement a process to ensure access to emergency services during hours when CES processes are not operating. • Develop and implement policies establishing that the CES assessment process cannot require disclosure of specific disabilities or diagnosis. • Develop and implement a process to enable CES participants to file a nondiscrimination complaint and properly notify all participants of their rights.
VI-SPDAT score distributions were significantly different when comparing across agencies, regions, and assessors, and assessments administered by 211 agencies had significantly lower scores than those administered by non-211 access points.	• Monitor VI-SPDAT score distributions by assessment type, prioritizing review of scores from agencies that administer the most assessments, to identify inconstancies. Access point agencies should consider monitoring the distributions of scores by assessor while the CoC should consider monitoring the distribution of scores by region and agency. When irregularities immerge, communicate with agencies and staff to identify reasons why assessments may not fit a normal distribution or be different than neighboring agencies. Provide training and targeted technical assistance as needed. • Identify assessment strategies leveraged by agencies that have consistent VI-SPDAT score distributions to inform ongoing technical assistance, training, and policy updates. • Consider requiring ongoing assessment training (e.g., annual refreshers with brief check-ins between trainers and

Finding	Recommendation(s)
	assessors) and include training on trauma-informed communication. • Consider integrating housing problem solving into coordinated entry. Provide housing problem solving services as the first step in the access and assessment workflow to support households in resolving their housing crises. Even where housing problem solving is unsuccessful in identifying a temporary or permanent housing solution, it can be a powerful way to build trust and rapport with households before administering the coordinated entry assessment.
CoC partners are concerned that the VI-SPDAT is biased and re-traumatizing and that it does not capture vulnerability in an accurate manner as fear, stigma, and cultural norms prevent people from responding openly to the invasive and sensitive questions.	• Partner with persons with lived experience of homelessness to develop and pilot alternative formulations of assessment questions to minimize re-traumatization and more effectively identify conditions and experiences affecting vulnerability. • Stay attuned to the national conversation, emerging ideas, and HUD guidance around coordinated entry prioritization and assessment approaches. There is no simple solution to this problem, but new ideas and concepts may emerge that provide a clearer path forward. Any system changes or redesign should be carefully analyzed and vetted by legal counsel to ensure full compliance with state and federal laws including Fair Housing. Notable developments in assessment and redesign efforts across the country include: ○ Allegheny County CoC worked with university researchers to develop an assessment process based on a predictive risk model to calculate the likelihood of three types of harmful events occurring in a person's life if they remain unhoused over the next 12 months: a mental health inpatient stay, a jail booking and frequent use (4+ visits) of hospital emergency rooms. The process/tool assigns a risk score that is used in combination with history of chronic homelessness as part of the housing prioritization process. ○ Hennepin County CoC has removed the VI-SPDAT from the coordinated entry process to prioritize households for permanent supportive housing and rapid rehousing openings solely based on disability status, chronically homeless status, and length of time experiencing homelessness. The CoC has also incorporated client choice into the housing match process by designing an assessment that estimates program eligibility, explains program and housing models (e.g., PSH, RRH, SROs, shared housing, on-site services, recovery focus), and poses questions regarding client preferences related to these options, housing location, accommodations related to health and disability, and any culturally specific services preferred by the client. The CoC is currently working to identify a series of questions to capture medical fragility to take the place of disability status as a prioritization criterium. ○ Chicago CoC is piloting a six-question assessment designed by a CoC work group and testing various scoring options. Pilot assessment questions are: 1. Have you ever in your life, spent any amount of time in a juvenile or adult correctional facility, jail, prison, or detention center? 2. Growing up, did your family experience housing instability such as frequently moving due to financial reasons, living with other families, relatives, (also known as doubling up), living in a shelter, living in nightly or monthly rentals, or anything like that?

Finding	**Recommendation(s)**
	3. Have you ever been discriminated against because of your sexual orientation or gender identity? 4. Do you identify as a Black, Indigenous/Native, and/or a Person of Color who has been discriminated against because of your race or ethnicity? 5. Have you experienced violence in a home where you lived or seen others experience violence in a home where you lived? Violence can be physical or emotional. 6. Are you currently being hurt or experiencing violence on the streets or in a shelter or attempting to avoid people who have hurt you since experiencing homelessness?

Prioritization and Referral to Permanent Housing

This section evaluates the effectiveness and equitableness of the prioritization and referral processes and focuses on assessing the timeliness and appropriateness of referrals and the efficiency of the enrollment process.

