



Incorporating Medical Complexity into Coordinated Entry: Findings from the Healthcare Feedback Forum & Beyond

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Agenda

- Foundationals
 - What are we solving for?
 - A Primer on Coordinated Entry
- Methods
- Findings
- Recommendations
- Implementation Notes
- Discussion & Questions



Foundational



50

The average age of death for a person experiencing homelessness in our community.

What are we solving for?

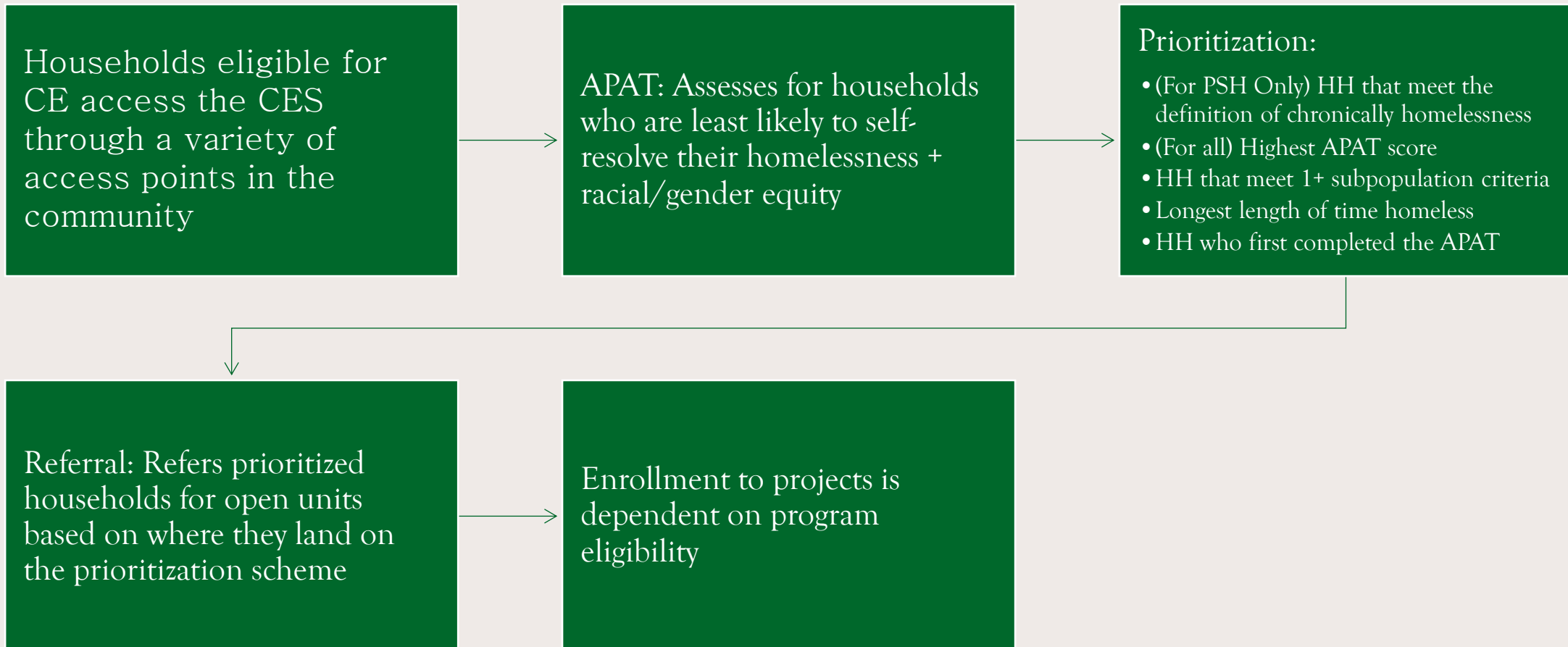
Today we bring you strategies to reduce avoidable suffering and early death in our unhoused community.

- We have learned that of the 1,010 people who died unhoused between 2018 – 2023, the median CA score was a 10, well below housing referral thresholds.
- While our CA includes a health domain, most of its questions—7 of 10 questions, representing 5 of 7 possible points—were [adapted from the VI-SPDAT](#).
- The result is a cycle of harm – of folks who are invisible within our HRS and cycling through ERs, jails, and the streets.



Coordinated Entry System Flow: A Primer

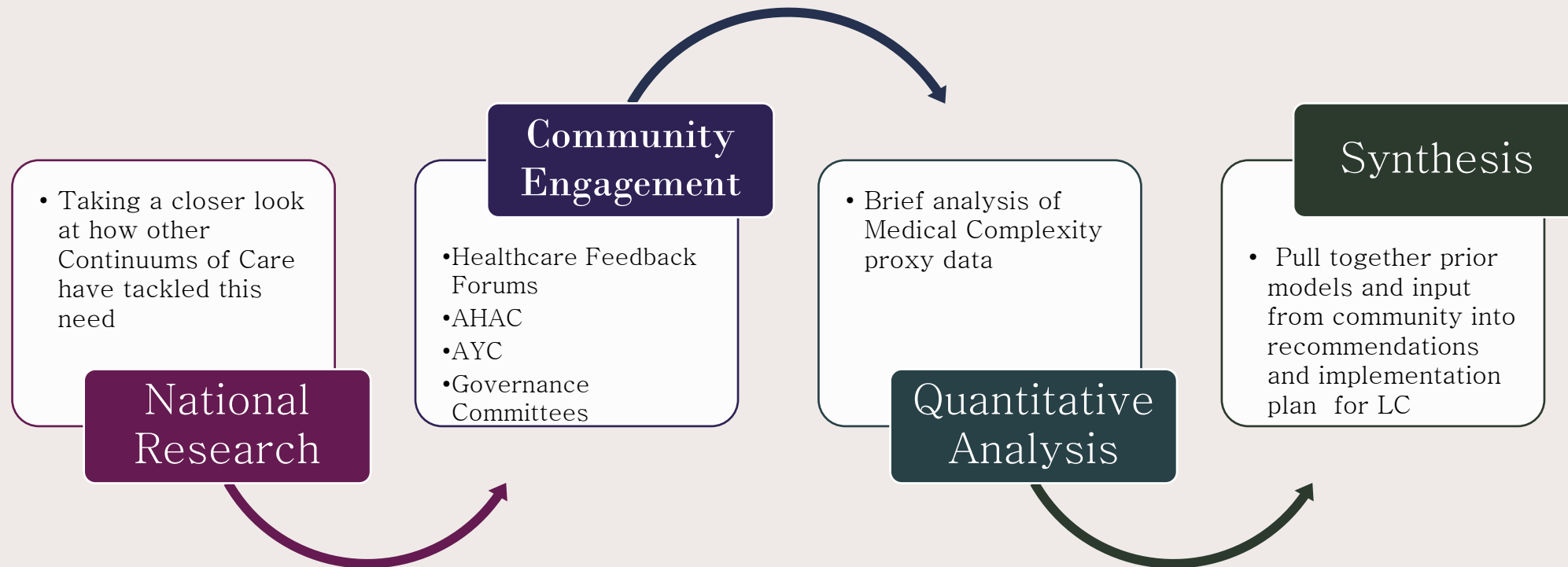
There must be alignment across every step of this process for there to be success.



