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The Impact of Coordinated Entry Implementation on Social Service Providers in the Lehigh Valley

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Abstract

The Coordinated Entry System (CES), a recent addition to the United States Housing and Urban Development's (HUD) Housing First model, aims to prioritize the delivery of support services to individuals experiencing homelessness according to their level of need. To standardize system implementation, HUD requires social service providers to fully comply with CES assessment, database, and participant prioritization components they provide. Providers that fail to do so are ineligible for certain federal operations funding. To examine the impact of these compliance requirements on the broader operational and financial vitality of social service providers in Pennsylvania's Lehigh Valley, this mixed methods study gathered data through in-person exploratory interviews with executive leadership of these providers and close-ended employee questionnaires. Results suggest that the Coordinated Entry System could be enhanced by both regional investments in related technology and user education as well as federal policy modifications.

Keywords: Coordinated Entry, homelessness, Housing First

1. Introduction

The federal response to chronic homelessness, a social challenge that has plagued the United States in its current form since the 1980s, relies on an underlying housing model known as Housing First. This model establishes a housing placement structure wherein social service providers grant homeless individuals housing without requiring their completion of any prerequisite self-improvement programs and has been verified of its effectiveness in various studies. To implement Housing First nationwide, HUD recently required local social service providers to participate in regional Coordinated Entry Systems, which pool participating providers' program vacancies and prioritizes those services for the most vulnerable homeless individuals. To incentivize their participation in Coordinated Entry, HUD requires that social service providers exclusively draw from its Community Queue to fill vacancies in order to receive crucial grant funding. Those providers that opt out of Coordinated Entry avoid these compliance requirements but also forego HUD funding.

Through prior experience with the Lehigh Valley service providers and preliminary literature review, issues with the Coordinated Entry became apparent. A common complaint observed among Lehigh Valley social service providers is the narrow lens through which Coordinated Entry forces their strategy to be examined and executed. This study aimed to document these concerns, explore their bases, and recommend system adaptations or responses where appropriate. It was postulated that while system participants more efficiently receive assistance under Coordinated Entry, Lehigh Valley social service providers' overall strength, as represented by broader measures of operational sustainability and financial vitality, are hindered by Coordinated Entry and federal mandates of its use for funding eligibility.

Data gathered through exploratory interviews with providers' executive leadership and close-ended questionnaires to employees under this mixed methods study elucidated Coordinated Entry's strengths and weaknesses and also revealed other factors behind certain system criticisms. Among other opportunities for improvement, these results suggest that Coordinated Entry could benefit from regional measures, such as investments in centralized personnel, technology and user education, as well as federal policy modifications that better connect neighboring regions and allow providers more flexibility.

2. Background

2.1 Understanding and Defining Chronic Homelessness

Chronic homelessness in the United States is defined by HUD as individuals' residence in "a place not meant for human habitation, a safe haven or in an emergency shelter, and [being] homeless and residing in such place for at least one year or on at least four separate occasions in the last three years." This chronic social problem has drawn the attention of government and social services since the 1980s.[1] Prior to this period, most American housing markets offered ample affordable rental or purchase opportunities to low-income and otherwise disadvantaged populations (excluding periods of cyclical economic downturn and the effects of discrimination among lenders).[2] The chronically homeless population experienced continual growth beginning in the 1980s due to a series of factors, including the depletion of affordable housing opportunities, divergent trends in the declining rate of wage growth and increasing cost of living, and the rollback of government-run psychiatric programs. This period of increasing chronic homelessness continued until 2007, at which point nationwide levels of homelessness began to drop at a thereafter increasing rate.[3]

2.2 Models Used to Combat Chronic Homelessness

Entities on every governmental level have used different policies and programs to address chronic homelessness. Through the 1980s and early 1990s, the chief response to chronic homelessness was to manage affected populations under a "sequential" model, which marshalled homeless individuals through a series of self-improvement steps.[4] Ranging from sobriety to mental health treatment, program architects designed these steps for successive completion as supposedly necessary prerequisites for housing, which only became available to participants upon completion of the sequence.[5] This model of treatment quickly came under fire as lasting reductions in the chronically homeless population failed to materialize.[6]