Compliance Review

Eastern Pennsylvania CoC's coordinated entry system falls short on various key HUD-required elements related to consistent and nondiscriminatory prioritization, uniform and coordinated referral, avoiding screening out potential participants based on perceived barriers to housing or services, protecting the right of participants to reject referral options, and providing recourse in instances of discrimination. The requirements for these areas as are as follows:[4]

1. CoC uses the CES to prioritize homeless persons within the CoC based on a set of criteria that are documented, made publicly available and applied consistently. CoC's written policies include information with which prioritization decisions are made.
2. CES includes uniform and coordinated referral processes for all beds, units, and services available at participating projects.
3. CoC and projects participating in the CES do not screen potential participants out for assistance based on perceived barriers to housing or services.
4. CoC does not use data from the assessment process to discriminate or prioritize households on a protected basis (e.g., race, gender identity) and CES policies document how determining eligibility is a different process than prioritization.
5. CoC's policies document conditions under which participants maintain their place in CES prioritization lists when the participant rejects referral options.
6. CES policies document process for participants to file a nondiscrimination complaint.

As described in more detail in the following two subsections, while the CoC has established, documented, and made publicly available a set of prioritization criteria, these criteria are largely nullified by the lack of a uniform and coordinated referral processes for all beds, units, and services available at participating projects. Instead, housing providers pick and choose their own referrals from the by-name list. While CoC policy indicates that households are prioritized by VI-SPDAT score and by certain disabilities and health conditions, HMIS data show that people with higher VI-SPDAT scores are no more likely to access permanent housing through coordinated entry than people with lower scores and that adult-only households with disabilities wait longer for permanent housing than those without disabilities. Qualitative data indicate that this trend is at least partly a result of housing providers screening potential participants out for assistance based on perceived barriers to housing or services. Furthermore, the 90-day time-out policy may be compounding the issue by disadvantaging high-vulnerability households, who are less likely to consistently engage in services and are systematically cleared from the by-name list despite continued need for assistance.

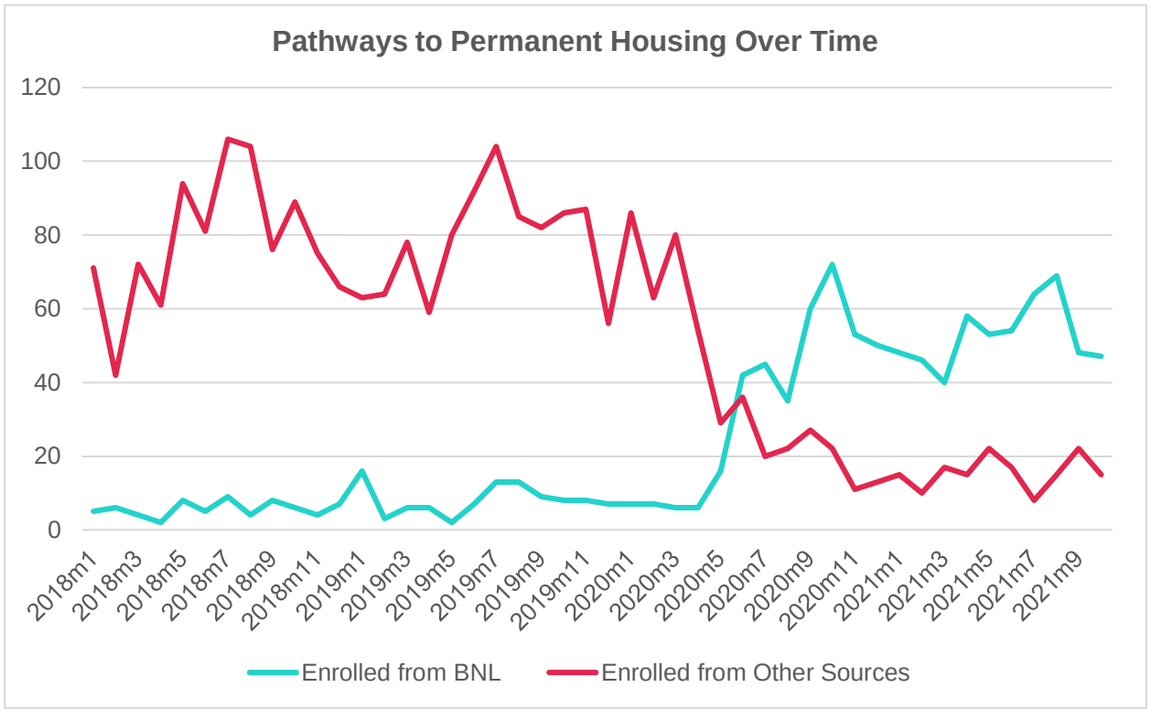
CoCs are prohibited from using the prioritization process to discriminate based on protected classes as defined by Federal Civil Rights laws and requirements. These protected classes include race, color, religion, national origin, sex, age, familial status, or disability. In certain circumstances some projects may use disability status or other protected class information to limit enrollment, but only if Federal or State statute explicitly allows the limitation (e.g., HOPWA-funded projects may only serve participants who are HIV+/AIDS). However, assessment and prioritization must be based on an individual's vulnerability or need level according to the specific and definable set of nondiscriminatory prioritization criteria. For more information, see CoC FAQ ID 3464. This means that while it is allowable to prioritize based on age and medical conditions in the context of the COVID-19 pandemic and based on CDC guidance, the CoC should consult with legal counsel regarding its use of familial status, intellectual and developmental disability, and physical and behavioral health challenges as prioritization criteria.