Our Methods



Scope of Work: Identify the best way for our community to incorporate medical complexity into Coordinated Entry



National CoC Research

Hennepin, MN

Sonoma County,
CA

North Colorado
CoC

Ft. Worth, TX

Houston, TX

Chicago, IL

Louisville, KY

Maricopa, AZ

Tucson, AZ

National
Healthcare for
the Homeless
Council

University of
Houston

UnitedHealthcare

Healthcare Feedback Forum Partners



viventhealth



The University of Texas at Austin
Dell Medical School



ASHwell



SOBERING
CENTER
SERVING AUSTIN & TRAVIS COUNTY



VA



U.S. Department
of Veterans Affairs
Veterans Health
Administration



Texas Harm Reduction Alliance



StDavid's | SOUTH AUSTIN
MEDICAL CENTER

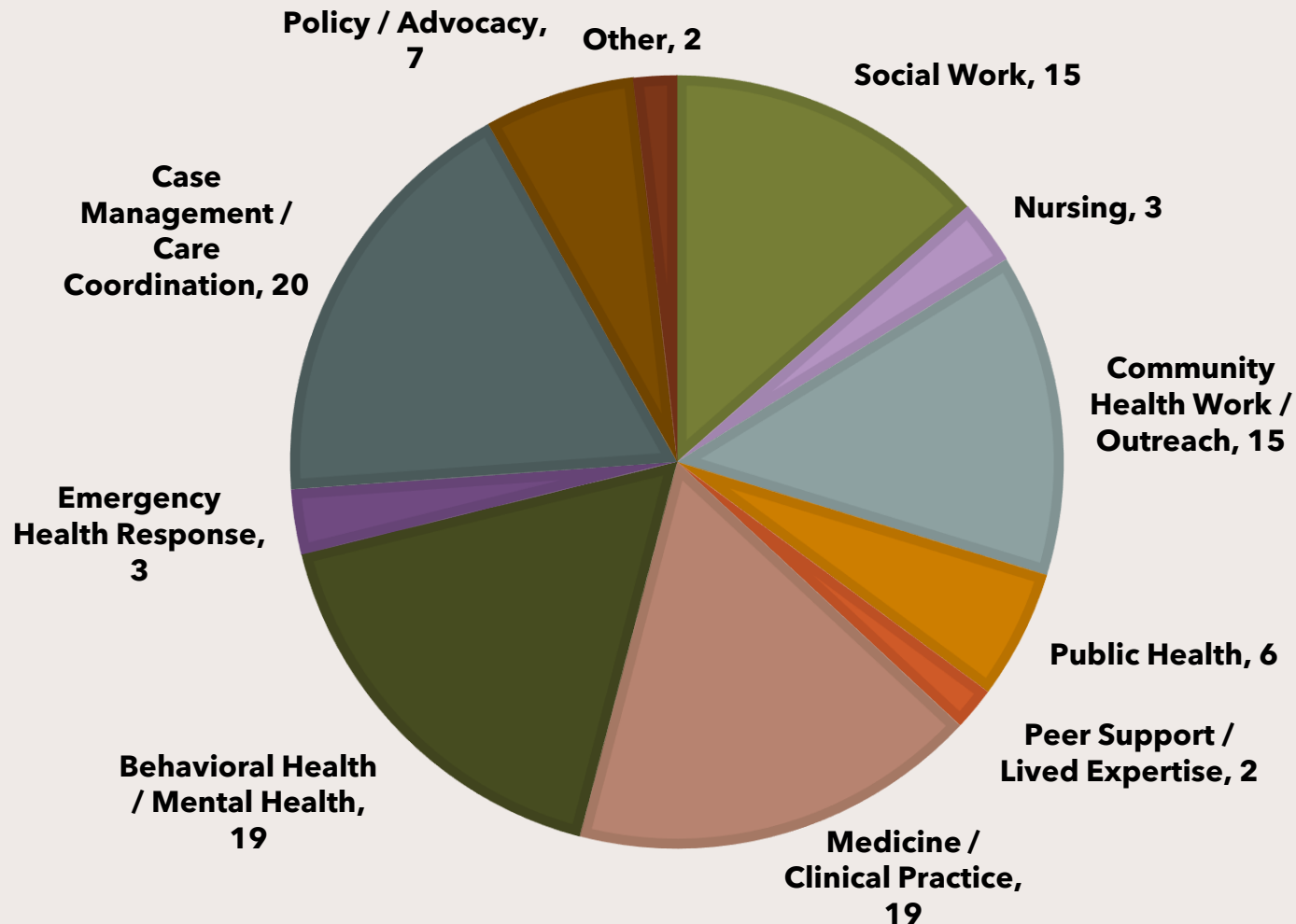
Ascension
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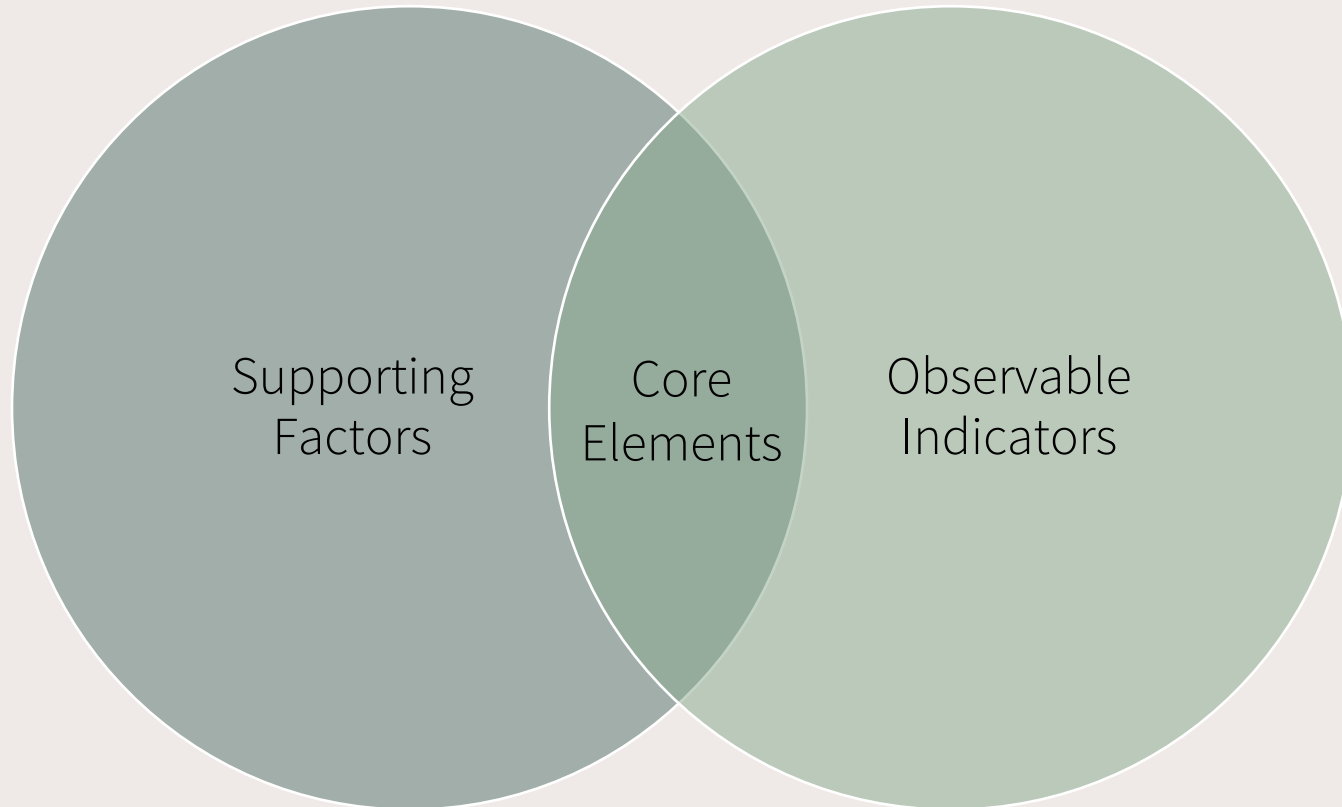
Healthcare Feedback Forum: Sessions Outline

WHAT LENS DO YOU BRING TO YOUR WORK?