In response to these program failures, a new model for reducing chronic homelessness, coined "Housing First," was developed as part of New York City's Pathways to Housing program in 1992.[7] Based on a fundamental premise that housing is an inherent right and should not be tied to sobriety and similar factors, Pathways to Housing saw tremendous success in achieving long-term housing security for chronically homeless individuals; 88% of program participants remaining in housing five years after entry into the program (compared to only 47% observed under the municipally-operated continuum of care).[8] This outcome divorced the traditional coupling of subjects' mental health from their ability to maintain independent housing. Further studies have confirmed this decoupling; in one study, 84% of subjects with serious mental illness retained their housing after one year in a Housing First program, half of whom spent every night of that period in their original residential unit.[9]

Decades from its initial application in the United States in 1992, Housing First is widely used to match chronically homeless individuals with housing solutions. Multiple studies find that Housing First reduces homelessness, extends newly housed individuals' respites from homelessness and decreases use of government-funded emergency care (hospitals, shelters, prisons, etc.).[10] Although no significant correlation has been observed between immediate housing provision and long-term clinical mental health outcomes, Housing First also remains uncorrelated with *regressions* in mental health, indicating the model lacks outcome-based downsides.[11]

2.3 Creation and Implementation of Coordinated Entry

To further streamline the practical application of the Housing First model in the United States, federal legislative and executive efforts established universal requirements for Coordinated Entry Systems across the country. The tandem passage of the 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (an amendment and reauthorization of the 1987 McKinney-Vento Homeless Assistance Act) and the 2010 release of the

Obama Administration's *Opening Doors* plan established statutory guidelines for these systems.[12] Operated by local social service providers across the country, these systems were created to funnel all individuals that report imminent or present homelessness into regional Community Queues. Each social service provider in a particular region then draws system participants from this queue in order of vulnerability, measured according to standard criteria, to fill program vacancies. More recently, one study identified Coordinated Entry as a primary pathway to improved rehousing of vulnerable youth due to the unique social and emotional challenges associated with underage populations. This basis of need for youth populations mirrors that of mentally ill populations, both of which represent a substantial portion of Housing First participants.[13]

To universalize this model nationwide, HUD subsequently required social service providers to participate in Coordinated Entry to become eligible for its Continuum of Care and Emergency Solutions grants. These grants form the backbone of many social service providers' funding streams. Although all social service providers are encouraged by HUD to utilize the model's resources, only those that pledge and report full compliance with it are eligible for the aforementioned funding grants from HUD. Relevant US Code now states :

> "A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool."
> "The [funding] recipient and its subrecipients must establish and maintain standard operating procedures for ensuring that Continuum of Care program funds are used in accordance with the requirements of this part and must establish and maintain sufficient records to enable HUD to determine whether the recipient and its subrecipients are meeting the requirements of this part"
> "In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services."[14]

The 2015 Federal Strategic Plan to Prevent and End Homelessness reflects this regulatory shift in Objective 10, arguing that "Coordinated entry is an important process through which people experiencing or at risk of experiencing homelessness can access the crisis response system in a streamlined way...Standardized assessment tools and practices used within local coordinated assessment processes take into account the unique needs of children and their families as well as youth...The most intensive interventions are prioritized for those with the highest needs".[15]

In actual implementation, the Coordinated Entry centers around use of the VI-SPDAT, a short questionnaire designed for use by all social service providers, walk-up sites and telecommunications hotlines to assess the vulnerability level of each self-reporting homeless individual. Individuals assessed using this questionnaire then join a centralized list managed through the Homeless Management Information System (HMIS) and accessible to all social service providers. This list ranks homeless individuals by level of vulnerability and directs providers to fill program availability and housing vacancies with the highest-ranking individuals first. Through multivariable regression-based evaluation, this method of prioritization has been shown to effectively prioritize the most vulnerable individuals.[16]