Coordinated entry policies and procedures do not address items 5-6 above.

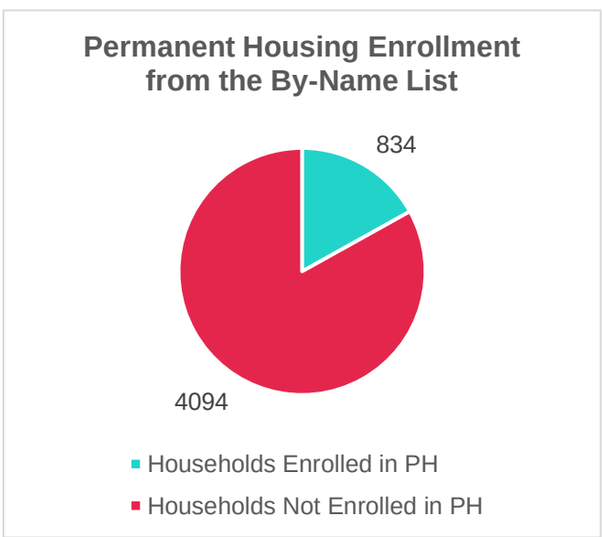
[4] See Appendix C for more details on the compliance review.

Analysis of Process and Effectiveness

Quantitative analysis of prioritization and referral is severely limited by the fact that, while a prioritization process and a housing enrollment process exists, there is no permanent housing referral process that is tracked in HMIS as housing providers self-select households from the by-name list. These aspects of coordinated entry must therefore be analyzed comparing data on households enrolled in housing programs to households on the by-name list. As mentioned above in the analysis of access process and effectiveness, pathways to housing have traditionally circumvented coordinated entry, but marked improvements have been made since June 2020 regarding permanent housing enrollments matching up with households on the by-name list. For this reason, our prioritization analysis is limited to the time period following June 2020.



Only 834 (17%) of the 4,928 households placed on the by-name list between June 2020 and November 2021 have enrolled in permanent housing. This rate of permanent housing placement underscores the large gap between the need for and supply of supportive housing in Eastern Pennsylvania, a resource challenge beyond the control of coordinated entry.



Most survey respondents (69%) indicated that overall, the by-name list process works well in supporting housing providers to identify prioritized eligible households – 60% reflected that **documenting household eligibility is easy** and 59% noted that they rarely or never run into problems with ineligible households pulled from the by-name list. The majority also observed that **coordinated entry makes it easy to fill vacancies** (65%) and that **vacancies are filled quickly through the by-name list process** (58%). The vast majority (81%) agreed that **survivors of domestic violence are afforded fair and equal access to rapid rehousing and permanent supportive housing via coordinated entry**.

Respondents appreciated the opportunity that coordinated entry provides for people experiencing homelessness to access services across regional boundaries. In interviews and focus groups, providers stated that **high-priority populations are being successfully referred and enrolled in programs** and reflected favorably on the work that the Regional Managers do to ensure that things run smoothly at the RHAB level.

Survey respondents' most cited challenge was locating persons pulled from the by-name list – 56% indicated that **getting in contact with households that have been identified through coordinated entry is difficult** and 59% indicated that they are **often unable to make contact** due to, e.g., a change in phone number. Pulling referrals is particularly challenging for victim services providers and other agencies serving survivors of domestic violence due to the added layers of confidentiality protections around survivor data, and these providers run into more ineligibility issues with households pulled from the by-name list.

Survey respondents were divided on the issue of ensuring clients understand the coordinated entry process – 51% indicated that this task was easy and 46% indicated that it was difficult. In interviews, individuals with lived experience consistently expressed a **lack of understanding about the coordinated entry process.** Those who were still waiting for housing rarely had any idea where in the process they were or what steps were next, those who had been successfully placed in housing did not understand how they got there, and many did not know what the expectations or process was going forward.

Survey respondents were equally split on how frequently they pull households that are not a good fit for their program (49% indicated very often/often, 47% indicated rarely/never) and households that are not document-ready by enrollment (46% indicated very often/often, 44% indicated rarely/never). Nearly half (42%) of respondents indicated that households pulled from the by-name list are often enrolled but do not move into housing. People with lived experience we interviewed indicated that the process of getting document ready was extremely cumbersome, and that they were **given very little support and sometimes told conflicting things about what they needed to do**. The most common reason individuals said they were not enrolled in a referral was conflicting information between counties, RHABs and providers, though some individuals navigated between RHABs without any incident.