- Session One: Setting the Foundation
 - CE Primer & Brainstorm Exercises
- Session Two: Building the Definition
 - Introduction of framework
- Session Three: Applying the Definition to Coordinated Entry
- Session Four: Refining Policy Recommendations

The Core / Supportive Factors/ Indicators Framework



- **Core (Essential) Elements** = must be part of the definition (the essence and heart of medical complexity).
- **Supporting Factors** = Factors that often accompany, but do not define, medical complexity on their own. These actors add nuance and describe risk patterns.
- **Observable Indicators** = measurable signs or data points that *reflect* complexity, but aren't part of the definition itself.

Our Findings





CoC Research Findings

Strategy Type One: Formal Review and Case Conferencing

- Sonoma County, CA
- North Colorado BoS
- Louisville, KY
- Fort Worth, TX

Strategy Type Two: Assessment Tool Redesign and Medical Acuity Integration

- Chicago, IL
- Hennepin County, MN
- Maricopa County, AZ
- Tucson, AZ

Strategy Type Three: Data-Informed and Cross-System Prioritization

- Houston, TX



Healthcare Feedback Forum Finding: Session One Findings

What does Medical Complexity Look Like to You?

<p>End-Stage/Severe Chronic Conditions/Organ Failure/Risk of Death</p>	<p>Contributing/Supporting Factors</p> <p>Age; Chronicity/Time Homeless ; Safety ; Insurance coverage ; lack of a support system ; quality of life; Difficulty controlling with current meds/meds stolen while unhoused. / Ability to secure medications; Meds that require refrigeration; LAIs;</p>	<p>Formula to Complexity</p> <p>Higher priority for folks with multiple conditions ; Chronic medical + psych + SUD ; 2 or more chronic medical conditions with risk of decompensation; Medical conditions including mental health, etc</p>	<p>Activities of Daily Living (ADLs)</p> <p>Inability to perform ADLs, incontinence, continued need for PT/OT/nursing care, Need for wraparound services (e.g nursing support, medication management, case coordination) to maintain housing stability</p>
	<p>Disabilities with Devastating Impact on ADLs</p> <p>Amputation; blindness; dementia; mobility issues ; paralysis ; spinal cord injuries; acute accidents resulting in reduced ADLs ; TBI ; IDD</p>	<p>Mental Health Needs</p> <p>un/undertreated mental health illness/ mental health / psych complexity / schizophrenia, acute psychiatric symptoms such as psychosis or catatonia, inability to consent to treatment</p>	<p>Health/ Systems Utilization</p> <p>Re-hospitalized within three months for the same issue ; utilizing the most resources (legal systems mentioned); high hospital/ER usage, etc</p>
<p>Congestive Heart Failure, End Stage Renal Disease, Diabetes, Cirrhosis, Cancer, Risk of death, Stroke, HIV/AIDS, Palliative care</p>			



Healthcare Feedback Forum Finding: Session Two Findings

Individuals with medical complexity are those who...

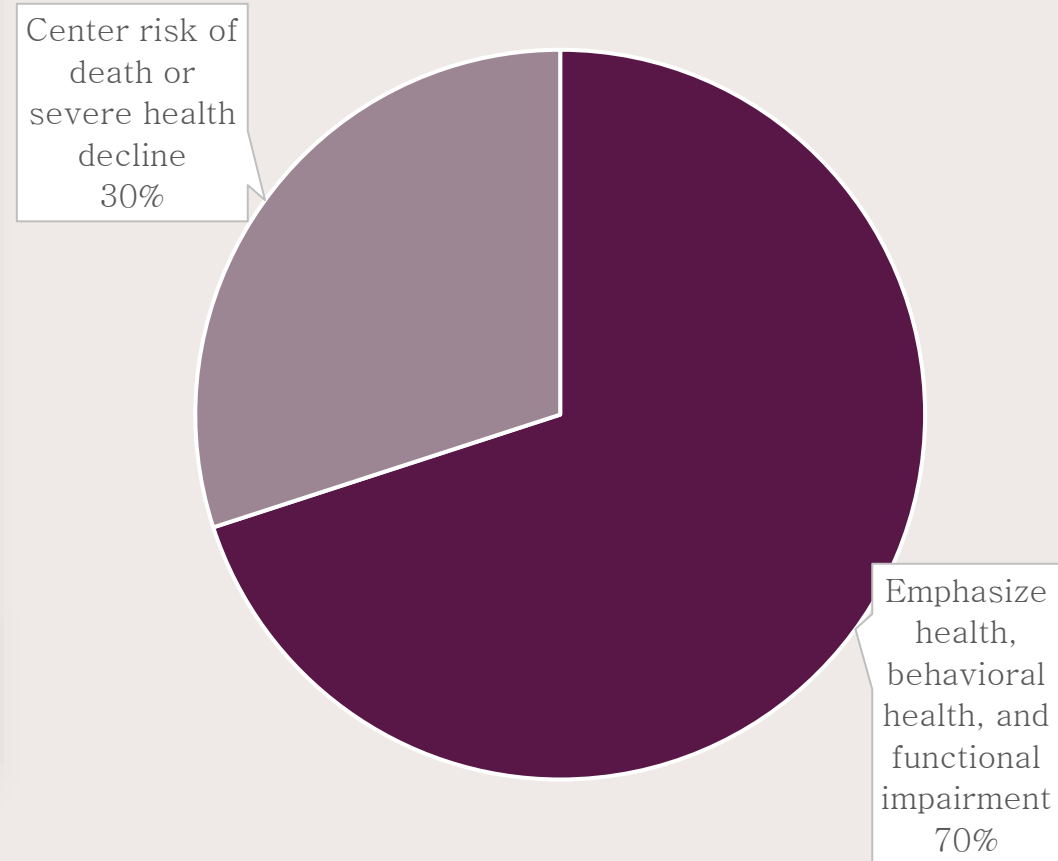
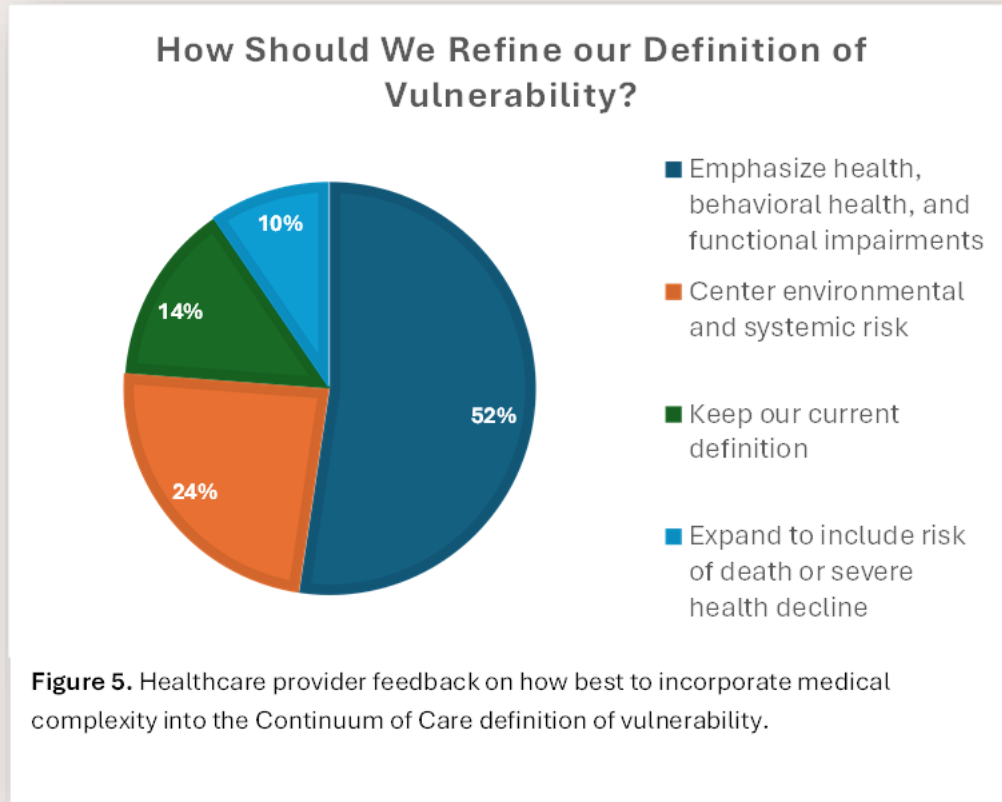
- Experience functional impairment caused or compounded by one or more **chronic, life-limiting, or serious health conditions** – including medical, behavioral health, or substance use disorders – with **elevated risk of decline** or death.
- Individuals *may* have **additional supporting factors that heighten vulnerability**. These should be screened for in Coordinated Assessment.
- Individuals *may* be identified through observable indicators in HMIS or other data systems, that can be used to triage and elevate needed care.





