HEALTH CARE FOR THE HOMELESS PROGRAMS & COORDINATED ENTRY

Below are a few examples of Health Care for the Homeless (HCH) Programs participating in their communities' homeless response Coordinated Entry Systems. This list is organized according to the key components of Coordinated Entry, but many of these HCH Programs may be participating in additional ways as well. This is not intended to be an exhaustive list of HCH Programs participating in Coordinated Entry around the country, but rather a resource for HCH Programs and homeless response system stakeholders to support conversations about collaboration within Coordinated Entry Systems.

SYSTEM ENTRY

- Yakima Neighborhood Health Services serves as a Coordinated Entry Access point for the local Continuum of Care, and provide permanent supportive housing and medical respite care for literally homeless individuals and families. As part of the Homeless Network of Yakima County (our Continuum of Care), YNHS participates in the Coordinated Entry system, identifying the most vulnerable individuals in need of health care and housing, and provides support services to maximize opportunities for success. https://www.nhchc.org/directory/yakima-neighborhood-health-services/
- Family Health Centers of San Diego operates the City's Housing Navigation Center, is envisioned to serve as an entry point of the Coordinated Entry System (CES), provide core services to address housing crises, and help clients access a range of mainstream services that impact housing stability. The Center, designed to centralize services and resources for persons experiencing homelessness, provides on-site intake, assessment, triage and referrals for permanent and longer term housing opportunities. https://www.sdhc.org/wp-content/uploads/2018/07/HCR18-055-HousingNavigation-Center.Final_.pdf, https://www.sdhc.org/wp-content/uploads/2018/07/SDHC.Housing-Navigation-Center-PPT_Final.pdf
- Heartland Health Outreach, an HCH program, serves as an Access Point for the Chicago Coordinated Entry System and conducts housing system navigation. https://www.nhchc.org/directory/heartland-health-outreach/, https://www.csh.org/wp-content/uploads/2018/02/CES-Policy-and-Procedure-Guide_January.pdf, https://allchicago.org/sites/allchicago.org/files/Chicago%20CES%20Slides%20HomeBase%20HF%20and%20CES%20Training.pdf

ASSESSMENT

- Albuquerque Health Care for the Homelessness operates as an assessment location for the NM Coordinated Assessment System. Trained Engagement Specialists complete housing assessments for clients using the VI-SPDAT. http://crossroadsabq.org/wp-content/uploads/2015/12/VI-SPDAT-Locations.pdf, https://www.abqhch.org/engagement-specialists-address-unmet-needs/
- Baltimore Health Care for the Homeless assisted in building and testing the Baltimore Decision Assessment Tool, the CoC's locally-created tool, and provided training for navigators to use the tool: https://www.nhchc.org/wp-content/uploads/2011/10/coordinated-entry-and-health-centers-1.pdf (page 6, Baltimore HCH case study)

PRIORITIZATION

- Alameda County Health Care for the Homeless participates in Home Stretch is a countywide collaboration that links homeless individuals with disabilities to appropriate supportive services and permanent supportive housing based on established priorities. The program maintains a countywide registry used to prioritize and coordinate access to services and housing. https://www.achch.org/home-stretch.html, https://www.achch.org/uploads/7/2/5/4/72547769/hch_overview_presentation_-_sw_10-19-16.pdf (page 4, Current Initiatives)

MATCHING

- Daily Planet Health Services in Richmond, VA serves on two Housing Teams operated by the Greater Richmond CoC – VetLink (for homeless Veterans) and Singles Housing Team (single adults experiencing homelessness). The teams focus on coordinating exits to permanent housing with the goal to allocate housing resources as equitably and effectively as possible. Case conferencing to monitor and advance the progress of various households toward housing. http://endhomelessnessrva.org/working-groups/housing-team, https://www.nhchc.org/directory/daily-planet-health-care-homeless/, https://www.nhchc.org/wp-content/uploads/2011/10/coordinated-entry-and-health-centers-1.pdf (page 7, Daily Planet Case Study)
- Hennepin County Health Care for the Homelessness participates in a bi-weekly collaborative review of the by-name list and case conferencing to target long stayer list for housing and services: (https://www.hennepinattorney.org/-/media/hennepinus/your-government/projects-initiatives/end-homelessness/fy2018-hc-collaborative-app-new.pdf?la=en&hash=4062508E7B935B92401B07112005D8035FFE0F26, page 41)

REFERRAL & PLACEMENT

- Houston's Coordinated Entry System, The Way Home, partners with three Health Care for the Homeless programs – Avenue 360 Health and Wellness, Harris Health, and Health Care for the Homeless - Houston – to refer clients to health clinics, dental health services, mental health services, HIV services, and housing. http://www.thewayhomehouston.org/wp-content/uploads/2018/11/The-Way-Home-Partner-List-Alpha-110718.pdf

OVERALL

- Colorado Coalition for the Homeless is am HCH program that operates Denver's Homeless Management Information System (HMIS), as well as serves as the lead agency for the Coordinated Entry System for Families in Denver, and the Continuum of Care (CoC) lead for the Colorado Balance of State. https://www.coloradocoalition.org/sites/default/files/2018-10/Policy%20brief-Denver%20housing-final%20%28002%29.pdf (page 1)