In interviews, providers stated that the prioritization phase was not well-coordinated as it relies on four different databases, silos people and providers, and prevents unhoused persons from getting the help they need as quickly as possible. Providers observed that buy-in was an issue across the board and that the **lack of a true referral system or an enforcement mechanism to ensure that the CoC prioritization policy is followed** made it impossible to ensure compliance among providers who are using coordinated entry. Providers felt that the role and meaning of the by-name list was confusing and misunderstood across the CoC and that, by clarifying that purpose and decreasing the number of people placed on the list, persons experiencing homelessness would receive better service across the board.

The vast majority (73%) of the households placed on and pulled from the by-name list have only been placed on the list once so far, 19% were placed on the list twice, 6% three times, and 2% four to eight times. The number of times a household is placed on the by-name list affects their likelihood of enrolling in permanent hosing only slightly.

Timeliness

The vast majority (73%) of the households placed on and pulled from the by-name list have only been placed on the list once so far, 19% were placed on the list twice, 6% three times, and 2% four to eight times. The number of times a household is placed on the by-name list affects their likelihood of enrolling in permanent hosing only slightly.

We observed the time that households spent on the by-name list in two ways. First, we measured the time that elapsed from a household's first placement on the by-name list to their permanent housing enrollment to evaluate how long it takes someone to be housed after they seek help through coordinated entry. The following table displays this timeline by project and household type, demonstrating that **adult-only households with disabilities wait longer for permanent housing than those without disabilities**.

Days from First By-Name List Placement to First Permanent Housing Enrollment

	Rapid Rehousing (n = 728)		*Permanent Supportive Housing / Other Permanent Housing (n = 106)*		*Total (n = 834)*	
	Mean	*Median*	*Mean*	*Median*	*Mean*	*Median*
Adult-Only Households (n = 441)	120.2	31	225.1	71.5	137.3	35
With Disability (n =249)	139.2	37	266.1*	82	167.2*	47
Households with Children (n = 316)	106.2	35	266.2	210	119.9	37
With Disability (n = 95)	113.3	38	169.1	67.5	116.9	38
Young Adults (n = 77)	127.7	25	34.7	20	119.3	24
With Disability (n = 22)	167.9	21	31	31	155.4	21
All (n = 834)	115.4	33	223.0	71.5	129.1	35
With Disability (n = 366)	133.5*	36	249.4	72	153.4*	42

** denotes statistical significant within family type group*

Note: No significant differences found between household types

Effectiveness of Prioritization

No correlation was found between VI-SPDAT score and likelihood of permanent housing project enrollment for most household types in most RHABs. In other words, **in direct contradiction to the prioritization policy, people with higher VI-SPDAT scores are no more likely to access permanent housing through coordinated entry than people with lower scores**. People with high scores are either timing out from the by-name list, are being skipped over by housing providers, or are ineligible for all housing programs in the CoC. Unfortunately, because there is no true referral system or tracking of by-name-list exits in HMIS, it is unclear what is happening. The following table summarizes the impact of VI-SPDAT score on likelihood of permanent housing program enrollment broken out by household type and region.

Are households with higher VI-SPDAT scores more likely to be enrolled in permanent housing projects?

	Central Valley	*Lehigh Valley*	*Northern Tier*	*Pocono*	*South Central*	*Outside CoC*	*Total*
Expectations	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Adult-Only Households	**No**	**Yes** (+31%)	**No**	**No**	**No**	**No**	**No**
Households with Children	**Yes** (+11%)	**Yes** (+33%)	**No**	**No**	**No**	**No**	**Yes** (+5%)
Young Adults (18-24)	Sample size is too small for statistical analysis						**No**

Assessment of Equitableness

As expected, households headed by persons with disabilities, those experiencing chronic homelessness, and veterans were more likely to be enrolled in permanent housing projects as many of these factors are requirements for specific housing projects. Notably, region also held significant differences with regards to housing enrollment. **All households in Central Valley and households without children in Lehigh Valley were significantly less likely to enroll in permanent housing projects compared to the overall CoC average and compared to other regions.** This disparity is compounded by the disparity in coordinated entry system access previously mentioned – Central Valley and Lehigh Valley are under-represented on the by-name list as compared to the PIT Count. In other words, persons in these two RHABs are doubly disadvantaged in that they are less likely to access coordinated entry to begin with and, once they do, less likely to obtain permanent housing through the system.

