



by
Martha R. Burt
Carol Wilkins
Natalie Matthews
Brooke Spellman¹

BRIEF #1. RAPID RE-HOUSING FOR HOMELESS FAMILIES DEMONSTRATION: THE ROLE OF CENTRALIZED INTAKE

November 2014

As required by the Continuum of Care (CoC) Program interim rule, many communities are in the process of designing coordinated assessment systems to help individuals and families who experience a housing crisis within their area to easily identify and access appropriate assistance.

Through an evaluation of the U.S. Department of Housing and Urban Development's (HUD's) Rapid Re-housing for Homeless Families Demonstration (RRHD) program, HUD learned how intake and assessment systems for homeless families work in 23 communities across the country. Communities need to define three primary elements when designing coordinated assessment systems: (1) clear points of access, (2) a tool and process for conducting standardized assessments of people's housing and service needs, and (3) protocols for making appropriate referrals based on the assessments.

This research brief describes observations from the evaluation related to the first element — clear points of access — and, to some extent, observations related to the third element — protocols for making appropriate referrals. A separate research brief — Rapid Re-housing for Homeless Families Demonstration: The Role of Assessment Tools — addresses observations related to the second element.

Communities often use the terms coordinated assessment and centralized intake interchangeably, but centralized intake is only one form of coordinated assessment—named centralized intake because it uses a central location as its primary point of access.

¹ Abt Associates, Inc.



The purpose of coordinated assessment is to establish a clear and easy way for people to find help and to effectively match the housing and service assistance offered by various programs to the needs of each particular family. With coordinated assessment, families get what they need as soon as possible and community resources are used efficiently. Without coordinated assessment, families may enter the first program they happen to find out about or may follow ad hoc referrals to agency after agency, spending a lot of time without ever receiving a placement. Families who do not need expensive, service-intensive programs may nonetheless get placed in them simply because they are eligible. Conversely, the highest needs families may fail to become stabilized because they may not happen upon appropriate help.

The 23 RRHD communities each designed their intake systems differently – some more coordinated and intentional than others. **The evaluation suggests that the clearer the points of entry and the greater the coordination and agreement among local service providers about who to refer to each program within the community, the easier the placement process is for families navigating it. In fact, the RRHD communities with centralized intake appeared to provide families with the most streamlined and consistent means of finding help and with a greater likelihood of getting admitted by the programs to which they were referred.**

In some communities, defining the primary point of access is easy because a community may have a single shelter that serves as the entry point into the system for all or most of the homeless families within the community. In other communities, several agencies serve homeless families either by managing shelters or by providing other services that families use to enter the homeless services system. For homeless systems that cover a broad geographic area, a single point of access to the system may

be impractical; instead, a set of neighborhood or regional points of access is required. One size does not fit all when it comes to defining access. All communities should be able to create intake structures that are easy to locate and serve the purpose of matching each family's needs to the best available housing and service assistance.

Based on the research team's observations in the 23 RRHD communities and general understanding of homeless assistance structures in many other communities over the years, the research team offers the following criteria for a community to use when determining whether its current intake system is fully functioning.

Communitywide. The intake system covers the entire community, and people know how to access help throughout the full geographic area.

Systemwide. The intake system can assess for and refer to all programs in the local homeless assistance network, from prevention to permanent supportive housing – or at least enough programs of each type to make triage into appropriate programs feasible.

Effective and Fair. The assessment determines the type of assistance that will be offered among available options based on the family's assessment. Families with similar characteristics are offered similar assistance.

Intake and Assignment of Resources.

The intake system is not simply a referral system; but is used to complete the intake into the homeless system, identify the appropriate assistance package. In addition, the intake system must confer upon the caseworker the authority to allocate the appropriate resources to the family, and follow up with that family to ensure that it receives those services.

About the Rapid Re-housing for Homeless Families Demonstration and Its Evaluation

In 2007, Congress appropriated \$23.75 million for the Rapid Re-housing for Homeless Families Demonstration (RRHD) program. The U.S. Department of Housing and Urban Development (HUD) awarded grants to 23 Continuums of Care, or CoCs, through its 2008 annual competition for McKinney-Vento homeless assistance funding. The legislation specified that the program was intended to serve families with “moderate barriers” to housing who could independently sustain housing, either subsidized or unsubsidized, at the end of the leasing subsidy that they received through RRHD.

