




Introduction to Coordinated Entry

EBGTZ Spring HIV Care
Continuum Meeting

4/24/26



Presenters:
Michael Drane &
Danielle Davidson

Alameda County Housing and Homelessness
Services

Home Together 2026 Community Plan

1 Prevent homelessness for our residents

1. Address racial disparities in mainstream/upstream systems to prevent racially disproportionate inflow into homelessness
2. Focus resources for prevention on people most likely to lose their homes
3. Rapidly resolve episodes of homelessness through Housing Problem Solving
4. Prevent racially disproportionate returns to homelessness



2 Connect people to shelter and needed resources

1. Expand access in key neighborhoods and continue improvements to Coordinated Entry
2. Lower programmatic barriers to crisis services such as prevention, problem solving, and shelter
3. Prevent discharge from mainstream systems to homelessness
4. Significantly increase the availability of shelter, especially non-congregate models, to serve vulnerable adults and families with children and to reduce unsheltered homelessness
5. Provide accessible behavioral health services to people with serious mental illness or substance use needs and who are unsheltered, in shelter, or in supportive housing programs



3 Increase housing solutions

1. Add units and subsidies for supportive housing, including new models for frail/older adults
2. Create dedicated affordable housing subsidies for people who do not need intensive services
3. Create shallow subsidies for those who can exit or avoid homelessness with more limited assistance
4. Add new slots of rapid rehousing for those who can pay full rent over time
5. Ensure new housing funding is distributed across the county according to need
6. Reduce entry barriers to housing and ensure racial equity in referrals and placements

4 Strengthen coordination, communication and capacity

1. Use data to improve outcomes and track racial equity impacts
2. Improve messaging and information availability
3. Build infrastructure to support and monitor new and expanded programs

Without addressing the impact of racism in our society, homelessness will continue to disproportionately impact African Americans and other people of color. Creating a mix of housing and services in order to reduce these enormous racial disparities is a major focus of this Plan.

Why is it critical to address the intersection of health and housing?

- The age-adjusted mortality rate for people experiencing homelessness in Alameda County in 2024 was 2,663 homeless deaths per 100,000, or **5.0 times that of the general population** of Alameda County. For many leading causes of death, mortality rates continue to be many times higher for people experiencing homelessness than the general population. **2024 Alameda County Homeless Mortality Report Executive Summary**
- “There is increasing evidence that you can prevent a lot of these deaths just by getting people housed.” **Dr. Margot Kushel, Director of the UCSF Action Research Center for Health and the UCSF Benioff Homelessness and Housing Initiative**

Homelessness in Alameda County

PRIMARY CAUSES OF HOMELESSNESS



TOP 4
RESPONSES *

Housing Loss Related	35.45%	Job Loss / Income Related	22%
Health Related Issues	18.1%	Household Loss / Breakup Related	18%