The following table summarizes the variables that affect a household's likelihood of permanent housing enrollment:

	VI-SPDAT Score	*Region*	*Age*	*Disability Status*	*Chronically Homeless Status*	*Veteran Status*	*Access Point Type / 211*
Expectations	Yes	No	-	Yes	Yes	-	No
Adult-Only Households	**No**	**Yes**	No	**Yes**	**Yes**	Yes	**Yes**
Households with Children	**Yes**	**Yes**	Yes	**No**	**No**	Yes	**Yes**
Young Adults (18-24)	**No**	**Yes**	No	**No**	**No**	N/A	**No**

To further investigate why RHAB may be more important than VI-SPDAT score, we compared the PIT Count proportions to the by-name list and permanent housing enrollments by RHAB and household type. Red text indicates a difference of 5% or more underrepresentation when compared to the PIT Count and blue text represents a 5% or more over representation when compared to the PIT Count. Central Valley and Lehigh Valley have consistently lower access to coordinated entry and permanent housing enrollment when compared to the PIT Count, while South Central has higher access and permanent housing enrollment proportions.

System Access vs Housing Enrollment: PIT Count Estimates (2018-2020), By-Name-List Placements, and Permanent Housing Enrollments

	Central Valley	*Lehigh Valley*	*Northern Tier*	*Pocono*	*South Central*	*Outside CoC*
Total PIT	25%	33%	12%	12%	17%	-
Total BNL Placement	21%	**20%**	12%	8%	**36%**	2%
Total Housing Enrollment	**14%**	**15%**	15%	10%	**42%**	4%
Adult-Only Households PIT	25%	32%	11%	14%	18%	-
Adult-Only Households BNL Placement	23%	**20%**	12%	9%	**35%**	1%
Adult-Only Households Housing Enrollment	**17%**	**9%**	16%	10%	**47%**	1%
Households with Children PIT	28%	34%	13%	10%	15%	-
Households with Children BNL Placement	**19%**	**24%**	13%	11%	**32%**	2%
Households with Children Housing Enrollment	**10%**	**23%**	17%	**16%**	**34%**	1%
Young Adults PIT	27%	28%	16%	8%	20%	-
Young Adults BNL Placement	**20%**	26%	**9%**	8%	**37%**	1%
Young Adults Housing Enrollment	**5%**	**38%**	9%	7%	**42%**	0%

While more resources are needed to expand access in every RHAB, targeted investment in Central Valley and Lehigh Valley may be warranted. Put another way, the rate of permanent housing enrollments

from the by-name list is low across all RHABS, but it is especially low among all households in Central Valley and among adult-only households in Lehigh Valley.

Rates of Permanent Housing Enrollment from the By-Name List

	Central Valley	*Lehigh Valley*	*Northern Tier*	*Pocono*	*South Central*	*Outside CoC*	*Total*
Adult-Only Households	**11%**	**7%**	21%	17%	21%	10%	15%
Households with Children	**8%**	16%	21%	24%	18%	8%	17%
Young Adults (18-24)	**4%**	27%	18%	16%	21%	0%	18%

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding prioritization and referral in Eastern Pennsylvania CoC's coordinated entry system.

Finding	**Recommendation(s)**
CES policies and procedures do not comply with HUD requirements related to prioritization and referral.	• Describe conditions under which participants maintain their place in CES prioritization lists when they reject referral options. • Develop and implement a process to enable CES participants to file a nondiscrimination complaint. • Consult with legal counsel regarding its use of familial status, intellectual and developmental disability, and physical and behavioral health challenges as prioritization criteria.
Only 17% of households placed on the by-name list wind up enrolling in permanent housing. A significant number of households simply time out from the list per the CoC policy and are removed despite their continued need for assistance.	• Consider integrating housing problem-solving into coordinated entry to support households in identifying choices and solutions to quickly end their housing crisis and preserve emergency shelter beds and supportive housing resources for households who have no alternative options. Consider the following resources and examples: Innovative Practices in Housing Problem-Solving, Tracking Dynamic Housing Problem Solving Conversations, and Santa Clara County Continuum of Care Housing Problem Solving Guidelines. ○ Train (on an ongoing basis) 211 and non-211 access point staff, shelter staff, and diversion program staff in housing problem solving techniques, including how apply motivational interviewing to have creative conversations that support participants in identifying and leveraging household strengths, support networks, and other resources in overcoming barriers to housing stability and identifying potential solutions to their housing crisis. Train staff to serve as mediators to assist households in having difficult conversations with individuals in their support network, such as friends and family, employers, debt collectors, and landlords. ○ Set up a flex fund accessible by access points and shelters to provide limited financial assistance for solutions that require monetary support, such as: ▪ Move-in costs, including deposit and first month's rent, moving supplies, the cost of a moving truck, and storage ▪ Rental application fees and payments for background and credit checks ▪ Fees for securing identification documents, birth certificates, and social security cards ▪ Transportation, including bus tickets for both local transport and to facilitate relocation to