HUD commissioned Abt Associates Inc. to conduct an evaluation of RRHD. The evaluation included site visits to all 23 communities to learn about their program models. The evaluation also tracked a cohort of families served in RRHD programs and attempted to conduct an interview with the family head approximately 12 months after program exit. The site visits and further work with the RRHD communities during the tracking process have produced in-depth information about the ways communities organize and implement their homeless services systems for families.

For more information about the study, contact Anne Fletcher at anne.l.fletcher@hud.gov or at 202-402-4347, or contact Brooke Spellman at brooke_spellman@abtassoc.com or at 301-634-1816.

Observations From the Intake Systems in the 23 Communities Implementing the Rapid Re-housing for Homeless Families Demonstration

The 23 RRHD awardees were required to operate a coordinated assessment system as a condition of their selection by HUD as a demonstration site. The communities were categorized by the research team into three groups: (1) those with centralized – or largely centralized – intake systems, (2) those with variations on centralized intake, and (3) those with decentralized intake systems that assessed whether the family should be accepted into the RRHD program itself but did not have the capability to refer or place families beyond their own program. Given the wide range of systems across the 23 communities, this classification system is not perfect, and few if any of the communities completely met the criteria presented in the previous section as characterizing a fully functional coordinated assessment system. However, results from the evaluation indicate that the sites that use a centralized intake approach (listed in exhibit 1) exhibit more of these characteristics than the others and, thus, appear to more effectively triage families with a housing crisis to appropriate assistance.

Exhibit 1. Rapid Re-housing for Homeless Families Demonstration: Sites With Centralized Intake Systems

1. Cincinnati, Ohio
2. Columbus, Ohio
3. Dayton, Ohio
4. District of Columbia
5. Kalamazoo/Portage, Michigan
6. Lancaster, Pennsylvania
7. Montgomery County, Maryland
8. San Francisco, California

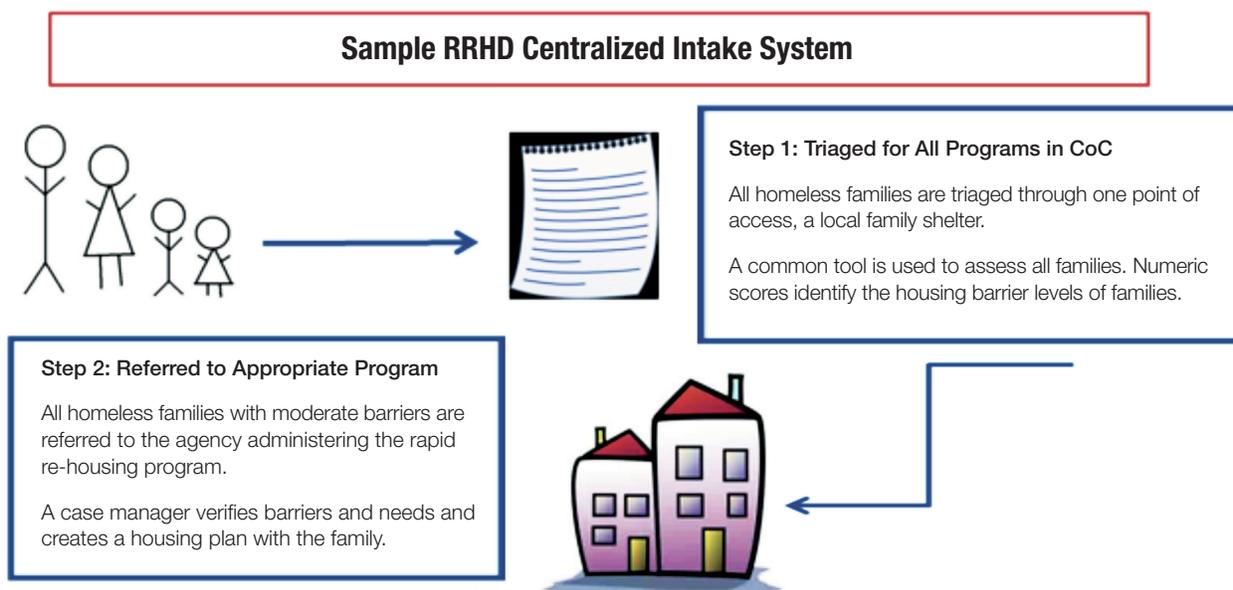
In most of the eight CoCs with well-defined centralized intake systems, the centralized system had been in place for a number of years. The RRHD programs usually were not administered by the agency responsible for centralized intake. Instead, families were referred to the rapid re-housing program after an assessment by the intake agency that determined that, among the range of homeless services options controlled by the intake agency, RRHD was the most appropriate. In a few communities, the same agency that was responsible for centralized intake also administered the RRHD program.