2024 SHELTERED / UNSHELTERED POP.	
67% UNSHELTERED	33% SHELTERED



Homelessness in Alameda County

SELF-REPORTED DISABILITY PREVALENCE

Current health conditions reported by survey respondents



60%

ANY DISABLING CONDITION



34.8%

SERIOUS MENTAL ILLNESS



32.5%

PHYSICAL DISABILITY



30.4%

CHRONIC HEALTH CONDITIONS



28.5%

SUBSTANCE USE DISORDER



17.4%

DEVELOPMENTAL DISABILITY

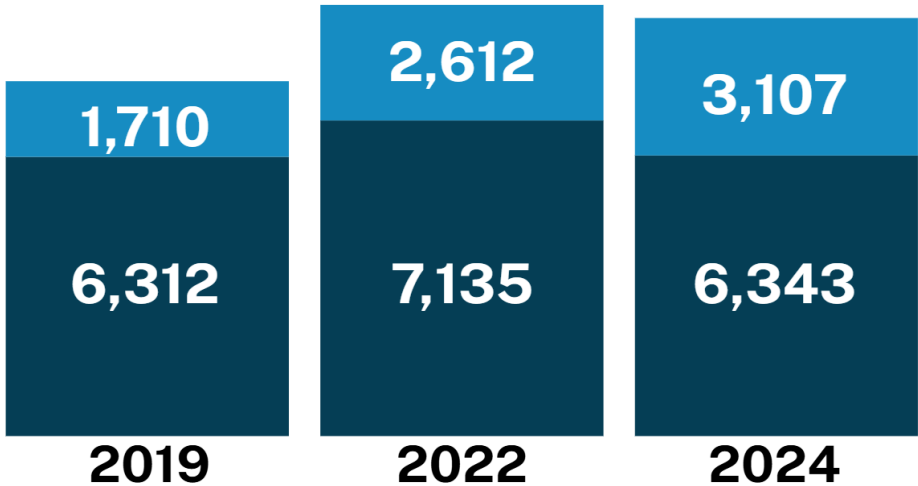


2.7%

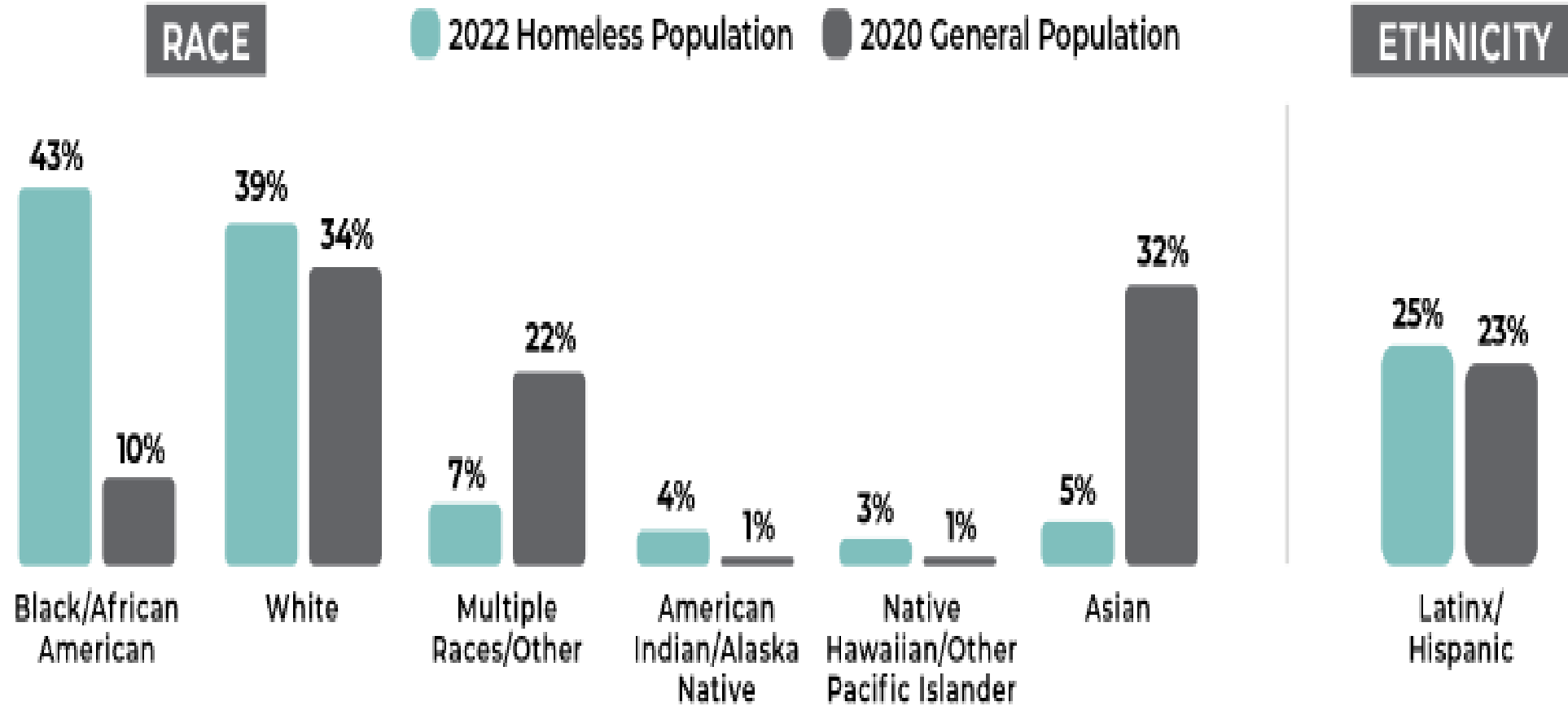
HIV / AIDS RELATED ILLNESS

CENSUS POPULATION: TREND

● Unsheltered ● Sheltered



RACE AND ETHNICITY COMPARED TO GENERAL POPULATION



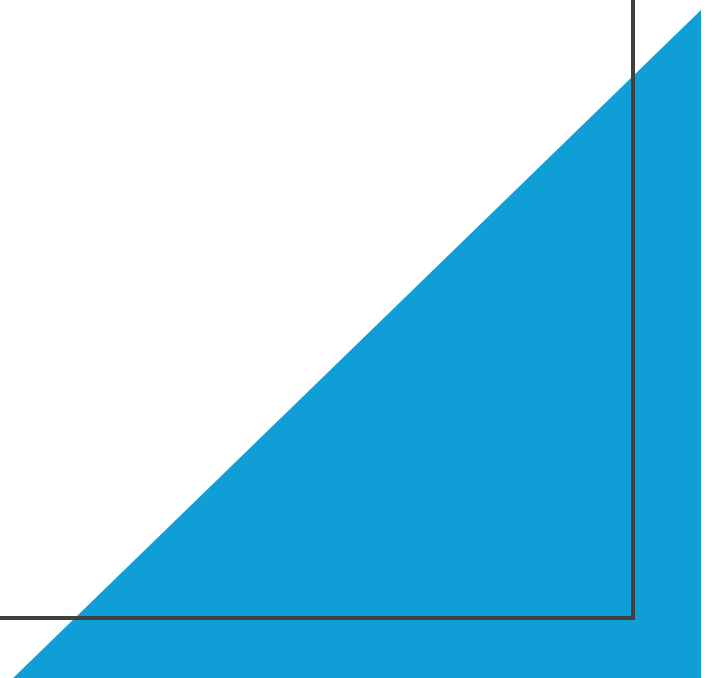
Source: Applied Survey Research, 2022, Alameda EveryOne Home Homeless Count & Survey, Watsonville, CA.

What is Coordinated Entry?

The Coordinated Entry process is an approach to coordination and management of the crisis response system's resources that allows users to make equity consistent decisions from available information to connect people efficiently and effectively to interventions that will end their homelessness.

AC Coordinated Entry components:

- Access
- Housing Problem Solving*
- Assessment
- Prioritization for available resources
- Referral/Matching to Housing/Homelessness Resources
- Grievances*