Finding	Recommendation(s)
	verifiable, safe housing out-of-the-area, car repair for ending homelessness (e.g., for travel from temporary/permanent housing to school/work ▪ Previous housing debt/rental arrears if resolving will facilitate an immediate housing placement ▪ Utility deposits and arrears needed to secure housing ▪ Certifications or license fees related to employment ▪ Household expenses such as groceries or cleaning supplies ▪ Fees for temporary childcare or other children's activities • Consider redesigning the prioritization criteria so that only households that are guaranteed to be referred within 90 days are placed on the by-name list, e.g., by setting an assessment score floor for inclusion on the list. Provide a warm hand-off to shelter and diversion programs trained in housing problem solving for those households that do not score high enough to be prioritized for permanent housing programs.
Adult-only households with disabilities wait longer for permanent housing than those without disabilities, and people with higher VI-SPDAT scores are no more likely to access permanent housing through coordinated entry than people with lower scores.	• Design and implement a uniform and coordinated referral processes for all beds, units, and services available at participating projects whereby, for example: ○ Housing programs track capacity and anticipated vacancies in HMIS, and eligibility requirements are tracked and updated in HMIS (alternatively, in a spreadsheet). ○ Regional Managers are responsible for sending referrals via HMIS to fill anticipated housing program vacancies based on the coordinated entry prioritization policy and program eligibility requirements. ○ Housing programs are required to respond to every referral in HMIS, and coordinated entry policies specify a limited set of reasons that warrant a referral denial, such as: ▪ Client could not be located ▪ Client declined services ▪ Client is ineligible ▪ Client is housed ▪ Client is working with another housing program ▪ Client is banned at agency/program ▪ Client is incarcerated ▪ Client deceased ▪ Other reasons, as needed/identified by the CoC ○ In cases where a referral is denied, housing programs are required to enter a referral denial reason (set up as a standard drop-down menu in HMIS) and may provide a message (set up as a comment field) to support more appropriate future referrals for the household. ○ Regional Managers are empowered by coordinated entry policy to monitor referral denials to ensure that housing programs are screening in vulnerable households, and referral denial rates and reasons are considered in evaluating funding applications.

Finding	Recommendation(s)
	○ Targeted technical assistance is provided to permanent housing programs to build capacity and support them in lowering barriers and implementing Housing First, as needed.
All households in Central Valley and households without children in Lehigh Valley were significantly less likely to enroll in permanent housing projects compared to the overall CoC average and compared to other regions.	• While expanding housing opportunities is important for households across the entire system, the CoC might consider making targeted investments in Central Valley and Lehigh Valley.
Getting in touch with households that have been identified through coordinated entry can be difficult.	• Develop a more comprehensive approach for collecting contact information, including various emergency and back-up contacts. • Develop a list of recommended strategies to support permanent housing staff in locating matched households by: ○ Leveraging HMIS alerts, stored contact information, service histories, case notes, program exit destinations, etc. ○ Linking with outreach teams and other service providers ○ Visiting homeless hotspots ○ Making use of community contacts, such as GA case managers, medical social workers, homeless advocates, etc. ○ Making use of online correctional system resources, such as court public portals and inmate locator tools

System Governance and Management

While a coordinated entry system requires the involvement of all the community's homeless service providers, HUD requires certain organizations to provide governance and management of the system. According to HUD's Coordinated Entry Management and Data Guide, a community must designate a "policy oversight entity" to make policy decisions about coordinated entry and a "management entity" to provide day-to-day operational management of the system.[5] This brief section summarizes findings around the management of Eastern Pennsylvania CoC's coordinated entry.

Complete and accurate data and information are crucial to evidence-based decision-making and effective system management, and accessible information and system buy-in among implementing partners are key to the overall success of coordinated entry systems

Analysis of Process and Effectiveness

Most survey respondents (65%) agreed that **the CoC has appropriate metrics in place to evaluate the performance of coordinated entry on an ongoing basis**, and 63% indicated that they know where to obtain data and information to understand how coordinated entry is operating on a system-wide level. **The vast majority of respondents noted that they know where to provide input (74%) and feel comfortable providing input (78%) when they have concerns about coordinated entry** and 64% felt that their input and concerns are heard and addressed. **In surveys and interviews respondents reflected favorably on coordinated entry training and the support that is provided to troubleshoot issues as they arise.**

Survey respondents also highlighted various challenges. They observed that **not all providers use the system the same way, so notes, enrollments, and other critical information is often incomplete or out of date**. This observation is corroborated by the data quality issues described throughout this report. Respondents expressed frustration about **frequent system changes and a lack of proper notice regarding their implementation**, noting that nonprofit organizations that experience high turnover rates have a particularly difficult time keeping up. **Respondents wished for more open conversations about system performance** regarding coordinated entry enrollment and by-name list placement and housing match and placement process – how many households are matched to programs, how many are contacted and offered services, how many are enrolled in permanent housing, how many are housed. Finally, respondents observed that **the CoC Board should strive towards diversity and inclusion and ensure that its membership is reflective of the communities that the CoC serves – both in terms of race and ethnicity but also lived experience of homelessness**.