Community Findings: Our CoC Definition of Vulnerability

Governance: How Should we Refine our Definition of Vulnerability?



Community Findings: APAT Health Domain Feedback

Language is too Clinical, Vague, or Confusing

- Terms like end stage disease, brain issues, independent living, and avoid help are unclear and inaccessible.
- Questions often feel condescending, reducing comprehension and trust

Questions Rely Too Heavily on Medical Self Awareness

- Many individuals do not know their diagnosis, disability status, or the cause of their ADL limitations
- Mental health and substance use questions require insight people may not have, leading to widespread underreporting

Several Questions feel Stigmatizing, punitive, or Unsafe to Answer

- Questions on violence, substance use, and mental health can feel punitive or tied to police/psychiatric consequences.
- Individuals reported withholding information to avoid perceived risk to housing or safety.

ADLs Questions need Clearer Functional Framing

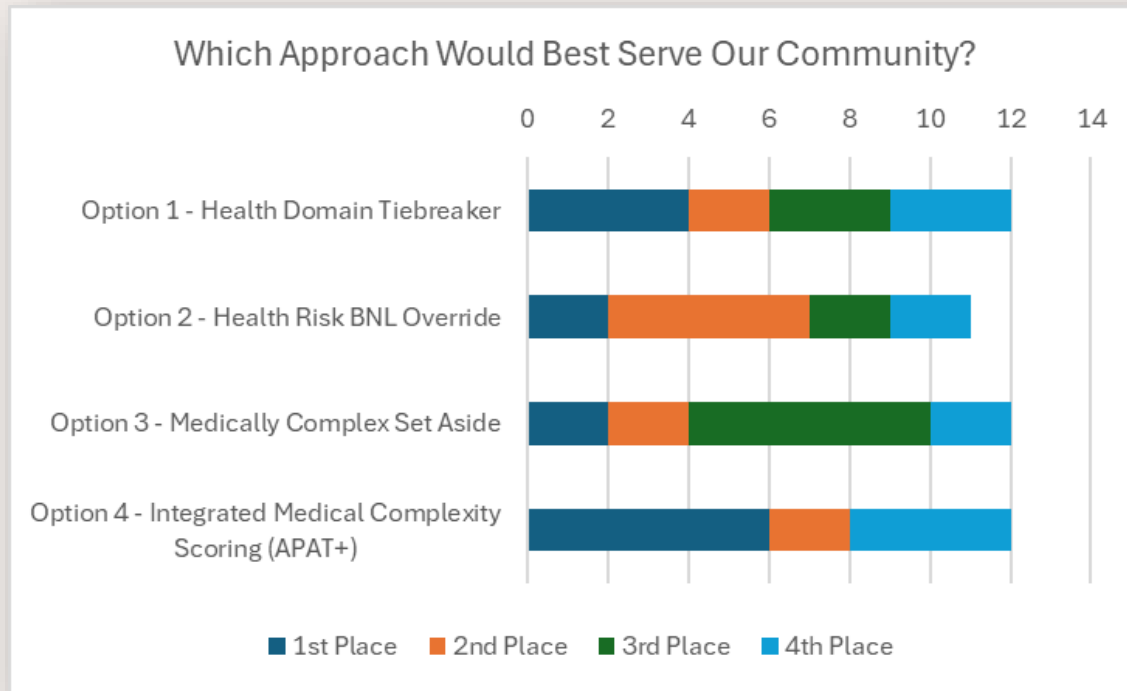
- People often do not realize ADL difficulties “count,” especially without examples.
- Stakeholders recommended explicitly naming assistive devices (wheelchairs, walkers, etc.) and concrete functional indicators.

Trauma-Informed, Culturally Competent Language and Better Assessor Guidance are Needed

- Questions should reassure people that answers **will not jeopardize housing**
- Assessors need clearer scripts and training in cultural competency, health literacy, and trauma-informed interviewing



Community Findings: Prioritization



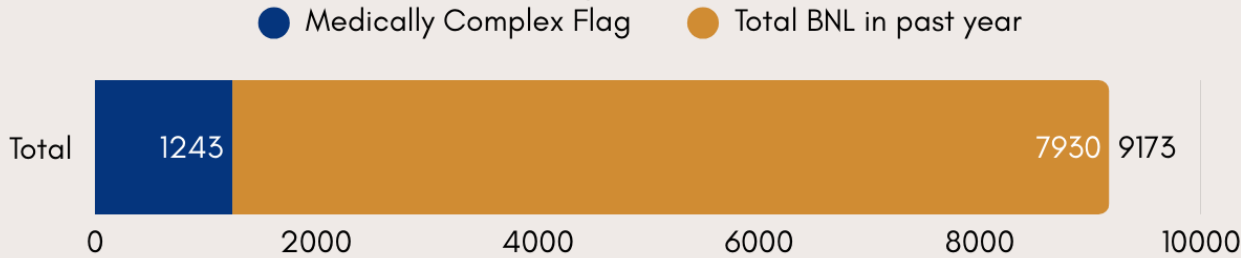
Healthcare Provider feedback. APAT+ was in first place, followed by BNL Override Policy.