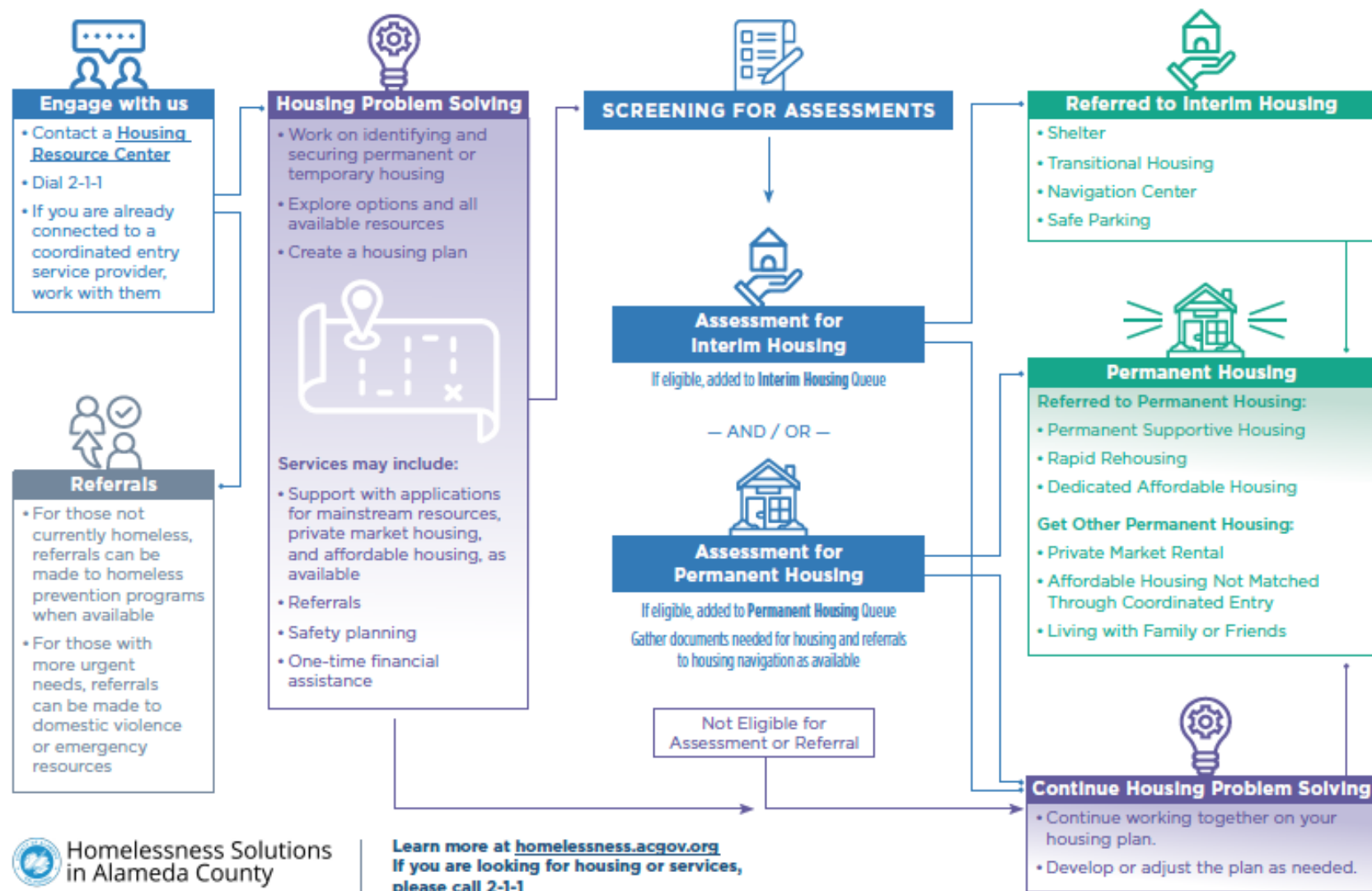
What Resources are Matched through Coordinated Entry?

- Matched through CE:
- Housing Navigation and Tenancy Sustaining Services (Housing Community Supports)
- Year Round Publicly Funded Shelter
- Some Navigation Centers
- Transitional Housing
- Rapid Rehousing
- Permanent Supportive Housing
- Dedicated Affordable Housing
- Shallow Subsidies
- Interim and Permanent Housing for Medically Frail Individuals*

- Not Matched through CE:
- Medical Respite
- Nightly, Seasonal and Privately-Funded Shelters
- Some Navigation Centers
- Skilled Nursing Facilities
- Board and Care Facilities
- Behavioral Health Care Facilities (substance use or mental health treatment)
- Shelters for Survivors of Domestic Violence, Gender-Based Violence, Intimate Partner Violence and Trafficking

FROM HOMELESSNESS TO HOUSING

Alameda County Coordinated Entry Workflow





Access

Access Points

- Housing Resource Centers (HRCs)
- 211 (Eden I&R)
- Emergency Shelters and navigation centers





Limited Access Points

What is a limited access point ?

An agency that can provide CES services to clients whom they have an existing relationship with

Housing Problem Solving



What is Housing Problem Solving?

Client Service Engagement and System Intervention

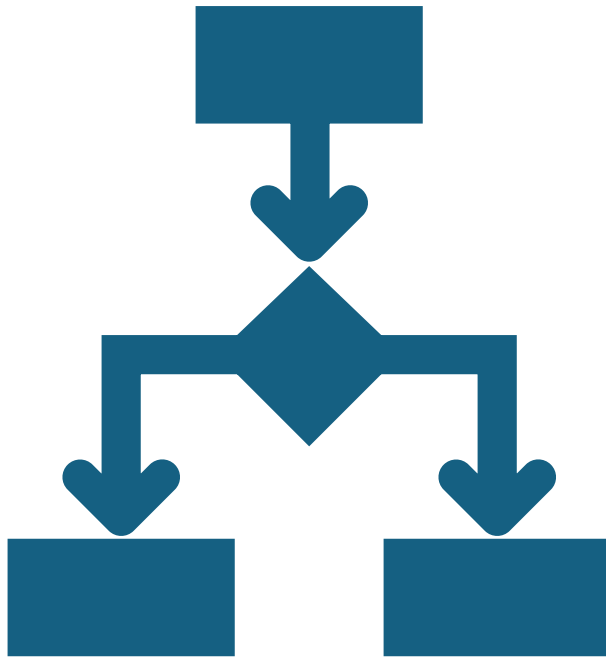
Client Service Engagement approach that is versatile

- Uses empowering Service Engagement to identify, explore possible options through creative, open, strengths- and resources-focused conversation and interaction.
- Determines options and possible client action to get safe viable housing solutions outside of the formal housing crisis response system asap and without need for ongoing support.