Although met with initial optimism because of its anticipated benefits, little third-party research on Coordinated Entry's broad effectiveness is available. The lack of external review regarding Coordinated Entry's fulfillment of its primary objectives is further shadowed by a lack of study on how Coordinated Entry impacts social service providers compelled to implement it. Relevant concerns expressed by other studies consider overreliance on data collection to assess the progress of homeless mitigation without consideration of the qualitative, "human" element inextricably linked to social services.[17] Similarly, some studies argue that the cost-benefit analysis used to justify the establishment of Coordinated Entry across the United States may ignore many of the non-quantifiable aspects of measuring success in the social services sector.[18] In his assessment of the broader nonprofit sector's vitality and efficacy, Lester Salomon argues that it consistently faces the challenge of *philanthropic particularism*, defined as the "tendency of nonprofits to target certain subgroups" instead of considering the success of their holistic social mission.[19]

2.4 Coordinated Entry in the Lehigh Valley

Coordinated Entry sees active participation among the Lehigh Valley's social service providers, largely embodying the national model with certain regional adaptations. Connect to Home, an overarching coalition broken into five distinct conglomerations of adjoining counties, organizes and administers Coordinated Entry in eastern Pennsylvania. Each subregion maintains a Regional Homelessness Advisory Board that secures and disburses HUD Continuum of Care and Emergency Solutions grant funding. These subregions share access to a Lancaster-based call center, each provided with one dedicated staffer reachable by calling 211, the region's Coordinated Entry hotline. Upon calling

211, call center staff evaluate eastern Pennsylvania residents self-reporting homelessness by administering the national VI-SPDAT, modified slightly to include four additional questions authored by Connect to Home. According to an individual's responses, weighted according to criteria excluded from this study to preserve the questionnaire's confidentiality-dependent effectiveness, he/she is assigned a ranking on his/her region's HMIS. Participating agencies with vacancies then intake additional participants according to order of priority as ranked in the HMIS, moving through the list until a prospective participant whose circumstances are responsive to the agency's vacancy requirements is reached successfully and accepts the available capacity.[20]

In the Lehigh Valley, at least five social service providers opt to fully participate in Connect to Home's Coordinated Entry System and receive HUD funding accordingly, while at least four opt out of full compliance with these standards and forego related funding. The study proposed herein explores the basis for this schism in organizational strategy by examining users' perceptions of how Coordinated Entry impacts social service providers' broader vitality.

3. Methods

The purpose of this study was to examine the ongoing health of social service providers in the Lehigh Valley as measured by leadership and employee perceptions of organizational effectiveness, staff morale, mission alignment, and financial stability. This study differs from other studies of Housing First and Coordinated Entry in its orientation; rather than focusing on the housing outcomes of providers' service recipients through Coordinated Entry, this study closely examines how Coordinated Entry requirements and application has affected the broader strength of providers themselves. This study uses the Lehigh Valley as a case study to ascertain policy implications for Coordinated Entry nationwide.

To assess the relationship of the Lehigh Valley service providers with Coordinated Entry, three guiding research questions frame this study:

1. What are organizational leadership and employee perceptions of Coordinated Entry's impact on multi-agency efforts to combat regional homelessness overall?
2. What are organizational leadership and employee perceptions of Coordinated Entry's impact on their social service provider's effectiveness and institutional stability?
3. What are organizational leadership and employee perceptions of Coordinated Entry's impact on their personal ability to excel in their respective roles?

This study used a mixed methods process in order to obtain strong qualitative and quantitative data responsive to these questions. The data was collected simultaneously through surveys and interviews from July, 2019 through March, 2020 and ultimately synthesized for macro-level comparison.

First, this study engaged lead agency directors, organizers and managers of relevant social service providers in live exploratory interviews regarding their administration of Coordinated Entry in the Lehigh Valley. Depending on availability, some interviews occurred in person, while others took place via phone. The interviewer asked all interviewees identical open-ended questions with inquiry variation limited to direct follow-up and statement clarifications. The interviewer recorded and later transcribed in-person interviews verbatim, while phone interviews allowed for live transcription. These, in addition to their review for qualitative consideration, were also coded for recurring positive and negative themes according to a defined code dictionary. The recurrence of these themes across interviews were tabulated and averaged for overall frequency and average repetition per interview in which they were mentioned.