- Governance Committees were tied in the approach they were most interested in: **APAT+** and the **Medically Complex Set Aside**, each 30% of top choice.
- AHAC was most enthusiastic by the **BNL Override Policy**:
 - *“Option 2 [BNL Override Policy] gives case managers power – this override does not exist currently.”*
 - *“Case managers have this information but can’t do anything with it.”*
- AYC was broadly supportive all of prioritization approaches but was most interested in combining elements of the **BNL Override policy** with **APAT+**.



Quantitative Findings: Medical Complexity Proxy (ADL + End Stage Disease Question only)

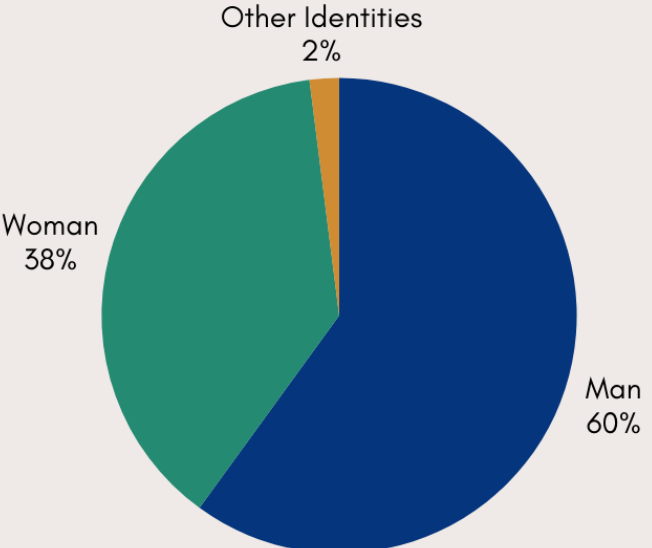
Total Prevalence of Interim Medical Complexity Flag on BNL (August 2024 - August 2025)



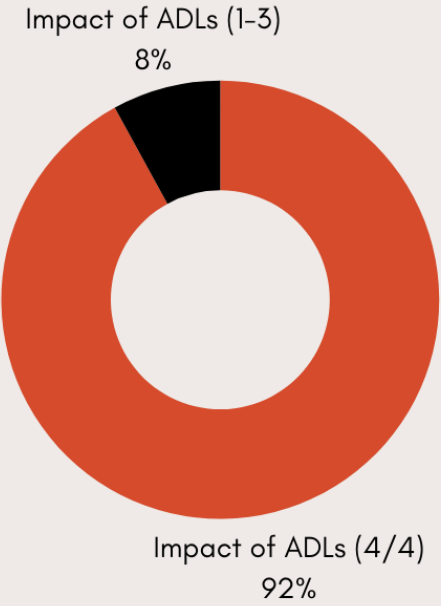
Average Age of those with Proposed Interim Medical Complexity Flag

51

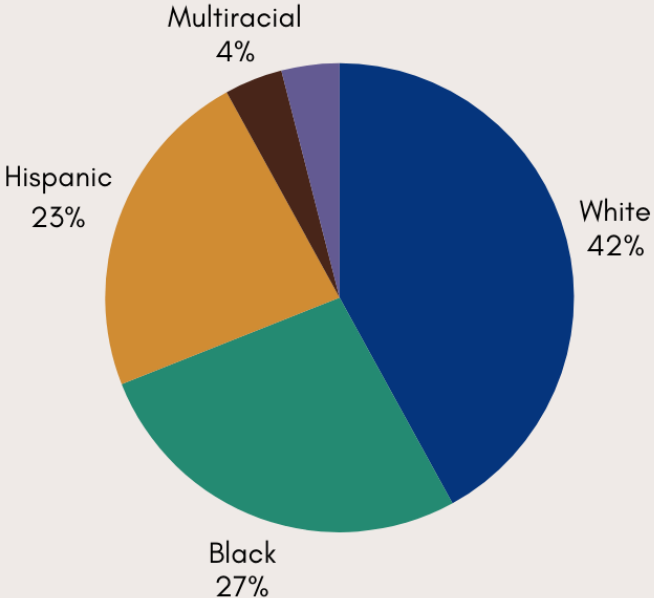
Proposed Interim Medical Complexity Flag by Gender



Proposed Interim Medical Complexity Flag by Self-Defined ADL Impact



Proposed Interim Medical Complexity Flag by Race/Ethnicity





Recommendations

*"This is what I've
wanted for seven
years."*

- AHAC Member

Policy Recommendation: Vulnerability

- To better identify and prioritize people who meet the definition of Medically Complex, the definition of vulnerability needs to be expanded to account for those with *high medical & behavioral health needs, functional impairments, and environmental and systemic risk.*
- Update our Community Coordinated Assessment Policy, which presently explicitly excludes CA from any attempt to triage by risk of death or identify acute health crises.

Proposed Definition of Vulnerability

Those least likely to self-resolve their homelessness without a formal intervention, especially those whose medical complexity or environmental risks make remaining unhoused unsafe or life-threatening.

Policy Recommendation: A New Coordinated Assessment

To better identify and elevate folks with medical complexity, CA requires substantial revision in the redesign:

- Replaces VI-SPDAT-derived items with trauma-informed, plain-language questions
- Incorporates all medical complexity elements currently absent from the CE (core and supporting elements)
- Establishes clear assessor guidance, scripts, and training requirements to ensure consistent, equitable administration.