Intervention: Engagement targeted at various points systemwide to resolve different types of homelessness

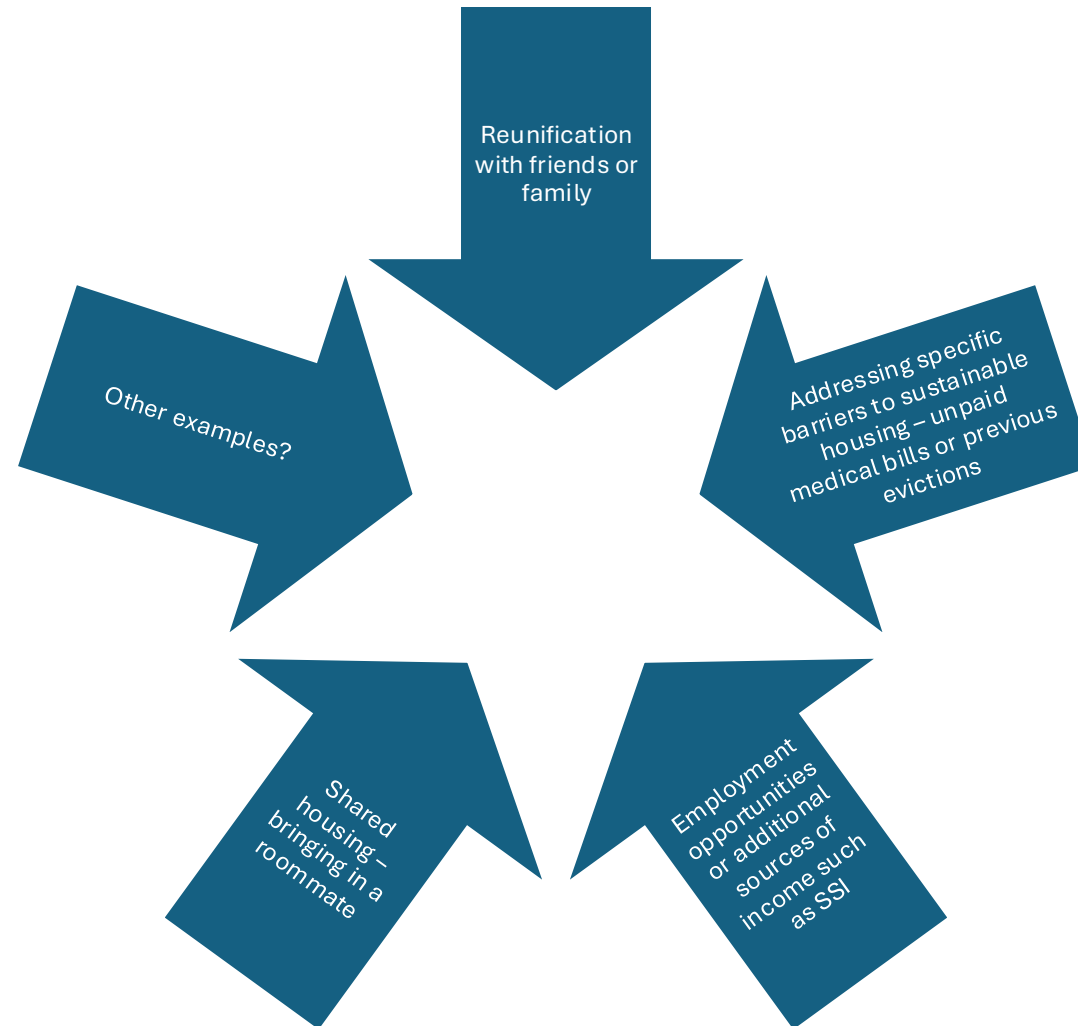
- | | | | | |
|-----------------------|---|-------------------|---|-----------------------|
| • Before Homelessness | → | Pre-System | → | Prevention |
| • Becoming Homeless | → | Front Door | → | Diversion |
| • Homeless | → | Already In-System | → | Rapid Exit/Resolution |

HOUSING PROBLEM SOLVING:



- Identify and explore possible options through creative, open, strengths- and resource-focused conversations
- Determine options and possible client actions to get safe, viable housing solutions outside the formal housing crisis response system, without need for ongoing support

What kinds of outcomes result from housing problem solving?





Assessment



Assessments and Queues

Interim housing

- Matched through **Crisis Queue**
 - Approximately 2,500 on Crisis Queue.
 - Only people interested in shelter and/or transitional housing receive a crisis assessment.
 - Matching is regional.
 - Focuses attention on highest-needs households in the queue.
- Wait times vary significantly based on prioritization and availability of interim housing in the region.
 - Wait time is Same Day to Unlikely to be Matched
 - People are given guidance about wait time based on assessment results.
- Not all shelter resources are matched through coordinated entry.

Permanent housing

- Matched through **Housing Queue**
 - Approximately 3,500 on Housing Queue. Pre-questions screen for eligibility to receive a housing needs assessment. Most (approx. 2,500) are in the PSH Pool.
 - Used to match to PSH, RRH, and DAH.
 - Those who score above the threshold score for the correct sub-population are added to the queue.
- People on the queue are likely to receive a match within 6-12 months.
- Focuses on households with the highest needs, vulnerabilities and housing barriers.
- Housing Assessment Prioritization Factors: Health, Housing Barriers, Duration of Homelessness and Chronic Homelessness, Age and Household Makeup & Safety

Prioritization



Crisis Assessment Prioritization Factors

The Crisis Assessment incorporates information from the participant profile and the Coordinated Entry enrollment, as well as additional questions for determining relative priority.