Second, available employees and/or volunteer service administrators of subject providers completed a close-ended digital questionnaire through Qualtrics to generate quantitative information about their perceptions of Coordinated Entry's impact on organization health and effectiveness. This questionnaire primarily used a Likert scale to assess agreement levels with statements regarding Coordinated Entry overall and its Lehigh Valley-specific subcomponents (the 211 system, VI-SPDAT and Community Queue). The resulting responses were tabulated to produce comparative absolute values and translated to numerical representation for correlational analysis.

The respondents in this study were professional staff members of providers, and the research methods were intended to illuminate benefits or challenges that Coordinated Entry brings to their service delivery. Because the providers' participant population was not directly surveyed, it was outside the scope of this policy evaluation to address or adjust for specific social determinants and demographics of that population.

4. Results

Of the 11 social service providers identified in the Lehigh Valley, seven of their respective executive directors (or leaders with synonymous titles), as well as the region's Coordinated Entry Regional Manager, participated in live exploratory interviews. The close-ended digital questionnaire secured 24 responses across six distinct social service providers.

Across all nine interview samples (treating open-ended survey answers as one collective "interview"), the most common positive sentiment regarding Coordinated Entry focused on its efficiency and effectiveness in delivering services to participants (referenced 22 times by 78% of interviewees), closely followed by support for its equitable nature (referenced 18 times by 56% of interviewees) and its unification of interagency coalition strategy (referenced 12 times by 78% of interviewees).

Conversely, the most common negative sentiment described by interviewees was the perception of unresponsiveness around the "waiting list" (Community Queue) and the 211 system overall (referenced 28 times by 67% of interviewees), followed distantly by unavailable resources to manage additional caseload created by Coordinated Entry (referenced 12 times by 56% of interviewees) and Coordinated Entry's technological inaccessibility to its users (referenced 11 times by 67% of interviewees). Users' belief in the need to breach the constraints of Coordinated Entry to serve desperate individuals was also a recurring theme (referenced 8 times, but by 78% of interviewees), and one interviewee repeatedly complained of the cost to access HMIS (three times in one interview).

Of survey respondents, approximately 55% of whom report "occasional" or less interaction with CES and 45% report engagement with it on a "regular basis" or "heavily," the vast majority report strong understanding and support for the broad objectives of Coordinated Entry. Respondents are symmetrically split across levels of agreement on whether Coordinated Entry enhances their organizations' strategic and operational effectiveness while skewed towards disenjoyment of utilizing Coordinated Entry.

Regarding the 211 system specifically, most respondents report a strong understanding of its objectives while skewed slightly towards disagreement that it is effective for its own purposes and slightly towards agreement that it is effective for their providers' purposes. This distribution is almost entirely mirrored by responses to identical questions regarding the VI-SPDAT. In both cases, the most popular response to effectiveness-related prompts was that of neither agreement nor disagreement.

Respondents report similar views of understanding and impact on organizational effectiveness regarding the Community Queue, but are sharply split over its standalone effectiveness, with a pseudo-equivalent number of respondents in agreement or disagreement and only one choosing neither. Most respondents express agreement that Coordinated Entry requires an appropriate and manageable amount of financial, staffing and technological resources to administer, although this distribution exhibits a notable tail of respondents in strong disagreement.

As for personal performance, respondents overwhelmingly disagree that Coordinated Entry hampers their personal growth and skew towards agreeing that it improves their ability to do so. However, respondents are evenly split over whether the Community Queue specifically discourages their work ethic.

5. Analysis

To identify response patterns that could illuminate rationale for respondents' viewpoints, this study converted survey data into numeric form through Qualtrics, with a one-to-five scale representing a low-to-high range of disagreement to agreement with each Likert-framed statement. IBM's SPSS Statistics program then correlated all data-yielding questions against one another, flagging apparent response relationships with correlation confidence levels of 99%. Of these, certain correlational relationships are excluded from the following analysis due to coincidental insignificance or obvious redundancy (i.e. respondent agreement with statement X is inversely correlated with respondent disagreement with statement X), and no correlations discussed have confidence levels of less than 99%.