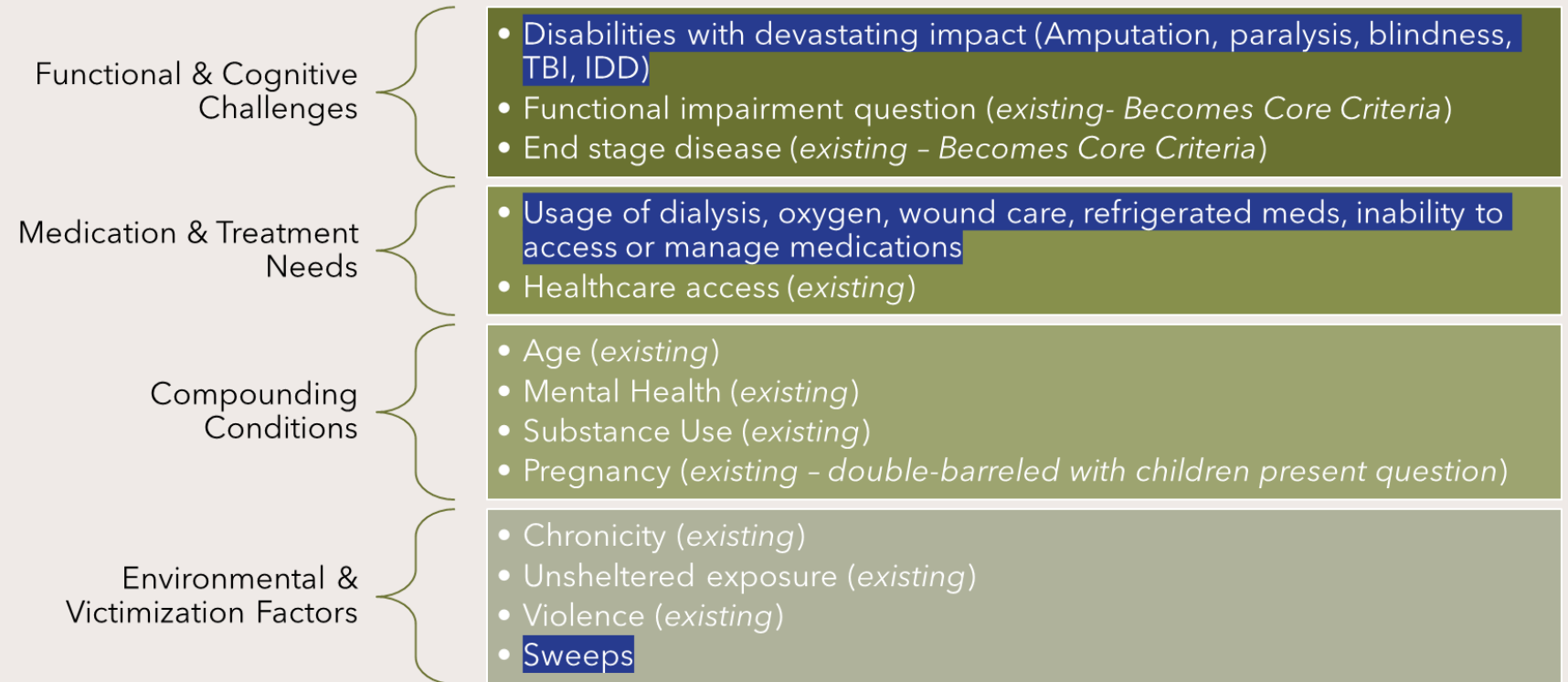


Figure 9. Breakdown of each of the Supporting Factors that are identified in our community definition of Medical Complexity. Areas in green are questions that exist already in present Coordinated Assessment, with elements highlighted in blue that are missing entirely. All questions must be evolved to be trauma-informed and add clarity.

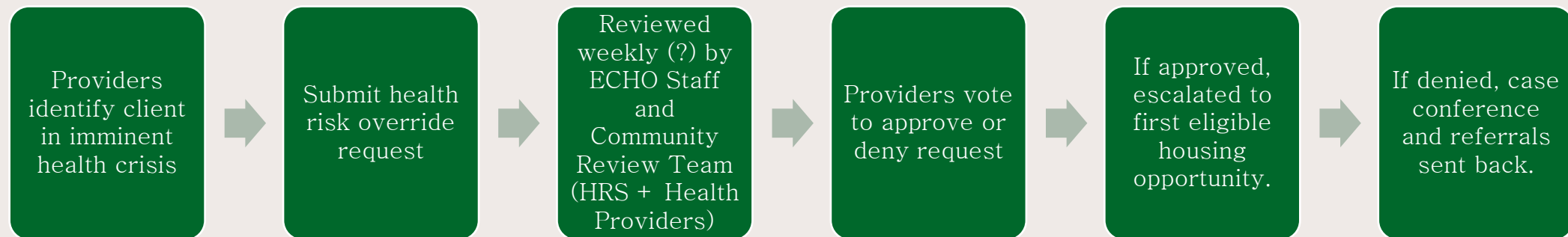
Prioritization Recommendation: Implement a Health Risk BNL Override Policy

Create a safety valve for acute health crises.

Summary: Introduce a process to temporarily elevate clients showing imminent health risk — for example, recent hospital readmits, inpatient hospitalizations, or verified clinical deterioration (illustrated below). A time-limited “override” (e.g., 30 days) triggers case conferencing or expedited referral review.

Impact: This is a life-saving housing connection for those who are clinically deteriorating and need housing in order to survive. Requires defined criteria and health-system communication but minimal CE rebuild.

Example: Client with new cancer diagnosis denied treatment without housing → temporarily rises to top of queue.





Prioritization Recommendation: Health Domain Tiebreaker with Medical Complexity Flag

Incorporate health data as a tiebreaker for PSH referrals.

This ensures that individuals with higher health risk rise when scores are otherwise equal. There is no change if both (or neither) of individuals have medical complexity.

Summary:

When households have the same total CA score, use a Medical Complexity flag as a tiebreaker after CA Score and Chronicity for PSH referrals. This flag should be in alignment with our community definition of medical complexity.

Impact: Adds a medical-complexity lens to prioritization without altering scoring or questions. Simple to implement, high feasibility.

Example:

Household A (CA 14 + No MC Flag) → lower priority

Household B (CA 14 + MC Flag) → prioritized for housing

PSH Prioritization:

- Households that meet the definition of chronically homeless
- Highest CA score
- **Health Domain Tiebreaker**
- Households that meet 1+ subpopulation criteria
- Longest length of time homeless
- Households who first completed the APAT

Prioritization Recommendation: Integrated Medical Complexity Scoring (APAT+)

*We create a data-informed and proactive housing-health lens within Coordinated Entry
(Supportive factors + Observable Indicators)*

- **Summary:** Coordinated Entry could integrate the **definition of medical complexity** directly into its workflow — screening for **core eligibility** in the CE assessment, weighting **supporting factors** that signal medical complexity.
- From there, we incorporate **observable indicators** (from health data like diagnoses, hospital readmissions, or crisis calls) into prioritization. Health partners could securely transmit this information to HMIS as a **numeric indicator** that enhances and informs prioritization.
- **Impact:** APAT+ strengthens our existing Coordinated Entry system by integrating verified health indicators into prioritization: **helping us act earlier, coordinate better, and save lives without increasing assessment burden.**





Policy Recommendation: Systems Alignment

Structural

- Align local government contracts with prioritization criteria
- Build a dedicated CE referral pathway to Emergency Shelter for Medically Complex individuals
- Enable data-sharing across housing + healthcare systems

Staffing

- Expand Health Care Collaborative Staffing & SOAR capacity
- Embed robust peer supports into PSH teams
- Cross train housing staff on medical complexity

Policy & Process

- PSH – to Skilled Nursing Facility/Long Term Care Transfer Protocol
- Pre/Post Referral Medical Case Conferencing
- Provider Input Form for Underreporting on CE

Future Planning

- Develop new housing types (Bridge Housing, LTC partnerships, Recovery Housing, Hospice)
- Pursue braided funded models