Questions associated with the following factors are used to establish a Crisis Assessment score:

Prior Living Situation and length of time homeless—longer durations and multiple episodes of homelessness, including chronic homelessness, are assigned more points.

Household Information – larger households, households with younger children, and heads of household under age 25 or over 55 are assigned more points than other households.

Combined household income – households with little or no income are assigned more points than higher income households.

Health – households in which one or more members of the household has a disability (including HIV/AIDS) or health condition are assigned more points than other households.

Housing Assessment Prioritization Factors

The Housing Assessment incorporates factors from the participant profile and the Coordinated Entry enrollment, the Crisis Assessment questions, if completed, as well as some additional questions.

Questions associated with these factors are used to establish a score:

- All Crisis Assessment questions including household size and ages, length of time homeless, disabilities (including HIV/AIDS) and health conditions

- Additional questions about health conditions and wellbeing – persons with higher use of health services and greater health and behavioral health care needs are assigned more points.

- Questions regarding housing history and housing barriers – persons with higher barriers to regaining housing on their own, including those with past housing loss and with criminal legal histories which may impact their ability to obtain housing are assigned more points.

- Questions regarding exposure to violence and risk of violence – persons who have experienced or are experiencing violence, exploitation, or other threats to personal safety are assigned more points.

Your Visit to the HRC

Alameda County Coordinated Entry Access Point Follow Up Template

Date: _____

_____ (agency) is an Access Point for the Alameda County coordinated entry process, which helps people experiencing homelessness get connected to certain types of services and housing. Today we (more than one may be checked):

- had a problem-solving conversation
- completed a crisis assessment (for shelter or transitional housing)
- completed a housing assessment
- Other: _____

Your Status within Coordinated Entry (more than one may be checked):

- Receiving Housing Problem Solving Services – you are working on identifying or securing permanent or temporary housing, including potentially receiving one-time support.
- Added to the prioritized list of people interested in shelter and/or transitional housing (Coordinated Entry Crisis Queue) – you will be contacted if and when a shelter bed or program has an opening you/your household is matched to, please make sure to keep your contact information updated with us at all times so we can reach you and make sure you check in at least once per month.
- Added to the list of people who are prioritized to be matched to a housing resource (Coordinated Entry Housing Queue) – you will be contacted if a participating housing program has an opening you/your household is matched to, most likely within the next 180 days if you have all the core documents and are open to various living situations and locations. Please provide a copy of the documents you have (such as identifying documents) to us at the access point. We can tell you which documents you need based on what you are likely to be matched to. Please keep your contact information updated with us at all times so we can reach you and make sure to check in at least once per month.
- Confirmed Contact Information – we confirmed your contact information and the contact information for others supporting you or who may be able to help us reach you.
- Provided referrals to other community-based programs or completed applications for other housing and services.

Not everyone who completes an assessment is eligible for the current resources available. If we were not able to add you to the queue we can still assist you with problem solving, short-term support and applying for other types of housing. If things change we can reassess in the future.

Please stay in touch with us and follow up with us using the below information:

Phone Number: _____ Drop in Days & Hours: _____

Drop in Location: _____

Name of Staff Member You Met With: _____

Next Steps (often includes obtaining identification or other documents):

- 1) _____
- 2) _____
- 3) _____

Future Appointment Information (if applicable):

Date and Time: _____ Location: _____



Referral/Matching to Housing

Crisis Queue Matching

Resources matched off the crisis queue:



Shelter bed




BHBH Housing



Transitional Housing

Housing Needs Assessment Matching

Resources matched off the housing queue:



Dedicated
Affordable

PSH

RRH

Permanente Supportive Housing (PSH)



Permanent Housing Referral Process:

Permanent Supportive Housing (PSH) &
Dedicated Affordable Housing (DAH)