Key Findings and Recommendations

Below is a list of key findings and corresponding recommendations regarding system governance and management in Eastern Pennsylvania CoC's coordinated entry system.

Finding	**Recommendation(s)**
Data quality is too poor to conduct an analysis of system equitableness (see p.13).	• Implement a data quality management process, prioritizing HUD Universal Data Elements and including training and targeted technical assistance to address data timeliness, completeness, and accuracy among access point agencies, shelter staff, and other CoC partners. • If the CoC wishes to analyze the experience of a specific population, data must be captured for both the ingroup and the outgroup. For example, if the CoC wishes to analyze the pathway through the system for those fleeing domestic violence, every head of household who is enrolling in coordinated entry must be asked the domestic violence question and that data must be recorded for all regardless of gender, age, and household type.
System changes are very frequent, and it is challenging for CoC partners to keep up.	• Release updates on a quarterly or biannually (rather than a rolling) basis. Provide a written summary of updates, live and recorded training (where applicable), and office hours to discuss changes.

There is a desire among CoC partners for more open conversations about system performance.	• Provide regular updates on data related to the functioning of coordinated entry through committee and case conferencing meetings, public dashboards, and/or other channels.
	  ○ Highlight success in areas such as number of referrals and housing stability of persons connected to housing programs via coordinated entry.
	  ○ Provide data regarding referral rates (consider breaking down by VI-SPDAT score) and timelines to

[5] https://files.hudexchange.info/resources/documents/coordinated-entry-management-and-data-guide.pdf

Finding	**Recommendation(s)**
	access point agencies to support them in setting clear expectations with clients.

CoC Board membership should strive to be reflective of the communities that the CoC serves – both in terms of race and ethnicity but also lived experience of homelessness.	• As a CoC, define the identities and experiences that the CoC Board should represent and revise the Governance Charter to include a diversity mechanism to meet these goals.
	  ○ Some principles to help start this process include:
	  ▪ Develop a membership profile chart that defines and tracks what special skills and qualities the Board will require of its members (see here for an example on pp. 7-8)
	  ▪ Ensure readability and accessibility of materials and communications
	  ▪ Determine who is making decisions about recruitment (current members, a sub-committee, the chairs, someone else?) and standardize this process. Consider building a standard rubric (e.g., CoC Board Rubric)
	  ▪ Acknowledge and address bias in the selection process
	  ○ Homebase has also identified and recommends the following resources:
	  ▪ "Equity, Diversity and Inclusion in Recruitment, Hiring and Retention," Desiree Williams-Rajee, Kapwa Consulting (2018). Prepared for Urban Sustainability Directors Network (USDN).
	  ▪ "Equity in Recruiting, Selecting and Retaining New Members." (n.d.). Homebase.
	  ▪ "Toolkit for Employing Individuals with Lived Experience Within the Public Mental Health Workforce." (2014). Working Well Together.
	  ▪ "Using Outreach to Increase Access." (n.d.) Community Toolbox.

Coordinated entry governance should be restructured to clarify roles and responsibilities, open lines of communication and collaboration, and empower partners to effectively carry out their duties.	• Consider redesigning the coordinated entry governance structure as follows:
	  ○ Regional Managers are responsible for making and monitoring referrals to permanent housing programs and are granted the authority to monitor referral denials, push back where appropriate, escalate issues to the Coordinated Entry Manager for support as needed, and address discrimination complaints. Regional Managers meet weekly to case conference and troubleshoot issues related to system operations.
	  ○ The Coordinated Entry Manager trains Regional Managers and assessors, coordinates Coordinated Entry Committee and Regional Manager meetings, monitors assessment score distributions across RHABs and access point agencies, and supports Regional Managers in addressing referral rejections as needed.
	  ○ The Coordinated Entry Committee meets monthly to review coordinated entry system performance and address workflow and policy issues. The Committee has the authority to revise policies and procedures that do not fundamentally alter the core design of the system. The Committee includes the Regional Managers, the Coordinated Entry Manager, 211 and non-211 access point representatives, shelter representatives, and supportive housing program representatives.

Finding	**Recommendation(s)**
	○ The CoC Board is responsible for overseeing major system changes, e.g., assessment overhaul (not minor edits), changes in prioritization criteria, changes in releases of information. The Board includes the Coordinated Entry Manager and two Regional Manager representatives.