Provider Input Form

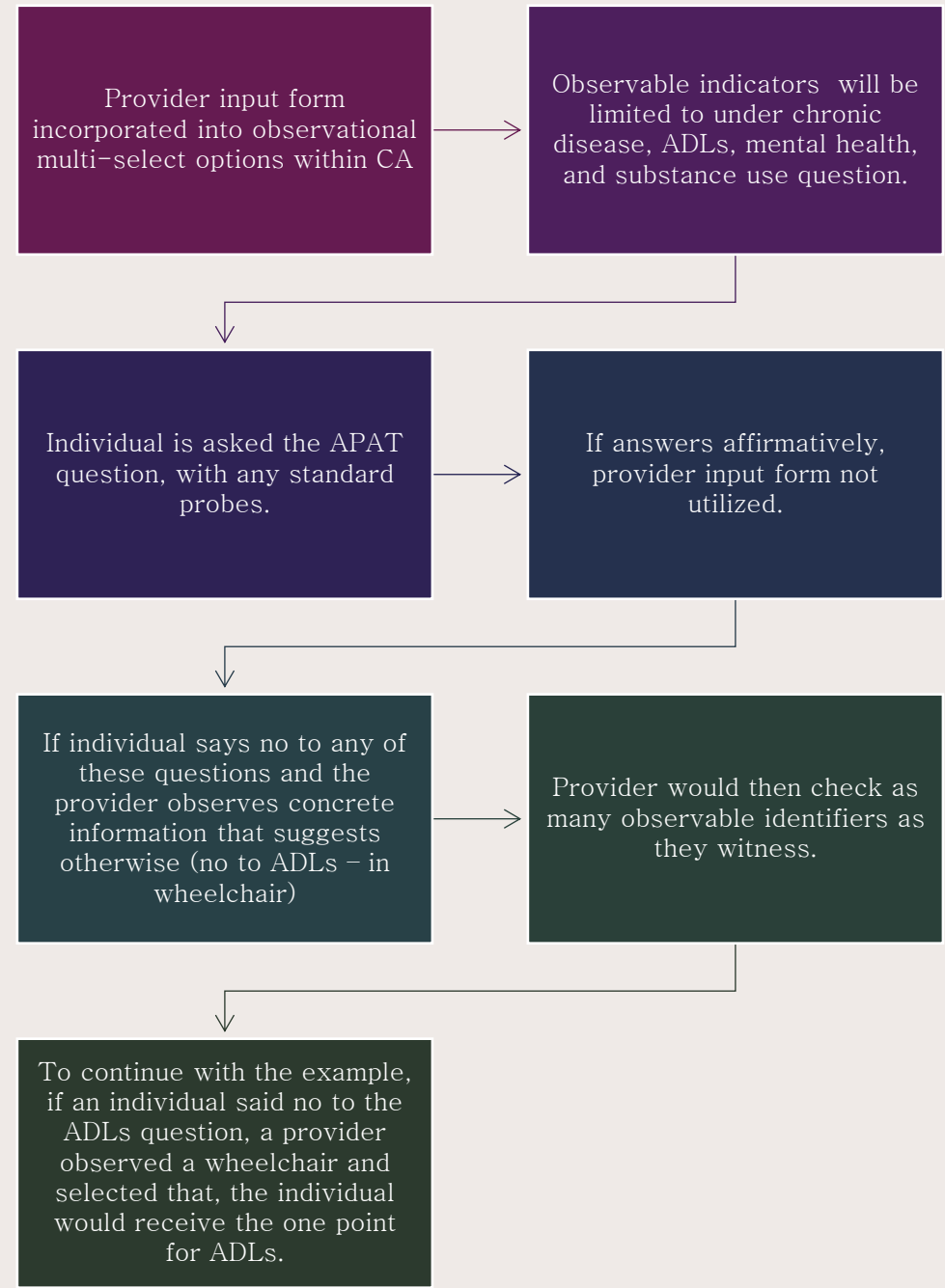
Recommendation: Support limited score adjustments within Coordinated Entry when documented health needs are not adequately captured through self-reported assessment responses.

Critically: An Assessor could only add one point to an individual's score based on *observable* health risk.

Provider input can only be used to **increase** a person's score (used only in cases of underreporting)

Only awards one point for each question (Maximum one point for each observable indicator, not additive: ADLs, Chronic Disease, Mental Health, Substance Use)

This form is drafted and welcomes feedback and review.