First and foremost, flagged correlations indicate that respondents in support of the Coordinated Entry's overall objectives generally believe that Coordinated Entry enhances their provider's strategic and operational effectiveness, that it both supports and productively expands upon their provider's mission, and that it inspires them to work harder in their roles at Pearson correlations of 0.768, 0.789, and 0.730, respectively. Respondents' agreement with the overall objectives of Coordinated Entry also appears to correlate with their agreement with the objectives of each of its three primary system components (the 211 system at 0.800, VI-SPDAT at 0.760, and Community Queue 0.750). These patterns indicate that users' approval of Coordinated Entry's operational impact parallels, and is possibly driven by,

their agreement with its broader purpose and conversely, that vocal disdain for its impact on providers could result from larger philosophical objections to HUD's rehousing strategy.

Meanwhile, respondents' perceptions of the overall and provider-specific effectiveness of Coordinated Entry correlates with their reported understanding of the 211 system, VI-SPDAT and Community Queue at 0.819, 0.730 and 0.730, respectively, indicating that greater education on Coordinated Entry's individual tools, in addition to their outright performance, may drive user opinion of them. This relationship suggests enhanced training on these functions could improve public opinion of them and, based on the sum of its parts, Coordinated Entry itself. This relationship also aligns with comments by interviewees, who often cited firsthand experiential knowledge of Coordinated Entry and its components to support their positive opinions of them.

Additionally, respondents' agreement with the amount of providers' staffing resources consumed by Coordinated Entry correlates with that of technological resources at 0.893, suggesting that Coordinated Entry's staffing and technological resource demands may be causally related. Respondents' reported level of enjoyment in using Coordinated Entry also correlates with their agreement on the amount of technological resources it consumes at 0.876, suggesting that organizations' technological facility could be key to bolstering staff morale regarding the system overall. Many interviewees reflected this possibility as well, often tying their greatest complaints regarding Coordinated Entry implementation and staff involvement to the steep learning curve and costs associated with its technological aspects.

The impact of existing negative sentiments regarding Housing First and/or Coordinated Entry on survey results represents an important limitation of the correlational relationships provided. Some respondents work for providers that foster strong oppositional sentiment towards Housing First and/or Coordinated Entry among their employees and opt not to participate in regional Coordinated Entry efforts. As a result, these respondents may have answered questions without specifically considering their prompts, possibly skewing (either by increasing or decreasing the strength of) observed correlations. Additionally, a specific limitation of results that correlate understanding levels with other responses is the inherently subjective nature of self-reported understanding; respondents' introspective appraisal of understanding may vary due to psychological and emotional factors outside the scope of this study.

6. Recommendations

If money were no object, the perceived weaknesses of Coordinated Entry identified herein suggest that the vast majority of users' concerns could be addressed through the creation of ample affordable housing to meet the needs of the Community Queue's entire index of participants and through the provision of adequate Connect to Home staff to eliminate 211 wait times and turnaround periods. These improvements would address users' primary objection to Coordinated Entry: the apparent stagnancy and unresponsiveness of the system's "waiting list." In the context of limited public and private funding resources, however, this simplistic solution is unrealistic.

6.1 Regional Improvements

To respond to the most pronounced criticisms of Coordinated Entry as revealed by 67% of interviewees and many survey respondents, system improvements should enhance the speed and agility of the 211 and Community Queue processes for system participants. A possible solution could be enhanced centralization of the Community Queue follow-up process, which currently requires every provider to tediously contact each participant listed in HMIS in order of priority repeatedly, gradually moving through the queue until successfully filling a vacancy. Instead, a single, centralized placement manager (or team) could both receive information regarding providers' vacancies and facilitate communication with and assignment of participants to these vacancies. The costs of such personnel, shared among subscribed providers, could be outweighed by the savings generated through lessened FTE (full-time employee) hours (and, based on correlated survey results pairing the two, technology costs as well) spent on Community Queue access and management. The aforementioned correlation of human and technological burdens suggests that this approach might produce a parallel offsetting reduction in technological costs as well. Relinquishing individual providers from this responsibility could also eliminate required staff training and expensive licensure involved in HMIS utilization, addressing a concern emphasized by one interviewee and further offsetting the costs of centralized personnel. From a non-financial standpoint, this staffing model could also encourage greater system participation from providers whose aged operational structures and/or personnel are presently averse to the software-driven nature of HMIS. The autonomy of centralized participant assignment would also ensure the equitable nature of Coordinated Entry's

prioritization, a benefit of the system referenced by 56% of interviewees. Such centralization could reduce the redundancy of "double entry" for organizations that continue to maintain their own participant tracking systems.