System Impact

Survey respondents indicated that they support the concept of coordinated entry and appreciate the fact that there is a centralized system in place to address the needs of people experiencing homelessness and willingness to make adjustments to improve the process. Respondents observed that **HMIS is helpful in supporting providers to coordinate client care** and track homelessness in the community and appreciated the fact that **unhoused persons do not need to call every agency in the CoC in order to access resources**. They reflected favorably on the **collaboration among providers** in the CoC and noted that **partner staff are supportive, caring, and respectful**. Respondents observed that the bottlenecks result primarily from a **lack of resources to meet the full need of Eastern Pennsylvania's unhoused population** and noted that the **distribution of funding is inconsistent**, leaving some counties with little to no permanent housing resources.

Housing Move-In Rates

Overall, 64% of households enrolled in permanent housing programs eventually move in, and **move-in rates are equitable by race, ethnicity, and gender**. However, once again, **region is an important factor in predicting likelihood of move-in after permanent housing enrollment**.

Adult-only households in the Northern Tier and Lehigh Valley moved in at much lower rates than those in other regions. Households enrolled in permanent housing programs in Lehigh Valley were 66% less likely to move into housing when compared to those in Central Valley and those in the Northern Tier were 87% less likely to move in. **Several additional factors affected likelihood of move-in among adult-only households, including age, the type of access point through which they entered coordinated entry, and the type of permanent housing project in which they were enrolled** (RRH vs PSH vs other PH). Specifically, an adult's likelihood of housing move-in increased by 49% with every additional 10 years of age. Adult-only households that accessed coordinated entry through 211 were 80% less likely to move into housing after being enrolled in permanent housing programs than those who accessed the system through non-211 access points. Households with children in the Northern Tier moved in at much lower rates than those in other regions as well. No disparities related to move-in rates were found among young adults.

The following table outlines move-in rates for households enrolled in permanent housing programs from the by-name list. Keep in mind that those enrollments that bypassed the coordinated entry and by-name list processes are excluded from this table.

Move-In Rates Among Households Enrolled in Permanent Housing from the By-Name List

	Central Valley	*Lehigh Valley*	*Northern Tier*	*Pocono*	*South Central*	*Outside CoC*	*Total*
Adult-Only Households (n = 388)	70%	59%	**35%***	80%	71%	40%	65%
Adult-Only Households Enrolled in PSH (n = 72)	92%	85%	**53%***	100%	63%	N/A	74%
Adult-Only Households Enrolled in RRH (n = 316)	65%	**38%***	**30%***	73%	72%	67%	63%
Households with Children (n = 258)	65%	62%	26%	70%	74%	50%	62%
Households with Children Enrolled in PSH (n = 20)	100%	100%	44%	100%	100%	N/A	50%
Households with Children Enrolled in RRH (n = 238)	62%	61%	**21%***	68%	78%	50%	63%
Young Adults (18-24) (n = 72)	100%	54%	50%	100%	70%	0%	67%
Young Adults Enrolled in PSH (n = 7)	N/A	100%	100%	N/A	60%	N/A	71%
Young Adults Enrolled in RRH (n = 65)	100%	52%	40%	100%	72%	N/A	66%

* denotes statistical significant with regard to the row

Timeline From Permanent Housing Enrollment to Housing

There is no significant difference among household types (households with children, without children, and young adults) in the time it takes to move into housing after controlling for the project type (PSH/OPH vs. RRH). The following table indicates that most move-in times are less than one week and often the same day as enrollment – **41% (194) first move-in dates were the same day as their first enrollment.** This is likely a data quality issue and prevents further analysis for this specific sample. Please see appendix E for more information.

Days Between First Permanent Housing Enrollment Date and Move-In Date

	Mean	*Median*	*Minimum*	*Maximum*
Permanent Supportive Housing	5.2	**0**	122	**0**
Rapid Rehousing	21.7	**6**	189	**0**
Total	19.2	**3**	189	**0**

In future evaluations, we recommend that the CoC revisit this timeline to assess whether the process of housing households is speeding up or slowing down and to re-do the analysis above to ensure that housing projects are documenting enrollments and move-in dates properly.

Conclusion

Coordinated entry constitutes myriad moving pieces and partners. It is never easy to implement effectively and equitably in any community, especially for participating organizations and staff, who take on extra responsibilities and surrender some level of independence and self-determination.

Indeed, there are already many successes to highlight and celebrate. Since June 2020, the number of people accessing supportive housing through a side door has decreased significantly. System partners applaud 211 for all they do especially considering the enormous demand and high staff turnover they have endured the past few years. Individuals with lived expertise generally feel respected by assessors. Housing providers indicate that coordinated entry makes it easy to fill vacancies, and vacancies are filled quickly through the by-name list process. The majority of CoC partners know where to provide input and feel comfortable providing input when they have concerns about coordinated entry and feel that their input and concerns are heard and addressed.

Eastern Pennsylvania can build upon its achievements by implementing the recommendations we lay out in Appendix A. We also advise the CoC to continue to assess coordinated entry on an ongoing basis and refine policies and practices to achieve even stronger results moving forward.