Those eight communities varied in the role that emergency shelters play regarding system intake. For example, in Cincinnati and Columbus, families for whom RRHD was found appropriate entered a shelter, and the RRHD services began immediately after shelter placement. In the District of Columbia and San Francisco, by contrast, the centralized intake agency made a decision between prevention services and shelter, depending on whether the family's housing crisis could be resolved without a shelter placement. After a family had entered shelter, the shelter conducted the assessment

that determined whether the rapid re-housing approach was appropriate for the family. In Cincinnati and Columbus, families were typically placed in permanent housing more quickly, likely because the process started sooner and emphasis was placed on permanent housing placement from the beginning.

Another variation among the communities with clear centralized intake was the degree of control that the centralized intake agency had over admission to the RRHD program. In some cases, the RRHD program was required to accept a family referred from centralized intake while, in others, the centralized intake agency made a referral to the RRHD program, and then the RRHD agency conducted its own assessment to determine whether the family should be admitted to the program. Centralized intake agencies with control over placement into programs were able to move families more quickly and with more certainty for families. Exhibit 2 illustrates how one RRHD community designed its centralized intake system. The design provided only one access point for families and relied on a common assessment tool to ensure that families were referred to the best possible resource in the community.

Exhibit 2. Rapid Re-housing Homeless Families Demonstration: Sample Centralized Intake System



CoC = Continuum of Care. RRHD = Rapid Re-housing for Homeless Families Demonstration.

Among the communities participating in the RRHD program that did not have centralized intake systems, many had some elements of centralized intake. For example, some had 2-1-1 telephone hotline systems that conducted light screening for eligibility and referral to homeless assistance programs (among other community resources.) Some communities did not have centralized intake but had common screening, intake, and assessment forms used by all programs providing services for homeless families or at least all rapid re-housing programs. These shared elements can be part of a coordinated assessment system, but they must be very well coordinated with universal protocols for referrals and decisionmaking, or these “decentralized” models will not deliver the consistent, effective placements that a strongly orchestrated centralized intake model can.

Developing Centralized Intake Takes Resources, Strategic Design, and Time

Given the potential for more effective and timely placements when using centralized intake, communities designing their coordinated assessment systems should strongly consider centralized intake or comparable means to achieve coordination and shared decision-making among homeless assistance providers. Whether using centralized intake or a different model of access, communities should aim to meet the criteria identified previously:

communitywide, systemwide, effective and fair, with the responsibility to conduct intake and assign resources.

Furthermore, communities should recognize that it takes time to design and implement a centralized intake or a strong, coordinated assessment system. Communities should consider moving in stages to build consensus among providers of services and to secure the resources needed to effectively adopt a centralized or strongly coordinated approach to triaging families with housing crises into appropriate services. Some of the communities from this study used the opportunity of RRHD – and of the Homelessness Prevention and Rapid Re-Housing Program, or HPRP, when it came along – to build an intake structure that encompasses a part of the community’s homeless services system. Seeing a centralized approach work for one aspect of homeless assistance may make it easier to convince providers who are not yet included in the system that it could work for them, too.

Through the interim rules of both the CoC Program and Emergency Solutions Grants (ESG) Program, HUD is requiring CoCs and ESG recipients to collaborate with each other to design a coordinated access system for their community. These new requirements are an opportunity for communities to consider how they can build on the experiences of RRHD grantees and to consider the recommendations in this brief on how to effectively design a system that will meet their local needs.