Another opportunity to enhance the turnover speed of both the 211 system and the Community Queue could be the provision of information on self-resolution resources to 211 callers prior to administration of the VI-SPDAT. Equipped with new options for resolution, participants may instead be encouraged to abandon their call, in turn freeing up the 211 queue and reducing the quantity of individuals unnecessarily or erroneously processed onto the Community Queue. With fewer participants entering the Community Queue in the first place, those with fewer alternatives may receive services more quickly. The modernization of the 211 call hold system to mimic those of modern corporate customer service centers could also improve its agility by offering automatic callbacks (to participants with personal phones) or scheduled times to call later in the day (to participants using public phones), scheduled in order of original call-in time. This approach could calm frustrations, expressed as comment field submissions by survey respondents, that 211 hold times are exorbitant without additional call center personnel. Because many participants utilize phones provided by providers, such call schedules would require alignment walk-in facilities' operating hours.

The aforementioned correlation of respondents' understanding of Coordinated Entry with their perceptions of its effectiveness also suggest that improved public awareness of Coordinated Entry's nuances could improve its overall approval among users across providers. Conversely, this correlation also suggests that some, although certainly not all, of Coordinated Entry's negative reputation is unfounded. Possible strategies for improving public opinion of the system could include enhanced public relations efforts (e.g. published profiles of Coordinated Entry "success stories") and the incorporation of required online trainings that detail the structure and effectiveness of Coordinated Entry into renewal processes for government licenses required by social service providers' staff.

6.2 Federal Improvements

Another strategy that could expedite the rate of turnover on the Community Queue could be a federally-funded stipend model for organizations that do not otherwise participate in Coordinated Entry. Operated on a per-bed basis, this program would offer a modest one-time financial stipend to providers who bypass their aversion to the Housing First model by facilitating the placement of a participant into their or their partners' housing. This mechanism could encourage some providers otherwise unwilling to commit the technological and financial resources of "buying in" to Coordinated Entry or undergo an ideological adjustment around Housing First to facilitate some of Coordinated Entry's operational objectives for a cash incentive (which, to the benefit of HUD's broader rehousing objectives, would likely be deployed to housing-related programs anyway). Hence this stipend structure could accelerate turnover on the Community Queue and alleviate frustrations around its efficiency without requiring HUD to sacrifice its adoption-for-funding mandate. This strategy could also have the long-term effect of exposing otherwise-disinterested providers to Coordinated Entry and enhancing their understanding of the system which, as demonstrated by aforementioned correlations of understanding and support, could strengthen their perception of Coordinated Entry and Housing First and, ultimately, elicit their participation.

45% of interviewees raised concerns of users' mental health, meanwhile, attributing these challenges to users' experiences rejecting homeless individuals that walk into their provider's site but must be dismissed despite available resources due to HUD-mandated adherence to Coordinated Entry's prioritization model. To alleviate the emotional stress and prospective burnout of this experience on a recurring basis, HUD could provide an "exception" allotment to providers, allowing them to fill a predetermined small percentage of their vacancies through methods unrelated to Coordinated Entry. In doing so, users that encounter particularly dire situations could utilize some services at their disposal to assist afflicted individuals, ensuring the emotional reward that often drives their career choice. According to 78% of interviewees, this "bending" of the rules prescribed by Coordinated Entry occurs at numerous providers anyway, so this policy adjustment would reflect an implicit best practice across the sector.

Another concern raised by users refers to non-Lehigh Valley residents' inappropriate participation in the Lehigh Valley's Coordinated Entry System. These individuals, according to one interviewee, travel to the Lehigh Valley to join the Community Queue of a less-populous region with fewer system participants in the hopes of receiving services faster than in their home regions. Because HUD allocates funding according to the results of an annual Point-In-Time (PIT) Count of findable homeless persons, providers' additional cost burdens driven by these outsiders go unmatched by grant funding. This shortfall in Coordinated Entry's design could be addressed through improved integration of neighboring regions' "Community Queue" access permissions in HMIS and by enabling users to assign participants to external queues attached to their region of residency. Accompanied by requirements for proof of residency where possible, participants could then be placed on queues consistent with where they were "counted" and thus where HUD has allocated hypothetical funding dollars for their services. A similar strategy to accomplish this objective could be the inclusion of residency verification in the VI-SPDAT and the award of greater prioritization to participants that

provide a predetermined form of residency proof. As a short-term measure, providers with outstanding waiting lists from years prior to Coordinated Entry's implementation or a record of previous program participants who have relapsed into new homeless situations could be permitted to independently exhaust these lists under a "grandfather" agreement, as these participants are more likely to be current residents of the same region as those providers.