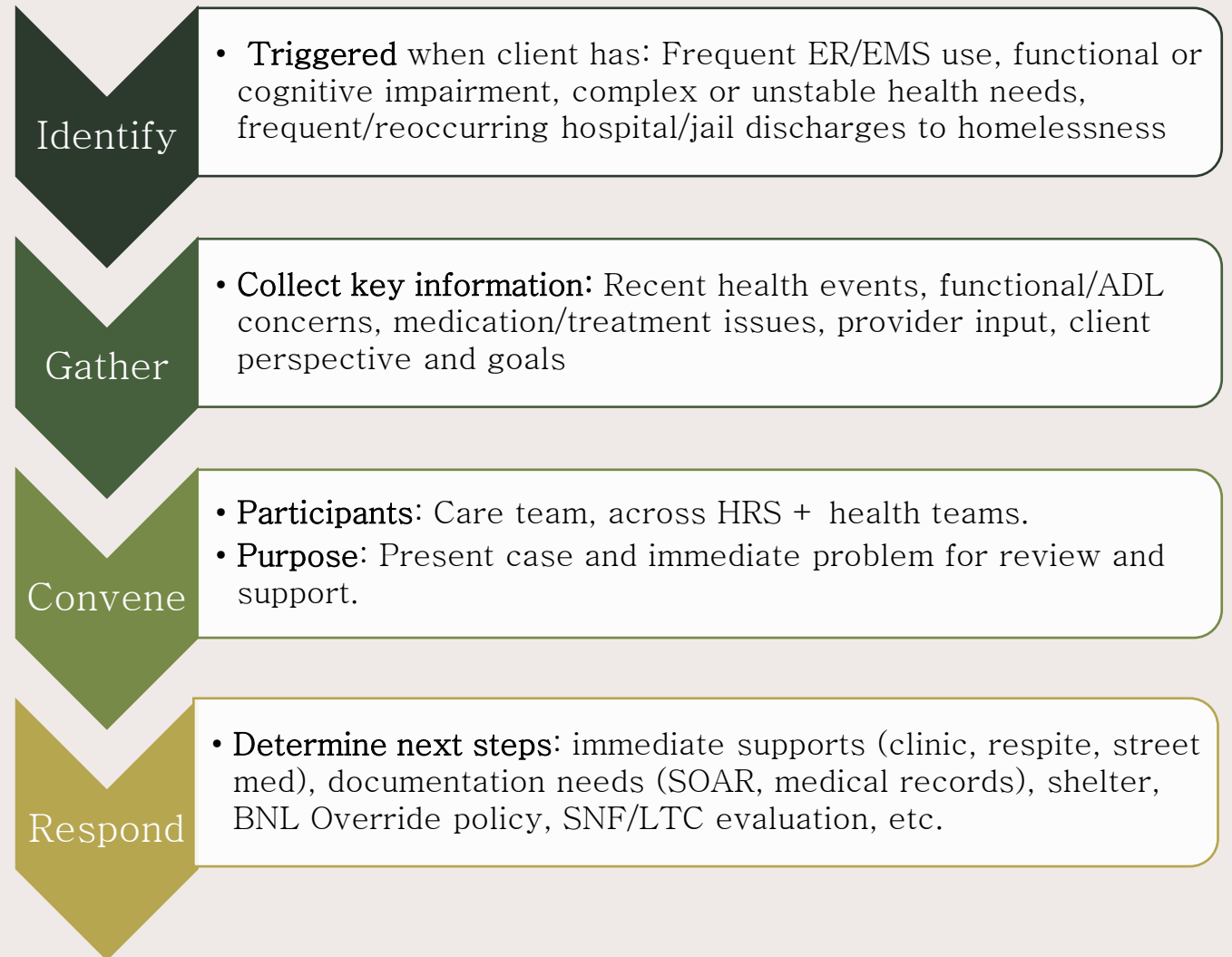


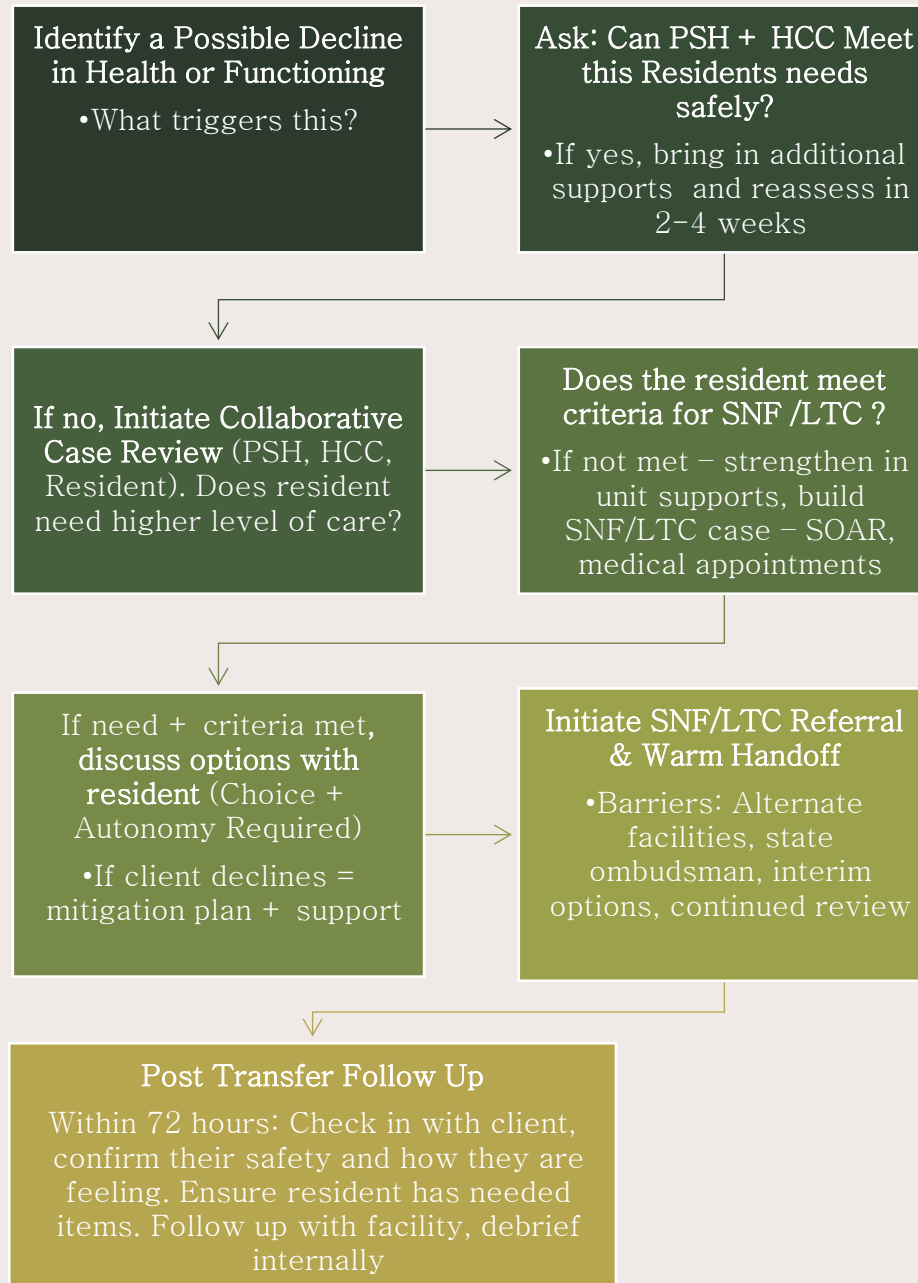
Medical Case Conferencing

Recommendation: Create a formal medical case conferencing mechanism that allows healthcare + outreach + navigation + housing providers to elevate high-risk cases that may not be adequately captured through existing assessments.

This process supports immediate intervention while also informing longer-term system design.

Piloting ~ June 2026 in collaboration with HSO's Outreach Team!





PSH to Skilled Nursing Facility/Long Term Care Transfer Policy

Recommendation: Develop a formal transfer protocol protects housing stability for Permanent Supportive Housing tenants whose medical needs exceed what PSH can safely provide.

This protocol will be developed in partnership with the Permanent Supportive Housing Health Care Collaborative and other supportive care teams that care for PSH residents.

Notes on Implementation





Integrating Medical Complexity into the Coordinated Entry Redesign

Medical Complexity as a Community Priority, not a Subpopulation

- Because medical complexity cuts across existing subpopulation categories and CE score ranges, it should be addressed as a **system-wide prioritization lens**, rather than as an additional categorical list.
- Redesign plans should demonstrate how medical complexity is surfaced and addressed across assessment, prioritization, and referral processes without creating a separate list or eligibility track.

Community Definition of Medical Complexity as a Design Foundation

- The community-validated definition of medical complexity—centered on functional impairment and elevated risk of health decline or death—will serve as **foundational input** for the CE redesign
- Redesign outputs should explicitly map how proposed assessment questions, prioritization logic, or referral workflows align with the core elements of this definition.

Assessment Design Requirements Related to Health & Function

- As new CE assessment tools or modules are developed, the redesign should ensure the consistent capture of the **Core and Supporting Factors** of the Medical Complexity Definition
- Question design should be trauma-informed, accessible, and grounded in lived experience rather than clinical self-diagnosis. See Appendix, Table 6 for prototype questions.

Incorporation of Medical Complexity Data into the CE SWOT Analysis

- Quantitative and qualitative data from the Medical Complexity project – including analysis and feedback from AHAC, AYC, healthcare partners, and governance bodies – must be intentionally incorporated into the CE SWOT analysis.

Integrating Medical Complexity into the Coordinated Entry Redesign

Medical Complexity Flag as a Persistent HMIS Attribute

- Individuals meeting the community-defined criteria for medical complexity will be assigned a **Medical Complexity flag within HMIS**. This indicator will function as a persistent attribute that can be updated over time as health circumstances change, rather than a one-time assessment outcome
- The Medical Complexity flag will support consistency and continuity across Coordinated Entry processes, including prioritization, referral, and evaluation.

Integration of Medical Complexity into Prioritization Logic

- Future CE prioritization frameworks should include clear mechanisms for surfacing and weighting medical complexity, including health risk as a differentiating factor among households with otherwise similar vulnerability profiles.
- Redesign documentation should specify where medical complexity is considered within prioritization decision points, including whether it functions as a tiebreaker, modifier, review trigger, or other structured approach.

Conditional Referral Pathways and Resource Matching

- As part of the CE Redesign, the Medical Complexity flag could inform conditional referral logic that supports appropriate matching to available interventions, such as PSH with enhanced supports, respite, recovery housing, LTC, or more.

Alignment with Systems Beyond Coordinated Entry

- The CE redesign should explicitly account for downstream system interfaces that affect medically complex individuals and develop a strategy for shared partnership and coordinated action, clarifying engagement needs and roles across housing, healthcare, and related systems



Questions?

Thank you!

Reach out anytime:

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