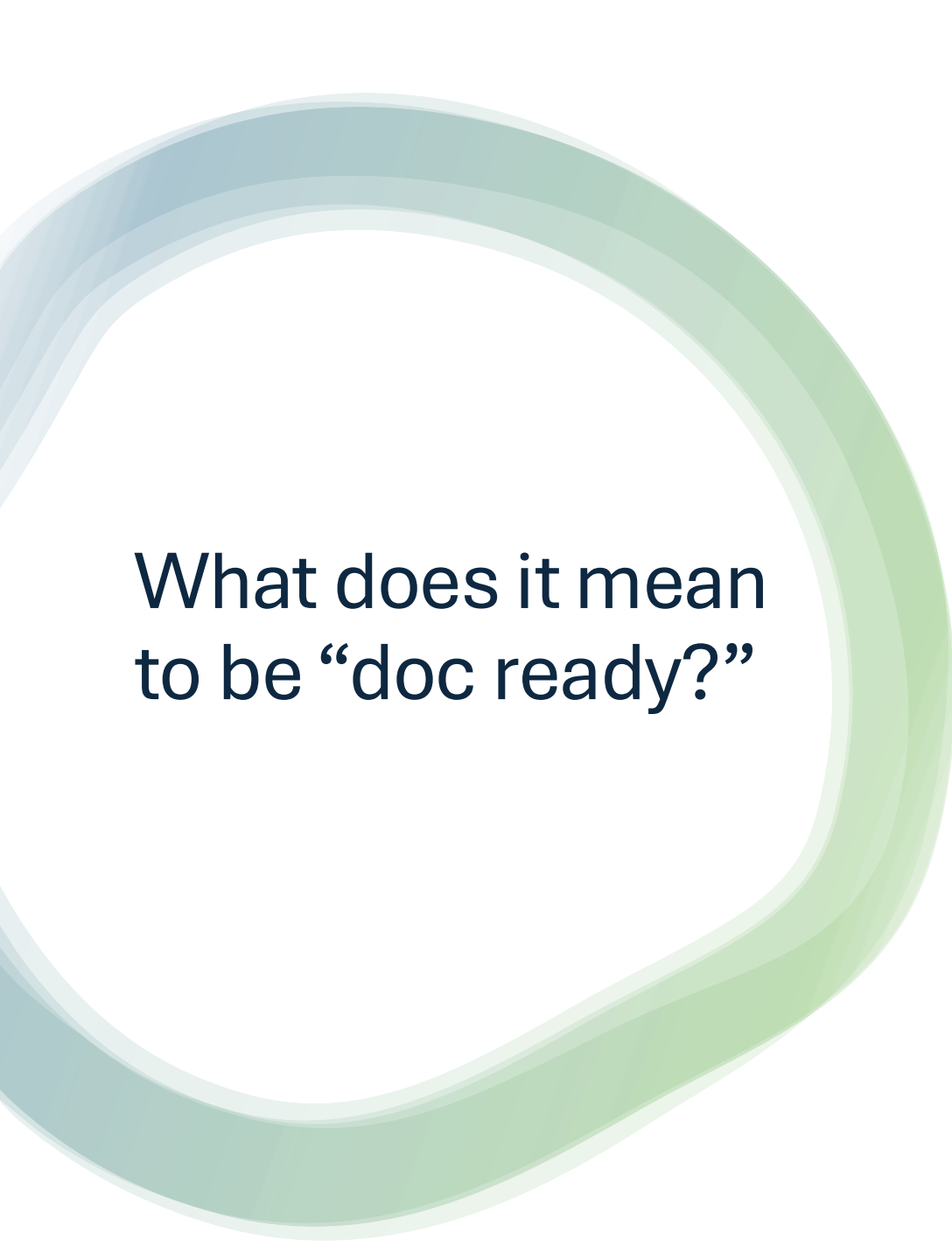


Permanent Housing Queue

- The Housing Queue is used to match individuals experiencing homelessness to Permanent Supportive Housing (PSH) and other permanent housing opportunities.
- At this time, permanent resources other than PSH are limited.
- PSH focuses on households with the highest needs, vulnerabilities, and housing barriers on the Housing Queue.
- Households with a Housing Needs Assessment score at/above threshold are added to Housing Queue.

Permanent housing type overview

Dedicated Affordable Housing (DAH)	Permanent Supporting Housing (PSH)
<p>Permanent housing resources matched through the Coordinated Entry System for households actively on the Permanent Housing Queue</p>	
<ul style="list-style-type: none">• Typically has less robust service model• HNA score below 80 for single adults, below 90 for households with minors• Few DAH resources available in CE inventory	<ul style="list-style-type: none">• Often includes ongoing supportive services• HNA score 80+ for single adults, 90+ for households with minors (PSH Pool)• Vast majority of CE inventory is PSH



What does it mean
to be “doc ready?”

Document Readiness: Four Core Documents

1. Color copy of Government Issued Photo ID
2. Color copy of Social Security Card (signed) or SSN Verification from SSA (Social Services Agency)
3. Disability Verification

For Medical Conditions: DO (Doctor of Osteopathic Medicine), MD (Medical Doctor), NP (Nurse Practitioner), PA (Physician Assistant)

For Mental Health & Substance Use Conditions: Any listed above AND PsyD/ PhD (Psychologist), LCSW (Licensed Clinical Social Worker), MFT/LMFT (Marriage and Family Therapist), LPCC (Licensed Professional Clinical Counselor)

4. Verification of Literal Homelessness

What is Gender-Based Violence Coordinated Entry?

People who are fleeing gender-based violence (GBV), seeking to flee and survivors of gender-based violence (collectively “survivors”) who experience homelessness have a right to access housing resources allocated through the Coordinated Entry System in Alameda County.

Survivors can be served at any HRC or any gender-based violence access points. Access points have staff with trauma-informed training and specific resources.

Building futures

(866) 292-9688

(A-WAY-OUT)

www.bfwc.org

dvhousingteam@bfwc.org

Family Violence Law Center

470 27th Street, Oakland, CA 94612

(510) 208-0220

www.fvlc.org info@fvlc.org

Monday-Friday 9:00 a.m. to 5:00 p.m.

SAVE (Safe Alternatives To Violence Environments)

3155 Kearney Street, Suite 220, Fremont, CA 94538

(510) 794-6055

www.save-dv.org

info@save-dv.org

Monday-Friday 9:00 a.m. to 5:00 p.m.

Medically supported housing program

During the COVID-19 pandemic, **a need was identified for unhoused people with very complex medical conditions**, some of whom are not prioritized for housing through the current housing assessment and some of whom need more medical support than offered in traditional permanent supportive housing. In response to this need:

1. **Medically frail housing was developed.** This is permanent and interim housing with additional on-site services (nursing and personal care as needed) that allow members to live independently.
2. The CoC System Coordination Committee approved a Medically Frail prioritization policy that **prioritizes unhoused people with complex medical conditions for designated “medically frail” housing.**
3. This referral system is part of the coordinated entry system and runs in parallel with other resources prioritized through the housing assessment.

Who is this Housing Designed For?

Individuals with Significant Functional Limitation, including those with:

- ✓ Limited ability to complete Activities of Daily Living (ADLs) independently.
 - ADLs are defined as walking, feeding oneself, dressing and grooming, toileting, bathing, or transferring (from chair to bed).
- ✓ Rely on assistive devices including a walker or wheelchair or are bedbound by illness or disability.
- ✓ Severe mental illness (complicated by or complicating other medical conditions), traumatic brain injury or other cognitive disability




Regional Housing Meeting

Regional Housing Meetings

take place on a monthly basis and are divided into two sessions.