Another results-based opportunity to improve Coordinated Entry could be adjusting HUD policies to allow providers to specialize according to areas of particular programmatic strength. Many interviewees described difficulty aligning the VI-SPDAT's rigid prioritization mechanism with their particular provider's areas of traditional strength. For example, the executive of a provider that serves only female victims of domestic violence described difficulty contributing value to Coordinated Entry's broad objectives during regional meetings because of her provider's disparate operational parameters. In another case, the executive of a provider that does not participate in Coordinated Entry because of his philosophical objections to Housing First expressed his disappointment in the system's constraints and willingness to involve his provider if its Housing First compliance requirements were relaxed. If HUD policy were modified such that each provider could set specific criteria for eligible participants that matched the skills and infrastructure of their traditional programming, Coordinated Entry could match participants to providers whose strengths fit the participants' particular needs and willingness to pursue certain program options. Much like the fundamental economic understanding that production is most efficient when firms produce according to their comparative advantage, such flexibility would likely result in the more efficient (faster) housing of homeless populations.[21] For the first aforementioned provider, this would mean a direct conduit via HMIS that limits its intake to female victims of domestic violence, while for organizations like the second, this would mean a channel of participants who indicate willingness to participate in programs antithetical to Housing First (such as completing prerequisite personal wellness programs in order to receive housing). Although seemingly contrary to the vulnerability-based prioritization tenet of Coordinated Entry, this diversification according to specialties could more quickly distribute system participants into channels by particular needs and choices, moving them through the aggrieved "slow" housing queue towards faster. Furthermore, permitting a partial buy-in model of this nature could resolve some of the gripes of exclusion raised by presently non-participating providers and allow the region's system participants to benefit from resources that, even if conditionalized, would not otherwise be drawn into the system at all.

A likely objection to this model, as supported by the 56% of interviewees that emphasized the equitable nature of Coordinated Entry's prioritization as one of its most appreciated attributes, might posit that allowing providers to heavily modify criteria for participation in their programs would cause the most challenging system participants, who many interviewees point out as the most vulnerable, to be excluded from care. This is a valid concern that might be overcome through restrictions on acceptable criterion and continued use of the prioritization model among participants within each provider's criteria-screened "sub-queue." That being said, the equitable focus of Coordinated Entry raises a substantive ethical question in this vein beyond this paper's scope, which asks whether a provider's contribution of fixed resources to the successful housing of more, "easier" cases of chronic homelessness provides more or less social benefit than the provider's contribution of the same fixed resources to successfully housing fewer, "harder" cases.

6.3 Areas of Further Study

The outcomes of this research provoke a number of suggested further research questions that could address new topics, explore discrepancies, and discover new possibilities related to Coordinated Entry. These proposals include studies centered on adjusting for some of this study's design oversights, psychological responses to VI-SPDAT adjustment and landlord marketing, and financial modeling around centralized queue management and provider resources.

Some of this study's survey respondents may be baselessly biased against Coordinated Entry due to their provider's disengagement with the program or its underlying philosophy. To adjust for their responses' distorting effect, a future study should replicate the survey herein and solicit responses only from the staff of participating providers. This exclusion would isolate the perceptions of Coordinated Entry maintained by those who regularly engage with it. Also worth further study is the precise bases on which certain respondents are biased against Coordinated Entry and what, if those respondents' bases are attributable to misunderstandings, are the sources of those misunderstandings in order to inform possible opportunities for enhanced provision of Coordinated Entry information.