- **First Session (45 minutes):** Open to everyone. This portion includes countywide announcements and short educational presentations on various topics.
- **Second Session:** Restricted to participants who have completed the HMIS privacy and security training and have been cleared by the county liaison team. In this portion, we review and discuss client matches from the past 30 days.



How do you talk
about housing with
your patients?

Language

- Easy to understand, acronym/jargon-free

Concepts

- Clearly explain the CE system and requirements
- Casting a wide net is a good strategy
- The system honors client preference; you can always decline a match without penalty
- Values-based exploration of housing options

Clinical strategies

- Open ended questions
- Being realistic while also holding hope/supportive future planning
- Motivational interviewing strategies

Tips for talking about Coordinated Entry

Describe the system:

CE **allocates** housing resources but doesn't own or control them

The more options you consider, the higher likelihood of getting a match

The system respects client choice and doesn't penalize individuals for declining housing options

This is the one pathway to getting short or long-term housing within the county matching system

Describe the process:

"A housing assessment involves asking a lot of questions. Some of them are personal and I'd like to encourage you to answer honestly because there are housing resources set aside for people with certain vulnerabilities. How does that sound to you?"

If you do have a disability, it may make you eligible for certain housing options

Define what it means to have a disability (emotional, physical, intellectual)

Answer the questions based on your hardest/worst/most difficult day



Questions

Glossary

- CE – Coordinated Entry
- HRC – Housing Resource Center
- HMIS – Homeless Management Information System
- PSH – Permanent Supportive Housing
- RRH – Rapid Rehousing
- DAH – Dedicated Affordable Housing
- Crisis Queue – Matches people to shelter
- Housing Queue – Matches people to permanent housing



SAMPLE CASE STUDY

CE Case Study: John

- Medical staff are providing services to John, a homeless individual currently residing in an area scheduled for abatement in the next week. John is 64 years-old and has mobility challenges. He lives in his tent with a small dog and has difficulty entering and exiting the tent. He is HIV positive and struggles to manage his diabetes. During a visit at his primary care clinic, John shares that he has been living in this encampment for nearly two years.
- John went on to say that nine years ago, he left his job as a bank teller to care for his mother, who was dying of cancer. Shortly after her death, he was evicted due to nonpayment of rent. John says that he's developed strong connections to some of the other residents and it would be stressful to be separated from them, but that he is interested in learning more about shelter and housing resources.



What is your first step in helping John connect to housing services?

1

1) Call 211 on speaker for immediate help

2

2) Tell him that housing options are limited and give him emergency shelter information

3

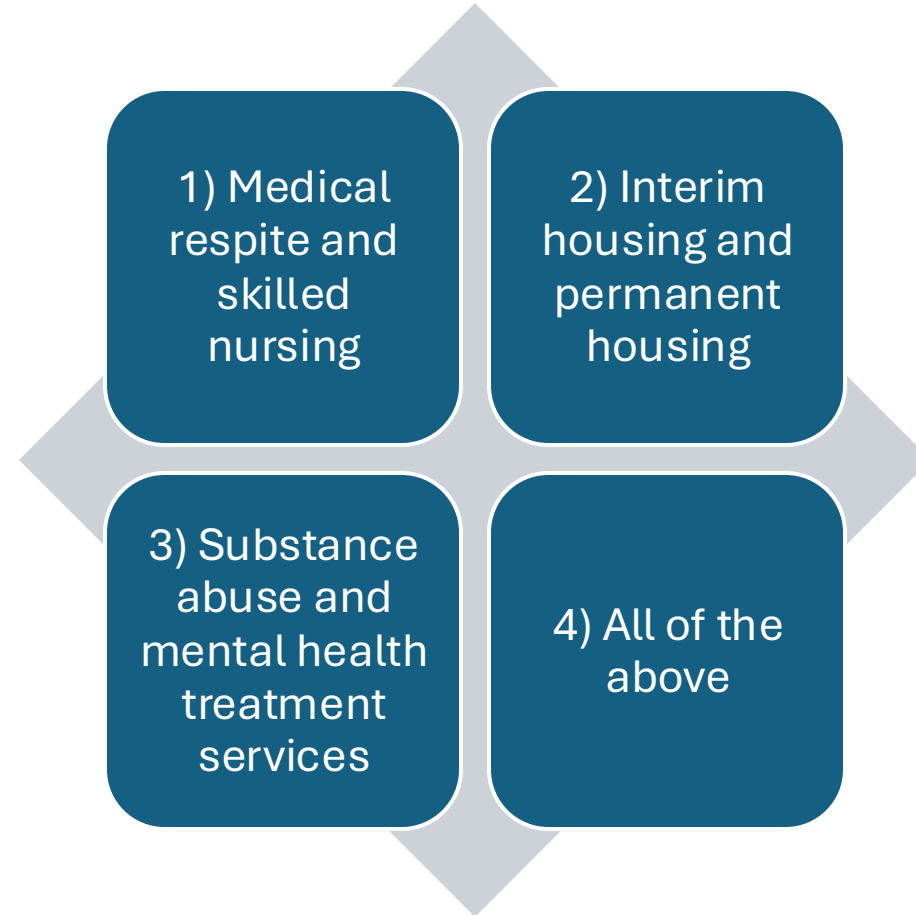
3) Locate the nearest Housing Resource Center (HRC), and provide as much logistical support as possible for John to attend drop-in hours

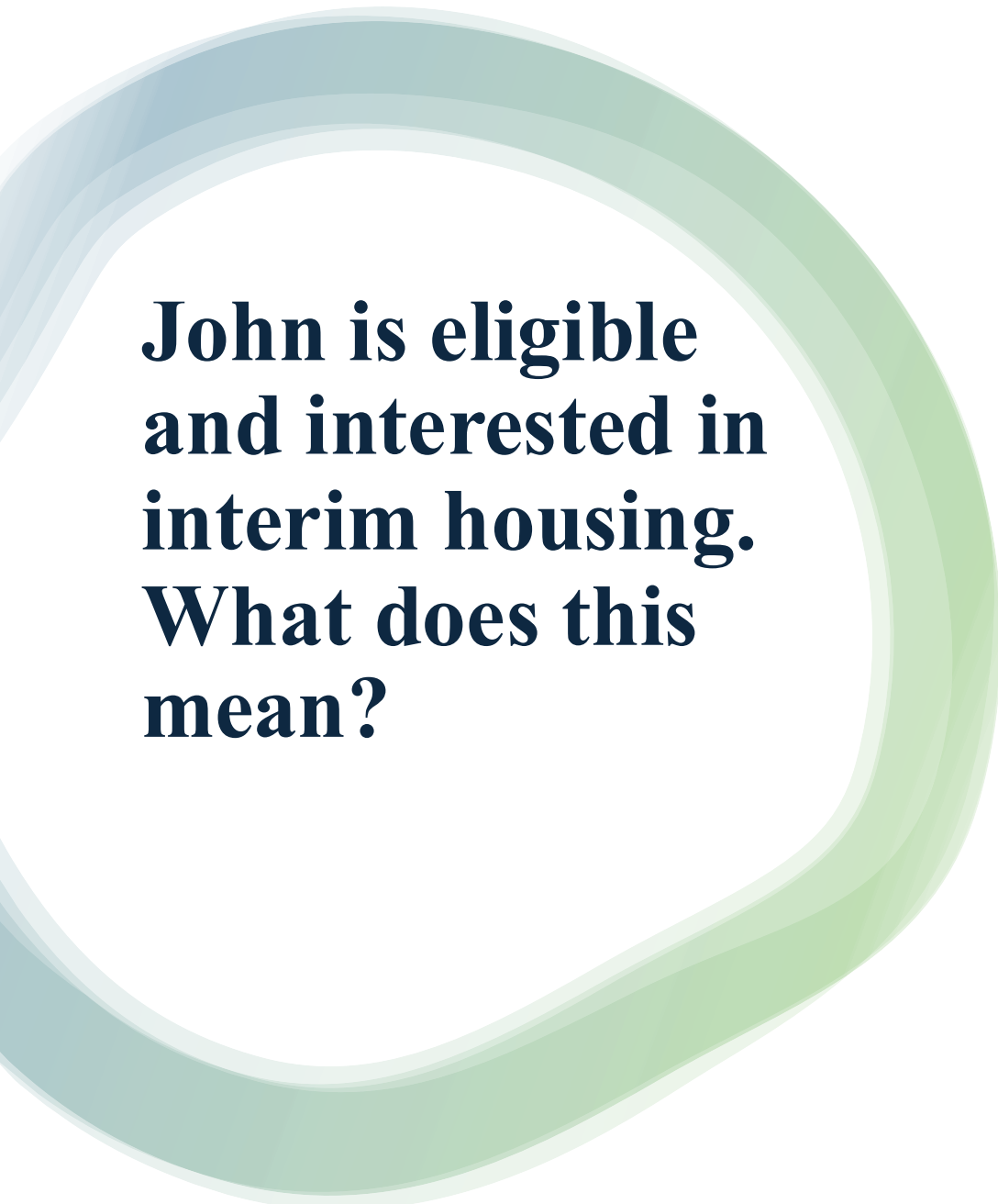
Before connecting John to the Housing Resource Center (HRC), what can you say to help prepare him for the experience?

- 1) The first step is to gather all of your documents (ID, SS card, benefits letters, other proof of income)
- 2) The first thing you'll do with a staff member is complete a housing problem-solving session to identify options and create a housing plan
- 3) As long as you make it to the appointment with your ID, you'll likely get a housing option today or tomorrow



During the housing problem-solving session, John will be screened for which types of assessments?





**John is eligible
and interested in
interim housing.
What does this
mean?**

- 1) The staff member he is working with will review the various types of housing options he is eligible to get within the next six months
- 2) He will receive a crisis assessment and, based on his acuity score, will be added to the Interim Housing Queue
- 3) He is likely to be matched to a shelter, transitional housing, navigation center or safe parking site within a week
- 4) All of the above

While John is on the permanent housing queue, what support can his provider offer to maximize his chances of getting housing?

- 1) Assist him to gather all required documents
- 2) With an ROI, maintain contact and coordination with staff at the HRC or with community providers that have HMIS access to keep updated about housing matches
- 3) Continuing talking about clinical issues related to housing
- 4) All of the above

Good news! John has a PSH housing match. How long does he have to confirm that he's interested?

- 1) 3 business days
- 2) 5 business days
- 3) 7 business days

Contact Us

Home Stretch general email: Stretchhomestretch@acgov.org

Ask us about: questions related to matching/referral to housing through CE

Housing & Homelessness Services : CoordinatedEntry@acgov.org

Ask us about: any other CE related questions (ex. access points/HRCs, general CE workflow, assessments/queues, etc.)

Coordinated Entry Manager

Anna Fellers Anna.Fellers@acgov.org

Housing Resource Center

<https://docs.google.com/document/d/1U6d4KIXAFMMF8E2H-VAi3gpLy71L3Tvm/edit>

Ask us about: Flex funds, housing problem solving, crisis/housing assessment

Health Care for the Homeless:

Danielle Davidson - Danielle.Davidson@acgov.org

Ask us about: Being added to the Regional Housing Meeting invitation list, regional questions, Medically Frail Housing questions

Michael Drane

Coordinated Entry Contracts and Compliance Manager

MDrane@acgov.org

Danielle Driver-Bellino

Gender-Based Violence Program Manager – Danielle..driver-bellino2@acgov.org

Medically Frail Housing

<https://health.alamedacountyca.gov/program/medically-frail-housing/>



Thank you