A future study should also repeat the basic research design of this study but initiate interviews and surveys with detailed information differentiating Coordinated Entry from Housing First. Numerous criticisms expressed by interviewees regarding Coordinated Entry in this study were seemingly unresponsive to questions regarding the effectiveness of Coordinated Entry itself and instead focused on the philosophical legitimacy of the broader Housing First model. Although these responses provided valuable context to those interviewees' other answers, future

questioning could more intentionally focus on interviewees' perceptions of Coordinated Entry alone and better encourage interviewees to temporarily disregard their beliefs around Housing First.

An important area of study that could alleviate many respondents' concerns around the effectiveness of 211 could adopt a psychological nature, testing the responses of homeless individuals to particular phrasing and syntaxes of questions within the VI-SPDAT. Results from this examination could inform modifications that would improve the accuracy of the questionnaire's prioritization output and better exclude individuals that are inappropriate to a particular region's queue (e.g. those from other governmental jurisdictions).

A study that could enhance the effectiveness of Coordinated Entry by expanding the available supply of housing could carry out semi-structured interviews with landlords throughout a given region to evaluate the factors behind their perceptions of subsidized tenant housing (i.e. taking in "Section 8" tenants). The same study could also test their impulsive responses to specific marketing materials and strategies around low income housing, informing possible strategies for future relationships between landlords and social service providers in search of additional housing stock.

A future study could also develop a financial model that identifies, using actualized and opportunity cost estimates, the hypothetical region-wide and provider-to-provider cost savings or burden generated by consolidating Community Queue management to a centralized employee or team as discussed. This study could identify the appropriate cost distribution among agencies that would maximize financial incentive for participation while minimizing incremental cost burdens borne by each.

To further illuminate the nature of the burden represented by providers' "staffing" or "technological" resources consumed by Coordinated Entry, a future study could monitor and categorize how staff spend their time interacting with Coordinated Entry. Possible categories of time usage could include technological support, follow-up calls to system participants, system training, and data entry into HMIS, the totals of each of which could be summed to identify the makeup of aforementioned resource burdens and inform the greatest opportunities for further efficiencies. A similar study could also quantify, in dollars, the incremental costs generated by Coordinated Entry's additional mental health impacts on providers' staff, which could include healthcare costs, turnover-driven training and transition costs, and lost labor hours due to reduced productivity, among other components.

Future studies could also examine the impact of providers' opt-out decisions within a region like the Lehigh Valley and evaluate their exclusion's impact on the region's available HUD funding and program effectiveness. A particular subtopic of interest is the potential disruption (or lack thereof) that excluded providers have on the vulnerability-based prioritization of the Community Queue and whether this strategy is circumvented by participants that independently utilize agencies who lack access to HMIS, in turn affecting Coordinated Entry's apparent performance.

One survey respondent commented without further specification that the VI-SPDAT is racist. A future study should test this claim through statistical analysis of VI-SPDAT prioritization placement results to ascertain any disproportionality between the racial makeup of those who are administered the questionnaire and the racial distribution of those who are thereafter admitted onto the Community Queue.

7. Conclusions

This study aimed to ascertain, through the qualitative and quantitative census of its primary users in the Lehigh Valley, the benefits and detriments effected by the Coordinated Entry System on social service providers. Overall, results suggest that although Coordinated Entry and its underlying principles are generally supported by its users, some of the system's mechanics and policies warrant modification to maximize the system's potential and minimize harm on social service providers. These adjustments range from regional measures, such as technological upgrades and staffing centralization, to changes at the federal level, like improved interconnection of regional systems and expanded flexibility afforded to providers. Importantly, this study also unearthed the role that misunderstanding and broader philosophical misgivings play in driving popular negative sentiment around Coordinated Entry.

At first glance, many of the recommendations herein appear bureaucratic and, perhaps, mundane. The ramifications of their implementation or dismissal, however, are from it. Each suggestion, whether for system improvement, policy adjustment or further study, prospectively carries the weight of consequence for Americans' almost 100,000 chronically homeless neighbors.[23] While discussion of system efficiency and effectiveness elicits a sense of detachment, the immediate improvement of those precise qualities could mean the difference between a night with shelter and a night without for thousands of individuals. In that spirit of common urgency, it is pivotal that these learnings be considered and acted upon with haste. Our neighbors need our help.

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